

Needs Assessment Report

- Abridged Version -

Work Package 4

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1. Introduction

1.1 Introduction of the project and Work Package 4 (WP4)

This Needs Assessment has been developed in the framework of Work Package 4 (WP4) of the Euregenas project “European Regions Enforcing Actions against Suicide” (Grant Agreement N° 2010 12 03) which is financed by the Executive Agency for Health and Consumers (EAHC) of the European Commission (EC).

The overall objective of the Euregenas project is “to contribute to the prevention of suicidality (suicidal ideation, suicide attempts, and suicide) in Europe through the development and implementation of strategies for suicide prevention at a regional level that can be of use to the European Community as examples of good practice” (Annex Ia).

More specifically, the project focuses on four different topics on which the needs assessment of WP4 is based.

- Firstly, the study aims at the development of technical specifications for an integrated model for e-mental healthcare oriented on suicide prevention.
- Secondly, the study aims to develop and to disseminate suicide prevention packages as well as awareness raising strategies for different targets (e.g. school, media, workplace) focusing on different risk-groups (e.g. youth).
- Thirdly, the study aims at an elaboration of training modules on suicide prevention for professionals.
- Lastly, the study has the goal to develop a tool supporting group facilitators to ensure an ongoing monitoring, to evaluate the group efficacy, and to adjust the management of the group.

The purpose of WP4 is to carry out a literature and good practice review as well as a needs assessment, both of which taking into account views and needs of different key stakeholders in all participating EU regions. This activity will provide a basis for the development of the Work Packages that are to follow.

The online library is already created and is available on the following internet link: <http://www.euregenas.eu/online-library/> (Online Library – Euregenas 2012).



1.2 Description of the data collection process

The structure of the present survey is cross national in specific EU regions.

In WP4, the data collection (selection of key stakeholders, needs assessment) was carried out by all partners who are included in the project. The project partners conducted the survey at a regional level or if appropriate at a local level.

Based on preliminary consultation with project partners and a profound literature review, a list of potential stakeholders was proposed (see Annex II). The stakeholders are divided into the following categories: Decision and Policy Makers (DPM), Mental Health Professionals (MHP) and persons from Non-governmental Organizations and Social area (NGO) whereby each stakeholder category includes different professional sub-categories.

Each partner was responsible for the ranking of the stakeholders (included in the list) based on the following three decision parameters (Gardner et al. 1986; Chinyio, Olomolaiye 2010):

- Power (dominant - dependent stakeholder)
- Dynamism (avoid negative effects, being proactive)
- Level of interest (in supporting suicide prevention, to reduce the number of suicides)

A detailed description of this procedure is included in the study protocol (see Annex II).

Three different questionnaires have been developed in accordance to the three categories of stakeholders and while some parts of the three questionnaires are similar, several paragraphs were adapted to the specific stakeholder category. The questionnaires include closed and open questions and the variables are mostly nominal and ordinal (Mayer 2008). The questionnaires are created in English and the project partners were responsible for the translation into their national language. Before the final use of the questionnaires, it was necessary to examine comprehensibility, manageability and consistency via piloting. Piloting is a key procedure to avoid inaccuracies in the data collection process (Geyer 2003). Each region was responsible for piloting the questionnaires in their national language (6 questionnaires: 2 of each stakeholder category). The comments and



suggestions of the piloting were taken up in the elaboration of the final questionnaires which are included in the Annex III-IV.

Each partner was responsible for sending out an adequate number of questionnaires per e-mail to stakeholders in their region in order to receive at least 30 completed questionnaires. A follow up was carried out to obtain the highest possible response rate. While one of the partners did not reach the desired response rate several partners reached a response rate of more than 30 questionnaires which were included into the analysis. At this stage the survey is not designed to be representative of the whole population of DPM, MHP and NGO of the participating research countries rather than focusing on the needs of the specific sample.

The following project partners of the mentioned regions (Table 1) joined the survey:

Table 1 Number of questionnaires by regions and stakeholders

project partner \ stakeholder	DPM	MHP	NGO	Σ
University Hospital Verona (AOUI-VR), Region Veneto - Italy	10	13	9	32
Research Association Public Health, Technische Universität Dresden (TUD), Region Saxony - Germany	9	9	12	30
National Institute for Health and Welfare (THL), Region Lapland - Finland	4	7	14	25
Romtens Foundation (Romtens), Region Bucuresti-Ilfov Region - Romania	10	19	3	32
Mikkeli University of Applied Sciences (MAMK), Region South Savo - Finland	3	14	17	34
Servicio Andaluz de Salud (SAS) & Fundación Progreso y Salud (FPS), Region Andalusia - Spain	9	9	12	30
Regional Public Health Institut Maribor (RPHIMB), Region Maribor - Slovenia	10	11	9	30
Flemish Agency for Care and Health (VAZG) & Unit for Suicide Research, University Ghent (UGhent), Region Flanders - Belgium	14	19	15	48
Region Västra Götaland (VGR), Region Västra Götaland - Sweden	10	13	8	31
Fundación Intrás (INTRAS), Region Castilla y Leon - Spain	7	38	15	60
Σ questionnaires	86	152	114	352

Within the following survey the names of the institutes simultaneously represent their respective regional arena as the results of the needs assessment refer to the data collection which was carried out on a regional level by the specific institutes.



1.3 Aims of the analysis

The central aim was to get an impression and overview of the “local needs” regarding suicide prevention in the participating regions. The views of the 3 different categories (DPM, MHP, NGO) were considered in the process. The analysis illustrates the basics for the next stages of this project. The results are meant to be a platform for development of the following: e-mental health model, suicide prevention packages, training modules for professionals and a tool for support groups. In the upcoming work packages of the project (WP5-8) the results of the needs assessment will provide a basis:

- to create e-mental health tool (WP5)
- to create a prevention package for the media, school and workplace (WP6)
- to create an effective training module for general practitioners (WP7) and
- to create a support tool for survivor groups (WP8).

1.4 Description of the statistical data analyses

Prior to the analyses presented here data cleaning was carried out using SPSS (version 19) in order to verify the structure of the dataset as well as the coding of the variables. In case a wrong coding was identified the corresponding value was replaced by the correct value whenever possible, otherwise it was removed from the dataset. Subsequently, data analysis was conducted using Stata. As the majority of research questions under consideration aim at assessing attitudes and needs of relevant stakeholders, the main part of this report relies on descriptive statistical analyses including the description of frequency distributions and the comparison of average values within and between stakeholder groups and regions. If applicable, statistical hypothesis tests like the chi-squared test are used in order to validate relationships and links between variables (Welkowitz et al. 2012).

A main drawback of the analyses presented here is the small number of observations (N=352). In some cases – particularly regarding the analysis of professional sub-groups such as staff from suicide helplines or staff of survivor support groups – the number of respondents was insufficient for analysis. Due to this it was not possible to shed light on every issue and to give answers to all questions of interest. In addition, the small sample size implicates that the obtained results have to be interpreted with caution since it casts further doubt on their representativeness. For that reason the findings reported here cannot be regarded as being



representative for the whole population; however they are representative for the respondents included in the sample. Being aware of these obstacles to the statistical analysis, we mostly abstain from using statistical tests aimed at making statements about the basic population, e.g. t-tests for differences in means. Instead we focus on the descriptive analysis of the data at hand.

1.5 Overview of the following chapters

The following chapters are organized in accordance to the structure of the questionnaires. According to “general information” evaluations of the “local networks” are carried out in each region. After that the report contains evaluations concerning “guidelines and toolkits for prevention”. Here the focus lies in the sectors of school, working life and media, followed by evaluations regarding “technology-based suicide prevention”. The main focus here is on the use of various web-based suicide prevention methods. The next step is in the form of listed questionnaire results in which the target group “general practitioners” is in the foreground. Lastly the reader finds Information on "survivor support groups" with focus on the development of an evaluation tool. The summary roughly describes the treated subject and contains a conclusion. Furthermore, only selected figures and tables were built-in into this report to make it clearer. The detailed analyzes are included in the annex.

2. Results of the Needs Assessment

2.1 General

2.1.1 Social-structural Characteristics

2.1.1.1 Please specify your gender, Please specify to which age group you belong

In this conducted survey the age distribution for all participating stakeholders was rather homogenous. Especially people between 50 and 59 participated as shown in Figure 1. The age distribution within each institution features small differences. In Belgium, mainly younger people (aged 30 to 39) participated in the survey whereas in Italy and Sweden the majority was over 59 years old, s. Table 34 in the Annex.

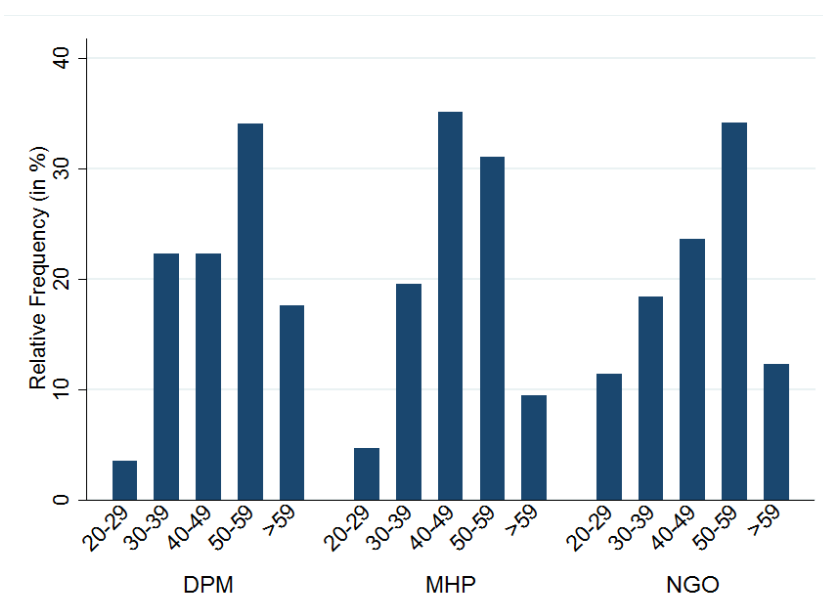


Figure 1 Age by stakeholder

Across all 3 stakeholder categories, the number of women participating in this study was higher (ca. 60%) than that of men (ca. 40%), s. Figure 2. However, there is an exception in Italy and Spain where these findings are reversed, s. Figure 53 in the Annex.

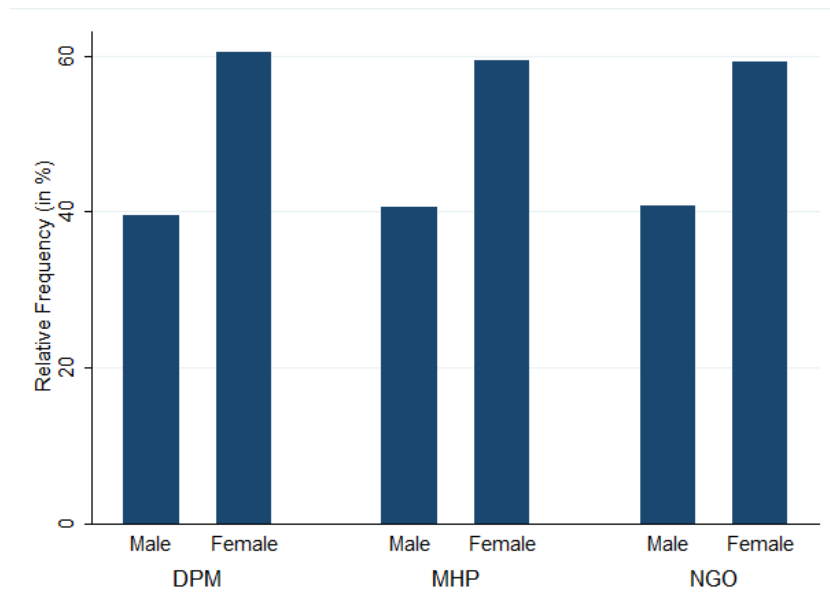


Figure 2 Gender by stakeholder

2.1.1.2 Please specify your professional sub-category

The participants of the survey can be grouped into various careers. In the NGO field most careers are represented in staff of NGOs, teachers, criminal justice stakeholders, social workers and suicide prevention workers, s. Table 35.

¼ of the respondents of the MHP division have a nursing background. Additionally a good number of employees of the inpatient psychiatry and general practitioners participated, s. Table 36. The field of DPM was mainly responded to by participants from the authorities divisions (39%) such as public health and education, s. Table 37. The detailed overview of each career can be seen in the Annex.

2.1.2 Suicide Prevention (SP) at Work

2.1.2.1 Please specify if suicide prevention is part of your job description

The 3 interviewed stakeholder categories are differently integrated in the topic of suicide prevention in their work. Figure 3 shows to what extent suicide prevention is part of the job description of the stakeholders. Almost 50% of the interviewed MHPs are confronted with suicide prevention in their job description and just as more than 30% of the NGO division is. The DPM division has the least contact with the topic of suicide prevention. More than ¼ of all participants definitely have the topic of suicide prevention in their job description; about 17% do not have this in their job description.

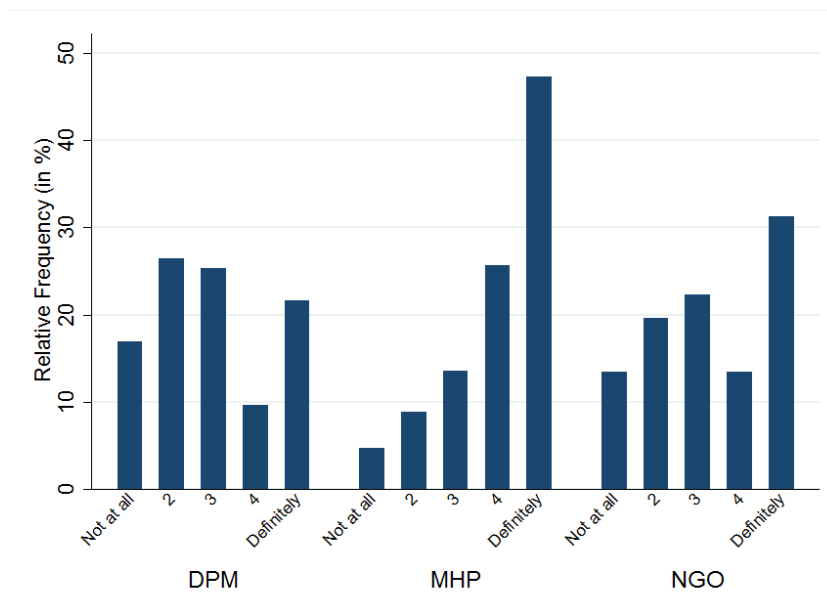


Figure 3 Suicide prevention as part of the job description by stakeholder

2.1.2.2 In your work, how often are you faced with suicide prevention or suicidal persons?

Similar to the previous paragraph, the frequency of contact with suicidal people is different among the 3 categories, s. Figure 4. The MPH's are those, who most frequently have contact with suicidal people (more than 30% has a daily contact), whereas less than 5% never have contact to suicidal people. About ¼ of the respondents from NGOs have daily contact and 13% have contact and to suicidal people once per week. Almost 60% of DPM respondents never had contact to this vulnerable group or only once a year and only about 5% of DPM have daily contact to suicidal people.

When separated into the individual countries the respondents from Belgium have the most frequent contact to suicidal persons, while participants from Finland-THL and Slovenia have the least contact, s. Table 38 in the Annex.

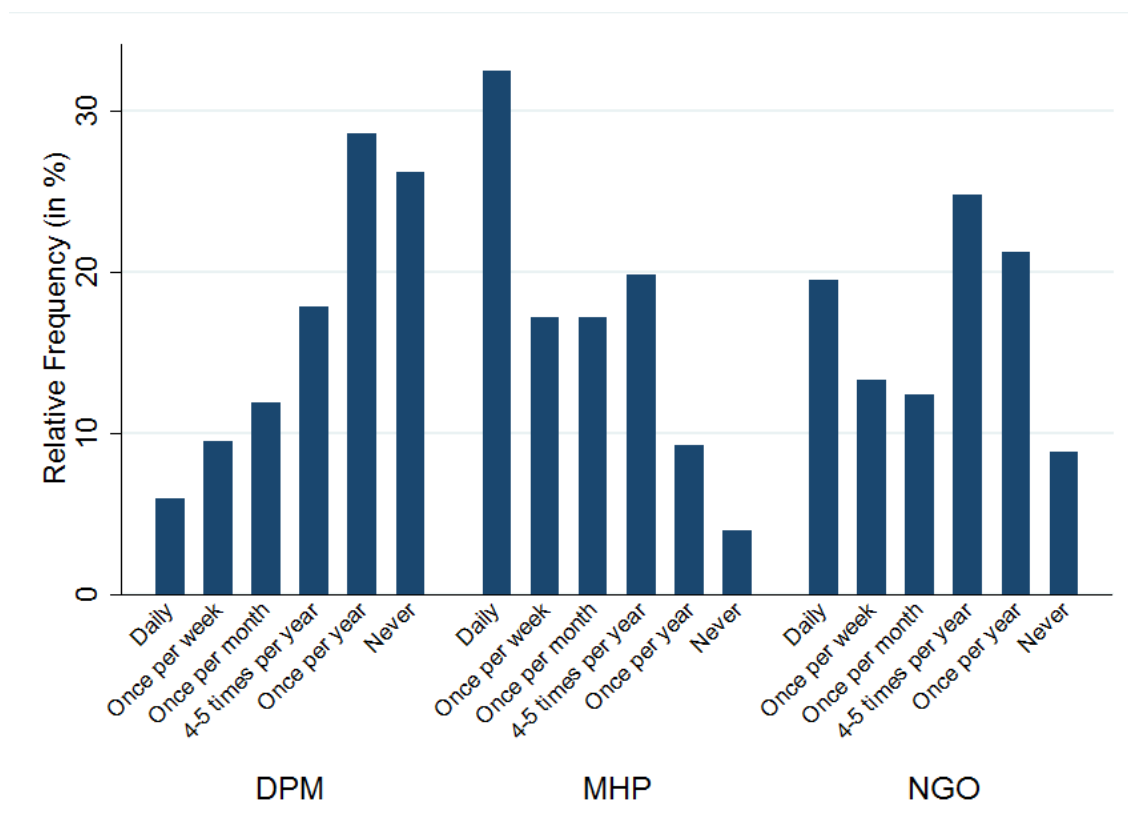


Figure 4 Stakeholder faced with suicidal persons

2.1.2.3 Which professional sub-categories are most often faced with suicidal persons?

As previously described, the DPM division has the rarest contact to suicidal people. In Table 2 it becomes clear that the NGO division has the most frequent contact to suicidal people especially the staff of suicide helplines or staff of survivor support groups as well as psychiatrists and nursing staff of psychiatric patients of the MHP category.

Table 2 Professional sub-categories most often faced with suicidal persons*

Professional category	Group
Staff of suicide helpline	NGO
Representative of religious group	NGO
Staff of survivor support group	NGO
Outpatient psychiatrist	MHP
Inpatient psychiatrist	MHP
Nursing staff of psychiatric patients	MHP
Staff of emergency room	MHP
Paramedics, emergency paramedics	MHP
*measured by median value	

2.1.3 Prevention Strategies

2.1.3.1 Please specify if you are aware of any suicide prevention program/strategy for patients in your institution/work area

Regarding the question of knowledge about a SP strategy in the work environment of the participants, the major difference can be found in the responses of the NGO division. The majority of DPM (57%) and MHP (54%) say that they know about the SP strategy in their work environment, whereas this is relatively unknown for NGOs (40%), s. Figure 5 .

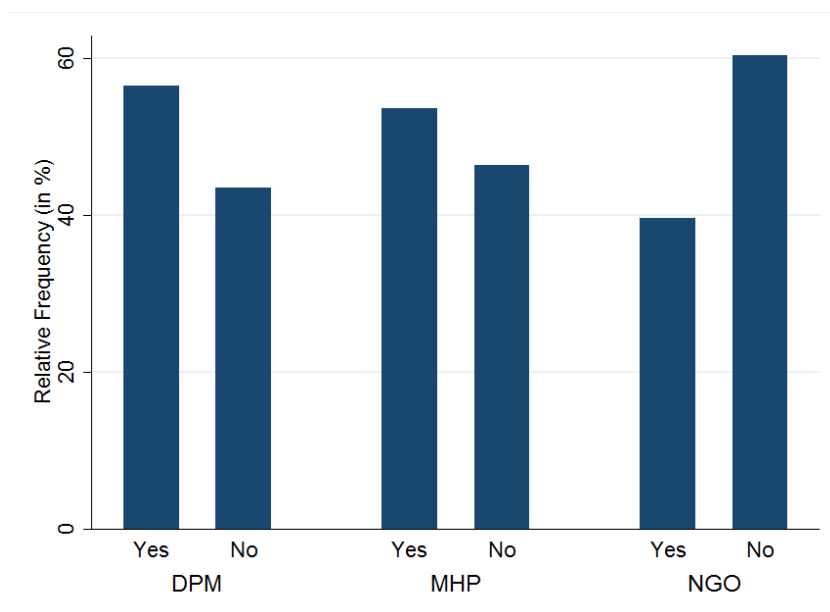


Figure 5 Awareness of suicide prevention strategies in the work area by stakeholders

However, between each country there are significant differences on the availability or at least on the acknowledgement of SP strategies in the respective institutions or in the workplace. While in Belgium, Germany, Sweden and Slovenia the majority of the respondents are informed about SP strategies in there institutions and workplaces, this is not the case for Spain, Finland and Romania where there is no such awareness. In Italy the number of respondents who state that they are informed about the SP strategies is equal to the number of those who are not informed about any SP strategies. In Finland there are concrete regional differences in terms of informing about the SP strategies in the work environment. Therefore, the variation of responses of the MAMK respondents is higher than that of the THL, s. Figure 6.

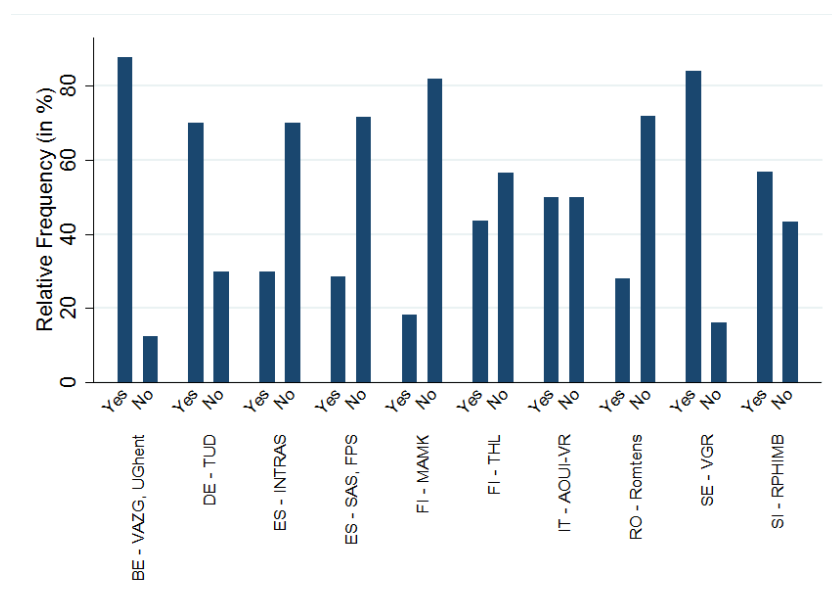


Figure 6 Awareness of suicide prevention strategies in the work area by region

2.1.3.2 Please specify the level of the strategy/program you use most

For most instances of the MPH and NGO groups, the SP strategies in the work environment are obligatory. In both categories the value reaches about 60%. However, for DPM the participation on SP strategies is mostly optional (49%), s. Figure 61 in the Annex.

If SP strategies are known the respondents in Belgium and Romania answered that they are mandatory, s. Figure 7. For Italy there is an equal distribution of approval and denial while in Spain as well as in Finland contradictory findings are documented. 56% of the INTRAS respondents said that the participation on SP strategies is obligatory while 56% of SAS/FPS

respondents said that the opposite is true. The regional differences in Finland are even bigger: while 80% of MAMK say that the participation on SP strategies is obligatory, 70% of THL say it's optional. It is worth mentioning, that in Italy and Romania the third response option ("don't know") was not used. Those who know about the SP strategy in their work environment are also well informed about participation conditions.

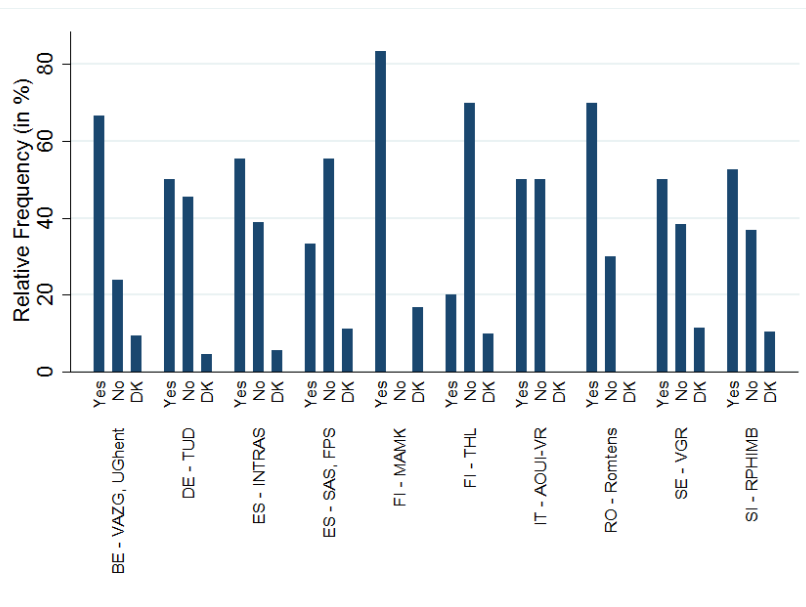


Figure 7 Mandatory implementation of suicide prevention in the work area by region

The DPM division has more local and regional SP strategies in the MPH, whereas the employers are responsible for SP strategies in the NGO categories. Noteworthy is that across all 3 categories the national and international platform is involved with a small percentage with regard to the SP strategies, s. Figure 8.

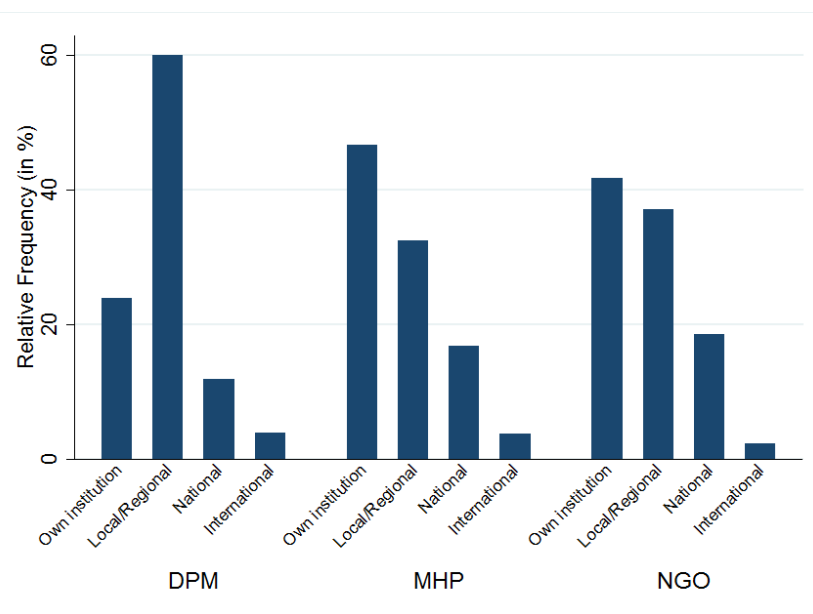


Figure 8 Most used level of the suicide prevention strategy by stakeholders

Table 3 shows the most used level of the suicide prevention strategy by regions. Only the respondents from the regions of Italy, Sweden and Slovenia answered that the used SP strategy is also on international level.

Table 3 Most used level of the suicide prevention strategy by region

Most used level of the suicide prevention strategy by regions (in %)										
Level	BE - VAZG, Ughent	DE - TUD	ES - INTRAS	ES - SAS, FPS	FI - MAMK	FI - THL	IT - AOUI-VR	RO - Rontens	SE - VGR	SI - RPHIMB
Own institution	30	64	56	38	50	20	56	20	13	47
Local/Regional	62	32	39	63	17	20	13	30	67	26
National	8	5	6	0	33	60	13	50	17	16
International	0	0	0	0	0	0	19	0	4	11

2.1.3.3 Awareness of suicide prevention programs/strategies in selected professions

The following evaluation with a focus on professional sub-categories allows a more precise analysis of work environments in which SP strategies are available and used (see Table 4).

Table 4 Awareness of suicide prevention programs by selected sub-categories

Awareness of any suicide prevention program/strategy in your institution/area (yes in %)	
Criminal justice stakeholders	10
Teachers	32
Nursing staff of psychiatric patients	39
Inpatient psychiatrist	42
Inpatient psychologists	50
Professional social workers	50
Decision and policy makers from local and regional authorities	52
General practitioners	53
Decision and policy makers in public health institutions	67

About 90% of the “criminal justice stakeholders” states that they are not aware of any SP strategies in their work environment, s. Figure 62 in the Annex.

The percentage of “Decision and policy makers from local and regional authorities” how know about SP strategies in their work environment or don’t is nearly equal (51 % and 49%), s. Figure 63 in the Annex.

The awareness of SP strategies in the sub-category of “Decision and policy makers in public health institutions” is slightly higher than 60%, s. Figure 64 in the Annex.

In case of the “general practitioners”, it appears to be similar to the “Decision and policy makers from local and regional authorities”. The majority of the respondents are familiar with SP strategies and the percentage of those who are not familiar is slightly lower, s. Figure 65 in the Annex.

The “Inpatient psychiatrist”-stakeholder sub-category predominantly announces that they don’t know anything about SP strategies in their work environment and the difference between those who responded with “yes” to the question is lower. Only one of the participants of these careers has an over-average confrontation with suicidal people, s. Figure 66 in the Annex.

The “Nursing staff of psychiatric patients” states that they’re not familiar with SP strategies. Here the difference to those who say that they are familiar with it is even higher than it is in the sub-category of “inpatient psychiatrists” (20% points), s. Figure 67 in the Annex.

In the “inpatient psychologists” sub-category there is a balance between those who have SP strategies and those who have no SP strategies at ones disposal, s. Figure 68 in the Annex.

The respondents of “Professional Social Workers” provide a split picture concerning the question of SP strategies in their work environment. Here the number of the respondents who say they are aware of the strategies is equal to those who say that they are not, s. Figure 69 in the Annex.

The majority of the “teachers” have no SP strategies at their disposal, however, almost 1/3 of the teachers know about SP strategies, s. Figure 70 in the Annex.



2.1.3.4 Please specify the type of strategy/program

As Table 5 shows the strategy of “raising awareness on suicide prevention” is represented the most followed by “Counseling suicidal persons” within the offered SP strategies. The strategy of “providing training on suicide prevention” is neglectable with 38,31% (in total) and “responding to situations in which individuals are acutely suicidal” is the least chosen strategy with 16,92 % (in total).

Table 5 References for documentation of the suicide prevention strategies

Type of strategy/program	%
Raising awareness on suicide prevention	56,16
Counseling suicidal persons	52,74
Crisis Intervention	44,33
Setting up a policy/protocol on suicide prevention	40,69
Providing training on suicide prevention	38,31
Responding to situations in which individuals are acutely suicidal	16,92

The Table 39 in the Annex presents the type of strategy which has the most awareness in the different regions.

2.1.3.5 In the future, would you see as necessary the introduction of a suicide prevention program/strategy for patients in your institution/work area?

Figure 9 shows that all 3 stakeholder categories see the necessity to develop and offer more SP strategies.

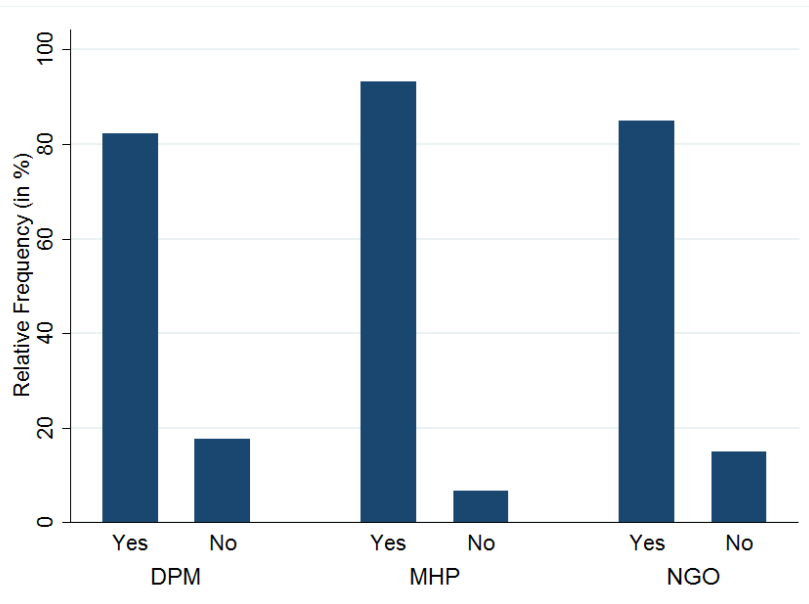


Figure 9 Necessity of the introduction of a suicide prevention strategy by stakeholder

The data of each country shows a high approval rating among the respondents concerning the future implementation or development of SP strategies, s. Figure 71 in the Annex.

2.1.3.6 If 'Yes', please specify the type of suicide prevention program/strategy you would consider as most necessary

Table 6 lists the SP strategies most wanted by the respondents in their work environment. Especially the placement of a single SP strategy (protocol) and a training program on the SP subject is wished for. The least attention with a percentage of 32,17% receives the answer possibility "responding to urgent situations in which individuals are suicidal".

Table 6 Most necessary type of suicide prevention strategy

Type of program/strategy most necessary	%
Setting up a policy/protocol on suicide prevention	55,75
Providing training on suicide prevention	55,4
Raising awareness on suicide prevention	51,92
Counseling suicidal persons	50,87
Crisis Intervention	40,21
Responding to urgent situations in which individuals are suicidal	32,17

Table 40 in the Annex presents the most necessary types of suicide prevention strategies for the different regions.

2.1.3.7 Do you feel you have “the knowledge and know-how” to deal with suicide prevention in your work?

The following graphic (Figure 10) shows, that the 3 stakeholder categories feel well informed/skilled to handle the SP topic, especially the MHP division (52%). For the NGO division the picture is more ambivalent: while 45% state that they are skilled enough there are still 40% who feel absolutely not informed about the necessary know-how in SP. The least expertise in this field is represented in the DPM division as 51% feel badly informed about SP (in contrast to 34% with know-how).

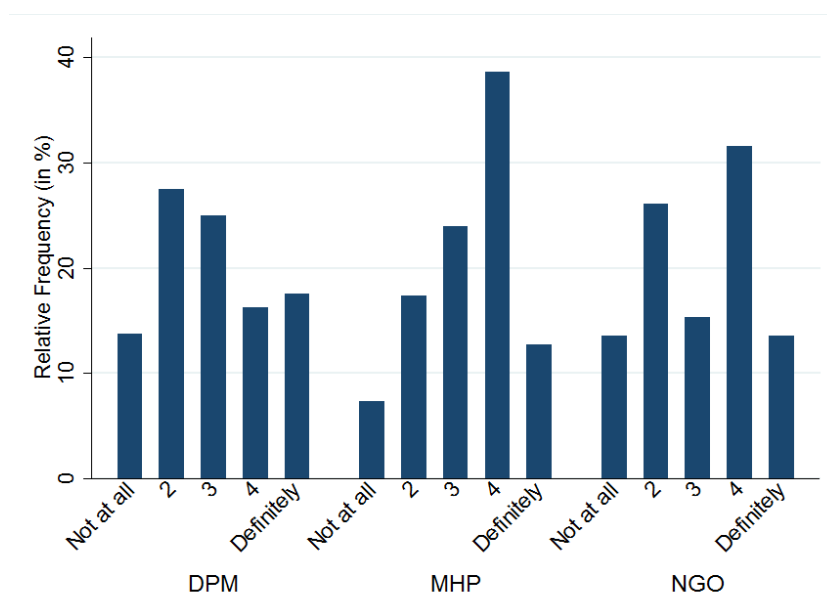


Figure 10 Knowledge and know-how when dealing with suicide prevention by stakeholder

All in all the respondents from Belgium, Sweden and Germany have the best know-how in SP (mean score > 3,5) whereas in Spain (SAS, FPS), Slovenian and the region of Finland that was researched by MAMK there is the highest insecurity concerning the know-how in SP (mean score < 2,8), s. Figure 11.

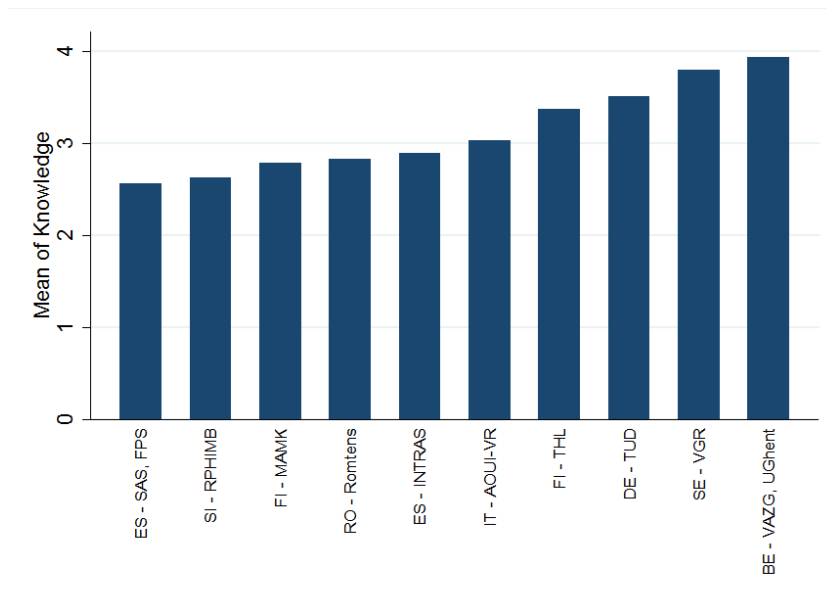


Figure 11 Knowledge and know-how when dealing with suicide prevention by region

2.1.3.8 Do those who are often faced with suicidal persons have the subjective know-how to deal with it?

As shown in Figure 12 below, those who are frequently confronted with suicidal people have the subjective know-how on how to deal with such a situation and the confidence in handling a SP situation rises with the number of contacts. The subjective knowledge and frequency of contact are correlating. This result can be reproduced with regard to each stakeholder category; however, overall participants of the MHP group are prepared best for the contact with SP when compared to other stakeholder categories, s. Figure 13.

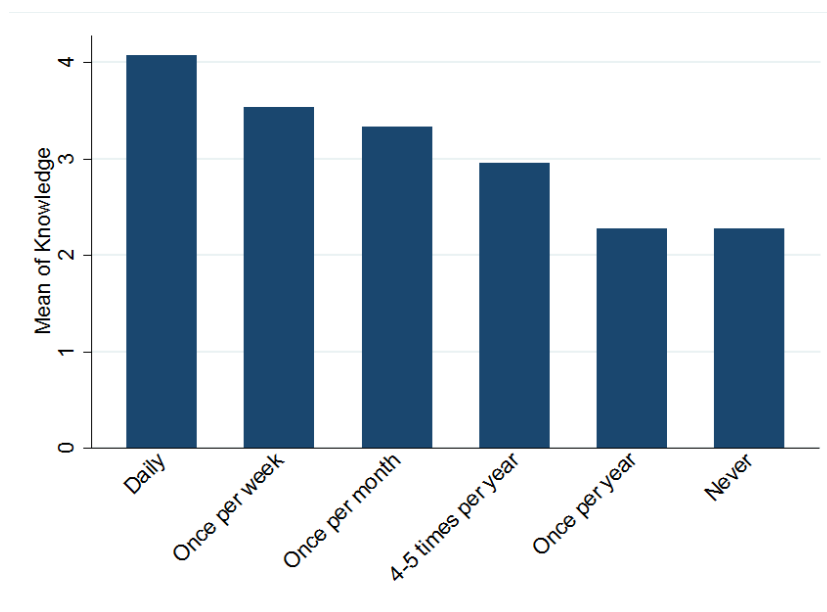


Figure 12 Mean of knowledge in correlation to the number of contacts with suicidal people

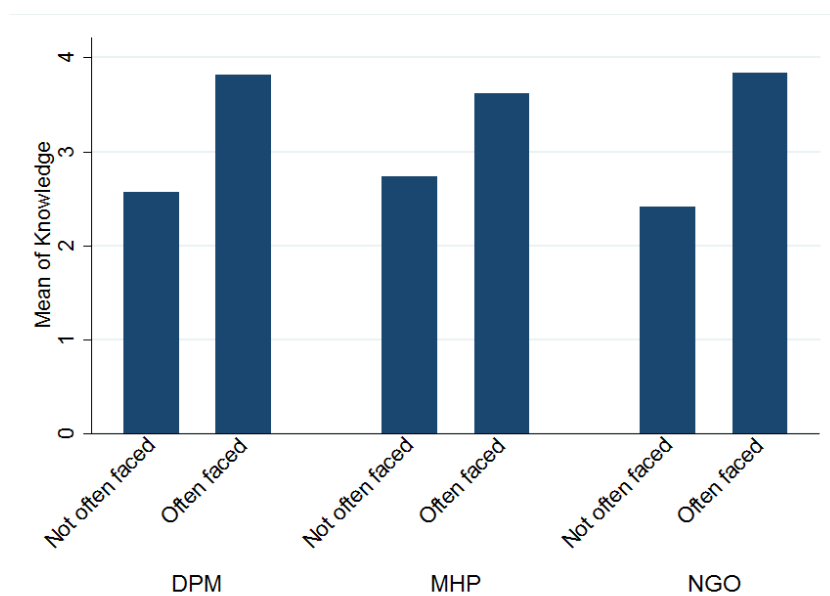


Figure 13 Mean of knowledge in correlation to contacts with suicidal people by stakeholder

2.2 Local Networks

2.2.1 Please specify if you are aware of any local (community, province, region) network working on suicide prevention

The awareness of local networks is similar in the MHP and NGO categories. More than 60% don't have the necessary knowledge about local networks in their region dealing with suicide prevention.

The respondents of DPM have partial knowledge about the existence of local networks (51%) s. Figure 72 in the Annex.

There are differences in the awareness of local networks concerning the participating regions, s. Figure 14. In Belgium and Sweden the majority of respondents know about local networks in conjunction with suicide prevention. In Germany and Finland (THL) the knowledge is well-balanced with half of the respondents knowing about local networks. In other participating countries the knowledge is not incisive with Spain (INTRAS) achieving the lowest level of knowledge.

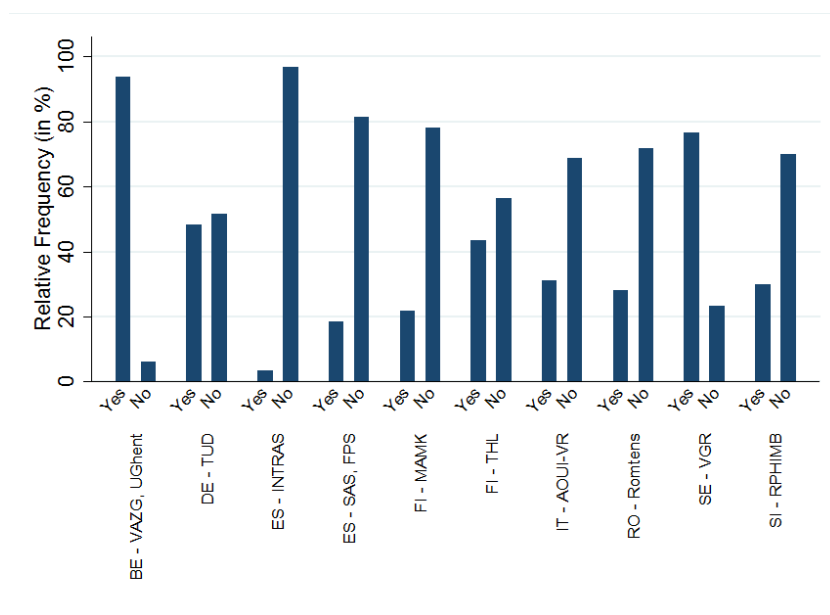


Figure 14 Aware of local networks by region

2.2.2 Please specify if you would be interested in being involved in a local network like this

The majority of respondents are interested in getting involved with local networks in conjunction with suicide prevention. With more than 70%, especially the DPM and MHP categories, showing a clear interest in integrating with a network in their region, s. Figure 15.

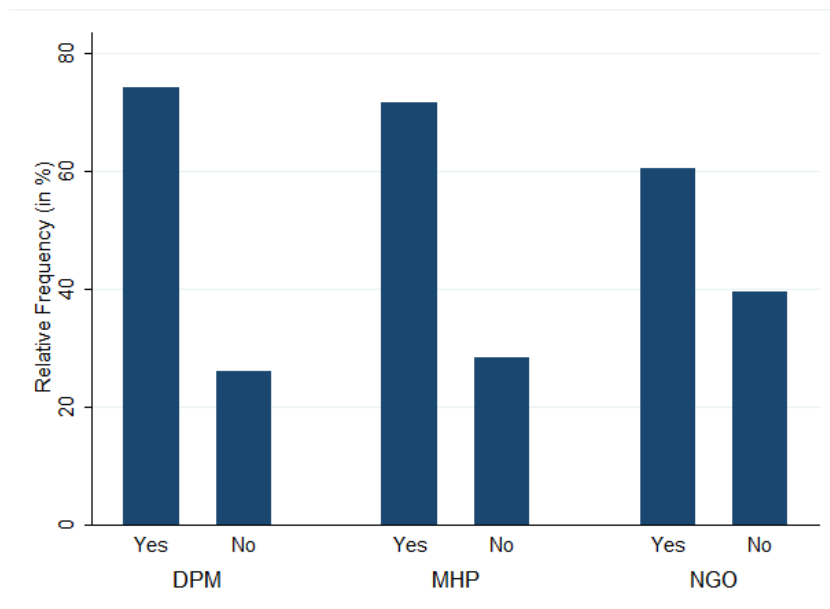


Figure 15 Interest in being involved in a local network by stakeholder

When considering the interest concerning the integration into a local network at a country level it becomes visible that especially Belgium and Sweden have a clear interest with more than 80% voting with yes. Spain (SAS, FPS), Finland (MAMK) (53%) and Slovenia (50%) represent a divided picture concerning the participation/integration in local networks, s. Figure 16.

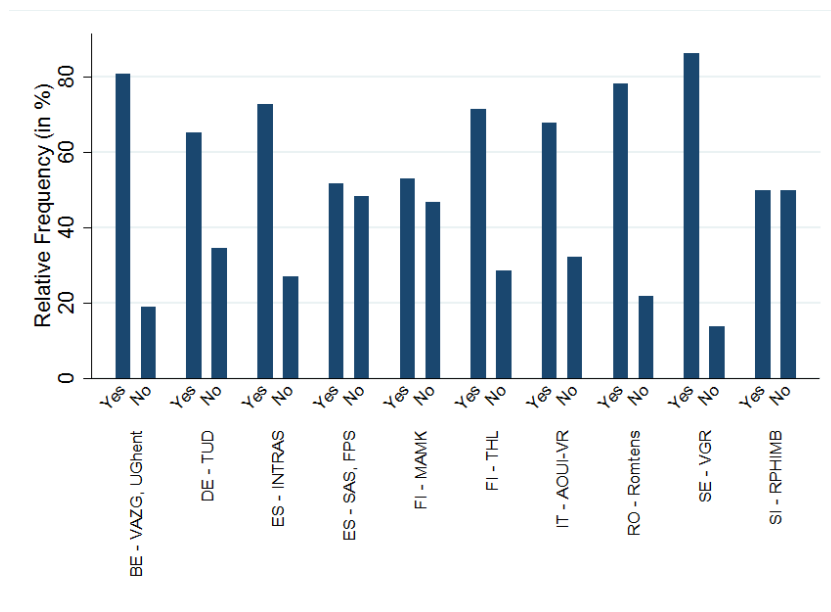


Figure 16 Interest in being involved in a local network by region

2.2.3 Please specify if you have previous experience in suicide prevention campaigns/projects

Figure 17 illustrates that 2/3 of the overall tested population did not have any experiences with conducted suicide prevention measures across the 3 stakeholder categories.

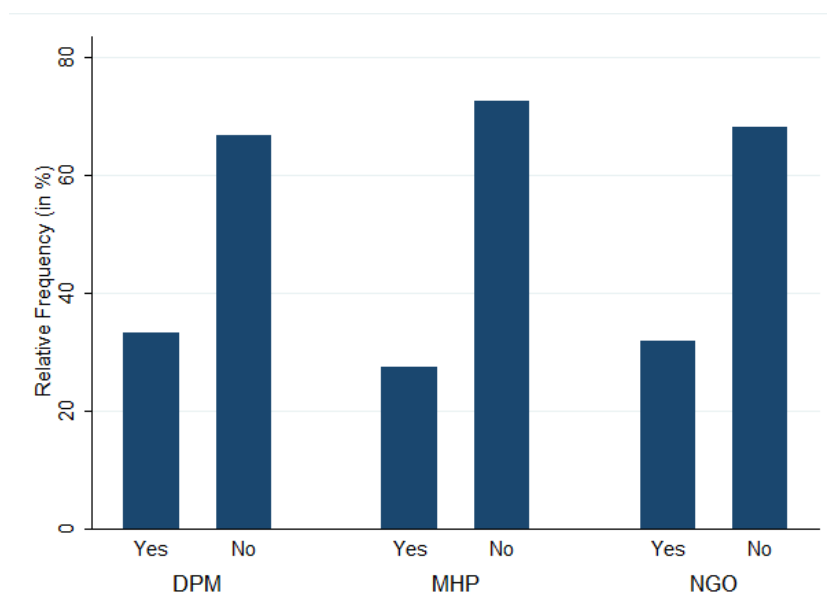
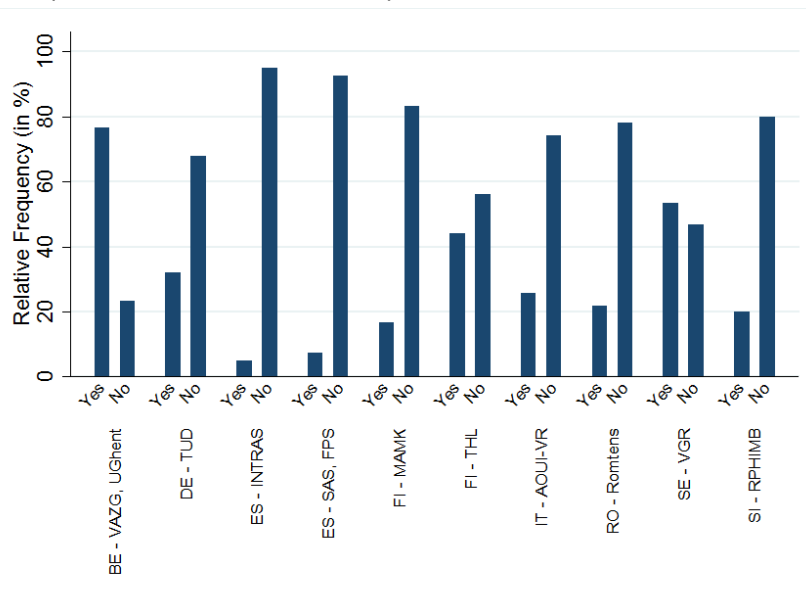


Figure 17 Previous experience in suicide prevention campaigns by stakeholder

This result varies when considering each participating individually as the respondents from Belgium (77%) and Sweden (53%) already have experiences with campaigns in suicide prevention (s. Figure 18). The least experience with such campaigns is to be found within the Spanish institutions (SAS, FPS: 7%: INTRAS: 5%).

**Figure 18 Previous experience in suicide prevention campaigns by region**

2.3 Guidelines and Toolkits for Prevention

2.3.1 In your region/country, are there guidelines or prevention packages available related to suicide prevention in your work area?

While guidelines or prevention packages are available for SP in the 3 stakeholder categories, they are not common at the moment with the DPM division (46%) having most access to guidelines, followed by MHP (39%) and the NGO category (33%), s. Figure 19.

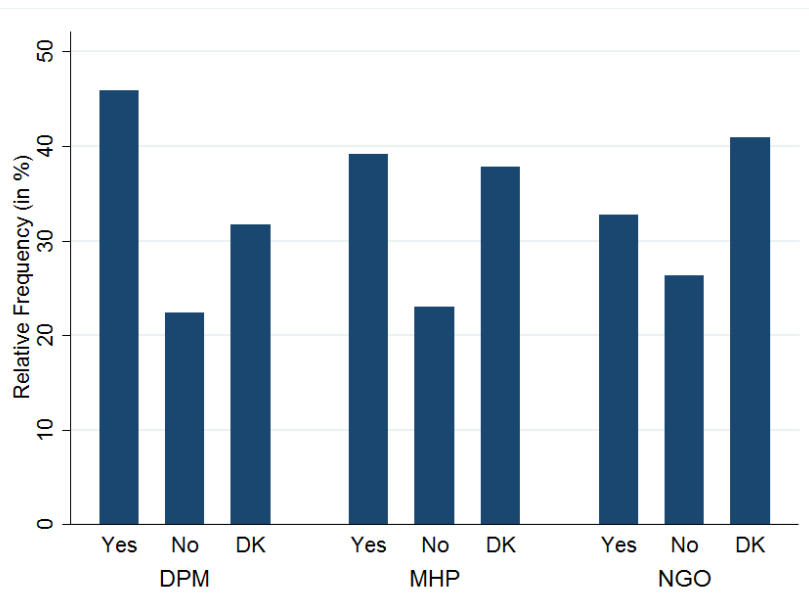


Figure 19 Availability of guidelines/prevention packages in the work area by stakeholder

On the question if there are guidelines or prevention packages offered in their work environment the respondents from Belgium, Germany and Sweden answered with “yes” (Figure 20). Other investigative countries answered “no” or “don’t know”. In Germany the findings are ambivalent as only 40% of the respondents chose “yes” and almost the same amount chose “don’t know”, 37%. Additionally, the distance to the respond opportunity “no” is only 23% points.

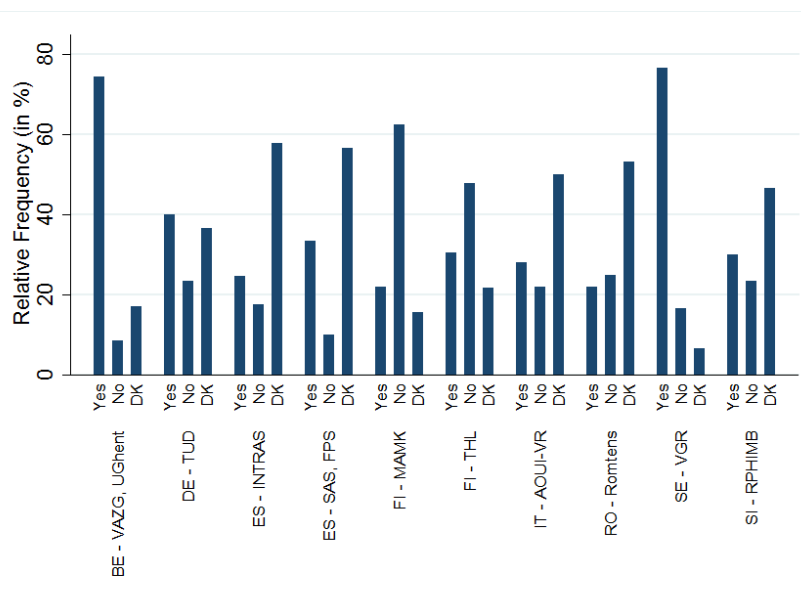


Figure 20 Availability of guidelines/prevention packages in the work area by region

2.3.2 Do you use these guidelines or prevention packages in your professional activity?

If guidelines are available for SP the usage differs for the different stakeholder categories. Within the DPM division the answer with the most responses was that they “frequently” (4) use the guidelines, however, the second most votes were given “not at all”, s. Figure 21. In MHP it is remarkable that the frequency is quite balanced in using guidelines and prevention packages. The NGO respondents answered to use such guidelines “very frequently”.

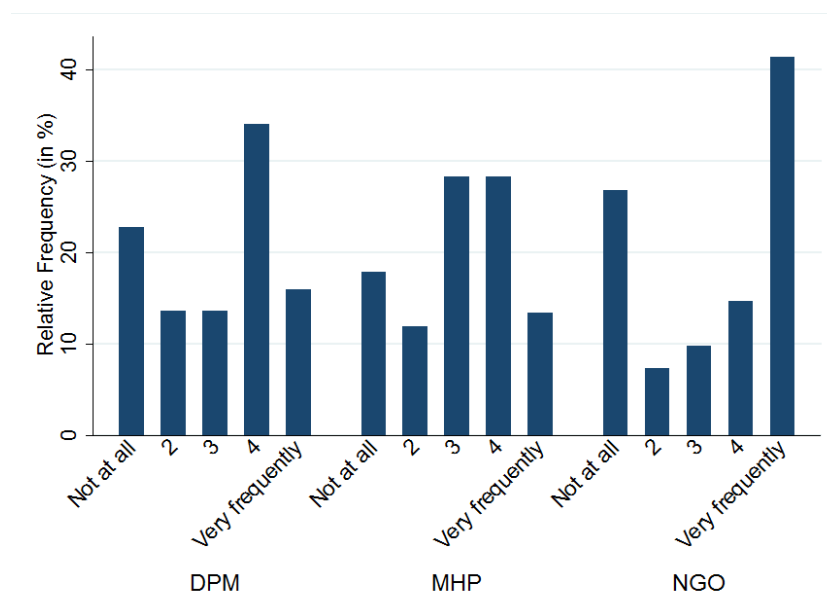


Figure 21 Use of guidelines/prevention packages by stakeholder

2.3.3 When reading and using guidelines and/or prevention packages, which format(s) do you consider most useful?

When tried to evaluate questions of “Which format(s) do you consider most useful?” and analyzed the results for individual format alternatives and stakeholder categories. Here the formats should be judged for their usefulness on a scale from 1 “very useful” to 5 “useless”.

The format “book or manual” was indicated to be useful by every single country. In Spain (the regions of Spain that were researched by SAS, FPS) the usefulness estimated lower than in other countries, s. Figure 22.

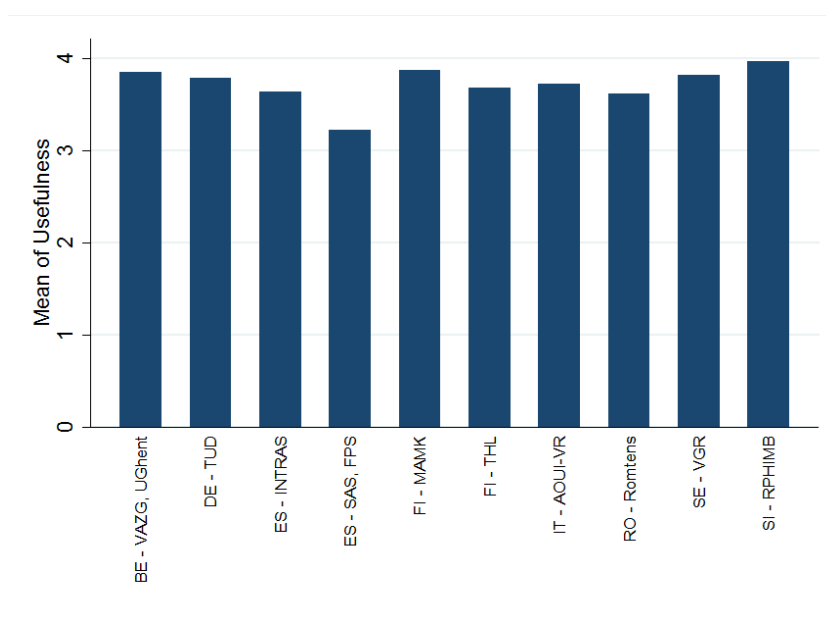


Figure 22 Use of book/manual by region

A “brochure or manual” to download from the internet was the most popular option for the research team from the Finland THL compared to other countries, where Italy is found this to be the worst alternative. The “brochure or manual” format for SP achieves a good assessment and fares better than the option of “book or manual”, s. Figure 23.

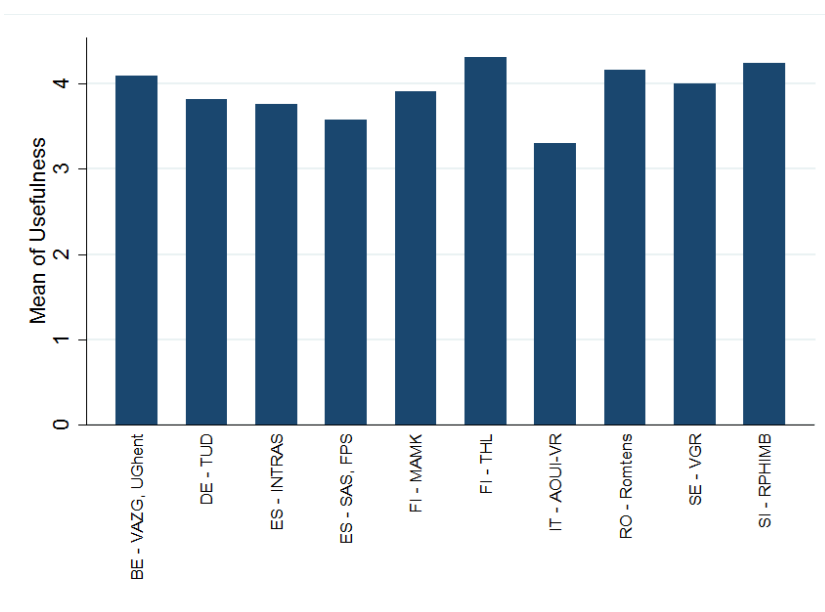


Figure 23 Use of brochure/manual by region

The “DVD format” is not as accepted as the previously named options, however it is not thought of as useless, s. Figure 24.

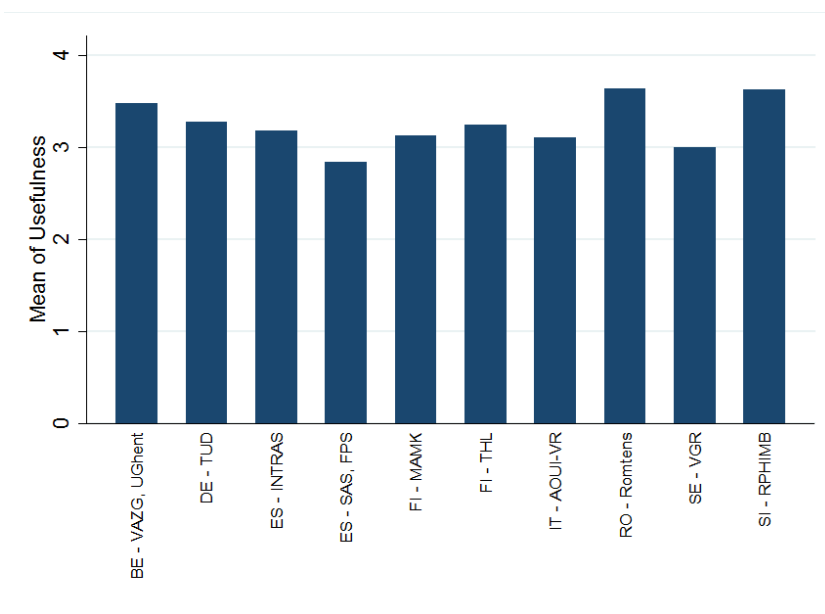


Figure 24 Use of DVD format by region

The “memory sticks” format gets similar data and is seen neither as useless nor as useful, s. Figure 25.

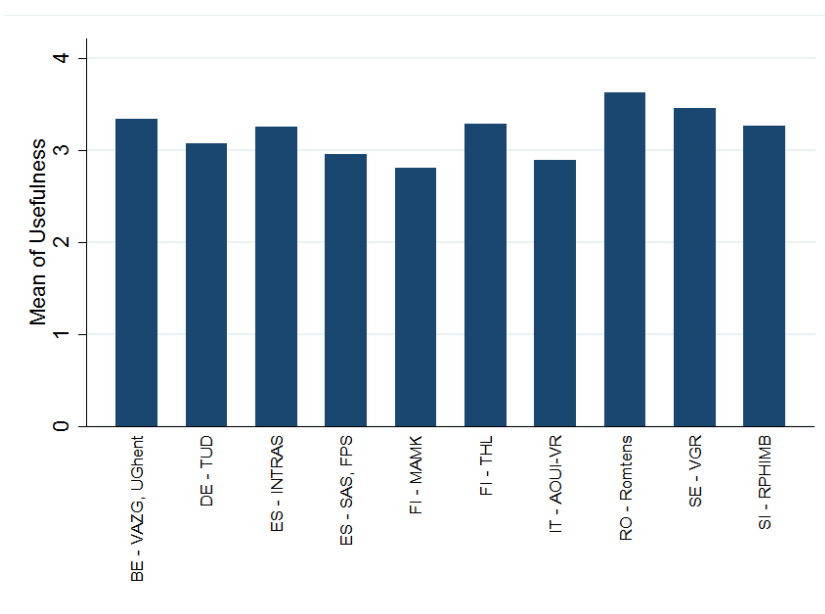


Figure 25 Use of memory sticks by region

The format of a “poster” is not regarded as useful by the participants with the exception of Slovenia, s. Figure 26.

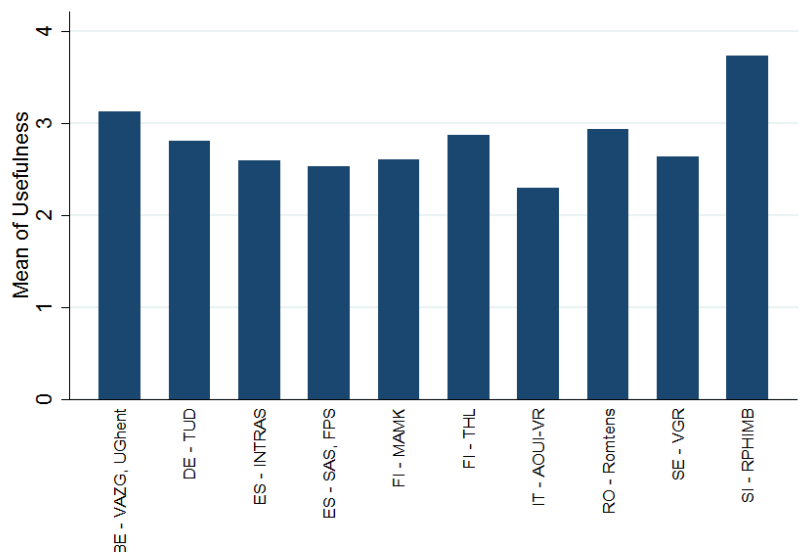


Figure 26 Use of poster by region

The idea of a “self-help module on the internet” is evaluated positively, however, there are differences. The participants in Belgium and Slovenia stated that the concept is good while in Italy and Germany it is seen as more neutral.

The findings from Finland vary (MAMK neutral, THL more positive), s. Figure 27.

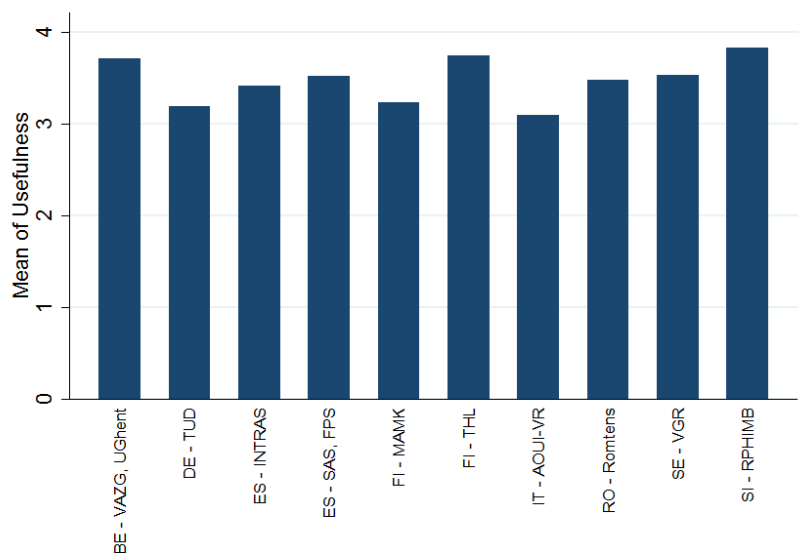


Figure 27 Use of self-help module on the internet by region

The “toolbox” format is received positively. The agreement values are around 4 across all participating institutes (on a scale from 1 to 5). In Belgium and Romania this concept almost reaches peak values, s. Figure 28.

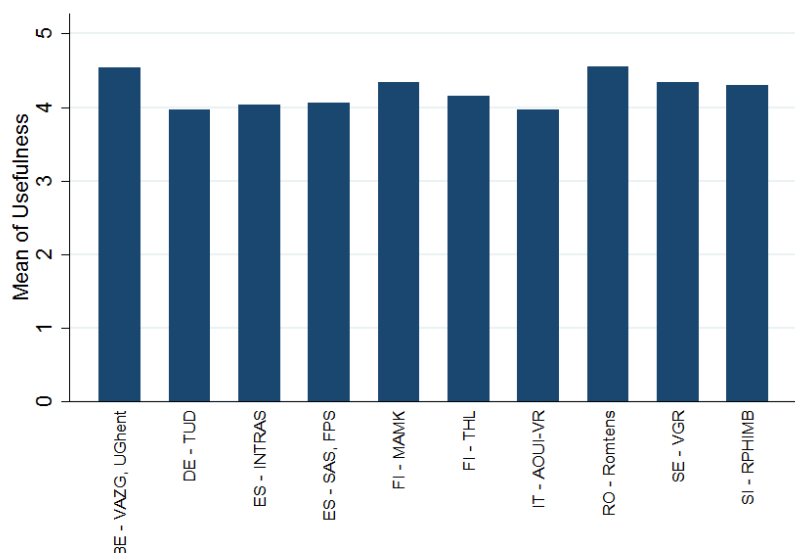


Figure 28 Use of toolbox by region

Also the “training sessions” concept is stated consistently well in the average of all participating countries, s. Figure 29.

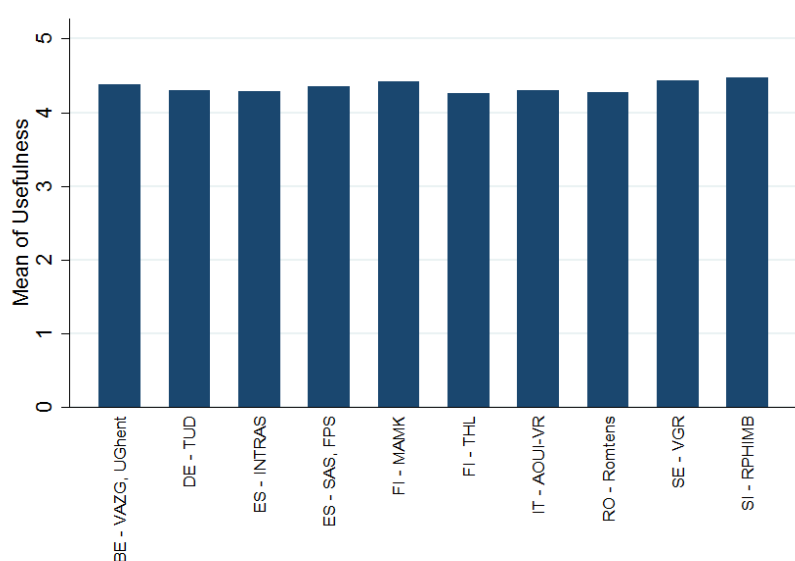


Figure 29 Use of training session by region

The participants generally consider the channel “website” as most useful, s. Figure 30. This format is seen as quite positive in Slovenia (4,5) and Belgium (4,4) but it is not as common in Italy (3,5) and parts of Spain (INTRAS) (3,7).

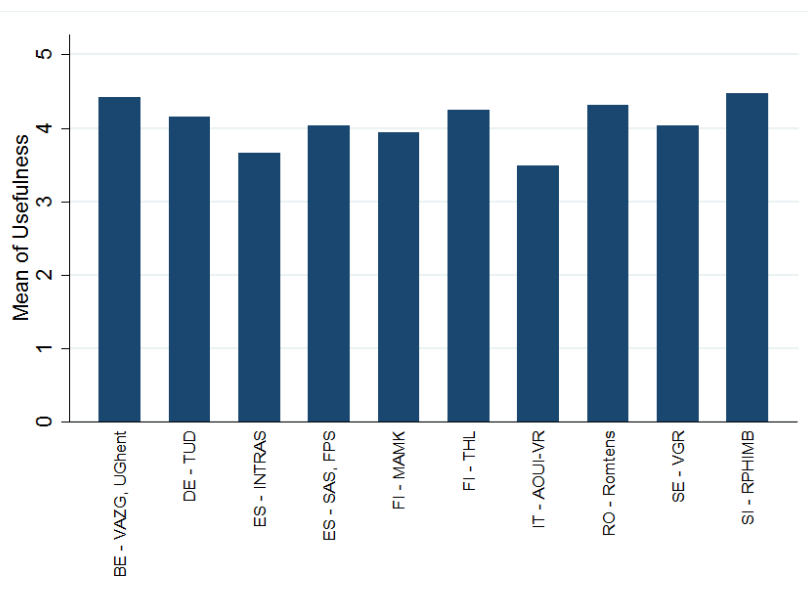


Figure 30 Use of website by region

The “webinar” for SP is not favored and is similar to the poster with some negative and positive votes. However, it is interesting that the East European countries (Romania and Slovenia) are more positive on “webinars” than other research countries, s. Figure 31.

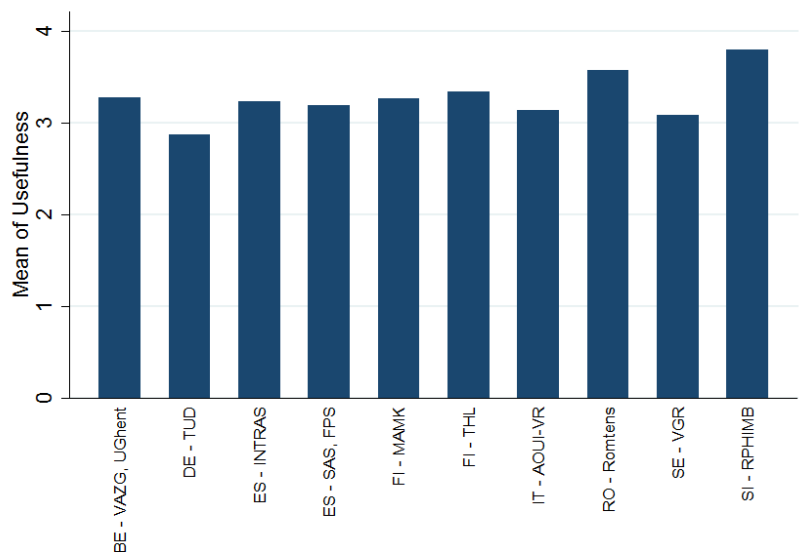


Figure 31 Use of webinar by region

Altogether, the formats toolbox and training sessions are seen as very helpful whereas the DVD and memory stick concepts are not as welcome.

In the following, the assessment of each format is analyzed with regards to the stakeholder category membership.

The formats "website", "toolbox", "training sessions" and "downloadable brochure/manual" appeal to the DPM stakeholder category. It's interesting that the concept of the SP website appeals more to the DPM than the "toolbox" or "training session" because those two were the ones that are most popular. The concepts "poster", "memory stick" or the "webinar" appeal less positive to the respondents of the DPM stakeholder category, s. Figure 32.

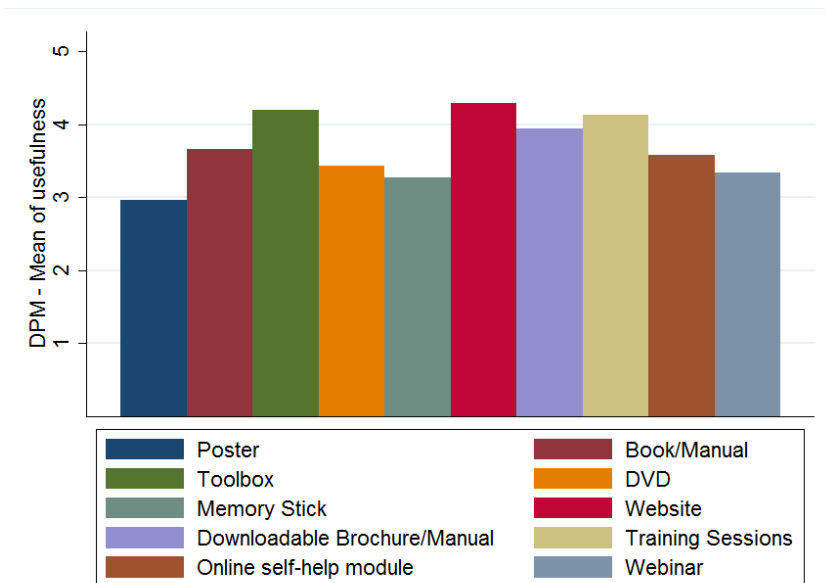


Figure 32 Use of different formats of guidelines/prevention packages by DPM

Additionally, the MHP stakeholder category evaluates the “trainings sessions” and “toolbox” formats as very useful. The respondents of this category are positive yet less interested on the “website” concept. The “poster” got the least positive feedback in this category followed by “DVD”, “memory stick” and “webinar”, s. Figure 33.

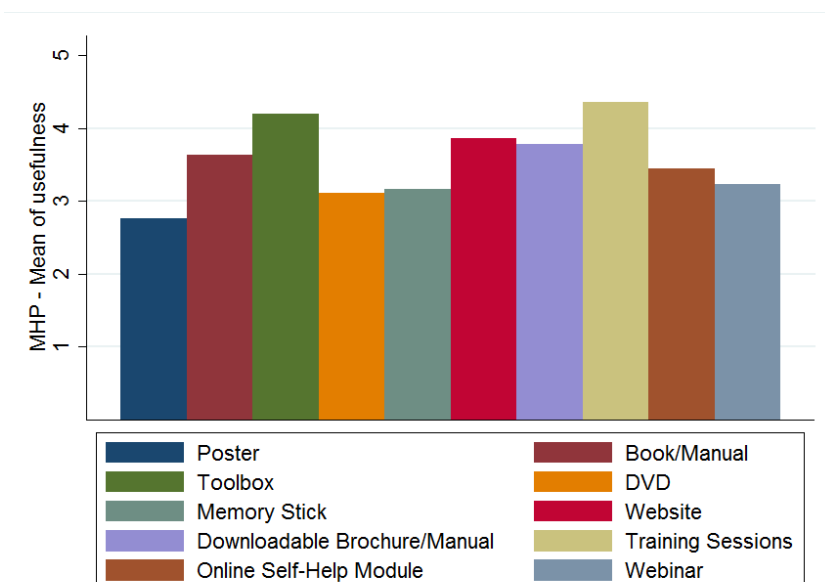


Figure 33 Use of different formats of guidelines/prevention packages by MHP

Among the NGO-Stakeholder category the “toolbox” and “trainings sessions” are rated as the best concepts. Additionally, the concept “website”, “downloadable brochure/manual” and “book/manual” are perceived well and “poster” gets the lowest feedback.

This is in line with the concepts of the “DVD”, “memory stick”, “online self-help module” and “webinar” which can’t convince this category as a format. It was noticeable that the NGO overall gave a more positive feedback when compared to the other categories with some values above 4 (scale of 1 to 5), s. Figure 34.

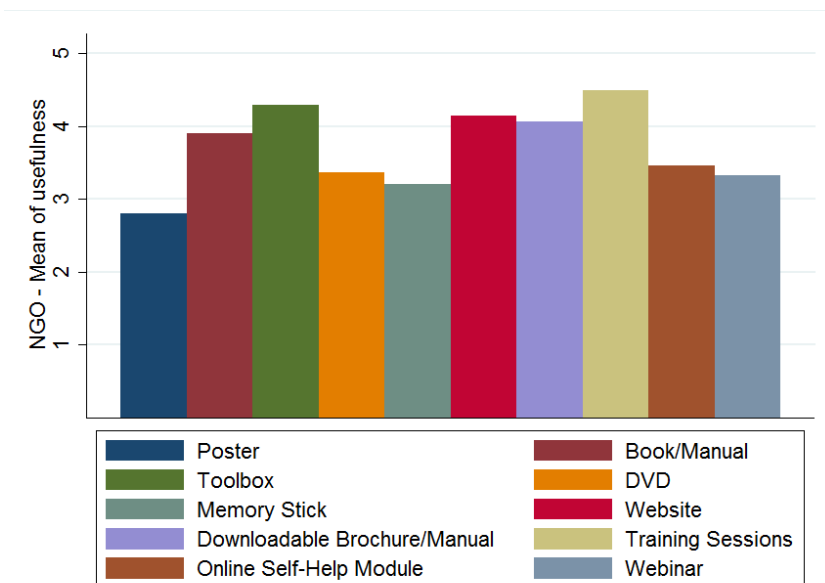


Figure 34 Use of different formats of guidelines/prevention packages by NGO

2.3.4 What is the relationship between formats considered most useful and professional sub-categories?

The following figure shows the exact distribution of the evaluations of the different SP formats structured according to the individual careers. Overall, the “Poster” is voted to be the least useful option and the best votes for the “Poster” come from the staff of a non-governmental organization as well as the decision and policy makers from local and regional authorities. Nursing staff of psychiatrist patients and inpatient psychiatrist voted with the lowest usefulness for “Posters”. The “webinar” is regarded as little useful as well and criminal justice stakeholders gave the lowest mark whereas the highest was given by social workers. The leaders of this ranking are the “toolbox” and “training sessions”. The “toolbox” got its lowest rating from the general practitioners whereas staff of non-governmental organizations and teachers did approve of this concept. The lowest grade for the training session was given by

the inpatient psychiatrists and the best grade by the professional social workers. When comparing the overall awareness from different careers it becomes clear that the inpatient psychiatrists and general practitioners were least impressed by the formats whereas staff of a non-governmental organization and professional social workers were those who were most positive, s. Table 7.

Table 7 Use of different formats by selected professional sub-categories

	Professional Social Workers	Staff of a non-governmental organization	Teachers	Criminal justice stakeholder	Decision and policy makers from local and regional authorities	Decision and policy makers in public health institutions	General practitioner	Inpatient psychologist	Inpatient psychiatrist	Nursing staff of psychiatric patients
Poster	2,9	3,2	2,8	2,7	2,7	3,2	2,8	2,1	2,9	2,4
Book/Manual	4,0	4,2	3,7	3,6	3,7	3,9	3,4	3,4	3,4	3,6
Toolbox	4,3	4,5	4,6	4,4	4,3	4,1	3,9	4,4	4,0	4,1
DVD	2,9	3,5	3,6	3,9	3,3	3,5	3,0	3,7	2,8	3,0
Memory stick	3,2	3,7	3,6	3,2	3,4	2,9	3,4	3,4	2,8	3,1
Website	4,6	4,6	4,2	4,2	4,1	4,6	3,7	3,8	3,7	4,0
Downloadable brochure or manual	4,5	4,4	3,9	3,8	3,8	3,9	3,5	3,4	3,9	4,0
Training sessions	4,7	4,6	4,3	4,6	4,1	4,2	4,1	4,5	3,9	4,6
Online self-help module	3,8	3,7	2,9	2,7	3,3	3,5	3,2	3,1	3,1	3,5
Webinar	3,9	3,5	3,2	1,7	3,1	3,1	3,1	3,3	2,7	3,4

2.3.5 Which topics do you think a prevention package on suicide prevention should address in the area of education (for teachers directed towards pupils) and the work-place (for employers directed towards employees)?

All of the proposed topics are important to the stakeholder category. However, the “general information on suicidality” is the least favorite in comparison in the 3 categories. Generally speaking the three categories are homogenous. The gap most noticeable which differs by around 0,3 points maximum is regarding “What to do after a suicide” between the categories MHP (4,2) and NGO (4,5). The topics “How to deal with suicidal Persons” and “How to identify Signals for Suicidality” get the highest (scale level of 1 to 5 as before, s. Table 8).

Table 8 Important topics regarding suicide prevention in the area of education and workplace by stakeholder

Topic	DPM	MHP	NGO
General information on suicidality	3,7	3,6	3,8
What to do after a suicide attempt	4,4	4,4	4,5
What to do after a suicide	4,3	4,2	4,5
How to deal with suicidal persons	4,6	4,6	4,7
How to identify signals for suicidality	4,8	4,7	4,8
How to train gatekeepers	4,2	4,4	4,4
How to set up a suicide prevention policy	4,0	4,0	4,1
How to integrate a suicide prevention policy in other policy's	4,1	4,1	4,1
How to communicate about suicide	4,1	4,1	4,3
Mean Score, Range: 1=useless, 5=useful			

Subsequently the analyses of the previous question are shown in detail according to the different countries. The above-average positive grading in Sweden is remarkable whereupon the high-value of 5,0 was not given by Sweden but Germany, s. Table 9.

Table 9 Important topics regarding suicide prevention in the area of education and workplace by region

Topic	BE - VAZG, UGhent	DE - TUD	ES - INTRAS	ES - SAS, FPS	FI - MAMK	FI - THL	IT - AOUI-VR	RO - Romtens	SE - VGR	SI - RPHIMB
General information on suicidality	4,0	3,8	3,4	3,3	3,4	3,8	3,5	3,7	4,6	3,8
What to do after a suicide attempt	4,6	4,5	4,3	4,4	4,6	4,6	4,3	4,3	4,6	4,8
What to do after a suicide	4,6	4,2	3,8	4,3	4,4	4,6	4,3	4,0	4,7	4,7
How to deal with suicidal persons	4,8	4,9	4,6	4,8	4,7	4,7	4,4	4,4	4,6	4,8
How to identify signals for suicidality	4,7	5,0	4,7	4,8	4,7	4,6	4,8	4,7	4,9	4,9
How to train gatekeepers	4,4	4,4	4,0	4,5	4,1	4,1	4,4	4,3	4,5	4,7
How to set up a suicide prevention policy	4,4	4,0	3,7	3,8	3,6	3,8	4,0	4,2	4,5	4,1
How to integrate a suicide prevention policy in other policy's	4,4	3,8	3,8	4,0	4,1	4,1	4,2	4,2	4,5	4,0
How to communicate about suicide	4,4	4,3	3,9	4,0	4,2	4,0	3,8	4,3	4,6	4,2
Mean Score, Range: 1=useless, 5=useful										

2.3.6 Which topics do you think a prevention package on suicide prevention should address in the media and communications area?

Dealing with the topics that should be discussed in the SP mass media it becomes apparent that there is a strong focus in the entire stakeholder categories on the “How to communicate about suicidality” (4,4) and „How to communicate after a suicide attempt or suicide of a public figure“ topics. The “terminology” appeals neither negative nor positive and “general

information on suicidality” is less demand in the entire stakeholder categories as well. There is accordance in the evaluation behavior between each stakeholder category. There are maximal distances of 0, 2 points, s. Table 10

Table 10 Important topics regarding suicide prevention in the area of media and communication by stakeholder

Topic	DPM	MHP	NGO
General information on suicidality	3,7	3,7	3,8
Terminology	3,3	3,4	3,5
How to communicate about suicidality	4,3	4,3	4,5
How to communicate after a suicide attempt or suicide of a public figure	4,3	4,1	4,3
How to set up a suicide prevention policy within the media	4,0	3,9	4,1
Mean Score, Range: 1=useless, 5=useful			

Fragmented in the individual research institutions there is a big accordance with the statements of each stakeholder category as well. That means the distribution is similar for both the negative and positive rated topics. However the evaluation on the side of the interview partner in Germany outstands because “terminology” is negative rated with 2,8 (“not useful”), s. Table 11.

Table 11 Important topics regarding suicide prevention in the area of media and communication by region

Topic	BE - VAZG, Ughent	DE - TUD	ES - INTRAS	ES - SAS, FPS	FI - MAMK	FI - THL	RO - Rontens	SE - VGR	SI - RPHIMB
General information on suicidality	4,0	3,9	3,2	3,4	3,9	4,1	4,2	4,3	3,9
Terminology	3,9	2,8	3,1	3,2	3,2	3,3	3,7	4,0	3,7
How to communicate about suicidality	4,8	4,4	4,1	4,1	4,1	4,3	4,5	4,6	4,6
How to communicate after a suicide attempt or suicide of a public figure	4,7	4,3	3,8	4,1	3,5	3,9	4,5	4,5	4,6
How to set up a suicide prevention policy within the media	4,1	4,1	3,7	4,0	3,8	3,8	4,1	4,4	4,1
Mean Score, Range: 1=useless, 5=useful									

2.3.7 Is there a difference regarding topics that should be addressed in the area of education and workplace, and in the media/communications area?

As is pointed out by the rank correlation coefficients reported in Table 12 there is a strong relationship between topics that should be addressed in the area of education and workplace,

and in the area of media/communications. A high score regarding “General information on suicidality” in the area of education tends to be associated with a high score regarding the same topic in the area of media/communications ($r=0.63$). The same holds true for “How to set up a suicide prevention policy” ($r=0.55$). Stakeholders placing emphasis on a certain topic therefore tend to highlight in both areas.

Table 12 Correlation between topics of the area of education/workplace and media/communications

Rank correlation coefficients (Spearman)	
Variable	Correlation
General information on suicidality	0,63
How to set up a suicide prevention policy	0,55

2.4 Technology-based Suicide Prevention (TBSP)

2.4.1 Knowledge and Usage of TBSP Methods

2.4.1.1 Please write down the names of technology-based suicide prevention methods that you know and how useful you consider each of them.

Regardless of stakeholder category the respondents state that website is the TBSP method they are familiar with and use most frequently. The MHP stakeholders state that they hardly know about the E-therapy and that it doesn't appear very useful. The respondents of the NGO category are skeptical about the usefulness of apps, s. Table 13.

Table 13 Known technology-based suicide prevention methods by stakeholder and analyses of the usefulness (1=not useful – 5=very useful)

Method	MHP		DPM		NGO	
	Relative Frequency (in %)	Mean Score	Relative Frequency (in %)	Mean Score	Relative Frequency (in %)	Mean Score
App	6	3,6	11	3,4	6	2,8
Chat	15	4,7	17	3,8	18	4,0
E-Therapy	11	2,6	11	3,8	6	4,5
Forum	9	3,8	15	3,6	15	3,5
Self help	15	2,6	9	3,8	10	3,7
Social network	14	4,7	12	3,8	8	3,4
Website	29	4,9	25	4,0	36	4,5

2.4.1.2 How often do you use/recommend technology-based suicide prevention programs?

About 50% of the entire stakeholder categories' participants never use or recommend TBSP. About 1/3 of the DPM category participants rarely use TBSP. Around 15% of all respondents use TBSP and sometimes recommend it to affected persons, s. Figure 73 in the Annex.

There is a great variation between countries regarding the usage and recommendation of TBSP, s. Figure 35 and Figure 36. The majority of respondents in Spain (71% SAS, FPS / 62% INTRAS) never use or recommend TBSP. The same holds true for Italy (77%) and Finland (71% MAMK / 58% THL). On the contrary, the respondents in Belgium tend to use and recommend TBSP more often. Thus, only 21% of the Belgian respondents never use or recommend TBSP.

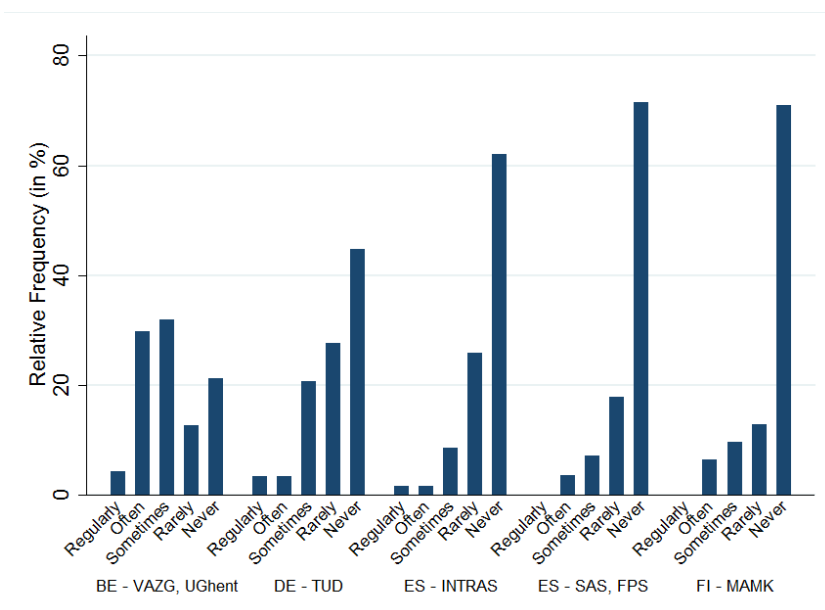


Figure 35 Use and recommendation of technology-based suicide prevention methods by region
1

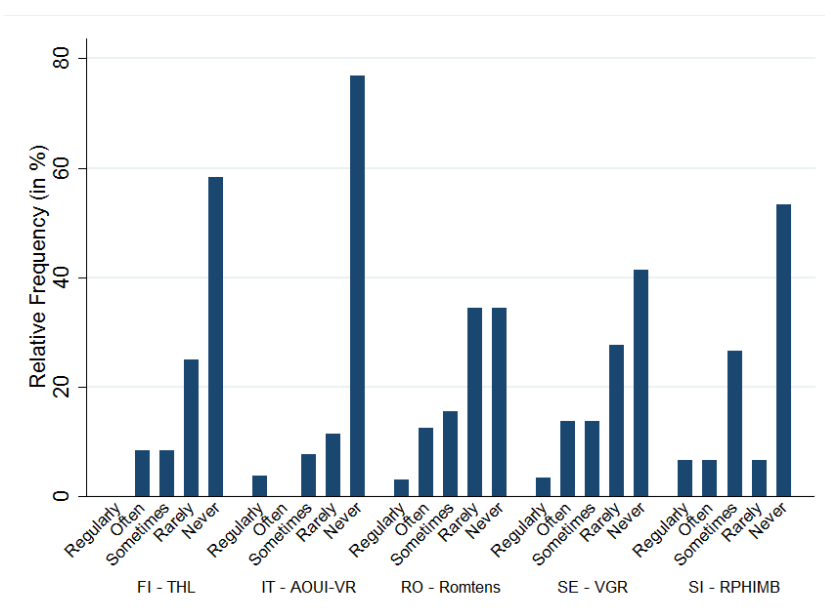


Figure 36 Use and recommendation of technology-based suicide prevention methods by region
2

2.4.1.3 How is the relationship between usage/recommendation of TBSP methods and age group?

Considering the relationship between attitudes towards TBSP methods and age it becomes clear that the younger participants (aged 20-29) most frequently use or recommend TBSP

methods (23% often, 27% sometimes). In the 30-39 age bracket 23% sometimes use or recommend TBSP. More than 50% of the participants aged over 40 never use or recommend TBSP, s. Figure 37 .

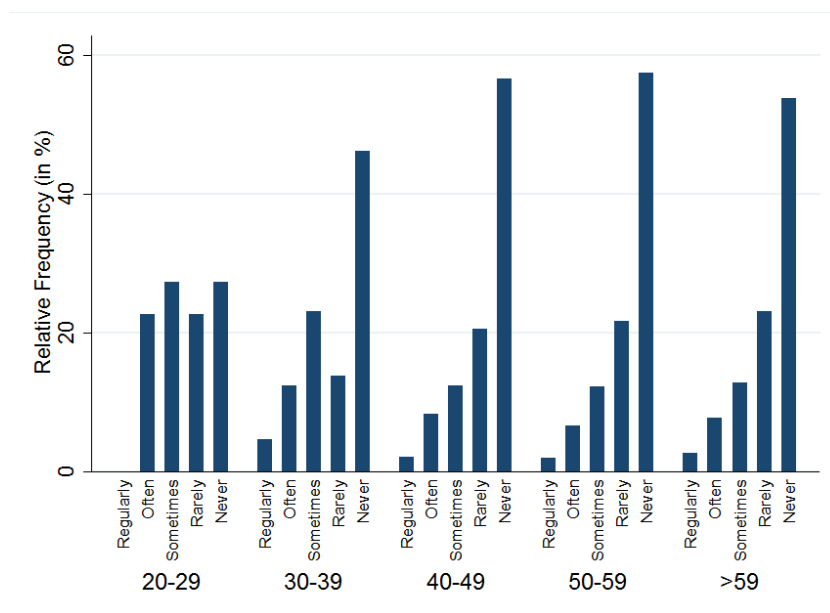


Figure 37 Use and recommendation of technology-based suicide prevention methods by age

2.4.1.4 What would encourage you to use TBSP methods?

The use of TBSP depends on various criteria which are differently important. The “easily accessible” and “free, no extra costs” criteria take the most important meaning. On the contrary, “more automated applications” seem to be of minor importance, s. Table 14.

Table 14 Facts that encourage the use of technology-based suicide prevention methods by stakeholder

Variable	DPM	MHP	NGO	MEAN
More information on the subject through training	3,4	3,9	3,8	3,7
More information on the subject through newsletter	3,2	3,3	3,3	3,2
More automated applications	3,1	3,3	3,0	3,1
Easily accessible	4,1	4,1	4,3	4,2
Guaranteed anonymity	3,9	3,8	4,0	3,9
Time saving	3,9	3,6	3,6	3,7
Cost saving	3,9	3,2	3,5	3,6
Free, no extra costs	4,3	3,9	4,2	4,1
Mean Scores, range: 1=Not at all, 5=Definitely				

Especially important for Germany, Romania and Slovenia was the ‘guaranteed anonymity’ criterion. The criterion ‘more information on the subject through newsletter’ appealed less important, s. Table 15.

Table 15 Facts that encourage the use of technology-based suicide prevention methods by region

Variable	BE - VAZG, Ughent	DE - TUD	ES - Intras	ES - SAS, FPS	FI - MAMK	FI - THL	IT - AOUI- VR	RO - Romtens	SE - VGR	SI - RPHIMB
More information on the subject through training	3,6	3,3	3,8	3,5	4,0	3,5	3,4	4,3	4,0	4,1
More information on the subject through newsletter	3,3	2,7	3,3	3,0	3,5	3,5	2,5	3,4	3,4	3,9
More automated applications	3,4	2,4	3,5	3,1	3,1	2,9	2,8	3,4	2,8	3,7
Easily accessible	4,4	4,0	4,1	4,3	4,1	3,7	3,7	4,6	4,4	4,0
Guaranteed anonymity	3,9	4,1	3,7	3,9	3,5	3,9	3,7	4,1	3,7	4,3
Time saving	3,8	3,5	3,6	3,7	3,4	3,1	3,6	4,2	3,5	4,1
Cost saving	3,2	3,4	3,6	3,8	3,0	3,2	3,6	4,0	3,1	4,1
Free, no extra costs	4,0	4,1	3,9	4,4	4,1	3,8	3,9	4,4	4,1	4,6
Mean Scores, range: 1=Not at all, 5=Definitely										

2.4.1.5 What keeps you from using/recommending technology-based suicide prevention programs?

Moreover, the use of TBSP is influenced by some negative criteria, s. Figure 38 . Considering the participants of the MHP division it becomes clear that almost 79% have “no knowledge about TBSP methods (59% DPM, 66% NGO). The “no knowledge about the evidence of the usefulness of TBSP programs” criterion plays an important role as well regarding negative attitudes towards TBSP (62% DPM, 69% MHP, 56% NGO). For the MHP division the “no TBSP programs available” (63%) criterion is also a reason for negative attitudes against this technology. At the country level the distributions are quite similar as can be seen in Table 41 in the Annex.

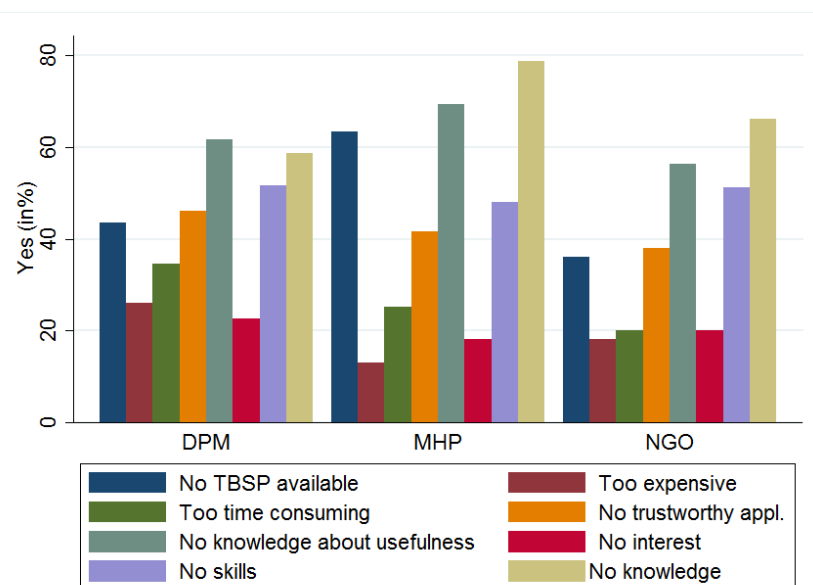


Figure 38 Facts that keeps the use of technology-based suicide prevention methods by stakeholder

2.4.1.6 Are there different factors enhancing/hampering the use of TBSP methods depending on professional sub-categories?

Regarding the question “What would you consider essential in the contents of a technology-based suicide prevention program for suicidal persons” especially “free, no extra costs” and “easily accessible” were mentioned. The “newsletters” format gets less support for the dissemination of information. The professional sub-category social workers have a less positive attitude towards more automated applications, s. Table 16.

Table 16 Enhancing factors for technology-based suicide prevention programs by professional sub-categories

Mean score (1=Not at all, 5=Definitely)	Professional Social Workers	Staff of a non-governmental organization	Teachers	Criminal justice stakeholder	Decision and policy makers from local and regional authorities	Decision and policy makers in public health institutions	General practitioner	Inpatient psychologist	Inpatient psychiatrist	Nursing staff of psychiatric patients
More information on the subject through training	3,8	4,1	4,3	3,9	3,2	4,0	4,1	3,7	3,5	4,0
More information on the subject through newsletter	3,7	3,6	3,6	3,1	2,8	3,9	3,4	3,0	2,9	3,2
More automated applications	2,7	3,4	3,4	3,0	3,0	3,2	3,2	3,2	3,1	3,3
Easily accessible	4,4	4,5	4,5	4,2	4,1	4,1	4,3	3,8	4,0	4,2
Guaranteed anonymity	4,4	4,1	4,4	4,0	3,7	4,1	3,9	3,7	3,6	3,8
Time saving	3,9	4,2	3,6	3,6	3,5	4,1	3,9	3,1	3,5	3,4
Cost saving	3,6	4,0	3,5	3,3	3,8	4,1	3,5	3,1	3,2	2,9
Free, no extra costs	4,5	4,3	4,2	3,9	4,4	4,4	3,7	4,2	3,8	3,9

The following points were frequently named on the question of “What keeps you from using/recommending technology-based suicide prevention programs?”: “No knowledge about the evidence of the usefulness of technology-based suicide prevention programs” and “No knowledge about technology-based suicide prevention programs”. On the other hand, “No interest in technology-based suicide prevention programs” plays a less important role, implicating that most stakeholders are in fact interested in TBSP, s. Table 17.

Table 17 Hampering factors for technology-based suicide prevention programs by professional sub-categories

Yes in %	Professional Social Workers	Staff of a non-governmental organization	Teachers	Criminal justice stakeholder	Decision and policy makers from local and regional authorities	Decision and policy makers in public health institutions	General practitioner	Inpatient psychologist	Inpatient psychiatrist	Nursing staff of psychiatric patients
No technology-based suicide prevention programs available	33	39	67	25	53	33	56	67	75	86
Too expensive	44	19	0	0	32	18	33	0	20	11
Too time consuming	30	6	67	25	39	27	50	0	27	16
No trustworthy applications	36	31	67	50	58	55	44	56	29	53
No knowledge about the evidence of the usefulness of technology-based suicide prevention programs	73	52	80	43	76	64	55	67	72	82
No interest in technology-based suicide prevention programs	20	12	33	0	24	9	9	10	6	26
No skills in the use of technology-based suicide prevention programs	60	29	78	60	63	50	62	40	35	53
No skills in the use of technology-based suicide prevention programs in persons at risk of suicide	59	63	88	60	63	58	81	92	59	80



2.4.2 Contents and Guidelines

2.4.2.1 What would you consider essential in the contents of a technology-based suicide prevention program for suicidal persons?

In order to design the analysis of the data more clear the test results were fragmented in these questions of the 2 charts.

Table 18, Table 19 and Table 20 shows the mean ratings for different contents of TBSP programs by stakeholder category. Most contents like information on suicide prevention, links to suicide prevention helplines, and information on warning signs receive a very high average score of 4 and above across all stakeholder categories. In contrast, all stakeholders are more skeptical about information on suicide methods. According to Table 20 evidence based therapy, supervision by professionals as well as the presence of a crisis plan are of high relevance. The latter is particularly highlighted by MHPs which might reflect their experiences in daily work. Even if one has to bear in mind that the differences are not excessively large the exchange of experiences as well as therapeutic chats and internet forums are on average rated relatively worse.

Table 18 Essential contents of a technology-based suicide prevention program (DPM)

Essential contents of a technology-based suicide prevention program (DPM)	
Information on prevention of suicide	4,3
Information on warning signs, risk factors and protective factors	4,2
Information on suicide methods	3,1
Links to suicide prevention helplines	4,5
Risk assessment test	3,9
Referral to a professional	4,2
Evidence based therapy	4,2
Offering solutions to the problems of a suicidal person	4,1
Crisis plan present in case person is highly suicidal	4,0
Chats led by a professional	3,9
Chats and internet forums serve as a support	3,6
Chats and internet forums should be therapeutic	3,4
Exchanging experiences between suicidal people	3,2
Supervised by a professional	4,2

**Table 19 Essential contents of a technology-based suicide prevention program (MHP)**

Essential contents of a technology-based suicide prevention program (MHP)	
Information on prevention of suicide	4,2
Information on warning signs, risk factors and protective factors	4,7
Information on suicide methods	2,8
Links to suicide prevention helplines	4,2
Risk assessment test	4,0
Referral to a professional	4,4
Evidence based therapy	3,8
Offering solutions to the problems of a suicidal person	4,1
Crisis plan present in case person is highly suicidal	4,5
Chats led by a professional	3,5
Chats and internet forums serve as a support	3,3
Chats and internet forums should be therapeutic	3,0
Exchanging experiences between suicidal people	3,0
Supervised by a professional	4,2

Table 20 Essential contents of a technology-based suicide prevention program (NGO)

Essential contents of a technology-based suicide prevention program (NGO)	
Information on prevention of suicide	4,4
Information on warning signs, risk factors and protective factors	4,2
Information on suicide methods	3,1
Links to suicide prevention helplines	4,3
Risk assessment test	4,0
Referral to a professional	4,4
Evidence based therapy	4,1
Offering solutions to the problems of a suicidal person	3,9
Crisis plan present in case person is highly suicidal	4,2
Chats led by a professional	3,7
Chats and internet forums serve as a support	3,5
Chats and internet forums should be therapeutic	3,2
Exchanging experiences between suicidal people	3,5
Supervised by a professional	4,3



2.4.2.2 Which contents are essential for different professional sub-categories?

Regarding the evaluation of the specific contents of a TBSP programs by different professions, the „Information on warning signs, risk factors and protective factors“ is rated most important, but never the less there are differences within professional sub-categories. Thus, the „staff of a non-governmental organization“ rank the “information on warning signs, risk factors and protective factors” quite high, but they indicate that “links to suicide prevention helpline”, “referral to a professional (organization)”, “evidence based therapy”, “crisis plan present in case person is highly suicidal” and “supervised by a professional” are even more important. The “teachers” see the reputation of contents like “exchanging experiences between suicidal people” and “supervised by a professional” as more important, which is also the case for the “inpatient psychologists” in the matter of “referral to a professional (organization)”. The “information on suicide methods” is generally ranked low throughout all sub-categories except for “teachers” and “general practitioners”. It is assumed that especially teachers highly value information on suicidal methods in order to be sensitive about relevant warning signals. For practitioners this information would be of great use in order to prescribe medication and to identify attempted suicide in patients, s. Table 21. The question is about what the content should be of a TBSP program for suicidal persons, not for people who work with suicidal persons. As research shows, it is not advisable to give information about suicide methods to suicidal persons (Boor, Myron 1981). This item was a tricky question. It seems that the people who scored high on this item either did not pay attention when filling out the question, or they do not know that you should not give information on suicide methods to a suicidal person.

Table 21 Essential contents of a technology-based suicide prevention program by professional sub-categories

Mean Score, range: 1-5	Professional social worker	Staff of a non-governmental organization	Teacher	Criminal justice stakeholder	General practitioner	Outpatient psychologist	Inpatient psychologist	Outpatient psychiatrist	Inpatient psychiatrist	Nursing staff of psychiatric patients
Information on prevention of suicide	4,5	4,5	4,6	4,4	4,3	4,5	3,8	4,4	3,8	4,5
Information on warning signs, risk factors and protective factors	4,7	4,2	4,5	4,5	4,6	4,9	4,6	4,9	4,4	4,9
Information on suicide methods	2,9	3,0	4,0	3,5	3,7	2,6	2,2	2,9	2,4	2,8
Links to suicide prevention helplines	4,7	4,7	4,2	3,8	4,1	4,4	4,5	3,9	3,9	4,4
Risk assessment test	3,8	3,9	4,2	3,9	4,4	4,4	3,8	3,4	3,8	3,8
Referral to a professional (organization)	4,6	4,4	4,5	4,4	4,2	4,6	4,7	3,9	4,2	4,4
Evidence based therapy	3,8	4,4	4,5	3,7	3,9	3,7	4,0	3,7	3,7	3,3
Offering solutions to the problems of a suicidal person	3,7	3,9	4,5	4,3	4,2	4,3	4,2	4,0	3,7	4,1
Crisis plan present in case person is highly suicidal	4,3	4,4	4,4	4,4	4,3	4,3	4,5	4,6	4,4	4,5
Chats led by a professional	3,9	4,0	3,3	3,3	3,6	4,3	3,7	3,3	2,8	3,4
Chats and internet forums serve as a support	3,6	3,7	3,3	3,3	3,2	4,1	3,2	3,3	2,7	3,3
Chats and internet forums should be therapeutic	3,3	3,3	3,5	3,1	3,1	3,4	3,5	2,7	2,4	2,9
Exchanging experiences between suicidal people	3,0	3,6	4,6	3,6	3,5	3,4	2,8	3,3	2,6	3,0
Supervised by a professional	4,2	4,4	4,6	4,0	4,1	4,2	4,6	4,0	3,4	4,4

2.4.2.3 What technology-based suicide prevention service do you use/would you consider using for suicidal persons?

The “website” appears most useful of all TBSP services/tools for suicidal persons to the entire stakeholder categories followed by “e-mail”. On the whole, the evaluation of the TBSP alternatives is quite similar between stakeholder groups. “Serious gaming” and “social networking” are rated on the last places although in the DPM stakeholder category the “social networking” is rated even worse – reversed to the other stakeholder groups, s. Figure 39.

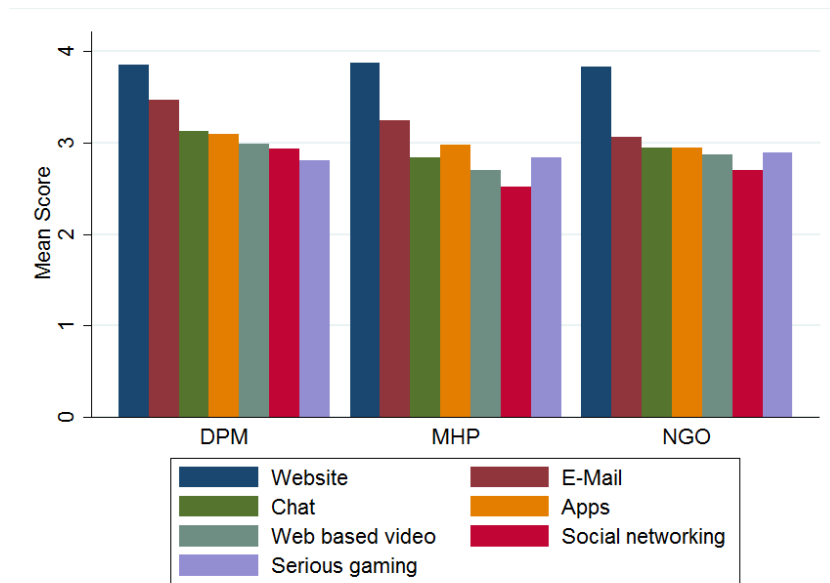


Figure 39 Use/ consider using of technology-based suicide prevention programs by stakeholder

The respondents in Romania and Slovenia expect “Apps” to be most useful regarding TBSP. On the one hand, the German interview participants don’t expect a lot of this possible TBSP format (1,8) on the other hand the evaluation of the other research countries lies in a neutral field with an average value of 3, s. Figure 54 in the Annex.

The TBSP format “chat” does not get good ratings either. The highest values are again given by Romania (3,9) and Slovenia (3,5). The interview partners from Sweden and Finland (MAMK) give more negative grades with an average value of about 2. In Finland, however, the regional difference of 1 scale point is quite clear (value Finland THL). Altogether the TBSP format “chat” is evaluated as not very useful as already mentioned, s. Figure 55 in the Annex.

The “e-mail” model is considered more useful. Even if not all of the respondents give to high values like those in Slovenia (4,1) and Romania (3,8) an average of 3 and better is the rule, s. Figure 56 in the Annex.

The fewest participants of the interview think that the TBSP format “serious gaming” is a good thing. Even the highest evaluation that was recorded by the THL institute in Finland only reaches a value of 3,6. The worst evaluations of the usefulness of this format come from Germany (TUD) and Italy (AQUI-VR), s. Figure 57 in the Annex.



Also the „serious networking“ model is rated negatively by the research participants. Here the most positive evaluation comes from the Romtens institute in Romania (3,3). The most negative evaluations comes from Germany (TUD) with a value of 2,0, s. Figure 58 in the Annex.

From the German Institution (TUD) an even worse evaluation concerning the TBSP format “web-bases Videos“ is existent with a value of 1,8. However, even if the interview partners from the other research institutions evaluate this format as not very useful as well, it appears more useful to them than the “Serious networking” model. The institutions of Romania and Slovenia give the highest ratings for this tool, s. Figure 59 in the Annex.

The Website gets significantly better grades. It is seen as the most useful TBSP format prior to “e-mail”. Particularly in Slovenia (4,4), Belgium (4,4) and Romania (3,5) the respondents are convinced of this. The respondents from Italy are more skeptical. However, with the value of 3,3 there is no negative evaluation, s. Figure 60 in the Annex.

2.4.2.4 Which ethical guidelines concerning technology-based suicide prevention programs are you familiar with?

It becomes clear that the majority of the interview participants across all stakeholder categories are not familiar with ethical guidelines regarding TBSP programs. There are almost similar results (90%) for the respondents of the DPM and MHP categories. In the NGO stakeholder category a higher familiarity with ethical guideline is reported although there are very high “not familiar”- values, too (80%), s. Figure 40.

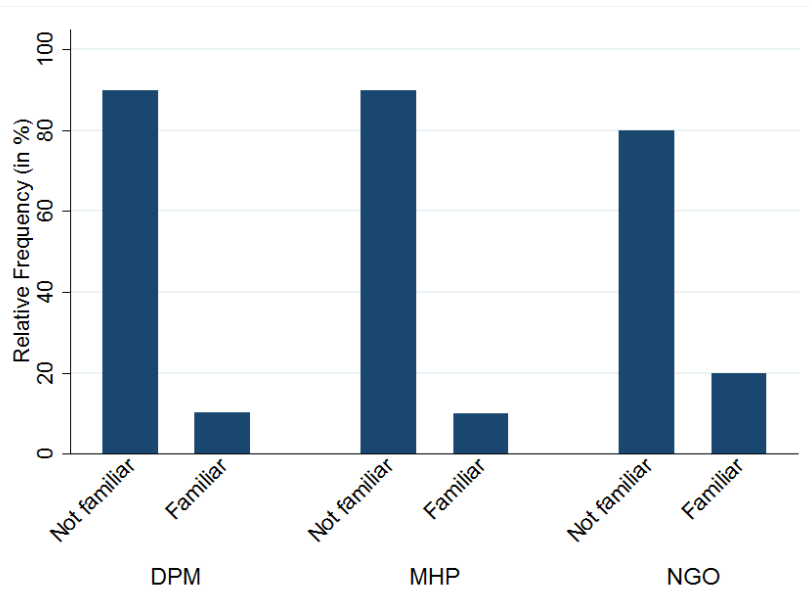


Figure 40 Familiarity with ethical guidelines by stakeholder

A more differentiated picture can be observed between different regions.

Whilst 100% of the respondents in Spain (INTRANS) state that they're not familiar with ethical guidelines concerning TBSP programs the majority of respondents in is familiar with them. However, the THL institution in Finland reports a lot more answers in "not familiar" than in "familiar". Even though the findings are quite clear for every research country the findings of Belgium, Germany and Spain (altogether) attract attention as the response decline in favor of the "not familiar" category is most considerable in these countries, s. Figure 81 in the Annex.

2.4.2.5 Do you use them?

Given that the ethical guidelines regarding TBSP programs are not known by the research participants in most instances, they don't use them. This holds true for all stakeholder categories whereupon the result of the MHP comes up clearest. Here about 70% of the respondents answered with "no" to the question "Do you use them (ethical guidelines concerning TBSP programs)?", s. Figure 41.

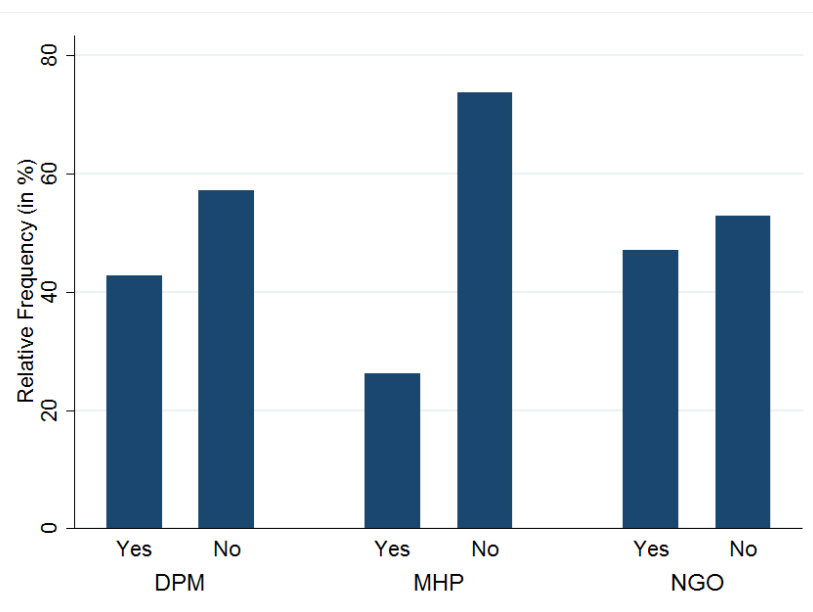


Figure 41 Use of ethical guidelines by stakeholder

Evaluated by institutions the differences becomes clearer. Besides Finland and Slovenia where the majority of respondents said that they use ethical guidelines concerning TBSP programs and Germany where at least half of the respondents use them, the response category “No” outbalances in the rest of the research countries. The highest values in this category were reached in Italy and Spain (INTRAS), s. Figure 42.

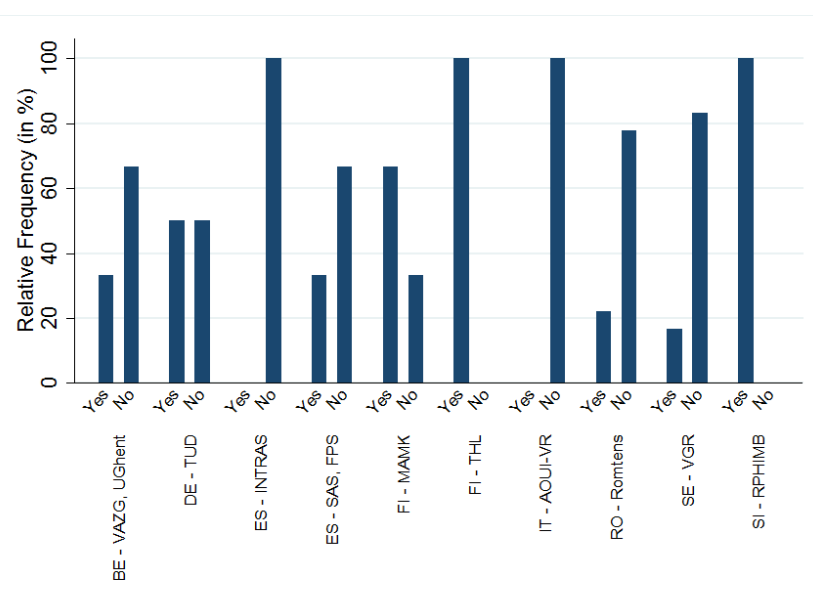


Figure 42 Use of ethical guidelines by region

2.4.3 Hosting and Financing

2.4.3.1 In your opinion, who should be responsible for financing and supervising (hosting, technical support, storage of data etc.) the service in your region?

For all three stakeholder categories it becomes clear that the assumption of costs for the various types of TBSP should basically be borne by regional governments and health authorities. This becomes evident for the website and e-therapy, s. Table 22.

Table 22 Responsible for financing of the technology-based suicide prevention by stakeholder

DPM (in %)							
Responsible for Financing	Website	E-therapy	Chat	Apps	Web-based video	Social networking	Serious gaming
National Gov.	36	18	23	28	31	26	28
Regional Gov./Health Auth.	53	39	27	32	25	22	25
Insurance Companies	4	8	6	9	9	4	13
Mental Health Institutes	5	30	30	15	13	16	13
End User	3	5	14	15	21	32	20
Total	100	100	100	100	100	100	100
MHP (in %)							
Responsible for Financing	Website	E-therapy	Chat	Apps	Web-based video	Social networking	Serious gaming
National Gov.	38	14	19	31	31	24	23
Regional Gov./Health Auth.	37	36	29	26	22	21	19
Insurance Companies	3	8	9	5	8	7	7
Mental Health Institutes	18	36	25	18	19	16	27
End User	3	6	17	20	20	32	24
Total	100	100	100	100	100	100	100
NGO (in %)							
Responsible for Financing	Website	E-therapy	Chat	Apps	Web-based video	Social networking	Serious gaming
National Gov.	39	21	20	29	27	18	24
Regional Gov./Health Auth.	40	39	33	27	26	28	29
Insurance Companies	3	12	8	10	9	9	17
Mental Health Institutes	18	26	21	21	24	24	12
End User	0	2	18	13	14	20	18
Total	100	100	100	100	100	100	100



The participants of the questionnaire had a very similar responding behavior in all of the three categories concerning the responsibility for the supervision of TBSP. Especially the Mental Health Institutes and regional governments/health authorities are seen as responsible for supervision. This mainly concerns the following applications: “Chat” and “Serious gaming”, s. Table 23.

In addition a clear separation for each country can be reviewed, s. Figure 82 - Figure 109 in the Annex.

Table 23 Responsible for supervising of the technology-based suicide prevention by stakeholder

DPM (in %)							
Responsible for Supervision	Website	E-therapy	Chat	Apps	Web-based video	Social networking	Serious gaming
National Gov.	24	10	14	20	19	24	23
Regional Gov./Health Auth.	43	36	30	37	31	24	19
Insurance Companies	7	5	3	3	4	5	11
Mental Health Institutes	27	48	49	37	37	33	42
End User	0	1	4	3	7	14	6
Total	100	100	100	100	100	100	100
MHP (in %)							
Responsible for Supervision	Website	E-therapy	Chat	Apps	Web-based video	Social networking	Serious gaming
National Gov.	31	15	21	26	25	23	22
Regional Gov./Health Auth.	32	27	22	29	23	24	16
Insurance Companies	2	1	1	1	3	2	2
Mental Health Institutes	35	56	48	39	39	38	51
End User	0	0	8	5	10	14	9
Total	100	100	100	100	100	100	100
NGO (in %)							
Responsible for Supervision	Website	E-therapy	Chat	Apps	Web-based video	Social networking	Serious gaming
National Gov.	24	19	14	24	24	19	19
Regional Gov./Health Auth.	38	31	32	33	32	34	36
Insurance Companies	1	5	3	7	5	3	3
Mental Health Institutes	34	42	41	31	30	33	32
End User	3	3	9	6	10	10	11
Total	100	100	100	100	100	100	100

The contingency tables reported in the annex point out a strong relationship between financing and supervising. Stakeholders holding a certain institution responsible for financing a service also tend to hold it responsible for supervision. As is indicated by the Chi-squared tests this result is stable across all services, s. Table 42 and Table 43 in the Annex.

2.5 Training Needs

2.5.1 Are you aware of training initiatives for early detection/recognition and referral of suicide risks (suicide prevention) in your institution/work area?

“Are you aware of training initiatives for early detection/recognition and referral of suicide risks (suicide prevention) in your institution/area?” over 60% of the respondents from each stakeholder category DPM as well as NGO answered “No” to that question. Only about 30% of the interview participants in both categories said that they are informed about such training offers in their environment. Interestingly, the values of both categories do not differ significantly. Therefore it does not seem that knowledge about SP or even the offering of it is a profession-specific phenomenon, s. Figure 43.

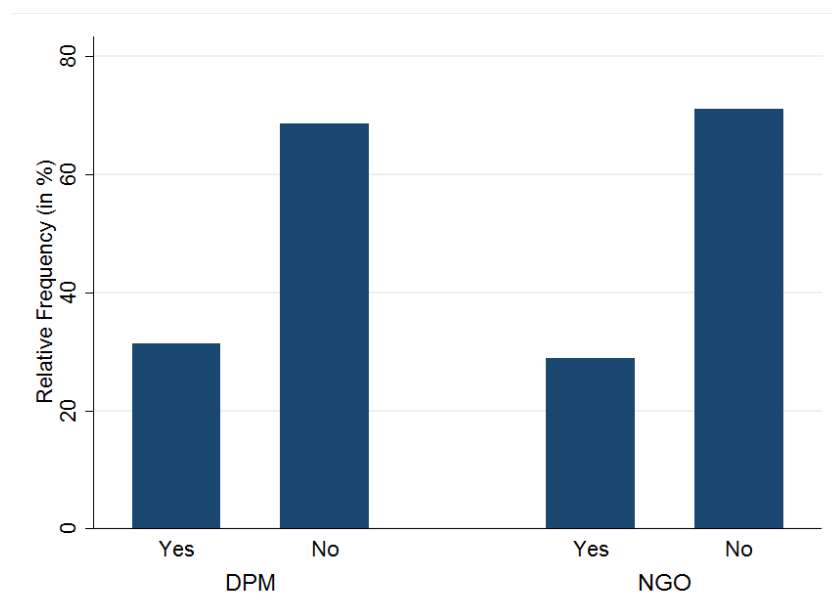


Figure 43 Awareness of training initiatives by stakeholder

2.5.2 Please specify which professional sub-category is involved in this training

According to the interview participants especially outpatient psychologists (58%), inpatient psychologists (50%) and general practitioners (49%) participate in “training for early detection/recognition and referral of suicide risks (suicide prevention)”.

Paramedics/emergency (26%), police (30%) and nursing staff (33%) are least integrated in such SP strategies according to the results. The analysis by region points out that especially the Belgian and Finns (MAMK region) participate frequently in these trainings whereas there is a low supply and demand for participating in “trainings for early detection/recognition and referral of suicide risks (suicide prevention)” in Italy (12%), Romania (23%) and Sweden (23%). Within Finland great regional differences become clear concerning to this object of investigation: while in the region that was researched by the MAMK the majority is involved in SP strategies (68%) there are not even half as many (26%) in the region researched by THL. Beside these results, the small number of observations underlying this specific analysis becomes obvious in Spain, Finland, Romania and Slovenia. This fact challenges the validity of the results, s. Table 24.

Table 24 Professional sub-categories which are involved in the training by region

Involved (in %)	BE - VAZG, UGhent	DE - TUD	ES - INTRAS	ES - SAS, FPS	FI - MAMK	FI - THL	IT - AOUI-VR	RO - Rontens	SE - VGR	SI - RPHIMB
General practitioner	72	67	0	80	67	33	11	100	11	50
Outpatient psychologist	67	50	100	60	67	33	16	50	39	100
Inpatient psychologist	78	83	100	40	67	0	11	0	22	100
Outpatient psychiatrist	50	50	100	40	33	33	16	50	28	50
Inpatient psychiatrist	44	83	100	20	33	0	0	0	17	50
Other	50	33	0	20	100			0	28	0
Emergency doctor	44	0	0	60	67	33	21	50	11	100
Nursing staff	78	33	0	60	67	33	5	0	50	0
Staff of emergency room	67	0	100	60	100	33	5	0	17	50
Paramedics, emergency paramedics	61	0	0	20	100	0	11	0	17	50
Police	72	33	0	40	50	63	28	0	17	0

2.5.3 MHP: Please indicate if you use guidelines for referral of persons at suicide risk to public health services

It is surprising how little such an important part as the referral of suicidal persons to Public Health Services is supported by guidelines. Only two countries, Romania and Slovenia, show a higher amount of “yes”- than “no” answers regarding the question if they make use of guidelines for referral of persons at suicide risk to public health services. Here, the gap between “yes” and “no” answers is lower than the gap for the other regions, which’s respondents state that there are no such guidelines. Most eye-catching in this context is Spain, instantly followed by Finland and Italy. In Sweden (55%) and Belgium (56%) there are scarcities concerning the guidelines for referral of persons at suicide risk to public health services as well, s. Figure 44.

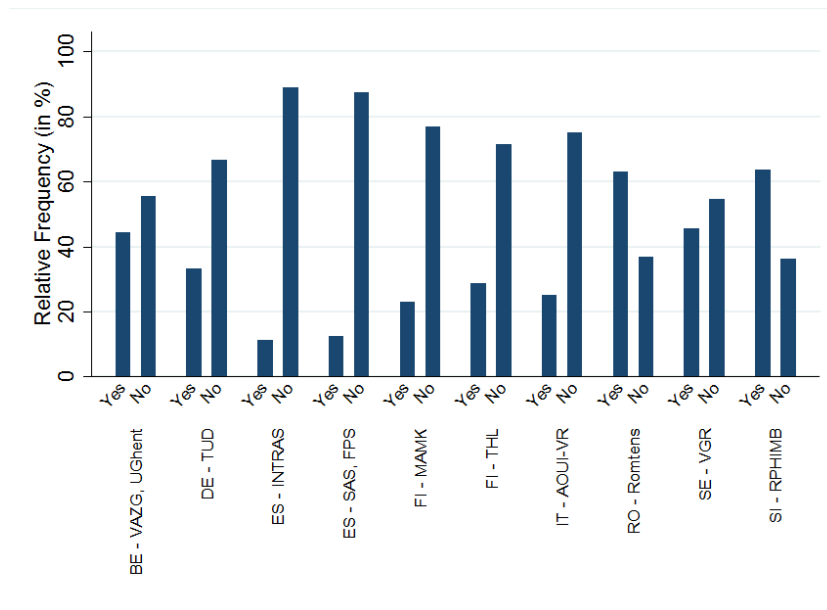


Figure 44 Usage of guidelines for referral of persons by region

2.5.4 How is the usage of guidelines in different professional sub-categories?

According to professional qualifications a differentiated pattern is observed.

A total of 100% of the “Staff of emergency room” state that there are guidelines for referral of persons at suicide risk to public health services. Interestingly, only 57,14% of the Emergency doctors answered this question with “yes”. It can be expected that country specific differences play a crucial role in explaining this result. It seems that there are few available guidelines for referral of persons at suicide risk to public health services for Inpatient Psychiatrists and Nursing Staff of psychiatric patients (17,65% and 28,57%). This could be related to the fact, that a psychiatry is often the end in a chain of referrals of suicidal persons, this means that there is little demand in a psychiatry itself for a possible referral of patients, s. Table 25.

Table 25 Usage of guidelines for referral of persons by professional sub-categories (MHP)

Professional category	Yes (in %)
General practitioner	47,06
Outpatient psychologist	62,5
Inpatient psychologist	50
Outpatient psychiatrist	33,33
Inpatient psychiatrist	17,65
Emergency doctor	57,14
Nursing staff of psychiatric patients	28,57
Staff of emergency room	100

Regarding the usage of guidelines for referral of persons at suicide risk to public health services, Figure 45 states that there is not much difference between age groups. In tendency, stakeholders in the age between 20 and 29 seem to make more use of corresponding guidelines whereas the lowest value is reached in the age group of 50-59 (23%). On the whole, the majority of stakeholders do not use these guidelines regardless of age.

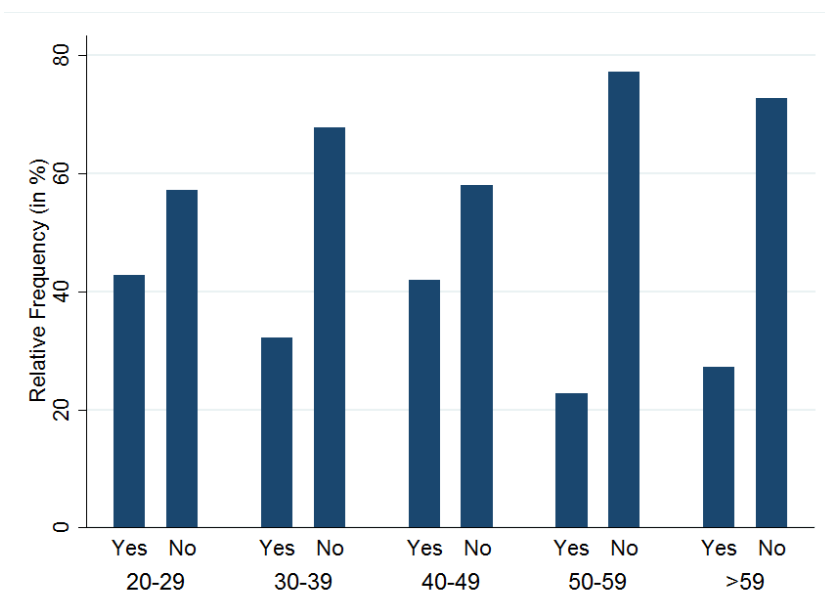


Figure 45 Usage of guidelines for referral of persons by age

2.5.5 Please indicate if you have received training in the use of these guidelines

The respondents, who stated the availability of guidelines for referral of persons at suicide risk to public health services are trained differently well in the usage of the guidelines according to the region of employment. In Germany and in the Region of Finland, which was researched by the THL, 100% of the respondents indicate that they received training in using the guidelines. However, in the region of Finland, researched by MAMK, this value is only about 50%. In the Region of Spain, researched by the INTRAS, the lowest number – in contrast – indicate to be trained in using the guidelines (ca. 21%), s. Figure 46.

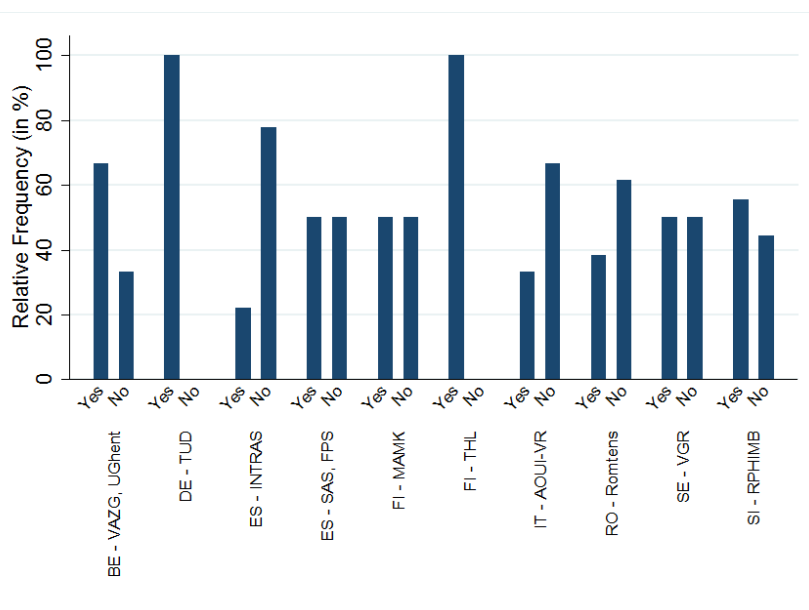


Figure 46 Received training in the use of the guidelines by region

Analyzing the respondent's answers by age shows that the strong increase of non-guideline trained interview partners above the age 59 years is noticeable. The second highest record in this matter is marked interestingly by the group of 20-29 year olds, s. Figure 47.

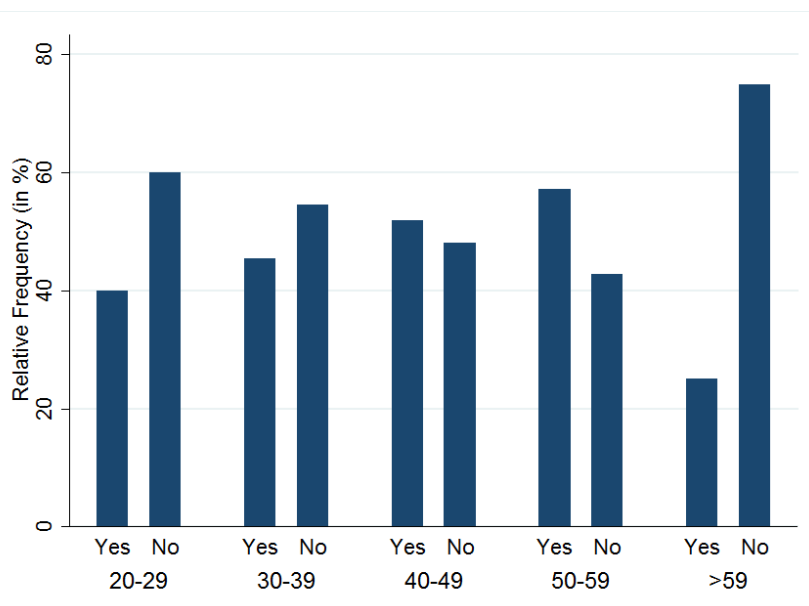


Figure 47 Received training in the use of the guidelines by age



2.5.6 Please indicate if you would find training in the use of these guidelines useful for your daily professional activities

Most participants who stated that they did not experience a training regarding the guidelines for referrals of persons at suicide risk to public health services would profit from such training and the acceptance for such training programs reaches scores over 100% (in Belgium, Spain (SAS, FPS), Finland (MAMK), Italy, Sweden and Slovenia). Such training is welcome in Spain (INTRAS) and Romania as well, s. Figure 48.

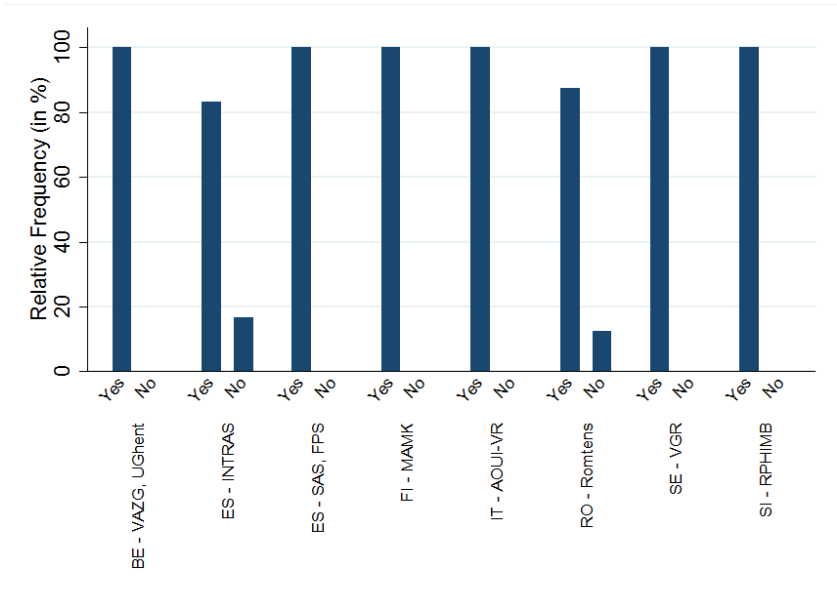


Figure 48 Usefulness of training in the use of the guidelines by region

All of the participants (100%), aged between 20-29 years, believe that a training concerning the handling of the guidelines for referrals of persons at suicide risk to public health services is useful. The age groups up to 59 years of age show a high level of acceptance as well, whereas this rate drops to about 67% for participants above 59 years of age, s. Figure 110 in the Annex.

2.5.7 Please indicate which, in your view, should be the contents of a training course for early detection/recognition and referral of suicidal risk

Most participants (81%) would prefer a training course for early detection to develop and share guidelines and protocols. A training for “practical Skills” is desired by 73% of the participants followed by an “Overview of services/resources in my local area” with 64% welcoming such an option. With only 55%, the lowest degree of interest is towards “scientific literature”. The lowest desire for a training in “Practical skills” can be found among emergency doctors with 29% as they prefer “guidelines and protocols” (100%), which is also favored by nursing staff of psychiatric patients (89%). In contrast, inpatient psychiatrist have a relatively low interest in “guidelines and protocols” (56%) and prefer an “overview of services/resources in my local area”, which interestingly is regarded as superfluous by emergency doctors with 0% of the participants being interested, s. Table 26.

Table 26 Contents of a training course for early detection by professional sub-categories

Yes (in %)	General practitioner	Outpatient psychologist	Inpatient psychologist	Outpatient psychiatrist	Inpatient psychiatrist	Emergency doctor	Nursing staff of psychiatric patients	Paramedics, emergency paramedics
Scientific literature	65	50	42	67	56	57	23	80
Websites and web tools for health professionals	53	75	58	83	44	43	74	60
Overview of services/resources in my local area	76	88	50	83	67	0	71	80
Practical skills	82	82	71	75	75	29	83	83
Guidelines/ protocols	76	88	75	83	56	100	89	80
	71	76	59	78	59	46	68	77

Regarding the evaluation of the “guidelines and protocols” of different results from different institutes, the one that stands out comes from the participants of the TUD (Germany). Contrary to the positive approval of most institutes the TUD’s respondents do not agree with possible benefits and almost 56% gave negative answers (no-category), s. Figure 111 in the Annex.

The interest in “scientific literature” as a possible key aspect of training is relatively low. However, the majority (55%) – except for the Spanish and Finnish respondents – do see a benefit (especially in Italy), s. Figure 114 in the Annex.

Most participants are interested in getting an “overview of services/resources in my local area”, with the exception of INTRAS in Spain and Romania having a lower degree of interest (INTRAS 50%, ROMTENS 53%),s. Figure 113 in the Annex.

“Practical skills” as a key point of training is favored by all participants, with the maximum value of agreement being reached in the THL Finland (100% Yes-Category) and the lowest in Rumania with 53%, s. Figure 114 in the Annex.

The concept of “Websites and web tools for health professionals” is perceived rather well. The highest level of agreement can be found in Belgium (86%) and the lowest in Italy and Sweden, s. Figure 115 in the Annex.

A more precise analysis can be performed when looking at the key points of training based on the answers of different age groups. Participants between 20 and 29 years of age were least interested in “scientific literature” (14%) and the highest point of interest in “scientific literature” can be found in the age group above 59 years with 67%, who at the same time gave “websites and web tools for health professionals” the lowest priority with 25%. This might be due to the fact that younger participants are still influenced by their educational career, whereas older participants might not feel as comfortable as younger generations in using digital media. All age groups saw a benefit in “practical skills” with the maximum agreement of 100% in the age group of 20-29 and the lowest in the age group of 50-59 years (73%), s. Table 27.

Table 27 Contents of a training course for early detection by age

Yes (in %)	20-29	30-39	40-49	50-59	>59
Scientific literature	14	57	51	36	67
Websites and web tools for health professionals	57	75	71	56	25
Overview of services/ resources in my local area	86	68	82	51	75
Practical skills	100	79	76	73	75
Guidelines/ protocols	86	79	90	73	58

2.5.8 How long should the training course last?

The question “How long should the training course last?” was answered with “several sessions during the year” (43,25% mean). The need for an extended training period becomes visible when looking at the shortest period of time (“Half a day”), where 4 out of 8 professional sub-categories answered with “0” stating that this is insufficient for training. However, this result needs to be differentiated a bit more. Taking a closer look at different professional sub-categories, 0% of Outpatient psychologists answered that “Several sessions during the year”

are necessary, which is close to Outpatient psychiatrists, who gave “Several sessions during the year” 17%, s. Table 28.

Table 28 Duration of training course by professional sub-categories

Yes (in %)	General practitioner	Outpatient psychologist	Inpatient psychologist	Outpatient psychiatrist	Inpatient psychiatrist	Emergency doctor	Nursing staff of psychiatric patients	Paramedics, emergency paramedics
Half a day	18	25	0	20	17	0	0	0
One day	35	25	17	0	11	14	26	20
Several sessions during one month	12	38	17	50	33	29	29	40
Several sessions during the year	47	0	67	17	39	57	59	60

Considering the age groups, the highest agreement towards “several sessions during the year” was among those of 59 years or more (92%). The participants between 30 and 39 years of age are least interested in such a training period and appear to be undecided, voting with 32% both for “several sessions during one month” and “several sessions during the year”. The age group 20-29 is most interested in “one day” and “several sessions during the day” (both 43%), s. Table 44 in the Annex.

2.5.9 Please indicate under which conditions it would be easier for you to participate in this training

In a nutshell, the question under what circumstances the participants would think of such a training as manageable the answer was: a training in the morning, that is free of charge, accredited by the employer, and consists equally of face-to-face training and e-learning. The only professional sub-category that would prefer a training in the evening was the group of general practitioners (47%) who, together with the outpatient psychiatrists (83%), also wish for such a training to be accredited by the national health system (65%). 100% of the outpatient psychiatrists answered that such a training should be free of charge, whereas outpatient psychologists would also be interested in a paid training. For the majority of the interview participants vesper time training is out of the question. Here the refusal is at 100% and accordingly 0% of approval. s. Table 29.

Table 29 Conditions for an easier participation in the training by professional sub-categories

Yes (in %)	General practitioner	Outpatient psychologist	Inpatient psychologist	Outpatient psychiatrist	Inpatient psychiatrist	Emergency doctor	Nursing staff of psychiatric patients	Paramedics, emergency paramedics
In the morning	29	63	42	50	39	43	26	40
In the afternoon	47	13	25	33	33	29	23	20
In the evening	24	0	0	0	6	0	3	0
Only Face-to-face training	24	13	17	0	22	14	9	80
Only E-learning	6	0	8	17	0	29	6	40
Blended training	53	50	42	100	61	57	57	60
Training acknowledged by my institution	53	63	50	67	61	57	74	80
Training credits acknowledged by national health system	65	25	50	83	39	57	60	0
Free of charge	47	13	42	100	44	71	65	60

A differentiation by ages can be found in Table 45 in the Annex.

2.6 Survivor Support Groups

2.6.1 Please indicate which local support options for the survivors you are aware of (MHP)

Survivor support groups play an important role in the suicide prevention; however, their reputation varies significantly between the professional sub-categories inpatient/outpatient psychologists and psychiatrists (s. Table 30). The highest awareness of support groups as an option can be found in psychologists/psychiatrists, especially in inpatient psychologists (86%). A second known support option are telephone helplines (outpatient psychologists 55%). Newer alternatives, such as internet forums or chat sessions, are known to a lower degree.

Table 30 Awareness of local support options by specific professional sub-categories

Yes in %	Inpatient psychologist	Outpatient psychologist	Inpatient psychiatrist	Outpatient psychiatrist
Self-help group for survivors	36	27	40	38
Informative Websites	29	27	15	14
Internet forum	7	18	10	0
Psychologists/psychiatrists	86	36	60	63
Chat sessions	7	18	0	0
Telephone helpline	50	55	45	14
Charitable organization	7	9	15	14

Taking a closer look at the different countries and institutes, the following peculiarities attract attention, s. Table 31.

In Slovenia, almost 53% of the participants know about “charitable organizations” regarding survivor support groups, s. Figure 116, Figure 117, in the Annex.

The awareness for “chat sessions” was high among participants from Belgium (41%), Sweden (47%) and especially Finland-THL (63%), s. Figure 118, Figure 119 in the Annex.

The highest awareness for “informative websites” is reported in Belgium (65%), whereas participants from Spain-SAS, FPS had almost no knowledge at all with 98% answering “Non aware”, s. Figure 120, Figure 121 in the Annex.

This result is reflected in the state of knowledge regarding “internet forums”. Participants from Belgium have a high rate of awareness (48%) and participants from Spain-SAS, FPS have no awareness at all (100%), s. Figure 122, Figure 123 in the Annex.

Several countries, such as Belgium, Germany, Spain-INTRAS and Finland-MAMK, put emphasis on support through psychologists/psychiatrist, s. Figure 124, Figure 125 in the Annex.

Numerous participants from Belgium, Germany, Finland-MAMK and Sweden stated that they know about local “self-help groups”. In contrast, 80% of the participants from Romania and Spain-INTRAS answered that they do not know any local self-help groups, s. Figure 126, Figure 127 in the Annex.

More than 70% of the participants from Belgium, Finland-MAMK and Slovenia know about “telephone helplines”, whereas only 14% of the participants from Spain-INTRAS know that this is a support option for survivors, s. Figure 128, Figure 129 in the Annex.

Table 31 Awareness of local support options by region

Yes (in %)	BE - VAZG, UGhent	DE - TUD	ES - INTRAS	ES - SAS, FPS	FI - MAMK	FI - THL	IT - AOUI-VR	RO - Romtens	SE - VGR	SI - RPHIMB
Self-help group for survivors	87	73	12	22	77	29	31	13	73	37
Informative Websites	63	33	15	4	17	25	9	6	40	33
Internet forum	48	20	4	0	10	71	19	3	10	20
Psychologists/psychiatrists	61	70	62	41	72	13	28	53	47	63
Chat sessions	41	3	0	0	3	63	9	0	47	17
Telephone helpline	76	40	13	27	72	33	25	28	47	87
Charitable organization	9	23	23	4	21	4	16	9	17	47

2.6.2 Please specify if you are aware of any support group for suicide survivors active in your institution/work area (NGO, DPM)

The following analysis does not encompass all three stakeholder categories as the partially low number of answers does not justify a statistical analysis.

Within the category of NGOs, one third stated that a support group for survivors exists in their work area or region (DPM 23%), s. Figure 49.

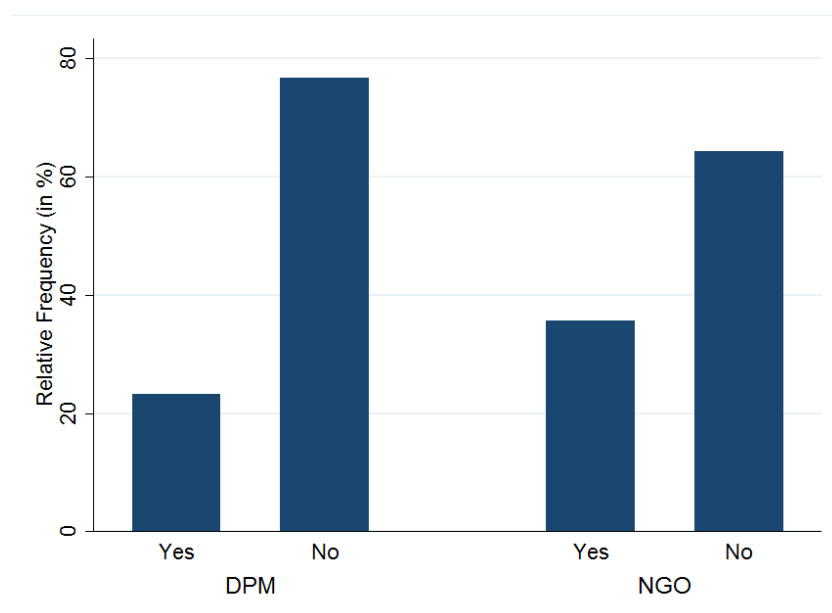


Figure 49 Awareness of an active support group for suicide survivors in the work area by stakeholder

This section evaluates the existence of support groups for the bereaved for different institutes or work areas: 80% of the participants from Belgium answered that such a support group exists in their work area or region. Partial knowledge of such support groups can be found in

Germany (37%), Finland-MAMK (41%) and Sweden (44%). In the Spanish regions of the institutes INTRAS (5%) and SAS, FPS (5%) the awareness of any support group for survivors is very low. No knowledge of support groups in their work area was found in Finland-THL, Italy and Rumania, s. Figure 50.

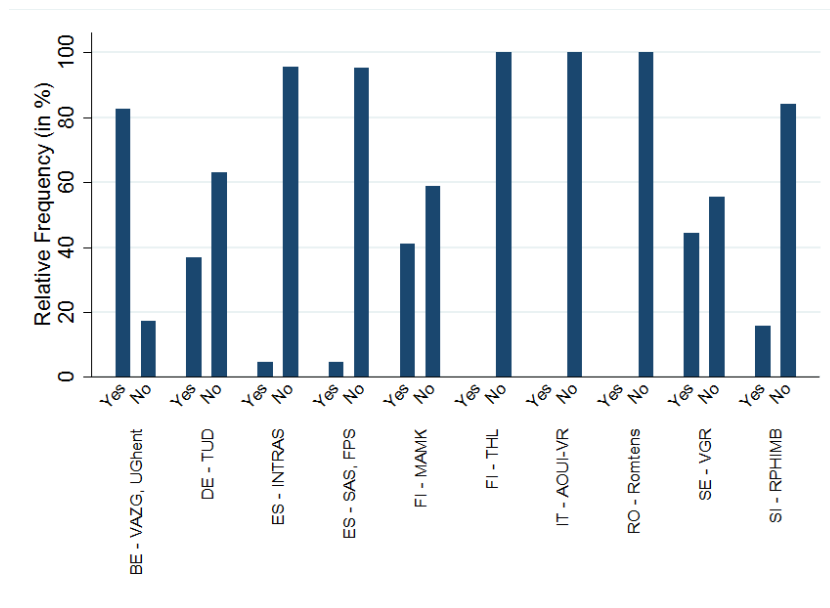


Figure 50 Awareness of an active support group for suicide survivors in the work area by region

2.6.3 Please specify whether the group is organized in the frame of the public health system or whether it is an independent group set up by persons directly affected by the issue

Support groups that are based in the area of NGOs are financed by the public health system (36,54%) and independent groups (63,46%). A differentiation into countries or institutes does not appear to be useful due to an insufficient number of observations, s. Table 32.

Table 32 Organization of the survivor support group

in %	NGO
Public Health System	36,54
Independent Group	63,46
* No observations for other stakeholder groups. Analyses by institutions not useful because of a very small number of observations	

2.6.4 Please specify the professional category that is responsible for managing the group

- Professional sub-category that is responsible for managing the group

Support groups are mainly managed by psychologists (40%) and to a lesser extent by psychiatrists (10%), s. Table 33.

Table 33 Management of the survivor support group

	Yes in %
Professional counselor	26,92
Psychologist	40
Other	35,14
Psychiatrist	10,2
Social worker	20,41
I don't know	12,12

2.6.5 Please name the key factors that make a support group for suicide survivors effective

Concerning the open questions of what makes a support group effective; the answers have been counted and grouped. The following answers were most often mentioned by the NGO respondents: availability, professionalism, skilled personal, confidentiality, empathy and listening.

2.6.6 Please specify if you are aware of any tools (e.g. guidelines, resource packages) to help a facilitator in monitoring and manage processes in such a group

20% of the stakeholder group NGOs answered that they have the awareness of any tool to help a facilitator in monitoring and managing processes in such a support group, s. Figure 51.

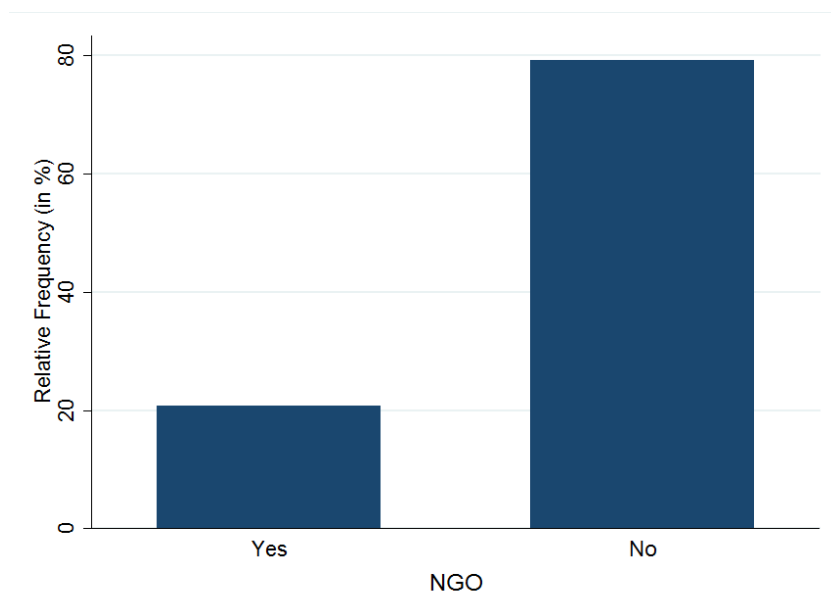


Figure 51 Awareness of tools which helps facilitators in monitoring and managing by stakeholder NGO

Considering different countries, only Belgium (60%) and Sweden (33%) have awareness of any tools for facilitators. In contrast, no such knowledge exists in Romania and Slovenia, s. Figure 52.

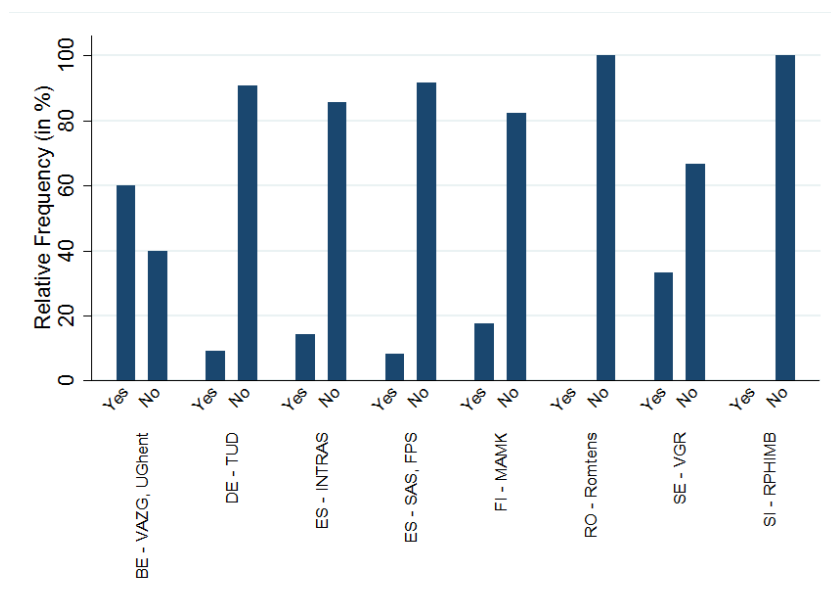


Figure 52 Awareness of tools which helps facilitators in monitoring and managing by region



3. Summary – Conclusion

The number of (officially) 58.000 suicides per year in the EU exceeds the number of deaths caused by road traffic accidents, homicides and HIV (Becker, Losert 2007). It is a serious public health problem demanding our attention, but its prevention and control are no easy task. The prevention of suicide involves a whole series of activities, ranging from the effective treatment of mental disorders to the control of risk factors. As the World Health Organization states, “Appropriate dissemination of information and awareness-raising are essential elements in the success of suicide prevention programs” (World Health Organization, Department of Mental Health 2000).

This questionnaire concerning suicide prevention, conducted by cooperating institutes all over the EU, helped in creating an overview for the participating countries. Overall, it is found that suicide prevention is least included in the job description of DPM stakeholders indicating the backlog on several levels, including the political level, and the need for further efforts in order to assure extensive suicide prevention.

Within the categories of NGOs and MHPs, knowledge concerning guidelines, TBSP methods or training needs, and support categories is rather heterogeneous for the participating countries. Again, there is an extensive need for more information concerning the topic, and towards the development of implementable preventative methods. Especially technology based methods are of minor importance to the participants, which might indicate a need for new approaches that are scientifically based and easy to use.

It is important to mention that Belgium appears to be quite aware of the topic of suicide prevention, as participants already have a lot of knowledge concerning different suicide prevention measures. Spain, Italy and Rumania appear to have little knowledge about local suicide prevention measures, indicating the need for more cooperation with countries like Belgium, in order to establish and create a manageable basis of methods.

This study finds a great lack of knowledge on suicide prevention. Asked for training initiatives for early recognition and referral of suicide risks in their institution/workplace, only 30% of the members of the DPM and NGO stakeholder categories state that they are informed about such a training initiative. Hence, it is possible that there is an offer of training initiatives on suicide prevention and there is not enough awareness created or they simply do not exist.



Concerning suicide prevention strategies (e.g. guidelines or prevention packages), in all three stakeholder categories seems to be a need for it; in particular regarding the stakeholder category NGO.

It is notable that none of the three stakeholder categories beholds a sufficient amount of suicide-prevention related guidelines or packages. The finding, that most of the existing guidelines belong to the DPM area, conflicts with the general lack of suicide-prevention-knowledge reported by this category. The results of our analysis implicate that such an important topic like referrals of persons at suicide risk to public health services is not really supported by guidelines or protocols. Only two out of eight countries (namely Romania and Slovenia) seem to have at least more areas where those guidelines exist than areas without. Not to mention the question whether these guidelines are helpful or not.

In this regard it is noteworthy that most of the recent work on suicide prevention is situated at the regional level or at the workplace, although there are suicide prevention programs on the national and international level, such as national suicide prevention programs in Spain and Sweden (Wasserman, et al. 2009) or international suicide prevention programs like the International Association for Suicide Prevention (IASP) or the suicide prevention program SUPRE of the World Health Organization. Furthermore, the lack of knowledge regarding suicide prevention strategies is reflected in a great demand for training. In general, most of the respondents wish for suicide prevention training sessions with focus on topics like “How to deal with suicidal persons” and “How to identify signals for suicidality”. These training sessions should last about a year and better be free of charge.

Our results show that differences exist both within as well as between countries. The huge ambiguity of answers to certain questions indicates that some questions have not been translated correctly or were misinterpreted by participants. Even with piloting prior to the actual testing, this flaw could not be evaded completely. More specific questions, most of all concerning the training needs and support groups for the bereaved, cannot be evaluated fully, due to the small sample size.

On the whole, the analyses presented in this report point out, that there is a backlog in the area of suicide prevention in the European regions. The main objective of the Euregenas project therefore is to contribute to the development of more adequate and effective prevention methods.



4. Discussion

The main focus of this report was to evaluate attitudes and needs of relevant stakeholders towards technology based suicide prevention in different European regions. As outlined above, the interest in as well as the knowledge about technology based suicide prevention methods is rather low across different stakeholder groups and regions. This might reflect a lack of scientific research and promotion of such methods among relevant stakeholders. Taking into account that TBSP methods provide an opportunity to reach plenty of persons at suicide risk since those technologies are integrated in their daily life, the results of this report further underline the need for attempts to improve existing and to invent new TBSP approaches.

In this regard, a main advantage of social networking sites is that they facilitate connections among peers with similar experiences. For that reason they have the potential to enhance supportive interactions and to create a supportive community. Online video might also be considered a useful tool for suicide prevention as it is able to provide information about the warning signs of suicide or to give advice how to seek help (Luxton, et al. 2011). A primary advantage of E-Mail is that it efficiently reaches a large share of the target group. E-mail is also effective for large-scale community outreach programs. For example, Haas et al. contacted college students at risk for depression and suicide via e-mail. As a result, students who participated in e-mail correspondence with a therapist had approximately three times greater likelihood of entering into face-to-face treatment compared with the students who did not take part in e-mail correspondence. (Haas, et al. 2008).

Virtual worlds may provide another innovative opportunity for suicide prevention. Behavioral health services on Second Life can be used as an adjunct to care or for aftercare (Gorini, et al. 2008). The Survivors of Suicide Project (<http://secondlife.com/destination/survivors-of-suicideproject>) is a simulation in SL that provides suicide prevention information and support. Most of the objects in the simulation are clickable and provide information regarding suicide prevention.

In a nutshell, one of the most significant benefits of many technological based suicide prevention methods is their accessibility. The use of technology increases the geographical and time-wise reach of suicide prevention programs. Of course, a prerequisite for the use of TBSP methods is that the corresponding technology is available for persons at suicide risk (e.g. internet access) which might be a problem, particularly regarding economically weak persons.



As the results of our analysis show, other relevant points to consider are confidentiality and privacy concerns. Although use of the Internet can provide a sense of anonymity, fear of a possible breach of confidentiality can prevent individuals from participating in suicide prevention programs.

Although social networking sites and chat rooms might enhance supportive interactions among those who are coping with similar problems, these services could also increase risk for suicide behavior among vulnerable persons. For example, shared instructions for suicide methods, bullying, and potential suicide pacts are a relevant concern. (Biddle, et al. 2008)

There is a lack of research on the effectiveness of technology based suicide prevention methods and on the question of how these methods influence behavior or attitudes toward suicide prevention. Studies that evaluate the number of visits to suicide prevention Web sites as well as usage of Web links to additional referral information or services will also help to evaluate the effectiveness of Web-based suicide prevention programs (Luxton, et al. 2011)

In conclusion, technology plays an important role in suicide prevention and one can expect it to become increasingly important. Bearing in mind the drawbacks and obstacles, TBSP methods nevertheless provide a great opportunity for effective suicide prevention.


5. Annex I: figures/tables

Table 34 Age by region

BE - VAZG, Ughent	Freq.	Percent	Cum.
20-29	11	22,92	22,92
30-39	15	31,25	54,17
40-49	11	22,92	77,08
50-59	9	18,75	95,83
>59	2	4,17	100
Total	48	100	
DE - TUD	Freq.	Percent	Cum.
20-29	2	6,9	6,9
30-39	6	20,69	27,59
40-49	7	24,14	51,72
50-59	10	34,48	86,21
>59	4	13,79	100
Total	29	100	
ES - INTRAS	Freq.	Percent	Cum.
20-29	1	1,69	1,69
30-39	14	23,73	25,42
40-49	20	33,9	59,32
50-59	22	37,29	96,61
>59	2	3,39	100
Total	59	100	
ES - SAS, FPS	Freq.	Percent	Cum.
20-29	1	3,33	3,33
30-39	8	26,67	30
40-49	10	33,33	63,33
50-59	9	30	93,33
>59	2	6,67	100
Total	30	100	
FI - MAMK	Freq.	Percent	Cum.
30-39	3	9,09	9,09
40-49	12	36,36	45,45
50-59	15	45,45	90,91
>59	3	9,09	100
Total	33	100	

FI - THL	Freq.	Percent	Cum.
30-39	3	12	12
40-49	9	36	48
50-59	11	44	92
>59	2	8	100
Total	25	100	
IT - AOUI-VR	Freq.	Percent	Cum.
20-29	2	6,25	6,25
30-39	5	15,63	21,88
40-49	3	9,38	31,25
50-59	12	37,5	68,75
>59	10	31,25	100
Total	32	100	
RO - Romtens	Freq.	Percent	Cum.
20-29	1	3,33	3,33
30-39	9	30	33,33
40-49	11	36,67	70
50-59	5	16,67	86,67
>59	4	13,33	100
Total	30	100	
SE - VGR	Freq.	Percent	Cum.
30-39	1	3,23	3,23
40-49	3	9,68	12,9
50-59	14	45,16	58,06
>59	13	41,94	100
Total	31	100	
SI - RPHIMB	Freq.	Percent	Cum.
20-29	5	16,67	16,67
30-39	5	16,67	33,33
40-49	12	40	73,33
50-59	7	23,33	96,67
>59	1	3,33	100
Total	30	100	

Table 35 Professional category by stakeholder – NGO



Prof. Cat	Freq.	Percent	Cum.
Staff of a non-governmental organization	16	11,59	11,59
Teacher	11	7,97	19,57
Criminal justice stakeholder	10	7,25	26,81
Professional social worker	9	6,52	33,33
Suicide prevention worker	9	6,52	39,86
Social worker in the community	7	5,07	44,93
Welfare officer	6	4,35	49,28
Staff of survivor support group	6	4,35	53,62
Pharmacist	5	3,62	57,25
Staff of suicide helpline	3	2,17	59,42
Employer, human resources, union representative	3	2,17	61,59
Representative of religious group	2	1,45	63,04
Youth worker	1	0,72	63,77
Domestic helper	1	0,72	64,49
Family and life counselor	1	0,72	65,22
Bachelor of Social Services	1	0,72	65,94
Doctor	1	0,72	66,67
Non-profit worker	1	0,72	67,39
Occupational counselor	1	0,72	68,12
Project assistant	1	0,72	68,84
Psychoterapist at a youth health care	1	0,72	69,57
Public health nurse working with immigr	1	0,72	70,29
Rehabilitation counselor/trainer	1	0,72	71,01
Responsible in a large compagny	1	0,72	71,74
counselor for health and wellbeing in w	1	0,72	72,46
Psychologist	1	0,72	73,19
Researcher	1	0,72	73,91
Sociologist, Cosultant	1	0,72	74,64
Voluntary	1	0,72	75,36
Worker in crisis center	1	0,72	76,09
Other (NGO)	33	23,91	100,00
Total	138	100,00	

Table 36 Professional sub-categories by stakeholder – MHP

Prof. Cat	Freq.	Percent	Cum.
Nursing staff of psychiatric patients	36	24,16	24,16
Inpatient psychiatrist	19	12,75	36,91
General practitioner	17	11,41	48,32
Inpatient psychologist	12	8,05	56,38
Outpatient psychiatrist	9	6,04	62,42
Outpatient psychologist	8	5,37	67,79
Emergency doctor	7	4,70	72,48
Paramedics, emergency paramedics	5	3,36	75,84
Staff of emergency room	3	2,01	77,85
Other (MHP)	33	22,15	100,00
Total	149	100,00	

Table 37 Professional sub-categories by stakeholder – DPM

Prof. Cat	Freq.	Percent	Cum.
Decision and policy makers from local and regional authorities	33	39,29	39,29
Decision and policy makers in public health institutions	12	14,29	53,57
Educational setting, policy makers	9	10,71	64,29
Media	8	9,52	73,81
European networks focusing on mental health promotion	4	4,76	78,57
Private companies influencing policy	3	3,57	82,14
Professionals working in financial services and human resources	2	2,38	84,52
Other (DPM)	13	15,48	100,00
Total	84	100	

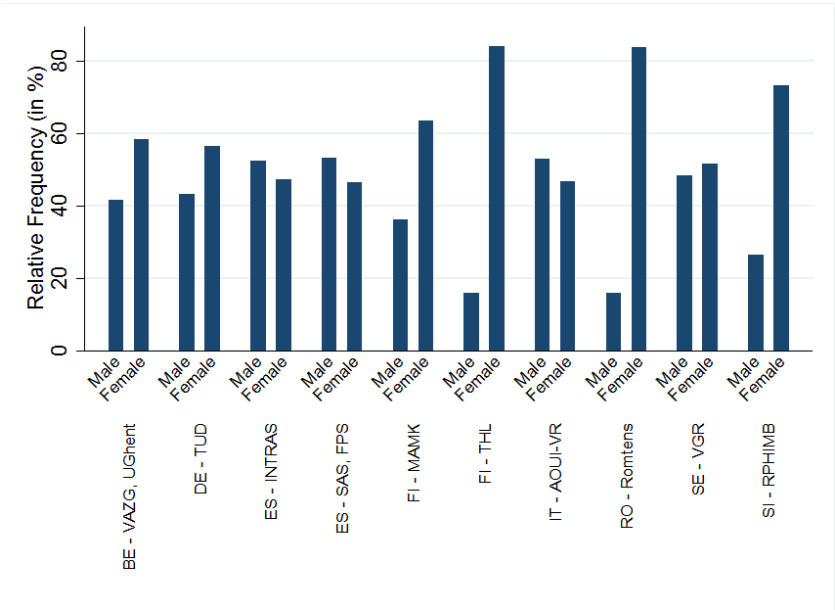


Figure 53 Gender by region

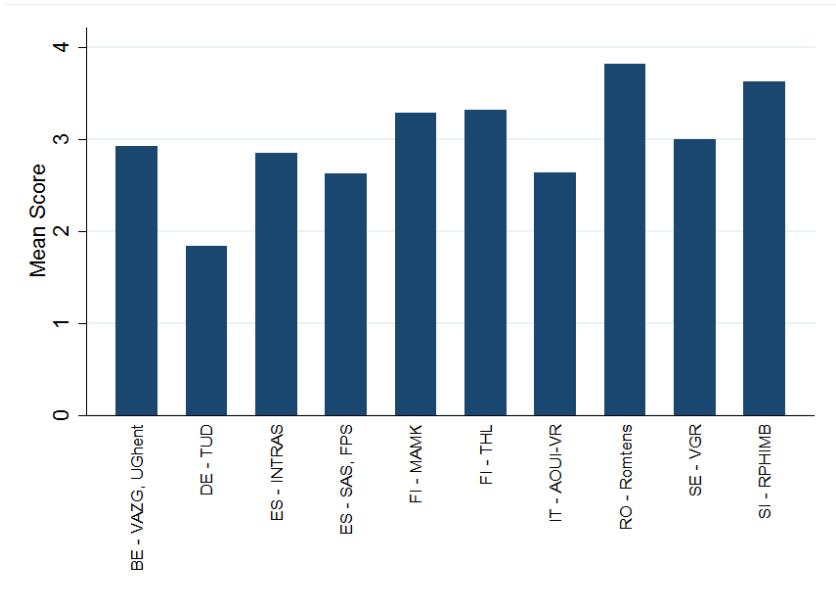


Figure 54 Use/consider using of Apps by region

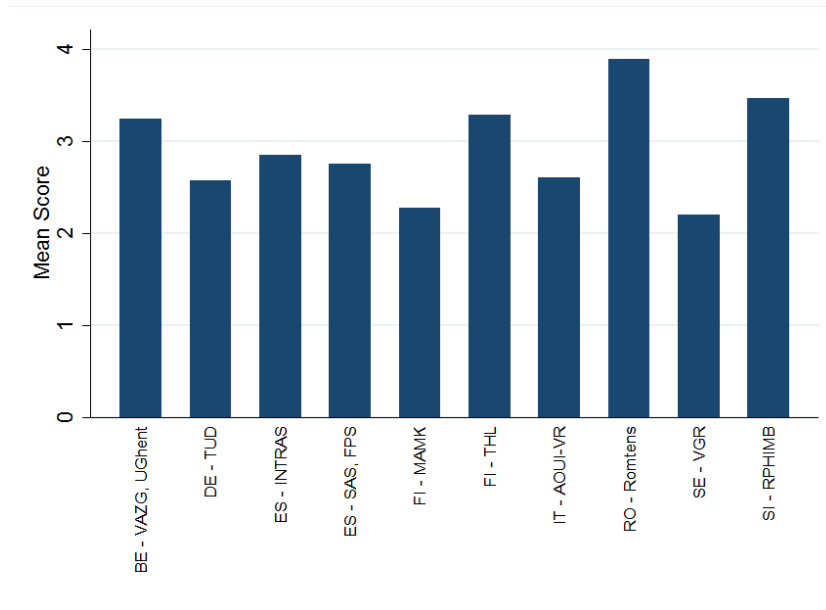


Figure 55 Use/consider using of chat by region

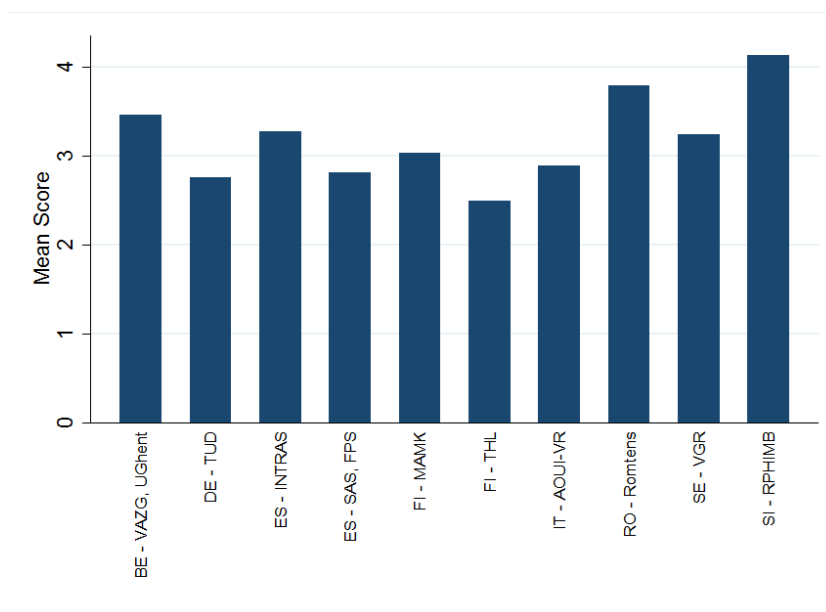


Figure 56 Use/consider using of e-mail by region

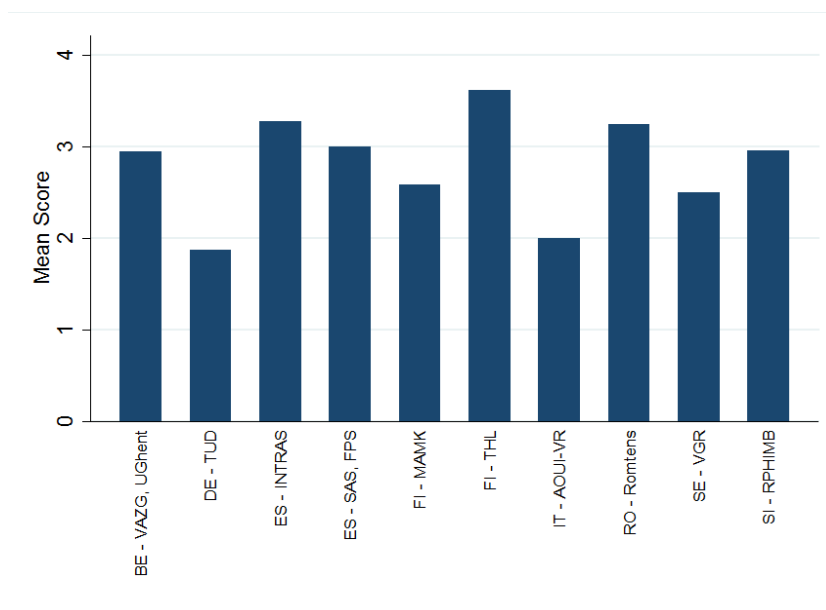


Figure 57 Use/consider using of serious gaming by region

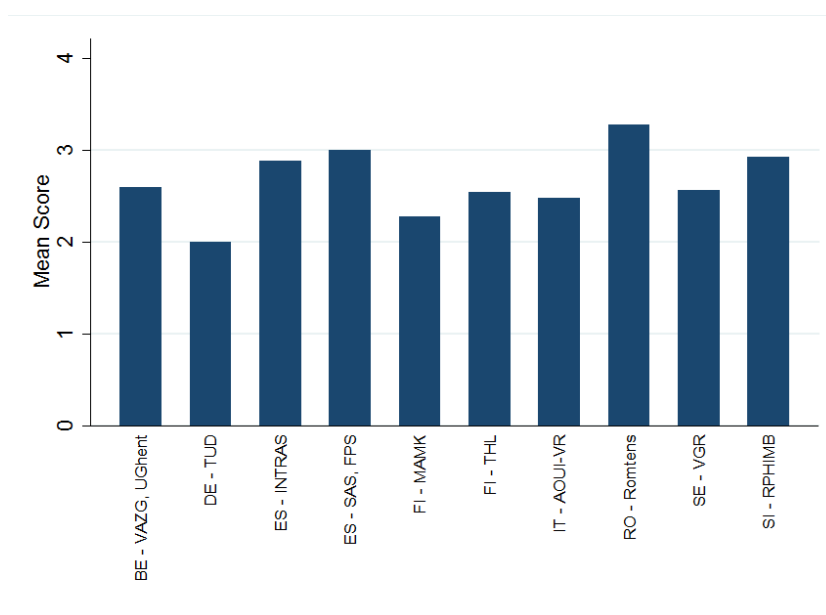


Figure 58 Use/consider using of serious networking by region

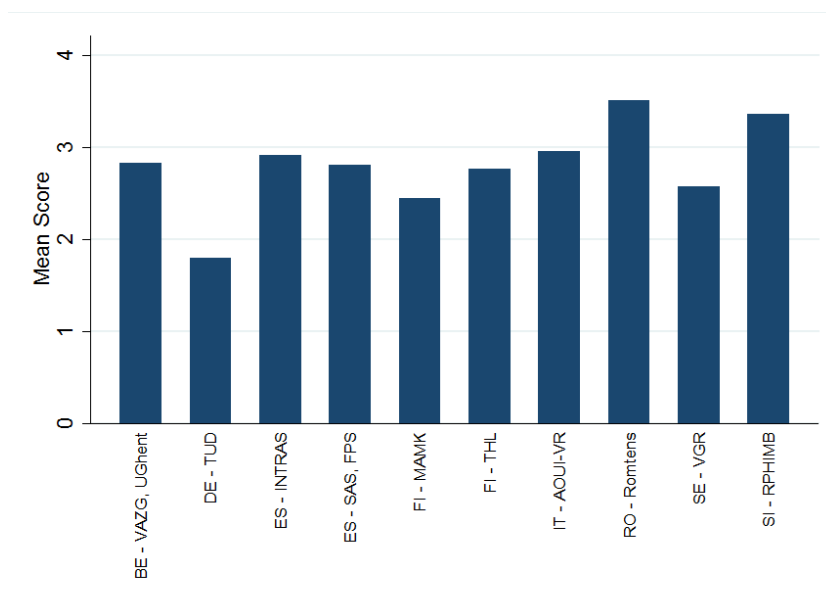


Figure 59 Use/consider using of web-based videos by region

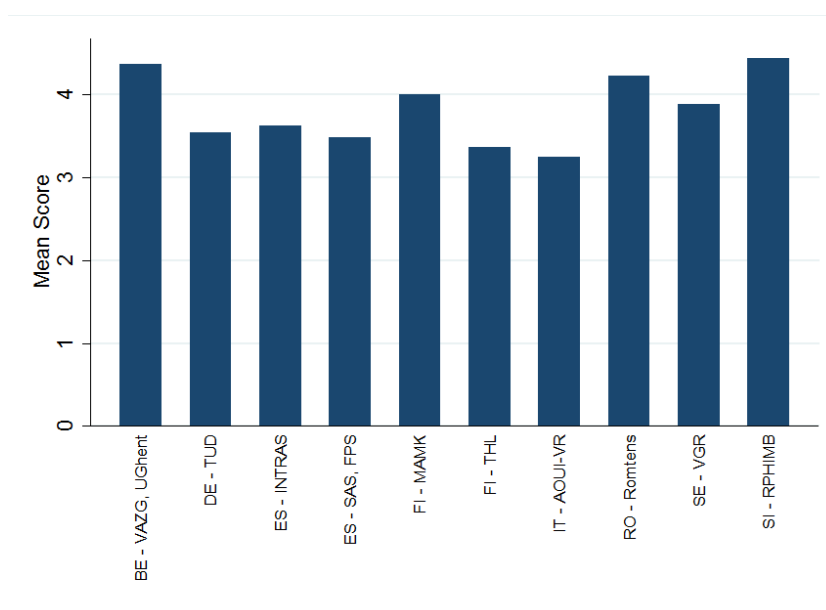


Figure 60 Use/consider using of websites by region

Table 38 Faced with suicidal people by region

BE - VAZG, UGhent	Freq.	Percent	Cum.
Daily	20	42,55	42,55
Once per week	5	10,64	53,19
Once per month	8	17,02	70,21
4-5 times per year	7	14,89	85,11
Once per year	5	10,64	95,74
Never	2	4,26	100
Total	47	100	
DE - TUD	Freq.	Percent	Cum.
Daily	9	30	30
Once per week	8	26,67	56,67
Once per month	3	10	66,67
times per year	2	6,67	73,33
Once per year	6	20	93,33
Never	2	6,67	100
Total	30	100	
ES - INTRAS	Freq.	Percent	Cum.
Daily	13	22,03	22,03
Once per week	5	8,47	30,51
Once per month	7	11,86	42,37
times per year	19	32,2	74,58
Once per year	12	20,34	94,92
Never	3	5,08	100
Total	59	100	
ES - SAS, FPS	Freq.	Percent	Cum.
Daily	4	13,33	13,33
Once per week	2	6,67	20
Once per month	3	10	30
times per year	8	26,67	56,67
Once per year	8	26,67	83,33
Never	5	16,67	100
Total	30	100	
FI - MAMK	Freq.	Percent	Cum.
Daily	6	18,18	18,18
Once per week	3	9,09	27,27
Once per month	5	15,15	42,42
times per year	11	33,33	75,76
Once per year	6	18,18	93,94
Never	2	6,06	100
Total	33	100	

FI - THL	Freq.	Percent	Cum.
Daily	4	16	16
Once per week	8	32	48
Once per month	3	12	60
times per year	4	16	76
Once per year	6	24	100
Total	25	100	
IT - AQUI-VR	Freq.	Percent	Cum.
Daily	4	12,9	12,9
Once per week	3	9,68	22,58
Once per month	7	22,58	45,16
times per year	5	16,13	61,29
Once per year	5	16,13	77,42
Never	7	22,58	100
Total	31	100	
RO - Romtens	Freq.	Percent	Cum.
Daily	4	12,5	12,5
Once per week	4	12,5	25
Once per month	4	12,5	37,5
times per year	9	28,13	65,63
Once per year	5	15,63	81,25
Never	6	18,75	100
Total	32	100	
SE - VGR	Freq.	Percent	Cum.
Daily	8	25,81	25,81
Once per week	7	22,58	48,39
Once per month	6	19,35	67,74
times per year	3	9,68	77,42
Once per year	3	9,68	87,1
Never	4	12,9	100
Total	31	100	
SI - RPHIMB	Freq.	Percent	Cum.
Daily	4	13,33	13,33
Once per week	4	13,33	26,67
Once per month	4	13,33	40
times per year	5	16,67	56,67
Once per year	6	20	76,67
Never	7	23,33	100
Total	30	100	

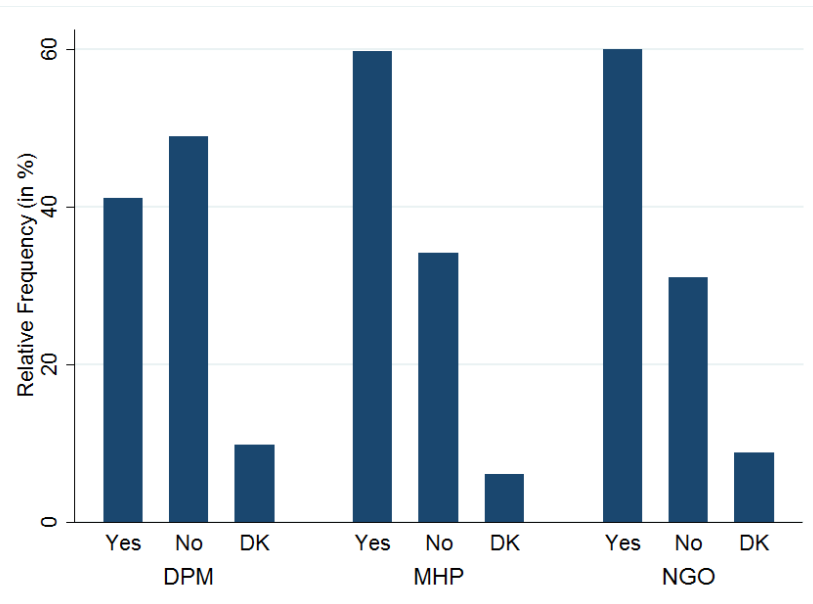


Figure 61 Mandatory implementation of suicide prevention in the work area by stakeholder

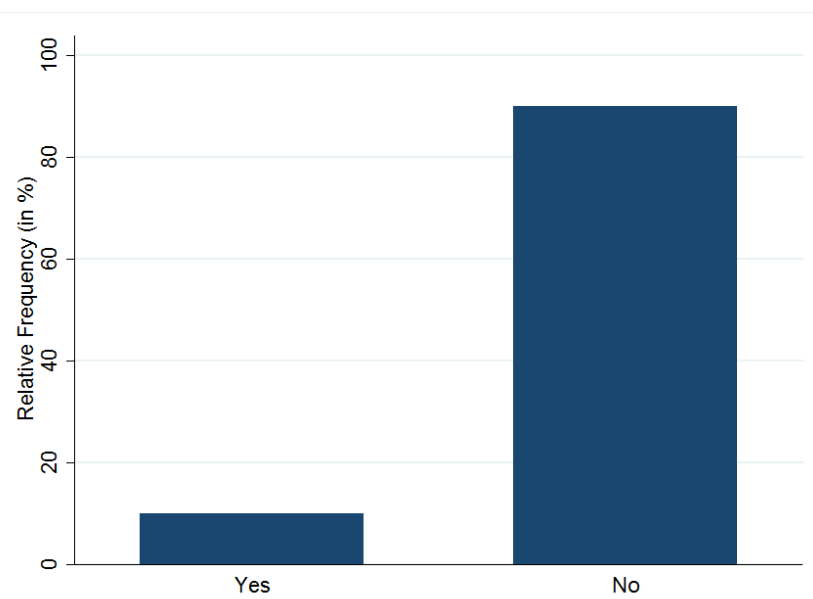


Figure 62 Knowledge of suicide prevention strategies of criminal justice stakeholders

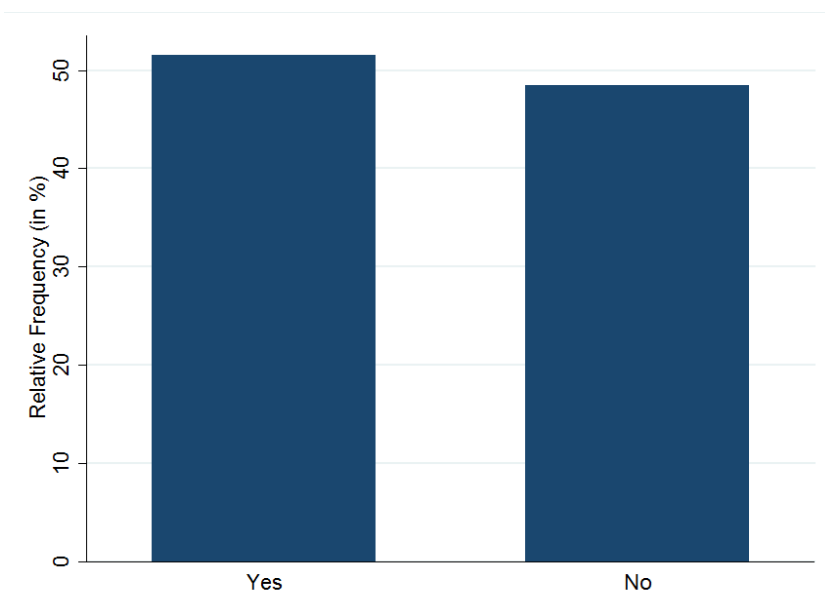


Figure 63 Knowledge of suicide prevention strategies of decision and policy makers from local and regional authorities

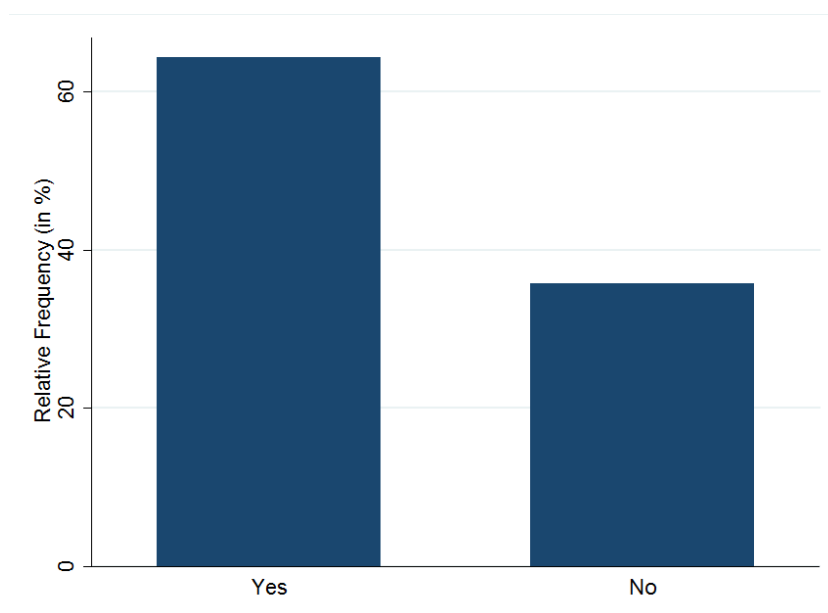


Figure 64 Knowledge of suicide prevention strategies of decision and policy makers in public health institutions

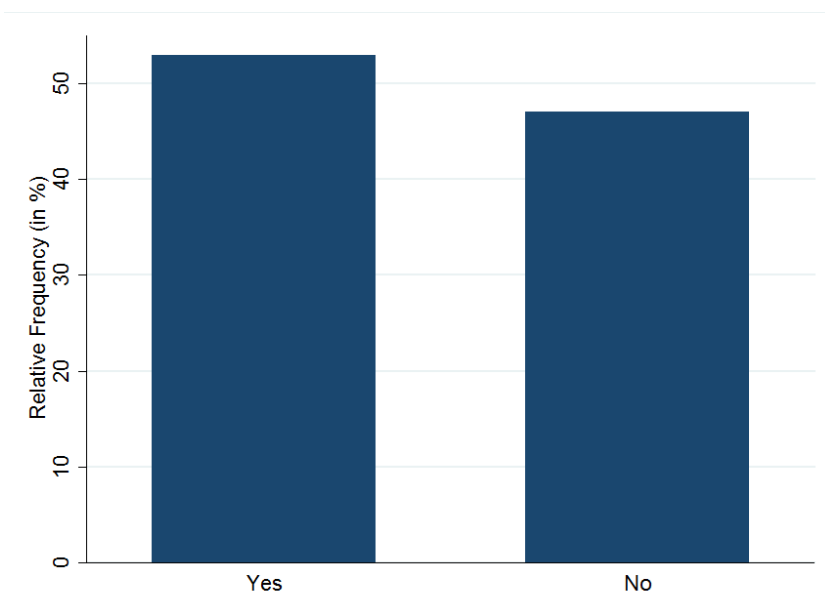


Figure 65 Knowledge of suicide prevention strategies of general practitioners

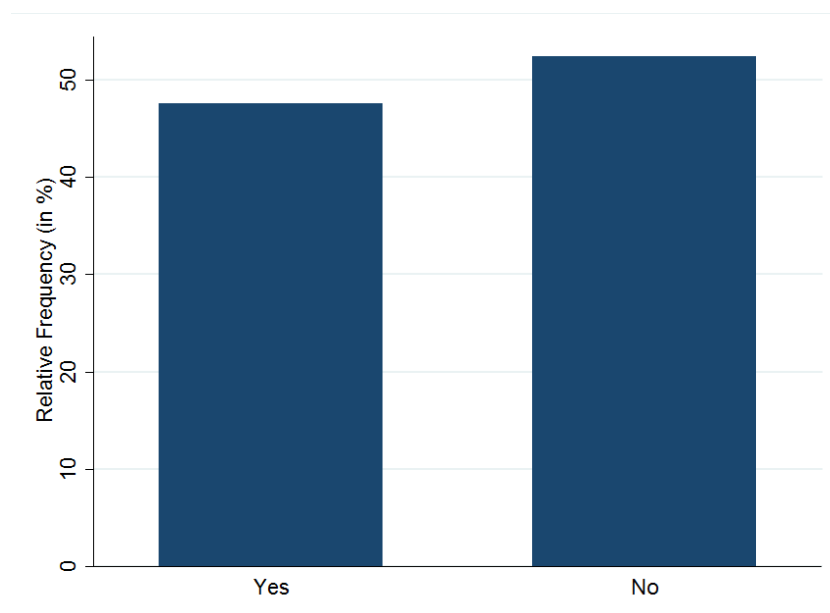


Figure 66 Knowledge of suicide prevention strategies of inpatient psychiatrist

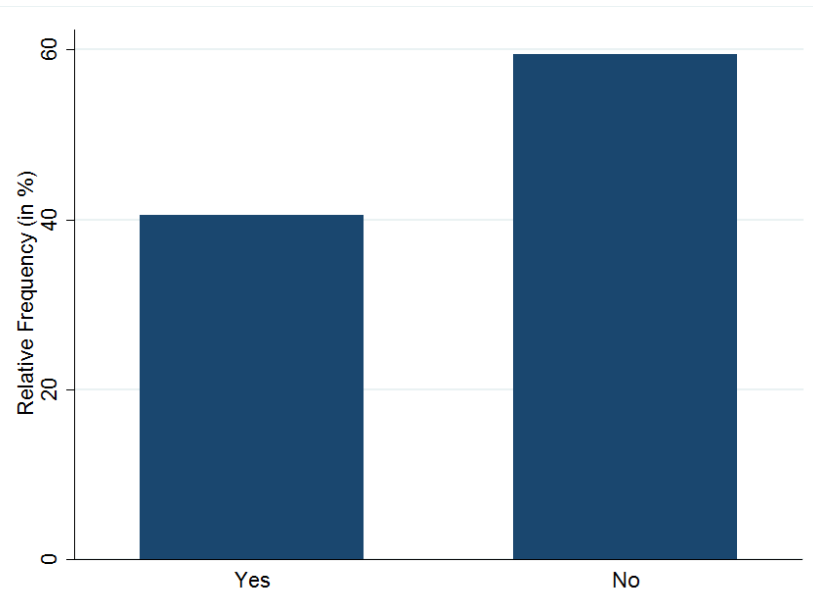


Figure 67 Knowledge of suicide prevention strategies of nursing staff of psychiatric patients

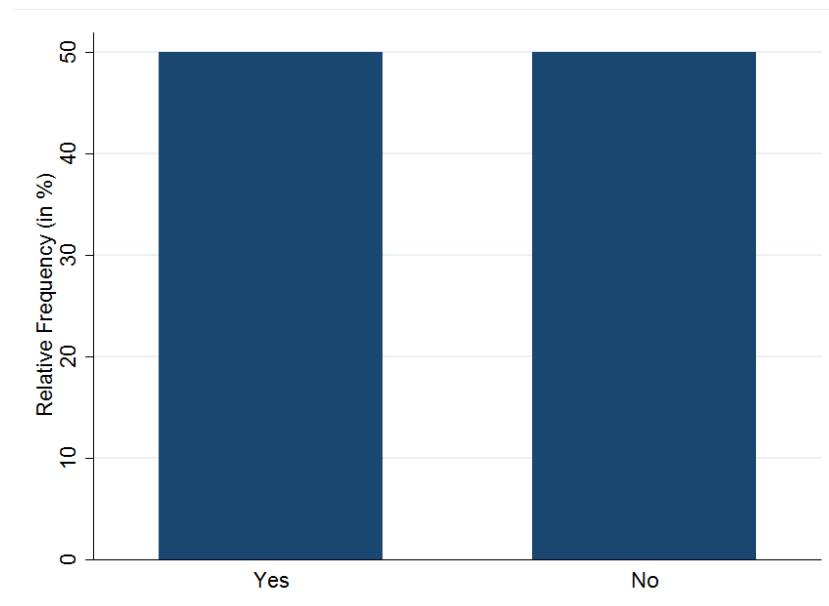


Figure 68 Knowledge of suicide prevention strategies of inpatient Psychologists

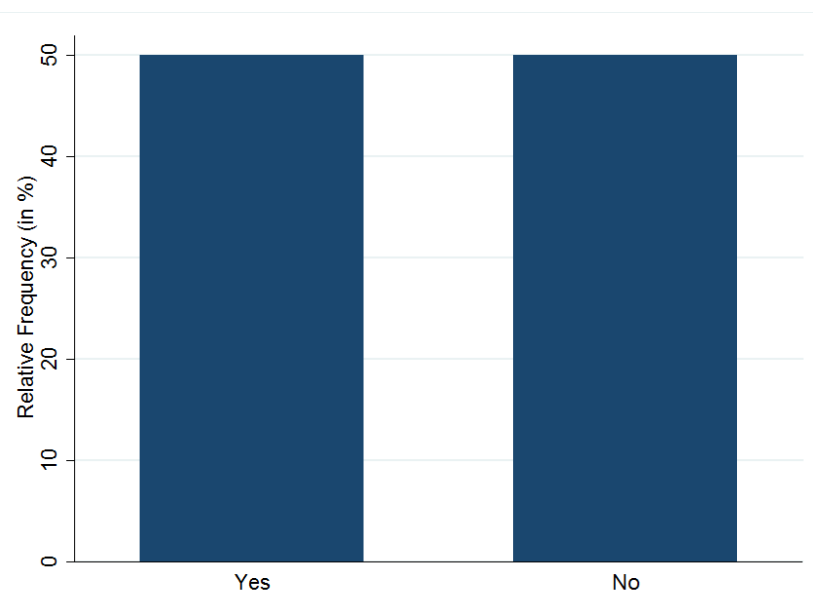


Figure 69 Knowledge of suicide prevention strategies of professional social workers

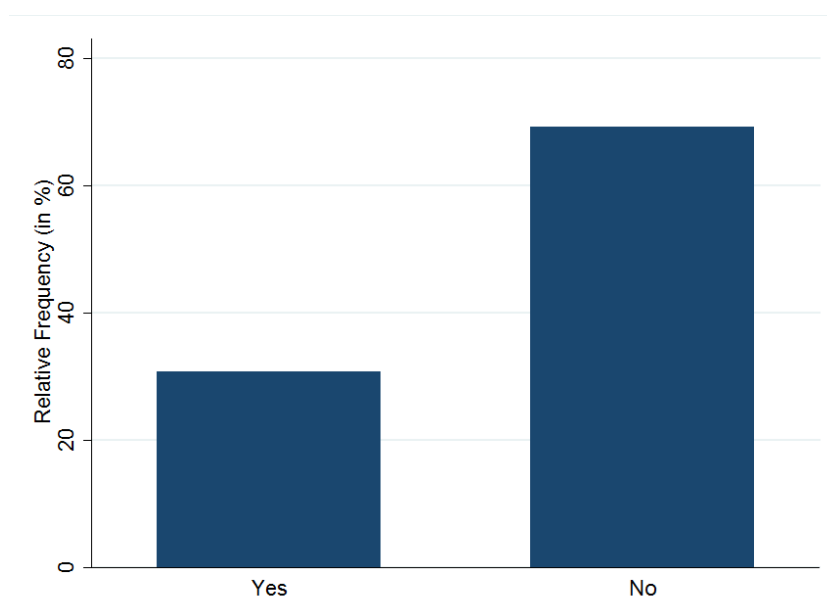
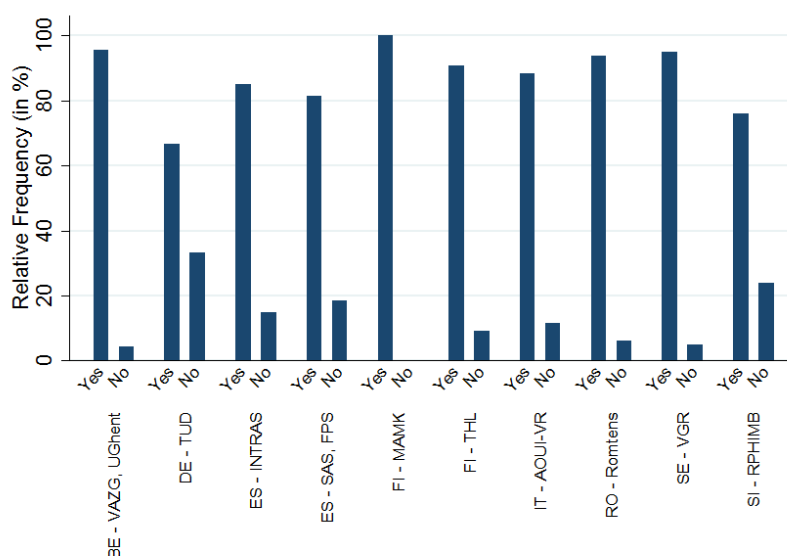


Figure 70 Knowledge of suicide prevention strategies of teacher

Table 39 References for documentation of the suicide prevention strategies by regions

Type of strategy/program (in %)	BE - VAZG, Ughent	DE - TUD	ES - INTRAS	ES - SAS, FPS	FI - MAMK	FI - THL	IT - AOUI-VR	RO - Romtens	SE - VGR	SI - RPHIMB
Counseling suicidal persons	43	76	78	50	100	24	41	70	55	47
Setting up a policy/protocol on suicide prevention	74	19	44	70	33	41	28	10	45	5
Crisis Intervention	33	81	67	56	83	18	34	40	24	63
Providing training on suicide prevention	62	48	28	50	67	25	19	10	41	26
Raising awareness on suicide prevention	81	67	44	67	50	35	19	90	69	42
Responding to situations in which individuals are acutely suicidal	14	19	17	29	67	12	3	40	14	21

**Figure 71 Necessity of the introduction of a suicide prevention strategy by institution****Table 40 Most necessary type of suicide prevention strategy by regions**

Type of program/strategy most necessary (in %)	BE - VAZG, Ughent	DE - TUD	ES - INTRAS	ES - SAS, FPS	FI - MAMK	FI - THL	IT - AOUI-VR	RO - Romtens	SE - VGR	SI - RPHIMB
Counseling suicidal persons	58	33	51	56	47	52	25	69	50	63
Setting up a policy/protocol on suicide prevention	67	17	50	60	66	67	47	59	57	42
Crisis Intervention	42	25	50	56	61	57	28	28	23	38
Providing training on suicide prevention	48	42	46	76	41	43	44	41	77	58
Raising awareness on suicide prevention	70	33	47	56	31	48	31	69	70	83
Responding to urgent situations in which individuals are suicidal	33	17	47	29	47	43	13	31	23	50

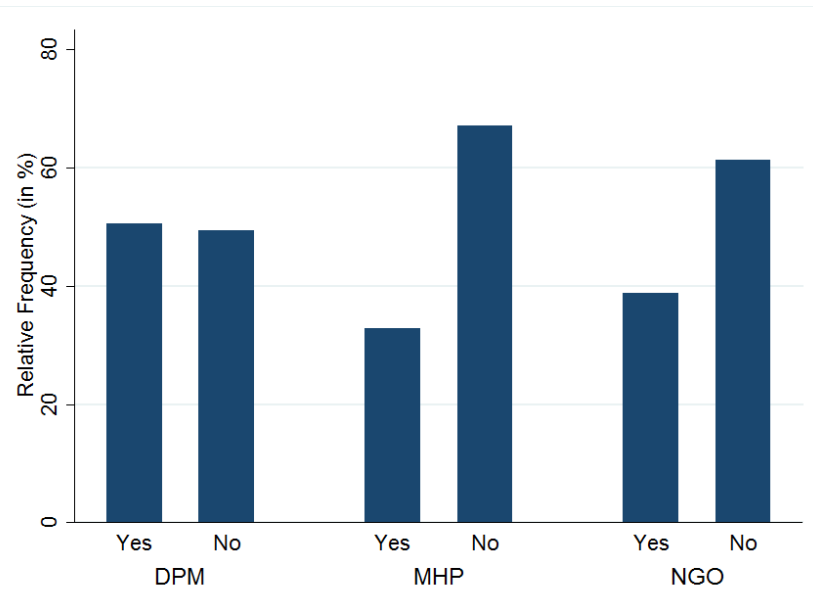


Figure 72 Awareness of local networks by stakeholder

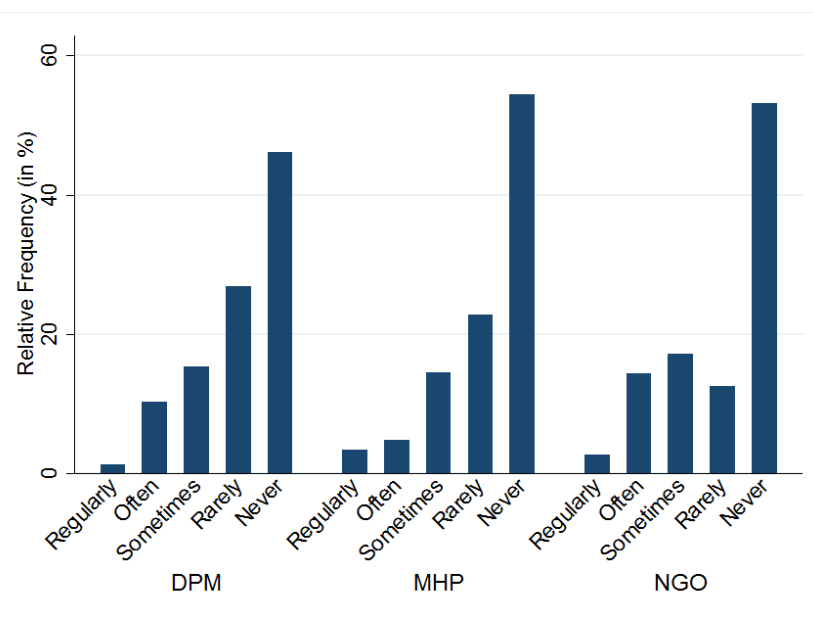
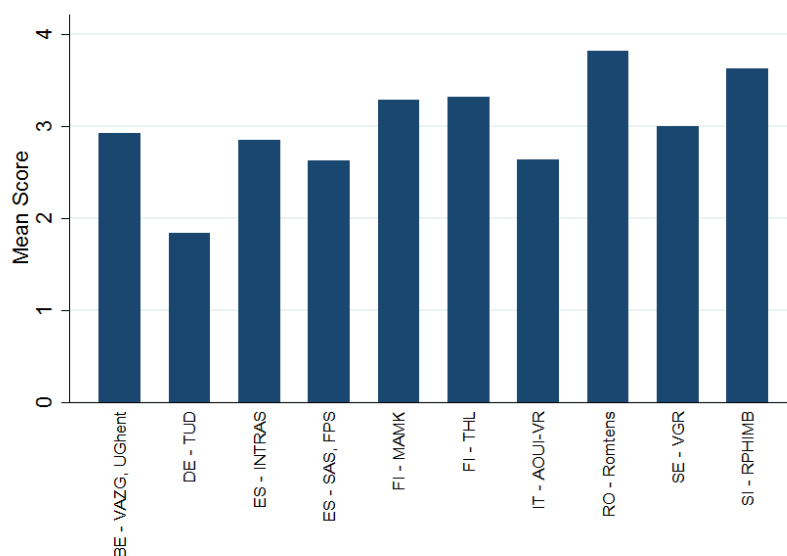


Figure 73 Use and recommendation of technology-based suicide prevention methods by stakeholder

Table 41 Facts that keeps the use of technology-based suicide prevention methods by region

What keeps you from using TBSP methods?	BE - VAZG, UGhent	DE - TUD	ES - INTRAS	ES - SAS, FPS	FI - MAMK	FI - THL	IT - AOUI-VR	RO - Romtens	SE - VGR	SI - RPHIMB
No technology-based suicide prevention programs available	33%	59%	62%	53%	65%	31%	43%	68%	50%	43%
Too expensive	25%	11%	23%	29%	0%	0%	23%	27%	18%	11%
Too time consuming	14%	26%	31%	29%	14%	40%	17%	35%	35%	27%
No trustworthy applications	33%	67%	42%	56%	31%	50%	55%	48%	40%	19%
No knowledge about the evidence of the usefulness of technology-based suicide prevention programs	63%	86%	79%	70%	40%	27%	69%	56%	71%	48%
No interest in technology-based suicide prevention programs	18%	29%	12%	22%	29%	0%	47%	26%	6%	18%
No skills in the use of technology-based suicide prevention programs	46%	55%	34%	44%	60%	65%	67%	62%	58%	29%
No skills in the use of technology-based suicide prevention programs in persons at risk of suicide	63%	61%	70%	62%	91%	80%	82%	61%	71%	86%
Percent of respondents answering "Yes"										

**Figure 74 Use/consider using Apps by region**

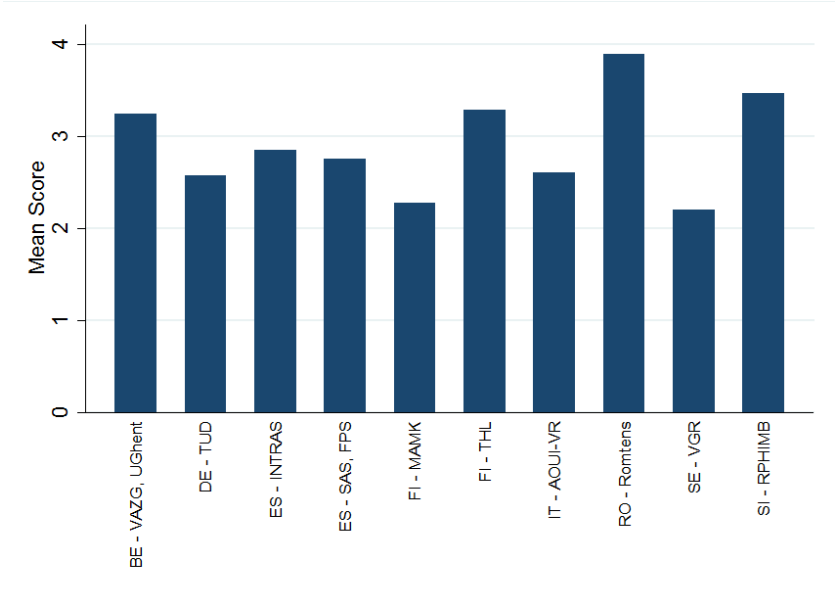


Figure 75 Use/consider using chat by region

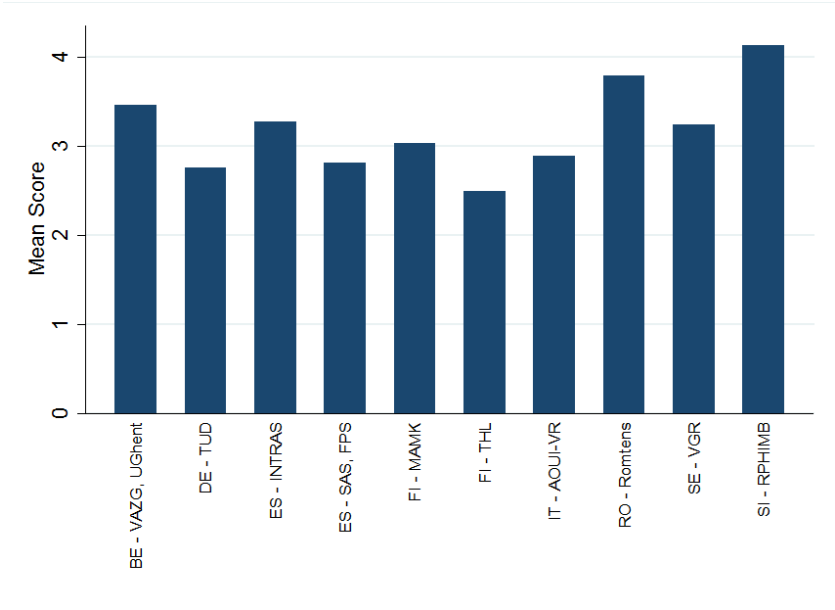


Figure 76 Use/consider using email by region

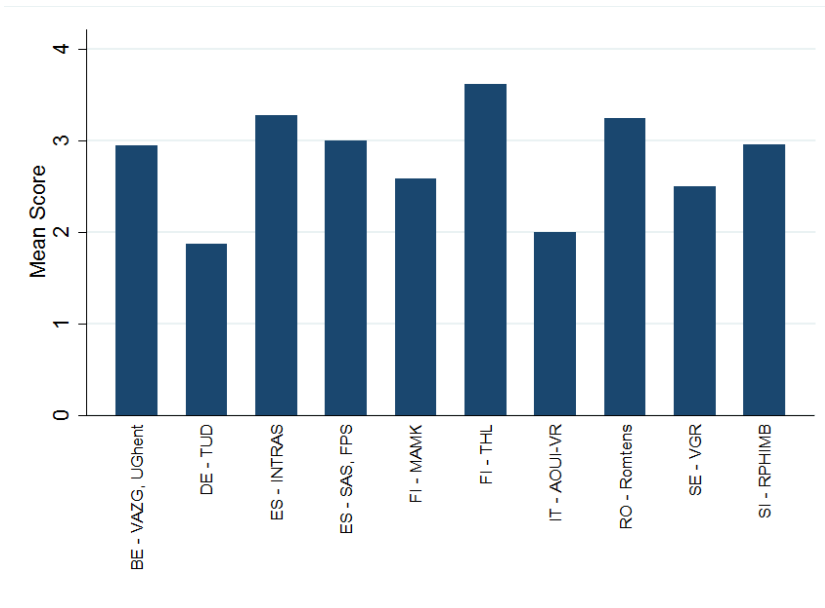


Figure 77 Use/consider using serious gaming by region

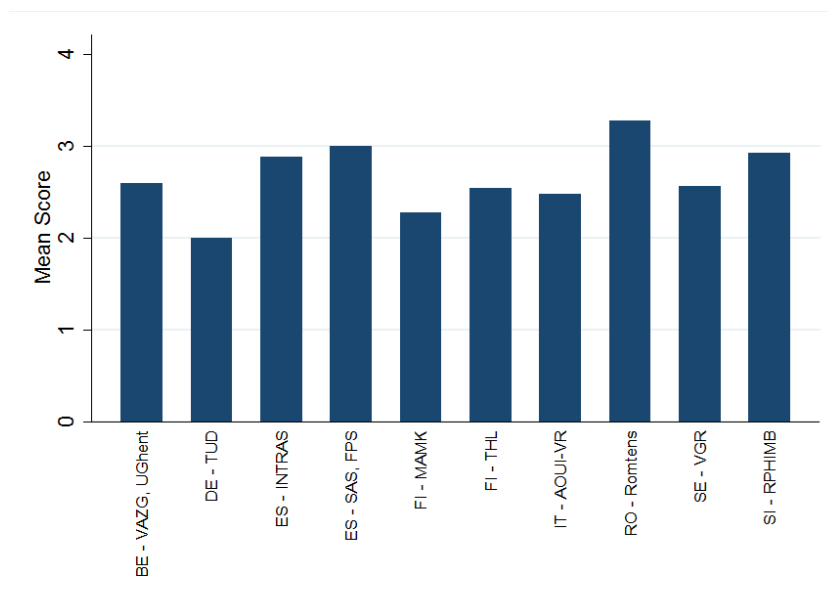


Figure 78 Use/consider using serious networking by region

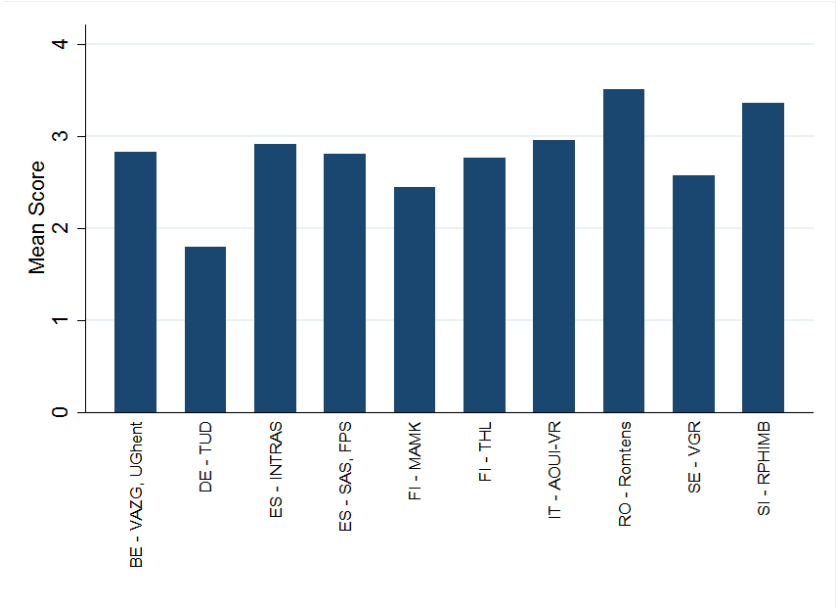


Figure 79 Use/ consider using web-based video by region

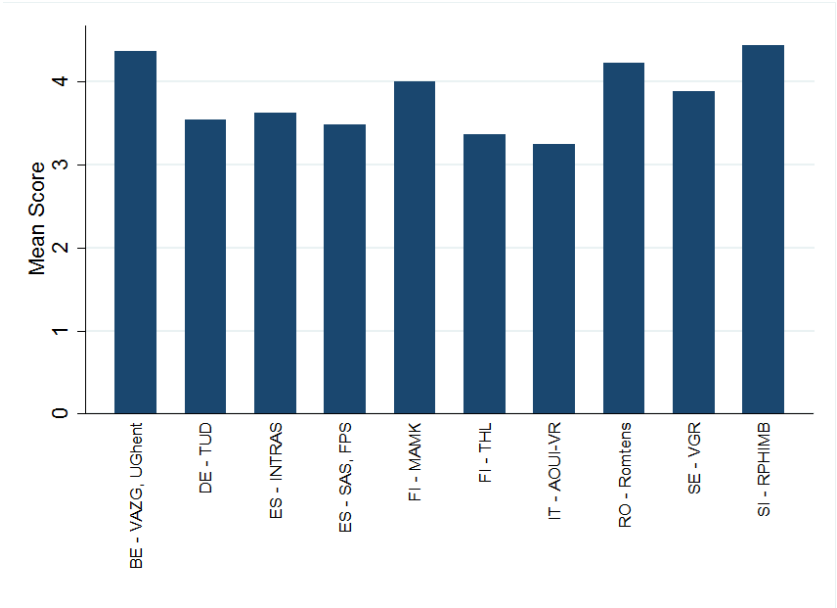


Figure 80 Use/consider using websites by region

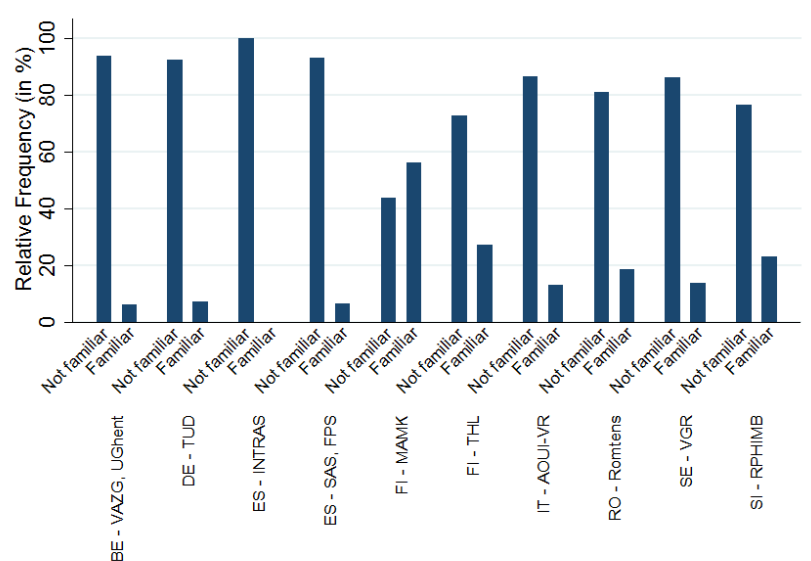


Figure 81 Familiarity with ethical guidelines by region

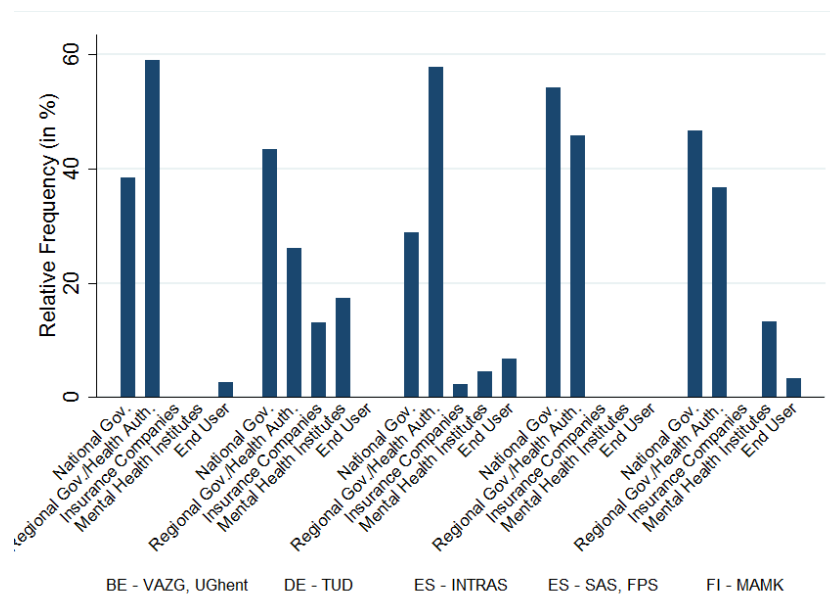


Figure 82 Financing website by region 1

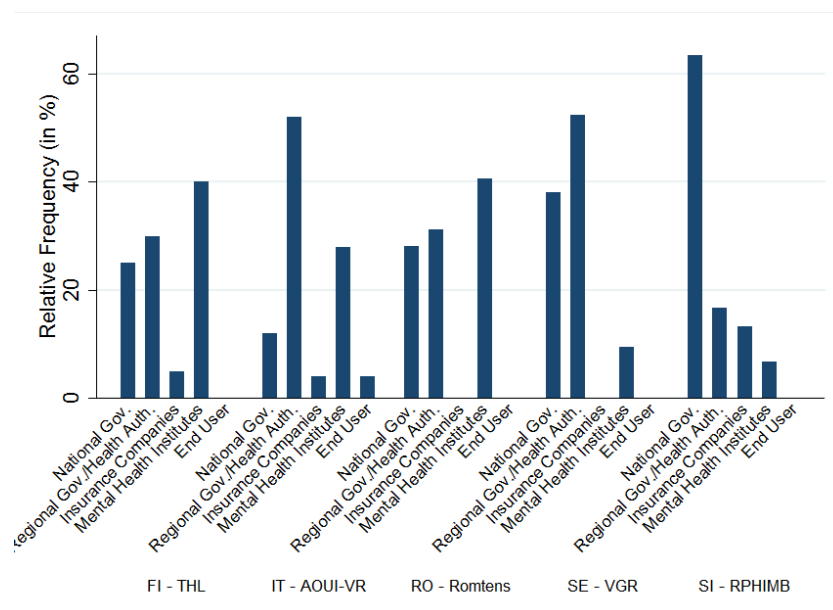


Figure 83 Financing website by region 2

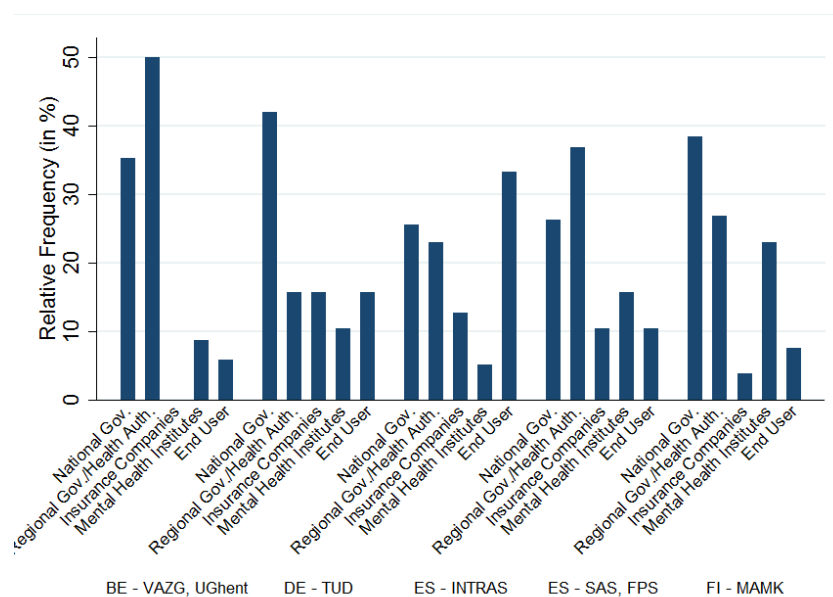


Figure 84 Financing Apps by region 1

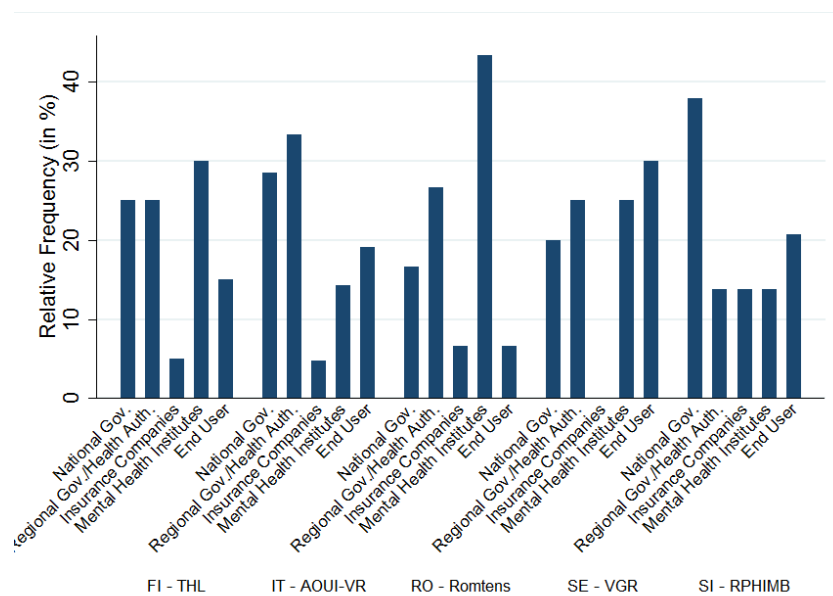


Figure 85 Financing Apps by region 2

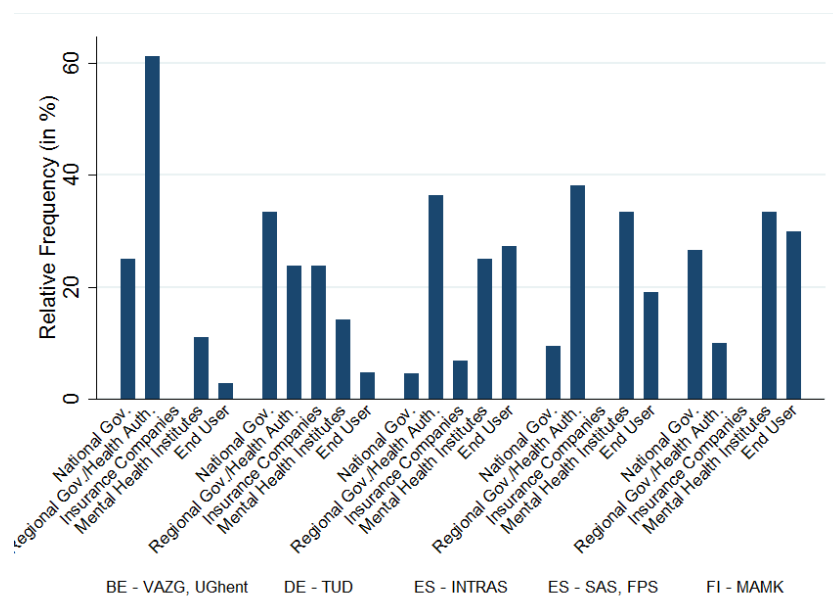


Figure 86 Financing chat by region 1

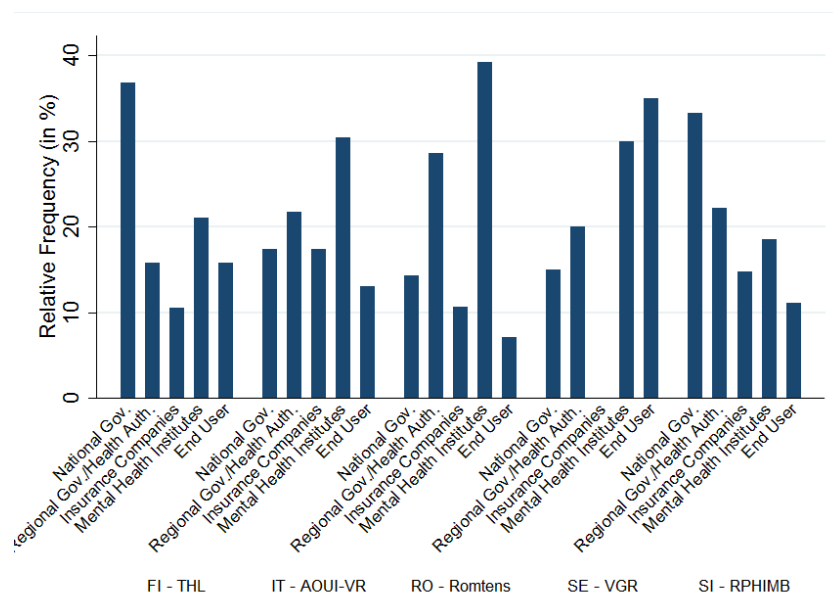


Figure 87 Financing chat by region 2

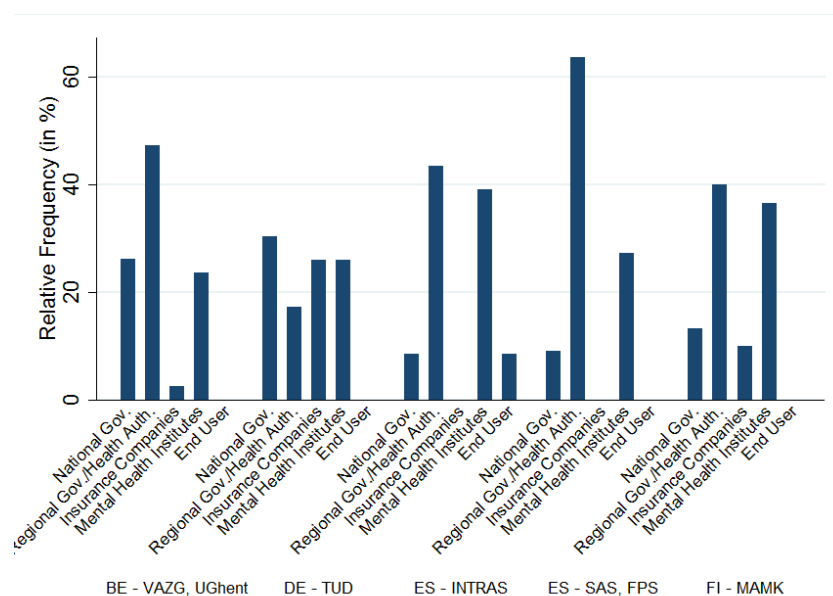


Figure 88 Financing e-therapy by region 1

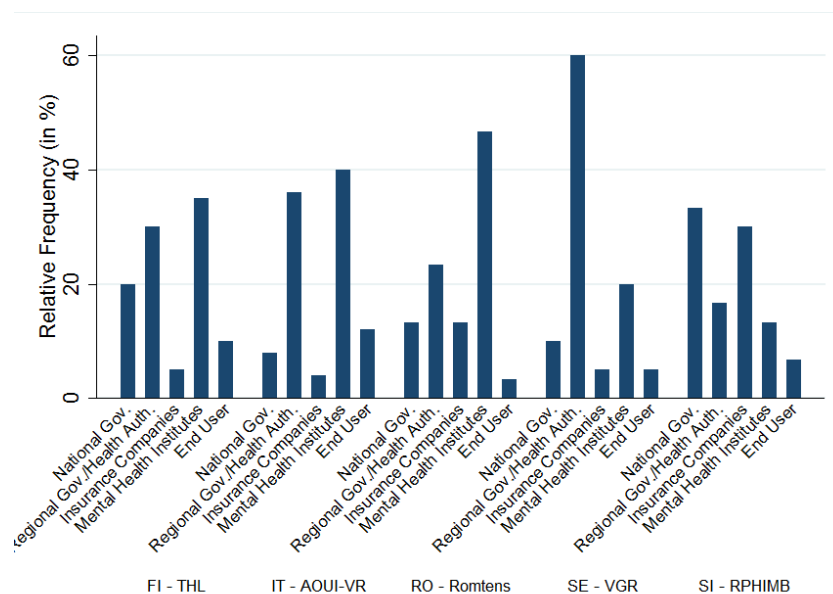


Figure 89 Financing e-therapy by region 2

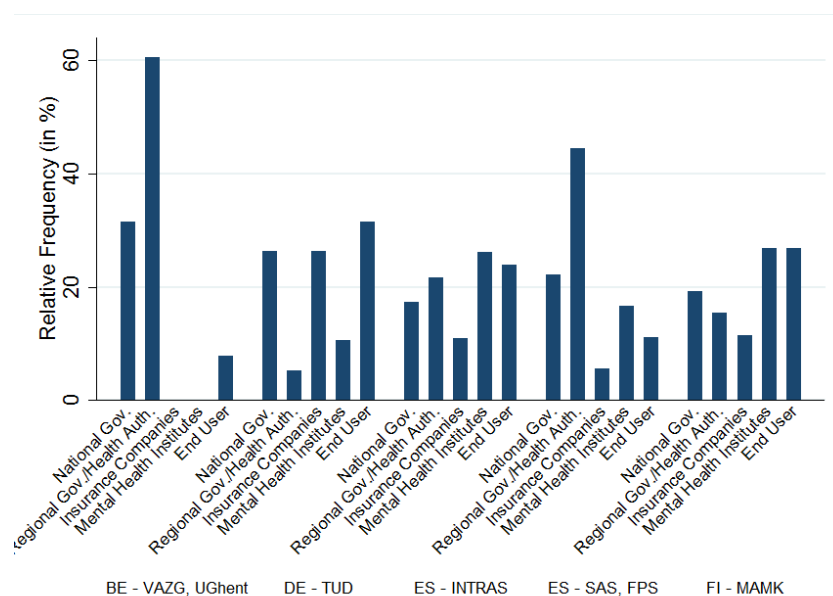


Figure 90 Financing gaming by region 1

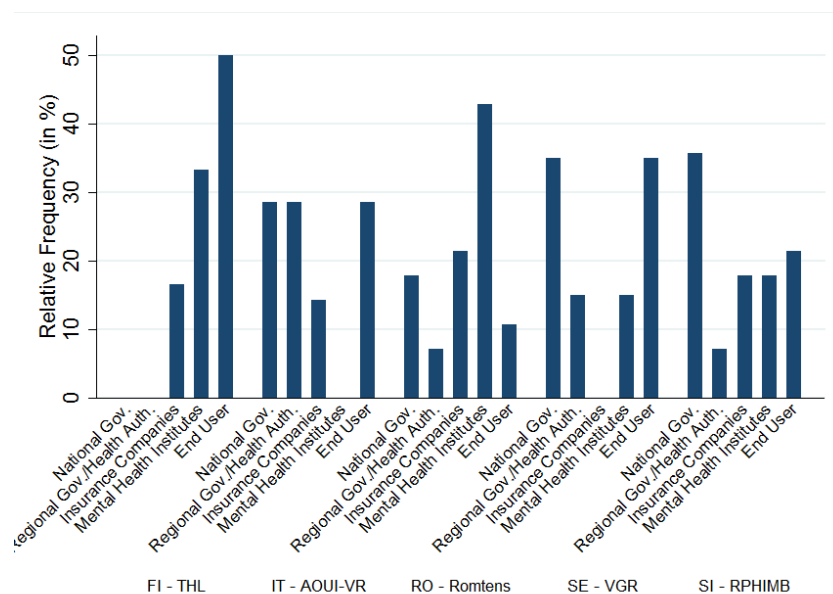


Figure 91 Financing gaming by region 2

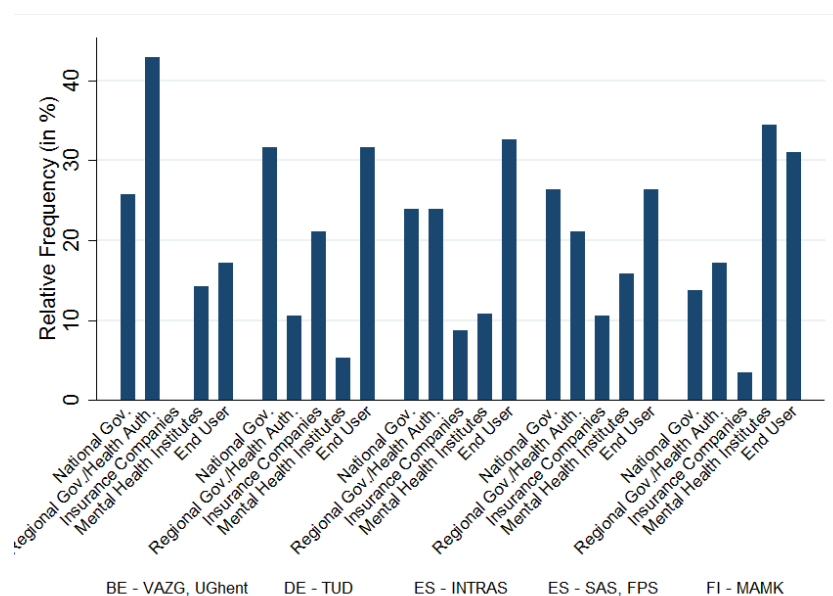


Figure 92 Financing social networking by region 1

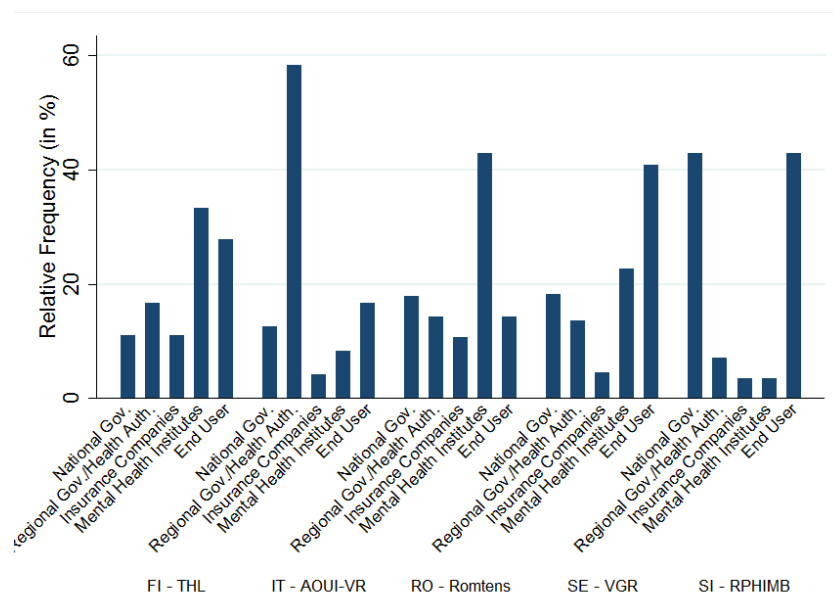


Figure 93 Financing social networking by region 2

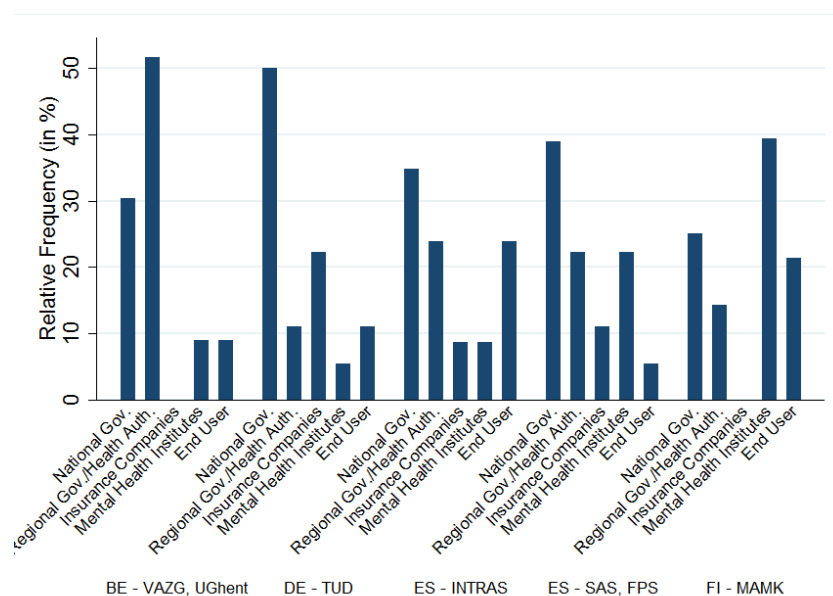


Figure 94 Financing video by region 1

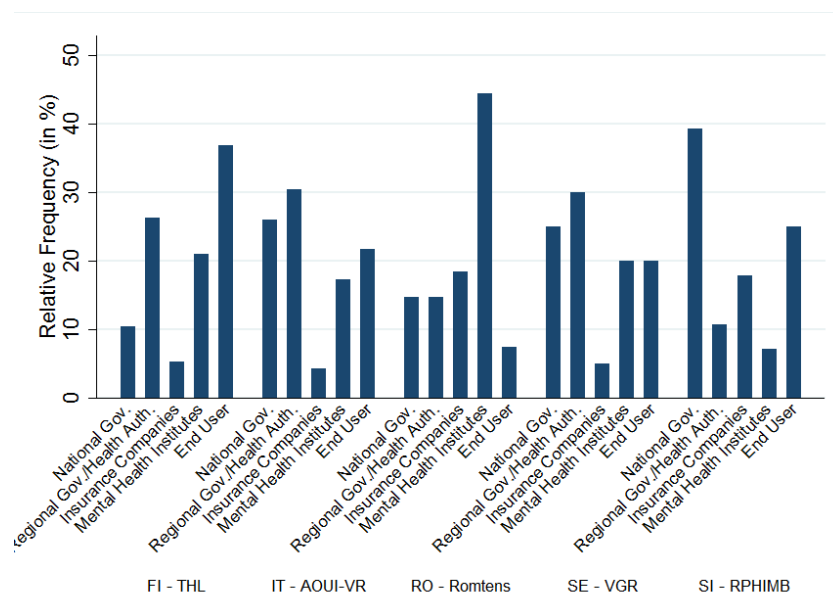


Figure 95 Financing video by region 2

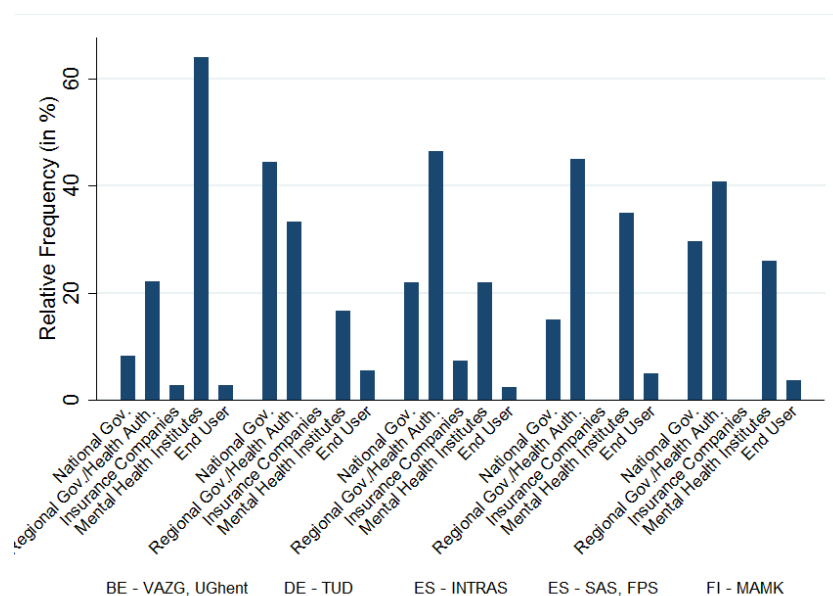


Figure 96 Supervising Apps by region 1

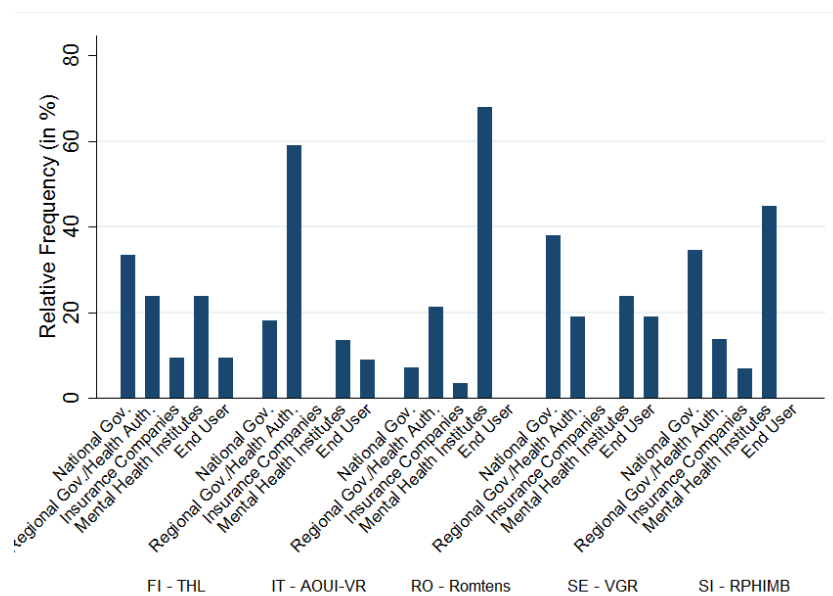


Figure 97 Supervising Apps by region 2

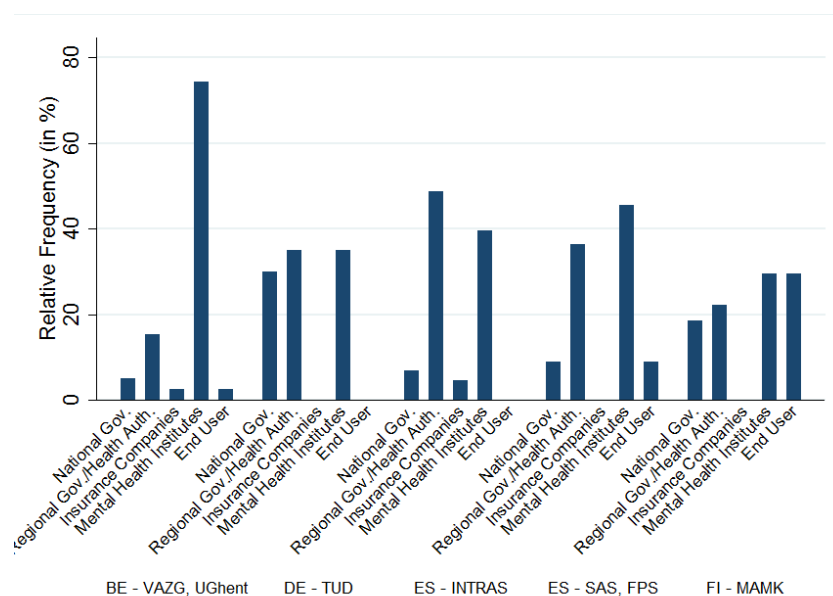


Figure 98 Supervising chat by region 1

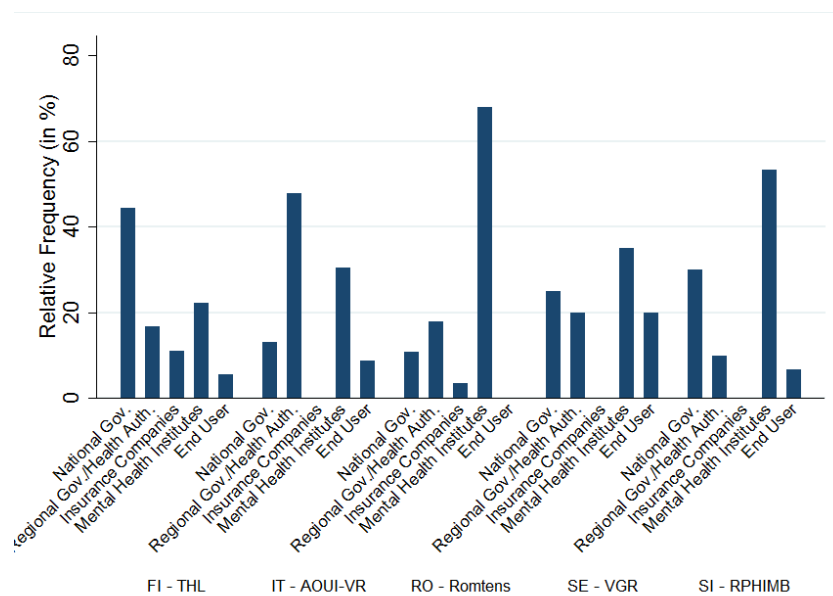


Figure 99 Supervising chat by region 2

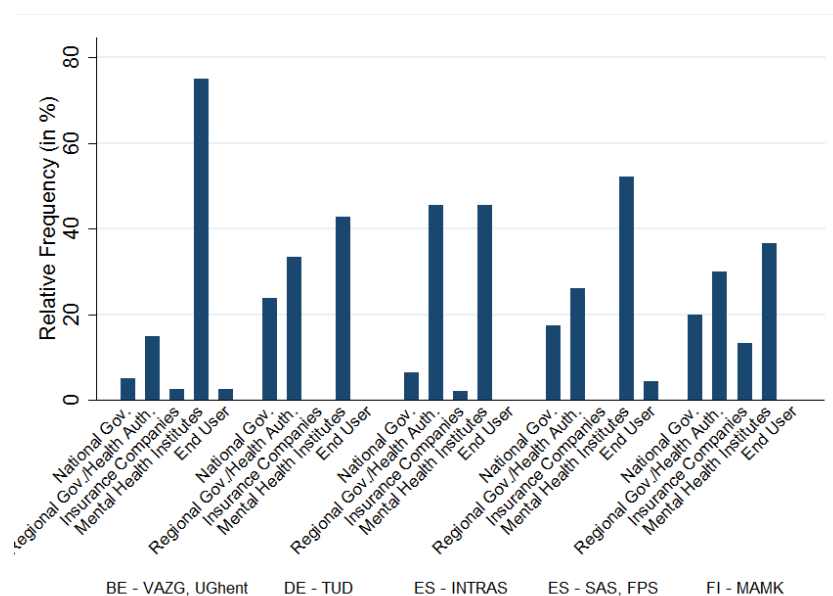


Figure 100 Supervising e-therapy by region 1

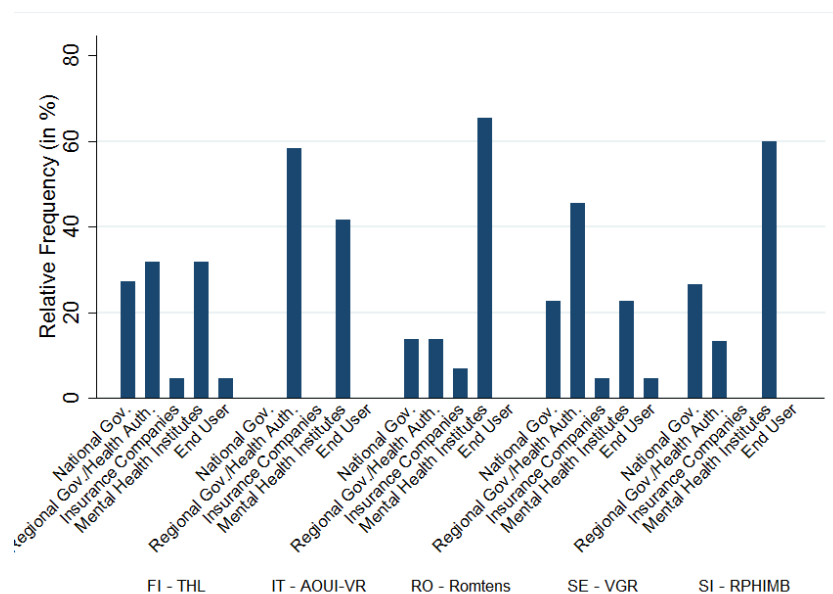


Figure 101 Supervising e-therapy by region 2

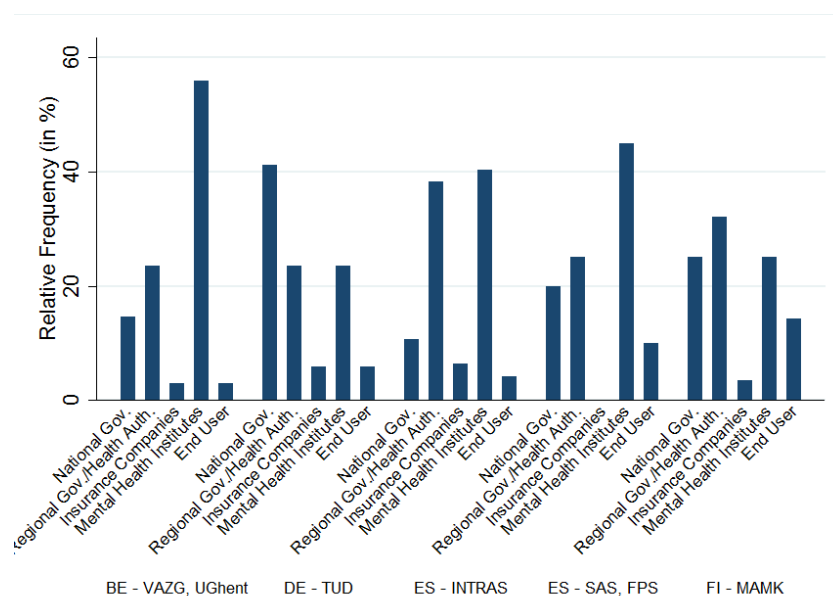


Figure 102 Supervising gaming by region 1

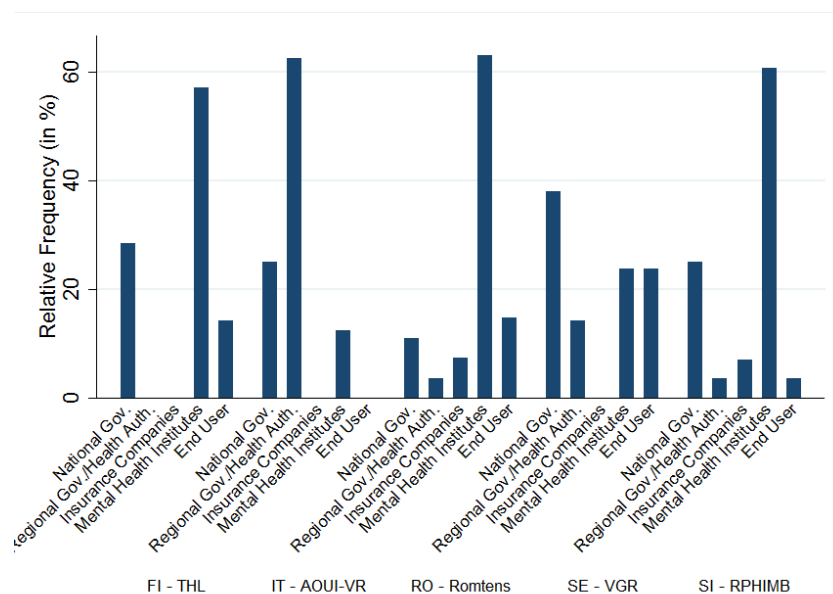


Figure 103 Supervising gaming by region 2

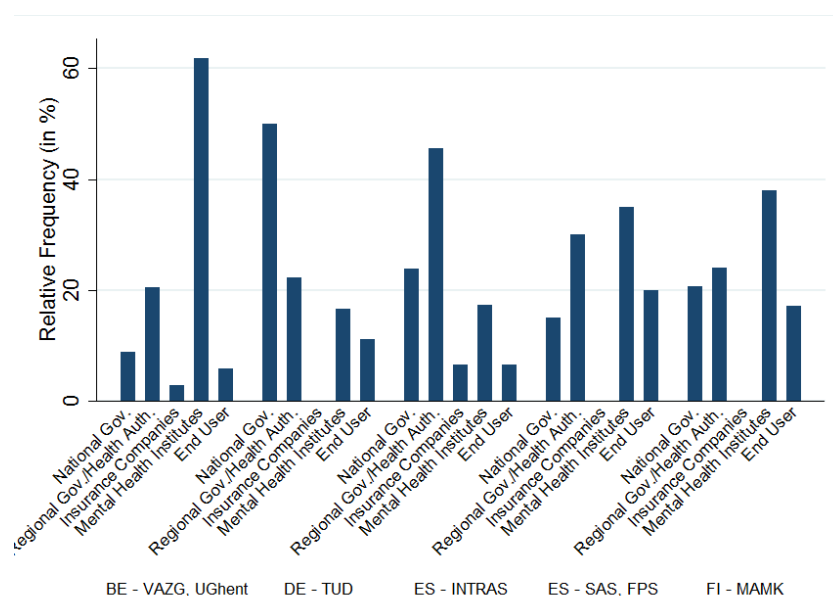


Figure 104 Supervising social networking by region 1

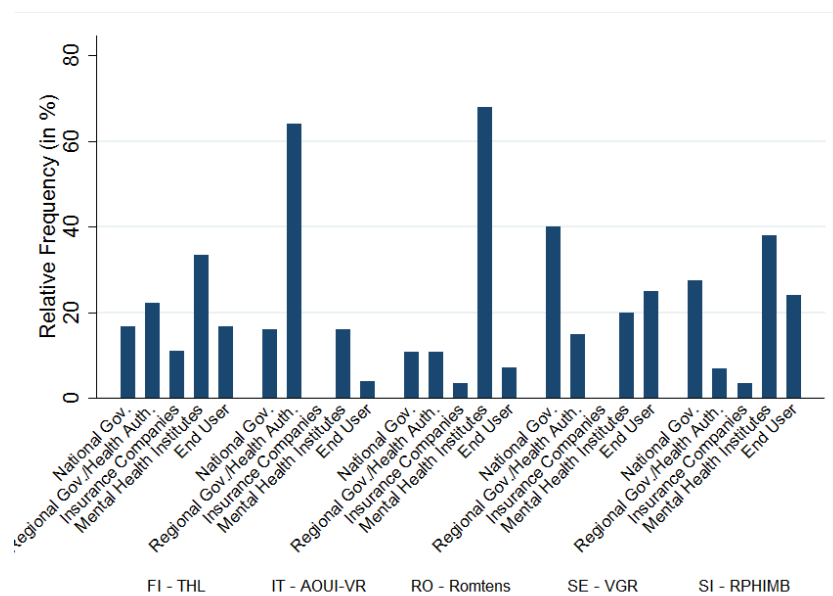


Figure 105 Supervising social networking by region 2

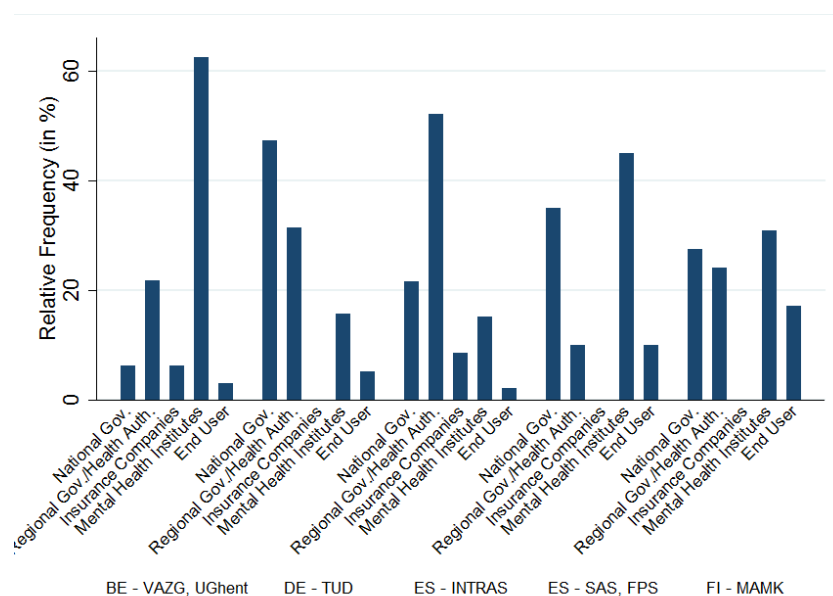


Figure 106 Supervising video by region 1

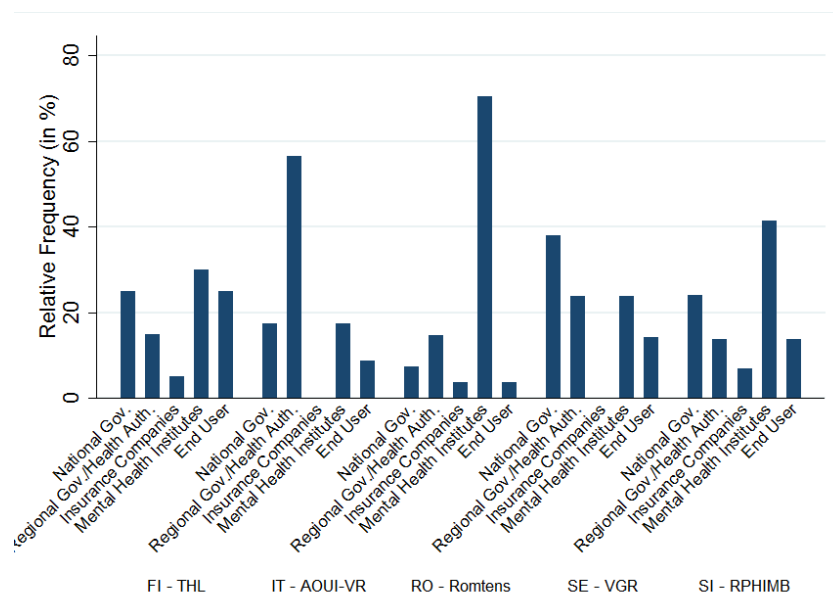


Figure 107 Supervising video by region 2

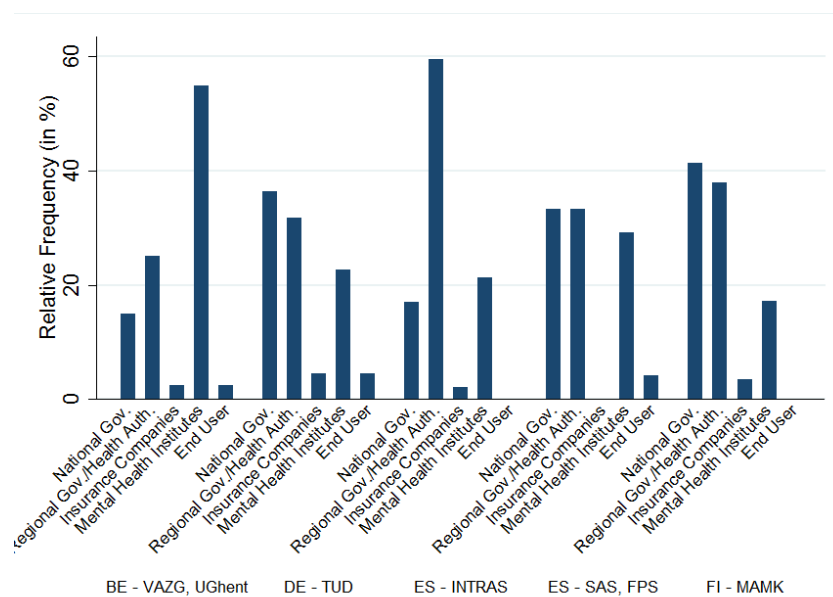


Figure 108 Supervising websites by region 1

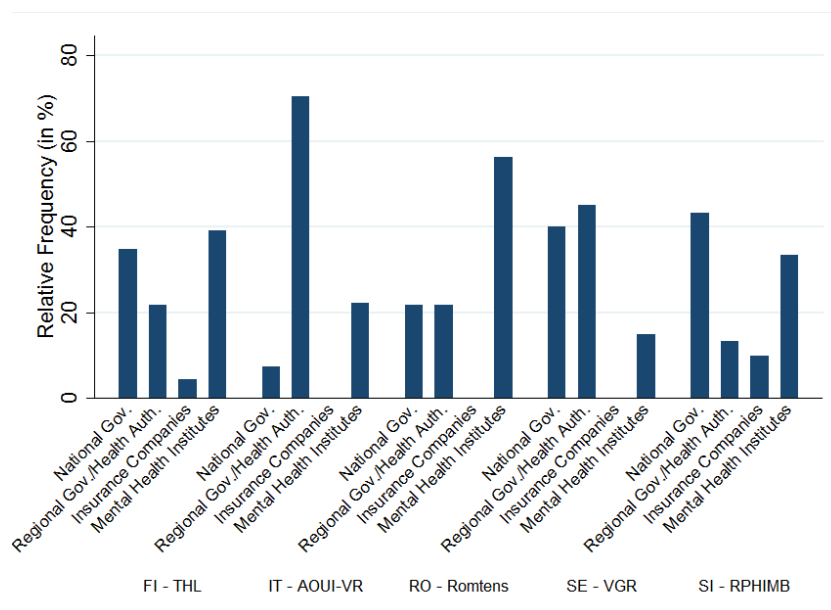


Figure 109 Supervising websites by region 2

Table 42 Contingency tables of financing and supervising of technology-based suicide prevention methods 1

Website	Supervising					
	National Gov.	Regional Gov. / Health Auth.	Insurance Companies	Mental Health Institutes	End User	Total
Financing						
National Gov.	64,08	10,68	1,94	21,36	1,94	100
Regional Gov./Health Auth.	5,13	64,96	1,71	27,35	0,85	100
Insurance Companies	22,22	33,33	22,22	22,22	0	100
Mental Health Institutes	7,14	16,67	2,38	73,81	0	100
End User	20	20	20	40	0	100
Total	28,26	35,51	2,9	32,25	1,09	100
$\chi^2 = 173.2450$ Pr = 0.000						
E-Therapy	Supervising					
	National Gov.	Regional Gov. / Health Auth.	Insurance Companies	Mental Health Institutes	End User	Total
Financing						
National Gov.	55,32	14,89	0	25,53	4,26	100
Regional Gov./Health Auth.	7,69	55,77	0,96	35,58	0	100
Insurance Companies	8,33	16,67	29,17	45,83	0	100
Mental Health Institutes	2,41	18,07	2,41	75,9	1,2	100
End User	30,77	15,38	0	46,15	7,69	100
Total	15,5	31,73	3,69	47,6	1,48	100
$\chi^2 = 171.5747$ Pr = 0.000						
Chat	Supervising					
	National Gov.	Regional Gov. / Health Auth.	Insurance Companies	Mental Health Institutes	End User	Total
Financing						
National Gov.	62,26	16,98	0	16,98	3,77	100
Regional Gov./Health Auth.	4	46,67	2,67	46,67	0	100
Insurance Companies	20	35	10	35	0	100
Mental Health Institutes	1,64	13,11	3,28	78,69	3,28	100
End User	11,9	21,43	0	30,95	35,71	100
Total	18,33	27,09	2,39	44,62	7,57	100
$\chi^2 = 180.5974$ Pr = 0.000						
Apps	Supervising					
	National Gov.	Regional Gov. / Health Auth.	Insurance Companies	Mental Health Institutes	End User	Total
Financing						
National Gov.	55,56	18,06	1,39	22,22	2,78	100
Regional Gov./Health Auth.	4,48	58,21	1,49	34,33	1,49	100
Insurance Companies	18,75	18,75	31,25	31,25	0	100
Mental Health Institutes	13,04	17,39	2,17	65,22	2,17	100
End User	17,95	33,33	0	28,21	20,51	100
Total	24,58	31,67	3,33	35,42	5	100
$\chi^2 = 144.2836$ Pr = 0.000						

Table 43 Correlation of financing and supervising of technology-based suicide prevention methods 2

Web-based video	Supervising					
Financing	National Gov.	Regional Gov. / Health Auth.	Insurance Companies	Mental Health Institutes	End User	Total
National Gov.	58,11	21,62	0	17,57	2,7	100
Regional Gov./Health Auth.	5,08	52,54	1,69	40,68	0	100
Insurance Companies	4,55	22,73	27,27	45,45	0	100
Mental Health Institutes	8,89	17,78	2,22	66,67	4,44	100
End User	10,64	27,66	2,13	17,02	42,55	100
Total	22,67	29,55	3,64	34,41	9,72	100
$\chi^2 = 201.5534$ Pr = 0.000						
Social networking	Supervising					
Financing	National Gov.	Regional Gov. / Health Auth.	Insurance Companies	Mental Health Institutes	End User	Total
National Gov.	58,33	11,67	1,67	25	3,33	100
Regional Gov./Health Auth.	9,84	59,02	1,64	27,87	1,64	100
Insurance Companies	17,65	23,53	23,53	29,41	5,88	100
Mental Health Institutes	8,51	6,38	0	82,98	2,13	100
End User	14,93	25,37	1,49	16,42	41,79	100
Total	23,02	26,59	2,78	34,52	13,1	100
$\chi^2 = 207.0264$ Pr = 0.000						
Serious gaming	Supervising					
Financing	National Gov.	Regional Gov. / Health Auth.	Insurance Companies	Mental Health Institutes	End User	Total
National Gov.	56,36	9,09	1,82	29,09	3,64	100
Regional Gov./Health Auth.	8	46	2	42	2	100
Insurance Companies	20	20	32	28	0	100
Mental Health Institutes	2,27	9,09	0	86,36	2,27	100
End User	17,78	24,44	0	26,67	31,11	100
Total	22,37	21,92	4,57	42,92	8,22	100
$\chi^2 = 171.4562$ Pr = 0.000						

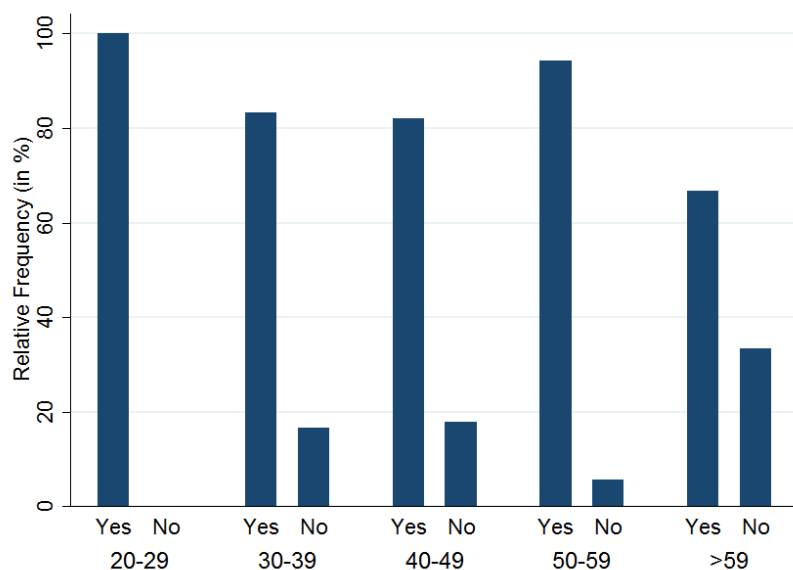


Figure 110 Usefulness of training in the use of the guidelines by age

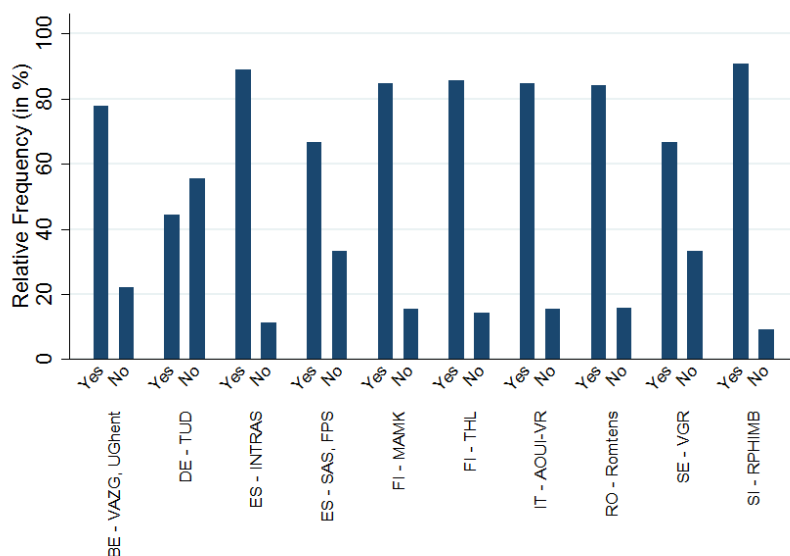


Figure 111 Guidelines and Protocols as contents of a training course for early detection by region

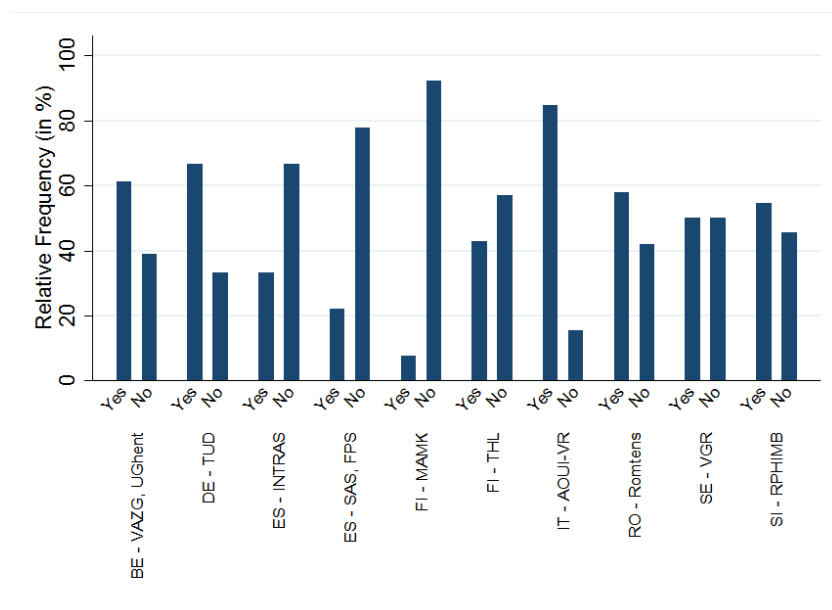


Figure 112 Scientific Literature as contents of a training course for early detection by region

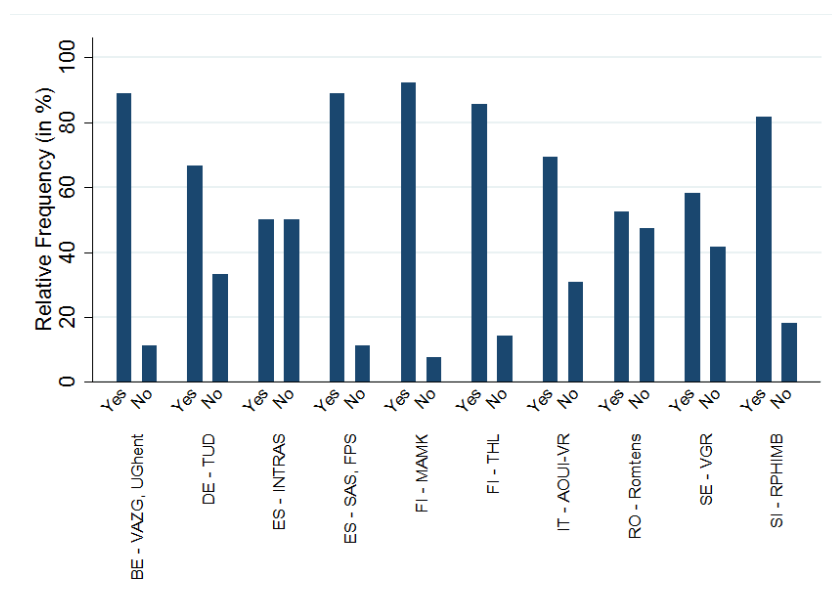


Figure 113 Overview of services as contents of a training course for early detection by region

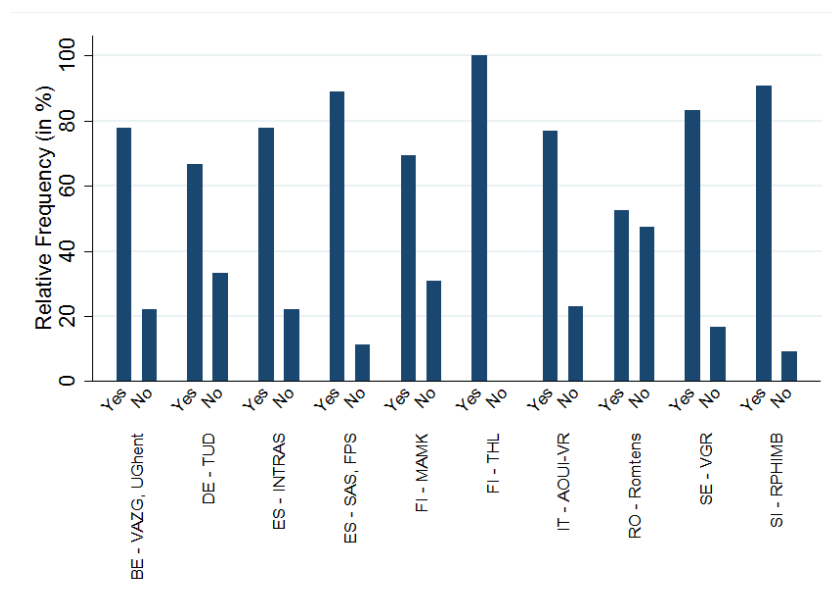


Figure 114 Practical skills as contents of a training course for early detection by region

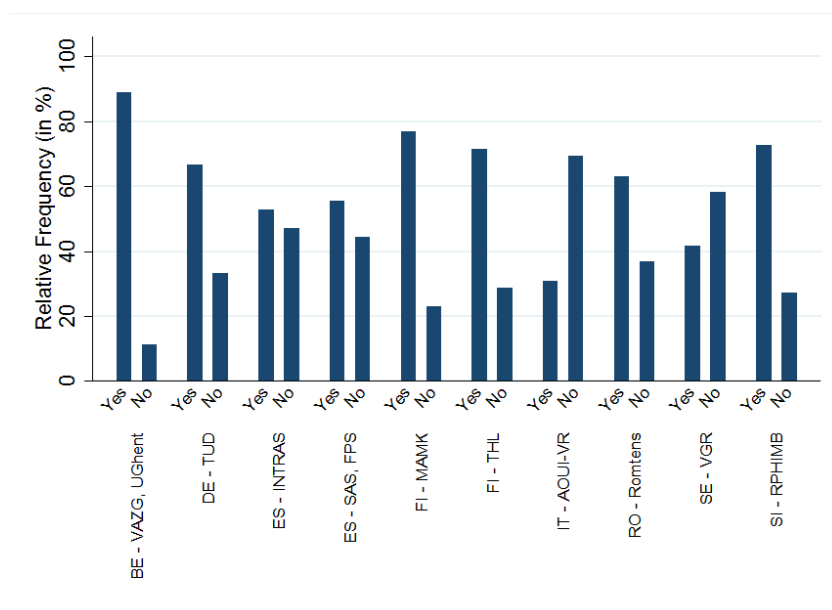


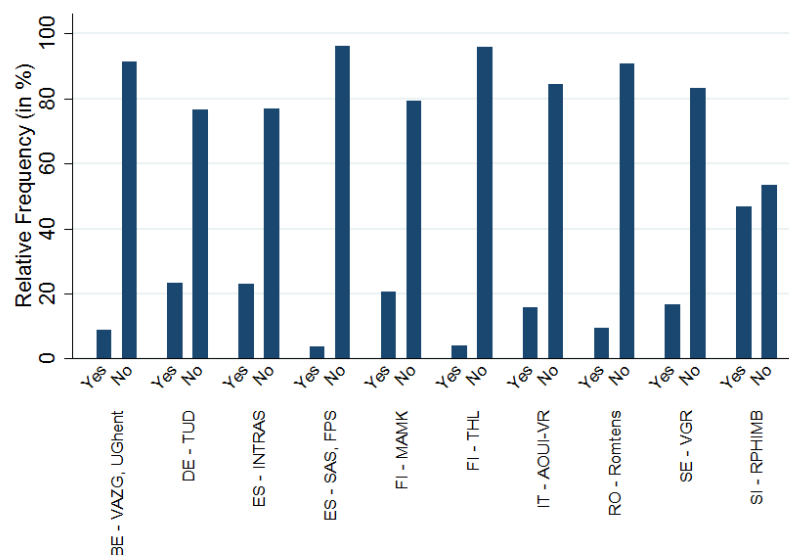
Figure 115 Websites/web tools as contents of a training course for early detection by region

Table 44 Duration of training course by age

Yes (in %)	20-29	30-39	40-49	50-59	>59
Half a day	0	7	8	9	8
One day	43	25	24	18	0
Several sessions during one month	29	32	28	33	8
Several sessions during the year	43	32	46	47	92

Table 45 Conditions for an easier participation in the training by age

Yes (in %)	20-29	30-39	40-49	50-59	>59
In the morning	43	46	31	30	25
In the afternoon	0	21	27	31	50
In the evening	14	0	6	7	8
Only Face-to-face training	14	21	27	7	17
Only E-learning	14	7	10	9	0
Blended training	71	68	57	53	33
Training acknowledged by my institution	43	61	73	51	50
Training credits acknowledged by national health system	29	39	53	62	33
Free of charge	43	50	48	52	58

**Figure 116 Awareness of charitable organizations by region**

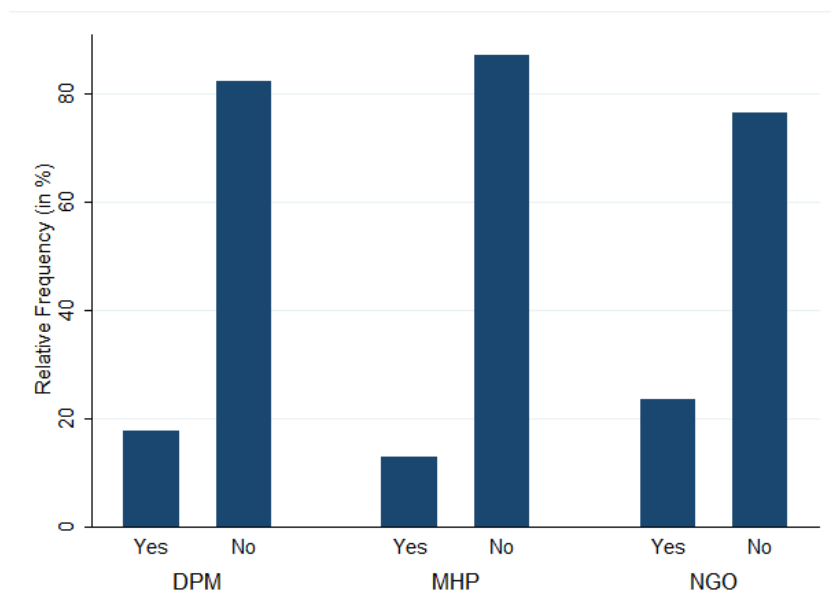


Figure 117 Awareness of charitable organizations by stakeholder

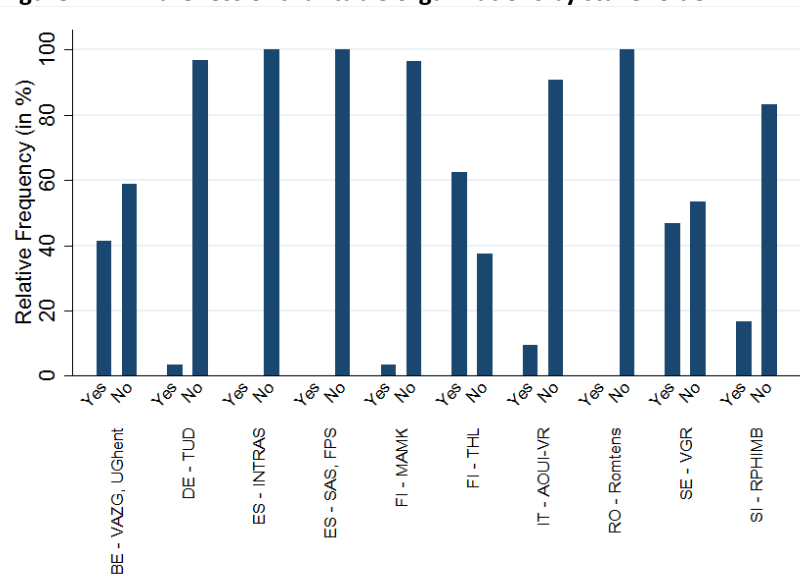


Figure 118 Awareness of chat sessions by stakeholder

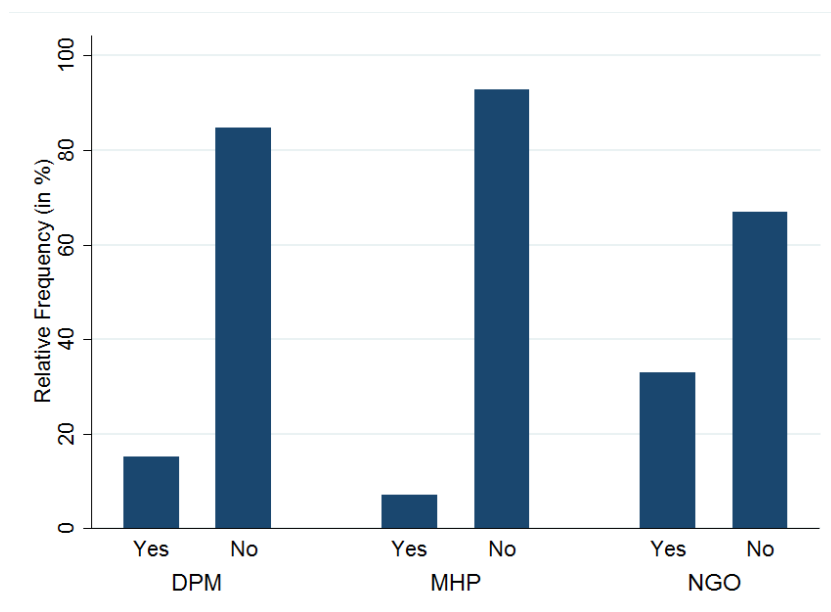


Figure 119 Awareness of chat sessions by stakeholder

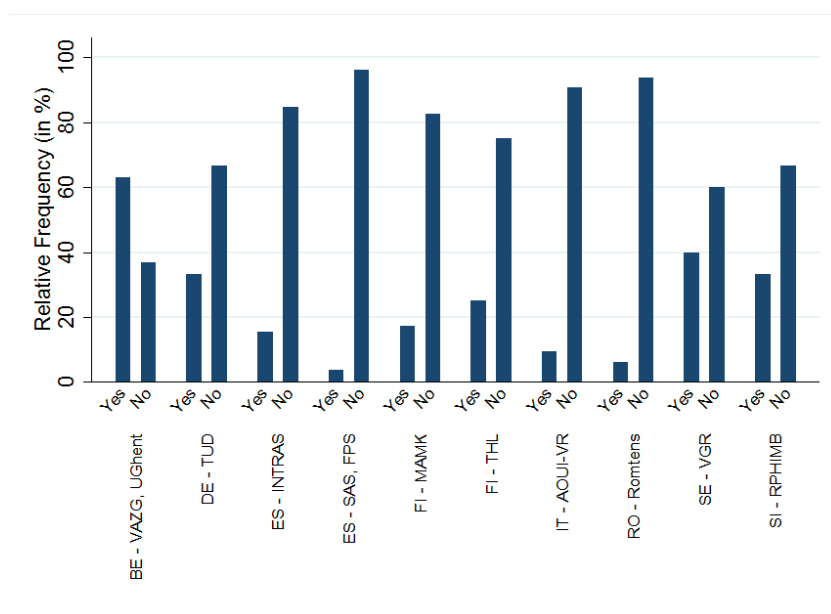


Figure 120 Awareness of informative websites by region

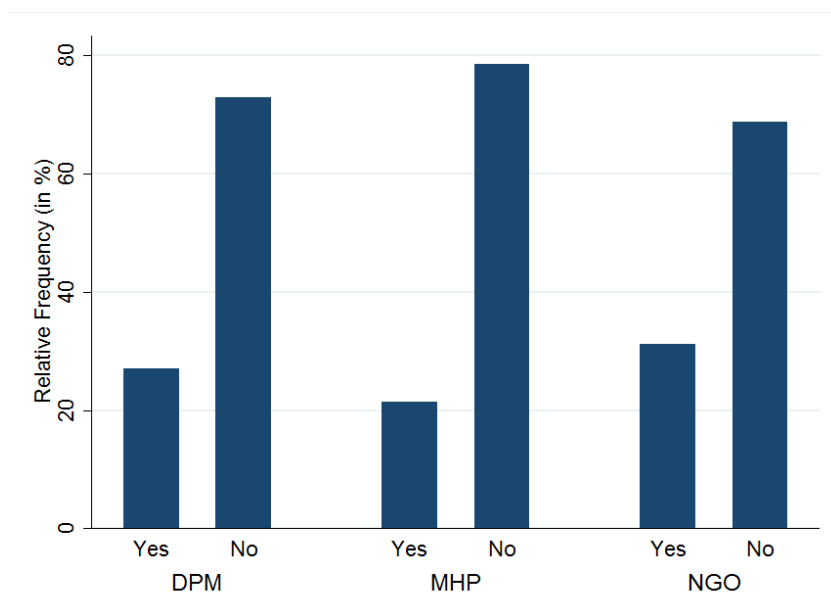


Figure 121 Awareness of informative websites by stakeholder

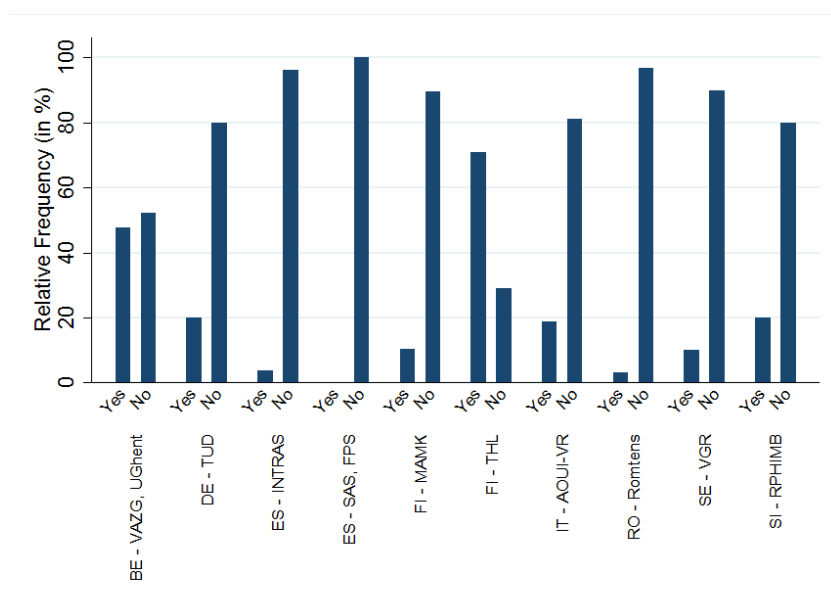


Figure 122 Awareness of internet forums by region

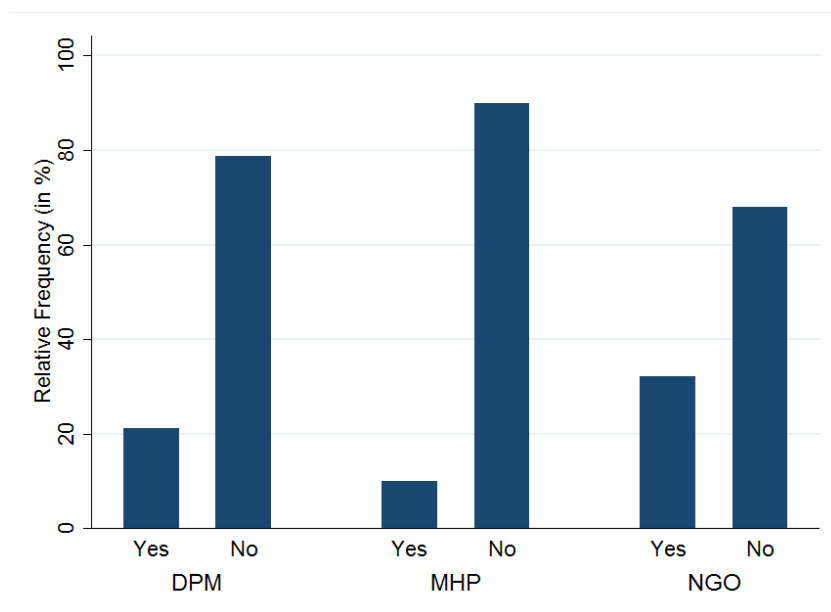


Figure 123 Awareness of internet forums by stakeholder

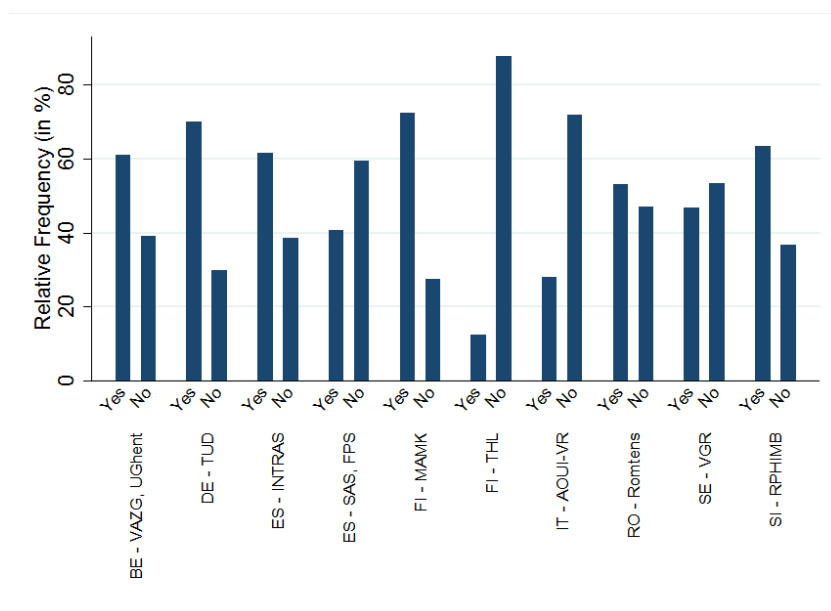


Figure 124 Awareness of psychologists/psychiatrists by region

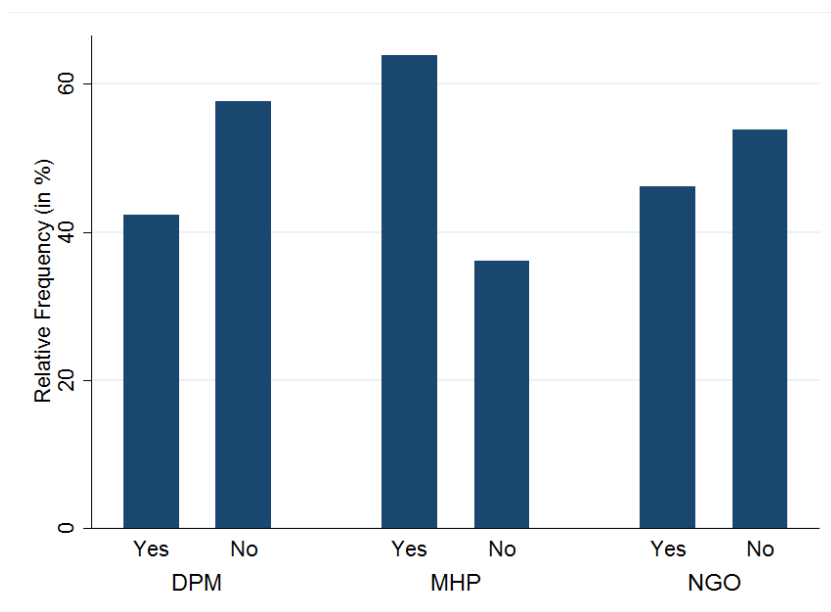


Figure 125 Awareness of psychologists/psychiatrists by stakeholder

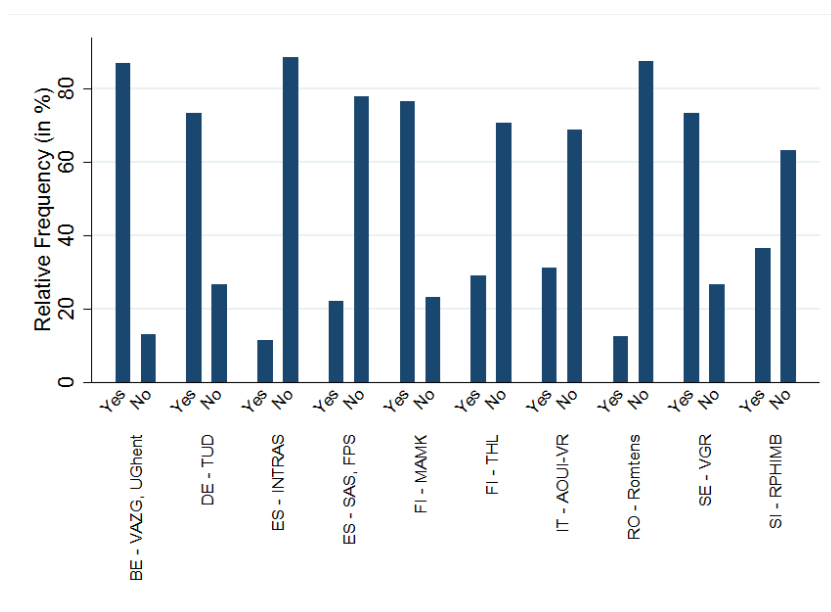


Figure 126 Awareness of self-help groups by region

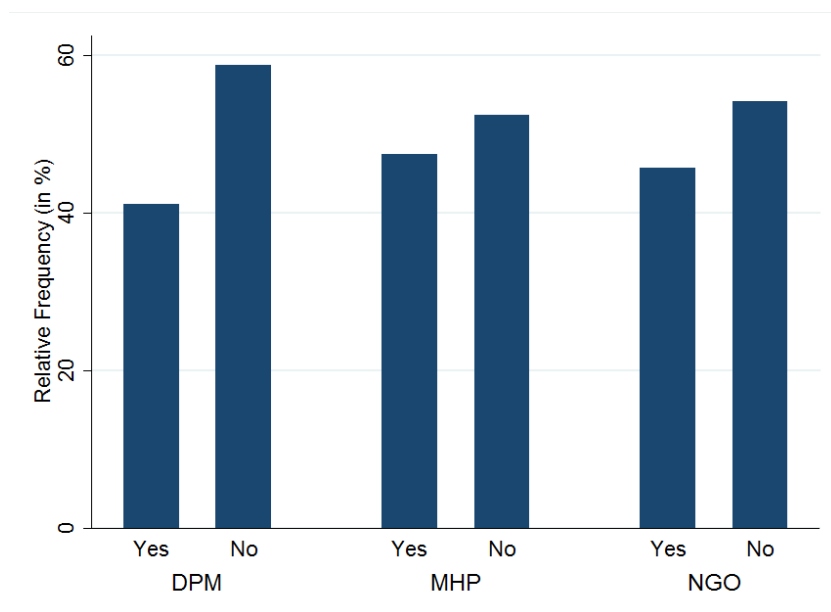


Figure 127 Awareness of self-help groups by stakeholder

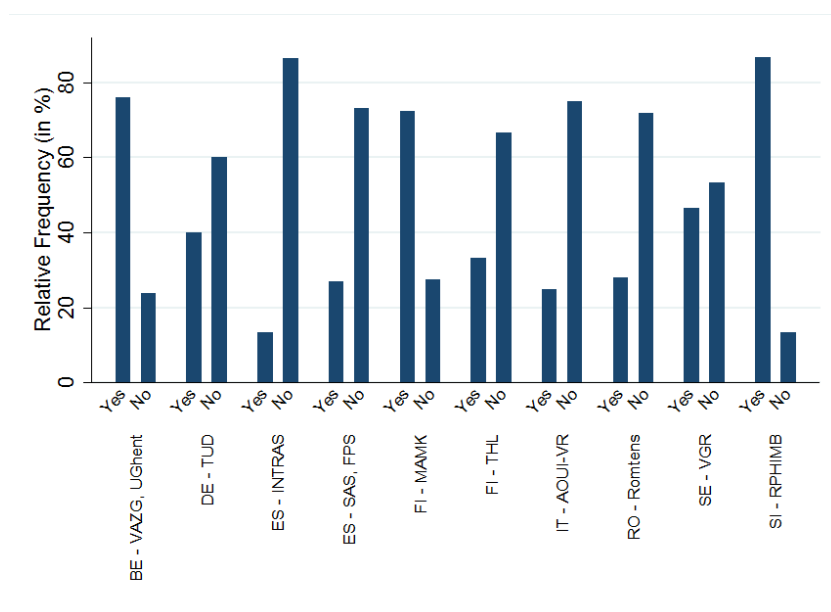


Figure 128 Awareness of telephone helplines by region

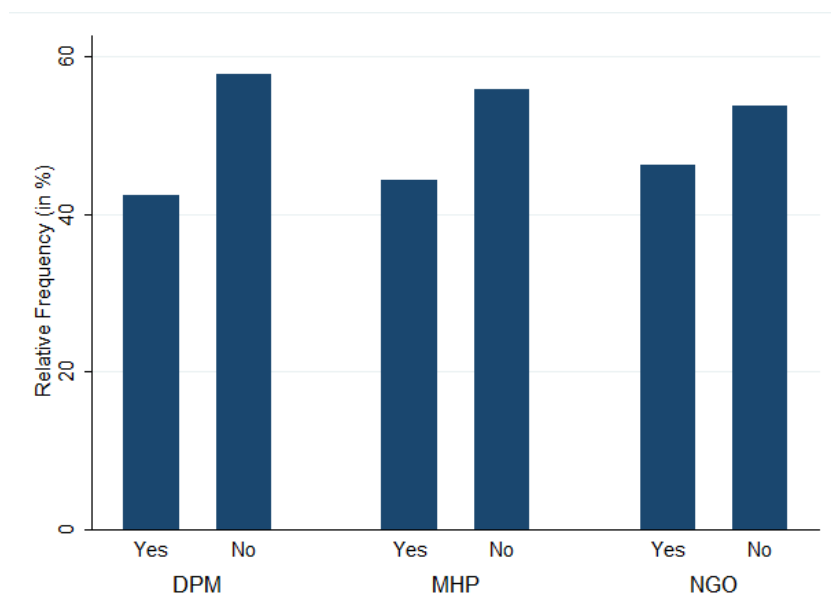


Figure 129 Awareness of telephone helplines by stakeholder



6. Annex II: study protocol

1. Introduction

This study protocol has been developed in the framework of Work Package 4 (WP4) of the Euregenas project “European Regions Enforcing Actions against Suicide” (Grant Agreement N° 2010 12 03) which is financed by Executive Agency for Health and Consumers (EAHC) of the European Commission (EC). The overall aim is the development of suicide prevention strategies in regional collaboration with European countries.

The purpose of this study protocol is to outline the procedures for the mapping of the relevant stakeholders and for the subsequent elaboration of the questionnaires to be submitted to the identified stakeholders.

The purpose of mapping and identifying key stakeholders is twofold:

- (1) to understand their needs in terms of knowledge, skills and resources regarding suicide prevention in order to develop the deliverables as foreseen in WPs 5, 6, 7 and 8 in a targeted and useful way.
- (2) to identify opportunities and to take advantage of their support throughout the implementation of the Euregenas project.

2. Objectives of Euregenas

The overall objective of the Euregenas project is “to contribute to the prevention of suicidality (suicidal ideation, suicide attempts and suicide) in Europe through the development and implementation of strategies for suicide prevention at a regional level that can be of use to the European Community as examples of good practice” (Annex Ia).

More specifically, the project focuses on four different topics on which the needs assessment of WP4 is based.

- Firstly, the study aims at the development of technical specifications for an integrated model for e-mental healthcare oriented on suicide prevention.
- Secondly, the study aims to develop and to disseminate suicide prevention packages as well as awareness raising strategies for different



targets (e.g. school, workplace) focusing on different risk-groups (e.g. youth, elderly).

- Thirdly, the study aims at an elaboration of training modules on suicide prevention for professionals.
- And lastly, the study has the goal to develop a tool supporting group facilitators to ensure an ongoing monitoring, to evaluate the group efficacy, and to adjust the management of the group.

3. Objectives of WP4

The purpose of WP4 is to carry out a literature and good practice review as well as a needs assessment taking into account views and needs of different key stakeholders in all participating EU regions. This activity will provide a basis for the development of the other project Work Packages.

4. Methodology

4.1. Study design

The structure of the present study is cross national in specific EU regions.

4.2. Involved countries

In WP4, data collection (selection of key stakeholders, needs assessment) will be carried out by all partners who are included in the project.

- Italy: AOUI-VR
- Belgium: VAZG, UGENT
- Sweden: (WS), VGR
- Romania: Romtens
- United Kingdom: KPCT
- Finland: THL, MAMK
- Spain: INTRAS, SAS, FPS
- Slovenia: RPHI MB
- Germany: TUD

Project partners will conduct the analysis at a regional level or if appropriate at a local level



4.3. Target group

Based on preliminary consultation with project partners and profound literature review, a list of potential stakeholders is proposed (see Table 1). The final list of stakeholders for each partner will be drawn up on the basis of the ranking exercise that will be carried out as described in section 4.4. Each sub-category should be considered in particular in terms of its relevance for e-mental health, education, and workplace.

Table 1:

Category	Sub-category	WP Relevance
1 Decision and Policy Makers (Macrolevel)	1.a European networks focusing on mental health promotion (EUREGHA, ENWHP, EUOSHA...)	(WP5, 6, 8)
	1.b Decision and policy makers from local and regional authorities (dealing with mental health, care, welfare, family matters, youth...)	(WP5-8)
	1.c Decision and policy makers in public health institutions (e.g. mental health care centers, hospitals)	(WP5-8)
	1.d Private companies influencing policy (e.g. health insurance)	(WP5, 6)
	1.e Media	(WP5, 6)
	1.f Educational setting, policy makers	(WP5, 6)
	1.g Professionals working in financial services and human resources	(WP5, 6)
2 Mental Health Professionals (youth, adult and elderly focused MHPs) (Mesolevel)	2.a General practitioners	(WP5-8)
	2.b Psychologists (inpatient, outpatient)	(WP5-8)
	2.c Psychiatrists (inpatient, outpatient)	(WP5-8)
	2.d Emergency physicians (on call doctors in Accident & Emergency)	(WP5-8)
	2.e Nursing staff who work with suicidal patient (primary health nurse, mental health nurse, emergency room nurse)	(WP5-8)
	2.f Rescue personnel (paramedic – ambulance crew)	(WP6-8)
	2.g Work setting, e.g. private companies and prevention advisors in occupational medicine	(WP5, 6)


	2.h Educational setting, e.g. schools, school counselors	(WP5, 6)
3 NGOs/Social Area (Mesolevel)	3.a Professionals in the social area (community social workers, home help workers, youth workers, social welfare services)	(WP5-8)
	3.b Staff of NGOs and agencies working in the following areas: youth, marital counseling, family and life counseling, welfare	(WP5-8)
	3.c Educational setting: teachers	(WP6)
	3.c Staff of suicide helplines	(WP5, 6, 8)
	3.e Representatives of religious group	(WP5,6 , 8)
	3.f Support groups with survivors	(WP5-8)
	3.g Work setting: employers, human resources, union representatives	(WP6-8)
	3.h Criminal justice stakeholders (e.g. police, penitentiary police, coroners ...)	(WP6, 7)
	3.i Pharmacists	(WP6-8)

4.4. Ranking of stakeholders

All project partners will be involved in the ranking of the stakeholders. The objective of this activity is to decide which stakeholders have the highest priority according to the regional context in each of the participating countries. The ranking is based on the following three decision parameters (Gardner et al. 1986; Chinyio, Olomolaiye 2010):

- Power (dominant - dependent stakeholder)
- Dynamism (avoid negative effects, being proactive)
- Level of interest (in supporting suicide prevention, to reduce the number of suicide)

5	very powerful	very dynamic	highest level of interest
4	quite powerful	quite dynamic	high level of interest



3	middle	middle	middle
2	not very powerful	not very dynamic	low level of interest
1	not at all powerful	not at all dynamic	lowest level of interest

The procedures for the ranking of stakeholders are common for all partners but the results are expected to vary across partners reflecting on the different regional contexts. Each project partner should assign a number from 1 to 5 to each stakeholder in the Excel sheet attached in annex 1 to this study protocol. The ranking should be done for all three parameters separately.

Given the purpose of the ranking procedure, the order of importance of the 3 parameters has been established as follows:

1. Level of interest (50%)
2. Dynamism (30%)
3. Power (20%)

The above-mentioned weighting is automatically calculated in the Excel sheet with the aim of creating a general index that respects the different importance attributed to the parameters. Once each partner has entered the ranking for the different stakeholders, it will be possible to view the general index automatically. The questionnaires will be administered only to those stakeholders who have a general index of above 3. In addition, the Excel table includes a formula to calculate the proportion of the total number of questionnaires to be sent to the different stakeholders.

Considering the timeframe, aims and resources of the Euregenas project, this procedure does not attempt to carry out a detailed stakeholder analysis, but to provide partners with a snapshot of a rapidly changing context, in order to identify how many questionnaires should be submitted and to whom. Once each partner has established the sub-category of stakeholders to be contacted, each partner is responsible for identifying the name and contact details of the actual persons (see annex 2). The annex 2 is only for internal use and the anonymity will always be preserved.

4.5. Creation of questionnaires

Specific questionnaires will be elaborated according to the categories of stakeholders listed in table 1. The WP4 leader is responsible for coordinating the elaboration of these questionnaires. The other WP leaders will be asked to

formulate questions which are relevant for their WPs. The major purpose is that stakeholders provide answers which are useful for the different WPs.

The (four) different questionnaires are the tools that will be used to obtain the necessary information for the needs assessment. These questionnaires will include closed questions (quantitative method), and variables are mostly nominal and ordinal and less ratio (Mayer 2008). The questionnaires will be created in English and the project partners are responsible for translating them into their own language. If some partners are from the same country only one questionnaire in the national language will be created according to an internal agreement between the two partners.

4.6. Piloting of questionnaires

Before final use of the questionnaires, it is necessary to examine comprehensibility, manageability and consistency through piloting. The piloting is a key procedure to avoid mistakes in the data collection process (Geyer 2003). The following criteria should be checked during the piloting phase.

- The respondents should understand and interpret the questions in the way it was intended by the examiner.
- The question must be formulated so that it could be collected in every situation and by all respondents in a consistent way.
- Over every situation and every respondent a question must be asked that it is clearly what response is required.
- The respondents must be able to answer a question accurate and correctly.
- A questionnaire must be designed so that motivation and concentration of the respondents is not affected.
- The respondents must be in the position to bring their answer in the required form (Geyer 2003).

Please note that:

- each region/country is responsible for its own piloting of the questionnaires in the national language.
- after finishing the translation of the questionnaires, the piloting should be carried out in field conditions.

- each questionnaire should be piloted with 2 persons in each region. This means that each region will have 6 completed questionnaires. These respondents should complete the questionnaire on trial basis.
- in addition to the answers of the questions, the respondents will be asked to give feedback on the structure and usability of the questionnaire. (The questionnaire also contains ca. 3 further questions relating to this topic.)

Quality deficits of questions, problems or conspicuity will be reported by each partner in a common template that will be prepared by the WP4 leader. In August every partner gets the different questionnaires and the template and is responsible for the piloting of the questionnaires, the fill in of the template and the return of the template to WP4 leader. After the piloting, the WP4 leader will include all comments and suggestions and elaborate the final questionnaires (September 2012).

4.7. Data collection

The overall number of completed questionnaires of the Euregenas project should be 390 (13 partners x 30 questionnaires = 390 questionnaires). This means that each region has to collect the information of 30 participants. Each region is responsible to send out a sufficiently large number of questionnaires (appr. 60) in order to have a minimum of 30 completed questionnaires at the end (AAPOR 2011). The number of questionnaires per key stakeholder group will be based on the ranking of stakeholders carried out by each partner and will be different for each region according to the different ratings assigned.

The estimated date for the distribution of the questionnaire is set at the beginning of Oktober 2012. The time period is 2 months to collect 30 completed questionnaires per region, and the exact number for each subcategory to be sent to the WP leader, will be the one calculated using the Excel sheet in annex 1, completed by each partner.

The follow up has to be carried out by telephone and email contacts 10, 20 and 30 days after sending out questionnaires (please also note down in annex 2).

4.8. Data entry/cleaning

The entry of the completed questionnaires should be at the end of November 2012. All project partners have to enter their data in a standardized file which will be created by the WP4 leader. As soon as the project partner has a completed database which includes the content of 30 questionnaires the



database should be sent to WP4 leader for further analysis (end of November 2012). Data cleaning and analysis are tasks of WP4 leader.

4.9. Statistical data analysis

Statistical analyses of data with the methods of empirical social research (descriptive and analytical statistics), using SPSS software tools and interpretation of findings, will be carried out by the WP4 leader (Raab-Steiner, Benesch 2010). At the end of March 2013 the analysis of the database should be completed.

4.10. Presentation of results

First results of the data analysis should be available at the Meeting in Dresden in December 2012. The results of the needs assessment should represent the basis for further WPs.



7. References

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