Pan-America Regional Forum

IASP

Abstract Book

Costa Rica, 2026

9-11 November 2026
DoubleTree by Hilton Hotel,
Cariari, San José, Costa Rica



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Welcome 5
Scientific Co-Chairs 6
Steering Committee 8
Scientific Committee 8
Invited Speakers 9
..... 14
Plenaries 15
Opening Plenaries November 9th 10am — 11am 15
Beyond the protocol: The human bond as a clinical tool in suicide prevention 15
Intensity, Recovery, and the Problem of Hope: What Lived Expertise Brings to the New Conversation on Suicide 15
Plenaries November 10th 8.30am — 9.30am 16
From audience to agency: Transforming suicide prevention through media and youth engagement 16
Suicide Prevention Hotlines and National Strategies. 16
Closing Plenary November 11th 4.00pm — 4.30pm 17
Do national suicide prevention strategies work? 17
Closing Remarks November 11th, 2026 4.30pm - 5.00pm 17
Panels 17
Panels November 9th, 2026, 11:30am — 12:30pm 17
Panel 1 - Hotlines 17
Panel 2 - Partnerships for Life Session November 10th, 2026, 3:30pm — 5:00pm 18
Panel 3 - Gambling, Addiction and Suicide Prevention 18
Plenary Panel November 10th, 2026 3.30pm - 5.00pm 18
Suicide Prevention in a digital world 18
Youth Space Session November 11th, 2026, 2:30pm — 5:00pm 19
Madrinas y Padrinos por la Vida/ Godmothers and Godfathers for Life 19
Workshops 20
Workshops November 9th, 2026, 3:00pm — 5:30pm 20
Workshop 1 Psychological Technology in Mental Health Care and Suicide Prevention 20
Workshop 2 Vida em Rede: From Policy to Practice — Implementing National Suicide Prevention Strategies through Implementation Science 20
Workshop 3 Suicide & the Media — Promoting safer communication and narratives about suicide and its prevention in traditional and social media including engagement with stakeholders 22
Workshops November 10th, 2026, 9:30am — 12:00noon 22
Workshop 4 From Evidence to Action: Strengthening Intersectoral Collaboration for Suicide Prevention through the WHO LIVE LIFE Framework 22
Workshop 5 Bridging the Gap Between Mayas and Charrúas: A Clinical Suicidological Approach to Suicide Risk Situations 23

Workshop 6 Basic Course: DBT-MXAU Skills Training for Suicide Prevention Among School-Aged Adolescents 24
Workshops November 10th, 2026, 3:00pm — 5:30pm 24
Workshop 7 RECOVER: Coping and Recovery for Clinician Survivors of Loss to Suicide 24
Workshop 8 Doing more: a community-based care model for suicide prevention. 25
Workshop 9 From Strategy to Action: Supporting Accountability in Suicide Prevention Across National and Community Contexts 25
Workshops November 11th, 2026, 10:00am — 12:30pm 26
Workshop 10 Comprehensive approach and collaborative work with churches and grassroots faith communities for suicide prevention. 27
Workshop 11 Tik Tok: Suicide Prevention in Digital Spaces: Building Partnerships Across Platforms, Experts, and Creators 27
Workshop 12 Withdrawn 28
Workshops November 11th, 2026, 1:30pm — 4:00pm 29
Workshop 13 Techniques for Addressing Common Challenges when Working with Families of Suicidal Individuals 29
Workshop 14 Artificial Intelligence and Suicide Prevention: Navigating Opportunities, Risks, and Responsible Practice 30
Lightning Presentations 31
Lightning #1, Cocorí 1-2, November 9, 2026, 1:30 PM - 3:00 PM 31
1.1 Treatment provided for Danish adolescents who attempt suicide: Comparison of those presenting and not presenting to hospital 31
1.2 The iceberg model of suicidal ideation and behaviour in Danish adolescents: Integration of national registry and self-reported data within a national birth cohort 32
1.3 Beyond Talking Points: Digital Creators as the New Gatekeepers of Mental Health Conversations 32
1.4 Duelo comunitario 33
1.5 Parent—Child Conflict and Suicidal Ideation and Planning Among U.S. Adolescents: Findings from the 2023—2024 National Survey on Drug Use and Health 33
1.6 The Evolving Use of Generative AI: Implications for Suicide Risk & Prevention 34
1.7 Capacitación en intervención de crisis suicida para operadores de una línea de ayuda en Quito, Ecuador: Un Proyecto Piloto Métodos Mixtos 34
1.8 Who is involved? Mapping Ground-level Institutional Responses to Mental Health Emergencies in Mexico City's Subway System 35
Lightning #2, Cocorí 3, November 9, 2026, 1:30 PM - 3:00 PM 36
2.1 Caregivers CARE (Connect, Assess, Respond, Encourage): Making Suicide Prevention Education More Accessible, Approachable, and Supportive for Veteran Caregivers 36
2.2 Suicidal behavior subtypes in late-life: Different risk factors and life trajectories 36
2.3 Impacto de la soledad y el aislamiento social en la salud mental y física de estudiantes de 6to a 12mo grado en Puerto Rico, 2022-24 37
2.4 Bridging Global Science and Local Practice: Cutting Through a Bibliometric and Clinical Lens in Costa Rica 37

2.5 Risk and protective factors for LGBTQ+ young adults: A latent class analysis....38
2.6 Romper el mandato de sufrir en silencio: La Red de Hombres de la CCSS como estrategia para prevenir el suicidio masculino....38
2.7 Saving Lives of Those Who Wear Camouflage: A Digital Suicide Prevention Education Application for Military Communities....39
2.8 De la crisis a la acción: habilidades clínicas y planificación colaborativa para responder al riesgo suicida....40
Lightning #3, Cocorí 4, November 9, 2026, 1:30 PM – 3:00 PM....40
3.1 From Hotline to System: Strengthening Suicide Prevention Through Integrated Crisis Infrastructure Across the Americas....40
3.2 Anxiety, depression, suicide risk, and sociodemographic variables in university students from México....41
3.3 Habilidades socioemocionales DBT para prevenir el suicidio en adolescentes de bachillerato agropecuario: un estudio mixto....41
3.4 Insights from a state-wide community to prevent suicide through behavioural health promotion in educational settings: An introduction of the Michigan Social and Emotional Learning Alliance....42
3.5 Using Artificial Intelligence to Study Associations Between Suicide Depictions in Child and Youth Television Shows and U.S. Population Suicide Rates....43
3.6 Conceptual Frameworks and Methodologies for Evaluating Large Language Models (LLMs) in Digital Mental Health and Suicide Prevention Interventions: A Scoping Review....43
3.7 Recognizing Akathisia in Suicide Prevention Across the Americas: Training for Clinicians, Suicidologists, and Crisis Responders....44
3.8 Buddy Up: A men's suicide prevention campaign....45
Lightning #4, Cocorí 1-2, November 11, 2026, 8:30 AM – 10:00 AM....45
4.1 Development and Evaluation of the ESTAR Suicide Postvention Training Program for Healthcare Professionals in Chile....45
4.2 Global Adaptation of the Clinical Service Quality Index: A Scalable Framework for Continuous Improvement....46
4.3 JovenSalud: un modelo digital integral para ampliar el alcance de la promoción de la salud y fortalecer los ecosistemas de prevención del suicidio en adolescentes y jóvenes. 47
4.4 Diferencias sexuales en suicidios de jóvenes en Jalisco, México. 47
4.5 La formación de agentes de ayuda como instrumentos comunitarios para intervenir la conducta suicida mediante un modelo enmarcado en el contexto socio-cultural hispano 48
4.6 Estudio descriptivo sobre los factores de riesgo asociados a la ideación suicida en la población universitaria asignada al Área de Salud Santa Bárbara de Heredia, el Hospital San Carlos y el Hospital Dr. Max Terán Valls. 48
4.7 Informe anual de casos de suicidios del año 2024 y propuesta metodológica de análisis 49
4.8 Identifying Types of Witnessed Suicides in Coroner & Medical Examiner Reports: Implications for Community Outreach....50
Lightning #5, Cocorí 3, November 11, 2026, 8:30 AM – 10:00 AM....50
5.1 Escalando la prevención del suicidio en la comunidad: modelo nacional de formación en cascada de gatekeepers....50
5.2 National suicide prevention strategies: evidence and challenges....51

5.3 Selecting National Metrics for Suicide Prevention: A Consensus-Based Approach to Monitoring Progress in Suicide Prevention in the United States 51
5.4 Una Alianza Pais por la Poblacion Adolescente: Acciones de Promocion, Prevencion Y Articulacion Para La Prevencion Del Suicidio....52
5.5 Beyond the Call: Quantifying the Economic Value of Arizona's Integrated Suicide and Crisis Response System....52
5.6 Suicide rates across occupational groups in Denmark: A nationwide population-based study....53
5.7 Partnerships for Life in the Americas: Findings and Recommendations from a Situational Analysis 2022-2026 54
5.8 AI Chatbots as Drivers of Change in Crisis Service Referral Pathways 55
Lightning #6, Cocorí 4, November 11, 2026, 8:30 AM - 10:00 AM 55
6.1 Play Your Way to Prevention: Using Play to Strengthen Protective Factors for Suicide Prevention....55
6.2 Un encuentro puede cambiarlo todo: el poder transformador de reunir a sobrevivientes de una pérdida por suicidio 56
6.3 No basta con reunirlos: diseñando espacios emocionalmente seguros para sobrevivientes de pérdida por suicidio 56
6.5 Comunidades por la Vida y para la Paz: Modelo Interinstitucional y Comunitario de Prevención del Suicidio desde Espacios Ciudadanos 58
6.6 The Relationship between Water Advisories and Suicide: A Coronial Analysis in Ontario, Canada from 2006-2021....58
6.7 CUIDA-FAM: Acceptability and Feasibility of a School-Based Parental Intervention for Adolescent Suicide Prevention in Chile: A Pilot Cluster Randomised Controlled Trial 59

Welcome

We are delighted to host the IASP Pan American Regional Forum in San Jose, Costa Rica,9 – 11 November 2026, bringing together researchers, practitioners, policymakers, and lived experience voices from across the region and beyond.

Hosted by the International Association for Suicide Prevention, this forum will provide a platform for connection, collaboration, and knowledge exchange, with a strong focus on regional priorities and context-specific solutions. A key theme will be the impact of isolation and the unique challenges of suicide prevention in the Americas, including access to services, workforce capacity, cultural considerations, and community-led responses. Participants can expect meaningful dialogue, practical insights, and opportunities to strengthen partnerships that support effective, culturally responsive suicide prevention efforts.

I would like to extend my thanks to our supporters, Ohio Suicide Prevention Foundation, Canadian Mental Health Association, American Foundation for suicide Prevention, Solari Crisis & Human Resources and Vibrant. Through their generous contributions, IASP can bring these events to regional communities.

Professor Jo Robinson
IASP President

Scientific Co-Chairs

Dr Elizabeth Seaward



President, ACEPS
Dr Seaward is a psychologist in private practice with more than 25 years of professional experience, specialising in suicide prevention and mental health.

Dr Karen Scavacini



Co-founder and Head of Instituto Vita Alere de Prevenção e Posvenção do Suicídio
Dr Scavacini is a psychologist and Co-founder and Head of Instituto Vita Alere de Prevenção e Posvenção do Suicídio (Brazil).

Dr Richard McKeon



Richard McKeon Ph.D., MPH has been engaged in international suicide prevention efforts since 2007 through IASP ,through the International Initiative for Mental Health Leadership, and through the International Zero Suicide and Crisis Now summits. He is the current US representative to IASP and has been engaged in IASP's Partnerships for Life efforts to promote the development of national strategies around the world. He also participated in the development of World Health Organization's first World Suicide Report.He served on the task forces that developed the 2012 and 2024 US National Strategy for Suicide Prevention.

In 2001, he was awarded an American Psychological Association Congressional Fellowship and worked in the US Senate for Sen. Paul Wellstone. He spent five years on the Board of the American Association of Suicidology as Clinical Division Director.

At SAMHSA in the US Department of Health and Human Services, he served for 12 years as Chief for the Suicide Prevention Branch. He oversaw development of the Garrett Lee Smith State/Tribal Youth Suicide Prevention

grant program which has demonstrated reductions in youth suicide in funded counties, as well as the Campus Suicide Prevention program, the Zero Suicide grants, the Suicide Prevention Resource Center, and the Native Connections program. He has worked with the National Suicide Prevention Lifeline since its inception in 2005, including establishing the foundation for 988 as the national suicide prevention number. In 2008, he was appointed by the Secretary of Veterans Affairs to the Secretary's Blue Ribbon Work Group on Suicide Prevention. In 2009, he was appointed by the Secretary of Defense to the Department of Defense Task Force on Suicide Prevention in the Military. He was instrumental in establishing the National Action Alliance for Suicide Prevention in 2010.

In 2023 he was awarded the American Association for Suicidology Dublin Award for Lifetime Achievement in Suicide Prevention. He was also honored for lifetime contribution to crisis care at the Crisis Now III Global Summit..

Steering Committee

Mrs. Wendy Orchard IASP CEO (Chair)
Dr Elizabeth Seaward (Scientific Co-Chair)
Dr Karen Scavacini (Scientific Co-Chair)
Dr Richard McKeon (Scientific Co-Chair)
Associate Professor Mark Sinyor
Mr Daniel Sanchez Morales
Dr Renato Oliviera
Professor Daniel Nunez
Dr Karla Valdes Garcia
Ms Wendy Cliff
Mrs. Katherine Thomson
Ms Kezia Taufik
Ms Leticia Silvela

Scientific Committee

Dr Richard McKeon (Co-Chair)	USA
Dr Elizabeth Seaward (Co-Chair)	Costa Rica
Dr Karen Scavacini (Co-Chair)	Brazil
Dr Camila Siebert Altavini	Brazil
Associate Professor Mark Sinyor	Canada
Mr Daniel Sanchez Morales	Canada
Dr Allison Crawford	Canada
Professor Brian Mishara	Canada
Professor Daniel Nunez	Chile
Professor Karla Valdés García	Mexico
Professor Gerard Hutchinson	Trinidad & Tobago
Dr Renato Oliviera	USA
Professor Yogesh Dwivedi	USA
Dr Diana Clarke	USA
Dr Eduardo Vega	USA

Invited Speakers



Dr Alexander Sánchez Cabo

Minister of Health

Served as the medical manager (gerente médico) for the Costa Rican Social Security Fund (Caja Costarricense de Seguro Social - CCSS), director of the National Center for Early Cancer Detection in Cartago, and general surgery postgraduate director at the University of Costa Rica (UCR). His administration focuses on mental health promotion, finalizing regulations for rare diseases, streamlining health ministry paperwork, and implementing national public health and drug strategies



Dr Elizabeth Seaward

President, ACEPS

Dr Seaward is a psychologist in private practice with more than 25 years of professional experience, specialising in suicide prevention and mental health. President of the first Association dedicated to suicide prevention in Costa Rica; ACEPS (Asociación Costarricense para el Estudio y la Prevention de la Conducta Suicida.Worked as an external psychologist with ACNUR, the refugee department in Costa Rica. Member of the team that created and implemented the first program for suicide prevention as a community-based strategy in the Municipality of Curridabat, Costa Rica.



Professor Ella Arensman

Professor Ella Arensman is Head of the School of Public Health, Professor of Public Mental Health at University College Cork and Chief Scientist at the National Suicide Research Foundation. She is Co-Director of the WHO Collaborating Centre for Surveillance and Research in Suicide Prevention, Vice President of the European Alliance Against Depression and past President of the International Association for Suicide Prevention. Over the past 39 years, she has initiated numerous national and international interdisciplinary research consortia in public mental health, with a focus on suicide and self-harm surveillance, intervention and prevention programmes for suicide, self-harm, depression, anxiety, excess mortality among young people and adults, and upstream approaches to mental health promotion and suicide prevention. Prof Arensman has published over 200 papers in peer review journals, and she has provided input into numerous mental health promotion and suicide prevention strategies and implementation plans at national and international level.



Dr Karen Scavacini

Psychologist; Co-founder and Head of Instituto Vita Alere de Prevenção e Posvenção do Suicídio (Brazil); Lead of CIP — Center for Innovation and Research in Mental Health, Technology and Suicidology at Instituto Vita Alere; Latin America Lead for the IASP Partnerships for Life program and Brazil National Representative at IASP.

PhD in Psychology from Universidade de São Paulo (USP), researching how awareness, literacy, and campaigns can prevent suicide, including the role of the internet and social media. Master's in Public Health (Mental Health Promotion and Suicide Prevention) from Karolinska Institutet (Sweden), researching postvention in Brazil.

Coordinator and lecturer in postgraduate programs, courses, and training on mental health promotion, self-harm, suicide prevention, and postvention. Organizer of events, videos and campaigns on the subject. Facilitator of suicide survivor support groups. Private practice in psychotherapy. Developer of programs for professionals, lived experienced people, schools, universities, companies, and the general public, including

A.P.O.I.A.R. (distance training of lay people in suicide prevention) and a suicide prevention program for the São Paulo subway. Creator of the Mental Health Map, which reached over 2.5 million people across Brazil.
Founding member of Vertentes, a mental health ecosystem. TEDx speaker. Author and co-author of more than 40 books, articles, and booklets on the subject.
Founding member and past board member of ABEPS (Brazilian Association of Studies and Suicide Prevention) and ABRASES (Brazilian Association for Suicide Survivors). Member of the CVV (Centro de Valorização da Vida) Advisory Board. Member of Meta's SSI Advisory Committee. Member of the IASP Postvention and Media Taskforce. Former Technical Director of CONATTS (National Commission for Technical Approach to Suicide Attempts). Reviewer of national and international documents and reports. Recipient of medals and awards in Brazil and abroad for work in suicide prevention.



Dr Richard McKeon

Richard McKeon Ph.D., MPH has been engaged in international suicide prevention efforts since 2007 through IASP, through the International Initiative for Mental Health Leadership, and through the International Zero Suicide and Crisis Now summits. He is the current US representative to IASP and has been engaged in IASP's Partnerships for Life efforts to promote the development of national strategies around the world. He also participated in the development of World Health Organization's first World Suicide Report. He served on the task forces that developed the 2012 and 2024 US National Strategy for Suicide Prevention.

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In 2023 he was awarded the American Association for Suicidology Dublin Award for Lifetime Achievement in Suicide Prevention. He was also honored for lifetime contribution to crisis care at the Crisis Now III Global Summit.



Dr Tamara Otzen

Tamara Otzen, PhD, is a psychologist with a Master's in Psychology from Universidad de La Frontera (UFRO), Chile, a Master's in Behavioural and Health Sciences Methodology (UCM, UAM and UNED, Spain), a PhD in Medical Sciences (UFRO) and a PhD in Evidence-Based Health from the Federal University of São Paulo (UNIFESP), Brazil. She is Director of the Doctoral Programme in Medical Sciences at UFRO and International Collaborating Professor in the Graduate Programme in Evidence-Based Health at UNIFESP.

She is founder and President of the OPA Foundation for Suicide Prevention and Southern Regional Lead of the IASP Partnerships for Life initiative in the Americas. She also belongs to the Suicidology Working Group of the Chilean Society of Neurology, Psychiatry and Neurosurgery (SONEPSYN) and the School Mental Health Study Group of the Chilean Society of Child and Adolescent Psychiatry and Neurology (SOPNIA) and has collaborated with Chile's Ministry of Health and National Youth Institute.

Her research focuses on suicidal behaviour, using psychological autopsy, systematic reviews, mortality analysis and meta-analysis, and on developing suicide prevention methodologies for educational and health settings. She is listed among the world's top 2% most-cited scientists (Stanford—Elsevier ranking), with over 17,500 citations (Google Scholar).



Eduardo Vega

Humannovations Founder, CEO and Principal.

Eduardo Vega, M.Psy. is founder/CEO of Crisis Ally Wellness and Executive Director of the Palliance Center for Peer Support and Lived Expertise. He is an international thought leader with 30 years' service in behavioral health programs, peer support, patient rights, crisis care and suicidology. Formerly CEO of MHA of San Francisco, Branch Chief at Los Angeles County Mental Health, and California State Commissioner, Vega worked in nearly every behavioral health care service setting over the course of 30 years. He has consulted for World Health Organization, the Office of the White House, the National Suicide Prevention Lifeline/Vibrant 988, Suicide Prevention Australia, International Bipolar Foundation, SAMHSA, Meta/Facebook and multiple private industries.

Vega is an innovator, artist and researcher with lived experience of suicide attempts, mental health and addiction challenges, family suicide loss, and family torture survival/PTSD. His leadership has been recognized by the State of California, the United States Senate, the US federal Substance Abuse and Mental Health Services Administration (SAMHSA), the nation of Fiji, the International Initiative on Mental Health Leadership and the United States Surgeon General among others. He serves on the board of Recovery Dharma Global, the Executive Committee of the US Action Alliance for Suicide Prevention and others.



Dr Marcelo Kimati

Director, Department of Mental Health, Alcohol and Other Drugs at the Brazilian Ministry of Health.

Psychiatrist and professor of Public Health at UFPR, Marcelo Kimati has previously served as Director of Mental Health at the Curitiba Municipal Health Department and coordinator of the Mental Health and Work Program at Fundacentro (MTE).



Dr John Draper

President of Research, Development and Government Solutions at Behavioral Health Link.

Dr John Draper has over 35 years of experience in crisis intervention and suicide prevention work and is considered an international expert in behavioural health crisis services.



Dr Dan Reidenberg

Managing Director, National Council for Suicide Prevention, and Founder and Director of Safe Online Standards at the Mental Health Coalition.

Dr Reidenberg was the first to bring technology companies together in 2006 to develop suicide prevention and mental health-related tools and the best practices for technology companies.



Mr Tony Coder

Tony Coder is the Chief Executive Officer of the Ohio Suicide Prevention Foundation (OSPF), a statewide nonprofit dedicated to preventing suicide across the lifespan. In this role, Tony leads community-based efforts across Ohio to reduce the stigma surrounding suicide, advocates for suicide prevention policy at the state and federal levels, and builds partnerships with legislative and business leaders to advance sound policies that promote mental health and wellness.

A registered lobbyist for more than 20 years, Tony has long been a voice for behavioral health policy in Ohio. He serves as an advisor to Governor Mike DeWine's RecoveryOhio initiative, which works to improve outcomes across the state's behavioral health strategies. In 2019, he led the statewide effort to create Ohio's first Suicide Prevention Plan, which Governor DeWine introduced in February 2020. From 2022 to 2025, Tony served as Chairman of the Board of Directors of the American Association of Suicidology.

Before joining OSPF, Tony served as Director of Programs and Services for the Ohio Association of County Behavioral Health Authorities, where he oversaw Recovery-Oriented Systems of Care, the Statewide Advocacy Network, and the organization's Committee to Address Suicide.

Earlier in his career, Tony worked in Governor Bob Taft's administration on behavioral health policy priorities and served as Legislative Director of the Ohio Department of Job and Family Services under Governor Ted Strickland, acting as chief lobbyist for the $20 billion agency.



Dr Christopher Drapeau

Christopher W. Drapeau, PhD, is a licensed psychologist and Assistant Vice President of Research & Evaluation at Vibrant Emotional Health, administrator of the 988 Suicide & Crisis Lifeline (USA). He is responsible for leading and guiding the 988 Lifeline in research and evaluation initiatives, dissemination efforts, and the development of external research collaborations. Before joining Vibrant, he worked in state government, where he oversaw suicide prevention efforts and led the planning and implementation of Indiana's 988 and behavioral health crisis care system. A former university professor, he is currently a Visiting Scholar in the Irsay Institute at Indiana University, where he continues to publish research broadly focused on the topic of suicide. He also co-produces suicide data sheets for the National Council for Suicide Prevention.



Daniel Sanchez Morales

Daniel Sanchez Morales is an M.A. student in Counselling and Clinical Psychology, awarded the Canada Graduate Scholarship — Master's Program by the Social Sciences and Humanities Research Council (SSHRC). He collaborates with Dr Mark Sinyor at Sunnybrook Health Sciences Centre, and currently supports the Partnerships for Life/Alianzas por la vida — Americas Region initiative as the project coordinator, assisting in English and Spanish. He has experience conducting research and policy analyses in both local and international contexts, across different population levels in the Americas, and with stakeholders ranging from policymakers and mental health professionals to people with lived experience His research interests cover suicide prevention strategies both locally and internationally, intersection between urban spaeces and accessing mental health services, individual-level risk factors for suicide, policymaking around mental health, and institutional responses to suicide prevention. Daniel is interested in providing support when translating research findings into pragmatic actions.



Adrian Gomez
Executive Director TeenSmart-Psychologist- Educational Technology Expert.

TeenSmart Internacional operates an online platform, www.jovensalud.net, which is used by more than 185,000 young people across Latin America – including nearly 70,000 adolescents and young adults from Costa Rica.

Folkloric dances in Costa Rica are one of the most representative expressions of the country's cultural heritage. They reflect history, customs and regional diversity, integrating indigenous, Spanish and African influences. Music, dance, and clothing combine to preserve and transmit Costa Rican identity from generation to generation.

The clothing of the folkloric group chosen to be part of the opening event is very special, as it pays tribute to Pancha Carrasco, a symbol of the courage, firmness and patriotism of Costa Rican women. Her figure recalls the bravery of those who, during the war in 1856, accompanied the Costa Rican troops in the fight against the filibuster William Walker, in defence of national sovereignty. Thus, her legacy remains an emblem of the participation of women in the history of Costa Rica and in the construction of its identity and spirit of nationhood.



Plenaries

Opening Plenaries November 9th 10am — 11am

Chair: Richard McKeon

Beyond the protocol: The human bond as a clinical tool in suicide prevention

Dr Elizabeth Seaward

Dr Seaward is a psychologist in private practice with more than 25 years of professional experience, specialising in suicide prevention and mental health.

Suicide prevention does not depend solely on clinical protocols or information campaigns: it is also based on deeply human gestures. The human dimension, used as a tool for detecting people at risk, has been actively promoted as a key component since the beginning of theorizing about suicidal behavior.

However, in the clinical setting, this function—articulated through listening, gazing, and interpersonal connection—has been relegated by the predominance of behavioral techniques and checklists imposed on professional personnel who attend to these crises.

This exhibition proposes to recover "humanity" — understood as empathy, connection and compassion — as a tool for concrete intervention and complementary to institutional frameworks, applicable by any professional in the area in their daily practice.

Más allá del protocolo: el vínculo humano como herramienta clínica en la prevención del suicidio

La prevención del suicidio no depende únicamente de protocolos clínicos ni de campañas informativas: también se fundamenta en gestos profundamente humanos. La dimensión humana, empleada como herramienta para la detección de personas en riesgo, se ha promovido activamente como un componente clave desde los inicios de la teorización sobre la conducta suicida.

Sin embargo, en el ámbito clínico, esta función —articulada a través de la escucha, la mirada y la conexión interpersonal— ha quedado relegada por el predominio de técnicas conductuales y listas de verificación impuestas al personal profesional que atiende estas crisis.

Esta exposición propone recuperar la ‹humanidad› —entendida como empatía, conexión y compasión— como una herramienta de intervención concreta y complementaria a los marcos institucionales, aplicable por cualquier profesional del área en su práctica diaria.

Intensity, Recovery, and the Problem of Hope: What Lived Expertise Brings to the New Conversation on Suicide

Eduardo Vega

For twenty years, suicidology has gained insight from those closest to the subject: people who live through, live with, and recover from suicidal intensity, including attempt survivors. In 2011, the author and the world's first Suicide Attempt Survivor Task Force set practical directions for integrating this expertise across clinical practice and science. Yet implementation has been slow and uneven, lacking

functional frameworks for engagement and co-learning. Meanwhile prevailing practices of risk assessment and inpatient hospitalization show limited effectiveness for prevention and are often experienced as shaming or punitive, driving service avoidance and disconnection.
Suicidality is often rooted in a sense of isolation, brokenness, rejection, and uselessness; systems and messages that echo these, however subtly, are creating harm. Lasting change requires shifting from studying, controlling, and prescribing toward listening, empowering, and co-creating with the millions who experience suicidal intensity yearly. Drawing on decades of work with attempt survivors and others with lived experience, and on his own recovery from suicidal intensity, the presenter invites attendees to examine specific entrenched assumptions, practices, and language. We will explore empowered perspectives, preferred terms, and concrete steps toward a global suicidology transformed by lived expertise.

Plenaries November 10th 8.30am — 9.30am

Chair: Mark Sinyor

From audience to agency: Transforming suicide prevention through media and youth engagement

Dr Karen Scavacini
Co-founder and Head of Instituto Vita Alere de Prevenção e Posvenção do Suicídio

Young people are often described as a priority audience for suicide prevention, yet they are still too rarely recognized as partners in its design, communication and implementation. At the same time, media and digital platforms have become central environments in which young people seek information, build relationships, express distress and create narratives about mental health and suicide.
This plenary will explore how the integration of safe communication, meaningful youth participation and collaboration with digital media platforms can transform suicide prevention. Drawing on experiences developed in Brazil, including initiatives with young people, content creators, educators, mental health organizations and technology platforms, the presentation will examine how prevention can move beyond the dissemination of expert information toward more participatory, creative and culturally relevant approaches.
The presentation will discuss the opportunities and responsibilities involved in engaging young people in the production of mental health content, the development of campaigns and the creation of safer digital environments. It will also address the importance of supporting media professionals and content creators with evidence informed guidance, while preserving authenticity, accessibility and the capacity to engage diverse audiences.

Suicide Prevention Hotlines and National Strategies.

Dr Richard McKeon

Suicide prevention hotlines are both essential services and essential components of national strategies In the first US strategy in 2001 there was no mention of hotlines Following the publication of samhsa funded evaluations demonstrated the effectiveness of the national hotline . The National Suicide Prevention Lifeline was incorporated into the 2012 National Strategy

This led to the establishment of 988 as the new national hotline number which since it's launch in 2022 has been used 30 million times. 988 is a core part of the 2024 National Strategy and recent research has shown that use of 988 is associated with reduced suicide mortality. Additionally, 988 has now been implemented across Canada.

National suicide prevention hotlines need to be considered an essential service and an essential component of national strategies

Closing Plenary November 11th 4.00pm — 4.30pm

Chair: Karen Scavacini

Joining forces: a small country's response to suicide

Ana Catlina Calderón Jiménez, Dra. Sinaí Valverde Ceciliano

Abstract to come.

Closing Remarks November 11th, 2026 4.30pm - 5.00pm

Elizabeth Seaward, Karen Scavacini, Richard McKeon.

Panels

Panels November 9th, 2026, 11:30am — 12:30pm

Panel 1 - Hotlines

Richard McKeon (Chair), John Draper, Daniel Sanchez Morales, Christopher Drapeau

This panel will examine the development and importance of 988 in the United States and Canada as well as the implications of such short codes for hotlines across the Americas including the role of hotlines in Latin and South America. The role of evaluations, standards, trainings and practices will also be explored including policy implications

Panel 2 - Partnerships for Life Session November 10th, 2026, 3:30pm — 5:00pm

Assoc. Professor Mark Sinyor, Dr Karen Scavacini, Dr Elizabeth Seaward

This presentation will introduce the Partnerships for Life initiative which aims to disseminate national suicide prevention strategies (NSPSs) and coordinated population-level prevention efforts in countries worldwide. It will discuss the importance of and evidence for NSPSs, how regional and global partnerships can be helpful, and how the initiative evolved over its first five years. We will then describe efforts undertaken in the Americas and how we hope to grow and strengthen this work including current goals. We will then break into small groups so that participants in the session can provide input into the direction of Partnerships for Life in the Americas in the coming years.

Panel 3 - Gambling, Addiction and Suicide Prevention

Dr Marcelo Kimati (Chair), Tony Coder, Adriana Gomez

This panel brings together leading voices from suicide prevention and public health to explore where gambling harm, substance abuse, and suicide risk meet. Panelists will share what the evidence tells us about who may be most at risk, the early warning signs, and how industry design and marketing practices may exacerbate these risks. They will also highlight what works: integrated screening, crisis line approaches, thoughtful policy and regulation, and ways technology can help identify and support people at risk while protecting their wellbeing.

Plenary Panel November 10th, 2026 3.30pm - 5.00pm

Suicide Prevention in a digital world

Dan Reidenberg (Chair),
Mark Sinyour, Dr Mike Baly Meta, Dr Jessica DiVento Dzuban TikTok, Lucia Urrutia TikTok, Guadalupe Lopez Roblox.

Social media is deeply embedded in most lives around the world with an estimated 6 billion people online daily. Social media shapes identity, relationships, and pathways to connection and help-seeking. While these platforms can foster belonging and support, they also present significant risks for people experiencing psychological distress or suicidal ideation. As artificial intelligence (AI) increasingly governs how content is created, recommended, and moderated across social media, its impact on safety, wellbeing, and suicide risk has become a critical issue for suicide prevention.

The field of suicide prevention is resultingly experiencing a period of profound transformation shaped by rapid advances in technology, evolving social environments, growing mental health needs, and increased recognition of the role that digital ecosystems play in human well-being. This is rapidly changing with the advancement of Artificial Intelligence both in terms of how technology platforms use AI and how users engage with AI. At the same time, researchers, clinicians, public health leaders, and technology companies face urgent questions regarding risk identification, ethical intervention, online harms, youth vulnerability, crisis response, privacy, and the responsible use of artificial intelligence and digital platforms in suicide prevention efforts.

This interdisciplinary panel will bring together leading experts from suicide prevention, and research, lived experience, digital trust and safety, to discuss the most pressing scientific and operational

challenges facing the field today. The session will explore current evidence regarding suicide risk factors in online and offline environments, including social isolation, exposure to harmful content, harassment, contagion effects, economic stressors, and disparities associated with social determinants of health. Panelists will also discuss emerging opportunities created by advances in predictive analytics, AI-assisted crisis identification, digital therapeutics, online safety interventions, and cross-sector collaboration.

Example of key topics to be considered:

- The evolving relationship between digital environments and suicide risk
- Addressing safe messaging, suicide and self-harm related communications online
- Ethical considerations in AI-driven mental health interventions
- Opportunities and limitations of predictive technologies
- Responsible platform governance and user safety standards
- Data privacy, transparency, and accountability
- Youth mental health and online vulnerability
- Integration of crisis systems, healthcare, and technology platforms
- Evidence gaps and future research priorities

This panel will examine the evolving role of social media systems in influencing online experiences, exploring both the potential harms and opportunities for prevention. Drawing on a range of perspectives, the session will consider how AI can be leveraged to reduce exposure to harmful content, strengthen early intervention, and support safe and appropriate help-seeking.

The panel will highlight the importance of cross-sector collaboration to ensure social media environments promote connection, safety, and hope, while minimizing harm and supporting effective, person-centered suicide. The panel will emphasize the importance of scientifically grounded, ethically informed, and human-centered approaches that balance innovation with safety, privacy, and equity. Through moderated discussion and audience engagement, the panel aims to identify actionable strategies for strengthening collaboration among researchers, clinicians, policymakers, nonprofits, and technology companies.

This session is intended for suicide prevention professionals, behavioral health clinicians, researchers, public health leaders, policymakers, educators, crisis service providers, and technology industry professionals seeking a deeper understanding of the opportunities and risks emerging at the intersection of mental health, digital technology, and suicide prevention. By fostering dialogue across disciplines and sectors, this panel seeks to advance practical, evidence-based approaches that can improve prevention outcomes and support safer, healthier digital and social environments worldwide.

Youth Space Session November 11th, 2026, 2:30pm — 5:00pm

Madrinas y Padrinos por la Vida/ Godmothers and Godfathers for Life

Mr Daniel Sanchez Morales

Aim: Connecting prospective university level researchers and/or interested students with established suicide prevention researchers to incentivize youth's participation and promote suicide prevention research in the Americas.

Objectives:
1. To introduce prospective university level researchers and/or interested students to suicide research culture, in-progress research projects, and present ways to get involved.
2. To promote suicide prevention research among youth, especially those coming from contexts in the global south.

3. To establish potential research partnerships and connections between research and youth at the end of the space.

Workshops

Workshops November 9th, 2026, 3:00pm — 5:30pm

Workshop 1 Psychological Technology in Mental Health Care and Suicide Prevention

Dr Tamara Otzen[1], Dr Karla Garcia[2]
[1]Universidad de la Frontera — Chile, [2]Universidad Autónoma de Coahuila — México

Overview:
This workshop addresses the role of psychological technology — artificial intelligence, telepsychology, and mental health applications — in mental health care and suicide prevention across diverse communities and contexts. It will review scientific evidence and concrete experiences, examining in greater depth a model developed by one of the facilitators in Chile (RedOPA) that has been scientifically validated in educational, university, and community settings. Through a participatory approach, attendees will critically discuss the strengths, limitations, and ethical implications of these technological tools, fostering the exchange of multinational perspectives among participants.
Learning Objectives
1. To become familiar with the main fields of use and application of psychological technology (AI, telepsychology, mental health apps) in mental health care and suicide prevention.
2. To analyse, drawing on concrete, evidence-based cases — including a model developed by one of the facilitators in Chile (RedOPA) — the impact of incorporating technological components into mental health care models across diverse communities and contexts.
3. To reflect on the practical and ethical implications of using technology in mental health and suicide prevention.

Learning Outcomes
1. Identify and differentiate the main psychological technology tools applicable to mental health and suicide prevention.
2. Evaluate, based on evidence and applied examples, the impact and relevance of these technological components for participants' own institutional or community context.
3. Apply ethical and practical criteria for the responsible use of technology in mental health and suicide prevention, outlining initial ideas for small-scale development or validation projects in this field.

Target Group
Mental health professionals, educators, and management teams from educational and community institutions, public policy makers in health and education, researchers in mental health and suicide prevention, and other stakeholders interested in incorporating technology into diverse care and prevention contexts.

Workshop 2 Vida em Rede: From Policy to Practice — Implementing National Suicide Prevention Strategies through Implementation Science

Dr Raquel Pinheiro Niehues Antoniassi[1], Dr Camila Siebert Altavini[1]
[1] Brazilian Association for Suicide Prevention and Studies (ABEPS), Brazil

Overview:

Many countries in the Americas have developed National Suicide Prevention Strategies (NSPS), yet a critical gap persists between policy design and local implementation. This workshop presents "Vida em Rede" (Life in Network) , a pioneering Brazilian initiative currently under implementation that applies Implementation Science principles to translate national guidelines into operational capacity at the municipal level.This proposal is currently under evaluation and in its initial execution phase, developed through a technical cooperation between the Ministry of Health of Brazil, the Pan American Health Organization (PAHO/OPAS), and the Brazilian Association for Suicide Prevention and Studies (ABEPS) . Our goal in this workshop is to share the methodology, challenges, and early insights with colleagues from across the Americas — particularly those engaged with the Partnership for Life initiative — to foster collaborative learning and adaptation.The workshop will be interactive and hands-on, using a real-time simulation of our Cascade Training Model: (1) Regional seminars for knowledge dissemination, (2) Sequential tutorials for applied learning, and (3) Local modeling in pilot municipalities (Maringá and Petrópolis). Participants will work in small groups to diagnose implementation barriers in their own contexts, map intersectoral stakeholders, and draft actionable implementation plans.Key themes addressed:
- Design, implementation, and evaluation of NSPS in different contexts
- Intersectoral collaboration (health, social assistance, education, security)
- Building local governance through Municipal Committees
- Practical strategies for overcoming bureaucratic and political barriers

Learning Objectives
1. Understand the core principles of Implementation Science applied to suicide prevention and why the gap between policy and practice persists across the Americas.
2. Analyze the cascade training model (Regional Seminars → Sequential Tutorials → Local Modeling) as a replicable methodology for capacity building in low-resource settings.
3. Identify key barriers and facilitators for intersectoral articulation (health, social assistance, education, security) in implementing NSPS at the municipal level.
4. Explore strategies for institutionalizing suicide prevention through local governance structures (Municipal Committees), informed by the Brazilian experience under evaluation.

Learning Outcomes
1. Diagnose the implementation gaps in their own national or local suicide prevention strategies using a structured framework from Implementation Science.
2. Design a preliminary action plan for a cascade training model adapted to their regional context, including stakeholder mapping and intersectoral engagement strategies.
3. Apply practical tools for overcoming bureaucratic barriers to intersectoral collaboration (health, education, social protection) in suicide prevention.
4. Articulate strategies for building sustainable governance structures (committees, protocols, monitoring systems) that outlast political transitions and funding cycles.
5. Engage in a collaborative network with other Latin American countries to share progress, challenges, and adaptations of NSPS implementation — contributing to a regional learning community aligned with the Partnership for Life framework.

Target Groups
Policy makers and government officials, Program coordinators and technical teams, Mental health professionals and suicide prevention practitioners working at the community level, Researchers and academics focused on suicide prevention, implementation science, and public health policy, Representatives from civil society organizations engaged in suicide prevention advocacy and program delivery, and International development partners and cooperation agencies (PAHO, WHO, Partnership for Life)

Workshop 3 Suicide & the Media — Promoting safer communication and narratives about suicide and its prevention in traditional and social media including engagement with stakeholders

Associate Professor Mark Sinyor[1], Dr Karen Scavacini[2] Dr Dan Reidenberg[3]
[1] University of Toronto / Sunnybrook Health Sciences Centre, [2]Instituto Vita Alere de Prevenção e Posvenção do Suicídio, [3]Johns Hopkins School of Public Health

Overview:
Guidelines exist regarding responsible suicide communication in traditional media (e.g. IASP/WHO guidelines) and on social media (#Chatsafe). In this workshop, participants will learn the importance, rationale, and details of these recommendations and discuss strategies for implementing them including engaging with journalists and social media content creators to promote safer communications.

Learning Objectives:
1. Understand the content, rationale and evidence base for guidelines for journalists and those who post on social media.
2. Appreciate common ways in which responsible communication guidelines are violated.
3. Learn about the Papageno effect, why Papageno-type messages can save lives and how to effectively promote them.

Learning Outcomes:
1. Generate safer and more helpful suicide prevention-related content.
2. Spot and know how to correct common errors.
3. Engage more effectively with content creators.

Target Group:
Academics, journalists, social media content creators, policy regulators/government stakeholders

Workshops November 10th, 2026, 9:30am — 12:00noon

Workshop 4 From Evidence to Action: Strengthening Intersectoral Collaboration for Suicide Prevention through the WHO LIVE LIFE Framework

Dr Belen Vargas[1], Mr Daniel Sanchez Morales[2]
[1] Ministerio de Salud Chile, [2]Department of Psychiatry, Suicide Prevention Research Collaborative (SPRC) Canada.

Overview:
Suicide prevention requires action beyond the health sector. The WHO LIVE LIFE framework identifies multisectoral collaboration as a foundational element for implementing evidence-informed suicide prevention interventions.

However, the participation of multiple sectors does not necessarily translate into meaningful intersectoral action. Differences in institutional mandates, priorities, resources, incentives, capacities and levels of authority can create barriers to collaboration, while existing relationships, political commitment, knowledge and community resources can provide opportunities.

This interactive workshop will use a realistic Latin American case to explore these challenges. Participants will first analyse barriers, opportunities and leverage points affecting intersectoral collaboration. They will then redesign the collaboration by identifying concrete changes and considering how to determine whether collaboration has actually improved.

The workshop is particularly relevant for researchers, policymakers and practitioners working at the intersection of research, policy and practice. It invites participants to consider not only what should be done, but also what needs to be understood, changed and measured to make intersectoral collaboration work in real-world suicide prevention systems.

Learning Objectives:
1. Understand key concepts and practical dimensions of intersectoral collaboration within the WHO LIVE LIFE framework.
2. Explore common barriers, opportunities and leverage points that shape intersectoral collaboration in suicide prevention.
3. Consider how implementation research and evaluation can contribute to strengthening and assessing intersectoral collaboration.

Learning Outcomes:
1. Identify key barriers and opportunities affecting intersectoral collaboration in a realistic suicide prevention scenario.
2. Develop a concrete proposal to strengthen collaboration among relevant sectors, considering actors, contributions and implementation conditions.
3. Identify potential indicators or signals that could be used to assess whether intersectoral collaboration has meaningfully improved

Target Group:
Researchers, policymakers, public health and mental health professionals, practitioners, programme managers, and other stakeholders involved in suicide prevention.

The workshop is particularly suited to participants working across research, policy and practice, and to those interested in implementation of national or local suicide prevention strategies.

Workshop 5 Bridging the Gap Between Mayas and Charrúas: A Clinical Suicidological Approach to Suicide Risk Situations

Dr Silvia Pelaez[1], Dr Maria Jose Di Agosto[1] Dr Karla Patricia Valdes Garcia[2]
[1] Ultimo Recurso Uruguay, [2]Autonomous University of Coahuila, Mexico

Overview:
A theory-and-practice workshop focused on the initial clinical approach to individuals at risk of suicide. Participants will gain key skills for the initial patient encounter, learning to identify warning signs and accurately assess the level of risk. Through practical tools and role-playing exercises, the workshop will cover essential courses of action—specifically, what to do and what to avoid when intervening in cases of suicidal ideation or crisis.

Learning Objectives:
1. Identify and diagnose suicide risk situations in a timely manner using precise clinical indicators.
2. Master fundamental guidelines for action (dos and don'ts) during the initial encounter and interview with a patient in crisis or experiencing suicidal ideation, integrating interviewing skills and techniques for managing suicidal crises.
3. Acquire practical and methodological tools for immediate clinical intervention, ensuring stabilization and risk management.

Learning Outcomes:
By the end of this workshop, participants will be able to:
1. Conduct a rapid and accurate clinical risk assessment during the first encounter with a patient presenting with suicidal ideation.
2. Apply evidence-based, interview-specific communication skills, knowing exactly which interventions to use and which counterproductive actions to avoid.
3. Implement practical safety tools and immediate action protocols adapted to the level of risk.

Target Group
suicide prevention in primary care and education and training in suicide prevention

Workshop 6 Basic Course: DBT-MXAU Skills Training for Suicide Prevention Among School-Aged Adolescents

Dr Alicia Edith Hermosillo de la Torre[1], Stephania Montserrat Arteag De Luna[2]
[1] Universidad Autónoma de Aguascalientes (México), [2]Autonomous University of Aguascalientes, Mexico

Overview:
This intensive workshop trains professionals in the implementation of the DBT-MXAU program, an evidence-based intervention effective for emotional regulation and suicide prevention in adolescents. It was developed and adapted in Mexico based on the principles of Dialectical Behavior Therapy (DBT).

Learning Objective:
General objective: To develop theoretical-practical competencies for the effective implementation of the DBT-MXAU program in clinical, educational, and community settings.
Specific objectives: to understand the foundations and strategies of DBT; to understand DBT as a standalone treatment supported by international and national evidence; and to become familiar with the DBT-MXAU program regarding its structure, operation, and DBT strategies.

Workshop Outcome:
Participants will be able to acquire the theoretical and practical knowledge needed to implement the DBT-MXAU program.

Workshops November 10th, 2026, 3:00pm — 5:30pm

Workshop 7 RECOVER: Coping and Recovery for Clinician Survivors of Loss to Suicide

Dr Andrew Meisler[1], Dr Mayumi Gianoli[1]
[1] Yale School of Medicine

Overview:
The workshop uses the RECOVER acronym to provide a structure for education, training, and support for clinicians on (1) Review of grief for survivors of suicide; (2) Envisioning a postvention plan; (3) Cognitions surrounding responsibility, self-blame, risk, fear, and healing; (4) Obstacles: identifying and managing personal, external, and systemic barriers to healing; (5) Validation through community, clinician-survivor supports, and other resources; (6) Engagement with the survivor community: helping self through helping others by improving knowledge, prevention, and postvention among

clinicians; and (7) Reconciliation with self, loss, and other survivors. One of the presenters has lived experience as a survivor of client loss to both suicide and murder-suicide, and will draw on personal experience, grief, learning, and recovery throughout the workshop.

Learning Objectives:
1. To present a comprehensive model for understanding the multi-faceted and complex nature of being a clinician survivor who has lost a client to suicide
2. To provide a framework for understanding the grief reaction for clinicians, the challenges faced, and the key elements of a postvention plan
3. To provide knowledge and insight gained through lived experience by a clinician who has survived both a suicide and a homicide-suicide in practice

Learning Outcomes:
1. Participants will understand both the shared and unique aspects, both emotional and practical, of being a clinician survivor who has lost a client to suicide.
2. Participants will understand how to create a postvention plan and the importance of having one in place in regular practice.
3. Participants will understand the multi-tiered nature of effective management and recovery following the unexpected and tragic loss of a client to suicide

Target Group:
Clinicians, counselors, survivors, community/988 workers, policy makers

Workshop 8 Doing more: a community-based care model for suicide prevention.

Dr Yaocihuati Martinez Menchaca[1], Dr Alfonso Cepeda Garza, Gabriela Arreola Bautista, Eliezer Cerda[2]
[1] Fundación Hacer Más, [2]Hacer Más Foundation (Mexico)

Overview:
To present the community intervention model for suicide prevention developed by Fundación Hacer Más, Alfonso Cepeda Martínez A.C., a civil association based in Saltillo, Coahuila, Mexico.

Learning Objectives:
1. Review the results of the community project from 2020 to the present.
2. Understand radical acceptance as a tool in postvention with survivors.
3. Presentation of cases involving patients with suicidal behaviors, viewed through the lens of Dialectical Behavior Therapy principles.
4. Raising awareness from a survivor's perspective.

Learning Outcomes:
Participants in the workshop will acquire theoretical and practical knowledge regarding community interventions, grounded in theory and the analysis of case studies. It offers a perspective on raising awareness through the eyes of a suicide survivor.

Target Groups:
Professionals working with patients exhibiting suicidal behaviors, emotional dysregulation, and suicide-risk behaviors in community settings; survivors; and the general public interested in clinical and community-based suicide prevention work.

Workshop 9 From Strategy to Action: Supporting Accountability in Suicide Prevention Across National and Community Contexts

Dr Deborah Stone[1], Dr Karen Scavacini[2] Dr Elizabeth Seaward[3]

[1] The Jed Foundation, USA, [2]Instituto Vita Alere, São Paulo, Brazil, [3]ACEPS, Municipality of Curridabat, Costa Rica

Overview:
As countries and communities invest in comprehensive suicide prevention strategies, a critical question emerges: How do we know whether we are making progress?

This interactive workshop will explore emerging approaches to measuring progress toward suicide prevention goals across different contexts. Drawing on the United States efforts to develop a national evaluation framework for the National Strategy for Suicide Prevention, the Brazilian experience, and community-based suicide prevention work in Curridabat, Costa Rica, participants will engage in a learning exchange about how data, partnerships, and shared accountability can support meaningful change.

Rather than focusing solely on outcomes such as suicide mortality, the workshop will examine how communities and nations can track implementation, short- and intermediate-term outcomes, partnership development, systems change, and other indicators that contribute to long-term impact.

Facilitators will share examples of theory- of-change approaches, nested evaluation models, and community-engaged strategies for monitoring progress while fostering continuous learning and improvement. Participants will have opportunities to reflect on their own contexts, identify challenges and opportunities related to measurement and evaluation, and discuss how diverse stakeholders can contribute to a shared understanding of success.

Through dialogue and peer learning, the workshop will highlight both common principles and context-specific approaches to strengthening suicide prevention efforts.

Learning Objectives
1. Explore approaches for measuring progress in suicide prevention at national, community, and systems levels.
2. Examine how utilizing an overarching theory of change with shared metrics, and community engagement can support accountability and continuous improvement.
3. Facilitate cross-country learning about the opportunities and challenges of monitoring and evaluating comprehensive suicide prevention initiatives.

Learning Outcomes
1. Describe key components of a comprehensive suicide prevention measurement and evaluation framework, including implementation, process, and outcome indicators.
2. Identify strategies for engaging stakeholders and communities in tracking progress and using data for learning and improvement.
3. Apply lessons from international and community-based examples to strengthen measurement and evaluation efforts within their own settings.

Target Group
Suicide prevention practitioners, Community leaders and community-based organizations, Public health professionals, Policymakers and government officials, Researchers and evaluators, Mental health service providers, Health system leaders, International and regional suicide prevention networks

Workshops November 11th, 2026, 10:00am — 12:30pm

Workshop 10 Comprehensive approach and collaborative work with churches and grassroots faith communities for suicide prevention.

Rev. Dr. Pablo Rivera Madera [1], Sinaí Valverde Ceciliano[2]
[1]Life Assisting Fellowship Corporation, Costa Rica, [2]Ministerio De Salud Gobierno De Costa Rica

Overview:
The workshop strengthens the skills of professionals working in suicide prevention, enabling them to build partnerships with churches and faith communities using an evidence-based approach that respects beliefs and remains free from doctrinal perspectives. Through participatory activities, the analysis of biblical narratives, a review of evidence regarding spirituality and mental health, and practical case studies, participants develop strategies to build trust, communicate with religious leaders, distinguish spiritual support from clinical intervention, and establish referral pathways. The workshop fosters a collaborative approach that integrates faith, hope, and community support as protective factors in suicide prevention.

Learning Objectives
The goal of the workshop is to strengthen participants' skills in fostering respectful dialogue with faith-based communities—integrating biblical elements, pastoral insights, and psychological theories—to prevent suicide and promote mental health. The workshop aims to:
(a) analyze the relationship between spirituality, religiosity, and mental health in light of scientific evidence;
(b) reflect on accounts of suicidal behavior in the Bible and their interpretation; and
(c) develop strategies for outreach, raising awareness, intervention, and collaboration with religious leaders

Learning Outcomes
The aim is to convey the message of suicide prevention within a framework that is understandable and scientifically grounded, while utilizing language familiar to the church. The workshop will address topics such as moralizing interpretations of suicide, discrepancies between scientific approaches and religious interpretations, and the integration of church-based language with public health terminology.
Participants will gain tools to engage in more open dialogue about mental health with religious leaders, thereby helping to reduce stigma and mistrust, establish referral protocols between health services and faith communities, and integrate hope and love as protective resources that strengthen mental health promotion and suicide prevention.
The initiative will help recognize religious authorities as strategic allies in promoting mental health, providing community support, and identifying individuals in need of specialized care in a timely manner, ultimately strengthening collaborative efforts between both sectors.

Target Group
Mental health and suicidal behavior intervention professionals

Workshop 11 Tik Tok: Suicide Prevention in Digital Spaces: Building Partnerships Across Platforms, Experts, and Creators

Jessica di Vento Dzuban[1], Dr Dan Reidenberg[2]
[1] Global Mental Health Policy Lead TikTok, USA, [2] Johns Hopkins School of Public Health, USA

Overview:
Suicide prevention efforts are strengthened when platforms, clinical experts, and content creators work together — sharing knowledge, building trust, and supporting one another's roles in reaching communities at scale. This workshop brings together representatives from TikTok's Trust & Safety

team, the WHO-FIDES network, a suicide prevention expert, and a regional mental health NGO to discuss how these partnerships have developed in practice and where there is room to grow.
Rather than presenting any single approach as definitive, the session is designed for shared learning: facilitators will draw on direct experience supporting creators and partnering with regional and global mental health organizations, while inviting participants to contribute perspectives from their own institutional and cultural contexts. The workshop will also highlight existing mechanisms — including the WHO-FIDES network and TikTok's Mental Health Education Fund — through which creators and organizations in the region can access further support.

Learning Objectives
1. Examine how partnerships between platforms, clinical experts, and content creators can strengthen suicide prevention efforts in digital spaces.
2. Learn more about how external partnereships can look like in practical application in digital spaces
3. Learn more about existing collaboration mechanisms — such as TikTok's Mental Health Education Fund — that support creators and community-based or NGO-led prevention initiatives.
4. Reflect on practical steps for building or strengthening similar partnerships within participants' own organizational and regional contexts.

Learning Outcomes
1. By the end of this workshop, participants will be able to describe how collaboration between platforms, clinical experts, and creators contributes to suicide prevention efforts.
2. By the end of this workshop, participants will be able to identify at least one existing network or funding mechanism, such as WHO-FIDES or the Mental Health Education Fund, relevant to their own organization's work.
3. By the end of this workshop, participants will be able to articulate the role of creators and lived experience groups in suicide prevention partnerships.
4. By the end of this workshop, participants will be able to outline at least one practical step for building or joining similar collaborative structures in their own context.

Target Group
Researchers, NGO practitioners, public health officials, clinicians, and community leaders with an interest in platform—NGO collaboration, creator partnerships, and suicide prevention in digital spaces.
Relevance to Regional Collaboration and Action

This workshop reflects the Forum's commitment to cross-sector, cross-border collaboration in suicide prevention, bringing together voices from platform trust and safety, clinical expertise, and content creation. For Pan-America practitioners and policymakers, the session is an opportunity to learn from one another's experience building these partnerships, including emerging best practices for how tech companies can responsibly engage in this space, and to identify concrete ways to connect with existing networks and resources, such as the WHO-FIDES network and TikTok's Mental Health Education Fund.

Workshop 12 Withdrawn

Workshops November 11th, 2026, 1:30pm — 4:00pm

Workshop 13 Techniques for Addressing Common Challenges when Working with Families of Suicidal Individuals

Associate Professor Laura M Frey[1], Quintin Hunt[2]
[1] University of Louisville, USA, [2]LMFT, Founder of Olive View Therapy, USA

Overview:
Many suicidal individuals both want more support from loved ones and recognize the challenge of reaching out to them for help. Family members are often recipients of disclosure, yet existing family dynamics and stigma towards suicide may likely provoke unhelpful reactions. A recent study of hospitalized adolescents indicated their desires for professionals to educate their family about suicide, to help them talk to their family, and not to forget to focus on the adolescents' needs rather than only focusing on family's needs. Simultaneously, many family members and friends express deep concern for their suicidal loved ones while acknowledging the difficulty of responding compassionately when simultaneously managing their own panic, fear, or fatigue. Family members are asked to serve as emergency support persons; yet, evidence-based interventions for suicide omit clear strategies for how to help these family members overcome common challenges. This workshop will cover four common challenges faced by practitioners working with individuals and their families related to suicide risk, management, and treatment. With over 15 years of experience as academics, educators, researchers, and licensed clinicians, workshop facilitators will use a summary of existing research and anecdotal case studies to demonstrate common pitfalls for working with suicidal individuals and their families. The content will cover how to (1) navigate disclosure decisions and improve family response, (2) develop a family support plan for responding to risk, (3) process previous interactions to improve future family responses to risk, and (4) response to a loved one's chronic ideation in a way to prevent fatigue about family caregivers. The workshop will utilize interactive discussion, case examples, and role plays to provide hands-on experience.

Learning Objectives
During this workshop, the facilitators will...
1. Present current research findings and clinical case examples illustrating common challenges and pitfalls encountered when working with suicidal individuals and their families.
2. Demonstrate evidence-informed approaches for navigating disclosure decisions, improving family responses, developing family support plans, and addressing caregiver fatigue associated with chronic suicidal ideation.
3. Facilitate interactive discussions, role plays, and case-based exercises to provide participants with opportunities to practice and apply strategies for engaging families in suicide risk management and treatment.

Learning Outcomes
By the end of this workshop, participants will be able to...
1. Apply strategies to help suicidal individuals and their family members navigate disclosure decisions and improve communication about suicide risk.
2. Instruct family members in helpful ways to respond after a loved one attempts suicide
3. Guide suicidal individuals to understand various reasons why they might feel or say they are suicidal
4. Develop a family support plan that outlines specific roles, responses, and resources for managing suicide risk and promoting safety.
5. Understand factors that prevent fatigue in family caregivers

Target Group
Counselors, Practitioners, Crisis Workers, Academics

Workshop 14 Artificial Intelligence and Suicide Prevention: Navigating Opportunities, Risks, and Responsible Practice

Professor, Dr Annika Schoene1 Kimberly Martin2, Breanna Reeser2, Mr Sean Smith2
1 Northeastern University, USA, 2Riverside Community Care, USA,

Overview:
The rapid advancement and increasing prevalence of Artificial Intelligence (AI), particularly Generative AI and Large Language Models (LLMs), have profound implications for many aspects of our lives, including mental health and suicide prevention. AI is already being used by clients, clinicians, educators, crisis responders, and community organizations across the globe, often without organizational policies, professional guidance, or formal training. As a result, professionals are increasingly faced with decisions about when AI may be appropriate, when it may introduce unacceptable risk, and how to communicate transparently about its use with those they serve.

Therapy and companionship now rank among the most common uses of generative AI (Zao-Sanders, 2025), and OpenAI (2025) reports that more than one million ChatGPT users each week engage in conversations that include explicit indicators of potential suicidal planning or intent. These technologies have the potential to expand access to mental health information and provide immediate support, particularly in settings where resources are limited. At the same time, they raise important questions about safety, effectiveness, clinical quality, privacy, transparency, and algorithmic bias.

This workshop intentionally brings together expertise from computer science, AI research, and suicide prevention to bridge the gap between rapidly advancing technology and responsible clinical and community practice. Riverside Trauma Center will represent the suicide prevention expertise and speak from a critical response and organizational capacity-building perspective. Co-presenting this workshop is expert AI researcher and professor at Northeastern University, Dr. Annika Schoene P.h.D., who brings a technical AI foundations perspective.

This interdisciplinary session will examine how AI and suicide prevention intersect, with attention to both technological considerations and clinical implications. The workshop will also explore AI and suicide prevention from a global perspective, including how these issues emerge across regional, linguistic, and cultural contexts. Dialogue is intentionally designed to open discussion about AI's impact on suicide prevention to surface critical questions and positioning attendees as co-learners in developing ethical organizational readiness frameworks.

Participants will gain the knowledge and skills needed to responsibly navigate this evolving digital landscape, first building a foundation in AI literacy with a brief definition and history, then exploring how AI intersects with suicide prevention through current research and real-world case studies. We will highlight common threads present in AI related suicide deaths globally and explore emerging AI-driven suicide prevention tools used in mental health systems.

The feature of this session is a guided discussion focused on strengthening critical thinking skills and developing ethical best practices for using AI in clinical settings. Participants will be invited into small-group discussions on organizational readiness, ethical dilemmas, and effective communication with clients about their own use of AI tools. Participants will have opportunities to share lessons learned and discuss strategies for professional use.

By providing a platform for critical analysis, discussion, and the sharing of best practices, the workshop seeks to contribute to the ongoing regional and international conversation about the role of AI in promoting mental health and preventing suicide in an increasingly digital world. By the end of

the workshop, attendees will have a foundational understanding of AI's role in suicide prevention, along with practical insights for professional use.

Learning Objectives
1. Explain how Generative AI and Large Language Models are influencing suicide prevention practice across diverse healthcare and community settings.
2. Analyze opportunities, risks, and ethical challenges associated with AI-supported suicide prevention using international case studies.
3. Apply an ethical decision-making framework to address operational readiness and guide responsible AI use in clinical, educational, crisis response, and community-based suicide prevention settings.

Learning Outcomes
1. Assess potential benefits and limitations of AI tools within their own suicide prevention settings.
2. Apply an ethical framework to evaluate AI use in clinical and community practice.
3. Develop practical strategies for operational readiness including organizational policies, client communication, and professional decision-making related to AI.

Target Group
Clinical, educational, crisis response, and community-based suicide prevention settings

Lightning Presentations

Lightning #1, Cocorí 1-2, November 9, 2026, 1:30 PM - 3:00 PM

1.1 Treatment provided for Danish adolescents who attempt suicide: Comparison of those presenting and not presenting to hospital

PhD Stine Danielsen[1], Professor Katrine Strandberg-Larsen[2], Professor Keith Hawton[3], Professor Merete Nordentoft[1], PhD Annette Erlangsen[1], **Associate Professor Trine Madsen**[1,2]
[1]Danish Research Institute For Suicide Prevention, Copenhagen Research Center for Mental Health, Bispebjerg Hospital , Copenhagen, Denmark, [2]Section of Epidemiology, Department of Public Health, University of Copenhagen, Copenhagen, Denmark, [3]Centre for Suicide Research, Department of Psychiatry, University of Oxford, Oxford, England

Introduction:
After a suicide attempt, adolescents should ideally receive psychosocial assessment and aftercare. We investigated the proportion of girls and boys receiving mental health treatment and social interventions within the first weeks and one year after a suicide attempt.
Methods:
This study included a national cohort of children born in Denmark in 1996—2003 who had a hospital-recorded suicide attempt before age 18 years (N=3650). We also had information on self-reported suicide attempts without hospital presentation on those participating in the 18-year follow-up of the Danish National Birth Cohort (N=1489). Examined treatment included: i) psychiatric in- or outpatient contact, ii) psychotropic medication, iii) primary care mental health-related contact, and iv) social interventions. Further, factors associated with not receiving treatment were examined in regression analyses.
Results:
Two weeks after a hospital-recorded suicide attempt, 55% of girls and 58% of boys had received in- or outpatient treatment at a psychiatric hospital. After one year, 13% of girls and 16% of boys had not received any type of treatment. Younger age at first suicide attempt, no previous psychiatric contact and lower parental education were associated with not receiving treatment. The proportion receiving treatment was lower among adolescents with self-reported suicide attempts compared to adolescents with hospital-recorded attempts.

Conclusion:
Efforts should focus on ensuring that adolescents receive psychosocial care after a suicide attempt, particularly younger adolescents and those without previous experiences in the psychiatric system, as well as those who do not present to a hospital with their suicide attempts.

1.2 The iceberg model of suicidal ideation and behaviour in Danish adolescents: Integration of national registry and self-reported data within a national birth cohort

PhD Stine Danielsen[1], Professor Katrine Strandberg-Larsen[2], Professor Keith Hawton[3], Professor Merete Nordentoft[1], PhD Annette Erlangsen[1], **Associate Professor Trine Madsen**[1]
[1]Danish Research Institute For Suicide Prevention and Department of Epidemiology, University of Copenhagen, , Denmark, [2]Section of Epidemiology, Department of Public Health, University of Copenhagen, Copenhagen, Denmark, [3]Centre for Suicide Research, Department of Psychiatry, University of Oxford, Oxford, England

Hospital records are used to identify suicide attempts in many countries but not all individuals present to hospital after a suicide attempt i.e., suggesting a 'hidden number'. Our aim was to present the prevalence of suicide ideation, plans, attempts, and suicides among Danish adolescents, including attempts not resulting in hospital contact. The study population consisted of participants in the Danish National Birth Cohort participating in an 18-year follow-up, with individual-level linkage to national register data. Prevalence was estimated with a variable with mutually exclusive categories ranging from no suicidality to self-reported suicide ideation, -plans, -attempt and hospital-recorded suicide attempt. The 'hidden number' was estimated as the ratio between suicide attempts with and without hospital contact. Among 47 858 participants, all aged 18-years, 36% girls and 28% boys reported suicide ideation at least once in their life. In addition, 6% girls and 3% boys had either reported or been recorded with a suicide attempt. For every attempt recorded in the hospital setting, two girls (ratio, 1:2) and six boys (ratio, 1:6) reported having attempted suicide without hospital contact. The prevalence of any suicide attempt was 8% and 3% in the lowest and highest income group, respectively. Before age 18, 0·011% girls and 0·016% boys had died by suicide. In conclusion, suicidal ideation and behaviour are common in adolescents and there is a substantial 'hidden number' of adolescents with suicide attempt. These results emphasize the need for early age suicide preventive interventions in community-settings e.g., school environments.

1.3 Beyond Talking Points: Digital Creators as the New Gatekeepers of Mental Health Conversations

Dr. Laura Erickson-Schroth
[1]The Jed Foundation, New York, USA

Young people are increasingly turning to online creators as an important source of mental health information, guidance, and community. As creators become an early touchpoint for conversations about mental health and suicide, they are shaping how young people understand emotional wellbeing, navigate challenges, and decide when and how to seek support, often without professional training in safe messaging practices or support for the pressures this role brings.

Digital creators represent a new generation of trusted mental health communicators. Unlike many of the institutional gatekeepers we traditionally engage in mental health promotion and suicide prevention, creators often operate independently, building direct relationships with communities that may include people experiencing significant distress. Because their influence is built on their own voice, experiences, and audience trust rather than the organizational structures that reinforce public health guidance, traditional approaches centered on messaging guidance and talking points alone may be ineffective.

Research suggests that engaging creators around their own experiences and the unique pressures of their role before introducing storytelling guidance provides a stronger foundation for effective mental health communication. In convenings JED has held with high-profile creators across the United States, we have consistently heard that many are struggling themselves while navigating the emotional demands of supporting their audiences, including setting boundaries, feeling responsible for followers who disclose distress, and connecting people with appropriate resources.

Those insights have shaped JED's work with creators, researchers, clinicians, and platform partners to build the ecosystem of care needed to support safer storytelling and creator wellbeing. Because creators communicate through lived experience, the foundation for safer storytelling begins with supporting their own mental health before introducing messaging guidance. Starting there allows creators to establish healthier boundaries, adopt safer storytelling practices, communicate hope and recovery responsibly, and connect followers with appropriate support while recognizing the limits of their role.

This presentation will examine the research, creator insights, and practical lessons that inform this approach, including the boundary and responsibility challenges creators face, the development of JED's Digital Storytelling Guide, and the broader ecosystem of support needed to sustain safe storytelling at scale. Attendees will leave with practical strategies for engaging creators, supporting healthier boundaries, and embedding safe, positive messaging practices that strengthen mental health promotion and suicide prevention while supporting creator wellbeing.

1.4 Duelo comunitario

Facilitadora Y Participante Ana Catalina Calderón Jiménez[1]
[1]Ministerio De Salud, , Costa Rica

El suicidio es un fenómeno complejo y multicausal, es decir, está influenciado por diversos factores interrelacionados, ya sean personales, psicológicos, biológicos, ambientales o socioculturales. La muerte por esta causa afecta indudablemente a familias, comunidades y países en todas las regiones del mundo, generando repercusiones emocionales en los sobrevivientes. Como señala la Organización Mundial de la Salud, por cada suicidio consumado hay muchos intentos de suicidio.

Rocamora (2012) describe el suicidio como un acto privado que afecta a la sociedad; es decir, trasciende los límites del individuo, empujando a diferentes grupos como la familia, la escuela, la comunidad y los lugares de trabajo a una experiencia de fragmentación social. Esta situación puede generar diversas emociones como culpa, vergüenza, estigma y sentimiento de abandono, entre otras, que pueden provocar conductas autodestructivas. Por lo tanto, según la Fundación Rescatando Vidas (2010), la alta carga de suicidio en las familias representa un riesgo.

Asimismo, Castelblanco (2020) describe que una conexión inadecuada con la comunidad también se convierte en un riesgo para la salud de los dolientes, por lo que las comunidades también son vulnerables a la pérdida de una persona cercana a su vecindario o que realizará el acto en algún sector de la comunidad.
Por otro lado, Valdivia (2015) describe que el estigma y la ignorancia constituyen factores de riesgo extremadamente graves para la prevención del suicidio, sin olvidar que la estigmatización también afecta a la familia de la víctima. En este sentido, Fonnegra (2001) menciona que quienes consideran la idea del suicidio y quienes realizan intentos, tanto exitosos como fallidos, son vistos negativamente por la sociedad, que puede tener actitudes que van desde la lástima y la compasión hasta el juicio sobre su decisión. El autor añade que este tipo de actitud subestima las consecuencias emocionales que pueden derivarse de comentarios y explicaciones basadas en la ignorancia.

1.5 Parent—Child Conflict and Suicidal Ideation and Planning Among U.S. Adolescents: Findings from the 2023—2024 National Survey on Drug Use and Health

Mr. Joseph Olasupo[1], Dr. Holly Wilcox[2], Dr. Mark Sinyor[1]
[1]Sunnybrook Research Institute, Toronto, Canada, [2]Johns Hopkins Bloomberg School of Public Health, Baltimore, United States

Background:
Suicide remains a leading cause of death among adolescents, and identifying modifiable risk factors is critical for prevention. Parent—child conflict has been linked to poor mental health outcomes, but evidence examining how the frequency of conflict relates to suicidal ideation and planning in nationally representative samples is limited.

Methods:

We analyzed data from the 2023 and 2024 National Survey on Drug Use and Health (NSDUH), nationally representative annual surveys of noninstitutionalized U.S. residents aged ≥12 years. Analyses were restricted to adolescents aged 12—17 years. Outcomes were past 12-month suicidal ideation and suicide planning (binary). The primary exposure was the frequency of parent—child conflict in the past 12 months (0, 1—2, 3—5, 6—9, or ≥10 times). Past-year major depressive episode and substance use disorder were included as covariates because of their potential confounding effects. Survey weights accounted for the complex sampling design and produced nationally representative estimates. Logistic regression models estimated unadjusted and adjusted odds ratios (ORs) with 95% confidence intervals (CIs) for suicidal ideation and planning separately. Effect modification by sex was assessed using interaction terms. Analyses were conducted using Stata.

Results:
The study included approximately 12,000 adolescents in 2023 and 11,000 in 2024. Greater frequency of parent—child conflict was consistently associated with higher odds of suicidal ideation and suicide planning in both survey years. In 2023, a clear dose—response relationship was observed. Compared with adolescents reporting no parent—child conflict, those reporting ≥10 conflicts had significantly higher adjusted odds of suicide planning (OR=4.17, 95% CI: 1.53—11.39) and suicidal ideation (OR=3.41, 95% CI: 1.92—6.06). In 2024, unadjusted analyses demonstrated similar dose—response trends. After adjustment, adolescents reporting ≥10 conflicts remained at increased odds of suicide planning (OR=1.69, 95% CI: 1.03—2.75), while conflict frequencies of 3—5, 6—9, and ≥10 were associated with significantly greater odds of suicidal ideation (adjusted OR range: 1.84—3.10). Although adjustment for mental health status attenuated the associations, elevated risks persisted among adolescents experiencing more frequent parent—child conflict. Associations were directionally consistent across both survey years.

Conclusions:
Frequent parent—child conflict was independently associated with increased odds of suicidal ideation and suicide planning among U.S. adolescents. The observed dose—response pattern suggests that escalating family conflict may be an important risk factor beyond underlying depression and substance use disorders. These findings underscore the importance of incorporating family relationship assessments into adolescent suicide risk screening and support the development of family-based interventions and conflict-resolution strategies as components of comprehensive suicide prevention efforts.

1.6 The Evolving Use of Generative AI: Implications for Suicide Risk & Prevention

Dr. Laura Erickson-Schroth[1], CMO Christine Moutier
[1]AFSP/JED, New York, United States

Artificial intelligence is changing the way people access information, seek support, and increasingly, experience connection. As AI becomes more personalized, conversational, and integrated into everyday life, it is playing a growing role in how people seek advice, companionship, and support, while also altering many of the protective factors, pathways, and systems on which suicide prevention depends. These technologies may offer important opportunities, but they also raise questions about psychological dependence, human connection, and safety, particularly for individuals experiencing psychological distress or suicide risk.

The American Foundation for Suicide Prevention and The Jed Foundation have been working with researchers, clinical experts, people with lived expertise, policymakers, and leading AI companies to address suicide prevention and safety in AI. This brief presentation will explore the evolving role of AI through the lens of suicide risk and prevention, including the opportunities these technologies may present, their potential unintended consequences, and the critical questions they raise for reach, practice, and policy. The session will also discuss the importance of incorporating suicide prevention considerations into the design, evaluation, implementation, and governance of AI tools.

1.7 Capacitación en intervención de crisis suicida para operadores de una línea de ayuda en Quito, Ecuador: Un Proyecto Piloto Métodos Mixtos

Mr Daniel Sanchez Morales[1], Pablo Francisco Analuisa Aguilar[2], PhD Lorena Campo Aráuz[3], Ms Elizabeth Seaward[4], Dra. Sinaí Valverde Ceciliano[5], Mr. César Marcelo Sandoval Tapia[2], PhD, MD Allison Crawford[6,7], MD Janet Ellis[1], Dr. Mark Sinyor[1,7]

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Los esfuerzos de prevención del suicidio son frecuentemente limitados en el Ecuador; esto se debe a la falta de presupuesto para recursos que apoyen iniciativas de salud mental y su infraestructura, cambios de gobierno y, en general, el tabú alrededor de las conversaciones sobre el suicidio, entre otros factores. Entendiendo cómo los servicios de líneas de ayuda representan recursos de bajo costo para la implementación y de largo alcance, este estudio piloto busca evaluar la utilidad de un proceso de capacitación para la intervención en crisis suicidas enfocada en operadores de la línea de ayuda en Quito, Ecuador, e identificar factores institucionales que moldean su aplicación. Para esto, se empleó un diseño piloto de métodos mixtos convergentes paralelos, cuali-cuantitativos. Se administró el Suicide Intervention Response Inventory (SIRI-2), utilizando una prueba t para medidas repetidas con el fin de identificar cambios en los puntajes (pre y post capacitación). La metodología de Etnografía Institucional (EI) guio el componente cualitativo, apoyado de mapeo institucional y análisis temático para profundizar en los resultados provenientes de entrevistas semiestructuradas. Un total de 16 (89%) operadores participaron tanto en la capacitación como en las actividades de investigación (56,35% mujeres y 43,75% hombres, edad media de 32,7 años, DE = 3,9). No se observaron diferencias significativas en las puntuaciones del SIRI-2 entre las mediciones pre y post intervención (t(15)= -0.83, p=0.421; 95% CI[-0.70, 0.29]). El mapeo institucional ayudó a identificar rutas de acceso a la línea de ayuda, diferencias internas entre los dos equipos de respuesta (servicios ECU911 y Teleconsulta), y los procesos que se activan al recibirse una llamada. El análisis temático destacó tres temas predominantes: pasar de vacíos de conocimiento a mayor confianza para ofrecer una respuesta en crisis, identificación de desafíos persistentes dentro del sistema de respuesta al suicidio, e identificación de oportunidades para mejorar la calidad en atención. Este estudio representa uno de los primeros en examinar la capacitación de personas que atienden líneas de ayuda en América Latina, donde la implementación fue factible. Este piloto no detectó mejoras postintervención en las puntuaciones del SIRI-2, sin embargo, los hallazgos cualitativos sugirieron un aumento de la confianza de quienes responden las llamadas e identificaron brechas en el sistema.

1.8 Who is involved? Mapping Ground-level Institutional Responses to Mental Health Emergencies in Mexico City's Subway System

Mr Daniel Sanchez Morales[1], PhD Silvia Chaine Morales[2], Dr Jeffrey Ansloos[1]
[1]Department of Applied Psychology and Human Development, Ontario Institute for Studies in Education, Toronto, Canada, [2]Psychology Department, National Autonomous University of Mexico, Mexico City, Mexico

Mental Health (MH) challenges are a worldwide public health concern and a rapidly rising issue in Mexico City. Urban spaces (e.g., transportation systems, libraries, public parks, etc.) often intersect with the aftermath of undiagnosed and unaddressed MH concerns, which can be reflected in MH crises such as homelessness, unsafe drug consumption, behavioural outbursts, and suicide, among others. For example, Mexico City's Subway Collective Transport System (STCM acronym in Spanish) has witnessed a troubling rise of suicide deaths often linked to unmet MH needs, with approximately 16.2% males vs. 4.7% females per 100.000 individuals dying by jumping to the tracks (1). Yet, little is known about the process, protocols, procedures, actors, and interactions when responding to MH crises within public transportation settings, and how actively in place strategies (e.g., "Salvemos vidas" program) support the de-escalation of a crisis and/or prevention of a suicide death. This presentation addresses the first question for this exploratory study: What institutional policies, legal frameworks, training activities, role descriptions, and supports shape ground-level worker responses to MH crises in Mexico City's subway (STCM)? The study followed a qualitative environmental scanning approach, informed by institutional ethnography, to examine how STCM's ground-level workers are positioned to respond to MH distress-related events and to map the processes involved in the response. A total of eight STCM ground-level workers participated in individual and in-person semi-structured interviews, sharing their experiences and knowledge related to MH crisis intervention and suicide prevention response; participants included personnel from the Salvemos Vidas team, civil protection, industrial safety, and subway drivers. Additional observational fieldwork was conducted to contextualize spatial responses, interactions with riders, and the implementation of procedures. A thematic analysis of the interviews, observational process, and

final mapping elaboration is currently underway, with results expected to be available by the time of the conference. These results are expected to contribute to identifying strengths and areas of improvement in the current crisis suicide response initiative lead by the Salvemos Vidas team, its conjoined work with other departments inside the STCM, and to showcase a system of response to MH crisis emergencies in a transportation setting.

Lightning #2, Cocorí 3, November 9, 2026, 1:30 PM - 3:00 PM

2.1 Caregivers CARE (Connect, Assess, Respond, Encourage): Making Suicide Prevention Education More Accessible, Approachable, and Supportive for Veteran Caregivers

Dr Mayumi Gianoli[1], Dr. Andrew Meisler[1]
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Veterans are at increased risk for suicide, which highlights the need for prevention efforts that reach beyond formal clinical settings and include the people who may notice when a veteran is struggling. Caregivers are often in a unique position to recognize changes in mood, behavior, speech, functioning, or day-to-day stress, because many are with the veteran every day or nearly every day. With clinical grant funding from the Virginia Department of Veterans Services (VDVS), we developed Spot the Signs, a caregiver-focused suicide prevention curriculum to help caregivers learn what to watch for, how to respond, what to say, and how to support both the veteran and themselves.
This effort originally started as a traditional one-hour educational presentation. However, recruitment for that format was difficult, and through conversations with VDVS representatives, VA Caregiver Support staff, VA caregivers, and others involved in caregiver support, it became clear that we needed to rethink both the format and the time commitment. Many caregivers cannot easily give up an hour of their time, and many also have difficulty leaving the house because of their caregiving responsibilities. We therefore intentionally moved toward shorter, virtual, and more engaging formats that would be easier to access, easier to receive, and more likely to feel approachable.
This lightning presentation will describe three components of Caregivers CARE (Connect, Assess, Respond, Encourage), all based on the same core curriculum about suicide warning signs, including what to watch for in speech, behavior, mood, and circumstances, how to act, and what to say. First, we developed a 30-minute virtual Bingo night using prompts related to caregiver burnout, stress, suicide warning signs, and supportive responding. Bingo gives caregivers a way to talk about hard topics in a less intimidating format, while also creating space for social connection, peer support, and fun. Second, we created a virtual escape room that is more educational and structured, but still interactive and designed to be completed in less than an hour. Third, we developed a series of brief videos, ranging from about two to five minutes, that teach key curriculum concepts in short, practical segments.
Although created with caregivers of veterans in mind, Caregivers CARE can be adapted for other groups, including veterans looking out for other veterans, family members, peers, providers, and community members. The larger goal is to make suicide prevention education practical, approachable, easy to access, and easier to use in real-life relationships and communities.

2.2 Suicidal behavior subtypes in late-life: Different risk factors and life trajectories

Professor Katalin Szanto[1]
[1]University Of Pittsburgh, United States

In late-life identifying those who are at high-risk for suicidal behavior is especially challenging, partly due to the considerable heterogeneity among late-life suicide attempters. I will summarize a series of studies from the Pittsburgh Longitudinal Studies of Late-Life Suicide to show that risk factors for suicide differ by subgroup/subtype of attempters. Late-life suicide attempters provide a unique opportunity to delineate suicidal trajectories, based on whether suicidal behavior in old age is linked to a first suicidal crisis (late-onset suicidal behavior (LO)) or to the continuation of recurrent or chronic suicide risk from earlier life (early-onset suicidal behavior (EO)).

To be eligible, depressed participants needed to meet criteria for a current unipolar major depressive episode (non-psychotic). Upon enrollment into the study, suicide attempters had at least one self-injurious behavior with the intent to die. Among depressed older adults, we found that those elderly whose first suicide attempt occurred during adolescence or young adulthood exhibited higher levels of neuroticism, introversion, and cluster B traits than those who first attempt suicide in late life, while the personality trait, conferring increased vulnerability to LO suicidal behavior was high conscientiousness, need for closure, and rigidity. EO attempters had higher levels of familial and social transmission of suicidal behavior and history of childhood abuse, were more likely to have co-morbid post-traumatic stress disorder and substance abuse compared to non-suicidal depressed elderly. LO suicidal behavior was associated with a broad range of cognitive deficits, including memory, processing speed, and executive dysfunction.

In a sample comprised of 382 depressed middle-aged and older adults (50 years or older, mean age = 63.5 years). We assessed 83 variables, grouped into 7 domains, to distinguish EO and LO suicide attempters from depressed non-attempters. Variables from the behavioral control and planning domain had a high importance in differentiating both early-onset and late-onset attempters from depressed non-attempers. Early-life history as well as emotion regulation and positive/negative affectivity were important in distinguishing the EO group from depressed non-attempters, whereas social dynamics/interactions and cognition/decision-making distinguished the LO group from depressed non-attempters.

In a recent analysis during a median follow-up time±IQR = 3.95±6.20 years, we found that EO attempters had increased odds for dying by suicide, while LO attempters had an about 4-fold increased risk dying by non-suicide all-cause mortality than depressed non-attempters. Our results show different risk profiles (and different life-time trajectories) based on the integration of multiple individual characteristics of older suicide attempters.

2.3 Impacto de la soledad y el aislamiento social en la salud mental y física de estudiantes de 6to a 12mo grado en Puerto Rico, 2022-24

Dra. Linnette Rodriguez-Figueroa[1], Dra. Margarita R. Moscoso Álvarez
[1]Universidad de Puerto Rico, Escuela de Graduada de Salud Pública, San Juan, Puerto Rico

La soledad y el aislamiento social tienen un impacto significativo en la salud física y mental de nuestros jóvenes, aumentando su riesgo de depresión, conducta suicida, consumo de sustancias y diversas enfermedades físicas. Nuestro objetivo fue evaluar la asociación de la soledad y el aislamiento social con enfermedades físicas y síntomas de salud mental entre estudiantes. La muestra (n=7,356) en esta encuesta escolar fue representativa de todos los estudiantes de 6to a 12mo grado en Puerto Rico. Se ajustaron modelos de regresión logística múltiple para estimar razones de probabilidad ajustando por posibles factores de confusión; se evaluó la interacción. Aproximadamente 4.3% de los estudiantes reportaron soledad severa y el 5.7% reportaron altos niveles de aislamiento social. La prevalencia de soledad severa fue mayor en féminas y en jóvenes de 14 a 15 años; el aislamiento fue mayor en varones y en estudiantes menores de 14 años. La prevalencia de problemas mentales y físicos fue mayor en estudiantes con soledad y aislamiento severos. Tras ajustar por posibles factores de confusión, la soledad severa se asoció significativamente con síntomas depresivos y de ansiedad, ideación suicida y diagnóstico de problemas de salud mental tanto en varones como en féminas. También se asoció con diabetes en féminas y con hipertensión arterial en varones. Un alto nivel de aislamiento se asoció con síntomas depresivos e ideación suicida en ambos sexos, y con asma y diabetes en féminas. Este estudio destaca el impacto que la soledad y el aislamiento social parecen tener en la salud mental y física de los jóvenes. Asimismo, subraya la necesidad de desarrollar programas que faciliten la comunicación e interacción entre ellos para reducir el número de jóvenes que se sienten aislados o solos.

2.4 Bridging Global Science and Local Practice: Cutting Through a Bibliometric and Clinical Lens in Costa Rica

Paula Mora Mora[1]
[1]Escuela de Psicología, Sede de Guanacaste

Background: Scientific research on self-harm and suicidal behavior has grown steadily worldwide, yet this growth has not translated into region-specific knowledge for Latin America. In Costa Rica, clinicians report a rising number of cutting cases — a form of self-injury prevalent among adolescents — while no national

bibliometric or clinical evidence base exists to guide practice, and suicide deaths across the Americas rose 56% between 2000 and 2019 (PAHO, 2021).
Aim: This study establishes the global trend in scientific production on cutting and examines its relationship with the criteria of Costa Rican mental health experts, identifying the extent to which international evidence reaches local clinical practice.
Methods: A sequential mixed-methods design was used. First, a bibliometric analysis was conducted in Scopus (30 articles, 2011—2025) and Web of Science (8 articles, 2006—2023) using Bibliometrix/Biblioshiny, examining themes, keywords, approaches, production, collaboration, and impact indicators. Second, semi-structured interviews were conducted with five Costa Rican experts in clinical psychology and suicidology, selected through purposive and snowball sampling, and analyzed through open and axial coding. Findings from both phases were triangulated.
Results: Global scientific production on cutting has grown exponentially since 2006, concentrated in the United States, Ireland, the United Kingdom, and Australia; Costa Rica and most of Latin America are absent from the corpus. Dominant themes include female adolescents, social media, and cognitive-behavioral approaches, particularly Cognitive Behavioral Therapy including Dialectical Behavior Therapy and Nock's Tetrafunctional Model. The Journal of Affective Disorders, author Paul Corcoran , and articles by Brunner (2014), Brown (2018) and Lavis (2020) lead in visibility and impact. Costa Rican experts corroborated the demographic and clinical profile identified bibliometrically and enriched it with psychosocial factors such as family dysfunction and digital contagion. However, none of the five experts interviewed were familiar with Nock's Tetrafunctional Model, the leading authors, articles or the leading journal identified in the global literature.
Conclusions: A clear gap separates the global evidence base on cutting from Costa Rican clinical practice. Bridging this gap requires the critical, contextualized incorporation of international findings into local training, alongside stronger regional scientific production and open-access, Spanish-language publishing to increase the visibility of Latin American clinical knowledge.

2.5 Risk and protective factors for LGBTQ+ young adults: A latent class analysis

Dr. Kelley Cook[1]
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Lesbian, Gay, Bisexual, Transgender, and Queer or questioning (LGBTQ+) people experience elevated suicide risk compared to cisgender and heterosexual people. Drawing on intersectionality and minority stress theory, the present study explored suicide risk and protective factors for LGBTQ+ people. Analyzing data from the 2021—2022 Healthy Minds Study conducted in the United States among college students, a latent class analysis was conducted with a subsample of sexual minority students from institutions that completed the Brief Resilience Scale (N = 10,169) to identify subgroups based on race and ethnicity, gender minority status, suicidal thoughts and behaviors (STB), identity-based discrimination, and related psychosocial variables. Three classes emerged and were named: (1) 'Resilient' (n = 4885; 48%), (2) 'At-Risk' (n = 4661; 46%), and (3) 'Discriminated-Against' (n = 623; 6%). The Resilient group were characterized by low suicide risk and high protective factors. The At-Risk group were marked by elevated risk and STB. And finally the Discriminated-Against group were defined by high levels identity-based discrimination. The Resilient group reported the highest levels of well-being and protective factors, while the Discriminated-Against group reported the highest exposure to discrimination and distress. Multinomial logistic regression were conducted to examine associations between participant characteristics and class membership. Emergence of a distinct group characterized by experiences of identity-based discrimination, separately from the high-risk and low-risk groups—adds to a growing literature that suggests nuanced relationships between minority stressors and mental health issues among LGBTQ+ people. Importantly, the latent class model highlights heterogeneity within LGBTQ+ people, demonstrating that not all LGBTQ+ people have the same mental health risk profile. Most notable is the emergence of a class with identity-based discrimination as the distinguishing feature. Ongoing research should investigate the unique role of discrimination and how it relates to mental health outcomes among LGBTQ+ people.

2.6 Romper el mandato de sufrir en silencio: La Red de Hombres de la CCSS como estrategia para prevenir el suicidio masculino

Mpsc. Dagoberto Solano-Marín[1]
[1]Caja Costarricense de Seguro Social, San José , Costa Rica

Cuando cuatro de cada cinco muertes por suicidio en un país corresponden a hombres, una prevención que no incorpore la perspectiva de género deja sin abordar una parte decisiva del problema. En Costa Rica, durante 2024 se registraron 366 muertes por suicidio; 297 correspondieron a hombres, equivalentes al 81,1 %. Este patrón, presente también en la Región de las Américas, no debe interpretarse como una vulnerabilidad inherente a los hombres, sino como el resultado de múltiples factores personales, sociales y culturales que interactúan a lo largo de la vida.
Entre esos factores se encuentran los mandatos tradicionales de masculinidad que enseñan a los hombres a ocultar el sufrimiento, mostrarse autosuficientes, resolver solos sus crisis y considerar la búsqueda de ayuda como una señal de debilidad. Estas normas pueden dificultar la expresión emocional, el autocuidado, la construcción de redes de apoyo y el acceso oportuno a los servicios de salud. También pueden favorecer el aislamiento, el consumo problemático de sustancias, las conductas de riesgo y la elección de métodos de mayor letalidad. Por ello, transformar las masculinidades no es un tema periférico: constituye un componente necesario de una estrategia integral de prevención del suicidio.
La presentación sistematiza la experiencia de la Red de Hombres por la Igualdad de Género de la Caja Costarricense de Seguro Social (CCSS), una iniciativa institucional, multidisciplinaria y de alcance nacional. Su nómina incluye 34 funcionarios, con representación en las siete direcciones regionales de la CCSS, oficinas centrales, Areas de Salud y Hospitales Nacionales. Durante 2023, la Red ha ejecutado diversas acciones de capacitación y divulgación programadas. Entre sus iniciativas destacan talleres, actividades virtuales, el espacio Hombres en Construcción y el Primer Congreso de la Red, donde se abordó explícitamente la prevención del suicidio masculino.
Los principales tópicos a abordar en esta presentación relámpago serán la socialización masculina y riesgo suicida; alfabetización emocional; estigma y búsqueda de ayuda; autocuidado; consumo de sustancias; violencia; presiones asociadas con los roles masculinos; redes de apoyo y acompañamiento durante las crisis.
Se pretende dejar claro que prevenir el suicidio masculino exige actuar antes de que el sufrimiento se convierta en una emergencia. Mientras los hombres continúen aprendiendo que deben sufrir en silencio, los sistemas de salud seguirán llegando tarde. La experiencia de la CCSS muestra una vía factible y replicable para transformar esa realidad.

2.7 Saving Lives of Those Who Wear Camouflage: A Digital Suicide Prevention Education Application for Military Communities

Dr. Kenitha Woodhouse[1]
[1]Kenitha Woodhouse Consulting, LLC, Woodbridge, United States

Military suicide remains a significant public health concern, with service members, veterans, and military families often facing barriers to accessing prevention resources and support. To address this challenge, the Saving Lives of Those Who Wear Camouflage mobile application was developed as a culturally responsive suicide prevention education tool designed specifically for military-connected populations.

Grounded in Social Learning Theory, Attachment Theory, and the Invisible Armor Framework, the application provides education and practical resources related to self-care, safety planning, gatekeeper engagement, firearm safety, crisis resources, and military-specific risk and protective factors. The project was developed through a community-engaged process that incorporated professional practice experience, research findings, and stakeholder feedback.

This lightning presentation will highlight the application's development, theoretical foundations, and implementation. Preliminary findings from the inaugural demonstration event will be shared, including strong participant knowledge outcomes and positive perceptions regarding the application's usefulness as a suicide prevention education resource.

The presentation offers an example of how technology, community engagement, and culturally relevant content can be integrated to expand suicide prevention education beyond traditional service delivery models. Attendees will gain practical insights into developing accessible prevention tools that can strengthen suicide prevention efforts, increase awareness, and support military-connected populations across diverse communities.

2.8 De la crisis a la acción: habilidades clínicas y planificación colaborativa para responder al riesgo suicida

M.Sc. Diana Jara Vindas, Psicologa clinica

La conducta suicida constituye un fenómeno clínico complejo, frecuentemente asociado con sufrimiento psicológico intenso, desregulación emocional y dificultades para identificar alternativas eficaces ante situaciones de crisis. Desde el modelo biosocial de Marsha Linehan y la Terapia Dialéctico-Conductual (DBT), determinadas conductas suicidas pueden comprenderse funcionalmente como intentos de escapar o aliviar experiencias emocionales percibidas como intolerables. Esta conceptualización permite orientar las intervenciones hacia la adquisición de habilidades y la ampliación del repertorio conductual.
Objetivo: Destacar la importancia del entrenamiento en habilidades de regulación emocional, tolerancia al malestar, atención plena y efectividad interpersonal como estrategias clínicas para la prevención del comportamiento suicida, integrando la activación conductual y la planificación colaborativa de crisis.
La DBT plantea que las personas pueden aprender respuestas más eficaces frente al sufrimiento mediante el entrenamiento sistemático, la práctica y la generalización de habilidades. Desde esta perspectiva, cuanto mayor sea el repertorio de estrategias disponibles, mayores serán las posibilidades de identificar alternativas a la conducta suicida durante situaciones de elevada vulnerabilidad emocional.
La intervención no pretende eliminar inmediatamente el dolor psicológico, sino desarrollar capacidades para experimentarlo sin recurrir a comportamientos potencialmente letales. La validación emocional, el análisis funcional, las habilidades de supervivencia a las crisis y la construcción de planes de seguridad colaborativos constituyen componentes fundamentales de este abordaje.
Complementariamente, la activación conductual favorece la reducción de patrones de evitación y la recuperación progresiva de actividades significativas, reforzando la conexión con fuentes de bienestar, propósito y vinculación social.
Aplicación clínica: En el Hospital Nacional de Salud Mental de Costa Rica dirijo un grupo de entrenamiento en habilidades dirigido a personas con ideación suicida, así como un grupo de activación conductual. Para 2027 se proyecta implementar un programa de habilidades para familiares, orientado a fortalecer la validación emocional, la respuesta ante crisis y las redes de apoyo.
La prevención del suicidio requiere trascender la identificación del riesgo y promover competencias para afrontar el sufrimiento. El propósito terapéutico no se limita a preservar la vida, sino a favorecer la construcción de una vida que valga la pena vivir.

Lightning #3, Cocorí 4, November 9, 2026, 1:30 PM - 3:00 PM

3.1 From Hotline to System: Strengthening Suicide Prevention Through Integrated Crisis Infrastructure Across the Americas

Mr. Justin Chase
[1]Solari Crisis & Human Services, Tempe, United States

Effective suicide prevention requires more than a single hotline or standalone intervention. It depends on a coordinated crisis system that connects immediate access, skilled response, follow-up support, community partnerships, and broader behavioral health care. Drawing from leadership experience in large-scale crisis system operations, this presentation will examine how suicide prevention efforts can be strengthened when they are embedded within an integrated behavioral health crisis continuum.

This lightning presentation will highlight practical lessons from designing and leading crisis services that support individuals experiencing suicidal distress through multiple access points, including 988 and related crisis response systems. The session will focus on actionable strategies for translating suicide prevention goals into frontline practice, including workforce development, service coordination, technology enablement, and cross-sector collaboration. It will also explore how strong crisis infrastructure can improve timely access to care, reduce fragmentation, and create more responsive pathways for people in need.

Particular attention will be given to the importance of building models that are scalable while still adaptable to local context. Across the Pan American region, suicide prevention efforts must reflect differences in language,

culture, geography, community resources, and system maturity. This presentation will share insights on how crisis systems can balance consistency, quality, and local responsiveness while advancing a more connected and humane approach to care.

The session is relevant to practitioners, policymakers, researchers, and community leaders seeking practical approaches to strengthen suicide prevention through systems design and implementation. By sharing operational and leadership insights, this presentation aims to contribute to regional dialogue on how communities can move from aspiration to action and build crisis systems that are more effective, collaborative, and responsive to those at risk.

3.2 Anxiety, depression, suicide risk, and sociodemographic variables in university students from México

Phd. Karla Patricia Valdés-García[1], PhD. Bárbara de los Angeles Pérez-Pedraza[1]
[1]Universidad Autónoma De Coahuila, Saltillo, Mexico, [2]Universidad Autónoma de Coahuila, Saltillo, México

According to the WHO, more than 700,000 people die by suicide every year, and suicide is the third leading cause of death among people aged fifteen to twenty-nine. International research shows that a large share of students meet criteria for a mental disorder and that suicidal thoughts are prevalent in this group.
The objective of this quantitative cross-sectional study was to estimate suicide risk in a sample of 19,994 students between 16 and 30 years (mean= 20) from 17 universities in the state of Coahuila, México, and to map how it relates to anxiety, depression, well-being, lifestyle, sleep, and social conditions. The participants responded to sociodemográfic questions and four validated instruments: Ryff's scale of psychological well-being; a health-promoting lifestyle profile; the Hospital Anxiety and Depression Scale; and the Roberts scale of suicidal ideation, with a cut-off of six or more to flag risk. All were answered in an online form distributed by their teachers and directive personal.
The primary results show that 6.2% of the sample screened positive for suicide risk, and when analyzed by sex, young women carry a heavier load of suicidal ideation. Two regions of the state presented the highest risk, with percentages between 7.1 and 7.3. The correlation map of the psychological variables shows that anxiety had the strongest positive association, and well-being showed an almost equally strong negative association; sleep, physical activity, and lifestyle matter too, but more modestly.
The logistic model to predict risk distinguished at-risk students with an AUC of .89, and the odds ratios identify anxiety as the dominant risk factor (OR=2.26); depression and being female also raise the odds; and well-being was the strongest protective factor (OR= 0.39). A path model and a network analysis were conducted, and two findings emerged. First, well-being protects in two ways at once: directly, and indirectly by lowering anxiety and depression. About forty percent of its protective effect flows through reduced distress. Second, the network identifies anxiety and well-being as the most central hubs — the nodes that connect everything else to suicide risk. This could imply that raising well-being and easing anxiety doesn't just help reduce symptoms; the benefit ripples outward and reaches risk along several paths at once.
In conclusion, we found in this study that risk is highest in women, among those who sleep poorly, and among lower-income students, and that it concentrates in specific regions; also, that the strongest drivers are modifiable. Our recommendations are to screen routinely for anxiety and depression on university campuses; invest in well-being as a frontline protective strategy; address sleep; and prioritize the highest-risk regions and groups.

3.3 Habilidades socioemocionales DBT para prevenir el suicidio en adolescentes de bachillerato agropecuario: un estudio mixto

Dra. En Psicología Laura Elena De Luna Velasco[1], Doctor en Psicología con Orientación en Calidad de Vida y Salud Marco Antonio Santana Campas[1], Doctor en Ciencia y Tecnología Felipe Santoyo Telles[1], Doctora en Psicología Alicia Edith Hermosillo de la Torre[1]
[1]Universidad De Guadalajara-Centro Universitario Del Sur, Ciudad Guzmán, Municipio de Zapotlán el Grande, Mexico, [2]Universidad De Guadalajara-Centro Universitario del Sur, Ciudad Guzmán, Municipio de Zapotlán el Grande, Mexico, [3]Universidad De Guadalajara-Centro Universitario del Sur, Ciudad Guzmán, Municipio de Zapotlán el Grande, Mexico, [4]Universidad Autónoma de Aguascalientes, Aguascalientes, México

Presentar los hallazgos del programa de entrenamiento en habilidades DBT-MX-AU Rural —adaptación cultural de la Terapia Dialéctico-Conductual para bachilleratos agropecuarios mexicanos— evaluado con diseño mixto y triangulación concurrente. El estudio parte de un diagnóstico territorial contundente: un tamizaje universal a 203 estudiantes no encontró ninguno sin riesgo psicosocial asociado al suicidio, desde donde se argumenta que el bachillerato agropecuario puede operar como nodo estratégico de prevención allí donde la nueva ruralidad y la ausencia institucional configuran el riesgo suicida adolescente. Se proponen condiciones para la transferencia del modelo a otros contextos rurales latinoamericanos.
Hallazgos clave: El programa se implementó con 14 adolescentes (10 completaron; M=16.4 años; 70% varones) en 11 sesiones semanales. Los resultados cuantitativos (Wilcoxon) mostraron reducciones significativas en pesimismo (p=.047, r=-.896) y desregulación emocional (p=.025, r=-.618), e incremento en optimismo (p=.001, r=-.568) — efectos grandes, coherentes con los mediadores del cambio identificados en la evidencia internacional DBT-A. El riesgo de suicidio agudo no se modificó (p=.496): en una muestra con 67% en nivel alto, el componente grupal sin terapia individual ni manejo de crisis es insuficiente para el riesgo agudo. Este es un hallazgo éticamente informativo, no un fracaso del programa.
Los hallazgos cualitativo (SCAT 1.0, IGC, Atlas.ti 9.0), el 80% reportó cambios en sus acciones, el 79% en sus ideas y el 52% en sus afectos. El hallazgo central fue la resignificación del grupo como espacio de pertenencia: "Es mi lugar, quiero estar aquí porque quiero estar aquí" (P2L140). En una población que el sistema ha convertido en ausente, ese dato es tanto un resultado clínico como un argumento de política pública.
Relevancia para la colaboración y la acción regional
La nueva ruralidad latinoamericana —agroindustria, migración, precariedad, brecha digital— es un escenario compartido desde México hasta el Cono Sur. Este estudio aporta evidencia transferible a diferentes ruralidades del continente. La presentación nos muestra tres preguntas para el diálogo: ¿Cómo adaptar intervenciones basadas en evidencia a la diversidad de ruralidades latinoamericanas sin perder rigor cultural ni científico? ¿Qué mecanismos intersectoriales pueden acelerar esa transferencia entre países? ¿Cómo traducir hallazgos en recomendaciones de política pública que lleguen a las escuelas rurales donde el riesgo es mayor y la atención más escasa? La invitación es a construir juntos una agenda de presencias institucionales, donde hoy solo hay ausencias.

3.4 Insights from a state-wide community to prevent suicide through behavioural health promotion in educational settings: An introduction of the Michigan Social and Emotional Learning Alliance

Dr Michael MacDonald[1]
[1]University of Windsor, Windsor, Canada

Recent research has documented increases in youth and young adult suicide rates, suicidal attempts, and levels suicidal ideation in the United States (Centers for Disease Control, 2023) and other countries (Chang et al., 2024). The reciprocal connection between student learning and well-being has led to the development of social and emotional learning (SEL) standards, policies, curricula, and interventions. It is argued that SEL contributes to comprehensive efforts to prevent suicide (Posamentier et al., 2022). SEL competencies (e.g., self-awareness, self-management, social awareness, relationship skills, and responsible decision-making) have been shown to effectively address various suicide risks among adolescents and provide necessary protection against suicidal behaviours (Liu & Wang, 2024). Decades of research demonstrates a link between the development of social and emotional competencies and positive personal, social, and academic outcomes (Hukkelberg et al., 2019). These competencies are predictive of higher graduation rates, lower rates of school dropout, less delinquency and crime, fewer mental health problems, and successful employment (Heckman & Kautza, 2012; Jones et al., 2015; Moffitt et al., 2011).

School communities and educators are positioned to promote child and adolescent well-being by supporting connectedness, inclusion, safe spaces, and through providing professional development to educational professionals. In response to these needs, the Michigan Social and Emotional Learning Alliance (MiSELA) was established a state-wide community to promote behavioural health in educational settings. MiSELA is made up of approximately 36 core representatives from education organizations, universities, infant and early childhood, K-12, and afterschool systems. The collective expertise spans teaching and learning, trauma and mental health, racial equity, research, policy, and practice areas. In the state of Michigan, there is not a unified or consistent mechanism to provide technical assistance, support, and resources to educators around implementation of SEL and other supportive initiatives to improve student mental and behavioral health. MiSELA was established to

help address this issue in a phased process beginning with a statewide survey and culminating in the rollout of training and technical assistance that leverages expertise of MiSELA members.

This objective of this presentation is to provide an overview of this state-wide learning community and provide key insights of relevance to regional collaborative actions aimed at suicide prevention and related areas of behavioral health and wellbeing.

3.5 Using Artificial Intelligence to Study Associations Between Suicide Depictions in Child and Youth Television Shows and U.S. Population Suicide Rates

Dr Shawn Varghese[1], **Dr. Mark Sinyor**[1,2], Dr Matt Spittal[3], Rachel Lebovic[1,2]
[1]Department of Psychiatry, University Of Toronto, Toronto , Canada, [2]Department of Psychiatry, Sunnybrook Health Sciences Centre, Toronto, Canada, [3]Centre for Mental Health and Community Wellbeing, Melbourne School of Population and Global Health, University of Melbourne, Melbourne, Australia

Background
The Werther Effect is a phenomenon where an increase in suicide deaths occurs after portrayals of suicide in media. This occurs through social learning whereby at-risk individuals emulate those who have died by suicide. Several studies have shown the impacts of the Werther Effect with specific exposures in time however studies have generally not examined aggregate effects of suicide portrayals in media over time. Children and youth may be particularly vulnerable to the Werther Effects given that this demographic is highly suggestible. Our study aims to explore the feasibility of using AI large language models to identify changes in suicide depiction in adolescent television (TV) shows and to evaluate the relationships between these suicide depictions and suicide rates in the U.S. population.

Methods
Claude Sonnet 4.6 was used to generate two lists of top 5 popular TV shows yearly in U.S. Markets (1970-2025) based on viewership, rankings, awards/nominations and reviews: a) shows popular among the tween and early teenagers and b) shows popular among the late teenagers and young adults. SuperGrok 4.3 was used to identify the first instance of suicide death and non-suicide violent death in each television show. The latter was obtained as a control to explore if changes identified are unique to suicide or part of larger trends in all violent death depiction on TV. Suicide and violent death instances were manually verified and coded to collect data on time to suicide/violent death instance, aspects of death depiction, and character demographics. IMDB and streaming services were used to collect data on episode number and lengths. CDC WONDER data was used to collect U.S. national suicide rate data. Statistical analysis will utilize a Suicide Depiction Score, which reflects both the frequency of suicide portrayals and the time to exposure, and ARIMAX models, which extend traditional ARIMA modelling by including predictors.

Results
We identified 545 unique TV shows between the tween and young adult lists with 15 shows in common between each list. Among tween TV shows, 40 suicide deaths and 87 violent deaths were identified. Among young adult TV shows, 64 suicide deaths and 168 violent deaths were identified. Full codes and relationship with U.S. population suicide deaths will be available at the time of the conference.

Conclusions
These results will shed light on whether there is an aggregate Werther Effect associated with child and youth television depictions of suicide.

3.6 Conceptual Frameworks and Methodologies for Evaluating Large Language Models (LLMs) in Digital Mental Health and Suicide Prevention Interventions: A Scoping Review

Mr Antonio Salinas[2], **Mr Álvaro Jiménez-Molina**[1, 4], Dr. Vania Martínez[2], Daniela Lira[3]
[1]Universidad San Sebastián, Santiago, Chile, [2]Universidad de Chile, Santiago, Chile, [3]Ministerio de Salud de Chile, Santiago, Chile

Background: Large language models (LLMs) are increasingly being integrated into digital mental health interventions (DMHIs), creating new opportunities for personalized assessment, emotional support, and

therapeutic interaction. However, their rapid adoption has outpaced the development of standardized approaches for evaluating their clinical, technical, ethical, and user-centered dimensions, particularly their capacity to respond safely and effectively to suicide risk.
Objective: This scoping review aimed to systematically map the frameworks, methodologies, and tools used to evaluate LLMs embedded in DMHIs, identifying the constructs assessed, instruments employed, and stages of evaluation addressed in the literature, with particular attention to interventions involving suicide risk and crisis response.
Methods: Following PRISMA-ScR guidelines, five databases (PubMed, Scopus, Web of Science, IEEE Xplore, and ACM Digital Library) were searched for studies published between January 2019 and September 2025. Empirical studies and theoretical proposals evaluating LLM-based mental health interventions were eligible, whereas applications limited to diagnosis, risk detection, data analysis, or clinical decision support without an intervention component were excluded. Data extraction captured intervention and LLM characteristics, evaluation frameworks and methodologies, measured constructs, instruments, evaluation domains, and evaluation stages ranging from feasibility and usability to efficacy, effectiveness, and implementation.
Results: The search identified 4,273 records, of which 2,980 remained after duplicate removal; 120 studies were included. Research was concentrated in the United States and China, with little representation from Latin America, and GPT-family models appeared in approximately 80% of studies. Only 23% explicitly used an evaluation framework, usually study-specific, while computational benchmarks and simulations predominated (60%). Eleven studies reached efficacy, one effectiveness, and none implementation. Evaluations focused mainly on generated responses (empathy, coherence, relevance, and therapeutic interaction), while clinical outcomes, safety, privacy, governance, and explainability were less frequently assessed; only 28% used standardized instruments. Nineteen studies (16%) examined suicide risk, self-harm, psychiatric emergencies, or acute crises, including 13 (11%) that empirically evaluated suicide-related safeguards or clinical actions. These studies relied largely on simulated scenarios, clinical vignettes, or red-teaming, with none testing LLM responses among people at real-time suicide risk. General-purpose LLMs performed better with explicit than implicit, complex, or multistep risk signals, and suicide-related evaluations relied mainly on ad hoc measures, with no standardized instruments identified.
Conclusions: This review mapped how LLM-based DMHIs have been evaluated and identified major methodological gaps, particularly in suicide risk and crisis response. Evidence remains dominated by early-stage simulation studies, with limited use of standardized instruments and little real-world clinical validation. More rigorous and context-sensitive approaches are needed to assess therapeutic interaction, technical performance, clinical effectiveness, safety, privacy, accountability, and reliable responses to suicide risk.
Funding: ANID – Fondecyt Project N° 1262084 and CIADES-CIN250054

3.7 Recognizing Akathisia in Suicide Prevention Across the Americas: Training for Clinicians, Suicidologists, and Crisis Responders

Ms. Kristina Kaiser, Ms Wendy Dolin
[1]MISSD, Chicago, United States

Objectives: To highlight akathisia as an under-recognized, medication-induced neuropsychiatric disorder relevant to suicidality and suicide prevention; to identify education needs for healthcare professionals, suicidologists, consumers, caregivers, and crisis response staff across the Americas; and to propose a practical training approach that supports translation of psychopharmacological knowledge into frontline practice.

Akathisia is a medication-induced neuropsychiatric disorder that can involve intense inner restlessness, agitation, panic, insomnia, and behavioral change, and it may be associated with suicidal thoughts and behaviors. Clinical reports and trials have described associations between psychotropic-induced akathisia and suicidality in some patient groups, underscoring the importance of monitoring adverse drug effects when assessing suicide risk. These concerns are particularly salient for children and adolescents, given suicide-related warnings on several commonly prescribed medications. Yet akathisia is often missed, misinterpreted as worsening psychiatric illness, or omitted from suicide-prevention education, which can delay appropriate response.

This presentation proposes that suicide-prevention training in the Pan-American region include targeted education on medication-induced suicidality and akathisia for four overlapping audiences: frontline clinicians; suicidologists and researchers; consumers and caregivers; and crisis communication and hotline personnel. For

clinicians and suicidologists, core competencies include recognizing symptom onset after medication initiation, dose change, withdrawal, or interaction; distinguishing akathisia from anxiety or relapse; integrating medication review into suicide-risk assessments; and ensuring evidence on akathisia and suicidality informs practice. For consumers, caregivers, and people with lived experience, plain-language education can improve recognition of abrupt behavioral change and support faster escalation to appropriate care.

Because the program includes crisis communication and hotline support, this presentation proposes that hotline staff and other crisis responders routinely ask whether suicidal distress began or intensified after a medication was started, stopped, or changed, and whether the caller is experiencing severe inner restlessness, pacing, inability to sit still, agitation, or terror. Asking brief, medication-related questions in crisis encounters can help identify medication-induced suicidality and akathisia more quickly and reduce risk.

Relevance to regional collaboration and action: In a bilingual forum designed to strengthen translation of research into policy and frontline practice across the Americas, akathisia education offers an actionable opportunity for safer suicide prevention. The Medication-Induced Suicide Prevention and Education Foundation in Memory of Stewart Dolin (MISSD), a 501(c)(3) international nonprofit headquartered in Chicago, supports this effort through free awareness and educational resources, including conference presentations, public health videos, podcasts, and accredited one-hour online akathisia courses for clinicians, consumers, caregivers, and crisis professionals.

3.8 Buddy Up: A men's suicide prevention campaign.

Mara Grunau[1]
[1]CAMH Alberta Canada

While 4000 people die by suicide in Canada annually, some sub-populations are disproportionately affected. Though universal intervention skills are needed, prevention initiatives must be tailored to and co-designed with the priority population they serve.

This lightning session uses the Buddy Up Campaign as an exemplar model of this process. Built by men for men, Buddy Up promotes authentic conversations among men and their buddies. The campaign focuses on help-offering behaviour, building on men's eagerness to help a friend.

Often, program design excludes the people needing intervention. Buddy Up was designed, implemented and evaluated by men. Buddy Up uses participant action research to create a movement for men's suicide prevention. Currently, 2000+ Buddy Up Champions lead the campaign in their communities and workplaces, touching thousands more participants. Participation is free of charge.

Early research indicates three overarching themes in participants' perspectives: engages men with relatable masculine content ("Buddy Up really spoke to them in their language"); enables men to initiate conversations and promote mental health ("it gives men language and license to start asking questions"); and drives new masculine cultures ("We start every meeting with a mental health moment"). The campaign is available in English and French.

Lightning #4, Cocorí 1-2, November 11, 2026, 8:30 AM - 10:00 AM

4.1 Development and Evaluation of the ESTAR Suicide Postvention Training Program for Healthcare Professionals in Chile

Mr Alvaro Jimenez-Molina[1]
[1]Universidad San Sebastián and Center for Research and Action on Social Determination and Mental Health (CIADES),

Background: In Chile, the National Suicide Prevention Strategy has recently (2025) incorporated postvention as a core component. However, important systemic gaps remain, including limited professional competencies and a lack of evidence-based protocols to guide tailored postvention interventions. ESTAR is a postvention training program developed in Chile.
Objective: To evaluate the feasibility, acceptability, and perceived effectiveness of the ESTAR training program in strengthening healthcare professionals' competencies in suicide postvention.
Methods: We conducted a mixed-methods pilot study with pre-, post-, and 3-month follow-up assessments across three regions of Chile. A total of 170 professionals from the public healthcare network participated (73.5% women; mean age = 35.6 years). Quantitative assessments examined changes in postvention knowledge, skills, confidence/self-efficacy, and attitudes, as well as program acceptability. Qualitative data were used to explore perceived effectiveness and identify barriers and facilitators to applying the training in routine practice.
Results: A total of 120 participants completed the post-program assessment. Significant improvements were observed in knowledge (d=1.64), skills (d=1.20), and confidence/self-efficacy (d=1.19), with gains maintained at the 3-month follow-up. No significant changes were observed in attitudes. Overall acceptability was high, with 95.7% of participants reporting that they were satisfied or very satisfied with the program. Participants primarily attributed the program's usefulness to providing a structured framework for suicide postvention. They also emphasized the need to provide ongoing post-training support to facilitate the implementation of acquired competencies in routine practice.
Conclusion: ESTAR demonstrated feasibility and high acceptability and was associated with sustained improvements in key competencies for suicide postvention.
Learning Objective: By the end of this presentation, participants will be able to: (1) Identify key systemic gaps in suicide postvention within Chile's public health system, particularly those related to professional competencies and evidence-based protocols; and (2) Describe the core components of a structured suicide postvention training program designed to support the integration of postvention strategies into routine public health practice.
Funding: ANID / FONIS Project SA23I0181 and CIADES—CIN250054

4.2 Global Adaptation of the Clinical Service Quality Index: A Scalable Framework for Continuous Improvement

Dr Tracy Costigan[1], C.Zack Upton, Jess Jarvis, Tara Logan Buckley
[1] Crisis Text Line

Background: In the rapidly expanding field of digital mental health there is no comprehensive system for clinical service quality measurement that looks beyond policy compliance. While compliance tracking is necessary to assure basic safety standards, it is not sufficient to support continuous quality improvement, nor to guide policy and practice standards. We developed a ground-breaking Clinical Service Quality Index (CSQI), a multidimensional framework and composite index that assesses the quality of digital crisis interventions. In this talk, we will introduce this new, more expansive quality framework and measurement system and help participants refl ect on how adoption of these standards can support service delivery, research, and policy making.
Methods and Results: The CSQI was developed through a rigorous, multi-stage process that was data-informed and expert-derived. Phases of index development included: framework development, indicator selection, calibration, weighting, aggregation, and validation. The resulting CSQI comprises nine indicators across fi ve dimensions: safety, effectiveness, people-centeredness, timeliness, and effi ciency. It provides a systems-level analysis of current quality levels and areas for improvement. This index has been developed for Crisis Text Line (United States) and has been adapted to two additional text-based crisis services — Shout About it (United Kingdom) and spunout (Ireland). We are also in the process of adapting the CSQI to Aquí Estoy (Spanish language service covering Latin America, Spain, and the Caribbean). The broader aim is to support the fi eld in adopting and adapting this measurement system to raise standards for digital mental health support and suicide prevention globally.
Conclusion: The quality framework and CSQI represent an innovative measurement tool and an important contribution to healthcare quality standards globally. It is a rigorous process that can
be adapted to frame, measure, and continuously improve crisis intervention services. From this presentation, attendees can refl ect on how this approach might inform measurement and continuous quality improvement

within their own services. This work aligns with the IASP's workshop goal of development and scaling of digital mental health interventions.

4.3 JovenSalud: un modelo digital integral para ampliar el alcance de la promoción de la salud y fortalecer los ecosistemas de prevención del suicidio en adolescentes y jóvenes.

Sra. Adriana Gomez[1] M Sc. Carolina Alfaro Gonzalez
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La prevención del suicidio requiere un enfoque ecosistémico que, además de respuestas especializadas ante situaciones de riesgo, incorpore acciones de promoción de la salud, fortalecimiento de factores protectores y acceso temprano a información, recursos y orientación confiables. Las herramientas digitales pueden contribuir a ampliar este alcance, particularmente entre adolescentes y jóvenes, cuando forman parte de modelos integrales y se articulan con las organizaciones y programas que ya trabajan con estas poblaciones.

Esta presentación introduce el modelo TeenSmart—JovenSalud, una intervención digital integral de promoción y prevención en salud dirigida a personas jóvenes. El modelo combina educación basada en evidencia, desarrollo de habilidades para la vida, recursos de autocuidado, participación juvenil, gamificación, orientación profesional y monitoreo y evaluación. Su enfoque holístico aborda diferentes dimensiones de la salud y el bienestar juvenil, incluida la salud mental, y busca fortalecer conocimientos, habilidades y factores protectores.

A partir de la experiencia regional de implementación y de los principales aprendizajes y resultados generados mediante sus procesos de monitoreo y evaluación, se mostrará cómo JovenSalud puede contribuir, desde la promoción y la prevención, al fortalecimiento de los ecosistemas de prevención del suicidio. JovenSalud se sitúa específicamente en el ámbito de la promoción de la salud y la prevención, ofreciendo a las personas jóvenes acceso gratuito, seguro y confidencial a información, aprendizaje, recursos de autocuidado y orientación. No brinda tratamiento clínico ni atención de crisis, funciones que corresponden a otros actores y servicios especializados. Desde una perspectiva ecosistémica, estas respuestas cumplen roles distintos y complementarios, todos necesarios para una prevención integral del suicidio.

Finalmente, se destacará el papel de las alianzas como componente central del modelo. Instituciones educativas, organizaciones juveniles y comunitarias, gobiernos, servicios de salud y otros actores pueden incorporar y promover JovenSalud como un recurso complementario dentro de sus propios programas y proyectos, ampliando así las oportunidades de promoción y prevención disponibles para las poblaciones jóvenes con las que ya trabajan.

4.4 Diferencias sexuales en suicidios de jóvenes en Jalisco, México.

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El análisis de los suicidios en jóvenes de 15 a 29 años en Jalisco durante el periodo 2013-2022 evidencia importantes diferencias sexuales que permiten comprender la conducta suicida desde una perspectiva de género. Aunque los hombres representan la mayoría de las muertes por suicidio, con una proporción aproximada de cuatro hombres por cada mujer, los patrones de riesgo y vulnerabilidad difieren significativamente entre ambos sexos.
En los hombres se observa una mayor frecuencia de suicidios en edades más avanzadas de la juventud, particularmente entre los 24 y 29 años, así como un incremento de las tasas en el grupo de 25 a 29 años durante los últimos años del periodo analizado. Asimismo, presentan mayor vulnerabilidad quienes poseen menor escolaridad y quienes carecen de derechohabiencia, lo que sugiere la influencia de factores

relacionados con la precariedad laboral, la exclusión social y las dificultades para cumplir con el rol tradicional de proveedor. La región Centro del estado concentra la mayor proporción de suicidios masculinos, asociada probablemente a las dinámicas urbanas, el estrés económico y las transformaciones en los modelos de masculinidad.
Por su parte, las mujeres muestran un perfil diferenciado. La mayor proporción de suicidios se presenta a edades más tempranas, especialmente entre los 15 y 16 años, lo que sugiere una mayor vulnerabilidad durante la adolescencia. Además, las mujeres fallecidas por suicidio presentan con mayor frecuencia niveles educativos superiores, a partir de preparatoria incompleta, y una mayor presencia en la región Norte del estado. Estos hallazgos indican la posible influencia de factores relacionados con la violencia de género, el aislamiento social, las tensiones familiares y las expectativas culturales impuestas sobre el rol femenino.
En conjunto, las diferencias observadas muestran que el suicidio juvenil en Jalisco constituye un fenómeno profundamente atravesado por el género. Por ello, las estrategias de prevención deben incorporar intervenciones diferenciadas, con énfasis en la prevención temprana en mujeres adolescentes y en el fortalecimiento de la inclusión social, laboral y emocional de los hombres jóvenes, mediante políticas públicas sensibles al género y al contexto sociocultural.

4.5 La formación de agentes de ayuda como instrumentos comunitarios para intervenir la conducta suicida mediante un modelo enmarcado en el contexto socio-cultural hispano

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El suicidio es un problema de salud pública que requiere esfuerzos comunitarios de prevención basados en evidencia científica y enmarcados en la región geográfica. La práctica de educar a las personas con el conocimiento para identificar a una persona en riesgo es un método eficaz de prevención del suicidio. Las personas se convierten en guardianes de vida en la comunidad. La capacitación de las personas como agentes de ayuda se ha implementado y estudiado en muchas poblaciones y se ha demostrado que este tipo de capacitación afecta positivamente el conocimiento, las habilidades y las actitudes con respecto a la prevención del suicidio. Los estudios han reportado resultados significativos en la reducción de la conducta suicida ya que el adiestramiento de guardianes mejora las habilidades específicas para atender el comportamiento suicida. Un estudio realizado en el 2022 por Spottswood y allegados, encontró que la implementación de estrategias comunitarias es vital para la prevención del suicidio. La participación de las personas en el proceso de ayuda es sumamente importante. De acuerdo a Holmes y colaboradores (2021), la práctica de educar a las personas en un ambiente de confianza y seguridad es un método eficaz de prevención del suicidio. Isaac et.al, (2009) evidenciaron que la capacitación de personas como guardianes de vida tiene éxito en impartir conocimientos, desarrollar habilidades y moldear las actitudes. La reducción en la conducta suicida es significativa cuando utiliza personas adiestradas de la comunidad. El enfoque propuesto es el Modelo de Intervención para Atender el Suicidio (MIPAS) el cual promueve el mejoramiento conductual dentro del marco contextual social y cultural de la comunidad latina. El objetivo principal es promover la vida y buscar soluciones viables, reconociendo los determinantes sociales, acuñados por la Comisión de Determinantes Sociales de la Salud, Organización Mundial de la Salud. Los factores de riesgo suicida son productos del contexto social y cultural y son propios de las regiones. Este modelo articula la interacción de los determinantes sociales y los factores de riesgo a nivel individual. La meta es promover el empoderamiento de las personas para detectar e intervenir con personas en riesgo suicida. El adiestramiento es interactivo y práctico. Las personas que asisten tienen la oportunidad de practicar intervenciones simuladas, de modo que se sientan confiadas al momento de intervenir.

4.6 Estudio descriptivo sobre los factores de riesgo asociados a la ideación suicida en la población universitaria asignada al Área de Salud Santa Bárbara de Heredia, el Hospital San Carlos y el Hospital Dr. Max Terán Valls.

Facilitadora Y Participante Ana Catalina Calderón Jiménez

Esta investigación es descriptiva y tiene como objetivo fortalecer los esfuerzos para comprender las posibles causas asociadas al aumento de conductas suicidas en la población escolar, presentando una visión general actualizada de estas y de los factores de riesgo asociados a la ideación suicida en el ámbito escolar.
La recolección de datos se realizó con la población asignada al Área de Salud Santa Bárbara de Heredia, el Hospital San Carlos y el Hospital Dr. Max Terán Valls, durante 2024.
El estudio fue mixto, combinando técnicas cuantitativas y cualitativas para el análisis descriptivo. Se aplicó un cuestionario autoadministrado a 415 estudiantes de entre 12 y 19 años y se realizaron 21 grupos focales con adultos que tienen una relación directa con este grupo poblacional (desde docentes y entrenadores hasta líderes religiosos y personal de salud).

Para el análisis de los resultados, se realizó una triangulación entre los datos recolectados mediante ambas técnicas y la bibliografía existente. En el documento se detallan los resultados por localidades, encontrándose algunas similitudes, como el aumento de conductas autolesivas, acoso escolar y ciberacoso, entre otras. Finalmente, se ofrecen recomendaciones para fortalecer la salud mental de la población adolescente y la intervención oportuna de la Red de Servicios del Fondo Costarricense de Seguridad Social, así como la participación interinstitucional y multidisciplinaria.

4.7 Informe anual de casos de suicidios del año 2024 y propuesta metodológica de análisis

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Diversas investigaciones científicas han evidenciado que el suicidio no puede ser comprendido únicamente desde una perspectiva clínica o psicopatológica. En cambio, se requiere un enfoque integral que considere los determinantes sociales de la salud, tal como lo propone el modelo de la Organización Mundial de la Salud (OMS).

Estudios realizados en América Latina han identificado factores estructurales como el rezago educativo, la desigualdad económica, el consumo de sustancias, y la exposición a violencia, como elementos que aumentan el riesgo de conducta suicida, especialmente en adolescentes y jóvenes. Estos factores actúan como determinantes intermedios y estructurales, influyendo en la salud mental y el bienestar emocional de las personas.
Otras investigaciones publicadas en revistas como Revista de Salud Pública y Revista de Psiquiatría y Salud Mental destacan que el suicidio debe abordarse desde una perspectiva multinivel, que incluya variables individuales, comunitarias y ecológicas. Se enfatiza que la privación social, el acceso desigual a servicios de salud mental, y el contexto geográfico son factores clave para entender las diferencias en las tasas de suicidio entre regiones y grupos poblacionales.

El estudio desde los determinantes es una oportunidad para generar conocimiento, el necesario para plantear intervenciones efectivas por lo que trascender del modelo clínico tradicional hacia una comprensión integral del suicido como fenómeno social, multifactorial y sobre todo prevenible desde la interdisciplinariedad, por lo tanto, con el objetivo de analizar la influencia de los determinantes de la salud en los casos de suicidio y los factores interinstitucionales en su abordaje técnico, se desarrolló un proceso de investigación mediante la revisión de bases de datos de muertes por este evento, reportados en Costa Rica en el 2024 con el fin de identificar patrones, factores de riesgo y posibles áreas de intervención en salud pública.

En el proceso de la investigación, se realiza un análisis de los datos enviados al Subproceso de Estadística de la Dirección de Planificación, del Poder Judicial la cual es la fuente de datos de donde con criterio técnico y de experto se seleccionaron las variables que se van a operacionalizar según las categorías de análisis seleccionadas (edad, estado civil, ocupación, entre otros)

Para ello, se ha seleccionado el software SPSS (Statistical Package for the Social Sciences) como herramienta principal para el procesamiento y análisis de los datos.

4.8 Identifying Types of Witnessed Suicides in Coroner & Medical Examiner Reports: Implications for Community Outreach

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Although witnessed suicides are relatively rare (e.g., roughly 4-10% of suicides), their impact on those who witness the death can be powerful and enduring. Previous research on this topic is minimal and inconsistent. Articulating features of witnessed suicides may contribute to identifying potential risk mitigation strategies, as research has indicated suicide exposure can increase one's own risk of suicide. The present study conducted a thematic analysis of witnessed suicides that occurred using de-identified coroner reports of suicide deaths (N=769) within an urban county in the Commonwealth of Kentucky in the U.S. from 2019-2024. Data included demographic data and the coroner's summary of circumstances surrounding the death. The research team developed a coding template to identify cases (n=245) involving someone present at the time of or immediately pre- or -post-death. Thematic analysis was used to identify and analyze patterns within the data. The team read through case narratives, generated initial codes, searched for patterns by groups of similar codes, and used group discussion to refine and define themes to increase trustworthiness of findings emerging from the data. Roughly one-third of all suicide deaths included a witness. Nearly half of these instances (46.5%) included a family member or friend as a direct audible or visible witness at the time of death (e.g., in the home and heard gunshot, visibly witnessed fatal attempt immediately following an argument). A smaller subset (23.6%) included family or friends finding the individual quickly after the attempt occurred, with 34.4% of those individuals providing direct aid to individuals (e.g., removing materials or from hanging, administering CPR). One-third of cases overall (33.5%) included family or friends engaging in a tense conversation or disagreement immediately preceding the fatal attempt. A small portion of cases (15.1%) occurred publicly and included multiple witnesses who did not know the deceased. Moreover, a small yet meaningful portion (11%) involved minors as a witness to the suicide death. Our study indicated both a wider variety and higher prevalence of witnessing compared to previous research. Findings have a range of implications for both policy and practice: States' policies vary on which agencies contact witnesses after a suicide death. Even counties within each state vary on which office (e.g., police, coroner's office, public health office) provides support for witnesses. Additional training is needed for each office on how to reduce stigma related to suicide and what postvention resources might be most applicable for witnesses.

Lightning #5, Cocorí 3, November 11, 2026, 8:30 AM - 10:00 AM

5.1 Escalando la prevención del suicidio en la comunidad: modelo nacional de formación en cascada de gatekeepers

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Antecedentes. El Programa Nacional de Prevención del Suicidio de Chile, dependiente del Ministerio de Salud, se cuenta entre las primeras iniciativas nacionales de prevención del suicidio lideradas por un gobierno a nivel mundial. Desde su creación, ha desarrollado progresivamente estrategias basadas en evidencia, alineadas con las recomendaciones de la OMS, integrando la intervención comunitaria como componente central de su enfoque de salud pública.
Una brecha crítica en la prevención del suicidio radica en la proporción significativa de personas en riesgo que nunca acceden a los servicios de salud mental. Las intervenciones comunitarias basadas en gatekeepers han demostrado su efectividad para reducir esta brecha, habilitando a actores no clínicos para detectar señales de alerta tempranas, entregar un primer apoyo y conectar a las personas con la atención que requieren. En 2024, el Programa puso en marcha un ambicioso plan nacional de formación en cascada para instalar duplas entrenadoras de gatekeepers certificadas en las 16 regiones del país, con alcance intersectorial que incluye organizaciones que trabajan con poblaciones en mayor exposición al riesgo suicida.
Modelo. La formación sigue una estructura de cascada en tres niveles: entrenadores nacionales certifican duplas entrenadoras institucionales, quienes posteriormente ejecutan entrenamientos de gatekeepers al interior de sus propias organizaciones, utilizando recursos institucionales existentes. El modelo de intervención adoptado es DAS (Detección, Apoyo y Seguridad), un enfoque basado en competencias desarrollado en Chile.

La certificación como entrenador requiere 24 horas presenciales e incluye el entrenamiento en competencias de gatekeeper más la metodología de facilitación. El modelo está diseñado para maximizar el alcance minimizando el gasto central, lo que lo hace especialmente pertinente en contextos de recursos limitados.
Resultados. Al cierre de diciembre de 2025, tras el primer año de implementación, se habían realizado 11 entrenamientos de entrenadores, certificando a 267 personas en 10 regiones e instituciones intersectoriales. Estos entrenadores certificados ejecutaron posteriormente 58 entrenamientos de gatekeepers, alcanzando a 1.212 personas certificadas. En la presentación se reportarán cifras actualizadas correspondientes a casi dos años de ejecución.
Discusión. El modelo en cascada demuestra que es posible construir capacidad comunitaria a escala nacional con un presupuesto central acotado, aprovechando el capital humano e institucional existente. Esta estrategia ofrece un modelo replicable y costo-eficiente para la prevención del suicidio a nivel nacional, especialmente relevante para países que buscan escalar programas comunitarios en contextos de recursos restringidos. La evaluación sistemática en curso permitirá el mejoramiento iterativo de la calidad de la implementación.

5.2 National suicide prevention strategies: evidence and challenges

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The public health approach to suicide prevention recognises the importance of maintaining a whole-of-government policy focus. In many countries, this focus is achieved through the planning and implementation of a national suicide prevention strategy (NSPS). Evidence on the outcomes associated with NSPSs is, however, both limited and inconsistent. We therefore conducted a comprehensive narrative review, identifying 26 studies that provide quantitative data on changes in the incidence of suicidal behaviour associated with the introduction of a NSPS. We find that reductions in suicide rates were observed in several countries, but there were also countries where there was no change or even an increase in the suicide rate. Multiple studies of the same NSPS and multiple iterations of a NSPS within the same country produce discrepant findings. In addition, there are differences in research design and risk of bias between studies. We highlight several methodological limitations identified in the course of our review, including threats to both internal and external validity, linked to the non-recognition of the NSPS as a 'complex' intervention. We also propose a realist approach to evaluation as the keystone of a mixed-methods, multi-level research design for NSPS evaluation studies that does justice to the characteristics and complexity of the phenomenon under investigation.

5.3 Selecting National Metrics for Suicide Prevention: A Consensus-Based Approach to Monitoring Progress in Suicide Prevention in the United States

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Background:
The U.S. National Strategy for Suicide Prevention calls for ongoing monitoring and evaluation of implementation progress. As part of this effort, the National Action Alliance for Suicide Prevention's Hope Counts team was tasked with identifying a focused set of national indicators capable of tracking progress toward implementation of the National Strategy. A key challenge was balancing comprehensiveness with feasibility while ensuring selected measures would support accountability, quality improvement, and public reporting.
Methods:
Hope Counts developed a structured metric selection process grounded in the National Strategy Evaluation Framework. The process combined a "top-down" review of the National Strategy's theory of change with a "bottom-up" environmental scan of existing data systems, literature, and expert recommendations. Candidate

measures were mapped to strategic priorities and reviewed for data availability, methodological quality, and implementation considerations. Multidisciplinary expert panels participated in a series of facilitated consensus-building sessions. Metrics were evaluated using predefined criteria, including applicability, validity, actionability, feasibility, understandability, timeliness, comparability, and reliability. The process was piloted within Strategic Direction #2 of the National Strategy, which focuses on healthcare and crisis systems. Candidate indicators were organized into three domains: Care Practices, Context and Tracking, and Coverage and Reach.
Results:
The metric selection process produced a prioritized set of candidate indicators for monitoring national progress on National Strategy progress in healthcare and crisis, as well as a parallel set of measurement gaps requiring future investment. Findings illustrate how expert consensus can be used to narrow a large universe of potential indicators into a manageable set suitable for national reporting while maintaining alignment with strategic objectives. Results also highlight areas where data infrastructure and standardization remain insufficient for comprehensive monitoring.
Conclusions:
Developing meaningful national indicators for suicide prevention requires more than identifying available data; it requires a transparent process for determining which measures best reflect progress, guide action, and support accountability. This presentation describes a replicable methodology for metric selection that may inform suicide prevention monitoring efforts in other countries and large-scale public health initiatives seeking to translate complex strategies into measurable outcomes.

5.4 Una Alianza Pais por la Poblacion Adolescente: Acciones de Promocion, Prevencion Y Articulacion Para La Prevencion Del Suicidio.

Tres iniciativas, un mismo propósito.

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Tres iniciativas, un mismo propósito: fortalecer la promoción de la salud mental y la prevención del comportamiento suicida en la población adolescente mediante la articulación interinstitucional, la sensibilización y el fortalecimiento de factores protectores.

1. Evento masivo con Nick Vujicic — "Vivir con esperanza"

Encuentro de más de 5.000 personas adolescentes y jóvenes, centrada en la esperanza, la resiliencia, el afrontamiento de la adversidad y la búsqueda de ayuda, en un encuentro con Nick Vujicic, una experiencia de promoción de la salud mental que, mediante la articulación interinstitucional y estrategias de alto impacto.

2. Cineforo "Entre Voces y Silencios"

Presentación de una metodología innovadora que utiliza el cortometraje El color rojo como herramienta para facilitar la reflexión sobre salud mental en la adolescencia. La experiencia integra un panel interdisciplinario, la participación de adolescentes y mensajes de esperanza para abordar el sufrimiento emocional, los factores de riesgo y protección, y la prevención del comportamiento suicida desde una perspectiva participativa e intersectorial.

3. Campaña interinstitucional e intergremial de prevención del suicidio en adolescentes

Estrategia nacional de comunicación y sensibilización desarrollada mediante un modelo de articulación interinstitucional e intergremial, en el que instituciones públicas, colegios profesionales, organizaciones no gubernamentales especializadas y el Ministerio de Educación Pública aportan, desde sus competencias y experiencia, al diseño e implementación de acciones dirigidas a promover la salud mental, desmitificar creencias, fomentar la búsqueda de ayuda y fortalecer los factores protectores en la población adolescente.

5.5 Beyond the Call: Quantifying the Economic Value of Arizona's Integrated Suicide and Crisis Response System

Mr. Justin Chase[1]
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Behavioral health crisis systems are commonly evaluated through access, speed, and clinical performance measures, yet policymakers increasingly require evidence that these services also reduce avoidable public

expenditures. This presentation examines the economic impact of Arizona's integrated crisis response infrastructure operated by Solari Crisis & Human Services, including the Arizona Crisis Line and 988 contact center, 911 diversion, crisis care coordination, and mobile crisis dispatch.

Rounds Consulting Group conducted an independent economic impact and return-on-investment analysis using fiscal year 2025 operational data. The analysis estimated the value generated when crisis specialists resolve or de-escalate behavioral health emergencies and connect individuals to appropriate community-based care rather than defaulting to higher-cost interventions. Estimated benefits included avoided emergency department utilization, inpatient psychiatric hospitalization, law enforcement response, and other healthcare and public safety costs. The study also considered the broader statewide economic activity supported by crisis system operations.

The analysis found that Arizona's crisis response infrastructure generated approximately $109.4 million in direct healthcare and public safety cost avoidance during fiscal year 2025. When broader economic and fiscal effects were included, the estimated total statewide value reached $111.9 million. Compared with the cost of operating the crisis system, this represented an estimated return of $4.39 for every dollar invested. These findings demonstrate that crisis lines create value beyond the immediate contact. Their greatest impact emerges when they function as the clinical and operational hub of a coordinated continuum capable of resolving crises by telephone, diverting calls from 911, activating mobile teams, and facilitating timely access to appropriate services.

The presentation will translate the economic findings into practical lessons for suicide prevention leaders across the Pan American region. First, crisis contact centers should be viewed as essential healthcare infrastructure rather than isolated call-taking programs. Second, system value depends on integration with emergency communications, mobile response, healthcare providers, and community services. Third, return-on-investment analysis can strengthen the case for sustainable public funding by connecting clinical outcomes with the priorities of government, healthcare, and public safety decision-makers. Finally, economic estimates should complement, not replace, measures of safety, equity, experience, and recovery.

Arizona's experience suggests that investing in an integrated crisis continuum is both a suicide prevention strategy and a responsible use of public resources. Quantifying that value can help communities move beyond short-term funding debates toward sustained investment in accessible, person-centered crisis care. This evidence offers a framework for jurisdictions demonstrating impact while designing locally responsive, sustainable crisis systems.

5.6 Suicide rates across occupational groups in Denmark: A nationwide population-based study

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Background
Workplace settings constitute a relevant venue for reaching out to individuals at risk of suicide. Therefore, it is important to have information on suicide in different occupational groups. The aims of this study were to examine suicide rates by occupational groups, including trends over time, suicide methods, and proportions of those dying who has had contact with psychiatric services.

Methods
We applied a cohort design to national data on all Danish residents aged 18-74 years during 1991—2023. Individual-level, yearly data on 72 occupational and related groups were linked to data on suicide deaths. Adjusted incidence rate ratios (aIRRs) were estimated using Poisson regression models with primary school teachers as a reference.

Results

Over 116 million person-years, 16 989 suicides were recorded. Elevated aIRRs were found for early retirees (3.0, 95% CI 2.8-3.2), fishermen (2.9, 95% CI 2.7-3.1), veterinarians (2.0, 95% CI 1.9-2.0), medical doctors (1.8, 95% CI 1.8-1.8), and other manual workers (2.2, 95% CI 2.2-2.3). Over time, suicide rates declined among medical doctors and disability pension recipients amongst others, whereas an increase was found for university teachers. Poisoning was more often used for suicide by healthcare professionals and veterinarians, whereas firearms was a more common suicide method among farmers, police and military service members. Among farmers, 25% had had lifetime contact with psychiatric services prior to suicide, compared with 54% in the full sample of those who died by suicide.

Conclusion
Elevated suicide rates were identified for certain occupational and related groups although rates had decreased in recent decades. Contributing factors may be access to occupational-related specific means used for suicide and lack of contact with psychiatric services. Preventive efforts might include means restriction and improving mental health literacy. As well as other occupation-specific measures.

5.7 Partnerships for Life in the Americas: Findings and Recommendations from a Situational Analysis 2022-2026

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Background: Suicide prevention across the Americas is characterized by substantial diversity in legislation, service delivery, cultural contexts, and available resources. While many countries are advancing national mental health and suicide prevention initiatives, opportunities to share implementation experiences and identify common regional priorities remain limited. This situational analysis was undertaken as part of the Partnerships for Life initiative to understand current suicide prevention contexts across the Americas and identify opportunities for regional collaboration and capacity building.

Objectives: This presentation will (1) summarize the current policy and practice landscape for suicide prevention across participating countries in the Americas, (2) identify shared strengths and implementation challenges across diverse national contexts, and (3) present priorities for regional knowledge exchange identified by partners.

Methods: A situational analysis was conducted involving suicide prevention leaders, clinicians, researchers, policymakers, and community partners from countries across North America, Central America and the Caribbean, and South America. Data were collected through structured interviews, collaborative discussions, and document reviews of national legislation, mental health policies, suicide prevention strategies, and publicly available reports. Country-specific findings were synthesized to identify common themes while preserving contextual differences.

Key findings: Despite marked variation in health systems and policy infrastructure, partners consistently identified several shared priorities. Many countries have established or are developing mental health legislation; however, translating policy into practice remains a common challenge due to funding constraints, workforce shortages, political instability, fragmented implementation, and limited evaluation mechanisms. Stigma surrounding mental health and suicide continues to influence help-seeking, public awareness, and political prioritization, although many partners observed increasing openness among younger generations. Participants also emphasized the importance of culturally responsive approaches, community leadership, involvement of people with lived and living experience, improved surveillance systems, and stronger intersectoral collaboration. Across countries, there was widespread interest in strengthening regional partnerships to exchange practical implementation strategies rather than developing solutions in isolation.

Conclusions: Although countries across the Americas differ substantially in their social, political, and cultural contexts, many face remarkably similar implementation challenges. This situational analysis highlights the value of regional collaboration as a mechanism for accelerating suicide prevention efforts through shared learning, capacity building, and mutual support. The presentation will conclude with practical recommendations

generated collaboratively by regional partners to inform future policy development, implementation, and international cooperation throughout the Americas.

5.8 AI Chatbots as Drivers of Change in Crisis Service Referral Pathways

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Background: Crisis services have long served as a safety net for young people in distress, but the paths that lead youth to that safety net are shifting. General-purpose chatbots, including ChatGPT, Gemini, Character.AI, and Claude, have become a routine part of daily life for many teens and young adults, and a growing number of these chatbots now refer users toward crisis services when chatbot conversations turn toward self-harm or suicidal ideation. Crisis line staff and volunteers often encounter these referrals without a clear sense of what happened in the preceding conversation. Crisis services need to understand this pathway now, before caseloads and staffing models are built around an outdated picture of how people arrive.
Objectives: In the United States, Crisis Text Line has had over 1.7 million conversations with youth under age 25 in the past decade, in English and in Spanish. We use this broad national dataset to examine how chatbot interactions in youth are shaping referral pathways and identify common themes in chatbot-referred crisis conversations.
Methods: We examined responses to an optional post-conversation survey from 2025-2026. We also used natural language processing to identify and characterize mentions of chatbots within crisis conversations themselves, including how texters described their prior chatbot use.
Results: Eighteen percent of texters under 25 reported that a general-purpose chatbot referred them to Crisis Text Line. Texters who mentioned chatbots in their conversations often named the chatbot as their referral source, and many described using it as an ongoing source of emotional support.
Conclusions: Chatbot referrals are no longer a marginal intake pathway; they are a fast-growing and largely unplanned addition to the crisis response system. Chatbot providers have added referral procedures as a safety guardrail, but that guardrail places new demand directly on crisis lines already operating at capacity. We suggest that this shifting dynamic calls for new forms of partnership between crisis services and chatbot providers in order to meet this growing need effectively.

Lightning #6, Cocorí 4, November 11, 2026, 8:30 AM - 10:00 AM

6.1 Play Your Way to Prevention: Using Play to Strengthen Protective Factors for Suicide Prevention

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Suicide prevention requires more than responding to moments of crisis; it also involves intentionally cultivating the protective factors that help individuals navigate stress, recover from adversity, and remain connected to themselves and others. While much of suicide prevention focuses appropriately on identifying and reducing risk, emerging research highlights the importance of strengthening emotional regulation, social connectedness, psychological flexibility, self-compassion, and a sense of belonging. Play offers a practical, evidence-informed avenue for fostering these protective factors across the lifespan.

This lightning talk introduces "Play Your Way to Prevention," an evidence-informed framework that integrates principles from trauma-informed care, nervous system regulation, sensory-based therapeutic approaches, embodied practices, and contemporary research on creativity and resilience. Rather than positioning play as an activity reserved for children, the presentation demonstrates how playful experiences can enhance emotional awareness, reduce stress, strengthen interpersonal relationships, and support overall psychological well-being in adults.

The presentation highlights four practical domains of playful engagement. Creating environments of safety through imaginative activities encourages reflection on personal boundaries and emotional security. Gentle movement and body-awareness practices help participants recognize physiological signs of stress while

promoting nervous system regulation. Sensory-based self-care strategies provide accessible tools for grounding and emotional regulation that individuals can integrate into daily routines. Finally, collaborative games foster positive social interaction, shared laughter, trust, and belonging, all of which are recognized protective factors associated with improved mental health and suicide prevention.

Although play alone is not a suicide prevention intervention, it can strengthen many of the capacities that reduce vulnerability and support recovery. By helping individuals experience moments of joy, connection, agency, and self-understanding, playful practices contribute to environments where hope can grow and where meaningful relationships are strengthened. These experiences can complement clinical care, workplace wellness initiatives, school-based prevention efforts, and community programming.

Attendees will leave with an understanding of the evidence supporting play as a wellness strategy, practical examples that can be adapted to diverse settings, and a new perspective on how cultivating curiosity, creativity, and connection can contribute to comprehensive suicide prevention efforts by strengthening protective factors before individuals reach crisis.

6.2 Un encuentro puede cambiarlo todo: el poder transformador de reunir a sobrevivientes de una pérdida por suicidio

Licda. Jackie Secades[1]
[1]Independent, , Costa Rica

La pérdida de una persona cercana por suicidio tiene el potencial de generar un profundo aislamiento en quien la vive. Los períodos de retraimiento propios del duelo se ven acentuados por una decisión muchas veces consciente de abstraerse del entorno para no experimentar cuestionamientos y señalamientos. Si a este contexto hostil, se agrega el hecho de que una importante cantidad de personas supervivientes ingresa a sus procesos de duelo en medio del absoluto desconocimiento sobre el fenómeno del suicidio, las culpas y el malestar afloran con mayor intensidad. Se genera entonces una sensación de que quienes le rodean, no pueden comprender su pérdida, por lo cual debe explicarse y/o justificarse a cada paso; así pues, el aislamiento se convierte en una forma de auto-protección. Desafortunadamente, lo único que puede resultar de esta desvinculación del entorno, en medio de tanto malestar, es una mayor vulnerabilidad a la salud mental.
El aislamiento como protección es una estrategia a la cual se llega como resultado del dolor pero no anula la necesidad de contención y acompañamiento de los supervivientes. Ante esta realidad, la posibilidad de interactuar con otras personas que han vivido una pérdida similar, en un entorno emocionalmente seguro, se convierte usualmente en una experiencia profundamente significativa.
Esta presentación explorará el potencial transformador de los encuentros entre sobrevivientes de pérdida por suicidio, como una estrategia comunitaria de posvención. A partir de más de 15 años de experiencia en la creación y facilitación de espacios para supervivientes en Costa Rica, México y otros países latinoamericanos, tanto en formato presencial como virtual, se compartirán apreciaciones derivadas de las interacciones que resultan cuando los supervivientes comparten espacio.
La exposición se centrará en enumerar y brevemente desarrollar los principales hallazgos o beneficios que los supervivientes reconocen tras la participación en una actividad creada exclusivamente para ellos(as). Por mencionar algunos: visibilización, validación, psicoeducación, la posibilidad de apalabrar la experiencia, perspectiva del propio proceso, comunidad y esperanza.
La presentación también reconocerá que el estilo de participación de cada superviviente varía. Sin importar cómo cada quien lo viva, es incuestionable que un encuentro cuidadosamente creado, deja en los supervivientes algo que trasciende el rato compartido y se convierte en una semilla que puede dar frutos positivos a futuro.
Se busca contribuir a la colaboración regional destacando el potencial de estos espacios como una estrategia de posvención accesible y significativa.

6.3 No basta con reunirlos: diseñando espacios emocionalmente seguros para sobrevivientes de pérdida por suicidio

Licda. Jackie Secades[1]
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Reunir a sobrevivientes de pérdida por suicidio puede ofrecer oportunidades significativas de visibilización, validación, aprendizaje, pertenencia y esperanza. No obstante, para que así sea, deben tenerse mucho más que buenas intenciones pues éstos son duelos complejos y potencialmente traumáticos. No se puede dar por sentada la seguridad emocional del espacio, sino que se requiere una planificación intencional que considere no solamente las necesidades de los participantes, sino la anticipación de aquellas que se puedan suscitar sobre la marcha.
Esta presentación compartirá aprendizajes derivados de más de 15 años en la organización de encuentros y actividades para sobrevivientes de pérdida por suicidio en Costa Rica, México y otros países del continente, tanto en modalidad presencial como virtual. El objetivo es enumerar los principales elementos que deben estar presentes en el diseño de un espacio que permita a los supervivientes conectarse sin perder de vista su resguardo emocional.
Se presentará un modelo de encuentro que integra diferentes componentes complementarios. En primera instancia es vital transmitir que la creación del espacio es exclusiva para sobrevivientes de pérdida por suicidio, de manera tal que no sea necesario explicar aspectos medulares de la experiencia. Por otra parte, la presencia de un equipo de profesionales de la salud mental, idealmente con conocimientos en posvención, es indispensable no solamente para contener sino también para ampliar el rango de modalidades de trabajo que se puedan desarrollar. Si entre el equipo de trabajo hay supervivientes, aún mayor conexión con los participantes. En cuanto al desarrollo del encuentro, es vital incluir la psicoeducación en temas de suicidio y también de duelo, que ayuda a normalizar ciertos aspectos, así como la profundización de otros temas de interés posibilita ampliar la perspectiva de los asistentes. Se procura mantener la conversación a un nivel general en los espacios con mayor cantidad de participantes, guardando para los espacios en subgrupos la posibilidad de profundizar y compartir la propia experiencia. Finalmente, la memorialización reconoce la importancia de mantener un vínculo significativo con la persona fallecida, honrando su vida más allá de su causa de muerte.
Cabe mencionar que la seguridad emocional no debe convertirse en una solemnidad permanente. Especialmente en el contexto latinoamericano, la calidez, la espontaneidad y la posibilidad de reír también pueden constituir formas legítimas de conexión y regulación emocional.
Se requiere entonces, construir una experiencia cuidadosamente diseñada, y culturalmente sensible.

6.4 The Protective Capital Index: A Recovery—Informed, Strengths-Based Alternative for Community Suicide Protection and Prevention

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Suicide prevention practice remains dominated by risk assessment—instruments that catalogue vulnerability, pathology, and deficit. An established parallel field, addiction recovery, has spent three decades building "recovery capital"—a strengths-based framework quantifying personal, social, environmental, and cultural resources, operationalized through instruments such as the Assessment of Recovery Capital (ARC) and Recovery Capital Index (RCI). Recovery capital's measurement lineage is addiction-specific, but its broader philosophical corollary is the mental health recovery model itself (Anthony, 1993; SAMHSA, 2012), which defines recovery as a self-directed, non-linear, strengths-based process explicitly positioned against the medical/pathology model—the same model that continues to anchor most suicide risk assessment and crisis response. No equivalent unified instrument exists translating either lineage into suicide protective factors, despite decades of validated but fragmented tools: Linehan's Reasons for Living Inventory, Luthans' Psychological Capital Questionnaire (HERO: hope, efficacy, resilience, optimism), and interpersonal-theory-derived belongingness and connectedness measures.
This presentation proposes the Protective Capital Index (PCI), a trauma-informed, strengths-based instrument organized around four domains directly paralleling recovery capital: personal, social, environmental, and cultural protective capital. Each domain's subscales are theoretically anchored in empirically validated constructs already established in the suicide and positive-psychology literature, rather than adapted verbatim from existing copyrighted scales.
Development follows a two-phase pipeline. Phase 1 uses secondary meta-analytic data—published subscale correlation matrices from RFL, PsyCap, MSPSS, and recovery capital instruments—to empirically test whether a four-domain (or bifactor) structure is statistically defensible before any original item is written. Phase 2 involves original item generation keyed to the identified constructs, followed by pilot factor analysis and

convergent/discriminant validation against the source instruments using total scores rather than items, preserving intellectual property while establishing construct validity.
The PCI's relevance to regional collaboration is direct: peer support specialists, crisis workforce trainers, and public behavioral health systems currently lack a shared, positively framed metric to complement—rather than replace—clinical risk formulation. A validated protective capital measure could standardize how community-based and lived-experience programs demonstrate impact, support funding narratives grounded in resilience rather than pathology, and create a common outcome language across peer-delivered interventions operating throughout the region.
This session will present the conceptual model, the evidence gaps driving its design, and an invitation for regional partners and researchers to collaborate on Phase 1 validation.

6.5 Comunidades por la Vida y para la Paz: Modelo Interinstitucional y Comunitario de Prevención del Suicidio desde Espacios Ciudadanos

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1. Introducción y Justificación Tras la crisis por COVID-19, se incrementó el riesgo suicida en Costa Rica. Ante esto, la Asociación DÜO articuló el proyecto "Comunidades por la Vida y para la Paz", asumiendo la prevención como responsabilidad compartida. Respaldado como de interés cantonal en San Ramón y alineado a la Ley Nacional de Salud Mental No. 10412, el modelo vincula de forma inédita la salud mental comunitaria con los Métodos de Resolución Alterna de Conflictos (RAC) de VICEPAZ, promoviendo la cultura de paz como factor protector primario frente al sufrimiento psíquico.
2. Objetivos
General: Desarrollar y transferir herramientas prácticas para la detección temprana, contención, acompañamiento y derivación del riesgo suicida mediante el empoderamiento comunitario e institucional.
Específicos: Generar capacidades técnicas interdisciplinarias en profesionales regionales y consolidar redes de primera respuesta ciudadana para construir entornos seguros.
3. Metodología y Modelo de Ejecución El programa opera desde 2022 con un enfoque mixto y participativo en dos vertientes:
Modalidad Profesional (40 horas): Dirigida a sectores públicos y privados (educación, salud, gobiernos locales). Fusiona el programa "Gestores de Paz" de VICEPAZ con herramientas avanzadas de intervención en crisis y suicidología comunitaria (20 horas teóricas y 20 horas prácticas de codiseño de proyectos locales).
Modalidad Comunitaria: Talleres ciudadanos prácticos (sesiones de 2 horas) sobre diagnóstico participativo, comunicación no violenta, primeros auxilios psicológicos, derribo de mitos y mapeo local de riesgos.
Resultados y Logros Desde 2022, se evidencia un alto impacto en la región de Occidente:
Cuantitativo: Certificación de 100 profesionales mediante cuatro procesos (San Ramón, Grecia y un piloto latinoamericano) y capacitación de 75 líderes comunitarios en contención básica y rutas de derivación.
Cualitativo: Activación de redes de apoyo locales, reducción del estigma institucional y salvamento de vidas mediante canalizaciones oportunas.
Conclusiones y Relevancia Panamericana El modelo demuestra que la prevención del suicidio es efectiva cuando trasciende el ámbito clínico e integra la mediación social. Esta estrategia de salud pública, que articula efectivamente a ONG, Gobierno y Academia, es un modelo sostenible, replicable y escalable para la región panamericana.

6.6 The Relationship between Water Advisories and Suicide: A Coronial Analysis in Ontario, Canada from 2006-2021

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Introduction: Canada is recognized for its abundant freshwater resources; nevertheless, many Indigenous communities lack reliable access to clean drinking water because of longstanding infrastructure and governance challenges. Water advisories and their ancillary consequences may contribute to chronic stress, disrupt daily

life, and undermine community well-being; however, their relationship with suicide mortality remains underexplored. This study examined the association between water advisory exposure and suicide mortality within First Nations reserve communities in Ontario from 2006-2021.
Methods: We conducted a retrospective longitudinal ecological study using reserve- and settlement-related Census Sub-Divisions (CSD)-years as the unit of analysis. First Nations-related suicide deaths were identified through the Office of the Chief Coroner of Ontario, and residential postal codes were assigned to CSDs using the Postal Code Conversion File Plus. Water advisory locations were mapped to CSDs using QGIS and Statistics Canada's 2021 CSD boundary file. Annual exposures included any advisory, number of advisory days, and long-term advisory. Population-averaged generalized estimating equation Poisson models used annual CSD population as a log offset, clustered observations by CSDs, and adjusted for a linear time trend. A fixed-effect Poisson model was conducted as a sensitivity analysis to examine the effect of water advisory over time within CSDs.
Results: The analyses included 1,872 CSD-year observations across 117 CSDs and 163 suicide deaths. In the primary model, years with any drinking water advisory had significantly higher suicide rates than years without an advisory (b = 0.57, SE = 0.29, Wald = 3.93, p = 0.047). The corresponding rate ratio was 1.77, indicating that suicide rates were 77% higher in advisory than non-advisory years, after adjustment for population and temporal trend. Longer advisory duration was also associated with higher suicide rates (b = 0.00167, SE = 0.00085, Wald = 3.84, p = 0.05). The association between long-term advisory exposure and suicide rates was not statistically significant (b = 0.5259, SE = 0.31, Wald = 2.85, p = 0.091). The sensitivity analysis revealed a positive but not statistically significant relationship (RR=1.53, 95% CI [0.80, 2.93], p=.196).
Discussion: Drinking water advisory exposure was associated with higher suicide mortality across reserve-related CSDs, although the within-CSD sensitivity analysis was inconclusive. While there are limitations such as sparse outcome data and possible underidentification of First Nation suicides, policymakers should prioritize investment and partnership with First Nations communities to ensure reliable access to safe drinking water, and prompt further research on the mental health consequences of water insecurity.

6.7 CUIDA-FAM: Acceptability and Feasibility of a School-Based Parental Intervention for Adolescent Suicide Prevention in Chile: A Pilot Cluster Randomised Controlled Trial

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Learning objective: Describe the rationale, development, and preliminary evaluation of a parental intervention designed to complement school-based adolescent suicide prevention.
Background: School-based interventions provide an opportunity to reach adolescents with suicidal ideation, including those who do not seek professional help. Reframe-IT+, a blended cognitive behavioural intervention, has demonstrated effectiveness in reducing adolescent suicidal ideation and has been found acceptable, feasible, and safe. However, its effect on suicidal ideation attenuated at the 10-month follow-up and did not reach statistical significance (p = .06), highlighting the need to strengthen the maintenance of treatment effects. Parents and caregivers may contribute to this goal by supporting adolescents in applying therapeutic skills in everyday situations. Family communication, perceived parental support, and collaborative problem solving are relevant targets, while caregivers may themselves need support to recognise warning signs, respond to emotional distress, and regain confidence in their parenting. Interventions drawing on cognitive behavioural and dialectical behaviour therapy principles offer strategies to address these needs. However, evidence on parental interventions delivered alongside indicated adolescent interventions in educational settings remains limited. CUIDA-FAM was therefore developed to strengthen caregivers' capacity to support adolescents receiving Reframe-IT+ and potentially sustain reductions in suicidal ideation.
Method: CUIDA-FAM was developed in Chile during 2025 through focus groups with mothers of adolescents with suicidal ideation who participated in the previous Reframe-IT+ trial, a literature review, and expert consultation. It comprises five asynchronous online sessions and three facilitated face-to-face sessions addressing family safety planning, adolescent development, recognition of warning signs, communication, emotional validation, and collaborative problem solving.
A pilot cluster randomised controlled trial is being conducted in 2026. Schools are allocated to an intervention condition, in which students receive Reframe-IT+ and their parents or caregivers receive CUIDA-FAM, or a control condition, in which students receive Reframe-IT+ alone. Primary outcomes are the acceptability and feasibility of parental intervention. Feasibility indicators include recruitment, retention, session attendance, and assessment completion. Questionnaires and interviews assess perceived usefulness, satisfaction, and participants' experiences. Secondary caregiver outcomes include parenting self-efficacy, family functioning,

and problem-solving skills. Secondary student outcomes include suicidal ideation, depressive and anxiety symptoms, and emotion regulation skills.
Results: Preliminary findings on acceptability and feasibility will be presented.
Discussion: Findings will inform refinements to CUIDA-FAM and the design of the subsequent cluster randomised controlled trial, scheduled for 2027, which will evaluate whether adding the parental intervention to Reframe-IT+ improves and sustains reductions in adolescent suicidal ideation.

