again, according to a structured interview (if feasible). Alternatively, the person no longer meets the definition of remission/recovery (i.e., the person again scores 13 or above on the (C)Y-BOCS plus CGI-I rating of 6 ("much worse") or higher for at least one month, or needs to be withdrawn prematurely from the trial before one month has elapsed due to a severe worsening of OCD symptoms. Discontinuation of the trial due to reasons other than worsening in OCD symptoms (e.g. suicide risk) is not considered a relapse.

Two comments are worth adding. First, in Round 1, to consider a patient a treatment responder or remitter, many experts (56% and 58%, respectively) thought that sustained improvement should be present for at least one month. However, this proposed duration clashes with the (C)Y-BOCS, which asks about symptoms during the "previous week". In addition, response has been defined in most prior OCD trials at the end of treatment. In Round 2, despite explicating this, only 64% and 46% of experts agreed with the proposal of "at least one week" for the duration of response and remission, respectively. To accommodate this disagreement in the field, the duration for response and remission above allows for "at least one week" and we recommend additional follow-up assessments where possible to assess whether response/remission status has been maintained over longer periods.

Second, to judge that a patient relapsed, many experts (Round 1: 48%; Round 2: 87%) thought that worsening of symptoms should be present for at least one month to protect against transient flares in symptoms. However, some patients acutely deteriorate and require immediate clinical intervention[12]. For this reason, the relapse definition above indicates that patients who need to be removed from treatment protocols before one month because of worsening of OCD symptoms should also be considered to have relapsed.

In summary, agreement was reached on how to define response, remission, recovery and relapse across a range of international professionals with expertise in OCD. We recommend that researchers report their results using these definitions whenever possible. As outlined by Frank et al[6], doing so will lead to: a) improved design, interpretation and comparison of clinical trials of various modalities; b) improved communication of research findings between professionals and to the general public; c) improved guidelines for evaluation of clinical efficacy of various treatments by regulatory agencies; and d) development of improved treatment guidelines for clinical practice.

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Sustaining Individual Placement and Support (IPS) services: the IPS Learning Community

Worldwide, the deficiencies in community mental health services are well known: despite the development of many evidence-based practices, few clients with severe mental illness actually receive effective, recovery-oriented services[1]. Evidence-based practices are often implemented poorly and rarely endure beyond initial enthusiasm and grant funding. We examined two-year sustainment rates for a network of programs implementing Individual Placement and Support (IPS), an evidence-based practice to help people achieve competitive employment[2]. IPS is spreading in the U.S. and internationally[3], including in Europe, Australia, Asia, and North America. Yet, long-term continuation of these services has been uncertain.

Because multiple factors influence a program's long-term survival, a comprehensive international learning community has been developed to ensure sustainability of IPS. Beginning in the U.S. in 2001, the Dartmouth Psychiatric Research Center and the Johnson & Johnson Office of Corporate Contributions partnered to develop a multifaceted program to strengthen state and local infrastructures to promote access to IPS through broad dissemination, high-quality implementation, and long-term sustainment. After starting as a small demonstration in three states, the program has evolved internationally into a network of 19 states and 3 European countries known as the IPS Learning Community[4].

Historically, the term *learning collaborative* has been used to define a network of organizations with a shared goal of improving treatment for a specific medical condition, facilitated by regular communication and collection and dissemination of

objective information about procedures and outcomes, typically over a few months[5]. The IPS group adopted the term *learning community* to signify their long-term commitment to quality and intention to expand to other states and countries. The term differentiates our approach from time-limited quality-improvement learning collaboratives, such as those sponsored by the Institute for Healthcare Improvement[6].

The IPS Learning Community has encompassed a two-tiered, decentralized approach. In the U.S., Dartmouth trainers and researchers bring together state leaders and help them to build a viable infrastructure for implementing and sustaining IPS services within their states[4]. For international partners, regional administrators are the counterparts to these state leaders. In each state, the leadership team establishes liaisons with the two key state agencies responsible for employment services (i.e., mental health and vocational rehabilitation) and one or more state trainers. State leaders create parallel learning communities consisting of IPS programs within their states.

As part of their participation in the learning community, state leaders collect and submit employment outcome data for IPS programs within their states; Dartmouth analyzes and distributes the data back to the states[7]. State trainers conduct periodic fidelity reviews of both new and established IPS programs, using a validated fidelity scale[8]. Fidelity reviews evaluate the quality of program implementation. IPS programs are considered active participants once they begin submitting outcome reports, typically about nine months after start-up.

Altogether 157 programs joined the IPS Learning Community in the U.S. from its inception until 2012. However, we had not systematically tracked how long programs continued to provide IPS services after joining the learning community, or the rate of discontinuing programs. We therefore conducted a prospective study to determine the two-year sustainment rate of participating sites in the U.S.. We operationally defined sustainment as follows: a program is *sustained* if it continues to employ staff, maintains an active client caseload, and provides direct services.

We identified all programs participating in the learning community in the U.S. as of January 2012. The sample, consisting of 129 sites in 13 states, had participated in the learning community on average for 4.5 years (SD = 2.7, median = 3.9). Two years later we contacted these sites to determine which were still providing IPS services. A total of 124 sites (96%) were sustained over the 2-year period. This sustainment rate is higher than the 80% rate over a two-year period after the termination of the formal implementation phase in a national study of 49 sites implementing a new evidence-based practice[9], and also exceeds the 76% two-year rate in an evaluation of 33 demonstration projects[10].

Statistics on sustainability of evidence-based practices are rarely published. Many studies make it clear, however, that enthusiasm for an innovative program model often fades over time[11]. Funding initiatives targeting specific program models often spawn growth, followed by rapid dissolution when a state-sponsored funding ends. For example, over a span of less than a decade, one state experienced a cycle of rapid growth followed by a collapse of services for an evidence-based practice when the targeted funding for this program was abruptly curtailed[12]. To our knowledge, no one has examined the empirical literature on sustainment to establish benchmarks for target rates for sustaining programs over time.

Bolstering the case for sustainability in the IPS learning community, the 124 sustaining sites had been in existence for an average of 4.5 years at the inception of the study. In other words, taking into account the arbitrary start date for the 2012 interviews, the total length of time for sustaining IPS services was substantially longer, on average 6.5 years. The number of sites still active in 2014 represent 79% of the entire group of 157 programs joining the community over its 13 years of existence, further documenting the role of the learning community in helping to sustain a practice.

Throughout Europe, Australia, and the U.S., program leaders are developing regional and national learning communities of IPS programs. Another ambitious example, in an early stage of development, is an international network of advocates for IPS services in early intervention programs for first episode psychosis[13]. In the U.S., one state recently launched a statewide IPS initiative modeled after the IPS Learning Community. This initiative includes a technical assistance center that provides training and monitors fidelity and employment outcomes. Its initial employment outcomes have been similar to those in the national learning community[14]. It also established a dedicated IPS funding mechanism, which has contributed to the rapid growth of IPS services. By the end of 2014, 59 (69%) of 86 eligible programs had joined the initiative.

Sustainability of evidence-based practices appears to be enhanced through the mechanism of a learning community. Originating in the U.S., the IPS Learning Community is now spreading internationally, with preliminary reports that the concepts transfer readily to other cultures and service systems. The learning community approach has been relatively untested with other evidence-based practices, but its basic concepts are promising. The field needs controlled studies of long-term learning communities in comparison with usual methods. Replications are needed before drawing firm conclusions.

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Suicidal ideation and suicide attempts in Greece during the economic crisis: an update

The current financial crisis has exerted untoward effects on the mental health of the population worldwide, in the form of increasing prevalence rates of affective disorders and suicide[1]. Greece is among the countries most severely hit by the crisis and has thus attracted global attention with regard to the social and health-related repercussions of the economic downturn. In particular, throughout the years of recession, unemployment rates rocketed from 7.8% in 2008 to 9.6% in 2009, 12.7% in 2010, 17.9% in 2011, 24.5% in 2012, 27.5% in 2013 and 26.5% in 2014[2]. At the same time, the proportion of the population at risk of poverty or social exclusion rose from 28.1% in 2008 to 35.7% in 2013 and 36% in 2014[3].

Nonetheless, the impact of the recession on suicides has been a highly contentious issue in the country. Recently, a 30-year interrupted time series analysis on the influence of austerity- and prosperity-related events on suicide rates in the period 1983-2012 found a rise in total suicides by 35.7% after the introduction of new austerity measures in June 2011[4]. In a similar vein, another ecological study reported an increase in suicides by 35% between 2010 and 2012, with unemployment bearing a strong correlation with suicide mortality especially among working age men[5].

A series of nationwide surveys conducted by our research team has arrived at similar conclusions, confirming a significant rise in the one-month prevalence of suicidal ideation (from 5.2% in 2009 to 6.7% in 2011) as well as suicide attempt (from 1.1% in 2009 to 1.5% in 2011)[6]. In the same report, people suffering from major depression, married individuals, people experiencing financial strain, people with low levels of interpersonal trust and individuals with a history of suicide attempt were at elevated odds of manifesting suicidality symptoms[6].

In this frame, another cross-sectional study was implemented in 2013 in order to monitor the impact of the recession on suicidality as well as to identify at-risk population subgroups. A random and representative sample of 2,188 people participated in the study. Information about the occurrence of major depression, suicidal ideation and suicidal attempt during the past month was assessed with the pertinent modules of the Structured Clinical Interview for DSM-IV Axis Disorders[7]. Participants' degree of economic hardship was measured by the Index of Personal Economic Distress[8], while their levels of interpersonal trust was assessed by the germane questions of the European Social Survey[9].

Comparative results from surveys demonstrate that one-month prevalence of suicidal ideation has declined in 2013: 2.4% in 2008, 5.2% in 2009, 6.7% in 2011 and 2.6% in 2013 ($p<0.05$). Similar findings were observed for one-month prevalence of suicidal attempt: 0.6% in 2008, 1.1% in 2009, 1.5% in 2011 and 0.9% in 2013 ($p<0.05$).

Regarding the risk and protective factors for suicidality, a different pattern of results emerges for suicidal ideation and suicidal attempt. The presence of major depression (adjusted OR = 12.35, 95% CI: 6.34-24.08, $p<0.01$), a previous suicide attempt (adjusted OR = 5.54, 95% CI: 2.19-14.00, $p<0.01$), unemployment (adjusted OR = 2.55, 95% CI: 1.04-4.34, $p<0.05$) and economic hardship (adjusted OR = 1.07, 95% CI: 1.01-1.14, $p<0.05$) were found to increase the odds of manifesting suicidal thoughts. With regard to suicide attempt, the presence of major depression remained the strongest risk factor (adjusted OR = 8.02, 95% CI: 2.67-24.14, $p<0.01$), followed by previous suicide attempt (adjusted OR = 5.22, 95% CI: 1.44-18.94, $p<0.05$) and low levels of interpersonal trust (adjusted OR = 3.84, 95% CI: 1.17-5.81, $p<0.05$).

From the above-mentioned results, it is clear that the prevalence of suicidal ideation and suicidal attempt has returned to pre-crisis levels in Greece. This is consistent with the view that suicidal acts may reflect an acute response to an economic crisis[10], as evidenced by the surge in suicides after the outset of the recession in South Korea in 1998 and their subsequent decline[11].

Concerning the risk factors for suicidal ideation and attempt, the differences illustrate the multifaceted nature of suicidality, which is better conceptualized as lying on a spectrum from ideation to act, with different factors playing a prominent role in each step of the spectrum. The presence of major depression and previous suicide attempt increase the odds of manifesting suicidality symptoms throughout the whole spectrum, in line with other studies corroborating their strength of association[12], even amid recession.

Although suicidality rates have decreased in Greece, depression is still on the rise[13] and the socio-economic climate in the country remains unstable. There is imperative need for tailored public health interventions, including labour market and debt relief programmes, as well as for enhancing the social capital of the population[14]. From the clinical standpoint, timely screening of suicidal history and suicidal symptoms, effective