Preventing Suicide…, It's What People Do

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A model for change…

- Why will a community act?
- When will it act?
- What tools does it need?
- Who needs to be trained to do what?
- What can it expect if successful?

Questions to think about during my remarks…

- Does education and training matter?
- Does patient safety matter?
- If a loved one becomes suicidal tomorrow, who are you going call in your community?

Fundamentals

- 4 Cornerstones for a community model
- 5 Simple truths about suicidal people
- 3 Questions every community must ask

Theoretical Assumption #1

All communities care about human life and will go to great lengths to prevent and mitigate the human suffering that precipitates suicidal behavior and the agony and pain survivors experience in its aftermath.

Theoretical Assumption #2

Once communities are equipped with specific knowledge, training, skills, and leadership, efforts to reduce suicidal behavior will be successful.

US Air Force Ecological Approach – (more later)

Theoretical Assumption #3

Public health awareness efforts, gatekeeper training, and enhanced skills training across the full spectrum community first responders, health professionals, courts, and others in contact with suicidal people can dramatically lower the risk that an identified community member will attempt suicide.

Theoretical Assumption #4

By building shared community responsibility, and individual and group competence, to identify, assess, manage and treat suicidal members of the community, communities can define themselves as caring, confident and competent in the prevention of suicidal behaviors among their members.

Ask yourself

Is my city, town, village a safe place for people who become suicidal?

Simple truths about suicidal people…

What we know should guide what we do…

Tag line: “Closing the gap between what we know and what we do.”

Simple truth #1: Suicide is *Not* a Mystery

Suicidal behaviors are not rare…
Suicide is understandable…
Suicide makes sense to the suicidal person….
Suicide is not a crime
Suicide is not a sin

Suicide is the final solution to the experience of unbearable psychological pain which the sufferer believes is unending… Relieve this pain just a little, and the person will live.

Simple truth # 2

Those who are most at risk for suicide are the *least* likely to ask for help.

Thus, we must find our at-risk fellow citizens and help them where they are.

If we require them to ask for help, they will continue to die.

Simple truth #3

The person most likely to prevent you from dying by suicide is *someone you already know*.

Thus, those around us must know what to do if we become suicidal.

Simple truth #4

When we solve the problems people kill themselves to solve, the reasons for suicide disappear.

Thus, compassionate crisis intervention, problem resolution, and treatment will save lives.

Simple truth #5

Prior to making a suicide attempt, those in a suicide crisis are likely to send warning signs of their distress and suicidal intent to those around them.

Thus, learning these warning signs and taking quick, bold action during these windows of opportunity can save lives.

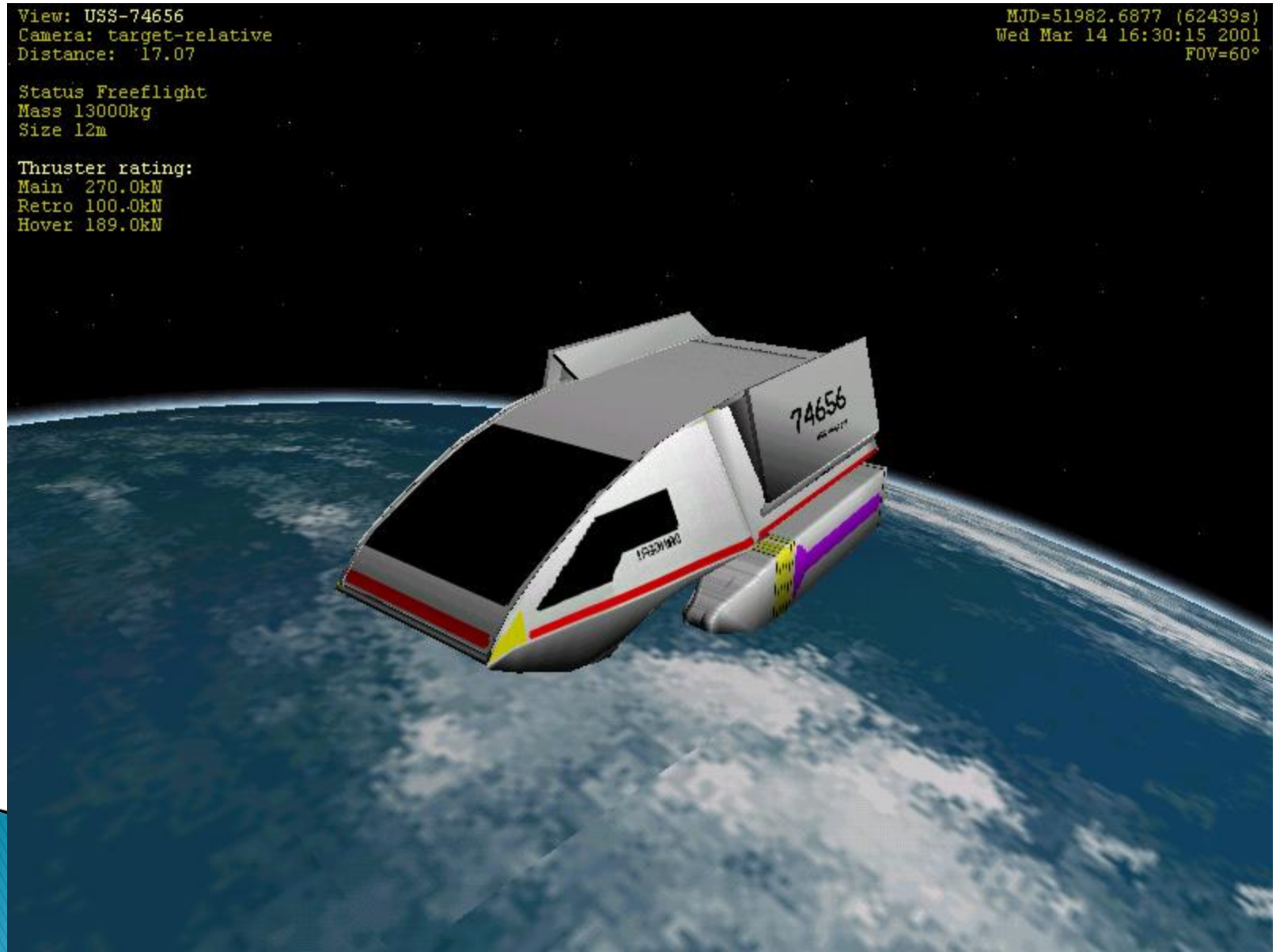
Points to consider

- Suicide prevention is too important to be left to government
- The pain to motivate change is at the family, community, and county level, not at the top of government (although support and technical advise is invaluable)
- Suicide prevention must begin in the communities most affected by these deaths

Hopi Elder advice…

"It is time to speak your truth, create your community and do not look outside yourself for the leader. We are the ones we've been waiting for."

Houston, we have a problem...



Wrong assumption…

Once a suicidal person is identified and referred for care to his or her doctor, or to a mental health professional, they should not kill themselves.

Today…

If suicide is preventable, then “Why did my brother die after I brought him to you for care?”

Today: 31% of suicide victims die in the care of a MH Professional

Suicide risk assessment training in current curriculum?

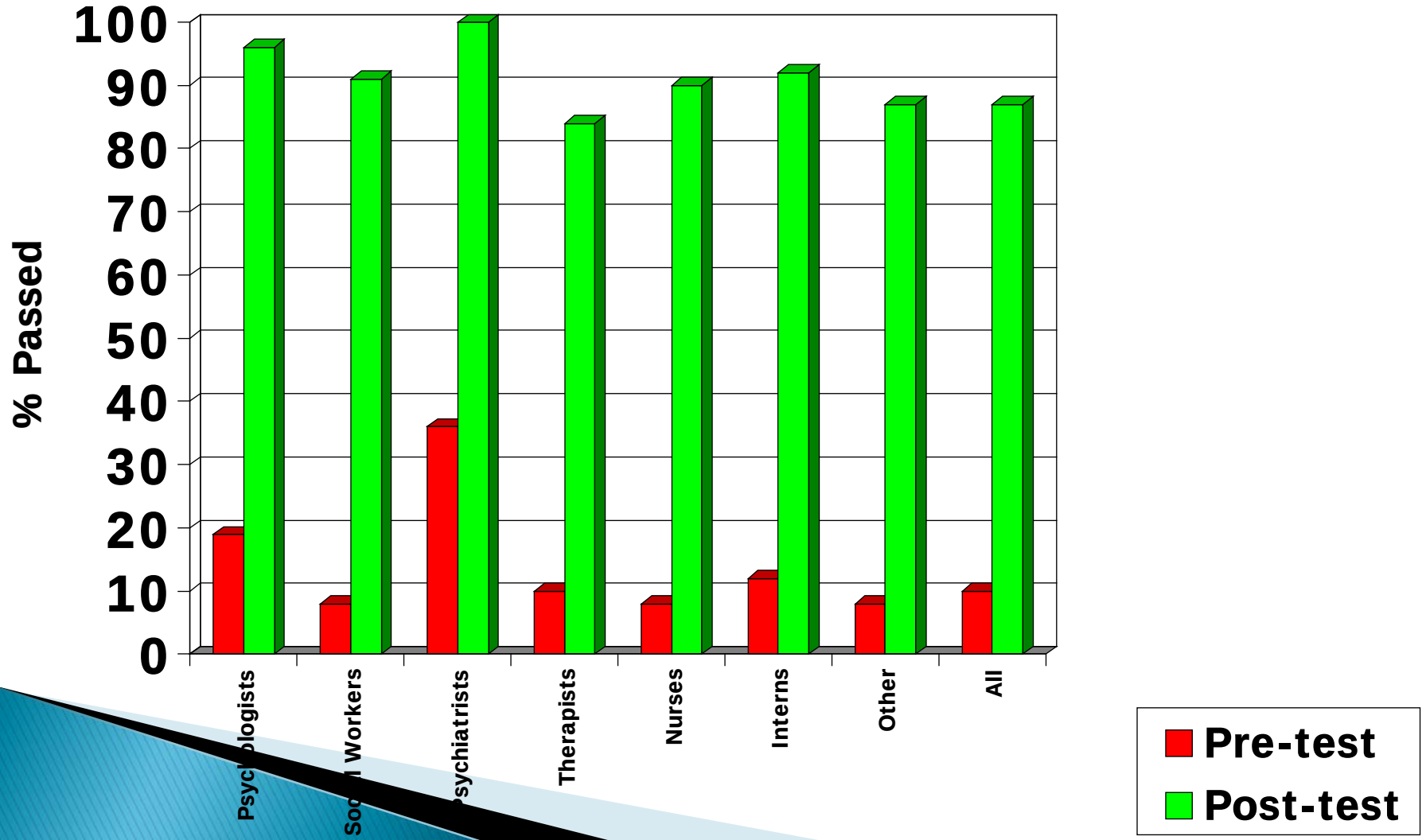
- Social Workers = 25% (<4 hours)
- Marriage and Family Counselors= 6%
- Accredited counselors = 2%
- Psychologists = 50% (poor)
- Psychiatrists = 94% (but not enough)

- US national surveys (it may be different in Ireland)

Community competence…

Requires advanced training in the detection, assessment, treatment and management of suicidal people identified by the gatekeepers you train…

Nationally standardized exam results: Pre-post Pass-fail rates by profession…



2013 emergent new goal for health care providers?

ZERO SUICIDES

My testimony ….

- Suicidal people should not die while in the care of mental health professional, but they do.
- Suicide prevention training is not taught or required of health professionals
- 31to 39% of all suicide deaths occur in active care with a mental health professional.
- People should not die from untreated illnesses

Matt Adler Bill …

What communities can do…

- Train ordinary citizens
  - Train all first responders
    - Train all health professionals
      - Train all clergy
        - Train all schools

And many, many more…

Suicide warning signs…

The person you already know needs to know what a SWS is, how to clarify that you are in trouble, and what steps to take to prevent you from attempting to take your own life.

This person is a “gatekeeper” for you….

He or she “has your back” and will take steps to keep you safe….

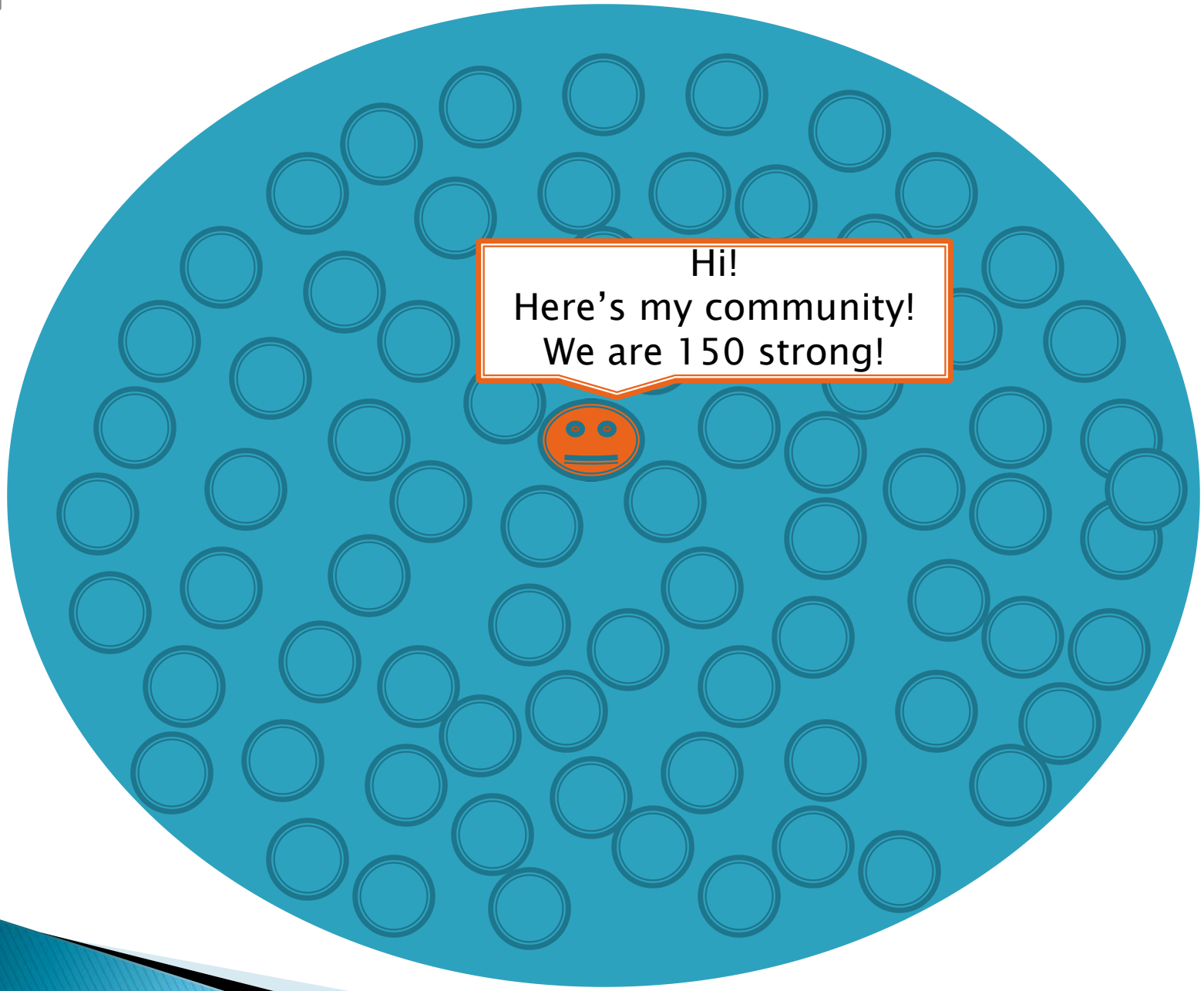
Having an out-of-hospital heart attack in the US?

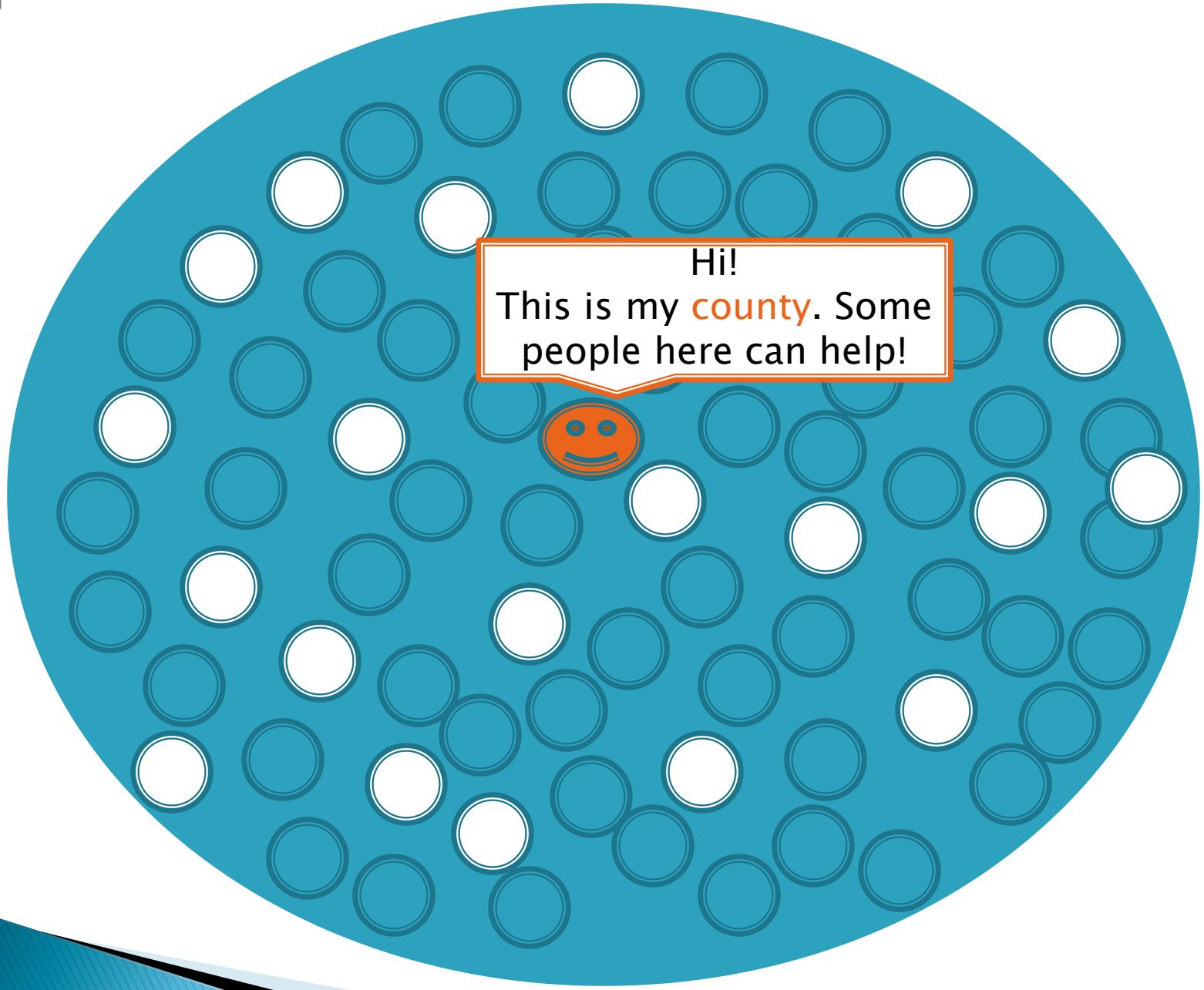
What city should you be in?

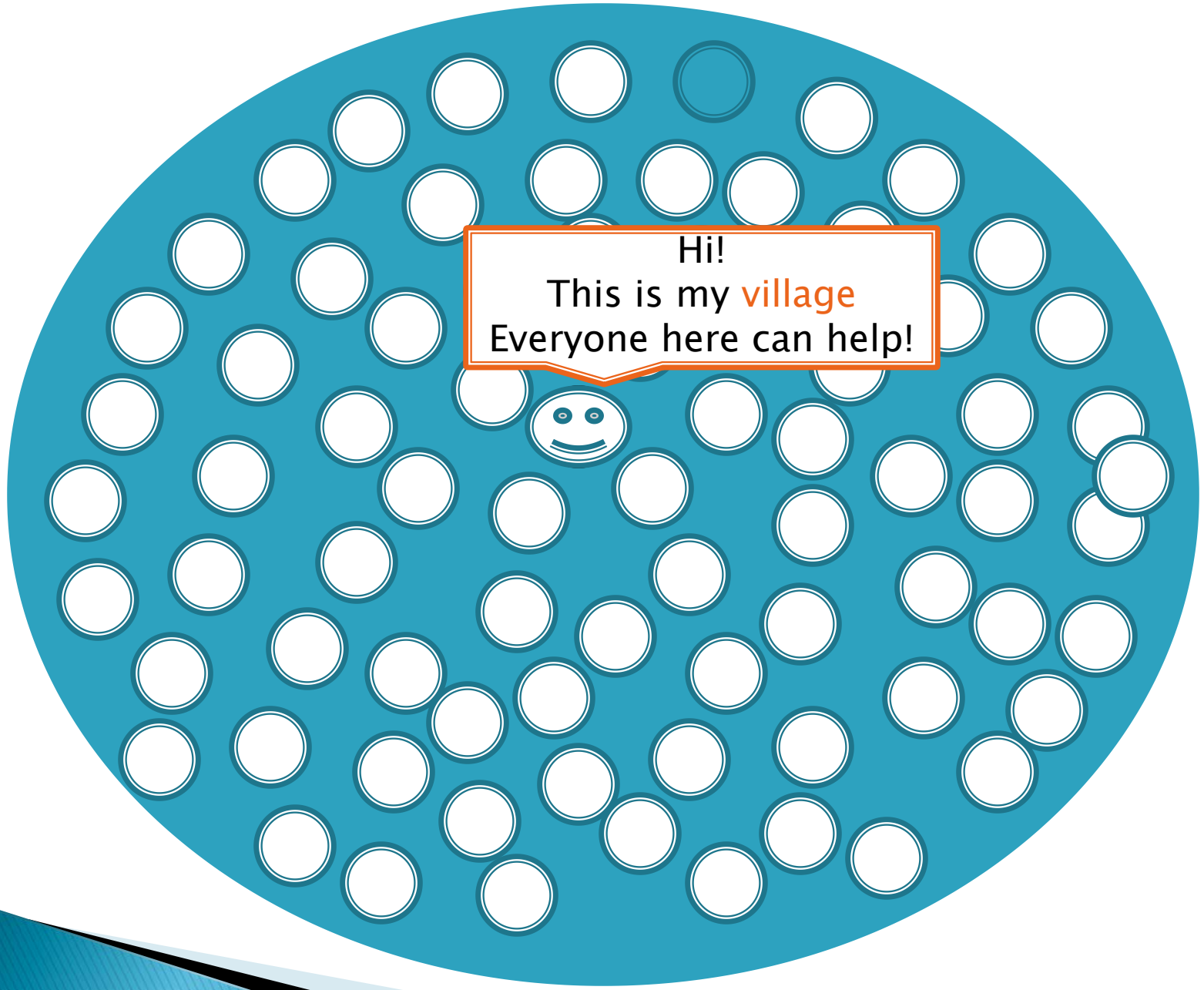
- Average US city = less than 10%
- Best city in the US = 52%
- Where is the very best place? = 70+%

Our aims…

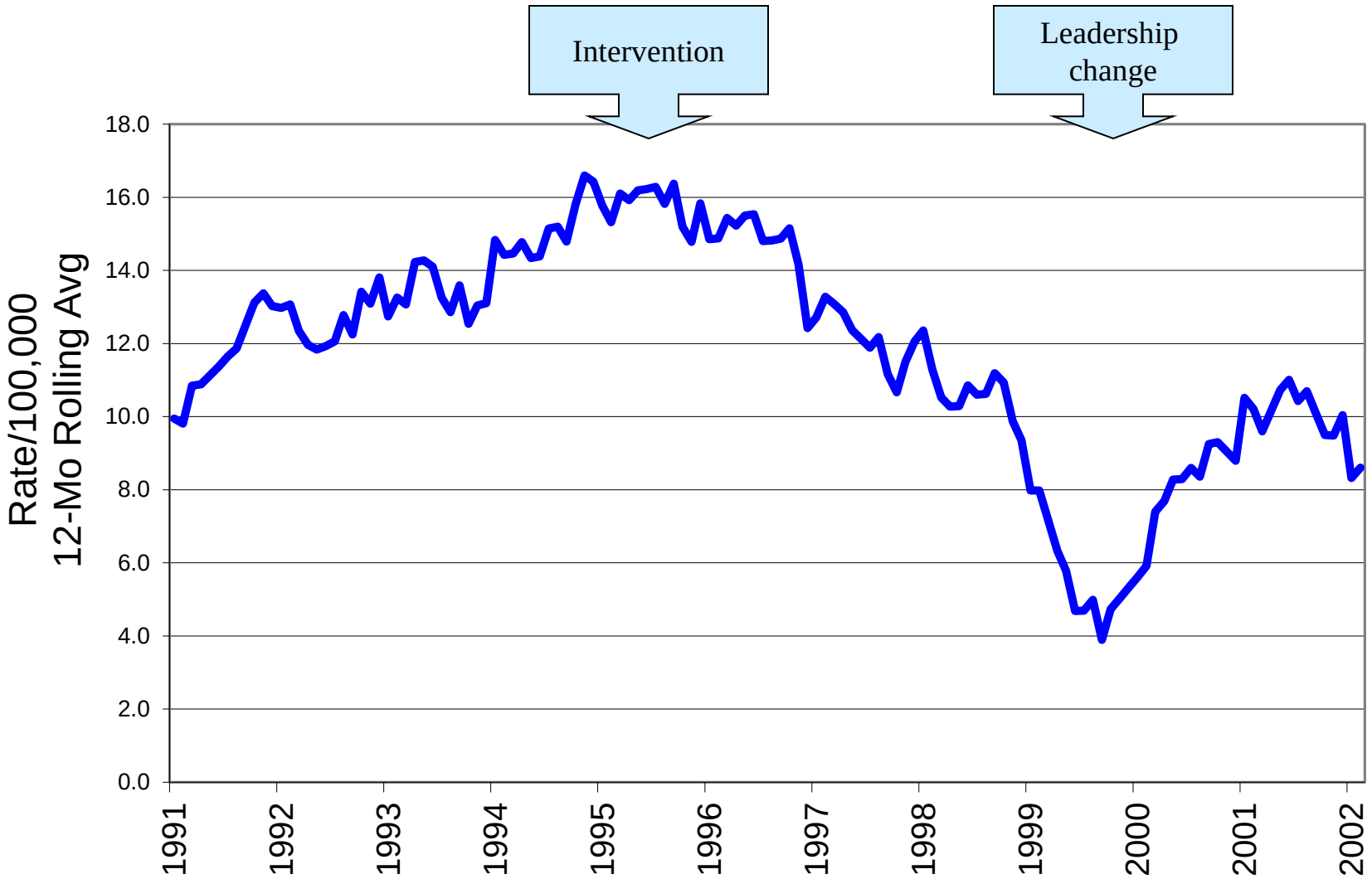
- Broad citizen training so that one person in every family has been trained in basic suicide prevention
- 6-8-hours of training for all public safety professionals
- Minimum of 3-4 hours of training for all school teachers and university faculty
- 8+hours of training for all healthcare providers, spiritual and religious leaders


Hi!
Here's my community!
We are 150 strong!


Hi!
This is my county. Some people here can help!


Hi!
This is my village
Everyone here can help!

Suicide Rate -- US Air Force Members 1990-2002



Evidence for the USAF program?

- 33% drop in suicides
- 51% drop in homicides
- 18% drop in accidental deaths
- 54% drop in severe domestic violence
- 30% drop in moderate domestic violence

As a Certified QPR Gatekeeper Instructor your first challenge?

To train enough of community members in your commnity to recognize and intervene with a sufficient number of suicidal persons to reduce suicide events by 50% in the next three years.

Your second challenge?

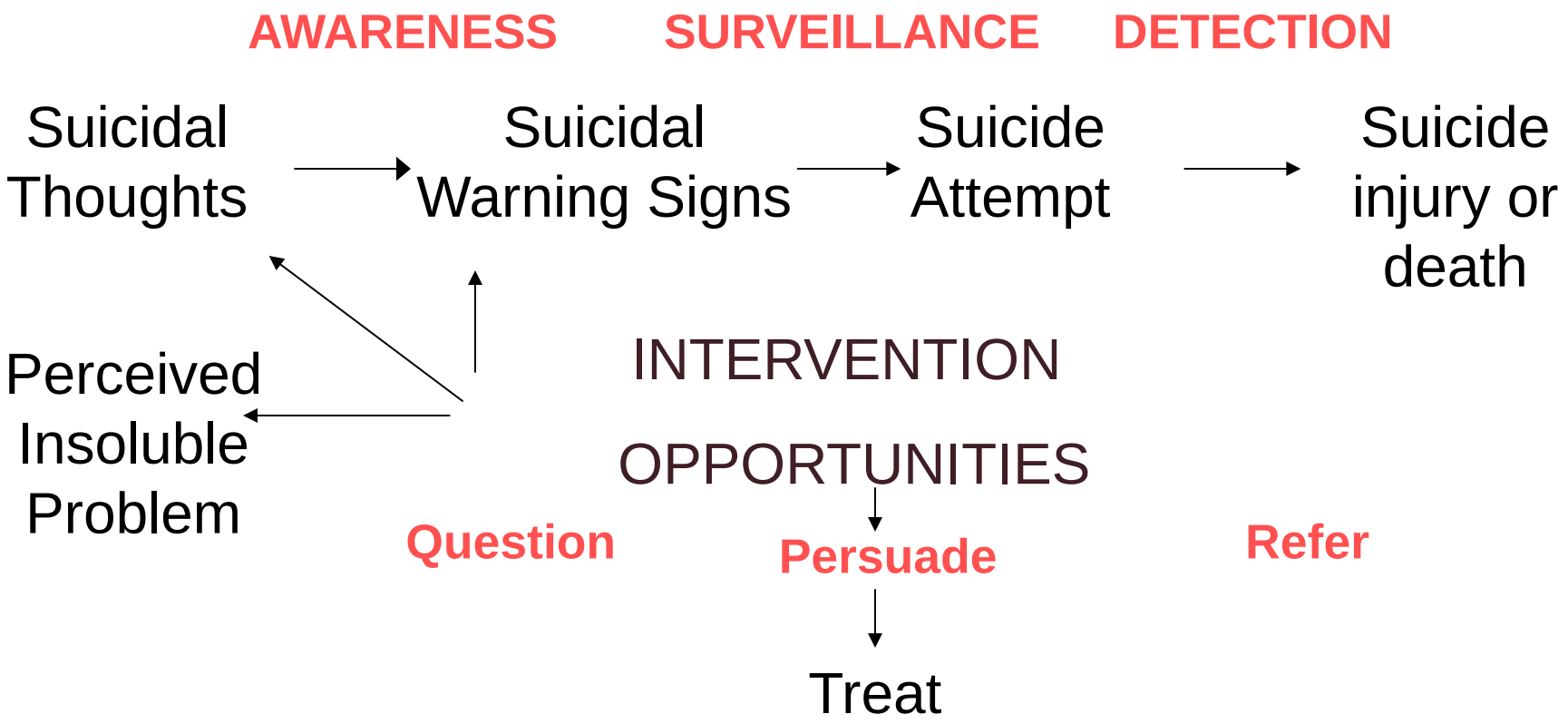
Sustain your first challenge and effort…

"How many children have died in a school fire in the past 30 years?"

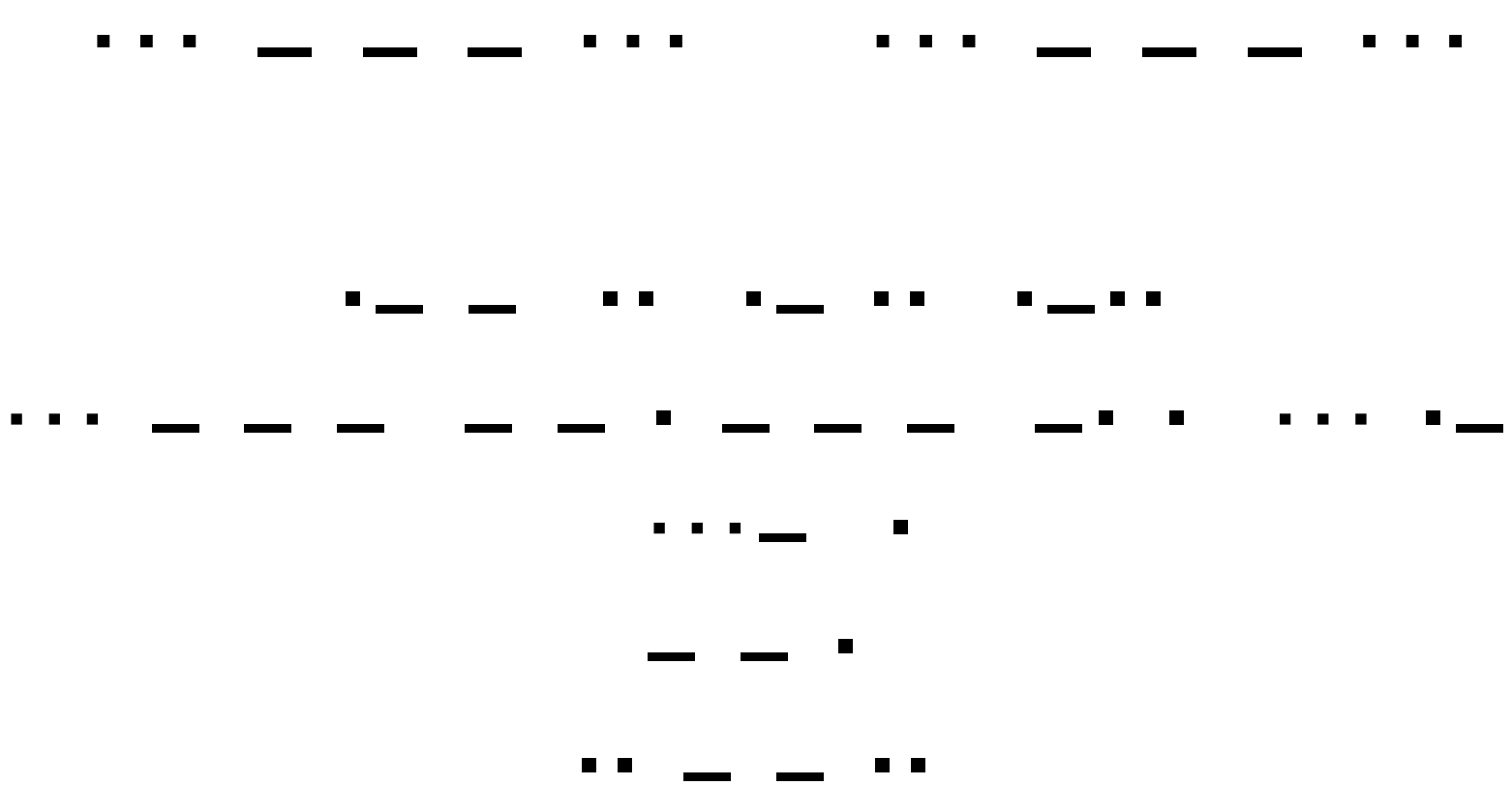
Why? Because the loss of a single child in a school fire is an unacceptable outcome for any community…

1958 Lady of the Angels School fire (93/3)

QPR PREVENTION STRATEGY



What is this person saying?



Rudd's 2006 SWS definition

- "A suicide warning sign is the earliest detectable sign that indicates heightened risk for suicide in the near-term (i.e., within minutes, hours, or days). A warning sign refers to some feature of the developing outcome of interest (suicide) rather than to a distant construct (e.g., risk factor) that predicts or may be casually related to suicide."

Which is a recognizable SWS?

Hopelessness?

“Don’t worry, when the going gets tough, the tough know what to do.”

“Is this enough medication to kill a person?”

“Don’t worry about me, I’ll be six feet under by Friday.”

Signal Detection Theory Applied

- SWS are not sent into a vacuum; they are heard and observed by those in the person's social network – or else why send them?

- SWS (distress signals) vary in signal strength:
  - Weak (2X2) = "It's no use going on."
  - Strong (5X5), "I'm going to kill myself tonight!"

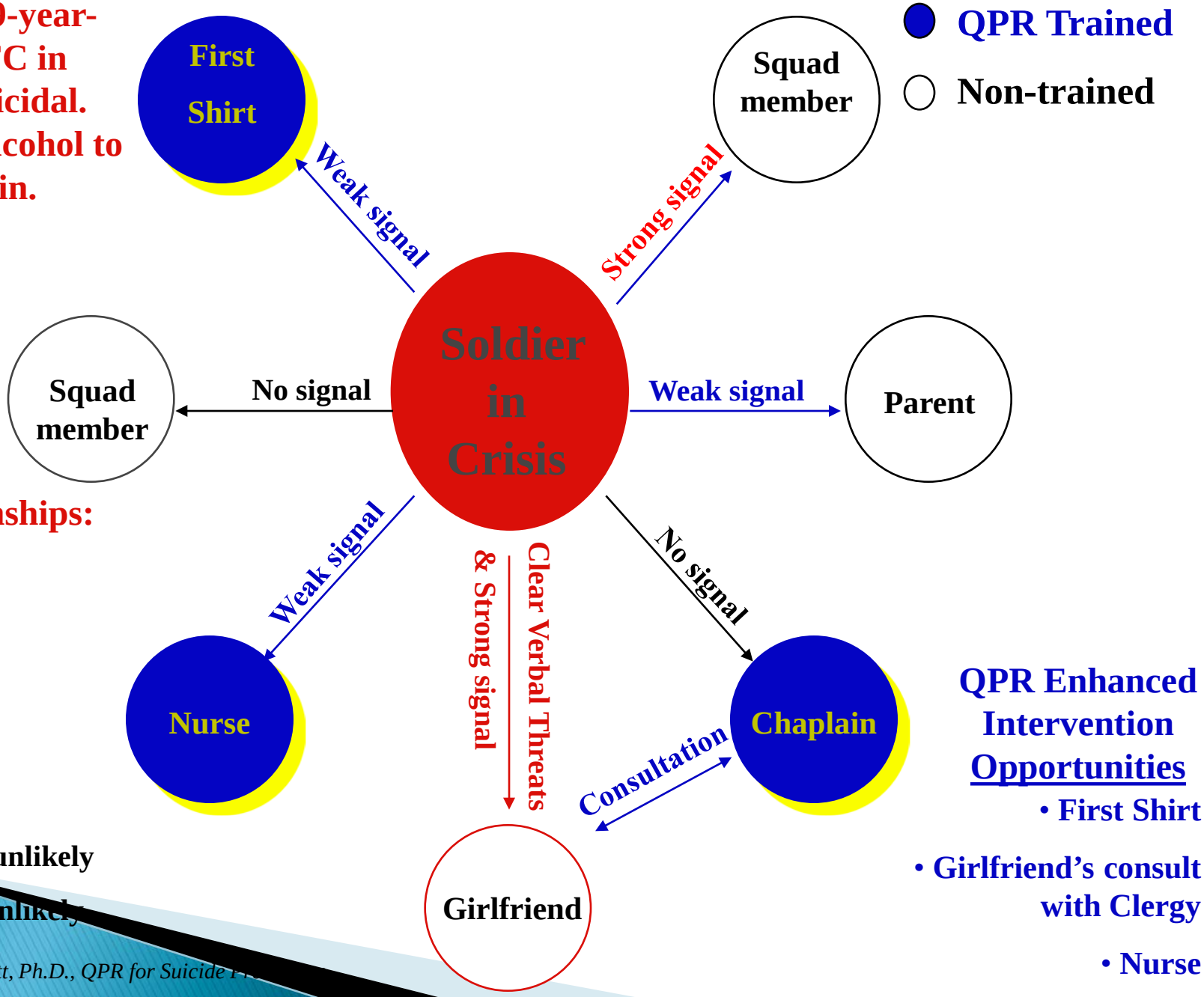
Because men are unlikely to ask for help, *all suicide warning signs at any strength level must be taken seriously by gatekeepers and acted upon immediately.*

QPR Detection Network

Diagram 2

Scenario:

Depressed 19-year-old single PFC in crisis and suicidal. Now using alcohol to cope with pain.



Note relationships:

Authority

Exchange

Communal

QPR Enhanced Intervention Opportunities

- **First Shirt**
- **Girlfriend's consult with Clergy**
- **Nurse**

- **Self-referral unlikely**
- **Hotline call unlikely**

Source: Paul Quinnett, Ph.D., QPR for Suicide Pr...

Everyone gets trained…

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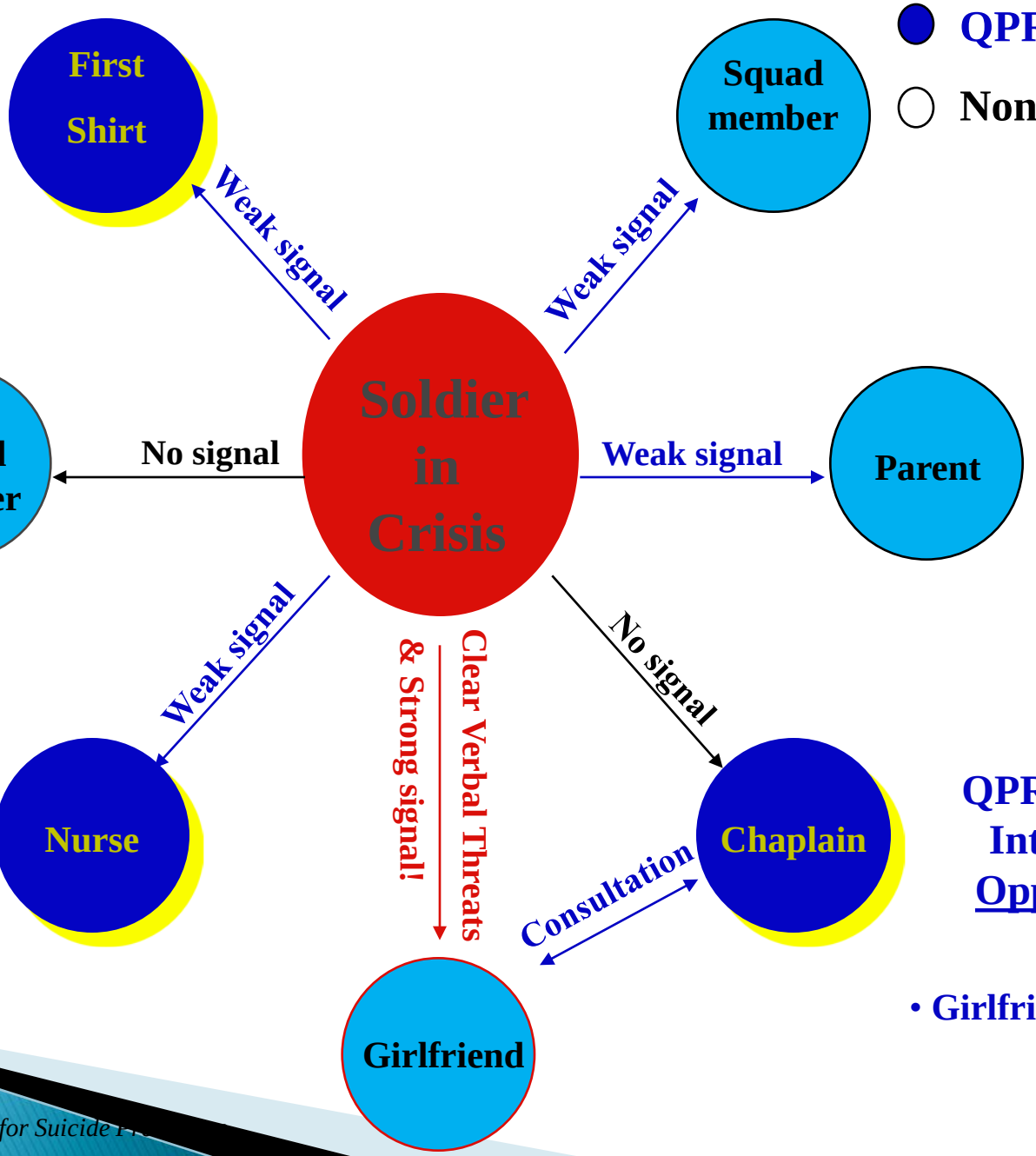

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Who should be trained? Army example

Who should be trained? 1,2,3 …

- 1. Traditional gatekeepers: nurse, clergy, mental health, a volunteer Buddy-to-Buddy soldiers (mandatory)

- Non-traditional gatekeepers: all squad members first shirts, base barbers, dentists, bartenders, dentists, pharmacists, etc. etc. (mandatory)

- *Anyone* identified by the soldier – best friend, family members, military or civilian (requested training)

Finally….

- We know the order of march
- We know *who* to train 1st, 2nd, and 3rd
- We know *what* to teach them (evidence)
- We know *where* to teach them (web/classroom)
- We have evidence that interventions work
- We have the measures to monitor our outcomes
- We have leadership -- all we need is a “go!”

I will leave you with this…

"The purpose of our lives is not see how well we can live, but if others live at all because of us."

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