Welcome to the QPR Gatekeeper Training Certification Course! The following readings are offered as background for your upcoming training and certification experience. Please review before the training day. Thank you.

PERSONAL EXPERIENCE WITH SUICIDE

Because suicidal behavior is such a common occurrence among human beings, it is possible that you, personally, may have seriously considered suicide at some time in your life, or perhaps even made a suicide attempt. Well, you are in good company. Many of our greatest contributors to mankind experienced, at one time or another, a serious suicidal crisis yet survived. The list includes the inventor Buckminster Fuller, the author William Styron, and President Abraham Lincoln, to name only a few. Having survived a suicide crisis can teach important lessons, lessons you may have the opportunity to share with other suicidal persons, your teacher, supervisor or other students taking this training program.

If you have had personal experience as a suicide survivor (lost a friend, loved one or family member to suicide), we wish you to understand that some portions of this course may be upsetting to you. If it is, we encourage you to discuss the matter with your teacher, supervisor, a therapist, rabbi, priest or pastor, or close personal advisor. You may also choose to not take this training at all, or take a break from time to time as you proceed through the training. The first order of business is to see to your own emotional needs.

We also wish to acknowledge all survivors of suicide (those who may have attempted suicide and lived and those who have lost a loved one to suicide) and to let you know that we are sensitive to your needs and situation. We hope to support your brave efforts to help others avoid the pain you have experienced. If you are recently bereaved, it may be too soon to learn to become a QPR Gatekeeper Instructor. Only you can decide when the time is right.

You may already have started down the road to healing and are on your way to recovery and helping others. If you are concerned about your emotional capacity for proceeding with this training, again, please see your teacher, supervisor, therapist or advisor.

PLEASE NOTE: The QPR Institute has an ongoing relationship with the National Hopeline Network and 1-800-SUICIDE. By special arrangement, hundreds of trained volunteers and professionals are standing by to take your call if you need help, either for yourself or someone you may be concerned about. They will offer immediate help, local resources and consultation for yourself or someone you know. All services are private and confidential.

Should you be actively considering suicide as you read this, we strongly recommend you let your loved ones know and seek immediate professional help. It is our belief that persons currently

experiencing suicidal thoughts or feelings should get help for themselves first, before they try to help others by teaching QPR.

Similarly, anyone who has very recently suffered the loss of a family member or loved one to suicide should seek counseling, grief support or, perhaps, help from a survivor of suicide support group. This suggestion is made with the welcome-to-return mat out. Survivors of suicide are some of the very best volunteers available anywhere.

A Brief History of Suicide Prevention

Here you will find a bit of history regarding suicide prevention. The goals of this reading are to help you:

- Articulate the role culture and societal expectations play in suicide
- Describe the dynamics associated with victim-precipitated suicide (homicide)
- Name three leading suicide prevention organizations

NOTE: Material for this reading was drawn from several sources, but primarily from George Colt Howe's *The Enigma of Suicide*, published by Touchstone Books (1992). We strongly recommend this book for an in-depth study of this subject. Unfortunately, the book has been out of print for several years, but it is on back order at this writing. It may be available through your local public or university library, or a used copy may be found on-line at www.bibliofind.com.

THE DISPUTE

Lo my name reeks
Lo, more than carrion smell
On summer days of burning sky…

Lo, my name reeks
Lo, more than that of a sturdy child
Who is said to belong to one
Who rejects him…

To whom shall I speak today?
Brothers are mean
One goes to strangers for affection…

To whom shall I speak today?
I am burdened with grief
For lack of an intimate…

Death is before me today
Like a sick man's recovery
Like going outdoors after confinement…

Death is before me today
Like a man's longing to see his home
When he has spent many years in captivity

The poem, *The Dispute*, may be the first suicide note ever discovered. It was written by an Egyptian man some 4,000 years ago and was translated from seven sheaves of papyrus found in an archaeological site. We do not know whether or not the author killed himself. The Dispute is actually an argument between a man and his "ba" or soul. A man divided, to live or die. He hates his isolation. His self-loathing is evident and he sees society around him as indifferent. He is overwhelmed by feelings of loneliness, hopelessness and despair.

This is the same interior desolation and journey that William Styron describes in his book *Darkness Visible*. Other suicidal individuals have written about the days and weeks of terror and despair they experience prior to making a suicide attempt or completion. The Dispute could just as easily have been written yesterday.

Note that in the last stanza the author writes "death is before me today, like a man's longing to see his home when he has spent many years in captivity." These lines underscore the view of the suicidal person that in death relief can be found. While we understand hopelessness is a major determinant of suicidal death, we also know that suicidal people hope that in death they will find relief from their unbearable suffering.

Since suffering is inherent in the human condition, and since suicide appears to have been with us since recorded history, this reading will provide a brief description of suicide in its historical and cultural context, ending with a snapshot of current suicide prevention efforts in America.

WHAT DO WE KNOW ABOUT SUICIDE IN ANCIENT TIMES?

From the time of our Egyptian poet's writing, we know there were no recorded religious or social prohibitions against suicide in Egypt. Written records from this time period suggest that times were bad; people were despairing and feeling hopeless. Suicide was common. In fact, suicide was so common it was written that the crocodiles along the Nile River were glutted with the corpses of despairing people who had drowned themselves.

Whether then or now, a culture's view of self-inflicted death appears to have a substantial relationship to its suicide rate. The following questions can be asked of any culture at any time down through that culture's history:

- Is suicide condemned?
- Is suicide legal?
- Is there a hostile reaction to suicidal persons, or only mild disapproval?
- Is suicide accepted or even approved for some, but not for others?
- Is suicide ever encouraged?
- Is suicide viewed as a sin, a crime, a response to social or economic conditions, or even in some cases as an act of altruism or heroics?

While a complete historical review is not possible here, consider that in pre-Christian Scandinavia, suicide guaranteed you a place in Viking paradise. Similarly, to many in the Roman Empire, suicide proved you were a glorious example of wisdom (you knew what to do when it

needed doing). In feudal Japan, disemboweling oneself to save face was a mark of honor for a man of principle. The pantheon of Japanese heroes down through history includes many suicides. Other examples from the past reflect the Christian condemnation of suicide. In 15th Century Metz, suicides were crammed in barrels and sent down the river. In strongly Catholic 17th Century France, suicides were hanged upside down, dragged through the streets or thrown on the public garbage heap. A similar approach to suicide in 17th Century England resulted in a suicide's properties and monies being forfeited to the crown, thus the word "coroner" comes from the word crown, and it was the coroner's duty to determine whether a death was due to accident, suicide or homicide. If the death was ruled a suicide, the crown benefited. The body was later buried at a public crossroads with a stake driven through the heart. The last crossroads burial took place in 1832 in London, at about the same time philosophers and scientists began to write about suicide as a human phenomena worthy of some study and understanding.

Early Christian theology and belief did not condemn suicide. There are eight suicides in the Holy Bible (some authors say ten) and none are condemned. After St. Augustine, however, suicide evolves into a mortal sin, and later is viewed as a crime against the state. At present, most Christian leaders view suicide as the result of a disturbed mind, not as a sinful act. Still, residual beliefs and taboos throughout the world contribute to the suffering of people with brain disorders, including those who kill themselves to stop the pain of their existence.

PUNISHMENT AS SUICIDE PREVENTION

The first historical record of an official effort to deter suicides comes from 600 BC, when a group of Roman soldiers were forced to cut drains and sewers. They considered this work beneath their dignity, and one Roman warrior then threw himself off the Capitoline Rock. Subsequently, another soldier jumped from the same precipice, and then another. Personal reasons for these suicides are not recorded.

To stop the epidemic officials ruled that any soldier who tried to kill himself would be crucified in a public place and abandoned to the birds and beasts. Crucifixion was the worst kind of death for enemies of the Roman State, and for a Roman soldier to be crucified was unthinkable. Thus, some authors believe that the desecration of corpses became the official reaction to punish would-be suicides by example. This prevention method remained basically unchanged for the next 2,000 years.

For centuries, punishment of the deceased served as a crude and probably ineffective effort to prevent suicides. Punishments included sermons to cast out demons, confiscation of the suicide’s property (thus impoverishing his family) or directly punishing the corpse in a kind of "look what will happen to you if you do this."

THE VIEW FROM THE WEST

The western view of suicide began to shift during the Enlightenment, basically from the perception of suicide as a sin to suicide being the result of some kind of pathology of the mind. If suicide was a choice made with a sick mind, then it could not also be a sin.

Our cultural reaction to suicide has been slow to change, even glacial. As late as 1955 an English-man was sentenced to two years in prison for attempting suicide. In 1969 on the Isle of Mann a teenager was flogged for an attempted suicide. Suicide was only decriminalized in Ireland in 1993. When the author first began his career as a psychologist in 1965, his first seriously suicidal patient was "sentenced" to treatment with him by a Superior Court Judge.

The important point here is that as a QPR Instructor you will be encountering attitudes in your audiences which are very similar to the attitudes prevalent during the Dark Ages of the 15th century, and not much farther removed from the almost Dark Ages of the middle 20th century. As suicide prevention workers, helping to change these attitudes is perhaps our greatest challenge.

To better prepare you for this challenge we will provide you slides and other educational content on, for example, the relationship of suicide to depression and other forms of mental illness. As the stigma around brain disorders is broken down, so too will the stigma towards suicide be broken down. You may select from among these materials to strengthen your presentations and to combat these unenlightened, life-endangering ideas and attitudes.

CROSS-CULTURAL PERSPECTIVES

Among others, in primitive African and Cambodian cultures, suicides were feared because the death was "unnatural." Like the English, some of these societies buried the suicide’s body at the crossroads so the ghosts would get no sleep and not return to the village to, for example, impregnate the women.

Similarly, in many Asian societies, there was a belief in the power of the ghost of the suicide and strong efforts were made to discourage these ghosts’ hauntings. In some cultures, bodies were chopped up so the ghosts could not walk. In others, a goat was hanged in the same noose used by the suicide to mollify the dead man's soul. Among others (e.g., the Omaha and Iroquois Indians), suicides determined the person’s place within the spirit world.

There are probably as many different views about suicide, its causes and meanings, as there are cultures in which it occurs. Much work needs to be done to gain a better of understanding of suicide in its cultural, racial and ethic context. Still, when working with various cultural, ethnic and/or racial groups, it is important for QPR instructors to help audiences explore their attitudes toward suicide and where they came from.

For example, are their attitudes helpful and protective, or harmful and increase risk? Attitude change is a significant part of the QPR mission. Any efforts that you make to impact such a change in attitude may eventually help save lives.

SUICIDE PREVENTION EFFORTS IN HISTORY

In 1774, London's Royal Humane Society began what may be the first humane suicide prevention program. With a kind of early paramedic flying squad, the goals of this organization were to "restore life to the drowned, those suspended by the cord, or otherwise suffocated,

lightning victims and accidental deaths." The members of this royal society were paid four guineas if the person they were rescuing survived, and only two in the event the individual died. They saved many lives over the years and intervened in some 500 cases over a five-year period. A segment of their outcome evaluation read as follows: "…350 of which [cases] inter-position has been providential enough to restore the despairing culprit to himself, his friends and to society and to rescue the soul of the sinner from the overwhelming depression of despondency and, perhaps, from the danger of everlasting condemnation."

You will note in this mission statement a subtle shift from rescuing people to save them from the fires of hell, to restoring them to their families by helping them survive an episode of “depression or despondency.” This group may be the first in recorded history to recognize that suicidal people were suffering from a depressed mood and could benefit from help, not punishment.

MODERN VIEWS TOWARD SUICIDE

When Sigmund Freud went to medical school the prevailing attitude toward suicidal people was that they were insane and untreatable. Moreover, they were cursed by bad blood and doomed to suicide. Many in the medical profession refused to treat them. Basically, they did not want their caseloads contaminated by suicidal people. Suicide was still a sin and a crime, and was not recognized as a medical or psychological problem until much later in the 20th century. Thus, suicidal people were typically scorned, ignored and locked up in asylums.

The idea that suicidal people could and should be helped, not punished, was formally raised in 1906 when Harry Marsh Warren founded the National Save A Life League. Warren was a Baptist minister who went to New York City and opened a "parish to all strangers." When a young girl asked to speak to him and he was unavailable, she later went to her hotel room and overdosed. He was called to her bed where she said, "Maybe if I had talked to someone like you, I wouldn't have done it," and then she died. Warren preached against suicide, took out an ad in local newspapers urging anyone considering suicide to call him, and thus began an open clinic for suicidal people. The Save A Life League grew, offered food, shelter, train tickets home and other solutions to life's problems other than suicide.

Among their social services, the Salvation Army started an anti-suicide program early in the 20th century in London. It included free consultation, advice and help. Suicide prevention efforts spread through Europe, with centers opened in Berlin, Zurich, Budapest and Vienna. Just as these life-saving efforts reached their peak, the Nazis came to power and began to invade their neighbors. The onset of war seems to have ended the hope promised by these efforts. As a result, most of these early programs disappeared.

In 1935, an organization called the Samaritans was founded by a 24-year-old Anglican minister. His name was Chad Varah. This young man was moved by the suicide of a 13-year-old girl experiencing her first menses. The Samaritans have been on the move ever since. By 1953, they had offices in London and throughout the world. Free counsel is offered through a process called "befriending." The Samaritans do not claim to offer therapy or professional counseling. As of

this writing, the Samaritans have been the greatest organized suicide prevention effort in the world, with at least 180 branches around the globe and 22,000 volunteers in 44 countries.

RECENT DEVELOPMENTS IN SUICIDE PREVENTION

In the United States there were other scattered efforts made to prevent suicide, but most of them disappeared as quickly as they began. There was no organized field of scientific inquiry associated with the study of suicide for the first half of the 20th Century. Prior to 1950, suicide was not identified as a particular issue by mental health professionals. Even though suicide claimed more lives than homicide, it got very little press or attention.

Suicide was still not a respectable subject of research and so not much was done. Then, in 1949, a young psychologist found himself in a room with hundreds of suicide notes.

THE FOUNDING FATHERS OF MODERN SUICIDOLOGY

Dr. Edwin Shneidman, one of the founders of the American Association of Suicidology, had a job in a Veteran's hospital where he was asked to draft letters to the families of completed suicides. He joined forces with Norman Farberow, also a Veteran's Administration Hospital psychologist, and together they began the scientific study of suicide notes. They learned the first major lessons about suicide, and began to publish them. Among the things they learned were the following:

- The vast majority of completed suicides were clinically depressed
- Those who threatened often attempted
- Suicides often occurred just as people began to feel better
- Most people who attempted and/or went on to complete suicide left clues
- Most completed suicides were not psychotic
- Most did not want to die

These young psychologists were soon accepted as the experts in the field and became the modern-day founders of the scientific study of suicide and its prevention.

SHNEIDMAN, FARBEROW AND THE LASPC

Shneidman and Farberow later enlisted the help of Robert Litman, a young psychiatrist at Cedars Sinai Hospital, who had written a paper on how to deal with suicidal people in the hospital. The legend is told that the two young psychologists took Dr. Litman to dinner in Beverly Hills, plied him with liquor, and explained how they would open a phone line for suicidal people. The psychologists would study the callers and Litman would treat them. Thus, the Los Angeles Suicide Prevention Center (LASPC) was founded. On September 1, 1958 they began their mission to save lives with one phone line and a staff of five.

The LASPC became the fountainhead of an entire crisis, urgent response and suicide prevention movement. These three men, Shneidman, Farberow and Litman are names to remember. They

started both a movement and a profession, and they established the respectability of studying suicide. Many of the terms and concepts of modern day suicidology can be attributed directly to these founding fathers.

By 1965 the National Institute of Mental Health established a center for the studies of suicide prevention and asked Shneidman to head the project. This was the first national recognition of suicide as a problem worthy of federal funding. In 1965 there were 15 suicide prevention centers. By 1968 there were 47, and by 1969 there were more than 100. Now, we have come to expect crisis response centers and systems and 1 (800) help-lines everywhere. Current federal funding is designed to enhance not only the skills and competencies of crisis line workers but to network crisis lines into a sophisticated national network of certified organizations.

SUICIDE PREVENTION HOTLINES

Some have argued that the suicide prevention hotline experiment has failed, and that based on national statistics suicide rates have not decreased as a result of these lines. This argument misses the point that a great many people receive important services and referrals through these lines, and that some lives are saved. Preventing a suicide is a statistical non-event, so it is not surprising that crisis lines have been wrongly accused of failure when suicide prevention requires integrated, comprehensive, systematic, evidence-based approaches before measurable gains can be expected. QPR gatekeeper training is only one of these strategies that may save lives.

Crisis lines serve to activate first responders throughout the country. First responders include mental health professionals, police, fire and paramedics. The problem with our understanding of how crisis lines should work is that, perhaps, we assume the severely suicidal, high-risk person will call a hotline prior to making a suicide attempt. As you will soon learn, QPR is premised on just the opposite notion: that those most at risk *may not call*. Rather, we have to go to them. We can only go to the assistance of those considering suicide if somebody already close at hand tells us help is needed. You will learn about the QPR theory at the training.

CURRENT STRUGGLES WITH THE LANGUAGE OF SUICIDE

While there is some dispute about where the word suicide first occurs in written English, the word does not occur in the Holy Bible. Saul's suicide is described as, "Saul took his own sword and fell upon it." In Greek times, examples of language to describe suicide included "to seek death," "to flee the light," and "to carry oneself off." In medieval England, one could "murder oneself," "destroy oneself," or "commit self-murder."

In 1642, Sir Thomas Brown first used the word suicide in his book Religio Medici. A quote from that text reads, "…here they are in extremes, that can allow a man to be his own assassin, and so highly extol the end and suicide of Cato." Edward Phillips takes credit for the word in a 1662 dictionary. In recent times, Webster's Third New International Dictionary defines suicide as, "the act or instance of taking one's own life voluntarily and intentionally."

At present, there is considerable controversy about what, exactly, a suicide is, and especially what constitutes a suicide attempt. As you might guess, the differential diagnosis between

accident and suicide is often difficult. In one major study, at least half of the high-speed, single-automobile crashes not involving another passenger or driver were determined to be probable suicides. In the absence of a suicide note, it is often difficult to determine the intentions of the deceased after the fact.

As noted earlier, many suicides are ruled accidents and are therefore not reflected in the suicide statistics. However, suspected suicides may have the same emotionally damaging effect on survivors, even though a medical examiner rules the death accidental. Because QPR instructors will encounter similar stories and associated questions, let's look at some actual, true-life examples where the determination of mode of death may be problematic. You determine whether you believe these deaths were the result of natural causes, suicide, homicide or an accident:

- An 84-year-old, depressed widow who lives alone with her cat is pressured by her children to sell her home in the southwest and move to California. She refuses. Her children put increasing pressure on her. She is isolated and without friends, and was very dependent on her recently-deceased husband. With even more pressure, she finally agrees to move to her son's home, at which time her son says, "Mother, you'll have to get rid of the cat." One day later the woman takes her cat to a veterinarian and has it put to sleep. On the way home she dies in a high-speed, single car crash into a utility pole. Her speed was estimated to exceed 80 miles per hour. She was not wearing a seatbelt.

- A 19-year-old young man with a recent diagnosis of Bipolar Disorder graduates from high school and breaks up with his girlfriend. He refuses to take prescribed medication for his illness. In his hometown where he grew up, he drives his mother's old car (not her new one) down a dead end street and into a ten-foot stone wall at what is estimated to be 100 miles per hour. There is no suicide note, but the boy knew this was a dead-end street with a stone wall at the end of it. On autopsy, the young man had no drugs or alcohol in his blood.

- A 32-year-old, drug-dependent father of two has been told by his wife that she wants a divorce. Out of money and losing support, the man enters a drug store in his small hometown in broad daylight with a revolver, and robs the store of narcotics. He drives out of town and up the side of a nearby mountain, where he begins to take the drugs. A police officer quickly finds him and orders him out of the car. The man gets out of the car and slowly raises the revolver, pointing it at the officer. The officer tells him three times to put the pistol down, but the man continues raising it and pointing it toward the officer. The officer fires and kills the young man. Afterward, it is found the revolver cylinders were stuffed with wadded up news-paper, not bullets.

In the course of your gatekeeper training, you will encounter many stories of this kind. Some of the deaths will have been ruled accidental, even though the person's state of mind was clearly suicidal and the clues and communications sent before the death were unequivocal.

The attribution of motive for death after the fact is a difficult, challenging and relatively new science called "the psychological autopsy." Unless you are asked to do it for some specific

purpose, and are an expert in this methodology, we recommend that you not engage in speculations about the possible suicidal motivations of deceased people. However, if the survivor of the death feels the death was a suicide, then a referral for bereavement counseling with a focus on suicide survivor issues is in order.

COMPLETED VS COMMITTED VS. SUCCESSFUL SUICIDE

In some sectors of the American community, an effort is being made to change the verb that precedes suicide. The term most commonly used today is that the person "committed suicide." Many believe that this suggests that suicide is a rational, fully reasoned act, more like a crime than the result of a poor decision by a disordered brain. Similarly, the phrase “successful suicide” can cast the same concept of rationality, while also implying that the act of suicide was, in some way, a condoned and/or positive action on the part of the individual. Conversely, if the individual was “not successful," there may be a stronger tendency to imply a critical judgment and add to the sense of shame, hopelessness or despair that the person already feels.

The phrase "completed suicide" does not have these same connotations. Where possible, it is recommended that you use "completed suicide" or “died by suicide” rather than the more commonly used "committed” or “successful” suicide. Your QPR curriculum over-heads or slides reflect this recommended change.

DIRECT VS. INDIRECT SUICIDE

Suicide exists on a continuum of high-risk behaviors. People engage in all sorts of life-threatening and life-shortening behaviors. Drinking and driving is an example, as is free climbing dangerous mountains or sharing needles when injecting drugs. Are these suicidal acts? Consider the following examples:

- Warned by his doctor to stop drinking, an alcoholic with cirrhosis of the liver continues to drink heavily and dies. Suicide? In most instances, this would be ruled a natural death.

- A 25-year-old man with a history of depression drives his pickup into a tree. Alcohol is found in his blood stream. There are no skid marks and no note.

Undetermined, accident or suicide?

- A 45-year-old woman overdoses on barbiturates at 4:30 p.m. in her kitchen, knowing her husband is always home by 5:00 p.m. to get a cold beer from the refrigerator. This day, he is delayed. She dies.

Undetermined, accidental or suicide?

You can see how difficult understanding the precise nature of suicide, or possible suicide, can be. Unfortunately, the people who would be most able to help us understand their true motivation for such behavior are not here to tell us.

HISTORICAL NOTES

The discussion regarding direct vs. indirect suicidal behavior is a long one. In 1637 John Sym described several means of ending one's life prematurely, yet indirectly. These included gluttony, drinking to excess, and dueling. A modern equivalent might be gluttony, drinking to excess and entering a biker bar after the inhabitants are intoxicated and shouting, “You’re all a bunch of sissies!”

Freud wrote about "half-intentional self-destruction" as people expressing the death wish unconsciously. He also referred to some deaths as "purposive accidents."

Carl Meninger catalogued 400 pages of self-destructive behaviors in his book, *Man Against Himself.* Self-inflicted, premature death has been described as "slow suicide," or "sub-intentional death," or "suicide by the inches." People who engage in behaviors that could ultimately shorten their lives have been described as engaging in ILTB, or Intentional Life-Threatening Behavior.

For example, the writer Jack Kerowac said that because he was Catholic he could not “commit suicide” (that would be a mortal sin), but that he could drink himself to death. He died in 1969 of a massive abdominal hemorrhage brought on by acute alcoholism.

A 20-year-old girl at death's door from anorexia said, "I was really depressed. I wanted to kill myself. I had thoughts of taking pills, but I couldn't. That would be suicide. I knew suicide was a sin, so I just stopped eating." Death by crashing an automobile is so common it has been called "autocide" and was the method of suicide chosen by Willy Loman in Arthur Miller's play, *Death of a Salesman.*

VICTIM-PRECIPITATED SUICIDE (HOMICIDE)

There are many references to deaths brought about by provoking others to an act of murder. Basically, this involves a suicidal person getting someone else to kill him or her. This behavior is a considerable challenge to police officers who, armed with deadly force, are often the unwilling executioners for suicidal people. In a recent article in the FBI Law Enforcement Bulletin (July 1998) researchers determined that approximately 16% to 46% of citizens shot and killed by police officers provoked the shooting out of suicidal motivation, resulting in what is commonly called, “officer assisted suicide.”

America is not the only place where this behavior occurs. Among some Malaysian groups, a man who wants to die runs amok through the village killing other people at random until someone kills him. In the 18th Century Australian prisons, Catholics who were imprisoned there knew it was a worse sin to kill yourself than to kill someone else. When two prisoners who shared the same cell could no longer endure their lives, they drew straws to see who would die first. After the draw, one killed the other, then the killer was put to death by the prison guards, thus the sin of suicide was avoided.

Among other unwilling participants in a suicidal person's plan are truck drivers and train engineers who must, being unable to stop their machines, run over people who put themselves in harm's way. At least some combat deaths are believed to be suicides (placing oneself in the enemy's line of fire), and many suicidal people request what they know to be lethal medications from their physicians with a conscious, premeditated plan to take all of them in a massive overdose.

THE FUTURE

Until recently, the future of suicide prevention in America appeared bleak. There was no significant state or federal leadership. Citizens and treatment communities seemed to believe that as long as troubled citizens had access to an emergency room, a toll free hotline, or a mental health service delivery system, they had done all they could to prevent suicide in their communities. Little attention has been paid to how adequate or responsive these systems are in reducing suicide rates. In reality, there is much more each of us can do to help reduce suicide rates.

In October 1998, a historic meeting took place in Reno, Nevada. A major national conference entitled, "Advancing the National Strategy for Suicide Prevention: Linking Research and Practice" was convened. This conference was co-sponsored by the Suicide Prevention Action Network (SPANUSA) and the Centers for Disease Control (CDC), with major participation and support provided by the Substance Abuse and Mental Health Administration (SAMHSA, the Maternal and Child Health Bureau of the Health Resources and Services Administration (HRSA) and others.

Leaders in suicide prevention from all 50 states were invited to attend. This first, major collaboration among widely representative non-governmental, public health and health services organizations was intended to raise suicide prevention as a public health priority and to help launch the first National Strategy for suicide prevention.

The major suicide prevention organizations available to support QPR instructors are listed in the resource directory of the QPR Trainer's Manual. These include the American Association of Suicidology, the American Foundation for Suicide Prevention, the Suicide Awareness/Voice of Education, the Suicide Education and Information Centre and others. As this new movement to prevent suicide in America gains momentum, QPR instructors will be called upon to provide more and more public awareness and basic "how to" information to larger and larger segments of their communities.

We encourage you to embrace these organizations, support them in any way you can, and be prepared to take on a leadership role in your community, your state and in your nation!

Developmental History of QPR

(QPR stands for how to Question, Persuade and Refer someone suicidal to professional help)

The concept of QPR for Suicide Prevention, a community gatekeeper training program, grew out of Dr. Quinnett's own personal experience with the challenge of delivering clinical services to at-risk elders living in their homes in the Spokane, Washington community. Together with Ray Raschko, MSW, Director of Elder Services, and Mary Higgins, CEO of Spokane Mental Health, the Gatekeeper's Program began in the 1980's and continues today. The program was designed to locate, identify, and refer frail elders living in their homes and at risk for premature disability, nursing home placement, hospitalization or death.

In a very brief training format, community gatekeepers (meter readers, telephone personnel, pharmacists, and others) were trained to identify and refer older persons showing signs and symptoms of significant distress and/or difficulties while still living in their homes and communities. The program was very successful and won the Ford Foundation's Innovations in Psychiatry award. Gatekeepers has gone on to become a national and international model for service delivery to at-risk elders.

While not an implicit goal of the program, independent studies of suicide rates among older Americans living in Washington State showed a steady, ten-year decline in Spokane County where the Gatekeepers were operational. As rates for similar older persons living in other counties climbed, deaths of persons over 65 by suicide dropped significantly.

Building on these findings, and based on Dr. Quinnett's experience as a suicidologist, QPR was a natural extension of the concept that those most at risk for self-destruction tend not to self-refer. These groups include elders, youth, ethnic and cultural minorities, law enforcement personnel, people in uniform, and gay and lesbian youth, among others. Based on this compelling and early research, it is the belief of the QPR Institute that if lives are to be saved in suicide prevention, we must first locate, identify and then *Question, Persuade and Refer* those most at risk to providers of care.

Given the fact that the symptoms for depressive illness have become increasingly well known, and that the majority of suicidal persons communicate their distress and intentions to suicide to others – often in plain language, the QPR concept moved to the next level.

Working with the Spokane County Health District and a broad range of community representatives from schools, youth groups, law enforcement, churches, mental health and others, a community task force was presented with the QPR concept and how it might work. With the support of county health officials and the Medical Director of SCHD, Dr. Quinnett developed a

core curriculum, wrote the first QPR booklet and, with community input and help, refined the text and content to meet the needs of a wide range of people and age groups. The first QPR Gatekeeper Instructors were trained in 1995.

Once community training began, the following highlights summarize subsequent developments:

- 1995. Evaluation of training is established, assisted by Dr. Dennis Dyck, Director, Washington Institute for Mental Illness Research and Training.
- 1995. Deanna Cooper, a health educator for Spokane County Public Health, conducts a community based effectiveness evaluation of QPR training to: change attitudes toward suicide; improve basic knowledge about suicide; and to assess the degree to which people trained in QPR report themselves more or less likely to act when intercepting a suicidal communication. The research showed positive and statistically significant results on all measures. This research project becomes the basis for Ms. Cooper's Masters Thesis at the University of Washington School of Public Health (available in public record).
- 1996. A formal core curriculum of eight hours of material, plus the reading of two books on suicide and suicide intervention and treatment is established for the training of QPR Gatekeeper Instructors. A course evaluation format is established and training instructors begins.
- 1996. Eli Lilly and Company fund a nine-minute QPR video for training the community gatekeepers. The $50,000 video is hosted by actress and author, Carrie Fisher. The video becomes a portion of the QPR Gatekeeper public health training format.
- 1996-1999. Spokane Mental Health helps underwrite research and development of the QPR concept and later, the QPRT Suicide Risk Assessment Inventory and its second and third editions.
- 1998. Albuquerque Public Schools enters into a joint research project with Spokane Mental Health (and what will later become the QPR Institute) to assess the effectiveness of QPR training in adult employees, and whether or not the training effect persists over time (out to 18 months). Again, the results are consistently positive and statistically significant.
- 1998. The QPR concept is expanded and integrated into a systems approach to suicide risk reduction, which includes enhanced training in suicide risk assessment for professionals and gatekeeper training. The program wins the 1998 J.J. Negley Presidents Award for Avoiding Suicide Malpractice.
- 1999. Due to funding cuts at Spokane Mental Health, Dr. Quinnett and staff form the QPR Institute, Inc., a suicide prevention training organization working to educate communities, professionals and institutions.
- 1999-2001. The QPR Institute contracts the Department of Health and the Washington State Youth Suicide Prevention Program, to train QPR Gatekeeper Instructors for Washington State, and to provide enhanced suicide risk assessment training to all 35 hotlines in the State of Washington. The contract includes evaluation of training effects for QPR Gatekeeper training, as well as assessment of the new QPR Suicide Triage Training Program. Again, the results for gatekeeper training are consistent and highly significant for those trained.
- The present: QPR is currently one of the most widely-approved citizen gatekeeper training programs in America and has been taught to more than 250,000 persons in 40 states. The program now reaches several foreign countries, and has been adopted by many states, major universities, military and law enforcement organizations. The program has been extended to

include the institutionalizing of suicide risk reduction practices and methodologies to enhance patient safety in more than 60 healthcare organizations.
- A large scale clinical trial of QPR is taking place in the South Eastern United States under the auspices of the University of South Florida and the University of Rochester.

How QPR Works

QPR trained citizen gatekeepers help create a community safety net for suicidal people by identifying them, questioning them, and persuading them accept a referral for professional evaluation and/or care. Initiating this chain of events is a significant responsibility, not unlike initiating CPR until professional medical help arrives.

In 1998 a survey of Certified QPR Trainers was conducted. Trainers where asked to report how many people in the citizen groups they trained were identified as in need of "immediate referral" for evaluation and/or treatment, or "knew someone" in need of evaluation and/or treatment. They were also asked to identify how many survivors of suicide emerged from the training.

Based on an analysis of the data reported by 136 QPR Trainers, the following was found:
* On average, trainers detected two "hot" referrals for every 25 people trained
* On average, trainers detected one survivor of a suicide for every 55 people trained.

Extrapolating these figures to the 200,000 people trained in QPR by late fall of 2002, more than 16,000 at-risk persons were identified and referred for professional attention, and approximately 3,600 survivors of suicide were given resource information and/or referral to services.

To be successful, the actions of citizen gatekeepers must be acknowledged and supported by the professional community. When a QPR intervention is attempted, and if a referral is made, professional providers must respond. Professionals must not only endorse QPR Gatekeepers as credible suicide prevention volunteers, but must also honor and respect their efforts to make life-saving interventions.

Volunteer QPR Gatekeepers must be fully informed, not only about the community resources available to them as citizens, but specifically who they should contact for support, consultation and/or advice when faced with what might prove to be a difficult intervention.

The possible outcomes from a QPR intervention may include any of the following:
- Concerns for suicide are not warranted and suicidality is clearly denied. No professional action is warranted.
- Someone believed to be suicidal refuses all contact by the gatekeeper. Once suicidality has been established, even by a third party, further action by a professional is required.
- The suicidal person accepts a referral, and a referral is available. No professional action is necessary except to implement the referral.
- The suicidal person accepts a referral for help, but refuses to travel to the site of the appointment. Further professional action is required, i.e., a home visit for further evaluation.

- The suicidal person is ambivalent about accepting a referral and is clearly lethal. Professional consultation and intervention is required.
- The suicidal person is ambivalent about accepting a referral but is not clearly lethal. Professional consultation and possible intervention is required.

For volunteer QPR Gatekeepers to be effective, community professionals must help and support their courageous efforts. The skills necessary to properly evaluate relative suicide risk, imminence of a suicidal act and what, if any, treatment may be needed, is clearly beyond the skills of citizen volunteers.

TRAINING DEFINITIONS

KEY INFORMANT: A key informant is a community member whose position in his or her community permits him/her the opportunity to know and observe changes within that community. Examples include a mental health center chief executive officer, a health district officer or a school district superintendent. For the QPR project, key informants may or may not be QPR Certified Instructors or Gatekeepers. No certification or re-certification is necessary.

QPR GATEKEEPER: A QPR Gatekeeper is someone who has received at least the one-hour *QPR Gatekeeper Training for Suicide Prevention* course. This program may have been provided as part of a larger educational program. A QPR Gatekeeper receives an accompanying QPR booklet and summary resource card as part of their one-hour training. A QPR Gatekeeper is someone in a position to recognize a crisis and warning signs that someone maybe be contemplating suicide. Based on enhanced awareness and familiarity with the QPR action steps, this parent, friend, teacher, minister, nurse, office supervisor, family member or other is in a unique and strategic position to initiate an intervention or contact someone who can. QPR Gatekeeper training may be taken one or more times. No certification or re-certification is necessary, although annual reviews of at least 20 minutes are recommended

CERTIFIED QPR GATEKEEPER INSTRUCTOR: To be a Certified QPR Gatekeeper Instructor requires that the individual be at least 21-years-old and able to work with small groups in an educational format. Preferred qualifications include good community connections, access to potential gatekeeper training audiences, good speaking skills and a passion to prevent suicide. A mental health or healthcare educational background is beneficial, but not necessary.

A Certified QPR Gatekeeper Instructor has received at least eight hours of specialized training in the QPR suicide prevention method and approach, has all the necessary current and copyrighted tools for quality training and receives and reviews quarterly training updates, research summaries and the QPR Times newsletter. Re-certification is required every three years.

CERTIFIED QPR MENTOR: To become a QPR Mentor the person must first be a Certified QPR Gatekeeper Instructor in good standing and must have trained no fewer than 250 gatekeepers with satisfactory evaluations. The person must also be willing to follow the mentoring guidelines as set forth by the QPR Institute and remain current with recent updates, research and resources in suicide prevention (extended definition and requirements available elsewhere).

QPR for Communities: A Suicide Risk Reduction Program

This proposal outlines a comprehensive community-based suicide risk reduction and prevention project using the QPR model (QPR stands for Question, Persuade and Refer, an emergency intervention undertaken upon the recognition of suicide warning signs in someone known to the QPR-trained person). The project would be carried out within a defined community and fully evaluated for effectiveness. The main goal of this systems approach to suicide prevention education and training is to build collective community competence through broad, systematic training of individual family members, key community "gatekeepers," and all health and mental health care professionals. In addition to the an expected increase in the community's sense of shared responsibility to prevent suicide, the resulting educational result should: 1) enhance measures of individual self-efficacy in how to assist suicidal family members or loved ones, 2) improve the performance of key community gatekeepers in assisting suicidal person (e.g., law enforcement personnel) and 3) improve measures of clinical competence and confidence in healthcare professionals who assess, manage and treat suicidal consumers. When these outcomes have been successfully achieved, a fall in community rates of morbidity and mortality associated with suicidal behaviors is predicted.

Background

The QPR concept grew out of a community-based suicide prevention effort lead by the Spokane County Health Department, Spokane Mental Health, Spokane Police Department, the help of citizens who had lost loved ones to suicide, and with the participation of more than a dozen community-based organizations, including schools, churches, and hospitals. The original "gatekeeper" program from which QPR originated was designed to train key gatekeepers for home-dwelling, frail, and multiply-impaired elders living in Spokane Country. The unexpected result of finding and assisting these at-risk elders was a 10-year decline in suicide rates among person age 65 and over.

As a community-based suicide prevention program it is essential that a unified community response is assured. Any community-wide suicide prevention project must be supported by local, state and national leadership, including university-based research and evaluation experts. At the community level, both lay citizens and professionals must work together to achieve two common goals:

- A greater sense of shared responsibility for the prevention of suicide
- A greater sense of community competence in learning the skills necessary to prevent suicide attempts and completions

A community is here defined as networks of people living together in the same geographical area and working in common cause for shared goals. Thus, a county with one or more small towns or cities located in a single geographical region would be defined as a "community." Suicidal deaths and non-fatal attempts in that community have a direct, costly and emotionally damaging effect on the entire community. However, 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, so long as they have the knowledge and tools to do so.

The underlying theory for this project rests on the belief that good people wish to do the right thing by those in their own community, and that what is needed is education, knowledge and specific suicide prevention skills to enable and empower community members to recognize, assist, refer, assess, manage and treat those suicidal community members with whom they come into contact. Once community leaders, family members, friends, volunteers, first responders and healthcare providers are equipped with evidence-based knowledge and training to reduce suicidal behavior, good will, fundamental American values, funding, and implementation of suicide prevention efforts can and will be successful in the defined project community.

The successful outcomes of this project will be reflected in measures of enhanced and shared community responsibility for at-risk persons, as well as improved individual and group competence to identify, assess, manage and treat suicidal members of the project community. A community thus educated will define itself as a caring, confident and compassionate community with regard to assisting its suicidal members. As this project targets a greater understanding of mental disorders, community and individual attitudes toward those community members suffering from the mental disorders that sponsor the vast majority of suicidal behaviors, are also predicted to move in a positive direction. Outcome measures to assess pre-post mental health literacy and stigma toward mental illness and suicide will be employed.

Research in defined communities, including that conducted by the Devereux Foundation, Inc. and the United States Air Force, has shown such community-wide efforts can be effective. In its comprehensive program the U.S. Air Force reduced its suicide rate by 33% over a four-year period Knox, et. al. al., 2003), while the Devereux Foundation has had a similar experience with its consumers of clinical services in a variety of behavioral healthcare settings.

The four cornerstones of the theory upon which this project will proceed are these:

- Those who *most* need help in a suicidal crisis are the *least* likely to ask for it.
  Thus, community and family members must recognize and respond positively to at-risk loved ones and fellow citizens, and go to them with help without requiring that they ask for it first.

- The person most likely to prevent *you* from dying by suicide is <u>someone you already know.</u>
  Thus, those around us must know what to if we become suicidal. This can only be accomplished when everyone *is trained in suicide warning signs and intervention strategies.*

- Prior to making a suicide attempt, those in a suicidal crisis are likely to send warning signs of their distress and suicidal intent to those around them.
  Thus, learning these warning signs and how to take quick, bold action during these windows of opportunity will save lives.

- When we solve the problems people kill themselves to solve, the reasons for suicide disappear.
  Thus, crisis intervention, problem resolution, enhancement of protective factors, and competent and accessible mental health treatment will save lives.

The QPR Model

Like CPR in the "Chain of Survival" for medical emergencies, successful QPR requires the following:

- **Early recognition of suicide warning signs**. The sooner warning signs are detected and help sought, the better the outcome of a suicide crisis will be.
- **Early QPR**. Asking someone about the presence of suicidal thoughts and feelings opens up a conversation, lowers risk and may lead to a referral for help.
- **Early intervention and referral**. Referral to local resources or calling 1-800-SUICIDE for evaluation and possible referral is critical, as most people thinking about suicide are suffering from an undiagnosed and/or untreated mental illness or substance abuse disorder for which excellent treatments exist. Also, the offering of hope and social and spiritual support can often avert a suicide attempt
- **Early professional assessment and treatment.** As with any illness, early detection and treatment results in better outcomes and fewer lives lost to suicide

In CPR the general public is educated about the classic signs of a heart attack: pressure, fullness, squeezing and pain in the center of the chest, sweating, and other symptoms, and how to respond with a simple intervention. In QPR the general public is educated about the known warning signs of a suicide crisis (AAS, 2003), e.g., expressions of hopelessness, depression, giving away prized possessions, talking of suicide, securing lethal means and how to respond with a simple intervention.

Community-wide training

In 2002 the American Heart Association estimated that over the past 35 years some 250 thousand CPR instructors have trained several millions of US citizens in CPR. As a result, lives are saved that might otherwise have been lost. As many people know the city of Seattle, Washington and surrounding King County has trained more citizens in CPR per capita than any other region in the country. As result, CPR-trained citizens are more likely to respond to perceived medical emergencies in Seattle than in any other city in the United States, which leads to more favorable survival rates. According to Sanddal and his colleagues (Sanddal, 2003), "In the Seattle cardiac care system it is estimated that one in four persons has been exposed to CPR training. One can conjecture that the recognition of, and survival from, an acute suicide event would be more likely if one in four persons were trained as a suicide lay gatekeeper."

At the end of 2003, an estimated 250,000 American citizens have been trained in QPR by Certified QPR Instructors in more than 30 states. Because of the nature of suicidal warning signs, and who is most likely to recognize and respond to them, a goal for this project would be to train at least one in four persons in QPR in the project community. Because suicides happen in families – where emergency interventions are more likely to take place - we believe that a goal of training at least one person per family unit would be highly desirable.

According to our theory, it is only through intimate, interpersonal knowledge of each other another that suicidal communications, behaviors and warning signs can be recognized, interpreted and acted upon in a quick and effective fashion. Without an educated and vigilant

family, friend, co-worker, supervisor, teammate or other person serving as a "community gatekeeper" safety networks for suicidal people will fail. Thus, while training one in four persons in QPR, or at least one family member per family in a defined community may seem ambitious, other suicide prevention strategies, e.g., crisis lines and traditional "in the box" mental health programs will remain largely unused by those most at risk for self-destruction: older adults, males, youth, Native Americans, some professionals, and other high risk groups.

Linking research to community practice

Suicidal warning signs and pre-attempt communications are reported to range from weak and coded to strong and clear, and may be sent to some people in the community and not to others. These communications and warning signs are often our first and only opportunity to intervene. While much research is needed on this dimension of human interaction and communication, we know enough now to train ourselves and others to act as gatekeepers for those at risk, and to train healthcare providers to better detect, assess and treat suicidal consumers. To prevent suicide at the community level, we cannot overemphasize the need for community members to become their "brother's keeper" and for treatment providers to deliver the very best in evidence-based diagnostics and care.

Once individual suicidal persons are detected by community gatekeepers, they must be referred for assessment and possible care by *competent community-based professionals.* Unfortunately, many healthcare professionals don't know what they don't know about suicide and its prevention. For a community to be competent to assist its suicidal members, community first responders and clinical providers must be trained in state-of-the-art assessment, management and evidence-based and effective treatments for persons with suicidal behaviors. For agency-based providers, a complete risk reduction program should be operational in that provider's agency, and should include the use of comprehensive clinical risk reduction practices and treatments.

The QPR Comprehensive Community Program

To accomplish substantial and sustainable change at all levels of a community, an innovation-diffusion educational program designed to alter individual and group behavior in the majority of lay and professional community members is recommended for this suicide risk reduction project. The QPR Institute has designed, built and tested a variety of gatekeeper, first responder, and healthcare professional training programs that, when taken together, constitute an integrated systems approach to reducing suicide risk among individuals and in identified at-risk populations living in their communities. This program is modularized, exportable, can be customized for local requirements, and is deliverable at reasonable cost using the latest advances in distance learning technology.

Leadership is Key

For a community-based, community-wide suicide risk reduction program to installed, evaluated, and sustained over time, it is critical that broad community acceptance and clear leadership be recruited, oriented and trained in the program at the outset. The prevention of suicide cannot be left to government alone. It is critical that, among others, businesses, city and county leadership, law enforcement, labor unions, mental health, public health and professional membership organizations be at the community suicide prevention planning table. Since most American suicides are by men in their middle years (employed males), it is essential that employers become stakeholders in community-based suicide prevention programming, even using the

worksite as a suicide prevention training venue. Only community-wide full public-private partnerships working together to build a sense of shared community responsibility for the prevention of suicidal behaviors can lead to the kind of "culture change" necessary to achieve and sustained the desired outcomes.

As of this writing, the QPR Institute has tested and successfully implemented a comprehensive and integrated systems approach to suicide risk reduction in more than 50 mental health and healthcare organizations in the United States. Another large, federally-funded clinical trial of QPR is underway in a community/school setting. This trial combines elements of the basic QPR gatekeeper training program with more advanced training for school counselors in the assessment of at-risk youth identified by adult gatekeepers in a large school system.

By marrying the basic citizen QPR gatekeeper program to a state-of-the-art suicide risk reduction training programs for professionals and institutions, a combined, integrated and systematic community-based suicide prevention program emerges. Three are three levels of training for participating community members.

Citizen training in basic QPR
In this project an effort will be made to recruit and train at least one adult member of each family in the target county (adult is defined as being of voting age), or at least one in four persons in the community. Training will be delivered by Certified QPR Instructors trained by the QPR Institute, or via web-enabled CD-ROM and distance learning technologies. Citizen training will proceed only *after* all key gatekeepers (see list below) have completed mandatory advanced suicide risk recognition, intervention and skills training.

Advanced Key Gatekeeper for First Responders
In addition to training at least one person per family in basic QPR, this project will train all first responders defined as "key gatekeepers" in the Surgeon General's *National Strategy for Suicide* Prevention. Participants will be trained to a level of knowledge and skill commensurate with their level of duty to community members. Advanced, competency, and university-based QPR training programs have been tested and successfully delivered to the following key gatekeeper group

- ER Nurses
- School counselors
- Law enforcement personnel
- Correctional workers
- Clergy
- Case managers
- Funeral directors
- Crisis line workers
- 911 call takers
- EMT and EMS workers
- Civil and criminal lawyers and judges

The desired outcome for key gatekeeper education and training in this project would be train all community members filling these roles to a pre-determined level of competence as measured by these four end points:

1. The participant attended and evaluated the training program (roughly 8 hours)
2. The participant passed a nationally-standardized quiz on course content
3. The participant passed an observed skills test in interviewing a suicidal person in a structured role-play rehearsal
4. The participant's supervisor reviewed and approved at least three documented suicide interventions against external and objective criteria

Advanced key gatekeeper training for healthcare professionals

The QPR Institute has developed, tested, and evaluated suicide risk assessment and management training programs for the following key gatekeepers and the institutions in which they are employed:

- Physicians, Physicians Assistants and Registered Nurse Practitioners
- Psychiatric Nurses
- School Psychologists
- All mental health professionals (psychologists, psychiatrists, social workers, etc.)
- Substance abuse treatment professionals
- Clinical pastoral counselors

National testing standards for competence in this area of practice have been established, and participants would be asked to meet an improved standard of care in suicide risk assessment as measured by these four end points:

1. The participant attended and evaluated the training program (roughly 8 hours)
2. The participant passed a nationally-standardized quiz on course content for his/her profession
3. The participant passed an observed skills test in interviewing a suicidal person in a structured role-play rehearsal
4. The participant's supervisor or reviewed and approved at least three documented suicide interventions against external and objective criteria

Ideally, the clinical providers targeted for advanced suicide risk assessment training in this project would elect to employ the QPR Institute's Suicide Risk Reduction Program for Institutions, currently featured as a "best practice" by the Joint Commission on the Accreditation of Healthcare Organizations and featured as a model program by the American Psychiatric Association's Task Force on Patient Safety.

Using Technology

Because of its cost-effectiveness, this project will use web-based distance learning technologies to provide the majority of training and licensing of community-based instructors who, in turn, will provide face-to-face education and training of citizen and key gatekeepers in more traditional venues. This same technology will be used to install suicide risk reduction programs for any healthcare facilities, colleges or universities or other large institutions located in the county. Quality improvement projects are provided free to any facility or institution desiring to

measure its suicide risk reduction outcomes for this project, and such reports could then be made available to community leadership as part of the overall community-wide effort.

Project Timetable

YEAR I:

- Formation of a suicide prevention task force and determination of key leadership roles and persons to carry out and support the program
- All task force members review of the Surgeon General's *National Strategy for Suicide Prevention: Goals and Objectives for Action* as well as review of a variety of community building kits and models available through the following national organizations: American Foundation for Suicide Prevention, National Organization of People of Color Against Suicide, Suicide Prevention Action Network USA, Suicide Awareness Voices of Education, and others.
- Completion of the Community Readiness Questionnaire
- Collect community-based cost data associated with self-destructive behaviors
- Determine clinical pathways, organizational agreements, and referral network agreements
- Secure local, state and national continuing education approvals for suicide prevention training to ensure professionals will attend, if not available through the QPR Institute or Eastern Washington University (the QPR Institute's higher education partner)
- Conduct a Professional Training Needs Survey
- Conduct a Readiness for Change Survey of major participating institutions
- Determine time frames for pilot and/or program implementation
- Determine end points and outcome measures by research team
- Determine a sustainability model for all project participants and stakeholders
- Write and publish and plan for the PR and awareness-raising program to gain community support
- Train community-based instructors in all QPR training programs to build local capacity and to ensure sustainability of the project over time
- Train to competence all key professional gatekeepers (list above)
- Install institutional suicide risk reduction programs any psychiatric hospitals, medical-surgical hospitals, correctional, residential or other facility housing at-risk community members.

YEAR II

- Launch public awareness campaign, e.g., billboards, books, booklets, cards, brochures, CD-ROMs, videos and access to these and other local, regional, state and national suicide prevention resources to all community members, and make these materials readily available to all libraries. Provide public service announcements for local television, news print media and others.
- Open public, free or low-cost QPR training to all community members, with the goal of reaching at least one adult person per household, or one in four adults. Use school, work, union, church and other community sites as educational venues
- Collect outcome date, e.g., changes in referral patterns, number of new psychiatric admissions, changes in morbidity and mortality associated with suicidal behaviors, etc.
- Complete first year evaluation and report to community and project leadership

- Conduct ongoing monitoring of program outcomes and provide annual follow up and report to community leadership

Project Goals and the National Strategy
In any project of this scope, it is important that the goals and objectives of such an undertaking help achieve the goals of the *National Strategy for Suicide Prevention.* In this project, the following national strategy goals will be addressed:
Goal 1: Promote Awareness that Suicide is Public Health Problem that is Preventable
Objective 1.1(awareness raising)
Objective 1.4 (use of World Wide Web for suicide prevention)
Goal 2: Develop Broad-Based Support for Suicide Prevention
Objective 2.2 (establish public-private partnerships to advance the national strategy)
Objective 2.3 (increase the number of national professional, voluntary, and other groups that integrate suicide prevention activities into their ongoing programs and activities)
Goal 4: Develop and Implement Suicide Prevention Programs
Objective 4.3: (increase college activity in suicide prevention efforts)
Objective 4.4: (increase number of employers that employ evidence-based prevention strategies)
Objective 4.5: (increase the proportion of correctional institutions, jails and detention centers with evidence-based suicide prevention programs):
Objective 4.6: (increase the proportion of State Ageing Networks that use evidence-based suicide prevention programs to identify and refer for treatment elders at risk for suicide)
Objective 4.7: (increase proportion of family, youth and community service providers and organizations with evidence-based suicide prevention programs):
Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm (All QPR programs address means restriction in all aspects of every training program offered to lay or professional audiences)
Goal 6: Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment
Objective 6.1: (define minimum course objectives for providers of nursing care in assessment and management of suicide risk...)
Objective 6.2: (increase the proportion of physician assistant educational programs and medical residency programs that include training in the assessment and management of suicide risk …)
Objective 6.3: (increase the proportion of clinical social work, counseling, and psychology graduates that include training in the assessment and management of suicide risk.…)
Objective 6.4: (increase the proportion of clergy who have received training in the identification.…)
Objective 6.5: (increase the proportion of educational faculty and staff who have received training on identifying and responding to children and adolescents at risk for suicide)
Objective 6.6: (increase the proportion of correctional workers…..)

While additional goals and objectives of the national strategy deal will be addressed in this project, the success and responsibility for achieving these, e.g., “establishing linkages between mental health and substance abuse treatment facilities” will be up to community members and their leadership. The necessary focus of the QPR Institute’s role in this project is to provide education and training of gatekeepers at all levels of society, community-based programming,

and in the installation and maintenance of institutional suicide risk reduction programs and practices that enhance patient and inmate safety.

Summary

This community-wide suicide risk reduction program addresses many of the goals and objectives of the national strategy while, at the same time, offering significant benefits to individual community members as well as employers, schools, colleges, law enforcement, hospitals, health insurers, and all major social and healthcare organizations. Excluding avoiding the very clear and direct medical, psychological and emotional costs of what are typically infrequent completed suicides to the project community, published research has suggested the following positive outcomes could be expected:

- Fewer self-inflicted injury-related emergency room and outpatient visits.
- Fewer community homicides, murder-suicides, accidental deaths and incidents of other-directed violence, including domestic violence.
- Earlier detection and treatment of emerging brain disorders with resulting enhanced intellectual, physical and work performance by students and employees.
- Fewer negative student dropouts from middle schools, high schools and colleges due to untreated brain disorders and/or suicidal behaviors.
- More depression screenings resulting in less absenteeism among students and employees from early screening/detection/treatment of depression and other mood disorders.
- More substance abuse screenings resulting in less absenteeism and other social benefits.
- Fewer community members reporting suicidal ideation or making suicidal threats and thereby activating expensive emergency response systems (911, law enforcement, ER rooms, etc.).
- Fewer citizens, professionals, and family members suffering from post traumatic stress resulting from non-fatal and fatal suicide attempts by fellow community members and loved ones.
- Fewer incidents of negative press coverage and public relations problems following preventable community suicides or other acts of suicide-related violence.
- Less litigation for suicide malpractice due to enhanced provider competence and documentation in the detection and assessment of suicidal consumers.
- College credit courses currently unavailable to the community.
- Budget sensitive and relevant continuing education credits for all healthcare and 1st responder professionals.
- Reduced professional liability premiums for community social service agencies electing to use the QPR Suicide Risk Reduction Program and if insured by underwriters for the SAFECO Insurance Company. The QPR Institute and SAFECO have partnered to help reduce exposure to claims of suicide malpractice and litigation by financially rewarding adoption of this program.
- Enhanced community pride in successfully taking on the last great taboo of the 21st Century by carrying out the goals and objectives of the President's Freedom Commission Report on Mental Health, the *National Strategy for Suicide Prevention,* and the recommendations of the prestigious Institute of Medicines recommendations for action.

References:
1. *The National Strategy for Suicide Prevention: Goals and Objectives for Action*, 2001, U.S. Department of Health and Human Services
2. Knox, L.K., Litts, D.A., Talcott, W.G., Catalano, F. & Caine, E.D. (2003) Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study. *British Medical Journal* Volume 327
3. World Health Organization, 2003, www.who.org
4. Reducing Risk in Behavioral Healthcare, 2002, Devereux Foundation (presentation at the spring meeting of the American Association of Suicidology)
5. QPR for Suicide Prevention, 1995, QPR Institute Inc.

QPR Gatekeeper Training Research

Summary Results for 1999-2000

Two primary research projects designed to evaluate the effectiveness of QPR gatekeeper training were conducted during the 1999-2000 biennium. The first project was a longitudinal study of Albuquerque Public School District employees who were trained as QPR Gatekeepers. The second project evaluated the effectiveness of QPR Gatekeeper training among those who received training as a part of the Washington State Youth Suicide Prevention Program initiative sponsored by the Washington State Department of Health.

Results

Albuquerque Public School Project

The QPR Institute trained 1,144 Adult Gatekeepers in the Albuquerque School District in the fall of 1999. Gatekeepers included teachers, administrators, counselors, and support staff. An 18-month follow-up study was done to determine the effectiveness of gatekeeper training in the areas of 1) knowledge of suicide facts, 2) resources and, 3) attitudes regarding asking the suicide question. Two hundred and twenty-six participants completed both the pre- and post surveys.

- When asked to rate their knowledge about suicide, warning signs, how to ask someone about suicide, how to persuade a suicidal person to get help, information about local suicide prevention resources, and their level of understanding about suicide and suicide prevention, participants rated their knowledge at 18-month follow-up significantly higher than they did immediately prior to their initial training ($p < .001$ for all items).

- Regarding attitudes related to intervention, participants rated the appropriateness of asking someone about suicide and the likelihood of asking someone if they are thinking about suicide significantly higher at 18-month follow-up than they did immediately prior to training ($p < .001$).

These findings suggest that learning from the QPR Gatekeeper training is retained over, at least, an 18-month period and that trainees demonstrate a long term change in their attitudes toward active intervention.

Washington State Youth Suicide Prevention Program Project

Twenty-nine adults from North Central and Southwestern Washington were trained to be QPR Gatekeeper Instructors in May of 2000. All were provided the full eight-hour QPR Gatekeeper Instructor Certification Course, which included training and promotional materials. The goal for each QPR Certified Gatekeeper Trainer was to train at least 100 individuals within one year. For each training, Gatekeeper trainers gave each trainee a pre- and posttest of their knowledge of suicide and attitudes toward intervention. To date, youth and adults have completed 463 pre/post surveys.

- Results indicate statistically significant gains in all knowledge areas measured: facts concerning suicide, waning signs, how to ask someone, persuading someone to get help, how to get help for someone, information about local resources for help with suicide, and level of understanding about suicide prevention (p. < .001 for all items).

- Results also indicate a significant increase in self-ratings of the likelihood of doing the following behaviors: asking someone if they are suicidal, telling a suicidal person who to talk to for help, calling a crisis line, and going with the suicidal person to get help (p. < .001 for all items).

- These gains were found with both young (14-24 years of age) and adult (> 24 years of age) gatekeepers. However, gatekeepers under 18 years of age rated themselves lower than adults in post-training understanding of the practical aspects of the intervention. Although showing significant increases in knowledge, they reflected less overall knowledge than their adult counterparts regarding how to ask about suicide, how to persuade someone to get help, how to get help for someone, and their awareness of local resources. Although they rated themselves as less likely to actively intervene with a suicidal person than adults, they made significant gains in their attitude to do so as a result of training.

- Ninety-four percent of the participants rated the overall training quality in the good to excellent range.

Summary

These data suggest that QPR Gatekeeper training is well received and achieves its intended educational goals of increasing the level of knowledge about suicide prevention and suicide prevention resources and raising the likelihood of intervening in a suicidal crisis. Furthermore, results from the Albuquerque Public School District study indicates that these gains endure over an 18-month period.

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Research Coordinator

These data were reported in a paper session at the 2001 Annual Convention of the American Association of Suicidology

A Final Note

Before attending your QPR Instructor certification training we recommend you schedule your first gatekeeper training. We have listed here a number of potential groups that will be interested in learning QPR.

First, from the Surgeon General's NATIONAL STRATEGY FOR SUICIDE PREVENTION, we will the following: **Goal 6: "Implement training for recognition of at-risk behaviors and delivery of effective treatment."**

This goal addresses the need to provide training to key community gatekeepers as well as professionals. Gatekeepers are community members who regularly come into contact with people who may be at risk for suicide."

Please note that, as defined by the Surgeon General, gatekeepers have varying levels of duty to the people with whom they have contact, e.g., a physicians duty is very different than a pastors." The QPR Institute has developed specific gatekeeper training programs for all levels of duty.

Mentioned in the National Strategy are the following groups:

Primary care providers
Physician Assistants
Physicians
Medical Residents
Nursing care providers
Other health professionals
Social Workers
Counselors
Psychologists
Poison control center personnel
Outreach workers
Case managers
Home visitation providers
Clergy from all faith communities
Educational faculty and staff
Youth development staff working outside school settings
Juvenile justice
Justice
Correctional personnel
Family members of people at risk
Survivors of suicide
Community helpers
Mail carriers
Meals on Wheels volunteers
Senior service volunteers
Firemen
Lawyers
Health educators

Also, consider teaching QPR to:
Youth leaders
Bartenders
Volunteers of America staff
Goodwill Industries
The Job Corps
Hotel service personnel
Problem gambling hotlines and counselors
Emergency Medical Technicians
Dentists and their staff
Pharmacists
Human resource directors
Domestic violence workers
Government workers in public welfare programs
Any large employer via HR
Funeral directors
Professional sports and coaching associations
Association of drama teachers
School counselors association
Christian Youth Counselors Association
Military services
Pastors
All state social service employees
Area Agencies on Aging staff
Area Health Education Consortiums

See you soon!

The staff and faculty of the QPR Institute