Title: Exploring the application of current intervention and postvention theories to suicide prevention practice

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I am indebted to my hosts who were so kind to me and afforded me their time and expertise. I am grateful to Dr Thomas Joiner, colleagues and students at the Psychology Department, Florida State University, Tallahassee; Dr Frank Campbell and colleagues at Campbell Consulting, Baton Rouge Louisiana; Yvonne Bergmans & colleagues at Arthur Sommer Rotenberg Chair in Suicide Studies and St Michaels Hospital; and to Heather Fiske.

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Abstract

This report is the result of a scholarship that enabled the scholar to visit the United States of America and Canada to explore current theories of suicide prevention and to consider how they might be applied in England, Scotland, Wales and Northern Ireland.

This scholar visited: Tallahassee, Florida to work alongside Dr Thomas Joiner and his team; Baton Rouge, Louisiana which is the base for Dr Frank Campbell and the LOSS Team; and to the University of Toronto to work with and learn from Yvonne Bergmans and Heather Fiske. The report provides a description of the lessons learnt with an analysis of how they could be applied in the UK.

Thomas Joiners interpersonal theory of suicide has the potential to transform how we care for suicidal people. His more recent work on the myths that surround suicide has the potential to demolish the ignorance and misinformation that is held about the topic. Heather Fiske has applied Solution Focused Brief Therapy successfully with suicidal people for many years.

Yvonne Bergman has used the solution focused approach and many others in group therapy for those who have made repeated suicide attempts.

Frank Campbell has been a tireless advocate of “active” postvention. In his work he has proved that active postvention enables survivors of suicide to access longer term help in weeks rather than the years it can take if postvention is provided passively.

Based on the learning and analysis the report makes recommendations on: - (whole community) prevention; intervention i.e. with those at risk of suicide and postvention - those bereaved by suicide.

Thomas Joiner has systematically provided the evidence that debunks many of the myths surrounding suicide. A large scale media campaign would have a major impact on removing the general ignorance of suicide that contributes to the stigma of suicide. The stigma of suicide may mean that suicide prevention is not seen to be as deserving of resources as other life saving activities such as cancer research or road safety campaigns. A call is made in this report for the issue of suicide to become a major political issue through the influence of high profile political figures being encouraged to “champion” the cause of suicide prevention. The UK countries could and should provide conferences on suicide prevention at least annually in each country and could potentially share international speakers.

The USA and Canada have national organisations that support and challenge the work of their respective governments’ efforts to prevent suicide. It is
recommended here that similar organisations should be set up in the countries of the UK and this scholar has begun preliminary work to realise this in Northern Ireland.

Mental health promotion is a significant component of suicide prevention. One of the recommendations made here is that campaigns to promote mental health should be oriented away from old evidence and be focused on the latest best evidence. The “5 a day for your mental health” from the Foresight’s report produced by a governments think tank made up of 400 scientists, Government Office for Science (2006), it should be the basis of current Mental Health promotion campaigns.

This scholarship report also recommends that all mental health nurses should be trained in Solution Focused Brief Therapy. This therapy is directly in line with the recovery approach being promoted in mental health care and it has been proven to be effective with the most at risk patients, those who are suicidal.

This study tour has reinforced for this scholar the huge contribution volunteers can make to suicide prevention. More use should be made of volunteers in crisis telephone services and in services provided to “survivors” of suicide.

Several recommendations have direct practical potential for those people struggling with suicide. These include use of hope boxes and virtual hope boxes; provision of crisis cards that include individually derived reasons for living; changing the way “low risk” self harm is considered and managed; transforming the attitudes of Emergency Department staff have towards self harming persons and those who self harm and abuse substances; use of Joiner’s INQ & ACSS in assessing suicidality and his cognitive ICARE approach in follow up treatment; the provision of “safe places” for those suicidal people who are intoxicated/incapable as the result of alcohol and/or drugs; wider application of the ground breaking work of the PISA (Psychosocial/Psycho educational Intervention for Persons with Recurrent Suicide Attempts) model for those with recurrent suicidal attempts which has been developed by Yvonne Bergmans and colleagues in Toronto.
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MAIN REPORT

Introduction

This scholar is a suicide prevention advocate in the proud tradition of nurse advocates. His involvement in suicide prevention began in 1998 when he was asked to evaluate responses by his local health trust to young people at risk of suicide. He was instrumental in bringing Applied Suicide Intervention Skills Training ASIST to Ireland in 2003 and became one of the countries first ASIST trainers. The scholar and his colleagues have trained several thousand participants and nearly 200 trainers. He now is a Senior Training Coach in ASIST and a safeTALK trainer.

This scholar’s passion for suicide prevention saw him, in 2004, being awarded a Florence Nightingale Foundation Scholarship to visit the United States of America and Canada to explore the elements of national suicide prevention strategies. On his return he helped form a coalition with suicide survivors and activists that lobbied to secure a suicide prevention strategy for Northern Ireland. He joined the working group that produced the strategy “Protect Life” Suicide Strategy & Action Plan 2006-2011 and later served on the Suicide Strategy Implementation Body until 2009.

The scholar has contributed to developing standards and educational resources for use in suicide prevention, intervention and postvention. This report is as the result of a second scholarship received from the Florence Nightingale Foundation when he again travelled to USA and Canada to examine the practical implications of emerging suicide prevention theories.

Theories as to why people kill themselves have evolved from that of Durkheim (1897) who contended that in all suicides the individual is disturbed by the regulation of society. Karl Menninger (1936) apparently came to the view that masturbation was an important factor in suicide. Harry Stack Sullivan (1953) contended and defended the theory that suicide results from the individual turning aggression or hate in on themselves. Edwin Shneidman (1996) put forward the theory that suicide results from the frustration of psychological needs and stated “in almost every case, suicide is caused by pain, a certain kind of pain – psychological pain, which I call psychache. Furthermore, this psychache stems from thwarted or distorted psychological needs”.

Probably the latest major theory on the cause of suicide is that by Joiner (2005) who has built on the thwarted psychological needs work of Shneidman. Joiner (2005) has claimed that that when individuals feel they do not belong and that they are a burden, no longer effective, they develop the desire for death. Suicide only becomes possible according to Joiner, if in addition to the desire for death comprised of these two elements, they have acquired the ability to “enact lethal self injury”. This hypothesis resonates with the clinical experience of this scholar and is reinforced by the stories
of families bereaved by suicide and people who have made previous suicide attempts

This desire for death has two components according to Joiner (2005)

(i) “burdensomeness” – the person has the perception that their death would be of more value to others than their life; and

(ii) the person has a sense that they are completely alone and disconnected from family, friends and all other social networks

In 2009/10 there were 4,637 people admitted to hospitals in Northern Ireland with a diagnosis of self-harm. For the year 2010 there were 313 suicide deaths recorded in Northern Ireland, the highest ever annual figure. Many of the people who present at Accident and Emergency Departments are offered a full psychosocial and psychiatric assessment depending on the presumed intent of the injurious behaviour. Many others are deemed “low risk” of imminent suicide and under the “Card before you leave” scheme are offered a next day appointment with Mental Health Services. This scheme was set out in “Delivering the Bamford Vision” (DHSSPS 2009) and in 2010 it became one of the targets set under Priorities for Action, 2010/2011 (DHSSPS 2010). Joiner (2005) has argued that the relationship between self harm and suicide is incompletely understood however. The implications of his theory are that some of the people who present at Accident and Emergency Departments and at that point are considered “low risk” are becoming familiar with pain, overcoming the fear and making eventual death by suicide more likely. This means that amongst the people currently being treated under “Card before you leave” there is a significant potential to intervene and interrupt the pattern of further or repeated self injury that according to Joiner (2005), leads to acquiring the ability to kill oneself, one of the three main components involved in suicidal deaths.

One of the main difficulties he claims, however, is the fact that many of those offered the follow up next day ” Card before you leave” appointment fail to attend. Some will be contacted by telephone and be persuaded to attend. Many others cannot be contacted and or persuaded and this is relayed to their General Practitioners for follow up and possible re-referral to Mental Health Services if required.

These then are people with a long term risk of suicide who are not receiving the care that would not only assist with their current difficulties and distress but could prevent the potential of suicide. The challenge then is now we offer them an intervention that is effective and provided in a way that will be accepted.

From this scholars studies it became apparent that new ways of engaging and working with people who are suicidal needed to be considered. Survivors of suicide, family member or friend of the deceased, are both among the people most at risk of suicide and are most easily identified as at increased risk. More active ways of caring for them has been advocated by Frank Campbell and others. Researchers in Canada & USA have produced new suicide prevention theories and hence the desire to visit and learn about these theories and how they could be applied in the UK.
Places visited and information gained

Dr Thomas Joiner

This scholar decided that it would be very fruitful to spend time with the man who developed this intrapersonal theory: Dr Thomas Joiner. Thomas Joiner is the Bright-Burton Professor and director of the University Psychology Clinic in the Department of Psychology at the Florida State University and author of hundreds of peer-reviewed publications, as well as the 2005 book Why People Die by Suicide. He lost his father to suicide in 1990.

In the afternoon of the first day of the tour this scholar sat in as Dr Joiner entered a conference call with the consortium for U.S. Military Suicide Research. The consortium is evaluating several suicide prevention interventions that can be readily applied in military contexts including battle zones. The total value of the research grants attracted by the consortium for this work is $18 million. The interventions are (i) Brief Intervention for sort-term suicide risk reduction in Military Populations (ii) Usability and Utility of a Virtual Hope Box (iii) A Behavioural Sleep Intervention for the prevention of suicidal behaviours in Military Veterans: A randomised control trial (iv) Military Continuity Project & (v) Development and Evaluation of a Brief, Suicide prevention Intervention Reducing Anxiety Sensitivity.

This scholar accompanied Dr Jones as he examined a final dissertation defence by one of his PhD students on the interpersonal aspects of depression. One of the things the young woman mentioned was the measuring of social networks with the use of the Social Network Scale.
Dr Joiner and I travelled to Panama City where he delivered a presentation on the myths surrounding suicide. The presentation was powerful and backed up by studies and videos to emphasise his points. Dr Joiner is an excellent presenter. This presentation comes from the work contained in Dr Joiner’s book “Myths about Suicide” (2010).

The main reason for visiting Dr Joiner was his interpersonal theory of suicide outlined in his book “Why people die by suicide”, Joiner (2005). His theory powerfully explicates the relationship between self harm and suicide. He argued that any kind of injury but particularly purposely inflicted self injury “habituates” the person to the fear and pain associated with suicide. Once familiar with the pain and fear, should the wish to die emerge then these natural deterrents are absent and death by suicide can occur.

The next five days of the scholarship was spent in the company of Dr Frank Campbell who had been Executive Director of the Baton Rouge Crisis Intervention Centre. Having retired from that position, Dr Campbell is now a senior consultant with Campbell & Associates Consulting which provides training and consultation on the active postvention model of response to suicide.

In the autumn of 1969 the student body president and several other students at Louisiana State University died by suicide. The University was plunged into grief, confusion and concern for all of the students. University leaders decided to turn the danger into opportunity. They decided to set up a peer support telephone line backed by staff and the University faculty. It was based in the Student Health Centre.

Quite quickly people like Dr Campbell in Baton Rouge came to the realisation that there was a need for such a crisis line in the wider community. In 1970 the Baton Rouge Crisis Centre was set up as a non-profit organisation with a call centre for people in crisis. The line was simply called “The Phone” and offered the opportunity for anyone, of any age, who didn’t or couldn’t talk to family to talk to trained professionals or trained volunteers anonymously.

Many of the staff who answer the crisis calls to the centre have experienced a death by suicide of a family member or friend. In Baton Rouge and increasingly around the...
world these people are referred to and refer to themselves as “survivors”. This name comes form the obituary notices which after the deceased’s name the notice then indicates that the person is “survived” by….

In Baton Rouge in 1981 a couple who attended a local Al–Anon group talked to another woman about support groups. All three were survivors of suicide. They saw the value of support groups and felt it would be great if such a thing were available for those people who have lost someone to suicide. They set up a survivors of suicide support group to meet weekly in the Baton Rouge Crisis Centre and agreed to offer the service free of charge.

Despite the presence and sterling work of the support group Dr Campbell studied the interval from the time of deaths to the time people come for help. On average it was four and a half years before survivors received help. In 1997 Dr Frank Campbell conceived the idea of a team to outreach to suicide survivors. He felt that a proactive approach was needed to ensure that people would not have to wait for help or discover it by accident. Dr Campbell felt the team should be composed largely of those who had themselves lost someone to suicide and were now ready to altruistically help others. The team was therefore made up of survivors of suicide and non survivors who had professional training and background. It was called Local Outreach to Suicide Survivors –LOSS Team

For ten years Dr Campbell’s plan to utilise the LOSS TEAM met with resistance. The scene of a suicide is a crime scene in the first instance and initially it is the domain of police and coroners, neither of whom wanted civilians destroying evidence.

A new Coroner, Louis Catalde, was appointed and although supportive of the idea he was reluctant to bring the LOSS Team in. Coroner Catalde however attended a scene where a toddler found her mother who had used a high calibre, high velocity weapon to shoot herself dead. It later emerged that this mother had, as a child, found her father who had shot and killed himself. Mindful of this contagion and the multi-generational effects that this death represented, Catalde said something had to be done. He called in the LOSS team and they became the first group in the country to be allowed at a crime scene

The LOSS team have a unique relationship with police that other communities could and perhaps strive to replicate. To be successful, according to Norma Rutledge of the Baton Rouge Crisis Intervention Centre, they also need sustainable community support. Before LOSS the average interval from time of death to time of accessing help was four and a half years. Since the LOSS team that average time has been reduced to 47 days for those who receive a LOSS call.
On leaving Baton Rouge the scholar travelled to Toronto for the final destination in the tour. The first hostess for this scholar in Toronto was Yvonne Bergmans who is a Suicide Intervention Consultant at the Suicide Studies Unit, Arthur Rotenberg Chair in Suicide Studies, St Michael's Hospital University of Toronto. The main reason for coming to see Yvonne was her new group approach for those people who had made multiple attempts to end their lives. The intervention is called “Psychosocial/Psychoeducational Intervention for Persons with Recurrent Suicide Attempts (PISA)”. This novel approach is targeted at both men and women from inner-city populations who are often “under housed, underemployed and undereducated” who have made two or more suicide attempts at any point in their lives. Clients who had a history of violence in the preceding three months or those with schizophrenia or other psychotic disorder that was active, were not considered eligible for this intervention. This client group have been identified to have many difficulties and deficits. According to Yvonne PISA has a design that is “simple, portable, and flexible”. She outlined the features of the intervention: hope as a central concept; client as expert and solution talk. She also briefed the scholar on the expectations, group structure: modules & content.

In relation to the group itself Yvonne outlined the values:

(a) Clients have ownership of the group
(b) Clients have access to resources that therapists do not
(c) Clients are taken seriously – it’s a mutual learning experience
(d) The intent is to work on content that holds meaning for clients
(e) In group participants are “treated like people not diseases”

Yvonne described the detail of a study undertaken to understand how young people can move away from suicide related behaviours. The process of their transition from higher to lower risk was explained as a pathway involving three major elements(i)
“living to die” ii ambivalence and tipping/turning points and iii a process of recovery that included small steps or phases toward life (“pockets of recovery”)

Yvonne then outlined another important area of her work in support of the Emergency Department (ED) and the Crisis Stabilisation Unit (CSU) at St Michaels Hospital in Toronto. We visited the ED, the CSU psychiatric unit and psychiatric intensive care unit at St Michaels. We then discussed those males with substance abuse problems who present at the ED in suicidal crisis.

The remainder of the time in Canada was spent with Heather Fiske author of “Hope in Action”: Solution-Focused conversations about suicide. The scholar met this warm and wonderful lady in downtown Toronto and we travelled to her home in the suburbs where we spent the first of three sessions. We talked through her recent book and how attractive the approach of Solution Focused Brief Therapy is to this scholar, a Mental Health Nurse and someone passionate about suicide prevention.

Heather outlined the background to Solution Focused Brief Therapy and shared the following definition “SFBT is a respectful, collaborative client centred approach to helping people make changes”. It was developed by Insoo Kim Berg, Steve de Shazer and their colleagues at the Brief family Therapy Centre in Milwaukee, Wisconsin. Described as “strengths based” the therapists help clients use their existing resources and strengths to achieve their goals. Centrally SFBT assists the client to envisage the possibility of a “different and better” future and thoroughly explores that future in detail. The therapy is described as brief not because there is a limit to the number of sessions but because the approach of utilizing the clients resources and strengths, results in shorter interventions. The maxim for treatment is “as many sessions as are needed – and not one more”. – Fiske (2008)
Analysis of the information and synthesis for practice

Dr Joiner and his colleagues in the U.S military suicide consortium are evaluating five specific suicide interventions (See Appendix 2). While it will be vital to have the proof of effectiveness there is arguably merit in proceeding to introduce some these to the UK as they seem self evidently sensible. The provision of crisis plans on a card already happens in many services and the addition of individual reasons for living could be achieved quickly and at fairly low cost and at least piloted in the scholar’s area.

The hope box represents an intervention that can be piloted with suicidal patients in the UK. It would seem that this could be initiated with patients who have been admitted to hospital following a suicide attempt to provide a tangible reasons for living resource.

The “virtual hope box” programme for smart phones is an intriguing idea. It can be difficult for the patient to keep an actual box with them all the time so having the hope box on their phone means the suicidal person has access to the resource of reasons for living at any time. It will have videos, photos, messages from loved ones, pieces of favourite music as well as who to contact in a crisis, “coping cards” and relaxation exercises. This initiative should be explored right away. The Smart phone application developers in the UK need to be engaged as soon as possible in this development.

Although the “caring texts” intervention has not yet been evaluated it does seem prudent to utilize this approach right away. This scholar believes that the organisation in Northern Ireland, Contact, who provide the 24 hour crisis line “Lifeline” should be advised of this work and encouraged to consider this approach for longer term follow up of those who have been suicidal. Similarly the Samaritans across the UK may be interested in this initiative.

The Sleep intervention and Reducing Anxiety Sensitivity programmes are more resource intensive and it would be prudent to await their evaluations before embarking upon them here.

The Social Network Scale is a tool which should be used in assessing and working with “failed belongingness”. The need to belong the perception is a “fundamental human motive” according to Joiner (2005). Failed belongingness occurs when individuals do not feel connected to anyone. Joiner contends that when failed belongingness comes to co-exist with burdensomeness then the desire for death emerges. It may prove fruitful then, at the point of referral to Mental Health Services, to measure the person’s social network. If it is found to be small the assessing practitioner could negotiate with the patient on how this social network could be expanded in a way that provides better and deeper connections. This tool would also help the practitioner to learn how the patient perceives themselves to be connected to others.

There may also be some benefit in trying to alleviate the sense of burdensomeness that some people feel by encouraging them to contribute more to the lives of others, by volunteering for example. Joiner however points to a potential problem. Individuals can actually be contributing extensively to the lives of others but still perceive that
they are a burden on others. The encouragement to contribute may need to be combined with cognitive work to challenge the burdensomeness perceptions.

In his book "Myths about suicide" (2010) Joiner passionately argues for greater understanding of suicide. A major barrier to compassion and proper care for those who are suicidal is the stigma that surrounds suicide. According to Joiner the stigma has two components fear and ignorance. Thomas Joiner asserts that the fear of suicide is healthy and should remain as a protective buffer against death. In his other book he has convincingly argued that those who die by suicide have been exposed to a lot of pain in the past in order to overcome the fear of death. Joiner makes the plea that we must demolish the ignorance that surrounds suicide by exploding the mythology that surrounds it.

The myths are arranged by Joiner in to those about the suicidal mind, suicidal behaviour and those that have grown up about causes, consequences and sub populations.

It seems evident that a public information campaign to tackle these myths about suicide should be prepared. Of the countries of the UK, Scotland has shown courage and commitment to explicit media campaigns about suicide. It is probably they who could be most easily persuaded to pursue such a campaign to expose these myths.

Mental health promotion has a major part to play in suicide prevention. The best current evidence of what is effective in promoting mental health is the Foresight report – Five a day for your mental health. Government Office for Science (2008). The report recommends that we all should: Connect with those around us; Be active; Take notice; Keep learning and Give. In the experience of this scholar current mental health promotion campaigns do not closely follow the recommendations of the Foresight report. Connecting and Giving, if widely practiced could potentially help to counteract the failed belonginess and burdensomeness and thus assist in suicide prevention efforts.

Dr Joiner is keen that his theory be tested in other contexts and has developed two tools which should be piloted in the UK. The Interpersonal Needs Questionnaire (INQ) was developed to measure beliefs about the extent to which individuals feel connected to others (i.e., belongingness) and the extent to which they feel like a burden on the people in their lives (i.e., perceived burdensomeness).

The original version of the INQ used 25 items: ten items measure belongingness (e.g., "These days other people care about me") and 15 items measure perceived burdensomeness (e.g., "These days I feel like a burden on the people in my life").

To complete the INQ, participants indicate the degree to which each item is true for them recently (on a 7-point Likert scale). Scores are coded such that higher numbers reflect higher levels of thwarted belongingness and perceived burdensomeness. The items were rationally derived from the hypotheses of the Interpersonal Theory.
The ACSS (Acquired Capability for Suicide Scale) assesses the acquired capability to inflict lethal self injury. The original version has 20 items which are self scored on a five point Likert scale with the higher scores indicating higher capability.

Dr Joiner's (2005) theory as to why people die by suicide, the Interpersonal theory, is in the opinion of this scholar, a compelling and convincing one. It has the potential to transform how people considered suicidal are cared for. It can redirect the efforts of all those charged with and concerned about suicide as it will help them focus on these important domains of failed belongingness, burdensomeness and the acquired capability to inflict lethal self-injury. Dr Joiner also provides the tools in the form of the INQ & ACSS to facilitate this work.

This scholar drew lots of learning from the time spent with Dr Frank Campbell in Baton Rouge. Dr Campbell outlined the origin of the intervention and active postvention elements of suicide prevention which could be replicated in any community.

One of the first key learning points from Baton Rouge is that volunteers can complement the trained professionals in the pursuit of suicide prevention. More than half of those answering the crisis line are volunteers. In Northern Ireland almost half of the annual budget for suicide prevention, £3.5 million, goes to fund the Lifeline which is staffed by paid counsellors. Northern Ireland should urgently consider directing contact (Lifeline) to recruit and train volunteers for the crisis line, the Suicide Strategy Implementation Body.

Survivors of suicide are passionate about suicide prevention but should not be encouraged to volunteer until they have taken the time they need to grieve their own losses. There have been lots of examples of Northern Ireland where survivors have been thrust in to postvention before they have had time to deal with their own grief and this has to safe – guarded against in the future.

Postvention needs to be expanded to include friends. Friends of the deceased are often overlooked as survivors though they may have been closer to the person who died than family members. There is a need then to plot the social network of the deceased in a similar way to that described for those at risk to ensure that these friends receive active postvention. This is an initiative this scholar will bring back to his practice.

Frank Campbell and his colleagues provide a compelling case for active postvention. Before LOSS the average interval from time of death to time of accessing help was four and a half years. Since the LOSS team that average time has been reduced to 47 days for those who receive a LOSS call.

The principle of honesty with children survivors is a key learning point. Children should be told about the death in an age appropriate way. On the other hand, children who are lied to will have difficulty trusting adults again.

This honesty is the first steps in breaking the legacy of suicide. Without this kind of help children who have lost a parent to suicide can be left with the sense of a foreshortened future. They tend to believe that they are doomed to die at the same
age as the parent who died by suicide according to Campbell (1997). Active postvention such as LOSS Team can alter the course of the lives of survivors including children. Children bereaved by the suicide of a parent may develop difficulties with alcohol, drugs, have relationships difficulties and may have work problems. Alongside the sense of foreshortened future they may have difficulty trusting others. It has also been reported that these individuals are hyper mature when young yet display prolonged adolescent behaviour as adults. In Northern Ireland there is an opportunity to identify all children who have lost a parent to suicide and ensure they receive the help they need. Police throughout the region who attend a suspected suicide complete a SD1 form and from April 1st 2012 this will uniformly be forwarded to helping agencies if the family agree. This scholar will work with colleagues to have this form amended so that a question about children, particularly those who did not live with the deceased, are identified.

From Yvonne and colleagues in Toronto there are several learning points that could have implications for practitioners in the UK. The PISA (“Psychosocial/Psycho educational Intervention for Persons with Recurrent Suicide Attempts) has been trialled in Dublin in a research context but should be available here as a treatment option for this client group.

It has long been recognised that people with self harm/suicide attempts often meet hostile attitudes when they present for help. Yvonne explained a pilot study she and her colleagues had undertaken with psychiatric trainees. The trainees were invited to join PISA intervention groups as therapists and co therapists. The pilot study provided data on the potential of the experiential PISA intervention to promote more positive attitudes towards the client amongst these trainees. This approach could be replicated in the UK.

Yvonne described the detail of another study undertaken to understand how young people can move away from suicide related behaviours. The study found that “an individual with repeated suicide-related behaviour has a long-standing, intimate relationship with death that serves a purpose or provides the youth with an identity”. This scholar believes that this relationship with death is very poorly understood. Arguably it is present for all who are suicidal. According to Joiner suicidal people do not feel connected to anyone and feel a burden on those people who surround them. The one significant relationship they have is with death. It seems to this scholar, that death is like a secret lover that the suicidal person is having an affair with. Giving up on the “affair” will not be easy and that needs to be fully understood by those trying to help the suicidal person. Efforts by helpers to move the person too quickly away from this relationship may leave the person feeling misunderstood, alone and hopeless once more.

Practitioners need to understand the ambivalent process that is being experienced by suicidal individuals may indicate that the reasons for dying may be weakening. To lose the relationship with death abruptly would represent a loss in itself.
The practitioner has to hear and talk about both the death pull and the life pull. Changing from a death orientation to one where life is fully embraced involves many “small steps” in journeys unique to the individual. Shifts to the life side according to Bergmans et al (2009) represent “pockets of recovery” along the way. Clinical practitioners need to be aware that relapses either in self—harm behaviour or in re-engaging with the relationship with death may just be part of the course of the person’s condition and can still be consistent with their recovery.

Another piece of work, that Yvonne carried out, concerned the experience of young men presenting with mental health and substance abuse problems at Emergency Departments. These patients represent a significant proportion of all ED visits, are often seen by ED staff as a burden on resources and are considered difficult to treat. Staff often respond to these self injury “repeat visitors” with frustration and anger. This often leads to a reduction of empathy and the patient feeling further stigmatised.

Understanding that these patients are trying the best they can, can help to reduce the level of frustration felt by care providers. Emotional literacy and problem—solving abilities are significantly affected in a crisis, with each patient requiring a tailored intervention that will meet his or her specific needs. Patients require an understanding that they are in extreme distress, that the caregiver will try his or her best to understand that distress, and that together; a safer solution can be found. The patients spoke of experiencing multiple interviews, long waits, feeling confined, loss of control and then being discharged. The long waits were a major contributor to the inability to stay in control and also contributed to the negative behaviours.

Not all staff were frustrated with these patients and many demonstrated empathy and understanding. Although the ED is not the ideal setting for caring for these patients, a lot can be done while they are there. Yvonne recommends that: staff validate the stress the patient is experiencing; complement them for coming to ED rather than choosing self—destructive behaviour; recognise that their presence and behaviour is not a personal attack but a manifestation of distress. Although this work can be challenging Yvonne suggests that staff seek to build up the interactions with these patients through brief chats and updates on the likely waiting time. This approach often helps to de-escalate the crisis and prevents disruptive behaviour. Yvonne advises that if staff can provide an atmosphere where de-escalation can occur then the patient can recover the capability to discuss their problems, consider solutions and make less harmful choices.

Yvonne has outlined a care strategy for managing these patients which is practical and self evidently effective. This scholar intends to collaborate with her on developing a training package for ED staff here.

Heather Fiske outlined the aims of SFBT:-to work with the person rather than the problem; to look for resources rather than deficits; to explore possible and preferred futures; to explore what is already contributing to those possible futures; to treat clients as the experts in all parts of their lives.
Heather and other SFBT therapists gather a detailed picture of what it will be like when the problem is solved. The client and the therapist then work backward to achieve that picture by systematically identifying times when part of the solution is already happening or could happen. This therapy has very little concern for causes or beginnings of the problem, the illness profile or on analyses of the client or his/her interactions with others.

This approach contrasts with the body of therapy currently practiced that identifies and focuses more on the deficits and problems of the client. One of SFBT’s developers, Steve de Shazer, calls this orientation away from problems to solutions “a true paradigm shift”.

Some Mental Health Nurses practice in a solution focused way. There has also been a call for Mental Health Nurses to train as life coaches to support the person on their journey of recovery. This scholar has been so impressed with SFBT and believes that all Mental Health Nurses should learn this approach. As part of a regional network of Service Improvement Managers in Mental Health services the scholar is well placed to begin the dialogue that can start to make this paradigm shift happen.
Lessons learnt for UK, place of work and of direct benefit to patients

A conceptual framework that helps understand suicide prevention is that which considers approaches for the whole population – prevention; meeting the needs of those of risk of suicide – intervention; and caring for those bereaved by suicide and seeking to prevent further suicides amongst those bereaved, the "survivors," – postvention. Arguably the lessons learnt from this study tour can be broadly considered under these three headings.

One of the first lessons learnt from this tour is that the stigma of suicide is a major barrier to people in need receiving the understanding and care that they not only need but that could save their lives. The stigma prevents people at risk saying the word suicide because in many cases they have not been given the permission, by professional carers, to say the words “kill myself”, “end my life” “suicide”. Thomas Joiner asserts that this stigma has two major components fear and ignorance. We must keep the fear of death because it will keep people alive but we must dismantle the ignorance that surrounds suicide asserts Joiner (2010). Ignorance is killing people. Perhaps a public information should be designed that would seek to systematically debunk the myths as Joiner (2010) has set out in his Myths about suicide” book. The place in the UK most likely to adopt such a campaign first is Scotland who has taken the lead in public campaigns explicitly using the word suicide. Other countries have been slow to adopt this approach. Such a campaign would have a major impact on those struggling with thoughts of suicide and those struggling to help them. For example if it was generally known that “talking about suicide CANNOT put the idea in the distressed persons head then the carer could reach out and openly talk about suicide. In many cases the at risk person needs the carer to be the one to say the suicide word. The at risk paerson then has the permission to agree that yes things have got that bad they are having thoughts of suicide.

This scholar, a mental health nurse who trained in the mid 1970s, is now convinced that all mental health nurses should be trained in Solution Focused Brief Therapy. This is based on the experience of this study tour. The prevailing discourse in Mental health care is about recovery. SFBT is such a good fit it will enable mental health nurses to recognise patient strengths and resources and enabling patients to envision a time when their difficulties do not exist. Nurses and patients can work collaboratively to make that a reality. For the patient, client, service user their nurse is now a cheer leader, a spotter of successes instilling hope that recovery is and can happen.

The therapeutic dynamic between nurse and patient would be transformed. A nurse, practising in line with SFBT would be having conversations rather than conducting interviews that may sometimes feel like interrogations for the patient. The conversation goes where the patient needs it to go according to Heather Fiske because “the next question is almost always built on the last answer” Fiske (2008).
It would also seem worth considering providing SFBT for nurses in the Emergency departments. The people with recurrent self harm are often treated with hostile attitudes as has been well documented and found by Yvonne Bergmans and her colleagues in Toronto. There is the hope and potential that a patient who presents at the Emergency Dept where nurses have been trained in SFBT would be met with something like “Hi John it’s three months since you ve been here, well done –how have you managed to cope since you were last with us”. This would be in complete contrast to the feeling of alienation some people currently experience and the attitude communicated, albeit non- verbally, of “Oh no, not you again”.

Dr Joiner has provided us not only with a theory as to why people kill themselves but the tools to better identify those at risk and intervene appropriately once the suicide risk has been established. The INQ enables the desire for death components of failed belonginess and burdensomeness to be identified. The ACCS tool measures the extent to which the person has acquired ability to enact lethal self injury.

The acquired ability component is a relatively fixed entity but the desire for death components are more amenable to treatment. The failed belonginess and sense of burdensomeness are perceptions held by the person at risk that can and do need to be challenged in therapy. Dr Joiner has provided a cognitive approach called ICARE for dealing with these faulty perceptions held by suicidal persons. The therapeutic approach aims at restructuring negative thoughts. Each letter of the acronym ICARE stands for a step in the process. I stands for identifying the specific negative thought. C relates to connecting the particular thought to generalisations that the person is making. The A in the acronym refers to the objective assessment of the thought and challenging the thought in the cognitive style of enquiring about the evidence supporting the thought pattern. R is for restructuring the thought based on the information gathered from the preceding steps. The restructuring seeks to “degeneralise” and replace the generalisation that led to the faulty thinking. The E relates to execution which means the client now has to act in line with the re-ordering thinking.

Learning from one of Dr Joiner’s students about the Social network Scale led this scholar to consider that this tool could be used by practitioners assessing someone at risk of suicide. The scale measures who the person has in their social network and this has the potential to have the client see their actual connections to others and may strengthen the sense of “belonginess”. If the scale indicates that the person actually has a small social network then one focus for the intervention is helping the client to expand and build their network with people who will be supportive.

The “caring texts” intervention is one that has immense potential as it builds on one already proven effective i.e.Motto’s (1976) “caring letters”. This scholar believes that organisations like Samaritans and Contact, who operate the Lifeline crisis line in Northern Ireland, should be persuaded to consider this approach.

The hope box and the crisis cards that contain the person’s reasons for living are tangible, external resources that people at risk of suicide can rely on when other
people are not around. These should be available for everyone who is identified as at risk of suicide. They are simple and can be easily provided by nurses and other professionals. The virtual hope box may take longer to realise but because of being in the persons Smart phone can be with them at all times. These resources can potentially make the difference between life and death. At times of crisis anything which delays acting on the thoughts like looking at a photo of a loved one, playing a favourite piece of music can remind the person that there are reasons to go on living or at least to delay acting on the suicidal thoughts.

One major “aha” moment for this scholar was around the relationship with death that people who make recurrent attempts have. Although aware of the ambivalence concept the work of Yvonne Bergmans helped this scholar to really understand that for some of these people, they feel estranged from other people and their relationship with death is the only one that they currently have. Practitioners need to better understand the value that these people place on this relationship so that the suicidal person feels understood. Ignorance of this death relationship, on the part of practitioners, or attempts to minimise the importance to the individual, now seem counter intuitive and counter productive. Training nurses and others to intervene with people who make recurrent attempts to end their lives must ensure that this ‘relationship with death’ concept is fully understood so that helpers can respond appropriately.

A major learning point from this study is the major contribution that volunteers are making to suicide prevention particularly on the crisis lines and postvention services in the United States. Much more could be done in the United Kingdom to harness the ability and willingness of volunteers. There is a huge untapped potential of “special” volunteers i.e. survivors of suicide who have the experience themselves of having lost someone to suicide. At a time when they have adapted to their own loss they can provide so much hope and help for the recently bereaved by suicide.

This scholar was very impressed by the PISA (“Psychosocial/Psycho educational Intervention for Persons with Recurrent Suicide Attempts) model. A previous attempt to end ones life by suicide is the most reliable predictor of future death by suicide. Joiner (2005) explains that those with repeated attempts are acquiring the ability to kill themselves. The PISA approach is therefore targeted at those people in our society most at risk of suicide. The model is being evaluated in centres in the Republic of Ireland but is not available across the UK. Consideration needs to be given urgently to enabling this approach to be applied here.

A third element of my visit to Toronto focused on national advocacy for suicide prevention. Heather and Yvonne are leading members of the Canadian Association for Suicide Prevention. I believe there is a need for similar organisations in Northern Ireland and other UK countries, independent of Government, that challenge and support suicide prevention efforts. I plan to fully explore the benefits and challenges associated with setting up and running a national advocacy organisation such as this.

Dr Campbell in Baton Rouge has articulated and proved the efficacy of active postvention in connecting survivors to the help they need in a timely way. This
approach is not widely available in the UK which presumably means that those who lose a loved one to suicide may spend a long time without help, may "stumble across it or may never receive it. Suicide prevention strategies at national and local levels must show that postvention has moved beyond the passive and actively seeks out and provides help to the bereaved by suicide.

Another key learning point from Baton Rouge centred on the proper identification of those impacted by the death of someone to suicide. It is striking that friends and peers of the deceased may not always be considered survivors even though they may have been closer to the deceased than many of the family members. Another neglected group potentially is the children of the deceased. Some children may live apart from the deceased parent as the result of breakdowns in parental relationships. It is imperative that all child survivors are identified and offered the help which can potentially change their lives. By breaking the legacy of suicide, proper help can save many of the lives of people that would have otherwise gone unidentified.
## Recommendations and intended implementation

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Intended implementation</th>
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<td><strong>Media campaign – myths about suicide</strong></td>
<td>Scotland seems the place in the UK where this campaign would be most favourably considered. Contact has been made with the Choose Life Publicity Officer, Laura Blair. A copy of this report has been sent and a teleconference has been set up for April 30th 2012.</td>
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<tr>
<td><strong>Suicide prevention must become a key political issue</strong></td>
<td>This scholar and members of Suicide Awareness and Support Group are due to meet the Lord Mayor of Belfast on Wednesday April 25th 2012.</td>
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<td><strong>Northern Ireland Association for Suicide Prevention</strong></td>
<td>A meeting to discuss the formation of such a group in Northern Ireland has been arranged for May 15th 2012. Future lobbying should compare/contrast the resources available for suicide prevention and that available for road safety.</td>
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<tr>
<td><strong>5 a day for Mental Health</strong></td>
<td>This scholar has arranged a meeting with the Health Improvement Manager, Public Health Agency responsible for mental health.</td>
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<td>your mental health. Current mental health promotion campaigns seem to be based on older evidence. Two of the 5 habits in particular, Connecting and Giving, if widely practiced would help to counteract the failed belonginess and burdensomeness and thus assist in suicide prevention efforts</td>
<td>promotion across the region to discuss widespread adoption of the 5 a day evidence in future mental health promotion campaigns</td>
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| **Suicide Prevention Conferences/virtual conferences.** More people should have the opportunity to hear directly about suicide prevention from Thomas Joiner, Frank Campbell, Yvonne Bergmans and Heather Fiske | All of these eminent speakers are willing to come to the UK to peak or present at a “virtual” Conference using Skype type technology. The first of these conferences is being planned for Northern Ireland to take place in October 2012 to coincide with World Suicide Prevention Day |

| **Transforming Mental Health care – solution focus –paradigm shift** | The shift from focusing on client problems and deficits to solutions and strengths is one that would be widely supported by clients and their advocates. The solution/strengths focus is inherent in the recovery approach. This scholar is well placed to influence this shift in his own workplace. A meeting to discuss initiating this project will take place with the acting Director of Adult Services on April 23rd 2012. A meeting to discuss this approach across the region of Northern Ireland has been planned with key stakeholders on May 11th 2012. |

<p>| <strong>Complement Lifeline counsellors on the crisis line with more volunteers</strong> | Of the £6.7million funding annually provided to the “Protect Life” Suicide prevention strategy &amp; action plan in Northern Ireland more than half, £3.5 million goes to fund the Lifeline. Baton Rouge and other places have clearly demonstrated that theses lines can be staffed with a proportion of trained volunteers. Contact, the |</p>
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<tr>
<th>Organisation that provide the line in Northern Ireland should be directed to bring more volunteers on to the line. The consequential savings could then be redirected to other suicide prevention activities. The scholar has asked for this to be raised at the next meeting of Suicide Strategy Implementation Body in June 2012.</th>
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<td><strong>Suicide Prevention Research institute funded by Government, business, survivors</strong></td>
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<td>We need more suicide prevention research. The scholar will meet with the Pro Vice Chancellor (Research &amp; Innovation in May to discuss formalising the network of existing suicide prevention researchers into a research institute</td>
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<td><strong>Using “caring texts” as an intervention</strong></td>
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<tr>
<td>This scholar intends to discuss this intervention with Suzanne Costello, Samaritans and Fergus Cumiskey, Contact (Lifeline)</td>
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<tr>
<td><strong>Making hope boxes available</strong></td>
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<td>Potentially patients admitted to Mental Health Inpatient Units and those who attend psychiatric day hospitals following a suicide attempt could be encouraged to make a hope box. This scholar will seek to explore this in his own organisation and hopes to pilot this intervention</td>
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<td><strong>Making virtual hope boxes</strong></td>
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<td>This initiative will require some discussion with companies who create Smart phone applications and the scholar will discuss with colleagues and seek to develop connections with these companies to realise this recommendation.</td>
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<td><strong>Crisis cards with reasons for living included</strong></td>
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<td>Some services already provide suicidal clients with a card with contact numbers i.e. emergency sources of help. The inclusion of a crisis plan and reasons for living is</td>
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<td>Social Network Mapping</td>
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<td><strong>New view of people who self-harm by ED staff – training DVD</strong></td>
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<td><strong>SFBT Outreach to Card Before You Leave clients</strong></td>
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<td><strong>Utilising Joiners ICARE model</strong></td>
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thoughts that emerge from burdensomeness and failed belongingness. The approach aims at restructuring negative thoughts and Joiner ascribes the acronym ICARE to it with each letter relating to a step in the approach. It seems logical and practical that this intervention is made available in the UK. This scholar has arranged to discuss it with psychology colleagues with a view to making use of the approach in our assessment of newly referred suicidal people.

<p>| Self –Harm. Preventing first attempts &amp; second episodes | Those who repeatedly self harm are according to Joiner acquiring the ability to kill themselves if and when the desire for death emerges. Qualitative research is required with those who have such a history to see if we can learn if anything could have prevented the first episode. There is also a need to carefully target interventions at those who have a first episode. The scholar will meet with the Pro Vice Chancellor (Research &amp; Innovation) University of Ulster in May to discuss a potential research proposal in this area. |
| Safe places including those similar to the Crisis Stabilisation Unit need to be provided | The scholar was very impressed by the work of the Crisis Stabilisation Unit at St Michaels Hospital Toronto. Work is ongoing in Belfast to provide “safe places” for those who are self harming and intoxicated. This scholar will meet with the manager of this project and collaborate on the development of the “safe places” |
| Better identification of friends/peers as survivors | Friends of the person who has died by suicide can be overlooked by the services providing care for the |</p>
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<tr>
<td>Bereaved family. An approach similar to the social network mapping should be utilised to better identify the friends and peers who require postvention. The scholar is involved in a steering group guiding the work of a service provider that provides postvention services. The friends/peers as survivors has been placed on the agenda for the next meeting in May</td>
<td></td>
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<tr>
<td><strong>Breaking the legacy – better identification and comprehensive care for children bereaved by suicide</strong></td>
<td>There is concern that not all children who lose a parent to suicide will receive the care they need particularly when the parents had divorced or separated. New regional postvention arrangements have been put in place in Northern Ireland. This scholar plans to advocate, lobby and collaborate with others to seek to ensure that all children are provided with a service that includes, trauma work if required, and the individual and family work that may be required</td>
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<tr>
<td><strong>Making Active Postvention happen across the UK</strong></td>
<td>Frank Campbell has championed the cause of postvention for many years with a convincing case. His success can be seen in many parts of the world. Some places provide suicide prevention and intervention but seem to forget about postvention despite the fact that survivors of suicide are people at an increased risk of suicide and they can be readily identified. This scholar intends to work with colleagues in England, Scotland and Wales to support the efforts at developing survivor support groups and outreach to survivors like Baton Rouge´s LOSS team</td>
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Conclusion

It’s time to walk the talk. The learning points gained as a result of this study have to be applied so that patients /clients/service users are better off as a result of the investment in this study tour. The ultimate success of this tour, though difficult to directly measure, is that more lives can be saved from suicide.

Passion is not enough. Emotion is not enough. Rhetoric is not enough. To realise and maximise the potential of the learning the recommendations have to be implemented with the power of evidence, emotion, influence, timing and skill. It’s a tall order. This scholar is acutely aware however that this work is done in the name of nurses and in the spirit of Florence Nightingale for the benefit of patients.

Implementation therefore must be strategic. Many of the recommendations can begin in a small scale way at a local level with the learning quickly shared and disseminated.

Several of the recommendations however have nationwide implications and require the support of many stakeholders to see their implementation. This scholar is excited about the possibilities and challenges that lie ahead. This study tour has enabled this scholar to meet and work with leaders in the field of suicide prevention. What a privilege and honour it has been. One of the most exciting things is that these giants are now personal friends. These friends continue to guide, advise and support the work of this scholar and will be an immense source of strength now the challenging work of implementing the recommendations has begun.
Appendices

Appendix 1

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what you think and feel.

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<th>1</th>
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<tbody>
<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Very</td>
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<tr>
<td>true for me</td>
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1. These days the people in my life would be better off if I were gone.
2. These days I think I give back to society.
3. These days the people in my life would be happier without me.
4. These days I think I have failed the people in my life.
5. These days I think people in my life would miss me if I went away.
6. These days I think I am a burden on society.
7. These days I think I am an asset to the people in my life.
8. These days I think my ideas, skills, or energy make a difference.
9. These days I think my death would be a relief to the people in my life.
10. These days I think I contribute to the well-being of the people in my life.
11. These days I feel like a burden on the people in my life.
12. These days I think the people in my life wish they could be rid of me.
13. These days I think I contribute to my community.
14. These days I think I make things worse for the people in my life.
15. These days I think I matter to the people in my life.
16. These days, other people care about me.
17. These days, I feel like I belong.
18. These days, I rarely interact with people who care about me.
19. These days, I am fortunate to have many caring and supportive friends.
20. These days, I feel disconnected from other people.
21. These days, I often feel like an outsider in social gatherings.
22. These days, I feel that there are people I can turn to in times of need.
23. These days, I feel unwelcome in most social situations.
24. These days, I am close to other people.
25. These days, I have at least one satisfying interaction every day.

ACSS
Please read each item below and indicate to what extent you feel the statement describes you. Rate each statement using the scale below and indicate your responses on your answer sheet.

0                   1                    2                   3                        4
Not at all like me                                                       Very much like me

______ 1. Things that scare most people do not scare me.
______ 2. The sight of my own blood does not bother me.
______ 3. I avoid certain situations (e.g., certain sports) because of the possibility of injury.
______ 4. I can tolerate a lot more pain than most people.
______ 5. People describe me as fearless.
______ 6. The sight of blood bothers me a great deal.
______ 7. The fact that I am going to die does not affect me.
______ 8. The pain involved in dying frightens me.
______ 9. Killing animals in a science course would not bother me.
______ 10. I am very much afraid to die.
______ 11. It does not make me nervous when people talk about death.
______ 12. The sight of a dead body is horrifying to me.
______ 13. The prospect of my own death arouses anxiety in me.
______ 14. I am not disturbed by death being the end of life as I know it.
______ 15. I like watching the aggressive contact in sports games.
______ 16. The best parts of hockey games are the fights.
______ 17. When I see a fight, I stop to watch.
______ 18. I prefer to shut my eyes during the violent parts of movies.
______ 19. I am not at all afraid to die.
______ 20. I could kill myself if I wanted to.

(Even if you have never wanted to kill yourself please answer this question.)
Appendix 2

Brief Intervention for Short- Term Suicide Risk Reduction in Military Populations

Principal Investigator:

Craig J. Bryan, PsyD.

Organization:

The University of Utah, National Center for Veterans

When a therapist has many weeks or months to work with a patient at risk for suicide, there are a variety of approaches that have proven to be effective in lowering the risk. One is traditional psychotherapy, in which a therapist works with a patient over time to understand his or her problems and to help the patient feel better. During such treatment as usual the patient is typically supplied with a list of sources of support, such as suicide hotlines, for times of crisis. An additional technique that has been found to be effective is to provide the patient with an individualized crisis response plan, written on a note card, with a list of warning signs things to try in a crisis. It may, for example, remind the patient to try a certain relaxation technique that has worked in the past.

Another extra technique which has worked exceptionally well with patients from the military is to put together a list, again written on a note card that the patient keeps, of things that make the patient’s life worth living. These can be loved ones, happy memories, hopes and dreams—anything that reminds the patient of why he or she would wish to keep living and that could counteract the hopelessness and lack of connection that typically precedes a suicide attempt.

Unfortunately, it is often the case that the only contact a suicidal person has with a clinician is at a moment of crisis, perhaps during a visit to an emergency room after a suicide attempt. Then a clinician has only a short period of time to deal with the patient, and there is no guarantee the patient will go somewhere for treatment later.

Thus Craig Bryan is seeking to determine if some of the same techniques that work well in multi-session psychotherapy could also be effective in these single, crisis-triggered sessions. In particular he and his coworkers will be testing the effectiveness of providing patients with note cards containing individualized crisis response plans and reasons for living. If the approach is anywhere near as effective for suicidal patients coming into emergency rooms as it is for patients in psychotherapy, it could be a big step in helping members of the military deal more effectively with suicidal thoughts and urges.
Usability and Utility of a Virtual Hope Box (VHB) for Reducing Suicidal Ideation
Principal Investigator:
Nigel Bush, Ph.D.

Organization:
National Center for Telehealth & Technology

When people are depressed and thinking about suicide, they generally find it difficult to come up with reasons to go on living, and the reasons for dying seem much more compelling. One of the strategies that clinicians have used to help such patients remember their reasons for living is the "hope box." It can be a real wooden box, a shoe box, a manila envelope, a plastic bag, or pretty much any other sort of container, for it is the contents that are important. In the hope box the patients keeps things to remind them that their lives are meaningful and worth living: photos of loved ones, a favorite CD of relaxing or inspiring music, certificates of past achievements, something written about future aspirations, a recording of a loved one saying something inspirational. The patient is asked to keep the hope box nearby and use its contents when it seems hard to go on living.

One problem with such a hope box, however, is that it is not convenient or easy for patients to have it with them at all times. Thus Nigel Bush and colleagues at the National Center for Telehealth and Technology are designing a "virtual hope box," a program for a smart phone that allows the patient to keep all those reasons for living close by at all times. It will have all the same life-affirming reminders that the usual sort of hope box does-photos, videos, favorite music, messages from loved ones, and so on-but it will have much more. It will include, for instance, a list of key contacts-people who have agreed to be available for a phone call in a time of crisis. It will have a collection of "coping cards" in which the patient has written down positive alternatives to each of the negative items that tend to cause problems. There will be relaxation exercises to help the patient calm down and puzzles to take the patient's mind off negative thoughts. But the most important thing about the virtual hope box is its accessibility-it can always be there, in a pocket or purse.

The virtual hope box is now under development. Once it is finished, it will be tried out with patients with the VA in Portland, Oregon. If it proves effective, it will then be made available much more widely.
A Behavioral Sleep Intervention for the Prevention of Suicidal Behaviors in Military Veterans: A Randomized Controlled Trial

Principal Investigator:

Rebecca Bernert, Ph.D.

Organization:

Stanford University

SAMHSA (2005) identified sleep problems as one of the top ten warning signs of suicide. The aim of this study was to manualize an integrated sleep intervention to decrease suicidal behaviors among Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans. It tested the outcomes of a Military Sleep-based Preventive Intervention (MSPI) using a randomized controlled trial. Participants attended 8 study visits, post treatment, as well as a 1 month and 3 month follow up. After initial screening, participants were randomized to either MSPI or Treatment as Usual (TAU). MSPI consists of Cognitive Behavioral Therapy for Insomnia (CBT-I) and Imagery Rehearsal Treatment (IRT). CBT-I focuses on the sleeping behavior itself by educating participants, consolidating fragmented sleep, cognitive restructuring, relaxation training and providing stimulus control techniques. IRT focuses on nightmare frequency and severity. At each visit, data was collected from a sleep diary as well as empirically supported assessments.
Military Continuity Project (MCP)

Principal Investigator:

Katherine A. Comtois, Ph.D.

Organization:

University of Washington

Motto’s 1976 study identified “caring letters” as an effective suicide intervention. This study aims to use text messaging or short messaging service (SMS) as a low cost caring contact, in hopes of decreasing suicidal thinking and behavior for active duty military personnel. The study will include service members from multiple installations who have been identified as suicidal by providers at the installation. Participants will be randomly divided into either Treatment as Usual (TAU) or TAU plus Military Continuity Project (MCP). Participants in the MCP group will receive text messages at pre-scheduled times over a 12 month period. After the 12 month period, participants from both groups will complete a follow up assessment containing the measures from the baseline interview.
Development and Evaluation of a Brief, Suicide Prevention Intervention Reducing Anxiety Sensitivity

Principal Investigator:

Norman B. Schmidt, Ph.D.

Organization:

Florida State University

For most people a rapidly beating heart, racing thoughts, or an inability to concentrate would seem nothing to worry about. For those with anxiety sensitivity, however, these symptoms appear to be a scary warning of something far worse: an impending heart attack, perhaps, or losing control of one’s thoughts and going crazy.

As Brad Schmidt, a psychologist at Florida State University explains, this syndrome is relevant to military suicide for at least two reasons. First, people suffering from post-traumatic stress (PTSD) disorder—as many soldiers do—are more likely to have a heightened anxiety sensitivity. And second, people with anxiety sensitivity are more likely to think about and attempt suicide. Given that soldiers dealing with PTSD or traumatic brain injury are already facing a variety of difficult and stressful issues, having anxiety sensitivity in addition may be enough to push some of them over the edge.

Thus Schmidt and colleagues are working to develop a simple Web-based treatment program to teach members of the military how to deal with anxiety sensitivity. Starting from a program that has been shown to be effective in reducing physical anxiety sensitivity—hypersensitivity to physical symptoms, such as pain or a racing heart—in civilians, they will revise it to target cognitive anxiety sensitivity in members of the military. The program will explain how stress can affect thoughts and emotions, emphasize that these effects are normal and nothing to fear, and offer techniques for effectively coping with stress. If it works as expected this intervention should ameliorate many of the adverse effects of PTSD and reduce suicidal thoughts and attempts among those who take part.
Appendix 3

Links

http://www.nfb.ca/film/drawing_from_life?

Videos for skills for safer living "self help alliance"
Bibliography

**Belfast Telegraph** Shock rise in number of suicides. September 28th 2011


Changing the legacy” DVD (2011) Baton Rouge Crisis Intervention Centre. Baton Rouge, Louisiana


