

## — Our Core Beliefs about Suicide and Its Prevention —

Suicide is a community health problem.

Thoughts of suicide are understandable, complex and personal.

Suicide can be prevented.

Help-seeking is encouraged by open, direct and honest talk about suicide.

Relationships are the context of suicide intervention.

Intervention should be the main suicide prevention focus.

Cooperation is the essence of intervention.

Intervention skills are known and can be learned.

Large numbers of people can be taught intervention skills.

Evidence of effectiveness should be broadly defined.



Following are a number of interrelated core beliefs that LivingWorks holds about suicide and its prevention. These considered opinions have evolved and shaped our work for many years. They will continue to evolve as we learn new things. We bring them forward now because it is increasingly apparent that people working in suicide prevention hold diverse beliefs, some quite different from ours.

**We hope our sharing will prompt others to disclose their core beliefs. We invite all persons concerned about preventing suicide to examine our beliefs and to compare them with the core beliefs of others.**

A note on terminology might be helpful. There are many ways of describing various types of suicide prevention activities, although no system of description is without limitations. We call activities that occur one-on-one with persons at risk of suicide “suicide intervention.” For us, “inter-vention” is about the help that “comes between” thoughts of suicide and suicidal acts. We regard activities that focus on factors that come before suicide thoughts as “suicide prevention.” We call activities for those who are impacted by suicidal acts “suicide postvention.”

### **Suicide is a community health problem.**

We hold that suicide is best viewed broadly as an issue for the entire community. We invite those with social, public or mental health perspectives to join this broader perspective. Everyone who wants to help is welcome. Many so called “ordinary” citizens have made anything-but-ordinary contributions to suicide prevention in modern times. We reject any attempt to maintain an exclusionary position. To make suicide one group’s territory is to re-stigmatize suicide in modern clothing by implying that suicide is so special, dangerous or unusual that only some can deal with it. Such a restriction also reduces the range and numbers of people who could help prevent suicide. Suicide is not the domain of any one discipline or viewpoint. We need everyone, working together, to bring an end to the long history of avoiding the community consequences of suicide.

### **Thoughts of suicide are understandable, complex and personal.**

Virtually everyone will think about suicide at some time in their life. It is just part of living. We do not see suicide as abnormal nor do we regard it as an illness. Whether the ultimate origins of the capacity for suicide are spiritual (e.g., free will), existential (e.g., consciousness), biological (e.g., adaptive in

some circumstances), or ever knowable, the potential for suicide is part of being human. Our view that thoughts of suicide are understandable does not mean that we accept suicide as just another way humans can die. We believe it is also part of being human to want to prevent understandable thoughts from becoming tragic actions.

Suicide is also very complex. We are biological creatures who think. Neither the body nor the mind is well understood and the interaction between the two even less so. It is clear the two influence each other in various ways and thoughts of suicide are not just thoughts. Feelings surround them and chemical changes can influence them.

Suicide is complex in another way: individual people have thoughts of suicide—people with unique lives, influences, disappointments, reactions, hopes and dreams. They have different stories to tell. We believe that there are as many reasons for suicide as there are people who are thinking about suicide.

### **Suicide can be prevented.**

Thoughts of suicide are dangerous. All persons with thoughts of suicide should be taken seriously. Distinctions that lead to regarding one person's thoughts of suicide as more serious than another's are almost as dangerous as suicide. This does not mean that all persons at risk need the same help. Safety plans should be tailored to minimize the risk factors that apply to the particular person at risk. This safety planning, however, should be done with care regardless of how many or how few risk factors apply.

We are optimistic about the prevention of suicide. While thinking about suicide may be difficult if not impossible to prevent, preventing thoughts of suicide from moving on to become suicidal actions is achievable. We assert that almost all persons at risk actively invite help and retain within them the desire to live, even if they are no longer in touch with that life force. In other words, persons at risk are ambivalent about suicide. We also assert that the capacity to actively hold suicide as an immediate option is almost always temporary. A caregiver often only needs to help prevent the immediate risk of suicide in order to

stop it for some period of time, maybe for a lifetime. To have thought about suicide and turned away from it, can make it clear that one has a choice—even the choice to live life fully.

### **Help-seeking is encouraged by open, direct and honest talk about suicide.**

All forms of help-seeking about suicide need to be encouraged. A decision to live is far more likely when a person at risk can make it in the company of a helper who is comfortable talking about suicide. The simple and yet profound first approach to any person at risk should be, "let's talk." That message regards the disclosure of thoughts of suicide as a potential "new beginning."

Help-seeking is supported by access to many kinds of resources that can provide help. Crisis line workers, persons aware of the danger of suicide and trained suicide interveners are some of the key resources needed to make help seeking credible. Without available resources, the suggestion that persons at risk seek help is cruel at best. Persons who inform or teach others about suicide should also be able to sustain open, direct and honest talk about suicide should a person in attendance be at risk of suicide, have someone close to them who is at risk of suicide or be struggling with a past suicide.

Punishment as a means of preventing suicide has been tried for many centuries and should be recognized as an utter failure. Automatic removal or restriction of privileges outside the context of a suicide intervention is punitive. The belief that such removal or restriction deters others from suicide is a modern form of the historical failure. So too is the idea that the life of a person who died by suicide cannot be celebrated as a whole, apart from the suicide. As much as we wish there was no stigma or taboo associated with mental illness, exclusively linking suicide with mental illness may stigmatize both even further.

### **Relationships are the context of suicide intervention.**

Relationships are central to understanding and preventing suicide. Measures combining all of the characteristics known to be best related to suicide

continue to falsely identify many persons who are not at risk (false positives) and to miss most of those who are (false negatives). The best way to find individuals at risk is to ask them, "Are you having thoughts of suicide?" Having a relationship with a person at risk or creating one through open talk about suicide, builds the trust that makes it possible to find out if the person is having thoughts of suicide.

Why a person comes to think about suicide or act upon thoughts of suicide is far more likely to differ among individuals than to be similar. Having a relationship with a person at risk is the best way to more fully understand what those reasons are. Having a relationship in which a person at risk can talk with a caring person about suicide counteracts the one consistently most dangerous risk factor: a feeling of being alone with thoughts of suicide.

**Intervention should be the main prevention focus.**

Prevention (intending to prevent thoughts of suicide or prepare persons for the possibility of thoughts of suicide in the future), postvention for those impacted

by suicide (intending to prevent future suicidal acts) and longer-term treatment/therapy (also intending to prevent future suicidal acts) and intervention (intending to prevent thoughts from becoming suicidal acts) are all important in an overall prevention strategy. Given current knowledge about reducing suicidal behaviors, we believe intervention should be a community's main suicide prevention focus. A one on one relationship between a person at risk and competent helper represents the best chance of effecting a life-saving or life-altering change. A map of these activities is provided in figure 01a.

Persons who are at risk of suicide are the ones with the most interest in staying alive, even if they do not immediately recognize it. Once they recognize that they may want to live, their need to do something to protect life is immediate. It is not about something that might happen in the future. It is literally about saving their life now. The intervention context provides the right moment to help persons at risk discover new energy to protect against this life-threatening danger. We can hope for a time when we collectively know enough about how to protect against suicide



Figure 01a: Suicide-Safer Community: Preserves, protects and promotes life

and promote life that suicide thoughts hardly ever occur and interventions are rarely needed. A more realistic hope, for now, is that effective suicide interventions are available to persons at risk of suicide.

### Cooperation is the essence of intervention.

We hold that a person at risk's involvement in decision-making is the key to the success of an intervention. There is a wealth of potential for cooperation in persons at risk if the intervener knows how to provide the leadership and direction to help uncover it. Every attempt should be made to obtain the person at risk's cooperation and consent. A person at risk who lets a helper know or find out about suicide is, in effect, giving permission for the helper to protect the part that wants to live. Thus almost all actions of a helper can, in good faith, be framed in terms of cooperation and consent.

### Intervention skills are known and can be learned.

Community members in various roles need different sets of skills to ensure that all persons at risk receive help. It is also important that these people be able to communicate effectively with each other. To prepare such a community of helpers requires more than one

learning experience about suicide intervention and these experiences need to be integrated to facilitate communication among helpers.

Currently, LivingWorks offers five interrelated programs. safeTALK, ASIST, WorkingTogether and suicideCare each offer a unique intervention skill set, linked by a common framework and layered to address increasing levels of helping competency. suicideTALK is a suicide prevention, suicide awareness program. Figure 01b shows the LW programs on the map of prevention activities.

All of our learning experiences share common learning elements:

- theory and content that is kept consistent with the suicide and education literatures;
- opportunities to explore personal experiences with and attitudes about suicide in a respectful and reflective atmosphere;
- exposure to a conceptual model that is comprehensive and elegant (theoretically pleasing) as well as easy to use, flexible and practical; and,
- multiple, graduated opportunities to examine and practice using the model in an atmosphere that is both challenging and safe.

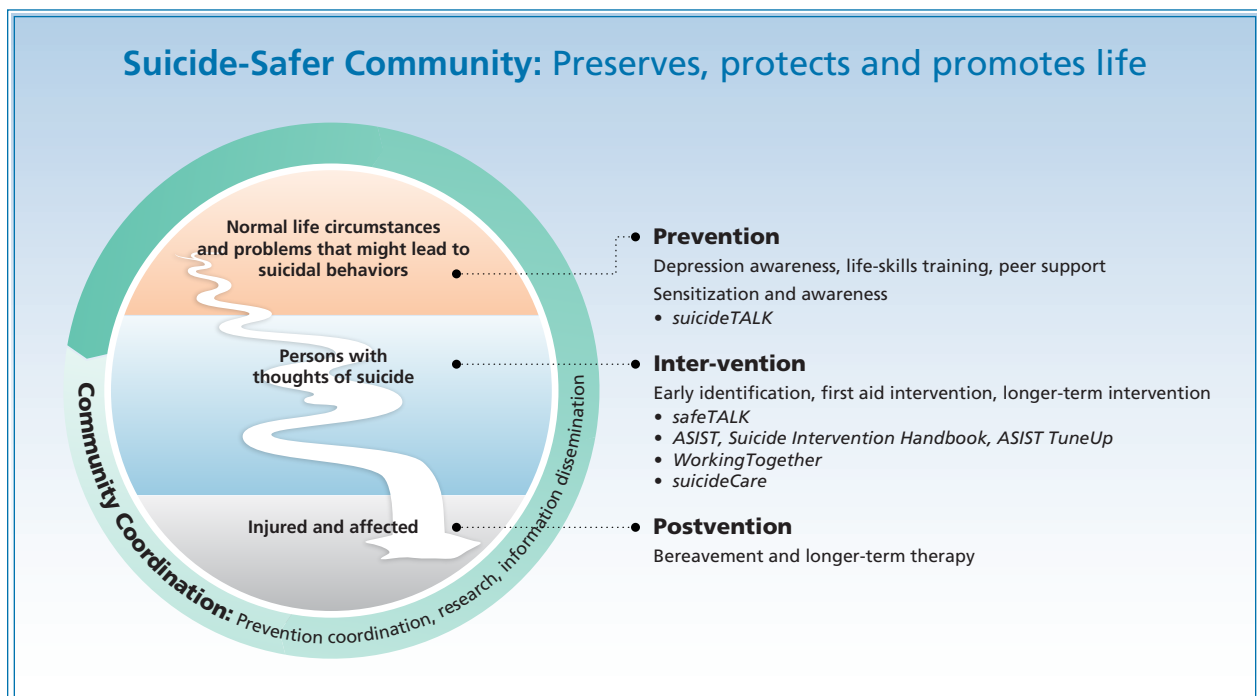


Figure 01b: Suicide-Safer Community: Preserves, protects and promotes life

Designing learning technologies with the requirements of a common intervention framework, layering of participant outcomes and active learning processes is not simple. Pre-screening for caregivers with particular attitudes or particular skills cannot shorten the kind of learning required. Neither can simply informing about and illustrating a model. We hold that a very powerful training technology is required to teach intervention skills. Suicide awareness programs, learning based solely upon media-based interactions or programs using largely didactic methods cannot produce caregivers who are willing, ready and able to help prevent the risk of suicide. Opportunities to practice in an environment that encourages mastery and success without sacrificing realism are required.

### **Large numbers of people can be taught intervention skills.**

We hold that almost everyone, quite apart from any professional qualifications, can learn intervention skills—given the right learning technology. Thus, there is potentially a very large pool of people who could help.

To keep the costs of teaching manageable, local trainers are taught the various programs and they cascade intervention skills into a community. To ensure that helpers learn the same skills across presentations, the program needs to be standardized. To ensure communication among helpers, training should feature generic language and concepts understandable by everyone. To maintain fidelity requires a central agency committed to ongoing development and quality control. With all of these supports, the initial, front-end investment in preparing local trainers to teach intervention skills can be expensive. The long-term benefit—which is potentially very large—depends upon enrolling the best local trainers and supporting them throughout their training career.

### **Evidence of effectiveness should be broadly defined.**

The evidence-based approach to informing policy decisions and good practice is making its way to suicide prevention. On the one hand, we welcome the new research efforts that such a view might encourage and the new information that might result. On the

other hand, we hold that the evidence-based movement must be tempered by one fundamental caveat: most of the more important questions regarding complex social problems, such as suicide prevention, either cannot be or are unlikely to be tested using the most rigorous of evidence-based research approaches. A broad view of evidence and effectiveness is needed.

Case studies of many different types can make an important contribution to the study of prevention program effectiveness. We would like to see indirect outcome measures, such as a stated intention to do something, regarded as evidence of change. It seems strange to require difficult-to-obtain and inherently limited behavioral indicators of change when it is well known that intention—or what we regard as a commitment—is often the best indicator of complex and multi-faceted action. Lastly, we strongly recommend the use of research and development models for testing helper-training programs that have broad aims. In the absence of any reason to assume otherwise, programs that pass all of a research and development model's testing, including wide and successful dissemination, should be considered effective.

## **Beliefs and Hopes**

### **Our beliefs sustain our hope that suicide-safer communities are possible.**

As these beliefs find expression in the community through our programs, we envision benefits that will live on.

- Suicide will be less of a community health problem.
- Suicide will be better understood.
- Suicidal behavior will be reduced.
- Help seeking will be more common.
- Relationships will be strengthened.
- More attention will be focused upon life preservation and promotion.
- Cooperation will grow.
- Intervention skills will be widely known and used.
- Large numbers of people will be taught intervention skills.
- More research funds will go toward exploring fundamental questions about suicide.

## — Our Core Beliefs about Suicide and Its Prevention —

Suicide is a community health problem.

Everyone can help.

Thoughts of suicide are understandable, complex and personal.

Approach people at risk with an open mind.

Suicide can be prevented.

It is possible to save lives and prevent injuries—now.

Help-seeking is encouraged by open, direct and honest talk about suicide.

If you are approachable, people at risk will seek you out.

Relationships are the context of suicide intervention.

Helping either relies upon or builds a relationship.

Intervention should be the main suicide prevention focus.

The emphasis should be on preventing suicidal behaviors.

Cooperation is the essence of intervention.

The helper and person at risk need to work together to prevent suicide.

Intervention skills are known and can be learned.

Helpful skills are known and most everyone can learn them.

Large numbers of people can be taught intervention skills.

The means to teach intervention skills on a large scale exists now.

Evidence of effectiveness should be broadly defined.

These means are effective.

