Authors Note:
The QPR theory evolved over many years. It integrates a variety of concepts and ideas from my 40 years of professional experience as a clinical psychologist, therapist and trainer, and work with hundreds of suicidal patients and their families. The concept and emergent program is also drawn from my years of consulting in public health, my study of Zen Buddhism and the psychology of hope, and reading the Motivational Interviewing literature regarding changing human behavior in brief, problem-focused interactions. My thinking about suicidal communications as our window of opportunity for gatekeepers to intervene was also influenced by communications theory and especially by my training as an intelligence specialist in the U.S. Army where signal detection and the decoding of encrypted messages required clarification, substantiation, and verification before any meaningful responsive action could be taken.

QPR Gatekeeper Training for Suicide Prevention
The Model, Rationale and Theory

© Paul Quinnett, Ph.D.
QPR Institute 2007

Abstract: Suicide and self-inflicted injuries represent a significant public health problem. For community-based suicide prevention programs, theory-driven research on Gatekeeper training and its effectiveness remains limited. This paper describes the QPR Gatekeeper Training program for Suicide Prevention, its theoretical basis, the three-step CPR-like intervention and implications for the detection of new, untreated at-risk cases in defined communities. QPR stands for how to Question, Persuade and Refer someone emitting suicide warning signs. The QPR intervention is contextualized within the published literature on brief but beneficial public health and clinical interventions. The program is available face-to-face or on-line or via a blended learning approach combining interactive online knowledge mastery with interpersonal Q&A and role-plays for community Gatekeepers. As a promising psychological and behavioral public health tool, QPR may prove a useful recognition-and-referral educational intervention in the prevention of suicide and suicide attempts and is currently being evaluated in a number of venues.

Keywords: suicide, prevention, gatekeeper, training, public health

Introduction

"Anyone who willingly enters into the pain of a stranger is truly a remarkable person." Henri J. M. Nouwen, *In Memoriam.*

According to the Surgeon General's *National Strategy for Suicide Prevention* (2001), "key gatekeepers" are "people who regularly come into contact with individuals or families in distress" and gatekeeper training has been identified as one of a number of promising prevention strategies. Key gatekeepers include a variety of professionals who are in a position to recognize a crisis and the warning signs that someone may be contemplating suicide, including, "teachers, school personnel, clergy, police officers, primary health care providers, mental health care providers, correctional personnel, and emergency health care personnel." The potential of gatekeeper training programs has been documented as a promising tool in school settings to enhance intervention for youth at elevated risk for suicide (Garland and Zigler, 1993; Kalafat and Elias, 1995), and research findings are encouraging with regard to enhanced knowledge, improved attitudes, preparation for coping with a crisis, and referral practices (Garland and Zigler, 1993; King and Smith, 2000; Mackesy-Amiti, et al., 1996; Shaffer et al., 1988; Tierney, 1994). Gatekeeper training has also been identified as one of a number prevention strategies outlined in comprehensive reviews of suicide prevention research (British Columbia Ministry for Children and Families, 1999; Centers for Disease Control and Prevention, 1992; Gould & Kramer, 1999; Guo & Harstall, 2002; US Dept of Health and Human Services, 2001).

With regard to other age cohorts and high risk groups, the author suggests a broader, more inclusive definition of gatekeepers for two reasons: 1) the more persons trained as gatekeepers the greater the odds community-dwelling suicidal persons will be identified by those who know them, and 2) studies show that large numbers of psychiatrically ill and potentially suicidal persons remain undetected in the general population (WHO, 2001a). The goal of gatekeeper training is straightforward: to enhance the probability that a potentially suicidal person is identified and referred for assessment and care *before* an adverse event occurs. As population-based approach, the greater the percentage of the members of a given community who are trained to successfully recognize and refer its suicidal members, the fewer suicide-related adverse events should occur. In one survey of adult school staff members in each of 32 middle and high schools, the vast majority of staff members reported that students did talk to them about their thoughts and feelings, but few staff thought they identify signs of suicidality, or would know what to do if these were recognized (Brown, et.al. 2005). Moreover, based on self-reported student survey information in this same school system (N=60,000), the authors anticipated 3,600 or 6% of students could be "harboring significant thoughts and/or plans about suicide" but that no more than 5% (193 of 3,600) of such suicidal children are actually identified and referred by school staff. If gatekeeper training is effective, substantial increases in appropriate referrals are to be expected.

In the author's experience in consulting on a number of university campuses where student suicides have occurred, students who died by suicide were almost never seen in either the student counseling offices or by the student health staff. In one large university (student population = 43,000) five students died by suicide in one academic year. Not one of these students was known to any university-based healthcare provider prior to his or her death. In terms of probability theory, the odds of identification, referral, and the initiation of what could prove life-saving treatment is a direct function of the proportion

of staff trained (Brown, et.al., 2005). Thus, to create safe-communities for suicidal people cost-effective saturation gatekeeper training should be the ultimate goal.

Inclusive of the roughly 25 groups specifically mentioned in the National Strategy, this expanded roster would include family members, friends, neighbors, co-workers, colleagues, teammates, office supervisors, squad leaders, foremen, academic and resident advisors, caseworkers, pharmacists, veterinarians and many, many others who are also strategically positioned *in existing personal and/or professional relationships* to recognize and refer persons identified to be at potential risk of suicide. Because suicide happens in families, among friends, in religious congregations and among co-workers, the author's fundamental position is that suicide prevention gatekeeper training should follow public health philosophy and include mass, saturation awareness raising and skills training for not less than one-in-four of the adult population, or one adult person per family. This theory rests upon the following observation: *the person most likely to prevent you from taking your own life is someone you already know.*

QPR stands for Question, Persuade and Refer, an emergency mental health intervention that teaches lay and professional gatekeepers to recognize and respond positively to someone exhibiting suicide warning signs and behaviors. Advanced QPR Institute clinical training programs teach professionals and others to detect, assess and manage suicide risk in a variety of professional settings across the age span. Created by Dr. Paul Quinnett, and first described in 1995 in a number of presentations and publications by the QPR Institute, more than 3,000 Certified QPR Instructors have been trained in America and abroad, and more than 300,000 American citizens had been trained as QPR gatekeepers by the end of 2005.

QPR like CPR

CPR stands for cardio pulmonary resuscitation, an emergency medical intervention created by Peter Safar and first described in his 1957 book on the ABC of resuscitation (A for airway, B for Breathing, C for Circulation). CPR is part of the "Chain of Survival," a term first coined in 1987 by Mary Newman, a founding member of the Citizen CPR Foundation. According to the Chain of Survival model of emergency cardiac care, the likelihood that a victim will survive a cardiac arrest increases when each of the following four links is connected (Lundberg & Kerber, 1992). These links are:

1. **Early recognition and early access saves lives.** The sooner symptoms of distress are recognized, the sooner 9-1-1 or local emergency number is called, and the sooner early advanced life support arrives.
2. **Early CPR**. Application of early CPR helps circulate blood that contains oxygen to the vital organs.
3. **External defibrillator (AED)** is ready for use or advanced medical personnel arrive.
4. **Early Advanced Life Support.** This is given by trained medical personnel who provide further care and transport to hospital facilities.

In like mode, for the QPR intervention to be effective the following four links in a chain of survival must also be in place:

1. **Early recognition of suicide warning signs**. The sooner warning signs are detected, the sooner an intervention can be initiated.
2. **Early QPR**. Directly asking someone emitting suicide warning signs to confirm or deny their meaning opens a potentially life-saving, caring dialogue which may a) immediately reduce anxiety and distress and, b) enhance protective factors and decrease risk factors, e.g., restore hope, decrease isolation, and increase social and spiritual support while removing the means of suicide.
3. **Early referral**. Linking the at-risk person to local resources or calling 1-800-SUICIDE for evaluation is essential to reducing immediate risk. As most people thinking about suicide are suffering from an undiagnosed and/or untreated mental illness or substance abuse disorder, accessible professional services are essential.
4. **Early professional assessment and treatment.** As with any life-threatening crisis or illness, early detection, assessment and treatment results in reduced morbidity and mortality.

In a cardiac crisis the difference between recognizing and acting where there is chest discomfort before it becomes crushing chest pain can mean the between life and death. In a suicide crisis the difference between recognizing and acting where there are vague ideas of suicide and before these lead to a lethal planning and a self-inflicted injury can mean the difference between life and death.

It is the working philosophy of the QPR model that a well-executed, strong and positive response to the early warning signs of a pending suicide event may render subsequent links in the Chain of Survival unnecessary. Just as the prompt recognition of the scream of a smoke detector can eliminate the need to suppress a raging fire, so can the early recognition of suicide warning signs, confirming their presence, and opening a supportive, caring dialogue with a suicidal person – while securing consultation and referral from a professional and bringing other protective factors to bare - may prevent the need for an emergency room visit, medical treatment for non-fatal suicide behavior, or inpatient psychiatric hospitalization.

The QPR Gatekeeper Training Program

QPR is taught by Certified Instructors in a minimum of one hour, but often extended to two hours for role-play and practice. The adult learning program is straightforward but tightly defined and teaches lay and professional gatekeepers how to recognize a mental health/suicide emergency, how to Question the validity of suicidal communications, and how to Persuade and Refer someone at-risk to the next level of intervention. It is also taught using both Web-enabled, interactive, multimedia CD-ROM and over broad band internet delivery systems. Certified QPR Instructors are trained to teach this 1-2 hour program in traditional, 8-hour classroom setting using adult learning methods. The certification program consists of mastering ten integrated training modules covering facts, theory, program delivery and required content, teaching methods and answering audience questions. All instructors are licensed and agree to deliver the program according to specifications to insure both the fidelity and integrity of program delivery. The instructor course may also be taken via distance learning in self-study, or by a blend

of self-study and mentoring by an experienced Certified QPR Instructor. The content of the certification program is described elsewhere (Quinnett, 1995).

QPR is not a suicide risk assessment training program for lay gatekeepers. The assessment of suicide risk is a professional service provided by trained healthcare providers. It is one thing to ask lay citizens to clarify a suicide warning sign with a question, listen to a problem, and attempt to get that person to a professional; it is quite another thing to attempt to burden them to with assessment skills possessed by mental health professionals.

QPR is also a behavioral action plan designed to move a willing or ambivalent suicidal person to accept a referral for professional evaluation and/or treatment. The letters of the QPR concept were intentionally selected to:

1. Provide a progressive, stepwise intervention that leads to a specific, predetermined outcome, and which process is supported by the published literature on brief and effective interventions typically delivered by professional helpers.
2. Achieve a helpful dialogue between someone at risk for suicide and a trained gatekeeper, which may lead to a reduction in the risk of a suicide attempt.
3. Conceptually link QPR to CPR - a well known, universal intervention for emergent medical crises that can be executed by trained lay persons.

The QPR letters and their order were also selected because a) each represents an idea and an action, b) in combination they have a high probability of being remembered and, c) from a mass social marketing perspective, the acronym would have a certain "stickiness factor" i.e., become a quickly recognized and replicated concept that might produce a "tipping point" in the way society thinks about and responds to its suicidal members (Gladwell, 2000). For social marketing reasons, a short, memorable, three-letter acronym was deemed to have the potential to spread quickly through the public safety field as have other emergency public health educational programs, e.g., Stop! Drop! And Roll!

The Q in QPR

No misery can long be kept secret.
Welsh Proverb

Researchers have frequently documented the presence of verbal, behavioral and situational "clues" or "warning signs" which precede suicide attempts and completions (Miller, 1978; Osgood, 1985; Shneidman, Farberow, & Litman, 1970, Shneidman, 1996). Some researchers have seen these warning signs as a "cry for help" (Farberow and Shneidman, 1961), while others have attributed motives to these communications ranging from warning others, to attempting to hold onto a relationship, to a purposive act intended to bring about a change in the behavior of others (Robins et al., 1959; Rubenstein et al, 1970; Richman, 1978).

More recently, a CDC study of completed suicides among American public and private school students supports the need for gatekeeper training in the recognition of suicide

warning signs (2004), as the authors concluded, "These findings support the need for school based efforts to identify and assist students who describe suicidal thoughts…." Thus, the observed and reported presence of such suicidal communications as prelude to suicide attempts and completions appears undisputed; the question is, what do suicidal communications mean, and from a public health perspective, how might they be used effectively in preventing suicide?

As a behavioral progression from thinking about suicide to a suicide attempt, so long as someone is talking about suicide, he or she is not doing it; thus the "talking about" preceding the "acting on" becomes a window of opportunity to intervene, provided we understand the purpose, nature, and meaning of these suicidal communications and know what to do in their presence. This hesitation between idea and act, and provided suicide warning signs are observable, provides the interpersonal opening into which an intervention like QPR can be inserted. But gatekeepers must be trained in the use of the intervention, and the intervention must be supported by research to be safe and effective in its application.

Believing is Seeing

For QPR to be accepted, learned, and applied in suicidal crises, potential gatekeepers must first believe a suicide attempt may follow someone's talking about it, e.g., saying aloud that they wish they were dead. The common myth that immobilizes potential rescuers is the widely held false belief that "People who talk about suicide don't do it." So long as the general citizenry continues to believe this myth, they have no duty or felt responsibility to take action. Thus, the first step for any educational program is to undo this myth and train potential gatekeepers to overcome any inertia to act by helping them reverse this wrong belief.

One cannot predict an event that never happens. But suicide happens, and while rare, the public must believe that suicide is a possible cause of death in those they know and love, otherwise they will never learn what is needed or what to do quickly when someone they know is contemplating suicide and sending suicide warning signs.

From the idea of suicide, to talking about suicide, to making a suicide attempt is a cognitive-behavioral journey festooned with more or less clear warning signs posted along the route by suicidal travelers. It is up to those in an already existing and strategic relationship with the suicidal person to observe this journey and to make an effort to interrupt it with a helpful, hopeful intervention. The warning signs posted by the lonely sojourner spell danger and should alarm observers to take action. To excerpt a quote from the Buddha, "People should learn to see and so avoid all danger."

Suicide Warning Signs, Cause For Action

It has long been presumed that once suicide warning signs are identified and broadly taught to would-be rescuers, e.g., family members and professionals, life-saving interventions should follow. Exactly what these interventions should be, how they should be carried out, and with what end results, remains to be seen. Still, included in the objectives in Goal 6 of Surgeon General of the United States *National Strategy for*

Suicide Prevention, "gatekeeper training" has been recommended in an effort to enlist citizen and professionals already in a strategic position with those at elevated risk for suicide to learn the warning signs of suicide and to identify and refer potentially suicidal persons for professional assessment and care.

At the time of this writing there is currently considerable confusion about the nature and definition of suicide warning signs, or their empirical support (Berman, 2003). Recent articles have been published about suicide warning signs and their confusion with suicide risk factors. Also at issue is the lack of consensus opinion about what a warning sign is and how should it be defined as regards public health education (Rudd, et al, 2006, Mandrusiak, et al, 2006). The following definition of a suicide warning sign is offered by Rudd:

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

This is an important definition as its sets parameters for the temporal relationship between pre-suicide attempt behaviors and an actual suicide attempt or completion. In the QPR gatekeeper training program a specific distinction is made between suicide warning signs and suicide risk factors even though there is, in some cases, confusion between the two, e.g., purchasing a firearm.

The greater challenge is: Just what should the public and professionals be taught in order to respond in a timely and effective manner when warning signs are present? Many lists of suicide warning signs are actually blended lists of risk factors and warning signs. Confuse one with the other, and a quick, decisive response to either is unlikely. Owing a gun is a risk factor; talking about shooting oneself in the head with it is a warning sign. To mitigate the first requires safe gun storage practices or changes in law and regulation of gun ownership; to mitigate the second requires a thoughtful, interpersonal intervention.

Unlike tightness in the chest, radial left arm pain, and sweating (warning signs of a possible cardiac event), no similar set of reliable or universal warning signs exists for a pending suicide attempt. However, an expert consensus group has recently offered the following lists, each suggesting more or less urgent response by the gatekeeper (Rudd, et al 2006):

Consensus Warning Signs for Suicide
If any of the following are seen or heard, it is recommended to take immediate action, e.g., call 911

- Someone threatening to hurt or kill themselves
- Someone looking for ways to kill themselves: seeking access to pills, weapons, or other means
- Someone talking or writing about death, dying, or suicide

To this second list, it is recommended a mental health professional be contacted or that the person call 1-800-273-TALK

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in risk activities, seemingly without thinking
- Feeling trapped – like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, or society
- Anxiety, agitation, unable to sleep, or sleeping all the time
- Dramatic changes in mood
- No reason for living, no sense of purpose in life

The consensus group agreed that while there is a great deal of literature on suicide risk factors, relatively few empirical studies have been completed to help determine what suicide warning signs are and how valid they are in predicting a suicide attempt, especially in the short term, i.e., in the next hours or days.

While this list of warning signs is helpful, the items listed are actually psychological constructs which define sets of behaviors, e.g., "someone threatening to hurt or kill themselves" or "dramatic changes in mood" does not address the actual or specific behaviors or language a suicidal person might use to communication his or her distress.

QPR and Signal Detection Theory

Many coded or culturally-specific suicide warning signs might be described as "weak signals," e.g., "I won't be around much longer" or, "I think I'll take the spirit trail." Weak signals are those easily lost in background noise or mistaken for a benign communication when, in fact, what was said or done by the suicidal person was intended to elicit a possible rescue. Signal Detection Theory may help us understand how to better teach suicide warning signs as well as help potential respondents, gatekeepers, to recognize them for what they are.

Signal Detection Theory (SDT) is used by psychologists to describe how we measure human decision making under conditions of uncertainty. SDT assumes that the respondent is an active decision maker and not a passive recipient of information – the very goal we hope trained gatekeepers will assume. The following graphic describes how responses to a possible suicide warning sign might be sorted into one of four categories (where Warning Sign Present is defined as possible suicide warning sign, and Warning Sign Absent is a not a suicide warning sign):

	Gatekeeper does not respond	Gatekeeper does respond
Warning Sign Present	Miss	Hit

Warning Sign Absent	Correct Rejection	False Alarm

Using a series of trials with trained and untrained gatekeeper respondents, it would be possible to establish statistical estimates of sensitivity to varioulsy defined examples of suicide warning signs, as well as to measure the possible benefits of training efforts to teach these to potential gatekeepers.

Conceptually, *sensitivity* refers to how hard or easy it is to detect that a target stimulus is present from background events, whereas *bias* is the extent to which one response is more probable than another. There are both risks and benefits to responding or not responding to a percieved signal. In the case of not responding to a possible suicide warning sign signal the costs could be devestating (death), whereas the cost of responding positively could result in great benefit (saving a life). If a postive response is made to what turns out to be a non-signal (Warning Sign Absent), the "false alarm" response also has costs and benefits. Generally, a positive response to what proves to be a non suicide warning sign is not costly except, perhaps, for a some small embarrassment.

Whether or not a gatekeeper responds to a given signal depends, in part, on "responder bias" which is affected by wrong belives about suicide, e.g., "People who talk about suicide don't do it," or negative attitudes toward suicidal persons, or even extensive familiarity with suicidal behaviors. One can imagine an overworked case manager in an adolescent residential treatment setting where suicidal communications are common failing to respond sufficiently to a suicide warning sign -- especially if there is a penalty or significant cost for responding to what proves to be a false alarm. Calling in a psychiatrist to evaluate what proved to be a false alarm is a high cost, but the conseqence of missing the signal althogehter may be even worse – a completed suicide or suicide attempt, and perhaps a claim of suicide malpractice.

This latter example represents an example "conservative bias" – failure to respond vigorously to weak suicide warning signs. What most suicide prevention program teach now is a "liberal bias" toward suicide warning signs, i.e., respond to all possible warning signs vigorously. Why? Because the cost of not responding may be death.

In broad areas of general science, SDT is used to sort out noise from meaningful signals, and for practical applications in industrial work settings, e.g., alarm management. It does no good to search for radio messages from deep space if the receiver cannot sort out a signal from the background noise of the universe, and it is waste of time and money to build alarm systems whose signals cannot be detected by safety officers on a production floor. Equally, no alarm system is functional unless the person expected to respond to the alarm can hear or see it and knows what it means.

Just a soldier standing guard on the front lines in wartime Iraq is more likely to detect a weak signal (from a possible approaching enemy) than the same solider standing guard in peacetime Kansas, a suicide prevention gatekeeper must be sufficiently aroused by the possibility of suicidal behavior to be able to detect what may be a weak or faint suicide warning sign. Using SDT it would be possible to measure the effectiveness of suicide

warning sign detection in response to training, and excellent statistical models for such tests are available (Abdi, H. 2007).

In terms of SDT and the QPR Institute's approach to training gatekeepers, we have found that audiences respond better to specific examples of suicidal behaviors than to abstract psychological constructs. Rhetorically, which of the following "signals" is easier to detect and more likely to result in a "hit" verses a "miss" in our SDT matrix above:

Hopelessness vs. "I can see nothing in my future worth living for."

We would argue that hopelessness is more noise than signal and lacks both clarity and specificity as to its meaning, whereas a verbal statement defining the underlying psychological state of mind (construct) that motivates such utterances provides a much clearer signal and, therefore, detection of such a signal is more likely to result in a gatekeeper intervention.

Failure to clearly define examples of suicide warning signs impedes our development of the training content and tools necessary to effectively train the hundreds of thousands of persons necessary to recognize these warning signs as valid indicators of suicide danger, and to deliver an effective emergency response in a timely fashion. Just as the signs of a pending heart attack may only signal indigestion, the warning signs of suicide attempt may also produce false positives. But because the risk of a true positive in either case may lead to death, it is better to act and be wrong than not act at all.

Face Valid Suicide Warning Signs

A number of researchers have identified categories of suicide warning signs (Miller, 1978; Osgood, 1985; Shneidman, Farberow, & Litman, 1970), many of them derived from the actual words of persons who had died by suicide. Some authors have used the word "clue" to describe suicide warning signs that have less than perfect face validity or could be considered weak signals, e.g., "I'm going away forever" vs. "I'm going to kill myself." These have been categorized as follows: 1) verbal clues, direct and indirect; 2) behavioral clues and 3) situational clues (circumstances from which the only apparent escape is through suicide).

A direct verbal warning sign might be, "I am going to commit suicide." Excluding a humorous context, this strong-signal statement should require no interpretation as to its meaning on the part of an observer and direct and positive action appears indicated. When presented with a direct verbal suicide threat, e.g., "I am going to kill myself" a gatekeeper need only confirm that what was heard was also understood, e.g., "You just said you were going to kill yourself, do you really mean it?" If the answer is in the affirmative, then a "perception check" has been accomplished, intent is confirmed, and intervention steps can be initiated.

However, Wolk-Wasserman (Wolk-Wasserman, et al., 1986) found that on interviewing significant others following the suicide attempt of an intimate other, and despite apparent clear and unambiguous statements of intent to die by suicide, family members and

significant others were reluctant to act, and even immobilized. In a step-by-step development following the communication of suicidal intent, reactions of significant others included a) silence and increased tension in the relationship, b) obvious ambivalence and, c) in due course, "visible indications of aggressiveness in some cases." What was common to all significant others in all groups studied was that the most common response to a suicidal communication was "almost total silence – a verbal vacuum" followed by reports of increased tension, anxiety, evasiveness, and in some cases anger and aggression.

At least in this study it appears little or no helpful dialogue followed the verbal expression of suicidal intent between intimate others. Since all cases were recruited from an emergency room population of attempters, no conclusions can be drawn about the potential for more favorable outcomes (e.g., averting a suicide attempt) had there been a helpful, understanding dialogue between the parties.

One conclusion seems clear: if the most common reaction to a direct verbal statement of intent to attempt suicide is silence, anger and/or avoidance, how much easier might it be for an observer to deny, ignore or fail to respond to an indirect statement of intent, e.g., "You won't be seeing me around much longer?" The answer to this question lies in the examination of whether or not the observer understood the meaning of an indirect statement, and whether the observer can comfortably explore suicidal thoughts and their implications with someone they already know. In Signal Detection Theory, this would require an examination of response bias on the part of the observer, i.e., liberal bias vs. conservative bias.

The Role of Gatekeeper Fear

In the author's experience in training healthcare professionals in how to make a differential diagnosis for major depressive disorder – and despite repeated instructions to do so – the majority of hundreds of otherwise skilled participants found it extremely difficult to inquire about the presence of the 9th symptom in the diagnostic criteria for Major Depressive Disorder; namely, "recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without specific plan, or a suicide attempt or a specific plan for committing suicide" (American Psychiatric Association, 1994). As one participant remarked "The word suicide just sticks in my throat." Another clinician explained, "They're already depressed, I don't want to put the idea in their head." Researchers have reported this stress/fear reaction to suicidal presentation in clinicians more than once (Deutsch, 1984; Farber, 1983).

Over a three year period of training professionals under a federally-funded Depression Awareness, Recognition and Treatment (DART) grant, our training team found the single most difficult probe to teach professionals was to directly inquire about presence of suicidal ideation, plans, and past history in role-play situations during which trained actors were scripted to emit a direct or indirect suicide warning sign, e.g., "I think I'll just it all over with" or, "I wouldn't worry about me too much, I've got other plans."

Not infrequently, untrained participants responded to this role-played warning sign communication with, "You're not thinking of suicide, are you?" This question can be interpreted as a request by the interviewer that the speaker retract the threat, which says more about the clinician's anxiety and fear than it does about the patient's. This is such a common response to suicidal communications by both professionals and lay people that the QPR program specifically teaches potential gatekeepers *How Not to Ask the Suicide Question*.

To address this training challenge, our multidisciplinary team set up an instruction and coaching system to assure that all participants a) observed a role-play of the suicide question being asked by a skilled interviewer conducting a diagnostic interview (later called the "S Question") and, b) personally asked the S Question under supervision in a role-play with a "suicidal patient." Even with this considerable effort to assure students had some personal experience in asking about suicide during a two-day training event, some could still not ask the S Question and open up a suicide risk assessment interview.

One has to speculate about the implications for suicidal healthcare consumers who, unknown to them, visit a licensed practitioner unable to probe for and comfortably discuss the presence of suicidal thoughts, feelings, plans and past attempts, even though these symptoms may be the very reason for the visit. Given this observation of practicing clinicians, it is not surprising that more than one researcher has noted that suicide risk assessment is far from a routine procedure for at-risk consumers (Luoma, Martin, & Pearson,2002; Brown, et al., 2003).

Another unpleasant consideration is that if the consumer voluntarily reports suicidal thoughts or preoccupations with death and the professional does not respond with concern or additional inquiry regarding severity, persistence, history of similar feelings, and other risk determination questions, a non-response may be interpreted as "permission to proceed."

Why Indirect Warning Signs?

In another uncontrolled experiment involving hundreds of participants learning to teach the QPR for Suicide Prevention Gatekeeper program (which training includes the teaching of suicide warning signs, their purpose, meaning and importance in suicide prevention), participants are asked to form into groups of three and discuss the following questions:

1. Who would you tell if you were contemplating suicide? Why? Why not? How would you tell them and in what language?
2. Would you write a suicide note? Why? Why not?
3. If you wrote a note, to whom would you write it?

After a small group discussion of 15 minutes a reporter for each group shares the findings. While this is a highly artificial setting and the circumstances are quite unlike those in which truly suicidal persons find themselves, the vast majority of participants report they would use indirect verbal statements of intent, not direct ones. The majority would not write a suicide note. Approximately one third stated they would send no warning signs at all. When the latter group is reminded that if truly suicidal they would

be suffering severe and unbearable psychological pain, a greater number of them report they would "hint" at what they were planning to do, but still not use the direct language or a clear and unequivocal statement of intent to die by suicide or write a suicide note.

The following list of reasons was given by participants for issuing an indirect verbal statement instead of a direct one:

- I'd want to see if anyone was listening.
- I'd want the person I told to care about me enough to ask what I meant.
- If they didn't understand what I just threatened to do, perhaps they don't really care.
- I wouldn't tell anyone who I thought couldn't rescue me, provided I wanted to be saved.
- If I wasn't sure I really wanted to die, I'd want to be able to later deny what I'd said.
- I know I've been a big problem for them, so I wouldn't want to force them to take notice of me.

Among a variety of responses, it appears that at least part of the reason participants elected to use indirect verbal statements in the throes of a suicide crisis are twofold:

1. Participants appear to experience the same classic ambivalence about the decision to die as do suicidal people, and they reflect this ambivalence in their equivocal statements of intent.
2. Participants appear to be testing a private hypothesis regarding a would-be rescuer's willingness and ability to intervene; in which case the equivocal statement becomes a "test" of commitment, competence, caring or trust.

From the interpersonal-psychological theory of attempted and completed suicide put forward by Thomas Joiner (Joiner, 2004), perhaps these suicidal communications are a way for the suicidal sufferer to confirm or disconfirm the accuracy of their perceptions that a) one is "a *burden* on loved ones" and b) one no longer *belongs* to a "valued group or relationship." Joiner's arguments for these two necessary but insufficient precursors to suicide attempts and completions (being a burden and not belonging) fit well into the interpersonal communications model described here.

As a test of caring or willingness to rescue, an un-responded-to suicide warning sign could be interpreted by the suicidal person experiencing burdensomeness as evidence that, indeed, he or she has been granted permission to proceed.

Decoding Indirect Suicidal Communications

"What people really need is a good listening to." – Mary Lou Casey

In any communication between two people there is a margin of error between what the speaker intends and what the listener hears and understands. The words selected, voice tones and volume used, and the contexts in which the words are delivered by the speaker all contribute to the sending strength of the valid signal. In radio language the power of this signal to reach the listener is referred to as broadcast quality or signal strength. A "5

X 5" signal is "loud and clear" and if the sender's signal reaches the intended listener without static, interruption or interference, and at high signal strength (is clearly heard by the intended listener), then any errors in communication lie not in transmission or detection and reception of the message, but in the receiver's interpretation of the signal.

Secret codes have been used for centuries to hide the true meaning of clearly broadcast print or voice messages. The "code breakers" job is to detect/intercept the surface message and discern its true meaning by unscrambling code. If you do not understand Spanish but enjoy Mariachi music, you may tap your feet and hum along with the tune while remaining perfectly clueless as to the meaning of the song. Only a Spanish-speaking decoder can translate the lyrics and explain its meaning.

Consider in one case that a suicidal person might say to a friend "I've decided to kill myself" while the two of them are having coffee in a quiet restaurant. The friend – perhaps knowing the sender has been in crisis about a number of things for several weeks - might have no trouble receiving and correctly detecting and interpreting the sender's message. But to assure the sender that the message was heard *and understood*, the friend might say, "Now you're scaring me. You sound serious. Are you serious about killing yourself?"

In the identical situation (and for response bias reasons stated earlier), an ambivalent suicidal person might use indirect language to communicate the same current state of distress: "I just don't think it's worth going on anymore. I'm so tired of it all. What I really need is a long, long rest. I'm counting on you to take care of my dog after Saturday. You will, won't you?"

The speaker's equivocal statement may represent as much an expression of desperation, hopelessness, and powerlessness as it does a statement of intent to die by suicide, but without clarification as to its true meaning, the message remains unclear or coded. The choices before the listener are to a) ignore what was just heard (message received but unable/unwilling to decode and reply; b) acknowledge the message was heard and understood, but to ask for a retraction, e.g., "You're not suicidal are you?" or, c) to ask the sender to resend and/or decode the message so that its meaning is fully understood.

Unless the suicidal person switches from a coded message to clear one, e.g., "I said, I'm going to kill myself!" the only way to discern the true meaning of this alarming statement is for the listener to ask clarifying questions until the meaning of the message is fully understood. In radio communication language, the receiver of an unclear message whose signal is distorted by background noise or other interference repeatedly asks the sender to resend the garbled message.

Should the listener respond with a simple "yes" to a coded statement, e.g., "I just don't think it's worth going on anymore. I'm so tired of it all. What I really need is a long, long rest…," the suicidal person may confirm at least two unspoken hypotheses:

- My friend agrees with me that suicide is okay because I've made my situation and reasons clear. At least my dog will be okay.
- My best friend cannot recognize how unbearable my pain is and won't even try to talk me out of this. Obviously I'm a burden to him, too. It really is hopeless.

The goal of QPR training to teach the friend to ask clarifying questions in order to decode indirect but detectable suicidal communication signals, e.g., "What do you mean, 'take care of you dog after Saturday'? What's happening on Saturday? And what do you mean a 'long, long rest'?" Gatekeepers are also taught that at some point in the decoding process, a straightforward question regarding suicidal intent is required, e.g., "Are you thinking of killing yourself?"

These clarifying questions create an active dialogue between the speaker and the listener by which the true meaning of the speaker's statement can be fully, correctly and completely understood. The simple art of active listening, gentle questioning, and coming to a full understanding of a distressed persons communications lies at the heart of all successful healing trades, including the most sophisticated psychotherapies.

Of the listening skills taught to all professional counselors (and to those who learn the QPR method) learning to ask the clarifying question is key. The power of the clarifying question has been well documented as a source of therapist success in assisting ambivalent patients to elaborate on the meaning of a statement, and thus better understand their own circumstances and capacity for change (Miller and Rollnick, 2002). An old adage in the training of young therapists stands the test of time, "Never assume you know something you don't; without questions you may never really understand your patients."

A Logic Model for Suicidal Communications

Setting aside the direct verbal statements of suicidal intent for the moment, what can we say about the nature and possible outcomes of a sender's communicating his or her suicidal intent using ambiguous or indirect language? In the best case, the speaker's indirect statement is heard and completely understood as to its true meaning by an astute observer/friend/family member/trained gatekeeper and, following a confirmation of meaning, is followed by a helpful intervention, referral, and treatment.

In the next best case, the speaker's indirect statement is heard but not fully understood, but a dialogue is initiated by the listener through the posing of clarifying questions, e.g., "I'm not sure what you mean. Are you thinking of killing yourself?" These clarifying questions may lead to any of the following outcomes:

- The speaker denies suicidal intent (you misunderstood me/I am not suicidal), in which case no intervention or referral is initiated. In the case of a non-psychotic, non-intoxicated and mentally competent liar who is, in fact, planning a suicide attempt, the risk for suicide may remain high but a gatekeeper can take no further action when presented with a flat and convincing denial of intent. (A trained clinician evaluating this same person may conduct a much more thorough, persistent and

detailed examination, including the interviewing of friends and family, but we cannot ask ordinary citizens to become clinicians.).

- The speaker confirms suicidal intent (you understood me) and the gatekeeper initiates an intervention and/or a negotiation for seeking help.
- The speaker is evasive to the first clarifying question(s), requiring the gatekeeper to ask additional clarifying questions.
- The speaker's statement cannot be clarified with additional questions and the gatekeeper remains concerned and fearful for the speaker's safety. This equivocal outcome may lead the gatekeeper to seek external consultation.

Knowing the Question is the First Step in Knowing the Answer **Ancient Zen Wisdom**

The Q in QPR is taught to directly learn the meaning of indirect, coded or oblique suicidal communications - whether they are verbal or behavioral. QPR Gatekeepers are taught and provided print versions of specific clarifying questions to be used to a) confirm the meaning of a direct suicidal communication and/or b) clarify the meaning of a coded or indirect potentially suicidal communications. Only by gently confronting such statements or behaviors can those intimate others with whom the suicidal sufferer communicates provide a conversational context in which the recognition of psychic pain and suffering can occur, and though which hope can be restored with the promise of help.

Participants learning the QPR method often ask, "But when do I know that what someone says might be a suicidal communication?" Two answers are taught: 1) if in doubt, ask the question, and 2) anytime what the person says causes you to feel fear or concern for their safety. If you feel any discomfort, anxiety or apprehension, or are suspicious about the meaning of what you heard, ask the S question.

Useful Fear

Clinicians have long relied on the so-called "index of suspicion" to make decisions about what observable signs and symptoms may mean in terms of diagnosis and treatment of physical illness. Certain clusters of symptoms dictate diagnostic procedures, followed by established treatments. Suspicion about diagnosis is only lowered by confirming the meaning of symptoms, typically by careful history taking and/or diagnostic tests with clear findings. The purpose of a diagnostic examination is to clarify suspicious symptoms and rule out what is benign and harmless from what is malignant, dangerous and potentially fatal.

If the purpose of a suicide warning sign (however ambiguously delivered) is the equivalent of a symptom of internal psychic pain and suffering (over anything from the loss of a valued relationship to a fear of public humiliation), then the purpose of this symptom may be to raise an interpersonal alarm that a dangerous and potentially fatal outcome is in the offing. Whatever else a suicide warning sign may be, it at least appears to have one primary function: to warn others.

In his excellent book, *The Gift of Fear* - and on the subject of threat assessment - Gavin DeBecker agues that the nature of an alarm is to trigger an ancient, entirely natural and

intuitive fear response. For safety and survival of the species this fear response should always be trusted. Had humans not be "gifted" with a fear response the human race would have died out eons ago. DeBecker claims intuition is more trustworthy than rational thinking and that it is always correct in at least two important ways:

1. It is always in response to something
2. It always has your best interest at heart.

According to DeBecker fear is far quicker and more powerful than logic, and a failure to trust the experience of it can lead to tragic outcomes. In order of importance, the top seven in his list of 13 "Messengers of Intuition," are these:

- Hunches
- Gut feelings
- Doubt
- Hesitation
- Suspicion
- Apprehension
- Fear

These descriptors of emotional reactions in clinicians are often used in the diagnostic workup of a symptomatic patient in clear distress. Similarly, in the author's experience working with friends and relatives who have lost a loved one to suicide, many of these feelings were reported to have occurred in response to things the deceased said or did prior to a fatal suicide attempt. In short, the pre-suicide warning signs triggered a negative emotional response in the recipient.

In some cases, this fear-inducing statement motivated the recipient to demand a retraction or a denial of what the suicidal person had just said. As one frightened sister said to her brother after he threatened to 'stop the suffering and get this over with', "You wouldn't do anything crazy, would you!" Clearly upset by his statement, she responded not with a clarifying question, but with a fear-driven demand for a retraction and denial. In another case, a young boy being bullied at school overtly threatened to kill himself, to which the father said, "We don't talk about suicide in this house!" The boy died with a gunshot wound to the head one week later.

If suicide warning signs are interpersonal alarms that something bad is about to happen, and these alarms are effective in raising some level of felt fear, anxiety, or discomfort in an observer, this does not mean that the observer is necessarily knowledgeable or skilled in how to respond effectively. In fact, in case after case, just the opposite appears to be true, and the literature suggests that fear leads to immobilization and that the most common response to the reception of a suicide warning sign is silence (Wolk-Wasserman, 1986). Fear, silence and immobilization are very primitive and protective human responses to perceived mortal threats; thus the challenge of training potential suicide prevention gatekeepers to respond in a competent, comfortable and effective fashion should not be underestimated.

What is Needed

For community-based suicide prevention gatekeepers to be effective, they must be educated that suicide warning signs are at once genuine, observable, pre-suicide attempt indicators and danger alarms that, when present, are likely to produce strong emotional responses (fear, distress, anger, etc.) in the observer. To overlook this aspect training and to fail to acknowledge that these emotional reactions may inhibit a helpful response is to miss a critical aspect of the training. We cannot expect gatekeepers to take timely and effective remedial action if they cannot first validate that their experience of apprehension and fear in response to suicide warning signs are, in fact, confirming evidence for quick, positive action.

Gatekeepers must also be taught that because of the fear stimulated by these communications, engaging a potentially suicidal person will require a certain level of personal courage. Failure to act in the presence of warning signs may cause feelings of guilt and misplaced responsibility for the subsequent actions of the suicidal person. In order to mitigate this guilt, QPR trainees are specifically oriented to what emotional experiences they are likely to encounter and, in the event an opportunity to intervene is overwhelming and immobilizes them, they are taught, "If you cannot ask the S Question, find someone who can."

To help reduce any fear and reluctance to "get involved" gatekeepers must also be taught that suicidal warning signs provide a unique - *and sometimes the only* - opportunity to intervene in a developing suicide crisis. To bolster this affirmation and to increase a sense of self-efficacy, QPR Gatekeepers are taught that suspicious warning signs can be validated or invalidated by asking one or more clarifying questions, and that there is no negative consequence in learning that someone is not suicidal.

If more research is needed on the nature, definition and unique features of suicide warning signs, an equal amount of research is needed to further explore the emotional reactions and responses of those who intercept them. We cannot reasonably expect gatekeepers to respond quickly and with confidence if they must first overcome an immobilizing fear response. In our training experience we have found that the shortest route between knowing what to do and doing it is behavioral rehearsal in role-play, i.e., first recognizing scripted warning signs, and then asking easily-practiced clarifying questions. Thus, role-play exercises and instructions are provided to Certified QPR Instructors to use in training gatekeepers, and all instructor trainees must complete at least one role play as part of their certification process.

Gatekeeper Competence

To determine a suicide prevention gatekeeper's competency to engage a suicidal person in a helpful dialogue leading to a successful referral/link to further professional assessment requires a blend of knowledge, personal confidence in the intervention, and demonstrable skills. The following measurable behaviors are suggested to help determine gatekeeper competence:

1. Demonstrates ability to recognize and identify suicide warning signs
2. Asks clarifying questions to validate suicidal intent when warning signs are present
3. Demonstrates active listening skills with a suicidal person in role-play
4. Reports a high level of self-confidence, self-efficacy, and comfort in an interview situation, which self-report is confirmed by external ratings
5. Demonstrates ability to name at least 5 risk and 5 protective factors for suicide
6. Demonstrates ability to reduce risk of suicide attempt by immediately enhancing protective factors and reducing risk factors, e.g., removal of means of suicide
7. Demonstrates basic active listening skills in persuading a suicidal person to accept help
8. Demonstrates knowledge of national and local referral information, access, and contacts
9. Demonstrates ability to make a successful referral in role-play situations

Since the stakes are potentially so high and the costs not insubstantial, gatekeeper training programs must address these issues of competency, not only in terms of immediate training effects, but whether or not these brief training programs lead to lasting changes in learner attitudes, knowledge, and sustained behavior change as demonstrated over time in defined populations. These are all quite researchable questions and worthy of pursuit.

The P in QPR

Once the S Question in QPR is asked and the risk of a potential suicide threat has been clarified and established, the task shifts to persuading the suicidal person to take positive, even life-saving action. This is not always easy. If persuading suicidal persons to accept help or visit a mental health center were easy, the gatekeeper's job would take only a few minutes and there would be no need for involuntary detention in psychiatric treatment facilities. In reality, the ability to persuade a clinically depressed, alcohol abusing, or personality disordered person to accept professional evaluation and treatment depends on at least the following:

- The nature and quality of the relationship between the suicidal person and the gatekeeper
- The ability (competence) of the gatekeeper to motivate positive action through active listening and persuasive verbal skills
- The reasonable availability and accessibility of professional services, e.g., for a rural citizen a 100-mile drive to a professional
- The mental status of the suicidal person (intoxicated, paranoid, hostile, fearful, psychotic, belligerent, etc.)
- The suicidal person's past history of success or failure with mental health or other professional services
- The degree of ignorance, stigma and fear the suicidal person associates with seeking and/or accepting professional help.

Timing is Everything

As in many other ventures, timing determines success. Persuasion works best when commitment to a particular outcome remains undecided. Thus, the greater the

ambivalence about dying by suicide experienced by the sufferer, the greater the opportunity for a gatekeeper to negotiate a non-fatal outcome.

It is important to understand that a suicide attempt does not begin when the pistol is pointed at the head and fired, or when the gun is loaded, or when it is drawn from its holster, or when it is purchased with suicide as the motivation. A suicide attempt begins with the idea that suicide is an acceptable solution to unendurable psychological pain, whatever the source. From idea to act, the journey to suicide may be a matter of minutes, hours, days, weeks, months or years, but the suffering is always more benign in beginning than in the final hours before the attempt. The prediction of suicide becomes easier if we understand that the act of suicide is a process, and that from its beginning to its potentially fatal outcome the relative effectiveness of our ability to dissuade the person from suicide will vary with where we interrupt them in their journey. Our success may also rest on our collective capacity to quickly re-knit the ties that bind people together and, in so doing, reduce the suicidal sufferer's perception of being a burden on others and no longer belonging to the human family (Joiner, 2004).

Thus, if a QPR intervention is initiated early on when the suicidal person has only just begun to think about suicide passively for a few days, there should be little resistance to being persuaded to accept a referral for help, remove the means of suicide, and rebuild relationships. If, however, the suicidal person has been planning a suicide attempt for months or even years, has purchased a pistol, rehearsed shooting it several times, written a will, said his goodbyes, and has picked a time and place for the final act, the journey to suicide is entering its final phase and the intervention may prove difficult indeed. Once the suicidal sufferer has accepted death as the final solution, and the act of suicide is actually in progress, it may prove - much like a train that has left the station – impossible to reverse the direction of travel.

The Reluctant Referral

The P in QPR was selected because it is a behavior in which everyone has engaged, and which is completely familiar to anyone who has tried to influence the behavior of another. It was also selected because potential gatekeepers must use themselves in the intervention, together with whatever powers of influence and persuasion at their disposal. P was also selected because of the author's theory of the "reluctant referral."

An examination of those groups with the highest suicide rates, e.g., teenaged males, working males, older white males and alcohol abusers (AAS, 2004), suggests that these and other groups at elevated risk for suicide are also the least likely to self-refer for treatment. A reluctant referral may be defined as someone who a) is unlikely to ask for help in person or from a crisis line, b) is likely to refuse help when it is first and freely offered, and c) requires third-party persuasion to accept the very intervention, assessment and treatment that might save his or her life from suicide. Even a cursory review of news stories about completed suicides in most Western countries reveals a steady, relentless stream of stories about self-inflicted violent deaths by men in dire and obvious need of treatment, but apparently unable to ask for it. All too often loved ones, family members,

and co-workers report their observation of an alarming list of pre-suicide warning signs and yet seem unable to respond in a helpful fashion.

Evidence for why passive approaches to suicide prevention which rely on self-diagnosis and self-referral are not likely to be successful for reluctant referrals is building. In one recent study (Gould et al, 2006) found that of 519 teenagers surveyed on whether they had used a hotline number the vast majority knew was available, only 2.1% reported having ever used it. Of these 11 young people, only one was male. The authors also found that those who objected most to the use of a hotline were among those "most in need of help." Similarly, Wyman and his colleagues found that on youth health risk surveys those youth who reported suicidal thinking and attempts in the past year were two to three times less likely to see a school counselor or other adult as helpful if they were overwhelmed by life (Wyman, et al, 2006).

Included in the reluctant referral group are some of our brightest and most able citizens, including doctors, lawyers, military officers, political and business leaders, student-athletes and others. Reluctant referrals at elevated risk for suicide are, frequently, high profile, successful people who do not typically call hotlines, seldom avail themselves of mental health services, and who are generally resistant to seeking professional mental health treatment (Berman Al, Maris RW., et al. 1997; Hendin, H, 1994; Institute of Medicine, 2002).

The reasons reluctant referrals do not seek or accept help freely offered are myriad: fear, stigma, prejudice, cost, shame, early socialization, a belief that all therapists are "crazy" and a cultural expectation that one should be able to solve one's own problems without assistance. As a possible result of this attitudinal position, reluctant referrals can be identified both by their apparent resistance to help seeking, and by their elevated rates for suicide.

The very reasons reluctant referrals do not seek or accept help lies at the core of the life-and-death struggle with ambivalence experienced by suicidal sufferers. If these reasons for not seeking or accepting help were easily overcome with a simple media-delivered message, e.g., "If you have thoughts of suicide, see a professional" all the therapists would be busy and gatekeepers would not be needed. But this is clearly not the case, since the majority of people who die by suicide are not in active treatment with a qualified healthcare provider at the time of death (WHO 2001a).

If we assume that those suicidal people *not already receiving professional services* (the willing help seekers) remain undiagnosed and untreated in the community, and that this population is made up largely of reluctant referrals, then the gatekeeper's skill set must include a heavy emphasis on enhancing their specific powers of persuasion and influence. To avert some of these suicides we must train those people already in an existing strategic relationship with the reluctant referral, e.g., wives of successful, older white males, police officers, assistant coaches, and first sergeants. To be effective, then, what skills does the gatekeeper need to assure an initially reluctant person accepts a referral?

An Adaptation of Motivational Interviewing

The basic skill set and evidence-based knowledge selected to be taught to potential QPR gatekeepers to improve their powers of persuasion is based upon the work of many researchers, but is primarily derived from the now broadly established success of Motivational Interviewing as described by William Miller and Stephan Rollnick (2002). As motivational interviewing grew out of the addictions counseling field, its premises and practices deal directly with the very issues presented by suicidal reluctant referrals: Resistance to change and ambivalence about seeking help or treatment. The motivational interviewing method has clearly demonstrated its effectiveness to successfully bring about positive changes in precisely the behaviors targeted for influence by QPR trained gatekeepers.

As a reminder, the goal of QPR training is *not* to produce therapists, but to provide ordinary citizens with those key skills that have been shown to produce significant behavior changes via brief interventions (Bien, Miller, and Tonigan, 1993; Miller, 2000). In addition to learning basic listening skills, the training program includes understanding the power and thoughtful use of the following knowledge and skills:

- Faith and hope effects (Miller & Rollnick, 2002)
- Accurate empathy and empathic listening (Rogers, 1959; Luborsky, McLellan, Woody, O'Brien, and Auerback, 1985; Miller, Taylor, and West, 1980; Truax and Carkhuff, 1967; Truax and Mitchell, 19712; Valle, 1981)
- How to provide immediate support and reflection (Patterson and Forgatch, 1985)
- The nature of ambivalence and facilitating behavior change (Miller and Rollnick, 2002)

At present a number adaptations of motivational interviewing (AIMS) have been developed to test its effectiveness in brief encounters, primarily in busy primary care settings (Butler et al., 1999; Rollnick et al., 1997; Rollnick, Mason, & Butler, 1999). The goals in these settings are similar those of the QPR gatekeeper: to engage the person to accept a referral for specialized treatment.

Pragmatically speaking, and because suicide attempts and completions remain rare events, for a public health intervention like QPR to be effective *when and where* it needs to be applied, it must be teachable in a reasonable period of time, and be both brief and effective in its delivery. While working through the ambivalence of a chronic smoker is an essential element of addiction-oriented motivational interviewing, persuading an ambivalent suicidal person to accept help and begin the change process cannot take hours or days or weeks.

Rather, for a QPR intervention to be helpful in averting a suicide attempt, it must happen more or less immediately and must not require an inordinate amount of time. Thus, QPR is more like CPR in its urgency, directness, training requirements, and delivery, than it is like a leisurely interview with someone struggling with any of a number of addictive problems which, while life-threatening in the long term, are not fatal in the near term. In a suicide crisis, the difference between acting now or acting later can mean the difference

between life and death. Thus, citizens trained in QPR are advised to act quickly and not to wait for things to get better, and that any effort to assist a suicidal person may lead to a favorable outcome.

The QPR gatekeeper intervention then, as a potential adaptation of motivational interviewing (AIM), must work within the time constraints of what is likely to be a single, brief encounter of usually no more than one hour, as determined by informal surveys of potential gatekeepers (Quinnett, 1995). QPR as an adaptation of motivational interviewing needs additional research and testing, but does fit within the basic framework of one person trying to help another in an emergent health-risk crisis. Similar strategies of brief motivational interviewing have been adapted to, and tested for effectiveness, across a number of medical and health promotion platforms using the "teachable moment" concept, including alcohol use, diet, physical activity, diabetes control, pain management, screening, sexual behavior and medical adherence (see summary in Miller and Rollnick, 2004). As regards the teachable moment and the author's clinical experience with suicidal "reluctant referrals," the relief experienced by these individuals from a single therapeutic session appears to motivate commitment to additional treatment and behavior change. Research to support this conclusion, however, is scarce. None the less, a growing body of data suggests that motivational interviewing techniques hold considerable promise as a behavior change approach for public health initiatives.

What more teachable moment exists in life than the one in which a suicidal person is trying to decide between life and death? Clinical experience has shown that once a person is actually making a suicide attempt, the teachable moment has passed. Another opportunity may occur if the person survives, but the best window of opportunity would be during the "contemplative" or ideational phase. The author believes potential gatekeepers can be trained to recognize and exploit this contemplative phase of suicidal thinking, as the period of greatest ambivalence and internal struggle and, in so doing, open a helpful dialogue with active listening skills and gentle questioning. This intervention, when coupled with a belief in a positive outcome and specific referral resources, can then lead to a successful negotiation for the suicidal sufferer to stay alive, at least in the near term.

Finally, to relieve concerns about liability and "getting involved," QPR gatekeeper are informed of the Good Samaritan Act of 1985, and that a layperson or professional who does not have a legal duty to respond to a stranger's emergency, and who is acting in "good faith" and is not being compensated, and who is not guilty of Gross Negligence (deliberately careless conduct), is immune from liability. There are no recorded cases against a Good Samaritan since 1985 (ProCPR, 2003). There have been no complaints about QPR training brought to the attention of the QPR Institute in the past 10 years and no adverse events have been attributable to the training to date.

The R in QPR

The R in QPR builds, again, on familiar behaviors in which every adult has engaged thousands of times: asking Questions, Persuading others to do something they may not

want to do, and Referring people to everything from a lawyer to an Italian restaurant. Because suicidal people present a risk to themselves and sometimes others, QPR trained gatekeepers are taught to make the most reliable referral possible: to personally escort the suicidal person to the resource. In order of importance – and after negotiating the best possible outcome - gatekeepers are taught to:

- Accompany the suicidal person to the resource
- Secure an agreement from the suicidal person to see a professional and follow up to see that the appointment was kept
- Secure an agreement to see a professional, or accept help, even if in the future
- Secure an agreement to stay alive (not a no-suicide contract)

In many ways the R in QPR is its weakest element, and for two reasons. First, like politics, all referrals are local. Communities vary in the depth, breadth, quality, and accessibility of professional services and resources for suicidal persons. In some rural communities access to a qualified mental health professional may be hours away by automobile, even if the suicidal person is willing to go. With the exception of 1-800-SUICIDE or other national suicide prevention hot lines, local resources – however difficult to access and however understaffed or marginally qualified - remain the *only* specialized resources available to QPR citizen gatekeepers and those they try to help.

Even if resources and qualified services are available, referral success between integrated healthcare systems has been found to be successful only 50% of the time (Zedlow & Taub, 1981). Since the suicidal person will most often be referred to a mental health professional or service, the acceptability of that service to the suicidal person may be even lower. A suicidal police officer in a small town is highly unlikely to ever accept a referral to the local mental health center, as he or she most likely knows all the professionals employed by the agency on a first name basis. Access is not about admission policy or distance, but about stigma, fear, and shame. Where no mental health services exist and in some rural communities and on Native American reservations, the "go to" person - who is known to be understanding, reliable, a good listener, strong and respectful, and able to deescalate a suicide crises - may not be a licensed healthcare professional at all, but rather a mature community spiritual leader.

The second reason the R in QPR is the weakest element is that even if the gatekeeper is successful in making a referral and the suicidal person is seen by a professional, e.g., in an emergency room or mental health center, community-based professionals vary greatly in their clinical competence to assess, manage and treat suicidal consumers. In a public health model, gatekeepers attempting interventions with suicidal persons may find themselves in a community in which there is a) a high level of shared responsibility and community competence to assist suicidal members, or b) a low level of these community characteristics (Knox, et al. 2003). In the former case the gatekeeper's job is easy (referrals are readily accepted, assessed and treated); in the latter the job is hard (referrals are rejected, poorly assessed and may remain untreated).

As noted earlier, it could be hypothesized that community-dwelling suicidal persons identified by gatekeepers have a better chance of survival when these links in the chain are well established:

- Early recognition of warning signs
- Early application of QPR
- Early assessment by a qualified professional
- Early access to competent treatment for suicidal behaviors

To make such a system work effectively, gatekeeper referrals must be automatically accepted, properly assessed and triaged to a level of care that matches the level of assessed risk. In communities with high levels of competence and shared responsibility for its suicidal members, and where a complete chain of survival exits, acceptance of a gatekeeper's competence, knowledge, and role as a referrer in the community is likely to be smooth and successful. In sum, the presence of suicide risk is confirmed by the gatekeeper following the emission of a warning sign and clarified with one or more S Questions; Persuasion is made less difficult because stigma has been reduced, access to service is straightforward; and all parties know that the local community of care providers is willing and able to accept a Referral for professional assessment and care.

While the ideal referral is the hand-delivered one, this is not always possible, realistic or necessary, and we should not expect citizen gatekeepers to attempt to exercise authority they do not have or might be unwilling to use on a personal basis. However, QPR gatekeepers are provided print of verbal information (the latter on Q&A following training) on the generic availability, legal standing, and rationale for involuntary treatment statues for those who refuse to accept help and are considered to be at high risk for suicide. Participants are also provided the following print information upon which they may premise their actions: "In the wisdom of the state, suicide is not an acceptable solution to the problems of living."

As part of the R in QPR, gatekeepers are provided the names, phone numbers, addresses, and where appropriate, maps to emergency rooms, mental health centers, and college counseling centers. Research has shown that clinical risk information alone does not improve help seeking behavior, and especially if the behavior change requested may lead to a noxious or painful intervention, e.g., an inoculation (Leventhal et al., 1965). In the Leventhal study what made a dramatic difference in student self-referral rates to secure a tetanus inoculation was not the health information, but the provision of a map to student health services buildings and the times when the shots were given.

Enhancing Protective Factors

As being asked to accept help from a professional may create more ambivalence, if not resistance, QPR trained gatekeepers are taught to elicit from the suicidal person the name of someone *they are willing to talk to.* To initiate this marshalling of supportive others, gatekeepers are trained to ask, "Who else needs to know you are in this much pain?"

It is presumed this identified significant other person is at once supportive and understanding, and a likely protective factor against suicide. With the permission of the suicidal sufferer, one or more supportive others may then be called by the gatekeeper to rally critical emotional support and understanding, thus breaking down life-threatening isolation while simultaneously reducing the opportunities to make a suicide attempt. Again, directly addressing issues of perceived burdensomeness and lack of belonging by assisting significant others to rally around the suicidal person becomes an important aspect of even the basic QPR intervention (Joiner, 2004).

Finally, to instill a sense of self-efficacy in the suicidal sufferer through the enhancement of faith and hope (Frank and Frank, 1991; Miller, 1985; Shapiro, 1971), QPR gatekeepers are taught to encourage the suicidal person's belief that he or she will survive the current crisis. Gatekeepers are trained to "Offer hope in any form that works them and the suicidal person." They are specifically taught to say, "I'm on your side! We'll get through this" - both statements targeted toward reducing any sense of being a burden and that they are reconnected, at least for now, with someone who cares if they live or die.

The purpose of teaching these life-affirming, supportive statements and encouraging their use during an intervention are to a) set the gatekeeper's expectations for survival high while expressing confidence in a positive outcome, and b) establish a self-fulfilling prophecy with the suicidal person that, in fact, survival is expected (Jones, 1977; Leake and King, 1977; Parker, Winstead, and Willi, 1979). Healers have long known that nothing is so powerful in achieving a positive outcome as the patient's belief that it will happen, and the QPR training program is built upon this psychology of hope. A repeated refrain in the training program is "Hope begins with you."

From a public health perspective, and even if community-based professionals are less than helpful in their support of citizen-trained gatekeepers in terms of respecting their judgment and accepting their referrals, we can still teach gatekeepers to actively reduce as many suicide risk factors as possible as quickly as possible, e.g., remove alcohol and access to firearms, provide immediate support, enhance protective factors and to take other steps to immediately reduce the risk of a suicide attempt. By these actions, a clear message of hope is sent to the suicidal sufferer: "I want you to live!"

The Core QPR Gatekeeper Curriculum

Based on the needs of adult learners, extensive testing, and the available scientific literature, the QPR for Suicide Prevention Gatekeeper training program includes the following educational elements delivered in a multimedia format:

- A nine-minute celebrity-hosted video intended inform and orient participants to QPR
- Basic orientation to suicide prevention and the role of gatekeepers
- Disclaimer that QPR is not treatment, but a citizen emergency response to a mental health crisis
- Review of the common myths about suicide and an active cognitive correction of participant false beliefs
- Review and recognition of samples of evidence-based suicide warning signs

- How to set up a QPR intervention (timing, environment, resources)
- How to ask the S Question (examples, specific phraseology, anticipated results)
- How to persuade a suicidal person to accept help (active listening skills, focus on problem(s), requests for life-saving action)
- How to refer a suicidal person to local/national resources (accompanied referral, names, numbers, addresses)
- How to improve self-efficacy and enhance hope by offering a personal belief in a positive outcome
- Where possible and time permits, active behavioral rehearsal of QPR skills in role-play situations
- The take-home text QPR booklet which reviews the training and includes the following background risk and protective factor information:
  - definition of a gatekeeper and the role
  - overcoming negative emotional reactions to suicide
  - basic understanding of suicidal behavior
  - definition of suicidal behavior
  - review and listing of multiple warning signs
  - depression as a risk factor for suicide
  - alcohol as a risk factor for suicide
  - review of the progressive QPR steps/sample questions
  - brief tutorial on active listening skills
  - how to deal with resistance
  - what to do in the event the person refuses help
  - recommendations on removal of means of suicide
  - the value of hope and faith in preventing suicide

QPR trained gatekeepers are also provided a three-part reminder folding card suitable for wallet or purse that contains a review of suicide warning signs, the QPR steps, and local and/or national hotlines.

Rationale and Research Support for Gatekeeper Training

As noted earlier, gatekeeper training has been identified as a promising strategy for suicide prevention and is one of a small number of strategies reviewed in suicide prevention research. Gatekeeper training to prevent suicide among adults and older adults has been little studied, but gatekeeper training in suicide prevention has become a key strategy recommended by both the Institute of Medicine and the *National Strategy for Suicide Prevention* (NSSP) (Goldsmith, 2002; PHS, 2001).

As a universal and possibly selective prevention strategy, gatekeeper training is designed to train those in a strategic position in the early identification of individuals at high risk for suicide within a community and to improve timely referrals for mental health services (CDCP, 1992). Targets for gatekeeper training include a wide variety of community lay and professional persons such as school counselors, clergy, police officers and others. In the school setting adults in contact with potentially suicidal youths might include teachers, coaches, food service workers and bus drivers (CDCP, 1992; Gould & Kramer, 1999). Gatekeeper training programs typically target goals of enhanced knowledge,

attitudes and skills in the identification and referral of those at risk (Gould & Kramer, 1999). In school settings links to, and support by, community resources are recommended to establish a comprehensive approach (CASP, 1994; Kalafat, 1999).

Due to high interest levels in youth, most studies on the effectiveness of gatekeeper training programs have focused on training for the identification of suicidal young persons. Findings have shown that gatekeeper training has positive effects on attitudes and knowledge about suicide and on referral skills (Eggert et al., 1997; King & Smith, 2000; Ramsey et al., 1994). One gatekeeper curriculum for school counselors showed positive effects on knowledge and skill in a three year follow up (King & Smith, 2000). Much more research is needed in terms of determining if gatekeeper training actually impacts detection and referral rates, as well as reduction in suicide morbidity and mortality.

Evidence for QPR Gatekeeper Training Effectiveness

Outcome effects of QPR training have been evaluated with several target populations. In 1999, QPR-Institute Gatekeeper Instructors trained 1,144 adult gatekeepers in the Albuquerque School District, including faculty, administrators, and support staff. Assessments at pre-training and at 18-month follow-up measured: knowledge of suicide facts, resources for at-risk youth in the community, and attitudes regarding asking a youth about suicide (Davis, 2001). All indices were significantly higher at 18-months follow-up compared to levels prior to training ($p. < .001$) in the direction of greater knowledge of suicide signs, resources, and more positive attitudes to questioning youths about suicide.

A second study was conducted with the Washington Youth Suicide Prevention Program under contract with the Washington State Department of Health and similar results were found. In this study 1,024 gatekeepers were trained. Pre-training and post-training scores on measures of attitudes and knowledge showed significant increases, suggesting positive effects on participants' perceived knowledge about suicide and willingness to engage in actions that may result in earlier detection, referral and prevention of suicide (Hazel & McDonell, 2003).

While well established, the QPR intervention, like all other gatekeeper-training programs, has never been evaluated through a randomized trial. In terms of the Institute of Medicine (1994) levels of evidence, QPR falls at a relatively moderate level, with only historical comparisons and pretest-posttest knowledge and attitudinal changes suggesting beneficial overall effects. However, QPR is currently undergoing much more rigorous, longitudinal evaluations in a variety of school, business, state, and community settings. Of note, the following evaluations are funded or submitted for funding by reputable research universities and state Departments of Health:

1. A 3-year National Institute of Mental Health funded random clinical trial of QPR in a large school district (60,000+ students) with full support of the Georgia state legislature. Grant completed May 2006, results expected 2007.
2. A two-year test of QPR effectiveness in corporate/business settings (grant funded).

3. A test of QPR for African-American colleges and universities sponsored by Howard University (grant funded, results pending).
4. A pilot test of QPR in African-American churches, sponsored by George Washington University (grant submitted).
5. A test of QPR on six university campuses (Harvard, MIT, Princeton, Columbia, Cornell and U of Rochester (DOD grant funded, in process).
6. A comprehensive data analysis and report on QPR Institute training programs has been produced in collaboration with the University of Northern Illinois and Eastern Washington University and is available on the QPR Institute web site.
7. Multiple states, colleges and universities funded under the Garret Lee Smith Memorial act are independently collection evaluation and outcome data.

QPR as a Tool for Case Finding

According to the Centers for Disease Control and Prevention, approximately 90% of all completed suicides are by persons suffering from untreated or under-treated mental health disorders (CDC, 1992). It is widely held that competent treatment of these potentially fatal disorders will save lives (WHO, 2001a). QPR was specifically designed to prevent suicides among that portion of this psychiatrically ill population that does not, for a variety of reasons, willingly avail itself of services.

The working premise of the QPR intervention is that it produces an adequate reason for referral, e.g., suicide warning signs have been confirmed as present and valid, and thus the assessment of current suicide risk by professionals should be routine. Gatekeepers are not trained to make discriminations in levels of suicide risk. But for QPR to become a successful public health intervention at the community level, healthcare professionals serving those communities must improve their skills in the assessment of suicidal consumers (IOM, 2002). It is one thing for a QPR citizen gatekeeper to assist a suicidal person to see a professional, but as some literature suggests, it is quite another thing for that professional to conduct a proper suicide risk assessment and carry out an evidence-based treatment and management plan (Luoma, Martin, & Pearson, 2002).

While no citizen intervention taught in a brief period of time can be expected to work with perfect fidelity and reliability, it is reasonable to assume that the QPR intervention need not be done infallibly to save lives; even a moderately competent intervention may reduce immediate risk and begin the restoration of hope. Given the low base rate of suicide in the general community, and based upon informal surveys of potential citizen gatekeepers groups regarding how much work-place time could be devoted to learning the gatekeeper role, the median answer was approximately “one hour.” Thus, the QPR program was compressed into a tight but comprehensive timeframe and accompanied by a take home booklet and reminder card for later reading and review, which might include secondary readership by family members or significant others.

Properly carried out, QPR training should help accomplish three sympathetic goals: a) mass public health awareness and basic education about suicide and its causes, b) an effective gatekeeper intervention to help prevent suicide, and c) the employment of voluntary gatekeepers to recruit high-risk suicidal reluctant referrals to treatment. Should the QPR intervention prove effective in increasing the detection and referral of

community-dwelling new cases of undiagnosed and untreated psychiatric disorders, it could be considered a success.

For example, if QPR training increased the detection of untreated depressions in developed countries from below the current estimated high of 45% to just 50% (Spijker et al., 2001; Dunn et al., 1999, Lawrenson et al., 1999, Souminen et al., 1998), and if these new cases were successfully treated 52% of the time (WHO, 2001), then the suicide rate among depressed persons in defined communities now being treated would see a reduction of 7.8% (Bertolote et al., 2004). On a global basis this would result in a reduction of suicide rates among clinically depressed persons from the current 15.1 per 100,000 to 13.9 per 100,000.

When the three leading psychiatric groups for completed suicide are combined (depression, alcohol-related problems and schizophrenia), and assuming current levels of estimated treatment success, community-based enhanced detection and treatment of these disorders worldwide could reduce the suicide rate as much as 20.5%, from 15.1 per 100,000 to 12 per 100,000 (Bertolote, et al., 2004). To quote Bertolete and his associates, in addition to the effective treatment of these major psychiatric disorders, the prevention of suicide depends in part on the "identification of psychiatric disorders in the general population."

To the degree suicide warning signs are reliable markers for the presence of serious psychiatric disorders, their recognition provides a unique opportunity to detect untreated cases whose symptoms may be otherwise masked, disguised, and minimized by the sufferer. Thus, QPR training represents a potential public health case detection method that addresses, quite directly, the severity of a potentially fatal illness before it is too late, e.g., the person is dead by suicide.

Given that suicide warning signs may be the most telling, observable, and undeniable symptoms that a serious undetected psychiatric disorder is present and entering its final, life-threatening phase, only trained gatekeepers *already living in the general population* in close proximity to the suicidal person are in a position to recognize warning signs, act on them, and refer. If, in the nature of human relationships we are "our brother's keeper," then it follows that the person most likely to save us from suicide is somebody we already know.

In a survey conducted among 134 reporting Certified QPR Instructors throughout the United States, approximately two persons per 25 trained in QPR in the general adult population reported themselves to be in a relationship with a significant other, co-worker or friend exhibiting suicide warning signs or extensive risk factors for suicide. These QPR training participants sought help, advice, and referral information directly from the QPR instructor *at the time of gatekeeper training.* In other words, participants learning to become QPR gatekeepers reported knowing someone within their family or social network exhibiting potential suicide warning signs that needed, according to the training just received, immediate exploration and possible assistance. In some cases the significant other was already in treatment with a healthcare provider; in other cases they

were not, but these were anecdotal reports and no data was collected to determine percentage of significant others already receiving treatment. In this same survey, approximately one in 54 participants revealed to the group or instructor that they had lost a blood relative to suicide, and some of these were survivors in need of referral for grief counseling. This survivor figure (one in 54) is very close to the one in 64 blood relative suicide survivors reported to be in the American population (AAS 2004).

In extrapolating these rough detection rates of eight potential suicide risk cases identified per 100 citizen gatekeepers trained to the total number of gatekeepers trained by the end of 2004 (250,000), an estimated 20,000 potential at-risk suicide cases were detected and attended to during several thousand QPR training sessions over a 10 year period. Assuming that 50% of the cases detected were already in treatment (10,000), it could be hypothesized that QPR training program detected roughly 10,000 new, potential suicide cases *at the time the training was delivered*, or one new, undetected case per 25 persons trained. It is presumed, but not known, that additional new cases were identified by gatekeepers in the days, weeks, months and years following the training.

If we further assume that QPR-trained participants were only 50% effective in generating a successful referral of the 10,000 potentially new cases in the hours, days and weeks following training (the suicidal person was seen and evaluated by a professional) then approximately 5,000 previously undetected and untreated potential suicide cases were seen and evaluated by healthcare professionals as an early and direct outcome of QPR gatekeeper training. Additional detection, referral, assessment and treatment interventions with new cases may have occurred in the weeks and months following training, as the QPR training effect and recollection of steps to be taken has been shown to persist in adult groups for at least 18 months (Davis, 2001).

Using the World Health Organization's estimated impact of the effective treatment of those mental disorders most commonly associated with suicide, and assuming an equal distribution of diagnostic categories in the QPR sample, and that all 5,000 cases referred received medically competent treatment, then a 20.5% percent reduction in the overall suicide rate for these newly identified cases could be expected (WHO, 2001a). In sum, an estimated 1,000 lives may have been saved through this program. Additionally, if there are approximately 25 suicide attempts per completion, then another 25,000 suicide attempts (25 X 5,000) may have been averted (AAS, 2005).

Admittedly, these are highly speculative observations. However, if QPR gatekeeper new-case detection data/referral success data can be replicated and confirmed, and given current, available suicide-behavior costs calculations, a cost-benefit analysis of program effectiveness could be conducted, as all costs of the QPR program delivery, training of trainers, materials, and other associated costs can be calculated from existing QPR Institute fiscal records.

These population penetration numbers, assumptions and extrapolations of any anticipated suicide prevention benefit for QPR training in the United States further assumes that America currently delivers competent and accessible mental health and substance abuse

treatment services which are comparable to other developed nations. According to 2003 *President's 2003 New Freedom Report on Mental Health*, and as a status report on the general health and well being of the nation's service delivery system to those at elevated risk for suicide, such an assumption would be as much a leap of faith as an attestation of fact.

Conclusions

The promise of mass public health training of both lay and professional suicide prevention gatekeepers has not yet been achieved, and much more research and evaluation is needed. New methods of broad public education must be explored and Web based technologies in the transfer of research to practice must be evaluated and, if effective, embraced. Given the low base rates for suicidal behaviors, careful cost-benefit examinations must be undertaken to justify the knowledge and skills taught to gatekeepers, what learning platforms achieve the greatest gains at the lowest costs, and the impact such training programs have upon on the recognition and referral behaviors over time in defined communities where outcome measures can be monitored over extended periods of time, e.g., 5 and 10-year time horizons.

The fact that those disorders most associated with death by suicide tend to be recurrent, relapsing, and chronic by their nature, and that suicide risk varies over time and with the course and acuity of a given illness, it is clear that those most in need of gatekeeper training are the family members, loved ones, friends, coworkers, case managers, employers, educators and care providers who are in the best possible position to recognize and respond to the early onset of symptoms and the distress signals that accompany psychological pain, despair and hopelessness, i.e., suicide warning signs. Given the millions who suffer from these disorders, and given our extrapolations of admittedly limited data, it appears we must train hundreds to save one, thousands to save hundreds, and millions to save thousands.

Clearly, detection and treatment are only a part of the solution to preventing suicide. Gatekeeper training, while it has key role to play, is an incomplete answer to the much larger social, psychological, and cultural strategies that might move entire populations toward less risk and lower suicide rates. Perhaps the positive but limited role gatekeepers are trained to play in detecting at-risk persons in the general population should be expanded to include, more directly, skills to enhance mental health literacy and understanding, the breaking down of stigma, and the immediate provision of known protective factors against suicide *before* someone becomes suicidal. To this end, much more is needed to be learned about those positive, protective, hope-instilling, faith-affirming words, acts, deeds, events and activities that make life much too precious to even consider ending it by suicide.

References

Abdi, H. (2007). "*Signal detection theory*". in: Salkind, N.J. (Ed.): Encyclopedia of Measurement and Statistics. Thousand Oaks, CA: Sage

American Association of Suicidology (2005) @ www.suicidology.org.

Berman, A.L. (2003) AAS to host conference on warning signs. *NewsLink. Vol* 29. No 2. p.4.

Berman A.L., Maris RW, et al. Panel Summary: Executive Suicide: Case Studies of Men of Influence, Proceedings from the Annual Meeting of the American Association of Suicidology (30th 1997, Memphis, Tennessee)

Bien, T.H., Miller, W.R., & Tonigan, J.S. (1993) Brief interventions for alcohol problems: A review, *Addiction,* 88, 315-336

Bertolote, J. M. & Fleischmann, A., De Leo, D., Wolk-Wasserman, D. (2003) Suicide and mental disorders: Do we know enough? *British Journal of Psychiatry* 183: 282-383.

Bertolote, J. M. & Fleischmann, A., De Leo, D., Wolk-Wasserman, D. (2004) Psychiatric diagnosis and suicide: Revisiting the evidence. *Crisis*, vol. 25 (4): 147-155

British Columbia Ministry for Children and Families. (1999). *Before-the-fact Interventions: A manual of best practices in youth suicide prevention.* J. White & N. Jodoin. Suicide Prevention and Resources Center of British

Brown, G. S., Jones, E.R., Betts, E. & Wu, J. (2003). Improving suicide risk assessment in a managed-care environment. *Crisis.* Vol. 24, No. 2, pp 49-55.

Brown, C.H., Wyman, P.A., Gno, J. & Pena, J. (2005). Dynamic wait-listed designs for randomized trials; new designs for prevention of youth suicide. (in press, John Wiley $ Sons, Ltd.)

Butler, C.C., Rollnick, S., Cohen, D., Russel, L., Backmann, M., & Stott, N. (1999). Motivational consulting verses brief advice for smokers in general practice: A randomized trial. *British Journal of General Practice, 49,* 611-616

Centers for Disease Control and Prevention. (1992). *Youth suicide prevention programs: A resource guide.* Atlanta, National Center for Injury Prevention and Control.

Centers for Disease Control and Prevention. (2004) June 11. *Morbidity and Mortality Weekly Report.*

Davis, P. (2001) Gatekeeper Training in School Settings, Poster session. Annual Meeting of the American Association of Suicidology, April

Debecker, G. (1997). *The Gift of Fear*, New York: Random House

Deutsch, C.J. (1984). Self-reported sources of stress among psychotherapist. *Professional Psychology: Research and Practice*, 15(b), 833-845

Eggert, LL, Randell BR, Thompson EA, Johnson CL. (1997). *Washington State Youth Suicide Prevention Program: Report of Activities.* Seattle, WA: University of Washington.

Farberow, N. L., & Shneidman, E.S., Eds. (1961). *The cry for help.* New York: McGraw-Hill.

Farber, B.A. (1983). *Stress and burnout in the human service professions.* New York: Pergamon Press.

Frank, J.D., & Frank, J.B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.

Garland, A.F., & Zigler, E. (1993). Adolescent suicide prevention current research and social policy implications. *American Psychologist*, 48: 169-182.

Gladwell, M. (2000) *The Tipping Point*, Little, Brown and Company, NY, NY.

Goldsmith, S.K., Pellmar, T.C., Kleinman, W.E., & Bunney, W.E. (Eds), (2002). *Reducing suicide: A national imperative.* Committee on Pathology and Prevention of Adolescent Suicide, Board on Neuroscience and Behavioral health, Institute of Medicine, Washington, DC: The National Academies Press.

Goldstein, A.S. (1998), *EMS and the Law*. Prentice-Hall Inc.

Gould, M.S., & Kramer, R. A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31* (Suppl): 6-31.

Gould, M.S., Greenberg, T., Nunfakh, J.L.H, Kleinman, M., & Lubell, K. (2006) Teenagers' attitudes about seeking help from telephone crisis services (hotlines). *Suicide and Life-Threatening Behavior, 36, 601-613.*

Guo, B. & Harstall, c. (2002). *Efficacy of suicide prevention programs for children and youth.* Edmonton, AB: Alberta Heritage Foundation for Medical Research.

Hazel, N., & McDonnell, M.G. (2003). A Summary of the Washington Youth Suicide Prevention QPR Training Sample. Does QPR Training Affect Self-Perceived Knowledge about and Willingness to Prevent Suicide. Washington State University. Unpublished manuscript.

Hendin, H, (1994). Fall from power, suicide of an executive, *Suicide and Life-Threatening Behavior*, v. 24, no 3

Joiner, T. (in press). Why people die by suicide. Cambridge, MA: Harvard University Press.

Jones, R. A. (1977). *Self-fulfilling prophecies: Social, psychological and physiological effects of expectancies.* Hillsdale, NJ: Erlbaum.

Kalafat, J. & Elias, M. (1995). Suicide prevention in an educational context: Broad and narrow foci. *Suicide and Life-Threatening Behavior,* 25, 123-133.

Kalafat, J. (2000). Issues in the evaluation of youth suicide prevention initiatives. In: Joiner T, Rudd MD, editors. *Suicide Science: Expanding the Boundaries*. (pp. 241-249). Boston: Kluwer Academic Publishers

King, K. & Smith, J. (2000). Project SOAR: A training program to increase school counselors' knowledge and confidence regarding suicide prevention and intervention. *Journal of School Health,* 70 (1), 402-7.

Knox, K. L., Litts, D. A., Talcott, W. G., Feig, J.C. & Cain, E.D. (2003) Risk of suicide and other adverse outcomes after exposure to a suicide prevention programme in the U.S. Air Force: cohort study, *British Medical Journal, Vol.* 327

Leake, G. J., & King, A.A. (1977). Effect of counselor expectations on alcoholic recovery. *Alcohol Health and Research World, 11* (3), 16-22.

Leventhal, H., Singer, R., & Jones, S. (1965). Effects of fear and specificity of recommendation upon attitudes and behavior. *Journal of Personality and Social Psychology, vol. 2, no. 1,* pp. 20-29.

Luborsky, L., McLellan, A.T., Woody, G.E., O'Brien, C.P., & Auerback, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry*, 42, 602-611.

Lundberg, G. (ed), Kerber, R. (chairman) (1992): Guidelines for CPR and ECC: recommendations of the 1992 national conference. *JAMA*, 268:2172-2183.

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*, *159*(6), 909-916.

Mackesy-Amiti, M.E., Fredrich, M., Libby, Goldenberg, D. & Grossman, J. (1996). Assessment of knowledge gains in proactive training for postvention. *Suicide and Life-Threatening Behavior,* 26: 161-174.

Mandrusiak, M., Rudd, D., Joiner, T.E., Berman, A.L., Van Orden, K.A., Witte (2006). Warning signs for suicide on the internet: a descriptive study. *Suicide and Life-Threatening Behavior, 36, (3)* 263-273.

Miller, M. (1978). Geriatric suicide: The Arizona study. *The Gerontologist,* 18, 488-495.

Miller, W. R. (1985). *Living as if: How positive faith can change your life.* Philadelphia: Westminster Press.

Miller, W.R., Taylor, C.A., & West, J.C. (1980). Focused verses broad spectrum behavior therapy for problem drinkers. *Journal of Consulting and Clinical Psychology, 48,* 590-601.

Miller, W.R. (2000), Rediscovering fire: Small interventions, large effects. *Psychology of Addictive Behaviors,* 14, 6-18.

Miller, W. R. & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. New York: Guilford Press.

Newman, M. (1990). The chain of survival: converting a nation." *Currents in Emergency Cardiac Care,* 1, 1:3

Osgood, N. J. (1985) *Suicide in the elderly: A practitioner's guide to diagnosis and mental health intervention.* Rockville, MD: Aspen.

Parker, M. W., Winsterad, D.K., & Willi, F.J.P. (1979). Patient autonomy in alcohol rehabilitation: I. Literature review. *International Journal of the Addictions, 14,* 1015-1022.

Patterson, G. R., & Forgatch, M. S. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. *Journal of Consulting and Clinical Psychology, 53,* 846-851.

ProCPR.org CPR Philosophy of Rescue @ www.procpr.org

Quinnett, P. (1995). *QPR: Ask a Question, Save a Life*. The QPR Institute, Spokane, Washington @ www.qprinstitute.com.

Ramsey, R., Tanney, B. Tierney, R. & Lang, W. (1994). *Suicide Intervention Handbook,* Calgary, Alberta Canada: Living Works Education.

Resnicow, K., Jackson, A., Wang, T., Dudley, W., & Baranowski, T. (2001). A motivational interviewing intervention to increase fruit and vegetable intake through black churches: Results of the Eat for Life trail. *American Journal of Public Health, 91,* 1686-1693.

Richman, J. (1979). The family therapy of attempted suicide. *Family Process, 18*: 131-142.

Robins, E., Gassner, S., Kayes, J., Wilkinson, R.H., Murphy, G. E. (1959). The communication of suicidal intent: a study of 134 consecutive cases of successful (completed) suicides. *American Journal of Psychiatry, 115:* 724-733

Rogers, C.R. (1959). A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework. In S. Kock (Ed.), *Psychology: The study of a science;* Vol. 3. *Formulations of the person and the social context* (pp. 184-256). New York: McGraw-Hill.

Rollnick, S., Butler, C.C., & Stott, N. (1997). Helping smokers make decisions: The enhancement of brief interventions for general medical practice. *Patient Education and Counseling, 31* (3), 191-203.

Rollnick, S., Mason, P., & Butler, C. (1999). *Health behavior change: A guide for practitioners.* London: Churchill Livingstone.

Rudd, M. D, Berman, L., Joiner, T.E., Nock, M., Silverman, M.M., Mandrusiak, M., et. al. (2006) Warning signs for suicide: Theory, research, and clinical application. *Suicide and Life-Threatening Behavior; 36,* 255-262.

Rubenstien, R., Moses, R., Lidz, T. (1958). On attempted suicide. *Archives of Neurology and Psychiatry, 79*: 103-112.

Safar P. & Bircher, N. (1998) *Cardiopulmonary Cerebral Resuscitation*. W.B. Saunders Company, Ltd., third edition.

Shaffer, D., Garland, A., Gould, M., Fisher, P., & Trautman, P. (1988). Preventing teenage suicide: A critical review. *Journal of American Academy for Child and Adolescent Psychiatry*. *27:* 675-687

Shapiro, A. K. (1971). Placebo effects in medicine, psychotherapy, and psychoanalysis. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (pp. 439-473). New York: Wiley.

Shneidman, E.S. (1996) *The suicidal mind* New York: Oxford University Press.

Shneidman, E. S., Farberow, N.L. & Litman, R. (1970). *The psychology of suicide*. New York: Science House

Tierney, R. J., (1994). Suicide intervention training evaluation: A preliminary report. *Crisis* 15:69-76.

Truax, C. B., & Carkhuff, R.R. (1967). *Toward effective counseling and psychotherapy.* Chicago: Aldine.

Truax, C.B., & Mitchell, K.M. (1971). Research on certain therapist interpersonal skills in relation to process and outcome. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (pp. 299-344). New York: Wiley.

Sanddal, N.D., Sanddal, T.L., Berman, A., & Silverman, M.M. (2003). A General Systems Approach to Suicide Prevention: Lessons from Cardiac Prevention and Control. *Suicide and Life-Threatening Behavior*, 33, 4, 341-352

Valle, S.K. (1981). Interpersonal functioning of alcoholism counselors and treatment outcome. *Journal of Studies on Alcohol, 42*, 783-790.

Wolk-Wasserman, D. (1986). Suicidal communications of persons attempting suicide and responses of significant others. *Act. Psychiatry. Scand*. 73.481-499

World Health Organization. World health report 2001; Mental health: New understanding, new hope. Geneva: World Health Organization

Wyman, P. A., Brown, C.H., Inman, J., Cross, W., Schmeelk-Cone, Pena, J. & Guo, Jing, Randomized Controlled Trial of a Gatekeeper Program Training Impact on School Staff, Paper presented at the Annual Conference of the American Association of Suicidology, Spring, 2006.

Zedlow, P. B. & Taub, H. A. (1981). Evaluating psychiatric discharge and aftercare in a VA medical center. *Hospital and Community Psychiatry, 32*: 57-58,