Lifeline (Saving Lives)

Crisis Support. Suicide Prevention.

Lifeline's Approach to Suicide Prevention

Date: 21 June 2012

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1.   Overview

Lifeline's approach to suicide prevention is based on a belief that it is possible to intervene in a suicidal crisis through the offer of help, and that this can save a life.

Crisis Intervention

The rationale for the establishment of the Lifeline telephone crisis line which has become 13 11 14 was informed – in part – by the seminal work of US psychiatrists Ed Shneidman, Bob Litman and Norm Farberow in the 1960's and 1970's which established that suicidal crisis is a phenomenon that is often associated with a suicide attempt, and that intervention in this crisis would often be positively received by the individual concerned – to achieve safe and life supporting outcomes. Telephone crisis lines – and more recently online crisis chat, or suicide hot spot emergency phones – are ways of placing the offer of help before a person in crisis, in ways that are convenient, accessible and effective for response.

Prevention of a Crisis

The Lifeline approach to crisis support also identifies the potential to intervene earlier to prevent the onset of events which may trigger a suicidal crisis, through the offer of help to persons experiencing difficulties in their lives.

It is not surprising, therefore, that many of the calls to the Lifeline telephone crisis line are about these factors, such as family and parenting issues, relationship difficulties, workplace and employment struggles, personal finances and housing deprivation, and the impacts of destructive behaviours such as alcohol and drug abuse, addictions such as gambling and domestic violence.

Lifeline's community based services, often developed through Lifeline Centres, reflect the emphasis on averting triggers to suicidal crisis.

Support Help Seeking Behaviours

A person's experience of a crisis state may be rooted in that individual's decline in mental health, and associated with emotional distress and an inability to cope, problem solve and find constructive means to bring about change. Help seeking may occur at this point with the realisation of the need for change. Lifeline recognises that through crisis there is the opportunity for growth and change, and that a empathetic and caring response to a person's call for help will set that person up well for further help seeking.

The emerging research evidence surrounding help seeking reflects this outlook, especially for males where problem identification may be delayed until significant personal distress or the impacts of mentally unhealthy behaviours are realised. Notably, this research also identifies the operation of help negation factors and signals the importance of giving attention to the promotion of help seeking in targeted ways appropriate to particular audiences.

Enable Recovery and Wellbeing

Lifeline also operates to create pathways towards mental health treatments and recovery programs. Suicide prevention may also be associated with recovery, especially for people who have attempted suicide, or have been bereaved by another's suicide. The research evidence suggests the provision of immediate post-crisis follow up and short periods of psycho-social support can deliver benefits in reducing a reoccurrence of suicidal behaviours and enabling a person to continue steps towards sustained mental health and well being.

2.   What Causes Suicide?

Lifeline's understanding of suicide recognises that it is a complicated human behaviour. Multiple factors apply.

Mental ill health is estimated to often be a factor in suicidal ideation. From the National Survey of Mental Health and Wellbeing, about three-quarters (72 per cent) of the survey's respondents who had had serious thoughts about suicide had a mental illness[1]. Additional research in Australia by Professor Robert Goldney at Flinders University found that "about two-thirds of those who die by suicide have symptoms consistent with major depression at the time of death".[2]

However, mental ill health is not a predictor of suicidal behaviour: the majority of people with mental illness do not die by suicide. An estimated 2-15 % of persons who have been diagnosed with major depression die by suicide. An estimated 3-20% of persons who have been diagnosed with bipolar disorder die by suicide. An estimated 6-15% of persons diagnosed with schizophrenia die by suicide. [3]

Psycho-social factors also operate in suicidal behaviours. The Australian LIFE Framework identifies the following where there is strong evidence of the links:
- age: 25-44 years
- gender: male
- personal: genetic factors and vulnerability (in built resilience)
- culture: indigenous and loss of cultural identity
- family: ongoing conflict, child custody
- location: rural and remote
- financial: difficulties and indebtedness
- education: performance orientation
- social: loss of status, lack of social support
- employment: unemployment, certain occupations
- traumatic events: abuse, public humiliation

Other factors where the evidence is less strong include:
- domestic violence
- divorce/separation
- gender identity
- physical illness
- economic deprivation
- bullying
- gambling
- imprisonment
- economic recession
- disaster
- suicide bereavement

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[1] National Survey of Mental Health and Wellbeing (200&) Australian Bureau of Statistics
[2] Goldney, R D (2005) Suicide prevention: a pragmatic review of recent studies. Crisis; 26 (3): 128-140.
[3] University of Washington (2013) Mental Health Reporting/Substance Abuse Mental Health Services Agency, USA.

Another factor may be 'tipping points' or 'triggers' for suicidal behaviour: an event or experience that precipitates a suicide attempt:
- relationship ending
- loss of status or respect, through a shameful event
- physical illness or accident
- death of a loved one (especially by suicide)
- suicide of a peer or socially admired
- abuse or conflict
- media reports on a suicide or particular methods of suicide

So, while mental illness is often in the background, other factors are at play - combining to form a lethal mix that can foster the desire to end one's life.

What is also apparent from the theory and evidence base on suicide prevention is that protective factors operate within an individual and act to prevent the onset of suicidal ideation: individual resilience, the presence of hope, positive mental health.

Increased treatment for mental illness will have an impact on suicide rates - population health approaches tell us that investments in a more mentally healthy population will support lower suicide rates. Clinical treatments play a real part in population health based suicide prevention.

Mental health promotion and prevention also plays an important role in building protective factors for suicide prevention. This involves attention to determinants for positive mental health in individuals such as exercise activity, sleep patterns, drug and alcohol use, stress management and social engagement. The basis for the Act Belong Commit mental health promotion campaign in Western Australia beings these elements together.

Similarly, the social determinants of health apply to mental health: social exclusion, discrimination and racism may play a part in suicidal developments; some studies suggest it is actually social inequality that hampers mental health more so than income levels and poverty, worldwide.

In viewing suicide as a behavioural phenomenon, the research evidence on help seeking and help negation emerges as a vital contribution to suicide prevention. Furthermore, stigma reduction regarding suicide and mental health issues is important in the promotion of help seeking, especially for sub groups and cultures where this is not the norm, such as older Anglo-Saxon males in rural and regional Australia.

For Lifeline applies, the combination of evidence on the factors and phenomena of suicidal behaviour reinforces the importance of an offer of compassion and connection with suicidal individuals to encourage help seeking actions.

The Lifeline Crisis Support Model which underpins Lifeline services can be seen to be as evidence based as is possible, drawing on theory-based models of suicide prevention and research findings on the practice of crisis intervention techniques in service provision that have been built over more than 50 years from Australian and international research work. Further refinement of the Model will continue as new knowledge emerges.

3. Theories on Suicidal Behaviour

The following theories on suicidal behaviour have been developed through research and allow us to examine the interplay of causal factors more carefully: they are presented as relevant to the Lifeline approach to suicide prevention.

3.1 Suicide and Crisis

Crisis is a situation where a person's coping capabilities are pushed beyond capacity.

There are several features of the crisis experience:

- emotional distress - intense emotions;

- emotions dominate and hinder cognitive processes;

- help seeking is elevated due to a desire to seek relief from distress.

Crisis is a dangerous situation for suicide. The US psychiatrists Ed Shneidman, Bob Litman and Norm Farberow found in their research that a person in crisis may move to a suicide zone, a state "when people feel overwhelmed in a given situation and feel helpless to influence the outcome. There is a painful sense of hopelessness and a constriction of perception, especially of choices or options."[45]

The evidence from the work by Shneidman and his colleagues[6] gives us hope:

1. First, they found that it is possible to identify a person entering suicidal crisis, and to check if possible triggers are having this effect. In crisis lines, techniques for identification of and engagement with a suicidal person, such as those skills taught in LivingWorks ASIST, or inquiry/response guides produced by the US National Suicide Prevention Lifeline, have built on this early work to improve the performance of crisis services in quickly identifying the person with suicidal intent and responding effectively to address safety concerns.

   Community based applications for identification of people in suicidal crisis exist. The 'gatekeeper' or first responding training such as LivingWorks programs and workplace programs Read the Signs operate to enable crisis intervention by motivating and equipping people to be help givers.

   More recently, emerging research evidence about rail suicide suggests that observation of people's behaviours at rail stations is reliable in predicting suicidal crisis and intent to act – which will further support crisis intervention programs in this context.

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4 Shniedman, E.S. (1996). The suicidal mind. Oxford: Oxford University Press.

5 Litman, R.E. (1996). A look at suicidology. Suicide and Life-Threatening Behaviour, 26, (1), 1-7.

6 Farberow, N.L. Heilig, S.M. and Parad, H.J. (1990, 1994). The suicide prevention center: Concepts and clinical foundations. In E. Shniedman, N.L. Farberow and R. Litman (Eds.), The psychology of suicide: A clinician's guide to evaluation and treatment (pp. 25-54). New Jersey: Jason Aronson.

2. Second, Shneidman and the others found that the suicidal person most likely does not wish to die - they simply wish the pain to subside. Shneidman coined the phase *'psycache'* to describe this intense pain. In taking steps to reduce the pain and psychological distress, he found many people were able to take on problem solving and treatments for the underlying factors that had built up prior to the crisis.

It may be that this state of crisis that consumes the ability to think differently at the time. This is why crisis intervention services are so important in the mix of suicide prevention services; it is this element of what Lifeline offers that may directly bring about a life changing reversal in intent to die.

3.2 Interpersonal-Psychological Theory of Suicidal Behaviour

More recently, Professor Thomas Joiner of Florida University author of the books "Why People Die by Suicide" and the "Myths of Suicide", identified through psychological autopsies that many suicide attempters come to the belief that other people's lives will be better off if they die. [7][8] This is highly distorted thinking, reinforced by the individual's perceptions of themselves and the world around them.

Joiner's theory suggests three critical elements that mix together: perceived burdensomeness, thwarted belongingness and an acquired capability for suicide. This is shown in the diagram, below:

Those Who Desire Suicide

Perceived Burdensomeness

Those Who Are Capable of Suicide

Thwarted Belongingness

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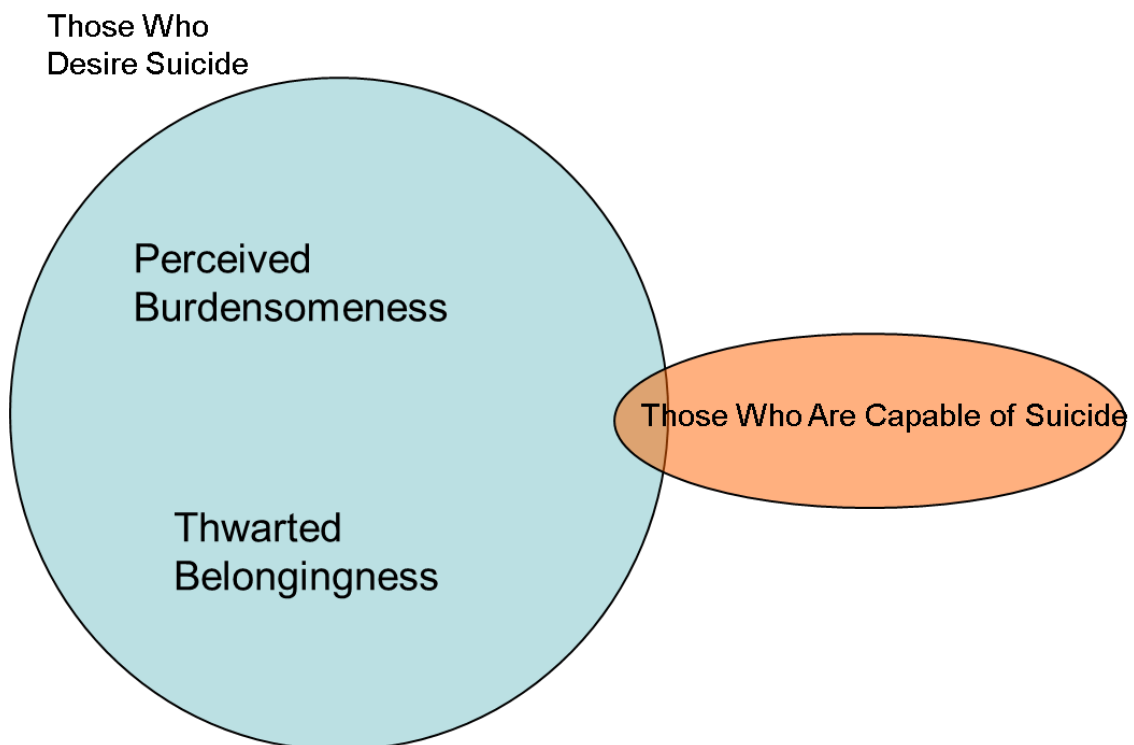
[7] Joiner, T.E. (2007) Why People Die By Suicide. Harvard University Press. USA.
[8] Joiner, T.E. (2011) Myths About Suicide. Harvard University Press. USA.

It is the last element that is the lethal ingredient: for a person to take actions to end their life their natural fear of death must be overcome. When the two earlier elements combine with this there is a high risk of a person attempting suicide.

Joiner suggests that the ambivalence towards dying that earlier theorists have identified may in part be due to the natural human fear of dying. This explains, in part, why individuals working in professions and occupations that constantly deal with death such as nursing and emergency services may be less constrained in attempting suicide if other elements develop, because of their diminished fear of dying.

Key features of Joiner's model include:

- burdensomeness and belongingness perceptions are just that: distorted thinking that build over time; Joiner refers to suicidality as a 'trajectory';

- individual and social factors apply: the world around an individual makes a difference in how these perceptions may develop;

- suicidal acts are often as a result of developing suicidality as the natural desire to live must be overcome in suicide: this may occur over a period of time, during which there is the potential to break the 'trajectory'.

The elements of Joiner's model may be seen in the various factors associated with suicidality: a sense of not belonging due to social exclusion, feelings if failure and burdensomeness on others.

In examining Lifeline 131114 crisis line call statistics, we can see the operation of Joiner's model: the high proportion of callers where loneliness and the sense of self in the community are presenting issues. In 2010, when statistic analysis was done, we discovered that aloneness was reported in 33% of suicide relates calls, and that 23% of those calls where loneliness featured were from people actually living with others.

Moreover, the recognised effectiveness with which barriers and techniques that restrict the access to means of suicide can operate is now understood to at least in part be due to this human characteristic, again reinforcing the importance of creating opportunities to interrupt the steps someone has taken towards suicide and make the offer of help and support. The matching of barriers at suicide hot spots with signage promoting a telephone crisis line is a model of service that applies this theory in practical action.

In further considering Thomas Joiner's theory, it is important to recognise that Joiner believes mental ill health is present in almost all people who die by suicide. He views mental ill health as contributing largely to the distorted thinking and dysfunctional response to situations that occur in suicidal thinking and acts.

For Lifeline, this theory suggest that where this distorted thinking can be challenged – through the offer of compassionate help and practical support with life's difficulties, and through encouraging a person to access treatments for mental ill health, there is the potential to reverse the 'trajectory' towards a suicidal act.

3.3 Integrated Motivational Volitional Model of Suicidal Behaviour

This relatively recent theory model is the Integrated Motivational Volitional Model of suicidal behaviour, which has been developed by Rory O'Connor from Stirling University and others.[9] This model has informed the Scottish Choose Life strategy.

This model maps the relationship between background factors and trigger events, with the development of suicidal ideation and eventual suicidal behaviour. It has been developed through the examination of published theory on suicidal behaviour over the past 25 years. There are elements in common between this model and that of Joiner.

This model introduces the concept of vulnerability - some individuals because of their background are more vulnerable to the onset of suicidal thinking. The spread of suicidal ideation is therefore not evenly spread across the population; some individuals are potentially more affected by trigger events because of their background. This is the case for targeted suicide prevention outreach to particular profiles and groups.

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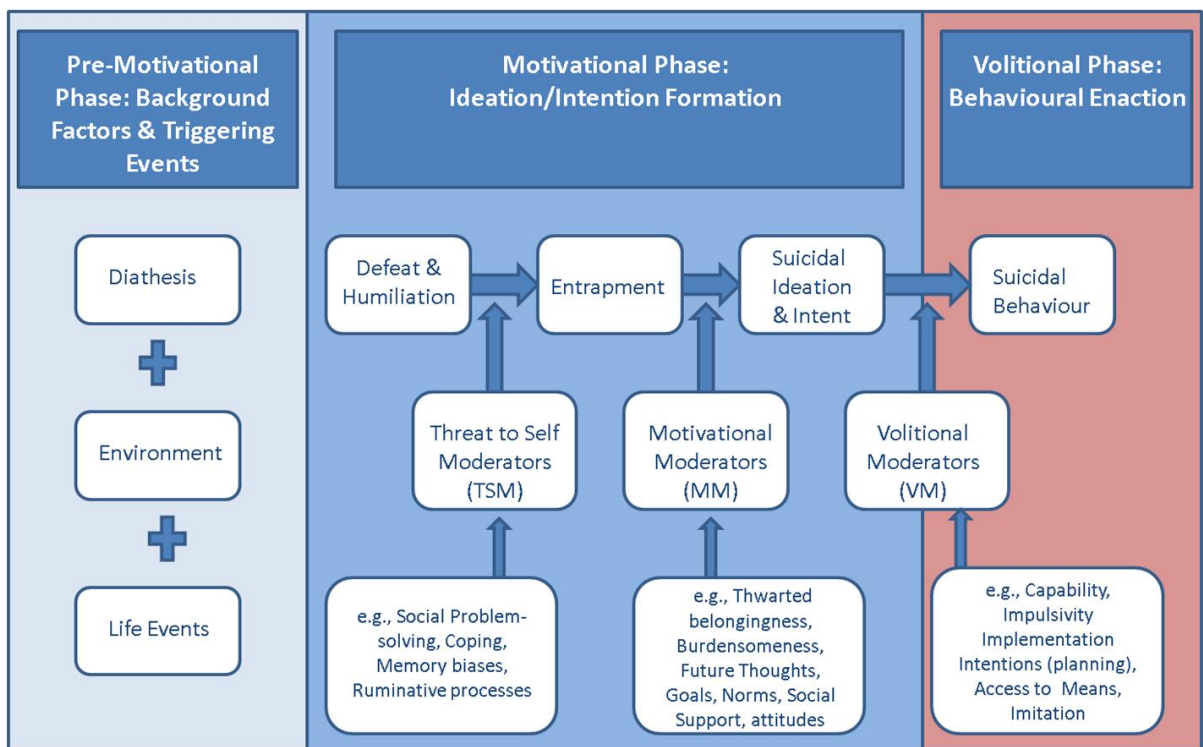
[9] O'Connor, R.C, Platt, S. Gordon, J. (Eds.) (2011) International Handbook of Suicide Prevention. Wiley-Blackwell. UK.
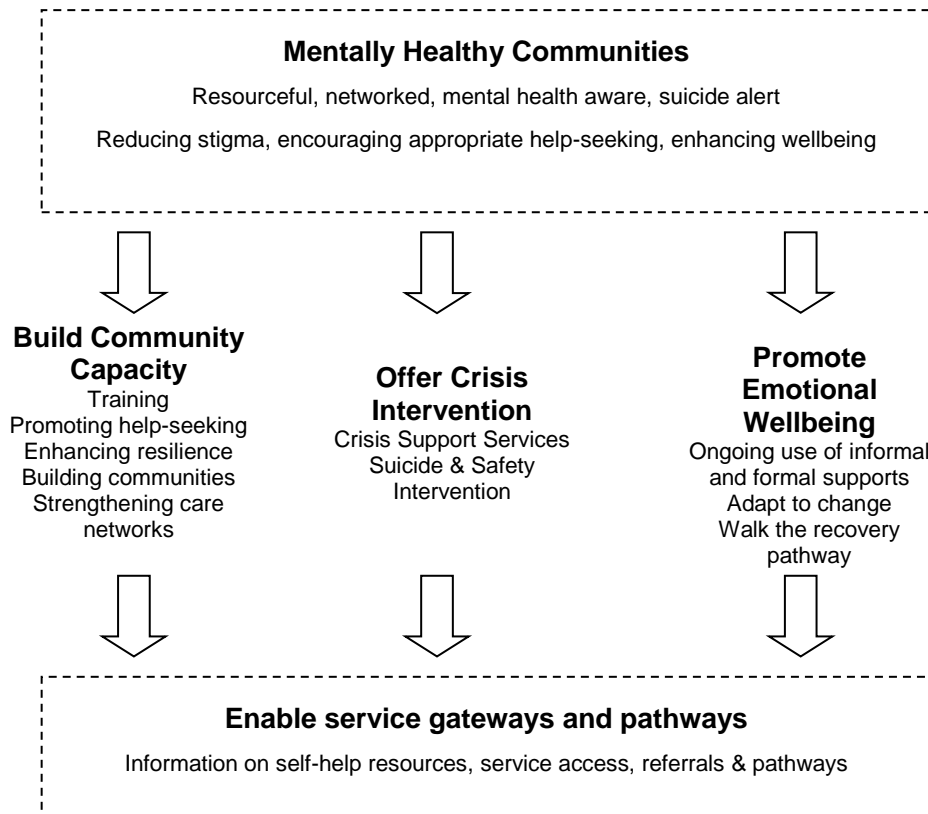
Importantly, this model does not use the language of 'at risk' individuals, which somehow suggests that inherent risk exists in some groups, i.e. the gay person is not 'at risk' because they are gay, but because being gay may involve some vulnerability in the experience of child development and the environment may involve elements of exclusion and discrimination. The implication from this model is that attention to the vulnerabilities individuals may hold must be factored into suicide prevention.

Crisis support may be understood as a response to the more motivational phase where an individual may experience crisis as a result of the pressures on their coping capability, coupled to the perceptions about themselves and their environment. The 131114 service and crisis chat are connecting with people on the full range of crisis presentations every day.

Finally crisis intervention may be identified as a suitable service response for suicide prevention as a person moves towards the Volitional phase - moving to halt impulsive behaviour in a suicidal crisis, and posing different choices to the act to end one's life.

4. Lifeline Service Model

Lifeline's approach to suicide prevention is multi-faceted, as shown in the Lifeline Service Model:

Mentally Healthy Communities

Resourceful, networked, mental health aware, suicide alert

Reducing stigma, encouraging appropriate help-seeking, enhancing wellbeing

↓   ↓   ↓

Build Community Capacity
Training
Promoting help-seeking
Enhancing resilience
Building communities
Strengthening care networks

Offer Crisis Intervention
Crisis Support Services
Suicide & Safety Intervention

Promote Emotional Wellbeing
Ongoing use of informal and formal supports
Adapt to change
Walk the recovery pathway

↓   ↓   ↓

Enable service gateways and pathways

Information on self-help resources, service access, referrals & pathways

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The Lifeline Service Model relates to the theories on suicide prevention:

1. Building individual and community resilience to avert the onset of crisis. This directly addresses the background factors and the movement unchecked of thinking towards perceived burdensomeness or thwarted belongingness.

2. Crisis support relates the importance of disturbing the movement towards suicidal thinking as challenges in life - events, triggers, and threats - occurs. Crisis intervention involves specific action to interrupt a state of crisis – which is the most dangerous phase when actions may be taken to end one's life.

3. Promotion of mental well being relates to suicide prevention: recognising that population health initiatives can impact on suicide rate overall. Further, the promotion of mental health services can be oriented towards vulnerable groups, like rural males, or LGBTI identifying people. Mental health promotion also involves tools for self-help and education and community based programs.

5.   Lifeline's Unique Contribution to Suicide Prevention

The theory and evidence base that relates to crisis support and suicide prevention reinforces the importance of making the offer of help in a compassionate and empathetic way to engage with people experiencing a crisis state or on the verge of a crisis.

Lifeline's unique contribution to suicide prevention in Australia is:

- Working at the 'pointy end' – offering services directly to suicidal persons

- Addressing personal and social factors that may trigger suicidal crisis

- Supporting help seeking and accessing other services – referrals and pathways

Lifeline is a non-government network of crisis centres in Australia. Lifeline has the capability to deliver services through a mix of national, local, technology enabled and face to face mechanisms.

Lifeline addresses the personal and social factors in suicide prevention - how a person sees themselves and the world around them. Crisis issues include relationship breakdowns, loss of status/job, perceived inability to solve life's problems, rejection and discrimination by others, addictions, abuse and trauma including domestic violence.

Lifeline can be a pathway for people experiencing mental health issues such as depression/anxiety – which often underpin the experience of suicidal crisis - to access services.

Lifeline's approach to suicide prevention recognises that earlier contact with a person as the crisis emerges can be very important in breaking the steps towards suicidal thinking: Lifeline Centres often address 'upstream' issues in their community based services and outreach work. The importance of mental health promotion and prevention in averting crisis situations, and therefore suicide, is an under-recognised aspect of suicide prevention.

Lifeline offers crisis support services through:

- Telephone - 13 11 14   Available 24 hours every day of the year;
- Online Crisis Support Chat   Available 8pm - midnight, 7 days a week
- Telephone services at specific 'suicide hot spots'
- Lifeline Website for self-help resources: www.lifeline.org.au/gethelp

Crisis support – especially crisis intervention - can play a key role in suicide prevention. Lifeline saves lives.