Question. Persuade. Refer.

ASK A QUESTION, SAVE A LIFE

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Ask a Question, Save a Life

What You Need to Know

QPR for Suicide Prevention

As someone who may be in the best possible position to prevent a suicide, you will find that QPR is designed to help you save a life. QPR consists of these three skills:

Question ... a person about suicide

Persuade … someone to get help and,

Refer … someone to the appropriate resource

QPR is not a form of
counseling or treatment.

Rather it is intended to offer hope through positive action.

By learning QPR, you will come to recognize the warning signs, clues, and suicidal communications of people in trouble, and gain skills to act vigorously to prevent a possible tragedy.

Much like CPR or the Heimlich maneuver, the fundamentals of QPR are easily learned. As with CPR and the Heimlich maneuver, the use of QPR may save a life.

Who Needs to Know QPR?

Suicidal thoughts are common. Suicide threats and attempts are less common, but much more frequent than most people realize. Suicide is the most common psychiatric emergency and a leading cause of death in America and around the world.

This means that the need for QPR knowledge also is common. If you are a middle-aged or older adult, you probably know someone who has made a suicide attempt. You may even know someone who died by suicide, and it is very likely you know someone who has thought, or is thinking, about suicide.

If you are a professional caregiver, police officer, fireman, minister, priest, rabbi, school nurse, coach, teacher, youth leader, paramedic, high school counselor, case manager, volunteer or paid staff in any of a hundred different kinds of human service organizations, you very likely have had firsthand contact with suicidal people.

We can all become gatekeepers.

Who is a Gatekeeper?

A gatekeeper is anyone in a position to recognize a crisis and warning signs that someone may be contemplating suicide. This could be you:

- *A high school wrestling coach notices one of his team members is uncharacteristically quiet and withdrawn. His grades are failing, his parents are divorcing, and his girlfriend just left him for another boy. He asks the boy to stay for a few minutes after practice.*
- *A clergyman observes an elderly parishioner saying goodbye to everyone at Sunday services. When he shakes hands with the man, the man says, "I'm going home now. Thank you for everything." This parishioner has a history of depression. The clergyman asks the man to join him in his study…*
- *As a friend, you observe your classmate's sudden heavy drinking and talk of "ending it all." The friend offers to give you his or her guitar. You sit down with your friend and…*

Since it is impossible for family doctors, counselors and mental health professionals to know everyone who needs help, the answer to the question "Who needs to know QPR?" is:

Everyone does.

QPR as a Universal Intervention

The QPR method was developed specifically to detect and respond to anyone emitting suicide warning signs. However, independent researchers and federal agencies who funded the original assessments of QPR have suggested that the QPR intervention could be useful in far broader applications.

Indeed, QPR is widely applied as a universal intervention for anyone experiencing emotional distress. It is not known how many individuals emitting distress signals recognized and responded to by individuals trained in QPR were false positives (not suicidal), but were still in need of professional help.

For example, a youth experiencing a personal crisis may very well send interpersonal distress signals/warning signs and would benefit from help of some kind, but may not be considering suicide as a solution. In fact, a 2002-04 U.S. study funded by the National Institute of Mental Health found that about 20 percent of youth are affected by a mental health disorder sometime in their life, but the vast majority of these young people never attempt suicide. Their disorders - mood, anxiety, ADHD, eating disorder, or substance abuse - resulted in significant stresses in the child's role in family, school or community, but did not lead to suicide or a suicide attempt.

When properly used, QPR works from a foundation of knowledge, compassion and understanding. The resulting intervention may help detect a wide range of personal problems that should respond to professional assessment and care. Early intervention may well prevent the development of suicidal thoughts and feelings downstream from a current crisis.

QPR Concept & Theory

It is no mistake that the term QPR is so similar to CPR. Just as widespread CPR training enables trained citizen action to save lives from heart attacks, QPR relies on trained citizen action to save lives from suicide.

QPR and CPR share other similarities. Both function as part of a "Chain of Survival," in which lay and professional citizens can respond to a life-threatening event, whether it is a suicidal crisis or heart attack. As well, both require training in recognition of signs and active intervention. For QPR, the chain of survival includes these four links:

1. Early recognition of suicide warning signs/distress signals

2. Early application of QPR

3. Early intervention, e.g., professional screening and assessment

4. Early access to competent care providers

Won't suicidal people reach out on their own? No, they won't. The theory underlying QPR interventions rests on evidence that most suicidal people:

- Tend not to self-refer
- Tend to resist treatment
- Often use drugs and/or alcohol as psychological pain medication
- Hide their level of despair
- Go undetected
- Go untreated

Passive care systems that wait for suicidal people to ask for help are largely ineffective in assisting those most at risk for suicide: males of any age, elders, first responders, veterans, farmers, minorities, LGTB and transgendered youth, and young adults.

QPR differs from other suicide prevention programs in the following ways:

- Recognition that even socially isolated suicidal individuals have contact with potential gatekeepers, e.g., friends, family, school officials, and care providers
- Outreach to high-risk people within their own environment, rather than requiring suicidal people to ask for help
- Teaching specific, real-world suicide warning signs
- Heavily researched

When you learn QPR, you learn to lean into the other person's pain, not lean away from it.

Thus, using QPR is an act of courage.

Overcoming our Emotional Reactions to Suicide

Research shows that the majority of those who attempt suicide give some warning signs - verbal, written, or behavioral. These warning signs are like markers left on the final leg of a journey that began with the idea of self-destruction as a way to end unbearable psychological pain.

These warning signs are often sent during the weeks preceding an attempt. QPR is designed to interrupt this terrible journey.

By recognizing the suicidal person's cries for help and offering hope through persuasion toward positive action, suicide can be prevented.

But for many of us, we must first overcome our reluctance to become involved and to act boldly.

Too often, those who are in a position to recognize the warning signs of an emerging suicide crisis either fail to see those signs, deny their meaning, or minimize such communications as "not serious."

Failure to recognize and respond to suicide warning signs may reflect both our lack of knowledge about suicide, as well as our basic fear about the subject itself. For the troubled person emitting warning signs to others that they are in serious trouble and considering ending their lives, our failure to respond may be wrongly interpreted by the suicidal mind as proof that we don't care about what they do. Sometimes it may even be seen as permission to proceed.

FEAR & DENIAL

The very idea that someone wants to die is frightening. When someone threatens or talks seriously about suicide, the most natural reaction is fear. Fear leads to denial. Denial is how humans cope when we are confronted with something too terrible to contemplate.

To convince ourselves we didn't hear what we heard, we deny the warning signs of a suicide crisis by believing the myth that "People who talk about suicide don't do it," or that the person is only seeking attention. Fear and denial are normal reactions to someone talking about ending his or her life by suicide.

FACT: People who talk about or threaten suicide often do go on to attempt or die by suicide. To prevent suicide we must overcome this natural but dangerous form of denial. Use QPR, and perhaps save a life.

SHOCK & ANGER

Expressing a wish to die is the most disturbing communication one human being can make to another. "How can this be?" we may ask ourselves. Shock, and sometimes anger, are also normal reactions.

You may be angry because the person didn't come to you sooner. You may be upset that any problem could be so serious. Fear, denial, shock, and anger: These are some of the expected and ordinary reactions to someone whose behavior or words suggest they want to kill themselves.

Effective QPR requires that we control our emotions while we try to help. And act we must, lest the person of concern take another step toward self-destruction.

TALKING ABOUT SUICIDE IS DIFFICULT BUT LIFE-SAVING

For most people talking about suicide is more difficult than talking about sex. Linguists have found that people use highly specialized language to discuss what are considered impolite subjects, including sex and suicide.

Research shows that physicians, nurses, even mental health professionals are uncomfortable talking about suicide. Our inability to talk frankly about a leading cause of death in the world is no accident or oversight; it is the direct result of taboo, stigma, fear, and ignorance.

If we accomplish just one thing in teaching you QPR it will be to recognize your fear about this subject and to overcome that fear so you can take quick, bold action to save a life.

Overcoming our Emotional Reactions to Suicide

TALKING ABOUT SUICIDE IS DIFFICULT BUT LIFE-SAVING *continued...*

For a moment, just imagine that you are suicidal. How might you try to initiate a conversation with someone about a sense of personal despair and mental pain so severe that ending your own consciousness seems to be the only path to relief?

What words do you say or text? What words would you avoid? How would you say that you are thinking about suicide and yet avoid the stigma, ridicule, anger or rejection that might follow if you just said, plainly, that you are contemplating suicide?

The suicidal person takes a terrible risk of losing face if he or she is blunt in a statement of desire or intent to die. Just as no teen-aged boy asking a girl for a first date can deny the anticipated terror at loss of face if she says no, no suicidal person can deny the guilt and shame he or she is likely to experience if his or her clearly-stated desire to die draws laughter or ridicule.

To avoid ridicule, suicidal people often use indirect language. They hint at what they are planning to do. Rather than say, "I'm going to kill myself" they say, "You will all be better off without me."

People who have been suicidal in the past have informed us of many unhelpful responses they received when they were in crisis and told others, plainly, they were contemplating ending their lives. Here are three:

"That's just stupid."

"You don't mean that."

"You're just looking for attention."

Each of these statements is a rejection, a denial that the suicidal person is experiencing a life-threatening crisis and needs help.

However, the most common response to someone expressing suicidal desire is silence. Nothing. An averted glance. A change in the conversation. An abrupt, "Well, I've got to get going."

Turning away from a suicidal person is fear in action.

Turning toward and helping a suicidal person is courage in action, courage we know you have.

The first QPR skill is careful listening. You will want to listen for both direct and indirect statements of intent.

Here are some examples:

- Problem gambler's call to hotline: "I know it's too late for me, but can you recommend a counselor for my wife?"
- Teenager's query to crisis line volunteer: "Is 24 aspirins and a bottle of vodka lethal?"
- Comment to a pharmacist: "The doctor said if I took all these at once it would kill me. It's probably a good thing, because I can't afford another prescription."
- Domestic violence hotline caller: "My boyfriend says if I leave him, he'd just as soon be dead. Being dead doesn't sound so bad to me either."
- Older woman to a case manager: "I can't take care of my two cats anymore, and where I'm going they can't come. Could you please tell me where the nearest animal shelter is?"
- Teenager to a friend: "Everyone would be better off if I wasn't around."
- From a boy who killed himself only minutes later, the following question was put to his highly religious mother following a severe family quarrel, "Mom, do you think God has a place in heaven for a boy like me?"

In this last true and tragic case, the mother responded "yes" to the direct question but missed the underlying message. Only moments later she heard the fatal gunshot.

Note: In all these examples the word suicide does not appear, yet each statement contains a hint that the speaker, or someone else, may be considering suicide. Thus, each of these statements is a suicide warning sign that needs clarification through QPR.

Understanding Suicide

Suicide is the most complex and difficult to understand of all human behavior. Yet, suicidal people are just like you and me. They have problems; we have problems. The difference between us is that, for the moment, we feel we can handle our problems rather than feeling overwhelmed by them.

In its simplest terms, suicide seems to be a solution to a problem – or a solution to many, seemingly insoluble problems. Thoughts of suicide occur during times of personal crisis, unrelenting stress, depression, or when we are confronted with a fear of failure or the specter of an unacceptable loss.

Suicide is the premeditated taking of one's own life.

Suicide is rarely an impulsive act. Most people will think about suicide for days, weeks, months or even years before they make an attempt. Oddly, thinking of suicide provides a curious blend of terror and relief: relief that all one's problems finally can be solved and terror at the idea of having to die to find that relief.

Since the beginning of time, suicide has been one way to deal with life's problems, problems that are causing overwhelming anguish. Tragically, suicide is the wrong solution. Many people who end their own lives do so for ordinary reasons or personal problems. Far too frequently what seemed worth dying for could have been treated, mended, or endured until time worked its own magical cure. Some suicide threats are efforts to control behavior of other people. These threats need to be taken seriously as well.

Most often, though, wanting to die and feeling suicidal is a primary symptom of untreated depression, a medical condition for which excellent treatment is available. It is important to understand that suicidal thoughts are strongly associated with disturbances in brain chemistry and that these changes can be reversed with appropriate biological and psychological care.

The vast majority of all suicidal people want to live, if only they can be shown a way. QPR opens a possible path to a new and better life.

It should be noted, too, that great strides are being made to better understand suicide. While mental illness and substance abuse are major risk factors for suicide - as studied mostly in the U.S. and other western cultures - clearly there are millions of persons in the U.S. and around the world suffering from these illnesses who do not attempt or complete suicide.

The million dollar question is: Among all groups we know to be at elevated risk for suicide, which individuals will actually attempt or die from suicide?

Based on years of research by a number of scientists, we now know more about who is at especially high risk for attempting or completing suicide than ever before. While we are still limited in our knowledge, and research is ongoing, it is not too soon to apply what we know.
For example, based on the work of Dr. Thomas Joiner and many others, we know that the desire to die is expressed by thinking about suicide while experiencing serious psychological pain. Those who are contemplating suicide often feel hopeless, helpless and intolerably alone. They feel isolated and trapped, with no way out. The psychological states being endured by those wishing to end their lives often includes and is completed by them feeling they are a burden to others.

This is a large group of people and includes many millions around the world each year.

Within this very large group is a much smaller group whose members have the actual capacity to act on their desire to die by inflicting lethal self-injury in a suicide attempt. It is one thing to think passively of how one might attempt suicide, but it is quite another thing to actually prepare and practice how to kill a living human being, including inflicting pain on oneself through cutting, shooting, strangulation, or overdose.

Through repeated exposure to self-inflicted injury, trauma, or vicarious experience of painful injury – for example, exposure to combat, explicitly violent movies, or witnessing domestic violence – some people develop a kind of fearlessness about injury and death, and become capable of inflicting physical harm on themselves.

Research has shown that suicide-capable people in this much smaller group are much more at risk for actually attempting suicide. They often have experienced one or more suicide attempts, have been exposed to others, and have been impacted by the suicide of someone they knew.

Sometimes suicide-capable people also have the means to end their own life readily available, e.g., a law enforcement officer's pistol, or a physician's access to lethal medications. Acute risk factors pile up quickly when this person also is intoxicated, experiencing the onset of a serious mental illness such as depression, and/or suffering from agitation or troubled sleep.

A key indicator of acute suicide risk occurs when an individual with an ongoing personal crisis shows serious sleep disturbance – the inability to get to sleep, stay asleep, or progressive sleep loss over several days. If this behavior is observed, a QPR intervention is needed.

Not everyone who has suicidal desire and the capability to make a suicide attempt will make a decision to act. We should all be thankful that the human will to live is as strong as it is. As a result, of the millions of people who think about suicide, only a very few attempt, and, of those, fewer still die.

WHEN HOPE IS CRUSHED

A depressed high school senior is dumped by his girlfriend on the same week he is cut from the basketball team. On telling his stepfather what happened, a quarrel erupts, and his stepfather yells at him to pack up and leave the house.

A police officer with chronic low back pain, insomnia, mild depression, and suicidal thoughts about his career ending is put on probation at work the same week his wife leaves him. On his way home from work, he is stopped by a co-worker for reckless driving.

An alcohol-abusing soldier receives a "Dear John" from his girlfriend just after deploying overseas for the third time. That night he learns his best friend was just killed by an IED.

These "perfect storms" of emotional stress can crush hope. If they occur over a matter of hours or days or weeks, their combined effect can dramatically increase not only the desire to die, but the intention to act.

Where does a QPR-trained gatekeeper's role start and stop?

QPR-trained gatekeepers need only confirm that some level of suicide risk is present, and then ensure the referral is made to appropriate professional assessment and care.

Others take different roles. Crisis line workers are trained to ask if a suicidal caller is engaged in self-injury, e.g., has already taken or started an overdose. The answer they receive will determine the level of response, including emergency rescue. Mental health providers will assess the degree of suicide risk, usually in a clinical setting.

As a QPR-trained gatekeeper, you represent one major buffer against suicide in the life of someone who may be contemplating death. You can make the difference through your support, your compassion, and your understanding.

Even very suicidal people are ambivalent about dying and still have some will to live. Numerous cases of highly probable fatal suicide attempts resulted in life, not death, and those who should have died were only able afterwards to enumerate reasons for living.

From the research, we know how to restore, rebuild and maintain hope. What helps suicidal people most is connection to others, planning for the future, engagement with a helper (you), a return to core values and beliefs, and confirming or finding a sense of purpose in life.

Remember – the vast majority of suicidal people want to live, if only they can be shown a way. QPR opens a possible path to a new life.

About Mental Illness and Suicide

The majority of people who die by suicide are suffering from a brain disorder, a disorder from which we now know recovery is possible.

DEPRESSION

Most suicidal people are depressed, and depression is the common cold of modern life. Depression is both biological and psychological in nature and is the number one cause of suicidal behavior. It is highly treatable.

Wishing to be dead is a frequent symptom of untreated depression. Other symptoms include sadness, loneliness, nervousness, crying, inabilty to concentrate, poor sleep, fatigue, irritability, and a general or specific loss of interest in friends, food and fun. The bad news is that depression is common; the good news is that it responds well to intervention and treatment.

Depression in youth bears special attention, since it is often undetected in middle and high school students, and young adults, and therefore goes untreated. At the other end of the lifespan, the same is true of our elders. Most young people and elders enjoy life, but for those who become depressed – if effective treatment is not initiated – death by suicide can become a significant risk.

Of note, groups at highest risk for suicide in the U.S. include older white males, middle-aged white males and Native American youth. If you are a health
professional we recommend you use QPR as a routine health screen for everyone, but especially people in these groups.

Also, as someone who cares, you need to know a few more things about depression and suicide. First, since depression saps energy and purpose, sometimes the depressed person is "too tired" to carry out a suicide plan.

However, as the depression finally begins to lift, the person may suddenly feel "well enough" to act. As strange as it sounds, once someone decides to end his or her suffering by suicide, the hours before death are often filled with a kind of chipper attitude, even a blissful calm. This change in appearance and mood is a good time to apply QPR.

Any sudden "happiness" in someone who has been depressed for a long time should alert you to the need to apply QPR. If in doubt, ask the question!

ALCOHOL

People who finally take their own lives must pass through a sort of psychological barrier before they act. This final wall of resistance to death is what keeps many seriously suicidal people alive. Quick-acting and readily available alcohol, at intoxicating levels, dissolves this wall of resistance and is found in the blood of large numbers of those who die by suicide – whether or not they had a drinking problem.

Alcohol makes depression worse, impairs thinking and judgement, increases impulsivity and, like driving without a seat belt, often contributes to tragic accidents, including "accidental" suicides.

Many people who are not sure they want to die drink to intoxication to dull their pain and then, because of the added depression and despair they feel under the influence, play dangerous games. Such risky actions include taking handfuls of pills, driving fast, playing with loaded firearms, and other high-risk behaviors.

Life's decisions are difficult enough when we are angry and depressed; adding drunkenness to our problems only makes things worse and usually much worse. The best thing you can do for someone contemplating suicide is to keep him or her sober until you can reach help.

We should note here that currently in the United States there is an epidemic of overdose deaths on heroin and prescription pain medications. Many of these deaths are unintentional, but some of them are clearly the result of suicidal self-directed violence. Experts all agree that there is no bright line between those who intended to die by overdose and those who died accidently. Only comprehensive "psychological autopsies" can help answer the question of motive.

For the suicidal person, there is no safety without sobriety.

About Mental Illness and Suicide

PSYCHOSIS & BIPOLAR DISORDER

The onset of a serious mental illness can set the stage for the development of suicidal desire and suicidal thinking.

While all mental illnesses are serious, some generate more suicide risk than others. Serious mental illness may begin in childhood, during teenage years, among young adults, and some illnesses, like depression, can emerge anywhere along the lifespan, including in late life.

While this booklet is not the place to examine all the kinds of problems many people encounter, it is the place to note that the onset of a mental illness can be life-threatening.

In addition to depression and alcohol misuse, these illnesses include any kind of psychosis, and especially what is called first episode psychosis. The term psychosis refers to a loss of contact with reality.

First Episode Psychosis (FEP) may appear in young people as a presentation of confused or disorganized thinking, hallucinations (hearing or seeing things others don't), and delusions (false beliefs about the world). These symptoms may be the result of a number of causes, including drug reactions, metabolic disturbances, or brain tumor, but unless you are a trained health professional, your only responsibility as a QPR-trained gatekeeper is to make a referral for an accurate diagnosis and effective treatment.

Much less common than depression, bi-polar disorder tops the list as a major contributor to death by suicide. As an example, among people with schizophrenia (a thought disorder), the lifetime risk for dying by suicide is 5%, while among people with depressive disorder it is 6%. Death by suicide among alcoholics is roughly 7%. But for people diagnosed with bi-polar disorder – a mood disorder in which the person experience cycles of mania, depression and sometimes psychotic symptoms - it is 20%. Yes, 1 in 5 persons with bi-polar disorder risks dying by their own hand.

Other mental illnesses, and many physical illnesses, may cause people to think about suicide and how to end their lives. Our mission here is not to help you become a diagnostician or professional care provider, but simply to help you understand it is the suffering from a treatable brain disorder that causes most people to feel bad enough to consider suicide.

It is good to remember that with the internet, people who have recently been diagnosed with a serious mental illness can – in a matter of minutes – learn just how seriously ill they may become in the future. Therefore, the better able you are to get people at risk into competent and effective care, the better the odds they can begin to feel better, find hope in recovery, and choose to live.

If recovery is possible, suicide is preventable.

TRAUMA & BULLYING

Studies have shown that experiencing or witnessing trauma can increase the risk of suicide. Rape victims, sexual abuse victims, victims of bullying, soldiers exposed to combat, police officers, and others may experience symptoms of post-traumatic stress and develop Post-Traumatic Stress Disorder, which is now known to increase suicide risk.

The link between bullying and suicide risk is clear. Some authors suspect that depressed children may appear "vulnerable" which may, in turn, trigger bullying behavior. All children identified as a peer victim or a perpetrator should be screened for suicide risk. Cyber-bullying has been found to be equally damaging.

We cannot overemphasize how important it is to make sure children can talk safely to an adult about bullying, and that children know – in advance – that their concerns will be taken seriously.

Of particular concern are victims of childhood sexual abuse, now shown to be the signature risk factor for later suicidal behavior among studies completed in the Canadian Army and in a 10-year follow-up study of U.S. Marines. Thus, any child victim of sexual abuse is automatically at higher risk of suicide, and should be screened for suicidal thoughts.

When to Use QPR

Before using QPR (Question, Persuade, Refer), you must first recognize the warning signs of a potential suicidal crisis.

SIGNS OF SUICIDE

Clues and warning signs come in several forms, but once understood they are not difficult to recognize. One clue or warning sign may not mean a great deal, but any warning sign suggesting acute distress, despair, or hopelessness about the future, or desire to "end it all," is worth asking about.

Many of the following statements were made by people who subsequently went on to kill themselves.

Direct Verbal Clues

- *I've decided to kill myself.*
- *I wish I were dead.*
- *I'm going to commit suicide.*
- *I'm going to end it all.*
- *If (such and such) happens, I'll kill myself.* The precipitating factor might be losing a job, being left by a spouse, or being arrested for a crime.

Indirect Verbal Clues

- *I'm tired of life.*
- *What's the point of going on?*
- *My family would be better off without me.*
- *Who cares if I'm dead anyway?*
- *I can't go on anymore.*
- *I just want out.*
- *I'm so tired of it all.*
- *You would be better off without me.*
- *I'm not the man (or woman) I used to be.*
- *I'm calling it quits, living is useless.*
- *Soon I won't be around.*
- *You shouldn't have to take care of me any longer.*
- *Soon you won't have to worry about me any longer.*
- *Goodbye, I won't be here when you return.*
- *It was good at times, but we must all say goodbye.*
- *You're going to regret how you've treated me.*
- *You know, son, I'm going home soon.*
- *Here, take this (cherished possession); I won't be needing it.*
- *Nobody needs me anymore.*
- *How do they preserve your kidneys for transplantation if you die suddenly?*

Behavioral Clues

- Relapse into drug or alcohol use after a period of recovery.
- Purchasing a gun.
- Stockpiling pills.
- Putting personal and business affairs in order.
- Making or changing a will.
- Taking out insurance or changing beneficiaries.
- Making funeral plans.
- Giving away money or prized possessions.
- Changes in behavior, especially episodes of
- screaming or hitting, throwing things, or failure to get along with family, friends or peers.
- Suspicious behavior; for example, going out at odd times of the day or night, waving or kissing goodbye (if not characteristic).
- Sudden interest or disinterest in church or religion.
- Scheduling an appointment with a doctor for no apparent physical causes, or very shortly after the last routine visit.
- Loss of physical skills, general confusion, or loss of understanding, judgement or memory.
- Sudden rejection by a loved one, (e.g., girlfriend or boyfriend), or an unwanted separation or divorce.
- A recent move, especially if unwanted.
- Death of a spouse, child, friend (especially if by suicide or accident).
- Diagnosis of a terminal illness.
- Flare up with friends or relatives for no apparent reason.
- Sudden unexpected loss of freedom (e.g., about to be arrested).
- Anticipated loss of financial security.
- Loss of a cherished counselor or therapist.

(Sources: Marv Miller, Suicide After Sixty, New York: Springer, 1979; Schneidman, Edwin & Farberow, Norman, Clues to Suicide, New York, McGraw-Hill, 1957; David Span, Post-Mortem, New York, Doubleday, 1974; and Louis Wekstien, Handbook of Suicidology, New York, Brunner/Mazel 1979; Paul Quinnett, Personal Archives, 2015).

When to Use QPR

Acute Suicide Warning Signs

These five behavioral warning signs represent an urgent need for immediate intervention, treatment, and monitoring.

- Suffering from severe anxiety and turmoil and unable to calm down even for a short time. Such people are pacing, wringing their hands, can't sit still, have trouble focusing, and look like they want to jump out of their skin. Basically, they appear to be suffering from an internal source of unbearable mental pain and suffering.
- Ruminating about the same thing over and over, for example, an irrational fear, and cannot be calmed down. In conversation, they keep coming back to the same topic, the same worry, the same focus, and cannot be easily redirected. If you think of a phonograph record with a scratch in it so that the needle skips back, and skips back, and skips back to the same stretch of music, you have it.
- Cannot get to sleep or stay asleep, and has gone without sleep for several days. Any report of acute onset and persistent inability to sleep should be considered a serious marker for a near-term suicide attempt. There are almost a dozen types of sleep disorders, and it is essential to get a proper diagnosis and treatment, as several nights without sleep presents great risk. Many suicidal people will say, "I just want to go to sleep and never wake up."
- Suffering delusions (false beliefs) of gloom and doom and belief that something terrible and unavoidable is about to happen. If they cannot be talked out this belief, vigorous treatment is needed.
- Recent alcohol intoxication and over-drinking whether or not the person has been diagnosed with an alcohol use disorder. Heavy drinking may be an effort to self-medicate to alleviate insomnia and anxiety.

Of note, each of these acute warning signs were observed and charted by nurses and physicians in the medical records of patients who, a short time later, killed themselves while still in the hospital and receiving care. When questioned, many of them denied suicidal thoughts, desire, feelings, or plans. Yet their behavior indicated great psychological pain which, recognized too late, became unbearable.

Finally, several researchers led by Thomas Joiner, Ph.D., have recommended a new diagnosis called "acute suicidal affective disturbance." This concept needs additional study and research. It is a state of heightened arousal that lasts no more than a few hours, but includes a sudden surge in suicidal intent. There are feelings of being alienated from oneself and a burden on others, coupled with at least two of the following: insomnia, nightmares, irritability, and agitation – some of the same symptoms observed in suicidal inpatients.

According to Dr. Joiner, some 15% to 20% of suicides are attributable to this highly aroused and dangerous state of mind. The bad news is we don't yet know much about this disorder, and too many professionals in a position to help may not recognize it. The good news is we know how to treat its symptoms. Observed by any gatekeeper, these acute warning signs are cause to immediately intervene with QPR. Even if suicidal thoughts and feelings are denied, see to an intervention with the goal of immediate assessment and care. Contact your mental health emergency services or take the person to a hospital emergency room.

Question

How to Question the Person about Suicidal Thoughts

Because suicide is such a taboo subject, asking the "S" question may, at first, seem awkward or difficult.

But the truth is that you may be the best person, in the best possible position to recognize the warning signs of a suicide crisis and to prevent suicide. Just as you have the courage to apply the Heimlich maneuver to help a stranger choking on a piece of meat, so too can you apply QPR to someone considering suicide.

Here are some guidelines for using QPR:

- Plan a time and place to ask the "S" question.
- Try to find a private setting.
- A QPR intervention may take up to an hour, so give yourself plenty of time.
- The most important step in QPR is asking the question. It is the hardest step, but also the most helpful.

Many people who've just been asked if they are thinking of suicide will have a great need to talk. Listening skills will be discussed in a moment.

STEP ONE *of* **QPR:**

There are several ways to ask the "S" question. You can begin by acknowledging the person's distress.

Less direct approach:
- "Have you been unhappy lately?"
- "Have you been very unhappy lately?"
- "Have you been so very unhappy you wish you were dead?"

Or, "Do you ever wish you could go to sleep and never wake up?"

Or, "You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way too?"

More direct approach:
- "Have you ever wanted to stop living?"
- "You look pretty miserable. Are you thinking of killing yourself?"
- "Are you thinking about suicide?"

If none of these questions "sound like you," then please use whatever phrasing works best for you. A bit of practice in asking the "S" question helps.

Perhaps you feel only a professional person should ask such a delicate question. Not so. Suicide prevention is everybody's business. Feeling some reluctance to ask the "S" question is natural and for good reasons.

First, a "yes" to the "S" question puts the subject of suicide on the table for discussion.

Second, once we ask someone if they are thinking of suicide and they say yes, we now must act. We have an obligation we didn't have only moments ago.

This is good, not bad. Research has shown repeatedly that once people are asked if they are thinking of suicide, they feel relief, not distress. You have come close enough to them to acknowledge a glimmer of their emotional pain. Until now, they have been bearing their pain in solitude. Anxiety decreases, while hope increases. A chance to go on living has been offered. It is almost as if by asking the "S" question we provide a ray of light where there has been utter darkness.

Asking the suicide question does not increase risk.

Next comes step two, ***Persuade.***

Persuade

How to Persuade Someone to Get Help

LISTENING

Once the question has been asked, most people thinking of suicide want to talk. Your role is to listen first.

Listening is the greatest gift one human can give to another. Advice tends to be easy, quick, cheap and wrong. Listening takes time, patience, courage, but it is always right.

Ask yourself, "Whom do I go to when I need advice?" You will seldom turn to someone who lectures you or makes quick judgments about what you should do. Rather, it is the good listener to whom we turn in times of trouble.

To become a better listener:

- Give your full attention
- **Do not** interrupt. Speak only when the other person has finished.
- **Do not** rush to judgement or condemnation
- Tame your own fear so you can focus on the other person.

After asking the "S" question and getting suicide out in the open, listen for the problems that death by suicide would solve. Confirm your guesses and suspicions with questions and, if you get nods or yeses, you have helped that person to begin finding a way to live.

The goal of persuasion is simple. All we want to accomplish is for the person to agree to get some help. A yes to any of the following questions confirms that you have been successful:

- "Will you go with me to see a counselor?" (Or a priest, minister, school nurse, psychologist, or whatever kind of professional person they are willing to see.)
- "Will you let me help you make an appointment with …?"
- "Will you promise me…?"

Sometimes suicidal people will agree to get help, but fail to follow through. Or they will resist the idea of getting help, even though they seem to recognize that they need it. The more hopeless and helpless they feel, the more difficult it may be for them to act on their own behalf.

Therefore, it is often a good idea to ask the person to agree to go on living and make a recommitment to life. Simply say, "I want you to live. Won't you please stay alive until we can get you some help?" A promise not to hurt or kill oneself and to go on living until help is gotten is most frequently met with relief and an agreement to stay alive.

This is not a so-called "no-suicide contract." Such "contracts" have never proven effective in suicide prevention. But because making a public promise to another person to stay alive appeals to our honor, and agreeing to stay safe may provide relief to the suffering person, the answer to this request is almost always yes. When the answer is no, don't worry - you still have options.

Ask yourself a simple question: If you were angry or depressed or intoxicated or terribly upset and not thinking clearly, would you want those who love you to stand by while you killed yourself?

No, you would not.

Just as you would not allow a friend or loved one to die if they were drowning or having a heart attack, or about to drive drunk, neither would you stand by and do nothing for someone prepared to die by suicide.

Persuade

How to Persuade Someone to Get Help

WHAT IF THEY REFUSE TO GET HELP?

Refusal to accept help does not mean QPR failed. Another course of action is available.

At present, the laws of the land do not permit someone to kill him or herself without first receiving the benefits of treatment. Involuntary treatment may be necessary. In other words, no one has the right to complete suicide without first being given an opportunity to get help.

In the wisdom of the state, suicide is not an acceptable solution to the problems of living. By calling the resource numbers on your QPR card or on the back of this booklet or provided to you by a Certified QPR Instructor, you can learn how to access the involuntary treatment professionals who have the authority, if necessary, to conduct an evaluation for possible detention in a hospital.

Duly authorized by law, these mental health professionals will objectively determine if your friend or loved one represents "a danger to self." If these evaluating professionals believe significant danger to self exists, and your loved one is not willing to accept an alternative outpatient plan for treatment with a good faith commitment to remain alive, a superior court judge may order him or her into involuntary, inpatient treatment.

The treatment is limited in time (usually a few days to less than two weeks) and typically consists of crisis resolution, counseling, and – only if your loved one agrees – medications aimed at reducing the mental and emotional pain and the mental illness that often causes suicidal thinking. Society stands with you against death by suicide.

When confronting a friend or loved one with QPR, remember that it is better to have an angry friend or loved one, than a dead one.

The involuntary treatment law is a wise law, especially when you consider that studies show that the majority of people who took their own lives suffered from a treatable mental illness. The message is clear. Treatment works even if, for a time, it has to be required by law.

Persuasion works best when you do the following:

- Persist in statements that suicide is not a good solution and suggest that better alternatives can be found
- Focus on healthy solutions to problems, not the suicide solution
- Accept the reality of the person's pain, but offer alternatives
- Show respect
- Collaborate with the person and assure them of your ongoing support
- Offer hope in any form and in any way

Referral

How to Refer Someone for Help

The last step in QPR is making the referral - or connecting your friend or loved one with a competent, local mental health professional. This means doing some homework. You should have the names and phone numbers of people you know to be competent and available to help. Enter them in your smart phone or write them on your wallet card.

Use these guidelines for an effective referral:

- The best referrals are when you personally make an appointment and take the person you are worried about to a mental health provider or other appropriate professional.
- The next best referral is when the person agrees to see a professional and you help them make the appointment, so that you can follow up later to learn that they actually kept the appointment.
- The third best referral is getting the person to agree to accept help, even if in the future, and providing them specific referral information.

Most suicidal people who agree to get help will act in good faith and get the help they need. However, because of the stigma associated with accepting counseling or professional help for disorders of the brain or emotional problems, some people may not follow through. This is why we recommend that, if possible, you physically take the person to someone who can help. Once you use QPR you will rest much easier if you are assured the person you helped has been seen and evaluated by a qualified professional.

DON'T KNOW A MENTAL HEALTH PROFESSIONAL?

If you do not know anyone in the counseling or helping professions, call your own family doctor, or 211 (a state-by-state directory of human services), your community crisis line, or a professional mental health organization and ask for a referral.

Of note, and because suicide is a public health problem too long ignored, several states have passed laws to require suicide prevention training for health professionals and others to improve the health and safety of students, the general public, and patients receiving health services.

Some suicidal people will want to talk to someone they already know - a pastor, priest, a counselor, or a school nurse, rather than a stranger. In that case, simply help and assist them with their own choice. If agreeable to the person thinking about suicide, you should accompany him or her to that known and trusted resource.

MAKE SUICIDE HARD

Most people in America use a firearm to kill themselves. Research shows that perhaps the most effective intervention a gatekeeper can make is to ensure removal of the means of suicide, especially a gun.

We strongly recommend temporary off-site storage of a firearm during any mental health emergency. In collaboration with firearm dealers, gun owners, and many gun rights advocate groups, we are all in full agreement suicidal people should not have ready access to a firearm.

Ask your friend or loved one in simple terms if they own or have access to a gun. Arrange to move the firearm to another location. Some police stations will agree to store the firearm during a crisis.

Simply put, removing the means to suicide – gun, rope, car keys, knives, poisons, and medications – makes an impulsive decision to end one's life more difficult. The intervention buys precious minutes, hours, and days during which the person's emotional temperature will likely fall; they will get a good night's sleep; or they may sober up only to learn something good has happened to change their lives in a positive direction.

Treatment will likely be needed to make some fundamental changes in the way the person is living life, but much can be accomplished in a relatively short time.

By making suicide hard, thousands of lives can be saved.

Referral

How to Refer Someone for Help

MAKE SUICIDE HARD *continued...*

When Abraham Lincoln was a depressed young man considering suicide, his friends and neighbors asked him to give them his guns and knives.

Our to-be president of the United States agreed he was not safe with a weapon. He wrote, "I am now the most miserable man living. If what I feel were equally distributed to the whole human family, there would not be one cheerful face on the earth. Whether I shall ever be better I cannot tell; I awfully forebode I shall not. To remain as I am is impossible; I must die or be better, it appears to me."

Some time after his depression lifted, Abraham Lincoln wrote to a depressed friend, "Remember in the depth and even the agony of despondency, that very shortly you are to feel well again."

In our role as QPR-trained gatekeepers we can do no less for our loved ones, friends, and colleagues than Abraham Lincoln's friends did for him.

We can buy them some time to get some rest, get professional help, and one day soon pass beyond this rough patch on the long road of life.

FINDING THE COURAGE TO ACT

To help you act with courage, here are three things to remember:

- Don't worry about being disloyal.
- Don't worry about breaking a trust.
- Don't worry about not having sufficient information to call for help.

If in doubt, act! Reach out! Don't wait!

If you, personally, don't feel comfortable asking the S question, find someone who can and share your concerns and fears with them.

Tips for Effective QPR

If you are in doubt about whether you should apply QPR to someone who perhaps is thinking of suicide, call the National Suicide Prevention Lifeline 24/7 at 1-800-273-8255. They know about QPR and can help guide you with advice and direction.

If you are a veteran, call Vets4Warriors at 1-855-838-8255, 24/7 and a trained veteran will answer your call in 30 seconds or less for peer support. He or she can also help you through a planned action step with a veteran you know.

To broaden the safety net for someone at risk of suicide, immediately after applying QPR, ask this individual, "Who else would you like to know that you're feeling this bad?"

Sometimes the suicidal person will name a parent, a family member or best friend who doesn't know how desperate he or she has been feeling. You might encourage the individual to call that relative or friend right away, while you are together. Or, with the suicidal person's permission, you may wish to call and let them know what is going on.

Create a team. Join a team. As with most life-threatening crises, a team approach is best. Abraham Lincoln's friends and co-workers formed a safety team around him. Professionals can provide treatment for the mental illnesses that often result in thoughts of suicide, but those who live and work with the suicidal person are likely in the best position to help with day-to-day problems while they observe and monitor how the person at risk is doing.

As well, the counselor, clergyman or woman, or mental health professional who has accepted your referral may ask you to join a team to build a safety net around your friend or loved one.

In case professional help cannot be found immediately, it often helps to be accessible to the suicidal person. Give them your phone number, if you are comfortable doing so, but also the 1-800 numbers listed here, or a local crisis line number. Staying connected has been shown to save lives.

THE SEEDS OF HOPE

When you apply QPR, you plant the seeds of hope. Applying QPR brings a personal crisis out of the dark and into the light. QPR is a positive, hopeful technique. And more than anything else, hope helps reduce the risk of premature death by suicide

Hope begins with you! Thank you for caring.

Free Resources

For a free electronic copy of Dr. Quinnett's book *Suicide the Forever Decision: For Those Thinking about Suicide and for Those Who Know, Love and Counsel Them*, visit the QPR Institute website at www.qprinstitute.com and download the book. The book is also available on Kindle e-readers and as a free iPhone app in English and Spanish (search QPRBook in Apple Store).

For the free Android phone app Helping Someone Survive and Suicide Crisis: click on "Market Icon" search for "Suicide" and select the app "Suicide Crisis Support."

Free training in how to restrict access to lethal means of suicide at Counseling on Access to Lethal Means (CALM) training and other important training - http://training.sprc.org/

Many thanks to editor and reviewer,
Marny Lombard

Specialized & Advanced Training

The QPR Institute offers advanced and specialized training programs for a wide variety of professions: law enforcement, firefighter/EMTs, clergy, mental health professionals, substance abuse counselors, physicians, nurses, school health professionals, occupational therapists and other allied health professionals as well courses targeting specific groups at elevated risk for suicide. These include veterans, youth, and older adults. The majority of the courses are offered only in self-paced online training programs. Some are offered through classroom options.

To view our online courses, please visit
http://courses.qprinstitute.com.

To learn more about classroom advanced and specialized training options, send us your inquiry at **support@qprinstitute.com.**

Question. Persuade. Refer.

ASK A QUESTION, SAVE A LIFE

QPR for Suicide Prevention

Q **Question the person about suicide.** *Do they have thoughts? Feelings? Plans? Don't be afraid to ask.*

P **Persuade the person to get help.** *Listen carefully. Then say, "Let me help." Or, "Come with me to find help."*

R **Refer for help.** *If a child or adolescent, contact any adult, any parent. Or call your minister, rabbi, tribal elder, a teacher, coach or counselor. Or call the resource numbers on this page.*

Warning Signs of Suicide

- *Suicide threats*
- *Previous suicide attempts*
- *Alcohol and drug abuse*
- *Statements revealing a desire to die*
- *Sudden changes in behavior*
- *Prolonged depression*
- *Making final arrangements*
- *Giving away prized possessions*
- *Purchasing a gun or stockpiling pills*

To Save A Life...

- *Realize someone might be suicidal.*
- *Reach out. Asking the suicide question DOES NOT increase risk.*
- *Listen. Talking things out can save a life.*
- *Don't try to do everything yourself. Get others involved.*
- *Don't promise secrecy and don't worry about being disloyal.*
- *If persuasion fails, call your mental health center, local hotline or emergency services.*
- *If you believe someone is the process of making a suicide attempt, call 911.*

Resource Numbers

1-800-273-TALK (8255)

1-800-SUICIDE (784-2433)

Vets4Warriors: **1-885-838-8255**

(509) 536-5100 | *email@qprinstitute.com*

www.qprinstitute.com