QPR INSTITUTE

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 acknowledges the Australian Aboriginal and Torres Strait Islander peoples as the first inhabitants of the nation and the traditional custodians of the lands where we live, learn and work.

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 appropriate help

QPR is not a form of
counselling or treatment.

Rather it is intended to offer hope through positive action.

By learning QPR, you will come to recognise 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, the fundamentals of QPR are easily learned. As with CPR, the use of QPR may save a life.

Who Needs to Know QPR?

Suicide is one of the most critical health concerns, both in Australia and on a global scale. In 2015, over 3000 Australians died by suicide. For every suicide death, as many as 25 individuals will attempt suicide, and for some communities, such as Aboriginal and Torres Strait Islanders and LGBTI people, rates of suicide attempts and deaths are even higher.

Over the past decade in Australia, there has been a 20% increase in the number of suicides and suicide is the leading cause of death for Australians aged 15-44.

We also know that suicide rates of Aboriginal and Torres Strait Islander people are at least twice that of non-Indigenous Australians, and that while women make more suicide attempts, 75% of suicides are by men.

Some people in the community are particularly vulnerable, for example men aged 18 to 24 who have previously served in the Australian Defence Forces are twice as likely to die by suicide as men of the same age in the general population.

Other workforces with higher risk of suicide can include those working in agricultural, transport and construction and health sectors.

Clearly, the need for QPR training across the community is very high.

You may know someone who has made a suicide attempt, or may even know someone who died by suicide. It is likely you know someone who has thought, or is thinking, about suicide.

If you are a professional caregiver, police officer, fireman, coach, teacher, youth leader, paramedic, school counsellor, case manager, volunteer or paid staff in any of a hundred different kinds of organisations, you very likely have had first-hand contact with someone who has contemplated suicide.

We can all become gatekeepers.

Who is a Gatekeeper?

A gatekeeper is anyone in a position to recognise a crisis and warning signs that someone may be contemplating suicide and help them open the gate to seek help. This could be you:

- *A high school basketball coach notices one of his team members is uncharacteristically quiet and withdrawn. His grades are failing, his parents are divorcing, and his partner just left him for someone else. He asks the student to stay for a few minutes after practice.*
- *Your friend is a transgender woman who you think may be feeling suicidal, possibly related to transitioning. You are aware that she has experienced significant abuse, discrimination and barriers to accessing inclusive support services. After seeing your friend, she says "I'm not sure when I'll see you again". You ask your friend not to go just yet and offer to sit with her and talk…*
- *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 and has recently become a widow. The clergyman asks the man to join him in his study…*
- *You observe your colleague's sudden heavy drinking and talk of "ending it all." Your colleague offers to give you some of her most prized possessions. You sit down with your colleague and…*

Since it is impossible for GPs, counsellors 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

QPR was developed specifically to detect and respond to anyone showing 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. Irrespective of whether a person does have suicidal intent, if they are distressed they may still benefit from professional help.

For example, a young person experiencing a personal crisis may very well send distress signals/warning signs and would benefit from help of some kind, but may not be considering suicide as a solution. In fact, data from the Mission Australia's Youth Survey showed that in 2016, just under a quarter (22.8%) of young people (15-19 years old) met the criteria for a probable serious mental illness , but the vast majority of these young people do not attempt suicide.

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 resulting 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 individual action to save lives from heart attacks, QPR relies on trained individual action to save lives from suicide.

QPR and CPR share other similarities. Both function as part of a "Chain of Survival," in which general public and professionals 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?

The theory underlying QPR interventions rests on evidence that most suicidal people:

- Tend not to self-refer
- Tend to resist treatment
- Often self-medicate with drugs and/or alcohol
- 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, young people, older people, frontline staff, former members of the ADF, professionals who may encounter stigma if they seek help and priority populations such as LGBTI people.

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

- Recognition that even socially isolated individuals who are contemplating suicide have contact with potential gatekeepers, e.g., friends, family, school staff, and care providers
- Outreach to high-risk people within their own environment, rather than requiring those at risk of suicide to ask for help
- Teaching specific, real-world suicide warning signs
- Evidence-informed and thoroughly evaluated

When you learn QPR, you learn to help face another person's pain, not shy 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 behavioural.

These warning signs are often sent during the days or weeks preceding a suicide attempt. QPR is designed to interrupt this escalation.

By recognising suicide warning signs and offering hope to someone in crisis through persuasion toward positive action, suicide can be prevented.

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

Failure to recognise and respond to suicide warning signs may reflect both our lack of knowledge about suicide, as well as our fear about the subject itself. For the person in crisis, if they show signs that they are in serious trouble, and no-one responds, this can be interpreted by them as proof that people don't care about them. Sometimes it may even be seen as permission to proceed.

FEAR & DENIAL

The very idea that someone wants to die may be frightening. When someone threatens or talks seriously about suicide, common emotional reactions are fear and denial. Denial is how humans cope when we are confronted with something too terrible to contemplate.

We may 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 suicidal 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

Shock and anger are also normal emotional reactions to hearing someone express suicidal thoughts.

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 common reactions to someone whose behaviour or words suggest they want to kill themselves.

Effective QPR requires that we control our emotions while we try to help.

TALKING ABOUT SUICIDE IS DIFFICULT BUT IT CAN BE LIFE-SAVING

Research shows that physicians, nurses and even mental health professionals can be uncomfortable talking about suicide. Our inability to talk openly 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 recognise your fear about this subject and to overcome that fear so you can take quick, bold action to save a life.

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?

Overcoming our Emotional Reactions to Suicide

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

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 risks losing face if he or she is blunt in a statement of desire or intent to die. Just as no teenager asking someone on a first date can deny the anticipated terror of potential rejection, 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 may say something like, "I wish I could just go to sleep for a long time" or "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 examples:

"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 counsellor for my wife?"
- Young person's query to crisis line volunteer: "Are 24 painkillers and a bottle of vodka lethal?"
- Comment to a pharmacist, possibly phrased as a joke: "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."
- Young man to the emergency department triage nurse: "I just want to take some sleeping tablets and sleep for a couple of weeks."
- 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."
- Young man to his ex-girlfriend "Don't worry you won't have to hear from me anymore."
- 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."

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 potentially a suicide warning sign that needs clarification through QPR.

Understanding Suicide

Suicide is the one of the most complex and difficult to understand of all human behaviour.

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

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

Suicide is often premediated. Many people will think about suicide for days, weeks, months or even years before they make an attempt.

Since the beginning of time, suicide has been one way to deal with problems that are causing overwhelming anguish or pain. Suicide is tragic, and is not the solution.

For most people who experience suicidal thoughts or behaviours, the primary cause is untreated mental illness, commonly depression, a medical condition that can be successfully treated with appropriate evidence-based treatment.

QPR opens a possible path to a new and better life.

It should be noted that there is significant research being undertaken both in Australia and globally to better understand suicide. While mental illness and substance abuse are major risk factors for suicide, not all people who experience mental illness or substance abuse will attempt or die by suicide.

The important question is: among those who may be at elevated risk for suicide, which individuals will actually attempt or die from suicide?

While there is no conclusive answer to this, research is providing valuable insight into who may be at especially high risk for attempting or completing suicide.

For example, the Interpersonal-Psychological Theory (developed by Joiner, 2005) proposes that, for an individual to suicide, they must both have the desire for suicide and the ability to carry out the act (acquired capability). Suicidal desire manifests from a combination of feeling like you are a burden on others and a sense of profound isolation and overall disconnection from friends, family or community.

The transition from suicidal desire to suicidal behaviour occurs with the acquired capability to carry out a lethal or near-lethal suicide act. This requires access to lethal means, as well as a reduced fear of pain and death which may result from 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.

Research has shown that these people are at greater risk of attempting suicide. They often have experienced one or more suicide attempts, have been exposed to others, or have been impacted by the suicide of someone they knew.

Suicide risk may be further heightened if someone has ready access to means of suicide (for example, a former member of the Australian Defence Force who has access to a gun, a police officer's pistol, or a doctor or nurse's knowledge of and access to lethal medications), is intoxicated, has a serious mental illness (such as depression), or has a history of previous suicide attempts.

It is important to remember that not everyone who has suicidal desire and the capability to make a suicide attempt will make a decision to act. Of the many people who may think about suicide, only some will attempt suicide, and, of those, fewer still will die by suicide.

Understanding Suicide

WHEN HOPE SEEMS LOST

- A depressed high school student is dumped by his girlfriend on the same week he fails an exam and plays poorly in a game with his local football team. On telling his stepfather what happened, an argument 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 partner leaves him. On his way home from work, he is stopped by a co-worker for reckless driving.

- A young man is discharged from the ADF due to injury and feels lost about his identity and direction at the same time as his relationship is ending.

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 an appropriate professional for assessment and care.

Others take different roles. Crisis line workers are trained to ask if a suicidal caller is engaged in suicidal behaviour, 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 suicide. You can make the difference through your support, your compassion, and your understanding.

Sometimes even very suicidal people still have some will to live. Numerous cases of what would have been 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 people at risk of suicide most is validation of their feelings, 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 people who are contemplating suicide, want to live, if only they can be shown a way to survive the pain and situation they are experiencing. 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 mental illness, from which we now know recovery is possible.

The onset of a mental illness can be a serious risk factor for the development of suicidal thoughts and behaviour.

Mental illness may begin in childhood or adolescence, or may 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 contribute to suicidality.

DEPRESSION

Many people who attempt suicide have experienced major depression.

Wishing to be dead is a symptom of untreated depression. Other symptoms include sadness, loneliness, crying, inability 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 young people bears special attention, since it is often undetected in teenagers, and young adults, and therefore goes untreated. The same is also true of older people. Most young people and elders enjoy life, but for those who become depressed – if effective treatment is not initiated – suicide can become a significant risk.

Of note, groups at highest risk for suicide in Australia include men (who are three times more likely than women to die by suicide), older people (particularly older men), and Aboriginal and Torres Strait Islander people (who have double the suicide rate of non-Indigenous Australians). If you are a health professional we recommend you use QPR as a routine health screen for everyone, but especially for people in these groups.

As someone who cares, you need to know a few more things about depression and suicide. When a person is depressed they can lack the 'energy' to carry out a plan to attempt suicide. When they initially start taking antidepressant medication, they may experience increased levels of energy, but there is a delayed effect on their mood. The combination of increased energy and ongoing low mood can put a person at increased risk of attempting suicide.

As strange as it sounds, for some people, once they make a decision to end their suffering by suicide, the hours before death are often filled with a kind of cheerful attitude, even a blissful calm. This change in appearance and mood, especially for someone who has been depressed for a long time is a warning sign and a good time to apply QPR.

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

BIPOLAR DISORDER

Bipolar disorder is a mood disorder in which a person experiences periods of mania, depression and sometimes psychotic symptoms – is a significant contributor to death by suicide. Recent studies indicate that 17-22% of people who suffer from bipolar disorder die by suicide (Chesney et al., 2014; Tondo et al., 2003), a suicide rate which is more than 25 times higher than among the general population (Tondo et al., 2003).

About Mental Illness and Suicide

ALCOHOL & OTHER DRUGS

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.

Alcohol and other substances (prescription or illicit drugs) act as intoxicants and decrease people's inhibitions which can break down, this wall of resistance. Alcohol and/or other substances have been found to be present in many people who die by suicide – whether or not they had a pre-existing problem with alcohol or drugs.

Alcohol and other drugs make depression worse, impair thinking and judgement, increase impulsivity and risky behaviours like speeding or driving without a seatbelt, and this can contribute to tragic occurances.

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

For the suicidal person, there is significant risk when they are intoxicated.

PSYCHOSIS

In addition to depression, bipolar disorder and alcohol and other drug use, psychosis, particularly first episode psychosis, may increase someone's risk of developing suicidal thoughts or behaviour. The term psychosis refers to a loss of contact with reality.

First episode psychosis may appear in young people as a presentation of confused or disorganised 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 tumour, 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.

Other mental illnesses, and many physical illnesses (particularly if they are chronic and severe), may cause people to think about suicide and how to end their lives contemplate suicide. 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 disorderillness that causes many people to feel bad enough to consider suicide.

Therefore, the better able you are to help people at risk get competent and effective care, the better the odds they can begin to feel better and find hope in recovery.

If recovery is possible, suicide is preventable.

TRAUMA & BULLYING

Studies have shown that experiencing or witnessing trauma can increase the risk of suicide. People who have experienced abuse (physical, emotional and/or sexual) or who have been exposed to trauma (such as Aboriginal and Torres Strait Islander people impacted by intergenerational trauma related to removal of children as part of the stolen generations, doctors and nurses exposed to trauma and high stress working conditions, soldiers exposed to combat, or police officers who have encountered acts of violence) may experience symptoms of post-traumatic stress and develop Post-Traumatic Stress Disorder, which is known to increase the risk of suicide.

Exposure to bullying, which includes both traditional bullying and cyberbullying, is also a risk factor for suicide. Children and adolescents who are being bullied or who are instigating bullying should be screened for suicide risk.

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

When to Use QPR

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

SIGNS OF SUICIDE

Suicide warning signs come in several different forms, but once understood they are not difficult to recognise. One warning sign in isolation may not always indicate risk of suicide, 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?*

Behavioural Clues

- Increased alcohol or drug use
- Checking, purchasing or changing life insurance policies or benefits
- Relapse into alcohol or drug use after a period of abstinence
- 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
- Engaging in self-harm
- Marked changes in behaviour, especially episodes of violent behaviour, conflict with others, or agitation
- Social withdrawal
- Risky or reckless behaviour
- Significant sleep disturbance
- Sudden interest or disinterest in church or religion

Situational Clues

- Sudden rejection by a loved one, or an unwanted separation or divorce
- A recent move, especially if unwanted
- Death of a loved one (especially if by suicide or accident)
- Diagnosis of a terminal or chronic illness
- Sudden unexpected loss of freedom (e.g., about to be arrested)
- Anticipated loss of financial security
- Loss of an important interpersonal relationship (e.g., a counsellor)

(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 and Behavioural Indicators of Severe Distress

Call 000 or seek immediate help from a mental health provider when you hear, say or see any one of these behaviours:

- 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 including on social media or in text messages
- Making or preparing to make a suicide attempt

The following behavioural warning signs indicate extreme distress, which may increase risk of suicide. In such cases, it is important to help the person to access immediate intervention, treatment, and monitoring.

- Speaking about feeling like a burden on friends and family
- Hopelessness
- Suffering delusions (false beliefs) of gloom and doom and belief that something terrible and unavoidable is about to happen
- Rage, anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use: 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
- Withdrawing from friends, family, or society
- Anxiety, agitation, suffering from severe 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
- 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
- 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
- Dramatic changes in mood
- No reason for living; no sense of purpose in life

While these signs have been observed in people who are at risk of suicide or have died by suicide, not all people who exhibit these signs are at risk. They are indicators that the person is highly distressed and needs help. Similarly, not all people who are at risk will exhibit these signs.

(Source: Rudd, M. D., Berman, A. L., Joiner Jr, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., ... & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. Suicide and Life-Threatening Behavior, 36(3), 255-262)

Question

How to Question the Person about Suicidal Thoughts

Because suicide is such a taboo subject, asking someone about suicide may, at first, seem awkward or difficult.

But the truth is that you may be the best person, in the best possible position to recognise the warning signs of a suicidal crisis and to prevent suicide. Just as you have the courage to apply CPR to help someone who isn't breathing, so too can you apply QPR to someone considering suicide.

Here are some guidelines for using QPR:

- Plan a time and place to ask if someone is suicidal.
- 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 have 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 if someone is suicidal. 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 resonate with you, you can use whatever phrasing works best for you. A bit of practice in asking the question about suicide helps.

Perhaps you feel only a professional person should ask such a delicate question – This is not so. Suicide prevention is everybody's business. Feeling some reluctance to ask about suicide is natural.

First, a "yes" to the question about suicide 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 about suicide we provide a ray of light where there has been utter darkness.

Asking someone if they are suicidal 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 takes time, patience and courage, but it is invaluable for someone in distress.

Ask yourself, "Who do I normally 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.
- Control your own emotional reactions so you can focus on the other person.

After asking about suicide 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 counsellor?" (Or a GP, psychologist, psychiatrist, school counsellor, or whatever kind of health professional they are willing to see.)
- "Will you let me help you make an appointment with …?"

Sometimes suicidal people will agree to get help, but fail to follow through. They may go to an appointment and not feel comfortable disclosing their feelings about suicide. Or they will resist the idea of getting help, even though they seem to recognise 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. Can you promise me that you will 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 honour, 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.

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.

If a person in crisis refuses help and you believe they are at imminent risk of suicide, you can call 000. Ambulance and police officers have the authority to transport a person to hospital involuntarily if they believe the person is a risk to themselves or others. Alternatively, if the person is willing to accompany you to the nearest emergency department, a doctor can make an assessment of risk and either voluntarily or involuntarily admit the person to hospital.

The treatment is limited in time (usually a few days to less than two weeks) and typically consists of crisis resolution, counselling, 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.
- Accept the reality of the person's pain, but offer alternatives.
- Show respect.
- Collaborate with the person and assure them of your ongoing support.
- If the person says they intend to take their own life, they should not be left alone. The aim is to stay with them and ideally accompany them to see someone who can help.
- 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. There are useful resources listed in this booklet, and other more localised resources can be easily found on the Internet, or by asking your local GP, hospital or Headspace centre or contacting the Primary Health Network for your area. It may be useful to enter these contact details in your 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 counselling or receiving professional help for mental illnesses, 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 counselling or mental health professions, call your own GP, a suicide crisis line such as Lifeline (13 11 14), or a professional mental health organisation such as Headspace and ask for a referral. You could also take the person in crisis to see their own GP, with whom they already have an existing relationship and may feel more comfortable talking to.

Some suicidal people will want to talk to someone outside the medical profession that they already know - a teacher, sports coach, or religious leader - rather than a stranger. In that case, help and assist them with their own choice and if they are intent on suicide, ensure you stay with them. If agreeable to the person thinking about suicide, you should accompany him or her to that known and trusted resource, while still encouraging them to seek help from a medical professional.

MAKE SUICIDE HARD

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

Removing the means to suicide – rope, car keys, knives, poisons, gun, medications, long periods of time spent alone – makes an impulsive decision to end one's life more difficult. The intervention buys precious minutes, hours, and days during which time there are opportunities to help someone get the help they need.

Suicide and mental illness can affect anyone, even celebrities and elite athletes. Ian Thorpe, the Australian swimmer who has won 5 Olympic gold medals, has spoken about his experience with suicidality and depression:

> "My illness was so severe that, at times, I considered suicide. I believe it's actually quite normal for people to think about killing themselves because it's part of the great conundrum of life and death, but the difference between those superficial, inquisitive kinds of thoughts and some of my bleakest periods of introspection was that I took the next step and planned how and where to do it."

Importantly, he acknowledges that mental illness is not a life sentence, and that support from those around him plays a key role in being able to effectively manage his depression.

> "I want the message to be positive: that things can get better. The key is to accept that it's an illness that can be managed properly. Like so many others before me, I wanted to fight it by myself. It felt

MAKE SUICIDE HARD *continued...*

embarrassing – particularly for an elite sportsman – and it became a weakness that couldn't be shown. In hindsight, I realise that it would have been much better to share it with my family and friends."

As QPR-trained gatekeepers, we too can have a significant positive impact on the lives of people who may be feeling suicidal.

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 someone about suicide, find someone who can and share your concerns and fears with them.

(Source: Thorpe, I., & Wainwright, R. (2012). Ian Thorpe: This Is Me. Sydney, Australia: Simon & Schuster Pty Ltd.)

Tips for Effective QPR

- If you are in doubt about whether you should apply QPR to someone who may be thinking of suicide, call Lifeline on 13 11 14, who can help guide you with advice and direction. Lifeline can also help you to locate help services in your area.

- 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 person who is suicidal will name a parent, a family member or 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 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. 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 person who is contemplating suicide. Give them your phone number, if you are comfortable doing so, but also the referral and crisis line numbers listed here. Staying connected has been shown to save lives. If you are not comfortable being their main support person, work with them to identify someone else whocan play this role.

- It is important to always have more than one number available as there are times when people are away from their phones. As a gatekeeper, you also need to share the load so that you yourself are supported.

- Finally, it is important to remember self-care. You may want to build a safety net for yourself, by talking to family, friends, or a mental health professional about any concerns you may be having.

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, it helps reduce the risk of death by suicide

Hope begins with you! Thank you for caring.

Free Resources

EMERGENCY AND CRISIS SUPPORT NUMBERS

Emergency

In an emergency situation call **000**.
If someone has attempted, or is at immediate risk of attempting to harm themselves or someone else call **000** immediately.

Lifeline

13 11 14
www.lifeline.org.au
Lifeline is a national charity providing all Australians experiencing a personal crisis with access to 24-hour crisis support and suicide prevention services.

Suicide Call Back Service

1300 659 467
www.suicidecallbackservice.org.au
A free service for people who are suicidal, caring for someone who is suicidal, bereaved by suicide or are health professionals supporting people affected by suicide.

Kids Help Line

1800 55 1800
www.kidshelpline.com.au
Kids Helpline is a free, 24/7 phone and online counselling service for young people aged 5 to 25.

Child Protection Helpline

132 111
www.community.nsw.gov.au/preventing-child-abuse-and-neglect/protecting-children
If you think a child or young person is at risk of harm from abuse or neglect, contact the Child Protection Helpline. The Child Protection Helpline is a 24 hours a day, 7 days a week, state wide call centre staffed by professionally qualified caseworkers to receive and screen all reports.

Carers Australia

1800 242 636
www.careraustralia.com.au
Short-term counselling and emotional and psychological support services for carers and their families in each state and territory.

MensLine

1300 78 9978
www.mensline.org.au
MensLine Australia is the national telephone and online support, information and referral service for men with family and relationship concerns. The service is available from anywhere in Australia and is staffed by professional counsellors, experienced in men's issues. MensLine provides a safe and private place to talk about concerns; confidential, anonymous and non-judgmental support; coaching and practical strategies for managing personal relationship concerns; and relevant information and linkage to other appropriate services and programs as required.

BeyondNow – A suicide safety planning app

https://www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning/create-beyondnow-safety-plan

If you or someone close to you is experiencing suicidal thoughts or feelings, safety planning can help you get through the tough moments. BeyondNow involves creating a structured plan – ideally with support from your health professional or someone you trust – that you work through when you're experiencing suicidal thoughts, feelings, distress or crisis. The safety plan starts with things you can do by yourself, such as thinking about your reasons to live and distracting yourself with enjoyable activities. It then moves on to coping strategies and people you can contact for support – your friends, family and health professionals.

While everyone's plan will be unique to them, the process and structure are the same – it prompts you to work through the steps until you feel safe.

Convenient and confidential, the BeyondNow app puts your safety plan in your pocket so you can access and edit it at any time. You can also email a copy to trusted friends, family or your health professional so they can support you when you're experiencing suicidal thoughts or heading towards a suicidal crisis. BeyondNow is free to download from the Apple Store or Google Play. If you don't have a smartphone or would prefer to use your desktop or laptop, BeyondNow is also available to use online.

Free Resources

QLife

1800 184 527 (3pm to 12am every day)
www.qlife.org.au
QLife is Australia's first nationally-oriented counselling and referral service for Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people. QLife provides nation-wide, early intervention, peer supported telephone and web based services to diverse people of all ages experiencing poor mental health, psychological distress, social isolation, discrimination, experiences of being misgendered and/or other social determinants that impact on their health and wellbeing. Online chat support available from 3pm to 12am every day.

eheadspace

1800 650 890
www.eheadspace.org.au
eheadspace is not an emergency service but offers mental health support and treatment where appropriate. eheadspace provides online and telephone support and counselling to young people 12 - 25 and their families and friends. If you're aged 12 to 25, you can contact eheadspace if you need support or are worried about your mental health. eheadspace can help you deal with a broad range of issues like bullying, drug and alcohol issues, depression and anxiety, relationships, concerns about a friend, fitting in and isolation. eheadspace specialists can also help you to get back on track with your study, career, job and other advice relating to employment and education. If you're a parent or carer who is concerned about the mental health of a young person aged 12 to 25, you can contact eheadspace for specialist advice and support.
You can also visit the headspace website for more information: headspace.org.au.

Veterans and Veterans Families Counselling Service (VVCS)

1800 011 046
www.vvcs.gov.au
VVCS provides free and confidential, nation-wide counselling and support for war and service-related mental health conditions, such as posttraumatic stress disorder (PTSD), anxiety and depression. VVCS also provides relationship and family counselling to address issues that can arise due to the unique nature of military service. VVCS counsellors have an understanding of military culture and can work with clients to find effective solutions for improved mental health and wellbeing.

1 800 Respect

1800 737 732
www.1800respect.org.au
1800RESPECT is the National Sexual Assault Domestic Family Violence Counselling Service. It is a confidential online and telephone counselling, information and referral service available 24 hours a day, 7 days a week. This service is staffed by professional counsellors with a minimum of a three-year tertiary degree in relevant fields and no less than two years' full time counselling experience. Callers are answered immediately and transferred to the service they need.

Domestic Violence Line

1800 656 463
www.domesticviolence.nsw.gov.au/
The Domestic Violence Line is a statewide free-call number available 24 hours, seven days a week. The Domestic Violence Line provides telephone counselling, information and referrals for women and same-sex partners who are experiencing or have experienced domestic violence. Domestic Violence Line staff are aware of the special needs of Aboriginal women and women from other cultures, as well as those living in rural and remote areas. Interpreters and TTY can be arranged where necessary to ensure that all people, regardless of their language or disability can use the service. The service has an extensive list of contacts, people and services across NSW who can help. The Domestic Violence Line makes referrals to women's refuges and explains what they are and what they do. It also makes referrals to family support services, counselling, the police and courts, lawyers and hospitals. It helps with transport, emergency accommodation and other relevant support.

Alcohol Drug Information Service (ADIS)

1800 422 599
You can call ADIS any time of the day or week for support, information, advice, crisis counselling and referral to services in NSW. ADIS counsellors understand the difficulties of finding appropriate drug and alcohol treatment and use their knowledge and experience to assist you.

Free Resources

Relationships Australia

1300 364 277
www.relationships.org.au
Relationships Australia provides relationship support services for individuals, families and communities. They offer services around the country that include counselling, family dispute resolution (mediation) and a range of family and community support and education programs. Fees for programs and services vary – please check the website for further information.

MyCompass

www.mycompass.org.au
MyCompass is free online, evidence based interactive self-help program. myCompass is designed to address mild to-moderate symptoms of stress, anxiety, and depression through personalised treatments delivered entirely online.

Mindspot

https://mindspot.org.au
The MindSpot Clinic is a free, evidence based telephone and online service for Australian adults troubled by symptoms of anxiety or depression. Mindspot provides free Online Screening Assessments to help you learn about your symptoms, free Treatment Courses to help you to recover, or Mindspot can help you find local services that can help.

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).

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

Specialised & Advanced Training

The QPR Institute offers online advanced and specialised training programs for a wide variety of professions: law enforcement, firefighters/paramedics, clergy, mental health professionals, substance abuse counsellors, 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 as self-paced online training programs.

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

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

Black Dog Institute also offers specialist advanced courses in suicide prevention which offer Continuing Professional Development points for Doctors and Specialists.

For more information please visit:
https://www.blackdoginstitute.org.au/education-training/health-professionals

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 GP, counsellor, teacher, coach, or religious leader.*

Warning Signs of Suicide

- *Suicide threats*
- *Previous suicide attempts*
- *Alcohol and drug abuse*
- *Statements revealing a desire to die*
- *Sudden changes in behaviour*
- *Prolonged depression*
- *Making final arrangements*
- *Giving away prized possessions*
- *Acquiring access to means of suicide, such as stockpiling pills*

To Save A Life...

- *Realise 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 centre, local hotline or emergency services.*
- *If you believe someone is the process of making a suicide attempt, call 000.*

Resource Numbers

Lifeline: **13 11 14**

Suicide Call Back Service: **1300 659 467**

Kids Help Line: **1800 55 1800**

www.qprinstitute.com