Authors Personal Note:

The following paper has never been published. The purpose of this ever-changing document is to keep it fresh with new ideas and inputs, and to add relevant research findings as they are published. It was last updated in December of 2013.

QPR theory, practice and research have evolved over many decades. The QPR intervention integrates a variety of concepts and ideas from my 40 years of professional experience as a clinical psychologist, therapist and trainer, and from my work with hundreds of suicidal patients, their families, and survivors of suicide - both those who have lost a loved one and those who have attempted and did not die.

The basic QPR concept and emergent training program is also drawn from my years of consulting in public health, my study of Zen Buddhism and the psychology of hope, and from reading the Motivational Interviewing literature regarding changing human behavior in brief, problem-focused interactions.

My thinking about suicidal communications as a window of opportunity for trained gatekeepers to intervene was also influenced by communications, linguistics, and politeness theory, and especially by my pre-academic training as an intelligence specialist in the U.S. Army where signal detection and the decoding of encrypted messages required clarification, substantiation, and verification before any meaningful responsive military intervention could be taken.

The following paper is divided into three parts: 1) a basic description of the QPR Gatekeeper Training for Suicide Prevention model, 2) a theoretical formulation for why the QPR intervention should detect new, untreated cases as intended, and 3) a summary of the supporting research through winter, 2012.

Based on a growing research and documentation base, and investigators employing random trial designs, the program has now been registered in the National Registry of Evidence-based Practices and Policies (NREPP) at: http://nrepp.samhsa.gov/ViewIntervention.aspx?id=299.

The NREPP web site describes the five key outcomes of the training program, together with the Quality of Research and Readiness for Dissemination. Utilization of the training program has grown quickly and widely, and some are urging that the QPR intervention become a universal intervention when any emotional distress signals are sent to others in our social networks. (see page Researchers are invited to explore...

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

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Abstract: Suicide and self-inflicted injuries represent a significant public health problem. For community-based suicide prevention programs, theory-driven research on Gatekeeper training and its effectiveness remains limited. This paper describes the QPR Gatekeeper Training for Suicide Prevention program, its theoretical basis, the three-step CPR-like intervention and implications for the detection of new, untreated at-risk cases in defined communities. QPR stands for how to Question, Persuade and Refer someone emitting suicide warning signs. The QPR intervention is contextualized within the published literature on brief but beneficial public health and clinical interventions and anchored in several theories of human communications. Available in face-to-face or on-line training, more than one million QPR gatekeepers have been trained to date. With further research, QPR may prove a useful recognition-and-referral public health educational intervention in the prevention of suicide and suicide attempts, and may emerge into a more broadly used intervention for non-suicidal persons sending detectable distress signals.

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

Part I: QPR Gatekeeper Training for Suicide Prevention, the Model

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

According to the Surgeon General's *National Strategy for Suicide Prevention* (2001), "key gatekeepers" are "people who regularly come into contact with individuals or families in distress" and gatekeeper training has been identified as one of a number of promising prevention strategies. Key gatekeepers include a variety of professionals who are in a position to recognize a crisis and the warning signs that someone may be contemplating suicide, including, "teachers, school personnel, clergy, police officers, primary health care providers, mental health care providers, correctional personnel, and emergency health care personnel."

The potential of gatekeeper training programs has been documented as a promising tool in school settings to enhance intervention for youth at elevated risk for suicide (Garland and Zigler, 1993; Kalafat and Elias, 1995), and research findings are encouraging with regard to enhanced knowledge, improved attitudes, preparation for coping with a crisis, and referral practices (Garland and Zigler, 1993; King and Smith, 2000; Mackesy-Amiti, et al., 1996; Shaffer et al., 1988; Tierney, 1994). Gatekeeper training has also been identified as one of a number prevention strategies outlined in comprehensive reviews of suicide prevention research (British Columbia Ministry for Children and Families, 1999; Centers for Disease Control and Prevention, 1992; Gould & Kramer, 1999; Guo & Harstall, 2002; US Dept of Health and Human Services, 2001).

With regard to other age cohorts and high risk groups, the author suggests a broader, more inclusive definition of gatekeepers for two reasons: 1) the more persons trained as gatekeepers the greater the odds community-dwelling suicidal persons will be identified by those who know them, and 2) studies show that large numbers of psychiatrically ill and potentially suicidal persons remain undetected in the general population (WHO, 2001a).

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

In the author's experience in consulting on a number of university campuses where student suicides have occurred, students who died by suicide were almost never seen in either the student counseling offices or by the student health staff. In one large university (student population = 43,000) five students died by suicide in one academic year. Not one of these students was known to any university-based healthcare provider prior to his or her death. In terms of probability theory, the odds of identification, referral, and the initiation of what could prove life-saving treatment is a direct function of the proportion of staff trained (Brown, et.al., 2005). Thus, to create safe communities for suicidal people cost-effective saturation gatekeeper training should be the one major goal.

Inclusive of the roughly 25 groups specifically mentioned in the National Strategy for Suicide Prevention 2001, this expanded roster would include family members, friends,

neighbors, co-workers, colleagues, teammates, office supervisors, squad leaders, foremen, academic and resident advisors, caseworkers, pharmacists, veterinarians and many, many others who are also strategically positioned *in existing personal and/or professional relationships* to recognize and refer persons identified to be at potential risk of suicide.

Because suicide happens in families, among friends, in religious congregations and among co-workers, the author's fundamental position is that suicide prevention gatekeeper training should follow public health philosophy and include mass, saturation awareness raising and skills training for not less than one-in-four of the adult population, or one adult person per family. This theory rests upon the following observation: *the person most likely to prevent you from taking your own life is someone you already know.*

What is QPR?

QPR stands for Question, Persuade and Refer, an emergency mental health intervention that teaches lay and professional gatekeepers to recognize and respond positively to someone exhibiting suicide warning signs and behaviors. Advanced QPR Institute clinical training programs teach professionals and others to detect, assess and manage suicide risk in a variety of professional settings across the age span. Created by Dr. Paul Quinnett, and first described in 1995 in a number of presentations and publications by the QPR Institute, more than 9,000 Certified QPR Instructors have been trained in America and abroad through 2011, and more than 1,000,000 American citizens had been trained as QPR gatekeepers by the end 2009, at a current rate of approximately 20,000 persons per month.

QPR like CPR

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

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

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

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

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

There three guiding principles around which the QPR method and training program were designed. In broad terms, the training is designed to increase *awareness* about the problem of suicide, enhance *surveillance* of others in possible distress, which leads to greater *detection* of observable suicide warning signs. Once detected and recognized as symptoms of distress, the gatekeeper can then apply the three-step intervention. Just as a patient with jaundice might not be recognized by a psychologist as medically ill, a psychiatrist with extensive training in skin coloration as a diagnostic sign would instantly recognize the condition and take appropriate action.

Of these three principles, awareness, surveillance, and detection, enhanced surveillance cannot be over emphasized. In a number of formal and informal reports from the American Heart Association and from the popular press, survival rates for persons suffering non-hospital sudden cardiac arrest (SCA) are highly dependent on a) recognition of signs and b) the rapid application of CPR and AED.

So important is the surveillance which allows a rapid response to the crisis that in one report, the odds of surviving a heart attack in a public place were lowest in Chicago (2%), while in another report highest in Las Vegas casinos. Because gamblers are under constant camera surveillance and responded to very quickly when they show symptoms of SCA, they enjoyed a 70% survival rate when the intervention is applied by casino employees (Valenzula, et al. 1998).

It is the working philosophy of the QPR model that a well-executed, strong and positive response to the early warning signs of a pending suicide event may render subsequent links in the Chain of Survival unnecessary. Just as the prompt recognition of the scream

of a smoke detector can eliminate the need to suppress a raging fire, so can the early recognition of suicide warning signs, confirming their presence, and opening a supportive, caring dialogue with a suicidal person – while securing consultation and referral from a professional and bringing other protective factors into place - may prevent the need for an emergency room visit, medical treatment for non-fatal suicide behavior, or inpatient psychiatric hospitalization.

The QPR Gatekeeper Training Program
PR is taught by Certified Instructors in a minimum of one hour, but recommended for 90 minutes to two hours for role-play and practice. The adult learning program is straightforward but tightly defined and teaches lay and professional gatekeepers how to recognize a mental health/suicide emergency, how to Question the validity of suicidal communications, and how to Persuade and Refer someone at-risk to the next level of intervention.

It is also taught over broad band internet connections via a carefully-constructed, SCORM compliant online delivery format. For classroom delivery, Certified QPR Instructors are trained to teach this 1-2 hour program in traditional, 8-hour classroom setting using adult learning methods.

The certification program consists of mastering ten integrated training modules covering facts, theory, program delivery and required content, teaching methods and answering audience questions. All instructors are licensed and agree to deliver the program according to specifications to insure both the fidelity and integrity of program delivery. The instructor course may also be taken via distance learning in self-study, or by a blend of self-study and mentoring by an experienced Certified QPR Instructor. International learners (outside of the US and Canada) may take the training entirely online. The content of the certification program is described elsewhere (Quinnett, 1995).

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

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

1. Provide a progressive, stepwise intervention that leads to a specific, predetermined outcome, and which process is supported by the published literature on brief and effective interventions typically delivered by professional helpers.
2. Achieve a helpful dialogue between someone at risk for suicide and a trained gatekeeper, which may lead to a reduction in the risk of a suicide attempt.

3. Conceptually link QPR to CPR - a well known, universal intervention for emergent medical crises that can be executed by trained lay persons.

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

QPR as a Universal Intervention?

Some have suggested that the QPR intervention by serve as a universal intervention in the detection of those not just at risk for suicide, but for those who may need assistance, assessment, and treatment for any number of mental health issues or problems.

While the QPR method was developed specifically to detect and respond to persons emitting suicide warning signs, QPR has also been more widely become something of a universal intervention for anyone who may be experiencing emotional distress. It has been suggested by independent researchers and federal leadership that funded the original assessments of QPR, that the QPR intervention could be useful in a much broader application, and not just for the detection of persons at risk for suicide.

Limiting the utility of QPR to the single goal of suicide risk detection accounts for the intervention's origination, but it is not known how many persons emitting distress signals recognized and responded to by individuals trained in QPR methodology were false positives (not suicidal), but still in need of assistance, assessment, and perhaps intervention and treatment. An RO3 research proposal is being submitted to the National Institute of Health at this writing (2013) to explore the impact of QPR-trained gatekeepers on not only potentially suicidal persons identified through the intervention, but those experiencing non-suicidal distress.

For example, one can imagine that 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, the NIMH-funded National Comorbidity Survey-Adolescent Supplement (NCS-A) found that about 20 percent of youth are affected by a mental health disorder sometime in their lifetime, but the vast majority of these young people never attempt suicide. These disorders - mood, anxiety, ADHD, eating disorder, or substance abuse disorder - resulted in a functional impairment of the child's role in family, school, or community activities, but did not lead to a suicide attempt or completion. (Kessler, et al., 2012). Similar findings for adults have been reported as well.

Moreover, a number known-at-risk populations e.g., police, soldiers, veterans, farmers, athletes and others, may be suffering from treatable disorders that are largely undetected and that go untreated despite public health messaging that attempt to encourage help-seeking behavior.

Since those most at risk of suicide are the least likely to ask for help, the application of QPR-based knowledge, compassion and understanding may prove the intervention to be useful for the detection of a wide range of treatable problems, e.g., non-suicidal self-injury (NSSI), perfectionism, eating disturbances, PTSD, TBI, sleep problems, bullying, depression, and other "easily masked" disorders that often lie "upstream" of the onset of suicidal ideation.

We invite researchers to further explore this potential for the QPR intervention.

Part II: The Nature of Suicide Warning Signs and Why the Q in QPR

No misery can long be kept secret.
Welsh Proverb

Several questions can be asked about verbal suicide warning signs. What forms of language are used? What words? What syntax and sentence structure? If some suicidal communications constitute threats made to control a relationship, how are these different from simple statements of intent? If they do differ, do they also differ in terms of direct or indirect forms of speech? Is there a difference between a suicide threat and a statement of a desire to be dead? Are verbal suicide warning signs most frequently presented clearly, or are they intentionally disguised by innuendo, hints, indirect statements, phrased in oblique language and, if so, why?

To the degree language has power and is a reflection of thought, what is the shape and form of the speech used by suicidal persons to communicate with those around them, and to what ends? Do suicidal people send verbal warning signs to loved ones differently than to, say, their physician or hair dresser? If suicide warning signs go unrecognized by adults in the general public, why is this so? Do people from different cultures speaking different languages show similar or different patterns of speech when expressing suicidal intent, desire or planning?

The theory section of this paper addresses several unanswered and unexplored questions about verbal suicide warning signs. So-called suicide warning signs are widely taught around the globe as part of a simple recognition, intervention and referral public health model to train “gatekeepers” to identify expressed suicidal thoughts and feelings that may precede fatal or non-fatal suicide attempts. In the author’s view, the problem is that too little contextual and cross cultural research has been conducted on these verbal suicide warning signs to warrant their teaching as currently agreed to by consensus expert opinion (Rudd, et al., 2006):

Background to suicide warning signs

Early in suicide prevention research investigators documented the presence of verbal, behavioral and situational "clues" or "warning signs" which observers reported to have witnessed prior to suicide completions (Miller, 1978; Osgood, 1985; Shneidman, Farberow, & Litman, 1970, Shneidman, 1996). Among these warning signs were verbal statements which were later interpreted to have expressed suicidal intent, desire, hopelessness, or planning. The founders of modern Suicidology framed these verbalizations as a "cry for help" (Farberow and Shneidman, 1961).

Others have attributed motives to these communications ranging from warning others of a pending adverse event, to attempting to hold onto a relationship, to a purposive act intended to bring about a change in the behavior of others (Robins et al., 1959; Rubenstein et al., 1970; Richman, 1978). Overall, however, researchers have noted 50%–69% of those who die by suicide communicate suicidal thoughts or intent to others in some way before they die (Coombs et al., 1992; Robins, Gassner, Kayes, Wilkinson, & Murphy, 1959), thus providing a window of opportunity for hearers to intervene.

In acute care hospital settings, however, explicit denial of suicidal ideation and intent has been found to be quite high; 78% of patients who die by suicide explicitly deny suicidal thoughts in their last communications before killing themselves (Busch, Fawcett, & Jacobs, 2003). One could speculate that denial of explicit intent to die by suicide when queried for in a hospital setting is one way for a determined suicidal patient to distract staff vigilance so as to create an opportunity to take one's life.

These verbal communications of intent to die by suicide have become part of the gatekeeper teaching content which has, in turn, become a core component of public health educational initiatives to prevent suicide based on the premise that once suicide warning signs are recognized, positive interventions can follow and lives can be saved. A CDC-funded study of completed suicides among American public and private school students supports the need for "Gatekeeper training" in the recognition of suicide warning signs (CDC, 2004). The authors concluded, "These findings support the need for school based efforts to identify and assist students who describe suicidal thoughts…."

Included in the objectives in Goal 6 of Surgeon General of the United States National Strategy for Suicide Prevention (2001), Gatekeeper training has been a recommended intervention and is now being widely taught. As noted earlier, gatekeeper training is designed to train those in a strategic relationship with populations at elevated risk for suicide to recognize suicide warning signs and to then take prompt action to avert a suicide attempt.

However, empirical support for what a suicide warning sign is has been limited (Berman, 2003). Recent articles have noted the confusion between warning signs and risk factors, as well as the problem of a lack of consensus opinion about what warning signs should be taught to the public (Rudd, et al., 2006, Mandrusiak, et al., 2006). The following definition of a suicide warning sign is offered by Rudd (2006):

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

This is an important definition as its sets parameters for the temporal relationship between pre-suicide attempt behaviors and an actual suicide attempt or completion. Distinguishing suicide warning signs from risk factors is critical. Confuse one with the other and a quick, decisive response to a legitimate warning sign is unlikely.

Owning a gun is a risk factor; talking about shooting oneself in the head with it is a warning sign. To mitigate the first requires means restriction efforts, e.g., not selling guns to suicidal people, safe gun storage practices, or changes in the laws and regulations of gun ownership and treatment of suicidal gun owners. To mitigate the second requires a thoughtful, interpersonal observation and intervention which hinges on the respondent’s recognition that something the potentially suicidal person said or did requires clarification and/or confrontation.

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

Consensus Warning Signs for Suicide

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

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

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

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

The consensus group agreed that while there is a great deal of literature on suicide risk factors, relatively few empirical studies have been completed to help determine what suicide warning signs are and how valid they are in predicting a suicide attempt, especially in the near term, i.e., in the next minutes, hours or days (Rudd et al., 2006).

While these lists of prioritized suicide warning signs are helpful, no evidence is offered to support a differential response to the first list verses the second. Interestingly, two items in the top priority list requiring "immediate action" are comprised of what appear to be verbalized suicide warning signs, such as "talking about" or "threatening to...," whereas the second list consists of largely psychological constructs which define supposed internal states of mind. "Hopelessness," "rage" and "feeling trapped" are, as interior states of thought and affect, meaningless to an outside observer unless some expression of these states of mind are verbalized by the suicidal sufferer.

Without evidence-based support for the actual verbal or behavioral expressions of these internal states of distress as described in list two, Gatekeepers have no external, easily-recognized "signs" upon which to initiate an intervention, but must make inferences from whatever it is they can see or hear. As examples of the actual language used to express these internal states are not presented in either list, the question remains: Exactly what verbal or behavioral warning signs do we teach Gatekeepers to recognize as legitimate indicators of near-term risk?

Unraveling the Puzzle of Oblique Verbal Suicide Warning Signs

A number of early researchers identified examples of both subtle and obvious verbal suicide warning signs (Miller, 1978; Osgood, 1985; Shneidman, Farberow, & Litman, 1970). These were direct quotes from persons who had died by suicide, all of whom are assumed to have been English-speaking Americans. Some authors used the word "clue" to describe verbal suicide warning signs that appeared cloaked in indirect language which, after the suicide, were interpretable in retrospect. An example of direct verses indirect statements of intent might be, "*I'm going to kill myself*" (a literal statement of suicidal intent), verses "*I'm going to go away forever.*" (a literal statement with, perhaps, an implied meaning).

Except for those who unequivocally threaten to kill themselves why, we might ask, don't suicidal people just speak plainly and clearly state their intent? Why do they hint at their state of mind? Why do they beat around the bush? Why must we learn what they meant after it is too late? Is suicide such a taboo subject, such an unpleasant subject for discussion, that even suicidal people cannot express themselves clearly about their thoughts and feelings? Or is something else at work?

Linguists have studied what is called "mitigated speech" for some time. Much of this work grew out of what has become known as "politeness theory" (Brown & Levinson, 1987). Mitigated speech refers to any attempt to downplay or soften the meaning of what is being said to avoid the appearance of being impolite, or disrespectful to others, especially in hierarchical relationships.

In this latter context, during multiple commercial air crash investigations, psychologists analyzing black box recordings between flight crew members have found a lethal pattern of mitigated speech by junior officers to the captain preceded avoidable crashes. Basically, those second and third in command failed to speak directly about a hazardous situation (Fischer & Orasanu, 1999). Further analysis showed that the speech problems fell into three categories: status of the speaker relative to the status of the addressee, the risk inherent in the situation, and the degree of "face-threat" involved in challenging a captain's error.

As an example, consider the following black-box recording of a conversation in the cockpit of the 1982 Air Florida flight that, with its wings covered in ice, was waiting for clearance to take off just before it crashed outside of Washington, DC.

FIRST OFFICER: "Look how the ice is just hanging on his, ah, back, back there, see that?"

Then:

FIRST OFFICER: "See all those icicles on the back there and everything?"

And then:

FIRST OFFICER: "Boy, this is a, this is a losing battle here on trying to de-ice those things, it (gives) you a false feeling of security, that's all that does."

The captain is then cleared for takeoff by the tower.

FIRST OFFICER: "Let's check those (wing) tops again, since we've been setting here awhile."

CAPTAIN: "I think we get to go here in a minute."

Just before the plane plunges into the Potomac River, here's the final exchange:

FIRST OFFICER: "Larry, we're going down, Larry."

CAPTAIN: "I know it."

In this oft-cited finding (one of many), at no time does the first officer state in clear, unequivocal terms that there is too much ice on the wing for a safe takeoff, e.g., "We better not try this, captain. Let's abort takeoff!"

As a result of multiple examinations of these post-crash conversations, a clear pattern of polite, indirect speech from subordinates to the captain emerges in which, to avoid face-threat, critical safety information is not transmitted in clear, unequivocal language. This kind of communication failure has been identified as a "monitoring/challenging error" by

the National Transportation Safety Board (NTSB) in over 75 percent of the accidents reviewed.

As a result of this linguistic research, major airlines - including flight crews from foreign countries where polite speech has lead to several preventable crashes - now train flight crews in how to speak bluntly and directly to the pilot about their safety concerns. (For a full review of this subject and how culture plays a role in airline safety, see Malcolm Gladwell's book *Outliers* published in 2008 by Little Brown, chapter 7.)

Saving Face, Losing Lives

Do suicidal patients speaking to their physician, therapist, a police officer, 911 professional, employer, human resource director, or other authority figure use mitigated speech to communicate their suicidal state of mind? Why wouldn't they? After all, who wants to hear that someone is considering suicide?

In Goffman's original article *On Face Work* (Goffman, 1967) and from which politeness theory grew, he writes, "In any society, whenever the physical possibility of spoken interaction arises, it seems that a system of practices, conventions and procedural rules comes into play which functions as a means of guiding and organizing the flow of messages. An understanding will prevail as to when and where it will be permissible to initiate talk among whom, and by means of what topics of conversation."

In no culture studied thus far do people just blurt out in plain language what is it they want or need from someone else (Brown & Levinson, 1987). Rather, they use a unique conversational logic and language that very carefully avoids what could be interpreted as rude or disrespectful, or that might lead to an unpleasant confrontation or face-threat.

To explore why suicidal people might use indirect language to communicate suicidal desire, intent and planning, Steven Pinker describes in his book *Stuff of Thought* the work and function of indirect speech and its necessary employment to negotiate potentially difficult areas of communication around such things as sex (Pinker, 2007). Pinker argues that, "Polite indirect speech can use any hint that cannot be pinned down as a request by its literal content, but that can lead an intelligent hearer to infer its intended meaning…"

According to Brown and Levinson (1987), politeness strategies are deployed in order to minimize face-threat. Face refers to the respect that an individual has for him or herself and which we all try to maintain while interacting with others. Most of us try to avoid embarrassing other people and will go to some lengths to avoid doing so. Politeness strategies are used to avoid making others uncomfortable and require the speaker to use hedges, vague words, innuendo and other cautionary language to negotiate the social world.

From an everyday example, imagine that you are an out-of-towner dining alone in an unfamiliar New York City restaurant and need some mustard for your hotdog. Which of the following sentences best protects the face of the hearer?

a) “Pass the mustard!”

b) “Excuse me, but could you please pass the mustard?”

c) “These are excellent hotdogs, but they would sure benefit from a little mustard.”

This last statement is made just loud enough to be heard by a stranger if the stranger “chooses” to listen. It is clear that option “a” is rude, option “b” is acceptable, and option “c” is a cleverly disguised request which can easily be ignored – and denied by the speaker…, “Oh, nothing, I was just talking to myself.”

The last statement is no less a request than first two, but contains one major difference: If the stranger chooses not to “hear” or “understand” the statement, and does not pass the mustard, the speaker retains plausible deniability that no request was ever actually made, and thus the hearer cannot possibly be offended.

Even if the mustard is passed, following the ultra polite hidden request, the speaker can save face by responding to the offer of mustard, “Oh, no thanks, I didn’t need any mustard, but thanks anyway.” In this final interchange no one loses face, everyone was polite and both parties can go on eating their lunch.

Such polite language use is widely employed. “*It’s too dark to read in here”* is an oblique request from a speaker that a hearer to turn on the lights. “*It looks like someone may have had too much drink”* is preferred to Y*ou are drunk!* The well-known mob extortion observation, “*You gotta’ a nice place here, it would be too bad if it burned down”* all carry unmistakable meaning.

Depending on the nature of the relationship between speaker and hearer (more later), requests to trouble others for help or assistance can be carefully hidden inside polite language through the use of indirect requests, rhetorical statements and a wide range of euphemisms. The reason for going to all this trouble is that we human beings are as much about making or maintaining a good impression of ourselves with others, and protecting the face of others, as we are about getting our needs met (Allan and Burridge, 1991).

Why Indirect Verbalized Suicide Warning Signs?

Politeness theory would predict that suicidal people might well use indirect speech to broach the subject of suicide with potential Gatekeepers and rescuers, especially if the Gatekeeper were in a position of authority; for example, a parent, teacher, professor or someone’s whose respect is essential to one’s well being.

- Suicidal patient to physician after receiving a prescription: “*If someone took all of this medicine at once, would it kill him?”*

- Physician: “*Yes, especially if taken with alcohol, but you’re going to be OK aren’t you, Fred?”*

- Patient: “*Of course. I was just curious.”*

Note: The form of the patient's rhetorical question allows plausible deniability while the doctor's presumptive request for a denial of suicidality (tell me you are not thinking what I am thinking), allows both parties to exit the interview with face intact and the unpleasant and taboo word "suicide" need never be brought into the conversation.

Coded communications

This patient-doctor interchange is essentially a "coded" conversation. Coded or indirect communication patterns contain two necessary elements, the literal meaning of a statement and the intended meaning. It is up to the speaker, and to the hearer, to agree to a mutual unscrambling of the coded interchange.

The classic invitation to sex – "*Would you like to come up and see my etchings?"* - is an example where both speaker and hearer know exactly what is being proposed, but each is provided a face-saving out and the speaker has full, plausible deniability if challenged, or slapped. A more modern version of this misadventure is described in a Seinfeld episode in which George fails to understand that when his date invites him "up for coffee" she means sex – which Jerry has to explain to the ever-socially impaired George.

From training materials developed by the QPR Institute for Gatekeeper training (Quinnett, 1995) here are some other examples of polite, indirect speech in which a possibly suicidal person used a statement with both a literal meaning and possible intended meaning:

- Problem gamble caller to hotline: "*I know it's too late for me, but can you recommend a counselor for my wife?"*
- Query to crisis line volunteer: "*Are twenty-four 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 literal and rhetorical question and moments later heard the fatal gunshot from the back porch.

Note that in all these examples the word suicide does not appear, yet each statement contains an indirect request for information or help, hints at a dire outcome, or is a rhetorical question whose answer may have potentially fatal implications. All are noticeably polite.

Suicide and Politeness Theory

If politeness is a universal human trait (Pinker, 2007), then surely polite and indirect speech bears investigation in any study of suicidal communications, not only in English but in all languages. Brown and Levinson (1987) documented a full range of polite forms of speech that closely matched those in English in both Tzeltal, the Mayan language spoken in Mexico, and Tamil, a non-Indo-European language in South India and Sri Lanka, as well as in many other languages. The framing of questions, the words used, the statements made, and in what context they occur become a critical aspect of what is taught to potential Gatekeepers in any culture.

Given the unacceptability of death by suicide in most cultures among most people, the suicidal person takes a terrible risk of being rejected and losing face if he or she is blunt in a statement of desire, intent and/or plan, or if an unequivocal request for help is made and then ridiculed by the listener. Just as no teenaged boy asking a girl for a first date can deny the anticipated terror at loss of face if she says no, neither can suicidal persons deny the guilt and shame they will experience if their clearly stated desire to die draws laughter.

A colleague in a college counseling center described a freshman co-ed who walked into his waiting room with both wrists bleeding profusely. Holding out her arms to the receptionist as the blood dripped onto the carpet, she said, "*Excuse me, please, but I think I need help?"* The question mark is added here because, in our latest cultural version of politeness, her voice rose on the word help in classic Valley Girl up-talk, thus transforming a statement into a question in case the hearer needed even more motivation to act.

If a direct statement of intent to die by suicide is scoffed at or ridiculed by the hearer, the suicidal sufferer has no way out. There is no loophole through which to escape with face intact and no plausible deniability that what said was not what was meant. Confronted by a non-sympathetic hearer, the loss of face might even push the suicidal sufferer beyond his or her natural resistance to act on a suicide plan.

However, if the statement of intent and desire is sufficiently vague and polite, and the word suicide is never mentioned, e.g., "*I'm going away forever",* the hearer can elect to question the intent of the statement or not. If the hearer dismisses the intended message with, "*You must be kidding",* the suicidal speaker has a face-saving escape and can respond with, "*I mean, I'm moving to California."*

Conversational Implicatures, Plausible Deniability and the Burden to Rescue

A conversational implicature (Grice, 1975) is the means by which the speaker uses words to imply meaning without spelling out exactly what that meaning is. The speaker is

counting on the hearer to "get the drift" by being intelligent enough to "read between the lines" and understand what was not said.

This language is in heavy use by critics, satirists, diplomats and comedians as well as all of the rest of us. Grice argues that the language of conversation is specifically rooted in the needs of the conversational partners so that, in the end, messages are transmitted with more or less fidelity to what was intended. Grice called this the "cooperative principal," by which means both parties adhere to certain aspects of human conversation that move the agenda forward efficiently and effectively without setting off gunshots, duels or civil wars.

Through implicatures that create plausible deniability, critics use unsaid words to make their deepest cuts. When the actor Raymond Massey played Abraham Lincoln on Broadway, the critic George F. Kaufman wrote of his performance, "Massey won't be satisfied until he's assassinated." This oblique assault on Massey's acting talents did not accuse him of being a hack and overacting, but no intelligent reader missed its meaning. Had Massey challenged Kaufman to pistols at dawn over the insult, Kaufman could have denied the intended message and stuck to the literal one.

Conversational implicatures seem perfectly designed for suicidal persons needing to talk to others about the terrible decision they are contemplating. Consider that if a suicidal person says "*I'm suicidal and I'm going to kill myself*" to another person, a potential burden for rescue emerges that was not there had the speaker said exactly the same thing in a polite, indirect way, e.g., "*Nothing seems worth it anymore, I can't go on any longer.*" The implied burden to assist is the same and a researchable question could be asked if suicidal sufferers appreciate the weight of the request they are making of others, whether that request is implied or plainly stated.

Unless the hearer is given a loophole through which to escape the obligation to rescue, the hearer (in most interpersonal human venues) has now been charged by the suicidal person with a Good Samaritan responsibility to render assistance and attempt an intervention. Hints, understatements, idle generalizations, and rhetorical questions are all excellent substitutes for direct requests for help. Not only are they polite, but they minimize discomfort to the hearer and provide everyone a way out the dilemma.

Here are three factual statements made to loved ones or others by people who went on to kill themselves within a week.

- Church member in the middle of an ugly divorce to his pastor: "*Do people who kill themselves go to heaven?*"

This rhetorical question, with the implicature that the speaker may be thinking about suicide, and perhaps seeking a blessing or approval for suicide, was answered at the literal level (Yes, they will be forgiven). Had the question been asked in the context of sermon on suicide and its consequences in the afterlife, it would have been within a

context that might not have raised the index of suspicion. But in this case, it was asked out of context and was, it appears, a coded suicide warning sign.

- Elderly father to an adult son while the son was visiting the father in his home to discuss nursing home placement: "*Stop worrying so much about me, I'll be going home soon.*"

This statement included a request to stop worrying (removing burdensomeness) with the implicature that the father is going to a "home" other than one in which the conversation occurred. Home was a euphemism for death.

- Said to a ward nurse by a World War II veteran at discharge from a psychiatric hospital where he had been treated for clinical depression and suicidal ideation: "*Don't bother about me. When the going gets tough the tough know what to do.*"

This D-Day veteran shot himself, in his home, five hours after discharge.

In each case the speaker used language that provided plausible deniability of his intentions had the hearer challenged the statement and asked for clarification of its intended meaning (the Q in QPR). Sadly, in each case the literal message was accepted and the burden to render assistance avoided.

A Little Research

In one study on the apparent impact of clearly stating your intentions to die by suicide in direct language, Wolk-Wasserman (Wolk-Wasserman, et al., 1986) found that on interviewing significant others following the suicide attempt of an intimate other, and despite apparent clear and unambiguous statements of intent to die by suicide, family members and significant others were reluctant to act and were even immobilized. The burden of rescue may have been perceived by the hearer as overwhelming.

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

At least in this study it appears little or no helpful dialogue followed what were later described as direct verbal expression of suicidal intent between intimate others. Since all cases were recruited from an emergency room population of suicide attempters, no conclusions can be drawn about the potential for more favorable outcomes (e.g., averting a suicide attempt) had there been a helpful, understanding dialogue between the parties. But one conclusion seems clear: if the most common reaction to a direct verbal statement of intent to attempt suicide is silence, anger and/or avoidance, then the use of polite, indirect speech to emit verbal suicide warning signs makes even more sense.

More recent research
In extensive qualitative studies conducted in the UK, Owen and his team interviewed 14 cases of suicide survivors following completed suicides between 2008-9 (Owens et al, 2009, 2011). In each case as many members of the deceased's social network were interviewed as possible, with a final range of from 1 to 5 interviews per case, for a total of 31 interviewers. Informants were persons in frequent contact, e.g., family members, and included ten general practitioners, therapists, and counselors.

In this study the authors introduce the term suicide communication event (SCE), and define it as follows: an SCE is *a set of circumstances in which a person expresses suicidal feelings, thoughts, intentions or plans, either directly or indirectly, in interaction with other people in their social environment."* To quote further, *SCEs are important observable elements of the suicidal process.* The term "observable" is key here, since a SCE, in whatever format, coded or clear, is something that can be seen or heard.

After eliciting the narrative "story" of the event, and following up with questions, a microanalysis of both the narrative and answers to questions was conducted relying on Speech Act Theory (Austin, 1962, Knizek and Hjelmeland, 2007). This approach helps analysts understand and classify the verbatim language recorded and its intended purpose.

To explore the meaning of indirect communications found in the analysis, the authors relied on the Thomas definition (Thomas, 1995, p. 119) of indirect speech as a universal phenomenon that *occurs when there is a mismatch between the expressed meaning and the implied meaning* of a communication, adding that when indirect speech is employed, more work is required of the intended receiver since this "strategic ambiguity" is needed when a conflicted subject - like planning to end one's own life - is introduced into an otherwise polite social interaction.

The summary findings of this careful examination of SCEs are as follows:

- Direct communications of intent, threats, or plans were found in five (5) cases, e.g., "I am going to hang myself."
- Direct communications of suicidal thoughts or feelings were found in six (6) cases, e.g., "I've had occasional feelings like I just wish I would not wake up."
- Indirect communications of suicide thoughts and feelings (more ambiguous and difficult to interpret) were found in nine (9) cases, e.g., "I can't do this anymore, Dad."

The authors review a number of other items and issues surrounding how those in the social network respond to SECs, e.g., barriers to understanding, sincerity conditions, politeness, face saving, and popular assumptions about suicide talk. They summarize that the failure of family members and others in the social network to respond were due to "pragmatic failures to correctly determine the meaning of the communication" and that this failure to respond may be due the "inadvertent closing down of the SCE" by those in the social network work.

This apparent "shut down" of suicide talk by a listener, has now been replicated in a verbatim study of verbal interactions between primary care physicians and their suicidal patients (Vannoy & Robbins, 2011), and is more generally described an avoidable medical risk when treating depressed patients (Feldman et al., 2007).

As noted elsewhere in this paper, the Q in QPR is designed specifically to address this single, key communication failure in how suicidal people attempt to communicate with those around them. To actually "ask the question" is a bold interpersonal step, but may be a life-saving one.

What Non-suicidal People Say

In an ongoing uncontrolled experiment involving hundreds of participants learning to teach the QPR Gatekeeper Training for Suicide Prevention (Quinnett, 1995), which includes the teaching of suicide warning signs, their purpose, meaning and importance in suicide prevention, participants are asked to form into groups of three and discuss the following questions.

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

After a small group discussion of 15 minutes a reporter for each group shares the findings. While this is a highly artificial setting and the circumstances are quite unlike those in which suicidal persons find themselves, the vast majority of participants report they would use indirect verbal statements of intent, not direct ones. The majority would not write a suicide note. Approximately one third state they would send no warning signs at all. When the latter group is reminded that if truly suicidal they would be suffering severe and unbearable psychological pain, a greater number of them report they would "hint" at what they were planning to do, but still not use direct, clear, unequivocal statements of intent to die by suicide.

The following list of reasons is representative of why participants say they would use indirect language:

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

From these selected samples, it appears that at least part of the reason participants would elect to use indirect verbal statements are twofold, 1) participants appear to experience

the same classic ambivalence about the decision to die as do suicidal people, and they reflect this ambivalence in their equivocal statements of intent and, 2) participants appear to be testing a private hypothesis regarding a would-be rescuer's willingness and ability to intervene; in which case the indirect statement becomes a "test" of commitment, competence, caring, trust and whether the hearer is willing to bear the burden of assistance.

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

As a test of caring or willingness to rescue, the rejection of an indirect suicide warning sign (no query is made to clarify the intended meaning) could be interpreted by the suicidal person as proof of his or her burdensomeness on others and/or lack of belonging to one's valued reference group. Indeed, the rejection of direct or indirect verbal suicidal communications regarding intent and desire to die could provide evidence to the suicidal sufferer that, indeed, they now have permission to proceed.

Signal Detection Theory Applied to Suicide Warning Signs

Another way to think about polite, indirect verbal suicide warning signs in a communications context is as "weak signals." In original Signal Detection Theory (Green & Swets, 1966) "weak signals" are those signals easily lost in background noise or mistaken for a benign event when, in fact, the signal was an important indication that something bad was about to happen. Home smoke alarms are obnoxiously loud so as to ensure the audio warning signal exceeds the threshold ambient noise of a busy household where the TV is blaring, the washing machine is running and children are playing. No alarm system is functional unless the person expected to respond to the alarm can hear or see it and knows what it means.

In discussions with people who have lost loved ones to suicide, a common report is that, yes, they knew they were having problems, but no, "*I just didn't think they were serious.*" There was concern, but uncertainty. Signal Detection Theory would suggest that whatever the verbal warning signs were, they were of insufficient strength or volume to rise above the hearer's threshold for recognition and alarm. If this analysis is correct, then we have three options:

1) Train Gatekeepers to recognize polite, indirect verbal suicide warning signs (weak signals) and to respond as robustly to these as they would to strong signals, or
2) Begin a robust social marketing campaign that produces greater help-seeking behaviors among suicidal people so that warning sign recognition is not needed, or

3) Train suicidal people to speak more clearly and directly about their suicidal thoughts, feelings, plans and intentions with potential rescuers as has been done with commercial airline flight crews.

As will be recalled, the National Transportation Safety Board required the training of flight crews to speak more directly to each other, use fewer implactures, and refrain from polite language in the cockpit when safety warning signs were present, with a resulting reduction in air crashes. Such an intervention with suicidal persons seems unlikely unless great strides can be made in teaching help-seeking behaviors to at-risk populations.

Signal Detection Theory (SDT) helps describe how humans make decisions under conditions of uncertainty. SDT assumes that the respondent is an active decision maker and not a passive recipient of information – the very goal we hope to attain in training Gatekeepers. The following graphic describes how responses to a possible suicide warning sign might be sorted into hit or miss categories.

	Gatekeeper does not recognize	Gatekeeper does recognize
Warning Sign Present	Miss	Hit
Warning Sign Absent	Correct Rejection	False Alarm

Using a series of trials with Gatekeeper respondents it would be possible to establish statistical estimates of detection sensitivity to any number of variously defined examples of suicide warning signs, including direct and indirect verbal warning signs unique to different cultures and languages.

For example, on a 5-point Likert-type scale the instructions might read: People considering suicide often make statements of their intentions before they make a suicide attempt. Please rate the following possible suicide warning sign as stated by one police officer to colleague: "*If they fire me I'm going to eat my gun*".

1 = not a suicide warning sign
2 = possible suicide warning sign
3 = probable suicide warning sign
4 = highly probable suicide warning sign
5 = unequivocal suicide warning sign

A list of suicide warning signs published from various sources could be evaluated for their effectiveness to trigger recognition "hits" (warning sign present) and "misses"

(warning sign absent), as well as gradations of perceptual certainty above threshold from "possible suicide warning sign" to "unequivocal suicide warning sign."

In SDT, *sensitivity* refers to how hard or easy it is to detect that a target stimulus is present from background events, whereas *bias* is the extent to which one response is more probable than another. Research on sensitivity would predict that some suicide warning signs would be obvious and easy to recognize while others would be subtle and difficult to recognize. For example, "*I'm going to kill myself"* is a strong signal, whereas, *"I don't think I can go on any longer"* may be a weak signal.

Bias refers to the probability that a Gatekeeper is more or less likely to recognize a suicide warning sign and respond in some way. The response to a warning sign, whether it is acute chest pain, a seat belt reminder beep, or a threat of suicide, has both risks and benefits. If the warning sign is a red traffic light, responding or not responding to that signal has consequences including injury or death. Failure to recognize and respond to acute chest pain or a suicide warning sign also has consequences up to and including death.

In this context, and as regards cultural differences in suicide warning signs, a warning sign (any warning sign) must first be an "emotionally competent stimulus." An ECS is a stimulus that triggers sufficient emotional arousal for a cognitive appraisal of the stimulus to be made, after which – depending on the results of the appraisal, an action, or no action, will follow.

A twig cracking behind a hunter in the dark woods is an emotionally competent signal, which triggers the appraisal, "Will it eat me, or can I eat it?" Some action will follow.

If a suicide warning sign does not breach this arousal threshold it is unlikely a) to be remembered by a gatekeeper-in-training and, later, b) to be match-recognized as a suicide warning sign of sufficient signal strength to cause the arousal-appraisal desired reaction – Questioning the actor as to the meaning of the communication or behavior.

If polite, indirect verbal suicide warning signs are, in SDT, weak signals that do not meet criterion for an ECS, then culture and context becomes the "background noise" against which the signal must be detected so that it can be appraised.

I think I'll take the spirit trail may be a weak signal in a largely white urban culture, but a strong signal on a Native American reservation. Without sufficient knowledge of the context and culture in which the statement is made, even specific verbal suicide warning signs cannot be properly taught or learned. While there may be universal themes in verbalized suicide warning signs, the author is unaware of any specific studies exploring how these vary by culture or language.

Rhetorically, which of the following suicide warning signs is an ECS likely to cause emotional arousal through signal detection and, therefore, more likely to result in a "hit" verses a "miss" in our SDT matrix above:

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

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

Why Context Matters

Verbal suicide warning signs are not sent into a vacuum. They are heard by others or else why send them? When evaluating warning signs context is everything. A soldier standing guard on the front lines in a hot combat zone in Iraq is more likely to detect a weak signal (the footfall of a possible approaching enemy) than the same solider standing guard in peacetime Kansas.

From a consultation to a corporation, the author was asked by the Human Relations Director if he should take seriously the statement shouted at him by an angry and distressed employee “*If you fire me you're going to see me fly by that window!*” As we sat in his office on the 10th floor, I assured him he should take the matter seriously.

The context in which a verbal suicide warning sign is detected must be factored into its likelihood of passing the recognition threshold as well as the weight and urgency it should be given when interpreted. The statement of a suicidal person who says “*It's no use going on*” means one thing if said to a nurse in a hospital consultation office, and something quite different if uttered to a police officer from a man sitting on the rail of a tall bridge with both legs dangling in space.

Not only must Gatekeepers be trained to recognize warning signs, but they must also understand the context in which they are detected. Using SDT to measure the effectiveness of suicide warning sign education within a variety of contextual settings would be a major step forward. Excellent statistical models for such tests are available (Abdi, H. 2007).

Relationships and Suicidal Communications

Finally, the language suicidal people use to communicate desire or intent to others likely varies across types of relationships, just as how polite we are varies with the contexts and persons with whom we are conversing. We might expect that a suicidal person may use different language with a friend, a co-worker, a spouse, his or her boss or with his or her doctor. Linguists have identified at least three major relationship dynamics in all societies, each requiring a different kind of speech pattern for proper interactions (Pinker, 2007). The dance of language varies within each of these types of relationship: Communal Sharing, Authority Ranking and Equality Matching.

Communal Sharing relationships are found in blood relations, extended families, tribal bands and in other kinship relationships where similar genetic material is shared. These relationships are close, warm relationships between people where trust is high but conflict not unknown. Authority Ranking relationships are defined by power, status, autonomy and dominance, as reflected in a company's organizational chart, military rank structure and employer-employee relationships. Finally, Equality Matching relationships are defined as those in which there is reciprocity, exchange and fairness (Fiske, 1992). Your relationship to your pharmacist is an example; you give him or her money in exchange for medications.

These three types of relationships likely require varying degrees of direct and indirect speech to be successfully negotiated and, to the degree they do, there are important implications for research and Gatekeeper training. In the National Strategy for Suicide Prevention (2001) physicians and hairdressers are mentioned as possible suicide prevention Gatekeepers, yet we might presume that people use different forms of speech to communicate with each of these professionals.

It seems unlikely that a suicidal, enlisted soldier is going to communicate that he is feeling suicidal to his commanding officer but very well might send warning signs to someone of the same rank in his unit. Or, he might do both, e.g., say to his sergeant, "*Please see to it that my wife gets my last paycheck",* and say to his best friend in the unit, *"I'm getting out this mess and I want you have my guitar*." In the latter, a Communal Sharing relationship at the squad level, the warning sign is configured for a close friend, whereas the request for the redirection of his paycheck is an administrative request in an Authority Ranking relationship.

As an example of an Exchange Relationship case, a patient remarked to a dental hygienist employed by his dentist, "*I'm going up the lake cabin this weekend, but I'm never coming back. It's been terrific knowing you. Tell Doctor Smith goodbye for me*." A report of the patient's suicide was published the following week in the local paper.

The commonly held notion that organizations should train Gatekeepers at mid-level and upper-level rankings, e.g., school teachers, supervisors and senior military personnel, could be wrong-headed if the aim is to ensure the safety of their subordinates. Until we have better research we don't really know if suicidal people are more likely to communicate their intent to those higher up in Authority Ranking relationships or across channels to their coworkers and colleagues, or perhaps, only to intimate others in their Communal Sharing relationships. Also, those suicidal sufferers who do communicate their desire and intent to others may use different language with different people in each type of group.

Since all cultures studied thus far appear to have these same three structural relationships between their members, an exploration of verbal suicide warning signs as transmitted in each type of relationship could prove important in training potential Gatekeepers in each of these groups. For example, research has shown that many suicidal people appear not to disclose their suicidal thoughts, intent, desires or plans to their physicians (Louma, et

al., 2002). However, since we have no video tapes of these "last conversations" with healthcare professionals we do not know if polite, indirect statements were made and if these statements might have been successfully challenged for clarity of their intended meaning. This is also a highly researchable question.

In general then, the evolving job of training Gatekeepers should include training them to recognize not only obvious verbal suicide warning signs, but polite forms of speech with suicidal implactures suggesting the need for clarification by the hearer so that the intended - not the literal - message is acknowledged and understood. The power of the clarifying question has been well documented as a source of therapeutic success in assisting ambivalent patients to elaborate on the meaning of a statement and thus better understand their own circumstances and capacity for change (Miller and Rollnick, 2002).

The following statement to a trained Gatekeeper should lead to clarifying questions: "*I just don't think it's worth going on anymore. I'm so tired of it all. What I really need is a long, long rest. I'm counting on you to take care of my dog after Saturday."* The speaker's statement implies desperation, hopelessness and powerlessness but does not directly state an intention to attempt suicide.

A simple logic model suggests the Gatekeeper has three options: 1) accept the literal statement and agree to take care of the dog, 2) acknowledge the literal message was heard and understood, but to ask for a retraction, e.g*., "You're not suicidal are you?"* or 3) ask the speaker to clarify or "decode" the literal message so that the intended message is fully understood. If the Gatekeeper sets aside options one and two, the clarifying question must then be asked. This clarifying question that decodes the intended meaning of an indirect warning sign lies at the heart of the QPR method (Quinnett, 1995).

General Recommendations

One considered goal for all Gatekeeper training programs must be to teach potential rescuers to become comfortable with asking clarifying questions, e.g., "*Are you thinking of killing yourself?"* This direct, bold interrogatory instantly offers to unscramble the coded language of the suicidal person and makes a strong statement that the Gatekeeper is, right now and at this very moment, willing and able to talk frankly about suicide.

Thus it seems we should continue to recommend a liberal response bias to Gatekeepers who "believe" they may have intercepted even a weak suicide warning sign and support their attempts to clarify the communication in order assure they did not miss its intended meaning. Just as the signs of a pending heart attack may only signal indigestion, responding to any suicide warning sign will produce large numbers of false positives. But because the risk that an un-responded-to true positive may result in an otherwise preventable death, our recommendation should remain: it is better to act and be wrong than not act at all.

It is also important to understand that in any communication between two people there is a margin of error between what the speaker intends and what the listener hears and understands. The words selected, voice tones, volume used, syntax and sentence

structure and the contexts in which the words are delivered by the speaker all contribute to the quality of interpersonal communications. Until the stigma and taboo around the word suicide are ancient history, and unless we intend to place the responsibility on suicidal people to state their intentions in unequivocal declarative sentences, we have much research and training ahead of us.

Believing is Seeing

For QPR to be accepted as a potentially helpful skill, learned, and applied in suicidal crises, potential gatekeepers must first believe a suicide attempt may follow someone's talking about it, e.g., saying aloud that they wish they were dead. The common myth that immobilizes potential rescuers is the widely held false belief that "People who talk about suicide don't do it."

So long as the general citizenry continues to believe this myth, they have no duty or felt responsibility to take action. Thus, the first step for any educational program is to undo this myth and train potential gatekeepers to overcome any inertia to act by helping them reverse this wrong belief.

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

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

The Role of Gatekeeper Fear

In the author's experience in training healthcare professionals in how to make a differential diagnosis for major depressive disorder – and despite repeated instructions to do so – the majority of hundreds of otherwise skilled participants found it extremely difficult to inquire about the presence of the 9th symptom in the diagnostic criteria for Major Depressive Disorder; namely, "recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without specific plan, or a suicide attempt or a specific plan for committing suicide" (American Psychiatric Association, 1994).

As one participant remarked "The word suicide just sticks in my throat." Another clinician explained, "They're already depressed, I don't want to put the idea in their head." Researchers have reported this stress/fear reaction to suicidal presentation in clinicians more than once (Deutsch, 1984; Farber, 1983).

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

Not infrequently, untrained participants responded to this role-played warning sign communication with, "You're not thinking of suicide, are you?" This question can be interpreted as a request by the interviewer that the speaker retract the threat (face threat).

This response says much more about the clinician's anxiety and fear than it does about the patient's. This is such a common response to suicidal communications by both professionals and lay people that the QPR gatekeeper training program specifically teaches potential gatekeepers *How* **Not** *to Ask the Suicide Question*. More, role-playing the actual interview is highly recommended, simply to enable learners to speak the word suicide.

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

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

More recently, the Joint Commission issued a Sentinel Event Alert in November, 2010, highlighting the need to screen Emergency Department and non-psychiatric hospital admissions for suicidal ideation, intent and desire following their considerable analysis of inpatient suicides where risk was never disclosed or detected and, thus, never addressed, assessed or mitigated. Mind you, these are not psychiatric admissions, but general medical-surgical and ED admissions.

Another unpleasant consideration is that if the consumer voluntarily reports suicidal thoughts or preoccupations with death and the professional does not respond with concern or additional inquiry regarding severity, persistence, history of similar feelings, and other risk determination questions, the consumer may feel even more isolated and alone and, accordingly, at even more elevated risk for suicidal behaviors.

As an example of how this appears to happen, in one study of physician-patient interactions exploring the detection and diagnosis of depressive illness, analysis of verbatim transcripts found that only 52 percent of patients who scored positive on a questionnaire for depression were later engaged in a discussion by their physician about depression. Even more alarming, where 59% of patients endorsed suicidal ideation (n=75) on the questionnaire, only 11% (n=13) had a suicide-related discussion with their physician. Thus suicidal patients who have just truthfully answered a questionnaire about their experiencing suicidal ideation has only a 1 in 10 chance of having a conversation about this symptom with their doctor. It was further noted by the authors that physicians frequently used language that encouraged suicidal patients to deny the suicidal ideation that had just reported on their pre-visit paperwork (Vannoy, S., & Robins, L. (2011).

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

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

Useful Fear

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

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

In his excellent book, *The Gift of Fear* - and on the subject of threat assessment - Gavin DeBecker agues that the nature of an alarm is to trigger an ancient, entirely natural and intuitive fear response. For safety and survival of the species this fear response should always be trusted. Had humans not be "gifted" with a fear response the human race would have died out eons ago. DeBecker claims intuition is more trustworthy than rational thinking and that it is always correct in at least two important ways:

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

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

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

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

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

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

challenge of training potential suicide prevention gatekeepers to respond in a competent, comfortable and effective fashion should not be underestimated.

Practical warning signs education

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

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

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

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

Gatekeeper Competence

To determine a suicide prevention gatekeeper’s competency to engage a suicidal person in a helpful dialogue leading to a successful referral/link to further professional assessment requires a blend of knowledge, personal confidence in the intervention, and

demonstrable skills. The following measurable behaviors are suggested to help determine gatekeeper competence:

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

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

The P in QPR

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

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

Timing is Everything

As in many other ventures, timing determines success. Persuasion works best when commitment to a particular outcome remains undecided. Thus, the greater the ambivalence about dying by suicide experienced by the sufferer, the greater the opportunity for a gatekeeper to negotiate a non-fatal outcome.

It is important to understand that a suicide attempt does not begin when the pistol is pointed at the head and fired, or when the gun is loaded, or when it is drawn from its holster, or when it is purchased with suicide as the motivation. A suicide attempt begins with the idea that suicide is an acceptable solution to unendurable psychological pain, whatever the source. From idea to act, the journey to suicide may be a matter of minutes, hours, days, weeks, months or years, but the suffering is always more benign in beginning than in the final hours before the attempt.

The prediction of suicide becomes easier if we understand that the act of suicide is a process, and that from its beginning to its potentially fatal outcome the relative effectiveness of our ability to dissuade the person from suicide will vary with where we interrupt them in their journey. Our success may also rest on our collective capacity to quickly re-knit the ties that bind people together and, in so doing, reduce the suicidal sufferer's perception of being a burden on others and no longer belonging to the human family (Joiner, 2004).

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

The Reluctant Referral

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

An examination of those groups with the highest suicide rates, e.g., teenaged males, working males, older white males and alcohol abusers (AAS, 2004), suggests that these and other groups at elevated risk for suicide are also the least likely to self-refer for treatment. A reluctant referral may be defined as someone who a) is unlikely to ask for help in person or from a crisis line, b) is likely to refuse help when it is first and freely offered, and c) requires third-party persuasion to accept the very intervention, assessment

and treatment that might save his or her life from suicide. Even a cursory review of news stories about completed suicides in most Western countries reveals a steady, relentless stream of stories about self-inflicted violent deaths by men in dire and obvious need of treatment, but apparently unable to ask for it. All too often loved ones, family members, and co-workers report their observation of an alarming list of pre-suicide warning signs and yet seem unable to respond in a helpful fashion.

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

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

The reasons reluctant referrals do not seek or accept help freely offered are myriad: fear, stigma, prejudice, cost, shame, early socialization, a belief that all therapists are "crazy" and a cultural expectation that one should be able to solve one's own problems without assistance. Another explanation is that through eons of natural selection males who had to ask for help because they were "lost" and, lost on someone else's turf, meant capture, torture, rape and premature death, thus leading to the most significant loss of all: access to the human gene pool for reproduction (Quinnett, 2013). In historical times, asking strangers for help was frequently a death sentence. As a possible result of this attitudinal position or biological fear of strangers and the risks asking for help represent, reluctant referrals can be identified both by their apparent resistance to help seeking, and by their elevated rates for suicide.

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

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

An Rough Adaptation of Motivational Interviewing

The basic skill set and evidence-based knowledge selected to be taught to potential QPR gatekeepers to improve their powers of persuasion is based upon the work of many researchers, but is primarily derived from the now broadly established success of Motivational Interviewing as described by William Miller and Stephan Rollnick (2002).

As motivational interviewing grew out of the addictions counseling field, its premises and practices deal directly with the very issues presented by suicidal reluctant referrals: resistance to change and ambivalence about seeking help or treatment. The motivational interviewing method has clearly demonstrated its effectiveness to successfully bring about positive changes in precisely the behaviors targeted for influence by QPR trained gatekeepers.

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

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

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

Pragmatically speaking, and because suicide attempts and completions remain rare events, for a public health intervention like QPR to be effective *when and where* it needs to be applied, it must be teachable in a reasonable period of time, and be both brief and effective in its delivery. While working through the ambivalence of a chronic smoker is

an essential element of addiction-oriented motivational interviewing, persuading an ambivalent suicidal person to accept help and begin the change process cannot take hours or days or weeks.

Rather, for a QPR intervention to be helpful in averting a suicide attempt, it must happen more or less immediately and must not require an inordinate amount of time. Thus, QPR is more like CPR in its urgency, directness, training requirements, and delivery, than it is like a leisurely interview with someone struggling with any of a number of addictive problems which, while life-threatening in the long term, are not fatal in the near term. In a suicide crisis, the difference between acting now or acting later can mean the difference between life and death. Thus, citizens trained in QPR are advised to act quickly and not to wait for things to get better, and that any effort to assist a suicidal person may lead to a favorable outcome.

The QPR gatekeeper intervention then, as a potential adaptation of motivational interviewing (AIM), must work within the time constraints of what is likely to be a single, brief encounter of usually no more than one hour, as determined by informal surveys of potential gatekeepers (Quinnett, 1995). QPR as an adaptation of motivational interviewing needs additional research and testing, but does fit within the basic framework of one person trying to help another in an emergent health-risk crisis. Similar strategies of brief motivational interviewing have been adapted to, and tested for effectiveness, across a number of medical and health promotion platforms using the "teachable moment" concept, including alcohol use, diet, physical activity, diabetes control, pain management, screening, sexual behavior and medical adherence (see summary in Miller and Rollnick, 2004).

As regards the teachable moment and the author's clinical experience with suicidal "reluctant referrals," the relief experienced by these individuals from a single therapeutic session appears to motivate commitment to additional treatment and behavior change. Research to support this conclusion, however, is scarce. None the less, a growing body of data suggests that motivational interviewing techniques hold considerable promise as a behavior change approach for public health initiatives.

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

Finally, to relieve concerns about liability and "getting involved," QPR gatekeepers are informed of the Good Samaritan Act of 1985, and that a layperson or professional who does not have a legal duty to respond to a stranger's emergency, and who is acting in "good faith" and is not being compensated, and who is not guilty of Gross Negligence (deliberately careless conduct), is immune from liability. There are no recorded cases against a Good Samaritan since 1985 (ProCPR, 2003). There have been no complaints about QPR training brought to the attention of the QPR Institute in the past 13 years and no adverse events have been attributable to the training to date.

The R in QPR

The R in QPR builds, again, on familiar behaviors in which every adult has engaged thousands of times: asking Questions, Persuading others to do something they may not want to do, and Referring people to everything from a lawyer to an Italian restaurant.

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

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

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

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

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

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

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

To make such a system work effectively, gatekeeper referrals must be automatically accepted, properly assessed and triaged to a level of care that matches the level of assessed risk. In communities with high levels of competence and shared responsibility for its suicidal members, and where a complete chain of survival exits, acceptance of a gatekeeper's competence, knowledge, and role as a referrer in the community is likely to be smooth and successful.

In sum, the presence of suicide risk is confirmed by the gatekeeper following the emission of a warning sign and clarified with one or more S Questions; Persuasion is made less difficult because stigma has been reduced, access to service is straightforward; and all parties know that the local community of care providers is willing and able to accept a Referral for professional assessment and care.

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

As part of the R in QPR, gatekeepers are provided the names, phone numbers, addresses, and where appropriate, maps to emergency rooms, mental health centers, and college

counseling centers. Research has shown that clinical risk information alone does not improve help seeking behavior, and especially if the behavior change requested may lead to a noxious or painful intervention, e.g., an inoculation (Leventhal et al., 1965). In the Leventhal study what made a dramatic difference in student self-referral rates to secure a tetanus inoculation was not the health information, but the provision of a map to student health services buildings and the times when the shots were given.

Enhancing Protective Factors

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

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

We should be reminded that when, as a young man, Abraham Lincoln was depressed and suicidal, a friend said of him, "Lincoln told me that he felt like committing suicide often." Seeing suicide warning signs, Lincoln's neighbors mobilized to keep him safe, watching over him, and removing his knives and pistol. They pulled together the same kind of safety net QPR gatekeepers can build today – and which included making sure our President did not have access to the means of suicide. It was said that when he again became depressed later in life he "dared not carry even a pocket knife" (Shenk, 2005)

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

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

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

The Core QPR Gatekeeper Curriculum

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

- A nine-minute celebrity-hosted video intended inform and orient participants to QPR
- Basic orientation to suicide prevention and the role of gatekeepers
- Disclaimer that QPR is not treatment, but a citizen emergency response to a mental health crisis
- Review of the common myths about suicide and an active cognitive correction of participant false beliefs
- Review and recognition of samples of evidence-based suicide warning signs
- How to set up a QPR intervention (timing, environment, resources)
- How to ask the S Question (examples, specific phraseology, anticipated results)
- How to persuade a suicidal person to accept help (active listening skills, focus on problem(s), requests for life-saving action)
- How to refer a suicidal person to local/national resources (accompanied referral, names, numbers, addresses)
- How to improve self-efficacy and enhance hope by offering a personal belief in a positive outcome
- Where possible and time permits, active behavioral rehearsal of QPR skills in role-play situations
- The take-home text QPR booklet which reviews the training and includes the following background risk and protective factor information:
  - definition of a gatekeeper and the role
  - overcoming negative emotional reactions to suicide
  - basic understanding of suicidal behavior
  - definition of suicidal behavior
  - review and listing of multiple warning signs
  - depression as a risk factor for suicide
  - alcohol as a risk factor for suicide
  - review of the progressive QPR steps/sample questions
  - brief tutorial on active listening skills
  - how to deal with resistance
  - what to do in the event the person refuses help
  - recommendations on removal of means of suicide
  - the value of hope and faith in preventing suicide

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

Part III: Summary Research Evidence

Research support for gatekeeper training

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

Early studies

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

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

These earlier, mostly unpublished papers were delivered at professional conferences and it was not until a number of research collaborations were established that more rigorous investigations have been undertaken. Because new studies on QPR are being published, please refer to the Evidence for QPR section on the Institute's web site.

In sum, more than 15 studies on QPR have been published, of which four were random clinical trials. All have show the training produces the desired effects and outcomes and that the intervention is safe and effective.

At this writing (Winter 2012), study selections were made for quality of research and variety of target populations, and were submitted to the National Registry of Evidence Based Practices and Policies.

To review all associated published studies on QPR, please visit the QPR Institute's web site and click on Evidence for QPR. There you will find the most current list of published studies. To see a review of the studies selected for expert review for inclusion in the National Registry of Evidence-based Practices and Polities, as well a list of the 18 replications, visit the NREPP site and click on: http://nrepp.samhsa.gov/ViewIntervention.aspx?id=299.

While a registered best practice and with more than 1,250,000 gatekeepers training by the end of 2011, like all other gatekeeper training programs the most important proximal outcome (fewer suicides or suicide attempts) has not been clearly demonstrated. Currently, the QPR method is being culturally adapted and tested in a number of racial and ethic groups, and additional research is underway.

Summary: QPR as a useful, life-saving intervention to prevent suicide

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

The working premise of the QPR intervention is that it produces an adequate reason for referral, e.g., suicide warning signs have been confirmed as present and valid, and thus the assessment of current suicide risk by professionals should be routine. Gatekeepers are not trained to make discriminations in levels of suicide risk.

But for QPR to become a successful public health intervention at the community level, healthcare professionals serving those communities must improve their skills in the assessment of suicidal consumers (IOM, 2002). It is one thing for a QPR citizen gatekeeper to assist a suicidal person to see a professional, but as some literature suggests, it is quite another thing for that professional to conduct a proper suicide risk assessment and carry out an evidence-based treatment and management plan (Luoma, Martin, & Pearson, 2002).

While no citizen intervention taught in a brief period of time can be expected to work with perfect fidelity and reliability, it is reasonable to assume that the QPR intervention need not be done infallibly to save lives; even a moderately competent intervention may reduce immediate risk and begin the restoration of hope.

Given the low base rate of suicide in the general community, and based upon informal surveys of potential citizen gatekeepers groups regarding how much work-place time could be devoted to learning the gatekeeper role, the median answer was approximately "one hour." Thus, the QPR program was compressed into a tight but comprehensive timeframe and accompanied by a take home booklet and reminder card for later reading and review, which has now be shown to include secondary readership by family members or significant others. Since inception of the program, 90 minutes to 2-hours are now recommended for training, which should include a role-play interactive practice session.

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

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

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

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

Given that suicide warning signs may be the most telling, observable, and undeniable symptoms that a serious undetected psychiatric disorder is present and entering its final, life-threatening phase, only trained gatekeepers *already living in the general population*

in close proximity to the suicidal person are in a position to recognize warning signs, act on them, and refer. If, in the nature of human relationships we are "our brother's keeper," then it follows that the person most likely to save us from suicide is somebody we already know.

In a survey conducted among 134 reporting Certified QPR Instructors throughout the United States, approximately two persons per 25 trained in QPR in the general adult population reported themselves to be in a relationship with a significant other, co-worker or friend exhibiting suicide warning signs or extensive risk factors for suicide. These QPR training participants sought help, advice, and referral information directly from the QPR instructor *at the time of gatekeeper training.*

In other words, participants learning to become QPR gatekeepers reported knowing someone within their family or social network exhibiting potential suicide warning signs that needed, according to the training just received, immediate exploration and possible assistance. In some cases the significant other was already in treatment with a healthcare provider; in other cases they were not, but these were anecdotal reports and no data was collected to determine percentage of significant others already receiving treatment. In this same survey, approximately one in 54 participants revealed to the group or instructor that they had lost a blood relative to suicide, and some of these were survivors in need of referral for grief counseling. This survivor figure (one in 54) is very close to the one in 64 blood relative suicide survivors reported to be in the American population (AAS 2004).

In extrapolating these rough detection rates of eight potential suicide risk cases identified per 100 citizen gatekeepers trained to the total number of gatekeepers trained by the end of 2013 (1,500,000), an estimated 120,000 potential at-risk suicide cases were detected and attended to during several thousand QPR training sessions over a 15 year period. Assuming that 50% of the cases detected were already in treatment (60,000), it could be hypothesized that QPR training program detected roughly 60,000 new, potential suicide cases *at the time the training was delivered*, or one new, undetected case per 25 persons trained. It is presumed, but not known, that additional new cases were identified by gatekeepers in the days, weeks, months and years following the training.

If we further assume that QPR-trained participants were only 50% effective in generating a successful referral of the 60,000 potentially new cases in the hours, days and weeks following training (the suicidal person was seen and evaluated by a professional) then approximately 30,000 previously undetected and untreated potential suicide cases were seen and evaluated by healthcare professionals as an early and direct outcome of QPR gatekeeper training. Additional detection, referral, assessment and treatment interventions with new cases may have occurred in the weeks and months following training, as the QPR training effect and recollection of steps to be taken has been shown to persist in adult groups for at least 18 months (Davis, 2001).

Using the World Health Organization's estimated impact of the effective treatment of those mental disorders most commonly associated with suicide, and assuming an equal

distribution of diagnostic categories in the QPR sample, and that all 30,000 cases referred received medically competent treatment, then a 20.5% percent reduction in the overall suicide rate for these newly identified cases could be expected (WHO, 2001a). In sum, an estimated 6,000 lives may have been saved through this program through the end of 2013. Additionally, if there are approximately 25 suicide attempts per completion, then another 150,000 suicide attempts (25 X 6,000) may have been averted (AAS, 2005).

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

These population penetration numbers, assumptions and extrapolations of any anticipated suicide prevention benefit for QPR training in the United States further assumes that America currently delivers competent and accessible mental health and substance abuse treatment services which are comparable to other developed nations. According to 2003 *President's 2003 New Freedom Report on Mental Health*, and as a status report on the general health and well being of the nation's service delivery system to those at elevated risk for suicide, such an assumption would be as much a leap of faith as an attestation of fact. However, the new Affordable Care Act being rolled out in America in 2013 could provide just the access to care needed to bring effective treatments to bear on this public health problem.

Finally, data are not stories about people; they are not meant to be. But typical of what happens during and after QPR training sessions, consider this summary contribution of observations made by Andrea Iger Duarte of the Connecticut Department of Mental Health and Addiction Services regarding QPR trainings conducted throughout her state under a federal grant (Duarte, 2013). To her statewide network of QPR trainers she wrote: *We don't always know the outcomes of our efforts, but the following anecdotes were sent to me by CT QPR trainers or I witnessed them.* A total of 4,200 gatekeepers had been trained at the time these stories were collected:

1) A woman shared that she is grateful to know that there are people in our communities who teach others how to listen and prevent suicide.

2) There were about 5 highly impacted adults at a series of QPR trainings for a school. Two addressed the groups when I was finished. One male staff shared on the barriers of gender and accessing help as a male, and the other female staff shared about the cultural barriers she faced growing up as an African American around this issue. It was beyond moving. The final session resulted in a young Hispanic male who hugged me after the training and thanked me.

3) Four youth who were emotionally impacted at training received help.

4) A woman stayed after the QPR training to talk to the trainer about her own depression and suicidal thoughts, and the trainer connected her with help.

5) At least 10 youth have reached out to an adult and utilized the skills of QPR.

6) One adult in the past week did an intervention for a youth who is now in treatment.

7) A woman who attended a training helped her mother the next day provide support to a coworker who's daughter was at risk of suicide.

8) The day after the QPR training, a staff member at the school intervened with a student at risk and brought them to help.

9) During training, a man spoke about his adult son who he's concerned could be suicidal. He was informed of local resources and given contact information of present support staff.

10) A woman came up after the training to talk about the needs of her young adult daughter with an extensive history of mental illness and treatment. Resources were provided to her that she had never heard of before

Stories like these are replicated every day throughout the US, New Zealand, Australia and elsewhere. We have every reason to believe - based on our collective research to date - that of the 20,000 gatekeepers trained each month in the US alone - roughly 100,000 "new conversations" about suicide and its prevention are being triggered each month, both through the training sessions themselves, as well as through follow-on conversations, referrals made, and through the sharing of the QPR learning experience and is accompanying handouts.

It is hoped that this now evidence-based "diffusion of innovation" will create sufficient new conversations about our most tabooed subject that the following new QPR Institute tag line can become a reality: *Preventing suicide... it's what people do.*.

Conclusions

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

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

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

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