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Self-harm and Suicide Prevention, Intervention & Postvention: Lessons from North America

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What was the aim of the Travel Fellowship?

The aim of this [Winston Churchill Memorial Trust](#) (WCMT) Travel Fellowship was to explore:

- i) Different approaches to preventing suicide and supporting people who self-harm.
- ii) The support provided to those bereaved by suicide or similar trauma.

Why focus on suicide, self-harm and suicide bereavement?

Suicide and self-harm are both major health and societal concerns in the UK:

- In 2011, 4,552 men and 1,493 women killed themselves in the UK, which is 18.1 and 9.6 per 100,000 population respectively.¹
- The UK has one of the highest rates of self-harm in Europe, at 400 per 100,000 population.²
- For every suicide, it is claimed that on average, six people will experience intense grief³ and may require special support to avoid long term problems.

My role at the Royal College of Psychiatrists' [Centre for Quality Improvement](#) has for many years involved working with health professionals who support self-harming and suicidal people on a daily basis. I have met many skilled and committed professionals from across the UK and I have learnt - through talking to patients, carers and professionals - what a profound effect good quality, compassionate care can have on a person in crisis. I am also aware of how challenging this work can be, particularly in the current NHS climate where scant resources are increasingly in demand. Whilst good practice clearly exists in the UK, there is a significant amount of unmet need – for example not all hospitals have access to mental health input and many of the professionals involved in helping suicidal or self-harming people say they do not feel equipped to do so effectively.⁴

Why travel to North America?

Like the UK, North America has high rates of self-harm and suicide and a long history of pioneering research and interventions in this area. After a successful application process with the WCMT, I spent one month abroad, in Toronto, New York, Chicago, Denver and San Francisco, to find out what UK services could learn from innovations taking place overseas.

Figure 1: My route, beginning in Toronto:



Key Findings

Many people who die by suicide have an underlying mental health problem that has not been diagnosed or treated.

Organisations such as the American Foundation for Suicide Prevention have developed interventions to successfully target and engage with young people who show signs of depression and suicidal behaviour. Other organisations are trying to understand the many reasons why some people do not access help - lack of provision, financial factors, poor quality information about the service, issues around stigma or a lack of confidence in services. More consideration needs to be given to why people choose not to access services and appropriate action taken to address this.

Voluntary sector organisations play a key role in helping people in crisis.

The Toronto Distress Centre (TDC) has been providing telephone support for decades and have learnt that the key factors in helping people are providing compassionate, non-judgemental care and giving callers the time to tell their story. Research suggests that some self-harming and suicidal individuals prefer to seek support from telephone helplines than be seen by mental health services, which suggests that statutory services could learn from this. For people whose needs are more interpersonal and social than psychiatric, a non-medical source of support is likely to be preferable, whether accessed by crisis lines, third sector counselling services, or the residential crisis houses/sanctuaries that are attracting increasing interest.¹¹ It should not be assumed that all self-harming and suicidal individuals require treatment using a medical model.

Another striking feature of the Toronto Distress Centre is its excellent links with local emergency, transport and health services, which helps provide speedy interventions, preventing a mental health crisis from becoming a tragedy. Steps have been taken in the UK to better link voluntary and statutory services, for example a Samaritans scheme which allows Emergency Department staff to refer patients to the Samaritans for additional supportive follow up work. Initiatives like this have great potential but take up from hospitals could be much better.

Physical and mental healthcare need to be better integrated.

Many general hospital patients have mental health problems, placing them at greater risk of depression, self-harm and suicide. In Toronto's General Hospitals, the psychiatric liaison team are integrated, working closely with physical health specialists. Unlike in the UK, psychiatric beds are situated in general hospitals rather than separate mental health hospitals and this makes the service more accessible, more 'joined up' and less stigmatising for patients. This approach differs to the UK, where not all hospitals have dedicated liaison psychiatry teams, and those that do exist are often limited in their reach due to a lack of resources, despite increasing evidence that liaison services save money.⁵

UK liaison teams are often funded and managed separately to the hospital and there still exists the unhelpful view that psychiatric problems are the domain of mental health organisations only. This dualist approach in the UK has long been criticised and although the presence of liaison psychiatry services is helping to break down the barriers between mental and physical health, there is a long way to go.

General hospital staff require greater knowledge of mental health issues.

It is important that staff such as physicians and nurses are competent in dealing with mental ill health. A US review found that educating physicians in recognising and treating depression reduced suicide rates.⁹⁰ The same review recommends that interventions designed to reduce mental health discrimination in Emergency Departments should be piloted and evaluated. In the UK, many hospital staff report that they do not feel equipped to deal with people who self-harm and attempt suicide. In some cases, this can lead to poor quality treatment, distress for patients and staff and negative staff attitudes and behaviour.⁶ This can also lead to patients self-discharging before they have received an assessment or offer of treatment.

People who self-harm or attempt suicide require a thorough psychosocial assessment.

It is critical that people who contact services are involved in a thorough discussion about any mental health and social needs they have, allowing them to talk through what has led to this point and consider what might help them cope better in the future. This assessment is a valuable opportunity to therapeutically engage the patient in potentially life-saving treatment. The assessment therefore needs to be conducted in a calm, compassionate and non-judgmental manner, demonstrating that the patient is valued, understood and is not made to feel stigmatised.

Although consideration of risk is important, clinicians should avoid trying to 'manage' suicide risk by using tick-box assessment forms that can never fully predict risk and can dehumanise the process. Instead clinicians should place greater emphasis on establishing trust and rapport with the patient, and mitigating risk by considering the patient's protective factors and helping them develop a safety plan.⁷ In general hospitals, this approach is probably best achieved by experienced professionals such as liaison mental health nurses, psychologists, psychiatrists and social workers. There is a role for physicians and trainees in conducting assessments with suicidal and self-harming individuals, but adequate training and support must be provided. Training programmes such as that in Toronto General Hospitals help ensure that staff understand the importance of conducting assessments in a collaborative manner.

Suicidal people need better support, follow up and continuity of care.

Evidence in the US suggests that rapid follow up with high risk populations after discharge from acute care services can reduce suicides. UK research also indicates that people are at heightened risk of suicide immediately after discharge from mental health or general hospitals and may benefit from being provided with clear information about follow-up plans and crisis services.⁸ In both the US and the UK, many people who have attended the Emergency Department following a suicide attempt will be discharged back to the community and may not access follow up support, so timely intervention is key to avoid further suicide attempts.¹⁰ Evidence suggests that scheduling the first outpatient appointment and making reminder phone calls are successful strategies.¹⁰ A goal of the US National Strategy for Suicide Prevention is to "increase the proportion of patients treated for self-destructive behaviour that pursue the proposed mental health follow-up plan."⁹ In Detroit, the Department of Psychiatry's 'barrier free depression service' appears to have successfully reduced suicides by focusing on rapid access to continual care.¹⁰ International initiatives to provide continuity of care- for example Norway's Chain of Care Model -have also proved effective.¹¹

Creative approaches can be successful in engaging hard to reach, at-risk groups.

Groups such as war veterans are at risk of self-harm and suicide but can be hard to engage in mental health services. Organisations such as the Coming Home Project in San Francisco support veterans to overcome 'emotional, social and moral damage' by inviting them to attend residential retreats held in areas of natural beauty. What is unusual about this approach is the great emphasis placed on involving the veterans' families – tapping into a major unmet need.

People bereaved by suicide can benefit from specialised support.

Organisations in North America have demonstrated that help from trained volunteers –many of themselves bereaved by suicide - can reduce the negative effects associated with suicide bereavement.

Cultural competency and knowledge of trauma are important in suicide prevention.

The groundbreaking International Disaster Psychology Programme at Denver University equips students with an in-depth knowledge of how to provide psychological support to people affected by disaster. Many mainstream UK services are ill-equipped to deal with the special issues faced by this high-risk patient group.

It is possible to improve mental health by bringing about social change.

Organisations such as the Adler School of Professional Psychology in Chicago seek to improve mental health by producing 'socially responsible clinicians' who learn to advocate for better services for marginalised groups. This is achieved through education, research and campaigns. Tools such as the Mental Health Impact Assessment (MHIA) enable organisations to gauge the impact a social policy will have on a community's mental health, helping to ensure that mental health is given due consideration by policy makers.

Some of the most powerful advocates for preventing suicide are members of the public.

The American Foundation for Suicide Prevention (AFSP) has helped to mobilise thousands of people to raise awareness, reduce stigma and advocate for changes in policy. This has successfully resulted in significant change to policy and practice. Small but powerful campaign groups like the Bridge Rail Foundation in California can effect change against the odds by engaging with the media and members of the public. People with lived experience of mental health problems are best placed to change attitudes to mental health and reduce stigma.

Media reporting of suicide can have a positive influence.

Many concerns have been raised about the impact of the media's portrayal of self-harm and suicide and excellent guidance now exists to help promote responsible reporting. What is less discussed is the positive impact the media can have, for example in helping campaign for physical barriers to be installed on suicide hotspots, raising suicide awareness in the general public and increasing public empathy for people with mental health problems by humanising the issue.

Suicide should not be viewed as inevitable.

Suicide is not inevitable and it is important to help suicidal people believe that help and hope exists. A significant number of suicide attempts are ambivalent and impulsive, which not only offers hope for intervention, it also confirms that reducing access to lethal means is one legitimate way to reduce suicides. The stigma around suicide can make suicide prevention a very difficult topic to broach but this should not be used to justify a lack of action.

Suicide and self-harm need to be openly discussed and stigma challenged.

Self-harm and suicide are shrouded in stigma, with misperceptions and prejudice rife in society. Healthcare professionals, third sector workers, charities, educators, policy makers, the media and ordinary citizens can all play a role in improving the public perception of people with mental health problems. Many of the organisations visited had made huge strides in this area and much can be learnt from them.

Conclusion

Suicide prevention must begin with empowering people to tackle whatever emotional, social, psychological or psychiatric problems they are experiencing. This is not the sole domain of the health profession – it is a wider social issue. Improving the quality of services and reducing access to means are important approaches, as is educating members of the public on the fact that suicide can be prevented. Every contact with a suicidal or self-harming individual offers an opportunity to intervene, ideally by opening up a meaningful, compassionate dialogue with the person, followed up by contact that demonstrates continued human interest in the individual, via a safety or care plan that provides hope for the future.

Recommendations

1. The implementation of the UK's various national suicide prevention strategies should be closely monitored and the impact of them evaluated.
2. Suicide prevention strategies and self-harm strategies should explore and strengthen the relationships between third sector and statutory sector providers.⁴
3. Leaders from health services, Royal Colleges and other professional bodies should explore options for greater partnership working with voluntary sector organisations, to learn from each other and to improve care for self-harming and suicidal patients and those bereaved by suicide.
4. Commissioners of services for suicidal and self-harming individuals should be open to alternative models, including third sector services/crisis houses which have a good evidence-base.
5. Commissioners should ensure that all general hospitals have an on-site liaison psychiatry service to assess the self-harming or suicidal patient and to agree a care plan and safety plan with the patient.
6. Liaison psychiatry services should be commissioned to provide follow up support to patients, through telephone work and out-patient appointments.¹
7. Follow up should be offered within 48 to 72 hours of discharge from hospital in order to maximise engagement and efficacy.
8. Liaison psychiatry services should be commissioned to provide training to general hospital colleagues in suicide and self-harm.
9. Those working with suicidal or self-harming individuals (including health professionals, teachers, social workers, police and professionals in the criminal justice system) should be provided with up-to-date education and training on suicide and self-harm awareness, ideally delivered by service users.
10. Those working with suicidal or self-harming individuals should be provided with training in providing a thorough, compassionate, collaborative assessment of the person's needs and risk.
11. Those working with suicidal or self-harming individuals should be offered regular support, supervision and opportunities for reflective practice.
12. Professional bodies, higher education organisations and third sector services should consider their role and impact in terms of advocating for better services and social change. If appropriate, future strategic plans should place a greater emphasis on this.
13. Interventions designed to reduce mental health discrimination in health services (such as Emergency Departments) should be piloted and evaluated.
14. Interventions designed to increase engagement with care plans for suicidal and self-harming individuals should be piloted and evaluated.

¹ The National Institute of Health and Clinical Excellence recommends that clinicians should consider offering people who self-harm 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm.

What is self-harm?

Self-harm – defined as ‘self-poisoning or self-injury, irrespective of the apparent purpose of the act’¹² - is generally an action someone takes in response to feelings of intense emotional pain or anguish. Examples of self-harm include cutting, taking an overdose, jumping from a height or burning. Self-harm is not a mental illness, but it can be the manifestation of emotional difficulties, mental ill health, social problems, or any combination of these.

What is the difference between self-harm and suicide?

Self-harm and suicide are not the same: often a person will self-harm as a way of coping with life, whereas suicide is a means to end one’s life. What self-harm and suicide do have in common is that they are often both a sign that a person is experiencing a level of emotional pain that they no longer feel able to endure. The lines between self-harm and suicide can often be blurred, for example a person who harms themselves and feels ambivalent about whether they live or die, or a person who takes their own life not because they are sure they wish to die, but because they feel unable to live. This ambivalence is important because it offers an opportunity for someone to intervene and potentially prevent a suicide.

How prevalent is self-harm?

The UK has one of the highest rates of self-harm in Europe, at 400 per 100,000 population.² About 1 in 10 young people in the UK will self-harm at some point: however, this is likely to be an underestimate because many people who self-harm do not come to the attention of health services and their self-harm remains under-reported.¹³ In a recent study of over 4000 self-harming adults in hospital, 80% had taken an overdose and around 15% had cut themselves. In the community, it is likely that cutting is a much more common way of self-harming than taking an overdose.¹³

Are certain groups more at risk of self-harm?

Research suggests that these groups may be more at risk:¹³

- Young women
- Prisoners
- Asylum seekers
- Veterans of the armed forces
- Gay, lesbian and bisexual people: this seems, at least in part, due to the stress of prejudice and discrimination
- People who have experienced physical, emotional or sexual abuse during childhood

People may be more likely to harm themselves when they feel:¹³

- That people don’t listen to them
- Hopeless
- Isolated, alone
- Out of control
- Powerless

How can people who self-harm be supported?

In England and Wales, the [National Institute for Health and Clinical Excellence](#) (NICE) recommends that people who self-harm should be offered a full assessment of their physical, psychological and social needs, by a professional who has been trained in the treatment of people who harm themselves, in an atmosphere of respect and understanding. This assessment might lead to a referral for more ongoing support. People who self-harm may benefit from being able to talk through the problems and feelings that have led to them self-harming and over time, they can be encouraged to find alternative ways to cope with their difficulties.

Support from family and friends is also important. It can be distressing for a loved one to discover that someone they care about is intentionally hurting themselves but it is important to remain calm and non-judgemental. It can be helpful to encourage the person to examine their feelings and to talk to someone about why they self-harm.¹⁴ Friends and family of people who self-harm or feel suicidal may need to seek support themselves and should not try to deal with this on their own.

How prevalent is suicide?

In England a person will die by suicide every two hours, and each year more people in the UK will die by suicide than road traffic accidents.¹⁵

Globally, one million people kill themselves each year, accounting for more deaths than murder and war combined. This means that every 40 seconds, somewhere in the world a person is taking their own life.¹⁶ Suicide is the second biggest cause of death worldwide among 15-19 year olds.¹⁷

These figures are unlikely to tell the full story for two reasons. Firstly, suicide is believed to be massively under-reported in many countries due to problems around ascertaining and recording the cause of death: it is believed that globally, suicide is underreported by between 20% and 100%.¹⁶ The stigma attached means that in many countries, probable suicide is often reported as something else, such as accidental death. Secondly, suicide attempts are up to 20 times more frequent than actual suicides, which equates to a large number of people who feel they are no longer able to face life.¹⁶

Suicide is a problem that is not going away: despite some excellent preventative work in many countries, global suicide rates have increased by 60% over the past 45 years.¹⁶⁶ The UK has had suicide prevention strategies in place for a number of years and rates had been falling over the past decade. Sadly however, the most recent UK statistics indicate an increase.¹

What causes people to feel suicidal?

Risk factors for suicide are complex and can include a combination of health and social problems, including depression, other mental or physical illnesses, alcohol or drug abuse, and adverse life events such as abuse, violence, bullying, loss, social isolation, neglect, family breakdowns, unemployment, financial problems and imprisonment. There is usually no one reason for someone to take their own life, often it is the culmination of many factors over a period of a time. Studies suggest that the majority of people who die by suicide—90% or more—had a mental disorder at the time of their deaths. Often, however, these disorders had not been recognised, diagnosed, or adequately treated.²⁰⁰

Are certain groups more at risk of suicide?

Research suggests the following groups are at higher risk:²⁰

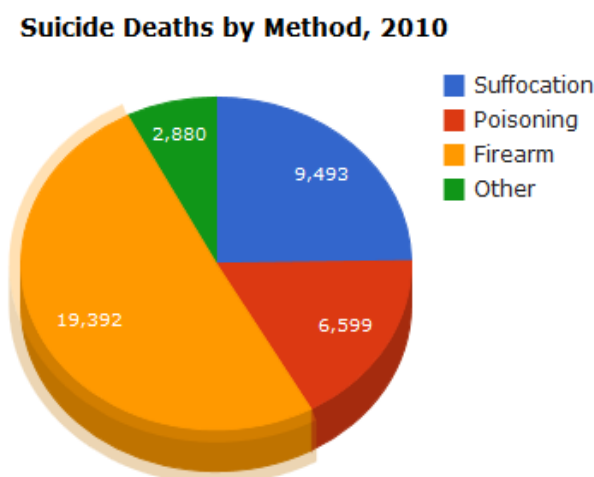
- Men are three times more likely than women to die from suicide, with the highest suicide rate in the UK being for males aged 30 to 44¹. In the US, statistics suggest that while males are four times more likely than females to die by suicide, females attempt suicide three times as often as males.²⁰ This difference is likely to be due to the fact that men tend to choose more lethal methods. Some have suggested that female suicide may be underreported due to uncertainty about the suicidal intent of methods such as overdose.
- People in the care of mental health services, including inpatients.
- People with a history of self-harm.
- People in contact with the criminal justice system.
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.
- People who have been bereaved by suicide.

What suicide methods are most commonly used?

In England and Wales in 2010, the two most common methods, accounting for 74% of all suicides were hangings and poisonings. Firearm use is rare – very few UK citizens possess a gun.¹⁸ Inhalation of domestic gas was the most common method of suicide in the UK during the mid-twentieth century. It was completely eliminated by the 1990s as a result of the replacement of coal gas containing toxic carbon monoxide by the non-poisonous natural gas.¹⁹ Later, suicide by inhalation of carbon monoxide from car exhausts became common, but has declined since the introduction of catalytic converters.

In the US, far and away the most common method of suicide death is by a firearm (50.6% in 2010), followed by suffocation (including hangings) and poisoning. Other methods include jumping from buildings.²⁰

Figure 2: Number of suicide deaths by method in the US, 2010²⁰



What can be done to prevent suicide?

Each country of the UK has in place its own suicide prevention strategy. The strategy for England¹⁵ cites six main aims:

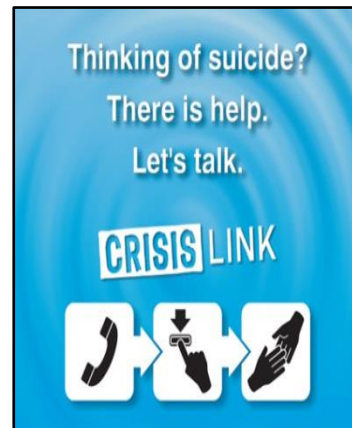
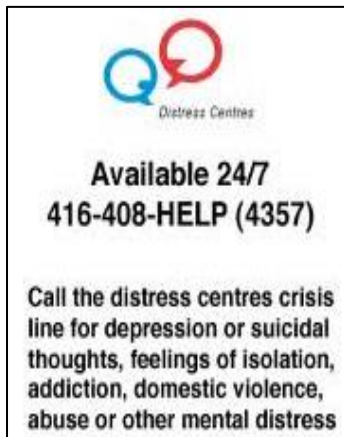
1. Reduce the risk of suicide in key high-risk groups.
2. Tailor approaches to improve mental health in specific groups.
3. Reduce access to the means of suicide.
4. Provide better information and support to those bereaved or affected by suicide.
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
6. Support research, data collection and monitoring.

Why is it important to provide support to those bereaved by suicide?

Suicide bereavement is acknowledged to be a particularly difficult type of grief to cope with, often giving rise to a complex combination of emotions such as guilt, blame, rejection and shame.²³ Those bereaved by suicide are themselves at risk of suicide and it is argued that their needs may require close attention.

The remainder of this report summarises several examples of innovative practice in North America, each linked to at least one of the aims in the above list.

The Toronto Distress Centre (TDC)



"There is no agony like bearing an untold story inside you."
-Maya Angelou

Background

Back in 1967, when attempting suicide was still illegal, a group of concerned community leaders formed the Toronto Distress Centre (TDC), providing Canada's first helpline for people in emotional crisis. Since then, the centre has gone from strength to strength, in recent years largely under the stewardship of its Executive Director Karen Letofsky. I met with Karen at the TDC site in central Toronto to find out more.

Mission - To create an emotional safety net for the vulnerable and at risk in our community.
Vision - To ensure that every individual in need receives life sustaining emotional support.
Motto - There's a life on the line.

Services provided by the distress centre:

The Distress Line

For 24 hours a day, 7 days a week, 600 trained volunteers, with the support of professional staff, respond to callers with a wide range of emotional needs, including those who are socially isolated, victims of abuse, depressed, or at risk of self-harm or suicide. The service is staffed mostly by volunteers, who are pre-screened in a phone interview, then invited to meet face-to-face with a trainer to assess their suitability before being admitted to the training. During 40 hours of training, including lots of role play, anyone who misses suicidal cues, appears judgmental or unempathetic is not accepted as a volunteer: only one in three make the grade. The volunteer's primary aim is to mitigate the impact of a mental health crisis by listening to callers, helping them work through their emotions, and assist them to identify the various options available to them. Staff from the distress line can also provide high-risk crisis follow-up by telephone when requested.

Unlike the Samaritans helpline in the UK, the TDC will call emergency services if they think this is needed. Karen Letofsky explained - "We assume, based on the fact that the suicidal person has called us, that there is a certain amount of ambiguity...and we do have the option of involving emergency services."

Indeed, the centres provide a dedicated support line for suicidal patients who have requested an ambulance, which means that emotional support can be provided whilst the person waits for the ambulance to arrive, helping to ensure the person waits for help and looks after themselves as well as possible before medical help arrives.

The distress line has become a huge success - since the agency's first call 46 years ago, the lines have been answered continuously 24 hours a day, 7 days a week, without a single missed shift.

Reducing suicide on the subways

Since 1954, when the subway line in Toronto first opened, there have been more than 1,200 incidents on the transport system, including fatalities and near misses.¹ Staff are now trained to identify and respond to people who might be contemplating suicide, by looking out for signs such as people who pace or wait near tunnel entrances; people who hang around without boarding trains; individuals in obvious distress; people behaving erratically such as people removing clothing or shoes or seen dressed in a hospital gown or nightwear. If staff have concerns they can arrange for trains to be slowed down or for trained staff to talk the passenger, asking them a direct question about if they are planning suicide.

In June 2011, a Crisis Link system was installed – a direct speed dial line to connect distressed callers to the trained volunteers at the TDC, 24 hours a day. Over 200 posters are placed in high risk areas to advertise the network of 141 phones. The Crisis Link was the first programme of its kind in the world and has resulted in several trains being slowed down and stopped. More than 320 calls were made in the programme's first year, of which around 120 required help. Since the programme has been introduced, the Distress Centre has received a general increase in the number of calls, not just from subway stations, suggesting raised awareness of the distress centre's helpline and an uptake in its service.

Key factors in the success of the helplines

Evidence suggests that helplines can help reduce suicidal intent, and this effect has been demonstrated immediately after the call and several weeks later, measured by levels of hopelessness and psychological pain reported by the caller.²¹ Helplines appear to tap into many important features of suicidal feelings:

1. Suicidal ideation often arises during a crisis – many helplines operate 24/7 and are immediately available, even when other services are not.
2. Helplines are staffed by people trained in providing crisis support.
3. Many suicidal people are ambivalent about death and crisis line staff have an opportunity to intervene, support the person and help them plan coping strategies.
4. Callers may be reticent to make contact with professional services. It has been suggested that callers who repeatedly call crisis lines may be relying on this rather than seeking mental health services; in one study callers were offered referrals to other services but generally did not follow this up.²¹¹ Lack of uptake may be related to stigma, lack of insurance cover, lack of access to out of hours health services or uncertainty about the value of services.
5. Individuals in distress often need an opportunity to express their emotional pain and have their experience witnessed and validated. For many people, approaching statutory services is not a viable option, nor is seeking support from their social network, if one even exists. Often, the most helpful thing for a person is to have someone willing to listen to their story without judgment, so that, in the telling, they can gain their own perspective.

Supporting those bereaved by suicide: 'a death like no other'.

"The question that incessantly arises is: Why? Could we, could I, have prevented it from happening? That question goes on and on, but there are other questions: How do we go on? How do we live beyond the death which looms so large in our lives?"

- A person bereaved by suicide

Suicide has been described as 'a death like no other'.²² For every suicide, it is claimed that on average, six people will experience intense grief²³ and some suicidologists believe this to be a very conservative estimate. Although the grief experienced following suicide is not necessarily more severe than in other types of death, certain features of grief can be more prominent following suicide, making it particularly difficult to cope with the loss.²⁴ These features include blame and guilt, shame and stigmatisation and a sense of rejection and abandonment.²⁵ Those bereaved by suicide (often called survivors of suicide) may benefit from particular support to help them deal with these features of their grief:

Blame and guilt

People bereaved by suicide often blame themselves for contributing to, or not preventing the death and may ruminate and agonise over what they could have done differently to help. Compared to other types of death, suicide survivors may view the death as more preventable, and over-estimate their own responsibility for the death. Linked to this is often the desperate need to understand why the person took their own life: making sense of a person's death can be an important part of the grieving process but is something which suicide survivors commonly struggle with. Anger is another common grief reaction but one which can cause survivors further guilt, because they also recognise that their loved one was suffering greatly when deciding to die.²⁶ For some survivors, there might be an element of relief that the suffering of their loved one, and to some extent perhaps their own suffering, is now over, but this can also cause guilt. In some cases the bereaved person may be blamed by others for the death, which can be a heavy load to bear. Some may try to punish themselves in various ways.

Shame and stigmatisation

Aside from self-blame, there may be additional difficulties related to the reaction in the community to a suicide. Where the reaction is negative – or at least perceived to be – additional shame, embarrassment or awkwardness can be felt, making survivors less likely to seek and receive social support. Acquaintances and friends of the bereaved may be reticent to discuss the 'elephant in the room':

"People never said anything really bad to me. It was not what they said; it was what they didn't say. Some people who I thought would offer solace remained quiet. And most people just said nothing [after my son's death] and seemed to try to avoid any discussion. It was as if my son never existed".

- A person bereaved by suicide.

Cited by Fiegelman and Fiegelman²⁷

Stigma and silence can pervade other potential sources of support too: bereaved people who might ordinarily seek solace from religious groups may find that option closed to them if their religion views suicide in a shameful way, or handles funerals in an atypical manner. Even when taking care of post-death financial matters such as insurance claims, survivors may face stigma in the shape of policies and clauses, or the response of the people dealing with their case. Wherever and however it is felt, stigma is likely to reduce the survivor's inclination to talk about their loss, resulting in increased social isolation²⁸ and a lack of support, all of which is likely to further compound their misery.

Sense of rejection and abandonment

Survivors may feel rejected and abandoned, wondering why their relationship with the person was not enough to keep them alive²⁹ and questioning whether the deceased really cared about them. This can be particularly painful when an adult partner has died. For children who lose a parent to suicide, this sense of abandonment can be profound because they have lost someone they normally rely on to take care of their most basic needs³⁰ and may feel lost without them. Some people bereaved by suicide have described it as the ultimate form of rejection. These feelings are likely to decrease a survivor's sense of self-worth and increase their vulnerability at an already difficult time. One author describes parental suicide as "the violent and immediate severing of the parent-child relationship, [where] family communication in its aftermath may be severely disrupted. The censoring of grief, ambiguity of stories told to the bereaved, avoidance of details and suppressing of grief are common threads. Consequently, the grief process may be delayed. The search for the why and how of the suicide, the memorialising, and the finding of a connection with the dead parent may take place many years later".³¹

What are the risks for people bereaved by suicide?

Survivors of suicide loss are at higher risk of developing complex grief,³² which is categorised as prolonged, distressful grief featuring yearning, longing and pain that does not abate with time and interferes with the person's functioning. Complicated grief is associated with poor mental and physical health, impaired occupational and social functioning and a greater risk of depression. Those bereaved by suicide are at a higher risk than the general population of subsequently taking their own lives.³³ Key additional factors likely to influence bereavement include the age of the deceased, the quality of the relationship, any conflict between the deceased and the bereaved, the attitude of the bereaved to the loss, and cultural beliefs.³⁴

The TDC's Survivor Support Programme (SSP) is another pioneering TDC initiative, developed in 1979 in response to the issues described above, and to help fill gaps left by a lack of community services. The SSP provides face-to-face counselling for individuals bereaved by a trauma-based grief event, specifically suicide and/or homicide. The aim is to enhance emotional self-management and reduce risk by strengthening the coping skills of survivors.

How the SSP works

People can be signposted to the programme by other services, or they can self-refer. An initial information-sharing session will be arranged, following which individuals or families are introduced to a team of two volunteer counsellors, both of whom are trained counsellors and one of whom is often a survivor of suicide, but never someone who is actively grieving.

The bereaved person or family is offered eight weekly individualised sessions with the pair of volunteers. The meetings last for one-to-two hours, each session focussing on a topic specific to bereavement by suicide, allowing the bereaved to discuss their current situation in a semi-structured, safe place in which they can identify, explore and clarify their thoughts and feelings. By helping individuals define their situations and acknowledge their emotions, the process leads them to consider what 'normal' grieving is under these circumstances, the meaning of the suicide, and a sense of how they can manage.

Once the individualised sessions are completed, survivors are invited to a series of group meetings. These provide people with the opportunity to share and compare their stories and reactions with those of other survivors. Participation in the programme is free. In 2011, the programme served 1,030 individuals from the area and an evaluation found that 90% of survivors completed the full programme and reported benefits from this. Whilst there are not many evaluations of this type of intervention, current evidence suggests positive benefits from suicide survivor support groups.^{24,35}

Karen Letofsky explained that many of the people who refer themselves to the SSP are those who have longstanding unresolved issues around their loss, including people whose bereavement goes back decades, but who have never felt able to talk about their grief due to unbearable pain or stigma. Often people have reached breaking point due to a current crisis or emotional difficulty, for which their feelings about the suicide bereavement resurface and become more intense. Many people who lost someone close to suicide describe it as the most difficult crisis they have ever faced, and for which they need to find inner resources to manage effectively.

Key factors in the success of TDC's survivor support programme

1. Focusing on suicide rather than generic bereavement is important, because some suicide survivors attending generalised bereavement groups have reported feeling different from other grievors and tend to drop out of these groups.³⁶
2. The opportunity to tell one's full-story in an accepting atmosphere is key; the individual and group work encourages members to be open and honest. Members are encouraged to help each other and enhance their own self-esteem in the process. The groups also provide survivors with successful role models.³⁷
3. The programme provides an alternative to professional support, which is important because some survivors find it difficult to accept help from other services, especially where there is anger around perceived failings of the mental health profession towards their loved one.²⁷
4. The opportunity to have individualised meetings is an excellent resource because it provides the bereaved with undivided attention and also primes them for joining the wider group. Almost all choose to complete the full programme, indicating a very high level of engagement.

When asked what she thought the single most important factor was in helping people bereaved by suicide come to terms with their loss, Karen Letofsky explained:

"Allowing people the time, space and guided support to create their story. Many of the people we help are so stuck in their grief, unable to talk about it. We help them create their story – people cannot grieve what they don't know."

In addition to the care provided to those in crisis and the bereaved, the TDC also provides essential services via community support, outreach work, responding to immediate crises by supporting communities and a large amount of teaching and education.

Conclusion

The TDC is a ground-breaking organisation with a proud and pioneering history. The core principles of the TDC centre on providing a compassionate, non-judgmental and accessible service to individuals in emotional need. The TDC also puts great effort into educating and enlightening the wider community, supporting them to better understand the needs of people in crisis and providing support to the bereaved. The secrets of the TDC's overall success appear to be i) a dedicated, well selected, well trained and highly supported army of volunteers, ii) a clear vision, which has resulted in the dynamic and impressive development of the service and iii) the strong leadership of Karen Letofsky, an inspiring individual who has been working in crisis intervention and the study of bereavement for over 35 years. Karen works tirelessly and has clearly had a huge impact on the service, yet is humble about her achievements and described herself to me as "the luckiest person in the world to be doing this job". Ongoing challenges for the TDC are likely to be continuing to secure funding in difficult financial times, whilst meeting the needs of an increasing number of clients. The TDC provides an essential service and it is hoped that the organisation will continue to go from strength to strength.

Mental health care at Toronto General Hospital



**Health is a state of complete physical, mental and social well-being.
- World Health Organisation, 1948.**

Background

According to the Public Health Agency of Canada:³⁸

- 20% of Canadians will experience a mental illness during their lifetime.
- 86% of hospitalisations for mental illness in Canada occur in general hospitals.
- Between 3-5% of all admissions in general hospitals (1.5 million hospital days) are due to anxiety disorders, bipolar disorder, schizophrenia, major depression, personality disorder, eating disorder and suicidal behaviour.

The [Toronto General Hospital](#) (TGH) is a major teaching hospital in central Toronto, and part of the [University Health Network \(UHN\)](#). The TGH has numerous medical and surgical specialties including heart disease, transplantation, eating disorders and psychiatry. The TGH's Emergency Department (ED) treats more than 30,000 patients each year. I visited the TGH to find out about the mental health care provided to general hospital patients and arranged to meet with Dr Susan Abbey and colleagues. Dr Abbey specialises in consultation liaison psychiatry—a branch of psychiatry concentrated on the interface of mind and body—with a particular focus on depression, quality of life and stress management with the medically ill and transplant patients. A former President of the Canadian Psychiatric Association, Susan is currently Head of Medical and Surgical Psychiatry at the UHN and has been described as a leader who thrives on 'advocating for patients, reducing stigma around mental health, protesting against social injustice and contributing to Canadian education and research in psychological medicine'.

What care is provided to people in a mental health crisis?

Triage, assessment and care by the Emergency Department (ED) staff

If a person attends the ED in a mental health crisis, they will be triaged and assessed by ED staff. If the patient has attempted suicide or expresses an intent to kill themselves, this should be flagged up and the patient seen quickly. The ED physician/house staff doctor will examine the patient, often with a nurse, to check for any medical or substance misuse symptoms. If physical health care is needed - for example treatment for an overdose - this will take place as soon as possible and the person's mental health needs will be discussed. Crisis workers who work across ED and psychiatric clinics may be involved in assessing the patient.

If the person is considered able to manage their mental health problems in the community, they will be discharged back to community services or their family doctor (GP) as soon as they have been medically cleared.

Referral to the Urgent Care Clinic

For people who may not be in need of immediate hospitalisation but who require more than discharge to the community, a referral can be made to the hospital's [Urgent Care Clinic \(UCC\)](#), a Monday-Friday clinic staffed by psychiatrists and mental health clinicians who specialise in crisis management. This option is particularly helpful for patients who are unable to wait weeks to be seen by other community services and require interim support. Referrals come through the UHN Emergency Departments and occasionally family doctors and other specialists. A person admitted here might be seen just once, or they may be offered follow up sessions (typically 6-10 visits) and provided with talking treatments such as Cognitive Behavioural Therapy (CBT) or Dialectical Behavioural Therapy (DBT) to help them with their mental health difficulties.

Inpatient psychiatric admission

If the person is deemed to be of high risk, they might be admitted to the [psychiatric emergency services unit \(PESU\)](#) at the [Toronto Western Hospital](#). The PESU is a 24/7 holding unit allowing people requiring urgent care to be assessed and treated before a decision is made about whether to admit them to the inpatient mental health unit at Toronto General (described below) or to discharge them to the community. The staff team at the PESU consists of psychiatrists and residents, psychiatric nurses, crisis clinicians and social workers. In 2012, the PESU saw 1500 patients of all ages.

The [inpatient mental health unit](#) at the Toronto General admits patients who require a longer stay – many of whom will already have been assessed at the PESU before arriving. There are 16 beds for people needing general psychiatric care, including 6 beds in a secure area for those who need close supervision. Once admitted, the patient is further stabilised and assessed, provided with brief interventions and an individualised care plan and discharge date. Average length of stay here is 1-3 weeks.

Mental health care services provided in the general hospital

Aside from emergency psychiatric beds, other services are provided at the hospital:

Specialist inpatient beds

- Beds for people with anorexia nervosa who require admission to an inpatient group therapy programme. The programme involves a 2-3 week inpatient stay, followed by day care attendance and finally follow up support.
- Geriatric psychiatric beds, for older adults with anxiety, depression, self-harm, memory loss, dementia and schizophrenia.

Specialist programmes of care

The UHN also provides the following services, all of which help to address mental health problems, including inpatients who feel suicidal or have self-harmed:

[The Neuropsychiatry programme](#), which treats people with problems related to thinking or mood that are a result of brain injury or neurological dysfunction.

[The Psychosocial Oncology and Palliative Care \(POPC\) programme](#) helps patients and their families deal with the emotional fallout of a cancer diagnosis by supporting their emotional well-being and helping them cope with the stresses of the condition.

[The Women's Mental Health programme](#) provides expert assessment and treatment of mental health problems associated with all aspects of the reproductive cycle as well as assessment and

treatment to women who have been victims of sexual abuse, sexual assault, domestic abuse, stalking, sexual harassment and abuse by authority figures.

[The Asian Initiative in Mental Health \(AIM\) programme](#) which offers mental health services to Chinese, Korean, Vietnamese and Cambodian communities.

[The medical and surgical mental health psychiatry programme](#) provides psychiatric and psychosocial care to patients whose physical illness is seriously impinging on their mental health.

[The mindfulness-based stress reduction clinic](#) that concentrates on teaching stress-reducing strategies to people with mental and physical health problems.

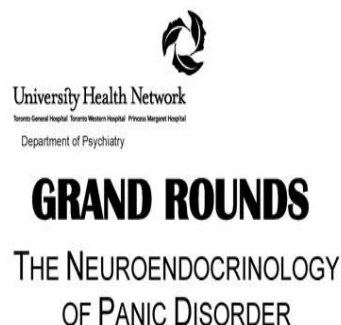
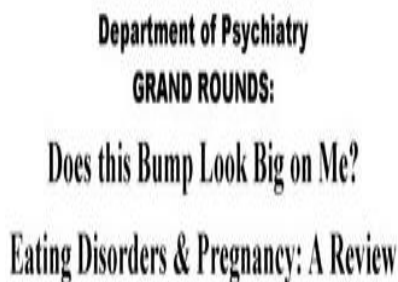
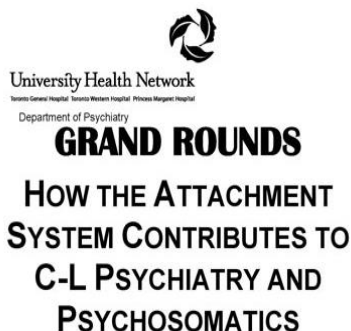
Susan Abbey and Sarah Greenwood explained how their mindfulness clinics work:

“The first part of the clinic involves clients going through ‘stress production’, focusing on how they normally respond to stressful situations, and getting them to think about the impact this has on them physically and mentally. They learn healthier ways to respond to stress and spend time each day trying out these techniques. People use formal practices such as structured breathing, concentrated meditation, paying attention to body parts and movements. ‘Informal’ practices are also important, these help people learn to be more ‘in the moment’, for example a person in the shower that morning – were they really ‘present’, or was their mind on an argument that happened yesterday?”

Psychiatric expertise at University Health Network

The UHN provides the largest psychiatry residency programme in North America, training psychiatrists in eight different sub-specialities. All trainee psychiatrists spend time in consultation liaison psychiatry, providing mental health care to patients in cardiovascular, oncology, transplantation, and neuroscience departments. Work focuses on psychiatric aspects of an illness along the disease trajectory (diagnosis, treatment, rehabilitation, survivorship and palliation). Trainees learn skills in assessment, formulation, development, coping, attachment and trauma. Trainees are also provided with training in delivering talking therapies including psychodynamic psychotherapy, interpersonal psychotherapy (IPT), couples therapy, CBT, DBT, family therapy, group work and mindfulness-based therapy. Dr Abbey is a teacher of medical students and residents and has won several awards recognising her excellence as an educator:

“Educating is an opportunity to get people to look at how they can be advocates for patients and how they can foster resilience in patients.”



Key factors in the success of mental health care provided by Toronto's University Health Network

1. In Toronto, and in Canada generally, inpatient psychiatric beds tend to be based in general hospitals rather than specialist psychiatric facilities, allowing a more joined up approach, encouraging joint learning and reducing stigma for patients.
2. The different options on offer for people with a mental health crisis are important; the Urgent Care Clinic appears to be particularly helpful in providing people with short term crisis support, or providing a bridging service while the individual waits for more substantial care to be provided.
3. The range of specialist services available for different patient groups is key – including eating disorder services, psycho-oncology care, and mindfulness-based stress reduction clinics for people with physical and mental health problems.
4. The hospital network prides itself on being innovative and creative, responding to patient needs, constantly evaluating its own performance and having a clear strategy.

Conclusion

The approach to mental and physical health care in Toronto appears to be less dualistic than in the UK. Having the majority of psychiatric beds in the general hospital is likely to aid joint working between physical and mental health practitioners and increase the expertise of both. Being treated in a general hospital is also likely to be more acceptable and less stigmatising for many patients.

The range of specialist services on offer for different patient groups is impressive, indicating a forward-thinking and innovative approach to meeting individual needs, and taking into account age, ethnicity, gender and a broad range of physical and mental health conditions. Toronto, like London and other large UK cities, has a richly diverse population and the care provided in Toronto is increasingly being designed to take different cultural factors into account.

When the system works well, Toronto patients have access to rapid and appropriate mental health assessment and care. This access is critical, because Canadian citizens can face long waits when trying to access family doctors and community services³⁹. National concerns have also been raised about overcrowding in Canadian Emergency Rooms³⁹, which does impact on people with psychiatric needs. The psychiatric leaders at UHN, like colleagues in the UK, have to fight hard for mental health to feature on the national health agenda. Nonetheless, Toronto's UHN approach to mental health care appears to be one which others could learn from. The clinicians I met in Toronto General were exceptionally enthusiastic, warm, open to new ideas and already actively sharing information with international colleagues, with a view to continually improving the quality of mental health care they provide in Toronto's hospitals.



“At the heart of suicide prevention is the need to create a life worth living” – Susan Beaton

Background

According to the [Centres for Disease Control and Prevention](#) there were 38,364 suicide deaths in the US) in 2010, which means that every 13.7 minutes someone dies by suicide. This is the highest rate of US suicide for 15 years, making suicide the 10th leading cause of death in the country and now the second leading cause of death in people aged 15-24.

The [American Foundation for Suicide Prevention \(AFSP\)](#) is the leading US not-for-profit organisation, exclusively dedicated to understanding and preventing suicide through research, education and advocacy, suicide prevention activities and support for people bereaved by suicide. I met with Kristen Smith, a suicide prevention specialist and Manager of the AFSP Survivor Initiatives, who explained more about some key strands of work:

Research into suicide prevention

Some recent highlights of AFSP-funded research include:

Area of research	Key findings
Alcohol and suicide risk ⁴⁰	Drinking alcohol was associated with a 6-fold increase in the risk for a suicide attempt and heavy drinking (4 or more drinks for females and 5 or more for males) was associated with a 16-fold increase in risk for an attempt.
Immunity, infection and suicide ⁴¹	Findings suggest an association between immune response and suicide and more research is being commissioned to explore this.
Suicide risk for veterans ⁴²	Veterans were at a much higher risk for suicide compared to nonveterans, especially women, who had nearly triple the rate of suicide relative to non-military women. Veterans who killed themselves with firearms were more likely to have had a recent stressful life event than those who used other means. Those who died by other means were more likely to have a diagnosis of mental illness and a previous suicide attempt. Many younger male veterans who died by suicide had very high levels of alcohol in their bloodstream at the time of death.
Decision making in suicidal adolescents ⁴³	Adolescents who attempted suicide were less likely to learn how to maximise decision-making skills in a task. Inflexible decision making may play a role in increasing risk for suicidal attempts.
Bullying and suicide ⁴⁴	Bullying is associated with suicide but only amongst students who were already at risk for suicidal behaviour.
Hospital staff attitude to means reduction ⁴⁵	Less than half of 631 Emergency Department staff advise suicidal patients on how to reduce access to suicide means (e.g. locking guns), and fewer than half considered suicide to be preventable.

Suicide prevention activities

The AFSP runs many initiatives, some of the most promising of which are described below:

The AFSP's Interactive Screening Programme (ISP)

This is an anonymous, web-based method of outreach that starts with a brief online stress and depression questionnaire. Students are invited to participate in the screening via an email invitation from the counselling centre director or another college/university official. All students who submit the questionnaire receive a personalised written response from a campus mental health counsellor through the website. At-risk students are urged to meet with the counsellor in person for further evaluation and discussion of treatment options. All students are offered the option of exchanging online messages with the counsellor without identifying themselves. An example of how this works can be seen by entering 'AFSP ISP' on [Youtube.com](https://www.youtube.com) or clicking [here](#).

This award winning programme is now being used at over 50 Colleges. Data suggest that:

- 85% of students who completed the online questionnaire had serious depression or other suicide risk factors and 90% of these were not receiving treatment.
- Students who exchanged online messages with the counsellor were three times more likely than those who did not to attend an in-person meeting, and three times more likely to enter treatment.
- 75% of students who entered treatment were described by counsellors as not likely to have sought mental health services without the programme.

The success of the ISP has led to further developments: it is now being used by the US Veteran's Association and the National Suicide Prevention Lifeline to facilitate effective use of the Veterans Crisis Line and online chat service. Similar programmes are provided for the National Football League, police officers in the Boston area and also the manufacturing industry.

Support for suicidal teenagers

The AFSP's 'More Than Sad' training programme is educating high school students about depression and teachers about the problem of youth suicide. Listed in the Best Practices Registry for Suicide Prevention, the programme consists of two 25-minute films that include internet and collateral materials. The film for teens contains an anti-bullying and de-stigmatising message, and is designed to be used in health classes. Over 12,500 films have been distributed, and some governments have implemented it in every high school in the state.

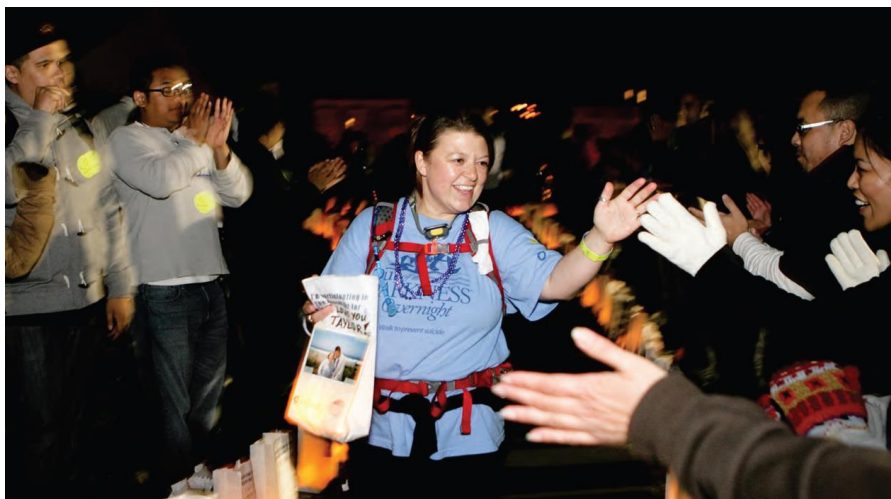
AFSP's teen suicide prevention campaign 'Suicide Shouldn't Be a Secret' consists of radio and television public service announcements, aired nationwide to an estimated 100 million people. The film 'The Truth about Suicide: Real Stories of Depression in College' is also promoted at colleges, universities and at national conferences.

Preventing suicide by working with the media

Research has shown that certain types of reporting can unintentionally contribute to copycat suicides. The AFSP advises journalists i) to avoid sensationalising the suicide or presenting graphic details, ii) to not include photos of the location or method of death, grieving family, friends or funerals, iii) to report on suicide as a public health issue, iv) to include a list of 'warning signs for suicide' and v) to avoid reporting that death by suicide was preceded by a single event, such as a recent job loss, divorce or bad grades. Reporting like this leaves the public with an overly simplistic and misleading understanding of suicide. See www.afsp.org for more details.

Raising awareness in the general public

AFSP branches (known as 'chapters') educate the general public about depression and suicide by organising events, distributing information and raising awareness via radio and television work. National Suicide Prevention Week involves nationwide activity. The 'Out of the Darkness' community walks involve over 100,000 participants a year taking part in walks to raise awareness and funds. Many participants walk because they or someone they know has been at risk of suicide or has died from suicide. The walks are organised by dedicated local volunteers.



Support for suicidal health professionals

Studies in the last 40 years have confirmed that US physicians die by suicide more frequently than others of their gender and age in both the general population and other professional occupations.²⁰ AFSP led in organising working groups of experts to develop recommendations in eight key areas: medical student and resident education, medical student and resident health, hospital policies toward physicians with depression and other mental disorders, policies related to licensing of physicians, policies related to physician malpractice and disability insurance, and research on physician depression and suicide. The AFSP helped develop educational films for physicians and medical students, as well as the website DoctorsWithDepression.org.

Figure 3: Profile of a Physician at High Risk of Suicide

Sex: Male or female

Age: 45 years or older (female); 50 years or older (male)

Race: White

Marital status: Divorced, separated, single or currently having marital disruption

Risk factors: Depression, alcohol or other drug abuse, workaholic, excessive risk taking

Medical status: Psychiatric symptoms or history (especially depression, anxiety), physical symptoms (chronic pain, chronic debilitating illness)

Professional factors: Change in status – threats to status, autonomy, security, financial stability, recent losses, increased work demands

Access to means: Access to legal medications, access to firearms.

Adapted from Silverman et al, (2000)⁴⁶

The AFSP has also been instrumental in the creation of a [best practices registry](#) of evidence based suicide prevention techniques.

Suicide prevention for lesbian, gay, bisexual and transgender (LGBT) individuals

The AFSP has helped to ensure that LGBT-related material features into the 2012 revision of the National Strategy for Suicide Prevention. The AFSP has begun to address the lack of sexual orientation and gender identity information among persons who die by suicide. A panel of experts assembled by the AFSP produced a report⁴⁷ detailing key suicide risk factors in LGBT people, some of which is highlighted below:

Key finding	Recommendation
Discriminatory laws and public policies have a profound negative impact on the mental health of gay adults.	Changes in all federal and state laws and regulations that create inequities based on sexual orientation or gender identity.
Although research points to elevated rates of depression, anxiety and substance abuse among LGBT people, the review found that these problems, by themselves, do not account for the higher rates of suicide attempts by LGBT people. Thus, the report identified stigma and discrimination as playing a key role, especially rejection or abuse by family members or peers, bullying and harassment, denunciation from religious communities and individual discrimination.	Advocate for anti-bullying legislation which includes sexual orientation and gender identity in protective legislation.
Significant numbers of LGBT people suffer from mood, anxiety and substance-use disorders. Evidence shows that targeted or modified mental health interventions for LGBT individuals may increase treatment acceptability, retention, and effectiveness.	Efforts should be made to encourage early identification of depression, anxiety, substance abuse and other mental disorders, and push for the development and testing of a wider range of culturally-appropriate mental health treatments and suicide prevention initiatives.
Health professionals and volunteers lack knowledge in suicide risks for LGBT people.	Professional bodies should provide comprehensive, empirically based education about LGBT mental health needs and suicide risk. Organisations should encourage training in LGBT suicide risk for staff and volunteers of suicide crisis lines, law enforcement, emergency care professionals, and others who work with suicidal individuals.
Suicide prevention strategies do not adequately address the risks associated with LGBT people.	Suicide prevention strategies should include LGBT suicide risk and possible interventions. Well-designed outcome evaluations should be incorporated into all suicide interventions aimed at LGBT people.
Not enough is known about the problems and needs of suicidal people with LGBT, partly because of a lack of research generally and also because the sexuality of people who die by suicide or attempt suicide is not always known.	More research is required to understand which aspects of sexual orientation and gender identity are most strongly related to suicide attempts. Measures of sexual orientation, gender identity and partnership status should be included in mental health research and certain population surveys, with appropriate safeguards for privacy and confidentiality.

The AFSP assembled the group of experts who wrote the report cited above and has also taken a lead in supporting many of the recommendations, including the creation of LGBT mental health educational resources and training tools. The AFSP has also been vocal about [anti-gay bullying](#) and its detrimental effects on the mental health of young people.

Advocating for change

- In 2012, the AFSP helped ensure mandatory suicide prevention training for school staff and mental health professionals in numerous states.
- The AFSP joined forces with others to highlight the need for full implementation of health insurance parity for people with mental illness.
- Advocates from 34 states made nearly 300 visits to government offices as part of an AFSP campaign, to share personal stories and educate congress about suicide prevention.
- Over 500 advocates helped educate public officials and their staff about policies affecting suicide prevention, put a "real face" on the battle to reduce stigma, and encouraged advocacy participation by others in their communities.
- The AFSP worked with Congress to secure \$40 million to support suicide prevention efforts for active-duty soldiers, reservists and veterans. AFSP also provided testimony before the Senate that would free up another \$8 million in funds for suicide prevention efforts within the Department of Defense.
- AFSP participates in the annual Federal Partners in Bullying Prevention Summit, hosted by the US Department of Education. The AFSP emphasised the need to ensure that vulnerable individuals receive safe and accurate messages about the complex relationship between bullying and suicide.

Supporting people bereaved by suicide

The needs of people who have lost a loved one to suicide (often referred to in the US as 'survivors') are already documented on pages 15-17 of this report. The AFSP provides the following support;

Information and support

[The Resource and Healing Guide](#) helps survivors navigate the experience of losing a loved one to suicide. It includes practical information about coping with suicide loss, personal stories, articles on bereavement, resource listings and an extensive bibliography. The AFSP also directs people to a directory of online and face-to-face support groups, and provides a very helpful guide to dealing with the [financial implications of a suicide](#).

Survivor support groups

The ASFP provides training and guidance to bereaved people who wish to set up and facilitate a support group. A hands-on training programme helps survivors of suicide loss and interested others learn the "how-to's" of creating and facilitating a suicide bereavement support group for adults, using lectures, interactive discussion and role-playing with feedback. A self-study package has also been created: 'Facilitating Suicide Bereavement Support Groups'.

AFSP Survivor e-Network

Over 50,000 survivors are involved in the e-Network, accessing resources and mobilising support for local research and education. The e-Network empowers those who wish to become advocates for suicide prevention.

Survivor Outreach Programme

Trained volunteers from AFSP chapters are available upon request to visit with newly-bereaved survivors to listen, support them and provide information about resources for healing. The programme is currently available in 34 chapters nationwide, with over 300 volunteers.

International survivors of suicide day

Every year, tens of thousands of survivors join together for support and information. In 2012, over 300 conferences in 20 different countries took place, including in Australia, Germany, Hong Kong and Guatemala. The programme, featuring a panel of experienced survivors and mental health professionals, was shown at local conferences and webcast in English, Spanish and French. An online discussion forum was made available afterwards.

After a Suicide: A Toolkit for Schools

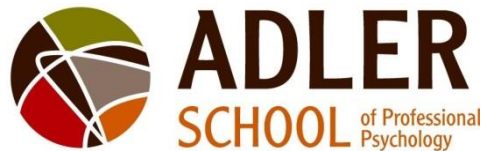
This online resource is for schools facing real-time crises. Specific areas addressed include crisis response, helping students cope, working with the community, memorialisation, social media and suicide contagion. It is currently available for download on the AFSP website.

Key factors in the success of the AFSP:

- The AFSP tackles the issue of suicide from all angles – research, education, campaigning, advocacy and support for survivors. This is an effective and powerful approach which allows the AFSP to be a 'one-stop shop' for all with an interest in suicide prevention.
- The work of the AFSP is organised and effective, resulting in a significant outreach across the country.
- The AFSP staff and volunteers are dynamic, forward thinking and dedicated and accomplish a huge amount for a relatively small staff team.

Conclusion

The AFSP plays a leading role in raising awareness of suicide prevention and supporting people bereaved by suicide. The network of AFSP chapters are well organised and enable the organisation to make an impact in every US state, which is an immense achievement. The mobilisation of volunteers is particularly impressive: the AFSP has helped thousands of individuals across the country to stand up and raise awareness locally, lobby politicians or support people affected by suicide. These advocates appear to be the driving force behind the nation's growing awareness that suicide is a preventable public health problem.



“Never doubt that a small group of thoughtful committed citizens can change the world; indeed, it’s the only thing that ever has.”
-Margaret Mead

Background

In 1952, Rudolf Dreikurs and colleagues established the [Adler School of Professional Psychology](#) in Chicago to equip practitioners with the skills and knowledge needed to apply Alfred Adler’s idea of social interest. Adler has been described as the first community psychologist - the first to focus on health and wellness in the community context. Adler advanced the revolutionary idea that responsible practitioners must advocate to change the social conditions that affect community health and well-being. The Adler School, as a higher education institution, continues his work today through the production of three outcomes which are specified in the Adler School Mission:⁴⁸

- **Socially Responsible Practitioners:** Socially responsible practitioners are educated to be effective personal and social change agents in the pursuit of justice. The school runs a doctoral programme in clinical psychology and various mental health masters courses.
- **Community Engagement:** Community engagement is collaborative partnership that strengthens communities, provides services, and prepares students.
- **Social Justice:** Social justice refers to equitable distribution of economic, political, civil, cultural, social, and other resources and opportunities in society in order to promote the optimal development of persons and communities.



To find out how this works in practice, I met with Kevin Osten, Director of the LGBT Mental Health and Inclusion Centre; Tiffany McDowell, Research Associate in the Institute of Social Exclusion; Christopher Holliday, Director of the Centre for the Social Determinants of Mental Health Institute on Social Exclusion; Elena Quintana, Executive Director, Institute on Public Safety and Social Justice; Paul J. Fitzgerald, Director of Master’s Counselling Training.

Educating practitioners to be socially responsible and advocating for better mental health care.

The Adler School's master's-level and doctoral preparation and training of students focuses on underserved populations through Community Service and Community Engagement placements. Adler School students are supported and trained to work in the community, including:

- Adult transition centres serving men during the work-release phases of their imprisonment
- Rehabilitation centres for formerly incarcerated men and women attempting to re-enter society
- A juvenile corrections centre
- A primary-care medical clinic serving the homeless
- Schools

The impact of the work of the clinical psychology trainees on an elementary school in a deprived area of Chicago is described below:

Four Adler School clinicians-in-training and a postdoctoral resident set up a counselling centre in a local school with no such existing mental health input. The team worked with students who revealed they suffered significant abuse, a 13-year-old disentangling himself from gang involvement, and the fallout of a case of "sexting." They addressed a systemic problem with bullying at the school, working to improve a sense of community and connection in the classroom. According to the staff psychologist: "The children moved from helplessness and hopelessness, to feeling more positive and being more articulate in the classroom, and open about experiences they kept hidden. Our students forged close relationships with children in pain, and helped them feel a sense of hope".

Educating and training culturally-competent clinicians in social justice and service delivery for sexual orientation minorities.

The Adler School's LGBTQ² Mental Health and Inclusion Centre provides students with evidence-based teaching and training on LGBTQ needs to develop 'culturally-competent behavioural health clinicians'. The Centre also hosts seminars, workshops, and continuing education for all clinicians who wish to improve their understanding of:

- LGBTQ Substance Use and Treatment
- LGBTQ Youth Mental Health and Bullying
- Legal Aspects of Working with HIV+ Clients
- LGBTQ and Religion/Spirituality
- LGBTQ 101 – Understanding Terminology and Groups within the Community
- HIV Grief and Loss
- Gender Transformations

Adler School interns can train in a local service which provides care for LGBTQ people with severe mental illness and addiction. A major Adler School mission is to improve understanding, inclusion, and service delivery to LGBTQ people, through education, community engagement, and research.

² Defined as Lesbian, Gay, Bisexual, Transgender and identify as queer and/or are questioning their sexual identity.

Training Clinical Psychologists in military mental health

The Adler School offers a Military Clinical Psychology course which prepares students to work as clinical psychologists as either members of the uniform services or as civilians in the Department of Defense, Veterans Administration, or public and private sector. The course examines the psychological impact of combat, war, low level conflicts, terrorism, nuclear-biological-chemical incidents, natural disasters, peacekeeping missions, and humanitarian operations. Students are trained in psychological consequence management. The Adler School identified this as a need due to the increased mental ill health of veterans and the fact that advances in medical treatment have resulted in greater numbers of veterans with severe injuries that require long-term clinical psychological services, including medical and rehabilitative psychology.

Improving mental health through community engagement and social inclusion

Focusing on childhood, families and relationships

The Adler Child Guidance Centre runs parenting classes to help parents and care-providers improve their parenting skills, aimed at raising children who are responsible, cooperative, and respectful of self and others. The centre runs many free-of-charge classes throughout the area, each emphasising democratic leadership, encouragement and respectful, non-oppressive methods of teaching discipline. Adler School students are themselves trained and supported to deliver the classes, which has two benefits: i) the school can ensure that parenting classes are available for a larger number of parents and ii) the Adler students graduate with valuable skills in parenting and knowledge of the importance of family relationships in mental health. Whichever area of clinical psychology the students eventually work in, it is likely that their grounding in this area will be of benefit to them.



Improving the quality of mental health care

Staff from the Adler School regularly speak out about the need to improve services, including emphasising the importance of good quality care for adolescents who self-harm, providing better support to older people who are suicidal and helping parents support a child on the receiving end of homophobic bullying.

Social justice

The Adler School analyses the ways in which structural features of society can condition human welfare. The school engages in practical work to address social marginalisation and works with local organisations to help create safer housing, better quality education and healthcare, fairer terms of employment, nutritious food, personal safety, and judicial equity. The following examples describe some of their key work:

Using Mental Health Impact Assessment to examine the effect of criminal arrest

Among the Chicago Police Department's districts, some communities have a high number of arrests that never lead to convictions. Employers often do not hire job applicants based on arrest records. This practice exacerbates already disproportionately high unemployment rates among Latinos and African-Americans. In vulnerable communities, that can affect income and other social determinants directly linked to community well-being. Employment discrimination has been linked to adverse mental health effects, including anxiety, depression and stress. These can lead to self-harm or suicidal behaviour.

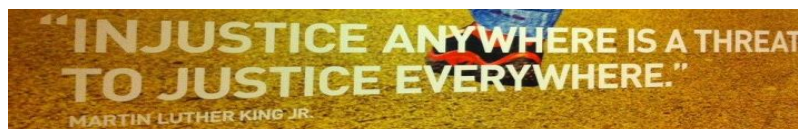
The Adler School worked with partners to research the impact that this employment legislation has on mental health and social opportunities. The School then made firm recommendations to the US Equal Employment Opportunity Commission. The campaign was successful and guidance for employers has been amended to reflect the recommendations. The impact of this is being monitored but the prediction is that it will improve mental health in the community and reduce social isolation. The Adler School is the first organisation in the US to use the Mental Health Impact Assessment (MHIA) approach in this way.

Campaigning for socially just solutions

The United States has the highest documented incarceration rate in the world.⁴⁹ At year-end 2007 the United States had less than 5% of the world's population yet 23% of the world's prison and jail population (adult inmates).⁵⁰ Concerns have been raised about the conditions of US prisons, particularly relating to overcrowding, violence, rape and solitary confinement.⁵¹ The prison population is known to be at high risk of self-harm and suicide.

There have been many debates in the US about privatised prisons. Supporters argue that private prisons are cost effective but others question the evidence for this and raise concerns about quality of care. A 2011 report by the [American Civil Liberties Union](#) argues that private prisons are more costly, more violent and less accountable than public prisons, and are a major contributor to increased mass incarceration. Private prison companies have been criticised for funding and participating in Criminal Justice Task Forces and been accused of directly influencing legislation for tougher, longer sentences and creating new crimes.⁵² In the 2009 'kids for cash' scandal in Pennsylvania,⁵³ two court judges were found guilty of sentencing children to extended stays in juvenile detention in exchange for payments from private prison companies. Children were imprisoned for offences as minimal as mocking a principal on Myspace, trespassing in a vacant building, and shoplifting DVDs from Wal-mart.

The Adler School also produced a recent White Paper⁵⁴ that concluded: "The average private prison employee receives 58 fewer hours of training than the average public prison worker. This scanting on costs leads to higher turnover and lower levels of experience among staff, leading to many documented instances of brutality against detainees, drug smuggling by guards, sexual assault and coercion, and other abuse...Private facilities also have a horrible track record regarding medical care."



Educating safety professionals

Adler School staff work with police officers, school security guards, judges and others to teach them strategies for handling conflict and preventing harm. These strategies draw from the fields of trauma-informed care, community justice, restorative justice, urban planning and community mental health.

Campaigning against solitary isolation

The School collaborates with other like-minded organisations to research and educate around the dangers and financial burden of solitary isolation.

Educating and influencing on the effect of gun use

The School contributes to debates about the nation's use of firearms and as Elena Quintana, explained in an interview, focus needs to shift to the community:

"For many marginalised populations, guns are glorified and become part of the culture. Pulling the trigger of a gun is like turning on a light switch for many people living in gun violence-ridden communities. When I walk into a juvenile detention centre, I see so many kids who are extremely marginalised, under educated and highly traumatised. For them violence is sometimes the only way they feel a sense of control. It is a reaction to forces that are normalised. To prevent this violence, we need to fix the environment in which these kids live and reallocate resources to provide support programmes and intervention for these kids – before they get to prison".

Key factors in the success of the Adler School

1. A clear strategy – the work of the School is grounded in theory with clear and measurable goals that are closely monitored.
2. Strong leadership from the individual directors who are dynamic, knowledgeable, passionate and persuasive.
3. Innovative approaches – the School is a relatively young but has achieved many 'firsts' in the US: such as creating a centre dedicated to improving the mental health and social inclusion of LGBT people and the use of the Mental Health Impact Assessment to influence social change .
4. A deep commitment to creating socially responsible clinicians – other schools and universities place little or no focus on this but this principle is at the core of the Adler School's mission. This approach is likely to produce mental health clinicians who feel connected to their communities and are equipped with the skills to advocate for patients and encourage patients to advocate for themselves.
5. Effective joint working – the School shrewdly develops important collaborations with other organisations to increase their collective clout and further their causes.
6. A persistently strong public profile – Adler staff regularly speak to local and national press and policy makers, enabling them to have a far-reaching influence.

Conclusion

The Adler School is a one-of-a-kind organisation. It views the mental health of individuals in the context in which they live, including the legislation and policies that shape their lives, the communities they live in and the opportunities (or lack of) available to people to help them fulfil their human potential. The remit of the School is hugely ambitious but the individuals who work there appear to have the talent, hope, passion and vision to achieve a great deal. This award-winning School should be a source of inspiration for any organisation seeking to improve the mental health of a community by creating social change.

**“The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma.”
- Judith Lewis Herman**



Background

Disasters such as war, civil conflict, political violence, health pandemics and natural catastrophes can have a devastating impact on individuals and communities. In some cases, effects may be short-lived but major disasters can result in serious mental health problems including post-traumatic stress disorder (PTSD). The effects of trauma can be notoriously difficult to overcome and leave people vulnerable to self-harm or suicide.

Whilst many mental health professionals will come into contact with people traumatised by disasters, not all feel equipped to provide effective care. It can be difficult for practitioners who live in relatively stable communities to even begin to contemplate some of the horrors experienced in disaster zones. Traumatized individuals who move to a country and culture far removed from where the original disaster took place may find themselves in great need of mental health input but find their needs unmet. Although training in trauma is becoming more commonplace, many mental health professionals working in generic mainstream services have little experience of helping those who have experienced a disaster. Also, a practitioner's knowledge of different cultures may be limited, depending on how much exposure they have had to different cultural groups.

In 2002, the University of Denver Graduate School of Professional Psychology launched a programme to train mental health clinicians to address the psychological and psychosocial needs of international communities who are adversely impacted by disasters. I met with the course director, Professor Judith Fox to learn more.

The International Disaster Psychology Programme

Aims of the programme

Judith explained the purpose of the programme:

“It was created because there really were no training programmes for international disaster psychology at a graduate level and there is a significant need for them. The programme trains people to provide effective mental health and psychosocial services to individuals and communities who are affected by trauma and disaster domestically and internationally. Some of our graduates are interested in working domestically—Hurricane Katrina, the Aurora theatre shooting—others pursue careers internationally. Graduates work in many settings: providing direct service, evaluating psychosocial interventions, training and consulting with communities, and developing emergency preparedness and response plans.”

Students complete two years of coursework and domestic field placements, as well as a summer internship at an international disaster organisation in areas including India, Bosnia, Serbia, Croatia and Africa.

Students are expected to apply the taught knowledge and theory into working practice abroad, and are encouraged to help locals develop their own skills; for example by training local teachers and school administrators on how to address the needs of children and families dealing with trauma. In Bosnia, students worked with orphanage staff, war widows and veterans. Students developed a mental health programme for workers involved in exhuming mass graves. In South Africa, students developed a programme to support refugee women, worked with youth in a residential treatment programme and developed a day treatment clinic for children orphaned by AIDS. Students are carefully selected for the course to ensure they are suitable for the work and comprehensive training, support and supervision is provided throughout by other clinicians experienced in providing trauma care and treatment.

Figure 4: Denver University students on placement in Ghana



Sample module	Students learn about:
Global mental health systems	<ul style="list-style-type: none"> • Mental health systems in countries around the world. • How to evaluate and improve basic and disaster mental health services. • Using the World Health Organisation guidelines on providing psychosocial interventions in post disaster settings. • Using the World Health Organisation instrument for evaluating and improving basic mental health services in low and middle income countries. • Treatment of refugees. • Treatment of high risk populations in post disaster settings.
Intercultural competence	<ul style="list-style-type: none"> • Psychosocial factors relevant to a variety of cross-cultural settings in countries with a history of acute, chronic, and/or cyclical human-made and natural disasters. • Students develop skills to anticipate and problem-solve cross-cultural challenges, including potential value conflicts and miscommunication that may arise while in the field.
Psychopathology and diagnosis	<ul style="list-style-type: none"> • Understanding psychopathology, diagnostic classification and treatment of mental health problems. An emphasis on the cultural factors relevant to understanding individual functioning domestically and abroad is included.

Sample module	Students learn about:
Gender based violence	<ul style="list-style-type: none"> • International scope and types of gender based violence. • Consideration of ethical dilemmas. • Practice intervention models and related human rights instruments. • Developing skills for identifying and responding to gender based violence in an international context, while remaining sensitive to complexities associated with culture. • Although the course emphasises violence against women, transgender and male victims are also considered.
Advanced course in disaster mental health	<ul style="list-style-type: none"> • Special issues in providing services in post disaster settings. • How to provide services for adults and children in post conflict countries and how to avoid provider burn-out in these settings. • Students prepare a competitive proposal for providing behavioural health and psychosocial services in a post disaster setting.
Cross cultural analysis	<ul style="list-style-type: none"> • Students are taught methodologies for conceptualising and understanding diverse cultures and cross cultural practices in psychology.
Psychology of loss and grief	<ul style="list-style-type: none"> • Diverse cultural differences in addressing grief and loss. • Interventions to address the needs of those who are grieving.
Crisis intervention	<ul style="list-style-type: none"> • Theoretical models, recent research, and contemporary debates in the field of international and domestic crisis intervention. • Assessing and responding to crises of lethality, conducting rapid needs assessment in complex emergencies, and utilising psychological first aid in a variety of disaster contexts.
Trauma therapy with children and families	<ul style="list-style-type: none"> • Psychotherapeutic approaches to children and families. • The perspectives and techniques of play therapy, behavioural interventions, cognitive-behavioural therapy and integrative work.

The benefits of the programme's approach

1. Well trained and supported students can provide a valuable resource to communities affected by disaster, improving mental health and potentially reducing self-harming and suicidal behaviour in people who otherwise would have little or no mental health support.
2. Students are expected to apply their learning in real-life settings- enhancing their understanding of the environmental and social context in which individuals are living.
3. The skills gained by the students not only helps them better understand how to support people psychologically damaged by trauma, it can also increase their cultural competency generally.
4. All of the topics covered in the programme are potentially relevant globally, including in the US and UK, and many of these topics may currently be under-represented in general training curricula for mental health professionals; for example gender based violence.
5. In some areas, where attitudes towards mental illness are negative, dismissive or otherwise unhelpful, the work of the students might, over time, lead to raised awareness of mental health problems and increased tolerance. This is only likely to succeed if the input of the students is respectful of local norms and values and felt by the community to be of some benefit.
6. The course content assists students in developing critical thinking skills, which are key to designing, implementing, and evaluating crisis intervention programmes.

Conclusion

The programme provided at Denver University is the first clinical programme of its kind in the US and has won awards for its innovative approach. Having studied the theory of trauma psychology, multicultural issues and international law, the students' knowledge is put to good use serving international communities. This approach helps students develop cultural competencies that will likely stand in them good stead for the rest of their careers, whether working at home or abroad, in trauma settings or general mental health services.

Additionally, students are expected to learn and apply skills in designing mental health services and evaluating the impact of these services. In a world with an increasing need for mental health provision, set against a backdrop of financial hardship where precious resources need to be spent on the most effective interventions, these are essential skills.

Finally, for a nation often accused of having an insular and non-global outlook, it was interesting to note the strong desire of the students to serve and understand the wider international community and their passion for national and international politics.



The Bridge Rail Foundation, California



**“It’s a majestic, stunning, hugely iconic bridge.
But it’s just a bridge” - Dayna Whitmer.**

Background

Since its opening in 1937, the Golden Gate Bridge (GGB) in San Francisco has become a suicide magnet, with over 1,400 confirmed victims of suicide to date. The bridge deck is 245 feet above the water, equivalent to 25 stories. After a fall of four seconds, jumpers hit the water at around 75 mph and most die from impact trauma. The lethality rate is about 98%⁵⁵ and the small minority who survive usually suffer terrible injuries.

In recent years, the suicide rate has been over 30 deaths per year, which is at least one person every two weeks. In addition to the 30 or so who jump, California Highway Patrol staff also remove about twice as many apparently suicidal people from the bridge or car park, following tip offs from friends, family or staff.

The GGB has also installed helplines for suicidal people to use to seek help. However, unlike many other structures of similar size and stature, the GGB has no physical deterrent to prevent people jumping. Research has shown that effective physical deterrents on bridges can reduce the number of suicides taking place at a site.⁵⁷ A group called the Bridge Rail Foundation based in California have for many years been campaigning for the GGB to erect a barrier. On October 10th, 2008, the GGB Board of Directors voted 14 to 1 to install a plastic-covered stainless-steel net below the bridge as a suicide deterrent. The net will extend 20 feet (6 m) on either side of the bridge and is expected to cost \$40–50 million to complete. Discussions about how it will be funded are ongoing and as yet there is not a definite date for its installation.

What is the Bridge Rail Foundation (BRF)?

The BRF is an all-volunteer, non-profit organisation, whose aim is to reduce suicides at the GGB. Members include families and friends of people who have died jumping from the bridge, mental health professionals, lawyers, and the long-time coroner of Marin County who, until he retired was responsible for conducting autopsies of the bridge victims. The BRF have been instrumental in persuading authorities to erect a barrier and I met with two BRF members, Dayna Whitmer and David Hull, to find out more.

³ Photo on the top right is the "Whose Shoes?" exhibition by the Bridge Rail Foundation, showing footwear commemorating the more than 1,600 people who have died jumping from the Golden Gate Bridge. Many of the shoes were once worn by the deceased. The exhibit is topped by a pair of World War I boots in memory of the first known bridge suicide, a WWI veteran.

Preventing suicide by reducing access to lethal means

How effective are barriers such as the one being proposed for the GGB in reducing suicide? To what extent will people simply go elsewhere to jump, or substitute jumping with another method? There have been fierce arguments both for and against the installation of a barrier.

Arguments in favour of physical deterrents

Supporters of a physical barrier refer to other success stories across the globe:

- Data on the suicide statistics from the Memorial Bridge in Augusta, Maine, USA were examined from 1960 to 2005. A safety fence was installed in 1984 and suicides from the site stopped. The number of suicides by jumps or falls elsewhere in the area remained unchanged, indicating that prospective jumpers from Memorial Bridge did not simply go elsewhere, despite the presence of a similar sized bridge nearby.⁵⁶
- The city of Bern, Switzerland has an unusually high rate of suicide by jumping—more than 28% of all suicides. Several sites were a problem but the greatest was the Muenster Terrace. In 1998, a safety net was installed to prevent jumps, and it was successful in stopping jumps from that site. Researchers also found that the overall rate of jumps declined—indicating that suicidal individuals did not simply go to another site to jump.⁵⁷
- Bristol in the UK is home to the world's oldest suspension bridge, the Clifton Bridge. The bridge was the site of 41 suicides between 1994 and 1998. A partial barrier was built in 1998, and the number of suicides from the bridge was reduced to 20 over the next five years. Researchers checked the jumping deaths from other bridges in the area and found no significant increase in jumps from those other structures.⁶⁰
- Research of people who survived a jump from a particular site suggests that for some people, the site was chosen due to its symbolism and status, and many survivors stated that they would not choose to attempt suicide using another site or method.⁵⁸

Some of the people who jumped apparently chose the GGB because it was so simple to jump from it. One man who jumped to his death had pointed this out. "Why," he asked in his final note, "do they make it so easy?"

The story of Kevin Hines

Kevin Hines is a young man with bipolar disorder and one of the few people to have survived a jump from the GGB. In high school, he started hearing voices and his torment became so intense that he finally decided to kill himself. One day, aged 19, he took a bus to the bridge, crying all the way. He had heard that the GGB was the easiest way to die. Kevin stood crying on the bridge for 40 minutes. When eventually a woman approached him, Kevin started to breathe more easily – at last, someone had taken notice of his distress. But she had only stopped to ask if he would take her photograph, and handed him a camera. Kevin said that was the final straw - clear proof that no one cared. He took several shots of her. Then, as the woman walked away, he placed his backpack on the walkway, took a few steps back, ran, and hurled himself over the barrier. Instantly, he realised he had made a mistake, and decided to throw back his head so that his feet would hit the water first. The impact was crushing, and Kevin hurtled 40 feet underwater. Miraculously, he survived. Kevin said his decision to kill himself at the Golden Gate came down to simplicity. "It's this simple," Hines said. "A 4-foot rail." Kevin was in a coma for months and then endured arduous physical rehabilitation after his near-death experience in 2000, but said dealing with his bipolar disorder had been far more difficult. He now works to raise mental health awareness and encourage people in distress to seek help.

Aside from the reasons stated above, another factor in favour of preventing jumps is the fact that many of the jumps are witnessed by members of the public, causing distress and potential trauma.

The strongest argument in favour of reducing access to means is this: it provides suicidal people with time to think, time to change their mind, and time to get help.⁵⁹ This is critical for those who are acting on impulse – individuals who are highly emotionally charged or intensely despondent and for whom *at that moment*, death seems the only way to escape their anguish. It takes just four seconds to jump to one's death from the bridge and unlike methods such as a moderate overdose or a self-injury episode, the person who has jumped has virtually no opportunity to change their mind and seek help. Many of the people who survive a suicide attempt do not subsequently die by suicide. The BRF understand that barriers are a small part of suicide prevention and that preventing people from feeling suicidal in the first place must always be the ultimate aim, but they also believe that the GGB makes it too easy for people to jump.

Arguments against physical barriers

In terms of evidence, not enough is known about whether people who would have jumped off the buildings cited above would instead go on to kill themselves by methods other than jumping. This is an important point because although suicide by jumping decreases after barriers are erected, it is not always the case that overall suicide rates in an area definitely decrease.⁶⁰

Another argument is that non-physical barriers already prevent many deaths. The GGB is fitted with suicide hotline telephones and staff patrol the bridge looking for people who appear to be planning to jump. The bridge is also now closed to pedestrians at night. A GGB patrolman interviewed in 2012 estimated that about 80-90% of suicidal people can be dissuaded from jumping if the patrol staff reach them in time and talk them down.⁶¹ Campaign groups such as the Bridge Rail Foundation acknowledge these positive and important efforts, but point to the fact that over 30 people a year are still jumping to their deaths from the GGB. It is neither realistic nor reasonable to expect patrol staff to be able to prevent all of these deaths. The emotional impact on the staff involved in trying to prevent deaths must also not be taken lightly.

The cost of physical barriers is often cited as a problem – the estimated cost of a barrier at the GGB is \$50 million for construction, followed by \$78,000 in annual maintenance costs. However, a recently published report suggests that a suicide barrier on the GGB would result in a highly cost-effective reduction in suicide mortality in the San Francisco Bay Area.⁶² In addition to these savings, it is argued that the barrier would reduce the costs of the suicide surveillance, suicide negotiation, and suicide recovery actions that involve bridge workers, first responders, Bridge Patrol, Highway Patrol, and the Coast Guard. Each time a person is recovered from the water, the average cost is about \$10,000, i.e. \$6.36 million over 20 years.

Engineering factors are sometimes mentioned – concerns that a poorly designed barrier could significantly affect the bridge's structural integrity during a strong windstorm. However, results from wind tunnel tests were released in the summer of 2007, confirming that a properly designed net system would not adversely affect the bridge.

Perhaps of most importance to those who oppose the barrier, whether overtly stated or not, is a concern about damaging the ascetic appeal of the bridge by altering its appearance. The GGB is one of the most well-known and revered man-made structures in the world and holds a place in the hearts of many local people. None of the people I spoke to from the BRF disputed this fact, despite their own personal losses and subsequent mixed feelings about the bridge. The deterrent being proposed is a 20 foot net underneath the bridge, which is far less visually obtrusive than raising the railings but nonetheless, it will change the appearance of the bridge.

The BRF members understand this but do not believe that ascetic factors are more important than saving lives. As Dayna Whitmer, who lost her son Matthew, said to me in particularly poignant moment: "It's a majestic, stunning, hugely iconic bridge. But it's just a bridge".

A reluctance to take action?

The campaign for a barrier has been a long and difficult one, and the authority in charge of the bridge - the Golden Gate Bridge Highway and Transportation District, or 'the Bridge District' - has been criticised for its repeated reticence to act.

Below are key points in the history of the campaign, as told by the Bridge Rail Foundation:

- Within weeks of the 1937 opening, the Golden Gate Bridge witnessed its first suicide. Within 18 months of opening, another 10 suicides had taken place and the California Highway Patrol expressed concern. The Bridge District's first study of the problem was in 1948. Engineers recommended a solution in 1953. Nothing was done.
- In 1973, media coverage exploded over the 500th suicide from the Bridge. The decade heralded an in-depth analysis of seventeen barrier designs but no action was taken.
- By the mid-90s, as the suicide total approached 1,000, Bridge officials finally took action—they stopped counting.
- Under public pressure, the District also installed telephones hotlines and arranged training for staff and emergency service personnel. The effectiveness of these interventions was not reviewed, nor were any suicide statistics presented to their board. The Coroner's office which *had* continued to count the deaths, stated that the average number of deaths was exceeding 30 per year.
- In October 2003, the New Yorker newspaper published a long expose of the GGB. The Bridge District ignored the story, but others did not.
- A local psychiatrist began a set of meetings with Bridge officials to advocate for a barrier.
- Around the same time, filmmaker Eric Steel pointed a camera at the Bridge for a year, resulting in the documentary film *The Bridge* showing people jumping to their deaths. The Bridge District was said to be outraged and embarrassed.
- In 2005, a hearing was held, where the board listened to individual stories of suicide. This attracted local, national and international press. In the end, the District called for studies to look at the design, testing and completion of a barrier. One caveat was attached to the plan—the Bridge District would allocate no funds to the effort.
- In the meantime, a group of local engineering students produced a set of scale model barriers with preliminary engineering calculations. Their work received extensive press coverage and was published in the influential *Journal of Architectural Engineering*.
- Families who had lost loved ones to the GGB, many of whom had spoken in great pain at the District's hearing, organised themselves to form the Bridge Rail Foundation.
- In 2005 a local newspaper ran a week long, front-page series on the problem of suicide.
- A local Coroner began publishing a yearly death toll at the bridge
- Within a year, the Golden Gate Bridge director had persuaded the Metropolitan Transportation Commission to release funds to actually study the potential barriers.
- In October 2008, after extensive public hearings and still more press coverage, the Bridge District finally accepted that some physical deterrent system was necessary. The board voted for the safety net proposal and designated it as the preferred option. A review was completed and finally approved on February 12, 2010.

The latest obstacle to installing the barrier is a lack of funds but some have questioned the legitimacy of that argument. An article in the *Washington Post* pointed out that in 2008, the bridge district found \$25 million to install a movable median to divide two-way traffic on the bridge, where a total of five head-on collisions have claimed a single life since 1997.⁶³

There are now encouraging signs that progress will be made, and in the view of the Bridge Rail Foundation, this is not before time, as David Hull said: "Where suicide is concerned, misdirection and delay have been the modus operandi of the Bridge District for years and years."

Key factors in the success of the campaign

Members of the Bridge Rail Foundation do not attempt to take credit for the progress that has been made in this campaign, pointing out that many others have also been involved in the cause for many years - but it is clear that the BRF has played a key role by:

1. Harnessing their collective expertise and skills into an organised, professional group. Though many BRF members are no doubt deeply driven by intense personal loss experienced by losing someone to suicide, at the core of their campaign is a strategic and pragmatic approach.
2. Ensuring that personal stories of suicides are told, capturing the imagination of the media and the public, and helping to sway public opinion by presenting the details of the people behind the statistics.
3. Ensuring that facts about suicide prevention are heard and that myths are challenged – members of the BRF make a very strong case both by citing research by others and conducting studies of their own. They also run campaigns to challenge the stigma attached to suicide. Their aim is not only to see a barrier go up on the GGB, they wish to see the public change their attitude towards people in crisis and for suicidal people to be provided with better care.
4. Never giving up – the irrepressible drive of the BRF and others over many years has been instrumental in maintaining and furthering the cause.

Conclusion

There is evidence that reducing easy access to lethal means can prevent suicides using those means. Despite this, it has taken decades for authorities to seriously consider erecting a barrier at the GGB, progress has been slow and fraught with resistance. Even now there are unresolved questions about how the work will be funded and when it might be finished. The minutiae of this particular campaign might not seem significant outside of San Francisco but the story suggests two things; Firstly, it is possible to challenge even the most entrenched stance by coupling real-life, powerful narratives of human tragedy with an organised and well thought out scientific and economical argument. Secondly, and perhaps most importantly, it seems that one of the biggest obstacles to change is that fact that to some, suicide is so repugnant, so shrouded in stigma, that people simply do not want to talk about it, much less become involved in trying to prevent it. As put by one commentator: "There is a stigma to suicide, and so much misinformation as a result that people are unaware that it's the most preventable form of death. When the Golden Gate Bridge has a barrier it will become a monument to compassion as well as beauty. But not before."



**“These are fragmented souls with moral injuries.
They need time, space and compassion to make sense of their stories.”
- Dr Joseph Bobrow.**

Background

The mental health of UK veterans has been the subject of considerable attention in recent years and improving mental health care for veterans is one of the targets listed in the current Government’s Mental Health Strategy.⁶⁴

Although the majority of those leaving the UK armed forces do so without suffering mental ill health, for some veterans, emotional and psychological problems can be serious and debilitating. Recent UK research suggests that 4% of veterans have probable Post Traumatic Stress Disorder (PTSD), 20% have depression or anxiety and 13% have problems with alcohol misuse.⁶⁵ These figures differ from those in the USA, where interestingly, there is around four times the prevalence of PTSD compared to UK forces, using the same screening tools.⁶⁶ The levels of alcohol consumption in the UK military are significantly higher than in similar groups within the general public.⁶⁵ Alcohol abuse may be a mask for existing mental health problems and is associated with violence and criminal activity. It is clear then that veterans need access to good quality mental health care.

It is also argued that more needs to be done to meet the emotional and mental health needs of veterans’ families.⁶⁷ Families play a key role in supporting military personnel - both during service and upon transition into civilian life – but the psychological impact on veterans’ partners, parents and children is little understood and there are many unmet needs.

The Coming Home Project (CHP) is recognised as being particularly successful in achieving positive outcomes for veterans and families by using a holistic and integrative approach. To understand more about best practice in caring for veterans and their families, I met with Dr Joseph Bobrow,⁶⁸ Founder and President of the CHP, based in California.

The Coming Home Project

The CHP is a non-profit organisation which provides expert, compassionate care, support, education, and stress management tools for Iraq and Afghanistan veterans, service members, their families, and their service providers...CHP’s evidence-based programmes are designed to address the emotional, social, moral, and spiritual injuries and the family challenges experienced, during all stages of deployment, especially reintegration.
CHP Website 2012.

Established in 2006, the CHP now has an experienced team of psychotherapists, veterans and interfaith leaders, most of whom are volunteers, including many therapists offering their time on a pro-bono basis. The therapist cohort includes people with collective expertise in mindfulness, psychoanalytical therapy, behavioural therapy, stress reduction techniques and EMDR (eye movement desensitisation and reprocessing). All Coming Home programmes are free, confidential, and non-denominational and the CHP offers a continuum of services:

- [Group Support and Stress Management Retreats](#) for male and female veterans, for veterans with their families, student veterans, and service providers.
- [Psychological counselling](#)
- [Veteran Toolkit Workshops](#)
- [Equine Assisted Workshops](#)
- [Training and Self Care for Service Providers](#)
- [Community Education and Consultation](#)

The group support and stress management residential retreats

The highly successful residential retreats are the cornerstone of the work of the CHP. The retreats are open to Iraq and Afghanistan veterans, military families, and their professional care providers. The CHP aims to target individuals who may be struggling with psychological, behavioural or emotional problems but have not accessed or received adequate support from other services. During the retreats, participants are supported to:

- Share experiences and stories, struggles and breakthroughs, in an atmosphere of mutual support, safety, and trust.
- Find understanding and acceptance.
- Learn new skills, such as mindfulness, qigong and yoga, for reducing stress and anxiety and enhancing well-being.
- Improve communication and relationships, particularly with family members, who can attend part of the retreat.
- Express what cannot be spoken through expressive arts such as journaling, drawing, music, dance and movement.
- Enjoy invigorating outdoor recreational activities in scenic, peaceful settings, including rope climbing and fishing.
- Tend and transform the invisible injuries of war in heart, mind, identity, spirit, and relationships.

Small group meetings take place daily, including groups for veterans, children, spouses, and other family members. The groups provide opportunities for peer support as well as family or couples' based therapeutic work. Retreats are not classified as psychotherapy but they are therapeutic, as evidenced by research published in a peer reviewed journal of the American psychological Association.⁶⁹ The meetings are facilitated by veterans, psychotherapists, and interfaith leaders who are experienced in working with trauma and the particular challenges faced by returning veterans and their families.

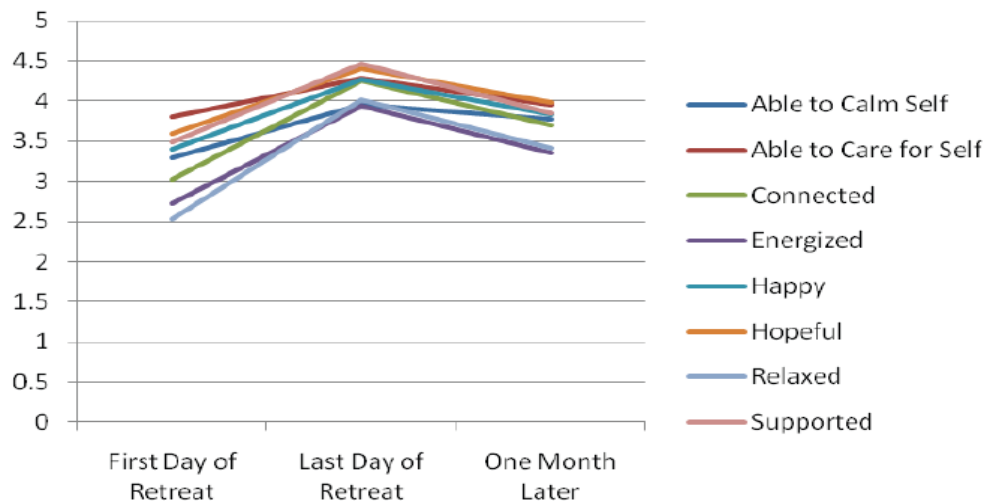
How successful are the retreats?

An independent evaluation of the impact of the retreats on 175 participants⁷⁰ concluded that:

1. From 2-4 weeks prior to the retreat, to 4-8 weeks following the retreat, participants reported statistically significant improvements in every intended outcome, including greater self-acceptance, connection to others, sense of meaning and purpose, healthy expression of emotions, skills for self-regulation, and ability to take action to improve their lives.
2. In addition, from the day participants arrived at the retreat to the day they left, participants reported substantially significant reductions in stress, exhaustion, feeling burned out, anxiety, isolation, hopelessness, and feeling emotionally numb.

- Participants reported significant increases in happiness, relaxation, ability to care for themselves and calm themselves after a stressful day, and feeling more energized, connected, supported, and hopeful. These improvements observed over the course of the retreat remained statistically significantly improved at the 4-8 week follow up.

Figure 5 – Trajectories of Change from First Day of Retreat to Last Day of Retreat to 4-8 Weeks Later for Positively Worded Items⁷⁰⁰ (Items were responded to on a five point scale with 1 being “Disagree” and 5 being “Agree.”):



Feedback from retreat participants on how they had benefitted:

“The group sessions helped me release a big demon from Iraq. I felt supported, and trusted the peers within those groups.”

“The high rope climb promoted team work between my wife and I because in order to succeed we had to work together”

“Learning to be able to calm myself so I don't explode- I hope I can stay dedicated to this”.

Key factors in the success of the CHP

Participant feedback and reflection from retreat leaders suggests that key factors include:

- The creation of a safe communal environment – often people will say things on the retreat that they have never said before. The supportive, compassionate and non-judgmental atmosphere, aided by the informal setting, flexible programme and focus on peer support, is critical to helping participants open up, tell their story and begin to make sense of their thoughts and feelings.
- The use of groups and activities – these are tailored to help people reflect, relax, improve family bonds, boost self-esteem, increase their trust in others and improve wellbeing. The programme of activities is designed to meet the specific needs of the veteran population.
- The provision of tools and healthy coping mechanisms - these equip veterans to better care for themselves, build up inner resilience and help veterans establish (or re-establish) better relationships:
- The reduction of stigma around seeking help – this encourages veterans and families to discuss problems and seek and accept support for their difficulties. On the final day of the retreat, service providers are invited to meet with veterans and families – this includes social services, housing, mental health services, thus opening up the options available in a relaxed, non-threatening, way and encouraging participants to consider accessing further support.

For these reasons, many participants report that attending the retreat is a major turning point in their lives. Joe Bobrow sums up the need for the retreats as follows:

“Many of the people we see have returned from war as fragmented souls, disconnected, with moral injuries. Some experience problems with trust, attachment and forming and maintaining healthy relationships... Some, who feel betrayed by the military, will be overwhelmed with a deep sense of outrage. Others are conflicted about the war and some are suffering from complex grief. What they often have in common is a sense of unbearable emotional pain – and they don’t know what to do with that pain. They may be self-medicating with alcohol or drugs, or they might be harming themselves or other people. Our aim is to create a safe, peaceful environment where people feel valued and accepted, can tell their stories, begin to make sense of their pain and develop better skills for dealing with it. The change we see in people after the retreats can be truly profound.”

Conclusion

One of the greatest strengths of the CHP retreat approach is the focus on providing a service that is designed to suit a traditionally hard-to-reach veteran population. The supportive atmosphere of the CHP retreat encourages veterans to reflect on the impact their mental health problems are having on their own lives, and the effect this has on their families. People attending the retreats report that they feel valued and cared for, and more open to accepting help, because they can see that support can make a real difference to their lives. This has important implications. In a study of 315 UK veterans, it was reported that among those who had mental health problems but were not seeking help, the most common reasons were ‘I could deal with it myself’ (72%) and the perceived stigma and embarrassment of consulting (20%).⁷¹ It is likely that the CHP approach can help to counter both of these barriers. It is recognised that there are well respected organisations in the UK such as [Combat Stress](#), providing support, but the CHP appears to be particularly focused on intensely involving families in this process, which contributes to the success of this approach.

The following organisations were not visited but are relevant to this report:

1. The Perfect Depression Programme, Detroit, Michigan

The "Perfect Depression Programme" is a model of integrated mental health and general health care designed to eliminate suicide among depressed patients of the Department of Psychiatry in the Henry Ford Health System in Michigan. The department has 10 outpatient centres, a 100-bed psychiatric hospital, a 64-bed residential and outpatient substance abuse programme, and numerous mental health specialty programmes. According to a published report on the programme, the department was able to reduce suicides in its patient group from 89 suicides per 100,000 patients to 22 per 100,000 over a four year period. The key factors in its success were identified as:

- Patients having a single electronic medical record accessible to all clinicians in the department.
- Establishing a protocol to assign patients into one of three levels of risk for suicide, each of which requires specific intervention.
- Creating 'perfect depression care' by removing barriers between services and providing timely and accurate recognition of suicide risk.
- Implementing a protocol for having patients remove weapons from the home.
- Training 30 clinicians in cognitive behavioural therapy.
- Establishing three means of access for patients: drop-in group medication appointments, advanced (same-day) access to care or support and e-mail visits.
- Developing a website for patients to educate and assist patients.
- Requiring staff to complete a suicide prevention course.
- Setting up a system for staff members to check in on patients by phone.
- Partnering and educating the patient's family members.

2. The United States Air Force

The us Air Force suicide prevention programme educates the Air Force community about prevention services, targeting high-risk service men and women, promoting early identification, referring people for help at the first signs of emotional troubles, counteracting the perception that getting help is a career-ending move, and eliminating barriers and discrimination associated with needing care. By 1999, over 90 percent of Air Force personnel had received suicide prevention training and education. A confidentiality policy permits at-risk individuals be placed in less risky roles. Suicides among Air Force members fell 37%. Chaired by senior force leaders, the strategy has been described as 'comprehensive, goal-oriented, and integrated'.⁹

I would like to thank:

- The Winston Churchill Memorial Trust, for providing me with this valuable opportunity.
- The individuals I met at the various sites in North America, who generously gave their time, thoughts and views.
- Those back in the UK who offered support, information and encouragement.

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