

Transcript of Keynote Address on Suicide Prevention and Intervention at the ACT ESA Peer Support Conference – November 2023

Dr Neil Percival

Thank you for the invitation to spend some time with you. Watching out for the well-being on emergency service workers is something very close to my heart.

My name is Neil Percival. My day job, when I have time, is working for the Anglican Diocese of Canberra & Goulburn. While I am Sydney born and bred, I've lived in rural NSW for more than 20 years. I like country town life. For the past 6 years I've lived in the town of Young, on the NSW Southwest Slopes, the Cherry Capital of Australia and the harvest is in full swing.

I have been a volunteer fighter with the NSW RFS for over forty years including quite a few years in senior operational roles.

I have been an RFS volunteer Chaplain for 25 years and my current responsibility the Southwest Slopes Zone.

I also have a PhD with a focus on the impact of trauma, multiple other degrees, and a career's worth of professional development and short courses in the trauma, mental health and well-being area.

Paul Scott, who I've worked alongside for many years, invited me to speak about a suicide prevention and intervention initiative based on the QPR model that I've been implementing within the NSW RFS since 2019.

I began this initiative purely for my own region, the Southwest Slopes, but word of mouth, combined with a real need, quickly led to calls for assistance from all around the state.

Before I talk about the detail, let me set this into a context.

The need for action in the suicide intervention space became clear to me when, in mid 2018, I moved from the South Coast of NSW, where I lived for 15 years, to the Southwest Slopes. In my first few months I was confronted by the significantly higher rate of suicide in rural communities as opposed to the coast in general, but also amongst our members, both volunteer and staff. The statistics for the general adult population are on the screen. In Australia in 2021, deaths by suicide rate ranged from approximately 10 per 100,000 in major cities to 15.9 (*Inner Regional*), 18.5 (*Outer Regional*), 21.2 (*Remote*) and 23.9 (*Very*

Remote) deaths per 100,000 population respectively. That translates to 9 deaths per day and 180 suicide attempts per day in Australia.

As well as the already higher rates of suicide in regional areas, Beyond Blue's National Mental Health and Wellbeing Study of Police and Emergency Services (Answering the Call) placed suicide at the top of the list of mental health and well-being issues faced by workers in our sector. I notice from the Conference Program that a number of others are being addressed as well.

The Beyond Blue report does break the data down by agency but for the Emergency Services sector in aggregate, the study found:

- **one in three** employees experience high or very high psychological distress; much higher than just over **one in eight** among all adults in Australia.
- more than **one in 2.5** employees and **one in three** volunteers report having been diagnosed with a mental health condition in their life compared to **one in five** of all adults in Australia.
- employees and volunteers report having suicidal thoughts over **two times higher** than adults in the general population and are more than **three times more likely** to have a suicide plan.
- **more than half of all employees** indicated that they had experienced a traumatic event that had deeply affected them during the course of their work.
- employees who had worked **more than 10 years** were almost **twice as likely** to experience psychological distress and were **six times more likely** to experience symptoms of PTSD.

Another study found that...

“The age-standardised suicide rate across all Emergency Service Workers was 14.3 per 100 000 (95% CI 11.0-17.7) compared to 9.8 per 100 000 (95% CI 9.6-9.9) for other occupations.”

Petrie K, Spittal M, Zeritis S, Phillips M, Deady M, Forbes D, Bryant R, Shand F, Harvey SB. Suicide among emergency service workers: a retrospective mortality study of national coronial data, 2001-2017. Psychol Med. 2022 Sep 8:1-8. doi: 10.1017/S0033291722002653. Epub ahead of print. PMID: 36073166.

And that's not allowing for the regional variations.

What brought that home to me was that I conducted two funerals for firefighters who took their own lives in my first 6 months in the Southwest Slopes as opposed to three in 15 years on the coast. That two in six months is unusually high, even for the regions. More realistically, it's been something like one per year over the last five years. So, this initiative was, at one level, need driven. But it's also a proactive response to that need. My aim was to get ahead, and stay ahead, of the curve so that my involvement didn't begin when I got the phone call asking if I could conduct a funeral and consist mainly of picking up the pieces. This plan is intended to stop that phone call from ever needing to be made.

To that end, I adopted the QPR program. You may or may not be familiar with it so let me describe it. But let me also stress that this isn't meant to be a sales pitch. I just want to explain how and why, with appropriate contextualisation, this has been an effective tool in my context.

So, what is QPR?

QPR is a suicide prevention training program originally developed in the United States in 1995. It is widely used around the world. To quote from the QPR research material...

QPR is “an emergency mental health intervention that teaches people to **recognize and respond positively** to someone exhibiting suicide warning signs and behaviours.”

Quinnett, P. QPR Gatekeeper Training for Suicide Prevention: The Model, Theory and Research. QPR Institute 2012. p.4.

And what does a positive response look like?

“QPR is also a **behavioural action plan** designed to move a willing or ambivalent suicidal person to accept a referral for professional evaluation and/or treatment.”

Quinnett, P. QPR Gatekeeper Training for Suicide Prevention: The Model, Theory and Research. QPR Institute 2012. p.6.

The name, QPR, stands for - Question, Persuade, Refer. These are the three core skills that make up the action plan. I'll elaborate on those mean in just a moment.

To my mind, one way of thinking about QPR is as a kind of first aid. It's not designed to create mental health specialists. It doesn't replace a professional clinical intervention. But just as we might perform CPR on someone whose

heart has stopped until the paramedics arrive, QPR is designed to provide the basic skills needed to keep someone exhibiting suicide warning signs and behaviours alive until they can access the professional help they need. In this sense, it needs to be one component of a multi-layered strategy. And just as we would want all our members to have first aid skills, I think they should also have QPR skills.

It's also worth noting that, while not it's primary purpose, QPR functions as something of a universal intervention, not just for those at risk for suicide, but also for those who may need assistance, assessment, and treatment for any number of mental health issues or personal problems. It creates a culture and a forum that enables those conversations to happen. At least, that's been my experience.

Even in the suicide area, while I've used this as a tool for suicide prevention and resilience building, it has been of benefit after the event to help affected people to process an experience. In fact, my first move out of the Southwest slopes was in response to a request from a brigade further north who were still struggling with the suicide of their Captain twelve months earlier. I conducted this program around the anniversary of his death and was able to use it address a number of unresolved questions.

“While the QPR method was developed specifically to detect and respond to persons emitting suicide warning signs, QPR has also been more widely become something of a **universal intervention** for anyone who may be experiencing emotional distress.”

Quinnett, P. QPR Gatekeeper Training for Suicide Prevention: The Model, Theory and Research. QPR Institute 2012. p.7.

So, let's look at the detail...

QPR can be delivered as a one hour face-to-face workshop or as a self-paced online course. The Murrumbidgee Primary Health Network, which covers my region, offers the online QPR program free to anyone living within their boundaries but, in my experience, most people are not self-motivated enough to take that up. However, if I go to a Brigade to run this program for them as an organised brigade training activity, I always get high levels of engagement.

The additional advantages of being there in person are that I can answer questions that an online program cannot and, by being present, I am able to triage people who might be in need of urgent assistance and become a referral agent. I have had people contemplating suicide turn up. In addition, I get to create familiarity and build trust, which then enhances my capacity, as the

Chaplain, to provide assistance in other contexts. Members are more comfortable and more likely to get in contact with someone they know and trust for help when they have other issues, rather than simply dialling a 1800 number.

What are the things that drew me to this program in particular?

First and foremost, it is contextually appropriate. What do I mean by that?

It is appropriate for the emergency services sector. QPR has been endorsed by the Black Dog Institute as part of their Lifespan Initiative. They identified two programs, ASSIST and QPR, as appropriate training for non-clinical first responders. Why did I choose QPR over ASSIST?

Because, when I began to develop the program, one of the first things I did was go out and consult with the people I was hoping would attend. These were country people, often farmers, many were isolated and were not going to travel to a centralised event. I found that I could get good buy in if I went to them where they were (accessible), and delivered a program that was short (1 hour or less), simple (not simplistic but easily understandable, no psychobabble, and simple enough to be remembered when under stress), and practical (what specifically can I do to look after those around me?).

ASSIST is a 2 day program, although I think there is a shortened version, and I simply wouldn't have got any takers from my target group whereas QPR, with some contextualisation, met my needs very well. It is accessible, short, simple, and practical.

In terms of the content of the program, we explore a range of risk factors for suicide in Australia.

- **Age** - Suicide is the leading cause of death for Australians between 15 and 44 years of age. It's the 15th most common cause of death overall. 1/3 of all deaths in the 15-24 age group are due to suicide.
- **Gender** – Men are three times more likely to die by suicide (2358/786).
- **Ethnicity** - The suicide rate among indigenous people is twice that of non-Indigenous Australians.
- **History Of Suicide** - Suicide risk is significantly increased in those who have previously attempted suicide and survived. It is also increased for those close to the suicide victim. For example, there is a 4-fold increase in children if a parent died by suicide. (Suicide clusters or contagion – in addition to all the other risk factors, geographical, social, and emotional proximity appear to play a significant role).

- **Location** – The rate of suicide in rural Australia, as we saw, can be up to 2.4 times higher than in capital cities. There are a range of reasons for high rates of suicide in rural areas.
- **Occupation** – 2020 research found that the worst sector is farming and agriculture closely followed by vets, doctors, and nurses. Many in my target group are farmers. In NSW, the rate is 1.6 times that of the general adult population. Explanations include social isolation, economic stressors, a lack of available support services in rural areas, and easy access to lethal means.
- **Emergency Services Risk Factors.** One subset of the occupation category are Emergency Service workers. We've already looked at factors that contribute to their increased risk. On the list of at-risk occupations, paramedics were fifth, firefighters were sixth, and police were seventh.
- **Education** – The risk is higher in those with fewer years of education. 2.6 times higher for those with no or secondary education vs those with tertiary degree.
- **Sexual Orientation - LGBTIQ+** - 42% considered suicide in the past 12 months. 10 times more likely to attempt suicide than the general population.

Risk factors are not predictors. That is, they don't identify who will make a suicide attempt and, indeed, many people can tick off a lot of these and will never contemplate suicide. I've been in groups where participants would tick off seven out of the eight. However, the data makes it very clear that the vast majority of those who do attempt, or end their lives by suicide fit into one or more of the categories. The average is 3-4.

These may not be predictors, but when taken in conjunction with a number of suicide warning signs, they indicate a need for urgent action. So having explored risk, we move on to explore the more immediate warning signs of suicide.

What is a warning sign?

“A suicide warning sign is the earliest detectable sign that indicates heightened risk for suicide in the near-term (i.e., within minutes, hours, or days).”

Quinnett, P. QPR Gatekeeper Training for Suicide Prevention: The Model, Theory and Research. QPR Institute 2012. p.7.

Warning signs are the clues or indicators that someone is considering self-harm. These can be verbal (direct or indirect), behavioural, and situational.

Direct Verbal warning signs are clear.

“I’ve decided to kill myself.”

“I wish I were dead.”

Indirect Verbal warning signs will need some decoding.

“My family would be better off without me.”

“You won’t have to worry about me much longer.”

Behavioural warning signs

Acquiring a gun or stockpiling pills.

(In rural area the means are readily at hand)

Putting person affairs in order.

Giving away prized possessions.

Situational warning signs – last straws

These tend to be major transitional or loss events.

Being fired from a job.

A financial crisis.

End of a major relationship.

Diagnosis of serious or terminal illness.

Loss of independence and fear of becoming a burden to others.

These are just examples. We talk through many others in the program. The purpose of detailing risk factors and warning signs is not about ticking boxes but to equip participants with enough knowledge and understanding to recognise those in their immediate social networks, that’s where the focus is, who may be in need of help, and open the door to early intervention.

I was involved in an incident just three weeks ago where a member in one of our brigades in a small town (Stockinbingal) hung himself. Three different people rang me almost straight away (that’s the benefit of building a relationship of

trust) and I arranged to go and meet with the whole brigade the next afternoon. The first thing everyone said was that no one saw this coming. But the reality is that most of those contemplating suicide do communicate their intention in the days leading up to the attempt, through a combination of these methods. The problem is that the communication is not heard because people don't know what they're hearing, and the signs are not recognised because people don't know what they're looking at. Those best placed to hear this communication are those within their immediate social network (by that I mean those with whom they have regular contact and a high degree of trust - family, work colleagues...). This is the strength of the QPR model. It is about equipping people to look out for those close to them and with whom they are in regular contact.

And having identified that person, what next? We then move to equipping participants with three practical skills that will enable them to link their family member, friend, or colleague in with the professional help that they need. As I said, this is where the name of the program comes from – QPR – which stands for question, persuade, refer. These are the three core skills.

Let's think about those.

Question

We've identified the problem, that is, we've noticed some warning signs or clues in a person's words, behaviour, or situation. This may just be a gut feeling rather than anything more tangible. Does it mean something, or does it mean nothing? Can we afford to ignore it? There is only one way to find out and that is to ask a clear and unambiguous question involving some variant of, "Are you thinking about killing yourself."

The purpose of asking the question is twofold: first, to clarify the meaning of any verbal or behavioural clues, but also, going back to an earlier comment, to show that the message has been received and the communication heard by someone and that opens the door to further conversation.

Persuade

Once a potential suicide threat has been clarified and verbally acknowledged, the second core skill is to persuade the suicidal person to take positive action to get help or get their permission for us to get help for them.

In my experience, persuading isn't difficult because most people don't want to die. But they are in a place where they can't see any other way to escape the emotional pain they are experiencing. Persuasion is about giving them an alternative.

And in practice it is as much about listening as it is about talking. Letting a person know that they are not alone and that there is hope.

Refer

And once we get permission, we need to act immediately to capitalize on the momentum of that decision by quickly referring, or connecting, them to the professional help that they need. So, we spend time looking at referral pathways – face-to-face with a GP, an emergency department, or psychologist, or the phone to access EAP's and other helplines.

Together, these three skills create a structured pathway that enable someone to move from recognizing suicide warning signs to connecting a potentially suicidal person with the help they need by knowing how to ask a QUESTION to clarify their intentions, knowing how to PERSUADE, or get their verbal agreement to accept help, and knowing how to REFER, or connect a person with a professional who can give them the help they need. Together, these things save lives.

So, to pull all this together, what are the advantages of QPR? Why has this been effective in my context and why might it work, with appropriate contextualisation, for you? It is...

- Need driven. That is, it addresses a very real and urgent issue confronting workers in our sector.
- Proactive. That is, it doesn't wait for an individual to seek help, but trains those around them to recognise and respond positively, and early, to the warning signs of suicide. QPR is about equipping and empowering people to watch each other's backs.
- The takeaway is a simple to remember, a three step action plan that anyone with minimal training can implement.
- It is a form of suicide first aid, keeping people alive until they can access the professional help they need.
- It doubles as a universal intervention by creating a culture where mental health and well-being issues can be talked about and opening up pathways to accessing care.
- It has met the very specific needs of my target audience in that it is accessible, short, simple, and practical.

- It's strategic. While this is a lightweight program with only one hour of training, the value of having many people with some skills embedded throughout the organisation, alert to the warning signs of suicide and equipped to intervene, can't be underestimated. I'm not denying the importance of skilled mental health professionals, especially for clinical interventions at the referral stage of the QPR action plan as part of a multi-layered strategy, but the initial response happens when people on the ground observe the warning signs in those they are working alongside and feel confident enough to get involved.
- Finally, I believe that this model has greatly enhanced my capacity to provide effective Chaplaincy support within my organisation.

I want to stress again that this is far from the only suicide intervention training available. There are many good programs out there, most of which provide a more in-depth treatment of suicide than QPR. I've done many of them myself. QPR is pared down to the absolute bare essentials. In fact, I've given you most of the content of the course today and you could probably go out and implement it. It may be basic, but in practice, the three core skills of the action plan are what I find myself using most of the time and, in my experience, they work, and they save lives.

Thanks for your time. I'm happy to take any questions.

Holistic view – spiritual, physical, emotional, behavioural

Artificial distinction given the interconnectedness of the domains. None exist in isolation.

Spirituality is an information processing system. Universal but unique.

- The capacity of the brain to identify and apply issues of meaning, purpose, beliefs and values to solving problems.
- Flowing from that, it is a source of intrinsic motivation that drives, directs, and selects behaviours.
- Allows for perspective. Has a transcendent dimension that enables people to step back and look at and evaluate life events from a larger and more objective perspective.
- Involves an awareness of connectedness and belonging and commitment to others and the larger whole.
- Is a transformative process that involves a movement from one state to another, a process of searching for and discovering the sacred, a process of conserving or sustaining a relationship with the sacred once it has been found, and “a process of transformation in the character or place of the sacred in the person’s life as a result of internal or external stressors.” Where circumstances cannot be changed, spirituality enables people to change themselves in such a way as to “rise above such conditions.”

Effectiveness - no way for collecting empirical data and I don’t want to impose one. First aiders don’t report in each time they use a skill. However, anecdotal evidence, from people who come up to me at subsequent events, suggests that 1 in 10 use something they have learnt, knowledge or skills, in the following 12 months.

The moments of crisis are when the benefits of Chaplaincy are experienced. Contrary to what many think, the hard work of Chaplaincy is done in the good times.

Disclosure on social media

Why? - Relative safety, familiarity, assumption of sympathetic audience

Risks – Not taken seriously, anonymity, diffusion of responsibility

