Preventing Suicide

The Solution Focused Approach, Second Edition

JOHN HENDEN

WILEY Blackwell

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About the author

John Henden is an internationally known and well-respected workshop presenter and trainer, who has a special interest in various challenging applications of the solution focused approach to psychological problems. The subject of suicide is one such interest.

John, having gained a first degree in psychology, worked in UK mental hospitals, along with many hundreds of other psychology graduates in the 1970s, to bring about positive change. During his NHS career, he had two papers published on the changing language of mental health and presented an early paper on this subject at a mental health promotion conference.

After 22 years in the UK National Health Service as both a practitioner and a manager, John set up a training, counselling, and consultancy partnership providing a wide range of products and services to public, private and 'third sector' organisations.

John Henden is a counsellor and psychotherapist and over time has specialised in couples work, drug and alcohol dependence, and working with abuse and trauma.

It is his specialised approach to suicide prevention which has gained most public attention over the last few years. He has lectured, presented workshops at conferences, run training courses in several countries, and has had numerous suicidal clients on which to field-test the radical tools and techniques he outlines. Suicide rates within mental health services have been reduced significantly in areas where this new approach has been applied.

John has a personal interest in the subject, as he had strong suicidal thoughts in his early years, lost a cousin to suicide, and witnessed an exceptionally high number of suicides while working within formal mental health services.

As a trainer and workshop presenter, John Henden has an energising and inspirational teaching style which incorporates case vignettes, humour (despite the topic's seriousness) and involves participants in paired and small group work.

As a solution focused practitioner, John never ceases to be amazed at how its effective and well-structured approach lends itself to the widest possible range of difficulties with which practitioners are presented.

John Henden is among one of the leading innovators within the solution focused field, having developed some interesting ideas and techniques of his own: 'leapfrogging' the problem, the five o'clock rule, the solution focused feelings tank, the 'triple twins' of solution focused success, and beating the 'if only …' monster.

In addition to *Preventing Suicide*, he has other works published on severe trauma and stress recovery. With regard to solution focused suicide prevention, he is now considered the leading international authority on the subject.

Foreword

The calendar reminder popped up on the computer screen, and my heart fell. Wow … another year had passed. Although it was late in the evening, I picked up the phone and dialled a number I had called on this same date for over a decade. Our conversation was brief:

'Hi Robert. Just touching base, checking on you. Another year has passed since Foster's[1] death.'
'Yeah, it's hard to believe …'
'Yeah. Twelve years … twelve years. How are you doing?'
'Holding it together… remembering him … holding my other family members close tonight …' (*He tells me how they are sharing stories about Foster.*)
'Well, I'll let you get back to spending time with them.'
'Yeah, I knew you'd call.'
'Love you, brother.'
'Love you, too.'

Every year on the same date I've connected with Robert in remembrance of a life cut short by suicide. On a fall evening like any other, his 14-year-old son Foster completed suicide without warning. In the coming days Robert leaned on me, and I was grateful I could be supportive. But our conversations were different from most I've had with suicide survivors. Like me, Robert was also a mental health professional. He was used to being on the other end of the relationships and conversations, comforting and aiding those left behind when a loved one completes suicide.

Why do I tell a story about the repercussions of a completed suicide in a book committed to its prevention? Because our preparation as helpers is complex when it comes to suicide. We have to sharpen our minds, hone our clinical interviewing skills, and prepare our hearts for the difficult work the threat of suicide brings. With over 40 years' experience as a therapist, I've come to believe a significant shift in thinking and acting is necessary if our profession is to move beyond prevention and support to proactive intervention that reduces the actual rate of suicide. This book fuels my hope for a generation of helpers trained to successfully intervene and have a more significant impact.

Welcome to the wonderful work John Henden has done for helpers connected to those afflicted with suicidal thoughts and threatening to end their lives. This solution-focused approach to suicide prevention may appear simple, but it is not easy. John's years of clinical experience and training have resulted in an invaluable book, bringing skill and insight to an area of mental health most helpers avoid. This second edition is even more complete than the excellent initial publication. John expands on his exceptional first edition with well-honed ideas and clear writing addressing telephone work with suicidal persons, responding to blaming those who complete suicide, and the importance of compassion in assessment and treatment.

My conversations with John over more than 14 years led me to believe in his clinical wisdom. But many in our profession have deep experience and useful ideas about self-harm from which we can draw. What stands out for me is John's commitment beyond suicide prevention toward 'rebuilding meaningful and purposeful lives' (p. 261). His dedication is our gain.

This is a book of hope – for survival, connection, and futures that hold promise for each person contemplating suicide. Learn. Practise. Prepare. Become part of a more promising future.

Frank Thomas, PhD LMFT-S
Professor of Counseling, Texas Christian University, Fort Worth, Texas, USA,
Clinical Fellow and Approved Supervisor, American Association
for Marriage and Family Therapy
Founding Archivist, Solution-Focused Brief Therapy Association of
North America (preserving the Brief Family Therapy
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Endnote

1 I've changed the names to honour their privacy.

Acknowledgments

First and foremost I would like to thank three past attendees of my training workshops who, quite independently, urged me to write the first edition of this book.

The work became "an ongoing project" for over four years. Over this time I consulted various friends and colleagues about how best to present my thoughts and ideas.

I was grateful to members of the Bristol Solutions Group: Kate Hart, Mark McKergow, Jenny Clarke, and Alasdair Macdonald, for their various comments and suggestions about how both to select and present the material. I also thank my AMED Learning Set colleagues: Hazel Valentine, Esther Cameron, Colin Heyman, Gerald Conyngham, Ginny Brink, Anita Hayne and Di Aldrich, who were very understanding, each time I raised particular points about the project's impact on me, my 'day-job', and the possible implications it may have within the field. Their well-targeted interventions were highly valued.

For both the first and second edition, I am grateful to my wife, Lynn, particularly, who listened to my ideas on the subject from the outset. At each twist and turn, she has been supportive and continued to encourage me – especially during the intensive research and writing spells, when I have gone away to one of several 'wordsmithery' retreats, for peace, quiet, inspiration, and research. I am grateful, too, for her forbearance when chapters of the book and various papers have spilt out from the study into many other parts of our home.

For the first edition I was especially grateful to Ginny Brink. She was helpful in the early days with her advice on the overall structure of the work and specifically with regard to some chapters. I appreciated her willingness to be sounded out on

particular points during the middle part. She was of great help, too, in the latter stages, in both coaching and encouraging me at various 'low' points.

My thanks go out to Chuffy Jenkins, who has a particular way of inspiring and encouraging people – both in her job and amongst her friends. I have felt the benefit of this quality of hers when, at various times, we have discussed the project. I was grateful, also, for the use of her home during the research stage for the first edition.

I am thankful to Kate Hart, who has been a great help to me during both the research and writing stage. Her 'little shed by the sea' with its tranquility and views across the Severn Estuary was the location for much of the note-making and writing over some two and a half years.

The helpful suggestions and peer advice I received during the early part of 2007 from Harry Procter was invaluable in both ensuring my overzealousness was curbed and that the work was positioned better within the specific academic field. Without his help on the original proposal, the book might not have reached a wider audience. My thanks go out latterly to Harry for reading and commenting on various chapters prior to submission to the publishers.

I am grateful to another BSG member particularly – Alasdair Macdonald, who has been able either to provide me with references and research findings off-the-cuff, or has pointed me in the right direction. Alasdair not only saved me a great deal of time when preparing the first edition, but also was an encouragement in my pulling together of the project during the final months.

I reserve particular thanks to my previous secretary, Alison Wright, who persevered long into the afternoons to word-process the whole book from a handful of mini-cassette tapes! Some chapters and sections have undergone many revisions and I am thankful for her patience with the process.

I am grateful, too, to Joy Minnitt, my current secretary, who has worked on the final chapter drafts and amendments to the manuscript for the second edition.

My final thanks go to Darren Reed, Commissioning Editor at Wiley-Blackwell, who, initially, provided clear advice and steered the project through the various committee stages. For the first edition, especially, I appreciated his patience, advice, and support, to ensure that it reached the bookshelves.

1

How to use this book

Whether you are a healthcare professional, an academic, advice-line volunteer, or someone who is feeling suicidal at the present time, you will find this book helpful.

If you are a healthcare professional (general practitioner, psychiatrist, psychologist, counsellor, therapist, mental health nurse, social worker, or another member of either a primary care team or a specialist mental health team); and, have already a basic grounding in solution focused brief therapy, then you might find it most helpful or useful to go straight to Chapter 8. Here you will find out about the specialised solution focused tools and techniques and see how they are applied to the suicidal service user.

If you have no previous knowledge about solution focused brief therapy and want to learn about it in a nutshell, then you might like to begin at Chapter 6, before picking up on the specialised techniques in Chapter 8.

You might be inquisitive as to how the solution focused approach to preventing suicide sits alongside other approaches and models of working. You might be from an established tradition (e.g. biomedical, cognitive behavioural, person-centred, etc.) and are curious as to how solution focused compares and contrasts with your own way of working. A number of other models are set out in Chapter 4. The author is respectful of other ways of working: all have validity.

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If your interest in the subject is purely academic and you are on a journey of discovery within the wider subject of 'suicidology', then you might like to begin at Chapter 2, 'The Book's style and purpose'.

You may be a tutor running a counselling or psychotherapy course, either wanting to understand the solution focused approach a little more and/or wanting to see how you might teach the tools and techniques herein to your students. You will find the book easy to follow and understand, and will find the many examples and sections of counsellor-client dialogue helpful in learning about which techniques to apply and when. Also, you will appreciate, I hope, that the solution focused approach is not simply 'techniquey', but is a relational process between worker and client that flows. Also, you will discover that the approach produces long-lasting results, despite the relatively few number of sessions required.

You might be a reader who has made an attempt on your life already or are thinking of doing so. I hope you will find the book both interesting and helpful to you in your current state of thinking. If you are such a reader, I would suggest you go straight to the 'worst case (graveside) scenario' in Chapter 8 and spend about 10–15 minutes answering it as carefully and honestly as you can, before reading other chapters in the book. You might like to read either *Suicide: The Forever Decision: For Those Thinking about Suicide, and for Those who Know, Love or Counsel Them*, by Paul G. Quinnett, or *How I Stayed Alive When my Brain was Trying to Kill Me: One Person's Guide to Suicide Prevention,* by Susan Blauner. (See Reference section at the back for full details.)

You might be a solution focused practitioner who is interested in finding out about yet another specialist area which has been given the solution focused treatment or had solution focused principles applied to it. In the spirit of generosity, which is a fundamental part of the solution focused tradition, this is my offering. Please feel free to use any of the exercises in your work for the benefit of others. All I ask is that you acknowledge the source. Throughout the book, apart from a little within Chapters 4 and 5, I have avoided using the jargon of the study of suicide. The main reason for this is to keep the book simple and understandable for the widest possible readership. As first and foremost a practitioner and trainer, my overall aim is both to save lives and to help others to save lives too. My 'academic hat' is very much secondary. This whole area of research, education and practice has been given the title 'suicidology'. For those readers wishing to know what the jargon of suicidology is comprised of, and for serious academics who may wish to study aspects of the subject further, I would suggest you enter this term into your preferred internet search engines, along with other terms such as, 'suicidal ideation', 'completed suicide', and 'postvention'. Many of the references at the back of the book will be helpful too.

Throughout the book, you will find many different titles for 'practitioner' and for 'client'. I have used a maximum of interchangeability with the many terms that refer to these two titles, in order to ensure the book is of widest appeal across the healthcare, helping, social care, and welfare sectors, where suicidal people are encountered. So for 'practitioners' the following alternative terms will appear: 'health professional', 'worker', 'therapist', 'helper', 'clinician', and 'counsellor'. For 'client' the following titles will be used: 'patient', 'service user', 'person', and 'helpee'. Also, I have used the male and female pronouns interchangeably from time to time.

2

The book's style and purpose

It is the quality of the personal encounters which, in the end, are the essential factors in creating positive change.

(John Eldrid)

Before people kill themselves, many have had recent contact with a helping agency. Two-thirds of those who contact their family doctor have received medication, which about half use to poison themselves.

(David Aldridge, 1998)

Suicide remains the leading cause of death in England and Wales for men aged 20–34.

(*The Daily Telegraph*, 19 February 2015)

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The book – in a nutshell

For decades, health professionals and policy makers have resorted to head-scratching, chest-beating and hand-wringing over high suicide rates. Questions were, and are still asked today, such as:

> Could we have asked the right question?
> Shouldn't we have recognised the signs?
> Wasn't there a clue somewhere in what he/she said?
> (Aldridge, 1998)

The issue of resolving the problem of suicide has taxed intelligent minds across many disciplines for a very long time. Camus (1942) in referring to it said, 'There is but one truly serious philosophical problem and that is suicide.' In spite of the vast increase in research into the problem, nearly two-thirds of a century later it seems, worldwide, we are little further forward. Another main purpose of this book is to shed new light and make in-roads such that there is a real focus amongst both clinicians and researchers on 'what works' in face-to-face suicide prevention, rather than focusing on statistics, demographies, risk factors and restricting access to methods. My hope is that we will reach a point when the following statement applies: Simon's (2002) statement ('There are two kinds of psychiatrist: those who have had patients commit suicide and those who will.'), can be revised to something more wide ranging along the lines of: 'There are two kinds of mental health care-givers: those who used to have clients take their lives and those who do not.'

More recently, conversations have shifted from finding ways to reduce suicide further within healthcare agencies to 'zero suicide rates' (see Chapter 15). From what we know now, about effective interventions and discussions with other compassionate practitioners, I believe this is achievable.

Much has been written about the subject of suicide, but little on the specific 'how-to-do' or 'what works' in the 1:1 relationship between worker and suicidal person.

This book concentrates on how lives are saved; what workers do and say that is effective; and, what clients have said they found helpful.

The book's style

I have aimed to make the style of this book clear, easy to read, and jargon-free, wherever possible. The principle of 'Occam's Razor' is applied: that is, if more straightforward words or stories can be used to describe something, then it is those which will be chosen.

Reasons for writing

An approach which is effective

The many tools and techniques outlined in later chapters were field-tested over the past 20 years or so. They have been demonstrated to work both efficiently and effectively. Students of training workshops have reported similar success rates over the past six years or so. There is a growing body of practice-based evidence which shows significant reductions in suicide rates both in individual caseloads and within teams. It is my hope that soon, researchers will conduct a randomised control trial to demonstrate a clear evidence-base for SF suicide prevention, to be added to the seminal work of Franklin et al. (2012).

A shortage in the literature of effective brief therapy treatments for suicidal clients

From my extensive literature review, it seems the vast majority of research, review, and discussion material on the subject of suicide, is concerned with matters other than the matter of central concern: *the verbal and non-verbal communication that occurs in a 1:1 relationship with a suicidal person*. Instead, writers become lost in national suicide trends and statistics, methods used in completed suicide, community attitudes, and beliefs towards suicidal behaviour, and so on. There are numerous research and discussion topics on suicide, generally, and these are dealt with more than adequately elsewhere. Should readers be interested in following up any of these, there are various avenues of inquiry. My concern is to emphasise the crucial matter of how to manage the one-to-one encounter with someone experiencing strong suicidal thoughts and ideas. There is a strong case for how the first ten minutes is conducted to make a significant difference to the outcome (see Chapter 7). This is the central focus of the book.

Personal involvement in the territory

My personal interest in this subject can be traced back to my early childhood years when I tried suffocating myself on many occasions, under the bed covers, in order to escape severe and enduring emotional abuse and neglect. On other occasions I prayed to God that he would take me away in my sleep. I am pleased to realise now that He had other plans! It is only in recent years, while talking to my brother, two years my junior that I learnt that he hoped to die too, as a way out.

No doubt another source of my interest is that my cousin, John Neil Henden, took his life by carbon monoxide poisoning some 15 years ago, as a result of various personal and employment difficulties. (He had been diagnosed earlier as being 'clinically depressed'.) His death impacted on me both in that I lost a cousin, but also the less-than-satisfactory treatment he received when asking for help. Both my personal experience of suicidal thinking and the experience of close family members, has given me a heightened empathy towards suicidal people.

The connections I have had with helping agencies, both statutory and voluntary, over the past 40 years or so, have opened my eyes to what works; what helps a little; and, what patently fails those whose problems and difficulties are such that they experience recurrent suicidal thoughts and ideas.

During the course of my life, to date, I have taken various calculated risks to achieve personal objectives. On some occasions these did not work out. At those times, I considered the suicide option, albeit briefly. I know now that this type of thinking is quite normal. At a time in the mid-1990s, I found myself in a changed job situation, where job satisfaction was deteriorating by the week. I began to have regular thoughts about how I might be able to set up an elaborate suicide in the cellars of the building in which I worked, and not be found for some time. I mentioned this to a very non-directive person-centred counsellor friend of mine, who responded in no uncertain terms by saying, 'John, you must leave as soon as possible!' My career, my contributions to the wider mental health field, and, my job satisfaction have progressed immeasurably since.

A How-to-do book

Practical guide

As you navigate through this book, you will get a clearer understanding of what is important to bring to the therapeutic encounter with a suicidal person, whether that be for ten minutes in an Accident and Emergency (A&E) Department, an Emergency Room (ER), or for a standard counselling session.

It is about how to be with the suicidal person. Much is taught about risk assessment and management: spotting the signs, applying various protocols and ensuring a rigid care programme is often set in place, but little mention is made about how, compassionately, to get alongside the person and their pain. This book is about just that.

All professionals undergo comprehensive training courses but, sadly, many graduates feel ill-equipped to deal with overt expressions of suicidal thinking or intent. Trimble, Jackson, and Harvey (2000) found that the majority of

psychologists working with clients who are suicidal, questioned the adequacy of their training in this area. This book addresses the shortfall of many courses, when it comes to working with the suicidal. A central aim is to increase confidence when working with such clients and also, to increase workers' sense of their own competence.

Help with 'the jitters'

In addition to feeling that their training has been inadequate in terms of what questions to ask and how to conduct themselves, and so on, workers can feel jittery or uncertain in a variety of ways. Richards (2000) when interviewing psychotherapists working with suicidal clients, found them to be deeply affected, both personally and professionally, by accompanying feelings of hopelessness and helplessness, and a sense of failure. I, and close colleagues, have found that this can result from particular lines of questioning – particularly those which go into excessive problem or despair-delving. This book enables workers to replace hopelessness and helplessness with hopefulness and a sense of feeling equipped.

Milton (2001), in an American study, reviewed several articles which addressed assessment and response to suicidal risk in clinical practice. He found many reasons why working with suicidal clients is particularly stressful. These included the fact that, as humans, we all experience a certain amount of anxiety about death, but there are also issues related to the levels of responsibility felt by therapists, should the worst happen, and the client take their own life. We must remember here that, when suicidal clients meet with either a professional or lay worker, their 'radar' is up, in that they have a heightened sensitivity towards, and awareness of the worker. Milton highlighted the danger in cases where the level of stress or distress experienced by the worker compromises their ability to be effective. Suicidal clients will pick this up as easily as a boxer sensing their opponent is feeling intimidated. Clearly, worker stress or distress is not helpful to client, therapist, or therapy. It is, he suggests, critically important for the therapist to attend to the suicidal thinking and ideas with as much respect as they would to anything else the client might present with. The key is not to panic. Once a therapist comes to understand the meaning and function of the suicidal thinking, they can work with it in a constructive way.

Reeves and Mintz (2001) used semi-structured interviews with counsellors to study their behavioural, cognitive, and emotional responses to suicidal expression, both on a personal and professional level. They found that the counsellors studied, experienced a range of responses including fear, anxiety, anger, and professional impotence. Self-doubt about professional competence was also

prevalent. Malinowski (2014) takes a detailed look at the nature of self-care, considering general stressors related to mental health practitioners' work, how to prevent burnout and secondary traumatic stress. Uniquely, he considers self-care in four dimensions of the psychological, the spiritual, the physical, and the social.

Reeves (2013), within a comprehensive work on counselling and psychotherapy, emphasised the importance of finding the right supervisor and making the most of supervision, to help with uncertainty.

Another concern amongst counsellors was the threat of litigation for negligent practice, should anything go wrong.

This book aims to replace the negative feelings mentioned above with calmness of approach; confidence in a way of working which works; and, a combined sense of challenge, hope, and optimism, thus removing or minimising any jittery feelings.

Relationship is key

Many suicidal clients will have made their minds up about the potential of the professional worker to help within the first few minutes of the encounter. It is crucial, therefore, that the worker gets it right in terms of what is important in establishing good rapport. (This aspect is dealt with more fully in Chapter 7.)

Carl Rogers (1951), in his *Client-Centred Therapy*, stressed that what is important is the trust that the therapist must have genuinely in the client: an attitude that trusts the client's capacity to change at every level. This quality is, of course, communicated to the client by the therapist's *genuineness* (authenticity, self-congruence), *unconditional positive regard* (non-possessive warmth, acceptance) and *empathetic understanding*. If this essential triad of qualities (or core conditions) for effective counselling is not in place, rapport will not occur and so no effective working relationship will be developed. I have come to the view that to some extent, these qualities can be developed on training courses.

Returning to genuineness in the therapeutic relationship, there is no real alternative to this. Clients' radar will pick up the slightest lack of it, as Truax and Carkhuff (1967) found. Even if the worker were a skilled, polished actor they suggest, it is doubtful that a therapist could hide his/her true feelings from the client. They go on to say, in this important study, that when the therapist pretends to care, pretends to respect, or pretends to understand, he is fooling himself only. The client may not know why the therapist is 'phoney' but he just knows. Clients can distinguish easily true warmth from phoney or insincere professional warmth. What can sometimes get in the way of professionals when working with clients is that either they have undue concerns about status or they want to masquerade as

a more genuine person. This hinges on the personality of the counsellor, rather than on their qualification and can, therefore, relate to both professional and lay therapists. There may be other factors as well which can hamper effective working with clients.

It is important to say some more about unconditional positive regard. Hurding (2003), in referring to it as 'non-possessive warmth', claims that the effective helper needs not only to be respectful and concerned towards the client, but also should be able to show that 'positive regard', both verbally (by words used) and non-verbally (through eye contact, facial expression, gestures, and silences). This warmth needs to be communicated, as people in difficulties are often desperate for someone *who really cares.* With this non-possessive warmth, it is helpful, Hurding suggests, if the counsellor is also at ease in the world of feelings and emotions – both his/her own and those of the client.

Accurate empathy (or empathic understanding) is the third core condition, which must be in place if rapport is to occur. Empathy may be defined as 'the power of projecting one's personality into, and so fully understanding, the object of contemplation' (Oxford English Dictionary). This sounds rather matter-of-fact, when applied to suicidal clients. A softer way of putting it might be to imagine being in the other person's shoes as if they were your own, but maintaining the 'as if' quality. Cole-King et al. (2009) talk about compassionate care and how clients appreciate being dealt with by compassionate clinicians. 'There is science enough to prove that compassion is not some woolly add-on we can afford to dispense with in our frenetic resource limited times: It is the creator and hallmark of quality care in' (p. 79).

So, to summarise, genuineness, unconditional positive regard, and accurate empathy must be in place for rapport to occur. The beginnings of a working relationship will then develop. Amazingly, all the above happens ideally within the first 10–15 minutes of the first interview!

The search for an approach that works

Reviews of the extensive literature show many cases where both academics and practitioners feel absolutely stumped as to what to do about high suicide rates among various sections of the population, despite their best efforts to bring about reductions. Heard (2000, p. 503) reviewed psychotherapeutic approaches to suicidal behaviours which have been well developed and been subject to randomised controlled trials. He looked at cognitive behavioural therapies, which included problem-solving therapies and cognitive therapies, and at outreach and intensive therapies (therapies that had outreach components to, or

intensified, standard psychotherapies). Heard considered first, whether the field had actually developed effective psychotherapies for suicidal behaviour. He found that, although a substantial amount of literature on psychotherapy existed for suicidal patients, a review of this literature revealed the absence of solid empirical data, particularly in the form of controlled treatment trials. With regard to the present solution-focused approach, this is called for within this book (see Chapter 11).

Prevention in the form of health promotion

Much has been written about the many and various strategies in targeting at-risk groups, providing better awareness, education, and signposting for when they feel at risk. This aspect of suicide prevention is a science all of its own and is outside the remit of this book.

Prevention in the form of effective interventions

Which treatments are effective?

Hawton and van Heeringen (2000, 2002), in their comprehensive study of suicide and attempted suicide, reviewed many different treatment strategies for suicide attempters. They suggested, of relevance to the primary care physician, is the fact that to date no form of treatment has been shown to be clearly effective in reducing the risk of repetition. How damning an indictment is this? Hawton and van Heeringen went on to say that continuity of care is a problem. A good question to ask here is: 'Was the therapeutic relationship established sufficiently well for the client to want to come back?' (see below and in Chapter 77).

Michel (2000, p. 668) said, 'There can hardly be any doubt that a trusting and consistent relationship with a health professional is of eminent importance.'

Gunnell (1994), in examining the evidence on the available interventions and points of access to the population at risk (i.e. suicidal clients), concluded that 'No single intervention has been shown in a well conducted, randomised, well controlled trial to reduce suicide.' Winter et al. (2014), in a systematic literature review, showed there was evidence for the effectiveness of the following approaches: cognitive behavioural therapy, dialectical behavioural therapy, and problem-solving therapy. The authors concluded that people at risk of suicide should have access to psychological interventions, broadly from within the

cognitive-behavioural spectrum. However, other therapies, which have been under-researched, have shown promising findings and these should be a research priority.

Gunnell (1994) called for more research into various interventions, and before the effectiveness of any intervention is accepted, controlled research is needed. The Gotland Study (Rutz, von Knorring, & Walider, 1989, pp. 22–23) was a programme targeting general practitioners (GPs) on an island off the coast of Sweden. Ten of the 18 GPs on the island of Gotland were given a two-day training course encouraging the early diagnosis and treatment of depression amongst the island's population. Following the programme, significant reductions in the suicide rate were noticed, and a reduction in the sickness rate for inpatient care for depressive disorders and the prescribing of tranquillisers was also achieved. Two years after the programme, both suicide rates and inpatient care for depression rates increased to the levels prior to the educational programme. Methodologically, the Gotland Study has received a degree of criticism. However, Macdonald (1993), by using a five-year moving average, after referring to a follow-up study, showed that the suicide rate had been on a downward trend for some years anyway, before the intervention. By making this point, I am not putting forward a case against better GP training in the area of depression identification and suicide detection: the more training, the better. One such training programme is Srivastava (2014) which was developed for education and training. Srivastava suggests there is strong evidence that the training of family physicians improves the outcome of identification and intervention for suicidal behaviours.

Silverman and Maris (1995) said 'It still remains an open question whether the development and implementation of successful preventive interventions will lead eventually to a refinement of development of a set of specific interventions for those already expressing self-destructive intentions.' As will be seen in later chapters, the good news is that there are some very successful preventive interventions outlined for immediate application by both professional and lay practitioners. Randomised controlled trials, as called for by Gunnell (1994), will be needed before these can be accepted as mainstream. The practice-based evidence, however, is building. Scott and Armson (2000, p. 710) and the work of Cole-King and colleagues (www.connectingwithpeople.com), have come nearest in support of the approach described in this book. In one section towards the end of their comprehensive review, when discussing potential developments in treatment they stated: 'It is essential that pragmatic brief therapies suitable for a sizeable proportion of suicide attempters, be developed.' Solution focused brief therapy is one such brief therapy and is a promising development.

Financial considerations

Another reason for this book is that the approach presented, is a cost-effective way of working with suicidal people. Allowing people with suicidal thinking to become psychiatric patients is a costly business, especially if they are admitted to an inpatient unit and receive lengthy aftercare.

In the first quarter of 2015, NHS trusts in England, racked up a deficit of £930 million (BBC News, 2015); so any ways in which scarce resources can be spread further to help the greatest number, must be welcomed. Heard (2000, p. 503) stated: 'In view of the limited resources for healthcare, those developing and delivering psychotherapies must now also concern themselves with the financial cost, as well as the clinical success of their therapeutic approach.' Also, the rising costs of drugs, more expensive sophisticated equipment, 'health tourism', and an ageing population, have stretched resources vastly.

Resources for working in the field of mental health have never been and will never be sufficient. Within the NHS over recent years, they have been stretched further as more money has gone into areas of healthcare provision seen as more glamorous; and towards projects which have achieved waiting list reduction for investigations and operations. Recent pay increases and the rising costs of drugs have also stretched resources vastly.

Many mental healthcare trusts have been encouraged to work only with 'serious mental illness' (SMI), turning away others whose degree of distress symptoms have been thought to be treatable within primary care. How many suicidal clients have not had the opportunity to be seen by specialists in secondary care, if they needed such an appointment? Waiting lists for outpatient appointments can be long in some areas.

A trend began in the 1980s towards GP practice counsellors. These counsellors, who generally, could offer around six sessions for GP referrals, again had long waiting lists, in some urban areas especially.

IAPT (Improving Access to Psychological Therapies) began in 2007 and is a national programme to increase the availability of 'talking therapies' on the NHS. Primarily, it is aimed at those who have mild to moderate mental health issues such as anxiety, depression, phobias, and post-traumatic stress. Cognitive behavioural therapy and interpersonal therapy are the main therapeutic techniques used. There have been many criticisms of the effectiveness of this programme (Summerfield & Veale, 2008; Timimi, 2015).

The employee assistance programme (EAP) sector has grown rapidly since the 1990s with many more organisations – both public and private sector – having enabled their workforces to access what is a truly confidential service. The downside recently has been that this sector has become more competitive with both the

number of sessions available to employees being reduced, and the hourly fee for counsellors being frozen at a low level. With takeovers and amalgamations, there are now much fewer EAP organisations.

Within the burgeoning private sector for counselling and therapy provision, there is a wide range of session fees charged, putting an increasing burden on clients who often have limited financial resources.

Solution-focused brief therapy (SFBT) has provided an optimum level of service to both public and private sector organisations for well over 30 years now. The solution-focused approach to mental health aims to be respectful, effective, empowering, and long lasting: it is cost-effective in terms of time and financial resources. Above all other considerations, these two factors have made the solution focused approach attractive to managers. After training their workforce in SFBT or recruiting staff with solution-focused skills, it does not take long to notice increases in caseload turnover, client goals achieved more quickly, fewer sessions needed, increased worker morale and higher staff retention rates (see European Brief Therapy Association website: www.ebta.nu).

This approach is applicable in wider services than just the mental healthcare sector. It is being taken up in education (Department of Education and Skills, 2003; Rae & Smith, 2009), social work, and probation (Milner & O'Byrne, 1998; Milner & Myers, 2007; Corcoran, 2015), the Prison Service and Youth Service, severe trauma recovery (Henden, 2008) and, importantly, the business sector (Lueger & Korn, 2006; McKergow & Bailey, 2014). All of these have embraced solution-focused ideas, with highly effective results being obtained.

Within the mental healthcare sector over recent years, we have seen cost-effective applications of solution focused ideas to alcohol abuse (Berg & Miller, 1992), eating disorders (Jacob, 2001), sexual abuse (Dolan, 1991), abuse and trauma survival (Dolan, 1998), and speech and language difficulties (Burns, 2005). Within all of these specialist areas, not only is there greater client satisfaction, but clients are held on caseloads for less time, with enormous savings resulting. Some of the longer-term savings are hard to calculate when consideration is given to the lower incidence of future physical problems, fewer re-referrals and other social and welfare services which are no longer needed as clients have built their own unique solutions and sorted their lives out. This is not to claim that this is true in every case, but the gathering body of evidence all points in this direction. There is scope here for some future research with a rigorous methodology using double-blind trials. I will refer to this again later. Maybe, also, some retrospective research could be useful, looking at large populations who have been exposed to different treatment approaches.

The subject of this book – the solution-focused approach to suicide prevention (Henden, 2005, 2008) – is now another specialist area which could have the cost-effectiveness spotlight cast upon it. Hospital admissions, long-term outpatient follow-ups, community mental health workers' time and long courses of psychotropic drugs, all add up to considerable expense. Many service users who are served by this route, also end up losing their job, spouse, and home; with other financial, personal, and social costs resulting.

Four to five sessions of SFBT from a healthcare professional trained in a particular range of specialised tools and techniques for working with suicide, adds up to a fraction of the cost.

UK health of nation and our healthier nation targets

Just before the turn of the present century, the UK Government produced a White Paper, *Saving Lives: Our Healthier Nation* (Department of Health, 1999), for a 20% reduction of suicides by 2010 which looked unrealistic.

The White Paper acknowledged that suicidal thoughts in the wider population are quite common, but are rarely acted upon. To support this, I am sure many can recall times in life when they have been under severe strain for whatever reason and at these times may have had a suicidal thought come to mind, albeit fleetingly.

Figures show that suicide rates within the UK are reasonably similar in England, Wales, and Northern Ireland, but Scotland's rate is slightly higher. It is noted, however, in the White Paper that suicide rates for the UK as a whole are one of the lowest across Europe.

Quite rightly, *Saving Lives: Our Healthier Nation* puts an emphasis on better mental health promotion as being a mainstay in reducing both the incidence of mental illness and the suicide rate. The first of two new National Service Frameworks has mental health as its subject. National standards have been set and service models defined for mental health promotion, suicide prevention, assessment, diagnosis, treatment, rehabilitation and care. The Frameworks are to be used to ensure that professional staff in these areas have the skills to detect early signs of mental illness and to assess suicide risk. Another valid question to be asked is: 'Have all these professional staff now obtained the necessary skills, not only to assess suicide risk, but to treat effectively the suicidal people whom they have assessed?' And if they have not had this training themselves, have the specialists they are referring onto had this professional training? What treatment models are being used and how much is their practice evidence-based? There is a real opportunity here, with appropriate and well-funded training, to reduce the suicide

rate significantly. There is a growing body of research to show the unacceptably and astonishingly high rates of suicide in recently admitted patients (Hunt et al., 2013), residing inpatients (Burgess et al., 2000 De Leo & Sveticic, 2010 and, Jayaram, 2014 And, recently discharged patients (Hunt et al., 2009; Redding, 2012; Bickley et al., 2013; and, Ahmedani et al 2014These high rates of suicide amongst those who have come for help provoke a long list of awkward questions.

The UK Government White Paper sets out to put in place a range of actions to reduce suicide. This would be achieved not only within the National Health Service (NHS) and its partner agencies, but in the media too. There would be others (e.g. pharmacies) who could be encouraged to reduce access to the methods of suicide. I believe that by setting a maximum number of paracetamol tablets to be purchased at any one time, the number of deaths by this method has been reduced.

Saving Lives: Our Healthier Nation has a nine-step plan to reduce suicide. This plan covers important issues such as better follow-up of suicide attempters, improved helpline services, and good practice guidelines for looking after suicidal people in both primary and secondary care.

The National Service Framework for Mental Health, in setting standards and service models in accordance with *Saving Lives*' recommendations, had a clear drive towards implementation and delivery. This was seen as a key element in reducing the suicide rate by a fifth by 2010, as it addressed the whole range of mental health service provision from primary care settings to formalised, secondary healthcare – the specialist mental health services.

In attempting to ensure that all this worked, the UK Government set up a high-level Task Force, accountable to the Chief Medical Officer. It was the Task Force's job to ensure that all the essential groundwork was in place to set the course of achieving the target for so many more lives to be saved (up to 4,000), which would be lost otherwise to suicide. In 2013, the National Confidential Inquiry into suicide and homicide produced a report (NCISH, 2013) which looked at reductions in suicides as a result of inpatient service changes, like removal of ligature points. Reductions in the number of deaths resulted.

In earlier works (Henden, 2005, 2008), I called for research into specialised solution focused interventions for those practitioners working with the suicidal population. In the meantime, the more practitioners – both professional and lay – that apply the principles, tools, and techniques outlined, the greater the body of evidence that can be gathered. My hope is that a wider application of this ground-breaking approach will make a significant contribution towards reducing suicide rates both across the UK and worldwide in the years to come.

The World Health Organisation (WHO)

For many years, WHO has been concerned about the global mortality rate resulting from suicide. In the year 2000, it was estimated that 1 million people died through suicide, which approximated to one death every 40 seconds.

WHO stated that suicide, which has increased by 60% worldwide over the last 45 years (WHO, 2000), is now amongst the three leading causes of death in the 15–44 years age group. The figures for suicide do not include attempted suicide, which is up to 20 times more frequent than completed suicides. In countries with market economies and the former communist bloc economies, suicide is estimated to represent 2.4% of the global burden of disease by 2020. WHO produced a publication, *Preventing Suicide: A Global Imperative* (WHO, 2014b), one of its stated aims being to make suicide prevention a higher priority on the global public health agenda (see Chapter 14 for more discussion on this).

The report provides a global knowledge base on suicide and suicide attempts. Also, it outlines actionable steps for countries based on their current resources and context, to move forward on suicide prevention.

Mental health problems, particularly depression and substance abuse, are connected in some way with more than 90% of all cases of completed suicide.

WHO is concerned about effective interventions and is aware of both the challenges and obstacles to any strategy to reduce the suicide rate. It points to the restriction of access to the common methods of suicide as being effective in reducing suicide rates. It calls for more crisis centres and states that there is compelling evidence for reducing suicide rates, resulting from the inadequate prevention and treatment of depression, alcohol, and substance abuse. With regard to reducing youth suicide, WHO points to school-based intervention programmes which involve self-esteem enhancement, crisis management, the development of coping skills, and healthy decision-making strategies.

One of WHO's specific objectives (WHO, 2000) was to raise general awareness about suicide and provide psycho-social support to people with suicidal thoughts or experiences of attempted suicide. If the contents of this book can help WHO with this objective, again much will have been achieved.

WHO made some helpful recommendations during the 1980s and a few countries (especially Canada, the United States, and the Netherlands) established national task forces, which were charged with devising all-encompassing national programmes for the reduction and prevention of suicidal behaviour (Diekstra,

1989). The main recommendations of these task forces, based on the WHO recommendations, were:

1. Scientifically sound information on the causation of suicide behaviour, the efficacy of intervention and prevention schemes, and effective methods for implementing such schemes in a variety of cultural and socio-economic contexts should be assembled;
2. Services dealing with suicidal persons or persons at high risk for suicidal behaviour should be expanded and improved;
3. Effective information and training should be provided for relevant organisations and the general public; and,
4. Special services should be provided for high-risk groups.

The WHO European Ministerial Conference on Mental Health in January 2005 called for an Action Plan for Europe. Two actions to consider were: (a) to establish self-help groups, telephone helplines, and websites to reduce suicide rates; and, (b) to target particular high-risk groups.

Contact with health professionals

Many who take their lives have been/or are currently in contact with health professionals. It says something about our services, when those in the midst of despair and hopelessness do the right thing by going for help, only to be let down in some way or another by the practitioners they are seen by. Questions have been asked and are still being asked about what happens in these cases:

> How have they been let down?
> What did the distressed person not find in the practitioner?
> In what ways were they not helped?
> What could the practitioner have done differently to have been more helpful?
> Did the person feel they were taken seriously enough and, if not, how not?

Almost all suicidal persons who contact physicians want to live (Tabatchnik, 1970). Barraclough et al. (1974) found that two-thirds of successful suicides had contacted their family doctor in the month before their death; 40% within the previous week. Similar figures have been reported by Murphy (1975), Morgan (1979), Michel (1986), Aldridge (1998), Gunnell (1994), and, Pirkis & Burgess (1998). Luoma et al. (2002) found in a review that 75% of suicide victims had contact with primary care providers within the year of suicide, and approximately

one-third of the suicide victims had contact with mental health services. Also, they found that about one in five suicide victims had contact with mental health services within a month before their suicide.Also, regarding secondary care by specialists, Barraclough et al. found that over a quarter were seeing a psychiatrist, and 80% of these were receiving psychotropic drugs. The issue of drug therapy for people who are suicidal has been a contentious one for some time. Morgan (1979) suggested that 'over half of all suicides are under medical or psychiatric treatment at the time they kill themselves and are receiving some kind of psychotropic drug' (p. 79). As self-poisoning with prescribed drugs is a large problem, he recommended practitioners question the efficacy of drug treatments, by asking themselves: 'Is this the correct dose; and should anything be prescribed at all?' Stenger and Jensen (1994), in discovering that many people had contacted some kind of help agency before killing themselves, found that two-thirds of those who contacted their GP had received medication. About half of these had used the medication to poison themselves.

Morgan (1979) found with regard to potentially suicidal patients, that although they made contact, many were 'not regularly recognised as being at risk of suicide' (p. 75). With regard to how the practitioner reacts, he found that 'a suicidal individual is more likely to declare his problems and actively turn for help if he thinks that a positive response will be obtained'. Maybe this is a statement about potentially suicidal people making a judgment on the ability of the practitioner to be accepting, genuine and empathic, as described above and looked at more closely in Chapter 7. For those who take their lives shortly after seeing a practitioner, clearly something is going wrong in that interview. What did the client not feel from the worker? Retrospective studies are of course not possible with the deceased; the results might help inform our training programmes for key groups of health workers. An interesting piece of research, which might shed some light on this area, would be to question serious suicide attempters who failed, due to circumstances outside their control. Morgan (1979) calls for medical staff to be trained in developing better skills in the area of relating well to suicidal individuals:

> We often forget the utmost importance of the basic ingredients of the helping process …
>
> Our ability to empathise, and our non-judgmental acceptance of the patient and his problems.
>
> (Morgan, 1979, p. 64)

Others have considered the need for better training generally, in this area (Maris et al., 1973; Bongar, Lomax, & Harmatz, 1992).

Vassilas and Morgan (1993), in reviewing case studies, found that approximately 40% have had contact with a healthcare professional in the month before death, and 25% in the week before. Of those who successfully kill themselves, 50% were found to have been under psychiatric care at some stage in their life and 25% were currently, or were recently under such care. Appleby et al. (1999) support these last figures. A UK Department of Health (10 May 2005) Press Release stated that one in four suicides are among people in contact with specialist mental health services, in the year before their death (Walsh et al. 2015). A systematic and meta-analysis review study concluded that the rates of inpatient suicides are excessively high when compared with the general population. Sakinofsky (2014) found that about 1500 suicides occur in US inpatient units annually (one-third of them on 15/60 watch) and 200 in the UK.

An annual report of the NCI (Appleby et al. 2013) in the UK covering 2001–2011 found that 25% had had contact with mental health services within the previous year; inpatient suicides accounting for 10% of total.

Meehan et al. (2006), from a four-year survey, reported a suicide rate of 16% among current inpatients & 23% within three months of discharge from psychiatric inpatient care. Post-discharge suicide was most frequent in the first two weeks of discharge, the highest number occurring on the first day. Conwell (1994), in referring to studies of older adults, found that many who took their lives had visited a primary care physician very close to the time of the suicide: 20% on the same day, 40% within a week, and 70% within one month of the suicide.

These findings raise more interesting questions. First, what was the quality of the care and treatment from the professionals first seen, and second, what was the type and quality of the treatment intervention such that a person decides eventually to take the last resort option?

Diekstra (1992) pointed out that no studies control for the effect of treatment history on subsequent attempts. Many suicidal people, including first attempters, have been in contact with helping agents and/or healthcare professionals and their experience in this respect may have been negative, rather than positive. With regard to future help, therefore, they may have negative expectations. This would go a long way in explaining low compliance with treatment services which is reported in most studies. So, it is this emphasis on the importance of the *relationship* that I want to cover in this book.

Feelings of isolation and being ignored

Whether someone has made a serious attempt and failed, or has made a cry-for-help, it is interesting to hear what survivors have said about how they were treated. Research in A&E Departments of general hospitals, has found that