IASP’s 2011 Agenda Sparkles with Events and Plans

September 2011 marks the occasion for IASP’s 26th World Congress in Beijing, to be jump started with World Suicide Prevention Day on September 10th. I very much hope to see you in China and eagerly await hearing of your plans for promoting suicide awareness and prevention in your home country on the 10th.

At our biannual general assembly meeting in Beijing, you will learn about several exciting programmatic initiatives being put into place by your board, ranging from development projects to a significant new membership campaign, designed to increase the reach and strength of the organization. As an organization, we remain healthy and positioned to make significant impact – but we are an organization of individuals and each and every member needs to be part of the whole in a way that the whole is greater than the sum of its parts. Please make your plans NOW both to attend the Beijing Congress and to be active on WSPD. Thank you!

Lanny Berman, Ph.D, ABP, IASP President

IASP World Congress in Beijing

IASP’s 26th World Congress will be held in Beijing from September 13th to 17th, 2011. This is the second time a world congress on suicide prevention will be held in Asia. The first was in India in 2001 – highlighting the important role of the Asia-Pacific in the global effort to reduce the toll of suicide. The central focus of the 26th IASP Conference is: Integrating Cultural Perspectives in the Understanding and Prevention of Suicide, a timely topic which will attract many participants from all continents!

An exciting conference program has been prepared, including experts from all over the world, such as: Lanny Berman, Eric Caine, Cindy Claassen, Yeates Conwell, Paul Corcoran, Diego De Leo, Madelyn Gould, Onja Grad, Keith Hawton, Nav Kapur, Ad Kerkhof, Birthe Løn Kniezk, Konrad Michel, Brian Mishara, Merete Nordentoft, Stephen Platt, Jane Pirks, Ping Qin, Xiao Shuiyuan, Morton Silverman, and Wang Xiangdong.

A wide range of important topics will be covered, including:

• New insights into treatment of suicidal behavior
• Postvention in different cultures
• Evidence-based suicide prevention strategies in schools
• Changing paradigms: Classification of suicide in ICD-11 and DSM-IV
• Information-communication technologies and suicide prevention
• Suicide prevention and new media

In addition to Plenary Sessions, participants can select a wide range of Symposia, Workshops, Debates and Master Classes to allow for in-depth discussion for those working towards the global goal of preventing suicide and of improving our strategies to deal with the consequences of suicidal behavior. A variety of social activities will be arranged for those who wish to explore the rapidly transforming culture of China’s capital or make side visits to other parts of China.

Welcome to Beijing!

Yueqin Huang, MD, MPH, PhD, Professor of Psychiatric Epidemiology, Institute of Mental Health, Peking University, Beijing

Important Dates:

• 31st May: Response to authors about acceptance of abstracts
• 15th June: Authors need to confirm participation
• 1st September: Deadline for registration

Congress Contact Details

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World Suicide Prevention Day 2011

The theme for the World Suicide Prevention Day (WSPD), 10th September 2011 is “Preventing Suicide in Multicultural Societies”.

The theme aims at raising awareness of the fact that all countries in the world are multicultural. Many countries harbour different minority groups in the form of various indigenous and/or immigrant groups, refugees and/or asylum seekers. Some countries also comprise many different ethnic groups due to artificial borders having been drawn by former colonial powers. This means that in all countries there are a variety of ethnic and religious groups living in the same society.

National suicide prevention strategies have now been implemented in several countries, but not all of them reflect the fact that the country is multicultural. The strategy/program is often aimed at a majority population, and a specific cultural perspective or focus is missing. Strategies therefore may need revision with this in mind and countries still not having initiated suicide prevention efforts should integrate a cultural perspective from the start.

Suicide prevention in multicultural societies requires cultural sensitivity as well as cultural competence, and needs to be targeted multidisciplinary. More information will be provided in the upcoming WSPD brochure to be published shortly.

The World Suicide Prevention Day brochure is available online at: http://www.iasp.info/wspd/index.php

You may want to use the actual link: http://www.iasp.info/wspd/pdf/2011_world_suicide_prevention_day.pdf

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Organisational Rep: Dr Jerry Reed
FROM THE PRESIDENT

Thomas Kuhn’s 1962 book, The Structure of Scientific Revolution, presented and popularized the concept of “paradigm shift.” The advancement of science, Kuhn argued, was not evolutionary, but rather a “series of peaceful interludes punctuated by intellectually violent revolutions.” These revolutions serve to replace one conceptual view with another.

Beyond the eyes and ears of most Suicidologists, such a paradigm shift may be occurring in our field at the very moment; in fact, paradigm shifts may be occurring and, at that, in diametrically opposed directions. One shift is occurring in the world of public health, the other in the world of mental health. Both have major implications for our field.

ICD-11

The International Classification of Diseases (ICD) provides the global standard to classify diseases and health-related problems. The ICD is revised periodically; the ICD-10 was adopted in 1990. Currently, proposed revisions toward the adoption of ICD-11 are open for comment.

One proposed revision is to restructure external causes of injury, suicide being an intentional injury. In ICD-10, when a non-natural death occurs or a nonfatal act of self-harm brings the perpetrator-victim to the emergency department (ED), the injury is coded first for Intent, then Mechanism, then Object. For example, if an individual shows up at an ED having cut him/her self with sharp glass, the coding might reflect the injury as intentional (assuming it was assessed to be), by cutting/piercing (Mechanism) by sharp glass (Object). Similarly, one might intentionally or unintentionally (Intent) fall (Mechanism) from a man-made structure (Object), such as a building. Further positions in the coding sequence delineate, for example, different sub-types of Intent. In the current ICD-10, Intent in is the first coded position. What is being proposed and considered is to move Mechanism to the first coded position, to be followed by Intent, so, for example, the injury coding will then be sequenced fall (Mechanism) intentionally (Intent) from man-made structure (Object).

The primary rationale for demoting Intent in this coding sequence is that (a) intent is not always easy to ascertain, whereas Mechanism is, and (b) it is more important to the international injury prevention community to, first and foremost, learn about Mechanism. That said, injury prevention specialists who are in favor of this change may not include injury prevention specialists who are Suicidologists. Embedded in the rationale for the proposed change is the reason why many in the Suicidology community are less than sanguine about this proposal, i.e. the further down Intent is in the string of items to be coded, the less often Intent will be inquired about, hence coded; consequently, suicidal behaviors will simply be coded less frequently and valuable data will be lost. Many of our colleagues are quite anxious about the impact this proposed change may have.

DSM-V

Since 1952, the American Psychiatric Association has published the Diagnostic and Statistical Manual of Mental Disorders (DSM), the bible of classification of mental disorders used in the United States and in many other countries around the world. The latest revision (DSM-V) is expected to be published in 2013 and its proposed changes are currently being discussed and field tested.

Two separate working groups are considering proposals to make both Suicidal Behaviors and Non Suicidal Self Injury unique diagnostic entities, i.e. disorders, in DSM-V. If these proposals become the law of the mental health land, a major shift in epidemiologic research will result; now non-existent data system linkages will become realities; documentation of clinical histories, hence inter-caregiver communication and patient care will improve dramatically, adverse events will be more validly reported, etc. – all powerful arguments for elevating suicidal behavior to the level of a disorder. That said, there are some major fault lines in the current proposal, and there also may be some major unintended negatives in doing this.

In contrast to the proposed changes in the ICD, the process for which has been reasonably transparent and in which the proposals themselves have been and remain open to comment, proposed changes to the DSM have occurred behind closed doors among a closed circle (the working groups) and only just now are beginning to come to light. It is unclear, however, whether it is too late for that light to shine back on these proposals before they become set in stone. The lack of transparency in this process has made a great many of our colleagues anxious.

IAST’s Death Certification Task force, headed by Paul Corcoran, is hard at work building its commentary regarding the proposed ICD-11 revision. Until we learn more about the DSM-V proposals, IASP members cannot build such a similar commentary. Cindy Claassen is on board to give a plenary presentation at IASP’s Beijing Congress this coming September on both these paradigm shifts and will better explain them and offer much greater insight into their pros and cons than I am able to at the time of this writing.

That these paradigm shifts are being well attended to in these ways by IASP and its members is just one more argument in favor of getting our colleagues to join IASP and to come to Beijing. Whether proactively or reactively, IASP, organizationally, and its members collectively have a great deal to say to influence the future of our field.

Cindy Claassen’s presentation is but one great reason to
(1) make plans now to come to Beijing, and the importance of these paradigm shifts to our field argues strongly for
(2) encouraging your colleagues to join IASP to help make our collective voice all that stronger.

I trust you will seriously consider and act favorably toward both of my proposals.

Lanny Berman, Ph.D., ABPP

REPORT FROM A NATIONAL REPRESENTATIVE

COUNTRY REPORT FROM RUSSIA

In Russia, in 2009 the suicide rate was 26.5 per 100,000 (vs 39.3 in 1999) and has declined during the past decade, possibly due to greater social stabilization in the country. Levels of suicide across regions in Russia vary considerably. Older people and rural residents are at particular risk for suicide as are social vulnerable groups. In Russia, there is no national suicide prevention programme. However, in some regions (e.g. Omsk, Sverdlovsk, Tomsk, Irkutsk) motivated and committed professionals (usually psychiatrists) have attempted to create integrated systems of care and prevention of suicidal behaviour. In the 80s the following steps were taken: telephone crisis care for adults, children and adolescents, medical and psychological support in mental health outpatient clinics and inpatient clinics. Ten to fifteen percent of people who survived a suicide attempt with serious mental disorders received treatment in psychiatric hospitals and psychiatric outpatient clinics. Systematic care (mainly pharmacotherapy) has become available only in recent years. Scientific research into identification of risk factors for suicidal behaviour in different age, professional and national groups is conducted in a few Russian scientific centers (e.g., Moscow, Tomsk, Krasnodar), National conferences for psychiatrists cover issues in relation to suicide. The first National Clinical Guideline «Psychiatry» (Dmitrieva et al, 2009) contributes to optimizing diagnosis and therapy, such as depression and acute suicidal crises. The Moscow Institute of Psychiatry offers a number of initiatives leading up to a future national suicide prevention programme: 1) Regional suicidological services, 2) Assessment of the burden of suicide and suicide attempts, 3) Suicide awareness in primary care, psychiatric services and in schools, 4) Holistic assessment of biopsychosocial approaches in specific patient groups. As part of national suicide prevention programme, we will establish other major initiatives such as interdisciplinary team cooperation of specialists and volunteers in public organizations, media guidelines for reporting of suicide, training of psychiatrists and social workers.

Evgeny Lyubov
Head of the Department of Suicidology, The Moscow Institute of Psychiatry and National Representative, Moscow, Russia, e-mail: lyubov.evgeny@mail.ru.
Since the first Norwegian Plan for Suicide Prevention was launched in 1994, major initiatives and activities have been implemented in Norway. The main objectives have been to establish and strengthen and resource communities, stimulate more systematic research, initiate systematic knowledge distribution, and organise public information sessions. Several centres, institutions and NGO’s are involved in a wide range of activities. Some institutions mainly focus on primary suicide prevention tasks through different kinds of research projects, whereas others are involved more intensively in increasing knowledge distribution and awareness. The suicide prevention work is located within three different groups which have collaborative links:

1. The National Centre for Suicide Research and Prevention (Professor Lars Mehlum) has research, dissemination of knowledge and counseling as their main areas of work. The Centre is running a masters in psychosocial work and suicide prevention, a website, a journal (Suicidology), as well as several research projects. Among the studies are: a) A study of DBT versus TAU in child and youth psychiatric clinics, b) A study of the chain of care for suicide attempters, and c) Evaluation of existing routine treatment for patients that are hospitalized for deliberate self-harm in emergency medical hospital units.

At the Ulleval Hospital Research Unit (Professor Øivind Ekeberg) several research projects are being conducted: a) Clinical, psychosocial and prognostic aspects concerning self poisoning, b) Follow-up after a suicide attempt by general practitioners (RCT), suicidal behavior among the elderly, c) The reliability of the suicide statistics in Scandinavia, d) Medical, ethical and psychodynamic aspects of suicide, and e) A study of the registration processes, law regulations and changes of classification for mortality coding and mortality statistics.

Finally, The Norwegian Institute of Public Health, the Suicide Research and Prevention Unit (Dr Gudrun Dieserud/ Dr Kari Dyregrov/Professor Heidi Hjelmeland and 2 PhD students) are working on: a) A large qualitative autopsy study aiming at generating phenomenological based understanding of the psychological mechanisms that are involved in the development of suicidal behaviour, b) Mapping the frequency of suicide in single vehicle road traffic accidents, c) General suicide statistics, d) A study of gender differences and suicide attempts, e) A longitudinal prospective study of suicidal behaviour, and f) Suicide bereavement in Sami (indigenous) regions of Norway.

2. A second group consisting of five Regional Centers for Violence, Traumatic Stress and Suicide are working mainly on knowledge distribution and awareness. Important work includes: a) Suicide prevention education for elderly people, b) Supervision of refugee reception centres, c) Implementation of National Guidelines in psychiatric health care, d) Cooperation with the Norwegian Association for Suicide Survivors (LEVE) to improve the situation for suicide bereaved people, e) Registration and evaluation of the effectiveness of bridge barriers to prevent suicide, and f) Suicide prevention education for lay people, teachers, students and professionals.

3. LEVE is an NGO for suicide bereaved people, working with support and care for their members through information, grief groups, telephone lines, etc. In 2009, a documentary for television was produced, and at present LEVE works on a list of local crisis teams to be distributed to all working in the field so that people bereaved by suicide can receive instant professional help when needed. A national conference about suicide prevention and immigration will be held in addition to local events in 19 counties on World Suicide Prevention Day 2011 (amounting to 25–35 registered activities including seminars, theatre plays, new circus, music, stand up). Also, LEVE is working on a project together with representatives from the ambulance service and police to get a public praxis of helping out with the expenses due to cleaning service after a suicide.

Dr Kari Dyregrov, Norwegian Institute of Public Health / Center for Crisis Psychology, National Representative for IASP, Bergen, Norway.

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US CONFERENCE A HUGE SUCCESS

Despite rain and clouds outside of the conference center, in mid-April a record-setting 950+ gathered from around the globe at the 44th Annual American Association of Suicidology Conference in Portland, Oregon, USA. The conference was entitled: Changing the Legacy of Suicide and inside highly involved discussions, information sharing and support took place with more than six plenary sessions, hundreds of workshops and several awards for work in suicidology and 70 posters during the 3-day conference. A gathering of over 100 also attended the Healing After Suicide conference focused on bereavement and survivor programs with a keynote address by the wife of former actor Spalding Gray.

The meetings offered clinicians, researchers, advocates, students and survivors a wealth of the most current thinking and understanding of suicide and suicide loss. During the conference the US recognized the 10th anniversary of the US National Strategy for Suicide Prevention, announced expansion of task forces for special populations for the recently developed National Action Alliance for Suicide Prevention and released the new Media Recommendations for Reporting on Suicide.

A number of US and international IASP members were in attendance and presented at the meeting. IASP members can also congratulate Diego de Leo who both presented and received the Dublin Award given annually for recognition of a career of outstanding service and contributions to the field of suicide prevention as evidenced by leadership, devotion and creativity.

Dr. Daniel Reidenberg, US National Representative, e-mail: dreidenberg@save.org

Mort Silverman (SPRC), Lanny Berman (AAS), Dan Reidenberg (SAVE), Jerry Reed (SPRC)
Leading up to the 2005 Durban conference, Lars Mehlum invited LivingWorks to do an article on new developments in suicide prevention training (Ramsay, 2004). It identified ASIST’s (Applied Suicide Intervention Skills Training) historical links to earlier reports. Maris (1973) reported the existence of a core knowledge base in suicidology that wasn’t adequately disseminated to practitioners. Practitioner surveys revealed the lack of adequate preparation in higher education and absence of continuing education programs (Boldt, 1982). Snyder’s crisis management study (1971) advised against referrals as standard operating procedure in suicide prevention activities.

The founders of LivingWorks (Richard Ramsay, Bryan Tanney, Roger Tierney, Bill Lang) rose to the knowledge transfer challenge using state-of-the-art social R&D (Roth-Drodz, 2004). The newest development was virtual simulation practice and to guide real interventions. Working with ambivalence and the collaborative skill to listen to reasons for dying is a new priority in suicide intervention. This parallels proponents in psychotherapy who favor a collaborative responsibility in treatment care (Jobes & Drodz, 2004). The newest development was virtual simulation technology to help bridge skill retention gaps between classroom training and real interventions. The John Hopkins Applied Physics Laboratory, LivingWorks and Army Material Command partnered to develop a state-of-the-art ASISTR (Applied Suicide Intervention Skills Training Reinforcer). This program provides post-training support and practice with a virtual person, whose suicide risk is different each time it is activated. Although only a pilot demonstration, ASIST was in the process of a major update. LivingWorks (and others) continue to be strong supporters of virtual technology for supplementary post-training activities.

In 2004, a significant new program emerged from an Australian Defense Forces (ADF) invitation to build something between their use of ASIST and 1-hour awareness presentations. The result was safeTALK, a 3-hour suicide alertness program. It was piloted with ADF and fully produced in partnership with a major metro transit system and a large regional health center in Canada. It is rapidly becoming a broader community dissemination program that complements ASIST training. The value of this mix is increasingly apparent under national strategy implementations in Ireland and Scotland. Scotland did a national field trial and (positively) evaluated video conferencing delivery of safeTALK to rural and remote island regions. An exciting technology innovation for safeTALK is an approved Apple App of its “help card” for those trained in the program, complete with built-in GPS to locate referral resources.

SuicideCare is 1-day post-ASIST training with a primary focus on refining helping (clinical for some) competencies of helpers of persons at risk beyond the initial suicide crisis. It caters to a small but growing number in longer-term care roles. LivingWorks has been thoughtful about online suicide prevention activities. Its awareness program, SuicideTALK, is provided to ASIST trainers. It goes further upstream than most programs to focus on “awareness exploration” that invites participants to explore attitudes about open and direct talk about suicide in personal and community contexts. Participants explore an extensive matrix of motivational opportunities to help create suicide-safer communities. The TALK steps are shaped to help participants be open about the possibility of their own risk and how they can engage others in safety planning steps to be helpful when a trained helper is not immediately available. The online adaptation is underway with a leading edge e-learning partner.

LivingWorks’ founders have a long history on the side of seeing niche suicide intervention training become part of the “core business” of mental and behavioral health care providers. Collaboration with a large provider of adult services to persons with severe mental illness and incorporation of suicide prevention into their core business is a current test of whether a cultural shift of this magnitude can be modeled. LivingWorks also has a keen interest in furthering the field’s differential use of gatekeeper training between those with required-referral procedures and those with referral options in their safety planning framework and sufficient training for first aid intervention to be an end in itself.

Looking to the future, LivingWorks is engaged in higher level thinking about the traditional prevention, intervention and postvention framework for suicide prevention activities. A revised cycle model has led to some exciting possibilities in “upstream” prevention work and innovative responses to Ed Shneidman’s long held belief that “postvention is prevention”. Some of the work is well into the R&D process. Some is still conceptual. The commitment of LivingWorks to suicide-safer communities is deep and robust. We are proud of our sustained contribution to the development and delivery of community-based suicide prevention activities.

Richard Ramsay,
Co-founder and President of LivingWorks,
e-mail: richard.ramsay@livingworks.net
Reference list available upon request.

GOOD WORKS OF LIVINGWORKS

H e l p l i n e s a r e i n c r e a s i n g l y b e i n g r e c o n i s e d a s v i t a l c o m- ponents of a suicide prevention strategy. Their effectiveness lies in the offer of accessible (by phone), convenient (often 24/7 delivery) and confidential (no names) support to people who are in crisis. Accordingly, helplines can attract suicidal persons to reach out for help at a critical time, thereby enabling a compassionate response to be provided and the potential for life-saving intervention towards safety and continuing support.

International experiences on helplines are being shared and attention is being drawn towards framing principles and techniques for good practice. While helplines were developed as long ago as the 1960’s through the community mental health movement, it is a relatively recent development that sees a shift towards ‘evidence-based’ practice and definitions of intended consumer outcomes. Crisis theory and the principles of consumer empowerment have formed the basis for suicide helplines in their operation. Many helplines world-wide use volunteers and non-professional workforces in their delivery. This shows the ability of the helplines to harness community resources towards suicide prevention.
NEW REPORT

How to reduce risk of suicidal behavior after patients leave emergency departments and hospitals

The National Suicide Prevention Resource Center and the American Association of Suicidology are pleased to announce the release of Continuity of Care for Suicide Prevention and Research, a comprehensive report offering recommendations for the ongoing care of patients at risk for suicide who have been treated in emergency departments and hospitals. Based on an encyclopedic review and analysis of existing research, the 150-page report was authored by David Knesper, M.D., Department of Psychiatry, University of Michigan, and is the first review of continuity of care as a means to prevent suicide.

The report includes ten principles for improved continuity of care, and provides real-world examples of seven integrated systems of care in the U.S. and Europe. Other key recommendations for practice and research address: targeting high-risk individuals; improving education and training for suicide risk assessment; responding to patients who have become disengaged from treatment; coordinating care; and improving infrastructure to provide continuity of care.

The American Association of Suicidology and the Suicide Prevention Resource Center have collaborated to produce this document which was funded by the Substance Abuse and Mental Health Services Administration.

It may be downloaded from the websites of either organization at http://www.sprc.org/library/continuityofcare.pdf or at www.suicidology.org. We would appreciate your assistance in promoting this report and forwarding it to others who may find it useful in their clinical or research work.

Dr Jerry Reed,
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International Association for Suicide Prevention (IASP)

The International Association for Suicide Prevention (IASP) is a worldwide non-governmental organization dedicated to the prevention of suicide. In official relations with the World Health Organization, IASP’s members come from over 50 countries across the world.

IASP CONNECTS PEOPLE WORKING IN SUICIDE PREVENTION AND RESEARCH ACROSS THE WORLD!

BECOME AN IASP MEMBER TODAY! YOUR BENEFITS:

• Free access to Crisis – The Journal of Crisis Intervention and Suicide Prevention – 6 issues per year
• Reduced registration fee for IASP conferences
• Access to a large international network of experts in suicide prevention and research

WHY WAIT ANY LONGER? BECOME PART OF IASP NOW!

Membership Dues
( Opportunity to pay for 3 year membership at a reduced fee)
Membership dues according to the zones used by the World Bank.

Here is the link for the Membership Application page:
https://www.iasp.info/application.php
Here is the PDF Application Form link:
http://www.iasp.info/forms/2011_application_form_may.pdf

Individuals
Zone 1: US $170 (3 years $460)
Zone 2: US $140 (3 years $380)
Zone 3: US $120 (3 years $310)
Zone 4: US $95 (3 years $260)

Organization
( Less than $1 million pa budget)
Zone 1: US $200 (3 years $550)
Zone 2: US $150 (3 years $400)
Zone 3: US $130 (3 years $340)
Zone 4: US $100 (3 years $270)

Organization
( More than $1 million pa budget)
Zone 1: US $220 (3 years $600)
Zone 2: US $170 (3 years $460)
Zone 3: US $150 (3 years $390)
Zone 4: US $120 (3 years $300)

Students, Volunteers and Associate Members
US $90 (3 years $240)

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