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# Recovery-oriented practice

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Recovery from suicidality is possible. Anyone can use active listening to support a person in suicidal crisis to help them identify their own reasons to keep living. This is a first step to recovering from a mindset preoccupied with suicide.

People who think about and attempt suicide don't want to die: they want a way out of their intense, psychological pain or their deep sense of burdensomeness. Suicidal ideation may continue intermittently throughout someone's life, but with appropriate caregiver support, social connectedness, and hope, people can recover from suicidality (Player et al., 2015).

## The power of connection

Joiner's *Interpersonal theory of suicidality* posits that people who attempt suicide feel that they, and their life, are a burden to others. They lack connection to others or society in general. Also, they must be able to overcome the powerful instinct for self-preservation, and this can be done through a habituation to the fear and pain of self-injury through repeated exposure. All three elements must be present for someone to die by suicide; we are biologically hard-wired to live (Joiner, 2005).

At the point of suicidal crisis, the individual has typically lost all hope. They are experiencing deep psychological pain, or 'psychache', which causes their thinking to constrict, leaving suicide as the only option they can see. Shneidman, who coined the phrase psychache, stresses that suicide in not the wish to die but rather a means to ending the psychological pain (Shneidman, 1993). Research tells us that people in suicidal crisis report feeling more hopeful when someone actively listens, reserves judgement, and promotes self-empowerment (Gould, 2013). Being a friend and a skilled listener helps people move out of crisis towards recovery: everyone has a role to play.

One study of people planning to attempt suicide at the Golden Gate Bridge found that 90% of those who were noticed and spoken to by someone before their attempt – either by a passerby, bridge patrol, or police – did not go on to attempt again (Seiden, 1978). The intervention of just one person was enough to jolt them out of their constricted mindset, believing that suicide is the only option, and out of their state of acute crisis. This caring intervention can refute deep-seated feelings of isolation and provide a lasting anchor for that person: they are not alone, and people do care if they live or die.

An article about people planning to attempt suicide at the Golden Gate Bridge quoted the suicide note of a young man who died. It stated, "If one person smiles at me, I will not jump" (Friend, 2003, p.6). The man desperately sought human connection.

Other studies have looked at how “caring letters” sent to discharged psychiatric inpatients affect future suicide attempts; it was found that those who receive short letters with supportive messages attempted suicide less often than those who did not (Motto & Bostrom, 2001). These studies powerfully illustrate howeven the smallest gestures to connect can generate profound therapeutic effects.

## What we can do as individuals

People can learn to skillfully respond to people considering suicide. The Applied Suicide Intervention Skills Training workshop trains people to make such hope-instilling connections by helping spark a conversation with someone thinking about suicide. Through active listening, they create a safe space and opportunity for that person to talk about how they are feeling and to tell their story, reflecting on why they might want to die and beginning to see their own strengths, identifying their own reasons for living. As indicated above, people in suicidal crisis are ambivalent about dying – a caring conversation helps them see their own possibilities and why living is the better alternative to dying. The ASIST model leaves the locus of control with the person in crisis, as opposed to with the helper. This collaborative discourse encourages the person to take an active role in their recovery. Further, should the person consider suicide later in life, they have the strength of this past experience from which to draw. They know that they were able to pull through the crisis once, then they can do it again.

## How systems can support recovery

Systems that can meet the complex needs of individuals, such as Recovery-Oriented Systems of Care (ROSC), can help people thinking about suicide, as well as those experiencing mental health and substance use issues, recover.

A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliency of individuals, families, and communities to achieve improved health, wellness, and quality of life for those with or at risk of harms from alcohol and drug use. Some models emphasize abstinence. According to the Government of Alberta, a ROSC approach helps individuals build recovery capital, which are “identifiable resources, internal and external, that a person may call upon to enter recovery and rely on to help navigate their ongoing journey. (The 8 domains of recovery capital are:) physical and mental health; safe housing and healthy environments; employment and resolution of legal issues; vocational skills and educational development, safe and meaningful family, social and leisure activities; peer-based supports; community engagement and cultural supports; and (re)discovering meaning and purpose in life. (In Alberta,) outcomes in the 8 domains are measured and monitored to evaluate programs, and the success of ROCS as a whole, and to inform future investments” (Government of Alberta, 2023).

A ROSC empowers individuals to “address a wide range of needs outside of their diagnosis” (Alberta Health Services, 2020), including housing, employment, education, in addition to a mental health diagnosis of, for example, substance use disorder or bi-polar disorder.

Other tenets of a ROSC include: strengths-based and self-directed approaches; collaborative decision-making; individualized services and supports; community-based services and supports; and continuity of services and supports.

Recovery-Oriented Systems of Care do not address addiction and mental health concerns sequentially or separately and “do not use exclusion criteria or impose treatments.”

Recovery is unique to the individual with optimal services tailored to strengths, needs, perceptions and experiences, including trauma, substance use and mental health issues (Canadian Centre on Substance Use and Addiction (CCSA), 2017).

According to CCSA, “Such a system involves a network of coordinated services and supports that includes prevention, intervention, treatment, harm reduction services, monitoring and long-term recovery maintenance supports” (CCSA, 2017).

When the focus is on substance use in communities, the objective is to create an infrastructure or “system of care” with resources to effectively address the full range of substance use harms within communities. These include resources for the full continuum of care - prevention, early intervention, treatment, continuing care, and recovery - in partnership with other disciplines, such as mental health and primary care (Substance Abuse and Mental Health Services Administration, 2010).

Examples of interventions that address different aspects of recovery can include: supported housing, supported employment and continuing education (Alberta Health Services, 2020).

**The MESH Program,** offered by five non-profit organizations in Calgary, is an example of a collaborative model for the delivery of recovery-oriented services. The goal of the MESH program is to provide comprehensive services to people with complex needs by increasing efficiency and access to care.

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