



FROM  
THE PRESIDENT  
**I A S P**

Louis Appleby has made a bold assertion. Writing in *International Psychiatry* (Appleby, 2012), he stated, "There is now no shortage of evidence on how clinical services and health policies can reduce suicide."

Basing this opinion on data from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI), he referenced reduced rates of suicide coincident with changes in mental health policies on ward safety, drug treatments, and assertive outreach. Further, he pointed to a most important study published last year by While et al (2012) in *The Lancet*, which documented significantly lowered suicide rates among patients receiving at least 7 of 9 mental health service recommendations.

It is of interest, then, that more recently in the same journal, Keith Hawton and colleagues (Hawton et al, 2012) wrote (specifically regarding self-harm behavior and suicide among adolescents), "There is little evidence of effectiveness of either psychosocial or pharmacological treatment, with particular controversy surrounding the usefulness of antidepressants."

Although these statements appear to be somewhat contradictory, they are both true.

The While et al data mirror data in the U.S. from the US Air Force's comprehensive, 11-initiative suicide prevention program implemented in the 1990's (Knox et al, 2003) – this program has been associated with a sustained decline in suicide rates and other adverse outcomes – and declines in suicide rates consequent

to comprehensive process improvements in the care of depressed patients within the Henry Ford Health System (Coffey, 2007). In Nuremberg, Germany, a 4-level community based suicide prevention program was associated with a 32% reduction of suicidal acts (fatal and non-fatal) over 3 years (Hegerl et al, 2010).

One key to the success of these three programs is the word *comprehensive*; these positive results did not come from a single arrow sent toward its target, but an integrated number of initiatives that, as a gestalt, had a far greater likelihood of hitting the target. The second key to understanding these success stories is that they occurred in *bounded systems*, where leadership and management support, when sustained, was integral to ensure success.

What we are missing are studies of similar comprehensive programs of integrated initiatives in real-world, unbounded settings – in a city, in a county, in a state or province. It is high time we mounted such a study, got it funded over a sufficient term to demonstrate a desired change in suicide rates, rates of self harm, positive treatment outcomes, etc.

Similarly, it is high time to take a good, hard look at what clinicians do, know to do, and have evidence to support doing with patients at-risk for suicide. Appleby (2012) notes that the NCI consistently shows "that over 80% of patients who die by suicide [had been] seen by their clinical teams as low risk!" This is a chilling finding, one that ought to cause us to step well outside the box to address a wide range of researchable questions, the answers to which should guide the next generation of clinicians to make more evidence-based risk assessments and formulations. Mort Silverman and I are currently writing a series of papers on what clinicians currently do that lacks empirical justification, calling for a new look at received clinical wisdom and a re-

newed emphasis on needed research on suicide trajectories and near-term markers for suicide risk to guide clinical judgment and decision-making. Better risk formulations, however, can only inform better triage decisions and treatment planning. What remains is the need for significant emphasis on developing and increasing evidence-based interventions that can be implemented with those judged to be at risk. As it takes years for research evidence to translate into clinical practice, we must vigorously pursue these ends in order to have any meaningful impact on clinical behavior, no less on suicide rates, in the decades to come.

Yes, we can point to some prevention successes and, indeed, these need to be replicated, widely disseminated, implemented, and modified, as appropriate, across countries and settings; and, yes, we have a great number of research and service-related questions that cry out to be addressed and answered. We have generations of hard work yet in front of us.

Lanny Berman, Ph.D, ABP.

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## 15th European Symposium on Suicide and Suicidal Behaviour

Welcome to the 15th European Symposium on Suicide and Suicidal Behaviour (ESSSB15) which will take place on August 27–30, 2014 in Tallinn, Estonia.



Airi Värnik

The ESSSB is a bi-annual event, where people acting in the field of suicide research and prevention – researchers, clinicians, volunteers – can meet, share experiences and present recent achievements in order to save lives all over the world. The ESSSB offers a high-level scientific programme with plenary lectures, parallel sessions, workshops and posters, but also social events that connect conference participants in an informal way. The slogan of the ESSSB15 – "Suicide prevention is mental

health promotion" – emphasizes an integrated and hopeful approach to suicide prevention.

The ESSSB15 will be organised in a vibrant Nordic city, Tallinn, the capital of Estonia. Conference organiser is the Estonian-Swedish Mental Health and Suicidology Institute (ERSI, [www.suicidology.ee](http://www.suicidology.ee)).

Information about the ESSSB15 will be updated regularly on the website [www.esssb15.org](http://www.esssb15.org) and in the Facebook. Looking forward to see you in Tallinn!



Prof Dr Airi Värnik,  
ESSSB15 President

Ass Prof Merike Sisask and Peeter Värnik  
ESSSB15 Vice-presidents

<http://esssb15.org>

## The 5th Asia-Pacific Conference of IASP, Chennai, India

Attending the 5th Asia-Pacific Conference of IASP, hosted at Chennai from 28th Nov to 2nd Dec, 2012, was an event full of proceedings and reminiscences. Chennai is a city of cultural history and great commercial importance to India. Coming to Chennai and experiencing its hospitality has always been a pleasure for Indians and people from all over the world.

India's high number of suicide deaths (more than 150,000 per year) require much more awareness and personnel involved in prevention. IASP, the president Dr Lanny Berman and Dr Lakshmi Vijayakumar must be individually thanked for bringing the conference to India. Such events generate wider interest and understanding on the subject. News coverage of the event generated much needed awareness. Since the conference took place in India and the Indian Psychiatric Society co-sponsored the event, this facilitated a large number of Indian delegates to attend. Many young psychiatrists, psychiatric social workers, clinical psychiatrists and NGOs presented papers and posters.

The conference also facilitated interaction between Indian and foreign delegates as well as exchanging views on each other's work. It was inspiring to see senior members offering advice to Indian delegates. Many Indian delegates indicated that the formation

of the special interest group for suicide prevention by pesticide ingestion was really helpful since the highest number of suicides in India occur due to pesticides. They felt that this would help them in having more inputs, exchange of ideas and strategies from an accessible small expert group.

The exchange of cultural aspects in suicide was the best part for me and my colleagues who attended the conference. Presentations on the work on suicide prevention by pesticides from China and Sri Lanka facilitated comparison with the work in this area of suicide prevention in India.

I am sure that the conference has motivated delegates attending from all over the world to improving collaboration in working in suicide prevention and making this world a better place to live. It was a perfect mix of immense academic learning and small enjoyment. I'm looking forward to have more of these events in India.

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Sateesh Babu

### IASP SPECIAL INTEREST GROUPS

## IASP Special Interest Group on culture and suicidal behaviour

This Special Interest Group (SIG) was officially launched at the IASP conference in Beijing (September 2012). Presently, the group has 39 members from across the globe (Canada, Australia, India, USA, Ghana, Norway, Hong Kong, Pakistan, Uganda, New Zealand, The Netherlands, Taiwan, Germany, Lithuania, Jamaica, Brazil, Sweden, Ireland, Italy). Since culture is a comprehensive issue, the main activity so far has been to discuss within the SIG what we should first focus on. An online survey revealed the following interests among members:

- Suicide prevention strategies in different cultural settings (86%)
- Culturally sensitive/appropriate research methods (67%)
- Suicidal behaviour in low income countries (62%)
- Gender issues (52%)
- Spirituality/religion (48%)
- Human/women rights (33%)
- Arts and culture (33%)

Other specific areas of interest mentioned were: Suicide among migrant and refugee communities; decriminalization of suicide and help for suicide attempters who are in prison; contagion/epidemiology; culture sensitive management of suicidal behaviour; capacity building/ training; and, youth cohorts in LMICs countries.

When asked "What do you think should be done and how would you like to contribute to this topic?", the majority of the participants provided suggestions relevant to "suicide prevention strategies in different cultural settings" (85%). In particular, members proposed to: continue to develop and disseminate knowledge about how suicidal behaviour can be understood differently in different cultures and how different understandings must have consequences for the

development of suicide prevention strategies; develop and assess culturally sensitive suicide prevention strategies; find resources to support activities such as this SIG; organise themed workshops and increase the focus on this topic in conferences/seminars; and, develop and refine innovative methods for working with minority groups (including indigenous communities).

With regard to spirituality and religion, members suggested to: expand research on spirituality/religion and suicide/suicide prevention; and, exploit the positive aspects of religious settings for suicide prevention in low-income countries. With regard to human/women rights, the main suggestions were to: advocate, through research and other activities, for a greater focus on human/women rights in suicidology; design pragmatic (i.e. cost efficient) interventions with use of local resources (i.e. local teachers, doctors, schools) that can reach the women. The following were suggested with regard to gender issues: research gender-related issues and suicidal behaviour (e.g. cultural pressures on males and females, autonomy, gender roles, women rights, perception of suicide among males and females), explore barriers and enablers to help-seeking, and develop gender-specific suicide prevention interventions. The following suggestions were made with regard to suicidal behaviour in low income countries: situate suicide prevention in the larger picture of social development; increase awareness, capacity building and collaboration (especially between researchers and practitioners); and develop 'Suicide first aid guidelines' and similar (gate-keeper) tools. Cooperation with artists and filmmakers to find other ways to express different aspects about suicide, and document systematically what the different religions say about suicide and how arts and culture portray this

understanding, were some of the suggestions under the sub-theme "Arts and culture". Finally, with regard to culturally sensitive/appropriate research methods, members suggested to: discuss how to understand and use the concept of culture in suicide research; write and reflect on the use of specific research strategies and methods, including arts-based and participatory/collaborative approaches, for research in different countries (e.g. edited book); and, develop test culturally appropriate research designs in partnership with communities to produce valid research methods.

Based on the results of the survey, a next step might be to establish a number of subgroups, each with a dedicated "driving force" to take the lead on the various activities. Some of these subgroups might have the potential to become task forces with specific goals and time lines. This will be discussed in the coming months. We will also establish a mailing list for the whole group, where the membership will be encouraged to share relevant information on new publications, funding opportunities, workshops, conferences, etc. Lastly, it should be mentioned that the SIG in January 2012 auspiced the workshop "Suicidal behavior of immigrants and their descendants in Europe", organized by two of our members (Amanda Heredia Montesinos and Diana van Bergen) in Berlin.

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Erminia Colucci  
Chair



Heidi Hjelmeland  
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# Young Researchers

In 2012, Elaine McMahon completed her PhD at the National Suicide Research Foundation and Department of Epidemiology and Public Health, University College Cork, Ireland. The following is a summary of her thesis.



Elaine McMahon

## Vulnerability or resilience? Psycho-social factors associated with self-harm among adolescents

### Background and Aims:

Psychological factors, negative life events and lifestyle factors have been found to be associated with self-harm in adolescents internationally. However, until recent years, large scale population-based studies of adolescent self-harm and its correlates using an international standardised methodology was lacking. The seven-centre Child and Adolescent Self-harm in Europe (CASE) study employed a rigorous methodology to explore adolescent self-harm and associated factors (Madge et al, 2008). As part of the CASE study, my PhD thesis examined psycho-social factors associated with self-harm in adolescents and also investigated resilient adaptation among at-risk adolescents.

### Method:

Data were obtained from a cross-sectional school-based study. In Ireland, 3,881 adolescents in 39 schools were involved in completing an anonymous questionnaire. Across the 7 CASE centres, over 30,000 adolescents participated. Data were gathered on health and lifestyle, self-harm thoughts and behaviour, a wide range of life events and psychological characteristics (e.g. anxiety and depressive symptoms, self-esteem, impulsivity and coping style).

### Results:

Factors independently associated with self-harm in Irish adolescents of both genders were drug use and knowing a friend who had engaged in self-harm. Among girls poor self-esteem, forced sexual activity, self-harm of a family member, fights with parents and problems with friendships also remained in the final multi-variate model. For boys, bullying victimisation, problems with schoolwork, impulsivity, and anxiety were associated with self-harm.

As findings on associations between bullying and self-harm among boys were striking and were unique to the Irish CASE sample, this was examined in greater depth.

Among Irish boys, strong associations were found between bullying victimisation and poor mental health and self-harm. 19.4% of boys reported having been a victim of school bullying at some point in their lives. Boys who had been bullied were four times more likely to report self-harm (OR 4.07, 95% CI:2.57-6.44) than those without experience of bullying. Among boys who had been bullied, psychological and school factors were associated with self-harm, while family support was protective.

Associations between coping style, mental health factors (depressive symptoms, anxiety and self-esteem) and self-harm were examined among Irish adolescents. Greater use of emotion-oriented coping was strongly associated with poorer mental health and self-harm thoughts and acts. A mediating effect of emotion-oriented coping on associations between all three mental health factors was examined and self-harm was found for both genders and between problem-oriented coping and mental health factors for girls. Similar mediating effects of coping style were found when risk of self-harm thoughts was examined; coping style also mediated associations between depressive symptoms, anxiety and self-esteem and self-harm.

Resilient adaptation among Irish adolescents exposed to suicidal behaviour of others was examined. A subgroup of adolescents who had been exposed to self-harm or suicide of others but did not report own history of self-harm was identified. Although this group displayed resilience to the development of self-harm, self-harm thoughts were common in these adolescents and they reported greater exposure to a wide range of negative life events and poorer mental health than their unexposed peers.

In an international collaboration with the 7 CASE centres, we examined links between stressful life events, psychological characteristics and self-harm. Increased severity of self-harm history was associated with greater depression, anxiety and impulsivity, lower self-esteem and an increased prevalence of ten different negative life events, supporting

the hypothesis of a "dose-response" relationship between these risk factors and the self-harm process.

### Conclusion:

These findings can aid in the identification of young people at risk of self-harm in the school setting and highlight the importance of mental health, peer-related and lifestyle factors in the development of self-harm. High-risk groups of young people such as bullying victims, those with a history of self-harm and those exposed to suicidal behaviour of others have distinctive profiles of risk factors which differ from those of their peers. Findings relating to the importance of positive coping skills can inform positive mental health programmes, many of which aim to enhance life skills and build resilience among young people.

By Elaine McMahon, Post-doctoral Research Fellow, National Suicide Research Foundation, Cork, Ireland (e.mcmahon@ucc.ie)

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*Publications arising from this work:*

McMahon, E.M., Corcoran, P., McAuliffe, C., Keeley, H., Perry, I. J., & Arensman, E. (2013). Mediating Effects of Coping Style on Associations Between Mental Health Factors and Self-Harm Among Adolescents. *Crisis*, Jan 28:1-9 [epub ahead of print].

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### IASP would like to announce:





Meeting Workplaces Where They Are: Crisis Response, Safety Planning and Cost-Savings. An Update from the Special Interest Group (SIG):

## Suicide Prevention in the Workplace

While most of us in the field of Suicidology can see the great benefits of enlisting employers to implement comprehensive approaches to suicide, most employers are not quite ready. They are unfamiliar with the idea of their role in suicide prevention and often find it initially daunting and significantly out of their usual business endeavors. For these reasons, we need to listen well, move slowly and let them lead.



Sally Spencer-Thomas

For these reasons, the Workplace Special Interest Group is focusing on three main areas where workplaces have concerns about suicidal behavior:

### 1) After death or a serious attempt has already occurred:

Unfortunately, most workplaces are in a reactive mode. To help workplaces in these situations, one goal of the Workplace SIG is to provide succinct guidelines on how best to handle the crisis and suggested best practices on how to support bereaved employees.

**2) As they relate to healthcare costs and lost productivity costs:** Most for-profit organizations make decisions based on how the choice will impact their bottom line. For this reason, the Workplace SIG will continue to gather data to make a strong business case for suicide prevention.

**3) As they relate to workplace safety:** with suicide-homicide cases capturing the attention of employers for decades, much concern exists on how dangerous suicidal people are to others. In order to alleviate this worry, the Workplace SIG will help link workplaces to policy, protocol and training that allows them to implement "early warning" systems and a process for linking at-risk people quickly to qualified care.

By aligning employers' goals with the goals of suicide prevention, we will have a much greater chance of successful larger-scale change, as one step can often lead to another.

To become a member of the Workplace Special Interest Group, please contact author Sally@CarsonJSpencer.org.

### About the Author:

Sally Spencer-Thomas (USA) is the CEO & Co-Founder of the Carson J Spencer Foundation (CJSF) and co-author of the Working Minds Toolkit ([www.WorkingMinds.org](http://www.WorkingMinds.org)). Spencer-Thomas is the Co-Chair of IASP's Workplace Special Interest Group and the Co-Lead of the National Action Alliance for Suicide Prevention's Workplace Task Force.

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## Clinical guide: Assessment of Suicide Risk in People with Depression

A clinical guide Assessment of suicide risk in people with depression was developed at the University of Oxford's Centre for Suicide Research to assist clinical staff in talking about suicide and assessing suicide risk in people who are depressed. The guide may be of value to a range of health-care professionals, including GPs and other primary care staff, mental health workers, psychologists, counsellors, A&E Department staff and support workers.

This guide is primarily about assessing risk in adults. However, the principles can be applied to all ages. The guide may also be useful for reviewing care of people, including when adverse events have occurred.

The contents include general information about suicide and risk factors, as well as specific information about risk factors in people with depression; advice on how to assess someone with depression who may be at risk of suicide; information on managing risk; frequently asked questions and common myths about suicide; and a selection of relevant resources (both websites and books). The guide also provides two useful tear-off pages: a Summary of Key Points page for clinicians, and a Useful Contacts page for patients.

This guide was informed by the findings of a systematic review of risk factors for suicide in people with depression: Hawton, K, Casañas i Comabella, C, Haw, C & Saunders, K E A (2013). Risk factors for suicide in individuals with depression: A systematic review. *Journal of Affective Disorders* (in press). It was also developed with input from experts in primary care and secondary care, and underwent piloting with several clinicians.

The guide was developed primarily for use in clinical settings in developed countries. Clinicians in other settings who wish to use it will need to take possible local cultural differences into account. The guide is available free of charge at: <http://cebmh.warne.ox.ac.uk/csr/clinicalguide/index.html> On this website there is also a downloadable PDF version: <http://cebmh.warne.ox.ac.uk/csr/clinicalguide/docs/Assessment-of-suicide-risk-clinical-guide.pdf>

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Keith Hawton

Carolina Casañas i Comabella



Kate Saunders

Camilla Haw

## IASP member and Past President Professor Diego De Leo

has been named on the 2013 Australia Day Honour's list and receives an Officer in the General Division in the Order of Australia for his "distinguished service to medicine in the field of psychiatry as a researcher and through the creation of national and international strategies for suicide prevention".

Professor Diego De Leo heads up the Australian Institute for Suicide Research and Prevention, at Griffith's Mt Gravatt campus in Brisbane. His research expertise includes definitional issues in suicidology, culture and suicide, international trends and national suicide prevention programs, making him one of the most preeminent figures in the field.

He has published extensively with over 700 publications, and is currently the Editor in Chief of our very own *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, and editorial board member of *Suicide & Life-Threatening Behavior*, *Archives of Suicide Research*, *Suicidology onLine* and *Advancing Suicide Prevention*.

As well as being a Past President of IASP he is also a Past President of the International Academy for Suicide Research. He serves as a board member of the Australian Suicide Prevention Advisory Council and is Chair of the Advisory Committee to the Queensland Government Suicide Prevention Strategy.

Professo De Leo is founder/co-founder of the Italian Society for Psycho-Oncology, the Italian Association for Suicide Prevention and the International Academy for Suicide Research. He is the ideator of IASP's World Suicide Prevention Day, which takes place every September 10 since its establishment in 2003.

Diego de Leo, e-mail: [d.d.ileo@griffith.edu.au](mailto:d.d.ileo@griffith.edu.au)



Australian Institute for Suicide Research and Prevention

# Obituary Norman Kreitman



1927–2012

Norman Basil Kreitman, psychiatrist, psychiatric epidemiologist, poet and philosopher, was born in London on 5 July 1927 and died in Edinburgh on 15 December 2012. He was the son of Jewish immigrant cobblers from Eastern Europe. The first doctor in the family (apart from a cousin), he received his training at Westminster Hospital, London. After graduation he spent 18 months in a tuberculosis hospital in the Isle of Wight, then a year at the Forlanini Institute in Rome on a fellowship in pulmonary physiology, before coming back to London to work as a registrar at the Metropolitan Hospital in London in 1952. He applied successfully for a post at the Maudsley Hospital where he was employed as registrar during the period 1954–8. While living in London and sharing a flat with his great friend Professor Henry Walton he met and married Susan Freeman.

In 1959 he joined the Medical Research Council's Clinical Psychiatry Research Unit in Chichester, where he worked for six years under Peter Sainsbury. He moved to Edinburgh in 1966 to work at the MRC Unit for Epidemiological Studies in Psychiatry, first under Morris Carstairs, later (from 1971) as director. He was appointed to an honorary chair with the University of Edinburgh in 1986. He retired in 1990, aged 62 and almost immediately gave up his interest in psychiatry and psychiatric research. He continued to write poetry (he had already published two collections: *Touching Rock* [1987] and *Against Leviathan* [1989], and would go on to produce two more: *Casanova's 72nd Birthday* (2003) and *Dancing in the Dark: New and Selected Poems* (2010)) and pursue an interest in philosophy, aesthetics and language. *The Roots of Metaphor: Multidisciplinary Study in Aesthetics*, published in 1999, explored the aesthetic experience, especially that derived from poetry, as a natural phenomenon that could be studied scientifically.

Norman's research interests during his time at the MRC Unit in Edinburgh were fairly wide-ranging: alcohol consumption and associated health and social adverse consequences; depression in women, including precipitating and vulnerability factors identified via population surveys, the role of poor self-esteem and other psychological variables, and pathways to treatment; and suicidal behaviour. It is for his work in relation to the latter that Norman will be best known among readers of this publication. His co-authored paper on "The coal gas story", published in 1976, is one of the most well-known and widely quoted epidemiological studies in the field. With the elegance and simplicity that was characteristic of Norman's work, the study demonstrated that the massive reduction in domestic gas suicide in Great Britain in the

1960s, resulting from the replacement of highly toxic coal gas with natural gas containing very low levels of carbon monoxide, led to a reduction not only in the domestic gas suicide rate but also in the total suicide rate, indicating little immediate method substitution. Norman also coined the term 'parasuicide', defined as "a non-fatal act in which a person deliberately causes injury to him or herself or ingests any prescribed or generally recognised therapeutic dose in excess." His intention was to resolve the terminological confusion in suicide research caused by other commonly used terms, such as 'attempted suicide', which implied or assumed understanding of the underlying motivation or intent. The 'meaning' of behaviour, he believed, was best omitted from the definition and studied empirically. At the same time, he was opposed to any term, such as 'deliberate self-harm', which lost all connection to suicide when evidence clearly showed that persons engaging in parasuicide and persons completing suicide were overlapping, rather than distinct, populations. Despite Norman's best efforts, 'parasuicide' was widely misunderstood, especially in North America, where it became synonymous with 'non-suicidal self-injury' (or even 'suicide gesture'). Norman made full use of a range of clinical and epidemiological methods, but recognised as "equally or even more important ... sociological enquiries to clarify the social characteristics of the population subgroups you want to investigate. It is there that creativity usually arises; new hypotheses generally spring from new ways of thinking the social structure – including their immediate interpersonal context as well as the larger scene."

In 1987 Norman was given the prestigious Louis I Dublin lifetime achievement award of the American Association of Suicidology for "outstanding services/contributions to the field of suicide prevention as evidenced by leadership, devotion and creativity." Those qualities were experienced in abundance by those of us who were fortunate to work with and for Norman when he was director of the MRC Unit in Edinburgh. He was an inspiring mentor, an outstanding scholar, a thoughtful communicator and a sensitive listener. In his poem *The Therapist* he writes: "Yes, I am listening, really,/although what I hear matters much less/than what you say..."

Norman is survived by his wife Susan, son Matthew, daughter Julia and four grandchildren.

Stephen Platt, Professor of Health Policy Research, University of Edinburgh, Scotland, UK (Senior Clinical Scientist, MRC Unit for Epidemiological Studies in Psychiatry, 1977–1989) [steve.platt@ed.ac.uk](mailto:steve.platt@ed.ac.uk)

# IASP Consultation on Proposed Constitutional Amendments

On behalf of the Executive Committee, IASP Central Administration Office has sent out a formal proposal to amend the IASP Constitution. If you did not receive this document please contact CAO immediately at [admin@iasp.info](mailto:admin@iasp.info).

Proposals to change elements of the constitution are suggested for your consideration and consultation. The vote for these changes will take place at the Oslo Congress in September. We have a short interview with IASP General Secretary, Tony Davis, regarding these:

## 1. Why did the Executive Committee consider that the constitution needed amendment?

The constitution has not been reviewed for a number of years (since 2007). On reviewing the constitution it became apparent that the association has moved on in many ways and that certain aspects of the constitution needed to be updated to reflect this.

## 2. What are the main aims of these amendments?

Our aims are to ensure that the amended constitution will accurately reflect the practices and organization of the association and that it will allow IASP to move forward efficiently in the future.

## 3. What consultations did you carry out in the preparation of these amendments?

A subcommittee was set up to review the constitution and look at where amendments needed to be made. This subcommittee reported back to the Executive Committee throughout the process. We also consulted with the Election Committee and some of the organizational membership with regards to specific changes that were proposed.

## 4. What is the biggest change to the constitution?

The most visible change is the removal of the Council of Organizational Members. This Council was considered to be somewhat ineffectual and superfluous. Following consultation, it was decided that the Organizational Membership would benefit more and be able to partake more in a less formal assemblage (we are hoping a future Special Interest Group) within IASP.

The other big change was to bring the voting procedures for National Representatives into line with those of the Executive Committee.

There are other proposed amendments throughout the constitution, which appear small but are nonetheless important in ensuring the accuracy of the constitution as the defining statement of IASP's charter and organization.

## 5. How do you think this will help IASP in the future?

We believe that these amendments will allow IASP to grow and provide its membership with a more contemporary platform for community and resource development.

## IASP Executive Committee Elections 2013

In accordance with the IASP Constitution elections are being called for all posts in the Executive Committee. Ballot papers will be sent out shortly, please check the IASP website [www.iasp.info](http://www.iasp.info) for updates.

## IASP 2013 National Representative Elections

In accordance to the IASP Constitution, the Executive Committee the elections for National Representatives from the following countries are underway:

- Bangladesh
- Belgium
- Canada
- Denmark
- France
- Germany
- Ghana
- Iran
- Ireland
- Japan
- Mexico
- New Zealand
- Norway
- Puerto Rico
- Singapore
- Slovenia
- Sweden
- Switzerland
- Taiwan
- USA

If you are from one of these countries and have not received information regarding these elections, please contact the Central Administrative Office as soon as possible at [admin@iasp.info](mailto:admin@iasp.info).

### Notice regarding Chairperson of the Council National Representatives

We regret that due to personal reasons Sunny Collings, Chairperson of the Council of National Representatives, has had to stand down from this role. Deputy Chairperson, Maurizio Pompili, is undertaking the duties of Chairperson, for the remainder of the term.



# THE 27TH IASP WORLD CONGRESS IN OSLO

We took the opportunity to interview the XXVII IASP World Congress Organiser and fellow IASP member, Professor Lars Mehlum, about what we can expect from the Congress this September in Norway.

1. The theme for the congress is “Preventing suicidal behavior on five continents – innovative treatments and interventions”. What was the thinking behind choosing this theme?

The theme covers two aspects:

**a.** Five continents; we think that it is important to be mindful that suicide is equally important across the globe and we want to address that in a culturally sensitive way, encompassing the variations in how suicide is studied and responded to, attitudes, cultures and religion. We want to encourage active participation from members all over the globe.

**b.** Innovations of treatments and preventions; we want the Congress not to be just about describing risk factors but to look at how we respond to them and we are especially encouraged by the submissions we've received which focus on this.

2. How do you think the Oslo Congress will make a difference?

Our target is to get more people from all the continents and we want to facilitate discussions – for example, alongside the Congress we are holding regional symposiums that will allow delegates to get together and discuss common challenges and lessons learned.

3. What is the Oslo Organizing Committee doing to target new groups to come to the Congress?

We specifically want to make newcomers and suicide survivors welcome. We will have at least one parallel session at a time for survivorship and postvention and we are working in close collaboration with the Special Interest Group for Postvention on this. For newcomers, we are mindful that people are coming to learn something that can add value to skills and competency. There will be a track of sessions for people who want to learn more about research, clinical practice skills and other things basic to suicidology.

4. The Preconference is an introduction to Complicated Grief Treatment (CGT). Why did you choose this subject and what do you hope it will bring to the delegates?

We chose this partly, as it is a matter of postvention and bereavement but also as this falls under the theme for innovative treatments and interventions. Randomised control trials have been carried out and this is the first evidence based treatment on grief treatment. Dr Katherine M Shear will present her new treatment and research and she and I they will do an introduction into the method over the day.



Lars Mehlum

5. You are offering delegates to attend “Lunch with the Experts” meetings every lunch break; what are the benefits of these meetings?

These are questions and answer meetings for those who wish the opportunity to ask questions on certain topics. There will be delegates who have read the work and know the name of the experts and this gives a chance to meet them in a less formal setting.

Also the Scientific Committee felt it was not a great use of the plenary time (which is only 1.5 hours) to have question time after the plenaries and so the ‘Lunch with Experts’ gives this opportunity.

6. What would be advantages for young researchers to attend the Oslo Conference?

We are holding “Young Researchers Supervision” for those new to publishing, which will allow young researchers the opportunity to submit papers and get feedback and we have facilitated several symposia on methods of research – e.g. register based studies. There will also be a few workshops. Our target is to have a certain amount of sessions on how to do things, research being one of them.

7. The Biennial IASP World Congress is a big undertaking, how are preparations going?

We have been working on this a long time and it has become part of the daily activity here. The only remaining thing to be done is the detail of the program. By 31 March we are expecting all of the separate presentation abstracts to be submitted and after that we will put those into time slots.

8. There are a variety of social events that focus on Norwegian Arts and Culture, during the Congress as well; what do you hope the delegates will learn about Norway from these events?

We want to make people feel welcome and comfortable at the Congress but also inspired and to have a good time. We have let culture be part of the program throughout. There will be classical music and modern art available and we have a live band for conference dinner. We hope to purvey some of our own culture and performing arts.

We also hope to offer jogging in mornings before the conference begins and mindfulness exercises on the Opera roof. Delegates can also opt to have dinner with locals, as a chance to learn about life in the Oslo.

9. What is Oslo like in September?

It will be late September and we hope for nice weather with bright evenings, but it could be chilly. The venue is close to the waterfront, boat trips in the harbour, and Oslo has many parks close by. If you wish to spend extra time before or after the conference, there are many options for tours e.g. “Norway in a Nutshell” 1 to 3 days from Oslo to Bergen via a fjord, the Conference Bureau can help organise this.

[www.iasp2013.org](http://www.iasp2013.org)

The XXVII World Congress of  
THE INTERNATIONAL ASSOCIATION  
FOR SUICIDE PREVENTION

*Preventing suicidal behaviour on five continents –  
Innovative treatments and interventions*

SEPTEMBER 24.-28.2013  
RADISSON BLU PLAZA HOTEL  
OSLO/NORWAY

