Dear custos, respected opponent, ladies and gentlemen,

Between 1986 and 1996, Finland implemented an ambitious suicide prevention program. Since 1990, the number of suicides in Finland has fallen by half. The change indicates that it is possible to influence the number of suicides.

In recent years, the number of suicides has remained stable in Finland. However, there are indications that the number of non-fatal suicidal acts, such as suicide attempts, has increased rather than decreased in recent years.

The need for both measures to prevent suicidal behavior and the development of services related to the treatment of these behaviors continues. To guide these efforts, it is important to have multi-perspective and multi-method research, also locally in Finland.

In my doctoral dissertation, I investigated the views of those who have attempted suicide on the services they had received and desired during the suicide crisis.

The study looked at participants' experiences of the weeks and months immediately following a suicide attempt.

From the point of view of preventing acts of suicidal behavior, that time is particularly important. While it is statistically associated with the highest risk of new suicide attempts, it is also full of hope and opportunity.

Most people who attempt suicide do not die by suicide. Even those who have suffered from severe and persistent suicidal behavioring behaviors often recover.

The quality and content of treatment received after a suicide attempt affect the number of new suicidal acts in this vulnerable group. How the service system responds to a suicidal crisis matters.

But what kind of responses do service users desire from the service system? And what do the Finnish service system’s current responses look like through the eyes of service users?

That is what I wanted to understand better.

For the study, I conducted in-depth interviews with fourteen adult residents of the Helsinki metropolitan area who had attempted suicide. All participants in the study had participated in the Attempted Suicide Short Intervention Program offered by the NGO MIELI Mental Health Finland to those who have attempted suicide. All also had experience of health services. During their suicidal crisis, they had visited, for example, student or occupational health care, health centres, emergency services and psychiatric outpatient care. Some had also received in-patient care due to the somatic consequences of the suicide attempt, their mental well-being, or both.

The participants included both first-timers and those who had ample experience of using mental health services, those who had attempted suicide for the first time and those who had made several previous suicide attempts, people who had suffered from serious and long-term mental health problems and people who had mainly experienced psychological well-being in their lives outside the current crisis. The participants’ age ranged from adolescence to the elderly, and the gender distribution was even.

Thus, the study participants represented the diverse group of suicide attempt survivors. Their stories formed the material for my doctoral dissertation.

The dissertation to be examined today consists of three original studies and a summary, the purpose of which is to combine the understanding produced by the original studies.

Study I examined how those who had attempted suicide had felt that health services had helped and sometimes hindered their recovery. Internationally, studies examining the perspective of service users have increased during this millennium, but there was no previous qualitative research data on the service experiences of Finnish adults who have attempted suicide.

All participants had experience of encounters with healthcare that they had found helpful. Most also had experience of interactions that they considered unhelpful or even harmful.

Many wishes regarding treatment were shared by the participants: View me as worthy of help. Help me explore and understand my suicidal act. Make sure that the supportive connection to services is not completely interrupted even at transitional points in treatment. Involve me in decisions about my medication. Also take into account the people and relationships that are important to me, or lack thereof. Offer help for the very problems I was looking to solve by the suicidal act.

When these wishes were fulfilled, hope and opportunities for action increased. When they were frustrated, experiences of hopelessness and helplessness took over.

Study II examined the participants' views on how participating in the Attempted Suicide Short Intervention Program, i.e., ASSIP, had affected them.

ASSIP is one of several brief interventions for suicidal behaviour that have been developed in the last decade.

The effectiveness of brief interventions in reducing suicidal acts has been studied using quantitative methods. However, qualitative research that sheds light on users' perspectives on them is scarce.

The growing popularity of brief interventions is in part due to the pressure to make scarce healthcare resources sufficient for as many people in need as possible. However, the developers of brief interventions targeted at suicidal behavior emphasize that brief interventions are not designed to replace but to complement other appropriate treatment after a suicide attempt.

In addition to resource pressures, the development of suicide-specific brief interventions has been motivated by observations of the service behaviour of those who have attempted suicide. People with suicidal behavior have often been observed to withdraw quickly from treatment. Therefore, the encounters that are available should be utilised effectively: the aim is both to reduce the risk of suicidal acts here-and-now and to strengthen commitment to other necessary services.

According to the study participants, ASSIP succeeded well in both reducing the risk of new acts of suicidal behavior and strengthening adherence to treatment. The ASSIP therapists' sincere interest and compassion had brought experiences of relief and hope. Thorough exploration of the suicide attempt had enabled new understanding to emerge and clarified what the changes required to avoid another suicide attempt. The safety plan built in ASSIP, as well as knowledge of ASSIP's letter follow-up and option to contact the therapist created a sense of safety.

After ASSIP, the participants were motivated to continue working towards recovery with the support of services. When the service path continued predictably enough after ASSIP, the participants felt that they were building on top of the gains they had already made.

However, the service system did not consistently succeed in taking advantage of the hopefulness and motivation created in ASSIP.

The interviews took place 4-10 weeks after the last visit to ASSIP. At the time of the interview, half of the participants described themselves as being unsure of the continuation of their treatment. Although most of them had a treatment relationship with specialised psychiatric care, it did not always guarantee actual treatment.

If the necessary support for working towards the change that had begun was not available after ASSIP, the gains made and the hope created began to fade. In other words, resources and the fruits of the work done were wasted on discontinuous service paths.

Study III examined the construction of the participants' own recovery-related agency in connection with the support they received from services. The concept of agency provided a useful lens for examining both the participants' suicidal behavior and their efforts to recover.

Agency is the ability to influence oneself and the environment in line with one's intentions. When a person loses agency, they feel powerless and at the mercy of circumstances. In preventing acts of suicidal behavior, agency plays a key role.

In the participants' stories, their recovery-related agency was described as dynamic and relational. The support received from services played an important role in achieving and maintaining it, and also provided safety when agency was momentarily lost.

The participants' accounts illuminated the variety of ways in which all participants had expressed recovery-related agency even in the midst of their suicidal crisis, and the variety of ways in which professionals could be instrumental in helping or even hindering these efforts.

Together, the results of the three original studies challenge the service system to better take into account the service users' own agency, their relationships and the continuity of the service path.

The three main propositions of my dissertation are as follows.

1) A rigidly individualistic approach to treatment does not meet the wishes and needs of service users. Instead, services for suicide attempt survivors should account for service users'

relationship context also and provide relationship-focused support when necessary. Support offered directly to loved ones is also important from the perspective of those suffering from suicidal behavior.

2) Brief interventions focused on suicidal behavior are an important part of services and their availability should be increased. However, it is also necessary to invest in the psychological predictability and continuity of the service path around these brief interventions, lest their benefits be wasted.

3) The service users own agency should be understood both as a primary target and as an important resource for helping efforts. Professionals must be able to help both form recovery-related intentions and strengthen their ability to carry them out.

My dissertation also reflects on the relationships between scientific paradigms, disciplines and professions in suicide research and Finnish healthcare.

What kind of evidence is taken into account when developing services aimed at preventing suicidal acts? What is the importance of the service users' own voice? And what opportunity do the different perspectives of medicine, nursing, psychology and social sciences have to complement each other?

I would argue that not enough.

In the development and management of mental health services, I believe that the medical perspective should be better balanced with the perspectives of other fields of health and social services, even – and perhaps especially – when the basic assumptions and perspectives of these different disciplines are in tension with each other.

I think that the perspectives of service users and psychology as a science need to have significantly more weight in decision-making wherever it is critical for treatment outcomes to consider motivation as the basis of human activity, the construction of psychological change and the significance of interaction for both motivation and change.

There is work to be done for all of us.

And that work matters.

One participant, who had experienced both several suicidal crises and good times in between them, described the importance of the help they had received as follows:

"I've always described suicidality, where the center point is the choice to die, that it's like a gravitational field where you're kind of sucked toward that point [of choosing death]. So then every step you take away from [that point] is crucial."

Every step towards life is crucial. Health and crisis services can be helpful in taking those steps.

The resources allocated to these services and their management, on the other hand, play a role in determining what kind of help can be found in them.

Helping someone who has attempted suicide or is in a suicidal crisis is emotionally demanding work. When professionals are overwhelmed by those demands, it may manifest itself as avoidant, belittling or coercive interactions, which the participants in this study also sometimes experienced.

Service users have the right to expect that professionals are able to withstand the difficult experiences with which the service user presents in services. It is our joint responsibility as professionals and the political leaders who decide on the framework conditions of our work to ensure that the professionals' ability for this withstanding is preserved.

In practice, the consistent provision of high-quality care requires that all professionals who encounter people suffering from suicidal behavior have sufficient training in identifying the emotional and relational challenges of that work, support from their team and supervision in demanding situations, and sufficient time and space to do the work.

This, in turn, requires sufficient resources for mental health work.

It is necessary to remind decision-makers that the number of suicidal acts can be influenced by political decision-making.

The Finnish government's understanding of these opportunities was reflected in the suicide prevention program for 2020–2030 published in connection with the mental health strategy. The program contains proposals for measures to reduce suicidal behavior at the population level and to strengthen its treatment. At present, however, there is a lack of sufficient and predictable funding for the implementation of the program.

In Finland, suicide prevention work has traditionally been carried out in extensive cooperation between the public sector and non-governmental organisations. NGO’s play a significant role in supporting people suffering from suicidal behavior and their loved ones. Now, however, cuts in funding for these organisations are leading to a significant reduction in their activities.

At the same time, psychiatric care in Finland has been underfunded for a long time, and political decision-making has not taken action to rectify the situation.

Improving services is a work in progress, and the work will continue.

While there is work to be done, hope is strongly present in the here-and-now. Suicidality can be overcome. A person suffering from suicidality can be helped.

The research interviews revealed many needs and opportunities for strengthening existing services. At the same time, however, another reality, just as important, emerged: help had been received and life had been allowed to go on.

Honoured professor, as the opponent appointed by the faculty, please present the comments that you see my dissertation has given grounds for.