

# New Developments in Suicide Intervention Training

By Richard Ramsay

*LivingWorks Education has been advancing new developments in suicide intervention training since the 1980s. Its primary program, ASIST (Applied Suicide Intervention Skills Training) was designed as a two-day suicide first-aid workshop for a wide range of community caregivers (professionals and others) to identify individuals with active thoughts of suicide and help them prevent the risk of suicidal behaviour.*

Workshop trainers receive a five-day Training for Trainers (T4T) course. They participate in a quality control program that supports them in their trainer roles and encourages ongoing program development feedback. ASIST provides a common language within and between groups of caregivers that encourages participation in broader community coordination and collaboration and strengthens their ability to provide immediate and follow-up assistance.

The program was originally developed for the province of Alberta and it is now widely disseminated in Australia, Canada, Northern Ireland, Norway, Scotland and the United States.



ASIST was introduced to Norway in 1998 via the Centre for Suicide Prevention at the Psychiatric Unit of the Regional Hospital in Tromsø (Silvola 2000). In 2000, the program became part of VIVAT (meaning "let her/him live" in Latin), a national education project at the Centre for Suicide Prevention established to disseminate suicide first-aid training throughout the entire country as part of the Norwegian Plan for Suicide Prevention (Mehlum and Reinholdt 2001).



## Foundation for New Developments in Suicide Intervention Training

In 1981, the Alberta government named a suicide prevention provincial advisory committee to develop the Alberta Model for suicide prevention, giving it a mandate to establish an information centre, training program, research centre and regional networks of coordinated community services (Boldt 1982). A member of the committee (the author) was asked to form a team to develop the training program. Literature from the previous decade had concluded that a core knowledge base existed, but it was not being adequately disseminated nor presented in skills training formats (Maris 1973). Practitioners reported the lack of adequate preparation and the absence of continuing education opportunities (Boldt 1976; Royal 1979). Those most in need of training were "gatekeeper" professionals and other community caregivers positioned to give "first-aid" assistance and link people to other sources of help (Snyder 1971). To address this deficit, the developers formulated three questions to be tested:

1. Could a standardized curriculum be designed for a diverse group of gatekeepers?
2. Could the curriculum be delivered on a large-scale basis?
3. Could quality control standards be developed and enforced?

Rothman's (1980) social R&D model was adopted as the knowledge transfer methodology to build the standardized curriculum. The model has four phases: Research/Retrieval, Conversion and Design, Development and Diffusion (Ramsay, Cooke & Lang 1990). The Diffusion phase has a feedback link to the Development phase to encourage ongoing review and further development

of the program. Between 1982 and 1985 the team developed a standardized Foundation Workshop (later to become ASIST) and a T4T (training for trainers) course that prepared trainers to present the workshop and facilitate dissemination to large numbers. Implementation of the curriculum began in 1985. By 2004, over 2,000 trainers had completed the T4T course and close to 500,000 participants had attended ASIST.

In developing the curriculum, the development team was aware of the long history of negative and punitive societal attitudes toward suicide but could find only one reference (Eismann 1977) that called for the inclusion of an attitudes component in suicide intervention skills training. Even though a more caring approach to suicide prevention was underway, caregivers who held any of these attitudes were at risk of being contributors to the cause of suicidal behavior but unlikely to openly explore the advantages and disadvantages of strongly held attitudes in training programs that only had knowledge and skills components. LivingWorks pioneered the inclusion of an attitudes component in standardized suicide intervention skills training on the assumption that "participants are not ready to acquire knowledge and skills until they have had an opportunity to deal with these attitudes and associated personal experiences" (Lang et al 1989: 264). To facilitate exploration of personally held attitudes, an innovative "trigger" audio visual, *Cause of Death*, was produced for ASIST. It was designed to evoke uncensored reactions to video vignettes that depicted the possibility of caregiver attitudes and behaviors as contributory or antecedent causes of suicide. Discussion of these reactions and associated personal experiences with suicide is conducted in the safety of a small group environment with facilitation and



guidance from a workshop trainer. The main goal of the discussion is to help participants feel free to acknowledge and examine the impact of their own “fears, frustrations and concerns regarding work with a suicidal person” (Lang et al 1989: 267). The success of this learning aid continues to be a core element in the attitude exploration section of ASIST.

To round out the three core components (attitudes, knowledge and skills) of the original workshop, the knowledge component was used to provide statistical evidence of the size of the problem and to help participants know what was the most and least useful empirical information in a risk factor approach to risk assessment (later modified to risk estimation). Although the predictive power of this approach in individual situations is limited, the risk estimation section did include estimate categories (High, Medium and Low) to assist participants in implementing individualized helping approaches. The intervention skills component introduced participants to a unique Suicide Intervention Model (SIM) designed by the developers. It was used to help them integrate their risk estimation knowledge into the phases and tasks of the model through guided simulation practice.

### **New Developments in Suicide Intervention Training ASIST X**

After fifteen years of ongoing development and dissemination, LivingWorks conducted an extensive two-year review of the program that culminated in the release of Edition X (ten) in 2003. ASIST X has five sections. The Preparing section sensitizes participants to evidence that suicide is a serious community problem. The Connecting, Understanding and Assisting sections helps participants integrate life promoting attitudes and first-aid knowledge within SIM to provide first aid care. Networking sensitizes participants to the importance of self-care and the value of coordination and collaboration at the community level. The essence of the original program was retained but new development changes were made to give participants more time

to learn and practice the intervention skills of suicide first aid.

#### Removal of Risk Estimation Categories

Risk factor approaches are commonly included in suicide intervention training to help caregivers assess or estimate risk in categorical terms such as high, medium or low. These approaches are based on research to identify objective indicators of risk from group data. The predictive powers of these factors, however, are generally limited in individual situations (Plutchik 2000). Factors that have the best predictive power such as current plan, pain, absence of resources, mental health concerns and prior suicidal behavior are often used to determine a level of risk that calls for a generalized response to a category of risk instead of an individualized response to each factor. A high-risk assessment might automatically get a policy-directed, high security intervention. A low risk assessment might be treated as a no-risk situation. Suicide risk instruments have also been developed to identify at risk individuals and found to have predictive value in some populations. However, current evidence suggests that a single “best” instrument is unlikely to be developed (Goldsmith, Pellmar, Kleinman and Bunney 2002: 231). Risk factors have become so numerous that each one has little predictive power unless there is also evidence of co-occurring suicidal thoughts. The primary factor to determine the potential risk of suicide is the presence of thoughts of suicide. This is best discovered in an interpersonal context by asking directly if thoughts of suicide are present.



Risk at this level does not need a category-based label; it needs an immediate willingness to genuinely listen to personal reasons for dying and development of a safety plan to support reasons for living. Although, the risk factor approach was used in previous editions to help caregivers determine an individualized helping approach, feedback over the years suggested that organizational policies or individual actions sometimes interfered with this happening. Risk factors are still part of ASIST X but risk estimation was removed in favor of a “risk review and safeplan framework” for living. The removal of estimate categories complements new developments in psychotherapy to reduce the tendency to objectify and categorize suicide risk in favor of listening to and understanding reasons for dying and living in a personal context (Shneidman 2004; Rogers & Soyka 2004).

#### Addition of Reasons for Dying and

#### Reasons for Living

Thoughts of suicide are generally linked to feelings of ambivalence or being of two minds at the same time (Shneidman 1985). Part of the person wants to die and at the same time a part of them wants to live. Being able to work with both sides of ambivalence is important, but often neglected in suicide intervention training. Intervention helpers can be understandably eager to find or suggest reasons for living or search for additional risk factors instead of genuinely listening to a person’s reasons for dying. Having the patience to listen to the part of a person that wants to die can free a person at risk to begin to discover and talk about reasons for living. Even something as small as a hope that there could be a reason to live can sustain life if a caregiver is comfortable listening to both sides of ambivalence. Dealing with ambivalence and being ready to listen to reasons for dying is a new priority in suicide intervention training. This development complements recent efforts in psychotherapy to reduce the dominance of therapist responsibility for care in favor of more collaborative and client-therapist joint responsibility approaches (eg. the Collaborative Model, Ellis 2004 and CAMS approach, Jobs and Drodz 2004).

### Addition of Risk Review and Safeplan Framework

Being able to help someone find a reason(s) for living by first listening to their reasons for dying provides an alternative way to recognize risk factors as dangers to reasons for living rather than predictors of suicide. Risk alerts for each factor identify the danger involved and serve as a target to develop individualized safeplan antidotes for each risk alert. This combination helps the first aid responder stay focused on a safeplan for living.

### **ASISTR**

A new development on the horizon in suicide intervention training is virtual simulation technology to help fill the training gap between workshop learned skills and real situations that require the application of these skills. The goal is to build simulations that give trainees the opportunity to interact with a virtual person, to reinforce and practice human interaction skills in a realistic, believable environment. The technology, developed by The Johns Hopkins University Applied Physics Laboratory, was adapted to suicide intervention training in partnership with the U.S. Army Material Command Chaplain's Office and LivingWorks Education. The ASISTR (Applied Suicide Intervention Training Reinforcer) project was launched in 2002 and completed in 2003 for Department of Defense members who have taken ASIST. An interactive CD-ROM program is provided at the end of the workshop as a take-home training support. It features "Billy Parker", a young, married soldier, who is approached by an ASIST trained colleague (take-home user) about some observed difficulties that he appears to be experiencing. The program is structured to allow the user to apply her/his ASIST learned skills in a first aid intervention although there are many other responses that could be made that would divert the user from the use of ASIST skills. The user is able to make mistakes and learn from them. At the end of each simulation, performance feedback is provided on ASIST skills that were used. The user can run the program once or multiple times in one sitting.

The program provides opportunities for hundreds of practice interactions and many variations of the virtual person at risk to reinforce workshop learning in an on-going and realistic way.

### **Conclusion**

Suicide intervention training has made remarkable progress in 30 years. Training approaches have expanded beyond didactic knowledge dissemination to include attitude exploration and skill development practice. New developments in virtual simulation technology offer a promising future to help with post-training skill retention. Training content is changing from a focus on suicide risk prediction to identifying thoughts of suicide and development of individualized safeplans to address specific risk alerts.

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