Applied suicide intervention skills training workshop

Kirsti Silvola
kirsti.silvola@unn.no
Psykiatrisk forskning- og utviklingsavdeling/Department for Psychiatric Research and Development
University Hospital of North Norway
N-9291 Tromsø

Tordis Sørensen Høifødt
Psykiatrisk forskning- og utviklingsavdeling/Department for Psychiatric Research and Development
University Hospital of North Norway

Thorbjørg Guttormsen
Tromsø University College

Olav Burkeland
Psykisk helsevern i Sør-Trøndelag HF/Mental Health Care in Middle Norway – Central Norway Regional Health Authority

ABSTRACT
Applied suicide intervention skills training workshop
This article discusses the benefits and limitations of applied suicide intervention skills training (ASIST), a two-day intensive, interactive and practice-dominated workshop designed to help caregivers recognise and estimate risk and learn how to intervene in case of immediate risk of suicide. It could appropriately be compared to training in cardiopulmonary resuscitation. The workshop sensitises participants to attitudes and presents a model for suicide intervention; it is flexible and employs learning aids and audiovisual material in order to encourage a high level of involvement. A growing body of evidence from assessments suggests that the workshop enhances caregivers' sense of readiness for suicide intervention and their actual level of skills for that role.

ASIST is a standardized learning experience that uses an effective implementation strategy through which local professionals are trained as instructors. It was developed by LivingWorks Education in Canada in the 1980s. In Norway, Vivat, a training programme originating in the National Suicide Prevention Plan, is in charge of implementation of the workshop and training of trainers.

Some, perhaps many, suicides could be prevented if suicidal persons receive support and aid (1). We need caregivers who are able to identify those who are at risk, and who can intervene so that suicidal behaviour is avoided (2, 3). Raising competence is an important element of suicide prevention (4), and competence is needed on many levels. Suicide intervention skills can be compared to training in cardiopulmonary resuscitation (5), which always involves life-threatening situations. Some suicidal impulses are so grave that life is at risk. Other cases may involve strong mental pain where the situation has not yet become life threatening. Early identification of suicidal impulses in both cases allows for the necessary intervention and may prevent injury and death. It is important to raise the competence of those present when a serious situation occurs until professionals with a higher degree of competence can take over.

If first aid or intervention skills are to function, the health service must be easily accessible and able to take over when needed.

Background

The Canadian Mental Health Association appointed an interdisciplinary task force of professionals connected to the University of Calgary to develop a standardized first-aid training workshop on how to intervene in the case of acute suicide crises. This team later established LivingWorks Education (6). Rothman's action research method was used to develop the training workshop (7). This method translates theoretical research-based knowledge into practical and feasible measures. The emphasis is on testing the content in practice and evaluating results. Then the manuals and other aids are developed, and the implementation is planned thoroughly.

Aims

After the training workshop, the participants should feel more comfortable and competent when intervening in acute suicidal crises. The aim is that suicidal thoughts should be identified as early as possible and that the appropriate professionals should be contacted.

The content

The training workshop has five learning modules (Table 1) (8). The design of the training workshop is based on principles from adult education. The participants already have many private and professional experiences and knowledge on suicide and this is used actively in all the modules. Only 10 - 15 % of the time is expended on traditional lectures. The participants work in groups of 24 and 12. All instruction requiring a more comfortable atmosphere is undertaken in groups of 12. Two training workshop heads, or trainers as they are called, are present all the time. A workbook is used throughout the training workshop, and participants receive a handbook detailing what has been learnt at the workshop.

Introduction

In the introduction module, anonymous background information is collected about the participants and their experiences with suicide. This is then used to introduce the experiences participants bring with them. Then a film is shown, *Cause of Death*, as the basis for discussion in the subsequent attitudes module.

Attitudes

The aim is to discuss the film and one's own experiences, and attention is paid to the caregiver's perceptions. Finally participants' responses to an attitude survey are discussed. The purpose is to make the participants aware of their own attitudes, or sensitize them to their own attitudes, and to see how these impact the interaction in a suicide intervention process.

Knowledge

The main part of the knowledge module concerns recognizing risk and simple risk assessment. The occurrence of suicidal behaviour is reviewed.

Intervention

The focus of the second day is intervention. Knowledge about this is compiled in an intervention model that structures a crisis interview. There are three phases: exploration, understanding and action. During each phase the helper has two tasks. During the exploration phase the helper must make contact with and draw the person at risk into a conversation. First information will often have been collected on stress and/or symptoms the person in question is showing that indicate that the situation requires more investigation. The exploration phase is completed by asking a direct question as to whether or not the person is considering suicide.

[Text box:

Facts

- The applied suicide intervention skills training workshop is a practical interdisciplinary workshop lasting two days
- The training workshop emphasizes knowledge, skills and interdisciplinary cooperation in the encounter with suicidal persons]

Table 1 Contents of the five training workshop modules

Module	Content	Teaching method
Introduction 1 h 15 min	Opening and presentation of anonymous background information on training workshop participants (age, gender, marital status, competence, experiences with suicide issues).	Lecture to a group of 24
	Information about the training workshop and work forms	
	Film: *Cause of Death*	Educational film
Attitudes 2 h 30 min	The film and personal experiences are discussed. Sensitizing of participant attitudes using attitude mapping.	Discussion in a group of maximum 12 persons
Knowledge 3 h	Knowledge on identifying suicide risk and risk assessment. The occurrence of suicidal behaviour.	Interactive presentation in a group of maximum 12 persons
Intervention 6 h 15 min	Presentation of an intervention model reviewing tasks, phases and interaction in a crisis interview.	Presentation and discussion in a group of 24 persons
	Film *It Starts with You*	Educational film
	Role play	Role play starts in a group of 24 and continues in a group of maximum 12 persons
Resources 35 min	Resources in the local community	Discussion in a group of 24

If the answer is in the affirmative, the next phase begins – the understanding phase. The aim is to help the suicidal person to speak about what is difficult. During the understanding phase information is collected on risk factors. This section is completed with an assessment of the suicide risk, which is then presented to the person in question.

Last comes the action phase. A plan is prepared to prevent the immediate danger and to bring the person at risk into contact with more skilled caregivers if the person providing first aid does not have the required competence. This plan depends on the degree of the suicide risk, the ability to cooperate and the availability of resources. In the implementation of the plan both the helper and the person at risk often have each their areas of responsibility.

After presenting the structure of the discussion, a film is shown, *It Starts with You*, which demonstrates an intervention. The film presents three alternative intervention methods and possible reactions they might have led to.

The subsequent instruction deals with interaction between the caregiver and the person at risk. Emphasis is placed on the fact that the helper is responsible for taking an initiative to inquire about suicidal thoughts, collecting information on risk factors and drawing up a plan. The helper must also help the person at risk to speak about his or her situation and his or her ambivalence. Ambivalence is given a great deal of attention during the instruction, as understanding this is an important requirement for the further activities. When the helper has gained insight into why suicide has become an option and suggests this to the person at risk, this person will often feel understood. Knowing about the resources available in the person at risk and the local community is important for realistic planning of aid measures. It is important that the helper should not proceed too fast or too slowly when talking with the person at risk. Vignettes in the film are used to point this out more clearly. The model is flexible, and it may be necessary to shift back and forth between the various phases.

Practising intervention

The intervention model is trained through role play. The most important learning in role play will often occur when the participants practise intervention skills or play a suicidal person. The frameworks of the role play are safe and structured, and the level of difficulty increases gradually. Initially the heads of the training workshop play four roles, and the participants practise parts of an intervention. Finally the whole intervention is practised so that the training workshop participants have the role of helper or suicidal person.

Resources

Emphasis is placed on resources in the local community and the importance of interdisciplinary and inter-agency cooperation. It is important that local helpers know each other and are familiar with the procedures other helpers are following.

Use of the training workshop in Norway

The Centre for Suicide Prevention in North Norway, which was founded as part of the Action Plan against Suicide in 1996, started to use this training workshop in 1998. The National Board of Health has chosen to distribute the training workshop throughout the country. The training workshop is integrated into the national strategy for competence development in suicidology (9, 10).

In January 2000, the teaching project Vivat was established. Vivat is centred at the Department for Psychiatric Research and Development at the University Hospital of North Norway, and has two employees and a regional coordinator in a 20% position in each health region. Funding is by the Directorate of Social and Health Affairs. Vivat is responsible for training trainers and supervisors for the training workshop and for developing and quality assuring the training workshops. Vivat cooperates with the Department for Suicide Research and Prevention at the University of Oslo and with LivingWorks Education. In Norway there are now about 120 active trainers and 10 supervisors. So far more than 5000 helpers have participated in Norway.

Training trainers

The training of trainers starts with a five-day training workshop which has a great deal of practical training in instruction. This training workshop is led by the teaching team which consists of experienced supervisors. These professionals have a minimum of three-year college training and other competence in guidance, instruction and clinical work, and have additionally received training to become Vivat's instructors.

The trainers are local professionals who must have experience of working with suicidal persons or suicide intervention, pedagogic experience, good communication skills and the ability to lead small groups, and they must be personally qualified. They must be able to instruct at the training workshop as part of their job. Most trainers have a three-year college education or higher education. After the trainer training workshop, the trainers must instruct at three training workshops during the first year and then once annually to retain their trainer status. The Vivat training workshop has special guidelines for quality assurance describing the requirements for trainers and supervisors and the procedure for approving trainers. The teaching team may remove a trainer if the quality of instruction is not up to the required standards.

The supervisors support the trainers during the implementation and completion of the training workshop. Annual meetings for trainers are arranged. Trainers receive comprehensive background material on both the content and implementation of the training workshop and continuous updates from LivingWorks Education and from Vivat.

Areas of application

Trainers most commonly come from the health-care sector, the social-services authorities, the police, clergy, colleges, schools, the military and NGOS. The training workshop is most commonly run with interdisciplinary participant groups. Many district psychiatric centres, hospitals and local authorities arrange the training workshops. The armed forces are about to take the training workshop into use. The training workshop is included in health studies in college and university colleges in numerous locations in Norway, at the Police College in Bodø and in the medical studies at the University in Tromsø (11).

Evaluation studies

International

The training workshop has been used most in Canada, the USA, Australia and Norway. It has been evaluated in many contexts, and the three most comprehensive evaluations are described briefly here.

The Canadian Roger Tierney tested the knowledge level (N = 159) and skills (N = 40) among participants with differing backgrounds before and after the training workshop. The knowledge on suicide increased, and there was a significant increase in the skills level. Interventions became more specific and targeted after the training workshop (12).

When the first training workshop was started in Australia, a questionnaire study was undertaken among participants with differing professional backgrounds before and after the training workshop and after four months (N = 1 000). Several participants stated they were willing to intervene after the training workshop, and the participants' attitudes to intervention changed to a more positive view of the effect of intervening in an acute suicide crisis. The effect was stable after four months. Changes of behaviour were also assessed. Eighty per cent stated that they had applied what they had learnt at the training workshop. In comparison 47% had applied their intervention skills before the training workshop (13).

Another evaluation in Australia measured the integration of theoretical and practical knowledge and change of behaviour (14). Ninety-one participants and a control group of 40 heard recordings of suicidal case histories before and a maximum one week after the training workshop, and responded to a questionnaire that emphasized participant understanding of the situation. The training workshop participants had significantly better knowledge on and skills in intervention than the control group. The control group had less experience with suicide intervention to start with than the training workshop participants. The training workshop also improved knowledge and skills for those who already knew a lot about intervention in the case of suicide risk.

Discussion

Suicide as a phenomenon is very complex, and it is difficult to predict suicide (15). Many persons who have committed suicide or attempt to do so have mental disorders (16, 17). Is the assessment of the risk of suicide a specialist task? How do we raise the level of competence of first aid for professionals with and without a health care background, and help them see their competence realistically in a larger context?

Identifying persons at risk of suicide is a task for many groups of professionals, but the health-care service has a particularly important role when it comes to identifying and treating them (18). The medical issues of recurring suicidal behaviour, suicide attempts and the relationship between mental disorders and the risk of suicide are not a topic at the training workshop. Professionals whose work tasks include follow-up and treatment need to extend their competence beyond the first-aid aspect.

Choosing competent trainers is extremely important, and the employer and Vivat both have a responsibility for this. It is nevertheless impossible to guarantee 100% the same standard. If such an implementation model is chosen this uncertainty must be accepted. Experience has shown that good trainers may have different backgrounds. It represents a major challenge for Vivat to provide guidance and follow-up so that the trainers develop the instructional competence at the training workshop. On a few occasions the teaching team has been forced to remove a trainer when the instruction given has not been up to standards.

The use of a standardized teaching programme originating in another country has been questioned. Such a programme may appear rigid, but the advantage is that it provides secure frameworks and enables efficient implementation and quality assurance. The rationale for standardization may be that the training workshop has a limited aim. Each training workshop nevertheless bears the mark of its participants, and requires a flexible approach by the trainers. Vivat has been able to adapt the training workshop to Norwegian conditions. The educational film has been produced using Norwegian actors.

Conclusion

There is always a danger of simplifying complex interaction between a helper and a person at risk. On the other hand, if the case is made very complicated and difficult, nobody will dare intervene, and the responsibility will be left to the specialists. This training workshop builds on the idea that all professional groups may contribute importantly in many contexts if helpers have more knowledge, if they have become sensitized to their own attitudes and if they have acquired some basic skills.

We extend our thanks to the Department for Psychiatric Research and Development at the University Hospital of North Norway for funding of the project.

Literature

1. Silverman M. Approaches to suicide prevention: a focus on models. In: Ramsay RF, Tanney BL, eds. Global trends in suicide prevention. Mumbai: Tata Institute of Social Sciences, 1996: 25 - 94.
2. Hoff LA. People in crises: understanding and helping. Menlo Park, CA: Addison-Wesley, 1984.
3. Shneidman ES. Some essentials of suicide and some implications for response. In: Roy A, ed. Suicide. Baltimore, MD: Williams and Wilkins, 1986.
4. Jenkins R, Singh B. General population strategies of suicide prevention. In: Hawton K, van Heeringen K, eds. The international handbook of suicide and attempted suicide. England: Wiley, 2000: 597 - 615.
5. Mehlum L. Hva alle bør vite om selvmord, selvmordsrisiko og intervensjon ved kriser [What everyone should know about suicide, suicide risk and life crisis intervention]. In: Mehlum L, ed. Tilbake til livet. Selvmordsforebygging i teori og praksis [Back to life. Suicide prevention in theory and practice]. Oslo: Høyskoleforlaget, 1999: 132 - 140.
6. Canadian Mental Health Association (CMHA: Alberta South-Central Region) Task Force. Strategies for suicide prevention: help for the helpers (A proposal to the Suicide Prevention Advisory Committee for a program of continuing education about suicide prevention). Calgary: CMHA, 1981.
7. Ramsay R, Cooke M, Lang W. Alberta's suicide prevention training programs: A retrospective comparison with Rothman's developmental research model. Suicide Life Threat Behav 1990; 20: 335 - 51.
8. Ramsay R, Tanney B, Tierney R, Lang W. ASIST (Applied Suicide Intervention Skills Training) trainer's manual, Calgary: LivingWorks Education, 1999.
9. Handlingsplan mot selvmord – sluttrapport [Action plan against suicide – final report]. Oslo: The National Board of Health, 2000.
10. Oppfølgingsprosjekt tiltak mot selvmord - prosjektplan utarbeidet av Statens helsetilsyn [Follow-up project Measures against suicide – project plan drawn up by the National Board of Health]. Suicidologi 2000; 5 (suppl).
11. Guttormsen T, Høifødt TS, Silvola K, Burkeland O. Førstehjelp ved selvmordsfare - en evaluering [Applied suicide intervention skills training – an evaluation] Tidsskr Nor Lægeforen 2003; 123: 2284 - 6.
12. Tierney R. Comprehensive evaluation for suicide intervention training. Doctoral treatise. Calgary: Faculty of Graduate Studies, University of Calgary, 1988.
13. Turley B, Tanney B. LivingWorks Australian Field Trial evaluation report on Suicide Intervention Field Trial Australia (SIFTA). Melbourne: Lifeline Australia and LivingWorks Education, 1998.
14. Turley B. Lifeline Australia Youth Suicide Prevention Project, final evaluation report. Melbourne: Lifeline Australia, 2000.
15. Goldney R. Prediction of suicide and attempted suicide. In: Hawton K, van Heeringen K, eds. The international handbook of suicide and attempted suicide. Chichester: Wiley, 2000: 585 - 95.
16. Moscicki EK. Identification of suicide risk factors using epidemiological studies. Psychiatr Clin North Am 1997; 20: 3: 499 - 517.
17. Lønnqvist JK, Hensikson MM, Isometsä ET, Marttunen MJ, Heikkinen ME, Aro HM et al. Mental disorders and suicide prevention. Psychiatry Clin Neurosci 1995, 49 (suppl 1): 111 - 6.
18. Rihmer Z. Strategies of suicide prevention: focus on health care. Affect Disord 1996; 39: 83 - 91.