LivingWorks safeTALK

safeTALK Literature Review: An Overview of Its Rationale, Conceptual Framework, and Research Foundations

Bruce Turley, DMin, MA

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Introduction

When someone is thinking about suicide, the immediate priority is to keep them safe. Increasing suicide safety is a community-wide responsibility to which everyone can contribute. People who are more adequately prepared are more likely to see intervention opportunities and respond helpfully.

LivingWorks has developed a layered suite of training programs that prepare people for a variety of roles in helping increase suicide safety. Each LivingWorks program forms part of a vertically integrated strategy designed to address and enable progressively stronger and enduring levels of safety for those encountering suicide experiences. At the foundational level, *safeTALK* helps people recognize when someone may be considering suicide and approach them in ways that facilitate safe connections. Building on these foundations, the *Applied Suicide Intervention Skills Training (ASIST)* workshop equips people to provide suicide first aid that culminates in the development of a SafePlan. A further level of suicide care is facilitated by *suicide to Hope*, a workshop for clinicians and other helpers that strengthens the sustainability of safety by assisting people to work through their suicide experiences and set recovery and growth goals that improve their quality of life.

LivingWorks' *safeTALK* is a half-day training program that helps participants recognize when someone may be considering suicide and respond in ways that connect them to suicide intervention resources. The learning process also invites people to consider some of the attitudinal barriers, in the community and within themselves, that may impede their ability to see and respond to these opportunities. While *safeTALK* is potentially beneficial to community members with diverse levels of helping experience, it is ideally suited to people seeking to improve their alertness to persons who may be considering suicide, and their ability to connect them with someone able to provide a suicide first-aid intervention and facilitate access to further ongoing help as needed. The training will contribute to an increased vigilance about suicide—in families, among friends, in diverse social settings, and for those in front-line public contact roles. Within organizations and communities, suicide-alert employees and citizens can provide a safety net, and become part of a network of care for persons considering suicide. The program can be customized to local organizational or community contexts, within guidelines provided in the *safeTALK Trainer Manual* (Lang, Ramsay, Tanney, Kinzel, & Tierney, 2016).

The purpose of this paper is to outline the rationale, conceptual framework, and evidence informing *safeTALK*. The theoretical and empirical support for *ASIST* and *suicide to Hope* have been articulated in separate documents that are accessible on LivingWorks' website, **www.livingworks.net**

Rationale

The fundamental rationale for *safeTALK* is that community-wide vigilance about suicide establishes the broadest possible foundations for effective prevention. Many, perhaps most, people considering suicide are not currently seeking or receiving assistance in formal helping relationships or are hesitant to seek it (Corrigan, 2004; Everall, Bostik, & Paulson, 2006; Pisani et al., 2012). There is some evidence that those in greatest danger of suicide are least likely to seek help (Yakunina, Rogers, Waehler, & Werth, 2010). Those needing help, especially young people, may be more likely to confide in trusted peers or be noticed by those around them in everyday settings than to seek professional help (Michelmore & Hindley, 2012). It is essential that those in a position to respond recognize that they could help and are adequately prepared for their helping role.

A foundational step in this preparation is to address the stigma, taboo, and myths surrounding suicide that erect formidable barriers to seeking and providing help (World Health Organization, 2014). In *safeTALK*, these barriers are framed as influences that cause people to "miss, dismiss, and avoid" the sometimes oblique, but often clear, signs that someone may be considering suicide and is "inviting" help (Lang et al., 2016, p. 18). Helping people recognize and overcome these barriers, and the myths that support them, helps create a community where honest conversations about suicide can occur in a non-judgmental manner that is more hospitable to seeking and providing support and finding pathways to further care.

The training also invites people to acknowledge the sources of reluctance and resistance within themselves that hinder their ability to see suicide clues and respond to these invitations in a direct and honest manner. It seeks to dispel fears about broaching the subject of suicide when there are concerns about safety. It involves helping people identify a vital, achievable role they could play in reaching out. It also helps people recognize that failure to respond is a lost opportunity to help someone KeepSafe and access further suicide intervention support. The program provides a way to initiate open conversations about suicide and suicide safety, guided by the *TALK* mnemonic—Tell, Ask, Listen, and KeepSafe.

More broadly, *safeTALK* seeks to heighten awareness of suicide safety as a community-wide enterprise, and responsibility, that visualizes some form of helping role for everyone. By offering people a clearly defined, yet significant, way of getting involved, it seeks to increase the likelihood that they will offer help. Increasing "suicide alertness" in participants helps heighten the level of suicide vigilance throughout the community.

The rationale for *safeTALK* training draws on a heritage of community-based responses to health and suicide safety that have emphasized the engagement of informal helpers prepared for their helping role by gate-keeper training.

Theoretical and Research Foundations

LivingWorks' *safeTALK* training is informed by three working assumptions.

- The primary arena for suicide safety is the community.
- Informal helpers play a vital gatekeeper role in building suicide-safer communities.
- Gatekeeper training helps prepare them for this role.

Each of these elements has informed *safeTALK*'s development and its role in suicide intervention training.

Community-based suicide prevention

Suicide safety is grounded in strategies that engage the whole community (National Action Alliance for Suicide Prevention, n.d.; United Nations, 1996; World Health Organization, 2014). Community-based approaches, which first emerged in the 1960s (Berman & Lindahl, 2001; Wallace, 2001), recognize that locally accessible supports and services are foundational to suicide safety and that widespread community engagement is needed for suicide safety strategies to be fully effective.

Community approaches also acknowledge that beliefs about suicide affect the willingness to seek help and the ability to provide it. They seek to address stigma, taboo, and judgmental attitudes. They invite people to be more mindful of their own beliefs and attitudes and how these might impact on their helping role. They encourage vigilance about suicide and enable timely responses that increase suicide safety. They invite people to consider a manageable role they could play in suicide safety and seek to strengthen community networks that identify multiple pathways to seeking and accessing help.

Informal helpers

A key feature of community-based approaches is the recognition that informal helpers are an underutilized resource that can and need to play a vital role in suicide safety. In the early 1950s, Varah (1973, 2001) pioneered engagement of community volunteers with distressed individuals—including those considering suicide. He found that volunteers provided a valuable adjunct to formal counseling services and sometimes pre-empted the need for them. This approach prompted his founding of Samaritans, the forerunner to Befrienders International, and influenced the establishment of telephone crisis centers in many countries (Scott, 2001). It prompted Louis Dublin, at the first meeting of the American Association of Suicidology in 1968, to declare that "the lay volunteer was probably the most important single discovery in the fifty-year history of suicide prevention" (Dublin, 1969, pp. 45-46).

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In developing its suicide intervention training programs, LivingWorks distinguished between engaging a growing number of "emergent" helpers—who were readily accessible to those with thoughts of suicide, yet not always expected to provide help—and "designated" helpers whose formal roles in fields such as psychology or social work were more commonly assumed to include suicide intervention capabilities (Ramsay, Cooke, & Lang, 1990). While people in formal and informal helping roles benefit from LivingWorks training programs, *safeTALK* is particularly focused on providing accessible training to a diverse range of potential participants seeking to bring suicide alertness into their everyday relationships with friends, family, and peers.

An expanded role for informal helpers, even within services such as crisis lines, has periodically met with resistance among some professionals, although Farberow and colleagues (1994) noted how, in the early development of crisis centers, this resistance was diminished by acknowledging that informal supports played an important role as part of a broader network of helping resources. Offering accessible avenues to help that provide valued immediate assistance and facilitate pathways to further care remains a defining feature in all community-based approaches to suicide safety. Role clarity, and role boundaries, for those who offer help informally, remain key factors in their effectiveness. The ability of these helpers to connect people with further assistance and to know who within their community can provide appropriate care are also key features of their role.

Research into the activities and effectiveness of informal helpers, sometimes called paraprofessionals, proliferated as their involvement increased. An early systematic review found support for the value of their work, provided that the scope and boundaries of their roles are clearly defined and that they are adequately trained for these roles (Durlak & Roth, 1983). Volunteer interventions in telephone crisis centers have been shown to reduce callers' suicidality during the call, with subsequent reductions in hopelessness and psychological pain evident several weeks later (Gould, Kalafat, Harris Munfakh, & Kleinman, 2007). However, this research also highlighted the need for more consistent, systematic approaches to follow-up care and the challenges in reliably measuring the duration of intervention effects.

Investigating the impact of informal helpers outside services such as crisis lines is more challenging. The periodic, informal, and diverse nature of these helping activities in everyday life situations is hard to anticipate, let alone measure. Ideally, the engagement of informal care networks needs to be incorporated into more comprehensive, multi-modal strategies at all levels of an organization or community, such as the strategy that yielded positive outcomes reported by the U.S. Air Force initiative (Knox, Litts, Talcott, Feig, & Caine, 2003).

The emergence of informal helpers as a key feature in community-based suicide prevention was accompanied by the development of training programs designed to equip them for their roles and improve the prospects for their effectiveness.

Gatekeeper training

Snyder (1971) coined the term "gatekeeper" to describe "any person to whom troubled people are turning for help"(p. 39). It was proposed as a value-neutral term unencumbered by judgments about the guiding philosophy that informed helpers or the extent and effectiveness of their response. It sought to describe where intervention opportunities occur and recognized that decisions about whether the gate was opened or closed were in the hands of those in a position to help. The term continues to have wide general use within community suicide prevention (World Health Organization, 2014).

An important feature of Snyder's (1971) gatekeeper philosophy, often subsequently overlooked, is that it was "an approach to crisis management that seeks to identify well trodden paths in the community which troubled people use in seeking help"(p. 39). The gatekeeper goal was to optimize the effectiveness of these natural pathways. This was not to discount the importance of such referrals, when needed, but rather to avoid overlooking the intrinsic value of the gatekeeper's connection with the person needing help. Snyder's approach also sought to recognize that formal services are not always perceived or experienced as beneficial and that referrals are less likely to be accessed if the necessary groundwork based on understanding the person needing help is not established. For Snyder, a large number of acute referral interventions within a community (such as hospital care) frequently reflected a breakdown in natural care supports and pathways. A diminished need for such measures reflected a more healthy community response through informal supports and effective primary care.

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The legacy of the gatekeeper philosophy is the recognition that these helpers have a pivotal role to play in effective intervention. It also affirms that the intrinsic value of gatekeeper responses can be positively

consequential, that revitalizing and sustaining natural care pathways is a hallmark of an effective community-based response to suicide prevention, and that a collaborative approach among informal and formal helpers and those needing assistance offers the best prospects for increasing suicide safety. The ideal balance is to engage appropriately prepared informal care networks whenever possible, while being open to engaging professional services as needed.

Gatekeeper training research

Given the widespread availability of gatekeeper training, evaluation and research on these programs is of considerable interest. A preliminary marker for recent research was established in a systematic review of suicide prevention strategies that found promising indications of benefit for training where gatekeepers had clearly defined roles as part of a multi-level strategy in organizational settings featuring clear pathways to further care (Mann et al., 2005). This investigation also highlighted the need for further research, particularly in community settings.

More detailed analysis of the potential and performance of gatekeeper training, along with its limitations and challenges, has been reported in two subsequent systematic research reviews. In their review, Isaac and colleagues (2009) noted the capacity for these programs to be tailored to organizational and community needs and the forum they provided for strengthening trust and networking among participants. They found support for the positive impact of gatekeeper training on knowledge, attitudes, and skills in diverse populations, particularly when incorporated within larger multi-modal strategies. Their investigation also highlighted the need for more research into the training's impact on intervention behavior, the sustainability of training effects over time, and the tracking of referral patterns following an initial intervention.

A recent review by Burnette and colleagues (2015) found that gatekeeper training did positively impact "declared" and "perceived" suicide intervention knowledge. The reviewers found emerging evidence of the training's value in overcoming participants' reluctance to intervene, promoting adaptive beliefs conducive to intervention, and increasing participants' intervention self-efficacy (although they noted some variability in findings). The conceptual model in their review also featured the interaction between personal and environmental factors that influence the pathways from training to implementation. They invited greater focus on measuring and addressing the impact of competing demands and organizational environments in which gatekeepers are potentially active, since these will impact implementation activity and outcomes. They also called for research that could identify key factors within training that appeared to be most strongly associated with good outcomes. The need for further investigation into organizational factors influencing participants' post-workshop training behavior was also identified by Evans and Price (2012).

Several key themes emerged from these reviews which can inform the implementation of gatekeeper training programs such as *safeTALK* and evaluations that assess their effectiveness and contribute to improvements.

- Gatekeeper training does have a role in increasing suicide safety, which needs to be clearly defined, and is optimally effective when integrated into a larger organizational or community strategy.
- While participants' learning relevant to the purpose and goals of gatekeeper training has been demonstrated, the fidelity and sustainability of these outcomes on subsequent behaviors requires further research.
- Implementation planning and research need to address the interaction between personal and environmental factors in achieving good outcomes.

- Given that these programs are designed to encourage and enable links to further care, it is necessary to understand factors that affect openness to accessing such supports, and to ensure that these supports are available and responsive.
- Demonstrating clear links between the prevalence of gatekeeper training and reductions in suicide rates is particularly challenging, given formidable obstacles such as the low base rates for suicide, and the complexity of determining which among many factors have been critical to good outcomes. Further, since the gatekeeper role is, by definition, part of a larger prevention process, measurable outcomes are likely to reflect the influence of many contributions to suicide safety. However, tracking and assessing gatekeepers' application of their learning in connecting people to further care is possible, particularly through qualitative studies that can describe intervention activities and their impact on persons needing suicide care. In organizational settings it is also possible to track the role of gatekeeper interventions in initiating access to pathways leading to further help.

Core Concepts in safeTALK

Safety

LivingWorks has made safety a central organizing construct in its suicide intervention training programs. This began with the transformation of the *ASIST* workshop in 2003 and its subsequent revision (Lang et al., 2012) that focused on the development of a SafePlan as the tangible framework for enabling a good suicide first-aid outcome. That outcome is realized when a person considering suicide is safe-for-now. The safety theme then featured in the development of *safeTALK*, introduced in 2006 and subsequently revised (Lang et al., 2016), where facilitating safe connections became the key training objective and intervention goal.

Several factors prompted LivingWorks' decision to give central prominence to the language of safety rather than risk in its training programs.

Safety is an immediate, practical, present-centered concept that is widely used and understood in workplaces and everyday life situations. Accordingly, safety is a more appropriate operating construct, especially for community-based programs that engage a wide range of informal helpers. Those offering and receiving help can usually readily agree on what will compromise or increase immediate safety and which ongoing supports are trustworthy. Safety may also be more readily acceptable and accessible to persons who do not yet feel ready to embrace life or face all the issues surrounding their thoughts of suicide. Importantly, safety is a positive goal—something to work toward, rather than something, like risk, to avoid.

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A further consideration is that programs like *safeTALK* and *ASIST* are focused on preparing helpers to provide effective responses in timely, one-off encounters with persons who have suicide experiences. In these situations, the detailed contextual, personal, and clinical information that guides formal risk assessments in an ongoing therapeutic relationship, and which can be monitored, reviewed, and revised over time, is seldom available and cannot be reliably factored into intervention decision making. Additionally, estimating risk relies on a level of judgment that is beyond the scope of these programs and often the capabilities expected of informal helpers or those providing suicide first aid. Reliable suicide risk assessments are challenging, even for experienced clinicians with considerable contextual and personal information, and they

certainly require a level of informed judgment that is unrealistic to expect, particularly for informal helpers engaging in one-off interventions.

Risk is a predictive concept, based on estimating the likely consequences of exposure to danger or precipitating harm in the foreseeable future. However, reliable prediction of any one person's suicide has proved elusive (Pokorny, 1993). Additionally, risk assessments seek to estimate time horizons and determine how soon the risk may result in actual danger, using the notion of "imminent risk." Yet "imminence" has never been successfully operationalized, despite its ubiquitous appearance in risk assessment literature (Simon, 2006). One recent proposal has sought to address some of these issues, shifting the focus of clinical risk assessments from prediction to prevention, in a promising model that incorporates personal and social strengths that aid safety (Pisani, Murrie, & Silverman, 2016). The model works toward more individually tailored safety interventions that derive action plans from its assessments, although it is clearly intended for application in clinical settings rather than first-response interventions by informal helpers.

The risk construct also remains constricted by its avoidance orientation and its attempts to calibrate estimates of exposure to danger. Given that the worldview of persons with suicide experiences is already inherently constricted (Shneidman,1996), a risk orientation is prone to intensify the sense of confinement and overlook the need for life-affirming empowerment. By contrast, safety seeks to engage the desperation of persons with suicide experiences to find alternative solutions to the problems in living that currently seem so intractable to them. While it does address threats to safety, it also features the opportunities associated with keeping safe and taps into personal strengths and social supports that make safety possible.

Helping participants make safe connections is a readily understandable task. In LivingWorks' training programs such as *safeTALK*, safety is both an outcome and a process. While helping someone make safe connections is the intended outcome, the prospects for open, honest talk about suicide that help achieve this goal are greatly increased if both parties feel that the helping relationship is respectful and trustworthy. Being able to talk openly about suicide, in a climate of trust, empowers people to seek and provide help.

Participants also need to feel safe within the learning process. Encountering suicide within training can prove confronting for some and may sometimes arouse memories of painful personal experiences. However, such experiences can also motivate learning, while open discussion about suicide in a safe learning setting can dispel fears associated with making an intervention. The *safeTALK Trainer Manual* (Lang et al., 2016) provides specific guidance on ways the person conducting the training can enhance participants' safety.

The possibility of iatrogenic effects for training participants has been raised as a concern about suicide intervention training. There is, however, a growing, reputable body of evidence refuting the notion that such talk about suicide compromises safety when conducted in a safe, trusting setting. A consistent finding is that screening and training programs based on asking directly about suicide do not cause iatrogenic effects when responsibly conducted. Prudence, care, and vigilance about vulnerability are always important in talking about suicide, but there is clear evidence indicating that these programs and screening processes are safe (Bailey, Spittal, Pirkis, Gould, & Robinson, 2017; Deeley & Love, 2010; Gould et al., 2005; Robinson et al., 2011; Rudd et al., 2006).

Connecting

Since Durkheim's (1897,1951) pioneering social science investigations of suicide, the negative impacts of isolation, alienation, and anomie have been recognized, along with the importance of strengthening social cohesion and connectedness. More recently, promoting connectedness within and between groups

has featured as a key element in developing comprehensive suicide prevention strategies, along with an emphasis on building social capital that strengthens the level of trust and engagement within communities (Stone et al., 2017). LivingWorks' aspirational goal of building suicide-safer communities seeks to contribute to this enhancement of connectedness, trust, and engagement in a defined way through LivingWorks training.

The *safeTALK* training identifies three vital connection opportunities on the pathway to suicide safety.

- The person considering suicide initiates communications that invite help.
- Helpers must then choose how to respond to these invitations—whether to connect with suicide, or miss, dismiss, or avoid such safety-seeking communications.
- Both parties to this conversation then work together to make one or more safe connections with others able to provide a suicide intervention, with a particular initial focus on suicide first aid.

These connection opportunities are captured in the *TALK* mnemonic—the person with suicide thoughts Tells others, directly or indirectly, what they have in mind. Helpers respond to this invitation by Asking about suicide and Listening to what is said. They then jointly work to meet the KeepSafe objective.

Communications inviting help

Most people contemplating suicide communicate their intent and their ambivalence about it. These findings were foundational to the pioneering work of the Los Angeles Suicide Prevention Center in the 1960s (Stone et al., 2017) and were subsequently articulated in the ten commonalities of suicide conceptualized by Shneidman (1996). The recognition that people considering suicide desire at some level to seek help and connect with others has become a cornerstone of suicide prevention and its descriptions of "warning signs"(Rudd et al., 2006; Van Orden et al., 2006).

LivingWorks has characterized these signs as "invitations" (Lang et al., 2012), partly to emphasize their relational aspect—the person's desire, desperation even, to connect with someone who may help. Invitations are also uniquely personal. They may relate to an infinite array of circumstances, events, or experiences, depending on their meaning for a particular individual, and are often intentionally directed to particular individuals perceived as trustworthy.

Many social and personal factors affect the clarity of help-seeking communications and influence the extent to which people venture to express them. Centuries of stigma and taboo surrounding suicide have led many to anticipate that responses to invitations may be judgmental, dismissive, or evasive. The *safeTALK* training highlights the implications of missing, dismissing, or avoiding suicide and illustrates the beneficial effects of creating a climate of openness and trust where help-seeking is encouraged and open, honest conversations about suicide are possible. Recent work on developing tools for understanding stigma and assessing the impact of stigma-reducing interventions creates possibilities for improving understanding of this important aspect of prevention (Corrigan, Sheehan, & Al-Khouja, 2017).

Connecting with suicide

The helper's willingness and ability to connect with suicide influence the outcome of the intervention opportunity that invitations present. When tentative invitations are met with helpers' reluctance to engage, it is much harder to clarify the present danger or find pathways to help. Conversely, there is evidence that certain helper qualities are associated with good outcomes. Mishara and colleagues (2007) found that

capacity for empathy and respect were paramount, and were supported by the ability to make good contact and engage in collaborative problem-solving.

Asking about suicide and actively listening to the response are identified by *safeTALK* as foundational tasks for working toward safe connections. When invitations are tentative or vague, the helper can seek clarity; when initial disclosures about suicide thoughts are made, the helper can ask for elaboration. In *safeTALK*, connecting with suicide does not require, and should not seek, a full understanding of all the person's concerns or a resolution of the issues associated with them. It aims to hear enough to emphasize that any suicide thoughts need to be taken seriously, to affirm that connecting to further help is essential, and then to take steps to facilitate safe connections.

Making safe connections

Identifying and making safe connections completes a *safeTALK* intervention. Ideally, this is a collaborative process, since the safe connection needs to be with someone that the person considering suicide trusts, and it needs to be someone who can strengthen that person's immediate safety and clarify what further help may be needed.

The person inviting help may be aware of supports in their own informal network, or through formal sources of help they have received previously or access currently. This is consistent with Snyder's (1971) original expectation that gatekeepers need to understand, respect, and utilize the networks known to the person inviting help, whenever it is clear these can offer support consistent with the immediate goals of keeping safe. However, it is also incumbent on helpers to be aware of potential safe connections in their community, to which people can be referred as needed. Part of the *safeTALK* trainer's role is to help participants share ideas about the suicide intervention capabilities required of persons or agencies to whom they refer and to share information about where such resources may be found.

The adequacy, availability, and timely accessibility of community resources able to attend to suicide safety is an ongoing concern. For example, Gould and colleagues (2007) found that even services such as crisis helplines did not always provide referrals when the need for them was evident. Additionally, many did not follow up on referrals they received, and dissatisfaction with services people did access was often expressed.

For individual interventions to be optimally effective, they need to provide clear pathways to care. Such supports need to be available, known to those seeking help, perceived by them as trustworthy, able to offer timely access, and willing to collaborate and coordinate. Above all, they need to be experienced as helpful by those who access them.

Conclusion

Community-based suicide prevention strategies have played a foundational role in keeping people safe from suicide for over half a century and remain a central feature of current international and national strategies. They present a vision of communities where everyone is contributing to suicide safety—creating a climate of openness to seeking and providing help and offering competent suicide intervention assistance. Engaging informal helpers, also known as community gatekeepers, in providing suicide care relies on appropriate training to ensure that this help is competent, role-appropriate, and effective.

safeTALK training provides an accessible forum for involving a broad range of community helpers in preparing for a defined, achievable suicide intervention role. Participants learn to approach and engage

people considering suicide in ways that help them make safe connections with further suicide intervention assistance—usually beginning with suicide first aid.

LivingWorks actively encourages research and evaluation of *safeTALK*, and all of its training programs. These studies need to measure what participants learn and assess how effectively they apply this learning to intervention opportunities. The impact of these interventions on those receiving help needs to be better understood, including the accessibility and helpfulness of the safe connections. Ultimately, the benefit of programs like *safeTALK* is the role they play in broader integrated strategies within organizations and communities. Evaluating these networking relationships will provide a clearer picture of how *safeTALK* is currently contributing to building suicide-safer communities and how this contribution could be further enhanced in the future.

A document describing the key features and objectives of *safeTALK*, and mapping the theory of change that informs the program, is available as background for researchers and evaluators (LivingWorks, 2018). It is accessible on the LivingWorks website.

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