Training Utilization and Penetration Interviews

Cross-site Evaluation of the
Garrett Lee Smith Early Intervention
and Suicide Prevention Program

Applied Suicide Intervention Skills Training Report

January 15, 2009

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BACKGROUND

ASIST is a 2-day workshop designed to teach the skills that enable an adult to competently and confidently intervene with a person at risk of suicide. Developed by LivingWorks Education, Inc., the workshop is designed to help all caregivers (i.e. any person in a position of trust) become more willing, ready, and able to help persons at risk. The workshop is for all caregivers including mental health professionals, nurses, physicians, pharmacists, teachers, counselors, youth workers, police and correctional staff, school support staff, clergy, and community volunteers.

ASIST Learning Modules

- PREPARING: sets the tone, norms, and expectations of the learning experience
- CONNECTING: sensitizes participants to their own and others' attitudes towards suicide
- UNDERSTANDING: provides an overview of the needs of a person at risk – participants gain the knowledge and skills to recognize risk and develop a "safeplan" to reduce the risk of suicide
- ASSISTING: presents a model for effective suicide intervention – participants develop their skills through observation and supervised simulation experiences in large and small groups
- NETWORKING: generates information about resources in the local community. Promotes a commitment by participants to transform local resources into helping networks

Workshops are 14 hours long, held over 2 days. The ASIST curriculum includes suicide intervention skill development, confidential and trainer-facilitated small groups learning environments, established trainer protocols to address vulnerable or at-risk participants, knowledge of local resources that can be accessed, consistent use of positive feedback, a blend of larger group experiential challenges and the safety of small-group opportunities to test new skills, no-fault simulation exercises, and the use of adult learning principles.[1]

Prior evaluations of ASIST have shown that most trainees report high levels of satisfaction with ASIST training, with few negative experiences. Self-reported knowledge, skills, and attitudes related to suicide are consistently shown to increase post-training, and this is reinforced by studies that have directly measured these outcomes. The few studies that have gathered follow-up information suggest that improved knowledge and attitudes are maintained, with some decrease in comfort discussing suicide. Approximately half of trainees studied reported using some component of the ASIST intervention model within 3 to 6 months following the training. Studies using measures other than trainee self-report have reported mixed results.[2]

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[1] U.S. Department of Health and Human Services. *To See the Great Day that Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2008.

[2] Griesbach and Associates. The Use and Impact of Applied Suicide Intervention Skills Training in Scotland. Annex: A Review of the International Literature. Scottish Government Social Research, May 2008. Accessed January 2009: http://www.scotland.gov.uk/Publications/2008/05/19160110/0

Most prior research on ASIST has focused on immediate training outcomes, and has included little qualitative data providing a richer context and understanding of what information trainees report learning, which information was most useful, and how they have applied the knowledge and skills learned. This report is intended to fill this gap in the research literature.

PURPOSE OF THIS REPORT

The purpose of this document is to summarize findings from follow-up interviews conducted with individuals who attended Applied Suicide Intervention Skills Trainings (ASIST). The trainings described in this report were implemented as part of State and tribal Garrett Lee Smith Youth Suicide Prevention and Early Intervention (GLS) programs and the data were collected through the cross-site evaluation of the GLS program. The report first presents a summary of the knowledge and skills that trainees mentioned learning in the training, and includes participant reports about which training components and techniques were most useful to them. The report then highlights the ways in which trainees used and applied the information and skills from the training, and concludes with respondent recommendations for future ASIST trainings.

METHODS

The Training Utilization and Penetration (TUP) interviews are a major component of the process stage of the cross-site evaluation of the GLS program. TUP interviews assess the content, utilization, and perceived impact of training activities conducted by GLS-grantees, as well as the challenges and facilitating factors associated with suicide prevention. The cross-site evaluation team selects TUP respondents from a sample of participants in GLS-supported training activities and conducts the interviews approximately two months following their target training experience. The TUP interview protocol includes information in three content areas: 1) respondent background information, 2) training content, and 3) training utilization and perceived impact. The semi-structured TUP interview includes 23 open-ended items and takes approximately 20-30 minutes to administer.

This report includes data representing 93 individuals, attending 13 ASIST trainings, sponsored by 10 GLS grantee sites. Additionally, one of the trainings was an ASIST training of trainers. Immediately following the conclusion of the Applied Suicide Intervention Skills Trainings identified for the TUP interviews, training staff introduced the TUP interviews and the consent-to-contact process to training participants. Interested trainees provided their contact information and written consent to receive further information about the interviews from the cross-site evaluation team. The cross-site evaluation team conducted interviews within 7 – 9 weeks following each training. Following the 20-30 minute semi-structured interview, the evaluation team mailed participants a $20 money order to compensate them for their time.

Analyses were conducted on these transcripts using the software package, Atlas.ti 5.2.9[3]. The first phase of data analysis involved the selection and categorization of text into broad categories designed to identify underlying themes. The second phase of analysis involved compiling the segments of text aligned with each general theme followed by a more detailed analysis intended to examine the responses within each category. This phase of analysis further identified new themes that emerged from the data.

Guiding Questions of TUP Analysis

1. What do participants remember about the training? What are the things that they report learning?
2. What are the practical skills or tools acquired from the training?
3. Which parts of the training do participants report as being the most useful? What modifications do they recommend?
4. How do participants report using the skills and tools learned in the training? Which populations are affected by the utilization of these skills?
5. What is the impact of the training on the individual being trained? What changes do they report in the ways that they communicate about suicide prevention? In what ways have their interactions with youth been influenced?
6. What are factors that help and hinder the suicide prevention efforts of recent trainees?

Participant responses were further analyzed according non-mutually exclusive primary roles. First, all participants were divided into one of two categories: mental health provider or non-mental-health provider, so that basic distinctions could be made between (1) those who might be expected to have some exposure to or experience with issues surrounding mental health, mental illness, and, to a certain degree, as well as some training in therapeutic technique, and (2) those who would not necessarily be expected to have that experience or exposure. **Mental health respondents** (n=35) include elementary, middle, and high-school counselors, social workers, psychologists, and psychiatrists; as well as university counseling center staff; mental health agency therapists, supervisors, and administrators; and clinical staff working within child welfare and juvenile justice systems. **Non-mental health respondents** (n=57) identified as nurses, community educators, teachers, suicide prevention coalition members, child welfare or juvenile justice case managers or residential staff; homeless shelter staff; adult residential care staff; substance abuse treatment center staff; community advocates and liaisons; family support staff; youth programming and extracurricular support staff; law enforcement officers; first responders; clergy; and community members.

Second, the most commonly reported professional roles were selected for distinct analysis; each of these roles included 10 or more participants. These roles include school-based staff (n=17); child welfare staff (n=11); military personnel (n=10), and a justice category composed of juvenile justice staff, police officers, and detention officers (n=13). These professional roles are subsumed within the two primary categories (mental health provider or non-mental-health provider) and also may overlap with each other.

[3] Muhr, Thomas. (2004). User's Manual for ATLAS.ti 5.0, ATLAS.ti Scientific Software Development GmbH, Berlin.

LIMITATIONS

Participants were randomly selected from a pool of those who consented to be contacted related to TUP interviews. While statistical analyses suggest that there are no differences in the training satisfaction reported by participants and non-participants immediately following the training, it is possible that participants who were more enthusiastic about their training experience were more likely to agree to participate in the interviews. Further, the open-ended TUP protocol asks respondents to describe how they used the information learned in the training, as opposed to requiring 'yes' or 'no' answers to a list of specific questions (e.g. Was your awareness heightened? Did you identify someone at risk for suicide? Did you make a referral?). Thus, despite efforts to systematically probe, it cannot be assumed that the responses of individuals are exhaustive or represent the entirety of their experience; in other words, participants may have experienced outcomes that they did not report. Finally, the sample sizes of the various trainee roles vary widely. In smaller samples, a difference of one or two respondents can affect the reported proportion by 10-20%, perhaps skewing the difference between the different trainee roles. In short, sample size and selection bias along with other methodological limitations restrict generalizable conclusions.

TRAINING CONTENT

Trainees most frequently reported learning the warning signs of suicide, as well as the ASIST intervention model. Participants particularly reported learning various components of the ASIST model, including asking directly about suicide and other specific questions to ask; safety planning; risk review; and making a referral. In addition to the model, participants reported learning effective communication techniques; general information about suicide and mental health; and of common myths, attitudes, and experiences related to suicide.

All trainees were asked to describe the knowledge and skills that they learned in the ASIST training. Respondents **most commonly reported learning the warning signs of suicide**, with mental health and non-mental health staff reporting learning this information in approximately equal numbers. Respondents reported learning the "red flags" of a person considering suicide, explaining that they learned to pick up on key phrases such as *"I'm not feeling that good, or I haven't been feeling that great lately, or I don't know what I'm going to be doing later, or I don't know how to take it;"*

Knowledge and Skills Obtained by Training Participants, in Order of Most Frequently Reported

- Warning signs of suicide
- ASIST model*
- Asking directly about suicide
- Communication techniques
- Specific questions to ask
- Safety planning*
- Exploring ambivalence*
- Risk review*
- Overview of suicide and mental health
- Myths and facts about suicide^
- Referral resources
- Making a referral
- Attitudes and experiences with suicide
- Train the trainer*

**reported more often by mh providers*
^ reported more often by non-mh providers

The ASIST training defines many verbal warning signs as "invitations," or statements made by an individual to signal their pain and offer others an opportunity to respond. Below, one participant explained how the ASIST training reframed the traditional discussion of the warning signs of suicide in way that encourages trainees to view warning signs or invitations as the first step of an intervention, thus necessitating their involvement,

> *"One of the things that it did was it presented it in a little bit of a different way and it gave sort of different names and different labels to things, such as saying 'invitations' as opposed to 'warning signs' and 'risk factors,' which I thought was very interesting. These are invitations to have this conversation, so that sort of rewording that and giving it a different look as far as what we're usually concerned about is are there any warning signs and risk factors and then that's when you, signals you to do your intervention."*

Following the warning signs and invitations, ASIST trainees most commonly reported **learning a model for intervention** that includes three phases, and specific key questions to ask an

individual possibly at risk for suicide. Mental health providers more frequently referenced the ASIST model when discussing knowledge obtained in the training, as compared to non-mental health providers. Below, one participant describes the key features of each phase of the model, including: asking directly about suicide ideation; exploring the individual's reasons for wanting to die and wanting to live; reviewing risk; and developing a safety plan,

> *"the first section was I believe the connecting phase where the person kind of gives the indications that they're having thoughts of suicide and you explore those and ask them if they're having thoughts of suicide… So we went over that, kind of like what types of indications they might give you and how to just come out and ask… And then the second part I think was the understanding phase, where you are really trying to understand why they're feeling this way and you ask them flat out what are their reasons that they want to die and also do they have reasons that they want to live. And we were taught to really explore all of that and focus on letting them see more reasons for living. And then also in that phase we took a look at their risk as far as how serious they are about it …. And then after that you kind of move on to kind of developing a plan with them, what you're going to do each of you to get them help or keep them safe, things like that, and then just to follow-up with them at the end and just kind of be involved with them."*

When discussing the ASIST model, participants most commonly reported learning the concept of **asking an individual directly about whether they are considering suicide**. Mental health providers reported learning this concept more frequently than non-mental health providers. Additionally, this information was reportedly new to many training participants, as they allowed that they were previously reluctant to address suicide directly for fear that it might introduce or encourage the option of suicide,

> *"[the training taught that] it's okay to ask if they're going to commit suicide where most people think that's taboo, don't bring up the S word because they'll do it. So just making sure that everyone knew it's okay to ask them and it's okay to explore that, and it's okay to ask them detailed questions to see, gauge kind of are they just having a bad day and they're really not going to do this or do they have a plan or do they just kind of really feel that there's no hope in their lives. And it gave a lot of different, and I can't quote you that, but it gave a lot of different things to look for and phrases to look for to see if this person is serious or not. And also just tell people, make sure you can tell people."*

Communication techniques were the next most frequently reported skill learned in the training. These techniques included active listening, building rapport, using appropriate language and terminology, empathy, and employing a non-judgmental and normalizing approach to the topic of suicide. The concept of active listening was the most commonly

mentioned communication skill, for example, *"I think I learned how to, I think I learned a little bit more about how to really listen and how to be in someone's, in the midst of someone's pain with them, and then move forward from that."* Another participant explained how the training provided a helpful reminder of the importance of listening,

> *"Well, it's just a refresher too when they talked about really listening to the person and kind of not having your own agenda in your head as far as trying to lead them to a specific place, but asking them really direct questions to have them answer. I think that's a good reminder for anyone in the helping profession to just remember to really listen."*

Another participant reported that they were taught about the implications of commonly used expressions and descriptions of suicide, for example, *"a person committed suicide,"* and the alternate language that they were taught to use in the training,

> *"Instead of somebody committed suicide, it was a completed suicide, just the little ways that society kind of portrays suicide is not necessarily an accurate picture of what's going on for the individual in crisis…So when we say well, he committed suicide and it sounds like it was a choice, for a lot of folks they don't feel like it's a choice. And there's something seriously going on with them that it's not like they're trying to be selfish…So it definitely sets the stage a little bit better when you're trying to do intervention and prevention to understand where that person is and kind of where they're thinking that they already feel like society has this stigma on suicide and it makes it even harder to talk about or to deal with or to come out of."*

Participants also frequently mentioned that they learned "a road map" for how to have a conversation with an individual considering suicide, and that the ASIST training taught **specific questions to ask**, and *"what to say, what not to say."* As one participant explained, *"You were taught to ask like why they were thinking of doing this and if they had a plan, things like that. And I don't know that I would have felt comfortable asking that before."*

While a key question outlined by the ASIST model is "are you thinking about suicide," other questions focus on **exploring the individual's reasons for living and for dying**, as well as **risk review questions** intended to assess the individual's risk for suicide. A few participants mentioned learning "CPR++" a mnemonic to remember key risk assessment questions (current plan for suicide, level of pain, available resources, as well as prior suicide attempts and prior receipt of mental health services). These risk review questions, as well as e*xploring ambivalence*, the terminology used by ASIST to describe the discussion of reasons for living and dying, were mentioned more frequently by mental health providers,

"It's kind of like a map for a conversation to have with a suicidal person so that you know here to go from point A to B and what questions to ask them, really questions that let you know just how great the risk is, especially if there are firearms nearby, do they have a plan, all of those things let you know just how serious the situation is because all situations are serious, but there are certain levels, like you shouldn't leave them alone if they have certain risks. And it really taught I guess what to say in a situation like that."

Another ASIST component commonly reported by participants when discussing knowledge and skills learned are those in the last phase of the ASIST model, the "assist" phase. **Developing a safety plan,** including the removal of lethal means, is the skill most frequently mentioned when participants describe this phase, and in general, mental health providers reported knowledge related to this phase more frequently than non-mental health providers. One respondent described these safety plans as, *"how we can prescribe contracts verbally, whatever, temporarily to keep that person safe, to feel safe, us to feel that they are relatively safe so that other assistance can be sought. Safe plans."* Another explained,

"Well, I had already learned in previous trainings to really have a plan before you leave that person and have it clearly kind of laid out, something that you both agree on, like a plan to prevent them completing suicide. So I guess that was really reemphasized for me to have that plan in place for what you're going to do… And you can even like write it down saying okay, now you're going to do this and I'm going to do this. And if you're thinking about hurting yourself or if you're having thoughts of suicide, you're going to call this person, and let's make sure you have that number with you at all times, and just really having the plan very specific."

Mental health and non-mental health providers reported learning **statistics and other overview information about suicide and mental illness** in relatively equal proportions; however, non-mental health providers were more likely to report that **the training dispelled myths about suicide**, for example, that it is not dangerous to speak directly about suicide, and that most suicidal individuals do not want to die. Below, two participants describe this component of the training,

"They had a pretty good synopsis or overview of the prevalence between different demographics, and especially I think one of the main points there, one of the main topics or ideas they really tried to hit on was the fact just because it may be more prevalent, there is nobody that is immune to it. It reaches across all people, all demographics, everyone."

"I think probably the most useful was to make sure that they understand it's okay to engage them in conversation, and it's okay to ask questions to see what answers you're going to get. And to get rid of that it's taboo to ask them, it's taboo to explore a little bit more in-depth on what they're feeling and what they see as a future, to see if they're into some hopelessness where I think everybody gets that way. I think everybody in their lives has valleys and peaks, and it's just kind of how they cope. Some people just don't cope well with the valleys. And I think that's what this instruction showed is if you can kind of get them past the crisis and get them some help, you can actually help these people."

Additionally, participants reported **learning to make a referral**, as well as the **referral resources available** to them locally, state-wide, and nationally. Participants explained that they were taught to identify formal and informal resources available to the individual, and to involve friends and family as a support system,

"As far as the ASIST model goes, a lot of different specific ideas as far as support or resources is trying to help people explore through the support on different levels, whether it was personal and friends and family, and even looking so much as far as to connections that we might have with a pet. And then connected also larger community resources and being fairly new to my agency, it was kind of nice to, it was helpful to hear about other specific agencies that also were represented there and different ways that we could connect or refer people out to them. The National Suicide Crisis Line that we got information for that I wasn't aware of, a lot of just specific resources."

Along those lines, participants reported learning significantly from other individuals in attendance, particularly when a diversity of service sectors were represented; as it afforded the opportunity to learn from the **experiences, attitudes, and approaches of other trainees**, as one participant noted, *"seeing other people's way of handling situations or dealing with things or the way they phrase things even, just seeing other people's techniques I think is useful as well."* Respondents also mentioned that the training encouraged networking among trainees, which subsequently facilitated referrals between community agencies and individuals,

"I think one of the things that was most useful was the diversity of people that were at the training because they had school counselors, they had drug prevention counselors, police officers there, and getting the different perspectives of all the people there and how they've dealt with the issue. I thought it was a good model for collaborating with other professionals… I think if nothing else what it helped me to do is understand the perspective of different people who may deal with people who are having suicidal thoughts."

Finally, the mental health respondents who attended the ASIST train-the-trainer reported learning skills related to training facilitation, e.g. *"how to present the material and how to interact with the groups that you're going to be training and how to cover the factual information in an interesting way."* Additionally, participants reported learning to effectively facilitate the role play activity and provide effective feedback,

> *"I learned how to give positive feedback and to kind of take a nonjudgmental stance when people are putting themselves out there, taking risks and saying what they would do that you don't really refuse anything because the person is acting in good faith and they're trying to help. So rather than correcting people and saying, not that you would say no that's wrong, but rather than correcting them, you sort of work their idea into the training. They were very positive, neutral or really positive, so that was helpful."*

USEFUL TRAINING COMPONENTS & TECHNIQUES

All participants, regardless of role, reported that the role play exercises were most beneficial. However, mental health and non-mental health staff endorsed other components to differing degrees. Non-mental health providers reported that learning the warning signs of suicide, having knowledgeable and skilled trainers, and learning from how others approached the issue of suicide were most useful. Mental health providers reported that learning to ask directly about suicide, learning how to respond to an individual following their disclosure of suicide ideation, and the ASIST intervention model in general were most useful.[4]

After respondents discussed the knowledge and skills presented by the training, they were asked to identify the components (e.g. knowledge or skills) and techniques (e.g. training activities or ways of teaching) which were most useful to them in their personal and professional lives. Over half of all trainees reported that **the role play exercises were most beneficial,** explaining that the role play allowed them to practice their skills and thus feel confident about their ability to intervene; desensitize them to asking directly about suicide; and learn from the variety of ways that other trainees approached a situation requiring suicide intervention, *"I think it's really beneficial to watch how other people learn and react in similar situations."* Additionally, as trainees were asked to play both the role of the intervener and the role of the suicidal individual, respondents commented that it was helpful to experience the intervention from the opposite perspective,

> *"I would just think the biggest part was giving us time to go through the role plays and being …okay to say 'have you thought about this' or 'have you thought about that,' and … 'I have to tell somebody about this.' And maybe some different ways*

[4] Similar proportions of mental health and non-mental health providers named the ASIST model as useful

instead of just saying 'well, I'm a mandatory reporter, so you signed your confidentiality and client rights, and in there it stated that if you' - it's just different ways of saying things so you don't come off as such as harsh person and you can still keep the rapport between those people…Yeah. It made you feel very comfortable. The way it was presented made me feel very comfortable with what I was doing. And that's the one thing that I like about training is that if I'm made to feel comfortable I'll probably utilize it more."

While mental health and non-mental health providers both reported role play as the most useful component of the ASIST training, the two groups endorsed other components to differing degrees. Table 1 provides a list of commonly reported techniques and training components, and how they were ranked by trainees. The training components are discussed in the *Training Content* section of this report, while descriptions of the training techniques follow. Non-mental health providers reported that learning the warning signs of suicide, having knowledgeable and skilled trainers, and learning from how others approached the issue of suicide were most useful. Mental health providers, however, reported that learning to ask directly about suicide, learning how to respond to an individual following their disclosure of suicide ideation, and the ASIST intervention model in general were most useful.[5]

Table 1: Useful training techniques and components, in order of most frequently reported

Mental Health provider	Non-Mental Health Provider
Role play (~50-60%)	Role play (~50-60%)
Asking directly (~30-40%)	Warning signs (~30-40%)
Responding to ideation (~20-30%)	Great trainers (~20-30%)
ASIST model (~20-30%)	Approach/experience of others (~20-30%)
Small group discussions (~10-20%)	Specific questions to ask (~20-30%)
Variety of training techniques (~10-20%)	Communication skills (~20-30%)
Specific questions to ask (~10-20%)	Asking directly (~20-30%)
Good trainers (~10-20%)	Wallet card/materials (~10-20%)
Approach/experience of others (~10-20%)	ASIST model (~10-20%)
Communication skills (~1-9%)	Responding to ideation (~10-20%)
Exploring ambivalence (~1-9%)	Small group discussions (~10-20%)
Wallet card/materials (~1-9%)	Variety of training techniques (~10-20%)
Warning signs (~1-9%)	Exploring ambivalence (~10-20%)
	Overview/understanding of suicide (~1-9%)

With regard to training techniques used, participants highlighted the **interactive nature of the training**, especially the **small group discussions** in addition to the role play activities, *"being interactive is a lot better than reading 3,000 pages of text and then taking a test... if you're in the right frame of mind and you're participating, if everybody's involved, I do believe it opens*

[5] Similar proportions of mental health and non-mental health providers named the ASIST model as useful

you up for better learning and better comprehension of the class." The small groups reportedly allowed participants to share their experiences, discuss training concepts, and practice intervention skills,

> *"I think it was nice that we were in smaller groups because it helped us feel more comfortable and some of the, especially some of the role playing that we might have had to do or also having other people share some of their experiences to help us learn some of the other warning signs and things that people might say about having suicidal ideations. So I felt smaller groups were definitely beneficial to me."*

Participants also highlighted the **variety of techniques and activities** used in the training, and the fact that they appealed to various learning styles, *"between videos, PowerPoints, overheads, and hands on with the workbook, discussion, and also listening, I think it applied to a lot of different learning styles, which I thought was beneficial."* **The trainers themselves** were also named during the discussion of helpful training components, with respondents reporting that they particularly appreciated trainers being knowledgeable; open to questions; providing clear and thorough instruction; sharing personal experiences; modeling techniques and giving encouraging feedback; and establishing a comfortable and safe learning environment. As one participant explained, "*You know, they were really wonderful about strength based, building on those strengths that we already have. They gave us a lot of feedback and wonderful support about what we already had and were focusing on how to help us build that into something that was a little more effective. So I really liked it a lot."* Another observed how the trainers shaped the structure and dynamic of the group,

> *"They were really, both of them were very, first of all knowledgeable, they were also really interactive, they were tuned in to the group. They were very sensitive to the possibility that there would be people in the room that had experienced suicide in their personal lives, either felt suicidal themselves or did attempts or lost someone possibly. So they were really tuned into that, and I think mostly just that they were well organized and interactive and well structured with the training. There was a lot of good balance of didactic presentation and interactive discussion and some exercises."*

Finally, several of the mentioned **materials used or distributed during the training** included the wallet cards summarizing the intervention model; PowerPoint slides; referral resource information; video vignettes; and the ASIST training workbook, described by one participant as *"very colored and very interesting, and it wasn't just a bunch of words. It was diagrams and statistics and stuff like that."* Respondents most frequently remarked upon the wallet cards, reporting that they are an easily referenced summary of the ASIST model, and provide step-by-step intervention instructions,

"Well, we did get these little pocket cards … And the back side has the whole model on there and it's in color and it just kind of helps you to follow along. And then it has like signs of indications that they're giving you to kind of pick up on and then it talks about that risk review, how you kind of decide where they're at and then ideas for the safe plan… And then it also has a little section of different resources that, informal meeting, family, friends, personal connections, things like that versus formal, like emergency personnel or health workers, things like that. So it's all on there, so it's a nice handy little thing to refresh your memory."

Participants further explained that the wallet card increased their confidence, as they were taught that they could refer to the wallet card in situations involving an individual at-risk for suicide, *"I find that card that they gave us to keep in our wallet really helps because I can take it out and then I know each step to do and I don't feel like I'm just randomly freaking out and not knowing what to do with somebody who is feeling like that."*

TRAINING OUTCOMES

After discussing what they learned, and which parts of the training were most useful, trainees were asked to describe how they had applied the information and skills learned in the training, and to identify specific ways that their communication and interaction styles had changed. Participants reported five primary outcomes of the training: increased self-efficacy; heightened awareness; improved communication skills; sharing information with others; and intervention, e.g. engaging in some way with an individual at risk for suicide.

Self-efficacy

Improved self-efficacy was the most commonly reported outcome of the ASIST training. Trainees, a slightly higher proportion of them mental health provider and child welfare staff, reported feeling more equipped and prepared to intervene, and more comfortable with the topic of suicide.

Table 2: Participants reporting increased self-efficacy

TRAINING OUTCOME	TOTAL (N=93)	MENTAL HEALTH PROVIDERS (N=35)	NON-MENTAL-HEALTH PROVIDERS (N=57)	SCHOOL STAFF (N=17)	JUSTICE STAFF (N=13)	CHILD WELFARE STAFF (N=11)	MILITARY PERSONNEL (N=10)
Self-efficacy	70-79%	80-89%	70-79%	70-79%	70-79%	80-89%	60-69%

The most frequently reported outcome of the ASIST training was **increased trainee comfort and confidence.** Trainees, a slightly higher proportion of them mental health providers and child welfare staff, reported feeling more knowledgeable, more prepared, and more equipped to respond to suicide ideation, *"I just feel more confident that if I am faced with the situation of coming upon a person who is suicidal, that I could work with them, not panic, know the right questions to ask."* Respondents also reported an increased comfort with the topic of suicide, including an increased willingness to discuss and/or raise awareness about suicide in a direct and straightforward manner. These outcomes are linked to almost every other outcome discussed below, as much depends on the trainee's willingness and capacity to address suicide and respond to ideation. This link is implied by one participant who stated, *"I'm probably much more open. But I feel prepared, equipped so I can. If I'm not knowledgeable about things, then I'm not going to talk about it a whole lot. So I'm very open, very agreeable to talk about it."*

Participants provided examples of how this comfort and confidence has affected the way they interact with and serve their clients. For instance, one participant remarked that while the training did not necessarily change the likelihood of intervention with a suicidal client, it did make the intervention more effective, *"chances are if someone was suicidal I would have intervened in some way before, but maybe it wouldn't have been as smooth or I wouldn't have felt as comfortable with it. I think the training just makes, for professionals it just makes you more comfortable with what you're doing."* Another respondent, a police officer, reflected that, following the training, they have found it much easier to respond to crisis calls,

> *"Well, the past, before I took the class I was kind of, I didn't really know what to do when I got a phone call on a suicidal person and I had to go respond to that. I was always nervous about what I was going to do and how I was going to act and what I was going to say. But after the class, I've had two of those that I've dealt with. And it's been a whole lot easier, I mean I just go and I know what I'm going to say and I know what I'm going to do and it's just been a whole lot easier to do, I'm more confident."*

One trainee, a social worker, observed that their increased comfort and confidence has equipped them to provide increased support to their depressed and suicidal clients, as they are no longer afraid or reluctant to explore and discuss their client's feelings,

> *"I mean suicide certainly still has a lot of taboo around it, so I've been in the past very uncomfortable. And so this just made it easier for me to open up and ask my client very direct questions and that way show him that I am somebody he can talk to about his feelings, that I'm not going to run away, I'm not going to just turn him off and pick up the phone and call the suicide hotline, that I will listen to him talk about his feelings. So that's the big change for me is just being able to broach the*

subject, being comfortable sitting down and actually having a conversation about it instead of getting scared."

Finally, another respondent, staff at a homeless shelter serving teenagers, described how their training-inspired confidence has affected their capacity to understand, address, and respond to suicidality and depression,

"But I think a good example is just when I sit down with a kid, there's more intent behind the questions and then if they were to say they were suicidal, I have more knowledge about the steps I can take, and I have more confidence about my ability. It's a scary thing to talk to people about, and to be able to just dive into that conversation with them and not have it be something where there's a stigma about it, like 'oh, you're suicidal,' but just 'wow, I'm sorry you're experiencing this. Tell me more about it.' And then going through those steps that you would go through to break down the barriers and then create a safety plan. And I've done that with a couple of youth, and it makes them feel a lot safer when they're in our shelter because, and they've even said that. One of them said like 'I felt unsafe with myself, and I don't know what I would have done if I hadn't set up that safety plan.' And so it works. And I thought that was great."

Heightened Awareness

Participants reported that the training heightened their awareness of the signs of suicide. Non-mental health providers, particularly military staff, most commonly reported this increased awareness, and were much more likely to report taking these signs more seriously.

Table 3: Participants reporting heightened awareness

		Total (N=93)	Mental Health Providers (N=35)	Non-mental-health Providers (N=57)	School Staff (N=17)	Justice Staff (N=13)	Child Welfare Staff (N=11)	Military Personnel (N=10)
Heightened Awareness	Heightened awareness of warning signs	70-79%	60-69%	70-79%	50-59%	50-59%	70-79%	90-100%
	Increased awareness of suicide prevalence and seriousness	10-19%	0-9%	20-29%	0-9%	10-19%	10-19%	50-59%

Respondents frequently reported an **increased awareness of suicide and its warning signs** following the training. Table 3 illustrates the frequency with which trainees indicated heightened awareness with darker shades indicating greater frequency. For example, one

participant described how their "antennae" had been raised to words or actions that might indicate suicide ideation,

> *"I think I'm more observant because a lot of people in our classes talked about denying or not wanting to believe the warning signs. They talked a lot about warning signs and I think it makes me more aware, I catch it quickly when a child may say 'oh, I'm depressed' or something like that, my radar goes off and I want to check in with them and make sure everything is going okay. I may have just kind of brushed it off before because I just thought oh, they're just a kid, but I learned a lot in my class that a lot of those times the people ended up committing suicide because no one would listen. So it's made me much more aware."*

Other trainees reported that, because of the training, they are more observant of their clients, and better able to identify true warning signs. For example, one participant, a staff in a residential youth facility, described how the training has decreased their anxiety because they have a better understanding of the mood and mental status of their clients,

> *"just to be aware, be more aware of the situations that are going on, try to be more aware of the moods of everyone and just paying attention to the subtle changes that may be occurring with them. I would say that maybe I feel more confident as far as that aspect of my job, so that might make me feel a little more at ease with the kids so that I'm not always like 'are they okay, are they okay' and then panic about it. I can sit there and make a rational judgment about what's going on and it just makes me feel better, and it would probably make them feel better knowing that I know what I'm doing."*

Non-mental health providers reported heightened awareness more often than mental health providers, and were also more likely to report **taking these signs of suicide more seriously** than they would have prior to their training,

> *"I guess as I think back about it, just again we in the business kind of get a little bit callused, we take things for granted or we don't realize certain things that might be going on that we need to be more aware of. And I think that the training helped me take a, refresh some of my thinking and thoughts about suicide and those kinds of things. So I think that it helped increase my awareness, sensitivity a little bit more too. So it was good. I enjoyed it."*

A few also reported a greater **overall awareness of suicidality and its prevalence**, e.g. *"just being aware of it, that it's out there probably to a greater extent than I ever realized;"* as well as a greater understanding of their own ability to prevent suicide,

"before I was all negative. If they were going to commit suicide, it wasn't me so before I didn't care. And now it's just like if there's somebody trying to think of committing suicide, I'd sure like to be there to help them see other ways, there's other ways out there rather than killing themselves. Life is precious."

Military personnel, many who reported losing fellow soldiers and colleagues to suicide, were most likely to report a heightened awareness; with each of the ten members of the National Guard included in this sample reporting this outcome,

"now I'm listening to some of their issues and I think I'm a lot more aware of when they're talking about depression and they start to isolate themselves and starting to do those things that make me think, you know what, I think that this guy is thinking suicide. So no, that's where I'm at with it"

Finally, this awareness continues outside of the workplace, with individuals reporting that they are aware of and looking for signs in their friends and families, as well as the individuals they interact with in the community and in church. As one participant, also military personnel, described,

"I would say even when I'm back out in the civilian world, which is not too often, but even when I'm out in the civilian world when I'm at the gym working out or standing in line at the bank or whatever, I tend to be more observant of people's discussions unless it's totally whacked out and crazy… But I tend to be a little bit more attentive to people's conversations in general. Not that I interfere with those conversations because again, that's not my job. But it is, I just become more attentive towards people's body language and the way they, how they look at life I guess."

Communication skills

Participants report being more willing and able to communicate about suicide, explaining that they know "what" to say and "how" to say it. While mental health providers and school staff most commonly reported this overall improvement; non-mental health providers and military personnel were more likely to report applying more specific communication skills, including active listening, empathy, and patience.

Table 4: Participants reporting improved communication

		Total (N=93)	Mental Health Providers (N=35)	Non-mental-health Providers (N=57)	School Staff (N=17)	Justice Staff (N=13)	Child Welfare Staff (N=11)	Military Personnel (N=10)
Improved Communication	More willing/ able to discuss suicide	50-59%	60-69%%	50-59%	70-79%	50-59%	50-59%	60-69%
	Used active listening skills	20-29%	20-29%	30-39%	20-29%	20-29%	30-39%	40-49%
	Other communication skills used	20-29%	10-19%	30-39%	10-19%	30-39%	20-29%	40-49%

The third most commonly reported training outcome was an **increased willingness to discuss suicide and ability to communicate.** Participants reported that they were more willing to raise awareness in their communities and discuss suicide in a direct and straightforward manner,

> *"typically people are, they're almost afraid to say the word but since going to that training I'm less hesitant to use the term suicide because what we learned was that a lot of suicides go unreported and people are afraid to address it straightforward head on and so I think I'm wanting to be more open with talking about it with even children because it's not something that you need to be afraid of."*

Participants also reported that they *"know what to say, what not to say,"* in situations where they are concerned that an individual is suicidal, and how to approach the topic, *"it shows you how to start. That's a big thing, how do you start talking about suicide?"* For example, a police officer described how the training has facilitated their crisis response, allowing them to better explain the process and what to expect,

> *"we explained to them that they have to come with us and go see a medical professional. And a lot of times they're hesitant on doing that, but with the training that I've had I could just sit down and explain to them or help them understand that they need help and this is what we can do. And so it's been a lot easier for them to understand that I'm just there to help them, I'm not there because they're in trouble, which normally law enforcement is there because you're in trouble. But when we're actually there trying to help them, with the class I can just show them 'okay, this is what we're, this is where we're at and this is what we're trying to do. You're not in trouble and you're not going to be in trouble.' And so it's just given me more confidence to talk to them."*

Participants reported that the training resulted in the use of appropriate language and terminology when discussing suicide; and for those colleagues who attended training together, has allowed coworkers to *"speak the same language"* and more effectively communicate around issues of suicide prevention,

> *"When we're doing debriefings we're able to, because other people had done the same training, so we're able to use a common language and ask is this, do you see any of these signs, what's happening here. So it's given us a common language, which is really helpful. It's also I think made all of us a little bit more aware of things that are the cues."*

Similarly, another participant reported that the training has helped them talk about suicide prevention in a way that is easily understandable to non-professionals,

> *"it's easier for me to go and explain it to somebody who is not a professional who doesn't know the lingo. Like even when I'm talking to you, I'm talking about suicide ideation and safety plan and all those kinds of things, which may be foreign to most people. And so being able to bring that down and okay, when we talk about safety plan, these are the things that, and making sure that I'm walking through it step-by-step so that people have that knowledge and that information."*

Participants also reported that the training emphasized how to talk to people, and stressed concepts like empathy, building rapport, patience, normalizing suicidal ideation and the discussion of suicide, and active listening, *"Just the ability to share information and normalize and communicate. I think it helps, with stuff like that the more confidence you have, the more accepting you are, the safer you are to talk, the better you can be for someone else who needs to talk about that."* One participant explained how learning these communication skills has assisted in talking with youth,

> *"Getting kids to open up. Getting them to trust me and being able to tell me things that are bothering them because a lot of kids will close up like clams and not open up and working on a level that I'm just here as a friend, and getting them to open up and talk to me is the biggest thing that I use as a resource with this training."*

Of the specific communication skills applied by trainees, respondents reported **using their active listening skills** most often, with non-mental health providers, particularly child welfare staff and military personnel, mentioning this more than others. Trainees reported that learning the importance of listening has affected many of their interactions and relationships, not just those with individuals considering suicide, and reported using their listening skills frequently,

"one of the instructors had talked about learning to just shut up and listen. And that was really powerful to me and I found it to be something that I use a lot because a lot of times, not always, but a lot of times when someone is, when it's more of like immediate crisis and not a long term depression issue, somebody just needs to vent and needs an ear to talk to who is going to listen and who is going to be willing to listen. And I've found that to be one of the biggest tools, especially working with these kids, teenagers typically in a situation where they don't feel like anyone listens or understands or can relate and just taking the time to listen to their ideas and help validate some of those things and recognize that yeah, that's a lot going on that's really rough can make all the difference in the world. And I've used that probably more than anything else in the world. A lot of times they'll get it off their chest and then feel quite a bit better about it and it will kind of help take care of itself from there."

Non-mental health staff were also much more likely to report that their **other communication skills had improved**. Below, two participants describe how they have applied patience, active listening, and skills related to de-escalating situations on an almost-daily basis.

"I pretty much use it every day with all of my consumers that I serve. I mean they benefit from me not being as eager to rush in, me being more open and patient and listening, that kind of thing, and be more positive, me be more let them come up with their own solutions."

"I'm a lot calmer, I have a more relaxed tone of voice. If I see that they are kind of escalating, you use a calm voice, short sentences, and try to ask them what's going on. And I actually start using the model thing as far as I can take it, like what's wrong? What's going on? And explore what their thought processes are at the time. Usually I don't have to go through the whole model before it comes out, and then we just try to get them to calm down. And it usually works, knock on wood."

Another participant, a member of the clergy, reported that their communication style around suicide prevention has changed because of the training, explaining that they have a softer, more empathetic approach when responding to ideation,

"I have various individuals … say things like I don't want to live anymore, I'm thinking about killing myself and so I just tell them straight up straightforward 'the only one that has authority to take life and death is God, and that is a fact you must understand and realize'…The training kind of led me to believe well shoot, maybe I shouldn't be so authoritarian in that type of situation and if I'm going to say something like that, maybe I should just tone it down a bit so as that I don't feel that I'm coming off too strong with them or to turn them away in case they

truly are serious… I don't want my tone of voice to scare them away to actually doing something either. So there is a balance that I think I need to maintain and some of that I learned in that training. It was pretty good stuff."

Sharing information

While mental health and non-mental health providers report sharing information with their colleagues equally, child welfare staff and military personnel report doing so more often than the other groups; and law enforcement/juvenile justice staff report sharing information the least. Mental health providers are slightly more likely to report sharing information with their clients, clients' families, and the community; while non-mental health providers, particularly military personnel, were much more likely to report sharing information with their friends and families.

The willingness and ability to discuss suicide discussed above is also related to the fourth most frequently reported outcome, **sharing information and raising the awareness of others.** Colleagues and coworkers are the most commonly reported recipients of this information, and participants report sharing warning signs and intervention steps with their colleagues both formally (e.g. small presentation or training) and informally (e.g. in conversation). Additionally, a few respondents reported utilizing the information from ASIST in the provision of clinical supervision. Below, two other participants, a clinician and a school counselor, describe how they have shared suicide prevention information with their coworkers,

"We have a clinical meeting every Tuesday morning and I've noticed that myself and the other staff member that went to the training, she and I often talk to people about the questions that they ask and kind of remind them of some things. So it's definitely changed our clinical meetings. And people will ask us questions because they know we've been to the training so they will come to us and say what should we do about this or a person is saying this or doing this and what do you think?"

"it's been more, it's more brought out in the open now. At the beginning of the year this year at a staff meeting I did a little mini-presentation on just how not to be afraid of kids when they say they're going to commit suicide and what to do and then when teachers refer me kids what I do. And so I think that hopefully it's increased the level of comfort with it."

	Total (N=93)	Mental Health Providers (N=35)	Non-mental-health Providers (N=57)	School Staff (N=17)	Justice Staff (N=13)	Child Welfare Staff (N=11)	Military Personnel (N=10)

Sharing Information	Shared information with coworkers	40-50%	40-49%	40-49%	30-39%	20-29%	60-69%	50-59%
	Shared information with clients/ others	20-29%	30-39%	20-29%	20-29%	0-9%	20-29%	20-29%
	Shared information with friends/ family	10-19%	0-9%	20-29%	10-19%	0-9%	0-9%	70-79%

Table 5: Participants reporting sharing information

One participant, a member of the military, explained how trainees have raised the awareness of the people around them, which echoes the patterns emerging from the ASIST data: **most trainees talk to their coworkers, many talk to their friends and families, and some share information with clients, students, parents, and other individuals in their general community.**

> *"I mean every one of us went out, and I think every one of us has talked to our families. So I would say the immediate people were the coworkers, and the next ring out was our families, and the next ring out from that is the soldiers that we're interacting with at our units or in our day-to-day dealings in medical command."*

Of those respondents who reported sharing information with their friends and families, a few identified a ripple effect, explaining that they friends they shared with then told other friends. Participants with children often reported talking to their children and their children's friends about the issue, and the importance of seeking help for depression and suicidality,

> *"Well, when I talk with my kids and their friends, when we talk, we discuss different thing that are going on in school. I just make them more aware of how young some of these kids are that are going out there and experiencing some of these awful things. And if you ever hear or you ever know of someone, they can always call me any time or they can, we have places and have people that they can call if they want to talk to somebody that they can't put a face to."*

Some also reported that their friends or families identified individuals they were concerned about after hearing about the warning signs of suicide, as mentioned by the participant below,

> *"Well, I did, I don't know, I'm a mentor, so I kind of talked about it with the girl that I mentor, and she was talking about her cousin who had mentioned some things. So I think she kind of took some of the information to see if the situation called for it. I wasn't obviously there when she talked to her cousin, but I don't know. So I guess spreading the knowledge, and I also talked to my dad about it, and he had someone at his work that he thought maybe after talking about some of the signs."*

Participants also reported sharing information with clients, patients, students, their families, and individuals in the broader community. For example, a few respondents reported sharing information with their church community, while a few others reported integrating information into awareness materials at wellness fairs, public service announcements, and in related workshops or presentations. A few participants reported posting stickers identifying themselves as suicide resources, *"I've placed stickers and notices on my door that I'm available if people are suicidal that I'm somebody that they can call upon to talk to the person about it."* One participant (who attended an ASIST training of trainers in the period between the initial training and the TUP interview) described how they have incorporated information and techniques from the ASIST into workshops that they conduct with youth,

> *"So read what you'd like into it, but as far as the actual how I've helped, I think it's helped tremendously. I've given workshops to our youth on many occasions and although it may not be ASIST, there are aspects of ASIST that incorporated into the training just kind of based on what the needs of that presentation were. So it may have been hey, can you come talk about substance abuse, well, that's great, we'll d that, but let's do this also, lead to those kind of risk factors that substance abuse leads to suicide. So it's really helped to make a connection between those things to bring in aspects of ASIST like kind of the role plays or what to do if in that situation on a smaller basis. And that's only because of the presentation."*

Intervention

Trainees reported intervening with suicidal individuals in equal proportion across roles. However, mental-health staff were more likely to report asking individuals directly about their suicide ideation and conducting risk reviews; they were also more likely to report using skills from the ASIST training in other ways (e.g. with non-suicidal clients). Non-mental health staff more commonly reported exploring invitations or informally "checking in" with individuals possibly at risk for suicide, creating safety plans, making referrals, and using the ASIST skills to provide support to their friends and families.

Table 6: Participants reporting engaging with a individual possibly at-risk for suicide

		Total (N=93)	Mental Health Providers (N=35)	Non-mental-health Providers (N=57)	School Staff (N=17)	Justice Staff (N=13)	Child Welfare Staff (N=11)	Military Personnel (N=10)
Intervention	Asked directly about ideation	30-39%	40-49%	30-39%	40-49%	0-9%	40-49%	30-39%

	Used ASIST skills in other ways	30-39%	30-39%	30-39%	10-19%	10-19%	40-49%	30-39%
	Explored invitations/ check-in	20-29%	0-6%	30-39%	10-19%	20-29%	20-29%	40-49%
	Intervened with suicidal individual	20-29%	20-29%	20-29%	10-19%	30-39%	30-39%	20-29%
	Reviewed suicide risk	10-19%	20-29%	10-19%	10-19%	10-19%	20-29%	10-19%
	Made referral	10-19%	10-19%	20-29%	10-19%	20-29%	10-18%	30-39%
	Developed safety plan	0-9%	0-9%	10-19%	0-9%	0-9%	20-29%	0-9%

For the purposes of this report, we are including any reported engagement with an individual due to a concern they may be at risk for suicide under the heading *intervention*. Of all such interactions, the most commonly reported was **asking an individual directly about suicidal ideation.** Many participants reported previous anxiety around or avoidance of such a question, primarily due to discomfort or concern that it might unintentionally encourage suicide. However, following the training, participants reported applying this technique successfully. Moreover, those with prior experience of engagement with youth potentially at-risk for suicide reported improved client response and rapport following the question. Below, an individual describes their post-ASIST experience asking directly about suicide:

> *"I think the parts that are the most useful is we have a lot of kids here who cut themselves and then people assume that they're trying to kill themselves. And whenever they would come to see me I was 'are you, do you want to hurt yourself,' I'd ask questions like that and I never would really just ask 'are you thinking of killing yourself,' and then 'do you have a plan.' I never was able to be very direct with them. And I think the ones that I have encountered since the training where I've asked directly I've kind of got the ball rolling, they were taken aback a little bit by me knowing that, and then I think it helped the whole dynamic because I wasn't skirting around the issue."*

Mental health staff were most likely to report asking a youth directly about suicide ideation. Participants, commonly non-mental health staff, also reported engaging with individuals they were concerned about less directly by **exploring invitations, or informally assessing possible ideation**. This also includes participants who do not directly report asking directly about suicide, for example, *"[I learned] not to be afraid to discuss suicide with people, which I'm, I don't usually do, but I always visit with depression. So now when somebody says they're depressed I go a little bit further."* Participants report being more likely to check-in with individuals who

are displaying a change in mood, or seem depressed, including coworkers, clients, and friends and family, for example, *"I've talked to people and personalities have changed and I'm in tune to it and I kind of strip it down and say hey, do you want to sit down and talk? So people open up, and it was really helpful to me."* Another respondent reported a similar outcome,

> *"But now I look at it, it is real, it's very serious, and we need to take it seriously, and talking to coworkers I ask, I work and stuff. If they look down and depressed it's like what's going on? Everything okay? And try to go in there, and usually everything is fine, they're just having a bad day. But you never know."*

> *"Just approaching people that are having issues like this or recognizing the symptoms. Now when I ask somebody how they're doing and if their answer is not what I think it should be, I actually do ask again. So things like that, the reiterating to them, not just giving a token 'how are you doing' and then leaving. When I'm asking somebody how they're doing, I'm actually wanting to know how are they doing."*

Along these lines, participants also report regularly following up with clients and individuals that have struggled with depression or suicide in the past, e.g. *"there has been situations of depression that I've had to talk with the kids and just make sure that they're doing okay and that they're not headed towards that way and so it's kind of like almost a daily check-in to make sure they're doing okay."* Another participant described similar monitoring of youth,

> *"just paying attention to some of the people, the kids that I deal with, just watching them and making sure that I don't see anything that I think that they're going to do something, self harm. I have asked a couple if they're okay or how things or going, just kind of like touch-up to see how they're doing today because I've noticed that maybe a couple of them here and there have had really bad days and you just want to make sure that they're okay. So I will go through a little bit of it, but once I figure out that hey, they're just having a bad day, and that's pretty much the basis of it…But that doesn't stop, I don't just walk away and say well, that's it, they're okay, fine, I'm not going to touch on it again. I'll still periodically check in and say 'hey, what's going on? How are things going?'"*

Mental health and non-mental health staff reported **encountering suicidal individuals** in equal proportions; however, child welfare and law enforcement/juvenile justice staff reported responding to suicidal youth in slightly higher proportions compared to other roles. Participants reported engaging with individuals at the hospital, after a suicide threat has been made; with youth in school; youth in child welfare and juvenile justice residential facilities; with soldiers deploying to or returning from combat; and with non-residential youth and adult clients including youth in foster care independent-living programs or homeless youth. Below,

one participant describes intervening with two youths at-risk for suicide, and how the training has allowed them to better identify and respond,

> *"Well, one of the girls… she had made attempts before, or said she was going to do it before and we were all very worried about her, we didn't really know what to do. We called 911, and now since I've gone to the training she came to me again and was acting the same, doing the same thing, and so I just confronted her and I said 'are you thinking of killing yourself.' And I think when I asked her that, she was kind of startled because nobody had ever said it before. And when I talked about 'do you have a plan and how are you planning on doing it,' it kind of came out that she was mostly just reaching out for attention and she wasn't seriously thinking about it… The other girl I had that I had to ask and kind of confront, she was thinking of killing herself and she did have a plan and everything. And then I was able to get the [crisis] team, and I was able to know to do that because of the training."*

Participants reported responding to suicide ideation in a number of ways, including **reviewing risk, developing a safety plan, and making a referral.** Below, two participants describe applying these steps; additionally, note that one participant reported using the ASIST wallet card to guide their intervention, while the other used the skills to assist a client with schizophrenia stay safe when voices were encouraging suicide,

> *"I've had one girl who was definitely hurting herself, and so I said let's pull this card out and let's see what's happening and let's see what we can do. So I walked through the steps and asked her 'where are you at? What's going on?' And then we set up kind of a kind of an agreement number one that she wouldn't do anything, the contract. I made sure that there was nothing available in the house for her to be able to do anything and set her up with counseling. And then another person, not through my job, was feeling suicidal and I think we made sure we got all of the guns out of the house, made sure that there was nothing available for them to be able to use, and I actually put them on the phone with the Care Crisis Line."*

> *"Well, there was one individual that I was working with … she was hearing voices that were telling her this was something that she should do. So it's like you're working with this almost like a third party…. the thing that was crucial was formulating like a safety plan with her, which could be used if this other party was having a lot of influence over… we had her do a, come up with a list of things that she would think about using to harm herself and potentially commit suicide with… like different household items that anyone could have them at home. So just kind of acknowledging those things and also coming up with people she could talk to if*

these feelings came about, like calling our crisis line or talking to her therapist or going back to treatment…."

While participants reported making referrals when they or their agency did not have the capacity to treat or monitor the individual (e.g. activate a suicide watch in residential settings), they also reported that they are more likely to know when *not* to refer. For example, the following two respondents explained that they are less likely to refer individuals considering suicide, as they are better able to assess immediate suicide risk, and have a greater number of tools available to stabilize the individual,

"As I said before, it makes me a little bit more comfortable with them if they're not actively suicidal because in the past if anybody mentioned the slightest thing about I don't know how much longer I can go on like this, or maybe other people would be better off without me and things like that, I would have immediately taken action to get them to a suicide or a mental health specialty facility or person. But now I don't have to do that."

"And here at the mental health center in our every day work life at least a couple of times a week we encounter a situation with children where somebody is threatening, probably more than that, but I'm just talking about here in my office…. typically we'd make sure that they're kept safe and that they are provided with the services that they need. But now with this new training, it doesn't necessarily call for somebody to be put on lockdown right away. It calls for them to kind of be stabilized and to begin to see things differently and then move on to helping their own selves be safe."

Respondents also reported involving the family members of suicidal individuals, in part because the ASIST training encouraged trainees to consider all supports and resources available to those in crisis. Participants also reported that they were better able to discuss suicide with the parents of youth at-risk.

"I think that just again my confidence level is up. I'm not afraid to talk about it, I'm not, if a parent calls me and is concerned about their child I'm just very, it's just not a subject I'm afraid to discuss anymore. And the times I've had to call home saying that I have a suspicion that their child is suicidal I don't feel like I'm, it can be a scary phone call to call home and say something like that, but I feel like I have more confidence in doing it and discussing it and not being like, well, I used to call home and be like 'I think your child is hurting themselves' and I just would never say 'I think your child is thinking of committing suicide.'"

A few individuals explained that they did not directly intervene with a suicidal individual, but rather **advised and assisted another intervener** as a supervisor or friend,

> *I actually had a friend I was on the phone with, and she was elsewhere, but she was dealing with a friend of hers that was feeling suicidal. And for the first time ever I felt like I had like real information that could help her. I helped a friend help another person through suicide …And she was then able to take those tools that I shared with her from the training and it affected this other person's life.*

Additionally, participants regularly reported **applying skills learned from ASIST in other ways** with individuals who are not in immediate suicide crisis. For example, trainees reported improved communication and regularly checking in with clients who are depressed or at some risk for suicide. Participants also reported regularly using a variety of other skills, i.e. motivational interview techniques; developing safety plans to promote coping skills; and connecting individuals to helpful resources in the community. Below, one participant reports applying safety planning techniques to assist non-suicidal youth, and another describes how direct and straightforward interviewing techniques are helpful in addressing a variety of serious issues experienced by the youth they work with,

> *"one thing I do regularly with kids here is do safety plans and so it's kind of a preventative measure where I just ask them questions about 'what's a really stressful day like' for them, like if they feel really sad or really stressed out, what can they do to help themselves through it and what can the staff, the adults around them do to help them through it. So I think working on a safety plan is really good for these kids to kind of plan what might happen, not necessarily in the event of suicidal thoughts, but it could apply to that, and it just applies to life in general if they're feeling really stressed out what can they do to stay safe, who can they reach out to and how can the staff around them help them."*

> *"Well, in the ASIST training, some of the things, some of the interviewing skills that you learned, like how to get at what are the issues or the problems, I'm using that with the youth that I speak to because many of the youth that I speak with, some of them could be traumatized. It could be physical abuse, sexual abuse, just something that's going on within the family unit that is causing a problem. And so being able to get at the problem in a way that allows the youth to share, that's the skill I think that's most, that I'm using the most right now from what I learned."*

Finally, several trainees also reported providing ongoing support to friends, coworkers, or clients struggling with depression or suicidal thoughts, including one young trainee (a survivor of their own suicide attempt) who reported assisting a suicidal acquaintance over the internet-based social networking site MySpace.

TRAINEE RECOMMENDATIONS

Trainees were asked to suggest any changes or improvements to the ASIST training. The most common response was that **trainees urged that the ASIST training be offered to as many individuals as possible, including both formal and informal caregivers.** For example, the following participants recommended that organizers seek out community members who frequently interact with youth:

> *"I think this would be even more effective if just regular community people were more involved, people that interact with youth, like lifeguards or a youth minister or someone that's going to be interacting with kids kind of in those fun situations besides more professionally. And I think if the ASIST training was offered to them, I think it would really benefit the community…"*

> *"I think everybody should take this training… Even people that are not in the field of mental health or just people in general, parents working with children that work volunteer, people that volunteer in organizations. I mean everybody really should be aware of what to look for. And if that were to happen, I think we would have a lot less suicide, and suicide is huge in the world. And the more people that are educated and become aware of what can be listened to and understood from people that may be suicidal or have the potential for suicide, what can be learned from this training would help everyone. I mean it even helps, even if you never, ever became in contact with anybody, it would help yourself. I just think it's a very good training."*

Additionally, several participants recommended that **the ASIST training be adapted to better meet the needs of certain trainee populations.** For example, while corrections and law enforcement personnel commented that officer training curricula should include expanded information related to suicide prevention and intervention, "*there should be more in-depth training…this ASIST training should be taught at our academy so every law enforcement officer coming out of there knows that, and has the tools to help people;*" officers also reported that the ASIST model did not prepare them for many of the acute suicidal crisis situations they respond to:

> *"There's some situations that you run into that you have to take the person's life into your own hands and restrain them because regardless of all the training and all the stuff that you learned, there are people that come in here that are intent on taking their lives. And that's when you have to take away their choices. And it's sad, but your program didn't really deal with that. So that's one thing that they might need to improve on would be to explain that there are some situations that individuals are so far into that black hole they're not coming out, they're going to*

do it. And that's where you have to, the physical containment, putting them in the rubber room, so to speak, and stuff like that, and keeping an eye on them every five minutes. That part wasn't really that well explained. Of course and they probably weren't expecting to deal with a prison setting either, they're just teaching people how to deal with suicide in the community and stuff."

Military personnel also recommended that the training be adapted to their needs, and include risk and protective factors specific to the military. For example, one respondent explained that soldiers preparing for deployment are at a particular risk for suicide, *"On every deployment we've lost somebody… the last three big deployments where we have sent over 500 people out the door, we have lost at least one person on every one of those to suicide."* When asked how the military-specific training would differ from the standard ASIST training, a participant suggested:

"70% of it is going to be the same, but there are going to be pieces of it that are different… you're dealing with killing people. So that weighs heavy on a lot of people… I would also like to see some of the training be a little more focused to "okay, how do you help them get out of that so they don't start that spiral." So that's the biggest piece… So the isolation from their family, and what they're seeing and doing every day… It's a war zone. So those are big stressors. So I'd like to if we could work with somebody around that in creating some new materials so that we could do some very specific intense training for the folks that are going over there…"

A few respondents working with Native American and Alaska Native populations similarly recommended that the ASIST curriculum be adapted to include culturally-specific healing processes and coping strategies, as well as additional risk and protective factors:

"I believe there could be additions more specifically tailored to native people, even to our reservation's community members in the sense of bringing cultural, that cultural healing process into it and recognizing that, and then also a spirituality component that may be for some people the one thing that gets them through … there wasn't necessarily a place in the model that says 'oh, and this is where you might want to think about inserting some cultural stuff to get them through.'"

Finally, while some participants reported that the training should be shortened, and some recommended that the training be lengthened, many trainees suggested that **a "Part 2" or "refresher" ASIST training should be offered,** that would include updated information and additional opportunities for role playing and strengthening communication and intervention techniques, "*it would just be good to kind of have a refresher once in a while, mainly, I mean I'm sure they're learning new things about it all the time and just because of my work I just want to*

feel more comfortable with it." As another participant explained, they do not come into contact with suicidal youth on a daily basis, so:

> *"if they say yes [to being suicidal], it's easier to kind of catch you off guard. So I think having just a, even if it was an annual shorter training where it was getting together again and going over more role playing to re-familiarize with different scenarios that could come up, just to keep comfortable with it and keep in practice with it would be really beneficial."*

SUMMARY DISCUSSION

The qualitative interviews summarized in this report provide information about what trainees retain two months following an ASIST training, insight into key components and techniques that are most useful to trainees, and an understanding of how the training impacts awareness, communication, and interaction related to suicide and its prevention. Comparisons between non mental health clinicians and other participants are intended to explore and further understand the training experience, not to suggest that the training is more beneficial for one group than the other. Indeed, differences emerging between the groups provide insight into the needs of various caregivers, and suggest additional questions for further research.

It is clear that almost all participants, regardless of their role, found the ASIST training beneficial; however, there are additional themes. Mental health providers, when describing the information presented in the training, focused most often on components of the ASIST suicide intervention model (e.g. asking directly, risk assessment, safety planning); while non-mental health providers most frequently mentioned warning signs and communication techniques. One likely explanation for this variance is that mental health providers have been previously exposed to information on suicide and therapeutic techniques, and instead found the intervention model to be new information. Another explanation is that mental health providers are more likely to expect to come into contact with suicidal individuals, thus the specific response skills are the most memorable.

Mental health and non-mental health providers also differed in their discussion of training components and techniques they considered most useful. Non-mental health staff identified warning signs and communication skills as most useful, and named other largely inter-personal and relational components- including learning from the experiences of others, high quality trainers, and specific questions to ask those potentially at-risk for suicide. Mental health providers, on the other hand, reported that skills related to intervention were most useful, e.g. learning to ask directly about ideation, and how to respond once suicidality is established. These beneficial training components mirror the information and skills acquisition most commonly mentioned by the different roles; it is clear that individuals remember best the information and skills that they find to be most useful.

Following the training, participants reported being more aware of warning signs and “red flags” in their professional and personal interactions with people; military personnel reported this outcome much more frequently than those in other roles. Over three-quarters of trainees reported that they were more comfortable and confident following the training, explaining that they felt equipped and prepared to intervene with potentially suicidal individuals. This self-efficacy was directly linked to the other training outcomes; particularly the increased willingness to discuss suicide and raise the awareness of others, as well as the capacity to

address suicide directly and intervene when necessary. Mental health providers were slightly more likely to report being more comfortable and more willing to discuss suicide; perhaps because they function in a role where they are expected to be knowledgeable about suicide and this training equipped them to more effectively apply this information.

Given that non-mental health staff frequently reported the utility of learning communication skills (e.g. active listening, patience, empathy), it is not surprising that they were more likely to report applying these skills. Non-mental health staff were also much more likely to report sharing ASIST information with friends and family; it is unclear whether this is due to a newfound awareness of the urgency of the issue, or because mental health providers did not attribute the content of their personal discussions to the ASIST training.

Despite these differences, participants reported engaging with those at risk for suicide in similar ways. Similar proportions of mental health and non-mental health staff reported asking individuals if they were suicidal, and intervening with those who were suicidal; however, many more non-mental health respondents reported informally exploring suicidality, without direct questioning. Additionally, the majority of the respondents attributed the success of their interactions and interventions to the ASIST training. Child welfare and justice staff most commonly reported interacting with suicidal individuals, which suggests that they should be a priority population for receiving this training.

Trainees recommend that the training be accessible to as many individuals as possible, and that refresher or "tune-up" sessions be periodically offered. Participants also commented that the training content should be made as applicable to the training population as possible, with military, justice, and tribal respondents commonly highlighting this as a primary recommendation.

These findings present implications for further research and program development, including investigation into how trainees' knowledge retention and application evolve over time. Additionally, differences emerging between groups suggest ways that the training may be adapted to meet the diverse needs of attendees.