

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



**APPLIED SUICIDE INTERVENTION SKILLS TRAINING**

Trainee Experiences,  
Recommendations, and  
Post-Training Behavior

October 30, 2010

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## EXECUTIVE SUMMARY

Gatekeeper training is a common strategy for suicide prevention that is used by many programs in education, child welfare, health care, and detention settings, among others. Gatekeeper training is generally intended for those without extensive training in mental health and therapeutic techniques and is used to develop the “knowledge, attitudes, and skills to identify (those) at risk, determine levels of risk, and make referrals when necessary.”<sup>1</sup> The Garrett Lee Smith Youth Suicide Prevention and Early Intervention Program (GLS Suicide Prevention Program), administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (DHHS) since 2005, has funded 65 unique grantees that implement an array of community-based suicide prevention efforts. Among their most significant accomplishments, GLS Suicide Prevention Program grantees have conducted more than 9,000 suicide prevention trainings, including more than 450 Applied Suicide Intervention Skills Trainings (ASIST).<sup>2</sup>

ASIST is designed to teach the skills that enable an adult to competently and confidently intervene with a person at risk for 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. Workshops are 14 hours long, held over 2 days. The ASIST curriculum includes suicide intervention skills development, confidential and trainer-facilitated small-group 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.<sup>3</sup>

Prior evaluations of ASIST have shown that most trainees report high levels of satisfaction with the training and self-reported knowledge, skills, and attitudes related to suicide are consistently shown to increase post-training.<sup>4</sup> The few studies that have gathered follow-up

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<sup>1</sup> Gould, M. S., Greenberg, T., Velting, D. M., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(4), 386–405.

<sup>2</sup> ICF Macro. (2010). *2010 GLS Cross-site Evaluation annual report*. Report submitted to SAMHSA for review.

<sup>3</sup> LivingWorks Education. *ASIST: An overview*. Accessed January 2009 from [http://www.livingworks.net/AS\\_Overview.php](http://www.livingworks.net/AS_Overview.php)

<sup>4</sup> Griesbach and Associates. (2008). The use and impact of Applied Suicide Intervention Skills Training in Scotland. Annex: A review of the international literature. *Scottish Government Social Research*. Accessed January 2009 from <http://www.scotland.gov.uk/Publications/2008/05/19160110/0>

information suggest that improved knowledge and attitudes are maintained, with some decrease in comfort discussing suicide. Although most evaluations reported increased intervention behavior after ASIST, when compared with pretraining behavior or a comparison group,<sup>5</sup> several reported no significant change in intervention behavior.<sup>6,7</sup> Interestingly, some evaluations reported increased interventions but decreased referrals.<sup>8</sup>

As part of an effort by the cross-site evaluation of the GLS Suicide Prevention Program to better understand the outcomes associated with commonly implemented gatekeeper trainings, 93 in-depth interviews conducted with gatekeepers 2 months following their participation in ASIST were compiled and analyzed. Participants were divided into two groups for the purposes of analyses: (1) mental health providers (n = 35) and (2) non-mental health providers (n = 57). In addition, the most frequently reported professional roles were selected for distinct analysis and included school-based staff (n = 17); a justice category comprising juvenile justice staff, police officers, and detention officers (n = 13); child welfare staff (n = 11); and military personnel (n = 10). Those professional roles were also represented within the two primary categories; for example, school staff include both mental health and non-mental health staff. The qualitative interviews summarized in this report provide information about what trainees retain 2 months following an ASIST workshop; 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.

## Findings

Approximately two-thirds of trainees reported learning the warning signs of suicide, and one-half reported learning 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, one-half of participants reported learning effective communication techniques, such as active listening, building rapport, and employing a nonjudgemental approach to the topic of suicide. In addition, participants noted learning general information about suicide and mental health as well as common myths, attitudes, and experiences related to suicide.

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<sup>5</sup> Rodgers, P. (2010). *Review of the Applied Suicide Intervention Skills Program*. Calgary, AB: LivingWorks Education, Inc. Retrieved October 18, 2009, from [http://www.livingworks.net/userfiles/file/ASIST\\_review2010.pdf](http://www.livingworks.net/userfiles/file/ASIST_review2010.pdf)

<sup>6</sup> Illich, P. (2004). *Suicide intervention training outcomes study: Summary report*. Waco, TX: Research Consulting Services.

<sup>7</sup> Organizational Research Services. (2003). *Youth suicide prevention program: Annual evaluation report 2002–2003, Evaluation of Program Training Workshops*. Retrieved July 11, 2009, from [http://www.yspp.org/downloads/about\\_yspp/YSP\\_02-03\\_Report.pdf](http://www.yspp.org/downloads/about_yspp/YSP_02-03_Report.pdf)

<sup>8</sup> McAuliffe, N., & Perry, L. (2007). Making it safer: A health centre's strategy for suicide prevention. *Psychiatric Quarterly*, 78, 295–307.

After discussing what they learned, 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: (1) increased self-efficacy; (2) heightened awareness; (3) improved communication skills; (4) sharing information with others; and (5) intervention, or engaging in some way with an individual at risk for suicide.

One-fourth of mental health and non-mental health staff reported intervening with individuals at risk for suicide. However, mental health staff were slightly more likely to report asking individuals directly about their suicidal ideation and conducting risk reviews. 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. One-third of respondents reported using their ASIST skill in other ways; for example, with nonsuicidal clients.

Improved self-efficacy was the most commonly reported outcome of the training. Three-fourths of trainees, a slightly higher proportion of them mental health providers and child welfare staff, reported feeling more equipped and prepared to intervene and more comfortable with the topic of suicide. In addition, three-fourths of 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 the signs more seriously.

One-half of participants reported 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 outcome, non-mental health providers and military personnel were more likely to report applying more specific communication skills, including active listening, empathy, and patience. Finally, close to one-half of mental health and non-mental health providers reported sharing information with their colleagues; child welfare staff and military personnel reported doing so more often than the other groups and law enforcement/juvenile justice staff reported sharing information the least. Mental health providers were slightly more likely to report sharing information with their clients, clients' families, and the community; non-mental health providers, particularly military personnel, were much more likely to report sharing information with their friends and families.

Trainees recommended that the training be made 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.

## *Discussion*

It is clear that almost all participants, regardless of their role, found ASIST to be beneficial. Training components identified as most useful mirrored the information and skills acquisition most commonly mentioned by the different role-players; in other words, trainees remembered best the information and skills that they found to be most useful. For example, non-mental health staff identified warning signs and communication skills as most useful and named other largely interpersonal 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; for instance, learning to ask directly about ideation and how to respond once suicidality is established. One likely explanation for this variance is that mental health providers were more likely to 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 were more likely to expect to come into contact with suicidal individuals; thus, the specific response skills were the most memorable.

Following the training, more than three-fourths of trainees reported 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 and 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 the information. In addition, 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. Military and justice staff were most likely to report using these other communication techniques, which suggests that this information might be lacking in their other professional education. Non-mental health staff were also much more likely to report sharing ASIST information with friends and family. It is unclear whether this finding 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 ASIST.

While similar proportions of mental health and non-mental health staff reported asking individuals if they were suicidal and intervening with those who were suicidal, many more non-mental health respondents reported informally exploring suicidality without direct questioning. In addition, respondents from various professional roles reported slightly different response behaviors and, consistent with prior evaluations, generally noted fewer referrals than interactions with suicidal individuals. These findings present implications for further research and program development, including investigation into how trainees' knowledge retention and application evolve over time and how professional and personal contexts shape gatekeeper behavior and choices during intervention. In addition, differences between groups suggest ways that the training may be adapted to meet the diverse needs of attendees.

# INTRODUCTION

Gatekeeper training is a common strategy for suicide prevention that is used by many programs in education, child welfare, health care, and detention settings, among others. Gatekeeper training is generally intended for those without extensive training in mental health and therapeutic techniques and is used to develop the “knowledge, attitudes, and skills to identify (those) at risk, determine levels of risk, and make referrals when necessary.”<sup>1</sup> In other words, if individuals are trained to identify suicide risk and ensure that the at-risk individual receives professional mental health care and/or other support services, then suicide attempts and mortality will decrease. The evaluation results from gatekeeper trainings have been mixed. While some studies have found increases in trainee knowledge and self-efficacy,<sup>9</sup> as well as increased referrals of at-risk students,<sup>10</sup> other studies have found that post-training suicide identification behavior improves only in those who were already discussing suicide-related issues with youths, with no effect on overall levels of identification and referral.<sup>11</sup>

The Garrett Lee Smith Youth Suicide Prevention and Early Intervention Program (GLS Suicide Prevention Program), administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (DHHS) since 2005, has funded 65 unique grantees that implement an array of community-based suicide prevention efforts. Among their most significant accomplishments, GLS Suicide Prevention Program grantees have conducted more than 9,000 suicide prevention trainings, including more than 450 Applied Suicide Intervention Skills Trainings (ASIST).<sup>2</sup> As part of an effort by the cross-site evaluation of the GLS Suicide Prevention Program to better understand the outcomes associated with commonly implemented gatekeeper trainings, in-depth interviews with gatekeepers recently trained in ASIST were compiled and analyzed. The qualitative interviews summarized in this report provide information about what trainees retain 2 months following an ASIST workshop; 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.

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<sup>9</sup> Schut, J., & Lockman, J. (2009, January). *Tennessee’s Statewide Gatekeeper Training: Preliminary Outcomes and Lessons Learned*. Presentation at the at the Garrett Lee Smith Suicide Prevention Program Grantee Meeting, Phoenix, AZ.

<sup>10</sup> *Evaluation of QPR training, January 2007– March 2008*. University of Buffalo. Accessed November 15, 2009, from <http://www.qprinstitute.com/>

<sup>11</sup> Wyman, P. A., Brown, C. H., Inman, J., Cross, W., Schmeelk-Cone, K., Guo, J., et al. (2009). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting and Clinical Psychology, 76*(1), 104–115.



ASIST is designed to teach the skills that enable an adult to competently and confidently intervene with a person at risk for 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.

Workshops are 14 hours long, held over 2 days. The ASIST curriculum includes suicide intervention skills development, confidential and trainer-facilitated small- group 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.<sup>3</sup>

Prior evaluations of ASIST have shown that most trainees report high levels of satisfaction with the training, with few negative experiences.<sup>4</sup> Self-reported knowledge, skills, and attitudes related to suicide are consistently shown to increase post-training, which 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. Although most evaluations reported increased intervention behavior after training, when compared with pre-training behavior or a comparison group,<sup>5</sup> several reported no significant change in intervention

### **ASIST LEARNING MODULES**

- **PREPARING:** Sets the tone, norms, and expectations of the learning experience
- **CONNECTING:** Sensitizes participants to their own and others' attitudes toward 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 “safe plan” to reduce the risk of suicide
- **ASSISTING:** Presents a model for effective suicide intervention—participants develop their skills through observation and supervised simulation exercises in large and small groups
- **NETWORKING:** Generates information about resources in the local community—promotes a commitment by participants to transform local resources into

behavior.<sup>6,7</sup> Interestingly, some evaluations reported increased interventions but decreased referrals; for instance, a Canadian hospital reported increased suicide identifications and assessments and fewer admissions 3 years following ongoing ASIST implementation (in combination with relevant protocols).<sup>8</sup>

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

## PURPOSE OF THIS REPORT

The purpose of this document is increase understanding of trainees' knowledge retention and gatekeeping behaviors following ASIST. The trainings described in this report were implemented as part of the Garrett Lee Smith State/Tribal Program, and the data were collected through the cross-site evaluation of the GLS Suicide Prevention Program. The report first presents a summary of the knowledge and skills that trainees mentioned learning in the training and includes participants' 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, includes respondent recommendations for future ASISTs, and concludes with a summary discussion of findings.

## BACKGROUND

This sample includes the perspectives of 93 individuals who participated in semistructured telephone interviews 2 months following their ASIST experience. Interview participants were gathered from 13 ASISTs, sponsored by 10 GLS State/Tribal grantees. In addition, one of the trainings was an ASIST training of trainers (TOT). Participants were divided into two primary roles for analysis, mental health providers (n = 35) or non-mental health providers (n = 57). In this way, a distinction could be made between those who might have some exposure to or experience with issues surrounding mental health as well as some training in therapeutic technique and those who would not necessarily be expected to have that experience or exposure. The most commonly reported professional roles were selected for distinct analysis; each of these roles included 10 or more participants. These include school-based staff (n = 17); a justice category comprising juvenile justice staff, police officers, and detention officers (n = 13); child welfare staff (n = 11); and military personnel (n = 10). These professional roles are also represented within the two primary categories; for example, school staff include both

mental health and non-mental health staff. For further information on the types of professionals included in each category, and for information on analytical methods, please refer to the Appendix.

## 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; creating a safety plan; reviewing risk; and making a referral. In addition to the model, participants reported learning effective communication techniques; general information about suicide and mental health; and common myths, attitudes, and experiences related to suicide.*

All trainees were asked to describe the knowledge and skills that they learned in ASIST, which are presented in this section in the order of most frequently reported. Respondents most commonly reported learning the warning signs of suicide, with approximately two-thirds of mental health and non-mental health staff reporting learning this information. For example, participants 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.”

The ASIST characterizes many verbal warning signs as “invitations,” or statements made by an individual to signal their pain and offer others an opportunity to respond. As one participant explained, ASIST reframed

### KNOWLEDGE AND SKILLS OBTAINED BY 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^
- Referring and resources
- Attitudes, experiences with suicide

the traditional discussion of warning signs in a way that encouraged trainees to view these signs or invitations as the first step of an intervention, thus necessitating their involvement.

Approximately one-half of the participants 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 with non-mental health providers. The key features of the model reported include (1) identifying warning signs and invitations and asking directly about suicidal ideation; (2) exploring the individual's reasons for wanting to die and wanting to live, with a focus on the reasons to live, and reviewing their suicide risk; and (3) developing a safety plan and action steps to keep the individual safe and following up with the individual following the intervention. These concepts and phases will be described in greater detail in this section.

When discussing the ASIST model, participants most commonly reported learning the concept of **asking an individual directly about whether they are considering suicide**. In general, mental health providers mentioned this particular concept somewhat more frequently than non-mental health providers and were also more likely to report this concept as being especially useful to them in their work. Among those working in the four main professional settings represented in this sample (schools, law enforcement, primary care, and military), school staff, including school-based mental health providers such as counselors and social workers, were the most likely to mention that they learned to ask directly about suicide. Similar proportions of mental health and non-mental health providers reported that they were previously reluctant to address suicide directly, either because they did not know how to introduce or adequately address the topic or for fear that it might encourage the option of suicide.

**Communication techniques were the next most frequently reported skill learned in the training**, with approximately one-half of participants and more than two-thirds of law

## CONVERSATION MAP

*"It's kind of like a map for a conversation to have with a suicidal person so that you know to go from point A to B and what questions to ask them, 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 that let you know just how serious the situation is ... like you shouldn't leave them alone if they have certain risks, and it really taught what to say in a situation like that."*

enforcement and military personnel mentioning these skills. These techniques included active listening, building rapport, using appropriate language and terminology, empathy, and employing a nonjudgmental and normalizing approach to the topic of suicide. The concept and importance of active listening was the most commonly mentioned communication skill; for example, *“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 reported that they were taught about the implications of commonly used expressions and descriptions of suicide (e.g., *“a person committed suicide”*) and alternate language to use. Participants also frequently mentioned that they learned *“a road map”* for how to have a conversation with an individual considering suicide and that ASIST 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 *“Are you thinking about suicide?”* is a key question outlined by the ASIST model, about 40 percent of respondents noted that they learned to ask questions focusing 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. In addition, 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 *“exploring ambivalence,”* the terminology used by ASIST to describe the discussion of reasons for living and dying, were mentioned more frequently by mental health providers.

Another ASIST component commonly reported by participants is in the last phase of the ASIST model, the *“assist”* phase. Developing a specific plan to keep the individual safe, including removal of lethal means and steps to take when feeling suicidal, was the skill most frequently mentioned when participants described this

## UNDERSTANDING SUICIDALITY

*“The most useful [component of the training] was to understand that it’s okay to engage them in conversation ... to explore a little more in depth on what they’re feeling and what they see as a future. ... I think everybody in their lives has valleys and peaks, and it’s just kind of how they cope. Some people don’t cope well with the valleys. And that’s what this training showed, if you can get them past the crisis and get them some help, you can actually help these people.”*

## NETWORKING

*“I think one of the things that was most useful was the diversity of people who were at the training, they had school counselors, they had drug prevention counselors, police officers, 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 ... it helped me understand the perspective of different people who may deal with people who are having suicidal thoughts.”*

phase; in general, mental health providers reported knowledge related to this phase more frequently than did non-mental health providers. For example, one respondent noted that *“you can even write it down, saying ‘you’re going to do this and I’m going to do this. And if you’re having thoughts of suicide, you’re going to call this person, and let’s make sure you have the number on you at all times.”*

Mental health and non-mental health providers reported learning statistics and **other overview information about suicide and mental illness** in relatively equal proportions (about one-third of respondents). As one participant explained, *“one of the main topics they really tried to hit on is that nobody is immune to it, it reaches across all people, all demographics, everyone.”* 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.

Participants also reported learning to make a referral, as well as the **referral resources available** to them locally, statewide, 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 a great deal from other individuals in attendance, particularly when diverse service sectors were represented at the training 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.

Finally, the mental health respondents who attended the ASIST TOT reported learning skills related to training facilitation, such as *“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.”* In addition, 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, you sort of work their idea into the training. They were very positive, neutral or really positive, so that was helpful.”*

### **Useful Training 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 suicidal ideation, and the ASIST intervention model in general were most useful.**

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) that were most useful to them in their personal and professional lives. More than one-half of trainees reported that **the role-play exercises were most beneficial**, explaining that role-play allowed them to practice their skills and thus feel

confident about their ability to intervene; desensitized them to asking directly about suicide; and helped them to 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.”* In addition, because 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 opposite perspectives.

While mental health and non-mental health providers both reported role-play as the most useful component of ASIST, 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 suicidal ideation, and the ASIST intervention model in general were most useful.

**TABLE 1: USEFUL TRAINING TECHNIQUES AND COMPONENTS, IN ORDER OF MOST FREQUENTLY REPORTED**

MENTAL HEALTH PROVIDERS	NON-MENTAL HEALTH PROVIDERS
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%)	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*



## SMALL GROUPS

*“I think it was nice that we were in smaller groups because it helped us feel more comfortable, especially with some of the role-playing and having other people share their experiences to help us learn some of the other warning signs and things that people might say about having suicidal ideations.”*

*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 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. 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; being 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:

*“Both of them were very 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*

## WALLET CARDS

*“We did get these pocket cards ... the back has the whole model on there ... and then it has [warning] signs or invitations to pick up on; and it talks about risk review, how you decide where they're at; and ideas for [a] the safe plan ... and a little section of different resources like informal meeting, family, friends, personal connections ... so it's a nice handy thing to refresh your memory.”*

*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 mentioned **materials used or distributed during the training**, including the wallet cards summarizing the intervention model; PowerPoint slides; referral resource information; video vignettes; and the ASIST 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 card, reporting that they are an easily referenced summary of the ASIST model and provide step-by-step intervention instructions. Participants further explained that the wallet cards increased their confidence, as they were taught that they could refer to them in situations involving at-risk individuals: “*[the wallet card] really helps because I can take it out and know each step to do and I don’t feel like I’m just freaking out and not knowing what to do with somebody who is feeling like that.*”

## TRAINING IMPACTS

*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: (1) increased self-efficacy; (2) heightened awareness; (3) improved communication skills; (4) sharing information with others; and (4) intervention (i.e., engaging in some way with an individual at risk for suicide).*

### *Intervention, Assessment, and Support*

*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 suicidal ideation and conducting risk reviews. 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. Participants also reported using their ASIST skills in other ways, for example, with nonsuicidal clients.*

For the purposes of this report, we are including any reported engagement with an individual due to a concern that they may be at risk for suicide under the Intervention heading. Table 2 presents the proportion of respondents who mentioned these intervention behaviors.

**TABLE 2: PARTICIPANTS REPORTING ENGAGING WITH AN INDIVIDUAL POSSIBLY AT RISK FOR SUICIDE**

TRAINING IMPACT	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)
Intervened with suicidal individual	20–29%	20–29%	20–29%	10–19%	30–39%	30–39%	20–29%
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/checked in	20–29%	0–9%	30–39%	10–19%	20–29%	20–29%	40–49%
Reviewed 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%	10–19%	30–39%
Developed safety plan	0–9%	0–9%	10–19%	0–9%	0–9%	20–29%	0–9%

### **Intervention**

Mental health and non-mental health staff reported **intervening with suicidal individuals** in equal proportions (approximately one-fourth of each group); however, those working in child welfare and law enforcement/juvenile justice settings reported intervening with suicidal youth in slightly higher proportions (approximately one-third of each group). Participants reported engaging with individuals at the hospital after a suicide threat has been made; with youth in school; with youth in child welfare and juvenile justice residential facilities; with soldiers

deploying to or returning from combat; and with nonresidential youth and adult clients including youths in foster care independent-living programs or homeless youths. In addition, 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 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.”* Below, one participant described intervening with two youths at risk for suicide and how the training allowed them to better identify and respond to this youths:

*“Well, one of the girls ... she had made attempts before, and we were all very worried and didn’t really know what to do ... and now since I’ve gone to the training she came to me again and was 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.”*

## TALKING WITH YOUTH

*“Some of the interviewing skills I learned, like how to get at the issues or the problems, I’m using that with the youth that I speak to. ... It could be physical abuse, sexual abuse, just something that’s going on with the family that’s causing a problem. And being able to get at the problem in a way that allows the youth to share, that’s the skill that I’m using the most right now.”*

Participants reported responding to suicidal ideation in a number of ways, including reviewing risk, developing a safety plan, and making a referral. Military personnel were most likely to report making a referral; among this group, proportion of referrals made was higher than the proportion of reported engagement with suicidal individuals. In addition, mental health staff were slightly more likely to report reviewing risk than non-mental health staff and slightly less likely to report making a referral. In addition, a relatively high proportion of child welfare staff reported using their safety planning skills. Below, two participants described intervening with individuals at risk for suicide and applying the steps learned in ASIST. One 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 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 some participants reported making referrals when they or their agency did not have the capacity to treat or monitor the individual (such as activate a suicide watch in residential settings), they also reported that they are more likely to know when *not* to refer, as they are better able to assess immediate suicide risk and have a greater number of tools available to stabilize the individual: *“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.”*

Finally, some respondents also reported involving the family members of suicidal individuals, in part because ASIST encouraged trainees to consider all supports and resources available to those in crisis. School staff were most likely to report talking with parents, and participants also reported that they were better able to discuss suicide with the parents of at-risk youths: *“The times I’ve had to call home saying that I have a suspicion that their child is suicidal, 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.”*

### **Assessment and Other Intervention Behaviors**

Of all the intervention behaviors, the most commonly reported (by one-third of respondents) was **asking an individual directly about suicidal ideation**. Many participants reported previous anxiety about 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. A relatively small proportion of justice staff reported asking directly about ideation, but it is unclear whether this was a function of their environment, clientele, or other factor. Those with prior experience of engagement with at-risk youths reported improved client response and rapport following the question. For example, one respondent described how ASIST has improved their ability to serve youths by asking them directly about suicide:

*“We have a lot of kids here who cut themselves and then people assume that they’re trying to kill themselves. And whenever they came to see me I was ‘do you want to hurt yourself,’ 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 the ones that I have encountered since the training where I’ve asked directly I’ve kind of got the ball rolling, and then I think it helped the whole dynamic because I wasn’t skirting around the issue.”*

Across groups, 30–40% of respondents reported asking individuals directly about their suicidal ideation; just staff was an exception, with less than 10% of them reporting this behavior. However, non-mental health staff, particularly military personnel, were much more likely to report engaging less directly with individuals they were concerned about by **exploring invitations, or informally assessing possible ideation**: *“[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

### **CHECKING IN**

*“Just approaching people that are having issues or recognizing the symptoms. Now when I ask somebody how they’re doing and their answer is not what I think it should be, I actually ask again ... not just giving a token ‘how’re you doing’ and then leaving. When I’m asking somebody how they’re doing, I’m actually wanting to know how they are doing.”*



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.”* Along these lines, participants also reported regularly following up with clients and individuals who have struggled with depression or suicide in the past; for example, *“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.”*

In addition, approximately one-third of participants reported regularly **applying ASIST skills in other ways** with individuals who were not in immediate suicidal 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, such as motivational interview techniques; developing safety plans to promote coping skills; and connecting individuals to helpful resources in the community. Below, one participant describes applying safety planning techniques to assist nonsuicidal youth;

*“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.”*

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.

### **Self-Efficacy**

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

**TABLE 3: PARTICIPANTS REPORTING INCREASED SELF-EFFICACY**

TRAINING IMPACT	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 ASIST was **increased trainee comfort and confidence**, as presented in Table 3. 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 suicidal 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. While these outcomes are linked to almost every other outcome discussed below, as much depends on the trainees’ willingness and capacity to address suicide and respond to ideation. This connection 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 ways they interact with and serve their clients. For instance, several participants remarked that while the training did not necessarily change their likelihood of intervening with a suicidal client, it did make the intervention more effective: *“Chances are if someone was suicidal I*

**INCREASED CONFIDENCE**

*“Suicide certainly still has a lot of taboo around it, so I’ve been in the past very uncomfortable. This made it easier for me to open up and ask my client very direct questions, and show him that I am somebody he can talk to about his feelings, that I’m not going to run away, and pick up the phone, and call the suicide hotline, that I will listen to him talk about his feelings. That’s the big change for me, being able to broach the subject, being comfortable sitting down and actually having a conversation about it instead of getting scared.”*



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." One respondent, a police officer, reflected that following the training, it has been much easier to respond to crisis calls: "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." Another 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 clients' feelings. Finally, another respondent, a staff member 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:

*"When I sit down with a kid, there's more intent behind the questions and 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 those signs more seriously.**

More than three-fourths of respondents reported an **increased awareness of suicide and its warning signs** following the training, as displayed in Table 4. For example, some participants described how their

### **INCREASED EMPATHY**

*"Before I was all negative. If they were going to commit suicide, it wasn't me so I didn't care. And now if there's someone trying to think of 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."*

“antennae” had been raised to words or actions that might indicate suicidal ideation. 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, a staff member of a residential youth facility described how the training has decreased anxiety because of a better understanding of the mood and mental status of their clients:

*“I am more aware of the moods of everyone and just paying attention to the subtle changes. I would say that maybe I feel more confident as far as that aspect of my job, 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.”*

**TABLE 4: PARTICIPANTS REPORTING HEIGHTENED AWARENESS**

TRAINING IMPACT	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 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%

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 before their training. About one-fourth of non-mental health providers also reported a **greater overall awareness of suicidality and its prevalence**—“*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. Military personnel, many who reported losing fellow soldiers and colleagues to suicide, were most likely to report a heightened awareness, with each of the 10 members of the National Guard included in this sample reporting this outcome: “*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.*”

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, *“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 just become more attentive towards people’s body language and the way they, how they look at life I guess.”*

### Communication skills

**Participants reported 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 outcome, non-mental health providers and military personnel were more likely to report applying more specific communication skills, including active listening, empathy, and patience.**

**TABLE 5: PARTICIPANTS REPORTING IMPROVED COMMUNICATION**

TRAINING IMPACT	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)
More willing/ able to discuss suicide	50–59%	60–69%	50–59%	<b>70–79%</b>	50–59%	50–59%	60–69%
Used active listening skills	20–29%	20–29%	30–39%	20–29%	20–29%	30–39%	<b>40–49%</b>
Used other communication skills	20–29%	10–19%	30–39%	10–19%	20–29%	20–29%	<b>40–49%</b>

The third most commonly reported training outcome was an **increased willingness to discuss suicide and ability to communicate**, as shown in Table 5. Approximately one-half of participants reported that they were more willing to raise awareness in their communities and discuss suicide in a direct and straightforward manner: *“What we learned was that a lot of suicides go unreported and people are afraid to address it straightforward, so I think I’m wanting to be more open with talking about it 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 about suicide 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."*

Of the specific communication skills applied by trainees, one-fourth of 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. Participants also reported that the training emphasized how to talk to people and stressed concepts such as 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."*

Non-mental health staff were also much more likely to report that their **other communication skills had improved**. For example, one participant described how they have applied patience, active listening, and

## LISTENING

*"One of the instructors talked about learning to just shut up and listen ... because a lot of times somebody just needs to vent and needs an ear to talk to. ... And I've found that to be one of the biggest tools, especially working with these kids, teenagers typically feel like nobody listens or understands or can relate, and just taking the time to listen to their ideas and validate some of those things ... can make all the difference in the world."*

skills related to de-escalating situations on an almost-daily basis: *“I pretty much use it every day with all of my clients. They benefit from me not being as eager to rush in, me being more open and patient and listening, that kind of thing, more positive, me letting them come up with their own solutions.”* Another participant, a member of the clergy, reported that their communication style about suicide prevention has changed because of the training, explaining that they have a softer, more empathetic approach when responding to ideation.

Finally, participants reported that the training resulted in the use of appropriate language and terminology when discussing suicide; for those colleagues who attended training together, this has allowed coworkers to *“speak the same language”* and more effectively communicate about issues of suicide prevention. Similarly, another participant reported that the training has helped them to talk about suicide prevention in a way that is easily understandable to nonprofessionals.

### **Sharing Information**

***While mental health and non-mental health providers reported sharing information with their colleagues equally, child welfare staff and military personnel reported doing so more often than the other groups and law enforcement/juvenile justice staff reported sharing information the least. Mental health providers were 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 is also related to the fourth most frequently reported outcome, **sharing information and raising the awareness of others**. These behaviors are reported in Table 6. Almost one-half of participants, and a higher proportion of child welfare and military staff, reported sharing warning signs and intervention steps with their colleagues both formally (e.g., small-group presentation or training) and informally (e.g., in conversation). In addition, a few respondents reported using the information from ASIST in the provision of clinical supervision.

#### **SHARING INFORMATION**

*“We have a clinical meeting every Tuesday, and myself and the other staff member who went to the training, we often talk to people about the questions that they ask and kind of remind them of some things. It’s definitely changed our meetings. People will ask us questions because they know we’ve been to the training, they’ll come to us and say ‘what should we do about this?’ and ‘what do you think?’”*

**TABLE 6: PARTICIPANTS REPORTING SHARING INFORMATION**

TRAINING IMPACT	TOTAL MENTAL HEALTH PROVIDERS (N = 93)	NON-MENTAL HEALTH PROVIDERS (n = 57)	SCHOOL STAFF (n = 17)	JUSTICE STAFF (n = 13)	CHILD WELFARE STAFF (n = 11)	MILITARY PERSONNEL (n = 10)	
Shared information with coworkers	40–49%	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%

About one-fourth of 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 TOT in the period between the initial training and the Training Utilization and Penetration [TUP] interview) described how they have incorporated information and techniques from the ASIST into workshops that they conduct with youths: *“It may have been ‘hey, will you come in and talk about substance abuse?’ Well that’s great, but let’s lead to those kind of risk factors that substance abuse leads to suicide. So it’s really helped make that connection.”*

Around one-tenth of trainees reported talking about suicide with their friends and family; however, three-quarters of military personnel reported doing so:

*“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 had friends they shared with who 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. Some also reported that their friends or families identified individuals they were concerned about after hearing about the warning signs of suicide.

## TRAINEE RECOMMENDATIONS

Trainees were asked to suggest any changes or improvements to ASIST. They most commonly **urged for the training to be offered to as many individuals as possible, including both formal and informal caregivers.** For example, one participant recommended that organizers seek out community members who frequently interact with youths:

*"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."*

In addition several participants recommended that **ASIST 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."* Law enforcement officers also reported that the ASIST model did not prepare them for many of the acute suicidal crisis situations to which they they respond:

*"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 that's where you have to, the physical containment, putting them in the rubber room, and keeping an eye on them every five minutes. That part wasn't really that well explained."*



Military personnel also recommended that the training be adapted to their needs and include risk factors and protective factors specific to their community. 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 training, a participant suggested:

*“Seventy percent 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 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 factors 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 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 Two” or “refresher” training should be offered** that would include updated information and additional

## EXPAND TRAINING OPPORTUNITIES

*“The more people who are educated and become aware of what can be listened to and understood from people that may be suicidal ... this training would help everyone. I mean, even if you never, ever become in contact with anybody, it would help yourself. I just think it’s a very good training.”*



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 youths on a daily basis, so an annual refresher training would maintain their confidence:

*“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 refamiliarize with different scenarios that could come up, just to keep comfortable with it and keep in practice with it would be really beneficial.”*

## DISCUSSION AND IMPLICATIONS FOR FUTURE RESEARCH AND TRAINING

The qualitative interviews summarized in this report provide information about what trainees retain 2 months following an ASIST workshop; 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 mental health staff 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 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 training to be beneficial; however, there are additional findings. 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). Non-mental health providers most frequently mentioned warning signs and communication techniques. One likely explanation for this variance is that mental health providers were more likely to 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 were more likely to expect to come into contact with suicidal individuals, thus the specific response skills were the most memorable.

Mental health and non-mental health providers also differed in their discussion of training components and techniques they considered to be most useful. Non-mental health staff identified warning signs and communication skills as most useful and named other largely interpersonal 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; for instance, 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 respondents in 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. Notably, more than three-fourths 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 the 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. In addition, military and justice staff were more likely to report using these other communication techniques, which suggests that this information might be lacking in their other professional education. 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 ASIST.

Despite these differences, participants reported engaging with individuals 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. In addition, the majority of the respondents attributed the success of their interactions and interventions to ASIST. 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. In addition, trainees in various professional roles reported slightly different response behaviors; for example, child welfare staff were much more likely to report safety planning with clients. Further, and supporting previous ASIST evaluations, respondents in all roles (with the exception of military) reported making fewer referrals than having interactions with suicidal individuals, indicating that non-mental health trainees feel equipped to handle some noncrisis situations without professional mental health assistance. That finding also indicates an area for further research and exploration.

The findings from the military sample were informative: Higher proportions of military staff reported having an increased awareness of suicide, using their active listening and other communication skills, sharing information with friends and family, exploring possible invitations and warning signs of suicide, and making more referrals than having interactions with suicidal individuals. In addition, most military personnel reported that ASIST was their first exposure to in-depth information about suicide. Following the training, it is clear that military personnel were on high alert for suicidal ideation, which is most likely a combination of the military's current urgency about suicide prevention, exposure to usable intervention guidelines, and a sense of being personally affected by suicide. However, several staff made recommendations for adapting ASIST for the military population.

Trainees also recommended that the training be made 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; military, justice, and tribal respondents commonly highlighted 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 and how professional and personal contexts shape gatekeeper behavior and choices during intervention. In addition, differences between groups suggest ways that the training may be adapted to meet the diverse needs of attendees.

# APPENDIX

## METHODS

The Training Utilization and Penetration (TUP) interviews are a major component of the process stage of the cross-site evaluation of the GLS Suicide Prevention Program. TUP interviews assess the content, utilization, and perceived impact of training activities conducted by 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 Suicide Prevention Program–supported training activities and conducts the interviews approximately 2 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 semistructured TUP interview includes 23 open-ended items and takes approximately 20–30 minutes to administer.

This report includes data representing 93 individuals who attended 13 ASISTs sponsored by 10 State/Tribal grantee sites. In addition, one of the trainings was an ASIST TOT. Immediately following the conclusion of the ASISTs identified for the TUP interviews, training staff introduced the TUP interview and 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 team conducted interviews within 7 to 9 weeks following each training. After the 20- to 30-minute semistructured interviews, the evaluation team mailed each participants a \$20 money order to compensate them for their time.

Analyses were conducted on transcripts of the interviews using the software package ATLAS.ti 5.2.9. 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.

### *Sample Description*

Participant responses were further analyzed according to non–mutually exclusive primary roles. First, all participants were divided into one of two categories: (1) mental health providers or (2) non–mental-health providers. In this way, 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, suicide, as well as some training in

therapeutic techniques; and (2) those who would not necessarily be expected to have that experience or exposure.

**Mental Health Provider** (n = 35). This group included elementary-, middle-, and high-school counselors, social workers, psychologists, and psychiatrists; 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 Provider** (n = 57). Respondents in this group were identified as nonpsychiatric 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 included school-based staff (n = 17); child welfare staff (n = 11); military personnel (n = 10); and a justice category comprising juvenile justice staff, police officers, and detention officers (n = 13). These professional roles are subsumed within the two primary categories (mental health providers or non-mental health providers) and also may overlap with each other.

## LIMITATIONS

Participants were randomly selected from a pool of those who consented to be contacted for TUP interviews. While statistical analyses suggest that there are no differences in the training satisfaction reported by participants and nonparticipants 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. It is also possible that more individuals with gatekeeping behaviors to report agreed to the interviews than those who had not used their skills. 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.