Applied Suicide Intervention Skills Training
Course Content

Course description

The Applied Suicide Intervention Skills Training (ASIST) workshop is for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Over a million caregivers have received this training. Just as "CPR" skills make physical first aid possible, training in suicide intervention develops the skills needed for life assisting suicide first aid. ASIST is a two-day intensive, interactive and practice-dominated course designed to help caregivers learn how to intervene to prevent the immediate risk of suicide and provide safety-for-now.

The workshop is designed for all caregivers (any person over age 15 in a position of trust). This includes professionals, paraprofessionals and lay people. It is suitable for mental health professionals, nurses, physicians, pharmacists, teachers, counselors, youth workers, police and correctional staff, school support staff, clergy, and community volunteers. In ASIST, sophisticated helping concepts are translated into generic language so that different types of caregivers can learn together. ASIST is the most widely used suicide intervention training program in the world. Additional information is available online at http://www.livingworks.net.

Course content

The ASIST workshop is divided into five sections. Here is a summary of the content of each section.

Preparing This short but important section introduces and sets the tone for the workshop. Participants arrive at the workshop with a number of different ideas about what might happen, based on their hopes, needs and experiences. In this section, you want to tell participants about the workshop and create an atmosphere for active participation during the rest of the two days.

Connecting Given the stigma and taboo that surrounds suicide, many participants will have had little chance to freely and openly discuss their attitudes about suicide. The Connecting section provides this opportunity. In workgroup discussion, participants explore, express, identify, examine and perhaps modify their attitudes about suicide and life assisting, suicide first aid. Looking at attitudes toward suicide is the first step in learning the knowledge and skills to work with persons at risk of suicide.

Understanding The Understanding section introduces participants to the *Pathway for Life Assisting (PAL)* model or guide. *PAL* is designed to meet the needs of persons at risk by guiding caregivers to do certain life assisting tasks that address those needs. This section supports the earlier discussion of attitudes and helps prepare participants for intervention practice on Day 2. If the objectives of the Connecting section are reached, participants end the morning with a commitment to learn more about life assisting, suicide first aid. This section is a chance to

follow up on that commitment. Participants will learn about and have a chance to practice some parts of *PAL*. This afternoon lays the foundation for Day 2 where participants will study *PAL* in more detail and have the opportunity to use it in a series of simulations.

Assisting This section focuses on the process themes that emerge in life assisting intervention. These themes are fluid and flexible while supporting the structural aspects of the PAL that are the same for every intervention. In the Assisting section, participants practice working with situations in which they can combine their desire to help with their understanding of what is helpful. Participants have the opportunity to practice and apply their learning.

Working Together This section is about community and human resources, including self care, and about working together with other helpers in their community. By the time participants reach this section, they are beginning to think about how they can be a part of their community's resources. In this section, participants first have a chance to explore further the way their role choices might impact their helping a person at risk. Next, they have a chance to experience how all community resources might aid a person at risk. Participants are also reminded of the importance of self care as a personal resource. Lastly, the section gives time for evaluation and concluding comments.

Course outline including contact hours
Day One
8:30	15 min.	1.1 Preparing-Registration Whole Group
8:45	15 min.	1.2 Preparing-Why First Aid? Whole Group
9:00	5 min.	1.3 Preparing-Why ASIST Training is Needed Whole Group
9:05	15 min.	1.4 Preparing-About the Participants Whole Group
9:20	10 min.	1.5 Preparing-About the Workshop Whole Group
9:30	10 min	break
9:40	20 min.	1.6 About Connecting and show video *Cause of Death?* Whole Group
10:00	50 min.	2.2 Connecting Feelings & Experiences with Suicide & Helping Workgroup
10:50	30 min.	2.3 Connecting Introductions Workgroup
11:20	10 min	break
1130	60 min.	2.4 Connecting Attitudes with Suicide and Helping Workgroup
1230:	1–hour	lunch break; return to workgroups after break
1:30	10 min.	3.1 Understanding-Introduction to Understanding Workgroup
1:40	15 min.	3.2 Understanding-Explore Invitations Workgroup
1:55	15 min.	3.3 Understanding-Ask about Thoughts of Suicide Workgroup
2:10	10 min.	3.4 Understanding Choices Phase Workgroup
2:20	10 min	break
2:30	20 min.	3.5 Understanding-Hearing their Story Workgroup
2:50	20 min.	3.6 Understanding-Supporting Turning to Safety. Workgroup
3:10	10 min.	3.7 Understanding-Assisting Life Phase Workgroup
3:20	10 min	break
3:30	30 min.	3.8 Understanding-Develop a Safe Plan Workgroup
4:00	10 min.	3.9 Understanding-Confirm Actions. Workgroup

| 4:10 | 20 min. | 3.10 Understanding-Concluding Understanding Workgroup |
End at 4;30

Day Two

8:30	15 min.	4.1 Starting the Assisting section. Whole Group
8:45	50 min.	4.2 Assisting-PAL in Action presentation & video Whole Group
9:35	15 min	break
9:50	10 min.	4.3 Assisting-Transition to practice Whole Group
10:00	10 min.	4.4 Assisting-Connecting simulation. Whole Group
10:10	15 min.	4.5 Assisting-Support Turning to Safety simulation. Whole Group
10:25	40 min.	4.6 Assisting-PAL simulation. Whole Group
11:05	15 min.	4.7 Assisting-Safety Framework Simulation Whole Group
11:20	15 min.	4.8 Assisting-Whole group closing; workgroup introduction. Whole Group
11:35	10 min	break Move to workgroup with
11:45	45 min.	4.9 Assisting-Complete at least one practice situations. Whole Group
12:30	1–hour	lunch break
1:30	115 min.	4.9 Assisting-Continuation of practice & closing of workgroup
	15 min	Refreshment break(s) during afternoon
3:40:	5 min	5.1 Assisting-Organizing and Starting Whole Group
3:45	20 min.	5.2 Assisting-Relationships with Persons at Risk discussion. Whole Group
4:05	15 min.	5.3 Assisting-Community Relationships discussion. Whole Group
4:20	10 min.	5.4 Assisting- Closing: ASIST sticker, feedback; certificates Whole Group
End at 4:30

Course Learning Goals and Objectives

The goals and objectives are listed for each section of the workshop

Preparing Section

The goal of this section is to prepare participants for the rest of the workshop.

By completing this section, participants will be able to:

1. Understand that the focus of this workshop is life assisting, suicide first aid
2. Describe the need for caregivers to be able to do life assisting interventions
3. Describe why ASIST is a good way for caregivers to learn life assisting
4. Describe the goals and objectives of the workshop
5. Be aware of the group's experiences with suicide
6. Know what they need to do to help make the workshop successful for everyone

Connecting Section

The goal of this section is to provide a chance for participants to learn how their feelings, experiences, and beliefs—their attitudes—might affect them in suicide first aid.

By completing this section, participants will be able to:

1. Recognize how feelings about and personal experiences with suicide might impact them in suicide first aid
2. Identify beliefs that might assist them to be direct and comfortable in suicide situations
3. Identify beliefs that might help them to be more flexible in meeting a person at risk's need for guidance

4. Talk more openly about their attitudes toward suicide and life assisting, suicide first aid.

Understanding Section
The goal of this section is to understand how *PAL* meets the life assisting needs of persons at risk.
By completing this section, participants will be able to:
1. Recognize *PAL* as a tool for meeting the life assisting needs of persons at risk
2. Name the six needs of a person at risk and the basic caregiver tasks of *PAL* that address those needs
3. Understand how to use *PAL's Safety Framework*

Assisting Section
The goal of this section is to help participants feel more willing, ready and able to assist a person at risk.
By completing this section, participants will be able to:
1. Appreciate *PAL* as a tool that helps participants combine their attitudes, knowledge and intervention skills to provide suicide first aid
2. Understand how *PAL* works in practice
3. Use *PAL* to help a person at risk of suicide through simulations

Working Together
The goal of this section is to have participants appreciate the value of improving their community's resources and the ways in which those resources work together.
By completing this section, participants will be able to:
1. Explore how their role choices might impact helping a person at risk
2. Experience how community resources might benefit a person at risk
3. Recognize the value of personal support networks and other self care ideas for caregivers**.**

Evaluation tools
Participants will:
1. Demonstrate that they can participate in a didactic role play with a caregiver and person at risk using the *PAL* model to provide a life assisting first aid suicide intervention.
2. Provide feedback to other participants demonstrating skill at recognizing the *PAL* model.
3. Complete a feedback evaluation that reveals pre and post workshop information about their ability to be willing, ready, and able caregivers. Finally, participants provide important quality assurance information.
Additionally:
4. All feedback evaluations and a completed trainer report are read by designated quality assurance and development staff.
5. ASIST uses on-going evaluation and program improvement. ASIST was developed using the Rothman Research and Development framework (Rothman, 1980). The Rothman framework posits four stages of intervention development and dissemination, which form a continuing process of program improvement. Using Rothman's framework and based upon feedback from participants, trainers, evaluation reports, and research studies. The ASIST

program (first developed in 1983) was revised in 2003, 2008, and 2013. The Rothman framework has also allowed for adaption of the ASIST program to meet local needs, customizing certain aspects of dissemination and implementation to best fit those needs, while holding constant those components that make ASIST effective.

Texts and Instructional Resources

The ASIST workshop has been developed using the principles of adult-learning. Here is a list of the core training processes and activities used in ASIST.

Presentations: lecture format is used for less than 10% of the workshop.

Mini-presentations: Mini-presentations or mini-lectures are information pieces that take only a few minutes to present. They are used in the Understanding section, in presenting the summaries of the whole group simulations, and for the ending of the workshop in the Working together section.

Open-ended questioning: Open-ended questions are used to start discussions. They are used in the Connecting section.

Socratic questioning: Socratic questions are used to help the participants appreciate the value of their individual and collective understanding of suicide.

Simulation experiences: There are a number of simulation experiences in ASIST, both in whole group and work group settings. Throughout these simulations, participants have the opportunity to intervene with trainers and participants role-playing persons at risk for suicide by practicing the PAL in various ways.

Running simulations: A running simulation is a special type of simulation that is regularly stopped to give time for questions, comments, and discussions. The simulation in the Understanding section is this type.

Commenting through restatements and summaries: Comments can be helpful to add to the learning process. The purpose of the restatements and summaries is to help participants integrate learning.

Required Texts, Readings, and Instructional Resources.

1. *24 page ASIST Participant Workbook*
2. *Helpers in Your Community handout that includes formal community resources and crisis lines*
3. *PAL model on quick reference cards and suicide first aid sticker*
4. *2 instructional videos used*
5. *95 slide PowerPoint presentation*
6. *Trainers attend a 40 hour Training for Trainers and use a 176 page standardized evidence-based trainer manual to provide fidelity and quality assurance*

References

Alberta Centre for Injury Control & Research. (2013). Brief report on suicide prevention in the school setting. Retrieved from http://acicr.ca/Upload/Suicide_Prevention_In_School_Settings2012_FINAL.pdf

Andriessen, K. (2006). Do we need to be cautious in evaluating suicide statistics? [Letter to the Editor]. *European Journal of Public Health, 16*(4), 445. doi:10.1093/eurpub/ckl056

Bertolote, J. M., & Fleischmann, A. (2002). Suicide and psychiatric diagnosis: A worldwide perspective. *World Psychiatry, 1*(3), 181-185.

Borges, G., Nock, M. K., Haro Abad, J. M., Hwang, I., Sampson, N. A., Alonso, J., ... Kessler, R. C. (2010). Twelve-month prevalence of and risk factors for suicide attempts in the World Health Organization Mental Health Surveys. *Journal of Clinical Psychiatry, 71*(12), 1617-1628. doi:10.4088/JCP.08m04967blu

Brent, D. A., Perper, J., Moritz, G., Allman, C., Friend, A., Schweers, J., ... Harrington, K.(1992). Psychiatric effects of exposure to suicide among the friends and acquaintances of adolescent suicide victims. *Journal of the American Academy of Child and Adolescent Psychiatry, 31*(4), 629-639. doi:10.1097/00004583-199207000-00009

Burke, A. K., Galfalvy, H., Everett, B., Currier, D., Zelazny, J., Oquendo, M. A., ... Brent, D. A. (2010). Effect of exposure to suicidal behavior on suicide attempt in a high-risk sample of offspring of depressed parents. *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(2), 114-121. doi:10.1016/j.jaac.2009.10.008

Cain, A. C., & Fast, I. (1972). The legacy of suicide: Observations of the pathogenic impact of suicide upon marital partners. In A. C. Cain (Ed.), *Survivors of suicide* (pp. 145-153). Springfield, IL: Charles C Thomas.

Cleiren, M. P. H. D., Diekstra, R. F. W., Kerkhof, A. J. F. M., & van der Wal, J. (1994). Mode of death and kinship in bereavement. Focusing on "who" rather than "how". *Crisis, 15*(1), 22-36.

Collins, J. M. (2003). Impact of patient suicide on clinicians. *Journal of the American Psychiatric Nurses Association, 9*(5), 159-162. doi:10.1016/S1078-3903(03)00221-0

Crosby, A. E., & Sacks J. J. (2002). Exposure to suicide: Incidence and association with suicidal ideation and behavior: United States, 1994. *Suicide and Life-Threatening Behavior, 32*(3), 321-328. doi:10.1521/suli.32.3.321.22170

Deeley, S. T., & Love, A. W. (2010). Does asking adolescents about suicidal ideation induce negative mood state? *Violence and Victims, 25*(5), 677-688.

Donaldson, A. E., Larsen, G. Y., Fullerton-Gleason, L., & Olson, L. M. (2006). Classifying undetermined poisoning deaths. *Injury Prevention, 12*(5), 338-343. doi:10.1136/ip.2005.011171

Dunbar, R. I. M. (1998). *Grooming, gossip, and the evolution of language*. Cambridge, MA: Harvard University Press.

Fairweather-Schmidt, A. K., & Anstey, K. J. (2012). Prevalence of suicidal behaviours in

two Australian general population surveys: Methodological considerations when comparing across studies. *Social Psychiatry and Psychiatric Epidemiology, 47*(4), 515-522. doi:10.1007/s00127-011-0369-5

Gibbons, R. D., Brown, C. H., Hur, K., Davis, J. M., & Mann, J. J. (2012). Suicidal thoughts and behavior with antidepressant treatment: Reanalysis of the randomized placebo-controlled studies of Fluoxetine and Venlafaxine. *Archives of General Psychiatry, 69*(6), 580-587. doi:10.1001/archgenpsychiatry.2011.2048

Gonçalves, B., Perra, N., & Vespignani, A. (2011). Modeling users' activity on Twitter networks: Validation of Dunbar's number. *PLoS ONE, 6*(8), e22656. doi:10.1371/journal.pone.0022656

Gould, M. S., Cross, W., Pisani, A. R., Munfakh, J. L., & Kleinman, M. (2013). Impact of Applied Suicide Intervention Skills Training on the National Suicide Prevention Line. *Suicide and Life-Threatening Behavior*. Advance online publication. doi: 10.1111/sltb.12049

Gould, M. S., Marrocco, F A., Kleinman, M., Thomas, J. G., Mostkoff, K. Cote, J., & Davies, M. (2005). Evaluating iatrogenic risk of youth suicide screening programs: A randomized controlled trial. *JAMA, 293*(13), 1635-1643.

Gould, M. S., & Shaffer, D. (1986). The impact of suicide in television movies: Evidence of imitation. *New England Journal of Medicine, 315*(11), 690-694.

Guo, B., Scott, A., & Bowker, S. (2003). *Suicide prevention strategies: Evidence from systematic reviews*. Edmonton, AB: Alberta Heritage Foundation for Medical Research.

Hawton, K. (2005). Psychosocial treatments following attempted suicide: Evidence to inform clinical practice. In K. Hawton (Ed.), *Prevention and treatment of suicidal behaviour: From science to practice* (pp. 197-219). New York, NY: Oxford University Press.

Heckler, R. A. (1994). *Waking up alive: The descent, the suicide attempt, and the return to life*. New York, NY: G. P. Putnam's Sons.

Hipple, J., & Cimbolic, P. (1979). The therapist's personal reaction to suicide. In J. Hipple & P. Cimbolic (Eds.), *The counselor and suicidal crisis: Diagnosis and intervention* (pp. 82-85). Springfield, IL: Charles C Thomas.

Jobes, D. A., Luoma, J. B., Hustead, L. A. T., & Mann, R. E. (2000). In the wake of suicide: Survivorship and postvention. In R. W. Maris, A. L. Berman, & M. M. Silverman. *Comprehensive textbook of suicidology* (pp. 536). New York, NY: Guilford Press.

Jordan, J. R., & McIntosh, J. L. (2011). Suicide bereavement: Why study survivors of suicide loss? In J. R. Jordan & J. L. McIntosh (Eds.), *Grief after suicide: Understanding the consequences and caring for survivors* (pp. 3-17). New York, NY: Routledge.

Kessler, R. C., Borges, G., & Walters. E. E. (1999). Prevalence of and risk factors for lifetimesuicide attempts in the National Comorbidity Survey. *Archives of General Psychiatry, 56*(7), 617-626. doi:10.1001/archpsyc.56.7.617

Mathias, C. W., Furr, R. M., Sheftall, A. H., Hill-Kapturczak, N., Crum, P., & Dougherty, D.M. (2012). What's the harm in asking about suicidal ideation? *Suicide and Life-Threatening Behavior, 42*(3), 341-351. doi:10.1111/j.1943-278X.2012.0095.x

McIntosh, J. L. (1996). Survivors of suicide: A comprehensive bibliography update, 1986-1995. *Omega, 33*(2), 147-175. doi:10.2190/BCWL-BLOJ-NLY2-K161

McKay, K., Hawgood, J., Kavalidou, K., Kolves, K., O'Gorman, J., & De Leo, D. (2012). *A review of the Operation Life suicide awareness workshops. Report to the Department of Veterans' Affairs*. Brisbane, QLD: Australian Institute for Suicide Research and Prevention. Retrieved from http://www.dva.gov.au/health_and_wellbeing/research/Documents/OpLife_workshops_final_report.pdf

Michel, K. (2000). Suicide prevention and primary care. In K. Hawton & K. van Heeringen, (Eds.), *International handbook of suicide and attempted suicide* (pp. 661-674). Chichester, UK: John Wiley & Sons.

Miller, C. L., & Druss, B. (2001). Datapoints: Suicide and access to care. *Psychiatric Services, 52*(12), 1566.

Mitchell, A. M., Sakraida, T. J., Kim, Y., Bullian, L., & Chiapetta, L. (2009). Depression, anxiety and quality of life in suicide survivors: A comparison of close and distant relationships. *Archives of Psychiatric Nursing, 23*(1), 2-10. doi:10.1016/j.apnu.2008.02.007

Moscicki, E. K. (1989). Epidemiologic surveys as tools for studying suicidal behavior: A review. *Suicide and Life-Threatening Behavior, 19*(1), 131-146. doi:10.1111/j.1943-278X.1989.tb00372.x

Moscicki, E. K., O'Carroll, P., Rae, D. S., Locke, B. Z., Roy, A., & Regier, D. A. (1988). Suicide attempts in the Epidemiologic Catchment Area Study. *The Yale Journal of Biology and Medicine, 61*(3), 259-268.

Ness, D. E., & Pfeffer, C. R. (1990). Sequelae of bereavement resulting from suicide. *American Journal of Psychiatry, 147*(3), 279-285.

Nock, M. K., Borges, G., Bromet, E. J., Alonso, J., Angermeyer, M., Beautrais, A., Williams, D. (2008). Cross-national prevalence and risk factors for suicidal ideation, plans, and attempts. *British Journal of Psychiatry, 192*(2), 98-105. doi:10.1192/bjp. bp.107.040113

Nock, M. K., & Kessler, R. C. (2006). Prevalence of and risk factors for suicide attempts versus suicide gestures: Analysis of the National Comorbidity Survey. *Journal of Abnormal Psychology, 115*(3), 616-623. doi:10.1037/0021-843X.115.3.616

Phillips, D. P., & Carstensen, L. L. (1986). Clustering of teenage suicides after television news stories about suicide. *New England Journal of Medicine, 315*(11), 685-689.

Pirkis, J., & Burgess, P. (1998). Suicide and recency of health care contacts: A systematic review. *British Journal of Psychiatry, 173*(6), 462-474. doi:10.1192/bjp.173.6.462

Ramsay, R., & Bagley, C. (1985). The prevalence of suicidal behaviors, attitudes and associated social experiences in an urban population. *Suicide and Life-Threatening Behavior,15*(3), 151-167. doi:10.1111/j.1943-278X.1985.tb00941.x

Ramsay, R. F., Tanney, B. L., Lang, W. A., & Kinzel, T. (2010). *Cause of Death?* [DVD -3rd ed.]. Calgary, AB: LivingWorks Education Inc.

Rockwell, D. A., & O'Brien, W. (1973). Physicians' knowledge and attitudes about suicide. *Journal of the American Medical Association, 225*(11), 1347-1349.

Royal, P. A. (1979). *Report of the Committee on the Nature of and Response to Personal and Family Crisis in the Province of Alberta*. Edmonton, AB: Government of the Province of Alberta.

Shneidman, E. S. (1967). Some current developments in suicide prevention. *Bulletin of Suicidology, 1*, 31-34.

Shneidman, E. S. (1971). Prevention, intervention, postvention. *Annals of Internal Medicine, 75*(3), 453-458.

Shneidman, E. S. (1985). *Definition of suicide*. New York, NY: Wiley. Silverman, E., Range, L., & Overholser, J. (1994-1995). Bereavement from suicide as compared to other forms of bereavement. *Omega, 30*(1), 41-51. doi: 10.2190/BPLNDAG8-7F07-0BKP

Stack, S., (1987). Celebrities and suicide: A taxonomy and analysis, 1948-1993. *American Sociological Review, 52*(3), 401-412.

Stanley, B., & Brown, G. K. (2006). *Safety planning to reduce suicide risk* (Unpublished manuscript).

Tanney, B. (1995). *Assessment and therapy with suicidal adults* [Handout]. American Association of Suicidology Summer Institute, Sante Fe, New Mexico.

Velting, D. M.,& Gould, M. S. (1997). Suicide contagion. In R. W. Maris, M. M.

Silverman, & S. S. Canetto (Eds.), *Review of suicidology, 1997* (pp. 96-137). New York, NY: Guilford Press.

Weissman, M. M., Bland, R. C., Canino, G. J., Greenwald, S., Hwu, H.-G., Joyce, P. R. Yeh, E.-K. (1999). Prevalence of suicide ideation and suicide attempts in nine countries. *Psychological Medicine, 29*(1), 9-17.