SUICIDE PREVENTION TRAININGS: EXPERIENCES AND RECOMMENDATIONS

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Abstract

Suicide rates have generally been on the rise for the last twenty years. While rates were decreasing between 2018 and 2020, they rose again in 2021. Almost two million adults attempted suicide in 2021, which shows the importance of suicide trainings. While there are a multitude of suicide trainings, I focused on four that I have completed. Unfortunately, there are not a lot of trainings that are free, online and self-paced, or made for the general public. As suicide is an issue that can affect multiple areas of life including family, the workplace, and more, it is imperative that effective training on suicide prevention and intervention is more widely available and accessible. In this paper, I will review suicide statistics, as well as generalities of current suicide trainings. I will then review research that has already been done on the effectiveness of suicide trainings, and go more into detail on the four trainings I have completed. Finally, I will describe my experiences with each of the four trainings, and give my recommendations for improving current trainings and creating new ones.

Introduction

Suicide is a hard topic to discuss. Asking if someone is suicidal or has been having suicidal thoughts can be a scary and overwhelming experience for many. Unfortunately, suicide rates have been on the rise over the last two decades, specifically for youth between the ages of 15-19 (*QuickStats*). Now, suicide is the second leading cause of death for people ages 15 to 24 in the United States, with about one in five high school students having seriously contemplated suicide (Cohen, 2022). It is the 12th leading cause of death in the United States, with an average of 130 suicides per day, with 12.2 million adults seriously considering suicide, 3.2 million adults making a plan for dying by suicide, and 1.2 million adults attempting in 2020 (Centers of Disease Control and Prevention, 2023). The increasing rates imply that the likelihood is somewhat high that people will encounter others who are experiencing suicidal thoughts; as

such, it is important to know how to have conversations about suicide, and what to do if you or someone you know is suicidal or having suicidal thoughts. Of course, this information is important for everyone to know, understand, and be comfortable with, since anyone can have suicidal thoughts, tendencies, or ideations, but it is especially relevant for people that work with youth. Half of the suicide trainings explained here are targeted toward people that support and work with youth, so learning more about what it means to be suicidal can give people the tools to support youth in need.

There are a variety of suicide prevention trainings and courses that can be completed to ensure that a person is ready and able to have these hard conversations. Along with teaching how to bring up suicide in conversation, suicide prevention programs work to educate program participants on decreasing risk factors and increasing resiliency factors (Centers for Disease Control and Prevention, 2022a). They are also used to teach people about these factors (Action Alliance). Risk factors include financial problems, substance use, a history of mental illness such as depression, impulsive and aggressive tendencies, no accessible healthcare, community violence, and stigma surrounding mental illness and seeking help (Centers for Disease Control and Prevention, 2022b). Factors that can protect against suicide risk, along with resilience, are healthy relationships, effective coping skills, access to healthcare, and having healthy connections to family, friends, and community (Centers for Disease Control and Prevention, 2022b). Different trainings focus on different populations, including teens and youth, teachers, and mental health professionals. There are also suicide trainings available for the general population. These trainings have the same major goal: to teach the general population what the warning signs and risk factors of suicide are, and how to intervene when someone needs help. Because the topic of suicide can be difficult to broach with someone, these trainings guide

people on how to have these conversations. They work to support people in getting more comfortable talking about suicide. Additionally, some provide resources and organizations that work to help people that are contemplating suicide. The trainings assist in having the conversation, while also explaining where and how to find professional help, if needed.

In this thesis, I will be reviewing what research has been done on the effectiveness of selected suicide prevention trainings. I will be explaining QPR training, Youth Mental Health First Aid, ACTS on FACTS, and the Columbia Lighthouse Project. I will also be describing my own experiences with these four trainings, and how effective the training was for me. Lastly, I will include recommendations for how suicide prevention trainings overall can be improved and made more efficient.

Previous Research

In this section, I will be exploring the research that has previously been done on suicide prevention trainings. Different trainings are targeted toward different populations, focus on helping different demographics, and provide various resources. Population-wise, there are trainings for people that work in schools or with youth in some capacity, mental health and healthcare professionals, youth, and the general population. Some trainings teach how to help youth, while others are focused on adults. Many describe the warning signs and risk factors that are associated with suicide. Some will also include organizations and professionals that someone can reach out to for additional information or help. There have not been many studies done about the impact of suicide trainings in general. Of the studies that have been done, many of them include participants in the medical or mental health professionals, so I am only including studies with participants from the general population. Additional studies have been done in different Asian countries, but I decided not to include them here because of the impact that cultural

differences may have had on the results. I am keeping my thesis United States-specific. One study found that while suicide trainings improve a person's literacy about suicide, people's behaviors do not necessarily change (Torok et al., 2019).

One of the more popular types of suicide trainings is called gatekeeper training. Gatekeeper training, abbreviated to GKT, is a suicide prevention tactic that works with people who are not clinicians. Participants learn how to determine if someone is feeling suicidal and where to find services that can provide the help they need (Hawgood et al., 2022). Two of the suicide trainings described here, QPR and ACTS on Facts, are gatekeeper trainings. One meta-analysis of GKT studies analyzed the levels of knowledge, self-efficacy (a person's confidence in their own abilities), and suicide prevention behavior (identifying, questioning, and referring). Overall, completing gatekeeper trainings increased a person's knowledge on risk factors and appropriate intervention techniques, with the information even being remembered up to two years after the training (Holmes et al., 2019). Every study that included self-efficacy reported an increase immediately after completing the training, although whether or not the confidence was sustained is unclear. Suicide prevention behaviors did not have as significant of an increase as the other measures. Only a few studies found that participants implemented suicide prevention behaviors after the training, although only the referring behavior showed major improvement (Holmes et al., 2019). This means that most people who implemented suicide prevention behaviors mainly focused on referring people to services, rather than having conversations with them. Outside of this gatekeeper training meta-analysis, studies have been done on some of the specific trainings I am including here, as outlined below.

Researchon QPR training found that support staff working in schools did not see youth suicide as an issue that needed to be addressed. Although many people who participated in this

training felt more likely to intervene with someone who was thinking about or planning to die by suicide, many people did not retain knowledge of QPR (Tompkins et al., 2010). From the study done regarding Youth Mental Health First Aid, the training only seemed to positively affect a person's "confidence, knowledge, and preparedness" in terms of responding to the emotional needs of youth *if* that person worked with youth (Childs et al., 2020). For jobs that did not involve working with youth, the training did not seem to make an impact. I could not find any study that was done on ACTS on FACTS, which means this is a tool worth exploring more empirically. Finally, the study done on the Columbia Lighthouse Project had positive results. Using this assessment tool, participants were able to identify if patients at a substance use disorder clinic were at risk for suicide. Additionally, the participants were able to give "referrals for preventative care" (Anyanwu, 2021). In the results of this study, two other studies that explored the Columbia Lighthouse Project were mentioned. Both studies found similar results: that this tool helped professionals effectively screen their patients for suicidal behavior. Based on these studies, there are effective suicide trainings and assessment tools out there. There is also a lot of room for improving on these trainings and tools.

Descriptions of Suicide Prevention Trainings

I decided to focus on four different suicide trainings, two of which are gatekeeper trainings, and focus on learning warning signs and services available to reach out to for help. I chose these four based on their availability and affordability. The first one I chose is the QPR training. This training stands for question, persuade, and refer. The purpose of the training is to "identify and interrupt the [suicidal] crisis and direct the person to the proper care" (QPR Institute). The QPR training centers around suicidal warning signs, and knowledge on giving hope and finding help to save a life. The website likens QPR to CPR, where both are utilized as

emergency interventions to save someone while getting them somewhere with proper care. QPR is not meant to be the final step in helping someone going through a suicidal crisis. Instead, it should be used in emergency situations in order to get someone to a place or to resources that can provide more care and treatment. Although they offer a few different online courses depending on the population a person works with, I was trained through an online session in one of my classes. There is a course for the general public that explains how to use the book “Suicide: the Forever Decision” in order to help someone that is contemplating suicide.

The second training I completed was the Youth Mental Health First Aid. As the name implies, this training focuses on helping youth. I completed the adult to youth training, since I am an adult who works with youth. There is also training available that is teen to teen and adult to adult. The main purpose of the youth training is to learn about signs and symptoms of various mental health challenges, explore how to interact with a youth in crisis, and how to connect the youth to health services (Youth Mental Health First Aid). Similar to the QPR training, this one also has an acronym on what to do. The acronym is ALGEE, and stands for *assess* for risk of suicide, *listen* to the person without judgment, *give* both information and reassurance, *encourage* professional help, and *encourage* self-help and other strategies. I took this training through the summer camp where I work, as an online five hour training. The training is offered both in-person and blended. The blended option includes a self-paced online course, and an instructor-led training either online or in person. If someone goes to the Mental Health First Aid website, you can search for trainings based on dates and locations that work for you. Each training also shows where the funding for that specific training comes from, so presumably Mental Health First Aid is free.

The third training I completed was called ACTS on FACTS. This one I found online, and decided to include it because it was free and self-paced online. This training is meant for teachers/others that work in schools, and when creating an account you had to choose your job (there was a student option, so I used that one). Both this training and the QPR are gatekeeper trainings, so they are specific for people that are not clinical professionals. The course may differ based on what job you choose. The training consisted of different modules, where you watched videos with mental health professionals and took a few quizzes after different modules. There was a pre-assessment and post-assessment quiz, which ranked your knowledge on warning signs, learning how to actively listen and validate what a person is thinking, feeling, or saying, and when to connect a person to other resources. Your knowledge was ranked on a scale from lowest to highest, but unfortunately neither assessment showed you the questions you missed or the correct answers.

The final training I completed was less of a training and more of an explanation into the Columbia Suicide Severity Rating Scale (C-SSRS). It did include a slideshow with videos about the C-SSRS, its history, and why it is set up the way it is. This was more focused on the C-SSRS rather than suicide prevention or intervention, but it is applicable here because it is free. Reading the C-SSRS can also help people learn the types of questions they can and should ask someone if they think they are contemplating suicide. The C-SSRS is a scale used to assess a person's suicide risk. There are two main sections to the scale: suicidal ideation and suicidal behavior. Suicide ideation refers to thinking about suicide. This includes asking a person if they have thought about killing themselves, and if so, have formed any sort of plan or details on how they would kill themselves.

Overall, the aim of these programs is to educate people on suicidal risk factors and warning signs and bringing up suicide in conversation. Understanding what to look out for, and subsequently learning how to approach these conversations and knowing available resources can increase a person's confidence in their ability to help those that need it. Each of the four programs outlined here approach these aspects in different ways, and I will be using my experiences with each to emphasize their strengths and weaknesses below.

My Experiences with Each Training

I became certified in QPR training through one of my Family Studies and Human Development classes. My professor had someone from the organization join us for two days on Zoom, and we completed the training in two one-hour classes. Since the training was done through one of my classes, I did not pay for it. It was given similar to a college lecture–the presenter had a slideshow that she used, and lectured about various topics regarding suicide–statistics about suicide, warning signs, risk factors, and how to start a conversation with someone about suicide. There was emphasis placed on the effective ways to approach a conversation about suicide, and a cartoon video about empathy was included. This was the biggest strength from the QPR training, since people might be worried about friends and family, yet not know how to initiate a conversation with such a heavy topic. Knowing that it is okay to not have all the answers, but to show your love and support for someone going through such a hard time is sometimes just what people need. Another strength was including various statistics about suicide. Before beginning the main part of the training, QPR gave various statistics on suicide rates in the United States. Learning about the prevalence of suicide helped put into perspective the importance of understanding how to support people that need it. On the other hand, the way this training was delivered did not emphasize interaction or applied skill practice.

Having auditory or visual aids are a good way to get information across the first time, but for retention purposes I think more interactive learning opportunities or follow-up information and resources is necessary. It is hard for me to retain information after only hearing it once, and because this topic can literally save lives, I think following up after the training with information in various [ways], such as through email, pamphlets, or websites, can assist people in keeping the knowledge in the back of their minds. The QPR training also did not focus on a specific population; it was more of a general overview on signs to look out for and ways to introduce this difficult topic in conversation. This is different from the Youth Mental Health First Aid training, which was more specific in its target audience and demographic. While usually QPR training gives out materials for participants to refer to after the training has concluded, this time I did not receive any, presumably because I took the training through a class.

Youth Mental Health First Aid (YMHFA) has two training options: adult to youth and youth to youth. I was able to complete the adult to youth training through my summer camp at no cost, and [also supervised the youth to youth training when my 15-year-old campers completed it last summer]. The presenter was a social worker who does this training throughout the US. This training was more extensive than the QPR training, having pre-work, a longer synchronous training, and post-work. The pre-work was two hours long, and consisted of completing different modules online [to see how much you knew surrounding suicide before taking the training]. The synchronous training was through Zoom, and was five hours long. The post-work was a mandatory quiz in order to receive the certificate. Because this training focused on the mental health of youth, the training talked a lot about mental health disorders that youth may have, including depressive and anxiety disorders, eating disorders, impulse-control disorders, and attention-deficit hyperactive disorder (ADHD). The biggest focus of this training is on ALGEE:

assess, listen, give, encourage [professional help] and encourage [self help and support strategies]. I learned how to listen without judgment and give someone both reassurance and information that the person may need. We talked through different scenarios and how to use the ALGEE approach within these scenarios. What I really liked about this training is that we received a downloadable participant processing guide. It contains a lot of the information that was explained during the synchronous session. I think this is really helpful and important, because it is a quick and easy way to remember the information that was taught during the Zoom session. Overall, this was probably my favorite training. I like that mental health disorders were mentioned, and that there is an acronym to remember the appropriate ways to talk to someone about suicide. I also like that the first few pages of the downloadable packet goes over what mental health first aid is, and what is overviewed in the pre-training work. The other training that included a pre-work assessment and post-work assessment is the ACTS on Facts training.

ACTS on Facts was the first training I researched myself. I decided to complete this one because it can be completed online, you can go at your own pace, and it is free. The cost was an important factor for me when choosing which trainings to review, since I believe suicide training and information about suicide prevention and intervention should be accessible to everyone. I did come across a hurdle when making my account to participate in this training- you needed to specify your job. Since the target audience of this training is teachers and other professionals that work in schools, ACTS on Facts is not accessible to just anyone. I marked my job as “student” and was able to create my account. The training itself included multiple modules, with videos and quizzes within each one. The modules, and embedded videos, communicated risk factors and warning signs, how to practice active listening, what your role is as someone working with students in a school community, and resources to support both professionals and students. I

enjoyed this training, but it was focused on scenarios that are applicable in school settings. It would have been great to see broader scenarios. As I have mentioned, there is also a pre-work assessment and post-work assessment. I really like this idea because it can show you how much you have learned from the training, but unfortunately you don't get to see what questions you missed or what the correct answers are. Instead, you get a knowledge ranking that uses a lowest to highest scale. So, you are able to see how much knowledge you have on youth suicide prevention, but not the specifics, such as risk factors or how to practice active listening.

The final training I completed was not actually a training. Instead, the Columbia Lighthouse Project, an organization focused on ending suicide, utilizes what is called the Columbia Suicide Severity Rating Scale (C-SSRS). This scale has a list of questions to ask someone if you think they are experiencing suicidal ideation or behaviors. The "training" I did was really interesting, since it gave me more insight into effective questions to ask. After I did the training, though, I went to the Columbia Lighthouse Project website and was blown away. On the website there is the C-SSRS (which they also refer to as the Columbia Protocol), which is available in a variety of languages. The website also explains how to use the Protocol in different settings, including for friends and family. There are only a few questions to the Protocol, and someone's answers puts them at low, moderate, or high risk. From there, the bottom of the Protocol says to either "seek behavioral healthcare for further evaluation", text or call 988 (the suicide and crisis hotline), call 911, or take them to the emergency room (Columbia Lighthouse Project, 2016). The website has a lot of really high-quality information and resources. It is all free and definitely worth checking out.

Recommendations

Although there are a variety of suicide prevention trainings already, I think there are many improvements to be made, both to existing ones and in the creation of new ones. First and foremost, I believe that suicide prevention trainings should be affordable. Many of the available suicide trainings cost money, which does not make it affordable for everyone. Additionally, there are intensive trainings that take place in person over the course of a couple of days. Not everyone can afford to take the time off work. Trainings should be long, so people have time to learn, understand, and process the information, but making it self-paced makes it more accessible. I also believe that trainings should be available for a wider audience. Most are targeted toward either healthcare professionals, mental health professionals, or people that work in schools. Suicide ideation and suicidal behaviors are things that anyone can go through, so the general population should be a targeted demographic for suicide trainings. One study theorizes that some trainings may translate better into certain professions, so trainings will need to ensure that they are applicable to a wide range of professions and also include people who are not working (Childs et al., 2020). Another study found that while trainings are effective in increasing people's knowledge, confidence, and competence when it comes to suicide prevention and intervention, these effects decrease the longer it has been since the training was completed (Holmes et al., 2019). Therefore, trainings should have mandatory follow-ups at least once a year, in the form of assessments or more training. Plus, sending information throughout the year, through newsletters or articles, is another way to ensure people have the most updated information on suicide prevention and intervention. I also believe that people need to practice talking about suicide, since it can be a difficult and sometimes taboo topic to discuss. It is important to know and understand this: asking someone if they are having suicidal ideations, are engaging in suicidal behavior, or have attempted to die by suicide does *not* put the idea in their head (Berman &

Silverman, 2017). In actuality, having the topic out in the open can be beneficial, and may even reduce a person's suicidal ideation. The QPR training emphasizes this, since the *q* stands for "question". This training encourages asking someone if they have suicidal thoughts or feelings as a first step (QPR Institute). Providing a safe space and listening without judgment can also encourage someone to open up and ask for help if they need (Youth Mental Health First Aid). One way for trainings to incorporate conversation practice into their modules is through computer-simulated dialogues. Having people converse with a computer simulation can help them get more comfortable hearing the questions to ask and potential answers. Trainings can also give lists of appropriate questions, so people do not have to worry about approaching this discussion in an uncomfortable way. Having a list also gives something people can reference as often as they need to. People thinking about dying by suicide may have underlying disorders, such as substance abuse, eating disorders, anxiety, or depression. Suicide trainings should include a little information on the fact that there is no one underlying cause of suicide, and that there one risk factor is mental disorders or substance abuse disorders (Suicide information for teens, 2017).

Although this section is about my recommendations, I want to touch on apps you can download that are already available. The Columbia Lighthouse Project has an app called the "Columbia Protocol", and essentially is the Columbia Protocol (Columbia Lighthouse Project, 2016). This way you can always have it with you. The Substance Abuse and Mental Health Services Administration also has an app for suicide prevention, titled "Suicide Safe by SAMHSA". This app includes a suicide assessment, case studies to see how the assessment is utilized, resources and help lines, conversation starts, and a Behavioral Health Treatment

Services Locator, to find services near you (Substance Abuse and Mental Health Services Administration, 2015). I highly recommend checking these out.

Overall, suicide can be an overwhelming topic to discuss or even think about. It can be uncomfortable to bring up, yet the statistics indicate that it is a necessary topic to be talked about. Feeling suicidal can be a tremendous burden, but thankfully there are so many resources to help both the person that is feeling suicidal, and their friends and family. Completing a suicide prevention training is a great way to learn what risk factors and warning signs to look for, and how to handle bringing suicide up in conversation. Finding websites with various resources or downloading apps can also provide you with information on suicide prevention and intervention. Above all, please know that there are resources available. There are many organizations working tirelessly to help people overcome these traumatizing thoughts and feelings. Know that while suicide is hard to talk about for so many people, talking about it can save lives. Keep an open mind, do not judge someone that is opening up to you, and encourage them to find professional help if they need it. You are not alone.

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