

Menninger Suicide Prevention Training sponsored by The Office of the Chief of Chaplains

Background Information

In 1993 the Office of the Chief Of Chaplains began sponsoring Basic Suicide Prevention Training and Advanced Suicide Prevention Training at the Menninger Clinic. The training is the standard for training chaplains in Suicide Prevention Training for their units.

Point of Contact:

Office of the Chief of Chaplains, ATTN: Soldier and Family Ministries (DACH-PPF)
2511 Jefferson Davis Highway, Crystal City
Arlington VA 22202-3907
DSN 329-1182 CML (703) 601-1182

LivingWorks

Education

ASIST: Applied Suicide Intervention Skills Training

Background Information

1. Origins: Four human service professionals, from psychiatry, psychology and social work, collaborated with the provincial and state governments of Alberta and California, and the Alberta Division of the Canadian Mental Health Association in Alberta to develop suicide intervention training programs for front-line caregivers/gatekeepers of all disciplines and occupational groups. Founded as a partnership in 1983, LivingWorks Education is a public service corporation.

One of the original four principals died in 1997. New principals have been added and LivingWorks has reorganized to ensure its long-term survival and commitment to public service.

LivingWorks programs are delivered through an extensive network of community-based registered trainers in Canada, the United States, Australia and several other countries. LivingWorks is dedicated to enhancing suicide intervention skills at the community level, and committed to making its suicide prevention training programs widely available, cost effective, interactive and easy to learn, with practical applications designed for all types of caregivers. The LivingWorks objective is to register qualified trainers in local communities, who in turn can prepare front-line gatekeepers with the confidence and competence to apply first-aid suicide intervention in times of individual and family crises.

2. Beneficiaries: Customers of LivingWorks' suicide intervention training workshops (Applied Suicide Intervention Skills Training - ASIST, formerly the Suicide Intervention Workshop, and before that the Foundation Workshop) include provincial, state, and federal government departments and agencies involved in alcohol and drug abuse, family and children, mental health, military, police and corrections services; public school boards, hospital departments,

native communities, and nongovernmental community mental health and crisis intervention organizations.

LivingWorks' Training for Trainers Courses have trained and certified more than 1,400 locally based suicide intervention workshop instructors since 1983. They, in turn, have given first aid suicide intervention training to more than 130,000 community participants from all walks of life. An average of over 10,000 participants annually attend ASIST. ASIST is by far the most widely used, acclaimed and researched program of its kind in the world.

Training for Trainers Courses and local ASIST workshops are user-financed through institutional sponsorships and individual registration fees. The specific benefits to caregivers are reductions in the fears and taboos associated with the word "suicide" and increases in the knowledge and skills, which empower them to effectively deal with almost any suicidal situation. Participants come away knowing that suicide is a preventable problem.

Evidence from properly integrated and coordinated suicide prevention program with other community prevention and health promotion programs has shown reduced rates of suicide in prison populations, public school regions, and in Native American communities. Apart from formal evaluations, anecdotal feedback from individuals and their families frequently describe life-saving benefits in specific situations.

3. Dissemination and Impact: A program originally developed to reduce the problem of suicide for individuals and families in Alberta has spread far beyond its original mandate. In addition to its widespread use in Canada, Washington, California Australia and Norway, there are resident certified trainers in Singapore, Denmark, and Sweden, and several other states - Georgia, Louisiana, New Mexico, Oregon, Tennessee, Texas, and Washington.

The U. S. Army (5th Corps) in Germany implemented the program in 1990. Successful demonstrations have been made in Australia, India and Russia. The programs have been successfully presented in a wide range of settings: family and child welfare services, school systems, correctional institutions, northern communities, hospital departments, police programs, mental health agencies, peer group programs, employee assistance programs, college and university settings, etc.

In 1993, LivingWorks Education was a co-sponsor of the United Nation's first inter regional experts meeting on suicide prevention and continues to work with the UN Department of Policy Coordination & Sustainable Development on the dissemination of national strategy guidelines for the prevention of suicide to member countries and interested NGOs around the world. In the United States, a grass roots movement, SPAN (Suicide Prevention Action Network) is actively lobbying the federal government to develop a national strategy plan.

The impact on workshop participants has been considerable. Individual caregivers consistently report increased competence and confidence in first-aid skills, provide frequent anecdotal reports of lifesaving interventions, and 99% recommend the program for others. Public users in the form of community agencies report increased grant support from charitable foundations; large correctional services have improved their community service image by providing trainers free-of-charge for community workshops; and the U. S. Army was sufficiently impacted that they had the developers provide critical incident stress debriefing and bereavement service training during the Gulf War.

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- Ph: 403 209 0242
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QPR Gatekeeper Instructor Certification Course

For any person or organization interested in preventing suicide in their community

Course Description:

This certification course trains instructors to teach QPR, CPR for Suicide Prevention to their community. Participants first learn about the nature of suicidal communications, what forms these communications take and how they may be used as the stimulus for a QPR intervention. To gain perspective, participants are introduced to the history of suicide, suicide prevention and the spectrum of modern day public health suicide prevention education efforts. The history, background and research support for QPR are reviewed. Participants then learn to market QPR, target potential gatekeepers, and how to teach the QPR curriculum. Participants also learn to deal with pent-up audience demand to talk about suicide, survivor issues and how to make immediate interventions and referrals. Each participant has the opportunity for individual rehearsal and practice.

Course Objectives:

- To understand the nature, range and importance of suicidal communications and their importance in preventing suicide.
- To review and understand the groups at greatest risk of suicide and why QPR can work for them. To train participants to teach QPR, CPR for Suicide Prevention.
- To gain a historical perspective about suicide prevention and how QPR fits into national efforts.
- To acquire specific knowledge about how audiences may respond to the QPR message and how to react in a helpful manner.
- To learn how to effectively market suicide prevention in their own communities.
- To gain the competence and confidence to teach others how to save lives and help prevent suicidal behaviors.

Course Content:

- Suicidal communications: video vignettes and discussion
- Suicide and suicide prevention in history
- Gatekeeper training; how, why and the research
- New and promising approaches to suicide prevention. Targeting prevention education efforts
- Review of the QPR video
- Teaching QPR
- Facilitating role plays
- Handling questions from audiences
- National and local resources and how to use them
- Expanding QPR to other community prevention efforts
- Completion of evaluations of training
- Orientation to the national QPR network and Greentree
- Awarding of three-year Instructor Certificates

Certification Program includes:

- A full-day training course
- A QPR Instructors Manual complete with:
 - QPR training video hosted by Carrie Fisher
 - Detailed teaching information
 - 35mm slides
 - Overhead masters for transparencies
 - Audiotape of a QPR Gatekeeper training
 - Two QPR booklets and QPR wallet cards
 - A copy of *Tender Leaves of Hope* booklet
 - Tool kit (continuously updated) with information on issues related to suicide
 - Two of Dr Quinnett's books: *Suicide: The Forever Decision & Suicide: Intervention and Therapy*
 - Access to Greentree's 800 number for consultations on QPR training
 - *QPR Times*: a newsletter created for QPR
 - Certified Gatekeeper Instructors

QPRT is an acronym for Question, Persuade, Refer or Treat

QPRT Training is one of the many programs offered by **Greentree Behavioral Health**. Greentree Behavioral Health, a nonprofit organization, is a division of:

Spokane Mental Health
524 West Sixth Avenue
Spokane, Washington 99204
509 458-7471 800 256-6996

Further information about QPRT can be obtained from the **QPR Institute (888-726-7926)**

QPRT

Suicide Risk Detection, Risk Assessment and Risk Management

For Counselors, Case Managers and Health Care Providers

Course Description:

This course introduces counselors and care providers to suicide risk detection, risk assessment, and risk management from a medical, psychological and legal perspective. The course is both didactic and interactive, and provides practice with the QPRT Suicide Risk Management Inventory. At the conclusion of the course, participants will be able to conduct a suicide risk assessment, complete the QPRT Suicide Risk Management Inventory, and engage an at-risk client and/or family in a no suicide contract and a shared risk management plan.

Course Objectives:

- Identify at least ten major risk factors for suicide.
- Describe current suicide risk assessment methods, their contributions and limitations.
- Make informed risk assessment judgments, based on actual experience in estimating suicide risk from clinical vignettes.
- Describe the rationale and components of the *QPRT Suicide Risk Management Inventory*.
- Be able to engage an at-risk patient in a frank discussion of suicidal thoughts, feelings and plans, including taking a pertinent suicide history.
- Be able to conduct and complete a risk assessment interview, complete the QPRT, and document a risk management plan, including a no-suicide contract.
- Be familiar with the QPR: CPR for Suicide Prevention public health education program.

Course Content:

- Suicide risk factors in clinical settings, epidemiology and overview.
- Detecting suicidal thoughts and feelings; understanding the problem of dissimulation.
- Risk factors and their assessment (practice in risk rating clinical cases).
- Completing the QPRT Suicide Risk Management Inventory (interview and practice\with form).
- Understanding para suicidal behavior.
- Managing the at-risk patient over time; risk windows and opportunities.
- Treatment considerations for depressive illness and co-morbid substance abuse.
- Avoiding bad outcomes: clinical and legal considerations.

QPRT POSTVENTION

In the Aftermath of Suicide

Course Description:

Trauma can occur at any time in an individual's life. Rarely is the impact greater than the death of a loved one to suicide. This training provides participants with the basic information and skills to assist survivors of suicide in processing their initial grief reactions and to assist them in the early phases of healing. Utilizing both didactic and interactive methods of presentation, participants will explore personal perspectives associated with death and suicide, characteristics of acute and/or posttraumatic stress reactions, a model for conducting a quality postvention interview, as well as concerns of contagion and strategies for contagion control. By learning effective intervention strategies, participants will be in the position to promote a healthy grief response in their clients or, in some circumstances, to intervene in the suicidal journey of a surviving family member or friend.

Course Objectives:

- Explore personal attitudes associated with death and suicide.
- Facilitate the awareness of trauma in general, and the impact of suicide in particular.
- Identify the major symptoms and characteristics of acute stress reactions and posttraumatic stress disorder.
- Describe the differences in grief and recovery related to anticipated versus unanticipated death.
- Be able to utilize a step-by-step format for conducting a postvention interview.
- Awareness of the prevalence of contagion and procedures for contagion control.
- To decrease the self-destructive acting out and/or number of suicides by a friend or loved one following a suicide.
- Explore the bereavement crisis associated with the clinician as survivor.
- To practice through role-playing, the application of postvention interview skills.

Course Content:

- Review of symptoms associated with acute and/or posttraumatic stress reactions.
- Exploration of differences in grief associated with anticipated versus unanticipated death.
- Overview of basic therapeutic intervention strategies.
- Identification of benefits associated with postvention efforts.
- A step-by-step format for conducting a postvention interview.
- Definition of contagion and its prevalence following a suicide.
- Policies and procedures for contagion control.
- Address factors that are present when clinicians are the survivors of suicide.
- Treatment and referral considerations.

CRITICAL INCIDENT STRESS DEBRIEFING

This section describes Critical Incident Stress Debriefing. This is a procedure that should be implemented for all caregivers who have worked with an individual who completes suicide or makes a seriously injurious attempt. This is just an overview. Formal training is required to provide this procedure. See resources listed at the end of this section.

Support Strategies for the Professional: Critical Incident Stress Debriefing

Assisting an individual who is considering or threatening suicide can be a highly stressful endeavor. On one hand, such stress can actually enhance the professional's ability to assess and intervene in the situation by sharpening attention to detail and creating the concern to thoroughly follow through with prevention plans. Some aspects of this stress are not quite as productive. In fact, fear or nervousness about the client's safety may be somewhat overwhelming and become an obstacle to thorough assessment and intervention. One type of stress associated with "high-consequence activities (HCA's), such as suicide prevention, is almost always negative and disturbing -- that is Critical Incident Stress.

"High-consequence activities" are defined as those tasks, such as suicide assessment, in which small oversights or omissions may result in serious, or perhaps tragic outcomes. This, of course, results in a great deal of both real and perceived pressure and responsibility on the professional involved in the suicide assessment or other "high-consequence activity". It is not unusual for the professional to express feelings of self-doubt or anxiety about the thoroughness of the evaluation or intervention plan when working with a client at risk of suicide. It is also not unusual for the same professional to be completely overwhelmed in those instances when a client may actually go on to hurt or kill themselves in the hours, days, or weeks following assessment, intervention and treatment.

While the prevalence of attempted and completed suicides is alarming, it would be unusual for any one practitioner to encounter such an emotionally difficult situation with any frequency. Such a powerful event as the death of a current or past client by suicide, would hopefully be a rare and isolated event. It is an unusual event, and the resulting reaction experienced by the professional who has worked closely with the client may vary in intensity and duration. This reaction or response to the news that a client has attempted or completed a suicide is known as Critical Incident Stress Reaction. *It is the normal reaction normal people have to an abnormal event.*

Critical Incidents have the power to overwhelm the normal coping abilities of even the most experienced professional. Typically, these rare, but overwhelming events, especially those which may end with a tragic outcome, often have the power to completely immobilize the professional or potentially an entire group of people. An example would be the client who begins to threaten suicide, and then actually injures or kills himself/herself while a "hotline" worker is still on the phone attempting to help them. It is not hard to imagine the emotional impact such an incident would have on the professional, but unless the worker has had prior experience with such incidents, they may feel as if they are very much out-of-control of their reaction.

By definition, "Critical Incidents are those events that overwhelm an individual's ability to cope. They are psychologically traumatic, causing emotional turmoil, cognitive problems and behavioral changes" (K. Johnson, 1989).

Typical Critical Incident Stress reactions affect each individual somewhat differently. This individual difference is influenced not only by prior life experience, but also by other personal factors, such as culture, pre-existing levels of stress and the professional's perception of their responsibility in the client's injury or death. There are also aspects of the client's behavior which may shape the professional's reaction. For example, a suicide completed in a very graphic or gory manner, may result in a more powerful response, as might a suicide completed during a time when the future appeared very bright for the client. Regardless of the multitude of variables specific to the client, the professional and the incident, there is a typical pattern of reaction impacting the professional in five different areas of functioning. The "typical" reactions, those which are considered the "normal reaction of normal people to an abnormal event" include:

Physical Reactions

Insomnia
Loss of appetite
Nausea
Headaches, light headedness
Muscle weakness
Elevated vital signs

Cognitive Reactions

Distractibility
Declining work performance
Recurrent intrusive images
Flashbacks, nightmares
Disorientation
Distortion of facts

Affective Reactions

Feeling sad or depressed
Feeling anxious or overwhelmed
A constricted or blunted affect
Feelings of guilt, anger, shame, fear
Global pessimism
Emotional numbness

Behavioral Reactions

Clinging to others
Isolation and distancing
Hypervigilance
Elevated startle reflex
Increased substance use
Possible phobic behaviors

Spiritual/Existential Reactions

Questioning one's faith
Questioning the purpose of life
Questioning one's competence
Questioning one's career choice
Question's concerning afterlife

Critical Incident Stress Debriefing (CISD)

Debriefing procedures have a long history in the military and have been adapted to serve many purposes and populations. A well-known and widely used variation of this procedure is Critical Incident Stress Debriefing (CISD), one of several debriefing formats, developed by Jeffrey Mitchell in the 1970's at the University of Maryland Emergency Health Services Program.

The Mitchell model of debriefing was initially developed to assist police, fire and Emergency Medical Service (EMS) personnel as a group method to help workers process and defuse their emotional reactions. The overall goal of CISD is to mitigate the likelihood of the development of posttraumatic stress disorder (PTSD). Therefore, it is often considered a form of "psychological first aid" to be used with individuals confronted with threatening or traumatic events, such as the suicide or sudden and shocking death of a client

The debriefing session, while therapeutic, is not psychotherapy per se. It is done by way of an educational, preventative and supportive process typically facilitated by a combination of CISD-trained peers and/or mental health professionals, for those persons directly connected to the powerful event. CISD and other popular debriefing formats generally employ a phase or stage model. Although the labels for the various stages may differ slightly, all models usually include:

1. Introductory Phase: to provide general guidelines for the session.
2. Fact Phase: Also known as the “reconstruction phase”, used to establish the facts related to the incident.
3. Thought Phase: May be referred to as the Cognitive Phase, involves discussion of the thoughts associated with the situation.
4. Reaction Phase: Used to discuss the emotions related to event.
5. Symptom Phase: A review of the signs and symptoms of distress.
6. Teaching Phase: Also known as the “psycho-educational” Phase, this segment is used to “normalize” the stress reaction by educating the participants about the “typical” response to critical incidents, and providing useful coping strategies.

While the Mitchell CISD model moves predictably from phase to phase, facilitators can conduct the debriefing process in a more flexible manner. In a small to medium-sized group (3-8 persons, not including at least a pair of trained debriefers), the entire process may last between 45 minutes and 1 hour. Participants are encouraged to share their stories, as well as their reactions, in a supportive dialogue with other group members and the facilitators, with a shared focus on “ventilation” of the powerful experience and “validation” of their reactions.

CISDs are thought to be most effective at stabilizing the immediate reaction to the powerful event and reducing the potential onset of PTSD when conducted within 12-72 hours following the event. Individuals may participate in debriefings up to 14 weeks after a critical incident with some positive affect, but the optimal benefit of the debriefing seems to be gained by using the debriefing format within the first few days.

In most cases, even when exposure to the traumatic event has been very direct and intense, the traumatic stress reaction begins to subside within 6 weeks to 3 months after the event. Debriefing is not a form of treatment; it is a proactive intervention, and when traumatic stress symptoms persist at a distressing level for several weeks or more following the incident, it is strongly recommended that the professional seek assistance from other qualified mental health providers.

Other Strategies for Recovery

For the caregiving professional who is trying to manage the emotional effects of client's injury or death, the symptoms often cannot dissipate quickly enough. Often confidence is shaken, belief systems shattered and career choices re-examined in the wake of such a devastating occurrence.

While participation in a structured debriefing following a serious suicide attempt or completed suicide is strongly recommended, and has become standard operating procedure in many organizations, it is not the only avenue of reducing the traumatic reaction of the professional. In addition to availing oneself to a debriefing, the following suggestions are also helpful in managing the effects of traumatic exposure:

For Yourself

Stay connected with others
 Try to resume a normal schedule
 Try to maintain your sleep habits
 Try to eat a little, even if not hungry at meal times

Talk openly with others, especially supervisors or coworkers about your thoughts and feelings

Don't be ashamed to ask for help or seek assistance for prolonged reactions
 Let loved ones know what you have experienced and what may be helpful for you
 Avoid caffeine, watch alcohol use

For Your Loved Ones

Allow space and quiet
 Encourage meals
 Don't personalize reactions
 Don't moralize or minimize
 Offer a sympathetic ear
 Protect private time and space
 Reduce noise levels in home
 Expect interrupted sleep
 Show your concern, don't smother

Summary

No one can prepare the professional for the sudden shock of learning that a client has attempted or committed suicide. Textbooks and classroom instruction seldom address the fact that in some instances a professional can do everything correctly and still face a tragic outcome. The emotional toll on the professional engaged in suicide prevention can be devastating in the wake of a suicide, and while the typical reaction to such a powerful event may be somewhat predictable, it is never pleasant. CISD is a highly recommended and widely used method of stabilizing and reducing the impact of the trauma. The secondary trauma experienced by the professional in the aftermath is an unfortunate but real hazard to the wellness of the professional. It must be recognized and attended to by anyone who intends to remain active professionally with "high-risk" clients.

References

The following references acknowledge the responsibility for the care of the soldier and state the need for suicide prevention:

AR 165-1, Chaplain Activities in the United States Army, February 27, 1998.

AR 600-63, Army Health Promotion, December 17 1987.

DA PAM 600-24, Suicide Prevention and Psychological Autopsy, September 30, 1988.

DA PAM 600-70, Guide to the Prevention of Suicide and Self-Destruction Behavior, November 1, 1985.

Resources

The following organizations can provide additional information about Critical Incident Stress Management and self-care for the professional:

American Academy of Experts in Traumatic Stress

368 Veteran's Highway
Comack, NY 11725
(516) 543-2217
www.aaets.org

American Red Cross

11th Floor
1621 No. Kent St.
Arlington, VA 22209
(703) 248-4222
www.redcross.org

International Critical Incident Stress Foundation

10176 Baltimore National Pike
Unit 201
Ellicott City, MD 21042
(410) 750-9600
www.icisf.org

International Society for Traumatic Stress Studies

National Organization for Victim Assistance
1757 Park Road, N.W.
Washington, DC 20010
(202) 232-6682
<http://www.icisf.com/>

National Organization for Victim Assistance

1757 Park Road NW
Washington, DC 20010
(202) 232-6682
www.try-nova.org

National Center of PTSD

215 No. Main St.
White River Junction, VT 05009

(802) 296-5132

www.dartmouth.edu/dms/ptsd

United States Army Center for Health Promotion and Preventive Medicine (USACHPPM)

5158 Blackhawk Road

APG MD 21010-5403

(410) 436-4656

<http://chppm-www.apgea.army.mil/dhpw/default.htm>