How to Move from Awareness to Action
in Suicide Prevention
and Mental Health Promotion

GUIDEBOOK ON TRAINING PROGRAMS

23 Characteristics that Make Trainings Great

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Training is a process, not an event.

Many school, workplace, and community leaders realize that preventing suicide and promoting resilience and well-being starts with raising awareness. But that is only the beginning. Beyond education, new skills and strategies are necessary.

Ineffective trainings are usually those implemented in reaction to a negative event like suicide. These "off-the-shelf" sessions are often given by someone who is outside of the system in which it's being delivered, or simply by well-meaning people who try to devise a mental health/suicide prevention training from scratch, despite having no expertise in these areas. This reactive "one-and-done" approach rarely sticks or creates meaningful change among the participants.

Here are some tips to help you choose suicide and mental health wellness programs that will have the biggest impact for your investment of time and money.

Developing an Effective Training Strategy

1. Transition from postvention to prevention.

The motivation for prevention training almost always seems to come after tragedy already has struck. Communities reeling from a suicide have an acute reaction to DO SOMETHING. But rushing into prevention without acknowledging the crisis and providing initial grief support is ill-advised and may lead to intense survivor guilt and other unintended consequences.

Rather than jump into prevention, we need to start with postvention – a retroactive response to offer psychological first aid and prevent further tragedy.

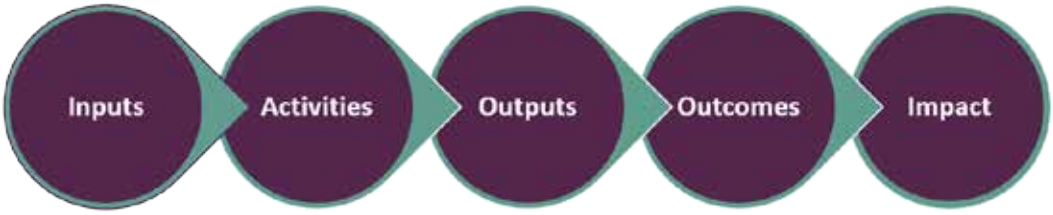
For more on what to do in the aftermath of a suicide in a school, workplace or community, consult these resources:

- A Manager's Guide to Suicide Postvention in the Workplace
- After a Suicide: A Toolkit for Schools
- Tool Kit for Survivors of Suicide Loss and Postvention Professionals

After the grief and trauma needs have been properly supported, training coordinators can begin the process of exploring prevention strategies.

2. Focus on a particular goal, and stay focused.

Identifying short- and longer-term goals of the training is essential for efficacious implementation. Whenever I am asked to consult, give the keynote address, or train a group, one of the first questions I ask is, "If I am wildly successful working with your organization, what will be different?" Based on the answer, we can talk about what their goals are and how to meet them. Typically, this requires setting several smaller goals that become the basis for a working logic model that bridges training to desired outcomes. This model then helps guide program development and evaluation methodology and helps keep the training focused on high-priority intentions.



The training goals should be regularly reviewed and recalibrated as the process unfolds. The most successful groups go beyond training and consider:

- "Are we achieving what we have hoped for?" and
- "Are there any unintended consequences we need to mitigate?"

3. Listen to community first.

Particularly around a crisis, many well-meaning people jump in to fix something before really knowing what the problems are. Before launching any major training initiative, assess where things working well and where gaps exist. By gathering information through several channels first, training is more likely to be relevant and accepted. This can take the form of

surveys, focus groups, in-depth interviews, and more. Through this process, champions (often "unusual suspects") of the training often emerge. Additionally, data captured during this baseline phase can be used as a benchmark to calibrate any change that occurred due to the intervention of the training. For example, you can ask people in a survey during this initial phase, how many know the number for the National Suicide Prevention Lifeline and then after implementing a training the highlights this resource, you can ask the question again as part of your training evaluation process. Having these pre- and post-test comparisons can go a long way in demonstrating cost effectiveness and justifying future resources of time and money.

4. Identify "grass-top"s and grassroots champions.

Trustworthy and credible endorsements from people within the community are essential to a training program's success, especially at the beginning. A few nay-sayers can kill the effectiveness before a training event gets going. During the listening phase, focus on finding people who can create excitement and hope. Some of these people will be valued peers, but at least one should be a recognized leader at the top level of the system.

Because mental health and suicide are such taboo topics, leadership can have a significant impact on shifting feelings and expectations by being "vocal, visible, and visionary" in support of the training.

> ***"Be vocal, be visible, be visionary. There is no shame in stepping forward, but there is great risk in holding back and just hoping for the best."*** *~ Higher Education Center*

5. Integrate with health and safety priorities.

"Accidents" and illnesses don't happen in a vacuum; they can be the result of distraction and behaviors driven by unchecked mental health conditions and overwhelming life circumstances. By embedding the training into your organization's overall wellness or safety initiatives, we can start to connect the dots.

In addition, when we integrate mental health and suicide prevention into these larger umbrella topics, we are more likely to see the training supported over a longer period of time.

6. Align with multi-pronged approach for change.

A stand-alone training that is not reinforced by other change strategy efforts will not be as robust as training that is accompanied by reinforcement. Examples of other supportive components might include:

- Leadership engagement
- Communication (internal and external)
- Community screening for mental health and suicide
- Policy review
- Participation in larger cause (e.g., volunteer opportunities with local mental health organization or group participation in a community walk)

7. Review evidence-base of training programs.

Many training programs for mental health and suicide prevention exist. Sometimes it can be overwhelming to figure out which model is best for your community. The Suicide Prevention Resource Center has created a database that highlights existing trainings and programs and their evidence of effectiveness. Mental Health First Aid also has demonstrated high efficacy.

NOTE: Organizations looking for a brief training on basic suicide prevention skills often start with what we call "Gatekeeper Training" – the idea is that lay people learn how to identify suicide warning signs and "open the gate" to help-seeking by connecting people in despair to support resources. Two great examples include the LivingWorks' training safeTALK and QPR: Question, Persuade, Refer

8. Select trainer deliberately.

A trainer's ability to engage the audience can have a significant impact on a trainee's satisfaction and overall learning. Beyond the appropriate credentials, consider if the trainer has disclosed lived experience with the topic – this brings in a very different lens of expertise. Finally, you may ask for recommendations from other recipients of the trainer's services on the following qualities of a great trainer (Human Capital Review):

- Creative, positive energy
- Good communication skills
- Enthusiasm for learning and teaching
- Good organizational and time management skills
- Ability to be flexible and work with others

9. Balance training fidelity with cultural responsiveness.

Here is the crux of effective training –carefully balancing the nuanced needs and strengths of a specific community with the standard protocol of evidence-based training. I believe this is not only possible, but our obligation to figure out.

When participants see their perspectives reflected back in training – through language, data, and stories – they feel validated. They feel like the training is by them, about them, and for them. This makes assimilating the experience much easier. However, this personalization cannot come at the expense of the evidence-based core tenets of trainings, or we are unlikely to get the same outcomes the research would predict when the fidelity to the basic model is held. Thus, training coordinators must work collaboratively with training developers to understand what – if anything – can be modified or supplemented to the standard delivery of the training.

10. Offer training beyond awareness and "stigma reduction."

Programs that focus only on reducing stigma by "raising awareness" are not going to be effective in the long-term. These programs might initially raise interest, but they don't stick due to the "State Trooper Effect" --when it's in front of you, you notice, but as soon as it's in the rear view mirror, you go back to regular behaviors.

Educating about stigma may even have the unintended consequence of increasing stigma. When we focus on the problem only, we magnify the problem. If people just hear "the stigma of mental illness" over and over again, that is what they remember. Patrick Corrigan, Editor-in-Chief of the American Psychological Association's new journal Stigma and Health, has demonstrated that what decreases stigma isn't education about stigma, it's regularly interacting with people who are living with the stigmatized condition. Read more here on a full review of stigma reduction effectiveness.

Finally, one more word about "stigma." The word implies that the problem lies within mental health conditions or the people living with them rather than the people who are perpetrating the prejudice, misinformation and discrimination. Something to think about...

11. Saturate delivery.

Everyone gets a dose of the training. Everyone. Leadership. Line staff. Managers. Custodial staff. Everyone. When leaders show up to a training, others see its importance. When everyone gets the same training, the community has a shared framework and language. Which leads to...

12. Prioritize brief, action-oriented, and self-reflective training agendas.

It's logistically complicated, if not impossible to implement multi-day trainings into most settings. When introducing suicide prevention and mental health promotion skills, I suggest brief, broad, action-oriented (not just knowledge transfer) and self-reflective programs. In other words, in 3 hours or less, can we train the masses to look inward toward personally held biases that may be getting in the way and then empower them to make steps to change? Prioritize trainings that cover these learning objectives in this time frame.

13. Include varying multi-sensorial learning methods.

Because different people take in information in a variety of ways, training should mix up learning styles to meet diverse participants' needs. Powerpoint slide decks and training workbooks should be supplemented with videos, storytelling, small group discussions, table-top exercises and other forms of engagement that get people up and moving and lighting up different parts of the brain to help them retain the information better.

14. Model and practice new skill sets.

Behavior Science in the 21st Century emphasizes that new behaviors are acquired through a 4-step process:

1) Instruct – describing the new skills and their rationale
2) Model – demonstrating what the new skill looks like
3) Practice – giving training participants a chance to rehearse the skills
4) Feedback – providing positive and constructive evaluation of the skill demonstration

The reason practice is so critical to include is because many participants resist it. Role playing conversations about mental health and suicide make people feel uncomfortable. People tend to want to avoid feeling uncomfortable or anxious, thus may want to skip over or minimize this practice part of training.

In prepping for the role play element of training, I usually say something like this, "I expect that the prospect of practicing these new skills right now is making a few of you feel uncomfortable and wanting to walk out of the room. I get it. This is hard, uncomfortable stuff. Here is the deal, what you do in the next 10 minutes or so will often make the difference between whether or not you engage in the behavior outside of this training. Whether or not you enact these skills, could save a life. I am asking you to sit for 10 minutes, with the cost of maybe feeling a little awkward and the benefit of increased confidence and memory for skills that could prevent the suicide or mental health crisis of your child, friend, partner, co-worker, etc. Do you think that's worth it? If so, I ask for your best effort."

15. Highlight lived expertise.

Stories of hope and recovery from dark times do more to shift culture than anything else I have seen. People with lived experience with suicide (loss, attempts, and suicidal thoughts) and mental health conditions have valuable perspectives and offer credible testimony that healing is happening. As much as possible, people with lived experience with suicide should be invited to help plan, implement, and evaluate the training. Personally relayed experiences of resilience embedded into the curriculum often bring the training to life in ways that statistics and skill instruction cannot.

When people with lived experience are part of the community in which the training is being delivered, the impact is even greater. Now, the perspective shifts from "us" and "them" to "we." For great examples of lived experience stories that can be used within trainings I recommend:

- Live through This
- Man Therapy Testimonial Videos

Logan

From ManTherapy.org

Disclosing personal experience with suicide and mental health conditions is not a small commitment and should be deliberated first and prepared for second. This topic warrants a whole separate article, so I urge you to review the following material:

- The Connect Program's "Telling Your Own Story"
- NAMI "In Our Own Voice"

16. Use safe and effective language.

Donna Hardaker, member of the National Action Alliance for Suicide Prevention's Workplace Task Force and I wrote a series of articles called "Words Make Worlds" talking about the power of language to shape cultural thinking around mental health and suicide:

- Language and cultural change
- Words about suicide
- Words about mental health

In addition, unsafe messaging practices may inadvertently romanticize or glamorize suicide, reinforce stereotypes or create a sense of hopelessness. More here on the framework of public messaging about suicide.

The language used for mental health and suicide training should model these best practices. For example, training that uses the phrase "commit suicide" would be seen as dated and stigmatizing, as that phrase emerged when suicide was conceptualized primarily as a sin or a crime (e.g., we "commit a sin").

17. Ensure your take-away materials reinforce the training message, and are practical and engaging.

Training materials matter. Ideally, they should be employed as an engagement tool during the presentation to reinforce key ideas. Additionally, they should offer prompts to recall the steps in the skills covered in training, and offer additional local and on-line resources. Professionally designed materials increase credibility with the audience and may make them easier to digest.

18. Bestow certificates of completion.

Because people appreciate the symbolism of a certificate signifying they have completed the work to build a new skill, many tend to display their certificate in a public place – such as on their office wall, a bulletin board, or door. The certificate then becomes a way this person (and organization) communicates caring about these issues, signaling this person may be safe to approach in case of any mental health crisis.

19. Recognize and reward trainees publicly.

Recognizing and rewarding trainees publicly gives positive reinforcement to the culture we are trying to shape. Some simple, inexpensive, but effective ways to do this are to:

- Mention certificate-earners in a community newsletter
- Post a picture of the training class on the website
- Ask trainees to give a summary of their experience in a staff meeting
- List training credentials in bios
- Acknowledge training completion as leadership development

20. Refresh and enhance skills over time.

Just like CPR, most mental health and suicide prevention trainings work best when offered repeatedly and over time through booster sessions. This review helps bring the content and skills to the front of the mind and builds confidence.

Consider offering more in-depth training to those who are advancing in their leadership within your system. For example, a suicide prevention organization aimed at construction workers in Australia offers three levels of training to its participants, all based in the LivingWorks models: General awareness training, Connectors, and Trained ASIST Trainers. Each time the construction workers advance, they get a different colored sticker for their hard hat. This becomes an outward-facing signal to their community and something of which they are proud.

21. Evaluate beyond participant satisfaction.

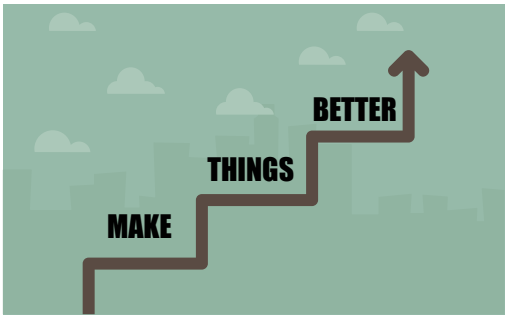
Ideally, a training program's effectiveness should be assessed by an external evaluator based on the logic model that was developed in the beginning of the process. If this is not possible, the next best thing is to evaluate the impact over time. Too often, trainers assess for program satisfaction (e.g., did you like the training, why or why not) but miss opportunities to measure real change and return on investment.

While this is not a guide on program evaluation, here are some resources for those who are interested in learning more.

- Program Performance and Evaluation (CDC)
- Basic Guide to Outcomes-Based Evaluation for Nonprofit Organizations with Very Limited Resources

In essence, when you are evaluating changes, you should search for existing validated tools that capture the constructs you are trying to measure. At the very least, your evaluation should identify any changes in attitudes, knowledge, and behavior that you would expect to result from the training. Qualitative feedback (e.g., what people say about the training) can also be instrumental in quality improvement over time, and can provide insights into how the training was implemented within the community.

22. Assimilate feedback for continuous quality improvement.



With this stage of training implementation, we begin again. Often new needs for training directions emerge as new skills or populations are identified.

23. Train new trainers from within the system.

Finally, systems that train their own people to be trainers are going to be more likely to have sustainable programs. Depending on outside resources to deliver consistent training over the years can be expensive and are less likely to understand the culture of the system.

In summary, in order for a cultural change to shift from awareness to action we must move beyond simply educating and train communities new skills. Many excellent training programs exist and can be adapted to a variety of settings and cultures. Embedding these best practices into an overall change management strategy while being mindful of additional suggestions offered in this article will help ensure the most optimal outcome.

About the Author

Sally Spencer-Thomas is a clinical psychologist, inspirational international speaker and an impact entrepreneur. Dr. Spencer-Thomas was moved to work in suicide prevention after her younger brother, a Denver entrepreneur, died of suicide after a difficult battle with bipolar condition. Known nationally and internationally as an innovator in social change, Spencer-Thomas has helped start up multiple large-scale, gap filling efforts in mental health including the award-winning campaign Man Therapy and the nation's first comprehensive workplace suicide prevention program. In 2016, she was an invited speaker at the White House.

Her goal is to elevate the conversation and make suicide prevention a health and safety priority in our schools, workplaces and communities. Spencer-Thomas has also held leadership positions for the National Action Alliance for Suicide Prevention, the International Association for Suicide Prevention, the American Association for Suicidology, and the National Suicide Prevention Lifeline. She has won multiple awards for her advocacy including the 2014 Survivor of the Year from the American Association of Suicidology, the 2014 Invisible Disabilities Association Impact Honors Award, and the 2012 Alumni Master Scholar from the University of Denver, the 2015 Farbarow Award from the International Association for Suicide Prevention and the 2016 Career Achievement Alumni Award from the University of Denver's Graduate School of Professional Psychology.

She has a Doctorate in Clinical Psychology from the University of Denver, Masters in Non-profit Management from Regis University, a Bachelors in Psychology and Studio Art with a Minor in Economics from Bowdoin College. She has written four books on mental health and violence prevention. She lives with her partner and three sons in Conifer, Colorado.

Connect with Dr. Spencer-Thomas by visiting her website: www.SallySpencerThomas.com and following her on Facebook @DrSallySpeaks, Twitter @sspencerthomas and LinkedIn. To learn more participate in her monthly podcasts, blogs and twitter chats!