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Immediate Impact of a Brief Suicide Prevention Training for Veteran Volunteers

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Abstract

Introduction. The concern that talking about suicide may intensify suicidal ideation is a common fear that has been dispelled by research, yet still lingers in popular consciousness. The aim of the current initiative was to develop a brief suicide prevention training for volunteers in a peer support program for veterans, given that layperson-facing approaches are critical to the U.S. national strategy for suicide prevention. *Method.* The study team adapted existing pedagogical approaches for use in a brief training and for a veteran population, and implemented the training with five new volunteer groups over 5 months ($N = 45$). *Results.* Anonymous pre- and posttraining questionnaires indicated immediate statistically significant improvements in self-reported preparation to talk openly about suicide, likelihood of asking about suicide, confidence in recognizing warning signs of suicide, and confidence in intervening and involving the National Suicide Hotline. *Discussion.* The project begins to demonstrate that self-reported suicide prevention knowledge and skills show immediate improvements after a brief training module nested within a broader new volunteer training. This work should support efforts to develop and implement research studies on brief suicide prevention training approaches in order to determine the extent to which they change behavior longitudinally and, ultimately, reduce rates of suicide.

Keywords

implementation, evaluation, volunteer experience, layperson

Few mental health topics cause more anxiety among clinicians and laypeople than suicide. The concern that talking about suicide may intensify suicidal ideation is a common fear that has been dispelled by research (Gould et al., 2005), yet still lingers in the popular consciousness and serves as a barrier to accessing care (Bajaj et al., 2008). As public health approaches are critical to the U.S. national strategy for suicide prevention (Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012), innovative pedagogy on suicide assessment and intervention is a critical need not just for clinicians but also for laypeople who interact with individuals at risk. In particular, there is a high need for training among laypeople who interact with military veterans and service members, as research has shown that after controlling for age and gender, being a veteran increases risk of death by suicide by 21% (U.S. Department of Veterans Affairs, 2016). In response to this need, the aims of the current project were to develop, implement, and evaluate a brief 1-hour suicide prevention pedagogical approach for layperson veterans who volunteer as peer supporters of other veterans.

In the past two decades, layperson-facing suicide prevention trainings have burgeoned, with approaches such as safeTALK (Tanney et al., 2006); Question, Persuade, Refer (QPR; Quinnett, 2007); and Skills Training On Risk Management (Appleby et al., 2000) showing some preliminary empirical support (Isaac et al., 2009) and widespread adoption (Kutcher et al., 2017). These trainings focus on basic skills in recognizing warning signs, asking questions, and referring people to clinical care, with a goal of preventing suicide through community-based intervention. Preliminary evidence suggests that existing layperson-facing suicide prevention trainings have increased knowledge, self-efficacy, and the ability to intervene with at-risk individuals (Clark et al., 2010; Cross et al., 2007; Hall & Gabor, 2004; Matthieu et al., 2006; Matthieu et al., 2008; Mishara et al., 2016; Morris et al., 1999; Skruibis et al., 2019; Stuart et al., 2003); however, the research literature has been critiqued for lack of rigor (Kutcher et al., 2017). Trainings have ranged

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from briefer 1- to 8-hour experiences (Clark et al., 2010; Cross et al., 2007; Matthieu et al., 2006; Morris et al., 1999) to intensive trainings occurring over multiple days (Stuart et al., 2003) or months (Skruibis et al., 2019). The lengthiness of many suicide trainings has been described as an important barrier to improving their adoption and spread (Ubido & Scott-Samuel, 2014). Nonclinical workers such as school employees (Clark et al., 2010; Stuart et al., 2003), helpline workers (Matthieu et al., 2006; Mishara et al., 2016; Skruibis et al., 2019), hospital staff (Cross et al., 2007; Matthieu et al., 2008; Morriss et al., 1999), and prison inmates (Hall & Gabor, 2004) have been trained using these approaches, but not veteran volunteers. In a review of gatekeeper suicide prevention literature conducted by Burnette et al. (2015), four gatekeeper trainings designed for military personnel were found. Two of the four trainings were part of the veterans' general military education (Bryan et al., 2009; Rozanov et al., 2002), whereas the other two consisted of longer trainings aimed at military mental health providers (Knox et al., 2003; Matthieu et al., 2008). No examples of volunteer-facing suicide prevention trainings that are brief, modular, and tailored to veterans were found.

There is therefore a need for brief suicide-related pedagogy for veterans that can be incorporated into broader training experiences that are unrelated to suicide—innovative training that would prepare nonclinicians to address suicidal ideation without taking much time away from skills more directly related to the organization's mission. As such, the current initiative aimed to develop and implement a tailored 1-hour suicide prevention module designed to improve knowledge and confidence related to suicide prevention among veteran volunteers who provide outreach and support to their peers that could be delivered over the course of the more general new volunteer orientation. Our objectives were to seek community guidance on training approaches, develop the training approach, deliver the training to new volunteer cohorts, and evaluate the training to assess changes in knowledge and skills, as well as satisfaction with training. Promising outcomes would support the concept that brief suicide prevention modules embedded in a more general orientation to a program are feasible, acceptable, and worthy of further study.

The suicide prevention training developed through the current project took place as a 1-hour module nested within a broader 2-day training for new volunteers with the University of Michigan Buddy-to-Buddy (B2B) Volunteer Veteran Program (see https://m-span.org/our-programs/buddy-to-buddy/) during 2019. The program's mission is to provide veterans and service members with outreach, peer support, and linkages to health and social services (Greden et al., 2010). The B2B program was developed in 2008 by Military Support Programs and Networks (MSPAN) at the University of Michigan Depression Center and Department of Psychiatry, in partnership with the Michigan Army National Guard, Michigan State University, the Ann Arbor Veterans Administration Medical Center, and other key stakeholders to address the unique challenges facing National Guard soldiers as they returned from combat deployments in Iraq and Afghanistan (Dalack et al., 2010). B2B volunteers use their own life experiences to help service members and veterans know that they are not alone; that asking for help is a sign of strength, not weakness; and that resources are available. While suicide prevention is not the program's explicit core mission, it has always been a priority to prepare volunteers for the possibility that someone they serve may express suicidal thoughts, as veterans are at significantly greater risk for suicide than their nonveteran counterparts (U.S. Department of Veterans Affairs, 2016). To ensure sustainability, after 11 years of program operations under University of Michigan auspices, at the end of 2019 the program was transferred to the Michigan Veterans' Affairs Agency (see https://www.michiganveterans.com/p/Buddy-to-Buddy-Volunteer-Mentorship-Program), the statewide veterans' affairs agency in Michigan.

Historically, B2B had attempted to provide their new and existing volunteers with a comprehensive day-long suicide prevention training. However, this approach was regarded by staff as unsustainable due to reports of volunteers expressing great anxiety related to the proportion of time spent on suicide content; it led to an incorrect impression and concern that suicide-related work would be the bulk of their volunteer duties. Program staff viewed this reaction as understandable: The volunteers were generously donating their time to serve other veterans, but they had never viewed suicide prevention as a key element of the work. Program data clearly indicated that encounters with suicidal veterans were infrequent, but staff wanted volunteers to be prepared for these situations should they arise. In the interest of volunteer satisfaction and retention, a new and more tailored approach to suicide pedagogy was needed.

Method

The project team consisted of the principal investigator (PI), the co-PI, the MSPAN director, the B2B program manager, a graduate student, and a research assistant. Community-engaged methodologies (Israel et al., 2012) were used to develop and evaluate the new training.

Training Development Process

First, the team adapted existing suicide prevention pedagogies to specific program needs using relevant phases

of the "ADAPT-ITT" approach (Wingood & DiClemente, 2008), especially in soliciting the feedback of the new priority population during the adaptation process. The investigators reviewed available literature and distilled longer layperson-facing suicide prevention trainings into three main elements: (1) recognizing risk factors, (2) asking direct questions, and (3) linking those at risk to resources or services.

Second, the PI and the program manager met with senior members of the existing volunteer corps to better understand volunteer needs and priorities. During a routinely scheduled meeting between the program manager and the senior volunteer corps members, the PI used a semistructured interview guide to lead a group discussion focused on the volunteers' beliefs and feelings about their role in suicide prevention and depression support. The volunteers' feedback indicated that the volunteer corps was indeed very aware of and concerned about veteran suicide but that they lacked confidence in their ability to intervene.

Third, the investigators reviewed the program's existing protocols and suicide-related decision trees. While the purpose of the project was to develop a pedagogical approach for volunteers and not to develop new protocols for the program, incremental changes were made to these protocols in the interest of streamlining the decision tree that veterans would use in the event of suicidal ideation.

Fourth, the PI and the program manager met with the Veterans' Research Engagement Council, a standing group of veteran stakeholders who provide consultation to make research more responsive to veterans' needs. A rough outline of the training plan and pedagogical approach were shared, and feedback was requested. This meeting resulted in a renewed focus on practical skills aimed at reducing volunteers' anxiety: For example, the Council suggested that training time be reserved for volunteers to add the National Suicide Hotline to their mobile phone contact list, and for a demonstration on how to make a three-way call to the hotline. The Council also emphasized the need to teach the volunteers strategies for supporting individuals with depression. They suggested using examples of scripts or conversation starters (e.g., "That must have been a pretty painful experience for you" or "I may not really understand what you're going through, but I am here to support and listen to you") for those volunteers who do not see themselves as skilled enough to come up with ideas themselves.

Fifth, the training plan was developed in accordance with the community feedback discussed above. The PI delivered the training to five new volunteer groups over the course of 5 months, consisting of a total of 45 trained volunteers.

Training Content

The resultant training was 1-hour long and covered the following topics: identifying warning signs for suicide; conversation techniques, including examples of scripted statements that can show empathy and validation; the importance of asking directly about suicide; the importance of disregarding confidentiality when someone's life is at risk; a decision tree for whether to involve emergency services; how to involve the National Suicide Hotline or clinical services when needed; and a practice session on how to make a three-way call on a smartphone. Content on how to support individuals with depression was also included. The general pedagogical approach was to destigmatize the topic of suicide so as to facilitate discussion and to emphasize the principle that talking about suicide does not make it more likely to happen. The anxiety that many people feel about suicide was discussed, while threading the needle between acknowledging the relatively high rates of suicide among veterans and the low base rate of completed suicides within all populations. New volunteers were provided with programmatic data indicating that suicidal ideation is a very rare event for any B2B volunteer to face, but that preparation is nevertheless necessary because it gives the opportunity to save someone's life if it does arise. Volunteers were also provided with resources for supporting individuals living with depression using the University of Michigan Depression Center Toolkit (see https://www.depressioncenter.org/depression-toolkit), an online public-facing website containing information and resources on depression.

Module Evaluation

The training was implemented with five new volunteer groups over 5 months, consisting of a total of 45 trained volunteers. Of the volunteers who were trained, 40 chose to participate in the program evaluation. To evaluate the program, volunteers were given brief, anonymous pre- and posttraining questionnaires to assess immediate reactions through domains such as reactions, learning, behavior, and results (Kirkpatrick & Kirkpatrick, 2006). These questionnaires were an element of a broader B2B program evaluation that was reviewed by the University of Michigan institutional review board and deemed to be program evaluation activities not regulated as human subjects research. The anonymous questionnaires included questions about extent of prior preparation to address suicide, perceived likelihood of asking someone directly and openly about suicide, and extent of confidence along the following four domains: talking directly and openly about suicide, recognizing suicide risk, intervening when risk is recognized, and involving

the National Suicide Hotline. The posttraining questionnaires also included questions about satisfaction with training. The questions about preparedness and likelihood of talking about suicide used a 4-point scale (e.g., not prepared, partly prepared, mostly prepared, very prepared), and the four questions about confidence used a 3-point scale (not at all confident, somewhat confident, confident). Demographic information was not requested on the questionnaires because this information would be potentially identifying, given that each training group consisted of only 3- to 10 individuals.

Surveys were analyzed by calculating the percentage change in scores. The *t*-based confidence intervals and test used two independent groups with heterogeneous variance estimates. While the groups are not independent, the independence-based version was viewed as conservative in the sense of wider but still valid confidence intervals. The percentage change numbers were obtained from the same *t*-based summaries but on the log scale and then transformed to a percentage change using the transformation $100*(\exp(x) - 1)$, where "x" is the difference in means or an endpoint for the confidence interval on the log scale.

Results

Of the 45 trained volunteers, 39 chose to complete pretraining questionnaires and 40 chose to complete posttraining questionnaires. All volunteers were veterans. The majority of volunteers (67%) had prior suicide training and prior experiences having conversations about suicide (Table 1). Statistically significant differences were found between six questions that were repeated in the pre- and posttraining surveys (Table 2): extent of prior preparation to address suicide, perceived likelihood of asking someone directly and openly about suicide, and extent of confidence along the following four domains: talking directly and openly about suicide, recognizing suicide risk, intervening when risk is recognized, and involving the National Suicide Hotline. The largest percentage change (44.2%) was noted on the item asking about confidence in recognizing warning signs of suicide. The participants' self-reported likelihood of asking about suicide significantly increased (Figure 1).

Table 1. Veteran's Prior Suicide Training and Experience.

Quantity	*n*	%
Prior suicide training		
None	13	33
1–3 hours	7	18
1–2 days	3	8
Longer course	15	38
Prior conversation about suicide		
None	9	23
Once	2	5
Two to five times	16	41
More than six times	12	31

Discussion and Lessons Learned

Conceiving of suicide prevention pedagogy as a module that fits within a broader training experience—such as initial training for individuals working for a social service organization—may help improve access to such pedagogy.

The current project begins to demonstrate that self-reported knowledge and skills related to suicide prevention show immediate improvements after a brief training module nested within a broader new volunteer training. The layperson volunteers who participated in the module reported significantly better preparation to talk openly about suicide, likelihood of asking about suicide, and confidence along domains of recognizing warning signs, talking openly, intervening, and involving key resources in suicide prevention.

The current project's results were similar to those of initiatives such as QPR and Samaritans of New York's Public Education Suicide Awareness and Prevention Training Program (see Matthieu et al., 2006; Matthieu et al., 2008) in that nonclinicians' suicide-related knowledge, confidence, and skills to intervene improved after a quite brief training. The current training was also tailored and homegrown through a community participatory approach to fit within a small organization's onboarding process for veteran laypeople seeking to volunteer. Layperson-facing interventions such as safeTALK and QPR are standardized programs that have shown promising research outcomes. Yet not all existing practices suit

Table 2. Percent Change in Veteran's Responses Pre- and Posttraining.

	n		% change	
Item	Pre	Post	% change [95% CI]	*p*
Preparation to talk openly about suicide	40	39	+35.8 [14.2, 61.5]	.00081
Likelihood of asking about suicide	40	39	+28.7 [13.0, 46.7]	.00029
Confidence in recognizing warning signs of suicide	40	38	+44.2 [27.0, 63.8]	.00000
Confidence in talking openly about suicide	40	38	+28.8 [11.0, 49.6]	.00125
Confidence in intervening	40	38	+30.9 [11.5, 53.7]	.00139
Confidence in involving National Suicide Hotline	40	38	+28.3 [15.1, 43.0]	.00003

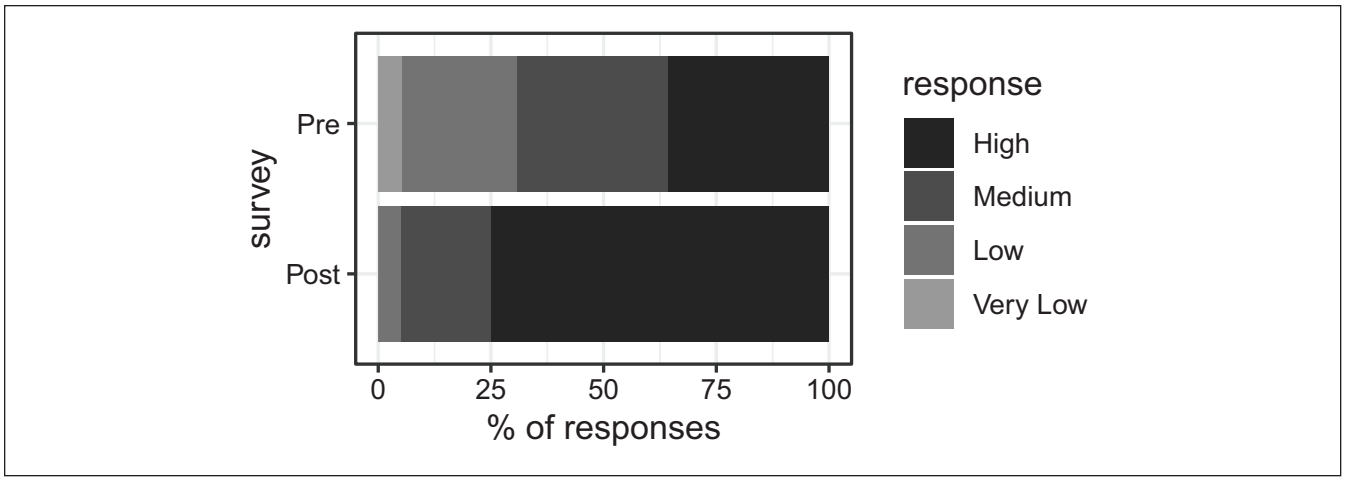

Figure 1. Veterans' self-reported likelihood of asking about suicide pre- and posttraining.

the needs of all organizations due to factors such as cost, length, and trainer credentialing requirements (Ubido & Scott-Samuel, 2014). A thoughtful process of synthesizing current practices and adapting them to local needs through community input can also result in successful programming. A key lesson learned was the extent to which community consultation with the Veterans Research Council better prepared the project team to create a training approach consistent with the local community's needs and priorities. Without their consultation, the clinicians making up the project team would perhaps have overestimated the extent of volunteers' comfort level with starting conversations about depression and suicide, and the extent to which technical practice of the suicide protocol was needed.

While an abbreviated training such as that of the current project will lack information and rehearsal opportunities contained within a more comprehensive approach, this concern should be weighed alongside considerations such as acceptability, feasibility, and access, all of which point to a need for briefer modular trainings to complement longer existing offerings. The results of the current initiative should not be interpreted to suggest that longer, more comprehensive training opportunities should be replaced by briefer ones. Nor does it assume that outcomes from a longer training would be equal. Rather, it indicates that there is a range of pedagogical approaches that could help improve suicide-related knowledge and skills for laypeople—some comprehensive and standardized, and some brief and tailored to the local environment. Given higher base rates of suicide among veterans (U.S. Department of Veterans Affairs, 2016), culturally tailored trainings designed for laypeople who interact with them—including social service providers, benefits counselors, and even those working in Veterans of Foreign Wars posts—could help improve outcomes, consistent with the U.S. National Strategy of layperson-facing approaches (Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). The current project findings also may support efforts to fund and implement new research studies on brief suicide prevention training approaches in order to determine the extent to which they change behavior longitudinally and, ultimately, reduce rates of suicide.

This work should also be considered in the context of its limitations. The project team only measured the training's immediate impact on knowledge and attitudes, not behavior change; the extent to which the training affected behavior over time remains unknown.

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