ASIST

APPLIED SUICIDE INTERVENTION SKILLS TRAINING

EVIDENCE IN SUPPORT OF THE ASIST 11 PROGRAM

Contents

Introduction

The Applied Suicide Intervention Skills Training program (ASIST) is a two-day workshop that provides participants with the skills necessary to connect, understand and assist persons who may be at risk for suicide. Distributed by LivingWorks Education Inc., over one million persons in twenty-two countries have been ASIST trained since its initial development in Calgary, Alberta, Canada in the early 1980s.

This report provides evidence in support of the rationale, content, teaching and learning processes of ASIST training, particularly as it applies to the newest edition, ASIST 11. This report does not address outcomes of the ASIST training; a review of evidence in support of ASIST outcomes, including satisfaction, knowledge, attitudes and behaviors was recently completed (Rodgers, 2010) and is available online at *www.livingworks.net*.

This paper is organized into the following main sections:

- Evidence in Support of the Need for ASIST Training
- Description of ASIST Training
- Evidence in Support of Critical Principles of ASIST Training
- Evidence in Support of the ASIST's Pathway for Assisting Life Model
- Evidence in Support of ASIST Training Methods

Unless otherwise specified, throughout this paper the term ASIST refers to the latest version of the training (ASIST 11). The ASIST model, Pathway for Assisting Life, is abbreviated PAL (this replaces the old Suicide Intervention Model or SIM that was used with prior versions of ASIST). The term caregivers is used for those learning or trained in ASIST.

There has been and continues to be much discussion about terms used to describe suicide and suicide-related thoughts and behaviors (Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007). Terms such as self-directed violence and self-harm are increasingly used to denote suicide-related behaviors (Crosby, Ortega, & Melanson, 2011). While we recognize that these designations are critical for accurate communication and tracking of suicide and suicide-related behaviors, throughout this paper we use the more common terms of suicide and suicide attempt.

Evidence in Support of the Need for ASIST Training

Suicide is a complex problem that results in over one million worldwide deaths each year and is projected to result in 1.5 million deaths by the year 2020 (Bertolote & Fleischmann, 2002; World Health Organization [WHO], 2009). For every person who dies by suicide, there are dozens or hundreds of persons that attempt suicide. It is estimated there are 200 suicide attempts for every suicide death among adolescents, but as few as four attempts for every suicide death among seniors (Berman, Jobes, & Silverman, 2006; Goldsmith, Pellmar, Kleinman, & Bunney, 2002).

A recent household survey conducted in the United States estimated that 8.3 million adults had serious thoughts about suicide in the past year, that 2.3 million had made a suicide plan, and that 1.1 million had attempted suicide (Substance Abuse and Mental Health Services Administration Office of Applied Studies, 2009). A random survey of Australian adults conducted by the World Health Organization found that 4.2% of respondents had attempted suicide at least once during their lifetime (De Leo, Cerin, Spathonis, & Burgis, 2005). Beyond deaths and injuries, suicide can have a devastating effect upon survivors—friends, family and loved ones of those who've died, as well as entire communities (Jamison, 1999).

In 1854, London physician John Snow removed the handle from the Broad Street water pump. With the removal of the handle, the distribution of cholera that had killed hundreds was put to an end. Unfortunately, there are no solutions as simple as removing a pump handle to prevent suicide. It is more complicated than that for several reasons:

- Those who are at risk for suicide are often hesitant to seek help. This may be due to fear, stigma, loss of face, shame, self-loathing or the perception that there are no caregivers who are willing and able to help them (Corrigan, 2004; Everall, Bostik, & Paulson, 2006; Pisani et al., 2012). And, unfortunately, those

who are at the greatest risk for suicide are the least likely to seek help (Yakunina, Rogers, Waehler, & Werth, 2010).

- Suicide is a complex behavior that has many contributing factors that vary across individuals, families, communities, cultures and societies (Fortune, Stewart, Yadav, & Hawton, 2007; Leach, 2006). What looks like suicide risk for one person may not be for another and what contributes to suicide risk for one person may be different for another (Sveticic & De Leo, 2012). As a result, identifying those who are at risk for suicide can be difficult and finding solutions to the problem of suicide vary amongst those who are at risk.
- A focus of many suicide prevention efforts is the identification, intervention and direct clinical referral of those at risk (Isaac et al., 2009). However, while direct referral may be the answer for some, poor access to qualified treatment, poor adherence to treatment and imperfect treatment effectiveness combine to make referral to assessment and treatment a sometimes problematic solution to those at risk for suicide, particularly for those who require a timely, immediate response (Frieden, 2010; Knesper, American Association of Suicidology, & Suicide Prevention Resource Center, 2010).

These barriers can limit the effectiveness of suicide prevention and intervention efforts. However, ASIST addresses these barriers in a variety of ways that effectively increases the immediate safety of individuals at risk for suicide and ultimately serves to prevent suicide:

1. ASIST develops attitudes that facilitate help-seeking and help-giving by training caregivers to be more open to the wide variety of possible invitations and to cultivate attitudes that convey they are nonjudgmental and are ready, willing and able to help.
2. ASIST focuses on the achievable goal of increasing safety now. Suicide is complex, but ASIST focuses not on the complexity of suicide and its causes, but on the simple concept and achievable goal of safety for now and how safety can be increased by collaboratively addressing the needs of the person-at-risk. Unlike many other programs, ASIST focuses on a personalized approach to safety.
3. Part of ASIST's personalized approach is a focus on hearing a person's story. As unique personal stories about suicide are heard, life connections also emerge, find their voice and invite support in turning toward safety.
4. ASIST provides a clear pathway toward safety, guided by a coherent safety framework. Turning toward safety requires clarity about how safety for now can be increased. ASIST's safety framework helps prioritize, plan for and confirm actions that achieve this goal. These plans and actions sometimes require and always consider referrals but typically feature a wide range of pathways to safety. ASIST provides caregivers and persons-at-risk with a richer array of options for assisting life than traditional models limited to the linear sequence of identify, intervene, and refer.

Description of ASIST Training

Applied Suicide Intervention Skills Training (ASIST) is a two-day suicide intervention workshop that had its origins from within the gatekeeper tradition. It was developed in Calgary, Alberta, Canada, in 1983 by four multidisciplinary human service professionals. Originally referred to as "Foundation Training" or "Suicide Intervention Training," development of ASIST was supported by provincial and state governments of Alberta and California. ASIST is disseminated and supported by LivingWorks Education Inc., which is based in Calgary.

Gatekeeper training is one of the more popular types of suicide prevention programs. It has been used widely in schools, military, business, health and community settings with both professionals and laypersons (Cross, Matthieu, Cerel, & Knox, 2007; Jacobson, Osteen, Sharpe, & Pastoor, 2012; Keller et al., 2009). Gatekeeper models are generally linear, teaching a three-step process of identification, intervention, and direct referral of those who may be at risk for suicide (Isaac et al., 2009).

ASIST training differs significantly from most gatekeeper training programs. In his seminal article on gatekeeper training, Snyder (1971) stated that, "The key to a full understanding of the gatekeeper philosophy is that it is against formal referral as a standard operating procedure" (p. 40). Instead of the linear—identify, intervene, refer—model used by most gatekeeper training programs, Snyder saw the gatekeeper philosophy as an "approach to crisis management that seeks to identify the well-trodden paths in the community which troubled people use in seeking help" (p. 39). ASIST has its basis in Snyder's philosophy, but significantly expands beyond Snyder's philosophy by teaching a suicide intervention model that envisions a wide range of pathways to safety and stresses the importance of developing SafePlans that persons-at-risk can fully commit to using. ASIST offers an approach that might be better thought of as assistance in helping persons-at-risk find their pathway through suicide to safety. In essence, ASIST helps persons at risk to identify their own "gateway."

Additional aspects of ASIST include the following:

- ASIST was developed using the Rothman Research and Development framework (Rothman, 1980). The Rothman framework posits four stages of intervention development and dissemination, which form a continuing process of program improvement. Using Rothman's framework and based upon feedback from participants, trainers, evaluation reports, and research studies, the ASIST program was revised in 2003, 2008, and 2013. The Rothman framework has also allowed for adaption of the ASIST program to meet local needs, customizing certain aspects of dissemination and implementation to best fit those needs, while holding constant those components that make ASIST effective.
- ASIST is disseminated through a network of trainers who have completed a five-day Training-4-Trainer (T4T) course. After completion of the course, trainers are considered "provisional" until they have conducted three ASIST trainings. With additional experience, Q&A feedback, and in some cases supplemental training, trainers can become Master Trainers, Consulting Trainers, Training Coaches, or Team Leaders. ASIST trainers are provided with continuing support and feedback to help them maintain skills and improve practice.
- ASIST training has been used in a variety of settings with trainees from diverse backgrounds and countries, including secondary and post-secondary schools, mental health centers, military bases, hospitals, social service and public safety agencies and numerous other public and private settings. Those trained in ASIST include social workers, psychologists, psychiatrists, medical students, teachers, public safety officers, military personnel, faith leaders, administrators, crisis line workers, and many others (Rodgers, 2010). Over one million caregivers have been trained in ASIST. ASIST trainings have been conducted in over twenty countries and ASIST training and materials are available in five languages.

The comprehensive reach and utilization of ASIST warrants discussion of the evidence upon which it is based. ASIST has always been developed using evidence-based processes and it is timely that the new edition of ASIST be accompanied by a paper outlining what these empirical and conceptual foundations are. Accordingly, this paper will provide the rationale and empirical support for (1) Overarching principles of ASIST training, (2) the Pathway for Assisting Life (PAL) intervention model, and (3) ASIST training methods.

Evidence in Support of Critical Principles of ASIST Training

While ASIST has its roots in the gatekeeper tradition, it is significantly different than standard gatekeeper trainings in several important ways. Included in those differences are are several critical principles, related to safety, risk and safety assessments, attitudes, collaboration, and guidance, found throughout ASIST training.

Safety is the First Priority

The first priority of all ASIST caregivers is safety: safety for the caregiver, safety for the person-at-risk, safety for others. The ASIST Safety Framework (addressed later in this paper) provides a series of safety levels and corresponding issues to be addressed that are dependent upon the specific safety needs of the person-at-risk. Corresponding actions to address these safety needs begin with emergency response (when required) and constant monitoring for a person-at-risk with an immediate safety concern to situationally appropriate responses when immediate safety is not such a concern.

Beyond Risk Assessment

Suicide risk assessment is the systematic and formal estimation of someone's suicide risk and is used in many gatekeeper programs (Stuart, Waalen, & Haelstromm, 2003; Wingate, Joiner, Walker, Rudd, & Jobes, 2004). Risk assessments usually involve asking about suicide thoughts, planning and preparation, past suicide attempts, family history of suicide and mental illness, current mental illness, psychological states and stressors. Sometimes the person-at-risk is asked about protective or buffering factors—those things that might moderate risk (Joiner et al., 2007; McKeon, 2009).

However, suicide risk assessments are not without problems. They can be unreliable, complex, and challenging (Mulder, 2011; Shea, 2002). They can be focused more on the treatment and management of those at risk for suicide than on immediate safety (Simon, 2009) and can rely on a degree of subjective clinical judgment rather than direct quantification of risk (Granello, 2010). This is not to say that suicide risk assessments are without value. Their use is critical to the management and treatment of suicide risk when used in clinical settings with appropriately trained professionals (Fowler, 2012).

Toward Life-Assisting Safety Assessments

ASIST, however, takes a different approach. Instead of conducting a risk assessment with its associated problems, ASIST conducts a safety assessment. This safety assessment focuses on those things that will keep a person-at-risk safe for now (using the ASIST Safety Framework) rather than the things that put a person at risk (using a suicide risk assessment).

This difference is not as great as it may seem—it is basically a shift in perspective and strategy. It views the intervention from the standpoint of the outcome (safety) and orients the whole intervention—the Pathway for Assisting Life—toward this goal. Understanding safety is related to understanding risk. Any accurate view of either should be related to the other. Even a casual glance at risk assessment tools and the items on ASIST's Safety Framework (later in this paper) will reveal that they were derived from the same literature. ASIST's Safety Framework provides a collaborative and caring vehicle to weave risk assessment into the ongoing collaborative relationship.

Attitudes Affect Helping

To be helpful, caregivers need to be aware of their attitudes and the impact their attitudes can have upon caregiving. Attitudes are judgments about persons, places, or things that influence our feelings, thoughts and behaviors. Everyone has a unique set of attitudes which reflect, among other things, experiences with and beliefs about suicide in regards to helping a person-at-risk, attitudes can help or hinder the caregiving process. Professional caregivers are not immune to attitudes that may form barriers to helping those at risk of suicide. When a person-at-risk perceives a less-helpful attitude on the part of a potential caregiver, it reduces the likelihood that the person-at-risk will seek help from that caregiver (Angermeyer, Matschinger, & Riedel-Heller, 1999).

A study of college students training to be caregivers found that "students who believed that a young person was responsible for their self-harm, reported higher feelings of anger towards them. Anger in turn was associated with…less willingness to help" (Law, Rostill-Brookes, & Goodman, 2008, p. 115). In addition to anger, attitudes of caregivers towards those who are at risk for suicide may include avoidance, rejection, hostility, anxiety, and fear resulting in lower quality and ineffective care (Sethi & Uppal, 2006). The origins of these attitudes, however, may be due to "lack of knowledge and uncertainty rather than hostility" (Berlim, Perizzolo, Lejderman, Fleck, & Joiner, 2007, p. 234). Unfortunately, negative attitudes can be consciously or unconsciously transmitted to those at risk, decreasing the likelihood of an effective intervention (Everall, et al., 2006).

Individual attitudes and how they may influence a caregiver's ability to help a person-at-risk are emphasized through film and small group exercises. The purpose of this is threefold:

1. Caregivers will have increased ability to identify attitudes that may help or hinder their ability to provide care to a person-at-risk,
2. Caregivers will have more favorable attitudes towards suicide prevention and intervention with a person-at-risk, and
3. Caregivers will have greater understanding, given their unique attitudes, of the potential range and limits of their ability to help a person-at-risk.

Not unsurprisingly, ASIST training has been found to increase caregivers' helpful attitudes towards those at risk for suicide, towards the effectiveness of interventions with those at risk for suicide, and towards the prevention of suicide generally (Rodgers, 2010). This has the overall effect of increasing their willingness to intervene with a person-at-risk (Turley, 2009).

Collaboration is Key

ASIST interventions rely on collaboration between the caregiver and person-at-risk. This is critical because the safety needs of persons-at-risk vary considerably (Fortune et al., 2007; Pompili, 2010). Therefore, the most effective suicide interventions are those that respond to the unique needs of a person-at-risk (Cutcliffe, Joyce, & Cummins, 2004). These unique needs are discoverable through the process of collaborative problem-solving. This process includes asking about the problem, identifying available resources, suggesting solutions and a plan of action and has a demonstrated relationship with positive intervention outcomes (Mishara et al., 2007). Collaboration is aided through the application of guidance.

Guidance is Needed

Guidance is the ability of a caregiver to monitor the intervention process to help ensure that the caregiver is providing the person-at-risk with what is needed to move towards safety. Guidance is offered in ways that respect and engage the person-at-risk to the extent possible. Those at risk for suicide may have difficulty communicating their story which would require greater caregiver guidance (Levi et al., 2008). In addition, the ability to monitor improves the quality, effectiveness, and safety of any intervention (Gawande, 2009). The importance of guidance is reiterated throughout ASIST training. Through practice, caregivers are taught to constantly assess their ability to meet the needs of persons-at-risk along with the nature and extent of their helping role.

Evidence in Support of ASIST's Pathway for Assisting Life Model

Pathway for Assisting Life or PAL is the tripartite intervention model that is the heart of ASIST training. PAL incorporates three phases, each with two objectives:

I. **Connecting with Suicide**

Objective 1: Explore Invitations

Objective 2: Ask about Suicide

II. **Understanding Choices**

Objective 3: Hear Their Story

Objective 4: Support Turning to Safety

III. **Assisting Life**

Objective 5: Develop a SafePlan

Objective 6: Confirm Actions.

Evidence in support of each of these objectives of each of these phases is provided.

Connecting with Suicide

Connecting with Suicide is the first phase of the ASIST model. In this phase, caregivers learn to identify and explore invitations and ask about suicide. Critical is the examination of how attitudes impact the helping process—how attitudes convey willingness and ability to help those who are at risk for suicide. Objectives of this phase are Explore Invitations and Ask About Suicide. This phase ends when the person-at-risk and caregiver agree that suicide is their focus.

Explore Invitations

Invitations are words, feelings, physical clues or actions that should raise concern about the possibility of suicide. They can be verbal or non-verbal, direct or indirect communications (Wasserman, 2001). Shneidman (1985) summarized invitations thusly: "Individuals intent on committing suicide…consciously or unconsciously emit signals of distress, indications of helplessness, pleas for response, and opportunities for rescue in the usually dyadic interplay that is an integral part of the suicidal drama" (p. 144). Once possible invitations are recognized, they should lead to exploration by caregivers and if warranted asking directly about suicide.

Understanding possible invitations and being open to exploring them is important because many of those who are at risk for suicide do not directly declare their intent. Perhaps only one-third to one-half of suicide victims explicitly state their intent to family members or health care professionals (Isometsä, 2001). The reasons for not seeking direct help for suicide are many and complex. Many of those who are at risk fear stigma associated with suicide including being seen as weak or of "losing face," they may be hopeless, feeling that nothing can be done to help them or they may feel a deep sense of shame (Everall et al., 2006; Moskos, Olson, Halbern, & Gray, 2007; Owen et al., 2012).

ASIST trains caregivers to explore invitations through a variety of experiential activities that explore possible invitations and allow participants to practice how they might respond. In addition, caregivers are trained to set aside assumptions about who may be at risk for suicide (usually based on membership in a "higher-risk" group) and to instead focus on unique invitations provided by individuals. This is critical because such assumptions may contribute to missing invitations when those invitations do not come from someone assumed to be at higher risk. And, as we know, suicide is not limited to those in higher-risk groups (Fortune et al., 2007).

Ask About Suicide

Ask About Suicide refers to the direct, calm, non-judgmental act of asking someone if he or she is considering suicide. Ask About Suicide seems simple, but it is not. Cultural norms, bias, fear and discomfort, among other considerations, can make it difficult for professionals and lay-persons alike to ask directly about suicide (Angermeyer et al., 1999).

A study of crisis line workers found that most did not even ask callers about suicide, despite the fact that asking about suicide was an integral part of their job (Mishara et al., 2007). One reason for this is an unfounded fear that asking about suicide may increase suicide risk (Mathias et al., 2012). However, studies have found that asking about suicide does not increase suicide risk (Cukrowicz, Smith, & Poindexter, 2010; Deeley & Love, 2010). Asking about suicide is a critical first step in helping those at risk for suicide.

Because Asking About Suicide is critical but difficult, simply telling caregivers to ask about suicide without rehearsing asking is unlikely to be effective. Instead, asking about suicide needs to be thoroughly practiced (Cross et al., 2011). The ASIST training employs trainer modeling, simulations, role-plays and guided practice to improve caregiver abilities in this critical skill.

Understanding Choices

Once the person-at-risk and caregiver agree that suicide is their focus, the logical next step is to further understand what suicide is about for them along with choices they face. Accordingly, this second phase of the model is about Understanding Choices. Its objectives are Hear Their Story and Support Turning. It ends when the person-at-risk and caregiver agree that the life connections in the turning point have been acknowledged and accepted, and a decision has been made to work towards safety.

Hear Their Story

Hear Their Story is simply that, taking the time and showing interest in hearing a person-at-risk's story about suicide. The purpose of hearing his or her story is to gain a sufficient understanding of why the person-at-risk is considering suicide, to acknowledge their pain and turmoil, and to listen for life connections that will allow the caregiver to tailor an intervention response that appropriately responds to the person-at-risk's unique safety needs. Not hearing their story has several risks, including jumping to conclusions, alienation and prescription of ineffective solutions. Taking the time to Hear Their Story allows the person-at-risk the "right and ability to define one's own experiences" and conveys respect and appreciation of the person-at-risk (Kogstad, Ekeland, & Hummelvoll, 2011, p. 485).

Hearing their story leads to the identification of specific life-connecting aspects of that person's story. Quite often, these life connections are unrecognized or not fully appreciated or coherently expressed by a person-at-risk. Taking the time and showing respect for a person-at-risk's story, as practiced in ASIST training, provides an opportunity for the person-at-risk to recognize his or her life connections and to turn towards life. And most importantly for the ASIST model, Hear Their Story provides an opportunity for the person-at-risk to work through the uncertainty and turmoil that accompanies suicidal thinking (Harris, McLean, Sheffield, & Jobes, 2010). This working through leads to a turning point—an initial, mostly emotion-based, move away from suicide.

Support Turning to Safety

Support Turning refers to the support given to move a person-at-risk towards safety by helping to define and build on the life connections found in their turning point. Turning points have been defined as special moments or experiences that lead to a distinct turning or change, and have been described as "A special meeting/special words, which, in a way, opened the person's eyes so it was possible to see that life was worth living" (Kogstad et al., 2011, p. 481) and as "transformative moments", from a state of weakness to a state of empowerment (Mancini, 2007, p. 238). Turning points have also been described by those at risk as a midway point between a state of "living to die" and "a process of recovery that included small steps or phases toward life" (Bergmans, Langley, Links, & Lavery, 2009, p. 120).

Turning points, and the resulting connection with life, are unique for each person. Life connections can include family and friends, sense of responsibility, religious beliefs, things they enjoy doing, plans they have made and the like (Horesh, Levi, & Apter, 2012). Persons-at-risk for suicide, particularly those at higher risk, may have difficulty communicating their story and identifying turning points (Levi et al., 2008), and therefore require caregiver help. A person-at-risk must be ready and willing to work on moving towards safety, but this can only be when the person-at-risk is ready to work on moving towards safety.

Assisting Life

Once a person-at-risk and caregiver agree that the life connections in the turning point have been acknowledged and accepted, a move towards safety makes sense as an immediate priority. The Assisting Life phase enables the person-at-risk and caregiver to plan how this can be done and confirm what actions are needed to achieve it. The Assisting Life phase has two objectives: Develop a SafePlan and Confirm Actions, and ends after actions are confirmed.

Develop a SafePlan

Develop a SafePlan is the process of working through the ASIST Safety Framework to ensure immediate safety of the person-at-risk and once immediate safety is assured, to work on short-term safety. SafePlans are conceptualized as a list of responses a person-at-risk can take to alleviate or address factors that contribute to elevated suicide risk. LivingWorks was a pioneer of the use of SafePlans which were a key feature of ASIST X released in 2003. Now, plans to address safety are increasingly being used in the management and treatment of those at risk for suicide (Jobes, 2006; Joiner et al., 2007; Stanley & Brown, 2012).

Traditionally, gatekeeper training programs have been based on a direct referral model, wherein persons-at-risk for suicide are directly referred to mental health service providers (Isaac et al., 2009). However, the referral portion of this model is problematic for several reasons. Appropriate help may not be available, referral may not be acceptable to or may not be what is needed by the person-at-risk, or the source of help may not be effective (Frieden, 2010). Providing options to the person-at-risk that address his or her unique needs and available internal and social resources is ultimately more safe and effective (unless the person-at-risk is, through incapacitation, unable to participate in

the development of a SafePlan or the person-at-risk is a danger to themselves or others, in which case the ASIST SafePlan calls for an immediate emergency response).

The ASIST Safety Framework prioritizes and addresses immediate danger while determining whether a proactive (high guidance) helping stance (now and in immediate future) is indicated due to compromised capacity of the person-at-risk to keep safe now. If the person-at-risk is at risk of doing harm to themselves, presents potential harm to others or if the person-at-risk is unable or unwilling to participate in the intervention an emergency response is required. Once immediate safety is assured Safety Guards are examined.

- **Safety Guards.** Safety Guards seek to contain immediate vulnerabilities threatening safety (such as having a suicide plan, or obtaining a means of suicide) and/or recognize, access and apply potentially life-assisting lessons learned from prior experience with suicide or mental health issues. Once Safety Guards are addressed, Safety Aids are examined.
- **Safety Aids.** Safety Aids seek to identify and enhance circumstantial, social and personal factors (sometimes referred to as protective factors) that aid safety, defuse suicidal intensity and fortify coping with threats to safety featured in the suicide story.

Confirm Actions

Confirm Actions is that process whereby a person-at-risk and a caregiver agree upon specific actions to be taken to ensure the person-at-risk's safety. SafePlans are collaboratively developed between the person-at-risk and the caregiver and represent a shared understanding of what will help the person-at-risk keep safe for now. Important in such collaborations is clarity and agreement upon actions to be taken: the what, who, and when of the SafePlan.

Evidence in Support of ASIST Training Methods

ASIST training incorporates a variety of experiential learning methods. Experiential learning exists when a participant "cognitively, affectively, and behaviorally processes knowledge, skills and/or attitudes in a learning situation characterized by a high level of active involvement" (Hoover and Whitehead, 1975, p. 25). The importance of experiential learning was recognized as far back as 400 BC, when Sophocles stated that, "One must learn by doing the thing, for though you think you know it—you have no certainty until you try" (Gentry, 1990). Key aspects of experiential learning found in ASIST training include:

- **Participation:** Learners are active participants in the training.
- **Interaction:** Learners interact with trainers and other learners.
- **Whole-person emphasis:** Training involves cognitive, behavioral and affective domains.
- **Structured and monitored:** Training is structured, purposeful and monitored to ensure fidelity.
- **Feedback:** Trainers provide ongoing feedback to learners.

Experiential learning methods respect learners as active participants in the training process, as opposed to lecture formats that treat learners as passive recipients of information. Experiential learning has been shown to increase the effectiveness of training (Prince, 2004). In a review of training programs for medical professionals, the most effective training strategies used practice, feedback and small group discussions. These are all aspects of the ASIST training (Berkhof, van Rijssen, Schellart, Anema, & van der Beek, 2011). Indeed, more than half of ASIST training time is spent in small group activities, which is more effective than working in large groups (Berkhof et al., 2011). Small group work has been shown to increase group cohesiveness which in turn increases group member comfort, participation, acceptance of others, and receptiveness to learning (Yalom, 2005). Additional time is devoted to practice, which has been shown to improve gatekeeper training (Cross et al., 2011). Less than one-fifth of ASIST training is devoted to direct instruction or lecture.

Adult Learning Principles

ASIST training is also based upon the adult learning principles developed by Malcolm Knowles (Knowles, Holton & Swanson 2005). Knowles recognized that adult learning (which he referred to as andragogy) was critically different than standard classroom learning (referred to as pedagogy) and helped popularize adult education as a distinct field. Knowles saw pedagogical learning as dependent upon the teacher, based upon a standardized curriculum of differing relevance to the learning, inconsiderate of the learner's experience and outcomes oriented towards knowledge gain. Knowles saw andragogical strategy as self-directed and based upon real-life needs, with experience providing a rich resource for learning and outcomes oriented towards the development of competence (Knowles, 1980). ASIST training recognizes the unique needs of adult learners by respecting and incorporating life experiences into training, particularly practice, addressing the real-life needs of trainees and focusing on the development of skills through practice and feedback.

Socratic Questioning

Socratic questioning is the process of engaging learners in patient, sequential questioning in order to bring them to a conclusion without having to tell them what that conclusion is (Carey & Mullan, 2004). Socratic questioning is concise, clear, open-ended, purposeful and constructive. It is designed to invite reflection, participation, and the exploration of ideas among participants (Neenan, 2009). As it is used in ASIST trainings, Socratic questioning is designed to facilitate guided discovery—the type of questioning and responding between individuals and within groups that leads to the discovery of valuable truths. Socratic questioning is the opposite of the more common, but less effective direct instruction wherein instructors lecture to participants whose role is to be passive recipients of knowledge. While direct instruction can effectively convey knowledge, it does not promote thought, change attitudes or develop behavioral skills (Bligh, 2000). ASIST trainers are practiced in the Socratic questioning skills and use this technique throughout training.

Practice

Practice is the systematic repetition of skills for the purpose of learning and improving performance. The ASIST training incorporates a variety of practice-based methods that allow caregivers to rehearse intervention skills and receive immediate performance feedback. ASIST training incorporates two primary types of practice: behavior modeling (having trainers and audio-visual demonstrations model appropriate intervention behaviors which are then rehearsed by caregivers) and role-playing (having trainees act out simulated roles). Role-playing progresses from trainees interacting with a "role-playing" instructor (sometimes referred to as simulation), to role-playing in front of groups, to role-playing one-on-one between trainees. All role-plays are supervised. Within practice activities, ASIST training incorporates trainer coaching and other methods of feedback that has demonstrated increased training effectiveness (Hysong, Galarza, & Holland, 2007). An added benefit of having caregivers role-play a person-at-risk for suicide is the fostering of increased empathy on the part of caregivers for those who are at risk (Bosse et al., 2012). Much of ASIST training, whether in large groups, small groups, or 1-on-1, involves practice.

Summary

ASIST is an evidence-based suicide intervention training program developed from within the gatekeeper tradition which builds on its often forgotten core principles and has progressively added new dimensions to caregivers' understanding and practice of how they can help persons at risk of suicide. The latest edition of ASIST (A11) invites caregivers to engage persons at risk in a personalized, collaborative helping process described as a life-assisting pathway that discovers practical ways of increasing their safety for now.

ASIST's rationale, found in the Pathway for Assisting Life (PAL) model, is based upon a collaborative model of person-at-risk and caregiver working together to move towards safety. Unlike other gatekeeper training programs, PAL does not require direct referral to a mental health professional, but rather seeks to find the best solution to meet the unique needs of the person-at-risk, which always considers but does not require referral. Essential steps along this pathway include exploring invitations, asking directly about suicide, hearing a person-at-risk's story, supporting turning towards safety, developing a SafePlan and confirming actions. And instead of focusing on the assessment of suicide risk, ASIST focuses on the assessment of safety and ensuring the immediate and short-term safety of the person-at-risk. Overall, ASIST provides a personalized, life-assisting, first-aid intervention that reinforces help-seeking by those at risk for suicide.

ASIST also incorporates evidence-based training methods that recognize learners as active participants in the training process. ASIST training is experiential with high levels of participation and interaction amongst participants. Participation and interaction is promoted through the use of socratic questioning and structured practice with feedback. Evaluations of ASIST have consistently demonstrated gains in the knowledge, attitudes and skills of participants.

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