The Certified QPR+ Pathfinder Training Program

Need, Concept, Framework, & Curriculum for a Global Approach to the Prevention and Mitigation of Suicidal Ideation and Deaths by Suicide

Summary treatment: a parable
Through the Bramble

Pathfinder: one that discovers a way; especially one that explores untraversed regions to mark out a new route. *Merriam-Webster*

People experiencing suicidal ideation often feel trapped with no exit; as if lost in a dense, dark, blackberry bramble with little light by which to see a clear path forward. Roots and vines tangle their every step. Stumbling in the growing dark, sharp thorns tear their flesh. They trip and fall on bleeding hands. Disoriented in a rising panic and seared by unendurable mental pain, fear rushes in. All light and hope fade toward black.

In this hour of terror, what do people wishing to die need?

A trustworthy guide. Someone who knows the bramble and knows the way through. Someone who can listen deeply to their fears. Someone who is unafraid to sit with them and hold their pain until it begins to ebb. A compassionate pilot who can shepherd them safely out of the nightmare.

Leading the way, the pathfinder carries a torch and wears thick leather chaps to turn away the thorns. The chaps were earned by training, by mastery of expert

knowledge and skills, and by the experience of having conquered the bramble before, sometimes alone, sometimes while helping others to rediscover their own strength.

In the middle of a life-threatening crisis, people thinking about suicide need someone who knows the territory ahead and how to keep them safe. They need someone who is fearless in the bramble, someone who knows how to dodge the thorns, and can help them help themselves. Someone who can steady their foot upon a good trail and lead them not just away from the thoughts of self-directed violence, but into a well-lighted place to begin a new life, one full and rich and meaningful.

Once safely out the bramble, the pathfinder's job is done. The two may stay in touch and remain friends, but the pathfinder's mission is to always return to the bramble, lace on the chaps, and wait there to listen for the cries of others who may be lost.

Abstract

According to the Substance Abuse and Mental Health Services Administration more than 12 million adults seriously considered suicide in 2019, compared to approximately 48,000 who died by suicide. Seriously thinking about suicide is a kind of misery index, a painful mental torment that negatively impacts all aspects of life. Extrapolating from the US ratio to the 800,000+ deaths by suicide the World Health Organization estimates would mean that around the world each year perhaps 200 million adults suffer from sufficient psychological pain, suffering, and hopelessness that they give death by suicide serious consideration. Since present or projected mental health manpower will never be sufficient to offer even one hour of a relief-producing counseling session to these millions of people in pain (and not counting many more millions of youth), this paper proposes a scalable, affordable, and accessible partial solution for community-based suicide intervention and prevention.

Introduction

According to the Three-Step Theory (3ST) of suicide, suicidal suffering and thoughts of ending one's life develop due to a combination of 1) pain and hopelessness, 2) loss of connection to others, 3) a progression from the idea of suicide to making a suicide attempt (Klonsky & May, 2015). This progression from idea to act is one familiar to anyone who has experienced suicidal ideation and has been referred by some (including the author) as "the journey to suicide." Along this psychological path from idea to act, suicidal sufferers often emit suicide warning signs that they are experiencing unbearable mental torment and may be planning to engage in suicidal self-directed violence to stop what has become unendurable psychic pain.

To detect these suicidal sufferers in our midst, suicide prevention gatekeepers have been trained by various organizations to recognize and respond positively to those emitting detectable suicide warning signs. Community gatekeepers are people in a strategic or personal position to observe others (National Strategy for Suicide Prevention, 2012), and, after training in how to recognize suicide warning signs, are taught to lean into the other person's pain, ask clarifying questions, and help them to talk about their pain and suffering. Most commonly, gatekeepers are taught to make referrals to a mental health professional for assessment and care.

This referral action can only be successful so long as competent and accessible mental health professionals are available to accept the person as a "new patient" in a timely manner. For reasons described below, this "system of care" is often nonexistent in some communities and/or acknowledged to be broken, inadequate, and sometimes harmful. Morethan half of the people with mental illness do not receive help for their problems because of stigma (public, self, or institutional), and fear of losing their jobs (American Psychiatric Association, 2021). This stigma is doubled for suicidal people who may be suffering from a mental illness, thus making even an available referral nearly impossible.

As regards the core causes of suicidal despair – psychic pain, hopelessness, and loss of connectedness to others – nothing in the current Western medical model of care has been shown to offer a superior benefit to an informed, compassionate, human-to-human response to known suffering, e.g., active listening, understanding, and collaborative efforts to reduce psychic pain, restore hope, and reestablish caring human connectivity over time. Despite decades of research into suicide prevention and how to provide safe and effective care for patients at risk of suicide, suicide

rates in the U.S. have only risen, not declined (Centers for Disease Control, 2020). Of note, a two percent decrease in adult suicide deaths has been reported from the years 2018 to 2019, however, five to ten-year trend lines are needed to determine actual declines in rates.

In review, those evidence-based interventions that have emerged from the last 30 years of research in the field are precisely those values, attitudes, and skills ordinary compassionate human beings use with each other to ease each other's suffering on this journey through life. When Abraham Lincoln was actively suicidal, there were no mental health services, but his friends took all the now evidence-based measures to keep him safe from himself: offered empathy, support, understanding, connectivity, a safe environment, and reduced his access to means (Shenk, 2005). It is true that evidence-based interventions for the specific care of suicidal persons are emerging, but to date few providers have adopted these recommended practices, leaving millions upon millions of at-risk adults and children who might benefit from such care unable to access or benefit from such best practices (Action Alliance, 2020).

Could citizen gatekeepers do more than recognize and refer?

For the 200 million adults suffering from suicidal ideation each year, but who are unlikely to go on to die by suicide, community gatekeepers are key in identifying their distress and offering some sort of comfort. The question is, "How much support do they offer?" "How much empathy?" "How much active listening?" Research to answer the basic question, "How much relief from psychological pain associated with suicidal thinking does a gatekeeper intervention bring?" has neither been asked nor answered. Like a headache resolved with two aspirins and nap – and not a trip to the emergency room or a neurologist – is a compassionate recognition of someone's pain and a lengthy active listening session enough to avert a trip to the expensive medical alternatives? The answer; we do not know.

But we do know that there are beneficial emotional impacts for the gatekeeper, including expressions of gratitude from those being helped. Dore and colleagues found that when we help others regulate their emotions to reduce distress, this action helps the helper by reducing depression and increasing the use of reappraisals in the helper's daily life (Dore, et al., 2017). In a word, the gatekeeper's well-being is enhanced through efforts to help others. We may not have numbers to justify how well we are helping others choose to live, but by at least trying to do so

it improves our own mental well-being and decreases our own risk of suicide. As St. Francis of Assisi said: *For it is in the giving that we receive*.

In the QPR model, gatekeepers are trained to prepare to "give" of themselves for at least an hour to someone they have confirmed is considering suicide – which rationale is the source for the original tagline, "Would you give an hour to save a life?" The QPR booklet that trainees receive includes a brief tutorial on expectations for how the gatekeeper should behave in this hour. The "medicine" includes instructions on the need to regulate your own emotions (shock, fear, anger, etc.), avoid passing judgement, and how to give the gift of active listening. An hour in a quiet place with an empathetic human being whose sole focus is on you and your troubles is a rare commodity for anyone in severe psychological pain. This hour expectation was set precisely because it mirrors a first appointment with a therapist.

Research has shown that some 70% of mental health patients get whatever benefit they perceive as enough help in one or two sessions of therapy – by simply dropping out of treatment (Olfson et. al., 2009). Therapists may think more treatment is needed, but the patients have already voted with their feet. Solution-focused, single session therapy showed significant improvements in psychopathology and respondents reported 95% satisfaction with the service after one visit (Perkins, 2008; Ewen et. al., 2018; Hymmen et. al., 2013).

A single hour of private conversation with what we trust is a good listener is no doubt valuable, but how valuable? To date we know very little about what happens in this hour, or what may turn into several hours. But we can speculate that empathic listening alone is somehow quite helpful to suicidal sufferers and produces an improvement in psychological well-being for many people. After all, non-judgmental active listening is the source code for all psychotherapies.

In short, whatever gatekeepers do in their community or culture, they typically provide the following: attention, compassion, empathy, active listening, and understanding, as well as someone with whom the person can establish an emotionally supportive relationship and connection. In short, and in the context of the Three-Step Theory, the gatekeeper intervention is likely to 1) reduce psychological pain and hopelessness, 2) establish or re-establish connectivity to

another human, thus reducing risk, and 3) slow or divert the journey to a suicide attempt while enhancing resiliency.

Never enough mental health professionals

Given the scope of the global mental health a suicide problem, we argue that formal mental health services for those identified as experiencing suicidal ideation will never be an adequate or even desirable solution to reducing the suffering of millions upon millions of people. Many argue the current mental health system is broken and likely beyond repair, with long waiting lists, lack of choice, and inaccessiblity by reason of cost and even the acceptability of the services offered. What is needed is a revolution, not an evolution of the current systems which attempt to help suicidal people. As an example, consider the success of the revolution in mental health care undertaken in the United Kingdom with the employment of low intensity Cognitive Behavioral Therapy (CBT) interventions provided by lessor qualified therapists who fill a vital role in delivering much-needed evidence-based therapy to vast numbers of people at lower cost (Bennett-Levey et. al., 2010).

Similarly, we believe that gatekeepers can be trained to become a kind of "super gatekeeper" capable of providing much more psychological first aid and benefit to people with suicidal ideation than is currently expected from a 90-minute gatekeeper training program targeting only recognition and referral skills. By building on their existing capacity for human warmth and understanding, these super gatekeepers can be trained to apply existing evidence-based interventions to immediately mitigate suicide risk as "pathfinders" leading the way out of psychological pain and suffering. As with the low intensity cognitive behavioral therapy (LICBT), super gatekeepers, or pathfinders, can be taught to use the same step-up model when more care is needed, e.g., referral to a higher qualified mental health professional for assessment and care, or even hospitalization.

Three historical problems

First, if millions are at risk, millions more must be trained in how to recognize and respond to a person who may be experiencing suicidal ideation. These "case finders" are currently trained in warning sign recognition and in how to offer initial emotional support and empathy, and to refer the person on for professional care. As noted, however, professional care simply does not exist in large swaths of our

communities and is stigmatized and unacceptable, inaccessible, unaffordable, and unavailable.

Second, to provide a more robust training to enhance and broaden these super gatekeeper's knowledge and skills, peer support training programs have emerged and been shown to be effective. Most of these programs are delivered in classrooms last between 40 hours to several weeks and lead to a certification. To scale the pathfinder training effort, and to prepare them to be a form of non-law enforcement suicide first responder for their community, the training must be sufficiently dosed and spaced over time to ensure a high level of readiness to respond. Only web-based e-learning technologies can help solve this problem at an affordable cost (described later).

Third, in communities where limited or no mental health resources are readily available, pathfinders must be trained, enabled, and empowered to initiate several evidence-based safe and effective risk mitigation interventions, inclusive of those in current practice by clinical providers, e.g., means reduction, safety planning and caring letters or follow up. Most importantly, they must be skilled in negotiating the mental health system when additional services are needed.

It is worthwhile to note that the COVID-19 pandemic will likely lead to universal approval for telehealth therapy, including adequate pay for therapists, thus reducing one barrier to professional care. This option does not reduce the need for pathfinders to do more at the community level to mitigate risk.

Finally, for suicide prevention, training must be acceptable to the community in need. The pathfinder role and training materials should be tailored to the specific needs of the audiences to be trained, reflecting their norms, values, morals, language, and existing social networks that provide support and services. Where referrals are available, non-traditional help providers must be included in the referral network, and all those receiving referrals (professional and non-professional) should be trained in basic counseling and suicide risk mitigation skills. Since many suicide warning sides are culturally coded communications, adjustments in the gatekeeper curricula must reflect these racial, ethic, or tribal realities.

Suicide ideation as a worthy target for intervention

The WHO estimates global deaths by suicide at approximately 800,000 per year. While this number is important to public health professionals and everyone interested in preventing suicide, the actual burden of significant psychological and pain and suffering is at least 250 times this number, or roughly 200 million adults per year. Not counting youth, whose suicidal ideation rates are higher, this figure is a misery index for millions of people each year. Suicide ideation is a justifiable target for intervention for these reasons:

- Persistent, recurrent thoughts of suicide is a special kind of torment of the mind, a measure of morbidity of thought and feeling like no other (Franklin, 2017).
- The number-one risk factor for future episodes of suicidal ideation is a past episode of suicidal thinking (Franklin, 2017). In other words, one experience of seriously considering ending one's life may lead to future thoughts of wishing to die, planning how to do it, and episodes of debilitating psychic suffering.
- Suicidal thinking was found to be the third most potent predictor of eventual death by suicide (Franklin, 2017).
- Suicidal ideation is a common reason for hospitalization (Bowers, 2005), and is universally recognized as a clear and present danger sign of worsening mental health.

The definition of suicidal ideation used by the U.S. Centers for Disease and Control is, "Thoughts of engaging in suicide-related behavior." This definition includes passive ideations, e.g., wishing to be dead, to making explicit plans to die, e.g., selecting a means by which to end one's life. Any intervention that can successfully detect observable signs of this internal pain and suffering has the potential to open a dialogue in which the person thinking about suicide in silence is – with the help of another human being – able to speak openly about what they are going through and find relief in a compassionate and understanding relationship with another human being – thus reducing the risk that they will act on their desire to be dead. Done on a massive public health scale, there is reason to believe we can, collectively, reduce this human misery index and, into the bargain, prevent the behavioral events of suicide attempts and deaths.

To grasp the scope, and by comparison, consider that 12 million Americans suffering each year from suicidal ideation represents every man, woman and child

in Belgium, Bolivia, Cuba, Portugal, Honduras, Hungary, Austria, Israel, and more than all the citizens in more than 135 smaller countries. In each of these countries we can expect similar levels of suicidal ideation. The pain is real. The suffering is real. The risk of suicidal ideation to health and safety are real. To quote two noted experts in the field, David Jobes and Tom Joiner, "Suicidal torment is universally dominated by millions upon millions of people with suicidal ideation." (Jobes & Joiner, 2019.)

In the second year of the COVID-19 pandemic, we have two sources of data on suicidal ideation. The Mental Health Technology Transfer Center (funded by SAMHSA) reported in August 2021, that one impact from COVID-19 was report that 11% of Americans seriously considered suicide. More, Mental Health America collected data from over 2.6 million users visiting Mental Health America screening in 2020. This is a large dataset available from a help-seeking population experiencing mental health conditions. Some 725,949 individuals took a depression screen (PHQ-9) in the United States in 2020. Of these 38% or 273,680 people reported experiencing thoughts of suicide or self-harm more than half or nearly every day of the previous two weeks. While distribution of suicide ideation rates varied by states and counties, the important thing to remember is this self-report data is only from people who sought help for themselves and that there are many times this number of people who struggle silently before turning to the internet or a healthcare provider for help (Mental Health America, 2021). To quote the authors of this report, "The suicide data presented throughout this report represents the minimum imminent risk in any community." Now, extrapolate this risk information to the rest of the world.

What to do? With what help?

As noted, there is a critical shortage of mental health professionals to detect, assess, and intervene with people experiencing suicidal ideation and urges almost everywhere in the world. A simple question: if 200 million people could benefit from some professional help, how will we ever meet that need? The short answer: we won't. As some have said, we cannot treat our way out of this problem. But we might build on what we have in place already – and especially peer support professionals - to expand the roles and responsibilities of those already working in the general space of helping others.

Preventing suicide is a multisector task within the public health mission and includes responsibilities for those working in primary care medicine. While this paper cannot explore the role of existing healthcare providers and their capacity for detecting suicidal ideation in their patients as a part of routine practice, calls for suicide screening in primary care are frequent and ongoing. While some people experiencing suicidal ideation and urges will be detected with improved routine suicide screening in primary care settings, millions will not.

As one response to people considering suicide, more than five million ordinary citizens have been trained as gatekeepers (QPR Institute, 2020). Thus far, this response is promising but inadequate. Of those 800,000 people who die each year from suicide, the WHO reports only about 15% of them receive any sort counseling or treatment (WHO, 2020). The rest die without the possible benefit of a single counseling session.

As asked earlier in this paper, could we train a large cadre of suicide prevention specialists to address this problem not as psychotherapists –but as knowledgeable, competent, and confident first responders to those considering suicide? Could we, with an online, scalable, task transfer training program, train tens of thousands of citizens to be QPR+ pathfinders to fill that role of providing a single – one to two hour long – structured, best practice guided active listening session? A deep listening session? A trauma-informed, "Tell me what happened to you?" listening session. Call it what you will, can we find a low-cost way to give people thinking about suicide some private time with a knowledgeable compassionate trained listener? Someone who knows how to talk comfortably about suicide, knows the terms, knows their meaning, and knows how to use these words as healing instruments?

Once trained these active listener pathfinders could fill any of the following roles after suicidal ideation has been identified: emotional support, advocacy, navigators of the "system", encouraging the use of self-help tools, providing direction and piloting those in need to additional safe and effective resources, e.g., manualized CBT therapy self-paced therapy, smart phone mindfulness and mediation apps, and web-based alternative approaches to reducing suicidal behavior through positive psychology and engagement.

Despite repeated calls for explicit suicide prevention training, existing mental health and healthcare professionals are often poorly trained, or not trained at all in how to talk comfortably to people contemplating suicide (Schmitz et al., 2012). This means that even those people experiencing suicidal ideation and urges identified by growing numbers of citizen gatekeepers are frequently referred to professionals who have insufficient training, and sometimes do not even know the language of suicide, and thus cannot speak with confidence with those suffering from acute and painful suicidal ideation.

Finally, in the wake of the COVID-19 pandemic, predictions for increased suicidal behaviors have been forecast by some experts. It may be too soon to know what effects the pandemic may have on deaths by suicide, but self-reports on increased suicidal ideation are up. Given the current lack of readiness of the healthcare system to respond competently to the projected rising tide of mental health and suicide prevention needs, a quickly scalable solution is needed.

The current environment

While training in evidence-based strategies for preventing suicide are emerging in many countries, most of these strategies are being taught in traditional classroom settings by a small cadre of suicide prevention experts who have chosen to specialize in this area of clinical practice or public health education. The membership of American Association of Suicidology constitutes a global collection of researchers, advocates, trainers, loss survivors, those with lived experience and clinicians, yet the total membership is fewer than 1,500 persons and, of these, only a small fraction are training health care professionals in how to prevent suicide.

While people have examined suicidal behavior for several hundred years, there is no profession whose practitioners can legally call themselves “suicidologists.” The road to a new profession dedicated to preventing suicide remains very much an aspirational goal (Berman et. al., 2021).

Worse, it is well established now that large numbers of suicidal patients die while in active care or within a few hours, days, weeks or months of care with a health care professional due, in some part, to provider ignorance and discomfort in even raising the subject of suicide with their patients (Vannoy & Robbins, 2011). These missed opportunities represent a huge window of opportunity for addressing this gap in education and training to improve known-at-risk patient safety.

Moreover, access to emergency room care for people experiencing suicidal ideation and urges is expensive, inaccessible, and when available, it is often inadequate and harmful. Training ER staff and others in the healthcare system to provide helpful interventions to suicidal patients using traditional classroom approaches is expensive, impractical, and usually low on the list of medical educational priorities. Also, treatment of a suicidal person in an emergency room is evidence of a public health failure. The person was most likely experiencing suicidal ideation – the unique precursor and symptom of a pending crisis – which symptom was identifiable by the person or others, and which recognition and early response could have averted an expensive trip to the hospital.

Finally, the committee of public health professionals within the American Association of Suicidology only formed in 2019. What goals and objectives emerge from this group, education and training in suicide prevention will surely be a priority. This outline of projected work is, at best for now, more aspirational than reality.

The bottom line: While we need a much-expanded suicide prevention global workforce, none such exists today.

Emerging public health legislation in the US

To address the public health problem of suicide some 11 states in the US now mandate suicide prevention training for licensed healthcare professionals, thus creating even greater demand for competent expert trainers, as well as a rising public expectation that competent and expert care is available.

Many of these states are requiring the training of lay and professional "gatekeepers" to maintain licensure, e.g., schoolteachers, school health professionals, and others. As more and more gatekeepers are being trained and more new cases are identified and referred to inadequately prepared healthcare professionals there is a need to catch up to meet demand (APA, 2020).

The greater problem remains; mental health professionals are in very short supply or simply do not exist in many rural and tribal communities where suicide rates are highest, even though many expect additional federal funds to flow to care for the mental health problems caused, and exacerbated by, the COVID-19 pandemic.

The treatment competency crisis

Safe and effective suicide prevention strategies that are unaffordable and unavailable are of no value to people experiencing suicidal ideation and urges who might benefit from them. Even if identified by community gatekeepers to be in need of treatment, and if no competent treatment exists, suicidal patients and their families must just hope for the best that the clinician they encounter (if they can access one) is qualified and competent. To date, only psychiatrists are required by residency accreditation standards to learn something about suicide risk assessment, treatment, and management, and most psychiatric residency training directors report what they teach is insufficient (Schmidt et al., 2012).

On the upside, the Zero Suicide initiative is being adopted by health care systems are undertaking systemic changes in creating safer treatment pathways for known-at-risk patients (Zero Suicide, 2020). This movement holds great promise but can do little to address the training deficit in the private sector or in under-serviced areas of the country or world. As an institution-based initiative, Zero Suicide is unlikely to be able to respond in a timely fashion to the millions of people at risk of suicide at the community level; and no system of care, however excellent, can hope to help those suffering from suicidal ideation who never seek help for a variety of reasons.

The workforce labor shortage

As a nation we in the U.S. already know of the shortages in behavioral health professionals available, and of those available, almost none specializes in the care of patients experiencing suicidal ideation and urges. In one collaboration between multiple national suicide prevention organizations, two years of effort led to the recruitment of only 750 clinicians willing to attest to, a) being willing to see known at-risk suicidal patients, and, b) having competencies in the assessment and care of suicidal outpatients (citation, personal communication). These brave few were willing to post their credentials and contact information to a searchable database for citizens searching online for a competent therapist to help them with their suicidal thoughts and desires.

In the meantime, in 2019 alone, the QPR Institute trained roughly 500,000 gatekeepers to recognize and refer people experiencing suicidal ideation and urges to providers. Other organizations trained thousands more gatekeepers. Busy hotlines referred even more thousands to professional services. In a word, case-

finding capacity is growing while competent referral resources remain limited or stagnant. While greater demand for competent care is rising, barriers remain that block the pipeline of qualified providers.

One bottom line. The odds that an adult experiencing suicidal ideation and urges will find a competent, well-trained, accessible, and affordable clinician – even via telehealth – is challenging . Thus, it is not just the training deficit that represents additional risk, but the absolute absence of even inadequately trained providers. No surprise, suicide rates in rural areas are often double urban rates, and Native American youth suffer from the highest suicide rate in the nation (AAS, 2020). The resource deficit in rural America is to be found in most developing countries worldwide, and certainly in rural areas in all developed countries.

In summary, there are too few well-trained licensed providers to care for the millions of people known to be at risk of suicidal self-directed violence. The current workforce that does exist is woefully undertrained, not only in the US but around the globe. Even if more experts existed, and even if the current workforce was better trained, the geolocation of mental health professionals for traditional face-to-face delivery of care in rural areas remains an impossible dream.

Three possible solutions

Solution A: train every licensed provider and extend tele-mental health

One solution is to democratize expert suicide prevention knowledge through the rapid dissemination of existing best practices by making such training widely available at low cost through e-learning technologies. To date however, voluntary training is a failed strategy (or it would already have worked by now) and so mandating such training would be required.

Mandating training and establishing competent care throughout the provider workforce is an experiment in progress in only some states, and it's an experiment whose results will not benefit the millions at risk now. To democratize training through a series of state-law driven mandates will require training hundreds of thousands of reluctant providers whose membership organizations will seek to water down the requirements and weaken the adoption of best-practice, evidence-based interventions with patients experiencing suicidal ideation and urges.

While mandating such training sounds good, resistance to mandates of any kind are legion and usually lead to minimum requirements and a check box approach to training hours completed. These often have no obligation to demonstrate knowledge or skills acquired, let alone a demonstration of competencies gained.

Even if a substantial number of providers could be trained, the availability of these providers would be restricted geographically by state licensing laws unless the relaxed regulations emerging from the pandemic allow cross-border service provision. But even with cross-border virtual mental health services available, the shortfall in adequately trained professionals – at current estimates – would be but a fraction of what is needed.

What's the takeaway? A few hours of required general suicide prevention education is an insufficient dose of training to establish the knowledge, skills, attitudes, and abilities that lead to the competence and confidence necessary for professionals to deliver evidence-based suicide care that is at once safe and effective. Moreover, the workforce shortage cannot be overcome by the deregulation of state licensing laws to allow cross-border mental health services.

Solution B: Create a suicide care specialist

Just as medicine began to specialize in oncology, cardiology, and a dozen other areas where specialized knowledge and skill are required to improve clinical outcomes, a second option would be train existing or developing clinicians to become *suicide care specialists*. Just as the various mental health and primary care professionals and care systems need specialists to help them assess, treat, and manage many of their patients, they would likely benefit from the consultation and assistance of expert suicide care specialists.

If suicide care specialists were available in every mental health, substance use treatment setting, and in all primary care clinics and hospitals, the entire clinical staff would have someone available to assess, consult, and help guide treatment and management through collaborative care models currently available. Patients and their families would benefit from the provision of evidence-based practices known to be effective in the mitigation of known suicide risk.

Typically, such expertise is provided by psychiatrists. But in the U.S. and globally, psychiatrists are far too few to solve this problem, even via tele-medicine strategies.

This is especially true in developing countries where the role of psychiatrists is miniscule indeed.

The creation of suicide care specialists (whatever their professional discipline) would require a certification process, institutional support, review boards, a probable national exam, and the blessings of professions already convinced they are competent to provide this kind of assessment and care, even though they are not. Thus, the road to a new specialty is a long and torturous one, and the crisis of suicide will not wait for the glacial policy movement necessary to achieve either a new specialty for any discipline, or a new profession.

Still, if the entire clinical workforce cannot be reasonably trained to provide competent suicide care – just as the entire primary care medical workforce cannot be trained to provide competent care for lung cancer - one way forward is to train suicide care specialists now to assist the existing clinical providers employ best practices as soon as possible. Also, suicide care specialists could provide supervision and task-transfer functions to an emerging new workforce of super gatekeepers or pathfinders.

As noted, the Zero Suicide initiative in healthcare has begun, but it remains to be seen how this effort will be implemented in such a wide venue of service delivery systems. Especially in primary care where roughly 50% of suicidal patients who died were seen within the last 30 days (Zero Suicide, 2020).

An orientation and toolkit are currently available for “suicide safe care” at the Zero Suicide and Suicide Prevention Resource Center To the degree suicide is a preventable medical error, this is a good start, and many organizations can benefit from simply learning about what is available and that patient safety is a decision their staff makes every day.

The problem is that while safety planning, means reduction, and case detection through routine screening are easy, the actual treatment of people experiencing suicidal ideation and urges remains a high bar. Suicide specific therapies are few and not well dispersed, although efforts to expand availability are underway. The fact that most people who die by suicide in the U.S. and around the world never make it into any care system in the first place, however safe it may be, underscores

the missing workforce problem. Many anticipate this problem is only going to be compounded by the emotional and psychological fallout from the pandemic.

Solution C: Create a new category of skilled suicide prevention professional
Let's assume for the moment that solution A (training everyone, even by mandate) does not pan out and that mental health professionals remain inadequately trained and resistant to gaining necessary knowledge and skills.

Now let's assume that solution B (training suicide care specialists) proves impractical for reasons of professional resistance, inertia, cost, a lack of leadership, and the inability to scale competency-based training, even to the willing. Psychiatrists as skilled suicide care specialists don't count as there are too few to make a real difference. What then, is left to do?

Solution C is to create a *new category* of suicide first responders who have been trained in the evidence-based knowledge and skills currently available (but largely unused) by healthcare professionals, and thus create a new workforce of community-based suicide risk responders. For the purposes of this paper, they are called pathfinders.

Solution C expanded view of "pathfinders"
This proposal addresses how an online, evidence-based, competency-focused, accessible, affordable, and adequate training solution can be built and delivered at scale to communities anywhere broad band is available that will directly target and benefit those at risk of suicidal ideation, attempts and death. This training program would teach specific knowledge, skills, and attitudes to tackle the misery index head-on.

Building up on existing training and skills of people in all helping professions, including willing lay adults, this training program would provide them the latest in evidence-based interventions to immediately reduce suicide risk and sustain a continuous risk reduction program for people struggling with whether to live or die. Moreover, by delivering the training online trainees can, in turn, be taught to provide essential emotional support and psychological first aid to people in remote areas.

The first rank of such a potential suicide prevention workforce is one that already exists: mental health and substance use disorder peer support counselors. This workforce goes by many names, e.g., peer support workers, peer coaches, peer recovery coaches, peer advocates, and peer recovery support specialists (Lynn et. Al., 2019). As a group they are already well-informed about populations known to be at elevated risk of suicide morbidity and mortality.

Peer Support Professionals already have training in mental health literacy, substance use disorders, basic counseling skills, and enjoy a robust evidence base to support their efficacy and ROI (Behavioral Health Workforce Research Center, 2019). They enjoy existing infrastructure, professional status, a credentialing process, and an accepted state and federal service reimbursement system. Many bring the benefit of lived experience and personal recovery. Training as a pathfinder would add an important credential to their current skill set.

A second rank of potential pathfinders are those that can be recruited from basic QPR training as delivered online and face-to-face to more than 30,000 adults per month in the US and abroad. While stepping up to help people experiencing suicidal ideation and urges in their own community might not appeal to many, if even a small percentage of those trained as basic gatekeepers stepped up to become pathfinders, the additional training and certification might lead to additional training in peer support training and rewarding new career. It is unknown how those trained in basic QPR might become a pipeline of new recruits for this work as pathfinders, but many ask for additional training in how to be helpful to suicidal people.

These recruits can also be successfully trained in basic counseling skills to provide essential and effective psychotherapy where no clinical providers are available (Chibanda et. al, 2015). Solution C would create a new workforce to directly assist people experiencing suicidal ideation and urges in their own communities.

In addition to basic gatekeeper knowledge, skills, and attitudes, this new category of gatekeepers would be much better skilled in how to identify, engage with, and carry out immediate risk mitigation best practices, e.g., reduce access to means, set up safety plans and conduct follow-up caring contacts – the identical best practices endorsed by the Zero Suicide initiative.

Just as first responders learn CPR to expand their range of helpful interventions, with more rigorous training, Certified QPR+ Pathfinders could become the go to people in their communities when someone in a suicide crisis is identified. Also, this expanded training and role definition could be offered to all existing gatekeepers currently serving in only a "recognize, respond, and refer" role, e.g., school health professionals, law enforcement, clergy, and all health care providers.

In general, these "super gatekeepers" would be willing and able to be trained in next-level skills to render the equivalent of mental health first aid and basic suicide-focused counseling to at-risk persons. As QPR-trained pathfinders, they would *willingly* take on the task of assisting people *during and after* a suicide crisis, inclusive of helping people deal with suicidal ideation. With attention to training fidelity and standards, training would be customized to be acceptable to local norms and expectations. Mental health providers might welcome the opportunity to shift some of the suicide care necessary for patient safety to this trained and certified workforce.

Essentially, pathfinders would be the recipients of "task transfer training" in which professional-level knowledge and basic assessment and counseling skills would be taught to a predetermined level of demonstrable competency, followed by an exam-based certification process. As an example, nurses are taught how to give an injection in nursing school and, in turn, teach their diabetic patients to do the same. Effective task transfer training is done all the time (including training more people to give injections in response to the pandemic), and there is no reason not to do it in suicide prevention.

The curriculum

The challenge of building a pathfinder curriculum is to decide what topics will provide a solid foundation of knowledge upon which best-practice skills can be taught. Personal attitudes, self-awareness, and especially confidence in carrying out interventions must be part of the assessment of outcomes. To the degree more training is better than less, it is unknown what "dose" of what kind of training produces the highest achievable self-efficacy scores and desired behavioral outcomes. This is a researchable question.

Following content guidelines published in 2014 by a Task Force of the National Action Alliance for Suicide Prevention, we can address both the scope and topic

relevance of training content recommended for the clinical workforce. This would include information about personal reactions, respect, confidentiality, risk and protective factors, screening, open and direct talk about suicide, safety planning, access to lethal means, and others. Treatment and scope of practice issues for various professions are not included as pathfinders are not necessarily mental health professionals. While pathfinders are not trained in suicide risk assessment per se, they are trained in most of other topics recommended by the task force.

To deliver this curriculum two-days or 14-hours of mostly interactive training is our starting place, although a 2-year continuing education program is planned to maintain skill readiness. Rather than itemize possible topics, pathfinder training program goals will be listed here as expected competencies. Upon completion of the QPR+ Pathfinder training program participants should be able to:

- Describe suicide as a major public health problem and burden of suffering
- Know how to find relevant statistics for their community or country
- Identify their own personal reactions to suicide
- Use proper terminology to describe suicidal behavior
- Be familiar with suicide language use sensitivities
- Explain the common myths and facts surrounding suicide
- Identify unique verbal, behavioral, and situational suicide warning signs
- Recognize the coded nature of suicide warning signs
- Describe risk factors and protective factors for suicide
- Describe the relationship of mental illness and substance abuse to suicide
- Outline the ethical standards for working with people in crisis
- Demonstrate increased knowledge, skills, self-efficacy in helping others
- Show increased intent to act to intervene with those at risk
- Explain how to detect, engage, assist those in crisis
- Conduct a deep listening guided interview with someone in crisis
- Engage supportive third parties in setting up a risk management plan
- Describe means reduction and how to reduce access to lethal means
- Carry out a means reduction intervention in role-play
- Describe a safety and/or referral plan and know how to develop one
- Understand and employ the caring contacts intervention
- Outline the elements one theory of suicidal behavior
- Describe trauma informed care

- Define and describe self-injurious behaviors and non-suicidal self-injury
- Utilize the book *Suicide the Forever Decision* as an intervention
- Define the "loneliness epidemic" and how to use QPR skills to reduce this risk factor
- Engage in an interactive and helpful conversation with the loved ones or family members of someone who has died by suicide
- Define and describe postvention and steps to take to reduce suffering
- Successfully complete multiple scenario-based simulations to demonstrate skill mastery
- Conduct a self-audit of competencies and address a personal plan for mental health well-being

An adult/older adult edition of the training includes these competencies:

- Describe basic QPR Theory, Research and Practice
- Identify diagnostic categories of serious mental illness and their relationship to suicide
- Know and identify the names and types of evidence-based Interventions for suicidal behaviors
- Outline and describe best practices in the assessment and management of those at risk for suicide in late life.

The youth/young adult edition includes these competencies:

- Describe youth at special risk for suicide, including LGTBQ
- Define and identify youth who may be experiencing first episode psychosis
- Describe suicidal behaviors in young children
- Recognize the role of bullying as a risk factor and complete a role-play

The curriculum is taught by four experienced, well published, and expert clinicians, two clinical psychologists, and two psychiatrists.

A global reach

Delivered online using the latest in e-learning technologies, Certified QPR+ Pathfinders training is scalable and deliverable worldwide. The QPR Institute has been providing online extended training programs for a global audience for more than 15 years, including basic counseling and risk mitigation interventions. Learner satisfaction with training is high.

Pathfinder training content can be customized for specific groups, languages, urban, rural, and indigenous audiences. The QPR gatekeeper training program has been successfully customized for several countries and is translated into more than a dozen languages. In sum, basic QPR travels well, and there is no reason to believe QPR+ Pathfinder training would not do the same.

Pathfinder training would be suitable for "any willing heart" and would include community members who fit the "natural helper" or "healer" or "curandero" role where they live, work, play, and pray. Experience has shown that saving lives from suicide is its own reward and finding people to fill this new category of job should not be difficult. The success of peer support programs for a wide variety of groups is well documented.

QPR+ Pathfinder: A universal intervention for human pain and suffering?
Since 1995 basic QPR has been taught to millions. The intervention has been used thousands upon thousands of times with no known adverse outcomes, and many thousands of positive stories reported. While some of those receiving the intervention were thinking about or planning a suicide attempt, an unknown number of persons sending distress signals received the intervention who were not suicidal - so-called "false positives."

We consider the identification and rendering of personal aid and support to these false positives – people in distress but not considering suicide - to be a favorable result from a QPR intervention. Anyone showing observable signs of personal distress suggesting possible suicide risk, e.g., statements of despair, futility with life, depression, or expressions of hopelessness or loneliness, is still a worthy recipient of a caring and compassionate outreach by someone trained in how to offer emotional support, help, and hope.

People identified as at risk for suicide are the tip of the iceberg
For every person who thinks seriously about ending their own lives, thousands more suffer silently and push on through what may be searing psychic pain associated with a mental health disorder. The NIMH-funded National Comorbidity Survey-Adolescent Supplement (NCS-A) found that about 20 percent of youth are affected by a mental health disorder sometime in their lifetime, but most of these

young people never attempt suicide. They suffer psychological pain, but do not become suicidal.

These disorders - mood, anxiety, ADHD, eating disorder, or substance use disorder - resulted in a functional impairment of the child's role in family, school, or community activities, but did not lead to a suicide attempt or completion. (Kessler et al., 2012).

Millions more youth endure psychological pain and suffering from life's challenges that will never lead to the diagnosis of a mental disorder or a suicide attempt, and yet could benefit from greater social and emotional support and richer connections to others.

Similarly, most adults suffering from mental health disorders are not suicidal, and most suffer in silence. Less than one half of those known to suffer from a treatable mental health problem will receive adequate or effective care in the next 12 months. According to a 2018 Pew Research Center survey of American adults, millions more experience painful loneliness and isolation.

According to the Health Resources and Services Administration, loneliness and social isolation can be as damaging to one's health as smoking 15 cigarettes a day and increases the risk for a premature death. Some 43% of seniors feel lonely on a regular basis, and this is our most at-risk for group for death by suicide. Loneliness can lead to a variety of psychiatric and medical disorders, and the overlap between treatable mental health problems and health-threatening loneliness is well established.

The bottom line is that our society needs more than just an intervention to prevent suicide, it needs to address the upstream social and emotional risk factors that lie at the root of human distress and the loss of connectivity with other humans. We need to provide an educational pathway to teach willing people how to make positive, sustainable, social connections across the age span with anyone suffering in silence - with or without a treatable mental health problem, and whether they are experiencing suicidal ideation or not, their personal misery index is real, no matter the cause.

Can QPR+ Pathfinder training be used to address loneliness epidemic?

Recent public health research lists loneliness as a top health concern (Holt-Lunstad, 2017). Research has found that social isolation among older adults is associated with a 29 percent increase of coronary heart disease and a 32 percent rise in the risk of stroke (HRSA, 2019). New York University loneliness researcher In 2019, Ami Rokach was quoted about the risks of social isolation in the *Monitor on Psychology*, "If reactive loneliness is painful, chronic loneliness is torturous."

By teaching pathfinders that – at the very worst – the person they are reaching out to may be thinking of suicide, learning they are not may come as a relief. Finding out the person is in pain and suffering – not from thinking of suicide but from being alone – means the pathfinder has still done a wonderful thing. With a few skillful questions, they have opened communications, reduced isolation, and enhanced connectivity through a compassionate conversation. They may have even begun a mutually rewarding and ongoing relationship for themselves which, in turn, may increase their own emotional well-being (Dore, et. al., 2017)

By teaching the simple UCLA 3-Item Loneliness Scale questions to pathfinders, and using one or more of the following probes – "Do you feel left out?" "Do you lack companionship?" and "Do you feel isolated?" citizen pathfinders could provide important opportunities for lonely people to acknowledge their isolation and, together with a little help from the pathfinder, open or reopen contact with a supportive social network and access its known psychological and emotional benefits.

If pathfinder training can embolden gatekeepers to willingly lean into the psychological pain that we know drives thoughts of suicide, surely those same skills can be applied to another person's agony of loneliness.

In sum, while the basic QPR method was developed specifically to detect and respond to persons emitting suicide warning signs, pathfinder training can become a second and higher order of training to enable ordinary people to access their personal capacity for empathy and understanding, and extend themselves into the lives of troubled people, thus reducing isolation, thereby enhancing social connectedness between people and improving the mental health of the entire community in which they live.

One illustrative story from a gatekeeper trainer

“Gatekeepers are good listeners. QPR training teaches participants to listen for certain words where someone sounds as if life has become hopeless and as if there are no options for relieving their psychic pain. In this case, the Gatekeeper recognized helplessness in the voice of a woman speaking over the phone. She asked a couple of questions to determine any specific problem she might be able to help with.

Quickly she placed a call to another Gatekeeper and shared the facts of the case. Briefly, a mother of two children had lost her job. She had been employed far from her homeland and was having trouble finding work. Not being native to the U.S., she was not aware of any programs that might support her and the family until she was once again employed. By the time her plight was discovered, she had completely exhausted her savings and was unable to buy gas for her car or food for her children.

Using all available resources, the two Gatekeepers found temporary employment for her and arranged for payment in advance for several weeks' work. Additionally, with the help of the woman herself, a plan was put in place to help her find permanent work in her professional field. Now able to pay her rent, feed her children, and put gas in her car, the woman quickly re-gained self-esteem and hope for her family's future. Within two months, she secured a job that matched her skills and training.

Later, the young mother shared with the concerned peer’s details about how dire her situation had become. In addition to suicidal thoughts, there were brief homicidal thoughts-- she considered taking the lives of her children and her own, as temporarily she feared that she could not provide for them, or herself. She was grateful that her friend had heard the desperation in her voice and further, that the Gatekeeper took action and provided her support at a time when she felt there were no options. Today, the once very depressed woman is a trained QPR Gatekeeper, and uses her own experience, plus the training to remain conscious of how she can help someone else, should that time arise” (Coursey, 2019).This story illustrates how QPR can be used effectively even when suicide risk maybe remote.

> *At times our own light goes out and is rekindled by a spark from another person. Each of us has cause to think with deep gratitude of those who have*

lighted the flame within us.

Albert Schweitzer.

Beyond basic QPR training

The basic QPR Gatekeeper Training for Suicide Prevention program has been taught to millions over the past 20 years, by more than 20,000 Certified QPR Instructors, and in multiple languages and countries. Like CPR training, studies of the potential for bystander rescue have shown (Latane & Darley, 1970), people willing to help others in a crisis must make five decisions before they will engage in an act of assisting another person. 1) notice the situation; 2) interpret the situation as an emergency; 3) decide to take personal responsibility; 4) decide how to help; and 5) decide to implement the decision. These same causes for action to help people in crisis would apply to QPR+ trained pathfinders.

Trained suicide prevention gatekeepers are only effective when they recognize the situation (suicide warning signs), accurately interpret their meaning, and then decide to accept personal responsibility to engage the at-risk person with interpersonal skills learned in training. Independent research studies over more than 20 years have now shown QPR training to be safe and effective in teaching the knowledge, skills, and attitudes necessary to help prevent suicidal behavior. Limited research suggests rates of suicide events (attempts and death by suicide) are reduced in those US counties where gatekeeper training has been delivered, verses in counties where training was not provided (Walrath et. al; 2015). QPR+ pathfinder training will build on this evidence base and beyond.

The Certified QPR+ Pathfinder

The QPR acronym is sufficiently established and linked to a suicide prevention intervention (gatekeeper training) that the QPR+ acronym should be enough to identify the aims and expected quality of the longer training program. Similar branding operations are underway by Disney+, ESPN+, and others, whose marketing goals are to identify and promise more of an already trusted and valued product or service.

The “+” portion of QPR+ Pathfinder refers to the extended training in the foundational knowledge and fundamental skills necessary to respond with greater

confidence and competence to the full range of suicidal behaviors, from suicidal ideation to suicide attempts and deaths by suicide. Using a faculty of several experts, the training will address emerging high-risk mental health issues as well, e.g., first episode psychosis and suicide risk, late-life suicide, and non-suicidal self-injury.

Expected training impacts

Studies have shown that when responders perceived they had received sufficient suicide-related training, self-efficacy improved together with reduced cognitive and somatic anxiety about helping suicidal people (Mitchel, 2020). Therefore, the aim of this training program is to reduce negative and anxious reactions toward suicidal people and measure training success against a limited range of available published competencies.

In addition to completing the basic QPR Gatekeeper training program, QPR+ Pathfinder training includes acquiring some knowledge of risk assessment and risk management, fundamental counseling skills, and tutorials on a variety of suicide-topics. A special training requirement will be to successfully engage in multiple simulations and interactive role-plays wherein knowledge and skills are practiced and mastered (see active learning section below).

The QPR+ Pathfinder training consists of two programs. One for those working with youth and young adults, and one for those working with adults and older adults. Core and overlapping content areas include 21 modules, while 4 distinct modules are included in the youth and young adult edition, and 9 additional modules are required for the adult and older adult edition. Interested students can complete all modules if desired.

A complete syllabus is in process, but the topics covered include roughly 90% of those listed in Suicide Prevention and the Clinical Workforce Guidelines for Training to advance the competency of the clinical workforce, as published by the National Action Alliance for Suicide prevention in 2014. Some topics relating specifically to clinical care, HIPPA, FERPA and professional legal responsibilities, as well administrative or policy-level recommendations were deemed not essential for pathfinder training and are not included in these courses.

Simulation-based active learning

Much of the training in this program will use a new e-learning technology called Mazetec (Mazetec, 2022). Mazetec is a new learning management system that allows learners to acquire knowledge and skills from the active learning process of interacting directly with the required content in unique ways to construct their own competencies.

The Mazetec program has been under research and development for several years and represents the latest in e-learning technologies. Training is deliverable on any PC or mobile device and was engineered for user's with low bandwidth, thus knocking down the brick-and-mortar costs of travel and traditional classroom suicide prevention and intervention training, even in remote areas where only satellite internet is available. Global distribution of our training programs is now operational where we engage everyday with students from Malaysia to India to Mexico.

Using real-world simulations and a scenario-based learning environment, QPR+ students are obliged to look at a problem or question and make a decision. Reflection, a key element in learning and consolidation of long-term memory, is required at every choice point. Immediate, customized feedback is provided on each decision (correct or incorrect), sometimes with a brief mini lesson authored by the course mentor or coach. Errors are expected. Participants may make as many attempts as needed to complete each learning task, thus enabling 100% score on all modules.

Train under pressure to perform under pressure

Some training simulations include a countdown timer to add a sense of urgency or conflict in, say, the recognition of a fleeting suicide warning sign. This gamified approach may take learners into wrong decision trees leading to adverse outcomes, e.g., making a wrong choice during an intervention can lead to a suicide attempt. Many jobs require making difficult decisions under conditions of uncertainty and time pressure, but few of them require making decisions upon which a life depends. In responding to acute suicide crises, time pressure is often very real. QPR+ training will include training under pressure.

Active verses passive learning

The intent of the simulation-based learning experience is to teach through interactivity, in "engage–fail–learn" or "test to teach" mode. This type of active

learning has been favorably examined and produces superior learning outcomes (Koedinger et. al. 2016). While the course includes some reading or passive watching of a video lecture, context exams follow each module.

In the Mazetec format the learner is presented with, as an example, a person in crisis with several options. Each option has consequences. The learner's selected response may end the lesson, warn the learner as to the nature of their erroneous choice, and loop them back to the previous question or move them on to the next step in the simulation and the next set of possible responses. Using branching logic, leaners can be decoyed down a decision tree until an adverse outcome occurs, then returned to the choice point where the error was made and given the option of another way forward.

As noted, some simulations are constrained by a countdown timer to build accurate, quick thinking in a crisis, as might be encountered with a crisis call from someone who has just taken an overdose. Quick, correct action under pressure can be practiced in the safety of timed simulation with no risk incurred.

In the active learning approach used in QPR+ certification training program, the learner makes hundreds of decisions to master the content, both in knowledge acquisition and in the application of that knowledge and skill to real-world scenarios where advanced QPR+ Pathfinder skills must be demonstrated to succeed. Each of dozens of learning and practice mazes must be completed successfully (100% compliance) for the learner to move forward and complete the certificate training.

Finally, the Mazetec software data collection system and analytics captures every student's key stroke, time to decide, choices made, and other information to enable a comprehensive record of the applicant's knowledge and skill mastery. A pre-post training survey will evaluate outcomes in several domains, including knowledge, attitudes, skills, abilities, and self-efficacy in working those at risk of suicide. This data provides an individual record and performance-based evaluation of Certified QPR+ Pathfinders, as well as inputs for program improvements.

Phase 2: Continuing education and skills refresher training

Once all training requirements are met and a certificate is awarded, the QPR+ Pathfinder will be registered in an international database and registry, thus allowing the institute to stay in contact with them.

In phase 2 of the program, Pathfinders will be invited to join our ongoing support and booster session micro lessons distributed via email. Under consideration is an online community of Certified QPR+ Pathfinders to provide each other a platform for mutual support in their important work, and as a place where ideas from around the world can be shared. This option may be hosted by another organization, or their preferred employer or network.

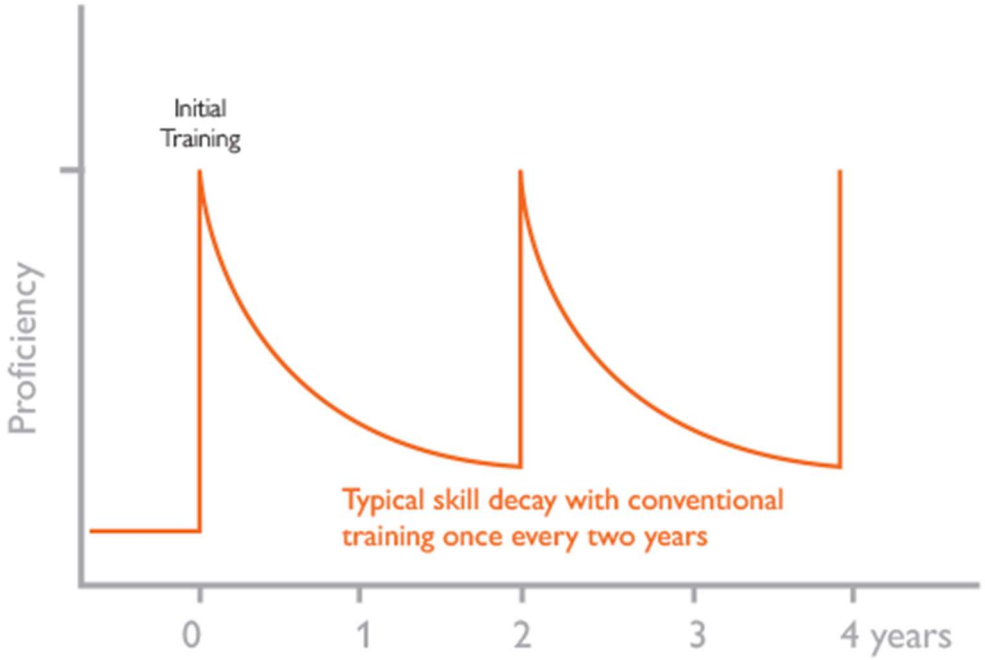
How to maintain the knowledge and skills of a global workforce?
Multiple studies have shown that basic QPR gatekeeper training impacts on knowledge, skills, and attitudes diminish over the months and years following initial training (Mathieu et al., 2008; Tompkins et al. 2011; Cross et al., 2011). This decay in knowledge and skills may negatively impact gatekeeper readiness to conduct a competent intervention in a timely and effective fashion.

However, recent research (Garraza et al., 2021) found that the combination of a role-play during the index QPR training session, followed by a low-cost emailed text-only online role-play booster session at six months produced a significantly larger proportion of gatekeeper identifications, referrals, and notifications of the referral source. The authors conclude that gatekeeper training can thus be enhanced through active learning strategies.

In light of this research and to address post-training diminishment in the knowledge, skills, and attitudes necessary to carry out a safe and effective interventions, the QPR Institute will launch research-to-practice QPR+ Boosters, a low-dose, high-frequency series of online booster sessions in the format of micro-lessons (2 to 10 minutes long) specifically designed to maintain the competencies taught in the Certified QPR+ Pathfinder training program.

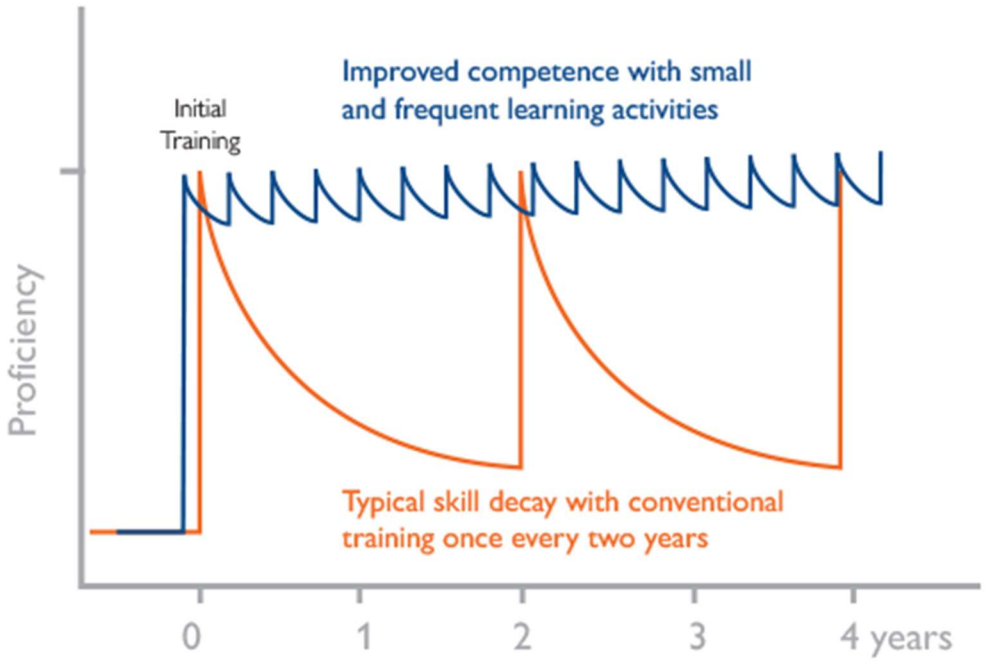
Using a blend of brief training review modules - and especially scenario-based, interactive real-world simulations - the QPR Institute aims to reinforce the confidence and competence of Pathfinders in the knowledge and skills they acquired during initial training.

As illustrated in the graph below, research on CPR training knowledge, skills, and attitudes decay is similar to what has been found with gatekeeper training effects.



The decay of learning impacts following initial training in CPR have been effectively addressed in what are called “low-dose high-frequency” training sessions. These LDHF training modules constitute a competence-building approach that promotes maximum retention of knowledge, skills, and attitudes from an initial training. Low-dose high-frequency training is a short, targeted, simulation-based learning activity spaced over time and reinforced with structured, ongoing practice sessions.

Low-dose high-frequency training is not only effective for skill building but helps to maintain confidence and competence over time. The following graphic describes the anticipated training effect from QPR Boosters.



The aim of *QPR Boosters*

The aim is simple: QPR+ Pathfinders will receive continuous, periodic, engage-fail-learn simulations in which they can test their knowledge and skill to enhance competence and confidence and *maintain* perceived self-efficacy to help suicidal people over time. The concept of "continuous certification" is under examination, as QPR+ Pathfinders can receive booster sessions and testing at frequent intervals to sustain important intervention skills.

Using a CPR comparison, studies conducted on the effectiveness of Resuscitation Quality Improvement training using the LDHF training model showed almost full course completion by participants (98%), large cost savings from less time used for off-site training, and a 21% increase in survival rates from cardiac arrest (Texas Health Resources hospital, Dallas, Texas).

CPR and QPR are clearly not equivalents in training content, skills, or practice, but the underlying learning principles at work are identical. Thus, similar results in enhanced gatekeeper knowledge, skills, and attitudes can be expected from LDHF, competency-focused, case-based simulation learning.

Micro-Learning techniques

QPR Boosters modules will be emailed to QPR+ Pathfinders at a minimum rate of six times per year for each 2-year interval of certification. Individual tracking of performance in these booster session training modules will be compiled and available to the learner and/or his or her employer, thus allowing for any compliance training requirements that may develop.

QPR Boosters can be taken at any time 24/7. A 2019 LinkedIn survey found that the #1 challenge for employers is finding time to train employees, and that:

- 68% of employees prefer to learn at work.
- 58% of learners want to move at their own pace.
- 49% want to learn in the flow of work.

QPR+ Pathfinder training, followed by LDHF QPR Boosters sessions, will enable individual performance measurement across more than three dozen domains of suicide prevention knowledge, skills, and attitudes, thus assuring that competency standards are being met, not once, but continuously and over time.

Competency-based training

The online training and examinations required to complete the QPR+ Pathfinder training program and earn a certificate have been carefully evaluated and designed to meet the recommendations set forth in the October, 2007 issue of the *Journal of Professional Psychology: Research and Practice*, wherein members of the American Psychological Association's Task Force on Assessment of Competence in Professional Psychology set forth 15 principles applicable to the education, training and credentialing of professional and practicing psychologists over their career life span. Adopting these principles for this online training program, and its recertification requirements, reinforces and supports a "culture of competence" for QPR+ Pathfinders.

Specifically, this training program incorporates evidence-based and culturally competent practices and specifically addresses a series of developmental learning steps to include knowledge, attitudes, skills, self-perceptions, beliefs, and dispositions necessary to work effectively with people experiencing suicidal ideation and urges. The training includes scenario-based learning, "thought experiments" using multiple vignettes to assess critical thinking, judgment, emotional and interpersonal intelligence, as well as the capacity to engage and successfully assist people at risk.

The evidence-based suicide risk mitigation methods taught in this program are identical to those taught to clinical professionals but are culturally adapted to be accepted at the community level. Therefore, a high degree of fidelity exists between the foundational competencies expected of professionals interacting with those at risk and those of successful Pathfinder trainees who earn a certificate.

Evaluations of competence in the QPR+ Pathfinder training program include multi-trait, multi-method, and multi-informant processes. More than one methodology of evaluation is used, including online quizzes, online simulated role-plays and collective feedback from other students, as well as the collection of individual performance metrics and analysis as measured against expert benchmarked standards.

Self-reflection and self-assessment modules are included to address the learner's own limits of expertise, need for personal insight in working with people lost in the bramble, and personal recognition of the needs for additional training or experience.

As this training program is intended to train learners to deal with persons coping with end-of-life decisions, it clearly fits the Institute of Medicine's description of practice as a "moral enterprise." Therefore, a training module devoted to ethics in human services as a cross-cutting competency is addressed in lecture, reading, and an ethics-specific scenario-based examination, including items related to helping services delivered over the internet. A self-care module is included as well.

Program parameters

Certified QPR+ Pathfinder training will:

- Be available to anyone 18 years old or older.
- Require no experience, education, or professional training.
- Require reading proficiency in English (translations will be available later)
- Require completion of basic QPR training and passing a 15-item quiz.
- Be available only online (self-paced and webinar)
- Require 20+ hours of training
- Require registration in an international database for 2 years minimum.

- Require receiving, opening and completing of 90% of all QPR Boosters booster sessions.
- Require 100% completion all training modules, exercises, scenario practice challenges, and an 100% correct passing score on final exams.
- Provide a printable certificate.
- Provide 20 contact hours of continuing education hours from the National Board of Certified Counselors, available in more than 50 countries.
- Allow recertification every 2 years upon passing a comprehensive exam, or continuous certification (process in development).

Cost: To be decided. Global pricing will follow World Bank guidelines for discounts by country to make QPR+ Pathfinder training accessible and affordable to developing countries.

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