

Is a Brief Education Enough Concerning Suicide and Threats of Suicide? Evaluation of an Educational Initiative for the Emergency Personnel

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ABSTRACT: *The present study is a qualitative evaluation of a brief course for emergency personnel in western central Sweden with the goal of increasing awareness and knowledge among the staff and concerns questions related to psychological ill health and suicidality. The question posed was whether a short but intensive workshop could raise the level of knowledge among the staff and provide them with new tools. Is "brief" enough in this context? The analysis yielded five broader categories: (a) Suicidal process, (b) Experiences from the course, (c) Future educational goals, (d) Interactions between the separate efforts, (e) Reflection and evaluation. These five categories formed the model of "educational triad" in which three themes, collaborative learning, experience and interaction are key components that influence the development process. The results showed that there was a great need for training in suicide prevention, mental health and treatment. Learning through interdisciplinary teams seems to work effectively. The conclusion was that within the framework for a unified and well organized campaign, brief can be enough.*

Keywords: *Collaboration, mental illness, rescue service, suicide prevention, treatment interaction*

INTRODUCTION

Every year about 1500 Swedes die by taking their own lives; the number of suicide attempts has been estimated to be at 10 times as many (Karolinska Institutet, 2013). To take your life or to try to take your life can be one of the most extreme consequence of psychological ill health. But the complexity of suicide is much more extensive than merely a by-product of a mental illness. Anyone who is troubled by thoughts of suicide does not readily express them, and many who are close to such a person report that they experienced hearing of the death as a "bolt from the blue" (Szanto et al., 2012). The primary reason for this silence on the part of the suicide prone is that they find it difficult to talk about their personal difficulties and problems (Ballard et al., 2013) because of the stigmatization they each feel. Inherent in each such individual's psychological state is the experience of being "an object of attention", despised, separated, and of having lower moral status (Brain et al., 2014). This stigmatization is often relevant when those close to the person who is experiencing suicidal thoughts, lack understanding. There are studies that show that even those close to individuals who suffer from psychological ill health, also experience stigmatization often referred to as "stigma by association" (Östman & Kjellin, 2002). Those next of kin are influenced by their relationship with others, and their psychological health may be affected and, in some cases, even lead to their own suicidal thoughts. Silence among the suicide prone or among those close to them has a strong influence on the situation. Our environment is affected by our interpretation of our interpretations and reactions and this in turn creates reciprocal reactions. This continuously occurring interplay is called "interactionism" (Ekberg et al., 2014). In a situation where both the individual and those around the individual are silent, this mutual interaction ceases and the person feels isolated and cut off from his or her fellow humans.

Being suicidal is not in itself an illness, even it is commonly true that psychological ill health, for example depression, was present in the background of the suicide prone (Mann et al., 2005). Over half of those who die by suicide meets the criteria for a diagnosis of depression and even more exhibits depressive scores. There may be a causal relationship between suicide and psychological ill health and if so often this psychological ill health is not treated. A significant element, especially for young people and men who take their own lives, is the absence of any ongoing contact with primary care or psychiatry (Mann et al., 2005). But possible relationships between experiencing suicide ideation and absence of treatment are not enough to explain why people died by suicide. There are many factors in complex interactions such as biology, psychology, environment and culture (O'Connor, 2011). There is a need to go beyond the psychiatric concept. What is crucial is not just to detect mental illness and identify "the suicidal mind" but also to develop the ability to predict sensitivity and specificity for suicidal thoughts, as well identifying markers for intervention. A model that illustrates this is the Integrated Motivational-Volitional Model of Suicidal Behavior (IMV) (O'Connor, 2011)

This gives us reason to support the general public by encouraging them to be watchful concerning any sign of psychological ill health and for them to encourage anyone showing such signs to seek professional help. There are an infinite number of reasons for suicide, but it is possible to distinguish certain common factors. Depression, alcohol misuse or dependency as well as previous suicide attempts are some of the most prominent risk factors (Runeson, Beskow, & Waern, 1996). It is common for people to use alcohol as self-medication against depression and anxiety. In the case of women who suffer from both depression and alcohol dependency, the depression appeared before the alcohol dependency in two thirds of all cases.

The opposite situation applies to men. The following risk factors also indicate a high risk for death by suicide (Hultén et al., 2001): (a) to be separated, divorced or widow/widower, (b) to be easily

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offended, (c) to be unemployed or retired, (d) to suffer from a chronic physical illness, (e) to have a psychological illness, (f) to suffer from personality disorder, (g) to employ violent methods in a suicide attempt, (h) to have left a farewell letter. These factors do not explain a suicidal behavior. But they can help the environment to be observant of how people feel and how they sometimes act. Although some risk factors are identified they cannot together explain why people try to end their lives.

The cause of suicidal behavior is influenced by more components than the above-mentioned risk factors. There may also be personality traits, cognitive factors, social aspects and life events that are perceived as negative (O'Connor & Nock, 2014). Once every six hours, every day, an individual takes his or her life in Sweden (Karolinska Institutet, 2013) which is, of course, a major public health problem. Suicide is the most common cause of death for men age 15-44 and is the next most common for women of the same age.

In 2008 the Swedish parliament decided to create a national program for suicide prevention (NBHW, 2006). The program contains nine different strategies for decreasing the number of suicides. The seventh strategy concerned raising the level of knowledge among the staff and key individuals in the health-care system as concerns people on the brink of taking their lives. This strategy deals with personnel who in the course of their work can expect to meet people with suicide problems. It is important to involve these personnel and get them to find good forms for cooperating with these people. Previous studies show (e. g., Saunders, Hawton, Fortune, & Farrell, 2012) that emergency and hospital personnel can often display a negative or ambivalent attitude toward individuals who harm themselves. Shame reactions frequently occur in combination with suicide attempts and do so among those close to the suicidal person (Wiklander, Samuelsson, & Åsberg, 2003) and the person with suicidal tendencies who has survived an attempt can often see the entire situation as a one more failure over and above the problems that originally led to the attempt. It was seen in addition (Wiklander, Samuelsson, & Åsberg, 2003) that the attempted-suicide patients were sensitive to the attitudes and behaviors of the personnel. If they experienced personnel as friendly, understanding, and non-judgmental feelings of shame among the patients were reduced and it became easier for them to accept treatment and even made them feel less ashamed for not living up to the expectations of everyday life. The conclusion was that greater awareness of the feelings of shame after a suicide attempt would help those who first take in the patient and those who provide treatment to understand and interact in dealing with attempted suicide patients. This would make it easier for the patients to accept and understand that they can benefit from psychiatric care after a suicide attempt. There is research that indicates that even an initial brief course or workshop can have a favorable effect on the perceptions held by emergency personnel on how suicidality is to be understood and is to be dealt with (Currier et al., 2012). A majority of the participants in the study experienced an increase in their understanding of suicide and 41% even indicated that the brief introductory presentation resulted in improving their skills in managing suicidal patients. Educational efforts in suicide knowledge, targeted to persons not directly related to health care, have a similar effect. The result of such training was that it resulted in positive changes for the participants in knowledge and attitudes to intervene in suicide threatening situations and participants also shared these new knowledge and skills with family, friends and workmates (Cross, Matthieu, Cerel, & Knox, 2007).

The present study is a qualitative evaluation of a brief course for emergency personnel in western central Sweden (northern Värmlands county) with the goal of increasing awareness and knowledge among the staff who are involved as concerns questions related to psychological ill health and suicidality. Data was analyzed according to The Empirical Phenomenological Psychological Method (EPP method) devised by Karlsson (1995).

The educational intervention consisted of seminars with group work and exchange of experiences on suicide and suicide prevention with participants from the relevant professions. Seminars lasted for about four hours. The intervention was intended as a first step in a broader effort where another element was recurring conferences that contained intergroup meetings between management staff. The persons concerned by this evaluation came from participating emergency personnel units affected by the educational intervention. It was the managers of those entities who decided that all staff should participate in the seminars. Not the participants themselves.

AIM AND SCIENTIFIC QUESTION

The aim of the present study was to explore participants' perceptions of the training effort regarding content, cooperation and exchange of experiences at threat of suicide or at completion of suicide. The scientific question was whether or not a short but intense training effort could give staff more knowledge and new tools and thus serve as a good introduction to a more comprehensive effort.

METHOD

Participants

An educational initiative was organized for all personnel in the Blue Light organizations, Emergency Services, Police, Ambulance Service, and SOS-Alarm in northern Värmland. This was done through the form of half-day workshops on the knowledge of suicide and suicide prevention where basic knowledge on suicide prevention was presented and where participants could share their experiences. Eighteen such seminars or workshops were carried out, with 17-19 participants on each occasion and with a nearly even distribution by gender. A total of 320 persons with gender balance and ages ranging from 23 to 65 took part in this activity.

Procedure

The material for evaluation consisted of responses from 320 participants who were asked to answer three questions: (a) What was positive about this day? (b) What was negative about this day? (c) Tips and ideas concerning suicide prevention? Participation was completely voluntary, and participants had the right to withdraw their participation when they wanted and without giving a reason. Participants responded anonymously and the surveys were submitted to the instructors in such a way that anonymity was not jeopardized. The time required for completing the survey was estimated on average to be about 5 to 10 minutes. The total data set included some 300 pages of participants' comments.

Method of Analysis

The material was then analyzed following Gunnar Karlsson's (1995) EPP method (The Empirical Phenomenological Psychological Method). The method consists of several steps during which it is required, among other things, to separate the answers into small content-bearing units, so-called "meaning units" (MU). The separation into units is not based on following any grammatical rules but is instead carried out with respect to the content of the text. During the next step the MU's are transformed linguistically. The goal was to transform a phenomenon from an implicit level to an explicit level. Further along in this process the transformed MUs were grouped in categories. The categories appear through a process of repeated consultation of the context in the raw data while at the same time testing to see if they were consistent with the overall character of units within the categories. The analysis produced 466 transformed content-bearing units which in turn generated 21 categories. Each category provides a perspective of the phenomenon which can be studied and described in a summary text, a synopsis

in which each is given a name. In the next step the focus is shifted from the categories to more general themes or structures. This step produces five dominant so-called index-categories (Nordén, Eriksson, Kjellgren & Norlander, 2012), specifically “Suicidality”, “Course content”, “Desired elements for future educational efforts”, “Roles during interaction”, Reflections and evaluation”. Finally, three themes were derived that could be brought together in a model.

Reliability and Validity

According to the principles of phenomenology all facts are dependent upon individual consciousness. Objects and the subjects are connected to each other by intentionality rather than as two separate entities (Karlsson, 1995). This means that it is the participants' experiences that form the basis of this study. The aim has been to follow Karlsson's three criteria (1995) for good validity: (a) The aim of the reduction is to ensure that the researcher does not impose his/her biases and prejudices upon his/her understanding of the protocol, (b) horizontal consistency of interpretations (i.e., different parts of the text fits together), (c) vertical consistency of interpretations (i.e., consistency between different meta-levels). The hermeneutic circle has been applied by making periodic shifts in perspectives between the part and the whole.

As a means of supporting the method for controlling the reliability of the results, the Norlander Credibility Test (NCT), a test developed for use with phenomenological methods, was used (e.g., Åsenlöf, Olsson, Bood & Norlander, 2007; Edebol, Bood, & Norlander, 2008; Edebol, Nordén, & Norlander, 2013; Ingvarsson, Nordén, Norlander, 2014; Niklasson, Niklasson, & Norlander, 2010). This test was applied according to the following: Ten synopses were randomly selected. Then five randomly chosen transformed MUs from each category were presented to two independent evaluators. Each of the two then independently placed the 50 text lines with meaning-bearing units with the most appropriate synopses. The mean value from the two evaluators showed a 73% level of agreement, which is in line with previous studies (e.g., Nordén, Eriksson, Kjellgren, & Norlander, 2012; Edebol, Nordén, & Norlander, 2013).

RESULTS

The analysis of the material resulted in 466 transformed MU's that could be assigned to 21 categories. These categories could then be easily assigned to five index-categories: (a) Suicidal process, (b) Experiences from the course, (c) Future educational goals, (d) Interactions between the separate efforts, (e) Reflection and evaluation. The index-categories are presented in the sequence in which they are given in Table 1. The analysis was then completed with a discussion section in which it was determined if it is possible to find repeated themes in the five in index-categories that can be viewed as the essence of the phenomenological analysis. When the MUs are presented in the result and discussion sections they appear as the original raw MUs and are marked in italics (Table 1).

Suicidal Process

This index category contains a total of 56 MU, divided into three categories: Suicide prevention, risk factors for suicidality, and to talk about suicidality. The findings strongly indicated that knowledge is important in suicide prevention work and that knowledge of suicide prevention is rare in educational contexts. The topic was also experienced as difficult but very interesting. The participants summed up a number of risk factors for suicidality and they stressed the importance of training sessions on how to talk about these things in order to develop skills for better communication with people who are planning to commit suicide and their related.

One participant expressed this as follows: “It really concerns all of us”. In work with “Blue Light” (Police, emergency services,

ambulance service, and SOS-alarm) alarms concerning suicide threats are part of the daily work load, as confirmed by this observation by a participant: “We frequently come in contact with suicide problems”. At that moment, the situation that arises is frequently acute. We stop the person from doing anything in an immediate problematic situation and hand them over to or transport them to the emergency room, a local health-care clinic, or to a psychiatric acute-care centre. These people frequently have a heightened sensitivity to stress and a vulnerability that lead them to react more strongly in various situations than other people might react. Suicide attempts must always be taken seriously. A strong risk factor for death by suicide is the occurrence of previous attempts. Another is depression. More than half of all those who die from suicide meet the criteria for a diagnosis of depression, and even more show a tendency for depression. Unemployment and changed rules in the health-insurance system lower the individual's threshold. “One thing that makes people more depressed and more exposed is that people who are ill are forced to work. Not enough jobs” is a comment from another participant.

People in general know quite a bit about physical illness but the general level of knowledge about mental illness is low. This lack of knowledge contributes to a judgmental and disparaging attitude toward those who suffer from mental illness. Examples of this attitude are that people believe that it is only weak people who become mentally ill. It is enough if one “straightens up and pulls oneself together to avoid psychiatric treatment”. The result of this ignorance is that people who are in psychological ill health are not taken seriously. An environment lacking in understanding by others can prevent or cause people to delay in seeking help for their ill health. To be in this situation and to then try to start a conversation telling someone that you are troubled by thoughts of taking your own life is not realistic, treatment in the presence of avoidance and lack of understanding leads the troubled person most often to keeping quiet and just suffering. “It is important to talk openly about this/ It is good to talk about a subject that one otherwise never talks about”. Silence and the need to talk about suicidality were pointed out by several participants.

Experiences with the Course

This index category contains a total of 110 MU, divided into four categories: group work, course leader, experience, interaction and cooperation. Participants felt that the group composition and the exercises were well planned. They perceived the group activity as

Table 1. Overview: Index-categories, categories and number of meaning bearing unites (MU)

Index-category	Categories	MU:s
1. Suicidal process	1. Suicide prevention	38
	2. Risk factors for suicidality	8
	3. To talk about suicidality	10
2. Experiences with the course	4. Group work	6
	5. Course leaders	17
	6. Exchange of experience	64
	7. Collaboration and cooperation	23
3. Future educational needs	8. Educational needs	75
	9. Areas to be developed further	24
	10. Caring and mode of approach	7
	11. Areas missed in the course	8
	12. Needs of next-of-kin	4
4. Interaction among units	13. Police	9
	14. Ambulance personnel	4
	15. Physician's role	5
	16. Responsibility for transport	3
	17. Psychiatry	14
	18. Routines	23
5. Reflection and evaluation	19. Participants' reflections	56
	20. The economy's effects	7
	21. Worthwhile and rewarding	61

instructive and course leaders showed great commitment and skills in the subject. Some of the participants also expressed gratitude to the course leaders for initiating the project. The need to meet colleagues from other emergency organizations was perceived as important, developing, rewarding and enriching. Participants felt that joint training strengthens cooperation opportunities and they demanded greater cooperation between emergency organizations and healthcare providers in outpatient and inpatient care. The participants' experience of participating in groups is described by these observations "Good with a small group/ Good group formation/ Just large enough group and participants/ Good mix of participating police, ambulance personnel, and emergency service people.."

One of several goals for the seminars was to start a dialogue between the participants and the leader of the course. There was a desire to seek a balance between the transmission of knowledge and the stimulation of reflection and discussion on the part of the participants. That this balance was achieved is confirmed by these observations: "Good communication between leader and listeners/ Plus to the lecturers who succeeded in making be very interesting." By meeting in a cross-disciplinary professional setting the participants developed an increased understanding of each other's roles and responsibilities. Those who work within the Blue Light system already are working closely with one another and can hand over tasks when their own work is finished. Personnel have been assigned specific roles and tasks by the organizations to which they belong. Since each person has a role and responsibilities to be carried out it is not possible to talk with the others while all are dealing with a specific situation. Within one's own organization "reflection and debriefing" does take place after the situation has been dealt with but there is no chance to talk with others in the Blue Light team. The experience of having had time set aside during the course to exchange experiences was expressed by several participants "Good to exchange experiences/Good with mixed-group meeting where different competences were met/That there are personnel from different fields so you get to hear things from their perspective/ Good with others' experiences in connection with suicide: police, emergency services, SOS as well as clergy."

The need for establishing a high-level of cooperation may be clearly seen from the material: "Emergency services and ambulance personnel must cooperate in responding to a suicide alarm/Full cooperation across boundaries is important/Emergency Services and ambulance personnel must work together on receiving a suicide alarm." We understand that, to a certain extent, things do work well at the individual level, but we also see a need for a more structured form of cooperation. An alarm plan does exist in some regions, for example in Jönköping and Stockholm. Emergency services are often found in several different locations in a county, which means that these can also be places for the police and ambulance personnel. Time is often the decisive factor in this type of alarm situation. The need for strengthened cooperation with medical personnel is sought: "Cooperation between different medical authorities must be promoted".

Future Educations Needs

This index category contains 118 MU, divided into five categories: education needs, areas to work on in the project, conduct and approach, issues or areas that were lacking in the particular course and relatives' needs. Participants felt that there was need for annual training and follow-up sessions. It was requested targeted training for persons with management functions. Furthermore, participants expressed a wish that resource persons should be appointed in the immediate area for high availability in order to support and help suicidal individuals. In addition, it was suggested that training in interview techniques and role play would be helpful in order to learn strategies that involves a quiet and not emotionally

treatment of persons that are anxious, desperate and agitated. Some participants lacked a deepening of the subject and called for more facts, more statistics and in-depth discussions and strategies to care for survivors and maybe treat an entire family who experienced a threat or completed suicide.

Participants also expressed wishes for recurrent training sessions with this group composition and ideally in the form of longer training sessions. "This course should be presented repeatedly/ Could have been a full day/ Too short a time/Influence every boss/Too little time for such an important subject/ Would like to have more education in this field". Several want to see even greater efforts made as concerns support and treatment of those who suffer from suicide problems. Some suggestions are: "This will require more resources such as more social workers and more adults around young people/Looking ahead, more adult involvement in the schools/Resource people who can be available nearby/ A social meeting place".

Within the framework of the project more training in giving care, in how one relates to the patients and guidance in conversing with the patients is being asked for. People are asking for better approaches in the acute situations so that people are met and given care professionally and with a better person-to-person approach. The starting point is of course to save lives but not only that but even to be able to master and be able to manage, on your own, to deal with the difficulties and the feelings of hopelessness. This is characteristic for the parallel processes that can arise between the helper and the helped. People on the brink of suicide frequently experience hopelessness and a sense of abandonment and even feelings of inferiority and shame. Faced with the threat of suicide or a suicide attempt, the person's thoughts circle around the idea of simply being helped as soon as possible. These people experience substantial ambivalence between wanting to be helped and the impulse to simply flee. A non-judgmental approach focused on showing the person that you care, that you are ready to listen and that you will try to understand and help are important in decreasing the ambivalence and the person's impulse to flee. In this situation it is even important to be aware of the fundamental needs such as rest, warmth, maybe something to eat or drink, when the person finds herself in a state of emotional shock and often is also completely exhausted. "I lack however more comprehensive guidance concerning what I should say/Communication technique-role playing/ What should one say to get the person to understand that it really is worthwhile living and be needed?/A suicidal person who often is aggressive" are thoughts from the participants. Suggestions concerning areas that the participants would like to be able to take courses or programs in on a future follow up day are the following: (a) The occurrence of suicide from a global perspective. (b) The occurrence of suicide in groups of immigrants. (c) More opportunities for facts to be presented, statistics and more space for discussions. "How does it work in the rest of the world?/ More facts/More discussion/Deal with the immigrant question, how does this look?"

To lose someone close to you through suicide can be very difficult. The sorrow experienced by the survivors is most often marked by a mixture of feelings such as guilt, shame, and anger. Possible support efforts are made difficult by the fact that suicide as a cause of death is a taboo subject. The survivors report that they are met by avoidance and to some extent even by a lack of understanding on the part of those around them. The stigmatization (depreciating comments, psychological branding) that the psychologically ill experience can be shared by those who have survived the suicide. The similarities can consist of those in one's surroundings who do not understand these intense feelings of guilt, shame, and anger. This can result in making the response to sorrow and the process of recovery complicated and time demanding. Strategies for care and questions about what is available for providing care, support for next of kin and survivors were sought by participants. "What should we say to next of kin?/ Treat the whole family/ Help directed to the next

of kin was lacking/ How can you take care of next of kin who have been affected and do so in a good way?”

Interactions among Units

This index category contains 58 MU, divided into six categories: police, paramedics, physician's role, responsibilities for transport, psychiatry and procedures. The police presence and availability is limited in the area. At suicide alarm is police presence very appreciated but there is also much frustration when this presence is absent or delayed. Participants asked for clarifications regarding the physician's role in connection to suicide prevention. The availability of doctors is limited in this area at the same time as there is a comprehensive prescription of drugs. A need for clarification was also requested regarding liability during transport due to the problem that suicidal persons often are refused ambulance transport to hospital for assessment. As the emergency organizations regard the psychiatric care as the institution with knowledge and experience concerning suicide prevention there were complaints from participants that there were no representatives from psychiatry at this training program. The largest category in terms of activities can be described as routines and participants wanted more and clearer procedures in conjunction with threats of suicide and actual suicide. Procedures are overlapped when different organizations, missions and roles ceases and is handed over to the next instance and therefore it would be valuable with an increased communication before, during and after the care.

The participants recommend that police responding to a suicide alarm come in civilian clothes. The person on the brink of suicide is already exposed so implementing this recommendation might help to reduce the feelings of being exposed. In most alarm situations it is the police team that is most close by that must be sent as quickly as possible. Some police in service are in civilian clothes, for example when searching for a missing person. However, most police in service are in uniform. The necessity for quick response has higher priority than choice of clothing. In the case of police assistance requested by a physician or by social services LPT (law on compulsory psychiatric care LVM (law on the care of substance abusers in certain cases) LVU (law with special provisions concerning the care of the young) assistance can take different forms as concerns level of priority, but most often, even in these cases it is given by uniformed police. Some asked what routines police follow on receiving a suicide alarm. Several participants said that they had experienced difficulty in getting help from the police in these situations but that police are a great help when they once turn up. In sparsely populated areas, the presence of police is a resource-limited question. In an alarm situation in such an area it is most often emergency service personnel of all the Blue Light teams that can respond most quickly. Participants observed that: “Pick up by police in civilian clothes/ Police in ordinary cars when responding/ Why is it so hard to get help from the police?/If the police do come, they are really god”.

The role of the physician within a common effort to carry out suicide prevention should be clarified. Access to physicians is limited in thinly populated areas and we see an extensive practice of prescribing medication in these areas. Blue Light personnel experience considerable frustration when the physician does not react promptly in acute situations; this has an effect on cooperative efforts in alarm situations. Personal experiences from the participants are that access to medication is substantial and they note that there is, however, a shortage of psychologists and psychotherapists in this part of the county. They would like to see more prompt reporting after the fact as concerns the physician's evaluation of the patients' suitability for being allowed to own weapons. In Värmland county, the per-capita ownership of weapons is high because of the level of interest in hunting on the part of residents. This is documented by the hunter registry (SEPA, 2014) showing that Värmland ranks high as concerns the number of hunting licenses purchased in 2012/13. Some quotations from participants: “Physicians should not be writing so

many prescriptions/Physicians' prompt reports on ill-suited weapon owners/Our credibility among next of kin or patients decreases the longer the time it takes for the physician to arrive/Better cooperation with the district physician-must come as quickly as possible.”

The definition of what is to be regarded officially as “transport of an ill person” as well as the question of responsibility for transport was a subject within this particular area concerned with interaction. The following quotations came from the participants: “Who is responsible if a patient, for example, throws himself out of a taxi? / If we are not provided with an ambulance, who takes responsibility for transport if the patient has not yet been psychiatrically evaluated?/ How are we to deal with transport between Torsby-CSK (Central Hospital Karlstad) if an ambulance is not provided?”. “Transport of an ill person” is the designation that applies when there is no need for medical care during transport. This is provided as support in taking the person to health care who suffers from functional disability, illness, or an inability to personally drive or use public transport. In the case of transport of an ill person, the driver has responsibility for transport and the patient is personally responsible for his or her health condition. If there is a need for care or for placing the person under observation and monitoring of health indicators, then SOS Alarm must be contacted. The recipient of the alarm is an experience nurse who makes the judgment concerning level of need. On the basis of this judgment, the level of priority is determined and thus whether police are to be involved or whether ambulances transport is to be ordered.

Participants wanted representatives from psychiatry to be present as participants in the course. Psychiatric personnel are seen as an important part of the interacting groups. Psychiatry is seen the leader who is the bearer of both knowledge and experience in the field. Psychiatry is not a part of the Blue Light enterprise. Psychiatry personnel were missed by some of the participants. “It would be interesting to hear how they (psychiatry) work with and against a suicidal person/ Missed representatives from psychiatry/ Would be good to have psychiatry with us “in the same boat”/ Better cooperation with psychiatric care/ As it is now, it difficult to reach outpatient care”. The wish was expressed for psychiatry to be part of the cooperative enterprise. According to the Final Report (SsiV, 2013) there is within the project a cooperative effort with the county council in the center and with the psychiatry division in northern Värmland. This cooperative effort is directed toward the internal suicide prevention project, and is intended to see over routines and health-care programs both within psychiatry as well as primary care.

Blue light personnel work at the frontlines and meet people in acute situations on whom they must quickly make critical judgments, save from an accident, take into care and more. To not be given any feedback or information on how routines, health care programs worked out can be experienced with feelings of frustration. Perhaps you will meet the same individual in repeat situations and then face the consequences of the failure of follow up or routines. We are asking for reporting on experience from psychiatric care and on the levels of competence. Increased cooperation with psychiatry is sought. A need was expressed for a comprehensive plan covering all the organizations and units that are involved no matter who may be in charge. The need to have access to resource people and others who can be contacted in certain situations was also expressed. The participants want to see specific routines to be followed by Blue Light personnel in “sharp” situations. In a “sharp” situation it might be a person with a weapon, someone who threatens to jump from a heavily trafficked bridge, or other such situation. There is even a need for routines concerning taking into care personnel who have worked in suicide situations. Here are some sample quotations: “In” sharp “situations, for example, there is a breaking point. How should we act?/ A well-developed follow up of those people who have suicidal thoughts, who have attempted to take their lives/ Would really like to see that the question about resource people-colleagues

who might be contacted in connection with a suicide-attempt could be taken up/ Not very good with debriefing is how we as personnel have experienced the situation”.

Reflection and Evaluation

This index category contains 124 MUs divided into three categories. The participants’ pondering after the training, economic impact, educational and rewarding. Some participants felt that the day was memorable and informative. It was thought that the training initiative could lead to increased opportunities for people in crisis to get help and also that the emergency staff had gained a greater understanding of people with suicidal problems. Other reflections were that the county’s resources must better match the need of the residents. One example is that there are long distances between home and hospital wards in the county’s northern part. It was further considered that the level of knowledge and case descriptions were at the right level and they were perceived as rewarding. The training day was perceived as well-planned and with an extensive content.

One of the goals of the lecture was to transmit basic knowledge within the suicide prevention body of knowledge and offer a chance to exchange experiences. Here are some quotes from the participants: I got aha experiences connected to my daily work/Set many thoughts in motion, that I can get help from both at work and privately/Has aroused thoughts that it is not dangerous to talk about suicide/Good that the soul gets some attention/ Very good knowledge to have with me in my backpack.

In northern Värmland it is apparent that the residents’ needs are not matched by the county’s resources. This depends first of all on the long distances between dwellings and the hospital as a result of the closing of departments and outpatient locales. The need for a social worker as well as more resources for the health-care providers is tangible and this can lead to difficulty in establishing contact with health-care providers. To recruit, or as an alternative develop, personnel specifically qualified to work in suicide prevention does not have high priority in an already stressed economy within county and county council. Within sparsely populated areas it can be difficult to recruit personnel or to further develop existing personnel when education is often linked to time-consuming travel. Participants report on high work load and stress and feel a sense of inadequacy. To work in this exposed group can be demanding in terms of both time and resources. This can require investigatory activities, if an individual misses a planned appointment or home visit. To be able to set aside ordinary planning and work actively on dealing with crises can be difficult. Examples from participants were: “Health-care staff need more resources if they are to be able to help this group/ More specialist-trained people, for example social workers and nurses with psychiatric training are needed/ Hagfors county has economic problems/ I believe it will need more money if they are to be helped/ Given present conditions it is difficult to get help and there are long waiting times for patients”.

In the evaluation material participants have picked out different opinions about this workshop. One opinion was that the day was education and that the transfer of knowledge took place at a satisfactorily high level. The use of case studies in the lecture was fruitful. Time passed quickly and the day was well planned with comprehensive content. Examples of quotations from participants were “Very good and interesting day/ Good and a satisfactory level/ Got a lot out of this day/ Good to meet people over the boundaries between us/ Good with case studies/ Thanks for a nice day”.

DISCUSSION

The Educational Triad

Taking as a point of departure the data we had collected, we carried out an analysis in which the phenomena were studied from different

perspectives. This took place by taking inventory of meaning-bearing units that were transformed in order to retain the context before creating categories and formulating synopses that could then be tested by applying tests of validity. It could then be seen that it was possible to group categories into larger comprehensive categories, index categories as described in the results section. The next step was to determine if it was possible to find repeated themes in the five index categories that serve to describe the essence of the material that was collected. This revealed three such themes taking the form of an “educational triad”, specifically “experience”, “interaction” and “collaborative learning”. These themes were amply represented in all the index-categories and even, to a large extent, at the category level and MU-level. The themes are linked together and can be seen as a model where we learn together (collaborative learning) by making use of each other’s’ experience in cross-disciplinary professional seminars (interaction) (Figure 1).

Experience

A key result of the study was that participants experienced education as important and evolving, which was based mainly on experience sharing and group work that was a prominent feature of the training program. This is in line with results showing that increased knowledge through the exchange of experiences about suicide processes and mental illness increases feelings of security when meeting people suffering from mental illness or who are suicidal (Hultén et al., 2001). The second largest category, number 6 (64 MUs), was indeed the exchange of experiences. Having the opportunity to share one’s own experiences from situations of alarm was seen as very relevant. A cross-professional training was seen as positive and one that strengthens collaboration at the time of an alarm. The need for insight into the roles and assignments was also illustrated. Working together in terms of group training was seen as meaningful. As Blue Light personnel we are ambitious, we have almost a reflex like instinct to save lives, and a desire to help people in an accident situation. Handing over the situation to the next organization, with feelings that some people do not obtain the best help, or are not taken seriously, is very frustrating. Personnel in the blue light professions have had experience with efforts in connection with a suicide alarm in the acute phase that was not sufficient. It has happened that blue light personnel repeatedly meet the same person on several acute occasions. There were phenomena even in the preventive and follow-up work that were seen as insufficient. The possibility of catching repeated cases was requested.

It was also evident that the emergency organizations have established good routines with debriefing and reflection. A need has been expressed for having some of these activities carried out together within the Blue Light organizations. In alarm situations where we work together across boundaries there is no space for exchanging

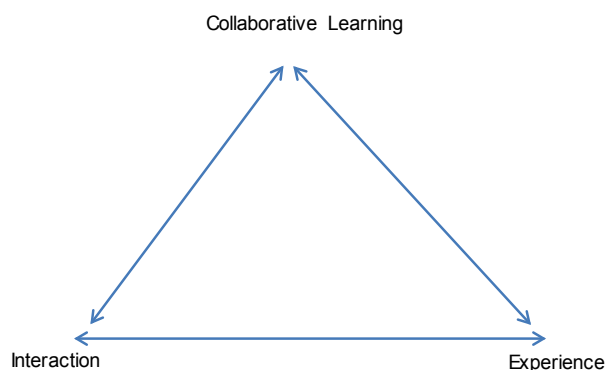


Figure 1. The educational triad begins with collaborative learning; we learn together by using each other’s competence and knowledge. By getting help through the sharing of previously reported experiences, suggestions are brought to the surface concerning possible interaction among the various parties engaged in the collective efforts made in response to a threat of suicide.

experiences as may easily be understood. Everything takes place in a structured and according-to-routine manner, and there is no place for conversation or reflection. In the case of suicide alarms there can be certain difficulties with being helped by the police. This is resource related. In northern Värmland's thinly settled areas it is emergency services that can respond most quickly. Consequently it is emergency services in these areas that play a more central role in connection with suicide alarms than other Blue Light units. This leads to an increased need for cooperation in these situations both within other Blue Light units as well as with health-care providers, something that was taken up in the workshop. Within Blue Light there is a high level of competence within the respective areas of responsibility but it has been noted that they lack or have insufficient competence in the area of suicide prevention, psychological ill health, and giving care and interacting.

Interaction

Participants regarded interaction in terms of partnerships in emergency situations across organizational boundaries as something that could be strengthened. This was experienced as special important when waiting for the arrival of the police. In northern Värmland, this is an important factor because in rural areas there are often sparse police presences due to lack of resources. A problem of interaction across boundaries between public safety and healthcare personnel are as already pointed out that it is often perceived as unsatisfactory. Several participants therefore demanded that to future meetings also psychiatrists and other health care providers should be invited.

Collaborative Learning

Within collaborative learning, which is an active and constructive process, it is possible to integrate new information and knowledge with what is already available. According to Dillenbourg's (1999) broad definition of collaborative learning, this takes place in situations where two or more individuals learn or try to learn something together. This is done by mutual exchange of experiences and interaction which are significant components in terms of developing a collaborative learning. It is fully in line with the current study which showed that there was a great need for education concerning the subjects of suicide prevention, mental illness and treatment.

Concluding Comments

The design of the investigation, including the questionnaire and number of participants, were already determined and implemented before the study began. Thus the present authors had no opportunity to influence the construction of the questionnaire. The project management wanted an overview of participants' spontaneous reactions on the program in order to facilitate future training efforts. Nevertheless it should be stressed that despite the design of the investigation, it was quite possible to follow the five steps of the method even if abstraction level was rather low. We plan for future studies in which emergency staff, significant others and patients will be interviewed in-depth and analyzed by phenomenological methods.

According to a final report (SsiV, 2013) from the current project (where the pedagogical interventions described here and the cross-disciplinary meetings at the leadership level are present) it is stated that the goals set for the project have been met to a high degree. The project's overriding goal was to decrease the number of completed suicides as well as attempted suicides. Other goals were to increase awareness and knowledge of questions that are related to psychological ill health and suicidality among the young and other elements of the population in northern Värmland. The number of completed suicides in 2009-2013 in the region has been lowered for men but not for women. To draw any conclusions as to a possible

relationship between this decrease and the project is, however, not possible. Experience from short courses in Australia and seven other countries (Kitchener & Jorm, 2008) demonstrated that the concept "first aid" is known by many as concerns physical illness and it is therefore relatively easy to broaden the concept and attitudes to include psychological ill health. By providing short courses in first aid, the general public's attitude toward intervention at an early stage can normalize views of psychological ill health and as a result make it easier for exposed individuals to seek support and help from health-care providers at, for example, primary care centers, psychiatry, and in places of employment and schools.

The present study confirms Currier and associates' (Currier et al., 2012) results that a "brief educational intervention" can have "beneficial impact" on providers' perceptions of how well suicidality was recognized and managed by emergency personal. Within the framework for a unified and well organized campaign, "brief" can be "enough".

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