Enhancing Community Suicide Risk Assessment and Protective Intervention Action Plans Through a Bystander Intervention Model-Informed Video

A Randomized Controlled Trial

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Abstract. *Aim:* The effects of a bystander intervention model (BIM)-informed intervention (video) for the general community on participant risk of suicide assessment ability (ROSAA) and protective intervention ability (PIA) were compared with an active control (non-BIM-informed video). *Method:* Video interventions with 628 participants (M_{age} = 47.99, SD_{age} = 17.34, range = 18–85 years) were conducted online. ROSAA and PIA were assessed immediately preintervention, postintervention, and at 2 months follow-up (n = 126). *Results:* Linear mixed model analyses indicated that the experimental and control conditions improved on both outcome variables postintervention/Time 2 (T2); however, the former yielded better outcomes than the latter (moderate ESs in both variables). Follow-up/Time 3 (T3) experimental ROSAA scores were higher than Time 1 (T1) and lower than T2 scores. Follow-up experimental PIA scores were higher than T1 and lower than T2 scores. Follow-up control ROSAA scores were higher than those of T1 and similar to T2. Follow-up control PIA scores were similar to T1 and T2 scores. *Limitations:* Limitations of the study include: sample homogeneity, small n at follow-up, self-report data only (no observable behavior was tested), fair inter-rater reliability, and a brief follow-up time frame. *Conclusion:* Current community information increased ROSAA and PIA. A BIM-informed intervention significantly enhanced these effects, which seemed to wane somewhat over time with the effect being lower at follow-up compared with postintervention. The BIM should be explored further as a basis for community suicide prevention interventions.

Keywords: community awareness, suicide risk assessment and intervention, bystander effect, bystander intervention model, technology

A nine-level approach has shown strong evidence for suicide prevention: reducing access to any lethal means to suicide, responsible media reporting of suicide incidents, community awareness programs, gatekeeper training, school-based programs, training of general practitioners (GP) in recognizing depression and suicide risk, training of frontline staff to effectively intervene, evidence-based psychotherapy, and follow-up for individuals with a recent suicide attempt (Hegerl & Wittenburg, 2015; Hickie et al., 2014; Krysinska et al., 2015; Werner-Seidler et al., 2016). Hill et al. (2020) have suggested that the community awareness domain is a more important component of these nine elements than what has previously been highlighted, since the majority of persons at risk of suicide are more likely to access informal forms of support through family and friends than through professional services (Bloch, 1987; Kalafat et al., 1993; Klimes-Dougan et al., 2013). This has been said to be due to high self-reliance, lack of perceived need for treatment, and stigmatizing attitudes toward suicide, mental health issues, and seeking professional help (Han et al., 2018).

Significant upskilling of the community in the early detection of suicide risk and protective responses may therefore represent a viable pathway for enhanced suicide prevention (Hill et al., 2020). Various studies of bystander behavior involving situations of suicide risk further indicate

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this need. In one study for example, approximately 75% of adolescent participants reported keeping the intentions of suicidal peers secret, that is, not escalating the issue and seeking professional help (Klimes-Dougan et al., 2013). In a sample of adults, even when someone had voiced suicidal thoughts and intent to die, participants were far less likely to report seeking emergency services for them than for someone with signs of a heart attack (Rudd et al., 2013).

The bystander effect is defined as the inaction by third parties to anyone in need of help due to fear of negative evaluation, incompetence, lack of confidence, and diffusion of responsibility. This effect has been found in scenarios involving suicide risk (Klimes-Dougan et al., 2013; Rudd et al., 2013). The bystander intervention model (BIM) is said to overcome this effect through promoting helping behavior through five steps: (1) notice a situation, (2) interpret it as important/urgent, (3) assume personal responsibility to help, (4) feel confident and competent to help, and (5) consciously decide to help. A recent study found that BIM-informed suicide prevention material for the community significantly increased participants' confidence, readiness, and intent to detect and respond to someone at risk of suicide compared with an active control (Hill et al., 2020). The present study aims to extend this research, by assessing what is deemed closer to actual behavior than confidence, readiness, and intent – action plans (Hagger & Luszczynska, 2014). Action plans, an account of how to complete a prospective behavior, are said to fill part of the intention–behavior gap. It is hypothesized that BIM-informed suicide prevention material will lead to significantly higher risk of suicide assessment ability (ROSAA) and protective intervention ability (PIA) postintervention and at follow-up compared with controls.

Method

Study Design

The study was a 2 × 3, between-group–within-group, repeated-measures randomized controlled trial. The within-participant variable was time (preintervention, postintervention, 2 months postintervention) and the between-participant variable was intervention content (BIM-informed vs. not BIM-informed). The dependent variables were ROSAA and PIA.

Ethics Approval and Registration

The university's Human Research Ethics Committee registration number is: HEC190008; the Australian New Zealand Clinical Trials Registry registration number is: ACTRN12618001331224.

Participants

Male and female participants from the general public aged 18 years and over were recruited. Exclusion criteria were previous bereavement by suicide, being distressed by the topic of suicide, and/or experiencing suicide ideation. Participants had to indicate they did not meet any of the high-risk group criteria before commencing the study. The study was conducted online, and participants could participate from anywhere. A power analysis was performed for a repeated-measures design to compute the required sample size, given an ES of Cohen's $d = 0.50$, significance level $\alpha = .05$, and a power of .80. The software G*Power 3.1.9.7 (Faul et al., 2007) was used. According to this analysis, a total of at least 86 participants was required to detect an ES of $d = 0.50$ with $\alpha = .05$, and power of $(1 - \beta > .80)$.

Intervention

Experimental

This group viewed a video (10 min, 22 s) showing a presenter explaining evidence-based, best practice guidelines in suicide risk assessment and protective action, specifically arranged to address each part of the BIM in order (see Electronic Supplementary Material [ESM] 1 for details).

Active Control

The active control group viewed a video (5 min, 43 s) showing the same presenter summarizing available information from the most well-known suicide prevention websites and organizations in Australia (as indicated by a pilot cohort of $n = 281$) about what to do when worried that a friend may be at risk of suicide. An audit of this video indicated that the information only addressed Part 1 (noticing) and Part 4 (competence/confidence) of the BIM, in minimal detail.

Vignettes

The study used two similar vignettes involving a person noticing a peer displaying warning signs and risk factors of suicide based on the study by Jorm et al. (2005; see ESM 2). After reading the vignette, participants were asked what concerned them, what else they would want to know, and what they would say, do, and ask. Despite evidence showing that gender of the person showing warning signs does not have a profound impact on helping behavior, one vignette presented a male (Steve), and the other a female (Kate) as per pilot feedback and requests for alternate vignettes pre- and postexposure to intervention content (Fischer et al., 2011).

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Measures

ROSAA

Participant risk assessment ability was measured by a checklist of best practice in detecting the most significant risk factors and warning signs for suicide (Page & Stritzke, 2014; see ESM 3, Part A). These included 15 components, for example, noticing a recent loss, increase in substance use, experience of intense guilt, and suicide ideation. Participants were awarded one point if they mentioned a risk factor or warning sign, two points if they elaborated and provided detail, and three points if they mentioned they would ask about suicide ideation. These were totaled to derive the ROSAA score (range = 0–31). Responses were elicited through three open questions: (1) What stands out to you about Steve/Kate that may be of concern about their overall well-being? (2) What else would you want to know about Steve/Kate? (3) How do you interpret the situation with Steve/Kate? The training taught participants how to identify immediate risk in others (if there are thoughts of suicide plus any plans and/or intent, where they were encouraged to access immediate support through going to hospital or calling emergency services) or present risk (suicide ideation and other risk factors but no plans and/or intent, where they were encouraged to monitor ongoing risk and access support through a GP and counselling/psychology and community support).

PIA

Participant PIA was measured by a checklist of best practice in nonprofessional bystander responses (see ESM 3, Part B). These included 27 components, for example, taking personal responsibility to help or find help, involving other family and friends, calling a crisis line for advice, giving the person a crisis line, encouraging and supporting the person to see a professional, encouraging and engaging in a healthy and meaningful lifestyle, and removing anything the person could use to harm themselves. Participants were awarded one point if they mentioned a protective intervention, two points if they elaborated and provided detail, and three points if they mentioned the most important part of overcoming the bystander effect, assuming personal responsibility. These were totaled to derive the PIA score (range = 0–55). Responses were elicited through three open questions: (1) Who do you think is in the best position to support Steve/Kate? (2) What do you think should be said to and asked of Steve/Kate? (3) What do you think should happen next to support Steve/Kate?

Two researchers, a clinical psychology registrar with a Bachelor of Psychology (honors) and Master of Psychology (clinical) and another with a Bachelor of Psychology (honors) scored these qualitative responses separately, blinded to intervention groups.

Inter-rater reliability analyses were conducted using the kappa statistic to determine consistency among raters for both measures, which were fair (see Table 1). The scoring of the researcher with more clinical experience was used for analysis.

Manipulation Check Scale

A manipulation check with 10 items was conducted by asking participants how much the video content related to the five-part BIM on a 5-point rating scale from 0 (*not at all*) to 4 (*an extreme amount*; range = 0–40). This scale aimed to test participants' comprehension of the video content and their perceptions of whether the independent variable was informative in a way as intended by the researchers. The control group's content only included two parts of the BIM, whereas the experimental content aimed to teach all five parts of the BIM. The manipulation check intended to test whether this differentiation in the two conditions was successful. An example item includes, "To what extent did the video help you notice Steve may be thinking about suicide?" The Manipulation Check Scale had very good internal consistency in the current sample ($\alpha = .96$).

Attention Checks

Participants were not allowed to continue through the survey until the length of the video had been passed. Furthermore, after watching the video, participants were asked to rate how much they agreed with the following statement: "I watched the video in full and attended to all content" on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Only responses which indicated 4 or 5 were included in the analysis.

Study Protocol

The online study was conducted using Qualtrics software (https://www.qualtrics.com). The study was conducted between May and September 2019 (follow-up conducted July–November 2019). Participants were recruited via social media, flyers delivered in local (Brisbane, Australia) libraries, gyms, retail shops, and universities, and through the Qualtrics paid platform. Participants were directed to the survey via a link on the flyer and allocated randomly to

Table 1. Kappa statistics for ROSAA and PIA

Time	κ	*p*	Level of agreement
Time 1, ROSAA	.22	<.001	Fair
Time 1, PIA	.33	<.001	Fair
Time 2, ROSAA	.21	<.001	Fair
Time 2, PIA	.23	<.001	Fair

Note. PIA = protective intervention ability, ROSAA = risk of suicide assessment ability.

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a condition by Qualtrics. The study advertisement and every survey page provided professional support information for anyone experiencing distress. The survey consisted of the following: demographics, Vignette 1, six open questions to respond to the vignette, video (experimental vs. control), Manipulation Check Scale, Vignette 2, open questions time 2. A follow-up survey was sent out via email 2 months post-intervention, which included Vignette 2 and open questions time 3. The time frame of 2 months was based on previous research in bystander behavior (Banyard, 2008). See ESM 4 for a CONSORT flow diagram.

Data Analysis

Mean level changes in ROSAA and PIA over three time points were examined dependent on condition. The SPSS 24 MIXED procedure was used to calculate linear multilevel models. In separate univariate analyses, the two outcome variables were specified as the Level-1 dependent variables with three time points, crossed in individuals (Level 2), with restricted maximum likelihood estimation, also accounting for missing values. Cross-level interactions were assessed to determine relationships between intervention conditions and the three time points. All assumptions were met for the analyses conducted.

Results

Participants

At Time 1 (T1), 320 participants were randomly assigned to the experimental intervention and 308 participants were randomly assigned to the control group. All participants were retained at Time 2 (T2), totaling 628. At Time 3 (T3), 67 experimental participants were retained compared with 59 controls, totaling 126. Although 167 participants responded at T3, not all identifier codes were matched, leaving 126 to be analyzed. See Table 2 and Table 3 for age and gender demographic data between groups and time points. See Tables E1–E3 in ESM 5 for ethnicity, country of residence, and occupation demographic data. As shown in the tables, demographics between T1, T2, and T3 were similar.

Table 2. Age

Time	Condition	*M*	*n*	*SD*	Min	Max
1 and 2	Experimental	47.99	320	17.34	18	85
	Control	47.65	308	17.17	18	81
	Total	47.82	628	17.25	18	85
3	Experimental	52.01	67	16.60	18	82
	Control	52.95	59	15.85	20	81
	Total	52.45	126	16.20	18	82

Note. *n* = number of participants.

Risk of Suicide Assessment Ability

The effect of the intervention on ROSAA at three time points was assessed via linear mixed models (see Table 4 for descriptive statistics). Table 5 shows that condition significantly predicted ROSAA, time significantly predicted ROSAA, and the interaction of time and condition significantly predicted ROSAA at a moderate ES (Cohen's d = 0.65; see Figure 1).

To understand this interaction, pairwise comparisons were carried out (see Tables E4–E7, ESM 5). Pairwise comparisons showed that participants in both conditions had significantly higher scores at T2 and T3 compared with T1. At T3, experimental scores were significantly lower than T2, whereas control scores were not significantly different to T2 (relative to T3). Experimental versus control ROSAA scores were similar at T1; however, at T2 and T3 experimental ROSAA scores were significantly higher than the controls.

At T3, there was a significant difference between the two conditions, F (1, 272) = 3.96, p = .048, although the error bars overlap. Note that the aforementioned result is based on maximum likelihood estimates (n = 628, accounting for missing values) whereas a less sophisticated graph would only consider the actual longitudinal sample with n = 126.

Table 3. Gender

	Time 1 and Time 2		Time 3	
Condition	Frequency	%	Frequency	%
Experimental				
Male	131	40.9	25	37.3
Female	188	58.8	42	62.7
Transgender female	1	.3	0	0
Total	320	100	67	100
Control				
Male	123	39.9	20	33.9
Female	182	59.1	37	62.7
Transgender male	1	.3	1	1.7
Transgender female	1	.3	1	1.7
Genderfluid	1	.3	0	0
Total	308	100	59	100

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Table 4. ROSAA Time 1, 2, and 3 descriptive statistics

Time	Condition	*M*	*SD*	95% CI	Cohen's *d*	Min	Max	*n*
Time 1 ROSAA	Experimental	2.37	1.56	2.22, 2.53	−0.07	0	8	320
	Control	2.49	1.60	2.34, 2.65		0	8	308
Time 2 ROSAA	Experimental	4.83	3.33	4.57, 5.09	0.65	0	20	320
	Control	3.00	2.19	2.73, 3.26		0	11	308
Time 3 ROSAA	Experimental	3.96	3.88	3.55, 4.38	0.17	0	11	67
	Control	3.35	3.41	2.91, 3.79		0	11	59

Note. ROSAA = risk of suicide assessment ability.

Protective Intervention Ability

The effect of the intervention on participant PIA at the three time points was assessed via linear mixed models (see Table 6 for descriptive statistics). Table 5 shows that condition significantly predicted PIA, time significantly predicted PIA, and the interaction of time and condition significantly predicted PIA at a moderate ES (Cohen's d = 0.42; see Figure 2).

To understand this interaction, pairwise comparisons were conducted (see Tables E8–E11, ESM 5). Pairwise comparisons found that experimental PIA was significantly higher at T2 and T3 compared with T1, although T3 scores were significantly lower than T2. The PIA of the control group was significantly higher at T2 compared with T1. At T3, the control scores were not significantly different to T1 or T2. Experimental PIA scores were not significantly different to controls at T1, were significantly higher at T2, and were not significantly different at T3.

Manipulation Check

An independent samples t test revealed that the experimental condition (M = 38.21, SD = 8.91) had significantly higher scores than the control group (M = 35.15, SD = 9.20), $t(626) = 4.24$, $p < .001$ (two-tailed). The magnitude of the difference in the means (mean difference = 3.06, 95% CI [1.64, 4.48]) was small-to-moderate ($\eta^2 = .03$).

Table 5. Fixed effects on scores based on linear mixed modeling

Source	Numerator *df*	Denominator *df*	*F*	*p*
ROSAA				
Intercept	1	648	1801.00	<.001
Condition	1	648	24.22	<.001
Time	2	392	159.76	<.001
Condition × Time	2	392	63.04	<.001
PIA				
Intercept	1	345	829.86	<.001
Condition	1	345	10.91	.001
Time	2	233	56.10	<.001
Condition × Time	2	233	15.45	<.001

Note. *F* = *F* test, PIA = protective intervention ability, ROSAA = risk of suicide assessment ability.

Discussion

This study was a trial of an educational video for adults in the general community that included information on how to assess for and respond to expressed suicide risk. The aim was to test whether a BIM-guided video increases ROSAA and PIA.

The results indicated that both groups improved in their abilities to assess and respond to suicide risk postintervention. However, the experimental group had significantly higher abilities immediately postintervention compared with controls. Although the intervention effects seemed to wane for the experimental group in both conditions, whereas the control group maintained learning between T2 and T3, the experimental group still had significantly higher assessment scores at T3 than the control group. Further, experimental ROSAA and PIA were still significantly higher at T3 compared with T1, where this applied only for ROSAA in the control group.

This indicates that the video education material guided by the BIM can enhance an individual's ability to assess for suicide risk and take appropriate protective action better than currently available information. As the Manipulation Check indicated participants deemed the experimental video content more in line with the five BIM components, this study provides evidence that a BIM-informed suicide prevention education video can enhance ROSAA and PIA in the general public. While current community awareness information can increase ROSAA and PIA, previous research suggests most community members do not intend to help when presented with someone at risk due to factors such as fear, uncertainty, and diffusion of responsibly (Rudd et al., 2013). Applying the BIM to inform community suicide prevention education content may counter these components acting as barriers to helping behavior. We may therefore see improved community responses to suicide risk, potentially leading to better prevention of suicide.

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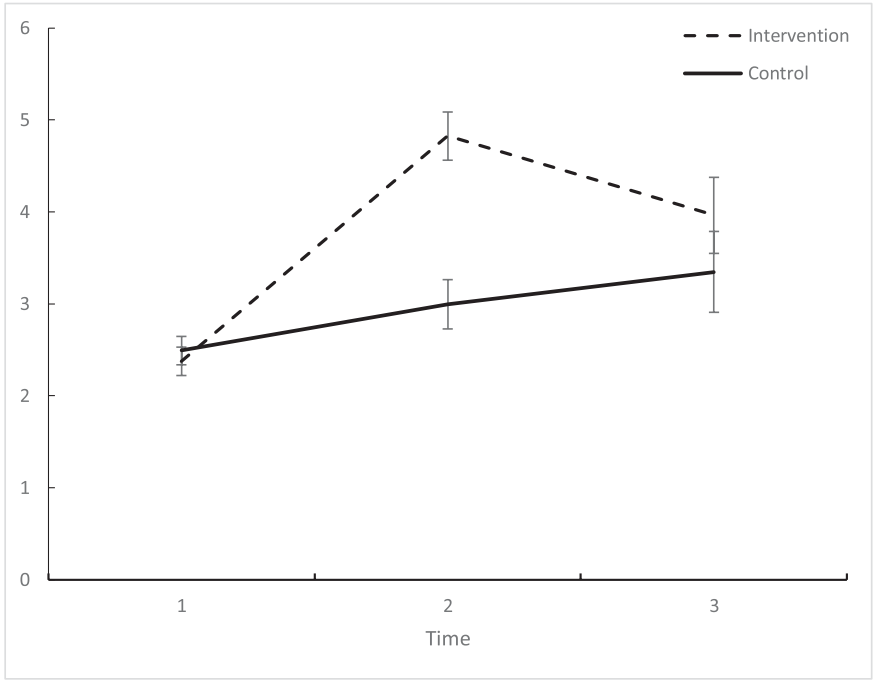

Figure 1. ROSAA mean scores at three time points with 95% CI error bars. ROSAA = risk of suicide assessment ability.

Intervention effects, however, were lower at T3 for the experimental group. These follow-up findings are similar to other longitudinal studies that often find significant decline in effect over time. This suggests community education should not be a one-off training. Rather, it should comprise an easy-to-access repository of information such as a website, booklet, social media page, or smartphone application (Cimini et al., 2014).

To our knowledge, this is the first study reporting the impact of video content informed by the BIM on action plans of risk assessment and protective intervention. The findings of this study suggest that following the five steps of the BIM of noticing, interpreting issues as an emergency, taking personality responsibility, feeling confident and competent to help, and deciding to help may generate a higher-level helping behavior from the public when someone presents with suicide risk. While actual behavior itself was not tested in the present study, the formation of an action plan can link to actual behavior (Gollwitzer, 1999).

Limitations and Strengths

Limitations of the study include the relative homogeneity of the sample, being Caucasian, Australian females working in the finance industry, which may limit generalizability to the general public. Furthermore, the sample size at follow-up was much smaller than the original sample despite follow-up reminders and incentives. This may have introduced undetected bias into the sample. Moreover, although action plans are a more in-depth way to explore efficacy than forced-choice questionnaires, no actual behaviors could be practically assessed. Additionally, the kappa statistic was reasonably low indicating low inter-rater reliability. This may be because the scorers were at different clinical levels of experience. One scorer had an honors degree in psychology with no clinical experience, whereas the other had a master's degree in psychology with 5 years of clinical experience. Future research may benefit from scorers with more similar

Table 6. PIA Time 1, 2, and 3 descriptive statistics

Time	Condition	*M*	*SD*	95% CI	Cohen's *d*	Min	Max	*n*
Time 1 PIA	Experimental	2.06	1.786	1.86, 2.26	0.0	0	9	319
	Control	2.07	1.903	1.86, 2.28		0	14	308
Time 2 PIA	Experimental	3.67	2.907	3.39, 3.95	0.42	0	19	319
	Control	2.57	2.226	2.29, 2.86		0	14	308
Time 3 PIA	Experimental	2.95	3.02	2.41, 3.50	0.29	0	17	67
	Control	2.24	1.74	1.67, 2.82		0	8	59

Note. PIA = protective intervention ability.

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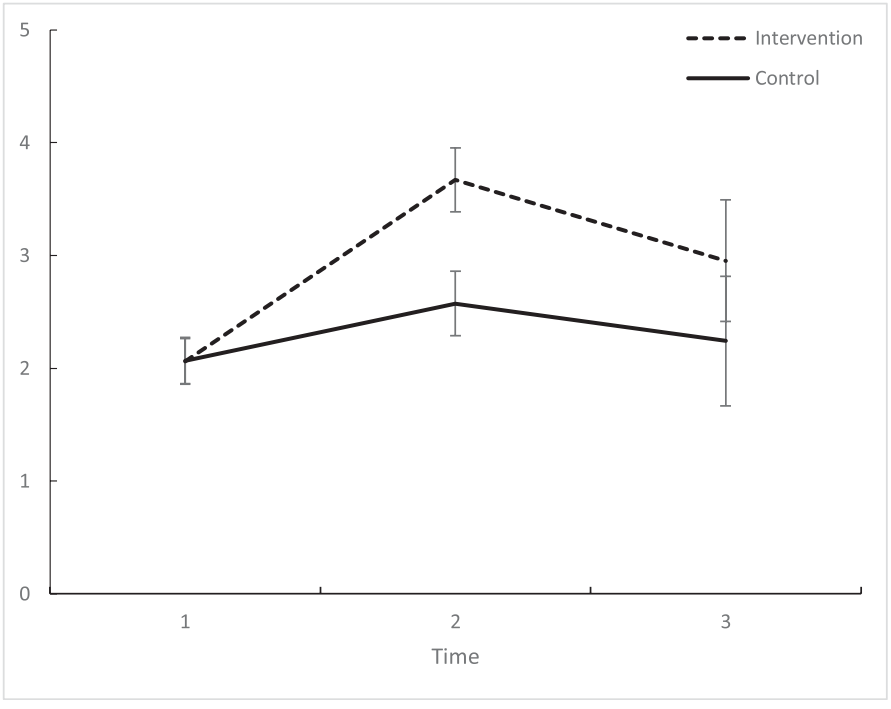

Figure 2. PIA mean scores at three time points with 95% CIA error bars. PIA = protective intervention ability.

experience. Further, the follow-up time frame of 2 months (although based on previous bystander research) was relatively brief and future research may benefit from a more extended follow-up time frame.

This study was unique and the first known application of the BIM in suicide prevention video material for the community. There is evidence that self-reported suicide risk assessment and PIA increased as a result of the intervention, although this effect waned somewhat at follow-up. Further, this study used an active control condition that had almost identical baseline scores preintervention to the experimental condition, compared with postintervention where experimental scores were significantly higher, a finding that deserves further investigation. Many studies assessing learning from suicide prevention material use forced-choice questionnaires, which are subject to social desirability effects, whereas the current study used an action plan format with open questions and written responses allowing a more in-depth exploration of learning and understanding.

Implications and Future Directions

The current study suggests that a BIM-informed community suicide prevention training video results in greater suicide risk assessment and PIA as compared with current publicly available material. This has important implications for future community suicide prevention campaigns (e.g., websites, flyers, workshops), which may benefit from being designed according to the five components of the BIM to increase likelihood of helping behavior.

Future studies are recommended to include a more diverse sample and assess beyond self-reported action planning (e.g., behavior through role play), allowing for a closer assessment of clinical significance. It is recommended that intervention information be more accessible in a variety of formats to suit different ages and preferences (e.g., video, booklet, website, smartphone application). Furthermore, based on the paucity of psychometrically validated measures in this area, it is suggested to adapt and/or develop and validate new measurement tools to assess the efficacy of BIM-informed education.

Conclusion

The results of this study provide evidence for the efficacy of a BIM-informed video in increasing suicide risk assessment ability and protective intervention. This can help shape future research to more efficiently address the high and increasing suicide rates. A substantially higher proportion of people at risk of suicide communicate their distress to community members than to health professionals. This warrants a focus on interventions to enhance general community members' ability to detect suicide risk, assess the risk, and take appropriate protective action to

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refer the person at risk to professional care. Interventions informed by the BIM may offer potential to enhance this response and, therefore, prevent suicide. This theory-based video manifested a clear short-term effect, and further research needs to identify ways to sustain this.

Electronic Supplementary Material

The electronic supplementary material is available with the online version of the article at https://doi.org/10.1027/0227-5910/a000806

ESM 1. Video content
ESM 2. Vignettes
ESM 3. Action plan checklist template
ESM 4. CONSORT 2010 flow diagram
ESM 5. Tables

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