TRANSCRIPT for Series 3, Episode 3: Around The World We Go

Introduction

Welcome to *A World Where LivingWorks*, stories of science and survival. Bringing together our heads and our hearts, to build a suicide safer world.

This podcast is brought to you by LivingWorks, a network of local suicide first aid trainers in your community and communities around the world visit livingworks.net to find out how you can play your part in suicide prevention.

Kim Borrowdale, host: You're listening to *A World Where LivingWorks* and I'm your host Kim Borrowdale.

First, I'd like to acknowledge Traditional Owners of the beautiful lands wherever you're listening.

I'd also like to acknowledge everyone out there who has been impacted by suicide, the pain it brings to our lives, but also the desire to make positive change, for all of us to live well.

Today I'm talking with Richard Ramsay, co-founder of LivingWorks.

This is the third episode in season three of A World Where LivingWorks, a season focused on learning about the history and evolution of their groundbreaking suicide first aid training practices, now being taught around the world.

We know LivingWorks today as a global leader in suicide intervention. Thousands of trainers in workplaces and communities around the world teaching gold class suicide first aid programs like the two-day ASIST workshop, the half day safeTALK suicide alert helper workshop and now the 90-minute online interactive introduction to suicide first aid, LivingWorks Start. Programs that have been endorsed in more than 50 peer reviewed journals around the world. That have informed international policy and are implemented everywhere from schools to military bases, hospitals to sports clubs and everything in between.

In the last episode, Richard was just about to tell us about how fellow co-founder Brian Tanney met Bruce Turley, who was key to LivingWorks' development – and, like us listeners, was also keen to know what was in Brian's suitcase!

Hello again Richard, thank you so much for joining us again. We need to know what's in that suitcase!
Hi again Richard.

Richard Ramsay, guest: Hello Kim, great to be back talking with you.

He was feeling kind of bad these Aussie people didn't care but Bruce walked up to him and said, you know I liked what you had to say and what's in that suitcase, Brian ceased the opportunity to tell him what was in the suitcase.

KB: Finally someone has asked me.

RR: Yeah right, that actually lead to Lifeline Australia and with us kind of in the background but Lifeline Australia wrote a grant, or proposal for Commonwealth grant which was approved and granted to do what was considered a three year portability study and the whole idea could you import something that was developed in North America into the Australian culture and have it accepted and they agreed on a three year study to see whether that was possible.

The first year, 1996 was to have three back-to-back training for trainers starting in Bundaberg, which is the rural part, then going to Wollongong which is sort of an industrial sort of city and then to Melbourne as the big urban kind of centre and we did three weeks of training for trainers starting in Bundaberg, we should have brought a bunch of rum but …

KB: You didn't?

RR: No, my brother was all about Bundaberg Rum but I hadn't sort of caught onto it yet, so he wasn't very happy the fact.

KB: Very un-Australian, I don't drink it myself, but it is very popular.

RR: Yeah, yeah, and anyway the three weeks were pretty onerous a few snorts of …rum.

KB: Bundaberg, Wollongong and Melbourne, you're covering thousands of thousands of kilometres there.

RR: Yeah, we finished up on Friday, Saturday was travel day Sunday was tourist day and checking the site for the next T4T and Monday was starting the five days all over again.

KB: That's a lot. I was going to say, did you get bums on seats readily? Were the people who worked for Lifeline keen to give this a go?

RR: Oh yeah, they were very good, it was a good relationship and the outcome of all this was Lifeline Australia then set up a LivingWorks Australia arm. LivingWorks Australia originally was auspiced under the Lifeline Australia, Bruce was in charge of it and in many respects it was another, fundraising arm for Lifeline, in the same way that they were connected with Goodwill Industries. It really was a good example of social enterprises being, connected or spin off from either a for-profit organization or a non-profit and in this case it was a non-profit owning a for-profit in affect to help raise money, apart from doing the training of their own people and so forth.

(5:57)

KB: That is an interesting model. Also, was this the first example then of crisis support services training in the LivingWorks ASIST model because now you see around the world, and I don't think people realise most of these services, you know your Lifelines and different support services where you have crisis calls, text or video all are trained up in the LivingWorks model behind the scenes.

RR: Yeah, this is and it became a challenge overtime, Australia was the first to really buy into the idea that something like, the ASIST training should be part of their Lifeline training, then in the United States when they set up a National Crisis Line and infrastructure organization to fund it, it was called NSPL National Suicide Prevention Lifeline, we ended up in a contract with them to amalgamate what they were doing with what we were doing and we actually had, if you want a conflict under the table most of the time but it was like, are they going to have us integrate our approach to training underneath their standard or are we getting them to adapt our training to their standard and there was a little bit of ego kind of stuff going on for a while.

But then what they did was, well actually one of their staff, Heather Stokes who came eventually to LivingWorks she was in charge of standards and practice committee and they had representatives from different training and other organizations, what she did was she said, ok this committee, we have to find all the training programs in the United States that might actually become our standard baseline, not that the crisis line will have to adopt

that particular training but they have to train up to it, and so they had 10 or 11, however many training programs and then they took each of the committee members and said, you have to go and experience that training and if you're associated with LivingWorks, let's say, you can't going to a LivingWorks training, you've got to go somewhere else. Then they brought all the information back and said okay, does anybody win and as it turned out, LivingWorks won, they decided that the two day ASIST was the baseline that they wanted everybody to either incorporate into their training if they could or to adjust their own training so it at least met those basic requirements. They started out back in 2006, I guess or 2007 with somewhere around 120 crisis agencies in the United States and the history of crisis lines in the United States, similar to Canada was not under the umbrella of one organization, they were all independents and they were organised in different kinds of ways and funded in different kinds of ways, but anyway, out of those 120 there was, I don't know, maybe 50/60% that were going to use the ASIST training and then over time, that number or the percentage of the total number has been getting bigger and bigger and bigger and the real full circle smile for me was when the Los Angeles Suicide Prevention Centre under its new name adopted ASIST as its new training program and again it's like, oh my god we were learning from you guys back in the 80s and now you've adopted our training as the standard for your training.

KB: That's so amazing.

RR: Yeah, that was a special feeling for me because myself and, well actually Brian and also Roger Tierney who had died, we had all got to know Dr. Farberow from that centre quite well and he was our idol really, for his faith in us in the 80s and then to have that organisation take on ASIST as their standard and incorporate it into their system was a big day.

KB: Yeah, that is a beautiful moment.

RR: And it was one of those private things, nobody else really knew why that was so important but it was just one of those private, wow this is really quite something because we were really, quite literally farm kids up in hinterland Canada that used to bring these experts from the United States up to conferences and get them to tell us how we should be doing things and in fact our first few years in California, we actually had quite a few discussions, informally most of the time but it was along the lines of, wow this is quite something, we were learning from you in the 70s, we would bring you up to Canada and you would present at our conferences, now here we are in California in the 80s and just think in the 90s maybe you will now have something new and you'll bring it to Canada and then the next decade it will be our turn to bring it back to the United States.

KB: Learning cycle.

RR: Yeah.

KB: What's interesting, it's happening with the international conference, you know, you talked about the South Africa one and Lars getting you to write that article ahead of that conference in the early 90s, what year was that?

RR: No the early 2000s, 2004.

KB: Early 2000s and then now 2021 the international conference is on Gold Coast in Australia this year and I just got a message from LivingWorks Australia just now, saying that they're actually presenting on people in trauma occupations with local first responders from Australia and around the world, the you're presenting and bringing together that symposium to show what you've learned back out again, it's just a nice synergy to see across the 20 years.

RR: And the presentation that we made in South Africa, it was a panel presentation that had to do with what was going on in Scotland at the time, what was going on in Norway, what was going on in Australia and what was going on in Canada, so the Australian presenters were Lindy and Lorna and Gaynor Hicks and then there was Elaine Loch who was from Scotland and Lars he was presenting on behalf of Kristy Silvola from Norway and I was sort of the overall kind of moderator/presenter of the Canadian start up.

KB: That's a great panel.

RR: It was just fantastic and Lorna had been working up in the Kimberley's and had some great stories working with Indigenous people and Lindy of course. She's been all over the world, I still, talking about South Africa, she would say, oh well, I mean I originally came from South Rhodesia of Zimbabwe and then she talked about the time she had in Hong Kong after she had to leave and then I think she was born in Singapore and now she's sort of the lead in places like South Korea and she's just an incredible lady.

(13:04)

KB: I can talk to her all day, I've got a soft spot for her too because she was my safeTALK T4T trainer, you know, she's my master trainer mentor, also lives in the Northern Beaches.

RR: Yeah, that's right and the first time I met Lindy was in, I forget which, it might have been the 1990s when we were back visiting, but she was the head of the Lifeline, sort of up the road in Manly or the next district over, I remember going in and meeting with her as a Lifeline person, not realising that in a few years she was going to become a LivingWorks person.

KB: And still now, yeah.

RR: Yeah, that's a little bit of those beginnings and it was like Australia was in the 1996 time and then it was late 90s that the people from Norway came and started to really develop the training in Northern Norway in TromsØ and they did something that no one has ever done before and they continue to do it, they started their training with medical students in the medical school and they also did something really unique is that they had a class of about 72 students, they divided them into units of 12 and then they went out into the community and got 12 community kind of people to come into the training, you were training doctors and community helper people together.

KB: Altogether. Was there any resistance to that or were they people thought that was a good idea because you know clinicians verses regular people, I guess, is there …

RR: Yeah, no they did like it, there may have been resistance, but they did a study two years later, published in 2007 and it was a qualitive study that went out to graduates of that school and to find out what they were doing as GP's in the community and what do they remember about their education and training.

KB: Now that they are in the workforce. What did that show?

RR: Well, it had sort of good and bad news, the bad news was that if they were a surgeon or somebody like that or internal medicine, they didn't remember anything about their courses back in medical school, I'm not so sure I want one of them practicing medicine on me.

KB: It sounds like they are just living for the day, their schedule on that day.

RR: Yeah, but they did remember was this two-day course they took on suicide prevention and they remembered it, they talked about using in, implementing it and they talked about how important it was to help them with their attitudes towards, you know, difficult patients and that was the good news.

KB: That is amazing, and they didn't retain their other medical knowledge, I'd much rather a surgeon talk to me about my suicidal thoughts than operate on my leg.

RR: Yeah, that's right, when you go to Norway, if you get into suicide trouble, it will be safe to go to a GP but if you get a broken leg, well maybe you should go to the local shaman or something.

KB: And what about the community people, did you manage to track their responses years on.

RR: No they didn't and the evidence there though is that this whole thing started in Northern Norway and within a year or two the Norwegian government decided that they should fund this program and then they funded them on a year to year basis and then a few years later they decided to make it permanent funding to the VIVAT organisation and then they went through a major reorganisation of health and trauma care services and they set up regional trauma centres and the VIVAT suicide prevention training became part of the regional centres and in fact at one point, in a sense they were going to make the VVAT people move from TromsØ into one of the central trauma centre and they put up a resistance and were granted the right to stay in TromsØ, it's still, the headquarters of the VIVAT is still in TromsØ but the network of suicide intervention training is in all the regional trauma centres across the country.

KB: Well that's fantastic.

RR: Yeah and it was our first test of real indigenisation of changing everything except the scripts to capture the Norwegian culture and to capture the Norwegian language and to film everything in Norway, and we had a very stringent kind of guidelines for anyone who is going to adapt our program and the Norwegians said they were happy to do that but then they got into a couple of problems that they would rather not follow how we did it in North America and one of the examples were, they said, you know the doctor scene where you have the doctor and the patient and in your original scene you have the patient sitting on one of those medical examination tables and the doctor is sort of talking down to her so to speak and the Norwegians said, you know we're prepared to do that if we have to but you know in Norway, that's not the way the doctor and the patient sort of relate to each other and it was like, what do you do in Norway and she said, well we actually sit in chairs side by side and it's what we said, of course.

(18:35)
KB: We'd like everybody to do that.

RR: And then we had the same problem when we indigenised in Northern Canada with the Inuit people and because of the rural nature of that part of Canada, you get into the typical rural problems of the helpers and the helpees, if you want, live in the same community and you can't do what a lot of helping organizations say is that you know, if I'm a social worker in town, I'm not supposed to be friends with you as my client, and it's like, how the can I not, you know.

Anyway when we did the filming in Northern Canada what we did was we had, it turned out to be sort of like a helper person, there was a conversation between the helper person with somebody in the office about a patient, about how they could help the patient and then the next part of the scene is the social worker now seeing the doctor with a suicide kind of problem, and we tried to normalize that you have to accept this kind of

cross over role differences in rural types of remote communities and we also filmed in English and Inuktitut at the same time, we had actors that could speak both languages and they were local actors, local people and we had also, it was interesting, we had you know, the literature in the old days sort of said, that these Eskimos/Inuit people didn't really kill themselves in the way in which we think about suicide but they would go off and onto an ice flow or something and just disappear and when we started working with them it was our Southern Canadian attitude that was history, they don't do that anymore, but we found out that's not true, that sort of thing still happens and when we did the film scene of the old man and the helper, we actually had set it in a way that he was going off on his snowmobile and that was the message he was intending to do the traditional ice flow kind of disappearance.

KB: You can give that indication.

RR: When you think you know somebody else's culture best you check, you find out whether or not you really know it or not.

KB: And what happens in reality verses what is assumed.

RR: Yeah, that's right.

KB: It was interesting talking to the community members involved in the adaptation of Indigenous peoples in this country, in Australia and what sort of conversations scenes and scenarios would be most relevant, when you were saying, giving people time to think about the attitudes and things like that, if that's one of the main things that came out of the I-ASIST development as well that actually I not only trust the trainer but I need to trust people in the room to be able to share the stories and experiences, so give me time to get to know you first and then let's go into more of the actual skills based training.

RR: That's what happened up in the north too, we did a day and a half of debriefing after one of our original demonstrations, 10 years ago now or more and afterwards we sat around in a room for a day and a half and the facilitator was a young man who educated in the south but he had come back home and he'd gone through the ASIST training for the first time but he was the facilitator and he had an in depth sort of sense of everything in behind ASIST that a lot of people don't get.

Anyway he was facilitating and he went around the group of 25 and he said, what do you think we should change to fit the northern culture and I was in the room and a couple of other people and they went all the way around the room and the answer was nothing and then he started to facilitate by saying, ok, let's look at page two and if he didn't get anything out of page two, then he would say, what about paragraph three and at some point it was, what about sentence ten, and then he started to draw out what people thought, oh well you know we could change this or change that but it was all very basic, it was things like, even if you just put a slide up that said welcome in our language, that would make a big difference. That is what Lindy had found out in the Pacific Islands some years before, if you let us use our own word for suicide in the role plays etc then everything else is fine, and then Lorna and some others who working up in sort of the Kimberley and they got into a number of Aboriginal communities. They discovered that the model by itself told enough of the story for them to understand, even the symbols that were obviously North American if you want Australian kind of symbols they made sense and it was like, you could walk into, in this case, any kind of community with the model and it will probably work.

KB: That's really interesting to learn, well don't they say, with any human being you should always communicate to the grade five level of reading anyway …

RR: Yeah, yeah and it's …

RR: If you're used to reading and it scares the hell out of you when you think, nobody's going to be able to read my book.

KB: Yeah, exactly. Especially when you've taken all this evidence and you know, practical application plus the academia and married it together, that's a lot of words and a lot of written evidence to put behind a model.

RR: It was another example of what taught in training of trust the process, it was like, trust the people and perhaps just the model and this thing is going to work, maybe it's not perfect but it's going to work and you can put away all the pamphlets and the handbook and the workbook and all that kind of stuff and just work with the people and use the model sort of like a talking stick, you triangulate the participant the instructor and the model and they can talk directly, when that's comfortable but if they need to they can talk through the model and communicate with each other that way and it just beautiful.

KB: It will still work.

RR: It will still work yeah and those are things that we had no idea about when we started building the curriculum. We developed the model, the actual physical, graphic model off of work that I was doing in social work with the geometrical thinking of Buckminster Fuller and his idea of holism, having to have a minimum of four and the shape is a geometric tetrahedron, it's like a triangle based pyramid and then we didn't know this at the beginning, we discovered tetrahedron structure is the same structure as the carbon molecule and the carbon molecule is considered the essence of life, or one of the essences of life, so it like wow.

KB: Wow.

(26:00)
RR: Then we took the model and I had figured out ways in social work to multiple the model into a bit more complex and then I could change it so that I could have a systematic phase like model and I could also have a systemic kind of context to it, and the power model came out of that thinking and one of the things we were never able to do, partly because of the time is that, it could never graphic if you want, or articulate the context parts, in other words the context of the person at risk or the person with thoughts and the caregiver and whatever discipline they might have been trained in or the personal life that they came from, because there are three context there that all interplay with each other and then you take them through a PAL kind of experience that goes from connection to assisting and all kinds of people just think that, oh it's just a pretty looking model, but you must have pulled it out of a shelf somewhere but when you understand the background of it, it's really quite exciting to think that we actually had chosen a structure that is connected to the essence of life kind of molecule, which is what it's all about.

KB: That's amazing, exactly, that's why we're all here and why we all want to help each other, you know.

RR: So many people will say, you know, I think there are a lot of people who like the model, they just like it, it speaks to them but to ask them why or where do you think it came from, it's probably a lot will say, it doesn't matter where it came from, I just like it.

KB: It just works.

What a great way to end this episode. It doesn't matter where it came from, it just works. Thank you so much Richard.

RR: Thank you Kim. Great to talk with you today.

I hope you've enjoyed hearing about the start of LivingWorks from the perspective of one of its founders. Join me for more conversation with Richard in the next episode.

Outro

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A reminder that if this episode has brought up tough emotions for you talk to a trusted family member, friend, or local support service about how you are feeling. Visit livingworks.net and click on Find Safety for international crisis services we are there to help you.