



scottishdevelopmentcentre  
for mental health

# **Evaluation of the Scottish SafeTALK Pilot**

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## **The Scottish Development Centre for Mental Health**

The Scottish Development Centre (SDC) is an independent, not-for-profit organisation that aims to achieve better mental health and well-being for people in Scotland.

We work all over Scotland for and with all kinds of organisations. Our clients and partners include voluntary organisations, businesses, health boards, local authorities, national bodies and networks. This breadth and scope means that SDC is ideally placed to bring a vision of the 'bigger picture' of mental health to everything we do.

We have an excellent record in canvassing the views of people with experience of mental health problems. This means that we can help their voices be heard clearly and promote their participation in decision-making. Firm believers in recovery, our working practices ensure people are supported to take part and that doing so is a positive experience.

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# Executive Summary

## ***Introduction***

SafeTALK is a new programme from LivingWorks Education. Developers in Australia and Canada designed and field trialled safeTALK in 2004-05 based on stakeholder reports of a training gap between LivingWorks suicide awareness sessions (suicideTALK) and its suicide intervention skills training (ASIST). These three programmes are part of a set of five LivingWorks programmes for enhancing suicide intervention capabilities.

As part of the development of a comprehensive suicide prevention training portfolio in support of the Choose Life objectives in Scotland, a 6 month pilot of safeTALK was initiated by the Choose Life National Implementation Support Team (NIST) in June 2006.

An assessment of the perceived relevance and quality of the course was required prior to implementing a Scotland wide programme of training. In response to this the Scottish Development Centre for Mental Health (SDC) was commissioned by NIST to evaluate the pilot introduction of safeTALK to Scotland and assess the implications for further roll-out of safeTALK.

## ***SafeTALK Goals***

SafeTALK is a half-day training programme, which can be used either as a stand alone or as a precursor for ASIST training. It has an awareness and training focus and teaches participants to recognise and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention.

After training, participants in the *safeTALK* programme should be able to:

1. Challenge attitudes that inhibit open talk about suicide.
2. Recognize a person who might be having thoughts of suicide.
3. Engage them in direct and open talk about suicide.
4. Listen to the person's feelings about suicide to show that they are taken seriously.
5. Move quickly to connect them with someone trained in suicide intervention

## ***Evaluation Aims***

The overarching aims of the evaluation of safeTALK were to ascertain:

- The views and expectations of key stakeholders of safeTALK
- Perceptions on relevance and use of safeTALK

The specific objectives were to obtain the perspectives of participants, sponsors and trainers on:

- Planning and set up of safeTALK
- Training content, materials and delivery
- Whether safeTALK training sessions meet the expectations of participants

- The extent to which safeTALK facilitates suicide alertness, that is, recognition of suicide risk and onward referral to ASIST trained helpers and other support agencies in the community
- How safeTALK fits in with other training
- Perspectives on targeting - for who should the training be provided?

The evaluation also aimed to identify whether and how participants used skills gained from safeTALK after the session.

### ***Methods***

A range of methods were used to evaluate the safeTALK pilot including:

- Analysis of safeTALK course feedback data completed immediately after training
- Telephone interviews with safeTALK participants
- ASIST Trainers Focus Group
- safeTALK pilot sponsors' focus group
- ASIST trained helpers email survey

### ***Key Findings***

The evidence from the pilot evaluation suggests that SafeTALK can achieve its goals and feedback from evaluation participants indicated that these objectives were largely achieved.

A consistent finding that emerged from the evaluation was participants' high level of satisfaction with the course despite the fact that in many cases this was a first training delivery by all trainers. The safeTALK programme content was very well received and the majority of concerns were about marketing and dissemination.

- Ninety-three percent (n=222) of those who completed feedback sheets said that they would recommend the course to others.
- Eighty percent (n=191) of safeTALK participants felt they were more likely to recognise the signs of someone being at risk of suicide, to approach the person, to ask them directly whether they were having suicidal thoughts and to be able to connect them to help. No course attendees felt unprepared to talk about suicide following the training.
- The participants interviewed by telephone were almost without exception full of praise for the content and the delivery of the training, often mentioning their positive experience when they were asked if they had anything further to add
- The interviewed participants who were involved in suicide prevention in their local area were all keen to bring safeTALK training to their area after attending the course.

### ***Roll-out of safeTALK: implementation issues***

The evaluation findings broadly support the roll-out of safeTALK across Scotland. However the evaluation also raises a range of development issues that should be addressed as part of the implementation of a roll-out programme.

Two overarching development issues arise from this evaluation:

- the need for clear information on the differences between, and appropriate usage of, suicideTALK, safeTALK and ASIST
- the need for agreement between services and agencies about roles and responsibilities regarding the support of individuals at risk of suicide.

### ***The appropriate usage of suicideTALK, safeTALK and ASIST***

Inconsistencies in evaluation participants' understanding of how safeTALK fits with other training suggest that awareness of the complementary relationship between different LivingWorks suicide prevention training courses amongst those involved in their implementation could be improved.

SafeTALK cannot be viewed in isolation and was designed to be part of a wider training framework as described in detail in the introduction to this report. Increasing awareness amongst those involved in the roll out of safeTALK of how it fits with suicideTALK and ASIST should underpin the approach to the roll-out programme.

Those involved in roll-out should consider the balance required between ASIST and safeTALK in each different setting in which the training is being delivered, based on identifying the need for intervention and/or alertness skills within that environment.

### ***Increasing capacity for delivering safeTALK training***

To ensure effective roll-out of safeTALK throughout Scotland, it was felt that more training for trainer places are needed and the issue of whether training for trainers should remain open only to ASIST trainers was raised alongside concerns that this could limit the potential for roll-out. Lifting this restriction should be considered for the roll-out. LivingWorks are in the process of piloting a number of T4T formats and opportunities for non ASIST trainers to become safeTALK trainers.

### ***Increasing uptake of safeTALK***

To increase awareness, uptake and the profile of safeTALK amongst those not already involved in Choose Life networks, more publicity is needed. This could be in the form of a national campaign, local publicity and/or the running of demonstration sessions. Linking in with local community networks and large organisations such as the NHS, councils and social services departments was also suggested as a way to increase interest in safeTALK.

### ***Roles and responsibilities regarding the support of individuals at risk***

The feedback from all groups of evaluation participants suggests that the main issue that needs to be resolved before further roll-out is systems used by people trained in safeTALK to link people at risk with appropriate intervention support such as ASIST-trained helpers. The evaluation suggests that the current networks and coordination amongst ASIST trainers, ASIST-trained helpers and other potential suicide intervention resources within local communities necessary to make this possible may not be sufficient.

Additionally, awareness of the 'referral' aspect of safeTALK amongst ASIST-trained helpers is debateable and those participating in the evaluation were split on their willingness to be identified as a contact point. It should be noted here that safeTALK was not advertised outside the pilot areas so awareness would be low, however given this low awareness it is encouraging that many ASIST-trained helpers said that they were willing to accept referrals. Although it is important to state that ASIST-trained helpers will not be *expected* to accept referrals from suicide alert helpers (it is a voluntary role) and therefore presents a key development challenge. It is crucial that this issue is carefully considered in settings or communities where safeTALK may be rolled out, so that neither safeTALK participants nor those they are linking people at risk with feel they are left "without back-up".

Potential options for development include:

- the development of a network of local agencies that are willing to accept referrals from safeTALK-trained helpers including voluntary agencies, helplines and statutory primary and secondary health and social services which have a key role to play
- employer organisations may wish to follow the example of SAMH, the MOD and the Forestry Commission, where safeTALK participants are given information about who the ASIST-trained individuals are, and clear referral pathways are developed
- when people who are trained in ASIST are to be a contact point, they should be consulted on and given the support they need to deal with this responsibility. (This has been added to the networking section of ASIST and is to be disseminated to trainers soon.)

In communities where there is no one identifiable that a safeTALK-trained helper might refer to, safeTALK may raise awareness of this issue and ask participants if they want to or believe something could be done about it.

# 1 INTRODUCTION

## 1.1 Policy background

### *Choose Life*

The National Programme for Improving Mental Health and Well-being was established in 2002 as a key driver of the then Scottish Executive's commitment to improve health and achieve social justice. A key policy aim of the National Programme is the prevention of suicide and suicidal behaviour. *Choose Life: the National Strategy and Action Plan to Prevent Suicide in Scotland* was launched in 2002 as a major strand of the National Programme's contribution towards achieving this aim.

The overall strategic aim of Choose Life is to reduce suicides in Scotland by 20% by 2013. To achieve this it has a number of supporting objectives which are:

- Early prevention and intervention
- Responding to immediate crisis
- Longer term work to provide hope and support recovery
- Coping with suicidal behaviour and completed suicide
- Promoting greater public awareness and encouraging people to seek help early
- Supporting the media
- Knowing what works

*Choose Life* action to prevent suicide is supported at both national and local levels: at a national level by a National Implementation Support Team (NIST) and at a local level, through suicide prevention action plans, agreed and supported by community planning partnerships (CPPs). In most areas, a *Choose Life* partnership was established as a sub-group of a CPP and a nominated Choose Life Co-ordinator identified, or appointed.

A key delivery route for both national and local suicide prevention action has been the development and provision of suicide prevention and awareness raising training and Choose Life has allocated £165k per annum towards a training strategy.

NIST has appointed a national training manager and a training co-ordinator to lead the development of a national training strategy. This has included the introduction and roll-out across Scotland of training packages such as suicideTALK, and mainly ASIST. At a local level, a range of training has been developed and implemented to meet local needs.

## 1.2 Suicide prevention training in Scotland

### *ASIST*

ASIST was developed in Canada in 1983 to facilitate early prevention and intervention for those who may be at immediate risk of suicide. ASIST also aims to support the development of a "suicide safer" community by informing and giving skills to members



of the community so that they feel confident to intervene if they encounter people they consider to be at risk of attempting or dying by suicide. ASIST is a 2-day course aimed at enabling people to spot the risk of suicide and intervene to prevent the immediate risk. ASIST implementation in Scotland is currently under independent evaluation.

### ***SuicideTALK***

SuicideTALK was designed to fill an awareness gap between what people generally know about suicide and what they need to understand about suicide including:

- Suicide is a major community health problem
- Anyone can be at risk
- Suicide can be prevented and there are things that can be done to protect oneself and others
- Open and direct talk about suicide is a key to prevention
- There are many different ways that one can contribute to the prevention of suicide

SuicideTALK does not aim to teach skills.

### ***SafeTALK***

SafeTALK is a new programme from LivingWorks Education. Developers in Australia and Canada designed and field trialled safeTALK in 2004-05 based on stakeholder reports of a training gap between suicide awareness sessions (suicideTALK) and suicide intervention skills training (ASIST).

#### ***SafeTALK Goals***

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After training, participants in the *safeTALK* programme should be able to:

1. Challenge attitudes that inhibit open talk about suicide
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5. Move quickly to connect them with someone trained in suicide intervention

#### ***Target audience***

SafeTALK is appropriate for most members of a community, to give participants the skills to recognise that someone may be suicidal and to connect the person to someone with suicide intervention skills.

### *Structure and content*

SafeTALK stresses safety while challenging taboos that inhibit open talk about suicide. The program recommends that an ASIST-trained individual or other community support person be at all trainings. The 'safe' of *safeTALK* stands for 'suicide alertness for everyone'. The 'TALK' letters stand for the practice actions that one does to help those with thoughts of suicide: Tell, Ask, Listen, and KeepSafe.

The safeTALK learning process is highly structured, providing graduated exposure to practice actions. The programme is designed to help participants monitor the effect of prevalent societal beliefs that can cause otherwise caring and helpful people to miss, dismiss, or avoid suicide alerts. Participants practice the TALK step actions to move past these cultural barriers. Six 60-90 second video scenarios are selected from a library of scenarios and strategically used through the training to provide experiential referents for the participants.

A table summarising the differences and similarities between safeTALK, ASIST and suicideTALK is provided in Appendix A. These three programmes are part of a set of five LivingWorks programmes for enhancing suicide intervention capabilities.

### ***Scottish safeTALK Pilot***

As part of the development of a comprehensive suicide prevention training portfolio in support of the Choose Life objectives in Scotland, a 6 month pilot of safeTALK was initiated by the Choose Life National Implementation Support Team (NIST) in June 2006. There was initial interest in safeTALK within the above network but an assessment of the relevance and quality of the course was required prior to implementing a Scotland wide programme of training. In response to this the Scottish Development Centre for Mental Health (SDC) was commissioned by NIST to evaluate the pilot and assess the implications for further roll-out of safeTALK. The pilot was jointly funded by NIST, and the pilot agencies which included the following self-selected organisations:

- Three Local Authority Areas:
  - Argyll and Bute
  - Dumfries and Galloway
  - Western Isles
- Scottish Association for Mental Health (a national voluntary mental health agency)
- COPE (a local voluntary mental health agency based in Drumchapel)
- Ministry of Defence

A total of 239 participants were trained in safeTALK over the course of the pilot. In each pilot area/organisation an ASIST trainer was responsible for the implementation of the pilot. There was no standard approach to the selection of participants or marketing of the safeTALK across pilot sites. Selection of participants for the training varied depending on which employers were signed up to participate in the pilot and how the pilot was advertised in each pilot site. Reviewing this activity was not a focus of the evaluation.

In all pilot areas there was a higher proportion of ASIST-trained helpers attending the training than would normally be expected due to their interest in how the course fitted with the ASIST training they have received and in some cases deliver.

During the pilot SAMH organised two demonstration safeTALKs for key stakeholders in the Choose Life suicide prevention and training networks, a number of evaluation participants attended these events.

### **1.3 Evaluation Aims**

The overarching aims of the evaluation of safeTALK were to ascertain:

- The views and expectations of key stakeholders of safeTALK
- Perceptions on relevance and use of safeTALK

The specific objectives were to obtain the perspectives of participants, sponsors and trainers on:

- Planning and set up of safeTALK
- Training content, materials and delivery
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- How safeTALK fits in with other training
- Perspectives on targeting - for who should the training be provided?

The evaluation also aimed to identify whether and how participants felt that they used skills gained from safeTALK after the session.

## **2 METHODS**

To address the key questions identified as of central interest in the implementation of the pilot, as set out above, the evaluation comprised a number of strands of data collection.

### **2.1 Analysis of safeTALK course feedback data**

Standardised feedback sheets developed and provided by LivingWorks Inc. were distributed to all safeTALK training participants immediately following completion of their training (see Appendix B). To gain insight into the background of safeTALK participants and their views on the training, these participant feedback sheets were analysed by the evaluation team. The feedback sheets included:

- profile information of safeTALK participants, including their occupation and employer, previous experience of suicide prevention (training) and route into safeTALK,
- their views on the impact of the course, its facilitation and their suggestions for improvement

SafeTALK trainers in each pilot area collected feedback sheets after each training session and secured written consent from training participants for SDC to use the data for the purposes of the pilot evaluation and to be contacted for follow-up interviews. The information on the 239 feedback sheets returned was entered into a database by NIST staff and passed on to SDC for analysis.

### **2.2 Telephone interviews with safeTALK participants**

To gather more in-depth information about how safeTALK participants utilised any skills, information and confidence gained from the training, it was intended to interview a sub-sample of 35 safeTALK participants. Evaluation consent forms were distributed by safeTALK trainers to participants at the end of each training session.

It was intended to sample participants to include a representative cross section from different courses, delivered by different trainers and from different parts of the country, as well as different professional backgrounds. However, delays in obtaining some consent forms, and difficulties recruiting interview participants, meant that the sampling plans needed to be revised. In the end, the evaluation team contacted all those participants who had submitted consent forms and invited them to be interviewed. Of the 106 who returned consent forms, 61 were successfully contacted and asked if they would like to be interviewed. Forty-four training participants agreed to be interviewed, although 10 of these were not available at the time of interview. A total of 34 individuals were successfully interviewed.

A structured questionnaire (Appendix B) was used to review participants' expectations of the content and impact of safeTALK, their perceptions of the value of alertness training and how the training had been and could be used in their communities. The interviewer used notes to record the interviews.

### **2.3 Trainers Focus Group**

The seven individuals from Scotland who were trained to deliver safeTALK as part of the pilot were invited to participate in a trainers' focus group. A focus group was held with four of these trainers to consider their experiences of:

- setting up and delivering the training
- the range of people reached (and not reached)
- cultural relevance of the material
- whether and how the course complemented other training
- perceived impact on other local resources and what else is required to improve/develop safeTALK as a resource

A copy of the trainers' focus group schedule is available in Appendix B. A further two safeTALK trainers, who could not attend the focus group, were interviewed at a later date by telephone using the focus group questions. The final trainer was not available to participate in the research due to other commitments.

### **2.4 Sponsors' focus group**

Five of the seven trainers were able to identify individuals or agencies who had financially sponsored them to become safeTALK trainers; the remaining two trainers were either self-funded, or had identified the funds to participate in the training themselves. A focus group discussion was held with representatives of four of the five sponsors of the training pilots. This included two Choose Life Co-ordinators, one local agency, Drumchapel Life, and one national agency, the Scottish Association for Mental Health (SAMH). The focus group explored:

- How safeTALK has worked in practice and any issues arising
- How the host agencies perceived safeTALK to fit in with other training and suicide prevention activities
- Practical considerations relating to costs, targeting and effectiveness
- How safeTALK could best be developed if it were to be rolled out more widely

A copy of the sponsors' focus group schedule is available in Appendix B.

### **2.5 ASIST-trained helpers email survey**

People who were ASIST-trained but had not been involved in the safeTALK roll-out were asked to participate in a brief, anonymous email survey to ascertain their views about

use of safeTALK and referral to people who have completed ASIST (see Appendix A for a copy of the questionnaire).

NIST provided a sampling frame to SDC which included the names and email addresses of those who had been ASIST trained in each Local Authority, apart from the pilot areas, who fitted the following criteria:

- Trained within the last year
- Having given consent to be contacted for the ASIST evaluation

It was expected that these individuals were likely to still have the same contact details and be agreeable to be contacted to participate in the evaluation. From this, a random selection of up to 30 individuals (in some areas less than 30 people had been trained within this timeframe) from each of the 23 local authority areas fitting the above criteria was made by SDC and this sample (n=514) was emailed to be invited to participate in the survey. From this sample, 383 proved to be working email addresses, with 131 returned as undeliverable. A survey questionnaire was attached to the email invite and sample members were asked to complete this within three weeks and return by email to the SDC. A reminder email was also sent.

Only thirty-five individuals responded to the survey (9% of sample). The number of incorrect email addresses contributed in part to this return rate, and low awareness of safeTALK training (as evident from those who did respond) may also have been a factor. The responses to the ASIST-trained helpers survey should therefore not be viewed as necessarily representative of all those trained in ASIST.

## **2.6 Analysis**

Quantitative data from the safeTALK feedback forms was analysed by taking frequencies and cross-tabulations using SPSS. Qualitative data were analysed using a staged content analysis to identify themes.

### 3 FINDINGS

#### 3.1 Course feedback forms

##### *Response*

A total of 239 safeTALK participant feedback sheets were completed during the pilot, i.e. all those participated filled out a form.

The analysis below includes all participants across the pilot areas, it was not considered useful to compare between pilot sites as a similar range of issues were raised by participants in each course.

Occasionally up to 2 participants did not answer a particular question so the total of respondents varies very slightly between questions.

##### *Participant Characteristics*

Just over half (53%) of participants had found out about the course through their employer, 14% through a friend or co-worker and another 14% through ASIST. The Choose Life website and other publicity were only mentioned by 6% of participants, while the remaining 13% had found out about safeTALK in other ways. Most participants (227) had taken the course to assist them in their work (20 of these participants said they took part because of their volunteer work) and another 20 participants citing personal reasons. Some participants cited both work and personal reasons. Table 1 presents an overview of participants' professional backgrounds. As the category options were fairly broad, many respondents ticked two or more occupations to best describe their role.

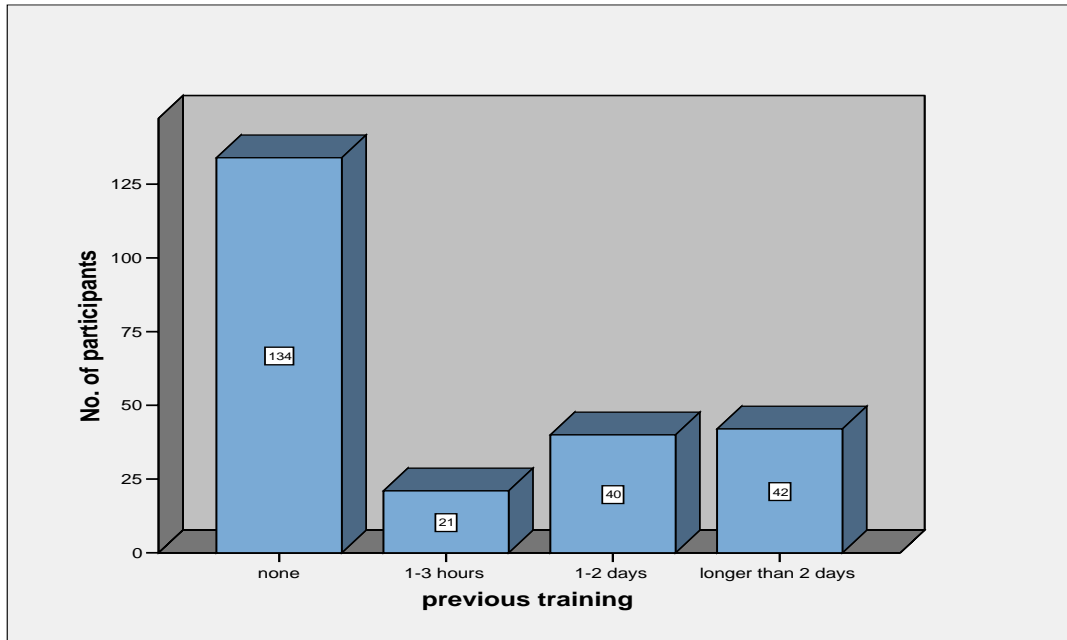
**Table 1: Participants' professions**

<b>Occupation</b>	<b>No. of participants</b>
Mental health	109
Physical health	33
Corrections / Police	26
Sport and recreation	20
Education and training	12
Service industry	11
Pastoral care / Clergy	10
Defence	3
Other	43

The most common professional background was mental health as a broad category which may include a variety of roles from Support Worker to Psychiatric Nurses. However, these results demonstrate that safeTALK training was undertaken by a broad constituency of individuals.

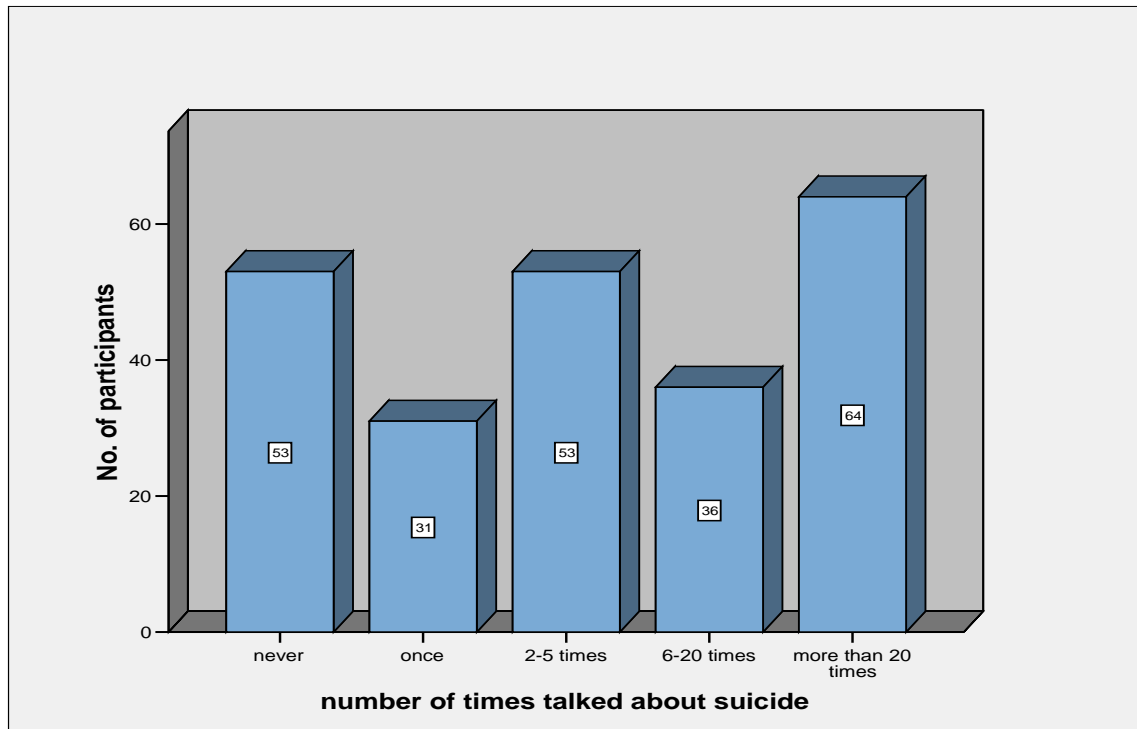
Figure 1 below provides an illustration of the level of suicide prevention training participants had attended prior to the safeTALK course.

**Figure 1: participants' previous training**



Just over half of all participants (53%) had not received suicide-related training before. The majority (75%) of all participants had experience of talking to someone with thoughts of suicide, as illustrated in figure 2.

**Figure 2: number of times talked about suicide**



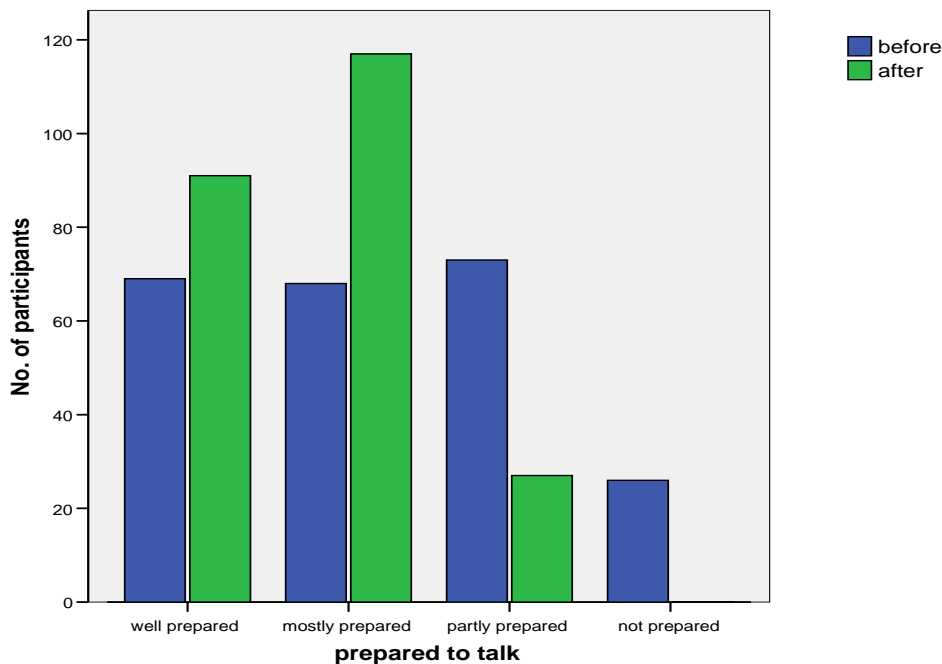


There was a positive correlation between the amount of training participants had received and how many times they had talked to someone about their thoughts of suicide. An analysis of the feedback shows that 71% of those with over two days' training in suicide prevention had talked to someone about their thoughts of suicide more than 20 times, compared to only 14% of those with no training. This suggests that previous training may have reached the right participants and/or had an impact on people's willingness to broach the subject.

***Perceived impact of safeTALK on participants***

Figure 3 below shows the difference between the preparedness of participants to talk about suicide prior to and following safeTALK training.

**Figure 3: Participants' preparedness to talk about suicide**



As can be seen in Figure 3, at the start of the course 58% of participants felt either well or mostly prepared to talk openly about suicide to people about their thoughts of suicide, which increased to 85% after the course. The percentage of participants who felt either partly or not prepared to talk about suicide decreased from 40% before the course to only 10% of participants feeling partly prepared and no one feeling unprepared after the course.

The reported impact of safeTALK on participants' perceived ability to respond to a person at risk of suicide is summarised in Table 2 below. When participants failed to answer each of the questions they were excluded from the analysis.

**Table 2: Impact of course on perceived ability to respond to person at risk**

	Recognise signs	Approach person	Ask directly	Connect to help
Much more likely	44% (106)	37% (89)	41% (98)	55% (132)
More likely	39% (94)	44% (106)	40% (95)	29% (70)
About the same	16% (38)	18% (43)	19% (45)	15% (36)
Less likely	0% (0)	0% (0)	0% (0)	0% (0)

In response to questions about how well participants felt able to recognise and respond appropriately to someone at risk of suicide, the course was felt to have had a significant positive impact (see Table 2). No one felt that safeTALK had made them feel less able to handle the situation. Over 80% of all respondents reported that after the course they were either more likely or much more likely to recognise the signs of someone being at risk of suicide, to approach the person, to ask them directly whether they were having suicidal thoughts and to be able to connect them to help.

A minority felt that the course had made no difference (less than 20%); it is possible that this could be partly accounted for by those attending the course who were also ASIST trained, who may have been less likely to experience a change in their abilities. To explore this further, analysis of this impact data was carried out to ascertain the impact of safeTALK on only those who had three hours or less suicide prevention training (n=157). The results of this analysis are in table 3 below.

**Table 3: Impact of course on perceived ability to respond to person at risk for those with less than 1-2 days training**

	Recognise signs	Approach person	Ask directly	Connect to help
Much more likely	46% (72)	33% (52)	38% (60)	54% (86)
More likely	41% (65)	50% (78)	46% (73)	35% (55)
About the same	13% (20)	17% (27)	16% (23)	11% (16)
Less likely	0% (0)	0% (0)	0% (0)	0% (0)
total	100% (157)	100% (157)	100% (157)	100% (157)

The data in table 3 demonstrate that there was no significant difference between those who had three hours or less previous suicide prevention training and those who had one day or more previous training in terms of perceived ability to respond to persons at risk.

### ***Feedback on the Quality of safeTALK***

Overall, the questions about the quality of the course were answered positively. Sixty-two percent of participants strongly agreed that the trainer was well prepared, one person disagreed with this statement, while the rest either partly agreed or agreed. Almost all participants (99.2%) either strongly agreed or agreed that the trainer had been respectful of and encouraged responses from participants, with no one disagreeing. Ninety-three percent of participants said they would recommend safeTALK

training to others. Also, most of the overall comments made on the form were positive, with such responses as:

*"Excellent course, has prepared me well for being Suicide Alert"*

*"The trainer was very clear and I feel the training has helped me to understand and feel more able to talk to someone suicidal."*

### ***Suggested improvements to course content and format***

When asked how the course could be improved, eleven participants felt that there was a need for more role play, to give participants more of a chance to reinforce the skills that they were learning. One person felt that role play would be more realistic if actors could play the part of the person at risk of suicide. However one participant felt that the current form of role play was perhaps not safe:

*"I didn't like participants turning to each other to ask about suicide in case someone actively was."*

Five (2%) participants felt that the videos should be improved, because they were unrealistic, hard to follow or difficult to take seriously. Six participants (2%) said the course should have been more heavily publicised so that more participants would have attended.

### ***Referral on to a suicide intervention trained helper***

The effectiveness of SafeTALK relies on the safeTALK-trained helper being able to refer the person at risk on to someone who can review the risk and develop a keep-safe plan. Ten (4%) participants commented they needed more and clearer guidance on referral resources in their local community.

*"Apart from participants in workplaces how will I recognise participants who can help?"*

*"There does not seem to be any way to link up with a person who is ASIST trained - needs to be sorted in order to make this an effective strategy."*

*"Training could be more effective if there was a more co-ordinated loop of help i.e. bringing together helpers with a possible list of ASIST workers to give a more continuous line of care."*

### ***Targeting***

There were also some suggestions for the targeting of safeTALK; several participants felt that training should be offered to new staff or early on in a new job, whereas two participants felt that more health care professionals, such as GPs, should attend suicide alertness training, such as safeTALK or suicide intervention training such as ASIST.

### 3.2 Telephone interviews with safeTALK participants

#### *Response*

The evaluation team contacted all those participants (n=106) who had submitted consent for the safeTALK evaluation. Those participants who were successfully contacted (n=61) were then asked if they would like to be interviewed. Forty four training participants consented to be interviewed. Ten were not available at the time of interview leaving a total of 34 individuals interviewed. The interviews took place up to six months after participants had attended safeTALK.

Participants were asked about their perceptions on the course and its impact, as well as how safeTALK fits in with other suicide prevention training and how it should be targeted.

#### *Interviewees' backgrounds*

Ten of the people interviewed worked in jobs in which they regularly came into contact with people with mental health issues, for example, in mental health support work or the ambulance service. Three people had gone on to do the ASIST training since attending the safeTALK course. Ten interviewees worked in jobs which did not explicitly have a mental health remit, such as teaching or positions in the department of work and pensions, one of these had gone on to complete ASIST. Table 4 shows the pilot areas interviewees were trained in.

**Table 4: Interviewees by area and profession**

<b>Area</b>	Mental health-related profession	Non-mental health-related profession	<b>Total</b>
SAMH	5	5	<b>10</b>
Western Isles	0	5	<b>5</b>
Dumfries & Galloway	1	0	<b>1</b>
Argyll and Bute	4	0	<b>4</b>
<b>Total</b>	<b>10</b>	<b>10</b>	<b>20</b>

In addition to these twenty interviews, fourteen ASIST trainers, Choose Life coordinators, members of NIST and those involved with local planning around suicide prevention training, who had taken the safeTALK course in order to see what it had to offer, were also interviewed. They had mostly attended safeTALK training provided by SAMH, but came from areas throughout Scotland.

#### *Expectations of and reasons for attending safeTALK*

*"I hoped it would make me less afraid. The word suicide is often quite frightening. I hoped I'd be more able to use the word suicide if I thought people were thinking about it. I hoped it would make me more approachable for people who were having thoughts about suicide and make people more confident that they can talk to me." (interviewee)*

In terms of their expectations of safeTALK, some interviewees had only heard a short time in advance that they were taking the course and therefore did not know what to expect, while the other interviewees' expectations mostly centred around learning how to recognise that someone may be at risk of suicide and how to help them. One interviewee who worked in a mental health organisation but had no direct contact with service users said she had actually been quite apprehensive about taking the training, feeling that it was outside of her comfort zone and that she would not have much to contribute, but afterwards she was glad she had attended.

Reasons for attending safeTALK also varied:

- Three people were required by their employers to attend the training while all others took the course because they felt it was an important topic
- Those working in the caring professions had often come across a situation in which someone was at risk of suicide and wanted to be able to deal with such situations better
- Interviewees in Stornoway mentioned the high incidence of suicide in their area as a reason for attending the training
- Six interviewees mentioned having been personally affected by suicide, ranging from having thought about it themselves in the past or having a family member who attempted suicide to more distant connections to people who completed suicide
- The ASIST trainers and those affiliated with Choose Life or local suicide planning understandably had different reasons for taking safeTALK. Most said that they wanted to see how safeTALK would fit in with ASIST and whether it would be useful to offer in their area. One interviewee also felt that attending would provide her with a good opportunity to meet others involved in suicide prevention training.

The feedback from interviewees was overwhelmingly positive with regards to which expectations had been met. Two interviewees had expected the course to give more opportunity for the sharing of personal experiences around suicide, but understood that there was little time for that in three hours. Other than that, all expectations were satisfied, and several people said that they had been exceeded.

### ***Longer term impact of safeTALK***

#### *Awareness*

Those who worked in professions outside the care sector all said that the course had an impact on their awareness of suicide. Four people said it had made them aware that suicide is much more common than they thought, and five people were shocked to hear of the high incidence of suicide in their area.

*"The main thing I took out of the training was that 1 in 20 people think about suicide in any given week; I thought that was eye-opening."*

Of those who worked in caring professions, only one person said that the course had increased her awareness; she was surprised to learn that her area, to which she had recently moved, had a high incidence of suicide.

One interviewee also said that attending the course had made her realise that having thoughts of suicide could be a normal reaction to life events and that it is not only those with mental health problems who are at risk of suicide. Other interviewees had gone on to discuss suicide rates with colleagues, which had resulted, in one instance, in colleagues describing their own experiences of depression.

#### *Recognising the signs*

Fourteen interviewees felt that the course had helped them recognise the signs of someone being at risk of suicide. Several people talked of having become aware of the need to read between the lines of what people are saying, or “looking behind their words” and thought that they would now pick up on signs that they may have missed in the past, such as a change in mood from someone’s usual disposition. People also felt more confident that they could detect the difference between someone who is just down and someone who may be at risk of suicide. Almost everyone felt that after safeTALK they were more aware of and open to the signs of people being at risk of suicide; two people thought they would have been just as aware before the training.

#### *Responding to someone at risk*

Ten of the interviewees who were new to suicide prevention training felt that the course had changed the way they would respond if they thought someone was at risk, with only one person feeling that it had not made much difference. People said that they were now less likely to stick their “head in the sand” or think that people at risk were okay, dismissing them with a “never mind”. Instead, they felt they were now more likely to act, to ask questions and to get people help. Several people said that the course had reduced their anxiety about approaching someone and their fear of saying the wrong thing, giving them the confidence to step in. One interviewee said that it had emphasised for her that she has a responsibility to intervene when she thinks someone is at risk of suicide.

Those working in mental health-related professions were just as likely to feel that the course had changed the way they would respond to someone at risk of suicide as those working in different types of jobs. However, as more of them had come across a situation where someone was at risk of suicide in the past, they were more likely to say that the course had also enabled them to check whether the ways in which they had handled these situations was appropriate. One interviewee said:

*“I had a certain amount of confidence, but it was refreshing to know that some of the ways I would have dealt with things were exactly the way to do it and some things we were told were different.”*

The interviewees who were also ASIST trainers understandably did not learn a new approach on the safeTALK course. Equally, it was difficult for those who had attended ASIST training after the safeTALK course to distinguish what the impact of safeTALK, on its own, had been.

*Issues regarding directly asking someone whether they are considering suicide*

The main way in which the course was thought to have impacted on the interviewees' responses to someone at risk of suicide was through learning the importance of asking directly whether an individual is considering suicide. While some of those in mental health-related professions indicated they might have asked before the course as well, most said this was a new approach for them. One interviewee said that in the past she tried to distract people from negative and suicidal thoughts, rather than address the issue.

Almost all of those in professions without a mental health remit suggested that prior to the safeTALK training, they would not have asked people at risk if they were thinking of suicide, at least not right away. In the past they were either afraid to bring up the subject, or had worried that they could "push people over the edge". Several people recounted how these fears were directly addressed and allayed in the safeTALK course and most interviewees said they would now ask if people were thinking of suicide, which constituted a significant change in thinking for many.

*"I would never have asked the question directly before; I would have shied away from it. Now I would not feel comfortable asking, but I would do it, because that's what we were taught and that's what you have to do. I wouldn't have before, so the course has been very good from that point of view."*

Four people felt they would only be able to ask people directly when they worked with them in a supporting capacity or knew them well. They felt it would be difficult to ask strangers something so direct and personal, although one person said she hoped she would be able to overcome this. Amongst the interviewees there were four teachers, two of whom felt that they could not directly ask children at risk in their school whether they were thinking of suicide. One said that she thought this would be inappropriate.

*"I couldn't do it with children, professionally I couldn't be seen to be suggesting it. Not in my line of work, anyway, I work with very young children."*

The other teacher felt that they should check with their line manager or another member of staff regarding the best course of action if she thought a child in her class was at risk of suicide. However, another interviewee, who had taken both safeTALK and ASIST, explicitly said that it was the safeTALK course, with its emphasis on the importance of asking, rather than ASIST, that had made her feel she could directly approach a child who she thought might be at risk.

Amongst those in professions without a mental health remit there were some interviewees for whom "asking the question directly" had not been a main message of the course, and one interviewee who felt that in her line of work it would be inappropriate.

*"I would never ask my customers whether they were thinking of suicide. I just couldn't. We deal with a lot of bereaved people and it's the last question you should ask them."*

Three interviewees, one of whom worked in mental health, questioned whether asking the question would be as straightforward and as successful as the course suggested. One of these interviewees had been suicidal herself and felt that she would not have opened up just because someone asked her and the mental health worker said that in her experience it can take an extended period of time and a lot of skill to get people to respond honestly to this kind of question.

### *Stigma*

Five interviewees felt that a main impact of safeTALK training was the way in which it counteracted stigma and gave people the chance to talk about the difficult topic of suicide and hopefully enabled them to be more open and comfortable with it in the future.

*“The media has a biased view on this subject, and promotes stigma and guilt, but this course blasts that away. It is about being open and honest.”*

### **Use of safeTALK skills**

Eight interviewees had, since their safeTALK training, been in a situation in which they felt that someone could be at risk of suicide. These instances and the interviewees' descriptions of their response are summarised below.

1. One person, who had also been trained in ASIST, was told on two occasions by clients that they were feeling suicidal and was grateful that she knew what to ask them and that she had gained intervention skills by taking ASIST.
2. Another interviewee, trained in ASIST, was worried about a client of her mental health service and felt that, while she drew on ASIST skills, the safeTALK training had also been relevant.

*“I picked up quickly that what they were telling me was different from what they had said before. I asked them directly if they were thinking of suicide, I wouldn't have used the word suicide before. It had a positive outcome because the person was like “She got it, she has understood what I am saying”*

3. One person, without a professional mental health remit, was told by a client over the phone that he was suicidal. She had been in a similar situation before safeTALK and felt that the training had not made much difference to her response; she kept him on the line and tried to put supports in place to help him deal with his situation, but did not refer him to someone trained in suicide intervention.
4. One interviewee, who had also attended ASIST training, came across a woman crying on a bridge and asked her if she was thinking of suicide.

*“She said she wasn't thinking of jumping but that she was drunk enough to fall in. We had a chat and she thanked me for talking to her and said that I had cheered her up. She was a traveller and not that many people speak to them. So*



*I was thinking to myself 'Well, I was wrong but at least I have cheered somebody up.'*

5. Another interviewee became concerned about her friend during a phone conversation in which her friend disclosed how down she was.

*"I asked her if she thought of harming herself, and was reassured that she didn't. She laughed it off and we talked a bit. I think she was depressed, but she wasn't at risk of suicide."*

6. One interviewee felt she used her skills when one of her clients at work was feeling down; she emphasised the importance of talking about one's feelings and helped him recognise the support that already existed in his life.

7. A few days after the course, one interviewee felt that someone was at risk of suicide and said that the course gave her the script to follow, which made her feel more confident about how to respond. As it happened there were no suicidal thoughts present, but safeTALK made it easier for her to find the words with which to raise the subject.

8. One of the interviewees without a mental health remit was approached by someone she knew who was worried about a friend. After discussing the situation, they both went to this friend's house and, while it took a long time for the door to be answered, the person in question was okay. She felt that she would have probably done the same before the safeTALK course, but that she would not have been as aware of the possible consequences of not acting.

Seven other interviewees said that, while they had thankfully not come across anyone at risk of suicide, they were now more aware of this being a possibility and more sensitive to any possible signs.

*"I am mentally looking out for it more; it's just never got to the point where I've been alarmed enough to do something about it. I did talk to people to find out how they were, but I didn't get anywhere near to having to ask the question."*

Note: It is important to note the short timescale between attending safeTALK and interview, given more time, a larger number of interviewees may have had experiences to report.

### ***Most useful aspects of the course***

When interviewees were asked what they thought was most useful about the course, challenging the stigma that surrounds suicide and the fear of broaching the subject were both emphasised again. Five people felt that the main thing they would take away from the course was the ability to be open about suicide, "to say the word loud and clear" and the confidence to ask the question directly.

Five people also said that the videos had been very helpful in that they showed *how* to ask people about suicidal thoughts and gave examples of signs that are easily missed.

There was further praise for the videos in that they provoked discussion and brought out the questions that interviewees had but may have been too reluctant to ask otherwise. They were also felt to be appropriately short and easily related to different situations.

Two interviewees mentioned the mix of the participants as an important contributor to the success of the course; having service users, mental health staff and others there meant that many different perspectives could be shared.

Other interviewees said that they had found the “miss, dismiss and avoid” language of safeTALK very catchy and easy to remember and that the role-play had been very useful and impressive in that it incorporated different age groups and possible reasons for suicidal thoughts.

### ***Suggested improvements***

Perhaps surprisingly, given the praise for the videos described above, the most common suggestion for improvement also referred to the video-scenarios; eight people said that they should be changed to fit the Scottish context.

*“We were watching videos that came from America or Canada, and they didn't really ring true to life. Like people were just meeting for the first time and within three minutes were asking about suicide. It didn't seem very realistic. Maybe it was a cultural thing, and it just wasn't the right theme for Scotland. The way the people were behaving I'd think 'That wouldn't happen'. It was a bit outdated too; it was obviously an old video.”*

Another concern about the videos from three interviewees was that they were too sanitised; that they made asking people about suicide look easy, straightforward and quick, rather than showing some of the complexities and the possibility of people responding in unexpected ways.

There was some disagreement about the usefulness of role-play; two of the interviewees said that they would have liked to have had more of a chance to practice asking people whether they are thinking of suicide, while two other interviewees found the role-play uncomfortable and unrealistic because it was conducted between colleagues.

Three interviewees felt that there should be refresher courses, similar to those in First Aid, because otherwise people who do not come into contact with people at risk of suicide may lose their skills or forget the main messages of the training. One interviewee also felt that there was not enough time to reflect built into the training.

The safeTALK course is described as not appropriate for those who had been recently seriously affected by suicide or suicidal behaviour and cannot focus on hope or helping others who are still alive. One person thought that there should be systems in place to enable any participants who may have been recently affected by suicide to leave in a discreet manner. It was suggested that an early break in the training would give people the opportunity to leave discreetly rather than having to walk out in front of other people, which they would currently be required to do.

Several of the ASIST trainers who attended a safeTALK course to familiarise themselves with it commented that there should be more training for trainer places for safeTALK, because restrictions on the numbers being trained could hamper the rollout of safeTALK across Scotland. Two people also felt that the training for safeTALK trainers did not need to be as extensive as it was currently for those who were already trained in delivering ASIST, while three others felt that the training for trainers should not be restricted to ASIST trainers as this unnecessarily limited the number of people who could become trainers.

### ***Putting people in contact with appropriate supports***

The safeTALK model recommends that participants should put people at risk of suicide in contact with ASIST-trained helpers or others with suicide intervention skills. Therefore, interviewees were asked specifically if they felt confident that they would be able to 'refer' people at risk of suicide to appropriate helpers. There was some variance amongst the responses about the amount of information participants had been given on possible referral points during the safeTALK training. One interviewee said she had been given lots of information and another mentioned the safeTALK card and stickers they had been given as information sources. However, one interviewee said that referral to ASIST-trained helpers had not been mentioned on the course at all and two interviewees were disappointed they had not been given a list of ASIST-trained helpers, feeling that this left them "without a back-up".

*"The training didn't tell you who the ASIST-trained individuals were, or tell you enough about ASIST to know why you should refer on to them; why you should sell ASIST-trained helpers as good people to speak to if you were feeling suicidal."*

One ASIST-trained interviewee mentioned that at the end of ASIST participants collected the contact details of suicide intervention resources in their area, and felt that this would be helpful for safeTALK participants as well. Two interviewees were concerned that the course did not cover how to respond when you were not in a position to contact anyone, or were dealing with other responsibilities at the same time.

However, with only a few exceptions, people felt that within their work place they knew who the ASIST-trained helpers were and felt confident that they could put people in contact with them. Several interviewees from Stornoway said that because they lived in a small community they would be able to put people in the community in contact with these work colleagues as well. One interviewee in this area said he would probably refer people to a GP or the Samaritans, although he felt that in the Islands men in particular did not like to go to their GP because they "see it as a sign of weakness".

Interviewees in other areas often mentioned the Samaritans or GPs as possible contact points in the community, with one interviewee mentioning Breathing Space as well. However, four interviewees (three of whom were ASIST trainers themselves) noted that putting people in contact with GPs or other health professionals could be problematic.

*"It gets complicated outside the work setting, within it you can see a process flow happening but outside you would have to try to get help from a GP, from mental health services or in the most serious cases go to Accident and Emergency. But that's where we are going to hit all sorts of attitude, where people at risk are not taken seriously. [...] Just because you're health trained doesn't mean you won't be missing, dismissing and avoiding."*

Putting people who may be at risk in contact with ASIST-trained helpers was seen as problematic by the ASIST trainers interviewed. With the exception of Stornoway it was not well known who the ASIST-trained helpers in the community were and during this pilot ASIST courses were not yet geared up to inviting participants to agree to take referrals from safeTALK-trained helpers.. Also, it was seen as unrealistic to expect people to be available to respond to contacts at all times.

*"It could possibly be time consuming if you were getting referrals and it is not part of your job. To say that someone could phone me at my work and I would drop everything, that is not going to go down well with my employers. And when you are at home, it may be a matter of life and death but you have to have a home life."*

One interviewee suggested that an alternative might be to designate existing agencies where all staff are trained in ASIST, like crisis centres, as the local referral point(s) for the community. All the ASIST trainers interviewed and two other interviewees were very concerned and keen for a proper system to be put into place so that people at risk of suicide and safeTALK-trained helpers are not left without appropriate intervention support and thought that this should be a priority for Choose Life.

*"It's very important that we can link people who take safeTALK with people who can do the intervention; it is very important that we get that right."*

### ***SafeTALK's fit with other training***

Most of the feedback on how safeTALK fitted with other suicide training came from the ASIST trainers. The other interviewees had often stated that they had not received any other training before safeTALK, even those who worked in mental health-related professions including psychiatric nurses. People who had attended talks on suicide before, which were organised by their employer (a government department), felt that safeTALK went deeper and offered more local knowledge. Three interviewees had gone on to do the ASIST training after safeTALK and two others would have liked to.

*"It made me want to do the ASIST training. Before I had never thought about it and didn't think I would be comfortable enough with it to train in it. But safeTALK was a very good precursor. Almost everyone who did the safeTALK training in our school wanted to go on to do the ASIST."*

The feedback from ASIST trainers indicated that safeTALK generally fitted in very well with ASIST. SafeTALK has added value in that it is able to reach a wider audience, because it is cheaper and less time consuming - important factors for employers - and is suitable for people who may not want the level of responsibility inherent in being ASIST

trained. SafeTALK generally was seen as a good lead-in to ASIST and as a better introduction to suicide training for those who are new to the topic.

The ASIST trainers interviewed also discussed safeTALK in relation to suicideTALK, a short course which was described as focusing on awareness raising, compared with safeTALK, which was seen as more focused and about “getting people to ask the question and linking in with people who can help”. While some people felt that safeTALK fitted in well with suicideTALK - one person said that the latter is for people who are not ready to talk about suicide and safeTALK is for those who are - three people questioned whether there would still be a place for suicideTALK once safeTALK came on stream.

Another training course mentioned was Scotland’s Mental Health First Aid, which was seen as a more general training course about mental health problems, and although covered suicide, did so in less depth than safeTALK. However, it was thought that SMHFA could lead people to safeTALK and/or ASIST training. Finally STORM training was also mentioned, but felt to be more exclusively for mental health professionals who more routinely have to recognise and manage the risk of suicide.

### ***Targeting of safeTALK training***

In general, interviewees felt that safeTALK was suitable for and should be available to as many people as possible. However, they realised that it needed to be targeted to some extent, and most recommended that it be targeted at groups of individuals who worked with vulnerable people. Professions that were mentioned more than once were social workers, health workers, the police, the fire brigade and home helps. People also referred to those who may fulfil the role of “unpaid counsellor”, such as bar staff, bus drivers and hairdressers. Some interviewees appreciated that the training was offered to those working outside the traditional caring professions and felt that this could potentially increase its impact.

Several interviewees had picked up on the fact that young people and children are at risk of suicide and mentioned youth workers, teachers and young people and children themselves as groups that should be targeted. SafeTALK was seen as an appropriate course for teenagers, and one interviewee felt that it could be slightly tweaked for children under twelve. One interviewee suggested that it would be good if safeTALK training was not exclusively offered in places of work, as those who are unemployed should also be able to access it.

Several ASIST trainers mentioned the training commitment in the Scottish Government’s Delivering for Mental Health, which places a commitment to train 50% of mental health services, primary care and accident and emergency key frontline staff in suicide intervention and/or risk management by 2010. Some felt that safeTALK could have an important role in reaching these targets, while two people questioned whether safeTALK would provide enough depth to meet the requirements of the Scottish Government. A suggestion that safeTALK could be suitable for people working in (mental health) teams where enough other people have already been trained in ASIST was offered by one interviewee.

### ***General perceptions of safeTALK***

As mentioned briefly above, the general feedback about the course and its delivery was very positive. Several people said that, considering the subject matter, they felt that it would be wrong to say that they “enjoyed it”; but that they had found the training very valuable and felt they had learned a lot in a short period of time. The delivery of the training also attracted many compliments; people felt that the material was handled very sensitively and that a good atmosphere was established in the groups so that participants felt they could contribute.

*“The most amazing thing was the ambience and atmosphere he created. He gave us so much to reflect on. It wasn’t an academic approach; he made it lively and gelled the group together beautifully. The material was presented in a humane way and you could tell he was passionate about what he was doing.”*

### **3.3 Email survey of ASIST-trained helpers**

#### ***Response***

An email survey was sent out to 383 people who had been trained in ASIST, in order to obtain this group’s views of safeTALK. Thirty-five (9%) of these people sent completed surveys back within the time frame of three weeks and their responses are summarised below. Because of the low response rate, these comments should not be viewed as necessarily representative of all those trained in ASIST.

#### ***Respondents’ characteristics***

Respondents’ stated occupations varied: 9 people identified themselves as support/project/social care workers and 4 others identified themselves as community development workers. Three social workers, welfare rights officers, volunteers and counsellors responded to the survey, with a police officer, a tutor, an occupational therapist and a hospital chaplain amongst the other respondents.

Eleven ASIST-trained helpers who responded to the survey worked for their local authority or council, with three working for a social work department and a carers’ project. Other organisations in which respondents worked included the NHS, Careers Scotland and a volunteer centre. Table 5 presents a breakdown of the local authorities in which respondents were based.

**Table 5: Email survey respondents by area**

<b>Local Authority</b>	<b>N</b>	<b>%</b>	<b>Local Authority</b>	<b>N</b>	<b>%</b>
Lothian	5	14	Scottish Borders	2	6
Moray	5	14	Grampian	1	3
Shetland	3	9	Falkirk Area	1	3
Lanarkshire	3	9	Perth & Kinross	1	3
Highland	3	9	Ayrshire	1	3
Angus	3	9	Renfrewshire	1	3
Dumbartonshire	3	9	Inverclyde	1	3
Clackmannanshire	2	6			

While all survey respondents were trained in ASIST, at the time of this survey, safeTALK had not been promoted outside of the pilot areas and therefore awareness of safeTALK amongst the email survey respondents was low. When asked to rate how familiar they were with safeTALK on a five point scale, ranging from very familiar to not familiar at all, 26 responded that they were unfamiliar with safeTALK, with only one person placing themselves at the very familiar end of the scale and five remaining neutral.

Several respondents emphasized in the “further comments” section of the survey form that they had very little knowledge of the safeTALK pilot. It is important to note that at the time of the survey safeTALK had purposively not been advertised to the entire network until the pilot was completed.

### ***Targeting***

The survey participants were asked who they thought would most benefit from safeTALK training. Their answers mirrored those of the safeTALK participants who were interviewed to a large extent: 12 respondents felt that statutory and voluntary agency staff who work with vulnerable people would especially benefit from the training, 6 people mentioned teachers and youth workers and another 6 thought safeTALK should be targeted at the general public.

*People in the wider community, for example health centre receptionists, post office staff, voluntary community support group leaders. Anyone who regularly comes into contact with the same people so would be likely to notice a difference in someone's behaviour or manner.*

Eight people felt that safeTALK could be a good precursor or add-on to ASIST, and 5 people responded that young people or those at risk of suicide themselves should be targeted. One participant reported having heard young children say they want to kill themselves, and felt it is of great importance that more awareness raising is done within the education system and that children in primary schools level are given the opportunity to talk about and acknowledge their feelings.

### ***Putting those at risk in contact with appropriate help***

As it is part of the proposed system that safeTALK participants will be able to put people at risk in touch with ASIST-trained helpers or similarly trained persons able to offer intervention help, survey respondents were asked how they felt about having people at risk of suicide ‘referred’ to them. Many ASIST-trained helpers felt that taking on such contact would be fine: 12 respondents said they would be happy to make contact, two of whom mentioned that this was partly because they had already helped several people since being trained in ASIST and therefore felt confident. Another 20% said they could accept contacts as long as a support system was in place, such as a referral system to other secondary services. On the other hand, 15 participants were not happy with the idea of receiving referrals; 7 felt they did not have the time or resources to cope with extra people at risk and 5 felt they did not have the confidence to deal with contacts, without further training and/or work experience.

*“I have used my ASIST training only once and do not feel qualified to be the person who would receive a referral.”*

Three people felt that ASIST-trained helpers in general are not equipped to receive referrals from others, since their remit is to be a "first aider". Five people said that they needed further information about safeTALK and the exact role ASIST-trained helpers would have before they could give their opinion.

When asked to rate how well they thought the referral system for safeTALK would work in practice in their area, 13 participants felt it would work either very well or well, with another 13 choosing the neutral option and 10 people thinking that it would work badly or not at all.

### ***Structural issues for roll-out***

Nineteen respondents felt that, in order to roll-out safeTALK effectively in their local area, local organisations and their staff members would need to be approached, made aware of the training and be well linked in. The safeTALK manual recommends this approach. Target groups and organisations mentioned were the NHS, councils, education, social services, GP's and prison and police staff.

Other respondents said that existing local community networks could be tapped into and that in large organisations in-house means of communications could be used to spread the word about training. One respondent mentioned that within their university community, students in a local peer connections scheme who had trained in ASIST and safeTALK "could act as spotters and referrers" for future safeTALK training.

In terms of new structures that need to be set up in order for safeTALK to be rolled out effectively, five people felt that some advertising and/or marketing would be needed in order to reach local agencies and the public. One respondent felt there should be a national campaign to raise safeTALK's profile, while others thought community talks and use of the local media would be effective ways to raise awareness.

*"There could perhaps at a Scottish national level be more advertising given to safeTALK and ASIST courses - informing the public consciousness of the need for safeTALK (similar to the See Me Campaign)."*

Three respondents felt that it would be important to make the training widely available, for example by becoming involved with training initiatives such as Get Ready for Work or New Deal. Two people mentioned the need for a coherent referral system, with two more suggesting that a database of organizations and ASIST-trained staff should be created for referral purposes. One person wrote that local groups should be set up for ASIST-trained helpers so that they can support each other and two respondents felt that refresher courses needed to be developed for ASIST-trained helpers so that their skills remained up to date.

### ***SafeTALK's contribution to local suicide prevention capacity***

When asked how useful they thought safeTALK training would be, there were more positive than negative responses: 20 respondents thought it would be very useful or useful, compared to 7 people who felt it would not be useful. Six people were undecided about safeTALK's usefulness and two people did not answer the question.



Sixteen people felt that raising general public awareness and increasing understanding of suicide would be the main contributions safeTALK would make to suicide prevention capacity in their areas. A further three responded that safeTALK would increase people's confidence in addressing and discussing the issue of suicide. Eight respondents thought that safeTALK would increase the availability of help for those at risk of suicide, while 6 people mentioned that safeTALK could enhance the ASIST programme, by filling a demand for further suicide prevention that has been unmet due to the limited availability of ASIST places and by giving people who do not have enough time to attend ASIST an alternative option.

*"Line managers and organisations are likely to be more open to releasing front line staff for a 3 hour safeTALK course & this may later pave the way for more frontline staff being released for ASIST courses - and this could save many lives."*

Despite some feeling that safeTALK could link in well with ASIST, respondents were more or less divided when asked how well they thought safeTALK would fit with other training and suicide prevention activities in their area. While 13 people felt that it would fit well or very well, another 10 respondents disagreed, with 13 people remaining neutral. One person wrote in the "further comments" section that meetings should be organised with the organisations which participated in ASIST in order to discuss the added benefit of safeTALK, before dedicating time and resources to this new training programme.

#### ***Potential barriers to safeTALK implementation***

Most respondents identified one or more possible barriers to safeTALK's implementation. The most commonly mentioned obstacles were:

- Funding
- Lack of staff time
- Targeting this to people who are currently unaware that they need to be more aware of suicide prevention.

Four respondents identified ineffective communication as a potential barrier and six people were concerned about organisational barriers or the fact that similar initiatives were already in place, (although they did not mention what these were). Other possible obstacles mentioned were the logistics of providing the training, including venues, stigma, a lack of experience in ASIST-trained workers and concerns about client confidentiality.

### **3.4 SafeTALK trainers' and sponsors' focus groups**

#### ***Perspectives on the purpose of safeTALK***

According to focus group attendees, one of the central purposes of the safeTALK training was to enable participants to recognise that anyone could be at risk of suicide

and that learning about suicide risk is of relevance to everyone's lives. Informal feedback received by trainers and sponsors indicated that individuals who participated in safeTALK training could experience an increase in confidence around discussing suicide which in turn made them more comfortable with broaching the subject with others. SafeTALK was also designed to give participants knowledge of how to connect a person with thoughts of suicide with support services and how to keep them safe in the intervening period.

Focus group participants also described the safeTALK programme as being designed to reach a wide cross section of the population. At 3 hours in length, it was perceived as offering a more accessible entry to suicide prevention training than ASIST. The length of course also made the training less expensive to run and attend. The combination of a shorter length and lower costs was described by one safeTALK trainer as a "force multiplier" for creating suicide safer communities; safeTALK had the potential to encourage a wider range of individuals on to the training, and also facilitate an onward progression to further skills acquisition, such as through ASIST. This in turn not only had the potential to increase a community's capacity to respond to local suicide "invitations", but also to change attitudes to suicide and break the "taboo" surrounding the subject.

### ***Providing the training***

The majority of trainers talked favourably about the safeTALK training materials, describing them as "high quality", "slick" and "professional", particularly when compared with suicideTALK materials. This helped to make the training straightforward for the trainer to deliver.

As a Canadian package, the relevance of the materials to a Scottish audience, and in particular the video clips, was discussed in both focus groups. The clips were broadly thought to be appropriate within a Scottish context, and if necessary a brief introduction provided by the trainer explaining the Canadian origins of safeTALK could overcome any cultural or language differences. Only one trainer saw the Canadian video clips as acting as a barrier to implementation, feeling that their "cheesy" scenarios would be viewed with some scepticism in their locality.

A number of concerns were raised that if a Scottish version of the training package was produced, then some of the nuances contained within the scenarios could be lost, and participants could place more emphasis on the appropriateness (or not) of the chosen accents. It was also suggested that the time taken to produce a Scottish version of safeTALK could cause considerable delays to the roll-out of the programme across Scotland.

While the trainers were broadly happy with the content of the materials, and felt the course was relatively "easy" to run, it was acknowledged that trainers required certain skills to manage the safeTALK training safely and effectively. Individuals indicated that while in ASIST the emphasis was placed on participant interaction, with safeTALK greater onus was placed on the trainer managing the emotions within the room, and keeping participants "safe". The emphasis on limiting the emotional involvement in the

training was viewed as a key benefit of the safeTALK package as it made the experience much less onerous and “risky” for participants, but potentially more difficult for the trainer who was required to skilfully “hold it together”.

This raised the question of which individuals or professions are best placed to run the safeTALK training. At present only ASIST trainers are eligible to undertake safeTALK Training for Trainers (T4T) and go on to facilitate safeTALK training courses, although LivingWorks are adapting safeTALK materials so that they can be delivered by people who are not ASIST trainers. Both focus groups saw ASIST trainers as an appropriate group to provide this training, having already obtained the skills required through ASIST T4T. One sponsor suggested that this made the safeTALK T4T an unnecessary extra, because “if you’ve delivered ASIST, then you can deliver safeTALK”.

It was agreed that a trainer’s knowledge of suicide and suicide prevention needed to be well developed, even when providing safeTALK, to prepare them for any eventuality. Trainers suggested that if safeTALK T4T was to be offered to individuals who had not completed ASIST T4T, then the safeTALK trainers’ course would need to be considerably “beefed up”. This it was believed would add to the costs of the programme. The question of quality control was also raised, and one trainer felt that using individuals already experienced in delivering ASIST was a means of ensuring that safeTALK would be delivered to a similar “high standard”. However, a participant in the sponsors’ focus group indicated that selection processes for ASIST trainers had not always been optimal in the past, and there was a need to ensure that a more strategic approach was adopted for both safeTALK and ASIST trainers to ensure that the most appropriate individuals were targeted for both T4T courses.

### ***Targeting safeTALK***

Opinions were mixed as to whether specific professions or roles should be targeted for safeTALK training, or whether the training should be open to anyone who was interested in attending. A consensus reached in one group indicated that these approaches were not mutually exclusive and some identified key professions could be targeted whilst still leaving space for those self-selected to attend.

Both focus groups listed a wide variety of professions and sectors that could benefit from safeTALK training. These included;

- Hairdressers
- Taxi drivers
- Bar workers
- Primary care - Practice managers, GPs
- Voluntary sector
- Clergy and church groups
- Uniformed professions – SPS, police, fire, ambulance, lifeboats etc.
- Guest house proprietors
- Rotary clubs
- Youth groups
- Teachers and guidance staff

- Council staff
- Parents
- Social care staff

However, not every safeTALK trainer had achieved success in encouraging their target groups on to the training; some areas reported difficulties recruiting GPs and NHS staff for example. In one area, where ASIST was freely available and widely taken up, safeTALK failed to attract interest. It was recognized that different approaches to targeting and marketing these two packages may be required.

Success with recruiting members of the public also varied from area to area, and the experience of how local communities responded to suicides seemed to impact on this. In one rural community, which had experienced a number of recent suicides, residents appeared keen to increase their knowledge of suicide response. However, in another area which had also experienced recent suicides, local people “didn’t want to know” and were reluctant to engage with the safeTALK training.

Strategies to facilitate uptake of safeTALK training included advertising in the press, running demonstration sessions, and encouraging employers to view the skills acquired through safeTALK as part of core competencies for particular roles.

A number of trainers had targeted whole organisations for the roll-out of safeTALK, including SAMH, the MOD and the Forestry Commission. Under this model, key individuals had been trained in ASIST, with a larger number trained in safeTALK. It was believed that safeTALK training should run across all levels within an organisation including admin workers, senior management and the Board. However, particular emphasis should be placed on those who acted as a first point of contact within the organisation, such as receptionists or PAs.

While safeTALK is not aimed at individuals with professional expertise in the area of suicide intervention, focus group participants nevertheless emphasized the value safeTALK training could also give to mental health professionals. This could be through refreshing existing knowledge, exploring attitudes to suicide, or simply through raising their awareness of the course and its approach.

***Putting those at risk in contact with appropriate help***

It was clear from the discussions in both focus groups that safeTALK training could not be developed in isolation and had to be viewed as part of a broader approach to training around suicide prevention. As part of a portfolio of training packages from Living Works in Canada, safeTALK is described as part of a suicide intervention pathway which moves from suicideTALK (awareness), through safeTALK (alertness) to ASIST (intervention).

Recognising that SafeTALK did not train individuals in suicide intervention, focus group participants advised that an onward referral would be required for those considered to be at risk. LivingWorks advocates safeTALK-trained helpers put people at risk in contact with an ASIST-trained helper or other suitably prepared suicide intervention resource, and a number of sponsors and trainers discussed how this system had been set up

effectively within organisational settings. In organisations such as SAMH, the MOD and the Forestry Commission, staff were given information about who the ASIST-trained individuals were, and clear 'referral' pathways were in evidence.

However, out with organisational settings, the recommendation to put individuals at risk in contact with ASIST-trained helpers was viewed as potentially problematic by some focus group participants. With ASIST training courses predating the introduction of safeTALK, sponsors indicated that those trained in ASIST were not made aware at the time that they could be contacted from other trained helpers in the community, although this was now being discussed. The suggestion that 'referrals' could be received had been viewed positively by some, but with reservations by others, who saw themselves as "first contact help" rather than a second level intervention. This view is also reflected in findings from the ASIST-trained helpers survey. Information on safeTALK and the possible role of ASIST-trained helpers has been added to the networking section of ASIST.

Concerns were also raised about the potential "liability" associated with being linked with people at risk by those trained in safeTALK, and whether ASIST trained individuals would be held accountable if something went wrong or they were not able to respond. This was felt to be a particular concern for NHS and social care staff. With a limited number of ASIST-trained individuals in some areas, the potential for them being seen as "on call" at all hours of the day and night was also thought to be present, a situation which was unanimously agreed to be unacceptable.

Because of these concerns, some trainers had taken the decision not to distribute contact details for ASIST-trained individuals to those on the safeTALK course. As a consequence, other referral routes, such as to A&E, were being recommended. Booklets with details of local support agencies were also being distributed.

### ***Systems and structures required to ensure the implementation of safeTALK***

Focus group participants were clear that a wider system of suicide prevention interventions was required to make the implementation of safeTALK effective. This included training more individuals in ASIST and improving other crisis services' ability to respond to individuals at risk of suicide such as A&E and crisis help lines. More T4T courses would be required to extend the reach of the training. Delivering for Mental Health's commitment to train 50% of key frontline staff in suicide prevention was again viewed as a lever for facilitating the roll-out of safeTALK.

However, quality control and ongoing evaluation were also viewed as crucial to ensuring the effectiveness of the safeTALK programme. This would help ensure that the standard of training offered was high, and that the appropriate audiences were being reached. Evaluation could also provide useful information about how the safeTALK training was being used on the ground.

It was also suggested that Choose Life could provide some guidance as to which groups should be prioritised for training. Particular guidance was sought around the appropriateness of the training to those under 18. It was recognised that there was huge potential to roll-out the training amongst young people, but that extra training and guidance would be required about how to manage this safely. Recommendations from

LivingWorks about using safeTALK with young people will be available in the next few months.

## 4 KEY ISSUES AND IMPLICATIONS FOR ROLL-OUT

### 4.1 Overview

A consistent finding that emerged from the evaluation was participants' high level of satisfaction with the course despite the fact that for many trainers it was their first safeTALK deliveries.

- Ninety-three percent (n=222) of those who completed feedback sheets said that they would recommend the course to others
- The participants interviewed by telephone were almost without exception full of praise for the content and the delivery of the training, often mentioning their positive experience when they were asked if they had anything further to add
- The interviewed participants who were involved in suicide prevention in their local area were all keen to bring safeTALK training to their area after attending the course.

Whilst some of the discussion below highlights some of the drawbacks and development opportunities associated with the course, this is within the context of a very positive response to the course overall.

### 4.2 Quality of SafeTALK content

The safeTALK programme content was very well received and the majority of concerns were about marketing and dissemination. Feedback about the content and facilitation of safeTALK was very positive: participants had found the training eye-opening and well delivered. Participants who were involved in suicide prevention and had attended a demonstration session were all keen to make safeTALK available in their area.

Although the videos were seen as very helpful by many, suggestions for improvements were that they should be adapted to the Scottish context, and go into more depth about the complexities of intervening when someone is at risk. Sponsors and trainers, however, thought this would diminish their key messages and cause delays. There would also be a cost to customising the videos that would need to be weighed against the benefits. LivingWorks can provide costings within a few days if required and delivery would be within several months.

Participants also thought it would be helpful to have more opportunity for role-play. Given some comments by participants it may be useful to build in more safeguards for safeTALK participants: this might include providing a break where people could discreetly leave if they were uncomfortable being there. LivingWorks recommend that if someone is unable to think about hope or helping others because of their previous experiences of suicide, then help with this should be offered and the person may or may not continue with the safeTALK session. One of the reasons why it is strongly

recommended that an assistant with suicide intervention skills is present at safeTALK training is so people who need to leave are offered some support.

### **4.3 Impact of safeTALK**

The evidence from the pilot evaluation suggests that SafeTALK can achieve its goals which are that, following training, participants in the *safeTALK* program should be able to:

1. Challenge attitudes that inhibit open talk about suicide
2. Recognize a person who might be having thoughts of suicide
3. Engage them in direct and open talk about suicide
4. Listen to the person's feelings about suicide to show that they are taken seriously
5. Move quickly to connect them with someone trained in suicide intervention

There was a clear sense amongst evaluation participants that safeTALK was designed to have an impact on participants' suicide awareness. This included making them aware of the widespread nature of suicide risk and raising their confidence in confronting the issue by asking directly if they think someone may be at risk. Feedback from participants indicated that these objectives were largely achieved.

SafeTALK seemed to be perceived by participants as having a key awareness raising function about suicide, and as tackling stigma and 'normalising' thoughts of suicide. This had the effect of making safeTALK-trained helpers more comfortable to discuss the subject and to act when they were concerned that somebody may be at risk.

Immediately after the training, eighty percent of safeTALK participants felt they were more likely to recognise the signs of someone being at risk of suicide, to approach the person, to ask them directly whether they were having suicidal thoughts and to be able to connect them to help. No course attendees felt unprepared to talk about suicide following the training.

Interviewees explained that they felt more confident that they could help and a feeling of responsibility to do so, despite some continuing to feel uncomfortable about addressing the topic of suicide with someone they considered at risk, and were able to give examples of how they had used their training to help people since attending the course.

SafeTALK has been found to be relevant and useful to a broad range of professionals such those working in mental health, the police, sport and leisure, education, the clergy and the service sector.

SafeTALK provided affirmation of skills of those more experienced in dealing with people at risk of suicide and a chance to reflect on practice and potential changes such as directly asking someone about their suicidal thoughts rather than using distracting techniques.



It is notable that 47% of the participants in safeTALK had already received some suicide intervention training experience. SafeTALK was not intended for participants at this level of experience but aimed at a more basic or entry level. Despite that, 57% of those already trained in suicide intervention found the programme useful and acknowledged its contribution to local suicide prevention capability.

#### **4.4 Fit with other training**

The feedback from people who had knowledge of the two training courses suggested that safeTALK fits very well with ASIST. They felt that safeTALK increases capacity to deliver awareness training, is more accessible for people new to the issue than ASIST and less time and resource-intensive, thereby making it attractive for employers. It was anticipated that people who have been safeTALK trained may be motivated to seek out further training, possibly in ASIST, and may be in a position to persuade their employers that ASIST is a worthwhile investment. Feedback from evaluation participants suggests that is beginning to happen.

However, suicideTALK was viewed less favourably by some evaluation participants than safeTALK, leading to questions about whether safeTALK could subvert the need for suicideTALK. Others felt that suicideTALK was more appropriate for people who may not yet feel ready to talk openly about the subject of suicide.

Inconsistencies in evaluation participants' understanding of how safeTALK fits with other training suggesting that awareness of the complementary relationship between different LivingWorks suicide prevention training courses amongst those involved in their implementation could be improved. LivingWorks are in the process of developing information on this for circulation to all trainers.

#### **4.5 Roll-out of safeTALK: implementation issues**

The evaluation findings broadly support the roll-out of safeTALK across Scotland. However the evaluation also raises a range of development issues that should be addressed as part of the implementation of a roll-out programme.

Two overarching development issues arise from this evaluation:

- the need for clear information on the differences between and appropriate usage of suicideTALK, safeTALK and ASIST
- the need for agreement between services and agencies about roles and responsibilities regarding the support of individuals at risk of suicide

### ***The appropriate usage of suicideTALK, safeTALK and ASIST***

SafeTALK cannot be viewed in isolation and was designed to be part of a wider training framework as described in detail in the introduction to this report. Increasing awareness amongst those involved in the roll-out of safeTALK of how it fits with suicideTALK and ASIST should underpin the approach to the roll-out programme.

#### ***Targeting***

The results of the SafeTALK feedback demonstrate that the course is relevant and helpful to a broad constituency of professions. Most people consulted felt that safeTALK is appropriate for the general public, and indeed that anyone could benefit from this type of training. It was felt that safeTALK could be usefully targeted at young people; the LivingWorks guidelines are that safeTALK can be delivered to anyone aged 15 and over. Good practices for using safeTALK with young people are contained in the safeTALK trainer manual and are currently being further developed by LivingWorks. They include the recommendation that participants are a mix of adults and young people.

Those involved in roll-out should consider the balance between ASIST and safeTALK in each different setting in which the training is being delivered, identifying the need for intervention and/or alertness skills within that environment.

#### ***Increasing capacity for delivering safeTALK training***

To ensure effective roll-out of safeTALK throughout Scotland, it was felt that more training for trainer places are needed and the issue of whether this training should remain open only to ASIST trainers was raised alongside concerns that this could limit the potential for roll-out. Lifting this restriction should be considered for the roll-out. LivingWorks are carrying out a pilot of safeTALK T4T for non-ASIST trainers.

#### ***Increasing uptake of safeTALK***

To increase awareness, uptake and the profile of safeTALK amongst those not already involved in Choose Life networks, more publicity is needed. This could be in the form of a national campaign, local publicity and/or the running of demonstration sessions. Linking in with local community networks and large organisations such as the NHS, councils and social services departments were also suggested as a way to increase interest in safeTALK.

### ***Roles and responsibilities regarding the support of individuals at risk***

The feedback from all groups of evaluation participants suggests that the main issue that needs to be resolved before further roll-out is systems used by people trained in safeTALK to link people at risk with appropriate support.

The evaluation suggests that the current networks and coordination amongst ASIST trainers, ASIST-trained helpers and other potential suicide intervention resources within local communities necessary to make this possible may not be sufficient. Additionally, awareness of the 'referral' aspect of safeTALK amongst ASIST-trained helpers was low at the time of this evaluation as safeTALK had not yet been advertised by Choose Life. But it is important to emphasise that those participating in the evaluation were split on their willingness to be identified as a contact point. Although it is important to state that ASIST-trained helpers will not be expected to accept referrals from suicide alert helpers (it is a voluntary role) linking people with an adequately trained helper still presents a key development challenge.

While participant feedback suggests that linking people with ASIST-trained helpers works relatively well when the ASIST-trained helper is known within the workplace, linking with someone in the community was considered to be potentially problematic. Reasons included a lack of clarity of who to link with and the unpreparedness or unavailability of suicide intervention supports. Sponsors and safeTALK trainers as well as the ASIST trainers interviewed felt that referrals from the wider community are an unfair burden to place on those who are trained in ASIST. This raises a wider issue for consideration regarding whose ultimate responsibility it is to provide support to those at risk of suicide.

It is crucial that this issue is carefully considered in settings or communities where safeTALK may be rolled out, so that neither safeTALK participants nor those they are linking people at risk with feel they are left "without back-up".

Potential options for development include:

- the development of a network of local agencies that are willing to accept referrals from safeTALK-trained helpers including voluntary agencies, helplines and statutory primary and secondary health and social services which have a key role to play
- employer organisations may wish to follow the example of SAMH, the MOD and the Forestry Commission, where safeTALK participants are given information about who the ASIST-trained individuals are, and clear referral pathways are developed
- When people who are trained in ASIST are to be a contact point, they should be consulted and given the support they need to deal with this responsibility. Information on safeTALK and the potential role of ASIST-trained helpers has been added to the networking section of ASIST

In communities where there is no one identifiable that a safeTALK-trained helper might refer to, safeTALK may bring this issue to the attention of participants and ask them if they want to or believe something could be done about it.

## Appendix A Comparison between ASIST, safeTALK and suicideTALK

	suicideTALK	safeTALK	ASIST
<b>Brief description of programme</b>	<p>Suicide TALK is an exploration in suicide awareness that aims to:</p> <ul style="list-style-type: none"> <li>▪ Stimulate or build on concern about suicide</li> <li>▪ Help make communities more aware that something can be done to prevent suicide and</li> <li>▪ Break down the fear that often governs what people do or don't do about preventing suicide</li> </ul> <p>It does not aim to teach intervention skills</p>	<p>safeTALK provides suicide alertness training for recognition and referral functions.</p> <p>Content:</p> <ul style="list-style-type: none"> <li>▪ Fills a gap between recognition and connection to suicide intervention-trained resources</li> <li>▪ Stresses safety while challenging taboos</li> <li>▪ Provides a framework for understanding and addressing the low recognition rate of persons with suicidal thoughts</li> <li>▪ Proposes a mnemonic (TALK) for being "suicide alert"</li> </ul> <p>Learning process:</p> <ul style="list-style-type: none"> <li>▪ Highly structured</li> <li>▪ Graduated exposure to practice actions using non-alert and alert video scenarios</li> <li>▪ Respects participants while balancing support and required action steps</li> </ul>	<p>ASIST provides practical skills training to prevent the immediate risk of suicide.</p> <p>Content:</p> <ul style="list-style-type: none"> <li>▪ Teaches suicide first aid – helping a person at risk to stay safe and to seek further help</li> <li>▪ Participants learn to use a suicide intervention model to identify persons with thoughts of suicide, seek a shared understanding of reasons for dying and for living, review current risk, develop a safe plan and follow up, and become involved in suicide-safer community networks</li> </ul> <p>Learning process:</p> <ul style="list-style-type: none"> <li>▪ Adult learning principles</li> <li>▪ Highly participatory work in large and small work groups</li> <li>▪ Balances safety and challenge opportunities</li> <li>▪ Graduated skills development by lecture, discussions, group simulations, and role-plays</li> </ul>
<b>Target Audience</b>	Suitable for most groups of adults and assumes no prior	Anyone interested in learning to be suicide alert and for all	ASIST was designed for all types of caregivers; formal caregivers (e.g. health professionals, social workers etc)

	knowledge of suicide	levels of experience	and informal caregivers (administrators, teachers, carers etc)
<b>Length of programme</b>	1½ to 3 hours	Half day	2 consecutive days
<b>Material costs</b>	£0.00	£2.50 per person	£25 per person
<b>Venue requirements</b>	One room for up to three hours	One room for three hours	Two rooms for two full days
<b>Maximum numbers per session</b>	1 trainer and up to 30 participants	1 trainer and up to 30 participants	2 trainers and up to 30 participants or 3 trainers and up to 45 participants
<b>Equipment needs</b>	Laptop and data projector or an overhead projector	Laptop, speakers and data projector or a TV and DVD player	Laptop and data projector <u>or</u> overhead projector for each room TV and Video/DVD Player <u>or</u> speakers for laptop

## Appendix B1

## Safetalk Feedback Form

1. Is your main interest in attending this program related to:
  - Work
  - Volunteering
  - Personal
  
2. Which best describes the area in which you work or volunteer?
  - Mental health
  - Physical health
  - Education/training
  - Welfare/counselling
  - Corrections/police
  - Defence
  - Sport and recreation
  - Pastoral care / clergy
  - Business / trade
  - Service industry
  - Other (please specify)
  
3. What training in helping a person at risk of suicide have you had before?
  - None
  - 1-3 hours
  - 1-2 days
  - Longer course(s)
  
4. How many times have you talked directly and openly to a person about their thoughts of suicide?
  - Never
  - Once
  - 2-5 times
  - 6-20 times
  - >20 times
  
5. At this time, how prepared do you feel to talk directly and openly to a person about their thoughts of suicide?
  - Well prepared
  - Mostly prepared
  - Partly prepared
  - Not prepared

**IMPORTANT: Please do not complete the back of this form until the end of this training when asked by your trainer. *Thank you.***

**IMPORTANT: Please do not answer these questions until the end of this training when asked by your trainer. *Thank you.***

6. My trainer was prepared and familiar with the material

Strongly Agree	Agree	Partly Agree	Disagree

7. My trainer encouraged participation and respected all responses.

Strongly Agree	Agree	Partly Agree	Disagree

<b>Compared to where I was before the training...</b>	<b>Much More likely</b>	<b>More Likely</b>	<b>About the same</b>	<b>Less Likely</b>
8. I will recognize signs inviting help.				
9. I will approach a person with thoughts of suicide				
10. I will ask directly about thoughts of suicide.				
11. I will connect a person with thoughts of suicide to someone who can help them keep safe.				

12. How prepared do you now feel to talk directly and openly to a person about their thoughts of suicide?

- Well prepared
- Mostly prepared
- Partly prepared
- Not prepared

13. Would you recommend this training to others?

- Yes
- No

14. How could this training be more effective in preparing suicide alert helpers?

15. How did you find out about this program?

- Website
- Other publicity
- Employer
- Friend or co-worker
- Previous safeTALK participant
- Through ASIST
- Other (please specify):

16. My comments may be quoted anonymously to promote safeTALK:

- Yes
- No

**Other comments?**



## **Appendix B2 Interview schedule participants**

- 1. What were your reasons for undertaking SafeTALK training?**
- 2. What were your expectations of Safe TALK training?**
  - a. content of training (i.e. what you would learn)**
  - b. the impact it would have on your ability to support people in crisis / at risk of suicide ( i.e how you would use what you learned)**
- 3. How has the course impacted on:**
  - the way you think about suicide risk?**
  - your ability to recognise signs inviting help?**
  - the way you respond when you think someone may be at risk of suicide?**

**4. Do you feel confident that you can connect people with thoughts of suicide to ASIST trained helpers or others with suicide intervention skills?**

**If not why not?**

**If yes, whom would you connect them to?**

**5. Have you drawn on the skills you developed at your Safe TALK training since the end of the course?**

**If no, why not?**

**If yes, describe how:**

**(Prompts: Confidence/skill in recognising suicide risk?  
Confidence to approach someone with thoughts of suicide?  
Referring people to ASIST trained helpers or others with intervention skills)**

**On reflection:**

**6. To what extent have your expectations of SafeTALK been realised?**

**7. What did you think was the most useful aspect of the SafeTALK?**

**8. What could be improved?**

**9. How does SafeTALK training fit with other training you have e.g. ASIST, STORM, Mental Health First Aid?**

**10. Who would benefit most from receiving SafeTALK training?**

## Appendix B3 Trainers Focus Group Topic Guide

1. Why did you want to become trained in safeTALK / what were your expectations about this training? How does it fit in with your wider work responsibilities?
2. How has safeTALK worked in your area?
  - a. Who has safeTALK been targeted at? What has informed this decision?
  - b. What advantages and disadvantages do you see from the SafeTALK system?
  - c. What, if any, barriers and facilitators have arisen around implementing this system?
3. How does safeTALK fit in with other training and suicide prevention activities? E.g. ASIST, Storm, MHFA
4. How it has/may contribute(d) to capacity building within that organisation/network/community
5. What was the course's impact on suicide prevention activities in the area? Is it likely to facilitate onward referral (to ASIST or other resources)?
6. Does safeTALK translate into a Scottish environment? How can the relevance of safeTALK training as resource be improved?
7. How should safeTALK be rolled out in the future
  - a. Who should it be targeted at?
  - b. What systems and structures are needed to make SafeTALK work?

## Appendix B4 Sponsors focus group schedule

1. What is your understanding of the purpose of safeTALK
2. Why did you fund someone to undertake safeTALK training / what hoped to get out of it
3. Where fits in with wider organisations objectives
4. How has safeTALK worked in your area?
  - a. What advantages and disadvantages do you see from this system?
  - b. What systems and structures are needed to make this work?
  - c. What, if any, barriers have arisen around implementing this system?
5. Practical considerations relating to costs, targeting and effectiveness
6. How has safeTALK fitted in with other training and suicide prevention activities
7. How safeTALK could best be developed if it were to be rolled out more widely.

## Appendix B5 Survey of those who are ASIST trained (non pilot areas)

### About you:

- a. What is your profession / occupation?
- b. What organisation do you work for?
- c. In which local authority area are you based?

1. How familiar are you with safeTALK? (please click one box)

**very familiar**    1     2     3     4     5     **not familiar at all**

*(For further information on safeTALK please contact Ciara Byrne, NIST, at [ciara.byrne@samh.org.uk](mailto:ciara.byrne@samh.org.uk) or view the following web pages <http://www.chooselife.net/TrainingArticles/safeTALKPilot.asp> )*

2. How useful do you think the safeTALK training is/will be? (please click one box)

**very useful**    1     2     3     4     5     **not useful at all**

3. How well would safeTALK fit with other training and suicide prevention activities in your area? (please click one box)

**very well**    1     2     3     4     5     **not well at all**

4. Who do you think would most benefit from receiving safeTALK training?

5. As an ASIST trained person, how well do you envisage the proposed system of safeTALK trained people referring to ASIST trained helpers would work in practice in your area? (please click one box)

**very well** 1  2  3  4  5  **it would not work at all**

6. How do you feel about safeTALK trained people potentially referring people at risk of suicide to you?

7. Which existing organisational systems would need to be used to roll out safeTALK effectively in your area?

8. Which new organisational systems would need to be developed to roll out safeTALK effectively in your area?

9. What, if anything, do you think safeTALK would add to the capacity for suicide prevention activity in your area?

10. What, if any, barriers do you envisage to implementing this system?

If you have any further comments please use the space below.