Impact evaluation of the Choose Life training programme

Final report

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Contents

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Executive summary

This is the final report of an evaluation of the impact of the national Choose Life suicide prevention training programme.

The focus of the evaluation was on three courses — ASIST, safeTALK and STORM — which provide participants with knowledge and skills to enable them to intervene appropriately in situations where a person is, or may be, at risk of suicide.

The purpose of the evaluation was to improve the understanding of the effectiveness and impact of the nationally-cascaded training programme. The evaluation sought to answer the following questions:

- What has been the impact of the Choose Life training programme on practice and behaviour change in relation to people who have thoughts of suicide at the individual, community, organisational or systems level across different localities in Scotland?
- More specifically, is the Choose Life training programme effective in:
    - creating behaviour and / or practice change at the individual, community, organisational or systems levels
    - changing attitudes in the immediate environment of training participants and changing their organisations' policies and cultures in relation to suicide and people with thoughts of suicide
    - contributing to the creation of an environment of reduced stress and increased confidence in self and others with helping people with thoughts of suicide?

About the Choose Life training programme

Suicide prevention training has been a key part of the national Choose Life strategy since its inception in 2002. Training was seen to be important in raising awareness of suicide and giving people the skills and confidence they need to intervene. The development of a national training programme has been shaped by a number of factors. Some of those factors relate directly to the need for relevant and appropriate training for different groups. Others relate to changes in national and local policies and organisational structures.

The training programme initially began with a single course (ASIST), and expanded from 2006 onwards. It now offers a range of options for training designed to meet the needs both of professional staff and people who may come into contact with vulnerable individuals either through work or in the community.

Some of the expected outcomes from the national training programme were that:

- Participants are given the skills and knowledge they need to intervene with people at risk of suicide.
- Participants have greater confidence to intervene.
- Participants use the skills and knowledge they have acquired to intervene with people at risk of suicide.
- Participants use their skills to good effect.

- Organisations and communities in Scotland are more suicide-aware.
- Organisations provide better support to people at risk of suicide.
- Organisations work better **together** in supporting people at risk of suicide.
- The immediate risk of suicide is reduced in particular individuals.
- There is a reduction in suicide rates in Scotland (long term).

Methods

Both qualitative and quantitative methods were used in this evaluation. Information for the evaluation was collected through: a review of Scottish evaluations of training; survey of Choose Life co-ordinators, training organisations and former participants; the collection of routine monitoring data on training delivery and training participants; interviews, focus groups and participative sessions with trainers; and case studies in three local authority areas and in one training organisation.

What has been the reach of the training programme?

The findings of the evaluation indicated that there was comprehensive coverage across Scotland of ASIST and safeTALK. However, STORM was available in just over half of local authority areas in Scotland. In addition, among 17 training organisations that took part in the evaluation, only two (both universities) delivered STORM.

The delivery of refresher training is not common across Scotland, nor is the delivery of suicideTALK (a short awareness-raising session).

Every area in Scotland had at least two ASIST trainers available locally, and around half had more than six local ASIST trainers. Local areas were less well-endowed with STORM and safeTALK trainers, with a sizeable proportion of areas reporting only one or two local trainers for these courses. It would appear that, for all three courses, most areas had access to a range of local (and in some cases, non-local) trainers.

Between 2007-2010, ASIST continued to be the suicide prevention training course delivered most often in Scotland. However, course delivery and the number of participants attending all three courses has increased in the same period. From April 2007 – March 2010, it is estimated that there have been approximately 19,000 people trained. If these figures are added to the those available from before 2007, it would suggest that as of March 2010, around 30,000 people in Scotland had attended suicide prevention training in one form or another.[1]

During the period April 07 – March 10, suicide prevention training in Scotland was mainly attended by professional staff working in the NHS and in local authorities. In addition, a sizeable proportion of participants were also voluntary sector employees. ASIST and safeTALK were attended by a range of participants whereas the majority of STORM participants were NHS employees. Few participants in any of the courses were members of local communities attending in a non-professional capacity.

[1] At the time of writing this report in May 2011, NHS Health Scotland estimated that approximately 35,000 people in Scotland had been trained.

What has been the impact of the Choose Life training programme?

Suicide prevention training has been effective in bringing about changes in behaviour among those who have attended the training. After training, participants are more confident and willing to ask directly about suicide intent and they use their skills and knowledge to intervene effectively. This includes not only people in frontline mental health services, but also those in support roles who are reported to be more able to respond to, and 'signpost', vulnerable patients / clients.

Within organisations, training was attributed with creating a climate of greater openness. Suicide is more talked about generally and members of staff teams are more likely to discuss their experiences of intervention and provide mutual support. The training has also enabled the use of a 'common language' about suicide that has supported better inter-agency working. The recording of interventions is still not common practice, but there are new protocols and pathways in some areas that have led to improved documentation, e.g. assessment forms, and better recording. There were also examples of policies and procedures being developed as a result of training, although this type of impact may not be widespread across Scotland. Finally, in some areas, the training was also attributed with bringing suicide prevention up the agenda of senior managers.

From a community perspective, the training was seen to be effective in raising awareness, reducing stigma and challenging myths around suicide. It had also encouraged people to reflect on their attitudes and values.

What factors have affected the reach and impact of the training?

The availability of different courses to meet different needs has been welcomed and has increased the impact of the training programme. Other levers included, for example, the quality of the training, having a proactive local co-ordinator and helpful local structures.

Some of the barriers which have hindered wider reach and impact have included difficulties in retaining trainers; time, financial and other resource constraints; and the resistance of some staff to attend training.

However, there is a consensus that having a national programme has contributed to the positive impact of the programme by promoting consistency and quality across Scotland and there was a strong view that the national co-ordination of suicide prevention training should continue.

Conclusions

The findings of this evaluation clearly show that the delivery of a nationally-cascaded programme of suicide prevention training has made significant progress in increasing the understanding of suicide and reducing stigma in communities; and in giving people the skills, knowledge and confidence they need to intervene. The programme has also achieved its expected outcomes including, it may be argued, making a contribution to the decreasing rate of suicide in Scotland since 2000-02.

In order for the programme to have its desired impact, it is necessary to train enough people. At the same time, previous evaluations and the findings of this evaluation show that to achieve effective interventions with people at risk, it is necessary to train the 'right' people. There has been good progress in reaching large numbers of people in

Scotland and in reaching many of the ‘right’ people. However, there will be an on-going need to deliver training to maintain and increase the current impact. In addition, some of the ‘right’ people are still not being reached, including GPs.

The evidence from this evaluation shows that the impact of the Choose Life training programme has not merely been sustained over time, but has grown. At the same time, however, more can be done. It is not universally the case across Scotland that patients / clients are routinely asked by supporting services (as part of an assessment or review process) if they have ever attempted suicide, or are feeling suicidal. While there clearly have been changes in policies and procedures in some organisations which have been directly attributed to the training programme, again, these changes have not yet happened everywhere. In addition, there will be challenges to the future sustainability of training arising from the current financial constraints on organisations.

Training has clearly played a significant and effective part in the overall impact of the Choose Life suicide prevention strategy. Moreover, there is strong support — and will continue to be a need — for a nationally-cascaded programme that ensures consistency and quality of training delivery, and which is able to adapt and respond flexibly to future training needs.

1. Introduction

This is the final report of an evaluation of the impact of the Choose Life suicide prevention training programme. The evaluation was commissioned by NHS Health Scotland and was carried out by Dawn Griesbach and Patricia Russell (Griesbach & Associates).

The training programme includes four courses: ASIST (Applied Suicide Intervention Skills Training), STORM (Skills-based Training on Risk Management, including STORM Children and Young Adults), safeTALK (Suicide Alertness for Everyone) and suicideTALK (a short discussion and awareness-raising session). This evaluation focuses on the three courses — ASIST, safeTALK and STORM — which provide participants with knowledge and skills to enable them to intervene appropriately in situations where a person is, or may be, at risk of suicide.

1.1 Policy context

The national Choose Life strategy and action plan was launched in December 2002 under the auspices of the (then) Scottish Executive's National Programme for Improving Mental Health and Wellbeing (Scottish Executive 2002). Choose Life is a 10-year strategy that has set a target to reduce the prevalence of suicide by 20% by 2013. This target was adopted by Scottish Ministers as a HEAT target in 2007.[2]

The delivery of a nationally co-ordinated programme of suicide prevention training has been a significant activity undertaken as part of the implementation of Choose Life. This programme initially began with the delivery of ASIST in 2003, and was later expanded to include other courses in 2006-07.

In 2006, the Scottish Executive published *Delivering for Mental Health,* which had the aim of improving mental health services in Scotland, through setting a series of targets and commitments (Scottish Executive 2006). Commitment 7 (or C7 as it became known) stated that, 'Key frontline mental health services, primary care and accident and emergency staff will be educated and trained in using suicide assessment tools / suicide prevention training programmes; and 50% of target staff will be trained by 2010.'

At the end of 2007, the Scottish Government expanded the original HEAT target on the reduction of suicide to incorporate Commitment 7 of *Delivering for Mental Health*. This new target became known as HEAT 5. HEAT 5 not only increased the profile of suicide prevention training within NHS Boards, it also gave the delivery of training a more strategic focus.

In 2009, the Scottish Government's new mental health improvement strategy, *Towards a Mentally Flourishing Scotland,* continued to reiterate the priority of suicide prevention training (Scottish Government 2009).

1.2 Recent developments

Following the evaluation of Phases 1 and 2 of Choose Life, a national suicide review group, led by the Scottish Government, published a refreshed Choose Life Strategy

[2] HEAT (Health Improvement, Efficiency, Access and Treatment) targets are a core set of Ministerial objectives, targets and measures for the NHS.

in 2010 to refocus the work of Choose Life over its final three years (Scottish Government 2010). Objective 5 of the refreshed action plan is: To provide education and training about suicidal behaviour and promote awareness about the help available. It goes on to say,

> In considering objective 5, NHS Health Scotland should bring forward proposals for increasing the number of General Practitioners who have had suicide prevention training; and proposals for extending the training, as appropriate, to other staff groups such as those working for the Scottish Ambulance Service and the Scottish Prison Service.

Thus, training will continue to be an important part of the work of Choose Life over the next three years. It is therefore important at this stage to reflect on the successes and challenges of rolling out a nationally-cascaded programme of training, to consider what changes may be needed to continue to support the delivery of training, including how best to target training to those who need it in the future.

1.3 Aims and objectives of the evaluation

The purpose of the evaluation was to improve the understanding of the effectiveness and impact of the nationally-cascaded Choose Life training programme. The evaluation sought to answer the following questions:

- What has been the impact of the Choose Life training programme on practice and behaviour change in relation to people who have thoughts of suicide at the individual, community, organisational or systems level across different localities in Scotland?
- More specifically, is the Choose Life training programme effective in:
    - creating behaviour and / or practice change at the individual, community, organisational or systems levels
    - changing attitudes in the immediate environment of training participants and changing their organisations' policies and cultures in relation to suicide and people with thoughts of suicide
    - contributing to the creation of an environment of reduced stress and increased confidence in self and others with helping people with thoughts of suicide?

To answer these questions, the evaluation sought to:

- measure the 'reach' of the programme, i.e. numbers, geography, organisations and sectors
- examine the effectiveness of the programme and its impact — in particular, on the behaviour / practice of individual trainees, and on the organisations they work in (including organisational systems) or the communities they live in
- identify those factors that support and / or hinder the positive impact of the programme
- determine whether the effect of the different types of training has been sustained over time.

1.4 Structure of this report

This report has the following sections:

- Section 2 provides details of the background and implementation of the Choose Life training programme since its inception in 2003.
- Section 3 describes the methods used in this study.
- Section 4 sets out the findings of the evaluation in relation to the reach of the training programme.
- Section 5 considers the impact of the training programme, both on participant behaviour and on organisations, organisational systems and communities more widely.
- Section 6 examines the factors that have supported and / or hindered the positive impact of the programme.
- Section 7 discusses the findings, and considers the effect of the training and whether this has been sustained over time.

2. About the Choose Life training programme

This section provides a context for this evaluation. It explains why a national suicide prevention training has been developed in Scotland to support the Choose Life strategy, sets out the expected outcomes from the programme and provides a short history of its implementation.

This section does not provide details about the contents of each of the courses in the programme. However, this information is available in Appendix 1 for the three courses which were the subject of this evaluation — ASIST, safeTALK and STORM.

2.1 Why have a national programme of suicide prevention training?

The Choose Life strategy and action plan, published in 2002, set out seven broad objectives which had the aim of reducing the rate of suicide in Scotland. Two of these objectives focused on providing immediate support to people in crisis (Objective 2), and increasing public awareness of mental health issues (Objective 5). While there was no specific detail given, the importance of training was highlighted and a commitment was made by the (then) Scottish Executive to allocate funding to support 'the development of appropriate training programmes' (see page 13, *Choose Life* strategy and action plan).

The theory of change that underpinned the decision to invest in training was that training people from a range of backgrounds and in a variety of settings would increase the likelihood of intervention and, therefore, have a greater impact on reducing the number of suicides (Griesbach *et al,* 2008, see paragraph 4.3). This was consistent with the public health, community-based approach of the Choose Life strategy. Those responsible at the time for implementing the strategy considered that suicide prevention training would raise awareness and reduce stigma among the public by giving people the knowledge and skills to recognise the signs of suicide and to intervene. They had also identified a lack of understanding of suicide risk and a lack of skills and knowledge at local level, and believed that training could help to address these issues.

2.2 What was training intended to achieve?

Drawing on our understanding of the overall aims and objectives of the Choose Life strategy and action plan, and of the national Choose Life training programme, some of the expected **outcomes** from the national training programme are that:

- Participants are given the skills and knowledge they need to intervene with people at risk of suicide.
- Participants have greater confidence to intervene.
- Participants use the skills and knowledge they have acquired to intervene with people at risk of suicide.
- Participants use their skills to good effect.
- Organisations and communities in Scotland are more suicide-aware.
- Organisations provide better support to people at risk of suicide.
- Organisations work better **together** in supporting people at risk of suicide.
- The immediate risk of suicide is reduced in particular individuals.
- There is a reduction in suicide rates in Scotland (long term).

2.3 How has the training programme developed and expanded in Scotland?

Implementation of suicide prevention training in Scotland began in 2003 with the introduction of ASIST. The initial choice of ASIST was strongly influenced not only by its community focus which was consistent with the wider public health focus of the Choose Life strategy but also by its international reputation and longevity (Griesbach *et al,* 2008). ASIST began to be implemented widely across the country in 2004 with support from the then Choose Life National Implementation Support Team (NIST).

Between 2004-6, there was a very high level of demand for ASIST training. The decision was taken, therefore, to focus resources on meeting that demand, rather than undertaking any detailed exploration of alternative or additional forms of training (Griesbach *et al,* 2008, paragraphs 4.10 and 11.7). By 2007, ASIST was delivered in every local authority area in Scotland.

STORM was introduced to Scotland in 2004, and was initially adopted in the Highland region of Scotland which, at the time, had one of the highest rates of suicide in the country.[3] The implementation of STORM across Scotland has been slower than for ASIST, in part because of the focus on ASIST. By 2007, STORM was delivered in only five Scottish local authority areas, and until 2007, all of the co-ordination and support for STORM training in Scotland was provided by the course developers at the University of Manchester. However, from 2007, STORM T4Ts began to be funded by Health Scotland, and quality assurance for STORM training was taken over by Health Scotland in 2010.

safeTALK began to be implemented in Scotland in June 2006 — initially as a pilot in three local authority areas (Argyll & Bute, Dumfries & Galloway and the Western Isles) and in three organisations (Scottish Association for Mental Health, COPE and the Ministry of Defence). An evaluation of the safeTALK pilot was published in August 2007, and safeTALK began to be rolled out more widely in Scotland in 2008.

2.3.1 The development of a suite of training courses

The introduction of safeTALK in 2006 was part of a process to begin developing a more comprehensive portfolio of suicide prevention training courses. This subsequently led to the availability of the suite of courses delivered within the current nationally-cascaded training programme by NHS Health Scotland.

There were a number of factors that have influenced the direction and implementation of the national training programme.

One of the most significant factors was the HEAT 5 target, for which NHS Health Scotland had a key implementation role. Given the different types and levels of staff who were the subject of the HEAT 5 target, it was important to offer a range of courses that would allow managers to take a more strategic view of the appropriate level of training for those different staff groups.

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[3] The suicide rate in Highland for the period 2000-2004 was 24.0 per 100,000 population. This was the highest rate of suicide among local authority areas in Scotland – along with Shetland which had a rate of 23.7 per 100,000 population. See local authority spreadsheets at: http://www.scotpho.org.uk/home/Healthwell-beinganddisease/suicide/suicide_data/suicide_la.asp

The findings of the Phase 1 evaluation of Choose Life (Platt *et al,* 2006) were also a major influence. It identified the need for a more strategic and targeted approach to national and local training with a clearer focus on the training of frontline services and practitioners. This requirement for a more strategic and targeted approach was reflected in the Scottish Executive guidance for Phase 2 of Choose Life to Community Planning Partnerships in 2006. It is perhaps worth mentioning here that, although there had been some work done on producing a national training strategy, it had not been finalised and was superseded by the requirement to produce a national competence framework for the delivery of Commitment 7 (later HEAT 5).

Importantly, the Phase 1 evaluation also recommended combining the existing public health and community-based approaches to suicide prevention with a greater focus on higher-risk groups, for example, people with mental health problems, problem alcohol and drug users, and prisoners. Effectively, this represented a development from the original theory of change that had guided the early phase of the training programme. It recognised the importance of ensuring that those who had a greater degree of contact with high risk individuals also had the knowledge and skills they needed to be able to intervene with those individuals effectively.

The Phase 1 evaluation also proposed that the implementation function of the national co-ordinating body (then located in Scottish Executive) would be more effective within a different structure that would match its implementation function. In 2007 the Scottish Government decided to move NIST into NHS Health Scotland and in August 2007 the training team became employees of NHS Health Scotland (eight months prior to the remaining NIST staff) to begin work to support NHS Boards in relation to the HEAT 5 target. New support structures were subsequently developed in Scotland such as a national T4T delivery team for ASIST and the signing of an International Collaborative Committee (ICC) agreement with LivingWorks Education in 2007, which transferred all quality assurance responsibilities for ASIST and safeTALK in Scotland to Choose Life.[4]

The emerging findings and subsequent publication of the ASIST evaluation highlighted and / or reinforced a number of issues needing to be addressed to improve the impact and effectiveness of ASIST. These included: the potential barrier to training attendance created by the two-day aspect of the course; the potential benefit of a suite of courses; the need for better targeting; difficulties with the recruitment and retention of trainers; and the need for better recording and monitoring (Griesbach *et al,* 2008).

There have been changes in the funding and support models for training as a consequence of the Concordat between the Scottish Government and local authorities. Decisions about the scale and funding of suicide prevention training are now made locally without any Scottish Government guidance. These changes put more onus on local leadership by local authorities and the NHS. They also made the role of NHS Health Scotland in promoting, managing and co-ordinating the national programme more important.

[4] LivingWorks Education is the licensing body for ASIST and safeTALK, based in Canada.

As part of their role in co-ordinating a national programme of suicide prevention training, the NHS Health Scotland National Training Support Team (NTST):

- manages the processes for selecting trainers
- funds and organises all T4T courses (for ASIST, STORM, safeTALK and suicideTALK)
- distributes training materials (for all courses) to local trainers
- has developed a national learning framework for the HEAT 5 target (described below)
- has introduced a quality assurance support framework for trainers building on the existing quality assurance schemes run by the licensing providers
- organises national trainers' conferences and supports regional events
- has developed a database to monitor the delivery of training and information about training participants.

2.4 How has training been targeted?

From the beginning of the Choose Life strategy and the introduction of ASIST in 2003 ASIST training was open to anyone who had an interest in suicide prevention, in keeping with the key message of suicide being everyone's business. This included professional health and social care staff working in the voluntary or statutory sectors and community caregivers such as pastors / ministers and volunteers. This model was continued in the roll out of safeTALK.

However, as noted above, the Phase 1 evaluation of Choose Life advocated more targeting of training. This was reinforced by the finding of the ASIST evaluation that, where people reported having had no experience of putting their ASIST skills into practice after training, the reason for this was generally that they had not had the opportunity to do so. Thus, the evaluation recommended that training should be targeted at the 'right' people to ensure the maximum impact, and that training should be prioritised for those who have greatest contact with people at greatest risk — both in their jobs and in their communities.

The introduction of the HEAT 5 target was a key driver in making the delivery of T4T training for ASIST, STORM and safeTALK trainers more strategic, with a focus on ensuring that local areas had a sufficient number of trainers available to deliver on the HEAT 5 target as well as maintaining existing delivery. The intention, by the National Training Support Team was to create a balance between NHS and non-NHS trainers, and T4Ts were targeted in such a way to achieve this balance.

The targeting of training for the HEAT 5 target has been largely informed by the development of a HEAT 5 National Learning Framework, which was published in February 2008 and updated in May 2009.[5] This Framework was developed with partners and set out a series of learning levels, and the skills, knowledge and attitudes expected to be associated with each level. The Framework also provided information about which of the courses in the national Choose Life training programme met the requirements for each learning level. It should be noted that

[5] Available from: http://www.chooselife.net/Training/HEAT5/HEAT5.asp. See *New Learning Framework,* dated May 2009.

there are other ‘approved courses’, which are not part of the national training programme, which were also deemed to meet, in part or wholly, the requirements for each of the three competency levels.[6] (Further details about the National Learning Framework is in Appendix 2.)

2.5 Key Points / Summary

Suicide prevention training has been a key part of the national Choose Life strategy since its inception in 2002. The development of a national training programme has been shaped by a number of factors. Some of those factors relate directly to the need for relevant and appropriate training for different groups. Others relate to changes in national and local policies and organisational structures. The training programme, however, has continued to expand. It now offers more options for training designed to meet the needs both of professional staff and people who may come into contact with vulnerable individuals either through work or in the community.

[6] These courses are mainly delivered in Tayside and Fife.

3. Methods

This section describes the methods used in this evaluation. Both qualitative and quantitative methods were used. In our approach to the evaluation we used the Kirkpatrick model as framework for the evaluation. According to the Kirkpatrick model, a training intervention can be evaluated on four levels (Kirkpatrick 1959):

- **Level 1 – Participant reaction:** Did the participants enjoy the training?
- **Level 2 – Participant learning:** Did the participants learn anything new?
- **Level 3 – Participant behaviour:** What changes have there been in the participant's behaviour? Has the participant applied the training, and if so, have they done so in the way anticipated?
- **Level 4 – Organisational / community change:** Did the training lead to any changes in organisations, communities or society more widely?

In this evaluation, the focus was on Kirkpatrick levels 3 and 4 only.

3.1 A review of Scottish evaluations of the training

This evaluation took place from May 2010 – February 2011. The purpose was to examine the impact of the Choose Life training programme from its inception, beginning in 2003. However, the main focus of data collection for the current evaluation was the period April 2007 – March 2010, which was the three years preceding the start of the study. For the period prior to April 2007, evidence was drawn from the reports of previous training evaluations conducted in Scotland.

A review was carried out of the findings of evaluations previously undertaken on ASIST (Griesbach *et al,* 2008), STORM (Gask *et al,* 2008) and safeTALK (McLean *et al,* 2007).[7] The purpose of the review was to identify what these previous evaluations had learned about: (a) the reach of each training course (up to the point the evaluation was undertaken); (b) the extent to which participants had used the skills they acquired in the courses to intervene with someone at risk of suicide; and (c) the wider social / organisational impact of the training. Sections 4 and 5 of this report contain a summary of the findings of these evaluations as it relates to reach, participant behaviour change (Kirkpatrick level 3) and wider organisational / social impact (Kirkpatrick level 4).

We have also referred to relevant findings from the evaluations of the first phase of Choose Life (Platt *et al,* 2006) and the second phase of Choose Life (Russell *et al,* 2010).

3.2 Survey of Choose Life co-ordinators and training organisations

A web-based survey was carried out among Choose Life co-ordinators and a separate web-based survey carried out of organisations that are involved in the delivery of ASIST, STORM and / or safeTALK. The latter survey was intended to

[7] It should be noted that the ASIST evaluation was the only national evaluation among the three. The STORM evaluation focused on the implementation of STORM in Highland, and the safeTALK evaluation was an evaluation of the pilot implementation of safeTALK in three local authority areas and three organisations. Only the ASIST and STORM evaluations looked at the wider organisational / social impact of training (Kirkpatrick level 4).

capture information from agencies that do not report to their local Choose Life co-ordinator on their delivery of training.

Both surveys sought to identify, for each of the three courses:

- which courses were being delivered in their area (or by their organisation)
- when delivery began (i.e., what year)
- whether refresher courses were delivered
- whether there had been any changes in training delivering since the introduction of the Concordat and the HEAT 5 target
- whether there were any perceived barriers to wider roll-out (or take-up) of training.

In addition, the surveys also asked whether the respondent held data on: the number of courses delivered; the number of people attending each course; the participants' employers; participants' job role / occupation; and participants' email addresses.

3.2.1 Respondents

All 32 Choose Life co-ordinators in Scotland were invited to take part in the survey and all 32 responded. It should be noted that in Dundee City and Angus, suicide prevention training is co-ordinated and largely delivered by staff at the University of Dundee. This training is available to university staff, staff from other external agencies and members of the community. Until March 2010, in Glasgow City, suicide prevention training was co-ordinated on behalf of the local authority by the Scottish Association for Mental Health (SAMH). For the purposes of this evaluation, individuals from the University of Dundee and SAMH submitted responses on behalf of the Choose Life co-ordinator in those respective areas. It should be noted, however, that in Glasgow, there are a number of other voluntary sector agencies which independently deliver (mainly ASIST) training. These agencies were included in the survey of training organisations.

Representatives from 22 agencies from around Scotland were invited to take part in the survey of training organisations. (A list of these is shown in Appendix 3.) These agencies were mainly in the voluntary sector (working in housing, mental health or addiction). However, the sample also included four universities (Stirling University, University of the West of Scotland, Glasgow Caledonian University and Edinburgh Napier University[8]), the Police training college, the British Transport Police, the Ministry of Defence and two NHS Health Promotion departments.[9] Seventeen agencies responded to the survey — a 77% response rate. Ten of these said their organisation operated at a national level, and seven at a local level. In addition, two

[8] Dundee University completed the survey on behalf of the Choose Life co-ordinator for Dundee City and Angus. There was no separate response submitted from the University to the survey of training organisations.

[9] It should be noted that the person who completed the questionnaire on behalf of the Ministry of Defence, is not actually employed by the Ministry of Defence. This individual was formerly employed by this organisation and now delivers training to MoD personnel on a freelance basis.

organisations (the British Transport Police and the police training college) replied to say that they do not deliver ASIST, STORM or safeTALK.[10]

3.3 Collection of monitoring data from co-ordinators and training organisations

Following the survey of co-ordinators and training organisations, survey respondents were contacted again to request additional data on their course delivery and their course participants. In particular, we attempted to collect data for three financial years (07-08, 08-09 and 09-10) on the following:

- number of courses delivered per year
- number of participants attending the courses per year
- participant employer
- participant job role

Data on the first three items was received from 25 out of 32 local authority areas. It is important to bear in mind that not all of these areas have delivered all three of the courses for the past three years. In addition, in some cases, even if they did, they did not necessarily hold data for that course for all three years.

Very few areas were able to provide data on participant job role, and those who did collect this information collected it in different forms. In some cases, it would have taken substantial additional time and resources from the local area in order to process the data for an external evaluator to be able to interpret. In addition, some areas only had the data for ASIST participants, but not safeTALK or STORM participants (even if they delivered these other two courses). Given the very small number of areas that supplied any data on participant job role, and the incompleteness of the data, no attempt has been made to report on this data.

Only four of the 17 training organisations provided data on the number of courses they delivered per year and the number of participants attending the courses. None of the training organisations were able to provide data on participant employer or participant job role.

3.4 Survey of training participants

A web-based survey was carried out among a sample of individuals who had participated in ASIST, STORM or safeTALK training over the past three years. The main purpose of the survey was to gather information about people's experience of using their skills, and to get their perspectives on whether any changes had taken place in the organisations they work in as a result of the training.

For data protection reasons, training participants were contacted and invited to take part in the survey by their local Choose Life co-ordinator, rather than by the evaluation team directly.

[10] It was reported by the National Training Support Team that some training has begun to be delivered in the Police Training College from 2011.

3.4.1 Sample selection

In the survey of Choose Life co-ordinators (described above), respondents had been asked to state whether they held email addresses for former training participants for individual courses over the past three years (07-08 to 09-10). Nine out of the 32 co-ordinators indicated that they did **not** keep a record of participant email addresses.

The co-ordinators in the remaining 23 areas reported that they held email addresses for participants for at least one of the previous three years. (Six said they only held email address for participants for one or two years only – not for the entire three years.)

In NHS Ayrshire, a survey of training participants had recently been carried out as part of a local evaluation, and therefore a decision was taken **not** to re-contact participants in North, South or East Ayrshire for the purposes of **this** evaluation. Some of the main findings of the Ayrshire evaluation in relation to the impact of training are discussed in Section 7 of this report.

The remaining 20 co-ordinators were asked to select a random sample of 30 participants for each course, for each of the years for which they held data. Detailed instructions were given to co-ordinators about how to do this. (A copy of these instructions are included as Appendix 4.) Based on the information co-ordinators had provided in their initial survey, it was expected that this process would result in a sample of 2,850 former participants. It was anticipated that there would be some difficulties in contacting former participants (because individuals had moved jobs, or otherwise changed their addresses), and this sample of this size was felt to be adequate to provide a representative sample while allowing for the likely low response rate.

Once local co-ordinators had identified their samples, they then were asked to email the participants and invite them to take part in the survey. (An email text was given to co-ordinators for this purpose.)

It transpired that not all of the 20 co-ordinators were able to participate in this part of the study. In general, this was either because of a lack of administrative support or because of the pressure of other work. Given these difficulties, and the expected reduction in sample size due to invalid email addresses, it is estimated than only around 1,200 individuals received a request to take part in the survey of training participants, rather than the 2,850 expected.

3.4.2 Respondents

One hundred and fifty-nine (159) people took part in the survey. Based on the estimated sample of 1,200, this represents a 13.3% response rate. In surveys such as this, a response rate of between 20-30% is generally considered average, and therefore, the response to this survey is low. Furthermore, of the 159 people who began the survey, only 126 (79.2%) completed it.

Four-fifths of the respondents (80%) were female, and three-quarters (75.7%) were aged 35 or over. Respondents lived in 19 (out of 32) local authorities, and worked in 21 local authorities. However, in many cases, there were only 1 or 2 responses from a local authority area. Overall, the highest proportion of responses (more than 9% of responses) came from individuals living or working in: Argyll & Bute, Dundee City,

Fife, North Lanarkshire, Renfrewshire, Shetland, West Dunbartonshire and West Lothian.

The majority (82.1%) reported they had attended an ASIST course, and just over two-fifths (42.3%) said they had attended a safeTALK course. Only nine individuals (5.8%) said they had attended STORM. Fifty-two respondents indicated that they had attended more than one of the courses and seven (7) said they had attended all three. (Note, therefore, that 7 of the 9 STORM participants had also attended both the other two courses.) About a third of respondents (32.4%) were local authority employees at the time they attended the training (22.0% were employed in social work departments); a fifth (21.4%) worked in the voluntary sector; and just under a fifth (18.2%) were NHS employees. (See Table 1.)

Given the small number of responses to the participant survey, the resulting sample cannot be considered as representative of the wider participant population and caution should be used in interpreting the quantitative data from the survey. Despite these caveats, it is perhaps worth noting that the proportion of men / women who took part in the survey, and the proportion of participants who attended in a professional capacity are similar to the proportions reported in a survey of a representative sample of participants in the ASIST evaluation (Griesbach *et al,* 2008).[11] In addition, if the survey results are treated more as qualitative data, the findings, along with the responses to the open-ended (qualitative) questions, provide a useful insight into the ways people are using their training skills.

3.5 Case studies

Case studies were carried out in three local authority areas (North Lanarkshire, Renfrewshire and West Lothian). These were chosen primarily because all three courses were delivered in these areas and because none of these areas had previously participated as case studies in either the earlier evaluation of ASIST, or the more recent evaluation of Choose Life, Phase 2.

A case study was also undertaken in one organisation (University of the West of Scotland, UWS). This organisation was selected because, of those that took part in the organisational survey (described in section 3.2 above), it was the only one that delivered all three courses.

The purpose of the case studies was to assess the impact of the training programme in more depth at a local or organisational level. We were particularly interested in the views of managers and trainers who we expected would have a perspective on whether and how training had had an impact on participant behaviour and on organisational policies or practices in their areas, as well as the wider impact of the training on the community.

[11] NHS Health Scotland also reported that the proportions of men and women who took part in the survey were also the same as the male-to-female ratio in the centrally held training database.

Table 1: Description of respondents to the participant survey

		n	%
Sex			
	Male	31	20.0
	Female	124	80.0
Age			
	Under 21	2	1.3
	21-35	36	22.9
	35-50	74	47.1
	51-65	44	28.0
	Over 65	1	0.6
Training attended			
	ASIST	128	82.1
	STORM	9	5.8
	safeTALK	66	42.3
Attending in:			
	Personal capacity (informal carer or out of personal interest)	12	7.8
	Professional (paid) capacity (to help clients, patients, other service users, etc.)	126	81.8
	Voluntary capacity (to help members of a community)	16	10.4
Organisation type (at time of attending course)			
	Social work	33	21.4
	Other local authority (housing, community learning, etc.)	17	11.0
	Voluntary sector	33	21.4
	NHS	28	18.2
	Education (primary, secondary, further / higher)	20	13.0
	Substance misuse	12	7.8
	Other (police, private sector, church / religious org, etc.)	11	7.1

* Sex – four individuals did not reply to the question about sex.
Age – two individuals did not reply to the question about age.
Training attended – three individuals did not reply to the question about type of training attended.
Attendance – five individuals did not reply to the question about the capacity in which they attended.
Organisation – five individuals did not reply to the question about the organisation they worked in

Case studies involved interviews with the Choose Life co-ordinator (or equivalent at UWS), local trainers and service managers. In some areas (where feasible), focus groups were carried out with trainers instead of interviews. For the case study at UWS, interviews were also carried out with University staff who taken part in training (ASIST and safeTALK). Suggestions for suitable, knowledgeable interviewees were provided by the local Choose Life co-ordinator (or equivalent at UWS).

In the case studies, an effort was made to try to speak to a range of individuals to obtain a variety of perspectives on the local impact of training. Individuals who were invited to take part were identified in discussions with local co-ordinators, but not all agreed to take part. It is possible that those who **did** agree to take part may have had more positive experiences of the training than those who did not take part.

However, as most of those who did **not** take part were either trainers or service managers, it seems likely that the pressure of work (and lack of time) were the more significant factors in their decision not to participate in the evaluation.

Short reports of all four case studies are in Appendix 5 of this report.

3.6 Interviews / focus groups with trainers

The views of trainers were gathered through a variety of ways.

- A focus group was carried out with the Consulting Trainers group. This is a group of very experienced ASIST trainers who have a role in supporting less experienced trainers. The focus group was attended by four of the 12 Consulting Trainers.
- Telephone interviews were undertaken with four trainers who deliver all three of the courses. One of the individuals who was interviewed was also a member of the Consulting Trainers group, but this individual was not present for the focus group meeting.
- A participative exercise was carried out at the annual Trainers Conference (held in January 2011), to gather the views of trainers about the impact of the three courses. Conference attendees were seated at tables, and each table was given the same three questions to discuss among themselves:

  (1) What difference(s) have you seen / heard about in attitudes and behaviours of staff / community members who have been trained?

  (2) What, if any, would you say has been the longer term impact of ASIST training – on organisations / services, communities (e.g. policies, procedures, client assessment, etc.) (Give examples.)

  (3) What factors do you think help or hinder the positive impact of ASIST training? And in particular, what, if any, are the benefits of having a nationally co-ordinated, cascaded suicide prevention training programme?

  The trainers at each table recorded their joint responses onto a sheet of paper provided, and the responses were analysed qualitatively to identify the main themes.

3.7 Analysis

Frequency analysis was undertaken on data received in the three main surveys of this evaluation. The main focus of quantitative analysis was on measuring the reach of the Choose Life training programme.

Systematic analysis of qualitative data sought to ascertain the effectiveness and impact of the programme in terms of participant behaviour change, and in terms of changes in organisations and communities. Analysis also specifically focused on identifying the factors that supported (or hindered) positive changes.

4. What has been the reach of the training programme?

This section presents findings regarding the reach of the training programme. The focus here is on answering the following questions:

- How widely has training been implemented in different areas and organisations across Scotland? (i.e. Which areas / organisations have rolled out which courses, and for how long?)
- How many trainers are available and what is known about the people who deliver training?
- How many people have participated in training?
- What do we know the people who have participated in training?

Chapter 7 (the Discussion) will consider whether the reach of the programme has so far been sufficient / adequate, and whether the 'right' people have been and are being trained.

The information in this section focuses on numbers. The information has come from:

- a web-based survey of Choose Life co-ordinators and a separate web-based survey carried out among organisations involved in the delivery of ASIST, STORM and / or safeTALK
- monitoring data held by Choose Life co-ordinators and training organisations about their course delivery in the period April 2007 – March 2010.

Note that the picture presented here is a Scotland-wide picture. Appendix 6 contains details about the implementation of each course within individual local authorities and within the organisations that took part in our survey of training organisations.

4.1 What was the reach of the training programme prior to 2007?

As mentioned above, the focus of data collection in the current evaluation was from April 2007 – March 2010. However, the evaluation sought to assess the reach of the Choose Life training programme **from its inception** — that is, from 2003. Therefore, information about the reach of the programme prior to April 2007 was gathered from the published reports of the previous evaluations of ASIST, safeTALK and STORM. As mentioned in Section 3, the ASIST evaluation was the only one of the three previous evaluations which was carried out at a national level.

- **ASIST:** Griesbach *et al* (2008) found that, as of September 2007, 576 ASIST workshops had been held in Scotland and 10,477 people had been trained. This represented approximately 1 in 500 of the Scottish population. By 2007, ASIST had been rolled-out to every local authority area of Scotland.

  The vast majority (78.3%) of ASIST participants were women and were individuals who had attended the training as a professional caregiver (i.e. to help clients, patients, pupils or other service users) (77.9%). The largest proportion of participants worked in the voluntary sector (just over one-third). In addition, a fifth were from social work and a tenth were from NHS primary / community care services.

  As of November 2007, there were 271 individuals trained as ASIST trainers, although at the time of the evaluation over a quarter of these (28%) were inactive.

- **safeTALK:** The evaluation of the safeTALK pilot in Scotland (McLean *et al,* 2007) found that 239 participants were trained during the pilot, and nearly half of those (n=109) worked in the area of mental health. This category included a variety of roles ranging from support workers to psychiatric nurses. The vast majority of participants (n=227) had attended the course to assist them in their work.
- **STORM:** The evaluation of STORM in Highland (Gask *et al,* 2008) did not specifically state the number of people who attended the training. However, it reported that the number of people who completed pre- and post-training questionnaires was 203. Training participants included nurses (38%), social workers (20%) and a wide range of other health and social care professionals, including support workers, doctors (including 3 psychiatrists), health visitors, occupational therapists, a housing officer, nursery nurses and a police officer.

As safeTALK did not begin to be rolled out more widely in Scotland until after 2007, the figures shown above for the number of safeTALK participants prior to 2007 is likely to be accurate. STORM began to be rolled out in a small number of areas prior to 2007, but information on the number of STORM participants is only available from the Highland evaluation. Therefore, there is a gap in our knowledge about the number of STORM participants prior to 2007 and who those participants were. The figures provided above for ASIST are likely to be reasonably accurate because a dedicated administrative worker was appointed to the training team in May 2007 specifically to address data quality issues which had previously been identified in the (then) national ASIST database.

4.2 The current picture — how widely has training been implemented across Scotland?

A survey of Choose Life co-ordinators undertaken for the current evaluation confirmed the findings from the previous ASIST evaluation that ASIST is delivered in all 32 local authority areas in Scotland. Moreover, STORM was reported to be delivered in 19 areas and safeTALK is now delivered in 31 areas. (Figure 1.) The only area where safeTALK was reported **not** to be delivered was Moray.

As mentioned above, ASIST has been delivered in all local authorities since 2007. safeTALK began to be rolled out in 2006 / 07 as part of the pilot, but was not adopted more widely in other areas of Scotland until 2008 / 09. STORM has been rolled out more slowly: until 2008, there were only seven areas in Scotland where STORM was delivered. (Figure 2.)

Across Scotland, the delivery of suicide prevention training is largely organised on a local authority basis through (although not always **by**) local Choose Life co-ordinators. However, in some areas, training is also delivered by agencies which do not necessarily report on their training activity to the Choose Life co-ordinator (i.e. voluntary sector agencies, NHS Boards, etc.). These organisations were identified with assistance from NHS Health Scotland and local co-ordinators, and they were separately surveyed to gather data about their course delivery.

It was found that ASIST was delivered by all but one of the 17 organisations that took part in the survey. (Stirling University does not deliver ASIST.) In addition, 10 of the 17 also reported delivering safeTALK, and two delivered STORM. Of those

Fig. 1: Number of local authorities delivering ASIST, STORM and safeTALK

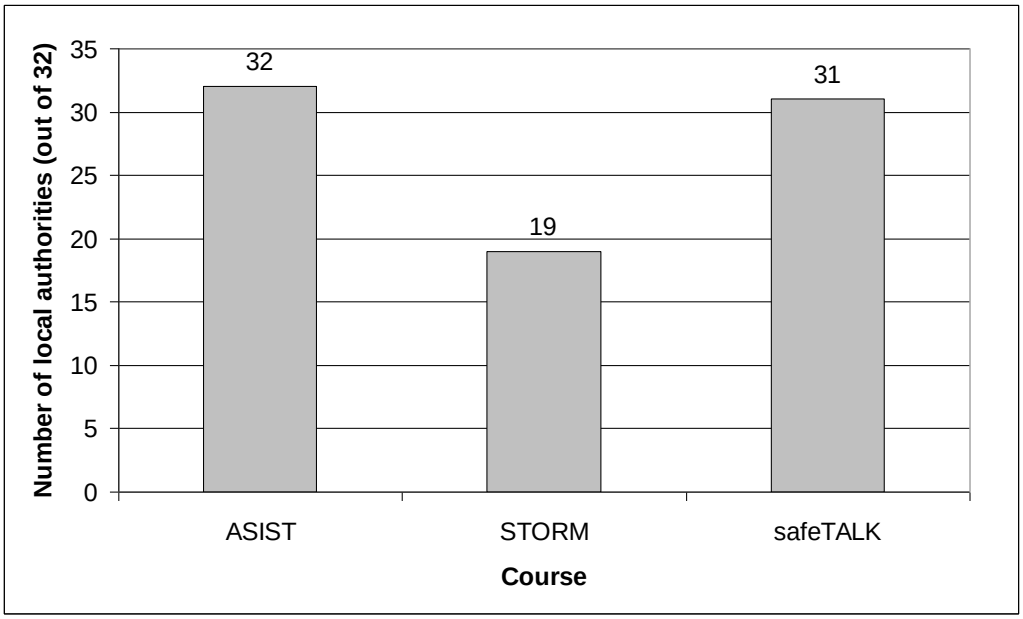
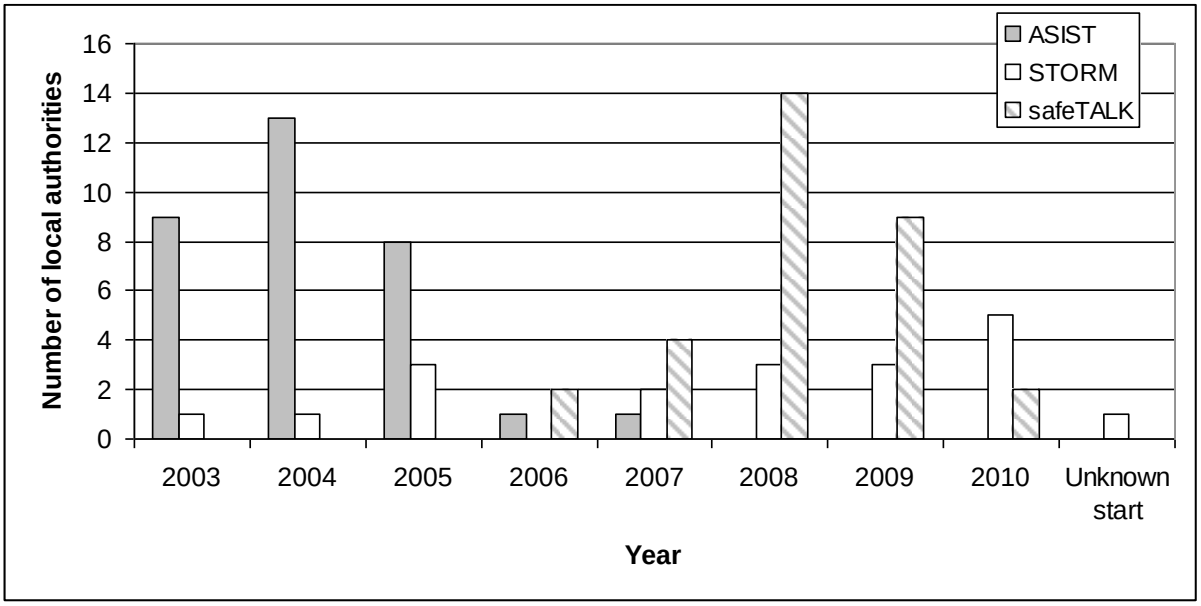


Fig. 2: Implementation of suicide prevention training over time, 2003-2010



organisations that took part in the survey, only the University of the West of Scotland reported delivering all three courses.

As mentioned above, Appendix 6 contains further details about which local authorities and which training organisations deliver ASIST, safeTALK and STORM.

4.2.1 Refresher training

Co-ordinators were asked whether refresher courses were delivered in their area to help people to keep their skills up-to-date. More than half of co-ordinators (n=18) said they did **not** deliver refresher courses. However, refresher courses are delivered once or twice a year in 10 areas, and less frequently in four areas. Only one of the 17 training organisations reported delivering refresher training.

4.2.2 Delivery of suicideTALK

Co-ordinators were asked whether suicideTALK, a short suicide awareness-raising session, was delivered in their area. Twelve (12) out of 32 said that it was. In addition, five of the 17 organisations reported delivering suicideTALK.

Appendix 6 contains details of which local authorities and which training organisations deliver refresher training and suicideTALK.

4.3 How many trainers are there and who delivers training?

As of April 2011, NHS Health Scotland had records of 405 ASIST trainers, 199 safeTALK trainers and 93 STORM trainers. However, not all were active trainers and work was being undertaken to identify which were currently delivering training. It should also be noted that some trainers deliver more than one course, and so these figures cannot be added to get the total number of trainers.

Co-ordinators were asked how many people were involved in the delivery of ASIST, STORM and safeTALK in their area in the past 12 months, including trainers who had been contracted in from outside. Every local authority area in Scotland had at least two ASIST trainers available and just over half had more than six ASIST trainers available to them in the past 12 months. On the other hand, only 5 areas had more than six STORM trainers, and only two areas had more than 6 safeTALK trainers. Six areas (or a third) had only one or two STORM trainers and 13 areas had only one or two safeTALK trainers. (Figure 3.)

In 13 local authorities, the Co-ordinator was involved in the delivery of ASIST and safeTALK, while STORM was delivered by the Co-ordinator in only four areas. Most local authorities also had other local people available to deliver ASIST and safeTALK, and 15 areas out of the 19 that deliver STORM also had other local people available to deliver the course. (Figure 4.)

In the past year, very few training organisations had six or more trainers for any of the courses. It was more common for training organisations to have only one or two trainers for particular courses.[12]

[12] One agency that delivers STORM reported that there were three individuals involved in delivering the course in the past 12 months. However, one of these was no longer available, and one was not routinely available.

Fig. 3: How many trainers available in the past 12 months, by course

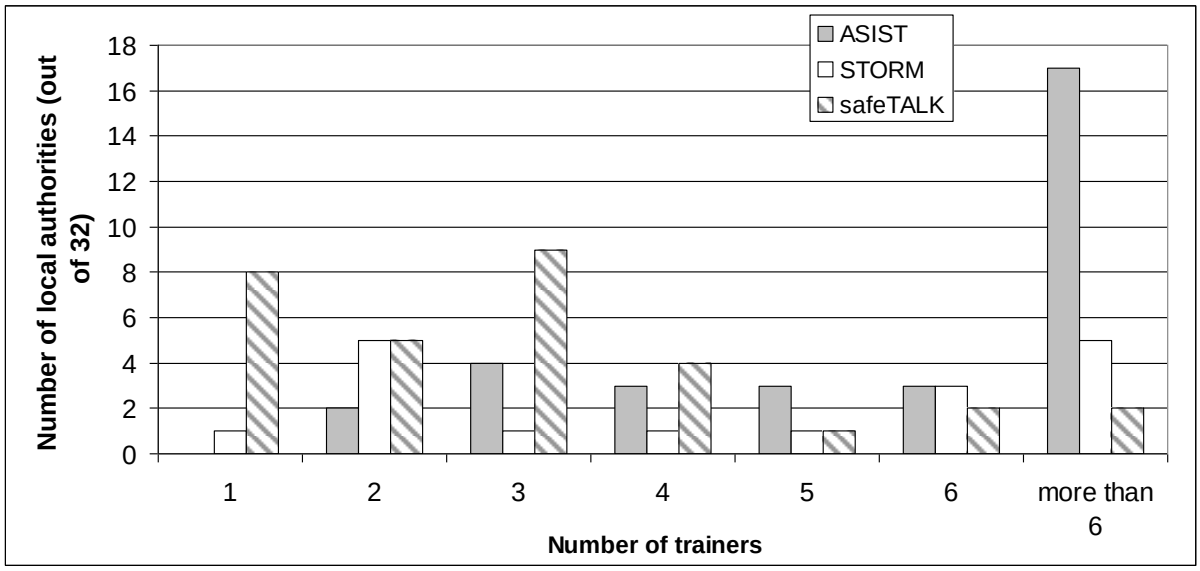
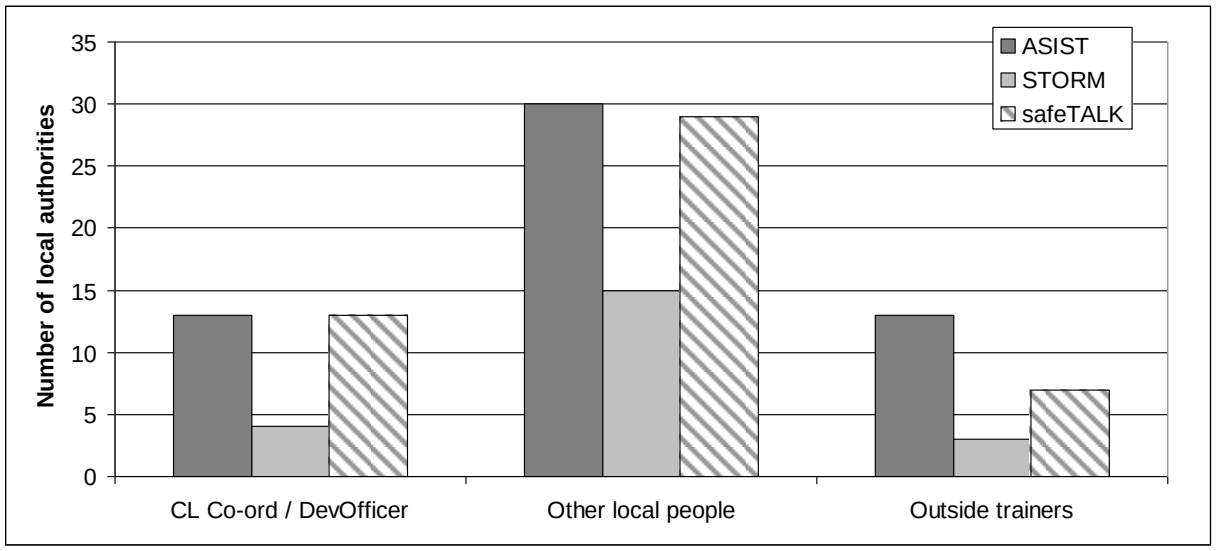


Fig. 4: Who delivers training, by course



4.4 How many people have been trained?

Choose Life co-ordinators and representatives of training organisations were asked to provide information on the number of courses delivered and the number of participants who have attended training in their area / organisation between April 2007 – March 2010.

Data was received from 25 out of the 32 local authority areas – or just over three-quarters. Among the training organisations, only four supplied data on their course delivery and number of participants.

According to the data received, 955 courses were delivered during the three-year period between April 07 and March 10, and 14,986 participants attended training in that period. (Table 2.)

Nearly half (47.4%) of all suicide prevention courses delivered in Scotland over the past three years were ASIST courses, and over half of participants (55.8%) attended ASIST. A third of courses (34.1%) were safeTALK courses, and a third of participants (33.8%) attended safeTALK courses. STORM courses comprised about a fifth (18.4%) of courses delivered, but only 10.4% of training participants attended a STORM course.

Furthermore, the data suggests that both the number of courses delivered and the number of participants in each course have increased each year since 2007, and that by 2009-10, the number of safeTALK courses had begun to exceed the number of ASIST courses. (Table 3.)

It is important to note that the information shown in Tables 2 and 3 is incomplete as it does not include data from all local authority areas, or from all training organisations in Scotland. Therefore, the actual number of courses delivered across Scotland and the number of participants will be considerably higher than the figures shown.

Table 2: Total number of courses delivered and number of participants attending each course for all three years (2007-08 to 2009-10)

	Number of courses delivered	%	Number of participants	%
ASIST	453	47.4%	8,362	55.8%
STORM	176	18.4%	1,559	10.4%
safeTALK	326	34.1%	5,065	33.8%
Total	**955**	**100.0%**	**14,986**	**100.0%**

Note: Based on responses from 25 local authority areas and 4 training organisations.

Table 3: Number of courses delivered and number of participants attending each course, by year

	ASIST			STORM			safeTALK		
	07-08	08-09	09-10	07-08	08-09	09-10	07-08	08-09	09-10
Number of courses delivered	126	155	172	36	64	76	27	123	176
Number of participants attending	2262	2928	3172	317	510	732	658	1892	2515

Note: Based on responses from 25 local authority areas and 4 training organisations.

Indeed, data held by NHS Health Scotland for ASIST and safeTALK indicates that the total number of ASIST and safeTALK courses actually delivered across Scotland in this period was approximately 43% higher than the figures shown in Table 2 above. Moreover, the total number of participants in ASIST and safeTALK courses was approximately 26% higher than the figures in Table 2 would indicate. (See Appendix 7 for details.)

The information held by NHS Health Scotland on course delivery is considered to be accurate, as it is based on data provided directly by trainers when they request training materials for courses.

Using the data provided by Choose Life co-ordinators and training organisations, and the data supplied by NHS Health Scotland, it can be estimated that there were approximately 1,400 courses delivered between 2007-2010, and approximately 19,000 people across Scotland trained in suicide prevention during the period 2007-2010.[13] These are rough estimates. However, if these figures are added to the totals for pre-2007 training, it would suggest that there have been approximately 30,000 people trained in suicide prevention in Scotland between 2003 and March 2010.[14]

4.5 What types of people have attended training?

In the early years of the Choose Life training programme, training was rolled out widely not only to service providers in the statutory and voluntary sectors, but also to members of communities and those working in a voluntary capacity. In more recent years, the HEAT 5 target has led to greater targeting of training to front-line staff working with people at risk.

To obtain a picture of the types of people who have attended training, Choose Life co-ordinators provided details of the employers (e.g., local authority, NHS, voluntary sector, etc.) of training participants for the period April 07 – March 10. (Figures 5, 6 and 7.)

The data shows that ASIST and safeTALK were attended by a relatively large number of individuals from a range of agencies. Both these courses were also attended by members of the public and individuals working in the private sector, although the numbers of these individuals were small.

STORM, on the other hand, was attended by a smaller number of people, and these were almost exclusively NHS employees. The proportion of non-NHS employees attending STORM courses in the past three years comprised less than 15% of participants. This is because STORM is primarily aimed at a clinical audience.

Altogether between Apr 07 – Mar 10, NHS employees have comprised the largest proportion of training participants for all three courses (39%). In addition, about a quarter (24%) of participants were local authority employees, and a fifth (19%) worked in the voluntary sector. Only 2% were members of the community not attending the training in a professional capacity. (Table 4.)

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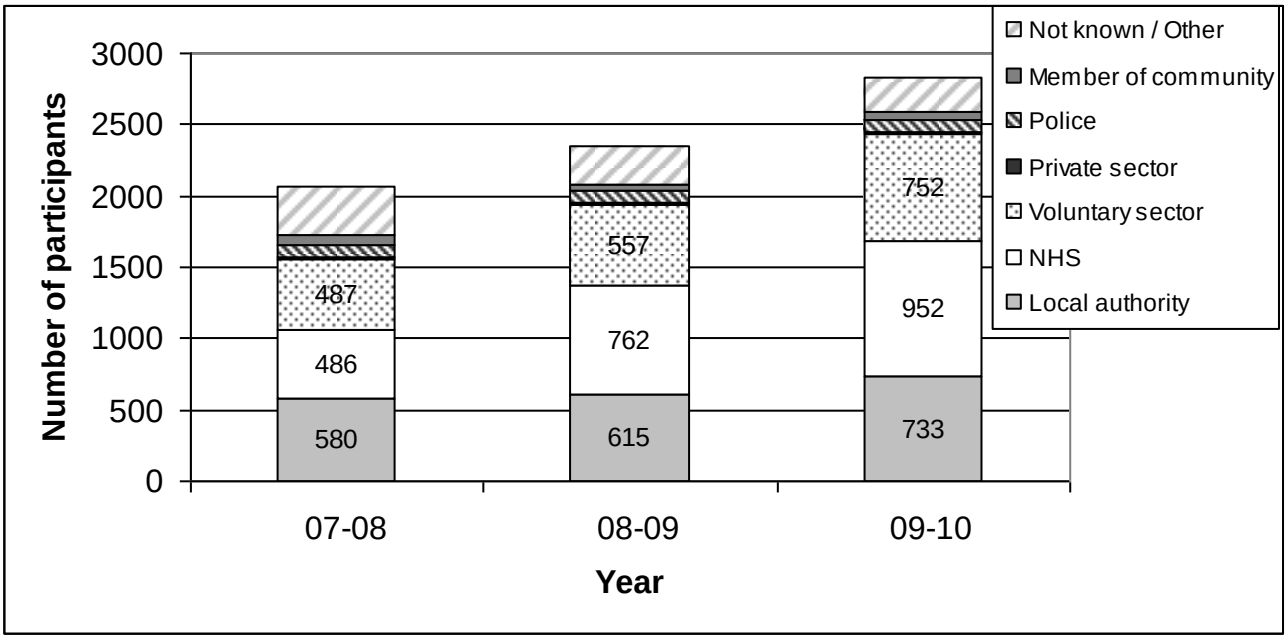
[13] Estimated number of courses: 955 + 43% x 955 = 1,366 (rounded up to 1,400). Estimated number of participants: 14,986 + 26% x 14,986 = 18,882 (rounded up to 19,000). Data is not available from NHS Health Scotland on STORM delivery during the period 2007-2010. However, the proportions of 43% for courses and 26% for participants have also been applied to the information collected by evaluation for STORM delivery.

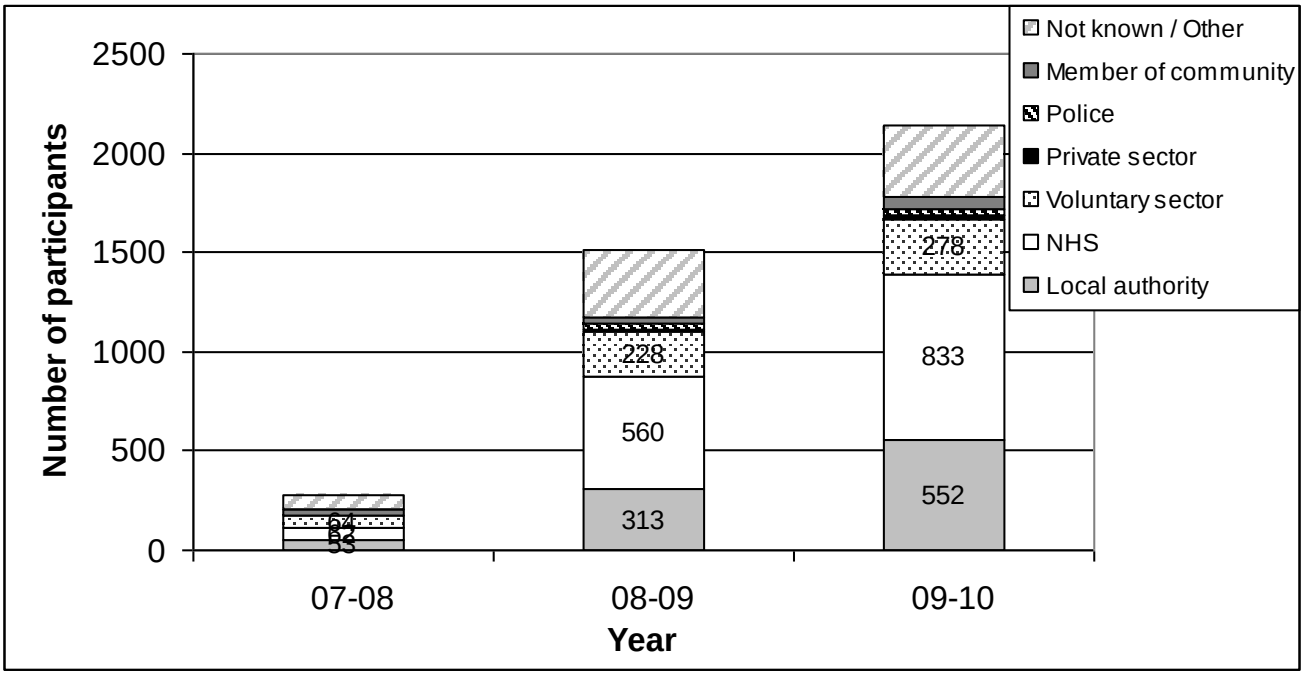
[14] As of May 2011, NHS Health Scotland estimated that around 35,000 people in Scotland had been trained.

Fig. 5: Number of people attending ASIST training, by employer and year



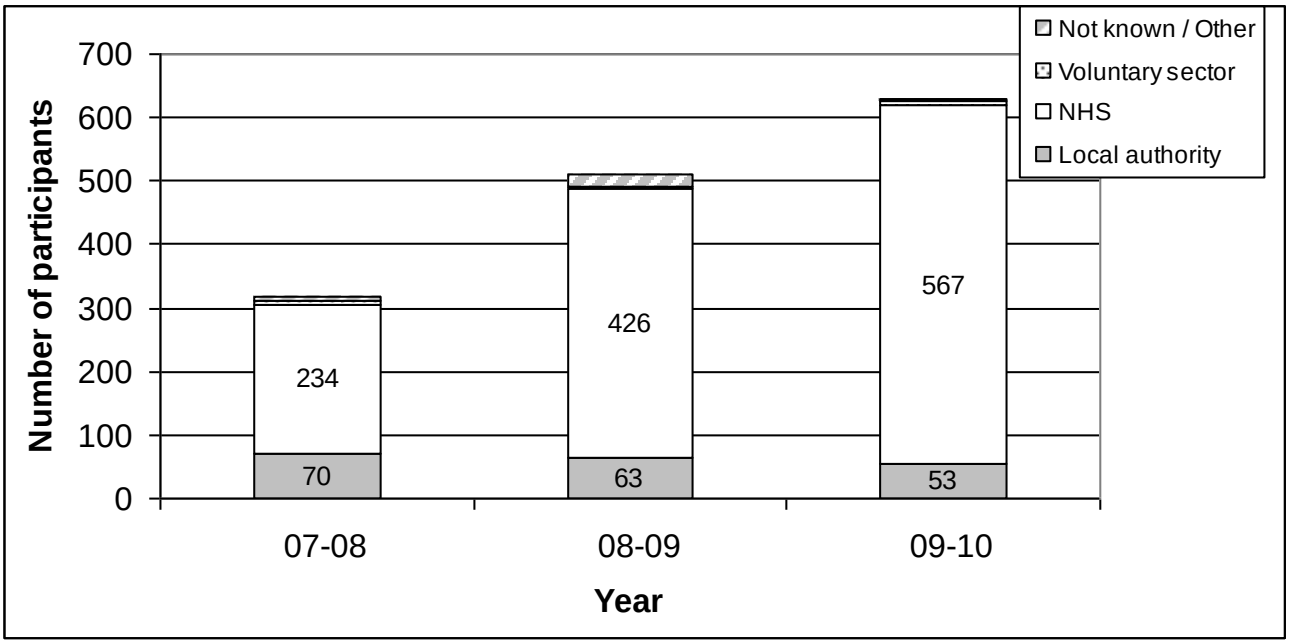
Note: Based on data from 25 local authority areas.

Fig. 6: Number of people attending safeTalk training, by employer and year



Note: Based on data from 25 local authority areas.

Fig. 7: Number of people attending STORM training, by employer and year



Note: Based on data from 25 local authority areas.

Table 4: Total number of participants attending ASIST, STORM and safeTALK training for the period April 07 – March 10, by employer

	n	%
Local authority	3,032	24%
NHS	4,882	39%
Voluntary sector	2,381	19%
Private sector	84	1%
Police	312	2%
Member of community	287	2%
Not known / Other	1,661	13%
Total	**12,639**	100%

Note: Not known / Other includes students, pupils, participants from the Ministry of Defence, national non-governmental organisations, etc. Based on data from 25 local authority areas.
The total number of participants shown here does not tally with the figure in Table 2 above because Table 4 does not include data from training organisations, only from local authorities.

In addition to the data provided by Choose Life co-ordinators, representatives from the 17 training organisations who took part in the evaluation were asked a more general question about who their organisation delivered training to. The responses suggested that many organisations have adopted a fairly wide training remit — in most cases delivering training not only to people who work in their own organisation / agency, or their own geographical area, but also to people outside their organisation from across Scotland. Several also delivered training to college and university students, and five agencies also reported that they delivered suicideTALK to service users as well as to their own staff.

4.6 Key points / Summary

These findings indicate that there is comprehensive coverage across Scotland of ASIST and safeTALK. However, STORM is available in just over half of local authority areas in Scotland. In addition, among the 17 training organisations that took part in our survey, only two (both universities) delivered STORM.

The delivery of refresher training is not common across Scotland, nor is the delivery of suicideTALK.

Every area has at least two ASIST trainers available locally, and around half have more than six local ASIST trainers. Local areas were less well-endowed with STORM and safeTALK trainers, with a sizeable proportion of areas reporting only one or two local trainers for these courses. It would appear that, for all three courses, most areas have access to a range of local (and in some cases, non-local) trainers.

Between 2007-2010, ASIST has continued to be the suicide prevention training course delivered most often in Scotland. However, course delivery and the number of participants attending all three courses has increased in the same period. In total, from April 2007 – March 2010, it is estimated that there have been approximately 19,000 people trained. If these figures are added to the number of participants prior to 2007, it would suggest that approximately 30,000 people in Scotland have received suicide prevention training between 2003 – March 2010. These figures are rough estimates.

During the period April 07 – March 10, suicide prevention training in Scotland has mainly been attended by professional staff working in the NHS and in local authorities. In addition, a sizeable proportion of participants were also voluntary sector employees. ASIST and safeTALK have been attended by a range of participants whereas the majority of STORM participants have been NHS employees. Few participants in any of the courses have been members of local communities attending in a non-professional capacity.

5. What has been the impact of the Choose Life training programme?

The second main objective of this evaluation was to examine the impact of the Choose Life training programme. In particular, the focus was on whether the training had resulted in changes in participant behaviour in the first instance, and secondly, whether any changes within organisations, communities and systems more widely could be attributed to the training programme. In Section 6, we will examine the factors that resulted in positive impact as well as those that have been barriers to wider impact. In Section 7, we will consider the extent to which changes (in behaviour and organisational change) have been sustained over time.

The findings presented here are based on:

- focus groups, conference sessions and telephone interviews with trainers
- a web-based survey of former ASIST, STORM and safeTALK participants
- case studies in three local authority areas and in one training organisation.

Throughout the evaluation, an effort was made to explore the differences in impact between the three different courses. However, it was not always possible to do this. Although it is clear that the courses were often delivered in different ways to different target groups, the individuals we spoke to in this evaluation did not always distinguish between the impact of the different courses. Nevertheless, where individuals felt they **could** differentiate between the impacts of the different courses, this information is included below.

Before presenting the findings of the present evaluation, it will be helpful to summarise the findings of previous evaluations of ASIST, STORM and safeTALK in relation to the impact of the training.

5.1 What do we know about the impact of training from previous evaluations?

Findings from the ASIST evaluation showed that, after being trained in ASIST, there was a 20% increase in the proportion of people who had the experience of intervening with someone at risk of suicide. There were also positive impacts on workplaces and communities. These included: raising awareness, reducing stigma, promoting more integrated working practices, and including questions about suicide in client assessments. However, the evaluation also showed that where the reach of the programme had been less effective (e.g. because of low priority given to training or difficulties in recruiting trainers), the impacts were limited (Griesbach *et al,* 2008). (This point will be picked up again in Section 7 of this report.)

Both the STORM and safeTALK evaluations were relatively small-scale, and findings in relation to participant behaviour change were based on small samples. However, from the STORM evaluation, there was evidence of participants asking **more**, and asking more **direct** questions during risk assessment of clients after training (Gask *et al* 2008).

In the STORM evaluation, there was also some evidence of the training having had an impact on organisational policies and procedures in relation to suicide risk assessment and management, and although these findings were based on a

relatively small number of interviews in a single local authority / NHS Board, they echoed the findings of the national ASIST evaluation.

It is perhaps worth noting that the impact of training was also one of the main issues examined in the evaluations of Choose Life Phase 1 and Phase 2. The Phase 1 evaluation (Platt *et al,* 2006) found that, 'At the local level, the most successful activity to be mainstreamed was suicide prevention training. Training was seen as a sustainable resource that benefits the wider community by building capacity and strengthening existing skills and knowledge'.

The Phase 2 evaluation described training as, arguably, the most successful element of Choose Life which had created 'the real sustainable legacy' of the strategy (Russell *et al,* 2010). The wide availability and uptake of suicide prevention training was seen to have raised awareness and reduced stigma, increased skills and capacity in agencies and services, and in the community. It had also helped to build partnerships, e.g. with Community Health Partnerships and substance misuse services.

Taken together, the findings from these previous evaluations would indicate that training has clearly played a major part in the overall impact of the Choose Life suicide prevention strategy.

5.2 The current picture – what has been the impact on participant behaviour?

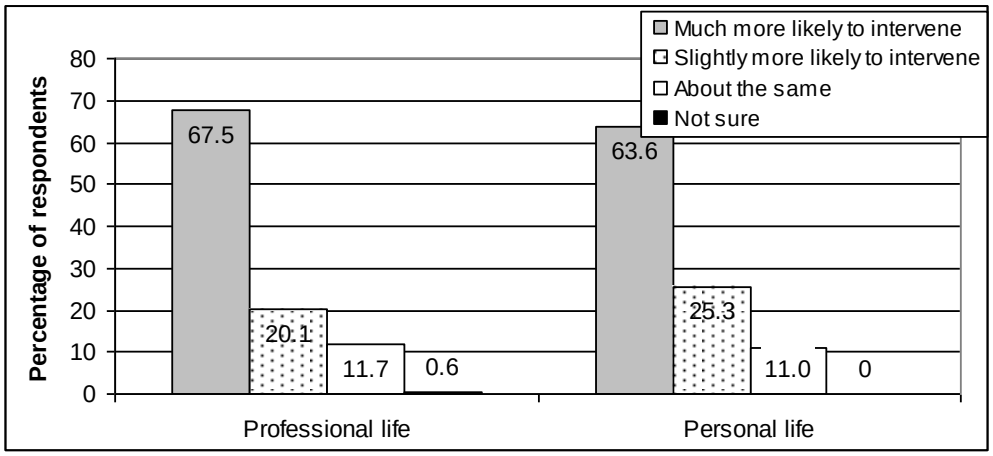
Turning now to the current evaluation, we will first consider the impact of the training on participant behaviour, where the main changes appeared to be in relation to a heightened awareness of suicide, an improved confidence and willingness to intervene, and a greater effectiveness in intervening.

Respondents to the participant survey were asked whether they felt the training they attended had made them more or less likely to intervene with someone at risk of suicide than they were before they attended the training. The majority said that they would be more likely to intervene, both in their professional life and in their personal life. None of the respondents said they would be **less** likely to intervene. (Figure 8.)

Participants were then asked about their experiences of taking specific action when they thought that someone might be at risk of suicide – both before their training and afterwards. The results would suggest that the greatest changes in behaviour have been in relation to asking someone if they were thinking of suicide, and making a plan (or agreement) with the person to keep them safe. (Figure 9.)

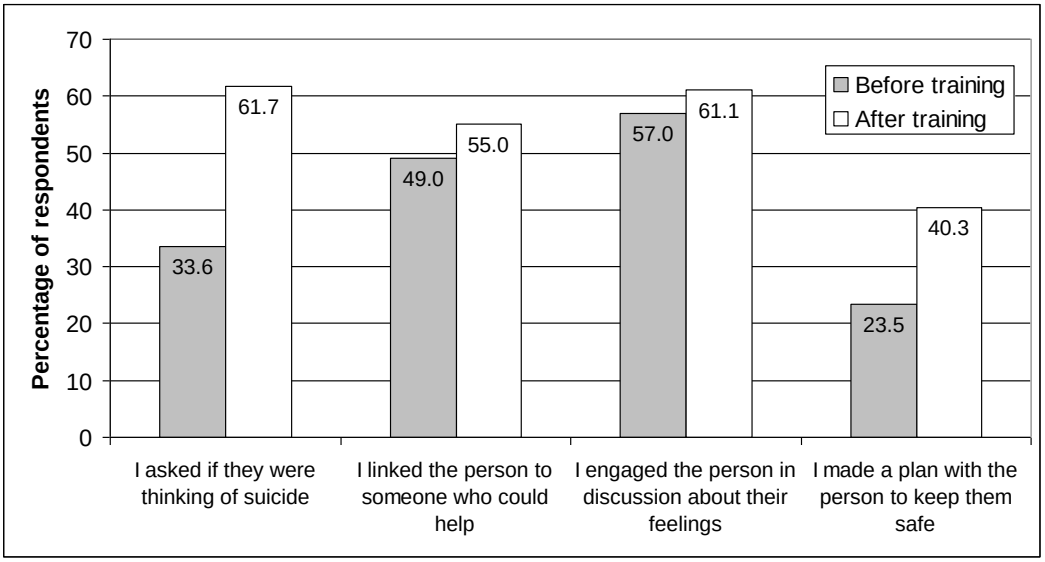
Respondents were then asked how **frequently** (i.e. how many times — 'never', 'once or twice' or 'three or more times') they had **actually** intervened with: (a) clients / patients in their professional life, (b) colleagues, and (c) individuals in their personal life – both before and after their training. The findings would seem to suggest that, among these respondents, there has been little change, and in fact, a slight decrease in the number of times they had intervened with these different groups (data not shown).

Fig. 8: Respondents who said they were more or less likely to intervene with someone at risk, in their professional and personal life, after training (%)



Base = 154.

Fig. 9: Actions taken by respondents before and after training (%)



Base = 149.

Given the data quality issues with the participant survey and the lack of representativeness of the sample, caution should be used in interpreting this finding. At the same time, it is possible that this finding may be partly explained by the fact that the majority of respondents took part in training in a front-line professional capacity. Many of these individuals will have already been working with groups who are at high risk of suicide, and as a result, it is likely that the **frequency** of intervening by these individuals has not changed. However, this finding, taken together with the data shown in Figure 9 suggests that even if, in this group, the frequency of intervening has not changed substantially, the **form** that those interventions take **has** changed. The key change is that they are now more likely to intervene by first asking the person at risk specifically if they are thinking of suicide, and they are more likely to make a plan with the individual to keep them safe. In other words, it would appear that interventions are more **effective** (i.e. more direct and specific) after training.

It is important to note, in relation to this, that others who took part in this evaluation (through interview and case studies) were very clear that the question about suicide intent was being asked more frequently and more directly in their services.

When respondents were asked their reasons for **not** intervening since their training, nearly all said it was because 'the situation had not arisen'. This echoes the findings of the ASIST evaluation and suggests that there may still an issue about targeting of training.

Respondents (n=114) who had experience of intervening **since** their training were asked for some details about their most recent intervention. More than half (n=66) said that their most recent experience of intervening was with someone who was female. Most interventions were with people aged 55 and under. (Just over a quarter were with people aged 25 and under, and another quarter were with people aged 36-45.) Two-thirds of interventions were with clients / patients / service users in a professional context, but one-quarter were with personal contacts. The majority of interventions were carried out in a face-to-face situation.

Respondents were invited to describe their most recent intervention. Sixty-four individuals did so. One respondent chose not to describe a particular intervention, but instead made comments about the training. These suggest that the individual had used the skills acquired in the course(s) in an on-going way.

> 'I deal with many students who have suicidal thoughts on a regular basis and many have attempted suicide before. I do not want describe any one situation but I have used my ASIST and safeTALK training probably at least twice per week. Therefore I have found this training some of the most valuable awareness sessions I've had since I started my student support role. (I have had ongoing training in all aspects of student support in the last 4 years.)' [Female, aged 35-50]

One respondent, after describing her intervention with a family member, wrote:

> '…. Sadly I don't think that this will be the last time I will need to intervene but the course did give me the confidence and skills to do so without feeling I was being ridiculous, dramatic, or putting ideas into her head.' [Female, aged 35-50]

The quotations in Table 5 below have been selected to provide an indication of the range of situations in which respondents have intervened, and to show *how* they have intervened in those situations.

The stories also show the positive impact of the training – in that the respondents were describing situations in which they actively intervened and in which they believed they had a role in preventing a suicide. All of the respondents to the participant survey believed that the intervention they described, had been effective. Most of those who had experiences of intervening following training agreed with the statement that: 'I have had one or more experiences of intervening when I felt it went well.' However, it is perhaps also worth mentioning that about a tenth of this same group **also** agreed with the statement that: 'I have had one or more experiences of intervening when I felt it did not go well.'

Furthermore, as the comment from one respondent illustrates, there can be barriers, or at least some practical difficulties faced by staff in intervening in certain contexts:

> 'When doing duty in a busy social work team, it's extremely hard to take the time needed to talk someone down from suicidal thoughts – the temptation to pass it to the GP is extremely hard to resist.' [Female, aged 51-65]

Moreover, one individual pointed out that intervention can also have an impact on the person intervening:

> 'I feel intervening can be quite draining as you absorb the person's emotions and essentially transfer their burden to you.' [Female, aged 35-50]

In relation to this latter point, nearly half of respondents in the participant survey agreed with the statement: 'More support is needed for people who have intervened.'

Many of the stories reported by individual training participants in the survey were supported by the comments of managers and trainers from around Scotland about how the behaviour of staff had changed over time. These service managers reported that their staff who had attended training appeared to be more comfortable when talking about suicide. Managers consistently said that their staff had greater confidence 'to ask the question' about suicide intent and to refer people on for help if appropriate.

In one of the case study areas, this was further supported by a review of documentation relating to the local Mental Health Integrated Care Pathway which showed that the question about suicide (previously often left blank) is now being completed because staff have the skills and confidence to ask, and also know what to do with the response. In a second case study area, it was reported by one mental health service manager that he had observed positive changes in the way his staff documented their clients' needs in relation to suicide risk.

Table 5: Respondents' most recent experiences of intervening, selected quotes

'While as a student studying for an HNC, I observed that one of my colleagues seemed more withdrawn, tired, weepy and just not her bubbly self. I approached my colleague and asked her how she was feeling – to which she replied that being a young single mum and a student was becoming too much for her that she 'felt she could not cope anymore' and 'financially she was struggling' and felt 'everyone in my family expects me to cope'. She than went on to explain how alone and lonely she was feeling. I asked her, 'Are you considering suicide,' to which she replied, 'Yes'. I told her my concerns and put into action a plan to keep her safe and discussed how I could link her into the appropriate people who could help. She agreed to this and I phoned the appropriate people on her behalf and set up immediate help. The outcome of this intervention was that she was helped financially, mentally and emotionally by professionals, friends and family which made it easier for her to continue her studies and pass her course. She has now graduated and found permanent employment, which had led to a better life for her and her children. She now feels less isolated and has a network of support for the future.' [Female, aged 35-50]	'Service user had previously attempted suicide prior to coming to homeless unit in which I work. He stated that this was due to a recent breakup in his personal life and the pressure of being homeless, as well as a drug misuse problem. I spoke with him concerning his immediate emotional status and put a plan in place that would assist him to continue to access counselling support. During his stay at the unit, the service user engaged with support from staff and external agencies to openly discuss his feelings and did not make any further attempts to take his own life.' [Male, aged 35-50]
'Working for a person with mental health difficulties, I got to his house where he had written a note saying how he was suicidal and needed help. I engaged with him and I asked him if he could talk about these feelings. I went on to ask him about how and if he had actually planned suicide. Addressing his issue of needing help, I tried to make it apparent that he was in the middle of his doctor's treatment. If his feelings were to continue like this, then we (his family and I) would help him get the help he needs, through other appointments with heath professionals or someone else he feels comfortable talking to. He seemed consoled by what I had said.' [Male, aged 21-34]	'Young person came into school to say that she had tried to hang herself the night before, and was going to try again. Young person had been sexually abused in the past. I and the other Child Protection officer spoke to her. We contacted [other professional agency] and her GP to get an appointment for her to then be referred to self-harm nurse at hospital. She was seen by self- harm nurse, but still had suicidal thoughts, so admitted to hospital.' [Female, aged 21-34] 'My friend is an anorexic young lady who has already had struggles in the past with depression and eating habits. I sat her down to investigate how she was feeling, as I was getting increasingly concerned for her well-being and she admitted to have thought about suicide on a number of occasions when I asked. Her reason was because she had nothing to live for any more and that she felt like a failure. I asked her if she knew how she'd do it or if she had any immediate plans but there were none, she claimed. I told her to go to her GP and tell him / her of her struggle but she has not seemed to have said anything yet.' [Female, aged under 21]

Note: Minor details have been slightly changed in some of these texts to protect the identities of those involved.

One lecturer at the University of West of Scotland had noticed that mental health nursing students who had attended ASIST training were using their ASIST skills in other situations later in their course (i.e. weeks and months later) — for example, in role play exercises on different topics, weeks after the training, students appeared to be more confident in asking their 'patients' about suicide. Another UWS lecturer commented on the transferability of the skills taught in ASIST and STORM — e.g. skills in communication, building relationships, interviewing and problem-solving — which are crucially important in all areas of a nurse's job.

There were also reports of staff in team meetings speaking about their experiences in a way that showed it had become common practice for them to identify suicide risk, to intervene and to follow up when required (for example, by phoning an individual to see if they were alright). Managers were also aware of their staff using their suicide prevention skills with friends and family members.

The change in the behaviour of administrative and support staff (e.g. in hospitals and local authority reception points) was noted by a number of interviewees. It was a consistent theme arising in the case studies that administrative staff who have attended training had become more confident in responding to calls from people who are suicidal and knew how to refer them on.

In one case study area, the comment was made that staff are now dealing better with older people who at risk of suicide — a risk which has not often been recognised among this group in the past.

While most managers provided examples of how training had resulted in changed practice among their staff, one interviewee expressed a view that the impact of STORM training on the behaviour of participants may have been less than expected because participants in STORM training generally already have some knowledge of suicide. However, the training was nevertheless seen as beneficial — not only for increasing staff confidence and skills — but also for giving staff a structure to work within. This comment may be relevant to the finding from the participant survey that interventions were not necessarily more frequent but probably more effective.

Trainers referred to the 'anecdotal' feedback they frequently received from ASIST participants – often days and sometimes weeks after they attended a training course – about their experiences of intervening.

However, in attempting to assess the impact on behaviour and practice, it has to be noted that recording of interventions has not been commonly done. Some interviewees commented that there were now examples of recording in incident reports, risk assessments, integrated care pathways and the outcomes of multi-disciplinary meetings. Moreover, in one voluntary sector service, the manager reported that there were recovery stories and letters from clients and carers acknowledging the confidence of a worker in speaking to the client about suicide. However, in general, there is little formal data on the extent to which training participants are intervening with people at risk of suicide following their training. This is more properly an organisational issue – a gap in systems — but is noted here because of its relevance to understanding the impact of training on practice.

Similarly, information about whether an intervention has made a difference to the patient / client does not seem to be readily available, although it was reported in one

area that advocacy services have had feedback from service users that they have recovered from suicidal feelings.

5.3 What has been the impact on organisations and systems?

In assessing the impact of the Choose Life training programme on organisations and systems, the focus was on questions such as:

- How has the culture of organisations changed since the introduction of training?
- Has training led to any changes in policies or procedures within organisations or wider organisational systems?
- Has the training led to any specific changes in the way organisations work together?

5.3.1 Organisational culture

One measure of the impact of suicide prevention training on organisational culture is the extent to which the wider workforce of an organisation has been trained, and uses the skills they have acquired. Therefore, respondents in the participant survey were asked what proportion of their colleagues (in the team they **currently** work in) had attended ASIST, STORM or safeTALK training. Out of the 131 who responded to this question, 45% said that half or more of their colleagues had also been trained. Nearly a fifth of respondents said **all** of their colleagues had attended suicide prevention training.

In addition, when respondents were asked how often (roughly) in the past six months had they seen or heard their colleagues intervening with people who were at risk of suicide, almost two-thirds said they had heard their colleagues intervening.

In the case study areas, there was a consensus that the training had been a major factor in increasing awareness of suicide, and that this had been accompanied by a change in attitudes, and a reduction in stigma.

There was a strong view that there had been a change in the culture and environment which was now 'less fraught' in relation to suicide, and that training had been an integral and important part of this. Several interviewees commented that suicide is now more 'talked about' in their organisation; others noted that it is 'on the agenda' for senior managers. Also, it has now become acceptable to talk about suicidal thoughts with patients / clients and to work together with the individual at risk to get help.

Service managers interviewed as part of case studies reported that since many of their staff had attended suicide prevention training, there was now a greater openness in teams in relation to talking about suicide. There is a more constructive environment and staff are now better able to support each other in these situations. Managers suggested that the training had helped to alleviate staff anxiety in working with people who are at risk. In addition, it was suggested that staff are also better able to cope when a suicide **does** occur, because they know they have done all they could to help the person.

5.3.2 Organisational policies and procedures

A third of the respondents to the participant survey said that, in their service, service users were asked routinely (as part of an assessment / review process) if they have ever attempted suicide, or if they were feeling suicidal, and nearly two-fifths of respondents said that their service had (written) procedures which were followed if a service user was identified at risk of suicide.

Half of respondents said that their agency had systems in place to give staff an opportunity to debrief or receive emotional support after intervening with someone at risk of suicide, and a quarter were aware that certain procedures were followed if a staff member was identified at risk of suicide. (Figure 10.)

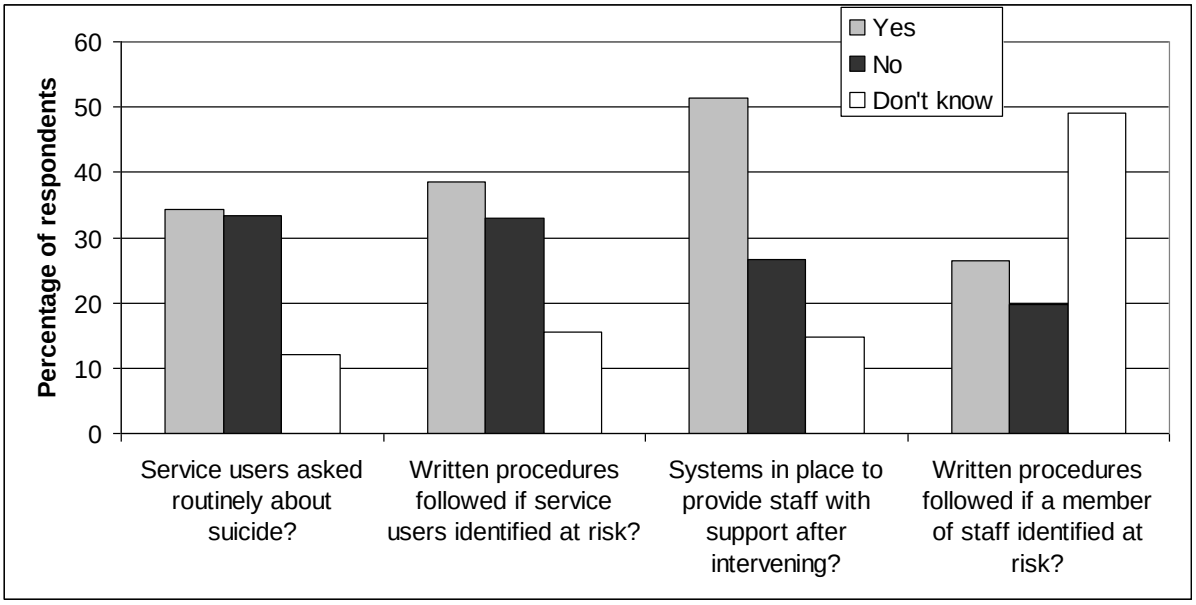
The relatively small proportion of participants who reported these changes would suggest that the changes are not widespread across Scotland. However, in case study interviews and in discussions with trainers, similar examples were cited of questions about suicide being incorporated into standard client assessment forms in agencies ranging from homeless support services to addiction services. In some of the case study areas, STORM documentation had been adopted across NHS teams and other participants in this evaluation also described this development in their local area.

Examples were also given of jobs adverts specifying that previous ASIST training was required or desirable, while other agencies required that ASIST training be completed as part of induction.

Finally, respondents to the participant survey were asked specifically whether, as far as they were aware, **any changes** in procedures had been introduced into their team **as a result** of staff attending suicide prevention training. Only 36 individuals replied to this question, and most indicated that they were unaware of any changes in procedures **as a result** of staff attending training. However, among those who responded affirmatively, examples were given of the way training had affected patient assessment / review procedures, created a 'common language' for staff, and increased the awareness and confidence of staff in intervening.

In the University of the West of Scotland, two interviewees (one trainer, and one member of university staff who had attended ASIST training) had been directly involved in developing new university procedures for responding to student mental health crisis, which included information about appropriate action to take in asking students about suicidal feelings. In Renfrewshire, steps have been taken to develop suicide policies in schools. One interviewee reported that schools in the area had previously been reluctant to even consider this. However, now there are so many school staff trained in suicide prevention, there is less fear about the subject.

Fig 10: Participant survey – responses to questions about organisational procedures (%)



Base = 109.

5.3.3 Inter-agency working

It was suggested that suicide prevention training (in particular, ASIST and STORM training) had led to better communication between agencies and professional disciplines in managing suicide risk among shared clients / patients. For example, in Lanarkshire, it was felt that STORM training and the introduction of standardised documentation on suicide risk assessment had led to the use of a common language and a mutual understanding of what is described as 'medium' or 'high' risk. This point was also highlighted by trainers at the national Trainers Conference.

It was also reported that professionals are also now acknowledging assessments carried out by other agencies — whereas previously this was not often the case.

Table 6 below sets out some additional examples, gathered through this evaluation, of the ways in which suicide prevention training has resulted in changes in organisations and in the way organisations work with each other.

Table 6: Additional examples from case studies of the influence of suicide prevention training on organisations and inter-agency procedures / policies

North Lanarkshire

- The most significant example of the impact on organisations in North Lanarkshire (and in Lanarkshire generally), is the development of the Suicide Assessment and Treatment Pathway for NHS, social work and voluntary agencies. The pathway focuses on appropriate assessment, identifying risk, referral, planning, follow-up and communication. It acts as a prompt and a reassurance, for example, in relation to interventions and where to go for help when a patient / client is feeling suicidal. The Pathway has been influenced both by STORM and ASIST.
- The Psychiatric Liaison Team now follow up people who have spoken about suicide when drunk.
- Emergency Department staff were reported to be more aware and more sympathetic towards people who present following an episode of self-harm or attempted suicide.

West Lothian

- A protocol for the identification of suicide risk is being introduced by the CHCP. The aim is to provide a guide / structured approach to help staff identify people at risk of suicide among their clients. It will also help to deal with the aftermath of suicide.

Renfrewshire

- There has been improved joint working between mental health services and the police in relation to drug-related deaths. This work involves an investigation of each drug-related death when it occurs (rather than waiting for the publication of annual statistics), and the information is used to inform better targeting of suicide prevention training.
- Local trainers have offered to act as resources to training participants — to be available at the end of a phone if people need advice or support in relation to their suicide interventions.
- Training has been widely taken up by staff working for Kibble (housing association) and the Renfrewshire Association for Mental Health. As a result of the influence of training, it was reported that both had developed written policies on what staff should do if they think that a service user may be suicidal.

University of West of Scotland

- One trainer at UWS was a member of a university-wide Healthy Working Lives committee, and as a result, suicide awareness would be included in a month-long event for staff later in 2011.

5.4 What has been the impact of training on communities?

There was evidence from the participant survey that people used their knowledge and skills of suicide prevention not only in their professional roles, but also among their family and friends, and others in their communities. When participants were asked how often they had intervened with individuals in their personal life (as opposed to with clients / patients or colleagues in their professional life) since they received training, more than half said they had intervened at least once. Moreover, nearly a third of those who said they had experience of intervening since their training, said that their **last** intervention was with either with a personal contact or with someone not previously known to them (i.e. a stranger in a non-work context).

As mentioned above, in the case studies, managers also reported that they were aware of their staff using their knowledge and skills with friends and family. Trainers (from the trainers conference) commented that in some areas, the training of

domestic workers, maintenance workers and service users / clients had helped to raise awareness and reduce stigma within these groups.

A similar point was made in Renfrewshire, where it was reported that '80% of Renfrewshire Council staff live in the Renfrewshire Council area'. Therefore, training targeted at a wider range of Council staff (not simply those who were front line workers) was seen to have potentially a strong impact in helping to create a suicide-aware community in the local area.

Also in Renfrewshire, one senior manager reported that there had been fewer suicides in in-patient wards in recent years. She attributed this to an increased awareness and improved practice of suicide intervention among staff in the wards.

In two other case study areas where there had been significant training in the community (including training of construction workers, hairdressers and taxi drivers), it was reported that suicide was better understood and accepted. For example, in North Lanarkshire, training was seen to have contributed to the wide prevalence of suicide prevention messages in train stations, at the football club and on taxis, and to have led to raised awareness and changed attitudes among the public. In West Lothian, training was attributed with having helped reduced stigma and challenging myths about suicide.

5.5 Key points / Summary

Suicide prevention training has been effective in bringing about changes in behaviour among those who have attended the training. After training, participants are more confident and willing to ask directly about suicide intent and they use their skills and knowledge to intervene effectively. This includes not only people in frontline mental health services, but also those in support roles who are reported to be more able to respond to, and 'signpost', vulnerable patients / clients.

In organisations, training has been attributed with creating a climate of greater openness. Suicide is more talked about generally and members of staff teams are more likely to discuss their experiences of intervention and provide mutual support. The training has also enabled the use of a 'common language' about suicide that has supported better inter-agency working. The recording of interventions is still not common practice, but there are new protocols and pathways in some areas that have led to improved documentation, e.g. assessment forms, and better recording. There were also examples of policies and procedures being developed as a result of training, although this type of impact may not be widespread across Scotland. Finally, training was also attributed with bringing suicide prevention up the agenda of senior managers.

From a community perspective, the training was seen to be effective in raising awareness, reducing stigma and challenging myths around suicide. It had also encouraged people to reflect on their attitudes and values.

6. What factors have affected the reach and impact of the training?

This section addresses the third objective of this evaluation, which was to identify the factors that support or hinder the positive impact of the training programme. Again, although efforts were made to explore this question for each of the individual training courses, it was frequently the case that participants in this evaluation raised generic issues, rather than course-specific issues.

This information has come from:

- responses to a series of open-ended questions included in both the survey of co-ordinators and the survey of training organisations
- responses to the participant survey
- interviews carried out with a wide range of individuals as part of the case studies
- interviews, focus groups and the conference sessions with trainers
- the review of previous training evaluations and the Choose Life Phase 2 evaluation.

6.1 What has been the impact of having different courses available?

One of the factors affecting reach and impact is the perceived relevance and utility of each of the courses for different groups. There was a consistent view from interviewees about the differences between courses and their usefulness to particular groups.

STORM was seen as more relevant for NHS staff, particularly clinical staff, because of the focus on risk assessment and management. NHS staff themselves saw ASIST as being about keeping people 'safe' while STORM was seen to be about on-going assessment, risk management and problem-solving. One trainer noted that because STORM training involves the use of specific paperwork, it made sense to deliver STORM to entire teams at once, who will then adopt the new changed paperwork across the board. As a result, STORM training has an immediate organisational impact.

The value of ASIST was seen by some interviewees to be greater for people who do not have clinical roles. However, they also recognised the benefits of ASIST for clinical staff — particularly in relation to the 'myth-busting' and the discussion of attitudes, which takes place as part of the ASIST course.

Several interviewees commented on the value of safeTALK. It was felt to be suitable for a wide range of staff who have some contact with clients / patients but who do not have a direct role in supporting people (unqualified ward staff, junior staff, reception and administrative staff). safeTALK was felt to be useful in giving people confidence to talk to a person at risk and explore their feelings, and information about how to refer them on. safeTALK is also shorter than ASIST and can be delivered to staff in-house. It is, therefore, easier to release staff to attend. One of the disadvantages, however, noted by a number of interviewees, was that the convenience of delivering to a single-staff group had to be balanced against the loss of the mutual learning that comes from multi-agency groups.

It was also recognised that ASIST provides greater depth (than safeTALK) and equips people to intervene, so it was seen to be relevant for staff or community members who had more direct contact with vulnerable people.

Some interviewees noted the value of the suite of programmes – which makes it possible to meet different needs, but also to allow progression if appropriate. One service manager said that, 'Different programmes have a different slant so it can be worth attending more than one'.

One interesting point was that safeTALK was widely viewed as a good **introduction** from which some people can progress (i.e. go on to ASIST), while for others it is enough. Trainers who were familiar with all three courses also saw a progression between them. safeTALK was felt to provide an introduction, to correct misunderstandings (about 'asking the question') and to raise awareness. ASIST was seen to offer greater depth, to encourage people to reflect on their attitudes, and to give people the skills they need to provide a first-aid intervention. And finally, STORM was felt to be appropriate for people who need to regularly assess risk among people who are suicidal.

This progression is also reflected in the nursing curriculum at the University of the West of Scotland (UWS). At UWS, safeTALK is delivered to all nursing students in their first year. However, ASIST and STORM are delivered only to mental health nursing students — ASIST in the second year, and STORM in the third year.

The courses were not designed as a series of 'steps' or a progression. Nor is that how NHS Health Scotland promotes them. There was also some evidence of confusion in one of the case study areas about whether ASIST was a pre-requisite for STORM, and this may be an issue for Health Scotland to address.

Overall, it appeared that the availability of different courses to meet different needs has been welcomed and has increased both the reach and the impact of the training programme.

6.1.1 Issues to do with STORM

In Section 4, it was reported that only 19 local authority areas in Scotland are currently delivering STORM. This raises a question about why STORM is not being delivered in the other 13 areas. Is it because local decisions have been made to focus on safeTALK and ASIST training only? Or is it that there has so far not been the time or resources available to deliver STORM?

Unfortunately, in this evaluation, there is insufficient information to answer this question, and the evidence on this is anecdotal. One trainer in discussing the delivery of STORM in her area, commented that: 'Some ASIST trainers don't rate STORM. I'm not one of those. I **do** rate it, but think it could be tweaked a bit to include a discussion of attitudes and values.' This comment suggests that one reason for the less comprehensive cover for STORM may be that at a local level, individuals do not see the benefits of it. It would also seem that in some areas at least, there was a lack of trainer capacity to be able to deliver STORM regularly.

It is perhaps worth noting that in all the case study areas, STORM was being delivered as a two-day course, rather than in a modular fashion.

6.2 What have been the levers and barriers to positive impact?

Previous evaluations identified a number of levers which support the impact of the training and barriers which hinder the positive impact of the training programme.

Among the factors that have supported impact were: good local leadership and support, a proactive co-ordinator, engagement of senior managers, the quality of the training and enthusiastic trainers. Barriers included: a lack of trainer capacity in some areas and problems of retention; poor take-up by some key groups (e.g. GPs and A&E staff); difficulties of getting staff released for training; lack of administrative support for training; and concerns about whether the training was being put into practice.

While there has been progress in the past few years in addressing some of the barriers, respondents in this evaluation also highlighted some of the same issues again. Most of the comments were related to levers and barriers affecting the wider roll-out (or reach) of the programme. There were fewer comments in relation to the levers and barriers that affect the ability (or willingness) of participants to change their practice as a result of the training. Nevertheless, some important issues were raised and these are discussed below.

As in previous evaluations, it was reported that there continues to be a low uptake of training by GPs and A&E staff. This was widely agreed to be a major issue. However, there were also some examples of action to address the problem. North Lanarkshire has done some safeTALK training with GPs and they hope to provide on-line training for GPs in relation to the Suicide Assessment and Treatment Pathway. In Renfrewshire, two GPs have attended safeTALK training when the course was delivered to their entire team and part of a team training day.

The difficulty of retaining trainers was also a recurring theme and this applied to ASIST, safeTALK and STORM. Suggestions for improving this situation included; more local and regional support networks; closer links between the national recruitment mechanisms and the local Choose Life team; and more information and guidance about the practicalities of being a trainer for potential trainers and new trainers.

Locally, managers wanted to continue the training but were concerned about financial constraints and there were fears that these are likely to get worse. There was also concern about the end of HEAT 5 and the possible impact of that on participation by NHS staff who will have other mandatory training requirements.

In Table 7 below, the levers and barriers identified in this evaluation are summarised.

Table 7: Levers and barriers to the positive impact of the Choose Life training programme

Levers	Barriers
Quality and good reputation of training – word of mouth main source of new trainees	Getting trainers released to deliver courses
The role of the national team in co-ordinating the training programme	Lack of admin support for trainers
Quality and commitment of trainers	Difficulties of getting staff released to attend – likely to get more difficult in light of financial constraints
Good advertising, e.g. intranets and support from learning and development departments	Drop-off of trainers (need for more support for trainers)
Support of senior managers and Councillors	Need to buy in trainers from other areas
Proactive Co-ordinator	Lack of access to TuneUp
Helpful structures, e.g. Choose Life based in Health Improvement (WL), Joint Housing and Social Work Department (NL), local trainers networks	Resistance or reluctance from some NHS staff / non-MH staff to attend training ('They don't see the relevance to their job.')
Strong Choose Life Implementation Group and good partnerships	Time constraints – the requirements of the two-day ASIST but also of the two day STORM
HEAT 5 impetus	Competition with other mandatory training, especially now HEAT 5 is ended
Training is free, local and regularly available	Some managers haven't attended training (and so find it difficult to provide adequate supervision / support to staff during / after interventions)
Shortness of safeTALK and ability to deliver to whole staff groups	Difficulty of finding cheap venues
Benefits of multi-agency training – mutual learning and information exchange (ASIST)	
The perceived greater relevance of STORM training for NHS mental health professionals	

There were also some barriers identified to putting the training into practice.

In two of the case study areas there were reports of NHS staff not accepting 'referrals' from ASIST-trained people because they did not accept the validity of the training. In other areas, however people highlighted the greater willingness of NHS staff (particularly emergency department staff) to accept 'referrals' from ASIST-trained people. Where this was happening, it was attributed to the fact that training had helped to create a 'common language' which facilitates and improves communication between agencies.

The other barrier is the time needed to carry out interventions. For staff in busy services, e.g. A&E, particularly in terms of staffing constraints, there is concern that they cannot take the time needed to spend with an individual who may be at risk of suicide.

One voluntary service manager also cited the new HEAT target on the time between referral and treatment (3 weeks) as a potential barrier to releasing staff for training.

Another factor that affects the continuing impact of the training is the maintenance and updating of skills and knowledge. There was reported to be a need for more refresher training to maintain skills. As mentioned in Section 4, Tune-up is delivered regularly or occasionally in only 10 local authority areas, rarely in four local authority areas, and not delivered at all in 18 areas. (The reasons for this seem to be largely related to capacity among trainers.) Interviewees expressed the view that Tune-up needs to be offered more frequently to help maintain the skills of people already trained. This comment was also corroborated by respondents to the participant survey, a majority of whom expressed a need for refresher training, and updated information about the community resources available in their areas where they can refer people for help.

While Tune-up was intended to be, and is seen to be a good refresher course for people who have attended ASIST, there was also a call for refresher training for safeTALK. Moreover, in one area, there was also some consideration being given to the need for refresher training for STORM.

6.3 What has been the impact of having a national programme?

Finally, we would like to consider how having a national programme has contributed to the impact of the training.

In general, interviewees who took part in this evaluation felt strongly that having a nationally-supported, nationally-cascaded suicide prevention training programme had been a significant factor in the positive impact of that programme. Within the case study areas, there was clear support for continuing with a nationally co-ordinated programme of suicide prevention training. The main reasons given for this were: the 'authority' / status that a national programme gives to the training; and the consistency (i.e. same format, standards, common language) that it provides. It was seen to be important that, if someone moves to another agency, or another local authority area, they will find the same approach being used. Access to resources, T4Ts and materials, and the role of NHS Health Scotland in ensuring the quality of the training, and maintaining the training database were all mentioned as other benefits of having a nationally co-ordinated programme.

6.4 Key points / Summary

The availability of different courses to meet different needs has been welcomed and has increased the impact of the training programme. Other levers included, for example, the quality of the training, having a proactive local co-ordinator and helpful local structures.

Some of the barriers which have hindered wider reach and impact have included difficulties in retaining trainers; time, financial and other resource constraints; and the resistance of some staff to attend training.

However, there is a consensus that having a national programme has contributed to the positive impact of the programme by promoting consistency and quality across Scotland and there was a strong view that the national co-ordination of suicide prevention training should continue.

7. Discussion and conclusions

The purpose of this evaluation was to assess the impact of the nationally-cascaded Choose Life training programme on participant behaviour / practice and on wider organisational attitudes, policies and systems within Scotland. This section will now draw together and discuss the findings with a view to directly addressing the evaluation's main questions:

- What has been the impact of the Choose Life training programme on practice and behaviour change in relation to people who have thoughts of suicide at the individual, community, organisational or systems level across different localities in Scotland?
- More specifically, is the Choose Life training programme effective in:
    - creating behaviour and / or practice change at the individual, community, organisational or systems levels
    - changing attitudes in the immediate environment of training participants and changing their organisations' policies and cultures in relation to suicide and people with thoughts of suicide
    - contributing to the creation of an environment of reduced stress and increased confidence in self and others with helping people with thoughts of suicide?

7.1 Overview

The findings of this evaluation reflect the findings of previous evaluations that, overall, the impact of the Choose Life suicide prevention training programme has been significant. The programme has delivered a high volume of training to a range of people from professional disciplines, administrative and support services, and the wider community and given them the knowledge, skills and confidence to recognise the signs of suicide risk and intervene effectively. It has played a major part in raising awareness and reducing the stigma surrounding suicide. There has been a positive impact both on the behaviour and practice of individuals and on organisational and community attitudes, culture and, where appropriate, policies and procedures.

A notable feature of the training programme is that, over the period of its existence, it has not only grown but has adapted to the lessons learned from previous evaluations and responded to changes in national policy. While there have been some difficulties arising from these changes, the programme has shown itself to be flexible, adaptable and well-placed for further development. Its status as a national programme is widely considered to be a key factor in its impact.

The key findings of this evaluation are discussed in more detail below but it is first necessary to comment on some of the limitations of the study.

7.2 Limitations of the data

There are two points to make here. The first is in relation to the participant survey and the second is in relation to the case studies.

7.2.1 Participant survey

This study involved the collection of both qualitative and quantitative data. Three surveys were carried out: a survey of Choose Life co-ordinators (or other appropriate individuals) in each local authority area, a survey of training organisations, and a survey of individuals who attended one or more of the three courses over the past three years. Responses to the first two surveys were excellent. However, the response to the participant survey was poor.

As explained in Section 3.4, a combination of factors resulted in a response rate to the participant survey that was lower than expected. Given the small number of respondents, the resulting sample cannot be considered to be representative of the wider participant population, and caution must be exercised in interpreting the responses to the quantitative questions in the survey. However, despite the weaknesses of the survey data, the responses to the survey have been generally corroborated by evidence gathered through interviews and case studies. Furthermore, the responses to the open-ended (qualitative) questions from the survey provide a useful insight into the ways people are using their training skills.

7.2.2 Case studies

The case study areas were chosen in consultation with NHS Health Scotland. In discussing which areas to choose, it was agreed to choose areas (and an organisation) where all three courses — ASIST, STORM and safeTALK — were being delivered. In hindsight, there may have been some benefit in choosing at least one area where all three courses were *not* being delivered, as this would have given us a greater understanding about why 13 local authority areas in Scotland are not currently implementing STORM. Is this a deliberate decision, or is it due to lack of time and resources? It is suggested that further work could be done by NHS Health Scotland to explore this issue.

7.3 How has the reach of the programme affected its impact?

The first of the questions posed in this evaluation is now considered: What has been the impact of the Choose Life training programme on practice and behaviour change in relation to people who have thoughts of suicide at the individual, community, organisational or systems level across different localities in Scotland?

One of the main findings of the earlier ASIST evaluation was that ASIST training was **effective** in giving people skills, knowledge and confidence to intervene with those at risk of suicide. However, the **impact** of training was greater where there were fewer barriers to roll-out and where more people had participated. This suggests a strong correlation between the reach of the training and impact on behaviour.

The issue of reach is, therefore, important in assessing the overall impact of the Choose Life training programme, and so it is necessary to first address the question: How comprehensive has the spread of the training been?

7.3.1 Reach of the training programme

Suicide prevention training is delivered in every part of Scotland and this is a significant success of the programme. As shown in Section 4, ASIST and safeTALK have the most comprehensive coverage, and in the period April 07 – Mar 10, ASIST continued to be the course delivered most frequently. However, although the

implementation of safeTALK began much later than the implementation of ASIST, the number of safeTALK courses across Scotland in the period April 07 – March 10 has grown dramatically. So by 2009-10, safeTALK had begun to overtake ASIST as the course being delivered most frequently. As discussed below, this rapid growth of take-up of the shorter course shows that it has met a need but, importantly, it has also widened the reach of suicide prevention training.

The coverage of STORM has been less comprehensive. As noted in Section 4, there are 13 areas which do not deliver STORM at present. One factor is that the adoption of STORM in most areas has been relatively recent (since 2008). However, it was also notable that, in some areas where STORM had been introduced, few courses had so far been delivered. Furthermore, the decision to deliver STORM appears to have been driven mainly by the HEAT 5 target and a view that STORM's focus on risk assessment and management is more relevant to people working in clinical settings. With the lapse of the HEAT 5 target, and the relative newness of the course in some areas (some only began to deliver STORM in 2010), there may be an issue about whether local areas will reduce the number of STORM courses or stop altogether.

Another factor is that many areas have only one or two STORM trainers available. Staff mobility may therefore make the infrastructure to support future implementation of STORM vulnerable (as was recognised in one case study area). There may be a need to review both the demand for the training and the recruitment of trainers on a regular basis.

If fewer STORM courses are available in the future this may have implications for participation by clinical staff in suicide prevention training and that could reduce the reach and overall impact of training. Conversely, expanding the reach of STORM could increase the impact of the training, particularly for clinical staff who might not otherwise attend ASIST.

Further investigation is needed in those areas where STORM is **not** delivered to explore why that is the case. It will be for Health Scotland to decide whether effort and resources should be invested to encourage those areas to deliver STORM.

7.3.2 Numbers and types of people trained

The number of courses delivered and the number of people trained have continued to increase from one year to the next, so that it would appear that the number of people who have been trained in the three years between April 07 and March 10 is nearly twice the number of people trained in the first three years of the programme. As of March 10, an estimated 30,000 people were trained in suicide prevention in Scotland. This represents approximately 7 in every 1,000 people in Scotland over the age of 16.

In addition, the training has been delivered to a wide range of people — not only frontline staff working in mental health services, but also to care staff, staff working in housing, addictions and education, police, university students, administrative staff, voluntary sector workers and members of community groups, among others.

For the most part, ASIST training has been attended by participants from a range of disciplines and services, who took part in the training in a professional capacity.

These participants have come from NHS, local authority and voluntary sector agencies. Only small numbers of community participants (e.g. volunteers, representatives of community or faith groups, etc.) have attended in the past three years. In some areas this was attributed to the drive to meet the HEAT 5 target which had led to an almost exclusive focus on frontline staff. In other areas, however, training for the community was continued or at least efforts were made to ensure that some places were offered to community members. It was suggested that in the future, in some areas at least, there would be a shift of emphasis back to the community as the HEAT 5 target has been met.

The reach of the programme is wide, as these findings illustrate. However, there are gaps among key groups as noted below. Also it is known that people move regularly from jobs and from their communities, so there is and will continue to be a need for ongoing training to maintain, and if possible increase, the pool of trained people.

7.3.3 Factors having a positive effect on reach

There have been two main factors that have supported the increased reach of training.

First is the **diverse nature of the training programme**. Having a range of courses available to suit the needs and interests of different training participants has been valuable. Offering the half-day safeTALK option has enabled many people to attend training (including front-line administrative workers, social care and housing support staff, general (non-mental health) nurses, and even some GPs) who might not otherwise have had either the time or interest to attend the two-day ASIST course. At the same time, a number of interviewees commented that they were aware of some safeTALK-trained individuals going on to attend ASIST because the training had piqued their interest. In the areas where STORM has been rolled out, it has had a positive response from many clinical staff (who may have been sceptical about the relevance of ASIST), who see STORM as relevant because of its risk assessment and management focus, and helpful because of its structure and documentation.

It was also interesting to learn that in local areas where all three courses were delivered, there was perceived to be a progression between courses. This may have had some benefits in that it has encouraged people to undertake more than one course. On the other hand, it has led to confusion in some areas where it is believed that there is a required order for the courses (which is not the case).

Although it was not part of the remit of this evaluation to explore the use of suicideTALK (a short awareness-raising session) in any depth, the survey of training organisations did ask about whether any of the organisations delivered suicideTALK, and if so, to whom. Interestingly, five of the 17 organisations that took part in the survey said that they delivered suicideTALK to their own service users. Unfortunately, it was beyond the scope of this study to explore the impact of suicideTALK on service users. However, it may be expected that raising awareness of suicide, and the need to ‘ask the question’, among service users could possibly lead to a situation where service users themselves are helping their friends and family members to talk about their suicidal feelings. At the very least, such training will help to reduce the sense that suicide is a forbidden subject. It should also be noted that suicideTALK has also been used in some areas to raise awareness within

communities, and at least one local evaluation reported that suicideTALK attendees have gone on to attend safeTALK or ASIST (Watts, 2010).

The second factor which has supported wide roll-out of the training has been the focus on **targeting individuals who work with high-risk groups**. One of the recommendations of the national ASIST evaluation was that, to maximise the impact of the training, training should be better targeted to the 'right' people — i.e. those who work with, or live in communities among people who are at high risk of suicide. Initial concerns had been expressed by national and local stakeholders about the effect of the HEAT 5 target on the community focus of training because of the shift in focus to frontline staff (Russell *et al,* 2010). However, the individuals who took part in this evaluation were unanimous that the take-up of training, particularly among frontline staff who come in regular contact with people who are at risk of suicide, had had a positive impact on the profile of the training. Furthermore, suicide prevention training has, in one form or another, also been widely incorporated into university nurse-training courses. An entire new generation of Scottish nurses are being given the skills and confidence to intervene effectively with people who are at risk of suicide. All of these changes are extremely positive.

7.3.4 Barriers to increased reach

Some of the barriers to wider reach have been:

- **Perceived lack of relevance:** It was noted that some people within the workforce whose jobs do not relate to mental health (e.g midwives, A&E staff, general nurses, etc.) do not always see the training as relevant for them, and so can be reluctant to attend.
- **Lack of trainer capacity:** A lack of trainers, or a lack of trainer capacity, has inhibited the wider roll-out of training in some areas and in some organisations. In particular, there may be a need (acute in some areas and organisations) for additional safeTALK and STORM trainers.
- **Need for trainer support:** Many trainers had received positive support from local trainers' networks and through their participation in regional and national events. However, comments were made that this wasn't necessarily the experience of all trainers. Structures currently being put in place by Health Scotland (through the quality assurance support framework) should help to ameliorate the difficulties that some trainers have had with a lack of support.
- **Practical issues:** The lack of administrative support and the need to pay for venues has been an on-going difficulty for some training organisers, and these difficulties are likely to become worse over the next few years with increasing cuts to local budgets.
- **Failure of the HEAT 5 target to reach GPs:** It has been widely reported, both in this evaluation and in other evaluations of different aspects of the Choose Life strategy that engagement with GPs in relation to mental health interventions has been an on-going difficulty (Russell *et al,* 2010; Griesbach *et al, 2008,* Griesbach *et al,* 2010). The findings of this evaluation confirm that GPs are still not being reached in sufficient numbers by suicide prevention training. This is unfortunate, given the crucial role that GPs have in working with the general public. The difficulties of getting GPs to attend training are well-known. Moreover, given the

pressure of time that GPs face on a daily basis, there are implications for GPs in carrying out even a relatively simple safeTALK-style intervention. In principle, such an intervention can be carried out very quickly, but in practice, asking someone if they are thinking of suicide, and then **listening** to the answer and responding appropriately, will take more than 10 minutes. Nevertheless, it seems clear that this issue needs to be tackled. Finding a way to incorporate suicide prevention training into GP training could have a huge positive impact on reducing the number of suicides in Scotland.

In addition, as noted above, the loss of the HEAT 5 target was seen to be a possible barrier to continued wide roll-out of training in the future. While some interviewees saw the removal of the HEAT 5 target as an opportunity to deliver more community-based training, others expressed concern that the loss of the training focus of the HEAT 5 target could have a negative impact on: (a) the willingness of managers to release staff to attend training and (b) the ability of trainers to deliver training. Participants in this evaluation generally agreed that the HEAT 5 target had provided a positive impetus for getting people to attend suicide prevention training. Without it, there was a fear that there would be a reduction in training activity. This would have implications not only for meeting the on-going aim of the Choose Life strategy to reduce suicide in Scotland, but at another level, it could also make it increasingly difficult for qualified trainers to meet their requirement to deliver three courses per year.

7.4 What has been the impact on participant behaviour?

At the time of the introduction of ASIST in 2003-04, the aim of the training was to equip participants, both professional staff and community members, with the knowledge, skills and confidence to recognise suicide risk and to intervene. Previous evaluations have consistently found that ASIST, and later, safeTALK and STORM, have met that aim.

This evaluation has looked more closely at changes in the behaviour and practice of individuals.

Perhaps the most consistent message from service managers has been that the training has led to increased confidence and willingness among staff to ‘ask the question’ and respond effectively. In some areas (Lanarkshire and others), the question is now routinely asked as part of client assessment and review. Most notably, there were frequent comments that the training had dispelled the fear that asking the question would in itself increase the risk of the person completing suicide. Moreover, interviewees working in frontline roles reported that the skills and confidence that came from the training had helped reduce the stress of their job.

There were also many examples from service managers that the work environment had changed and that staff were less stressed when dealing with suicidal patients / clients. Teams that deal with vulnerable patients / clients are now much more open and confident in discussing instances where they had intervened and providing mutual support in a culture of greater openness.

One of the most interesting findings was the change in the attitudes and behaviour of administrative and support staff who had received safeTALK training. These staff are often the first point of contact for clients and the greater knowledge and

understanding that they now have enables them to deal more sympathetically with these clients and to refer them to the right person or service.

There was a suggestion that STORM training may be having **less** of an impact at the level of participant behaviour because people who have generally attended STORM training often already have a knowledge of suicide and suicide intervention. While it has been difficult in this evaluation to tease out the separate impact of STORM (as compared to safeTALK and ASIST), the previous evaluation of STORM in Scotland found that STORM participants asked **more** and more **direct** questions of patients during risk assessment. And, as shown in Section 5, STORM **has** had a clear impact on organisational procedures.

The previous ASIST evaluation found that there was a 20% increase in interventions following training. The findings of the current evaluation are less clear in this respect. However, this may be because of the problems with the representativeness of the participant survey, as previously noted. Evidence from the interviews and case studies indicates that there **has** been an increase in interventions. Most importantly, however, is that people are intervening **more effectively** because they are specifically asking about thoughts / intentions regarding suicide, because they have better information about who to link the person with for help, and because they are making a plan / agreement with the person to keep them safe.

However, it is perhaps worth noting that even after training, less than half of participants who reported intervening, said that they had made a plan / arrangements with the person to keep them safe. One of the reasons for this may be that, having asked an individual if they were thinking of suicide, it transpired that the answer was 'no', and therefore, there was no need to make a plan to keep the person safe. On the other hand, there was also evidence from the participant survey and from interviews with a range of individuals, that participants feel the need for occasional updates on the services and resources available in their areas. If participants are unsure about where they can refer someone for help, they may feel less able or less confident about making a plan with the individual to keep them safe.

When respondents to the participant survey were asked for details about their **most recent** intervention, more than half reported that the individual they had intervened with most recently was female. However, annual statistics show that three-quarters of suicides in Scotland are completed by men. Since most of the respondents to the participant survey were service providers, this finding could reflect the fact that, although men are more likely than women to complete suicide, women are more likely than men to be in contact with services.

There may be an issue here to do with the effectiveness of the training programme in reaching men, particularly since the majority of training participants are also women. Further efforts may be needed to target services (e.g. prisons and criminal justice services), and community locations (e.g. pubs, sports and leisure facilities) where men can be found. At the same time there may be an argument (one which was raised by interviewees) for shifting the balance of training back towards more a focus on communities now that the HEAT 5 target has been met.

Trainers frequently receive feedback from participants following their attendance at training about their experiences of intervening with individuals at risk of suicide. This

type of feedback was often referred to as 'anecdotal'. However, given the number of trainers who report receiving such feedback, it is difficult to dismiss it as merely 'anecdotal'. Service managers also consistently commented on the increase in engagement, confidence and effectiveness in intervening that they observed among staff. These findings reflect and corroborate similar findings from previous evaluations. However, it was clear that, with some exceptions, recording of interventions is not commonly done, and there may be a need for a more consistent approach to gathering evidence in this area. This could potentially take the form of a small-scale audit — for example, all the services in a particular area could be asked to record the number of times their staff carry out an intervention with someone at risk of suicide over a randomly-selected one-week period. Thirty-two such audits carried out annually in local authorities across Scotland could help move the evidence base for the effectiveness of suicide prevention training beyond the 'anecdotal'. (See below for further discussion of this point.)

7.4.1 Factors that help or hinder use of participant skills following training

One of the concerns raised in the Choose Life Phase 2 evaluation was whether training was put into use as often as might be expected. In this evaluation, some factors were found that helped or hindered the use of the skills and knowledge acquired. Factors that hindered were:

- **'Entrenched attitudes':** Many trainers commented that a minority of training participants continue to attend training, not because they value the opportunity to learn about suicide prevention, but rather 'because they've been sent by their manager'. The perception among trainers is that these individuals don't believe that the training can teach them anything they don't already know. Sometimes these entrenched attitudes are transformed during training. However, on other occasions, these individuals can make the course difficult for all the other participants. Such situations can also be very discouraging and extremely challenging to new, inexperienced trainers.
- **Time factors / practical difficulties:** For staff in some services, including social workers and A&E staff, there were difficulties finding the time to carry out an intervention. Voluntary sector managers also noted this issue. The problem of GPs not having sufficient time to carry out interventions has already been noted above.
- **The emotional impact of intervening:** Interventions can be emotionally draining and, while some agencies noted that they had support systems in place for staff, this was highlighted as a gap by other interviewees and to some extent also by the participant survey.
- **Need for refresher training:** as time passes since attendance at the training, there is a need for some updating or refresher training to maintain skills and knowledge, and sustain confidence. This point is discussed in further detail below.

Factors that helped were:

- managers who had attended the training or at least supported it and were committed to putting it into practice

- policies, pathways and protocols that set out steps for dealing with suicide risk (as in West Lothian and North Lanarkshire)
- the inclusion of questions about suicide in client assessment and review documentation.

7.4.2 Refresher training

The need for refresher training was a consistent theme throughout this evaluation (and indeed previous evaluations) so it is worth saying more about it.

Only 10 local areas in Scotland reported delivering ASIST Tune-up on a regular or occasional basis (once or twice a year). However, many of the trainers who took part in this evaluation felt that it would be beneficial to deliver Tune-up in their areas, or to deliver it more regularly. In addition, two-thirds of respondents in the participant survey said that they would find it helpful to attend a refresher course. The benefits of Tune-up were that:

- It provides a refresher for people who have been trained — this was seen to be particularly important for people who had had little opportunity to use their intervention skills since attending training.
- It provides an opportunity for trainers to gather formal (as opposed to 'anecdotal') data about the extent to which people **have** used their skills, and what the outcome has been.
- It gives former training participants the opportunity to share useful learning (what has worked, what hasn't worked as well) with other former participants.

At present, the Tune-up refresher course is intended only for ASIST participants. It is not clear from this evaluation whether there would be benefit in developing a similar refresher session for safeTALK participants, given that safeTALK is more geared towards awareness-raising, rather than teaching intervention skills. A similar proportion of ASIST **and** safeTALK participants (two-thirds in both cases) in the participant survey expressed a desire for a refresher course. However, the numbers related to safeTALK were small, and therefore the finding is perhaps not representative of the wider safeTALK-trained population.

It is less clear about whether there is a widespread need for a refresher course for STORM participants. The findings from this evaluation suggest that in Scotland, at present, STORM is largely being delivered to NHS staff working in mental health services, and who have frequent contact with people who are at risk of suicide. These individuals are likely to use their STORM intervention skills on a regular basis, and so there may be less need for a refresher course for STORM-trained individuals. We would suggest that the National Training Support Team may (in the future) wish to explore whether individuals trained in STORM and safeTALK feel the need for a refresher course.

In any case, there is some evidence from this evaluation that participants from all three courses may value regular updates about the services and other resources available in their area where they can refer people who at risk of suicide, and their families who are in need of support.

7.5 What has been the impact on organisations?

There is evidence from this and previous evaluations that the training has had an impact on the attitudes, culture and ways of working within organisations and staff teams. While this is not universal, it does show that the training has been a powerful tool for making changes in a difficult and sensitive area.

Where training had been delivered across organisations, there was believed to be a 'less fraught' and more constructive environment that was conducive to people talking about suicide, and using their skills to intervene. As a topic it was more likely to be on the agenda for senior managers. At operational level, teams were sharing experiences of interventions and supporting each other, There was, consequently, less stress and anxiety for individuals and collectively. This change to a more confident and proactive workforce was clearly attributed to the training.

One of the most interesting impacts of training noted by a number of interviewees was that the skills acquired in the training, such as listening, interviewing and problem-solving, were transferable skills, applicable to many other areas of work. Thus, the training has had an impact on the overall skills base of organisations.

There were a number of examples of changes to documentation, policies and procedures. Similar changes were also found in an evaluation of suicide prevention training conducted in Ayrshire (Watts, 2010).

HEAT 5 has had a considerable impact on the NHS. It has created a high profile for suicide prevention training both within the NHS but also in Social Work and addiction services. At operational level, there is now in some areas a common language that allows discussion of suicide between disciplines and with other agencies. In some cases this is supported by common documentation, often based on STORM documentation. Above all it has increased the number of clinical staff who have participated in training.

Finally it is important to note that there is now a body of unqualified staff who have received training. This is an important group within many organisations because they are the first point of contact with patients / clients and reflect the ethos of that organisation. They are also well-placed to recognise signs of risk and make the appropriate referrals.

7.5.1 Factors that help or hinder the impact on organisations and systems

- **Supportive managers and systems:** It is important to bear in mind that even when an entire workforce is trained, culture change within services is only likely to happen when managers and systems (e.g. client assessment and review documentation, inter-agency referral and client support arrangements, staff support following interventions) also support culture change. As noted above, there was some evidence in this evaluation that managers and systems around Scotland **are** supporting change. However, the findings from the participant survey would suggest that wide-scale systems changes are still in progress.
- Protocols / pathways are important tools in setting out clearly the expectations of staff and guidance on the steps to follow, as well as providing helpful documentation.

- In the current economic environment, financial constraints and staff cuts may reduce the opportunities for staff to attend training and to put it into practice.

7.6 What has been the impact on communities?

The findings of this evaluation indicate that, particularly in the past three years, training has been delivered to a relatively small proportion of people from communities (i.e. representatives of faith groups or community groups, or interested individuals from the general population attending in a non-work-related capacity).

However, in addressing the question of what impact the training has had on communities, it is important to reflect that the greatest proportion of people who have attended training are employees of local authorities and the NHS, the two largest employers in any local area. In addition, many of these people represent a range of disciplines — not only clinical and social work staff — but also administrative and support staff, social care staff, housing staff, teachers and so on, who are both living and working in the community. The point has been made by several participants in this evaluation that the best way to get the training out into the community is to train exactly this section of the local population. This, and previous evaluations, show that these people use their skills and knowledge with family and friends.

The Phase 2 evaluation of Choose Life commented that suicide prevention training has played arguably the most important role of any of the Choose Life interventions, in raising awareness and reducing stigma related to suicide (Russell *et al,* 2010). The ASIST evaluation similarly noted the perceived impact of ASIST training on reducing stigma and raising awareness, not only in organisations, but in communities more widely (Griesbach *et al,* 2008).

However, perhaps the most significant impact that suicide prevention training could have on communities is in the reduction of suicide — the overarching aim of the Choose Life strategy and action plan. It has been stated in previous evaluations that changes in the suicide rate in Scotland cannot be wholly or entirely attributed to training (Griesbach *et al,* 2008; Russell *et al,* 2010). Nevertheless, it is worth noting in this evaluation that based on the three-year rolling averages, the suicide rate in Scotland has been falling since 2000-2002 (Scottish Public Health Observatory, 2010).

7.7 Data issues

While it was not one of the objectives of this evaluation to explore the issue of data quality in any depth, it is nevertheless worth noting that some areas appeared to have little difficulty in providing data on their local course delivery, and on the types of individuals who attended training. Other areas clearly struggled with this. In some areas, it would seem that electronic records are not kept at all. This is often because there is no administrative support available to the local co-ordinator. However, there were also cases where records **were** held electronically, but the loss of an administrator made it impossible to access those records or the database in which the information was held could not readily produce reports.

NHS Health Scotland has taken steps to develop and maintain a central training database, and ultimately, this should provide better quality information about the reach of the national training programme.

The second issue which this evaluation has highlighted is that it is uncommon for any formal record to be made of when an 'intervention' takes place. This is perhaps not surprising, given that it is not clear what exactly constitutes in 'intervention'. It could be argued that asking the 'suicide question' is not the **only**, or even the **best** indicator of when an intervention has taken place. Indeed, interventions are likely to look very different depending on:

- the relationship between the intervener and the person at risk (i.e. whether it is a new relationship or an on-going relationship, whether they have attempted to intervene previously or whether this is the first time they have intervened, whether the intervener has a role in providing on-going support and care to the person at risk)
- whether the intervener has been trained in safeTALK, ASIST or STORM.

Getting the agreement of stakeholders on the definition of an 'intervention' **and** on whether there is, in fact, a **need** for better data on interventions is the first step to addressing any information gaps that there may be. The recording of information on interventions need not become a major data collection exercise. As stated above, this could take the form of a small-scale audit within a sample of services over a limited period of time. Where work on this issue is taking place at a local level (for example, West Lothian), it would be worth sharing the learning with others across Scotland.

7.8 Conclusions

In Section 2, it was noted that the two main aims of suicide prevention training in Scotland were: to increase the understanding of suicide and reduce stigma, thereby creating a more sympathetic, responsive climate within communities for those who are vulnerable; and to give people the skills, knowledge and confidence they need to intervene when someone is at risk. The findings of this evaluation clearly show that the delivery of a nationally-cascaded programme of suicide prevention training has resulted in significant progress being made towards meeting these two aims.

In Section 2, it was also noted that the expected outcomes from a national suicide prevention training programme would be that:

- Participants are given the skills and knowledge they need to intervene with people at risk of suicide.
- Participants have greater confidence to intervene.
- Participants use the skills and knowledge they have acquired to intervene with people at risk of suicide.
- Participants use their skills to good effect.
- Organisations and communities in Scotland are more suicide-aware.
- Organisations provide better support to people at risk of suicide.
- Organisations work better **together** in supporting people at risk of suicide.
- The immediate risk of suicide is reduced in particular individuals.
- There is a reduction in suicide rates in Scotland (long term).

There is evidence from this, and previous evaluations that these outcomes are being met through the delivery of suicide prevention training in Scotland.

And finally, in considering the second question that this evaluation sought to answer: Is the Choose Life training programme effective in:

- creating behaviour and / or practice change at the individual, community and system levels
- changing attitudes in the immediate environment of training participants and changing their organisations' policies and cultures in relation to suicide and people with thoughts of suicide
- contributing to the creation of an environment of reduced stress and increased confidence in self and others with helping people with thoughts of suicide?

Based on the evidence of this evaluation and previous evaluations in Scotland, the answer to this question is, undoubtedly, yes.

In order for the programme to have the desired impact, it is necessary to train enough people. At the same time, previous evaluations and the findings of this evaluation show that to achieve effective interventions with people at risk, it is necessary to train the 'right' people. There has been good progress in reaching large numbers of people in Scotland and in reaching many of the 'right' people. However, there will be an on-going need to deliver training to maintain and increase the current impact. In addition, some of the 'right' people are still not being reached, and GPs are at the top of the list.

The evidence from this evaluation shows that the impact of the Choose Life training programme has not merely been sustained over time, but has grown. At the same time, however, more can be done. It is not universally the case across Scotland that patients / clients are routinely asked by supporting services (as part of an assessment or review process) if they have ever attempted suicide, or are feeling suicidal. While there clearly have been changes in policies and procedures in some organisations which have been directly attributed to the training programme, again, these changes have not yet happened everywhere. In addition, there will be challenges to the future sustainability of training arising from the current financial constraints on organisations.

Training has clearly played a significant and effective part in the overall impact of the Choose Life suicide prevention strategy. Moreover, there is strong support — and will continue to be a need — for a nationally-cascaded programme that ensures consistency and quality of training delivery, and which is able to adapt and respond flexibly to future training needs.

8. References

Gask, L., Lever-Green, G. and Hays, R. (2008) Dissemination and implementation of suicide prevention training in one Scottish region. *BMC Health Services Research,* **8**, 246. http://www.biomedcentral.com/1472-6963/8/246.

Griesbach, D., Russell, P., Dolev, R. and Lardner, C. (2008) *The use and impact of Applied Suicide Intervention Skills Training (ASIST): An evaluation.* Scottish Government. Available at: www.scotland.gov.uk/Publications/2008/05/21112543/18.

Griesbach, D., Russell, P., Lardner, C. and Gordon, J. (2010) *Evaluation of the Scottish Recovery Network.* Scottish Government. Available at: www.scotland.gov.uk/Publications/2010/12/16111855/21.

Kirkpatrick, D.L. (1959) Techniques for evaluating training programmes, *Journal of American Society of Training Directors, 13*, pp. 3-9 and 21-26; *14,* pp. 13-18 and 28-32.

Platt, S., McLean, J., McCollam, A., Blamey, A., Mackenzie, M., McDaid, D., Maxwell, M., Halliday, E. and Woodhouse, A. (2006) *Evaluation of the first phase of Choose Life: The national strategy and action plan to prevent suicide in Scotland*. Scottish Executive. Available at: www.scotland.gov.uk/Publications/2006/09/06094657/22.

Scottish Executive (2002) *Choose Life. A national strategy and action plan to prevent suicide in Scotland*. Available at: www.scotland.gov.uk/Publications/2002/12/15873/14481.

Scottish Executive (2006) *Delivering for mental health.* Available at: www.scotland.gov.uk/Publications/2006/11/30164829/16.

Scottish Government (2009) *Towards a mentally flourishing Scotland: Policy and action plan 2009-2011.* Available at: www.scotland.gov.uk/Publications/2009/05/06154655/5.

Scottish Government (2010) *Refreshing the national strategy and action plan to prevent suicide in Scotland. Report of the national Suicide Prevention Working Group.* Available at: www.chooselife.net/AboutChooseLife/AboutChooseLife.asp.

Scottish Public Health Observatory (2010) *Suicide: key points.* Available at: www.scotpho.org.uk/home/Healthwell-beinganddisease/suicide/suicides_keypoints.asp.

Watts, S. (2010) *Ayrshire suicide prevention skills training and co-ordination evaluation.* NHS Ayrshire & Arran.

Appendix 1: About ASIST, STORM and safeTALK

ASIST

ASIST is intended as 'suicide first-aid' training: it aims to help people (both professionals and members of communities) to become more willing, ready and able to recognise and intervene effectively to help persons at risk of suicide. The course is delivered over two consecutive days in a workshop-type format. Participants develop skills through observation and supervised simulation (role play) exercises in large and small groups. All ASIST trainers must attend a five-day 'training for trainers' (T4T) course. In 2007, the Scottish Government commissioned a large national evaluation of ASIST.

STORM

STORM was originally developed by the University of Manchester. There are two STORM 'packages' available – one which is intended for front-line staff working with adults of any age, and a second which is intended for staff working with children and young people. The training, which is delivered through four half-day modules, aims to develop complex clinical communication skills through the use of role-play and video-feedback on performance. The course also attempts to address attitudes through interactive self-reflection and reflection on the experiences of peers and case material demonstrated on video.

The STORM modules are:

- **Assessment** develops skills needed to assess the risk of suicide
- **Crisis Management** focuses on the skills needed to keep a person safe once the risk of suicide has been identified
- **Problem Solving** involves helping a person take control of their problems
- **Crisis Prevention** focuses on developing a plan for the future in the event that the risk of suicide may arise again.

An evaluation of the Highland implementation was carried out by the University of Manchester following three previous evaluations of STORM in England. A further evaluation of STORM across Scotland is currently being carried out, again by the University of Manchester.

safeTALK

safeTALK is a half-day training programme which aims to teach participants to recognise and engage with people who may be having thoughts of suicide, and to connect them with someone else in their community who is trained in suicide intervention (for example, a professional mental health worker or someone trained in ASIST).

Appendix 2: National Learning Framework

This Framework set out a series of learning outcomes, and the expected skills, knowledge and attitudes associated with three suicide prevention learning levels, A, B and C:

- **Level A:** gives participants the skills to identify someone at risk; to ask about suicide; and to put the person at risk in touch with someone who can help
- **Level B:** gives participants skills to intervene with someone at a point of crisis; to keep them safe in the immediate term; and to put them in touch with resources to keep them safe in the longer term
- **Level C:** gives participants the skills to intervene at a point of crisis; as well as the skills to help the person at risk develop their own longer-term coping strategies.

In addition, the Framework linked individual learning levels to particular types of jobs. For example, it was recommended that a receptionist or care assistant should attain level A; a GP or an A&E doctor / nurse should achieve level B; and a psychiatrist, clinical psychologist or mental health nurse should have a level C competency.

The Framework also provided information about which of the courses in the national Choose Life training programme met the requirements for each level, as shown in Table A2.1 below.

Table A2.1: Proposed Suicide Intervention and Risk Management Training programmes to meet specified learning levels

Learning Level	safeTALK	ASIST	STORM Modules 1 & 2	STORM Modules 3 & 4
A	x			
B		x		
or B	x		x	
C	x		x	x
or C		x		x

Source: National Learning Framework. Available from: http://www.chooselife.net/Training/HEAT5/HEAT5.asp.

Appendix 3: List of agencies invited to take part in the survey of training organisations

- Blue Triangle Housing Association
- British Transport Police
- Carr-Gomm Scotland
- COPE
- Edinburgh Napier University
- Glasgow Addiction Services
- Glasgow Caledonian Univ
- Glasgow Simon Community
- Kibble
- LifeLink
- Loretto Housing Association and Loretto Care
- Ministry of Defence
- ParentLine Scotland Children 1st
- Penumbra
- Police College
- NHS Lothian Health Promotion
- NHS Tayside
- Rape Crisis Scotland
- Scottish Drugs Forum
- Stirling University
- Turning Point Scotland
- University of the West of Scotland

Appendix 4: Instructions to co-ordinators for selecting participant sample

How do I select a random sample of my local training participants?

There are a number of methods that can be used to select a random sample of your local training participants. None of these methods is necessarily better than any other. However, to make things simple, we are suggesting that you use the following method.

Step 1: Collate the list of names and email addresses for your training participants for a single year into a single list (i.e., if there were four ASIST courses delivered in your area in 08-09, then create one list containing the names and email addresses of all the participants who attended those courses in that year).

Step 2: Now, alphabetise the list by the participants' names (last name, or first name, it doesn't matter). [Note that, in Excel, you can do this automatically using the "Sort" command in the "Data" menu.]

Step 3: Go through the list, and select every third email address until you have selected 30 email addresses in total. It doesn't matter if you do not get to the end of the list. However, if you have got to the end of the list before you've selected 30 email addresses, then go back to the beginning of the list, and now select every third email address from those remaining until you have selected 30. [If there were fewer than 30 training participants for a particular course for one year — e.g., because only one or two courses were offered that year — then simply select *all* the participants for that year for your sample.]

Step 4: Put the email addresses for your randomly selected participants into a separate file and save it.

If we have asked you to select a random sample of participants for more than one course (ASIST **and** safeTALK **and / or** STORM) and / or for more than one year (07-08, 08-09 **and** 09-10), please use the same procedure to get a random sample of 30 participants for **each** course for **each** year.

I now have a random sample of training participants. Now what?

Some email systems put restrictions on the number of addresses you can email at one time. (This is done partly to protect people from junk mail – which often involves a single message being sent to large numbers of email addresses.) Therefore, we recommend that you do **not** try to email more than 15 people at one time.[15]

So, once you have your list of 30 addresses for one course for one year, then divide the list in half and:

Step 1: In the **To** field of a new email message, copy and paste the email addresses for the first 15 participants from the file you created in Step 4 above. (Depending on

[15] On the other hand, if you know for sure that your email system will allow you to email large numbers of addresses at once, then you can email everyone in a single message.

your mailer, you will need to separate each address with a semi-colon (;) or a comma.)

Step 2: In the **Cc** field, put **your own** email address (so that you automatically receive a copy of the message).

Step 3: In the **Subject** field, put: National evaluation -- Choose Life (suicide prevention) training programme

Step 4: Copy and paste the attached text (ParticipantInvitation.doc) into the body of your email message.

Step 5: Send the message.

Step 6: Repeat for the second 15 participants.

Step 7: If you are contacting participants for more than one course for more than one year, repeat Steps 1-6 for each course for each year until you have emailed everyone in your sample.

Step 8: Make a careful note of how many people you emailed for each course, for each year.

Step 9: Wait for 24 hours, and make a careful note of how many messages "bounce back" (with the error: "Message undeliverable") during that time. (Out-of-office replies can be disregarded, if the person is only away temporarily.)

OK, I've emailed everyone. Now what?

Please email Dawn Griesbach (d.griesbach@griesbach-research.co.uk):

(a) the total number of participants you emailed, and

(b) the number of participants whose messages bounced back.

VERY IMPORTANT: Please save the copy of the message(s) you sent. This will enable you to send a reminder to everyone about the survey one week after you sent the original message. Sending a reminder will be MUCH easier if you have kept a copy of your original message(s).

Problems you may encounter with NHS addresses

We are anticipating that messages to some individuals may bounce back (i.e., because the individual is no longer in the same job). The sample size we have chosen allows for this.

However, if, when selecting your random sample, you happen to choose an individual whom you **know** has moved post, and if you **know** what their new email address is, please feel free to substitute their new address for their old one. (We do not expect there will be many people for whom you would be able to do this.) If you **know** that the individual has moved post, but you **don't** know what their new address is, please feel free to substitute someone else from your list of participants for your random sample.

We also know that many NHS addresses have changed in the past 2-3 years to nhs.net addresses. Therefore, there is a possibility that email sent to an old-style NHS address will bounce back — or that it **won't** bounce back, but it won't be delivered and you won't be notified about this. On the other hand, some old-style NHS addresses may still be forwarding mail to the new address. Some old-style addresses may also generate out-of-office replies which will give you the addressee's new address.

It is very important for this survey that we include NHS training participants. Therefore, if it is at all possible, when you are selecting your sample, if you **know** that a particular individual has a new nhs.net email address (and if you know what the individual's new address is), please could you substitute the **new** address, rather than sending email to the person's old address.

We realise this is asking a lot of you, but we would be very grateful for your help and patience with this task!

Dawn Griesbach (01764 650378, d.griesbach@griesbach-research.co.uk)

Appendix 5: Short case study reports

A5.1 North Lanarkshire

In North Lanarkshire, training has been a significant focus of the Choose Life strategy because it was seen as the way to attain sustainability.

The multi-agency Choose Life Implementation Group decides which courses should be available. The Choose Life Co-ordinator has played a leading role in promoting and supporting the delivery of training, and is a trainer in ASIST, safeTALK and Tune UP. Altogether in North Lanarkshire, there are 8 ASIST trainers, of whom 4 deliver both ASIST and SafeTALK and one trainer who delivers safeTALK only. Another two people have done the safeTALK T4T. Suicide TALK is also available. The HEAT 5 target has been instrumental in the uptake of training in the NHS. There are eight NHS STORM trainers but ASIST and safeTALK are also delivered to NHS staff.

Implementation

Interviewees felt that the roll-out of training was effective, well-planned and organised, reaching out to both professionals and the public. Training is open to all Council staff because staff engage in different ways with a range of people: for example, support staff were trained because they work in reception points.

ASIST and safeTALK have been delivered to mixed groups of participants to promote mutual understanding and sharing of experiences. Participants include Social Work, NHS, Housing, Home Care, residential care, Education, young adults, police, fire services, voluntary agencies dealing with mental health problems and the private sector (construction, hairdressers and taxi drivers). In the NHS, ASIST is delivered mainly to professional staff groups and safeTALK to admin/support staff.

The training is run regularly and the courses are free. The Choose Life Co-ordinator has an administrator to help organise the courses. From 2007, the aim has been to run one ASIST and one safeTALK course each month and this has increased over time. Information is disseminated through the quarterly training schedule issued by Social Work Learning and Development. There is good advertising of courses including intranet and email. However, word of mouth and referrals from training departments of organisations are the main routes for attendance. Some people have a personal interest while others see it as a useful addition to their learning and development. Participation in safeTALK has also encouraged some people to go on and do ASIST.

safeTALK trained people mainly refer to 24 hour services e.g. NHS 24, Samaritans. If there is an ASIST trained person in the same organisation they may refer to them but this was not standard practice.

There was some evidence of targeting: for example, staff in care homes and integrated services units for older adults who are now recognised as a vulnerable group. Housing staff who work in Homeless Units have been targeted for awareness raising and training because there were suicides there among young people.

NHS Lanarkshire developed the use of STORM in the Practice Development Department in response to HEAT 5 and supported the training of a number of trainers. STORM was seen as ideal for staff working in clinical settings because of

the focus on risk assessment and risk management. It was thought to give staff a rationale and confidence in using their skills. For other staff whose role is to signpost or refer patients, safeTALK and ASIST were seen as more appropriate.

The number of people on a STORM course was originally 12 but that was reduced to eight. There was a high demand for STORM during the HEAT 5 period but there has been a recent drop-off in numbers. Another issue has been late call-offs because of mandatory training. There was some concern that, post HEAT 5, managers would prioritise other, mandatory training. In 2011, the number of STORM courses will reduce from 12 to 8. An emerging issue is the likely need for refresher courses. The number of trainers has dropped as people move on or develop other priorities e.g. clinicians. The aim is to keep a cohort to minimise the pressure on a small number of trainers. One pressure is lack of help with organising courses.

Differences between programmes

Among NHS staff, STORM was seen to go further than ASIST. They saw ASIST as being about keeping people 'safe' while STORM is about assessment and treatment. In addition, they felt that STORM gives people transferable skills, e.g. problem solving. It may be worth noting that in Lanarkshire they specifically cover attitudes to suicide within the STORM training. In Social Work, some staff have done STORM, but ASIST is still the main course.

Several interviewees commented on the value of safeTALK. It gives a good grounding / raises awareness. It is suitable for a wide range of staff who have some contact with clients / patients but not a direct role (unqualified ward staff, junior staff, reception and admin staff). It gives them confidence to talk to the person and explore their feelings, and to know how to refer them on. It is also shorter than ASIST and can be delivered to staff in-house. It is, therefore, easier to release staff to attend. On the other hand, it was recognised that ASIST provides greater depth and equips people to intervene so it was seen to be relevant for staff or community members who had more direct contact with vulnerable people.

One service manager said that, 'different programmes have a different slant so can be worth attending more than one'.

HEAT 5

Interviewees agreed that the roll-out of HEAT 5 training was very good and helped by free access to T4T and good partnership working between NHS and others. Decisions about targeting for H5 training were governed by Scottish Government criteria. NHS Lanarkshire negotiated with North and South Lanarkshire Councils for a minimum number of places on ASIST and safeTALK courses. Targets were set for ASIST, STORM and safeTALK. NHS Lanarkshire provided trainers free. Participants were mainly from the NHS and from Social Work. This was beneficial because of mutual learning about different roles, e.g. ambulance services. If there were gaps, voluntary agencies were sometimes invited.

The HEAT 5 target has been achieved overall (54%) but not for GPs or A&E staff. One senior NHS manager felt that the HEAT 5 strategy should have taken more account of the difficulties of GPs and A&E staff in getting the time for training. There were some initiatives: e.g. 5 / 6 GPs did a condensed STORM and Modules 1 and 2 were delivered to some A&E nurses.

Effectiveness and impact
Expectations were that training would contribute to a reduction in the number of suicides by changing attitudes and reducing stigma, and by increasing the confidence and skills of staff and people in the community. Suicides have decreased although numbers are small. Interviewees believed that training had improved attitudes and created wide acceptance of suicide prevention as a valid issue for discussion and action. Overall, training is seen to have played a major part in mainstreaming suicide prevention.

Impact on behaviour
The service managers interviewed all had vulnerable clients who were at risk of suicide. In their services a good/high proportion of staff have attended training and it is seen as very relevant to their jobs .

There was a general view that staff are now more comfortable with talking about suicide and there has been some feedback about interventions. One senior NHS manager felt that it was still early days and that there was scope for further progress as the training continued in tandem with the new Suicide Assessment and Treatment Pathway now being introduced across Lanarkshire (see below)

Interviewees were unable to comment on the number of people being identified as at risk of suicide but felt that there is a more open atmosphere for talking about it. The drug-related deaths group now look at whether different interventions might have helped to prevent suicide among individuals whose deaths were classified as intentional self-harm. They are also looking at triggers, e.g. family birthdays.

One view was that the impact of STORM training may be less because participants already had some knowledge. However, the training was seen as beneficial in increasing confidence and skills, and giving staff a structure to work with.

Managers in both the statutory and voluntary sectors agreed that the training had had an impact over time on staff attitudes and behaviour. This included

- a better understanding and greater confidence to ask the question about suicide intent and to carry out interventions or refer people on; e.g., Public Health nurses, police, social work. Staff were also using the skills with friends and family.
- changes in the approach of staff: e.g., Housing staff towards young people; the Psychiatric Liaison Team now follow up people who have spoken about suicide when drunk; A&E staff are reported to be more aware and more sympathetic.
- at Tune Up sessions, about one-third of people described using the training with good results. Others had used elements of the training.
- a review of documentation relating to the Mental Health Integrated Care Pathway showed that the question about suicide (previously often left blank) is now being completed because staff have the skills and confidence to ask and know what to do with the response. This is seen as a direct result of the training.
- staff are dealing better with older people who are at risk of suicide which has often not been recognised among this group in the past.

- at team meetings staff talk about their experiences in a way that shows it has become part of practice to identify the suicide risk and intervene. They are also prepared to follow up: for example phoning back to see if the person is all right.
- admin staff in hospitals know what to do when taking calls and are confident.

Several interviewees commented on the key role that training had played in raising awareness and changing attitudes among the public. They felt that the training had helped to create widespread acceptance within the community of suicide prevention messages in the train stations, the football club, on taxis.

Impact on organisational culture, policies and procedures
Suicide is now more discussed in organisations and there has been an impact on organisational culture and polices. There were anecdotal reports but managers also gave some examples:

- Suicide prevention training is now required training in a number of organisations: for example, ASIST and safeTALK are in the organisational training plan of Lanarkshire Association for Mental Health and part of induction training in SAMH.
- The training has had an impact on communication between agencies and professional disciplines. The STORM training in particular has led to standardisation: the use of common language and a mutual understanding of what is described as medium or high risk. Professionals are also now acknowledging the suicide assessments carried out by staff in other organisations (previously often not the case). Documentation has been changed by agencies to reflect that common language and understanding.
- Motherwell FC has adopted Choose Life with no adverse reaction from supporters.
- Managers also identified a 'generic impact'. The training has created a better qualified workforce who can identify suicide risk and know who to go to. This has also alleviated staff anxieties. Moreover, it was recognised that the HEAT 5 target had raised the profile / focus of the training in the NHS Board. There is an expectation that the impact of HEAT 5 will continue.

- In addition, there was seen to be a culture change in the NHS, e.g. among mental health nurses who now understand suicidal ideation better (distinguishing it from self-harm).

The most significant example of the impact on organisations in North Lanarkshire, and in Lanarkshire generally, is the development of the Suicide Assessment and Treatment Pathway developed for use by NHS, Social Work and voluntary agencies. There was a clear view from key interviewees that both STORM and ASIST have influenced the development of the pathway.

The pathway focuses on appropriate assessment, identifying risk, referral, planning, follow-up and communication. It acts as a prompt and a reassurance e.g. about intervention and where to go for help. It is very close to STORM: language, terminology, risk assessment but also draws on ASIST, e.g. the section on myths.

NHS Lanarkshire has incorporated the pathway within its 5 Mental Health Integrated Care pathways. It should help staff to be clearer about what they are expected to do after training i.e. ask about suicide risk. Evaluation of the pathway might help to show the numbers of people being identified as suicidal.

The pathway is being piloted in Wishaw and East Kilbride with accompanying online training. So far feedback has been positive. The pathway is also a vehicle to promote ASIST and STORM training. It is hoped that the pathway will help to attract GPs and A&E staff to do the training.

The pathway has been incorporated into a new triage form for mental health nurses who then give it to the duty doctor or crisis assessment person. They are now asking the question about suicide intent which previously they thought they could not do in the 7 minute period. This is agreed to be an outcome of the training, i.e. they know how important it is to ask the question.

Factors affecting impact: Levers / helpful factors
A number of factors that help or hinder the effectiveness and impact of training were identified.

Choose Life has a high profile. The local Choose Life co-ordinator is well-known among services. Choose Life has been embedded in many services and there has been support from senior managers and most agencies. There is also good leadership from the Choose Life Implementation Group which has set objectives and plans, and monitored performance.

The quality of the training is highly regarded. It is seen to be a good use of resources because it can be delivered to a very diverse workforce and there are learning benefits of multi-agency training. It is also free and available. Moreover, there is now a body of people who know about the training and its good reputation; and HEAT 5 gave a further impetus. Clinical staff / practitioners see the value in STORM because it supports decision-making in risk assessment and risk management. safeTALK is seen as a good 'platform' or entry point for suicide prevention training, It is shorter and can be delivered to groups of staff in their own setting.

The Co-ordinator supports the trainers and they meet as a group to share experiences.

There are helpful structures and partnerships: e.g. the joint Housing and Social Work Department; good links to NHS contacts on HEAT 5 who have helped to promote ASIST and safeTALK; and good partnership arrangements with mental health, disability and addictions.

Factors affecting impact: Barriers / problems
- Despite the high profile of Choose Life, some staff still do not see the relevance. There are also negative attitudes: towards ASIST from NHS professionals who thought they 'knew it all' (although often this is overcome as the training progresses); and sometimes from trainers towards NHS staff.
- There are issues with people leaving posts — both trainers and 'supporters'.

- Difficulties about getting staff released e.g. A&E, especially when it is not mandatory training even though it is highly regarded. There are also difficulties in getting participation from non-mental health staff who may think suicide is not their business.
- Concerns about how to maintain the skills now that HEAT 5 is gone.
- Difficulties with engaging with GPs and A&E staff who have other priorities. There are also other, competing training priorities for all staff.
- For some staff, e.g. home care support staff, there is a need to pay overtime to cover absences.
- There is often a lack of help for STORM trainers with admin / organisation of courses.

There are some barriers to carrying out interventions. This is happening less now but there have been examples of an ASIST trained person taking someone to a place of safety and being turned away because ASIST is not recognised as relevant training or qualification. There are still examples of people being given anti-depressants and sent home. Also some staff have difficulty finding time for doing interventions e.g. in A&E where there may be 40 patients waiting.

Future Plans in North Lanarkshire

The Council and NHS are both supportive and show a lot of enthusiasm and willingness to support Choose Life and the training. This is shown in the development of the Suicide Assessment and Treatment Pathway. The NHS is committed to continue all training in 2011. There is no indication at this point that resource constraints will affect training although this might come in future.

Service managers will continue to send staff to suicide prevention training because they want staff to have the skills. They were, however, concerned about the potential impact of financial cutbacks on the amount of training that can be delivered e.g. to 1500 Home Care staff. The felt that the issue is how to be smarter about delivering training, e.g. online training. Other issues raised by managers were:

- how to support staff when people disclose their problems
- the need to maintain training as staff continually change
- there should be ‘refresher’ courses
- competing, mandatory training requirements
- a need for more training for the public / community members, e.g. Women’s Guilds.

The majority of interviewees saw benefits from having a national programme and felt that it helped to maximise the impact of the training. They felt that a national programme gives ‘clout’ by linking to national policy and creates a joined up aspiration across sectors. It gives consistency across Scotland, e.g. when staff are transferred to other areas. In addition, it enables access to resources, T4T, national recording and monitoring, and quality assurance.

There were some suggestions for future action. Particular attention needs to be given to those who have not taken on board the message, e.g. GPs and A&E staff.

For these groups there is a need to look at different ways of addressing their training, e.g. ASIST / STORM should be part of undergraduate medical / nurse training. Other ideas were: to combine suicide and self-harm; consider a qualification for the training, perhaps linked to the Social Services Standards Council; support trainers to maintain their skills; do more Tune Up and develop a Tune UP for STORM as well; and put more effort into remote and rural communities.

A5.2 Renfrewshire

Implementation of training

According to data provided by the Renfrewshire Choose Life team, ASIST has been delivered in the area since 2005, safeTALK since 2008 and STORM since 2010. It is local policy not to charge for any suicide prevention training.

Prior to HEAT 5, there had been a strategic decision in Renfrewshire to offer ASIST and safeTALK training to individuals in community groups as well as to service providers. With the introduction of HEAT 5, the local Community Health Partnership made suicide prevention training mandatory among all NHS staff who come into contact with patients (so all community and ward-based staff), and there has been a greater focus on training front-line staff to meet the target. Nevertheless, there has continued to be multi-agency attendance on all ASIST courses, so that out of the 24 places available on the course, six have been reserved for social work staff, six for health staff, and the remainder were available to individuals working in the voluntary sector or in the community. To some extent, there has also been multi-agency participation in safeTALK, but at the same time, safeTALK has been used to train entire teams together — for example, an entire primary care team, an entire pharmacy service, etc.

It was reported that GPs have generally not attended training, but practice nurses have attended in large numbers.

Efforts have been made to target staff working in areas where there have been concerns in the past. So, for example, staff working in secure residential accommodation for young people have been targeted for training. And some of the staff in such services (e.g. Kibble) have also gone on to become ASIST trainers, in order that they can provide in-house training.

One interviewee made the point that 80% of Renfrewshire Council staff **live** in Renfrewshire, and therefore, there has been some discussion about how to target a wider range of Council staff (in addition to front-line mental health and social care workers), to help to create a suicide-aware community in the local area.

Availability of trainers

The Choose Life co-ordinators and trainers themselves felt that there were a sufficient number of trainers in Renfrewshire for each of the three courses. In summer 2010, three individuals in Renfrewshire trained as STORM trainers.

It was reported (by trainers) that there is good local support for trainers. In Renfrewshire, there are periodic meetings of local trainers where ongoing issues can be discussed and where trainers are given updates of relevant developments. There appeared to be no particular problems in getting trainers released to deliver training. In 2010, a formal training plan (for delivery of ASIST and safeTALK) was created, and trainers signed up for all the available slots to deliver the courses. However, there was also a concern expressed by one interviewee that perhaps not all the trainers in Renfrewshire have been able to deliver their minimum requirement of three courses / year.

Courses delivered
In the one-year period between April 2009 – March 2010, ASIST had been delivered 11 times to 182 participants and safeTALK had been delivered twice to 33 participants.[16] As of January 2011, STORM had only been delivered once, but it is expected that a programme of STORM training will in place later in 2011. It was reported that some health staff have preferred STORM over ASIST because 'STORM starts off at a level which they feel is more appropriate to their existing skills.'

Tune-up is not routinely delivered in Renfrewshire, although several interviewees commented that there would be benefits in doing so, and it was suggested by one interviewee that there may be plans to deliver it in the future.

Impact — participant behaviour
Interviewees were asked about the extent to which they themselves had experience of using the skills they had acquired in training, or whether they were aware their co-workers (or individuals in other teams) using their skills.

There were reports about the frequent use of ASIST skills among staff in the Community Mental Health Team (CMHT). These reports came not only from members of the team, but others outside the team as well. One interviewee from the CMHT reported that having used the ASIST model three times in a single day in the previous week. The individual felt that ASIST training 'had taken the stress out of [work]' because, it provided a positive and effective way to respond to people who are at risk of suicide.

Other specific examples of people using their skills recently were given by interviewees.

- One individual (an ASIST trainer) said he had been on the phone with a school nurse immediately prior to our interview. The nurse had phoned for advice because she had just carried out a suicide intervention with an individual and she wanted to refer the person on to an appropriate service for support.
- Managers reported that they noticed a greater awareness of suicide in their teams — both in terms of people's willingness to discuss it openly and to plan for it pro-actively. It was also reported that staff have greater confidence in managing and communicating with clients who are suicidal — and in working collaboratively with them to keep them safe.
- One trainer reported that he occasionally received calls from former training participants to say that they had just carried out an intervention, but that 'it wasn't working.' The trainer said that his standard response to this was: 'Is the person still alive? If so, then it's working!'

It was also acknowledged by interviewees that some training participants do not use their skills 'because they don't get the opportunity' to do so. And indeed, this was the case for two interviewees who worked in administrative / management roles, who

[16] safeTALK has been delivered monthly since March 2010, but for the purposes of this evaluation, data was only collected on the number of participants until March 2010.

had received safeTALK training, but who did not have direct contact with clients / patients at risk. There was a view that, particularly for people like these, regular Tune-up courses are important for keeping people's skills fresh.

Impact — organisational / community change
Interviewees cited a number of changes that had taken place within their own service (in terms of policies and practices), in the way their service worked with other services, and longer-term social / community changes – all of which they attributed to suicide prevention training. Examples included:

- One service manager reported that client documentation in his service had been changed to better reflect suicide risk and to enable better recording of how risk is managed. This same individual also stated that he had observed positive changes in the way staff documented their clients' needs in relation to suicide risk.
- It was reported that there was improved communication between agencies about suicide and suicide risk among shared clients.
- There had also been improved joint working between mental health services and the police in relation to drug-related deaths. This work involves an investigation of each drug-related death as and when it occurs (rather than waiting for the publication of annual statistics), and the information is used to inform better targeting of suicide prevention training.
- Recently, steps have been taken to develop suicide policies in schools. Schools had previously been reluctant to even consider this. However, there are now so many school staff trained in suicide prevention, there is less fear about the topic.
- One senior manager reported that there had been fewer suicides in in-patient wards in recent years. It was suggested that this is likely to be because of an increased awareness (and improved practice) of suicide intervention among staff.
- Local trainers have offered to act as resources to training participants — to be available at the end of a phone if people need advice or support in relation to their suicide interventions.

In relation to the latter point, this seemed to be an informal arrangement, and it is not clear whether it was available to safeTALK as well as ASIST participants. There were no formal arrangements in Renfrewshire for safeTALK-trained individuals to have ASIST-trained individuals in their team to whom they could refer people at risk. Moreover, one of the two safeTALK-trained individuals who was interviewed for this study said that she was not sure **who** she would refer someone on to if they needed help. On the other hand, it was reported by several other interviewees that all safeTALK participants are given (during training) a list of local community / service resources where people can be referred. However, the discussion with this one individual may suggest there is a need for reminders, or updated information on resources to be given periodically to all former training participants.

Levers and barriers to reach / impact
Interviewees were asked what factors had helped to promote the delivery or take up of training, and its use locally (i.e. the levers), and what were the barriers to people attending training and / or using their skills.

In terms of levers, interviewees suggested that it was helpful to have employed two individuals who share the Choose Life Co-ordinator role. These individuals organise all local training, and also contribute to the delivery of training at a local level.

Interviewees also felt that service managers and senior managers have been largely supportive of suicide prevention training, and have allowed trainers to be released for training. In addition, there has been good support from local voluntary sector agencies (particularly Renfrewshire Association for Mental Health), who have allowed their own trainers to be active members of the local training team and to deliver training for free.

It was reported that the in-patient mental health service (in the past few years) has adopted more of a therapeutic, recovery-oriented approach to working with patients. This allows staff to spend more time with patients – thus they have more time to explore people's suicidal feelings, but also to provide better support.

One interviewee commented that completed suicides often provide an impetus for people to pursue training. For example, prior to the suicides of two adolescent girls who jumped from the Erskine Bridge in October 2009, staff in the residential unit where the girls were staying had not previously been trained in suicide prevention. However, following this tragedy, they have all now been trained.

In terms of barriers, it was reported that some staff still attend training with 'entrenched attitudes' — i.e. people don't feel it's relevant to their job. Others make it clear that they are only there because they've been sent by their manager. In such situations, it can be difficult to get people to engage with the training, or they engage grudgingly which can affect the atmosphere on the course for other participants.

Getting staff released to attend training (particularly the two-day ASIST training) was cited as a barrier for some staff and it was reported that this is not likely to get easier in the future now that the HEAT 5 target has been met.

It was also noted by one interviewee that there can be some barriers to intervening with individuals who may be at risk of suicide (barriers to using the skills that participants acquire in training). For example, a lack of relationship (or lack of **good** relationship) may inhibit some individuals from asking someone if they are thinking of suicide. In addition, families can sometimes be protective of a family member with a mental health problem, and may be concerned, even if a professional mental health worker asks the individual if they are thinking of suicide because of a fear that this may plant the idea, or encourage suicidal behaviour.

Other issues raised

Concerns were expressed about the lack of willingness by GPs to attend training. One interviewee made the point that if people are feeling suicidal, they tend to go first to their GP. This interviewee said that she had heard reports from families affected by suicide that GPs are simply not responding appropriately to people at risk. 'That's a consistent message I hear from this group – people feel let down by GPs.'

It was acknowledged by some interviewees that much of the evidence of people intervening with clients / patients / others at risk of suicide was 'anecdotal' — i.e. it is not recorded anywhere. However, it was reported that there have been discussions about whether it might be possible to capture this information formally.

There were concerns voiced by several interviewees that once the pressure of meeting the HEAT 5 target is off, it may be more difficult to get staff released to attend suicide prevention training. A reduction in training would also have an impact on the ability of existing trainers to meet their requirement to deliver three courses per year. Another interviewee saw a need for the National Training Support Team to do more in relation to co-ordinating training. For example, this could involve matching trainers with other areas where there is a need for trainers.

One interviewee – an experienced trainer – noted that there can be a high attrition rate among new trainers because of the demands and stress associated with delivering the first few workshops. This individual also suggested that the way the ASIST T4T is taught can contribute to unrealistic expectations among new trainers: 'The T4T felt as if you were being brainwashed. Everything was so positive. No one ever said anything negative. But you don't get that from participants in the first few workshops.' Having persevered through the first few difficult training workshops, this individual is now an experienced and confident trainer. However, this trainer commented that without the excellent support received from the local trainers' network, this would not have happened (s/he would not have continued as a trainer).

Plans for the future

When asked about the future of suicide prevention training in Renfrewshire, interviewees stated that they would like to see a shift back to more of a community focus for training now that the HEAT 5 target had been met. Indeed, it was reported that this change in focus had been agreed in principle by the local Choose Life management group. One interviewee said: 'We'll always get people from statutory services needing to and wanting to attending training, but we are keen to redress the balance and raise awareness of suicide among community members.'

STORM will be targeted specifically to staff in in-patient services, but for in-patient staff, the intention is also to include aspects of the ASIST course which involve an exploration of attitudes and values.

It is likely that there will be more training on self-harm in 2011-12, and there is an aspiration to begin delivering Tune-up refresher courses. Moreover, it was suggested by one senior manager that the delivery of Tune-up could be augmented through the use of e-learning (i.e. to get Tune-up participants to work through some exercises themselves before attending the Tune-up course).

Interviewees generally agreed that it has been helpful to have a national co-ordinated suicide prevention training programme in Scotland, and all felt that this should continue. The perception was that having a national programme gave the courses greater weight and value to participants (i.e. 'It hasn't just been made up yesterday.') Other benefits were seen to be: the **consistency** and **quality** of the training delivery (that it is the same in every part of Scotland); the national co-ordination of T4Ts; and the organisation of annual trainers' events.

A5.3 West Lothian

The strategic priority for suicide prevention training in West Lothian was to build capacity to deliver training across the Community Health and Care Partnership. The Choose Life Management Group makes decisions about which courses to run. The Choose Life Co-ordinator is a trainer in ASIST, safeTALK and latterly, STORM. Altogether, there are three ASIST and safeTALK trainers, four ASIST trainers and four safeTALK trainers. Tune Up is also new being delivered. In the period Apr 07 – Mar 10, there were 16 ASIST courses, one STORM course and 32 safeTALK courses delivered to a total of 803 people.

Implementation

The focus of ASIST and safeTALK training has been on the community and a high volume of training has reached a wide range of people. There has been some targeting, such as housing staff working with vulnerable groups, areas of deprivation, and young people. There has been a lot of enthusiasm because of the good reputation of the training and positive 'word of mouth'. The training is free but there is a mechanism to recover cancellation costs.

STORM is delivered to NHS frontline staff and that has mainly been done centrally through NHS Lothian who deliver safeTALK and STORM.

The location of Choose Life, and the training, within Health Improvement is seen to be very relevant and appropriate, fitting with the wider aim of addressing inequalities and preventing ill health. Some of the Health Improvement team are trainers in ASIST or safeTALK (or both). This is in part because of the drop-off rate among other trainers. The training, particularly safeTALK, is delivered through core Health Improvement activities such as **Health Issues in the Community**. safeTALK is also delivered to organisations on request (i.e. single agency training).

There is now more understanding among senior Council staff of the determinants of health and a greater willingness to engage with service providers and community groups which has also created a greater level of support for Choose Life activities.

Service managers were generally positive about the way that the training had been rolled out widely across West Lothian. Managers said that they support staff attendance because ASIST and safeTALK are relevant to their work. Some voluntary sector managers regarded it as core or essential training.

There is no referral link between safeTALK trained people and ASIST trained people. safeTALK participants are told that the resources are 999, Samaritans, A&E which is linked to the licence agreement. There was also a concern about the burden on ASIST trained people.

Differences between programmes

The main distinction made between programmes was that STORM was seen to be more appropriate for clinical staff whose role was risk assessment and that safeTALK and ASIST were more relevant for those who had little or no experience of dealing with people at risk of suicide. A further distinction was that safeTALK was a first stage / introduction and / or adequate for unqualified staff (who are often the first point of contact for patients / clients) while ASIST gives more depth and more skills, e.g. for substance misuse staff, Emergency Accommodation team staff.

These distinctions informed choices by managers and team leaders about which courses to send staff on. For example, one NHS manager said that Band 5 senior nurses were targeted for ASIST under HEAT 5 while nursing assistants and supplementary staff did safeTALK. In this context some interviewees noted the value of having a suite of programmes to meet a range of needs. However, among some interviewees there seemed to be a lack of clarity about which course is appropriate – when and for whom. There was a desire to understand better how to guide people, including service users, to the right course for them.

There was a view that the training was a progression and this was seen as a positive option. However, there also seemed to be some confusion in relation to STORM, i.e. that doing ASIST first was a requirement.

HEAT 5

NHS Lothian delivered the HEAT 5 training centrally for the majority of staff. There was some disappointment that the NHS had not engaged with the West Lothian training model, although efforts were made by the Choose Life Management Group to encourage that collaboration, particularly for NHS staff who work in communities. It was felt that training in mixed groups would have been an advantage.

A number of interviewees, including trainers, reported that NHS staff were often reluctant to attend even with the impetus of HEAT 5. This applied particularly to GPs, midwives and A&E staff. Among the reasons given were: some NHS staff feeling that suicide is not relevant to them; being **sent** on the course (a 'tick-box exercise'); and thinking that they already had sufficient knowledge and skills. Usually, however, the resistance dissipated as the course progressed

One NHS Mental Health senior manager with a large staff complement, however, noted enthusiasm among staff to do the training.

Impact — participant behaviour

All the service managers interviewed had vulnerable patients/clients potentially at risk of suicide: people with mental health problems, addictions, homelessness and health issues, brain injuries, eating disorders and personality disorders. All the managers supported the training and a high proportion of staff (80-90%) had attended training, primarily ASIST and safeTALK but some had received STORM.

Expectations of the training had largely been met. The training was seen to be effective in reducing stigma and challenging myths around suicide; encouraging people to reflect on their attitudes and values; increasing confidence and capacity to engage, and changing practice. The training was also attributed with bringing suicide prevention up the agenda of senior managers; for example, the Policy Development Scrutiny Panels for Health and Care and for Social Policy regularly discuss it.

Service managers felt that their expectations of the training had been met in terms of increased skills in dealing with patients / clients who had suicidal ideation / risk. They identified some behaviour changes:

- Greater skill in identifying suicide risk in clients at an earlier stage. Unqualified NHS staff who have done safeTALK can now recognise and report on signs when they do observations

- More confidence and willingness to 'ask the question' and address the subject of suicide directly. Training has dispelled the idea that asking about suicide increases the chances of completion of suicide. This was seen as particularly important for unqualified / inexperienced staff.
- Using the guidelines and procedures they learned from training to deal with difficult situations without calling the manager for advice.
- Better knowledge about who to pass information on to, e.g. CPN, GP
- Trained workers instil more confidence in their clients
- An impact on the way the police treat people in cells and on how they approach bereaved relatives.
- More willingness among staff to talk to each other about their experiences in dealing with suicidal clients which means better peer support.
- Staff are better equipped to cope with suicide when it does occur because they had the tools and had done all they could.

One manager also commented was that it was possible to see the difference between staff who had attended training and those who had not.

Impact — organisational cultures, policies and procedures
It was generally agreed that the training had led to a number of changes in organisations over time.

There was a consensus that the training had been a big factor in a major increase in awareness of suicide accompanied by a change in attitudes / decrease in stigma. It was acknowledged, however, that Choose Life and its link to the health improvement agenda had also been influential. One manager gave as an example of change the increase in referrals to the Homelessness and Health service while another noted that there had been a change in attitudes about people's rights.

There was very little information about any increase in numbers of people identified as at risk of suicide. Among service managers there was a view that there was more identification and more asking the question, and more safe plans in place. Some interviewees noted examples of recording in incident reports, risk assessments, integrated care pathways and the outcome of multi-disciplinary meetings. However, recording of interventions is not commonly done.

Information about whether intervention has made a difference to the patient / client does not seem to be readily available although it was reported that in the advocacy services they get some feedback from service users that they have recovered from suicidal feelings. There were also reports of recovery stories and letters from clients and carers acknowledging the confidence of the worker in speaking to the client about suicide.

Some interviewees felt that there had been a change in culture which is now 'less fraught' in relation to suicide and that training had been an integral and important part of the culture shift. It has now become acceptable to talk about suicidal thoughts with patients / clients and to get help.

A protocol for identification of suicide risk is being introduced by the CHCP. The aim is to provide a guide / structured approach to help staff identify people at risk of suicide among their clients. It will also help to deal with the aftermath of a suicide. A number of interviewees commented positively on the influence of the training on this development and in its acceptance.

Levers to positive impact

- The training is local and it is free. (This point was particularly noted by the voluntary sector.)
- The training occurs regularly which makes it easier to manage tight staff schedules and there is good advance notification and publicity, particularly by email alerts.
- The shortness of safeTALK can be an advantage but having a choice of programmes is good for service users who might want to do the training.
- The perceived value of ASIST in increasing the knowledge and skills of staff whose role might involve direct intervention, e.g. MH social workers.
- The good practical tools given by the training, e.g. ASIST 'safe plans'.
- The value of Tune-Up.
- The St John's Hospital venue is accessible.
- Some services have ASIST trainers among their staff.
- Multi-agency training is highly regarded and valued for increasing mutual understanding.
- Very positive 'word of mouth'. There is positive feedback from staff who consider the training to be helpful both professionally and personally — 'it has sharpened practice'. Both staff and managers are keen that staff should participate as a result.
- Training is seen as a good use of resources (cost-effective).
- Council Departments are interested and have taken up the training, e.g. Education, Children and Families teams, etc.
- The CHCP structure helps because it oversees mental health and social policy.
- There is support among Councillors.
- The new protocol (see above) should help to promote and encourage NHS staff to attend the training. The CHCP will roll out the protocol.

Barriers to wider impact / problems

- The attitude of some NHS staff including difficulties when trainers were not themselves from the NHS although that was often changed after attendance.
- The retention of trainers has been an issue. There is a support group for trainers — to share experiences, etc., but managers do not always release the staff to attend. Also, while the CHCP releases staff to deliver training, this is not always frequently enough and leads to more preparation time needed.

- Lack of venues, (especially for role play) and their cost. The hospital facilities are often used because the Choose Life co-ordinator is employed by the NHS and has access. Catering is no longer provided because of cost.
- There has been a drop in participation, particularly in safeTALK, recently which is attributed to constraints on staffing levels.
- Constraints on staff time particularly in relation to 2 days for ASIST and STORM
- A concern that the training in NHS had gone to people who already had some training. To maximise the impact it needs to be more widespread.
- A concern that the police had not been sufficiently involved in the training as they tend to be the first port of call for suicide risk.

A significant issue raised (by the trainers) was the 'frequent' non-acceptance of referrals / requests for help from ASIST trained staff for help for their clients, e.g. from A&E. There were examples of taking people in a state of distress to see psychiatrists / MH nurses and being sent away after waiting for hours. This was felt to be linked to the relatively low level of participation in training by A&E staff. On the other hand, one trainer did note good experiences with psychiatrists / hospital staff.

Future plans

There are now concerns about the future because of the financial cutbacks and staff reductions. However, West Lothian plans to continue to roll out the training as part of Health Improvement training and plans are in place for next year. The aim now is to incorporate the training into the West Lothian Life Stages approach which tailors work with key segments of the population to their specific needs and maximises partnership work with each group.

Retaining the trainers is very important but the aim is to get the Health Improvement staff to work more generically to allow for trainers leaving. West Lothian is determined to retain the community focus of training.

It is considered likely that STORM will still be delivered but potentially with fewer courses.

There are two mechanisms being put in place which will help to maximise the effectiveness and impact of the training:

- An analysis of which services have received the training followed by action research on how the training has been used, how useful it has been, how it has been incorporated it into their work, has it saved lives, is there anything else Choose Life can do. If it can be demonstrated that the training has had an impact on one service, it should be possible to identify other similar services where the same impact could potentially be achieved.
- Secondly, a suicide prevention protocol (see above) is being developed. It is envisaged that it will encourage people to do the training.

Service managers will continue to send staff to suicide prevention training because of the nature of their client groups. They identified some issues:

- They want to retain local training and accessibility.
- They would like publicity about Tune Up.
- Training should be spread to other areas, e.g. A&E, ward staff. Otherwise there will be no common understanding which will reduce the impact of the training.
- The training should be Incorporated into core training and not just for mental health.
- There is uncertainty about what happens after HEAT 5.
- The new HEAT target on the time between referral and treatment (3 weeks) could be a barrier to releasing staff for training.
- The (part-time) Co-ordinator post is to be reduced as part of staff cuts and dedicated admin support for the organisation of training will no longer be available (although a shared admin resource will be available).

All identified the value of multi-agency training but there were concerns that staff reductions would affect release of staff. Training of staff in their own locations might be more practical / manageable but that might also lead to fewer ASIST courses.

The biggest concern was the effects of the recession (a) cuts in staffing levels affecting services and reducing participation in training and (b) an increase in people losing jobs and benefits cuts leading to more suicide risk. A number of interviewees felt that in the current economic climate the training is needed more than ever.

There was wide support for the national programme and a national team to keep up the momentum and profile of the training. It was felt that having a national programme contributes to the effectiveness and impact of the training because suicide occurs across the whole population. Otherwise the effort would be fragmented. In addition, the national programme has enabled local activity – 'would not have got far without that'.

The benefits identified included:

- The 'power' of the national programme / importance of Government recognition and backing for an 'uncomfortable' issue.
- The consistency it offers (thereby reducing confusion): same message, same format, standards, everyone using the same / common language. This was seen to be important for cross-border transfers of patients / clients.
- A team at the centre to ensure quality and help with practicalities, e.g. materials, T4T, and updating.
- It promotes networking and sharing of good practice.

A5.4 University of the West of Scotland

The University of the West of Scotland (UWS) was chosen as an **organisational** case study because, at the time of this study, it was the only organisation which took part in the survey of training organisations that reported delivering ASIST, safeTALK **and** STORM — the three courses that were the subject of the evaluation.

Individuals who took part in the case study included lecturers (all of whom delivered all three courses), and members of University staff (library staff) who had previously participated in ASIST training. No UWS students were interviewed as part of this case study.[17]

Implementation of training

According to data provided by UWS, ASIST has been delivered at the university since 2005 (initially at Bell College in Dumfries before the Dumfries campus became part of UWS). SafeTALK has been delivered since 2007 and STORM began to be implemented in 2010. University lecturers in Mental Health Nursing at the four UWS campuses (in Dumfries, Ayr, Paisley and Hamilton) have been trained to deliver all three courses.

Suicide prevention training has been fully integrated into the curriculum for undergraduate nursing students at UWS. All undergraduate nursing students receive the half-day safeTALK course in their first year. ASIST is then delivered to all mental health nursing students as a two-day course in their second year, and STORM (all four modules) is delivered to all mental health nursing students, again, as a two-day course, in their third year, four months before they leave the programme. (ASIST and STORM are not delivered to second- and third-year students in the general adult nursing programme – only those in mental health nursing.)

In relation to the STORM course, it was reported that the 'theory' aspect of the course was delivered to groups of 30 students together, but the 'practice' (role-play, filming and feedback) part of the course, students were split into smaller groups of 12. In relation to safeTALK, the point was made that some first year nursing classes contain as many as 100 students. Therefore, to help make the course more interactive, classes are split up into smaller groups of 30 students each.

In Dumfries, there have also been a small number of staff from other parts of the university (library and IT services) who have been trained in ASIST. The decision to invite these individuals to take part in the training was strategic in the sense that these staff have contact with large numbers of students, and could potentially identify those who needed support. In the case of the library staff who were interviewed as part of this case study, the individuals were already qualified in First Aid at Work, and in their view, it seemed natural that they should also be trained in suicide first aid. These university staff attended the ASIST course with the second-year mental health nursing students.

[17] The primary reason for this was that the focus of this evaluation was on the impact of training on participant behaviour change and on wider organisational / community change (i.e. Kirkpatrick levels 3 and 4). The vast majority of undergraduate students would have had little if any experience of using their suicide prevention skills, and therefore, they would only be able to comment on their reaction to the training, and the extent to which the training had increased their knowledge and skills (i.e. Kirkpatrick levels 1 and 2).

In general, however, suicide prevention training is not currently delivered to other university staff at UWS. The issue had been discussed, and interviewees commented that there would likely be great interest among university staff in taking part in such training. However, at the present time, there was not sufficient capacity among the UWS lecturers to be able to deliver additional courses on top of what they were currently delivering.

Apart from their role in delivering safeTALK, ASIST and STORM to UWS students, UWS trainers in Dumfries and in Hamilton are also involved in helping non-UWS trainers to deliver training in certain non-university organisations. (See below.)

Availability of trainers
UWS has 20 lecturers across the four UWS campuses trained to deliver safeTALK, ASIST and STORM.

In addition, in Dumfries and in Hamilton, reciprocal arrangements have been made with NHS Dumfries and Galloway, and with Turning Point Scotland (in Dumfries and Hamilton) so that trainers employed by these other organisations co-train with the UWS trainers in exchange for the UWS trainers helping to train staff from the organisations. The benefit of this arrangement is that it helps to ensure that all local trainers have the opportunity to deliver three courses per year to maintain their registration as trainers.

As mentioned above, however, there is not sufficient capacity among the existing trainers to deliver training to UWS staff more widely.

Number of nurses trained
In the period April 2007 – March 2010, UWS trainers had delivered safeTALK to 1,140 undergraduate nursing students in their first year (380 / year) and ASIST to 570 mental health nursing students in their second year (190 / year).

As mentioned above, STORM began to be implemented at UWS in 2010, and in that year, UWS lecturers at the Dumfries campus delivered STORM training to 109 mental health staff from NHS Dumfries & Galloway. STORM did not begin to be rolled out to students across the four campuses until March 2011. Therefore, at the time of this evaluation, there were no figures yet available about the number of students who had been trained.

Impact — behaviour change
When asked about his / her expectations of the suicide prevention training at UWS, one interviewee focused on behaviour change: that every student nurse who came through the course should be aware of when thoughts of suicide may be an issue for someone. In addition, the student should be able to **ask** about suicidal feelings, and they should be able to **respond** appropriately to the answer they receive. This interviewee was confident that the suicide prevention courses **had** prepared UWS nursing students to do this.

At the same time, the point was also made that the courses not only teach suicide intervention skills, but they also teach ‘transferable skills’ such as communication, relationship and interviewing skills and problem-solving, which are useful in all areas of a nurse’s work.

Another lecturer noted that, although there had not been a great deal of formal feedback about how students go on to use their skills in a work situation, there had been an immediate difference (after training) in students' awareness of and attitudes towards suicide in other areas of their course work. A third lecturer echoed this point, saying that students regularly put their suicide prevention skills into practice — sometimes weeks after training — as part of role modelling exercises on other topics later in the course. In such exercises, the students were willing to ask 'patients' about suicide, and were confident in doing so.

Moreover, it was reported that, at one of the UWS campuses, there was at least one example every year of a nursing student carrying out a full intervention on his / her own following training — either in a placement context, or with a family member or friend.

One lecturer reported carrying out a suicide intervention about once a month with a student. This is generally done in the context of checking how students are feeling in relation to placements and course-related stress. This same individual was also aware of other colleagues in the course using both STORM and ASIST approaches with students on their courses who were in distress. Another lecturer (at another campus) echoed these comments and said that every few courses, there are one or two students who will come forward to the trainers for support following delivery of safeTALK, ASIST or STORM.

Two lecturers raised an important issue in relation to the use of suicide prevention skills (in particular, the use of the ASIST model) among student nurses. One commented that at UWS, they had needed to adapt the message of ASIST slightly to the role of a student nurse: 'It's not about **you** as an individual working with someone to come up with a safe plan. As a student nurse, you are very much working as part of team…. Students are not able to take responsibility for somebody's care.' A second lecturer reiterated this point: 'In ASIST, you have a partnership between a caregiver and a person at risk. However, a student nurse, in a clinical environment, is not in a position to act as a caregiver for that person because of the issues of clinical risk. The individual would need to be cared for by a more senior member of the team.'

The library staff reported that they had not had an opportunity to use their ASIST skills since attending training. However, they felt that the training had been very beneficial for them personally and for the university. They felt they had learned how to recognise when someone might be at risk of suicide. One of the library staff had had an opportunity to speak to a student who was under a lot of pressure and to offer support and options for helping them cope with the pressure so that they did not get to the stage of feeling suicidal. This willingness to speak to the student about how they were feeling was attributed to the ASIST training.

Impact — organisational / community impact

Interviewees were asked whether, as far as they knew, the delivery of suicide prevention training had had any impact on UWS as an organisation, on other organisations, or on local communities.

Several interviewees made reference to new university procedures for responding to student mental health crisis. Two of the interviewees who took part in this evaluation

(one lecturer and one librarian) had been directly involved in developing these procedures, and thus were able to ensure that staff training in relation to the procedures included a discussion about the appropriate action to take in asking about suicide.

A third interviewee was part of the Healthy Working Lives reference group at UWS, (attending as the mental health representative), and as a result, activities and staff training in relation to health and wellbeing at work have included information that aims to raise people's awareness of suicide and ways of helping to prevent suicide.

Levers to positive impact
It was reported that senior management within UWS have been very supportive of the inclusion of safeTALK, ASIST and STORM to the university nursing curriculum. The courses was seen to contribute to the fulfilment of essential nursing skills training required by the (national) Nursing and Midwifery Council for adult and mental health nurses at each level of the undergraduate course.

One lecturer also commented that the suicide prevention trainers at one of the campuses had received excellent support from the local Choose Life co-ordinator, in terms of being invited to participate as an active member of the local trainers' network in their area. However, this individual suggested that support for university trainers at some of the other campuses was perhaps more variable.

Barriers to wider impact
As noted above, there is currently not sufficient capacity among the UWS mental health nursing lecturers to make suicide prevention training available to UWS staff more widely, although all interviewees thought that there would likely be interest among many UWS staff in attending safeTALK or ASIST.

No particular barriers were identified in relation to the delivery of training to nursing students, although one interviewee commented that some colleagues in the wider Nursing programme did not feel that ASIST was necessary for mental health nurses. There was a perception that ASIST took up too many hours in the curriculum, and that STORM training provided mental health nurses with everything they needed to know. The Mental Health Nursing lecturers have argued to keep ASIST in the curriculum because of the examination of attitudes and values which is included in the first day of the ASIST course. One lecturer commented that, 'The nursing students we work with have never considered their own attitudes before – nor have they considered that their own attitudes might have an impact on their response to people who are suicidal.' For this reason in particular, the ASIST course is seen as important and valuable.

Views on the national programme
When asked their views about the benefits (or otherwise) of having a nationally supported training programme, interviewees unanimously felt that having a standardised national programme was helpful. It gave the training greater credibility than it would otherwise have, and it allowed for quality assurance. It also enabled trainers from one organisation to support trainers from another – since all trainers have received the same training and are delivering the same course.

Interviewees also appreciated the opportunity to attend conferences and other events, although one individual felt that, as university lecturers, they needed much more notice of annual conferences and other events than they were currently receiving. At least six months notice was needed for the university trainers to be able to make arrangements to attend such meetings.

When asked whether they had any comments about how the Choose Life training programme could be improved, two different lecturers focused on the cultural aspects of the safeTALK and ASIST courses. Both felt that these courses could be improved if the materials were more localised – i.e. more Scottish and less Canadian.

Plans for the future

There are no plans to change the way suicide prevention training is delivered at UWS in the future. Overall, the UWS trainers felt that safeTALK, ASIST and STORM fit well with the current curriculum for general nursing students, and for mental health nursing students, and each course seemed appropriate for the students at the point at which they were delivered.

However, one interviewee commented that, it may evolve that UWS trainers are doing more training with their non-university training partners to ensure that they keep their registration.

Appendix 6: Distribution of training courses around Scotland

Table A6.1: Distribution of courses across Scotland, based on replies from 32 local authority areas

Local authority	ASIST	STORM	safeTALK	Refresher training	suicideTALK
Aberdeen City	√	√	√	√	
Aberdeenshire	√	√	√	√	
Angus	√		√		√
Argyll & Bute	√	√	√	√	√
Clackmannanshire	√		√	√	√
Dumfries & Galloway	√	√	√	√	√
Dundee City	√		√		√
East Ayrshire	√	√	√		
East Dunbartonshire	√		√	√	
East Lothian	√		√		√
East Renfrewshire	√		√		
Edinburgh City	√	√	√		
Falkirk	√		√	√	√
Fife	√	√	√		
Glasgow City	√		√		
Highland	√	√	√		√
Inverclyde	√		√	√	
Midlothian	√	√	√		√
Moray	√	√		√	
North Ayrshire	√	√	√		√
North Lanarkshire	√	√	√	√	
Orkney Islands	√		√		
Perth & Kinross	√		√		
Renfrewshire	√	√	√		
Scottish Borders	√	√	√		
Shetland Islands	√		√	√	
South Ayrshire	√	√	√		
South Lanarkshire	√	√	√		
Stirling	√		√	√	√
West Dunbartonshire	√	√	√	√	√
Western Isles	√	√	√		
West Lothian	√	√	√	√	
Total number	**32**	**19**	**31**	**14**	**12**

Table A6.2: Distribution of courses across 17 training organisations that took part in the evaluation

Organisation	ASIST	STORM	safeTALK	Refresher training	suicideTALK
Blue Triangle Housing Association	√		√	√	√
Carr-Gomm Scotland	√				√
COPE	√		√		√
Edinburgh Napier University	√		√		
Glasgow Caledonian Univ	√				
Glasgow Simon Community	√		√		√
Glasgow Addiction Services	√				
LifeLink	√		√		
Loretto Housing Association / Loretto Care	√				
Ministry of Defence	√		√		
ParentLine Scotland Children 1st	√		√		
Penumbra	√				
NHS Tayside	√		√		
Scottish Drugs Forum	√		√		√
Stirling University		√			
Turning Point Scotland	√				
University of the West of Scotland	√	√	√		
Total number	**16**	**2**	**10**	**1**	**5**

Appendix 7: Comparison of monitoring data collected in the evaluation to data held by Health Scotland

For this evaluation, 25 out of 32 local Choose Life co-ordinators and four out of 17 training organisations provided data on the number of courses delivered and the number of participants attending each course (ASIST, STORM and safeTALK) for three financial years, 07-08, 08-09 and 09-10.

NHS Health Scotland also held data (provided by trainers directly) on the number of ASIST and safeTALK courses delivered and the number of participants attending ASIST and safeTALK during these same three years. This data is regarded as complete and accurate as trainers provide Health Scotland with the dates of their courses when they order training materials. Following each course, trainers are required to submit forms on the number of people who attended, and if this information is not supplied, Health Scotland sends reminders to the trainers until they supply it.

Table A7.1 below provides a comparison of the data on ASIST and safeTALK held by Health Scotland and the data collected in the evaluation. It can be seen from these figures that there are differences between the two. In general, figures held by Health Scotland are higher than the figures collected by the evaluation. However, in the case of safeTALK (for 07-08 and 08-09), the figures collected by the evaluation are higher than those held by Health Scotland.

The percentage of difference between the two data sets shows that there is no consistent pattern in the differences. For example, data held by Health Scotland on the number of ASIST courses delivered in 07-08 is 71% higher than the evaluation figure, whereas for courses delivered in 08-09, the Health Scotland figures are only 41% higher.

Similarly, data held by Health Scotland on the number of ASIST participants in 07-08 is 75% higher than the evaluation figure, but in 08-09 the Health Scotland figure is only 9% higher.

In Table A7.2, we have calculated the average differences between the two data sets. This shows that, in terms of the number of courses delivered, figures held by Health Scotland for ASIST are 49% higher than the figures collected by the evaluation and for safeTALK, the Health Scotland figures are 36% higher than those collected by the evaluation.

In terms of the number of participants, figures held by Health Scotland for ASIST are 35% higher than those collected by the evaluation, and figures held by Health Scotland for safeTALK are 12% higher than those collected by the evaluation.

Table A7.1: Comparison of monitoring data collected by the evaluation and held by Health Scotland for ASIST and safeTALK, Apr 07 – Mar 10

		ASIST			safeTALK		
		07-08	08-09	09-10	07-08	08-09	09-10
Figures held by Health Scotland (Based on data provided by trainers)	Number of courses	216	218	241	42	153	246
	Number of participants	3,966	3,203	4,115	526	1,716	3,408
Evaluation figures (Based on data provided by 25 local authority areas and 4 training organisations)	Number of courses	126	155	172	27	123	176
	Number of participants	2,262	2,928	3,172	658	1,892	2,515
Difference	Number of courses	90	63	69	15	30	70
	Number of participants	1,704	275	943	-132	-176	893
Percent difference	Number of courses	71%	41%	40%	56%	24%	40%
	Number of participants	75%	9%	30%	-20%	-9%	36%

Note: NHS Health Scotland does not hold data on STORM delivery during this period.

Table A7.2: Comparison of data on total number of courses and total number participants in ASIST and safeTALK collected by the evaluation and held by Health Scotland, Apr 07 – Mar 10

	Total number of courses delivered			**Total number of participants**		
	Evaluation	Health Scotland	% difference	Evaluation	Health Scotland	% difference
ASIST	453	675	+49%	8,362	11,284	35%
safeTALK	326	442	+36%	5,065	5,650	12%
TOTAL	**779**	**1,117**	**+43%**	**13,427**	**16,934**	**26%**

Note: NHS Health Scotland does not hold data on STORM delivery during this period.