National Centre for Suicide Prevention Education & Training

# Suicide First Aid Evaluation Report Summary

This document highlights the findings of two separate reports carried out regarding the effectiveness and longevity of SFA: Suicide First Aid courses within the UK. Please note that due to the time that's passed since these reports, there may be differences in language used around the SFA courses etc.

**Report 1 Summary:**

*This report was carried out in 2017 with the aim of examining and evaluate the effectiveness of the 'Suicide First Aid' training course in the United Kindom. Separate evaluations of the effectiveness of the course for the years 2015-2016 and 2016-2017 have been conducted. This report combines pre-post evaluative data from two years in a sample of all 315 course attendees. The data combined two data sets of independent evaluations previously commissioned by SFA.*

**Report 2 Summary:**

*This UK council report commissioned a pilot of suicide prevention (including self-harm) training across their constituency. The training was to be a combination of both direct delivery to frontline staff and training of staff from partner organisations to subsequently act as trainers. The selected provider was the National Centre for Suicide Prevention Education and Training (NCSPET) to deliver their Suicide First Aid (SFA) training and their Associate Tutor Training Development Programme (ATTDP).*

*The pilot ran from November 2018 to March 2019 and this six-month evaluation report appraises the impact of the pilot study and captures experiences and learning opportunities to date. It covers the period December 2018 – September 2019. During this evaluation, Eight standardised SFA training sessions have been delivered by NCSPET to 133 participants.*

National Centre for Suicide Prevention Education & Training

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**Report 1 – Methodology**

Two-year data of Understanding Suicide Intervention (USI) courses delivered by SFA, which ran from August 2015 to June 2017, was collated, coded, analysed and reported upon. The training consisted of 6 hours of tutor facilitated Socratic learning, tutor-led role- play, mini lectures, group work and audio-visual presentations. The learning outcomes being to:

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| ● *Understand the causes, intentionality, reasons for and magnitude of suicide as a community health problem.* |
| ● *Understand the use of risk assessment tools in suicide prevention* |
| ● *Understand the impact of personal values and attitudes in suicide interventions.* |
| ● *Understand the population-based approach to suicide prevention.* |
| ● *Understand the relationship between informal and formal resources in suicide prevention; partnership working.* |
| ● *Understand the role of the carer in managing suicide interventions; different roles with different people.* |
| ● *Understand approaches and process of suicide intervention including desired safety outcomes.* |
| ● *Understand the importance of self-reflection and personal impact when working with suicide and people with thoughts of suicide.* |

This resulted in 315 participants being asked to complete a series of questionnaires pre training (T1) and immediately post training (T2). Participants were informed that their data would be independent evaluated at a later date to determine the effectiveness of the course and that no identifiable data would be analysed and reported upon. Questionnaire completion was voluntary and was blind to the Trainers.

Questionnaires asked participants about:

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| • Standard demographic information |
| • Attitudes towards suicide prevention using a 5-point Likert scale with fourteen statements - the Attitudes to Suicide Prevention Scale (ASP). The ASP was developed following a series of |

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| interviews which were conducted with 36 health professionals. Interview questions were based on the previous literature. Interviews produced 60 preliminary attitudes. Finally, 28 items remained and were arranged as a series of statements. Factor analysis was conducted for the 28 items. Thirteen items with <0.5 loadings and one that led to lower internal reliability were eliminated. |
| • Confidence helping a person who is suicidal using a Visual Analogue Scale confidence helping a person who is suicidal. Five questions asked participants how confident they felt helping a person who is suicidal. |
| • Satisfaction of the training using a 3-point Likert Scale. Seven questions asked participants about their overall impression of the training, and its perceived effect. |

**Report 1 – Results and Findings**

The data from 315 participants was analysed.

**Demographic Landscape**

**Participant's Age and Gender:**

The participants mean age was 38.64 ± 11.52 years. the majority of participants were female representing 79.4% of the group, with males representing 20.6%.

**Participants' Country of birth:**

The majority of participants were born in the U.K. (75.2%). 7.5% were from European countries (excluding the U.K.), while 6.2% were from Trinidad and Tobago and 3.9% were from African countries. 4.8% (n=7) were from African countries. 7.2% of participants' country of birth was classified as 'Other'.

**Participant's Ethnicity:**

The ethnicity of the cohort was diverse. 73.3% were white, 11.7% were Black African/Caribbean/British and 8.3% were Asian/ Asian British. 4% of participants reported being of mixed ethnicity, while 2.7% of participants' ethnicity was classified as 'other'.

**Participants' Employment:**

Participants were employed within a range of roles including the following: *Emergency Services/Armed Forces, Support Worker, Housing, Local Councils, Social Care, Education and Voluntary sectors.*

**Participants' Place of Work**

the majority of the cohort worked in urban locations (61.5%). A quarter (24.7%) worked in a mixture of geographical areas, including rural, semi-rural and urban locations. 8.6% of participants worked in a semi-rural location and 5.2% worked in a rural area.

**Participants' previous experience of suicide training**

Less than a third of the course attendees had received any previous suicide prevention training prior to the course. 30.1% of participants had received previous suicide prevention training from a range of courses including SafeTALK, ASIST, STORM, ACT and others.

## Attitudes to Suicide Prevention

### Attitudes to Suicide Prevention (ASP)

Items of the ASP scale were scored from 1 to 5, with 1 representing a more positive attitude to suicide prevention, and 5 representing a more negative attitude to suicide prevention apart from 2 items which are reverse coded, as per the established published procedure. All available paired data for all participants were analysed (see Table 1). Lower mean scores indicated a more positive attitude to suicide prevention. A lower mean score at T2 indicated a change in attitude from T1 as a direct result of the training. An overall positive attitude change as measured by the ASP sum attitudinal score was found and

was statistically significant. Of the 14 items, NINE showed statistically significant positive changes after training.

**Table 1: Attitudes to Suicide Prevention Scale (ASP Scale) - T1 to T2**

| Q | Item<br><br>Item Question | n | Mean (SD)<br>Pre training | Mean(SD)<br>Post training | Mean Change<br>(95% CI) | p |
|---|---|---|---|---|---|---|
| 1 | I resent being asked to do more about suicide | 304 | 1.51<br>(0.828) | 1.33<br>(0.658) | 0.184<br>(0.086 to 0.283) | <0.001 |
| 2 | Suicide Prevention is not my responsibility | 311 | 1.60<br>(0.824) | 1.37<br>(0.659) | 0.232<br>(0.142 to 0.3210 | <0.001 |
| 3 | Making more funds available to the appropriate health services would make no difference to the suicide rate | 311 | 1.87<br>(1.166) | 1.71<br>(1.239) | 0.158<br>(-0.016 to 0.331) | 0.074 |
| 4 | Working with suicidal patients is rewarding | 305 | 2.30<br>(0.855) | 2.07<br>(0.926) | 0.230<br>(0.114 to 0.345) | <0.001 |
| 5 | If people are serious about committing suicide they don't tell anyone | 308 | 2.54<br>(0.986) | 1.96<br>(0.930) | 0.581<br>(0.458 to 0.704) | <0.001 |
| 6 | I feel defensive when people offer advice about suicide prevention | 302 | 1.85<br>(0.838) | 1.64<br>(0.755) | 0.212<br>(0.109 to 0.314) | <0.001 |
| 7 | It is easy for people not involved in clinical practice to make judgments about suicide prevention | 301 | 3.33<br>(0.947) | 3.41<br>(1.108) | -0.073<br>(-0.219 to 0.073) | 0.325 |
| 8 | If a person survives a suicide attempt, then this was a ploy for attention | 305 | 1.69<br>(0.871) | 1.58<br>(0.863) | 0.116<br>(0.013 to 0.220) | 0.028 |
| 9 | People have the right to take their lives | 302 | 3.04<br>(1.075) | 3.12<br>(1.082) | -0.081<br>(-0.193 to 0.030) | 0.154 |
| 10 | Since unemployment and poverty are the main causes of suicide there is little that an individual can do to prevent it | 308 | 1.69<br>(0.789) | 1.43<br>(0.669) | 0.263<br>(0.164 to 0.362) | <0.001 |
| 11 | I don't feel comfortable assessing for suicide risk | 304 | 2.52<br>(1.037) | 1.85<br>(0.838) | 0.666<br>(0.530 to 0.802) | <0.001 |
| 12 | Suicide prevention measures are a drain on resources which would be more useful elsewhere | 308 | 1.40<br>(0.582) | 1.31<br>(0.965) | 0.088<br>(-0.021 to 0.197) | 0.115 |
| 13 | There is no way of knowing who is going to suicide | 300 | 2.88<br>(1.090) | 2.35<br>(1.196) | 0.535<br>(0.388 to 0.682) | <0.001 |
| 14 | What proportion of suicides do you consider preventable (None - All) | 290 | 2.36<br>(0.799) | 1.96<br>(0.590) | 0.393<br>(0.304 to 0.482) | <0.001 |
| **Total ASP Scale Score** (Sum of items 1 - 14) | | 240 | 30.54<br>(5.078) | 27.22<br>(4.872) | 3.315<br>(2.656 to 3.973) | <0.001 |
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## Confidence helping a person at risk of suicide

Confidence was measured using a confidence scale. Participants were asked to place a mark on a continuous scale from 'Not at all confident' (0) to 'Very confident' (100) for each statement.

Paired data was analysed for all participants. An increase in mean scores indicated an increase in levels of confidence. A higher mean score at T2 indicated a change in confidence from T1 as a direct result of the training.

Table 2 shows that confidence increased significantly immediately after the training, indicated in all 5 Items ($p<0.001$).

**Table 2: Overall Confidence Time Point 1 to Time Point 2**

| Q | Item<br><br>Confidence Questions | n | Mean (SD) Pre training | Mean (SD) Post training | Mean change (95% CI) | p |
|---|---|---|---|---|---|---|
| 1 | I am confident that I can help a person who is feeling suicidal | 296 | 50.35 (23.193) | 78.53 (13.660) | -28.172 (-30.560 to -25.785) | <0.001 |
| 2 | I am confident that I can recognise when a person is thinking of suicide | 295 | 45.06 (23.450) | 78.44 (14.040) | -33.376 (-36.004 to -30.749) | <0.001 |
| 3 | I am confident that I know when support is necessary | 293 | 51.70 (23.178) | 79.19 (13.963) | -27.498 (-30.031 to -24.966) | <0.001 |
| 4 | I am confident that I know what sort of support is necessary | 294 | 42.42 (23.606) | 77.88 (15.359) | -35.459 (-38.127 to -32.791) | <0.001 |
| 5 | I am confident that I know how to signpost/refer to the relevant support agencies | 295 | 51.80 (26.014) | 79.61 (14.990) | -27.807 (-30.634 to -24.980) | <0.001 |

## 4.4 Overall Satisfaction with the course

Items were scored from 1 to 3, with 1 being 'Not at all', 2 being 'Somewhat', and 3 being 'Definitely' satisfied. Overall (as seen in Table 3) participants were very satisfied with the training. Overall, 90.1% found it 'definitely' enjoyable. The methods were 'definitely' useful

92.2%) and the course was 'definitely' clear and well organised (93.1%). Participants found the techniques taught were 'definitely' useful/relevant in their work setting (88.4%). Participants also found the opportunity to discuss

suicide 'definitely' useful (92.5%) and the exercises were also 'definitely' useful (86.8%).

**Table 3: Overall satisfaction with the course**

| Q | Satisfaction Questions | n | Not at all n (%) | Somewhat n (%) | Definitely n (%) |
|---|---|---|---|---|---|
| 1 | Did you enjoy the course? | 293 | 0 (0) | 29 (9.9) | 264 (90.1) |
| 2 | Did you find the training methods a useful way of teaching suicide awareness? | 293 | 0 (0) | 23 (7.8) | 270 (92.2) |
| 3 | Did you find the techniques taught on the course useful/relevant in terms of your work setting? | 292 | 1 (0.3) | 33 (11.3) | 258 (88.4) |
| 4 | Did you find the course was covered in a clear and well organised way? | 289 | 0 (0) | 20 (6.9) | 269 (93.1) |
| 5 | Did you find having the opportunity to discuss the issue of suicide with others useful? | 292 | 1 (0.3) | 21 (7.2) | 270 (92.5) |
| 6 | Did you find the exercises useful? | 289 | 1 (0.3) | 37 (12.8) | 251 (86.8) |
| | | | **Too much detail n (%)** | **Not enough detail n (%)** | **About right n (%)** |
| 7 | Do you think that the content of the course could have been different? | 293 | 1 (0.3) | 14 (4.8) | 278 (94.9) |

## Report 1 - Summary

SFA: USI training as delivered by SFA resulted in statistically significant changes in 14 of 19 areas of discrete suicide attitudinal/confidence measurement in a large sample of 315 attendees over a 2 year period. With 85%+ of participants reporting high, definite satisfaction with such training.

## Report 2 – Methodology

This six-month evaluation report aims to:

- Evaluate the impact of the pilot study by consulting participants who benefited from NCSPT training (direct delivery)
- Capture experiences and learning opportunities
- Provide initial recommendations based upon these findings

The scope of this report does not include financials or ROI data. Due to constraints around GDPR it only includes data from participants directly trained by NCSPT. It therefore excludes data from any beneficiaries of the SFA training delivered indirectly by the tutors.

The pilot study worked with a small group of participants who were categorised into two groups: 1) participants that were directly trained in Suicide First Aid by NCSPT and 2) a group of ten who received more extensive training (Associate Tutor Training Development Programme) to become tutors and deliver the training indirectly.

All participants were asked if they would volunteer to be part of the pilot evaluation and data was only collected from those who volunteered.

A post impact questionnaire was designed and distributed in hardcopy at the training, and subsequently emailed out using Survey Monkey (an online survey development cloud-based software). The frequency was set at pre course, after day one and then one, three, six and twelve months post course. Due to the constraints of GDPR it was decided that for the purposes of this initial pilot the indirectly delivered SFA training would not be tracked. Monitoring data and demographic data was collated utilising the pre course questionnaires.

All trained participants were emailed and asked to complete NCSPT's online course feedback using CourseCheck. This was used to evaluate the quality of the training and whether it met needs and expectations.

To evaluate the approach and the process undertaken tutors were asked to complete a tutor specific survey, as were the delivery team (Commissioner and NCSPT).

**Sample size**

Eighty-eight participants were part of the pilot study and completed the pre and post assessment undertaken at the end of day 1 (Post Day 1). As would be expected, respondent numbers reduced at the subsequent post assessments (Post one, three and six months) to 33 participants, representing 37%.

**Demographics**

The average participant was a 44-year-old female who identified as white, with a minimum of eight years professional experience and no previous suicide awareness training. The following statistics have been lifted from the demographic data.

- The average age of participant was 44 ranging from 23 – 63 years of age.
- Only 10 men (11%) participated in the training.
- 73 (83%) out of the 88 participants identified as ethnically white. 17% (15) identified as not being white.
- Collectively there were 431 years of service within current roles and an outstanding 732 years worth of total service. This is due to the average age of participant being 44.
- The majority had a professional background and were frontline staff with some pre-existing awareness. Some clearly had direct suicide prevention experience. The breadth of professions ranged from social workers, primary and secondary care, HR professionals, housing support and local government.
- 24% (21) had received previous training but this was predominantly in-house training courses (such as Oxford Health NHS, Relate, Samaritans and Childline) or elements within education courses (primarily counselling training). A few had received external training delivered by Mind and Community Mental Health Teams. Very few (5) had received recognised suicide first aid interventions (two individuals had received Applied Suicide Intervention Skills Training (ASIST), two had attended SafeTALK and one had received ACT training.)

**Findings**

The following list records the achievements of the pilot to date:

- 133 people were trained
- 88 filled in the pre-course and post course questionnaire on Day 1

- 71 people completed post course feedback
- 34 opted to take part in the impact evaluation spanning 12 months
- 10 nominated individuals, representing different geographies across the county, completed the Associate Tutor Training Development Programme and went on to indirectly deliver SFA training
- 6 tutors participated in the process evaluation
- 38 have completed the City & Guilds Level 4 qualification attached to this training

**The following section looks at the collective responses to the questions / statements and any associated change in attitude. It is recognised that some of the responses and attitudes will reflect a bias towards suicide prevention due to all participants self-selecting to participate.**

**1. I resent being asked to do more about suicide?**

The overwhelming majority (94%) disagreed or strongly disagreed with this statement both before and after the training (Post Day 1). This response was maintained over the six-month assessment period at 96 % (75% strongly disagreeing and 21% disagreeing).

This indicates that the pilot study participants did not feel any resentment from being nominated, suggesting that the recruitment process was extremely effective.

**2. Suicide prevention is not my responsibility**

97% disagreed or strongly disagreed with this statement before training and Post Day 1. This was maintained at all of the subsequent post assessments with 96% still disagreeing or strongly disagreeing at the six-month assessment.

Over 95% of participants recognised that they had a level of responsibility to prevent suicides prior to undertaking the training and this belief was maintained for the subsequent six months. This indicates that frontline staff are very aware of the role they could have when supporting vulnerable clients.

**3. Making funds available to the appropriate health services would make no difference to the suicide rate**

The majority (84%) disagreed with this statement both before and Post Day 1. Ten per cent of participants were uncertain at pre assessment on how to respond to this statement. After the training the majority shifted to supporting the belief that giving funds to appropriate health services would reduce suicide

rates (69% strongly disagreeing with the statement). Interestingly the percentage strongly disagreeing dropped by 10% at the six-month post-assessment, but the majority still supported the notion that funding appropriate health services would make a difference to suicide rates.

**4. Working with suicidal people is rewarding**

This statement promoted a mixed response at pre assessment with the majority stating that they were uncertain (48%) and 49% either agreeing or strongly agreeing. Post training on Day 1 this shifted to only 16% remaining uncertain and 77% believing that working with suicidal people is rewarding. The number of people who were uncertain about this statement gradually increased post assessment, rising back up to 30%; however, at all of the subsequent post assessments no one disagreed or strongly disagreed with this statement. The increasing levels of uncertainty about the rewards for working with suicidal people post training could be based upon the natural stretch experienced when applying new learning or it could be related to levels of enthusiasm and optimism dropping after so many months post training.

This response suggests that the training successfully explored the preconceptions held about people who are suicidal due to participants shifting their opinions.

**5. If people are serious about suicide they don't tell anyone**

This statement initially created a lot of uncertainty (39%), which shifted to 89% disagreeing or strongly disagreeing with the statement Post Day 1 (34 % strongly disagreeing). This remained around 80% at all of the post assessments demonstrating an attitudinal change for 39% of the participants.

This question demonstrates the impact of the training and how it raised participants awareness around the behaviours associated with people who are experiencing suicidal thoughts.

**6. I feel defensive when people offer advice about suicide prevention**

Eighty-six per cent of participants did not feel defensive about being offered advice both pre and post assessment.

**7. It is easy for people not involved in clinical practice to make judgements about suicide prevention**

The majority (58%) agreed with this statement, however at pre assessment

33% were uncertain. Post training the number of participants who remained uncertain dropped to 18%. After six months the results remained very similar.

**8. If a person survives a suicide attempt, then this was a ploy for attention**
Although provocative language, this statement showed an attitudinal shift from 41% strongly disagreeing at pre assessment to 61% strongly disagreeing Post Day 1. At all subsequent post assessment questionnaires over 50% strongly disagreed with this statement.

**9. People have the right to take their own lives**

The responses to this statement are subjective but they demonstrate that the training had been thought provoking illustrated by the attitudinal change. Fifty per cent were uncertain about their opinion on whether people have a right to take their own life. After the training Post Day 1, 25% remained uncertain and 49% agreed that people had a right. These levels were further polarised at six-months when 68% agreed that people have the right to take their own lives with only 20% remained uncertain.

The training encouraged participants to re-evaluate their beliefs and challenge their own preconceptions.

**10. Since unemployment and poverty are the main causes of suicide there is little that an individual can do to prevent it**
Before training the majority (92%) disagreed with this statement (61% disagreed and 31% strongly disagreed) and Post Day 1 this was further strengthened as 63% strongly disagreed and 34% disagreed. During the subsequent post assessments over 90% continued to believe that an individual had the potential to prevent suicide.

These findings indicate that the participants strongly believe there is the potential for an individual to support someone with suicidal thoughts.

**11. I don’t feel comfortable assessing for suicide risk**

Sixty-four per cent of participants were uncertain or agreed with this statement. However, after training, 91% disagreed or strongly disagreed with this statement indicating that the training had improved their confidence. Only one individual out of the 88 did not feel comfortable assessing for suicide risk after the training and eight felt uncertain. None of the 88 participants recorded a backward shift in direction.

The training resulted in 79 out of 88 participants feeling comfortable assessing for suicidal risk and their confidence being sustained over a six-month period.

**12. Suicide prevention measures are a drain on resources which would be more useful elsewhere**

There was little change in attitude with the majority of attendees supporting resources being directed towards suicide prevention (63% strongly disagreeing to the statement pre assessment and 71% strongly disagreeing Post Day 1). This response is not surprising due to the participants self- selecting to attend the training.

**13. There is no way of knowing who is going to suicide**

Thirty-eight per cent of attendees were uncertain about how to respond to this statement at pre assessment. Post training there was a 30% increase in the number of people disagreeing or strongly disagreeing, indicating that their ability to recognise people at risk of suicide had increased. Interestingly there was an increase of 8% strongly agreeing with this statement Post Day 1 suggesting that the circumstances and signs related to suicidal thinking could potentially be made clearer for a certain percentage. However, this statement could be open to interpretation, for example it might imply that stereotyping is not relevant when assessing types at risk of suicide.

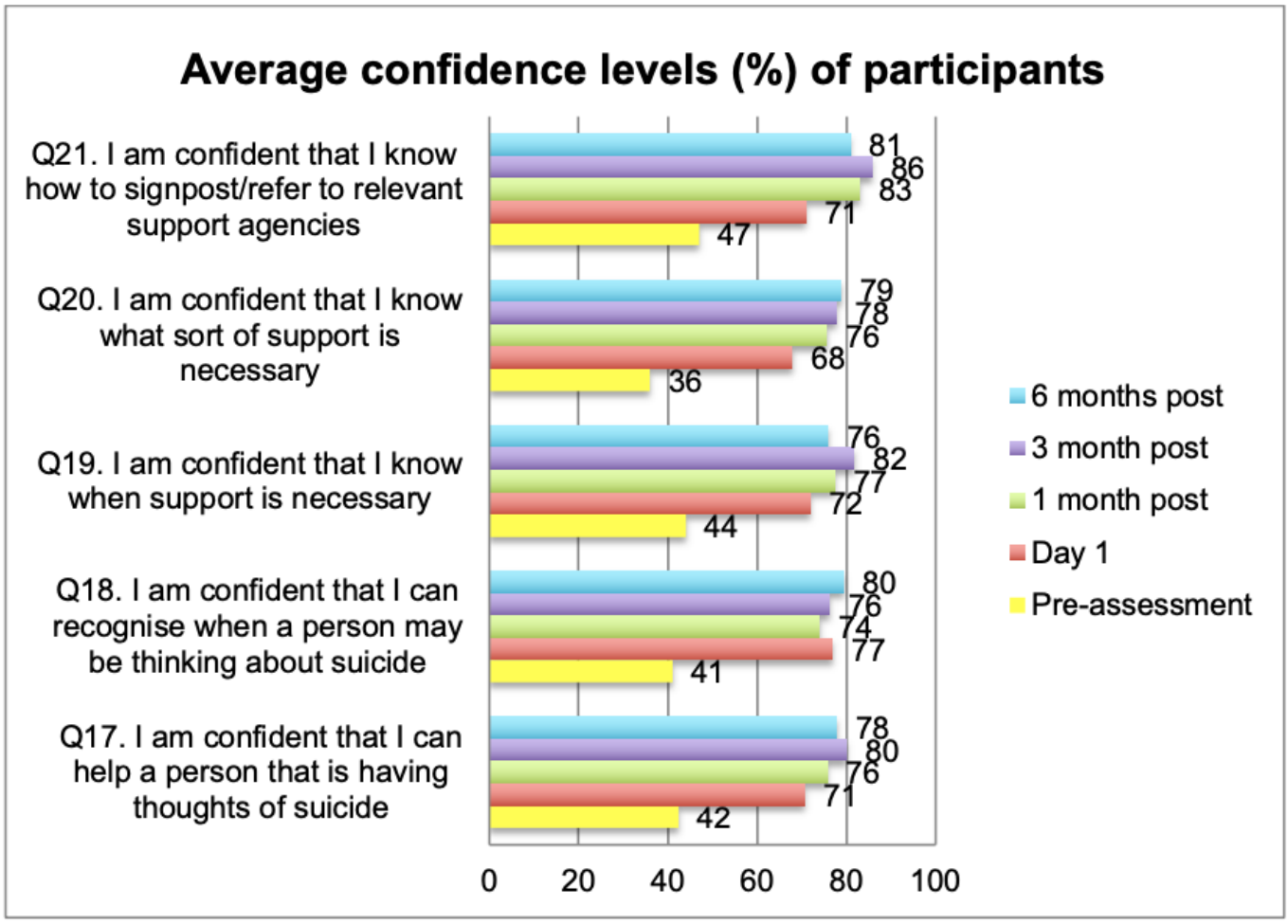
The training increased the majority of people's ability to identify and assess suicide.

**14. What proportion of suicides do you consider preventable?**

Sixty-seven per cent thought most or all suicides could be prevented at pre assessment, this rose to 92% Post Day 1. There was a 14% increase in participants that chose ALL suicides could be prevented Post Day 1 which rose to 30% above pre assessment at subsequent post assessments dropping back to a 14% increase at six-months. The distance travelled appears to be less for this particular statement, with the six-month results looking similar to pre assessment. This changing belief could be related to levels of enthusiasm and optimism dropping.

A recommendation could be to consider ways to re-engage at the six-month mark to maintain levels of enthusiasm.

**Confidence Levels of Participants:**




Participants were asked to self-assess their confidence levels in relation to risk assessing and supporting someone who is suicidal. The following statements were used to track confidence levels:

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| Q17. I am confident that I can help a person that is having thoughts of suicide<br>Q18. I am confident that I can recognise when a person may be thinking about suicide |
| Q19. I am confident that I know when support is necessary<br>Q20. I am confident that I know what sort of support is necessary<br>Q21. I am confident that I know how to signpost/refer to relevant support agencies |

The training resulted in an average of 30% improvement across all confidence statements. A range of 24 – 37% improvement was seen across all skills clearly

demonstrating the impact of the training. There were small but continued improvements at six-month post assessments for all of the confidence areas indicating that the content was memorable. Although fairly consistent, the areas where people felt most confident were in relation to recognising when a person may be thinking about suicide and knowing when support is necessary: the priority areas for Suicide First Aid.

Although the participants' confidence increased by a minimum of 24% immediately after the training it is worth briefly reviewing the areas which had the lowest percentage changes. Noting that these were very small percentage changes, taken from a small sample size.

At pre assessment the lowest confidence area was in relation to knowing what sort of support would be necessary. Although a 32% improvement was seen post training (Post Day 1) this was the lowest area of confidence (3% lower). However, it is important to note that the primary aim of SFA training is first aid, with referral agents (GPs, community mental health teams, caseworkers) with specialist training taking responsibility for providing a management plan. Interestingly this confidence increased the most in the subsequent months (11% increase upon Post Day 1). It is assumed this could be related to participants continuing to research local support provision after the training.

The confidence to signpost / refer to relevant support agencies was the highest at pre assessment and had the smallest percentage change of 24% immediately after training. This indicates that the participant's level of understanding prior to training was the highest but the training expanded their knowledge on average by a further 24%.

**Report 2 – Summary**

The pilot has achieved its objectives for the first year of delivery. After receiving the standardised SFA training 92% of participants believe that most or all suicides are preventable. Participants strongly believe that there is the potential for an individual to support people with suicidal thoughts and that 96% identified that they had an individual level of responsibility. There was an overwhelming belief (84%) at both pre and post training that investing in suicide prevention measures was not a drain on resources.

The training successfully explored preconceptions held about people who are suicidal and encouraged participants to re-evaluate their beliefs and challenge their own preconceptions. In several scenarios 24-34% of participants

transferred from being uncertain to holding a fixed opinion after receiving the training. After the training 77% stated that working with people who are suicidal is rewarding (an increase of 38% from pre assessment).

The training effectively raised the participants' awareness of suicidal behaviours, thereby increasing their ability to identify and assess the risks. Upon completion of the training 99% (79 out of 88) participants felt comfortable assessing for suicidal risk and this level of confidence was sustained six months after receiving the training.

An average of 30% improvement was recorded around levels of confidence for assessing and supporting people with suicidal thoughts. This clearly demonstrates the distance that participants travelled on the training. The confidences logged after training Post Day 1 hardly diminished at the six-month post assessment stage, indicating that the content was not only accessible but it was memorable.

Over 90% of the participants did not feel any resentment from being nominated or being part of the training indicating that the recruitment process was highly effective.