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Evaluation of Grassroots training programme to inform future provision and commissioning

Final Report, January 2017

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1. Executive Summary

1.1 Scope of the report

This is the final report of the evaluation of the two-year training programme commissioned by East Sussex County Council (ESCC) Public Health Department and provided by Grassroots Suicide Prevention (Grassroots). This project is part of a programme of work funded by ESCC to reduce the high rate of suicide in East Sussex, with particular focus on deaths at the cliffs surrounding Beachy Head. An evaluation of the Counselling Partnership Survivors of Suicide service was undertaken alongside the evaluation of this project, with some shared methods, and the findings of this evaluation are available in a separate report.

The evaluation was undertaken between September and January 2016, and assessed the following key areas: Grassroots approach to training; evidence for the effectiveness of the training courses; engagement with communities and organisations; training delivered; trainers' experiences; how the training impacted on participants; value for money.

1.2 Key findings

- Grassroots has met its primary target for this contract, providing training to prevent suicide and raise mental health awareness to over 250 frontline workers across sectors in East Sussex.
- The courses delivered are appropriate and well-respected, though claims for their effectiveness tend to be overstated in the course literature.
- It was ambitious to provide the suite of 2 suicide prevention and 2 mental health training courses, and greater emphasis was placed on suicide prevention in this contract.
- Participants have high levels of satisfaction with the training courses, and express increased levels of skills and confidence in talking and intervening with suicidal people.
- Some training course participants have evidenced putting their learning from the training courses into practice through making suicide interventions and talking directly to people who may be suicidal.
- The key elements of each course endure in the minds of participants; however, the evidence suggests that learning from courses is partial and needs refreshing or continually developing.
- Courses are delivered by skilled and passionate trainers. There were few opportunities for the trainers to meet and reflect on their training experiences
- Grassroots community education approach has the benefits of increasing community awareness of suicide and mental health, and especially of making inroads into reducing stigma.

- Some key groups of frontline staff are relatively hard to access and this may result in them being offered a lower level of training than their work requires (e.g SafeTALK rather than ASIST): staff with suicide prevention responsibilities that undertake SafeTALK (rather than ASIST) may require follow-up and further training to ensure they are appropriately skilled in suicide prevention.
- More flexibility in course delivery, perhaps including online learning, and a wider choice of training courses could improve access to training for some staff.
- To an extent there has been a lack of clarity by both commissioners and providers about which groups to prioritise, and for which level of training; reconceptualising how to identify staff training needs for those working with high risk groups is needed, leading to more focussed delivery of courses.
- The engagement and evaluation strategies need refinement to include more in-depth engagement with organisations, effective baseline measures including a needs assessment, independent evaluator input in design including at baseline, and methods that capture outcomes more comprehensively.
- The evaluation provides some evidence that training frontline staff is a justified priority within a local suicide prevention strategy. It is not possible within the scope of this evaluation to assess whether the training has directly contributed to reducing suicide attempts.

1.3 Recommendations

- Further training (by Grassroots or another provider) will be beneficial for continuing the task of increasing skills, knowledge and understanding of suicide prevention of frontline staff across sectors in East Sussex.
- The key values of aiming to reduce stigma, and building capacity across sectors, should inform future contracts.
- Future commissioned training programmes should continue to provide the same or similar training courses, prioritising as indicated by a needs assessment, alongside exploring the possibilities of more flexible course delivery, including online.
- Obtaining a balance between heterogeneous and single service/group courses should guide strategy for course delivery.
- Prioritising suicide prevention training, over mental health awareness, would make better use of limited resources.
- Greater engagement with organisations, including assessing their training needs, and the impact of training on skills and organisational culture relating to suicide prevention should form a key strategic aspect of future work.
- Providing opportunities for trainers to meet and reflect on their training

experiences should be built in to future contracts.

- Evaluation of future training should include baseline assessments of organisations' needs, strengths and training experience, and an integrated approach to assessing outcomes of training. This would be enhanced by engaging an independent evaluator from the beginning of the contract, as recommended by NICE.
- Though it is difficult and expensive to directly test the effectiveness of training courses in reducing suicide attempts, it would be worth approaching an appropriate research team to explore funding possibilities for undertaking an appropriate evaluation.

2. Aims and Objectives

This evaluation was commissioned by East Sussex County Council (ESCC) to assess the training they contracted Grassroots to provide. The overall objectives were to:

- assess whether the training courses were delivered in line with the aims and objectives, and to identify how these contributed to reducing suicide in East Sussex
- to provide recommendations for future commissioning and delivery

The evaluation aimed to explore and assess how the objectives in the ESCC contract with Grassroots were met and contributed to suicide prevention. The service specification identified the following:

The purpose of the service is to deliver training to a range of frontline staff including volunteers working in healthcare settings and within the community, to increase skills, knowledge and understanding in:

- suicide intervention
- mental health and mental health problems

The aim of the service is t**o** engage with a range of organisations which work most frequently with groups identified as being most at risk of suicide in East Sussex, and provide training courses that contribute to reducing the risk of suicide. Specific objectives are:

- By the end of December 2016 provide at least 250 (depending on the training courses that are provided) staff and volunteers with the skills to identify suicidal thoughts and mental health problems, and to respond positively to help someone to access more professional support and reduce any immediate risk to an individual.
- To provide those trained with the confidence to use their professional judgement in appropriate use of the skills learned.
- To provide those trained with the knowledge of where to obtain ongoing support and information with regards to the training content.
- To ensure those trained are aware of the local pathways and services in order to confidently refer individuals requiring additional support to the relevant service in East Sussex, or elsewhere.
- To ensure that training is appropriately adapted to meet the needs of different professionals and groups, including those working with young people, adults, and across services and sectors.

- To collect information to demonstrate effective application and targeting of training as part of robust monitoring and evaluation methods.
- To ensure those trained are aware of the groups of people most at risk of suicide.

3. Background and contexts

3.1 National context

Preventing suicide is a social and health policy priority worldwide; studies show that most suicides are preventable. The National Suicide Prevention Strategy (NSPS), *Preventing suicide in England: A cross-government outcomes strategy to save lives* (HMG/DH 2012) focuses on:

- reducing the risk of suicide in high-risk groups,
- improving mental health in specific groups;
- reducing access to the means of suicide;
- providing better information and support to those bereaved or affected by suicide.
- supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
- supporting research, data collection and monitoring

Risks for suicide vary according to **gender** (males are three times more likely to complete suicide and females are more likely to make attempts) and **age** (people aged 35-49 now have the highest suicide rate). People with **mental illness** are at elevated risks of suicide, and the **treatment and care** they receive after making a suicide attempt is an important factor in reducing repetition and completion. This recognises that a previous episode of self-harm significantly heightens the risks for ultimate completed suicide; a recent study showed that risks are 49 times greater after an episode of self-harm than for the general population (Hawton et al 2015). More than 30% of suicides take place in a public space (Owens et al 2009; PHE 2015).

Prediction of suicide depends on making holistic assessments of risk and need at the time of crisis, since risk assessments alone are inaccurate and inadequate; there are no scales that are reliable, an individual's intention changes over time, and the factors that precipitate suicidal behaviour are wide ranging (NICE 2011).

In 2012 the government published its current suicide prevention strategy, *Preventing suicide in England: A cross-government outcomes strategy to save lives,* which aims to achieve a reduction in the suicide rate in the general population in England, and better support for those bereaved or affected by suicide. One of the six key actions in support of these objectives has informed East Sussex County Council's Public

Health Department's commissioning of this project, namely:

Key Action 1 states that suicide awareness and education or training programmes teach people how to recognise and respond to the warning signs for suicide in themselves or in others. It recommends that:

- front-line staff working with high-risk groups receive training in the recognition, assessment and management of risk and fully understand their roles and responsibilities
- appropriate training on suicide and self-harm be available for staff working in schools and colleges, emergency departments, other emergency services, primary care, care environments and the criminal and youth justice systems.

3.2 Local Context

East Sussex has a significantly higher suicide rate than England; about 50 East Sussex residents die by suicide each year. In terms of suicides occurring in East Sussex (includes both residents and non-residents) there was on average 77 suicides per year in the period 2006 – 2013, a third of which (25) were for non-East Sussex residents. Beachy Head, a public place widely used for suicide attempts, was responsible for 32% of all deaths occurring in East Sussex during this period and 79% of the non-resident deaths (ESCC 2015).

In June 2013, the East Sussex Public Health team developed a proposal consisting of five interrelated strands of work in support of the suicide prevention agenda, focusing in particular on the reduction of suicides from Beachy Head. Much of this work was developed with the help of the Beachy Head Risk Management Group. Two of the main proposals that the group put forward were:

- Training in suicide prevention and mental health awareness for community organisations and primary care staff
- Services for those affected by suicide, or attempted suicide, and their families and carers

The structures for delivering suicide prevention work in East Sussex are the East Sussex Suicide Prevention Steering Group and the Beachy Head Risk Management Group. The East Sussex Suicide Prevention Group, a multi-agency partnership chaired by Public Health, is responsible for co-ordinating suicide prevention work across the county and developing an annual action plan. This evaluation of Grassroots training, and the parallel evaluation of the Counselling Partnership - Survivors of Suicide service to support those affected by suicide, or attempted suicide, and their families and carers, follows on from an earlier evaluation of the Place of Calm, a pilot non-statutory setting to address aftercare issues and reduce Section 136 cases (Briggs et al 2016).

3.3 Description of Grassroots Training Programme

Grassroots, based in Brighton since 2006, delivers training to prevent suicide and raise awareness of mental health, alongside campaigning to combat the stigma associated with suicide and mental health difficulties. Grassroots' approach is community focused, integrating training with community engagement; currently Grassroots is campaigning for Brighton to become a suicide safer city. ESCC Public Health commissioned suicide prevention training in East Sussex and awarded the contract to Grassroots. This led to Grassroots extending its reach into East Sussex, and thus building networks in the different, dispersed geography of a large county.

Grassroots take a community approach to suicide prevention. Their aim was to train more people in the community to feel confident in discussing suicide, and to learn suicide interventions skills in order to contribute to a reduction in suicide and suicide attempts in East Sussex. Training in developing mental health awareness aimed to help staff identify those most at risk of suicide through having mental health difficulties. For this contract, in accord with the service specification, Grassroots deployed four training courses, two focusing on suicide prevention, and two on mental health awareness:

ASIST (Applied Suicide Intervention Skills Training)
SafeTALK Suicide alertness for Everyone
Mental Health First Aid
One-in-Four: mental health awareness training

These courses are described in detail below (sections 4.1 and 4.2).

3.4 The Evaluation Approach and Methodology

The evaluation was undertaken between September 2016 and January 2017. The approach taken was to assess processes and outcomes, through robustly and sensitively capturing the available evidence, assessing and using this to reach informed findings and recommendations for future developments. This involved establishing cooperative working relationships with the key stakeholders in ESCC and the team in Grassroots, and to apply both qualitative and quantitative methodologies to collecting and analysing data.

Data was gathered from a range of sources to explore and assess the experiences of participants, organisations, trainers, staff, referrers and wider networks. The evaluation activities consisted of:

Analysis of written data: sources examined were:

- Annual and quarterly reports: Grassroots annual report of the first year of the initiative is a comprehensive document with detailed descriptions of the training activities, covering the first year of the project. Reports for each of the first 6 quarters document communications and networking, setting up, delivering and obtaining feedback on training courses.

- Web-based data: Background for and information about the training courses on websites – LivingWorks for ASIST and SafeTALK, and MHFA England.

- Study of secondary sources: Literature evaluating the effectiveness of the training courses drawn upon by Grassroots. There is an emerging literature relating to ASIST, fewer sources for safeTALK, and some literature available for MHFA.

- Evaluative feedback from participants: We analysed data from two online surveys conducted by Grassroots at the end of each training course and at 6 months after the training. Both on-line surveys provide answers to questions in the form yes/no and on a five-point scale ('very well' to 'not well') together with open questions inviting free text responses.

Interviews

- Interviews with Coordinators: We met the project coordinator at the start of the evaluation on 12/09/16 and followed this with meetings and discussions in Brighton on 03/10/16 and 31/10/16, supplemented by email and telephone conversations. Meetings explored the coordination, aims and objectives and management of the training courses.

- Interviews with trainers: We undertook in-depth interviews with four people who led these training courses. The interviews aimed to obtain detailed understanding of how the trainers experienced the role on each of the four kinds of training course, and the specific contexts of these trainings, including how participants from diverse backgrounds appeared to learn and make use of them.

- Interviews with people who undertook Grassroots training: we interviewed in-depth a small sample of 6 people who undertook the training. The interviews aimed to obtain detailed accounts of the experience of the training courses, to obtain feedback for all four courses, and their perspectives of how the training impacted on their capacities and confidence to work with people in a suicidal crisis. Interview schedules are appended.

3.5 Ethical issues

An application was made to the University Research Ethics Committee (UREC) and was approved on 17th August 2016 (UREC 1516 67). Ethical issues included obtaining informed consent, and a participant information sheet and written consent form were prepared (Appendix I); the importance of sensitivity to potential individual distress experienced by participants; maintaining confidentiality of all data, safe data storage, and risk-assessment. Research team members undertaking interviews explained the reasons for the study, what it would involve and explained the informed consent procedures, for which participants were invited to provide written agreement.

4. Findings

4.1 Grassroots approach to training and training delivered

Grassroots suicide prevention is a charity, founded in 2006, that aims to reduce suicide through training and campaigning. Grassroots has developed a significant standing in Brighton and Hove for the quality of its training, its campaigning to combat the stigma associated with suicide and mental health difficulties, and its contribution to national and local suicide prevention strategies. Grassroots approach is community focused, integrating training with community engagement aiming to raise awareness of suicide and reduce stigma. Currently Grassroots is campaigning for Brighton to become a suicide safer city. Community education is the overarching aim of Grassroots, and this links and integrates the kind of training it undertakes with the focus on creating a suicide safer and mental health tolerant society.

The training undertaken by Grassroots for this contract involved building networks in the different, dispersed geography of a large county. Engagement with services and communities to meet the objectives of the service specification is discussed below (4.3). Grassroots aimed to ensure coverage across the county and courses were delivered in different locations, including Hastings, Eastbourne and Uckfield. For this training contract, Grassroots offered to participants two courses in suicide prevention and two courses in mental health awareness. For suicide prevention, Grassroots training applied two training programmes developed by Living Works (https://www.livingworks.net):

ASIST (Applied Suicide Intervention Skills Training): This is LivingWorks' flagship course, described on Grassroots website as an intensive 2-day course for caregivers and key community members. It uses a workshop model to teach suicide alertness and an easy to remember framework of practical skills to safely initiate, complete and follow-up on a full suicide intervention. The trainers who deliver the course undertake a five-day training, ASIST Training for Trainers (T4T). Widely used internationally, ASIST has gained some evidence that evaluates its effectiveness

(see below, Section 4.). ASIST takes a sequential approach to teach a pathway towards safety; it is distinguished by its focus on achieving safety:

> "ASIST focuses not on the complexity of suicide and its causes, but on the simple concept and achievable goal of safety for now and how safety can be increased by collaboratively addressing the needs of the person-at-risk"[1].

This both provides a clear focus for training, and a limitation of its scope, since it does not aim to address causes, motivations and complexities of suicidal relatedness.

safeTALK: Suicide alertness for Everyone: A half-day LivingWorks course that introduces suicide alertness, suitable for everyone as workers and citizens needing to respond to suicidal people. The emphasis is placed on training participants to be able to provide an initial response to those who appear suicidal, through direct questioning and naming. The aim of safeTALK is to expand the reach of basic suicide intervention skills more widely into communities.

Grassroots also offered two courses that met the requirement in the service specification for raising mental health awareness:

MHFA: Mental Health First Aid: a two-day course that focuses on recognising the signs and symptoms of mental health issues, and how to provide help on a 'first aid' basis and effectively signpost towards support services. Promoted by Mental Health First Aid England (http://www.mhfaengland.org/), it aims to help people identify, understand and help a person who may be developing a mental health issue. MHFA was developed in Australia in 2000 and is now internationally recognised in 23 countries.

One in Four: Mental Health Awareness Training: A half-day, awareness workshop for anyone who needs to learn more about experiences of mental health. The title is based on the often-cited statistic that one in four people in the UK will encounter a mental health problem. The course aims:

- To improve understanding of various mental health conditions and issues.
- To decrease stigma and discrimination around mental health issues.
- To provide insight into the experience of living with mental illness.
- To build and reinforce positive attitudes towards people with experience of mental ill-health.

[1] ASIST, Evidence in support of the ASIST 11 program. https://www.livingworks.net/resources-and-support/research-and-evaluation/

4.2 Evidence of effectiveness for the training courses

There is an increasing literature reporting evidence for the effectiveness of ASIST. LivingWorks has produced a summary document of studies undertaken up to 2010[2]. Livingworks somewhat overplays the status of the evidence. One study, by Gould et al (2013)[3] found that Counsellors working on a telephone service trained in ASIST were more effective in reducing depression and suicidal intention in their callers. This study, the only one to date to evaluate ASIST using a randomised controlled trial design, measured changes in caller behaviour. The Scottish Government produced in 2008 a literature review and evaluation of ASIST, independent of LivingWorks[4]. Though undertaken some years ago now, this evaluation provides more nuanced findings than are reported by LivingWorks internal reports. Key findings were:

- Participants finding ASIST most useful came from local government and voluntary sector (rather than NHS) staff.
- Many people found the training methods positive but there were also some negative reactions, including dislike of the methods. Prior knowledge of the workshop methods helped participants engage with the methods.
- Skills and knowledge about intervening with someone who is suicidal increased considerably immediately after the training, but these fell off over time and updating was required.
- People who had worked with suicide before the course gained more benefits.
- There was an increase of 20% in people who intervened with a suicide situation after the training.
- ASIST had other positive impacts including reducing stigma.
- Implementation varied geographically: it was difficult to implement in some localities, including rural areas.

Overall, therefore, ASIST is becoming an evaluated training intervention for equipping people to respond to suicidal people; it appears to be more suitable for some groups than others, depending on local contexts and attitudes to the training method. It requires commitment to the 2–day training and the workshop model. The evidence shows that people trained to use ASIST feel more confident and able to intervene when faced with a suicidal situation; except for the study by Gould et al (2013), it does not assess the effectiveness of ASIST in reducing suicidal states of

[2] Rogers, P (2010) Review of the Applied Suicide Intervention Skills Training Program (ASIST) Rationale, Evaluation Results, and Directions for Future Research https://www.livingworks.net/resources-and-support/research-and-evaluation/

[3] Gould M. et al (2013) Impact of Applied Suicide Intervention Skills Training (ASIST) on National Suicide Prevention Lifeline Counselor Interventions and Suicidal Caller Outcomes, Suicide and Life Threatening Behaviour, 43, 6

[4] Griesbach D, Russell P, Dolev R & Lardner C (2008) *The use and impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: A literature review and evaluation*. Scottish Government. Available at: http://www.scotland.gov.uk/Publications/2008/05/21112543/0.

mind, nor are there comparisons with other interventions. There are no studies of its effects on suicide attempt rates. Such evidence requires employing randomised controlled trials, and most of the evaluative evidence is based on participant feedback. The training method used by ASIST is limited to being used with overt, immediate presentations of suicide, which are not linked with mental health conditions. Psychological therapies that are effective with these more complex presentations of suicidal behaviour have been reviewed by NICE (2011).

SafeTALK is less well evidenced than ASIST. A summary of the available evaluations is listed on the LivingWorks webpage (https://www.livingworks.net/resources-and-support/research-and-evaluation/). Five studies are reported, amongst these, an evaluation of safeTALK in the Niagara region[5], which concluded that most participants found the training useful, but there was no evidence linking safeTALK with reduced suicide and suicide attempts. A systematic review by Kutcher and colleagues[6] concerning youth suicide only identified a dearth of peer-reviewed studies for safeTALK. However, a small study of the pilot phase of safeTALK, the Scottish study,[7] provides two interesting outcomes: firstly, that the training is popular amongst participants, and secondly that safeTALK needs to be linked with other training; it "cannot be viewed in isolation and was designed to be part of a wider training framework" (page 6). As the primary aim of safeTALK is to raise awareness, so that people have the confidence to initiate a direct conversation about suicide, and to reduce stigma about suicide (rather than train people to intervene beyond an immediate, basic level) assessment of its effectiveness needs to be focussed realistically on these aims.

Mental Health First Aid has an extensive evaluative literature, summarised on the MHFA England website[8] in December 2016. Most evaluations were undertaken through participant self-assessment; these report an increase in confidence in relating to mental health problems. A few evaluations used surveys or questionnaires for participants of MHFA training; these found improved knowledge and attitude to mental health problems amongst participants. Thus evaluations have been conducted mainly through self-reported questionnaires feeding back on individual's experiences of the courses and at follow-up, using both quantitative and qualitative methods, for courses delivered in specific geographical locations or for services. No evaluations use more sophisticated methods, such as pre- and post- measures, or

[5] Evaluation of safeTALK Training in a Convenience Sample of 500 Niagara Region Residents Health Professionals and Volunteers, Niagrara Region http://niagarasuicideprevention.weebly.com/uploads/6/9/5/2/6952634/safetalk-report-2014-final2.pdf

[6] Kutcher S, Wei Y, Behzadi P. (2016) School- and Community-Based Youth Suicide Prevention Interventions: Hot Idea, Hot Air, or Sham? Can J Psychiatry. 2016 Jul 12. pii: 0706743716659245.

[7] McLean , J. et al (2007) Evaluation of the Scottish SafeTALK Pilot, Scottish Development Centre for Mental Health

[8] https://mhfaengland.org/evaluations-and-research/

controlled studies, or high quality qualitative studies. A summary of findings of all the evaluations shows that MHFA:

- increases both knowledge and confidence in how to support someone experiencing a mental health issue

- improves attitudes towards mental health issues, reducing stigma whilst normalising mental ill health to promote more empathetic approaches

- is used by between 68.5% - 88% of Mental Health First Aiders if they encounter someone experiencing mental ill health after attending a course, with many providing support to more than one person

- has a direct positive impact on delegates' own mental health and wellbeing, with many reporting an increased ability to manage their own stress

There is no current evaluative literature for One in Four

4.3 Engagement with communities and organisations

An essential part of the process of delivering training in East Sussex, and a key aspect of the contract, was the process of engagement with communities and organisations. The primary aim was to select which courses to run, where and for which staff and organisations; ensuring effective recruitment to courses needed to be underpinned by effective communication and engagement as well as advertisements.

Grassroots engagement strategy was based on networking, attending public engagement events and social media; the methods applied successfully in the urban setting of Brighton were applied in East Sussex. The strategy was focussed more on communities than organisations. The Grassroots CEO undertook extensive networking and engaging with the local communities in East Sussex to promote and describe the training offer in this contract, to generate community awareness of Grassroots aims and methods and to understand the local needs and resources,

Networking included participating in strategic meetings, including Mental Health Action Groups, The Mental Health Partnership Board and the East Sussex Suicide Prevention Strategy Group. Grassroots contributed to forums and promoted the contract, including Mental health and Policing in East Sussex - Emergency Mental Health (05/02/2015), the Eastbourne and Lewes & Wealden Health Improvement Networks (HIMP, 19/05/2015 & 21/05/2015), Eastbourne Carer/User/Education MH Conference: (18/03/2015).

Public Engagement Events where the training contract was publicised to individuals and mainly voluntary organisations including East Sussex World Mental Health Day in Eastbourne (10/10/2015), Out of the Blue, Suicide Awareness Race Event in Battle (04/05/2015), Wild Life Festival at Shoreham Airport (06/06/2015). Healthcare professionals were targeted at Quality Streets Ahead Surrey, Sussex & Kent NHS Conference (24/11/2015).

Newsletters and Publications various publications were used for engagement and for advertising courses including; SPARK Network e-newsletter, which listed courses; Grassroots e-newsletter, which listed courses and booking information; Funding Central promoted courses; Bexhill Observer Newspaper: 'Calls to tackle mental health stigma in East Sussex'; Public Health Bulletin for October 2015 to advertise courses.

Social Media Engagement was a dynamic feature of Grassroots communication and engagement, using three platforms, Twitter, Facebook and an email marketing platform, Mailchimp (*www.**mailchimp**.com)*; these were used to market courses through accessing organisations and businesses, and locations where training was being delivered. The reach of these was good. Grassroots collected and analysed analytics of the coverage of these media; Facebook reached 6867 users in the first year, with an engagement score of 81 (a combination of *Likes*, *Comments* and *shares*). Twitter, measured by 'impressions', reached 27,444 in the first year, with 408 engagements. Three training promotion emails were sent through Mailchimp, with, for example, 350 subscribers opening the 2nd email in September 2015.

An app - #StayAlive suicide prevention - offers help and support both to people with thoughts of suicide, and to people concerned about someone else. Its features include: access to national crisis support helplines; strategies for staying safe from suicide; how to help a person thinking about suicide; a mini-safety plan; a LifeBox to keep images reminding the user of their reasons to stay alive; suicide myth-busting. It had links to information about courses and course booking forms.

Twitter hashtags used included #EastSussex #suicide #suicideprevention #training #mentalhealth #Hastings #Eastbourne #Uckfield #Seaford #Lewes #Sussexhour. Twitter was also used for general course promotion and creating twitter lists for organisations and individuals. Twitter reached widely with 31,000 followers which included key individuals and organisations, including the Police, Jobcentre, Local Child Safeguarding Board and voluntary services, amongst others.

Social media communications were supported by emails and bookings through Eventbrite. The outcome was that Grassroots reached widely across the county, and communicated with individuals from a wide range of settings.

The impressive social media approach to engagement was accompanied by direct contact with organisations after training courses had taken place to assess further training needs and publicise and recruit to courses. Grassroots contacted over 70 of the organisations who received training during the first year of the East Sussex contract. They asked:

- How many staff and volunteers do you have at your organisation?
- How many would be interested in suicide prevention and mental health awareness training that haven't already taken the training?

Organisations were contacted by email, with a follow-up reminder phone call. Responses from 18 of the 70 organisations contacted showed that there was high interest in further training from 7 organisations, a mixture of larger and small organisations: Age Concern, YMCA Downslink Group, The British Red Cross, The Fellowship of St Nicholas, Mediation Plus, Sanctuary Supported Living, Sussex Oakleaf.

The outcomes of the engagement strategy were that, firstly, there was a rapid uptake for places on courses, and, secondly, an awareness of the breadth of the task, given the number of people and organisations that could be potentially engaged in training for suicide prevention. Grassroots worked within the service specification, including where some interpretation of key target groups was required.

Engagement focussed more on communities and less on organisations prior to training courses being delivered; the aim was that individuals would apply for courses having been alerted by networking and publicity. The approach characteristic of engagement through organisations was therefore not undertaken, including identifying organisations that were high priority for interventions. Baselines of skills and knowledge about suicide prevention interventions, and how these could be improved or enhanced by training, previous training and current provision, such as CPD in healthcare were not established. Rather than fitting a training strategy and programme around an assessment of current knowledge – and gaps – the approach provided opportunities for individuals to attend courses. Therefore, organisations or staff groups that showed resistance to attending training were not engaged and assessed. GPs for example are often reluctant to attend face-face courses such as these, and tend to prefer other modes of delivery including online. BMJ Learning, for example is popular with GPs and this contains modules on suicide and self-harm (http://learning.bmj.com/learning/home.html). An understanding of current levels of training and knowledge underpins training strategy. The evaluation methods Grassroots, together with the commissioners of the contract, established indicate a gap in the engagement strategy; though the evaluation plan was influenced by NICE

(2014) guidelines, it did not include an independent evaluator from the outset, and it did not provide a pathway to identify the impacts of training. The method of follow up after training was by anonymous responses to online survey, and so it was not possible to identify directly how training impacted on organisations. This is further discussed in section 4.6, below.

Training is generally more easily embedded in organisations through courses delivered to single groups of staff. For the training for the Police, within the contract, and the Fire Service, Beachy Head Chaplaincy, and other organisations outside the contract, there was direct contact with the organisation as a whole. For these courses, organisational training needs and aims were discussed (see 4.4). A combination of participant led and organisation led training appeared to fit the aims of the contract; and Grassroots staff are very aware of this. Getting the balance between these two approaches, and attending to gaps and emergent learning about individual and organisational needs are inevitably difficult to achieve.

4.4 Training delivered

Grassroots was commissioned to train up to 250 professionals with target numbers for specified sectors. These targets were reached within 18 months of the contract. Training course details are reported in Grassroots Year 1 Evaluation Report and quarterly reports for years 1 and 2[9]. Grassroots delivered courses in Eastbourne, Hastings, and Uckfield. There were 5 ASIST trainings, 6 safeTALK, 2 MHFA and 4 One-in-Four. Overall, 104 people completed ASIST courses, 108 completed safeTALK, 21 MHFA and 34 One-in-Four, as shown in Table 1, below. The total number of people trained within the contract was 267.

Table 1: Attendance and completion of Grassroots courses

Course	Location	Date	Attendance	Total completing
ASIST	Eastbourne	16/17 April 2015	24 booked 23 completed	104
ASIST	Uckfield	6/7 July 2015	29 booked 18 completed	
ASIST	Hastings	22/23 Oct 2015	26 booked 21 completed	
ASIST	Eastbourne	9/10	28 booked	

[9] Evaluation Report – Suicide Intervention and Mental Health Awareness, G*rassroots Suicide Prevention* & *Public Health at East Sussex County Council* Year One – December 1st 2014 – November 30th 2015, Grassroots training contract quarterly performance report, Year 2 Quarter 1, and Year 2 Quarter 2, March 1st- May31st 2016

		December 2015	24 completed	
ASIST	Hastings	22/23 Feb 2016	24 booked 18 completed	
SafeTALK	Eastbourne	6 May 2015	33 booked 28 completed	108
SafeTALK	Eastbourne	25 June 2015	20 booked 11 completed	
SafeTALK	Hastings	24 Sept 2015	31 booked 16 completed	
SafeTALK	Uckfield	17 Nov 2015	32 booked 26 completed	
SafeTALK	Eastbourne	1 Dec 2015	25 booked 19 completed	
SafeTALK	Hastings	26 Jan 2016	12 booked 8 completed	
MHFA	Eastbourne	15/22 May 2015	13 booked 9 completed	21
MHFA	Hastings	8/15 Oct 2015	14 booked 12 completed	
One in Four	Eastbourne	3 June 2015	21 booked 11 completed	34
One in Four	Uckfield	3 Dec 2015	20 booked 8 completed	
One in Four	Eastbourne	28 Jan 2016	16 booked 12 completed	
One in Four	Osborne Energy	8 Feb 2016	3 places in contract	
Total				267

The service specification identified target numbers of people to be trained from different sectors; the priority was to train frontline staff who work with suicidal people, or are likely to encounter them in the course of their work, or in the community. This aim generated broad target populations of potential training participants, which broadened further when the additional aim of raising mental health awareness was included. The target population was categorised as follows:

- Healthcare staff, including: General Practice staff; pharmacy staff; allied health professionals (i.e. physiotherapists and community nurses), alcohol services; those working with people with physically disabling or painful illnesses including chronic pain and with people with long term conditions; midwifes and those working in ante-natal and post-natal care

- Criminal Justice staff, including: East Sussex Probation Officers; Police Officers

- Social Care and Housing Staff

- Staff from the voluntary sector, including: Beachy Head Chaplaincy; Homeless services; carers, people with mental health problems, transgender people, LGBT people,

- Staff from the private sector, including but not exclusively: Veterinary Staff, Taxi Drivers, Job Centre, Farmer and agricultural worker representatives / organisations

- Staff working across sectors, including: staff that frequently work with young and middle aged men, local businesses, coastguards, those with limited intellectual functioning (including mild or borderline learning disabilities)

- Self-selecting participants

Based on figures quoted in their quarterly and first year Annual reports, Grassroots identify the numbers trained in each of the categories (see Table 2 below). This shows that training provided exceeded targets for social care and housing, and the voluntary sector; it was under target for the private sector and was on target for health care, criminal justice and (approximately) self-selecting individuals. Reported numbers here do not exactly match the numbers for course attendance in Table 1, (270 against 267).

Table 2: Training courses by sector target groups

Staff Group	Target number	Number trained
Health care	35	35
Criminal Justice	20	20
Social Care and Housing	35	68
Voluntary sector	35	63
Private sector	35	26
Working across sectors	30	25
Self-selecting	35	33
Total	225	270

These categories evidently embrace very wide ranging groups of people whose knowledge and experience of suicidal people is likely to be extremely varied; some groups are more coherent than others. This is partly an outcome from the risk factor

approach to predicting suicide risks as embedded in the current approach to suicide prevention (HMG/DH 2012); risk factors proliferate from this research (Briggs 2010), creating many categories of people 'at risk'. Taking a broad risk-factor led approach is therefore inclusive and in effect close to taking a whole community approach to suicide prevention. For setting priorities for training within a limited budget, across a whole county, the guidance thus offered a broad remit. The need for further and more specific prioritisation has been recognised by Grassroots and the commissioners, ESCC, and discussed at the East Sussex Suicide Prevention Steering Group on June 21st 2016[10]. Priorities recommended here are linked to risk factors; men (young, middle-aged and older), and key settings and locations, including Beachy Head. A host of risk factors identify other groups, including, people in the care of mental health services, with a history of self-harm, in contact with the criminal justice system, by occupation (health care workers, vets, farmers), LGBT people, rough sleepers, individuals and families with multiple economic disadvantage, BME groups, ex-service personnel, people with mental health issues not in contact with services, and reducing access to means. These high-risk categories have been cross referenced[11] to identify organisations directly working with these groups, and this provides more direction for future commissioning. It gives greater clarity to the training task, but other factors need to be accounted for, as discussed above (4.3.1), including assessing the baseline of staff knowledge and skills before training, where other training is already available (e.g. online training for GPs), the motivation – or resistance – of some groups to engage in training.

As Grassroots aimed to apply their model, honed in the urban environment of Brighton to the more varied setting of the county, with its combination of town and rural populations, there were particular challenges involved in delivering these courses in the smaller towns, such as Uckfield. This was chosen as a venue because it was central for a part of the county. The ASIST training held there in June 2015 and the One in Four training delivered in December 2015 both experienced reduced numbers, when people who had booked places did not attend.

A further challenge for courses involving groups of participants from a range of different and diverse sectors was how to pitch training for heterogeneous individuals with very different backgrounds, experiences, skills and knowledge, including of working with suicidal people. The cross-fertilisation approach of heterogeneous courses has the advantages of providing opportunities for sharing across sectors, and the disadvantage of reducing the potential impact of the training on organisations[12]. At least 96 organisations, of varying size, were represented by the 267 individuals attending the training courses in this contract. Therefore on average

[10] Potter, G., Proposal for future commissioning and delivery of suicide intervention and mental health awareness training.
[11] *ibid*
[12] This question is raised in the ESCC proposal for future commissioning, *ibid*

2-3 people per organisation attended; how training of individuals could embed training in organisations, when few members of that organisation – or sector – attend these training courses is a key question. The fragility of the approach lies in the dependence on one or two trained people, who may leave the organisation (one example is provided in the feedback from participants, section 4.6, below). The momentum gained from training and networking, raising awareness, and visibility on the ground and through social media is crucial for following up on learning from the training courses to generate embeddedness in organisations and communities. Therefore, as noted above (4.3), there is a strategic dilemma for planning training courses with regard to the balance between courses open to all and those designed for a single service.

As noted above (4.3), Grassroots provided courses within and outside this contract for single organisations. A safeTALK training was delivered for the police within the contract; the Fire Service received a bespoke version of safeTALK through additional funding. ASIST courses were delivered through extra funding for the Beachy Head Chaplaincy, the Place of Calm and the Survivors of Suicide Counselling Service, demonstrating interlinking of different strands of the suicide prevention initiative. The training delivered for the Police and Fire Service illustrate flexibility shown by Grassroots in adapting safeTALK for the organisational contexts where attending training was a challenge. These additionally funded courses included:

- safeTALK: Hastings Voluntary Action safeTALK: 21/07/15
- safeTALK: National Citizens Service Young People 26/08/2015
- ASIST:– SOS Counselling Partnership: 09-10/12/2014
- ASIST:– Place of Calm: 02-03/06/2015
- ASIST:– Beachy Head Chaplaincy Team: 08/10/2015
- safeTALK:– Sussex Police trained in safeTALK: 06/05/2015
- Four Two-hour bespoke suicide prevention training sessions – East Sussex Fire Service, October 2015

4.5 Trainers' experiences

Interviews with the trainers who led Grassroots training courses provided rich and in-depth insights into the processes and experiences of these training courses. We interviewed four people who have delivered Grassroots courses in East Sussex; all were freelance trainers, with wide experiences of training in different areas and organisational settings, and who were able to contextualise the trainings delivered in East Sussex. Two of the four had previously worked for Grassroots and all four were closely associated with and fully subscribing to the community education approach. The four trainers were experienced between them in training all four of the courses delivered in East Sussex. Three are trained ASIST trainers, having undertaken the T4T (Training for Trainers) Living Works course, and two are also trained to deliver

T4T courses and they also deliver safeTALK; the fourth trainer delivers the mental health awareness training courses, MHFA and One-in-Four. Trainers maintained contact with the Grassroots CEO to provide feedbackand reflect on the courses, but they ddi not have opportunities to meet as a group to reflect on the training aexpericnes, and this could be considered for future contracts.

The trainer's accounts emphasised the community focus of the training, evidenced through the heterogeneity of people attending courses:

> *You have people from diverse background from mental health service users, carers of people with mental health problems; we also have professionals working in all kinds of aspects of [health] care and social [care]. You have doctors, nurses, Occupational therapists … people from the chaplaincy in Beachy Head. (Trainer A).*

> *All kinds of people from youth workers, mental health support workers, drug and alcohol support workers. All kinds of groups from mental health workers. Sometimes there were formally trained professionals but mainly voluntary sector workers (Trainer B)*

This community-led approach fits well with the courses:

> *One of the things that is strong about ASIST is it believes in a whole community approach. The workshops in Sussex have really embraced that, to encourage people to get together from all walks of life. (Trainer A)*

The trainers described that working with communities also means integrating the training with lived experience, and reducing the perception gaps between trained professionals and people with lived experience, with beneficial outcomes for reducing stigma. People with lived experiences, including carers have found the courses valuable. Trainers are aware that people attending courses will have experiences of suicide:

> *I know that if I am training a group of 24, I think that there is one person in that group who would have thought of suicide in that year (Trainer A)*

And that these can become uncomfortable during training, raising the importance of attending to safety issues:

> *Many people who have contemplated suicide it brings back memories and some people become emotional very often. I have had people who had to leave the course and we had to make sure we provide them with support*

during and after the course. So we take the safety of everyone very very carefully (Trainer D)

The aim of reducing stigma is a strong and ever-present theme in these interviews. The courses are seen as a powerful medium for achieving this:

We can get rid of the shame and the stigma and deal with the stress and the symptoms and reduce the isolation, the guilt (Trainer C)

A feature of these courses is that they facilitate working with feelings and attitudes through the emphasis on direct conversations and communications about mental health and suicide, which increases confidence and reduces anxiety about talking about these matters. Participants we interviewed provided accounts of how impactful – and difficult – these conversations can be (see below, section 4.6). An aspect of the courses is that participants are encouraged to talk about themselves, to tell their own stories. Specifically for ASIST, at the end of the training, participants are asked:

'who will you tell if you thought of suicide' (Trainer A)

and to make a pledge,

"promising that they will ask for help if they need" (Trainer A).

Stigma is felt to be reduced also by the primary objectives of the training, of learning an intervention, in the case of ASIST and MHFA, and raising awareness in the shorter courses. However, the practicality of talking directly about suicide and mental health blurs the distinction between intervention and awareness in the shorter courses such as safeTALK and One-in-Four. Trainers felt the shorter courses are effective in giving confidence and learning practical actions; so in safeTALK:

The main message is how to support others to get support; that is the main message you are putting across (Trainer C)

The longer courses provide opportunities to work with risks:

Learning a skill, learning how to intervene, also it is important to realise about uncertainty and ambivalence and also to be able to assess the risk of suicide. That is really important. Gives them the tool to actually work with people who are suicidal (Trainer D)

This group of trainers had few criticisms of the courses, though they commented on the antipathy encountered in some settings with the Canadian origin of LivingWorks:

> *Why is the material foreign (Canadian) and not English? This [questions] is [raised] maybe to avoid the subject and it is easier to talk about [than] the subject [suicide]. People's experience about death and life is very similar although they might be [from] different cultures (Trainer A)*

Trainers were passionate about the potential and outcomes from the courses as *'making an impact on people's practice' (Trainer C),* and supporting the Grassroots aim of a suicide safer community. On the other hand, they were uncertain, perhaps tentative, about the direct effects of the training, perhaps blurring course participants and the people they work with. However, they commented on the difficulty of knowing, directly, how or whether training reduced suicide, as distinct from its indirect effects on suicide prevention of increasing skills and awareness:

> *The huge challenge is you never know how many people didn't go on to commit suicide or attempt. You also never know how it affected behaviour. How many people didn't abuse alcohol. How many people didn't do this kind of risk behaviours that increase suicide (Trainer A)*

Evaluating the impact of training on suicide rates is an important and difficult task that is further discussed below (Section 5).

4.6 Outcomes: How the training impacted on participants

To assess how the training courses impact on participants, the feedback taken by Grassroots at the end of each course, and at 6 months follow up has been analysed. Both these on-line surveys provide answers to questions in the form 'yes/no' and on a five-point scale ('very well - not well'), together with open questions inviting free text responses. Limitations of this method and data have been identified above (4.3)

Feedback at the end of each course:

Grassroots takes feedback at the end of each training course, and the data was collected in their end of first year evaluation report[13]. Response rates were high, at 90%. Responses show that the courses were well received. The average score for people that attended ASIST courses rating the overall experience, on a 10-point scale, was 9.2. For safeTALK the overall rating was 8.7/10.

For ASIST participants at the end of the training felt that the course had increased their capacities to directly ask about suicide (96% after, 56% before), to undertake a suicide intervention (96% after, 60% before), prepared to do a suicide intervention (92% after, 56% before) and confident to do one (90% after, 56% before)[14].

For safeTALK, 51% of participants felt that safeTALK had well prepared them to talk openly and directly about suicide, and another 40% felt partly prepared.

To summarise, feedback provided at the end of courses demonstrated high levels of satisfaction with the courses and that participants felt the courses had prepared them well to respond to suicide, in accordance with the different aims of each course: for ASIST this meant feeling able and confident to undertake a suicide intervention; for safeTALK being able to talk openly about suicide with someone in a suicidal crisis.

Feedback 6 months after training.

Grassroots invited feedback through an online survey of participants 6 months after they attended a training course. Response rates are good for an online survey 6 months after the intervention, as shown in Table 3.

Table 3 Responses and response rates for each course

Course	Responses	Total attending	Response rate
ASIST	41	104	39%
safeTALK	35	108	32%
MHFA	10	21	48%

[13] Evaluation Report – Suicide Intervention and Mental Health Awareness, G*rassroots Suicide Prevention* & *Public Health at East Sussex County Council* Year One – December 1st 2014 – November 30th 2015,

[14] Figures converted from a 10 point scale

One in Four	11	34	32%
All courses	97	267	36%

The data for this online follow-up survey combines capturing participants' perceptions of the training after 6 months, and examples of how they have used it in practice, through providing brief but specific examples. Findings from the survey are set out below, including the examples of interventions provided. For ASIST, 66% of respondents felt the training prepared them well for a suicide intervention, and 86% felt it prepared them very well or quite well. 59% had applied the training in an intervention.

ASIST:

Table 4: Training evaluation form: ASIST

	Very well	Quite well	Not very well	Not well	No response	Total
Overall, how well did the training prepare you for a suicide intervention?	27 (66%)	8 (20%)	2 (5%)	0	4 (10%)	41 (100%)

	Yes	No	Total
Have you applied the understanding, knowledge and skills gained from the ASIST training within the last 6 months?	24 (59%)	17 (41%)	41 (100%)
If YES, to Q1, please use the boxes below to record a log of any suicide interventions or conversations about suicide you have been involved in since completing the ASIST 6 months ago.	18 (44%)	23 (56%)	41 (100%)

A selection of additional comments is displayed below. These highlight the range of responses, from feeling the training was very effective for the individual in their role, to not being the style of training that suits the individual (1 response). The latter point maps on to the findings from the Scotland evaluation (see section 4.2). Comments indicate a range of responses to the question of whether the 2 days is sufficient to provide the skills, some indicating further training may be necessary, or 'top ups' desirable (which also maps on the findings of the Scotland evaluation).

- I have staged many suicide interventions since the training, too many to record, and be specific. It almost appears as if since the training was [sic] spectacular! It is an important training either in a professional sense or a personal one! I feel very lucky to have completed it. I wouldn't have been able to afford it without the funding.

- The training was to a very high standard and I felt more confident asking the questions "do you have any plans" which before seemed intrusive but now has become a possible lifesaver question.
- The training was good and I learned a lot about suicide prevention and some useful tips, but I would have needed a couple more days skills training to feel confident to use it.
- It's quite possibly the most useful insightful training I have ever been part of, thoroughly recommend it as VITAL to all mental health employees
- The training was excellent giving practical skills; and resources to take with us were good.
- It was useful to know that the direct approach when trying to ascertain whether a person is considering suicide is appropriate. I also feel better prepared should I encounter someone in the middle of a suicide attempt outside the therapy room.
- I think the main thing is to ask if they have a plan and also look at ways or support that can make them feel something/someone is taking them seriously.
- The one element of the course that has helped the most in my work is to simply ask someone if they are considering suicide. Before the course, asking that question felt too much of a personal invasion, impolite even. However, I now realise it is the one question you really must ask. And, if someone actually is feeling suicidal, it's the one question they want you to ask.
- The workshop approach was not in keeping with my learning style, one presenter in particular was constantly referring to his notes indicating his lack of familiarity with the subject and that this was a process he had to follow. Also, when challenged on some statements which were obviously opinion rather than fact no satisfactory response was provided and I was made to feel the question was not welcomed. This course is very much a product intended to generate revenue for "Livingworks" rather than training to meet the needs of people who deal with suicide and its consequences.
- I felt a bit rusty, since it had been quite a few months since I had taken the training, however I knew I had all the tips and tricks in my back pocket. Perhaps a reminder email boost to everyone who has completed the training, with tips or thoughts about mental health and a reminder to revisit the skills, would be useful.

Accounts of using ASIST post training: 27 respondents provided examples of how they had used the ASIST training, in the form of examples from experiences. Most of these are reproduced below (Table 5). Though provided anonymously, the examples indicate the range of settings in which the ASIST approach has proved applicable, at least 6 months after the training; these include interventions in professional and community contexts. A further and detailed example of an ASIST intervention occurring during the training for the Beachy Head Chaplaincy Team is available in

the Grassroots first year evaluation report. The detailed comments, relating both to specific incidents and general levels of confidence and skills, amply support the claims made for the outcomes from ASIST training.

Table 5: ASIST participants' accounts of examples applying the training

Brief outline and outcome:	Reflections:
I used the ASIST model with a family member	I found it useful to have something to fall back on in a very difficult situation
Checking level of suicidal ideation with counselling clients to gauge intent.	The training gave me the confidence to talk to people in a way that I would have been fearful of in the past
The first time I spoke to someone on the phone, they said they were suicidal. I used the steps taught in the training. I then informed the person who was overseeing him. They spoke to the service user whilst I called the mental health team. The team deemed him high risk, and staged an intervention. The service user thanked us later for intervening.	I wouldn't have handled this as well if I hadn't have had the training.
During assessments, clients have presented as suicidal and I have used the ASIST skills alongside generic counselling skills to discuss openly.	Training reaffirmed the need for open dialogue
Male in 20s/ beachy head contemplated/ hospitalised	Still depressed but now seeking help at worst moments and talking through feelings
Lady 36 slit wrists/ on release from hospital wanted to try different suicide method	Talking/ holding/ helping by getting specialist psychiatric care
Lady 29 sexually abused as child overdosing regularly	Talking specifically about the overdosing and looking at trigger moments
Managed to get clients to at least pause and stay safe until we can discuss in more depth their choice	Extremely useful mindset and tool to help tackle a suicide taboo
20-year-old male self-harming and contemplating suicide	Importance of using supervision to reflect on level of risk

Discussion over a young person telling me they were depressed, anxious and having social problems	Previously would have been unsure, but felt confident asking if they had thought about suicide, and had an open discussion about suicide, although they had not considered it.
Man in his 30's was able to be seen so quickly in his crisis when contemplating jumping off a car park. His life had been self-destructive with drugs and alcohol.	Having support so quickly helped enormously, and very quickly became non-suicidal.
It was established in an assessment for counselling that the client was almost inviting car crashes and already had a few minor scrapes, this was suicidal ideation	Being seen quickly was vital and realising the past was influencing the present, which helped take control of the now
Felt suicidal due to suicide of male gay partner… loss of sense of self merging into powerlessness	Forming his own identity and choice was a turnaround for him plus being comfortable with allowing himself to feel.
Person feeling low, crying, has lots of medical issues, suffers a lot of pain, stated she would like to take the medication she has to end it all. Contacted a friend of the person and arranged for them to stay for a while.	Very soon after training, hadn't expected to ever use the training. Picked up quickly how the person was feeling. Was direct in my questions which resulted in honest answers.
Young male having a medical episode and holding a knife to his throat	I talked him round and took him to hospital to speak to someone. He was very upset and lost. I needed to show care and be careful with what was said.
Female was trashing her home address and saying she wanted to die	I attended, calmed her down and got her to sit with me and talk to me. I booked her an appointment with our 136 nurse who in turn sectioned her in order to get a full assessment
I attended a house and female was sitting in an armchair with a kitchen knife. When anyone went near her she would raise the kitchen knife and threaten to stab herself.	I talked her round and in the end she agreed to go with paramedics to the hospital to try and get the help she needed.
Heavy drinker taking heroin as had enough of life. Talked about support	Main thing is to keep calm

and contacted STAR and safeguarding for support. Detox and rehab set up.	
Children's birthday for a male who doesn't see his children and misses them so much. Talked about going to a solicitors and family group and for this person it helped to do a cooking session to keep busy till he could see his doctor. Also helpline numbers given and health in mind application	Keep calm and ask if they have a plan
Evident self-harm and suicide ideation. Initial talking alleviated any possible suicide attempt. Further help sought from mental health team.	The training has helped with talking openly about feelings of suicide intent.
Request for paper and envelopes so that letters could be written to friends and family. Talking alleviated immediate suicide attempt. Further help sought from mental health team.	The training has helped with talking openly about feelings of suicide intent.
Unusual use of alcohol and low mood in person prompted discussion about mood which led to discussion about suicide intent. No intent identified.	The training has made it easier to approach a discussion about suicide.
Client suicidal - feelings subsided	Well informed and the tools I learnt really helped me facilitate the client to make a plan to stay safe
Group participant voicing suicidal feelings. Confidentially checked the risk and was satisfied there was no intent.	I felt really confident to have the conversation and a plan should I have needed it.
Used at work with a student. Asked the questions, got a yes, and then took her through the questions about her plan. She did not have one, so I focused on referral to counselling.	Felt confident exploring, asking the question, listening and asking about the plan. Did follow up as well.

SafeTALK:

For safeTALK, replies from 35 participants showed that 17% felt the training prepared them very well for a 'suicide alert', and 77% thought it prepared them very well or quite well. 43% had applied the training in some way. The findings are indicative of safeTALK being a short, introductory course and less likely to be applied in practice than ASIST. The findings map on to evidence of outcomes from other evaluations (section 4.3, above)

Table 6: Training evaluation form: safeTALK

	Very well	Quite well	Not very well	Not well	No response	Total
Overall, how well did the training prepare you for a suicide alert?	6 (17%)	21 (60%)	1 (3%)	0	7 (20%)	28 (80%)

	Yes	No	Total
Have you applied the understanding, knowledge and skills gained from the safeTALK training within the last 6 months?	15 (43%)	20 (57%)	35 (100%)
If YES, please use the table below to record a log of any suicide alerts or conversations about suicide you have been involved in since completing the safeTALK 6 months ago	9 (26%)	26 (74%)	35

14 people provided additional comments and a selection of these responses is shown below:

- I thought the training was well thought out and well delivered. I do feel that it will be useful in my career.
- I feel more confident to talk about the subject.
- My understanding and knowledge gained in training has led to open discussion with others however I have not been involved with anyone I am aware of that is considering suicide to date.
- Extremely useful. Helped my confidence in really listening to client and responding appropriately.
- Found the somewhat evangelical attitude to one particular approach uncomfortable.
- Very good training - has become applicable in my work role.
- I attended because over my whole team we do experience issues around suicide at times, but not often. I therefore feel I could support a colleague if there is an issue around suicide and a client, but since the training there have been none that I am aware of. The training has given me confidence.

- I haven't yet needed to use it.
- Made me more confident in talking to people about their suicidal feelings, how planned they were and to be able to judge the risk of suicide.

Accounts of using safeTALK post-training: 9 respondents (26% of total responding) provided examples of using safeTALK after the training, and these are shown below in Table 7. The responses show that, in comparison with ASIST, the interventions consist of signposting, and that these individuals show the capacity to recognise situations and the confidence to intervene at this level, including contacting or referring on to appropriate professionals; this meets one of the aims of the training contract (section 2).

Table 7: SafeTALK participants' accounts of examples applying the training

Brief outline and outcome:	Reflections
Client known to make continuous threats of feeling suicidal. Attempted to reassure client that issues would be resolved and reported to Adult Social Care.	
Have passed info on to many colleagues and service users and asked some people directly if they had been feeling suicidal.	
Client tearful and describing low mood symptoms of reactive depression. Client described feeling that it might be easier for her family if she was no longer around. Explored this with her - said she has thoughts of how good it could feel to simply walk into the sea. Offered her support to see GP and put in place a safety plan.	
Complainant became very upset, couldn't cope and wanted to end their life.	Difficult to try and obtain certain details to enable us to get the appropriate people out to help complainant. Set up a checklist to help the person on the phone.
Employee stated they felt suicidal	I had the confidence to ask the question direct using the words agreed at the training and signpost effectively
Advised managers on how to support	I feel better equipped to do this

and signpost employee who may be suicidal	
Spoke to the customer over the phone - advised them the outcome of threatening suicide	Conversations went well and they understood the severity
Gentleman shared he felt he couldn't go on and discussed his concerns over his health. We had an open discussion with another support worker (who had also attended training) and we gave him contact details for Samaritans.	
Client homeless after relationship breakdown, signposted and discussed options	Client willing to talk about their depression, history of mental health issues

Mental Health First Aid

Of 10 participants from MHFA courses, 6 felt they were well prepared for providing help and support and 8/10 had applied learning from the course. The sample is too small to draw further conclusions.

Table 7: Training evaluation form: Mental Health First Aid

	Very well	Quite well	Not very well	Not well	Total
Overall, how well did the training prepare you for providing help and support?	6	4	0	0	10

	Yes	No	Total
Have you applied the understanding, knowledge and skills gained from the MHFA training within the last 6 months?	8	2	10

Participants were invited to expand on how they applied the understanding, knowledge and skills gained from the MHFA training within the last 6 months, and provide examples of how it has been applied in practice. Responses included:

- In my personal life with others and also professionally.
- Passed on my knowledge to fellow members of staff.

- Asking if have had suicidal thoughts, had a plan been made and listening. Passed on information to colleagues. Passed on little pamphlet with telephone numbers.
- I have had the misfortune to have to assist varying friends with their mental health issues.
- During keyworking, discussing during team meetings.
- Individual and groups support.
- Working with students, I have used 'ALGEE'[15] to create a safe, supportive environment for listening and referrals.
- The training was really wonderful! I would give it a "very well", but (fortunately!) I have not had as many opportunities to try out my skills as I had anticipated. I think the main thing is building confidence, which is tricky to do without consistent practice, but I am so grateful for the opportunity to learn together and develop skills!
- Excellent manual alongside good training - some of training content was very basic but a good introduction to practically managing a difficult situation. I am a practitioner working with children and families and whilst this info was a useful reminder I knew a lot of it prior to attending the course.
- I believe it has helped a lot with one particular friend who has severe OCD and another with anger control issues.

One-in-Four

7/11 respondents felt the course had prepared them well and 10/11 had used the training in their work/lives (Table 8 below)

Table 8: Training evaluation form: One-in-Four

	Yes	No	Total
Have you applied the understanding, knowledge and skills gained from the 'One in Four' training within the last 6 months?	10	1	11

	Very well	Quite well	Not very well	Not well	Total
Overall, how well did the training prepare you for providing help and support?	7	4	0	0	11

[15] The Mental Health First Aid Action Plan: **A**ssess for risk of suicide or harm; **L**isten nonjudgmentally **G**ive reassurance and Information; **E**ncourage appropriate professional help; **E**ncourage self-help and other support strategies

Participants were invited to expand on how they applied the understanding, knowledge and skills gained from the MHFA training within the last 6 months, and provide examples of how it has been applied in practice. The following is a selection of these responses:

- I have been more alert for mental health problems in clients.
- Working with a group of people who access mental health services in an exercise session. It has helped deepened my understanding of how they may be feeling and their barriers to exercise. It has helped me to find ways to motivate them sympathetically.
- Helped clients access mental health services and adapted support to meet the needs of people with mental illnesses.
- Was able to refer one of my residents to mental health team due to symptoms recognised.
- I thought the leader of the session was fantastic and incredibly welcoming and warm.
- The course provided an insight and reminded me that mental health problems do exist and may not always be immediately evident.
- A half day was quite short to deal with lots of aspects so a longer course (or a follow up half day) would be useful.
- Excellent course and very detailed information.
- It was very well presented. I was particularly struck by the honest personal testament and description of living with mental health.
- I thought that the training was well presented, interactive and informative. I learned a lot about different types of mental health and what we can do in our own capacity for those suffering.

4.7 Interviews with Grassroots participants

We undertook in-depth interviews with a small sample of participants of Grassroots training to further explore the meaning of the experiences of participating in these courses and to supplement the survey results. The sample was chosen to ensure participants had experience of all four Grassroots trainings and that they came from a range of organisations, or had a range of reasons for attending. The 6 participants, some of whom had attended more than one course, had attended ASIST (3), safeTALK (2), One in Four (2) and MHFA (1). Their backgrounds included social care, foster care, coastguard, coach, working with learning disabilities, supporting carers as an independent living coordinator, working in the Place of Calm.

In accordance with the online survey, participants mainly expressed high levels of satisfaction with the courses, and were very positive about the trainers and Grassroots approach. Some more critical comments were made. One participant expressed dissatisfaction with the course (ASIST) feeling it was packaged and the

trainer was working to the script not with the people in the room. The Canadian context was off putting for this participant (see above, Section 4.4). Two people, who attended safeTALK, felt the course had too many people, and there was too much to cover in the time available; this participant attended a course with 32 participants which was slightly above the recommended maximum. One participant on One-in-Four and safeTALK questioned that participants sat in rows, which was experienced as formal and not encouraging communication between attendees.

Different motivations for attending courses were mentioned. Participants attended courses after hearing about them from colleagues:

> *A colleague of mine attended a Grassroots conference who was a learning disability nurse and after she attended that she was completely blown away and thought it was absolutely brilliant, and thought that everyone should attend (Participant E)*

Others attended when an ASIST course was set up for their organisation (2 participants), and one because they are keen on Grassroots:

> *I love Grassroots, everything they do is brilliant, trainers are knowledgeable, sensitive. I like that people with personal mental health experience take part (Participant C)*

Participants elaborated on the personal aspect as a motivating factor:

> *To be part of a movement that destigmatises, I was bereaved by suicide. That nudged me around. It was great to talk about it and it was helpful to know where I stood. But also to contribute to that movement and being there (Participant F)*

The emphasis on lived experience was also important for Participant A, attending One-in-Four, who identified as someone with lived experience of mental health issues:

> *I enjoyed one of the trainers, who had lived experience and brought it in effectively, towards the end, so the training ended on a high note for me (Participant A)*

Learning from the course was described in terms consistent with the online survey. Those attending ASIST felt enabled to talk more confidently about suicide:

I feel that I am able to bring up the topic of suicide in a comfortable natural way which makes it a very accepted subject for us to share and explore and look at. It gives me that confidence and I always carry in my purse the ASIST framework (Participant F)

The structure and framework of ASIST was important to another participant:

It's the structure, I keep it in my mind and I used it a lot [in previous job], looking for the turning point (Participant B)

This participant 'used ASIST all the time' in her previous job, and provided examples during the interview, but has less call on her suicide prevention skills in the new role, with implications for embedding the training in organisations (see Section 4.1).

For participants attending the shorter courses, the outcomes were described in similar terms, emphasising learning intervention skills and gaining confidence, but perhaps with an accompanying sense of anxiety. For example, one SafeTALK participant referred to the immediacy of the encounter being described in the training and related the experience vividly:

I think the account of one person taking, noticing another human being in distress in a busy area and making that decision to have that simple conversation and the taboo of it actually, something I particularly took away was saying the question out loud. "Are you considering suicide? I didn't realize how difficult or uncomfortable I felt saying that phrase until I was offered to say it out loud." (participant 5)

The training provided a sense that it would be possible to put the approach into effect, despite the anxieties:

The thing that I don't feel confident about or maybe not confident because I am sure I will be able to deal with it when the training and everything will kick in and just the humanity itself (participant 5)

Another safeTALK attendee (participant 3) thought that everyone should take the course as it changes how we relate to each other and suicide.

Therefore these participants' accounts illuminated and nuanced the findings from the survey, and are, at the same time, consistent with these and the literature from other evaluations.

4.8 Value for money

Value for money can be assessed through calculating the cost per training participant. The overall value of the contract was £44,425, and 267 participated, thus the average cost per participant was £166. This calculation can be refined by assessing the cost for participants on each course. The costs for participants on each course, assuming maximum take up of places is shown in Table 9.

Table 9: Costs of courses for maximum number of participants

Course	Cost of course	Max Participants	Cost per participant
ASIST	£4,248	24	£177
SafeTALK	£1,494	30	£50
MHFA	£2,884	12	£240
One in Four	£1,162	16	£73

Actual numbers on courses varied from the maximum, providing actual costs for each course, as shown in Table 10.

Table 10: Costs of courses for actual number of participants

Course	Number delivered	Maximum participants	Actual participants	Cost per participant
ASIST	5	120	104	£204
SafeTALK	6	180	108	£83
MHFA	2	24	21	£275
One in Four	4	64	34	£136.70

Comparisons with comparable courses are approximate, but show that fees of between £100 and £175 are usual for a 1 day course. Using this benchmark, ASIST and MHFA would cost between £200 and £350, safeTALK and One in Four would cost between £50 and £85. Therefore the costs for ASIST are at the lower end of the range, MHFA in the middle range, safeTALK at the higher end and One in Four was more expensive than the norm. The successful uptake of places and completion of courses has a crucial effect on costs using these criteria for calculation.

Overall, Grassroots training appears to provide good value for money. These costs do not take account of the additional development work undertaken by Grassroots in engaging with the various sectors working with suicidal risks in East Sussex. Grassroots also adds value through working closely with other organisations involved in the Beachy Head Risk Management group, linking up with national associations and groups, and follow up work with training course participants that facilitates post-course application in practice and being linked with other services.

This includes all participants receiving resources to enhance their work, including resource cards, pledges, and the StayAlive suicide prevention app.

5. Discussion of findings

The findings will be discussed by evaluating to what extent courses provided by Grassroots have met the aims and objectives of the contract to provide training in East Sussex to a range of frontline staff to increase skills, knowledge and understanding in suicide intervention, and mental health and mental health problems.

Grassroots training was delivered to over 250 participants within the first 18 months of the contract. It was delivered to the target groups of frontline staff as in the service specification across the specified sectors, health, social care, criminal justice, voluntary, private and across sectors staff, and self-selecting participants. Courses were delivered mainly to heterogeneous groups of staff, through individual applications, though some courses were also delivered to discrete single organisation staff groups; most of these were through funding additional to the contract. There are advantages and disadvantages to each method of training delivery. The heterogeneous approach offers wide access, enables community building and sharing of perspectives. The disadvantage is that organisational learning is thinly spread with only 2 or 3 people from each organisation gaining the benefits of the training; learning is weekly embedded in organisations. The homogenous staff group approach has a stronger impact on embedding the training, but provides less opportunity for wider networking and linking. Grassroots themselves believe that a balance between the two approaches is ideal, though difficult to achieve.

The predominant approach of training heterogeneous groups was based on the engagement strategies for promoting the training. This involved a community-oriented approach through networking, public engagement events**, n**ewsletters and publications, and the well-coordinated use of social media. The success of this approach can be measured simply by the fact that the training courses recruited well in most cases and that the target numbers of staff completed the training. There is also evidence that the greater openness about talking about suicide, of overcoming inhibition and anxiety, experienced by course participants, leads to reducing stigma. The community engagement approach has mixed results; it is well suited to the task of training the very wide groups of staff identified as working with people at risk of suicide and for developing capacity, and reducing stigma. It does not lead to effective prioritisation of key groups, since the take-up of places on courses is individually driven, and thus self-selecting, nor to follow through of impact of training within organisations. A more structured approach to prioritising key staff groups in the service specification and Grassroots approach to engagement may have countered the tendency to diffusion of the training effort. More rigorously identifying key high risk groups and focussing training on these is being considered by commissioners

and Grassroots and this approach could be usefully further developed for future training. Alongside this, needs assessment at baseline would facilitate providing courses that meet the current levels of skills and confidence. Greater flexibility may be achieved through applying other training delivery approaches, including online; these may be more acceptable to some key staff, including, for example, GPs.

Grassroots used four established training courses for this contract: ASIST, safeTALK, MHFA and One in Four. These four training courses are Grassroots staple courses, tried and tested in their previous work, well known and respected nationally and internationally, and having evaluative evidence of their acceptability and popularity amongst those who attend. Grassroots delivered the courses skilfully and added value through the ways they engaged with participants during the training and the resources they provided for follow up. The courses were delivered by skilled and experienced trainers, who are passionate about their work, and the wider objectives of reducing stigma and preventing suicide. Trainers and the small sample of participants who were interviewed provided insights into the processes of the training, and the ways that this impacted on their knowledge and understanding of suicide prevention and mental health. These can be characterised as offering a clear structure, on the one hand, and an emotional and personal engagement on the other hand.

Most of the training was in suicide prevention, through ASIST and safeTALK; 80% participants attended one of these two courses. There is a case to be made that the remit of the service specification was too broad, or ambitious, in also including mental health awareness training, risking diluting the effort, given the resources – including funding - available for this contract.

The outcomes of the training appear to map on to the findings from existing evaluative data for these courses. The training courses themselves were popular with participants, overall, and there is evidence from the feedback, follow up and interviews that individuals did gain skills, knowledge and understanding that better equipped them to confidently face and intervene in suicide situations. The two suicide prevention courses have different aims; safeTALK is a short introduction to raise awareness and the ability to talk about suicide, whilst ASIST is a more intensive training that leads to being more able to make interventions. Both therefore have a role and need to be delivered according to the needs of staff being trained; this did appear to have been the case in this initiative, though safeTALK was delivered as a fall back for some staff with restricted availability. The published evaluative literature for safeTALK (see section 4.2) strongly suggests that practitioners who have responsibilities for suicide prevention will need more extensive training than safeTALK, and those in this category need to be followed up with a view to initiating further training. There is some evidence that for all these

courses, there is a need for follow-up training, or refreshing of learning, and this accords with findings from other evaluative studies (section 4.3). This is not a surprising finding; objectively, a course of two days duration is not a long course for equipping frontline staff to work with the complex intensities and variable presentations that pertain in suicide situations.

Evaluation of the training was undertaken through participant feedback and follow up online survey. This generated some useful outcome data, especially where individuals recorded examples of putting the training into practice through interventions in suicide situations. Weaknesses in the evaluation design were apparent at follow up, which was anonymised, and thus connections between feedback and follow up could not be made. Obtaining more robust data was constrained by the evaluative methods in place for this contract; there was no baseline measurement of staff skills and knowledge and a more systematic measurement using outcomes tools could have drawn out more effectively the impact on participants and their organisations. How organisations benefited through increased knowledge and skills cannot be assessed for the heterogeneous courses.

How effective the courses have been is difficult to assess; on the one hand, there is evidence of positive feedback, but on the other hand, limitations of the data restrict which conclusions can be reached. The evidence from participants, from the surveys and interviews, provides some powerful accounts of how the courses impact individually, and it can be concluded that, at least for some participants, the training courses provided a productive and enduring learning experience; for some the experience appears to have been transformative. Personal learning was evocative and emotionally rich. These people emerged from these courses with a new or renewed conviction to prevent suicide and reduce stigma in their work and personal lives. It is clear that the courses were popular with those who responded to requests for feedback. In the end of training survey, participants expressed satisfaction with the courses and rated themselves as having increased knowledge and skills, in line with the objectives of the different courses. Some individuals have clearly described that learning from the courses was put into effect after the training, in the form of suicide interventions - post ASIST, talking about suicide - post safeTALK, and greater awareness and confidence in speaking about mental health issues. The overarching aims of raising confidence, promoting openness and reducing stigma are described in the accounts provided by both survey and interviews. This provides a strong sense that the courses appear to be positively impactful for individuals and that in meeting their objectives they do contribute to greater awareness of suicide prevention and mental health at both individual and community levels. However, whether the training courses lead to a reduction of suicide attempts is an important but complex question; evaluative methods that test this robustly are required. The evidence from this evaluation is therefore indirect; by raising awareness, skills and

confidence, Grassroots has contributed to a more informed workforce in East Sussex, which is now more capable of responding positively and appropriately, to suicide situations.

6. Recommendations

- Further training (by Grassroots or another provider) will be beneficial for continuing the task of increasing skills, knowledge and understanding of suicide prevention of frontline staff across sectors in East Sussex.
- The key values of aiming to reduce stigma, and building capacity across sectors, should inform future contracts.
- Future commissioned training programmes should continue to provide the same or similar training courses, prioritising as indicated by a needs assessment, alongside exploring the possibilities of more flexible course delivery, including online.
- Obtaining a balance between heterogeneous and single service/group courses should guide strategy for course delivery.
- Prioritising suicide prevention training, over mental health awareness, would make better use of limited resources.
- Providing opportunities for trainers to meet and reflect on their training experiences should be built in to future contracts.
- Greater engagement with organisations, including assessing their training needs, and the impact of training on skills and organisational culture relating to suicide prevention should form a key strategic aspect of future work.
- Evaluation of future training should include baseline assessments of organisations' needs, strengths and training experience, and an integrated approach to assessing outcomes of training. This would be enhanced by engaging an independent evaluator from the beginning of the contract, as recommended by NICE.
- Though it is difficult and expensive to directly test the effectiveness of training courses in reducing suicide attempts, it would be worth approaching an appropriate research team to explore funding possibilities for undertaking an appropriate evaluation.

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8. **Appendices**

Appendix I: Participant Information Sheet and Consent Form

University Research Ethics Committee: If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:
Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, EB 1.43, University of East London, Docklands Campus, London E16 2RD (Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk).

The Principal Investigator: Professor Stephen Briggs (researcher)
Cass School of Education and Communities, Stratford Campus, Water Lane E15 4LZ, Telephone 0208 223 4266, Mobile 07957 178938, Email: s.briggs@uel.ac.uk

Funding: This research evaluation is commissioned and funded by East Sussex County Council

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title: Evaluation of Grassroots training programme to inform future provision and commissioning

Project Description: This research project aims to evaluate Grassroots training programme to assess how it delivers training to frontline staff working in healthcare settings and within the community, to increase skills, knowledge and understanding in suicide prevention and mental health problems. We will review and evaluate the work undertaken by Grassroots over the past two years. The research will consist of a comprehensive evaluation of the Grassroots training programme with the aim of identifying positive factors and any emerging obstacles that can be addressed through refinements. We will aim to reach informed findings and recommendations for future development of the service.

Your participation in this project will involve meeting with the one of the researchers in the team at a suitable agreed venue for an interview lasting not more than 1 hour. The interview will consist of some open questions about your experiences and reflections of Grassroots training. It is possible you may experience distressing or thought provoking feelings and we will ask you if you are experiencing any of these feelings during the interview. If this is the case we will be pleased to discuss how you may be supported.

Confidentiality of the Data

We will transcribe interviews and store these on a password protected UEL computer using a numbered key to protect confidentiality. Once the interview has been transcribed, the tape will be erased. When the evaluation has been completed the data will be retained in accordance with the University's Data Protection Policy. The data will be available only to members of the research team. Confidentiality of all stored data can be subject to legal limitations e.g. freedom of information enquiries.

We will protect your confidentiality in written and any conference reports by using pseudonyms and removing any identifying information. Anonymised quotes from your interviews may be used in publications.

However, as this is a small study with few participants it will not be possible to wholly protect your confidentiality and you may be recognizable. We will take every step to minimize the risks of recognition and we will offer you the opportunity to read and comment on any report involving your interviews. Should the interviews involve information about risks of imminent harm to anyone (yourself or others), we will need to ensure with you that these are acted upon appropriately and we may be obliged to inform the relevant authorities.

Location:

We will undertake the interviews at Grassroots offices or at your workplace, but if for any reason this is not possible an alternative location will be identified. Some interviews will take place by telephone by mutual agreement.

Disclaimer:

You are not obliged to take part in this study, and are free to withdraw at any time during tests. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason. If you do withdraw any information you have already provided will be safely destroyed and will not be used in the study.

UNIVERSITY OF EAST LONDON

Consent to Participate in a Programme Involving the Use of Human Participants.
Evaluation of Grassroots training programme

I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the programme has been completed. It has been explained that full anonymity may not be possible in this study and that there are legal limitations to data confidentiality

I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.

Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)
…….

Participant's Signature
……..

Investigator's Name (BLOCK CAPITALS)
……..

Investigator's Signature
……

Date: …….

Appendix II Interview Schedules

Schedule 1: Staff and trainers

Thank you for agreeing to take part in this project. Confirm that participant information has been read and consent form has been signed. Any questions before we begin?

We are interested in your experiences of the Grassroots training programme. Is that OK? Do feel free to stop the interview at any point and ask any questions along the way if you want to

So the first question is

1. What is your role with Grassroots and how have you been involved in the training?
   (prompt for feelings about the role)
2. Can you tell us about which kinds of training courses you have been involved with?
   (prompt for quality of experiences)
3. Which staff have you trained, from which organisations and in which role?
   (prompt for quality of experiences, what issues they brought for which service users,)
4. What were the main things you felt the participants gained from the training?
   (prompt for detailed examples, positive experiences, challenges and obstacles)
5. How do you think the training impacted on the participants work with people's mental health and suicidality?
   (prompt for detailed examples)
6. Do you have thoughts about how the training could change and develop in the future?
   (prompt for examples)
7. Do you have any further thoughts, points or questions?

Thank you

Schedule 2: Participants in Grassroots training programmes

Thank you for agreeing to take part in this project. Confirm that participant information has been read and consent form has been signed. Any questions before we begin?

We are interested in your experiences of the Grassroots training programme. Is that OK? Do feel free to stop the interview at any point and ask any questions along the way if you want to

So the first question is

1. Can you tell us about your current work and role?

(prompt for feelings about the role)

2. Can you tell us about which Grassroots training courses you have participated in?
   (prompt for details, when, where, why choosing to attend)
3. What was your experience and learning from the course?
   (prompt for quality of experiences, what issues they worked with and learning from this)
4. What were the main things you felt you gained from the training?
   (prompt for detailed examples, positive experiences, challenges and obstacles)
5. How do you think the training impacted on your work with people's mental health and suicidality?
   (prompt for detailed examples)
6. Do you have thoughts about how the training could change and develop in the future?
   (prompt for examples)
7. Do you have any further thoughts, points or questions?

Thank you