A Review of the Operation *Life* Suicide Awareness Workshops

Report to the Department of Veterans' Affairs

Prepared by

the Australian Institute for Suicide Research and Prevention

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Suggested citation: McKay, K., Hawgood, J., Kavalidou, K., Kolves, K., O'Gorman, J. & De Leo, D. (2012) A Review of the Operation *Life* Suicide Awareness Workshops. Report to the Department of Veterans' Affairs. Australian Institute for Suicide Research and Prevention, Brisbane.

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Published by the Australian Government Department of Veterans' Affairs, Canberra, 2012.

Acknowledgements

This review was funded by the Department of Veterans' Affairs.

The authors acknowledge and thank the VVCS - Veterans and Veterans Families Counselling Service and the Ex-Service Organisation Reference Group for their input and support, as well as participation in interviews and a focus group.

Further, we extend our deep appreciation to those veterans who attended the workshops and participated in the evaluation. Thank you for so graciously sharing your time to help provide the evaluation with a deeper knowledge of the experiences of different veterans.

We would also acknowledge help from our colleagues Naoko Ide and Eeva-Katri Kumpula.

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Executive Summary

Operation *Life* is the National Suicide Prevention Strategy for the veteran community. It was developed in 2007 and is the overarching framework under which fall different suicide prevention initiatives, including mental health promotion.

The suicide awareness workshops conducted under Operation Life are safeTALK, ASIST, and ASIST Tune Up. safeTALK is a half-day workshop of approximately four hours duration that seeks to provide members of the community with sufficient information to recognize those who may be considering suicide and connect them with appropriate intervention services. ASIST is a two-day workshop with the aim of preparing participants to intervene when suicide is likely and reduce the immediate risk or secure additional resources for this purpose. ASIST Tune Up is a half-day 'refresher' workshop for people who have previously completed ASIST.

Following a review of suicide in the veteran community conducted in 2009, Professor David Dunt recommended that the DVA "closely consider the evidence-based literature on suicide prevention and should only implement programs that are evidence-based and most likely to be successful in veterans" (2009, p. 16).

The Australian Institute for Suicide Research and Prevention (AISRAP) was commissioned to conduct an evaluation of the suite of suicide prevention workshops provided under the Operation *Life* suicide prevention framework.

The evaluation sought to:

- Review the training products currently being delivered under Operation *Life* to the veteran community (both training content and the delivery mechanisms of the workshops);
- Review the short term impacts of the three training products (knowledge and skill acquisition and retention, and changes in attitudes at pre-, post- and three-month follow-up); and,
- Provide recommendations on the status of evidence-based material and approaches underpinning the Operation *Life* suicide awareness workshops, and on ways to achieve this in line with international literature, theory and best practice guidelines in suicide prevention.

It was beyond the scope of the project to include a longer-term impact study on suicide morbidity and/or mortality.

The evaluation included a literature review, a review of the training manuals for the workshops, analysis of participant feedback from previous safeTALK and ASIST workshops, pre-, post- and follow-up surveys of workshop participants, follow-up interviews of participants, a focus group with members of the VVCS - Veterans and Veterans Families Counselling Service and interviews with Ex-Service Organisation (ESO) Reference Group members.

The literature review indicated that the question of whether the suicide rate among veterans is elevated compared with that of non-veterans is still open. There is, however, a good deal of evidence indicating a higher risk for suicidal behaviour (suicidal thoughts, self-injurious behaviour) in this population in terms of known correlates such as gender, mental illness, alcohol abuse, and previous exposure to a culture in which familiarity with weapons is a requirement. Providing suicide prevention programs should therefore prove beneficial.

The literature review further indicated that gatekeeper training, and ASIST is a form of this, has been accepted internationally as one aspect of a suicide prevention program, although a clear demonstration of its effectiveness in reducing the incidence of completed suicide has yet to be reported. This is the case for both training targeted at the general community as well as veteran samples specifically. Nevertheless, ASIST when properly delivered has been found to enhance the perceived capacities of participants to deal with potentially suicidal individuals.

The analysis of data drawn from survey forms routinely administered as part of the workshop program and completed as part of workshops in a number of metropolitan and regional centres across Australia provided results very favourable for both safeTALK and ASIST. This was true for delivery of the workshops and for the beliefs of participants about their increased capabilities as a result of their participation. With 90% to 100% of participants endorsing positively the questions put to them about the workshops, participants clearly were satisfied with the experience and considered they had learnt something valuable from them.

A study of changes from pre-workshop to post-workshop and three-month follow-up in perceived capabilities and actual knowledge of participants in dealing with suicidal behaviour indicated that there were real and substantial improvements as a consequence of safeTALK. The differences were

statistically significant and in most cases showed practically important levels of change on the scales used to assess them, from ‘moderately capable’ to ‘very capable’ in perceived capability and of the order of 3 points on a 14 point scale of actual knowledge. These changes were maintained at follow-up.

In the case of the ASIST workshops, the results were less clear cut. There were substantial changes (from ‘moderate’ to ‘very capable’) for perceived capabilities, but for actual knowledge the changes were not always statistically significant. A conclusion with respect to change in actual knowledge as a result of the ASIST workshop must therefore remain open.

ASIST Tune Up was not evaluated as part of the present review.

Qualitative data gathered from participants through interview and responses to open-ended surveys supported the benefits of the workshops, as did the comments arising in the focus group with VVCS and interviews with Ex-Service Organisation (ESO) Reference Group members. The overall view of the evaluators was that the workshops were well presented and well received.

Conclusions

The conclusions warranted from the review are:

1. Participants in ASIST and safeTALK workshops strongly support their value. Although the sampling used in collecting these data was not systematic, the size of the samples and the fact that they were drawn from a number of centres across Australia provide grounds for expecting the conclusion will generalise to the wider population of those who may participate.
2. There are substantial increases in participants’ perceptions of their capabilities in dealing with those showing suicidal behaviour and substantial increases in their actual knowledge following safeTALK workshops. This conclusion is based on the results of one study and requires further replication before it can be generalised to the population of interest.
3. There are substantial increases in participants’ perceptions of their capabilities in dealing with suicidal behaviour following ASIST workshops, but again these need replication.
4. Change in actual knowledge following ASIST workshops needs further demonstration beyond the present study.
5. The effectiveness of ASIST Tune Up has yet to be assessed.

As well as reaching these conclusions about the workshops the review pointed to a number of recommendations.

Recommendations

1. That the Operation *Life* Suicide Awareness workshops be continued as part of the suicide prevention framework for veterans;
2. That materials for workshops be reviewed (a) to update information on risk and protective factors for suicidal behaviour in veterans, and (b) to provide current information on agencies in the region where a workshop is being held to whom veterans showing suicidal behaviour may be referred, if necessary, by workshop participants;
3. That consideration be given to encouraging veterans who participate in ASIST workshops to first attend a safeTALK workshop;
4. That consideration be given to telephone follow-up of veterans who participate in ASIST workshops approximately one week following a workshop to assess whether they have experienced any adverse effects as a result of the workshop and provide support and assistance as required.

1. Background

This report was prepared by the Australian Institute for Suicide Research and Prevention (AISRAP) as a result of a commission by the Department of Veterans' Affairs (DVA) to Review the Operation *Life* Suicide Awareness Workshops.

Operation *Life* is the National Suicide Prevention Strategy for the veteran community. It was developed in 2007 and is the overarching framework under which fall different suicide prevention initiatives, including mental health promotion.

Operation *Life* has five key priority areas:

1. the promotion of resilience, mental health and wellbeing;
2. the enhancement of protective factors by reducing risk factors of veteran suicide and self-harm;
3. support through different organisations for those most at risk of suicide and their families;
4. partnership development with the veteran and ex-service officer communities; and,
5. increased evidence-based research on suicide prevention and best practice

The suicide awareness workshops conducted under Operation Life are safeTALK, ASIST, and ASIST Tune Up. These are programs developed by LivingWorks, which originated as a private company in Canada offering programs in suicide prevention and which operates in Australia under the auspices of Lifeline (http://www.livingworks.net/page/A%20Brief%20History). The programs have been offered in Scotland, Norway, and the USA, as well as in Canada.

safeTALK is a half-day workshop of approximately four hours duration. It "teaches members of the community to recognize persons with thoughts of suicide and to connect them to suicide intervention resources" (p. 5, safeTALK manual). As such, safeTALK essentially focuses on suicide awareness; by recognising 'invitations', participants can become 'suicide alert' and consequently lead people to appropriate help and care.

safeTALK is a structured program with specific steps to follow: **T**ell, **A**sk, **L**isten and **K**eepSafe. The person with suicidal thoughts needs to tell the caregiver about them; the caregiver asks about these

thoughts and listens to the responses; the caregiver then links the suicidal person to the appropriate avenue to keep safe. Following these exact steps is stressed.

ASIST is the acronym for **A**pplied **S**uicide **I**ntervention **S**kills **T**raining. The ASIST program is a two-day workshop which "enhances caregiver skills to intervene until either the immediate risk of suicide is reduced, or additional life-assistance resources can be found" (p. i, ASIST manual). ASIST uses the image of a river into which a suicidal person has fallen and risks the waterfall into death; however, there are different stages along this river where help can be offered (prevention, intervention and post-vention). ASIST deals with "suicide first aid intervention [which] diverts persons already thinking about suicide, out of the river, avoiding the danger of the waterfall" (p. i, ASIST manual). Essentially, ASIST is a type of gate-keeper training for caregivers in the community, with varying degrees of previous training and experience.

ASIST has been developed to be "a standardised learning experience using a common language to help increase suicide first aid skills and build community networks among many types of caregiver groups". Like safeTALK, ASIST is a structured program with stress placed on the need to follow the steps correctly. Caregivers are required to connect with a suicidal person, by exploring their invitations and asking directly about suicide; they need to understand the person by listening to their reasons for living and dying and reviewing their risk; and, caregivers need to assist the suicidal person by contracting a safe-plan and following-up on the commitments made within this plan.

ASIST Tune Up is a half-day 'refresher' workshop for people who have previously completed ASIST.

In 2009, the Commonwealth Government released the 'Independent Study into Suicide in the Ex-Service Community'. In this report, prepared by Professor Dunt, it was recommended that the DVA "closely consider the evidence-based literature on suicide prevention and should only implement programs that are evidence-based and most likely to be successful in veterans" (2009, p. 16). AISRAP was commissioned to conduct an evaluation of the suite of suicide prevention workshops provided under the Operation *Life* suicide prevention framework. The overall goal of the project was a review of the safeTALK and ASIST workshops delivered to the veteran community, the evidence base of the workshops and recommendations for future suicide prevention training targeting the veteran community. It was beyond the scope of the project to include a longer-term impact study on suicide morbidity and/or mortality.

To achieve these goals, three specific aims were agreed with DVA:

1. Review the training products currently delivered under Operation *Life* to the veteran community (both training content and the delivery mechanisms of workshops to be examined);
2. Review the short term impacts of the three training products (knowledge and skill acquisition and retention, and changes in attitudes at pre-, post- and 3-month follow-up); and,
3. Provide recommendations on the status of evidence-based material and approaches underpinning the Operation *Life* suicide awareness workshops, and on ways to achieve this in line with international literature, theory and best practice guidelines in suicide prevention.

To achieve these aims the following tasks were undertaken

a review of the literature on suicide by veterans and on programs adopted to respond to this issue

a review of training manuals

analysis of participant feedback forms from safeTALK and ASIST workshops conducted prior to AISRAP's evaluation

analysis of effects on participants in the workshops using a pre-post-follow-up design

follow-up interviews with workshop participants, a focus group with VVCS staff, and interviews with ESO members

preparation of the report and recommendations

Subsequent chapters take up each of these tasks.

2. Literature review

Suicide among Veterans

Establishing the incidence of suicide in veteran populations is difficult for a number of reasons, including inaccurate data recording and missing data (De Leo & Sveticic, 2010; Cantor & Neulinger, 2000), failure to report occupation or veteran status on police reports and consequently death certificates, veterans' vulnerability to homelessness (Perl, 2011; Rosenheck et al., 1994), isolation and remote location which reduces the possibility of obtaining confirmatory data on status from next of kin, and in some cases lack of partner's knowledge of the veteran's previous service. Statements about suicide rates must therefore be made cautiously.

Recent research on suicide rates in veterans in the United States found that veteran males and females in the general population have a significantly higher risk of suicide compared to non-veterans (Kaplan et al., 2009). In Australia, the situation is less clear. Dunt (2009) reviewed six studies of Australian service personnel that provided data on suicide rates. The majority of these studied veterans of the Vietnam war, one included those who had served in the Korean war, and one included those who had served in the Gulf war. The study based on Korean war veterans showed a 31% higher rate of suicide for veterans compared to the Australian male population. One study of Vietnam veterans showed a rate of suicide 21% higher than that of the Australian male population. The other four studies failed to show significant differences.

There is more agreement on specific risk factors for suicide in veterans. These include demographic factors (e.g., male gender, younger age); psychiatric and psychological factors [mainly drug and alcohol abuse, Post-Traumatic Stress Disorder (PTSD) and major depression]; access to and availability of means and exposure to combat (Dunt, 2009). Other relevant risk factors are physical health problems, conflicts with the military system and major life events, such as separation and divorce (Thoresen et al, 2006). Veterans may be at particularly high risk for suicide as a consequence of the high prevalence of comorbid disorders, as well as physical disability (Gawande, 2004; Kang & Hyams, 2004; Hoge et al., 2006).

One of the most commonly cited risk factors for suicide among veterans is a diagnosis of PTSD, depression and substance abuse (Ikin et al, 2010; Pietrzak et al, 2010; Cacciola et al, 2009; Nye et al, 2009; Rozanov et al, 2009; Sher, 2009b; Kang & Bullman, 2008; Ikin et al, 2007; Boscarino, 2006; Ikin

et al, 2004; McKenzie et al, 2004; Reich, 1998; O'Toole et al, 1996). A recent study on Gulf War veterans from the Royal Australian Navy found that the onset of psychiatric disorders generally tended to occur two years after exposure to conflict, with problems with alcohol developing first (McKenzie et al., 2010). These conditions can continue and worsen for years after the military experience (O'Toole et al, 2010; O'Toole et al, 2009; Byles et al, 2000; O'Toole et al, 1996; Elder & Clipp, 1989). One study of Australian Vietnam veterans found that mental health problems, particularly PTSD, were still felt some 20-30 years after the conflict (O'Toole et al, 2010; O'Toole et al, 2009; see also Grayson et al, 1996). Such psychological trauma, often suppressed on re-entry into civilian life, can be triggered by new traumatic events, including illness or the death of a spouse, and subsequently lead to depression (Byles et al, 2000; Elder & Clipp, 1989). The incidence of PTSD following the Vietnam and Gulf wars was estimated at 15% (Kang & Hyams, 2005), and studies have linked PTSD with increased suicidal ideation and behaviours among veterans from different wars (Sher, 2009a, 2009b; Jakupcak et al, 2008).

The cultural environment in which the veteran was previously immersed is receiving increased attention from researchers as a possible risk factor. The ease of access to firearms, and intimate knowledge of their use, is likely to influence their choice by veterans as a method of suicide (Rozanov et al, 2009; Kaplan et al, 2007; Lambert & Fowler, 1997). In a US study, both male and female veterans were found to use firearms in suicide more often than non-veterans (Kaplan et al, 2009). Whether in Australia this effect on the veteran population has been moderated by stricter gun control legislation is unclear (Klieve et al, 2009).

A further feature of the cultural environment in which the veteran has spent a significant period of time is the valuing of masculinity, with the battlefield as a test of courage and physical strength. Those who survived are seen by many as heroes (Garton, 1998). With this can come a fear of failure, the constant need to prove one's masculinity, rigid and rational thinking, and an inability to express emotions and limit options in times of crisis. These dispositions were found in the psychological autopsies of veteran suicides (McKay et al, 2010). In the case of soldiers returning from Vietnam, the public perception of the war's failure may have affected negatively the veterans' future wellbeing (Creamer et al, 1996; Grayson et al, 1996).

Ideas about masculinity can also affect help seeking by veterans who are experiencing psychological difficulties. Help seeking can be seen as a sign of weakness and help seeking for intangible mental health problems, as distinct from physical ailments, can be seen as unacceptable (Galdas et al., 2005;

O'Brien eta al., 2005). A recent study in the United Kingdom reported ex-servicemen who struggled to talk about their feelings to those outside the military (Green et al., 2010; see also Greden eta al., 2010 and Pietrzak et al., 2010). Peer support was the most used and effective means of seeking support, but it was more readily employed by men whose bravery was already established (Green et al., 2010).

Although research to date has tended to focus on soldiers who are veterans from theatres of war, the modern military role includes that of peace-keeper (Litz et al, 1997). Not directly involved in conflict, peacekeepers have a complex role in managing escalating tensions between various groups and at the same time can be exposed to trauma (Rozanov et al, 2009; Thoresen et al, 2006; Thoresen et al, 2003; Litz et al, 1997; Ward, 1997). It is uncertain whether peace-keeping veterans have higher suicide rates than non-veterans (Thoresen et al, 2006; Thoresen et al, 2003; Ward, 1997), but a study by Ward of 117 veterans from the Somalian conflict found that approximately one-fifth reported significant psychiatric morbidity, including PTSD and alcohol abuse (see also Forbes et al, 2005).

Comment

It is not clear from Australian studies to date that the suicide rate among veterans is elevated compared with that of non-veterans, although two studies have demonstrated a higher incidence. There is, however, a good deal of evidence indicating a higher incidence of risk for suicidal behaviour among veterans in terms of known correlates such as gender, mental illness, alcohol abuse, and previous exposure to an environment in which familiarity with weapons is a requirement.

Suicide prevention and gatekeeper training

Limited evidence exists both internationally and nationally for the effectiveness of suicide prevention programs. Nevertheless, there is some evidence from international studies that education and training of primary health care professionals in the identification and treatment of depression may be effective, and that the provision of gatekeepers may reduce suicide rates (Mann et al., 2005). Further, restricting access to means of suicide has also demonstrated some success in reducing suicide rates (Mann et al., 2005). Additionally, there is an increasing pool of scientific information gathered from well-controlled research studies regarding risk and protective factors for suicide, which may be used to inform future suicide prevention and intervention efforts.

For some time, the need for suicide prevention training of general and specialised mental health workers, as well as primary care providers, has been highlighted by researchers, policy makers and

national and international government bodies. Recognition of the gatekeeper role for these health workers, as well as community workers, in suicide prevention has led to an increased focus on targeting workers for suicide prevention training.

Coined by Snyder, the term gatekeeper refers to 'any person to whom troubled people are turning for help' (Snyder, 1971, p. 39). However, the role of gatekeeper today has a more specific meaning and refers to the trained responder able to assist and support someone at risk of suicide. For example, Turley and Tanney (1998) describe a gatekeeper as 'any person in a position of trust whose potential contact with a person at risk may be informal (friend, family member, sports coach) or more clearly associated with a professional helping role (police officers, teachers, ambulance officers). Gatekeepers who are competent in suicide first aid and comfortable being a first responder with a person at risk play a vital role in the primary care network of a community' (Turley and Tanney, 1998, p.38). Gould and Kramer (2001) describe the objectives of gatekeeper training as 'to develop the knowledge, attitudes, and skills to identify students at risk; to determine the levels of risk; to manage the situations; and to make a referral when necessary' (p. 15).

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One of the most effective gatekeeper training programs is the US Air Force suicide prevention initiative for active duty military personnel implemented in 1996 (Knox et al., 2003), which is ongoing. This program aimed to reduce suicide risk factors and enhance protective factors, including changing policies and social norms, reducing the stigma of help-seeking for mental health problems and improving awareness of mental health issues. Implementation of the programme was associated with a 33% decline in suicide rate as well as reductions in levels of other related outcomes, such as accidental deaths, homicide and incidents of domestic violence among Air Force personnel.

Empirical support for gatekeeper training is mixed (see for example, Morris et al., 2000; Rutz, 2001; Knox et al., 2003; Appleby et al., 2001; Gould, et al., 2003; Wyman, et al., 2008). Isaac et al. (2009) reported a systematic review of the literature on gatekeeper training for suicide prevention. They concluded: 'Gatekeeper training is successful at imparting knowledge, building skills, and molding the attitudes of trainees: however, more work needs to be done on the longevity of these traits and referral patterns of gatekeepers. There is need for randomised controlled trials. In addition, the unique effect of gatekeeper training on suicide rates needs to be fully elucidated' (p. 260)

Even less is known about the effectiveness of gatekeeper training for peer support networks for veterans within the community (Tierney, 1994; Tierney et al., 1990). Only one evaluation study of gatekeeper training within veteran communities could be located. It was conducted on a community sample of counsellors (n = 602) from the US department of Veteran Affairs (VA) (Matthieu et al., 2009; Matthieu et al., 2008). This study used a very brief 1-hour multi-media training program known as QPR -- Question, Persuade and Refer, which resulted in significant differences in knowledge and self-efficacy of non-clinical VA staff pre- and post-training increasing their capacity to work with at risk veterans.

The ASIST program is a form of gatekeeper training adopted in several countries. It is differentiated from other gatekeeper training programs in being (a) longer (14 hours versus 1-5 hours) providing increased emphasis on attitudes and engaging skills using simulations, and (b) a non-linear approach to responding, in that it may not necessarily result in a referral if risk has been lowered in the interaction between responder and the person at-risk and a safe plan has been developed (Rodgers, 2010, p. 9).

Evaluation of ASIST programs for veteran communities in Australia does not appear to have been undertaken to date, but at least three studies have been conducted on the ASIST program in Australia for general community members (see Rodgers, 2010). These have indicated positive impacts of the training on participants, such as increased positive attitudes, increased perceived knowledge, increased willingness to intervene and high satisfaction with training. Internationally there have been more than a score of evaluations. Dunt (2009) gave an example of one such evaluation from Scotland which surveyed more than 500 participants over the period 2003-2007. Participants felt that their knowledge, skills, and confidence in being able to deal with an at-risk person had significantly improved after their participation in an ASIST workshop. Further, participants felt that after the ASIST workshop they would be more likely to intervene with a suicidal person; however, there was no indication whether any of the participants had had such an experience after the workshop or what they had done in such a situation. Although these evaluations focused on the impacts of training on participants, there was no measure of the impacts on reducing suicide risk, enhancing protective factors, and other general outcomes such as increased help-seeking.

Rodgers (2010) undertook a review of ASIST which was funded by Living Works Education Inc, under whose auspices the program is disseminated. His review was based on a total of 20 evaluations undertaken in five countries around the world. He concluded:

1. ASIST trainees have generally been very satisfied with the training.
2. ASIST trainees have demonstrated greater relevant knowledge and positive attitudes when compared to pre-training states or non-trainees.
3. ASIST trainees have demonstrated increased intervention skills, either through self-assessments or as assessed through simulations, when compared to pre-training states or non-trainees.
4. ASIST trainees have generally reported increased interventions with those possibly at risk for suicide, when compared to pre-training states or non-trainees; increases, however, have not been seen in all settings.
5. In a single evaluation, ASIST-trained school personnel reported fewer known suicide attempts when compared to schools that received other types of training, but caution is warranted when interpreting this result.
6. The use of ASIST training is dependent upon several factors outside the influence of the training. Most notable of these factors is the opportunity to engage those who are at risk for suicide.

Although it is clear that the ASIST program is popular among participants and routinely results in positive changes to knowledge, attitudes, skills, and in most instances, intervention behavior, its impact upon suicidal behavior has not been adequately evaluated.' (Rodgers, 2010, p. 4).

ASIST was reviewed by the American Suicide Prevention Resource Center (SPRC) in terms of adherence to standards based on the US National Strategy for Suicide Prevention. These standards relate to the accuracy of content, likelihood of meeting objectives, programmatic integrity, and safe and effective messaging. They do not relate to outcome of a program. The result of the evaluation was inclusion of ASIST in the SPRC best practice registry (http://www2.sprc.org/bpr/section-iii-adherence-standards).

Fewer studies relating to the effectiveness of safeTALk and none relating to ASIST Tune Up were located. McLean et al. (2007) reported on a pilot evaluation of safeTALK with 239 participants drawn from a number of health and community agencies in Scotland. There was a strong positive

response to the program, with 93% of participants indicating they would recommend the workshop to a friend and 80% indicating that they were 'more likely to recognise the signs of someone being at risk of suicide, to approach the person, to ask them directly whether they were having suicidal thoughts and to be able to connect them to help' (p. 5).

A small scale study of 17 self-selected veterinary studies undergraduates indicated that the 'vast majority' of them considered that they were more prepared as a result of safeTALK to recognise the signs of suicide risk, to engage with the person, and to be able to connect them to sources of assistance' (Mellanby et al., 2010).

A much larger study (N = 9000) was directed to suicide prevention in the construction industry in Queensland (Gullestrup, Lequertier, & Martin, 2011). As part of this program, safeTALK was included in 'connector' training to assist in identification and referral of workers at risk of suicide. Of the 424 for whom data on the value of safeTALK were available, 96% of participants reported feeling *well prepared* or *mostly prepared* to 'talk directly and openly to a person about their thoughts of suicide' and 74% reported that the training was 'very helpful'.

Comment

Gatekeeper training, and ASIST is a form of this, has been accepted as one aspect of a suicide prevention program, although a clear demonstration of its effectiveness in reducing suicide has yet to be reported. This is the case for both training targeted at the general community as well as veteran samples specifically. Nevertheless, ASIST when properly delivered can enhance the capacities of participants to deal with potentially suicidal individuals. Increased competence in suicide prevention does not necessarily equate to more effective client outcomes or reduced suicide morbidity or mortality rates, but the present evaluation of which this review is a part was not directed to the question of long term influence on suicide outcomes. There is less evidence with respect to safeTALK and ASIST Tune Up.

3. Review of the training manuals

Trainers for safeTALK and ASIST are given manuals which inform both the content they teach and ways in which the teaching is to be delivered. The evaluators reviewed both manuals. Upon request, the evaluators were given Version X of the ASIST training manual; the particular version of the safeTALK manual was not specified.

Both manuals are comprehensive and valuable tools for a trainer, especially one still gaining experience. Core learning objectives of each of the workshops (safeTALK's Tell Ask Listen KeepSafe and ASIST's Connect Understand Assist) are set out clearly and accessibly; the training itself is easy to follow.

One of the strengths of both the safeTALK and ASIST training is the allowances given for trainers to adapt the material to suit their audience. Although the core learning objectives cannot be deviated from – a point also particularly stressed during the ASIST workshops attended by the evaluators – the context of the training content can be varied to suit the target audience. For example, the PowerPoint presentation and the role plays can be made more relevant. One example is the introductory slide customised for the Australian Defence Force, with relevant images and quotes, shown on page 9 of the safeTALK manual. In this way, while the content essentially remains the same, at least in terms of the core learning objectives, the delivery can differ to best suit the target group. In the workshops attended veteran-specific slides were not included in the PowerPoint presentation.

The role-plays practiced during the workshops can also be customised. In both workshops, participants are shown two examples of the different scenarios – one where intervention does not occur and one where it does. Given the shorter duration of safeTALK, there are fewer chances to practise different scenarios within the group. The examples practised were more general awareness-raising than veteran-specific. In contrast, there were several opportunities to practise different interactions and role-plays during the ASIST workshops. In ASIST, some of the role-plays are initially broken down into separate learning objectives; for example, participants could practise the principles of Connect first before practicing the whole process.

The evaluators were only provided with the training manuals, and not the videos that are presented during the workshops. In both safeTALK and ASIST, the videos are used as a visual learning aid as well as providing a précis for the role-plays each participant will subsequently perform. The flexibility allowed in the workshop delivery can mean that different versions can be shown. For example, at one site the Australian version of the intervention scenario was played while, at another, the Canadian version was shown.

The research cited within the 'Preparing Notes' section is predominantly peer-reviewed and rigorous; however, it is relatively out-dated (most recent publication date 2003) with no reference to Australian-based findings. Further, some of the conclusions attached to specific references may not be entirely accurate (see the Canetto and Sakinofsky reference on p. 57 of the ASIST manual); other statistical conclusions are not referenced at all ("…as few as 6% of the population who will attempt suicide at some time in their lives arrive at medical treatment facilities" p. 62 of the ASIST manual). Although the 'Preparing Notes' section does not claim to provide a systematic review of current suicide research, this may be all the trainers learn or know about suicide, which limits their ability to answer complex questions in the field of suicide intervention and prevention or to guide reflective discussions. Furthermore, there is no information on specific risk factors for occupational groups such as veterans.

4. Analysis of participant feedback from previous workshops

The data reported in this section come from the participant feedback forms collected during safeTALK and ASIST workshops conducted prior to AISRAP's evaluation. These feedback forms were developed by LivingWorks and are generally included as tear-sheets in the workbooks given to all participants at the beginning of each workshop.

safeTALK Participant Feedback

Two different types of feedback surveys were used. One incorporated pre- and post-workshop sections and one which had only a post-workshop section. Where questions were consistent, the two groups have been analysed together; otherwise questions have been analysed separately. The safeTALK session conducted in Launceston (3 August 2009) used both feedback forms but has been analysed with the pre-/post-workshop group.

Participants

The participants were those who attended a safeTALK workshop as part of Operation *Life* between May 2009 and November 2010, inclusive. Altogether, there were 29 workshop sites, 33 workshops held, with a total of 370 participants. 227 participants completed pre- and post-workshop surveys (Group 1) and 143 participants completed only a post-workshop survey (Group 2). Participants did not answer every question. It is not clear how many veterans attended the workshops.

Materials

Participants who completed the pre-/post-workshop feedback form (Group 1) were asked to provide background information prior to commencement of the safeTALK workshop. This included: the date and location of the workshop, participants' main area of work, reasons for attending safeTALK, previous suicide prevention training, and previous experiences responding to suicidal people including how prepared they felt in this circumstance. Following the session, participants were asked to respond, using Likert scales, to a series of statements about their perceived capacity to help someone with suicidal thoughts and their satisfaction with the with the training and the trainers.

The participants who completed the post-workshop survey only (Group 2) were not asked for background information. They were asked to respond to questions regarding their perception of the training and trainers and their perceived capacity to help. Some questions used Likert statements and some allowed for written answers. The results from the former are reported here.

Results

The number of participants by the date and location of the workshop are summarised by group in Tables 1 and 2. Inspection of these tables indicates that Group 1 respondents were drawn from two capital cities and regional centres across Australia, whereas the largest proportion of Group 2 respondents were drawn from the capital cities of Sydney, Melbourne, and Brisbane. These differences are simply noted.

Only Group 1 was asked about their reasons for attending safeTALK and about any previous suicide prevention training they had undertaken. The majority of participants reported that they attended safeTALK in a volunteer capacity (52.5%); 27.9% attended for personal reasons and 17.4% for work. Participants worked primarily in the areas of welfare/counselling (42.1%), defence (21.8%), mental health (12.5%) education/training (3.2%), and corrections/police (2.3%). A number (18.1%) ticked the ‘other’ category. The majority (68.6%) had not previously undertaken any suicide prevention training. Of those who had, 5.8% had completed a course of 1-3 hours duration, 17% had completed a 1-2 day course, and 8.5% had completed longer courses.

For the majority of participants (153 or 68.6%), safeTALK was their first experience of suicide prevention training. However, some three-quarters of the sample had had some experience of talking about suicide. Participants were asked *How many times have you talked directly and openly to a person about their thoughts of suicide?* Of the 223 participants responding to this question, 24% indicated ‘Never’, 12% indicated ‘Once’, 32% ‘2-5 times’, 12% ‘6-20 times’, and 19% indicated ‘More than 20’.

Table 1. Number (n) of safeTALK participants by date and location-Group 1

Location	Date	n	Percent
Lismore		22	9.7
	09.06.10	10	
	30.06.09	12	
Perth		21	9.3
	16.11.10	8	
	25.08.09	13	
Warradale	27.02.10	19	8.4
Launceston	03.08.09	17	7.5
Cooloola	21.10.10	15	6.6
Cairns	28.05.09	15	6.6
Bendigo	15.04.10	14	6.2
Canberra		13	5.7
	01.06.10	4	
	02.07.10	9	
Sydney	19.01.10	13	5.7
Lakes Entrance	03.09.09	12	5.3
Altona	02.06.09	12	5.3
Frankston	27.10.10	11	4.8
Gosford	09.03.10	11	4.8
Wodonga	04.07.10	10	4.4
St. Helens	21.09.09	8	3.5
Albany	20.08.09	8	3.5
Goodna	24.11.10	6	2.6
Total		227	100

Table 2. Number (n) of safeTALK participants by date and location – Group 2

Location	Date	n	Percent
Sydney		32	22.4
	07.06.10	10	
	17.03.10	22	
Melbourne	18.12.09	16	11.2
Brisbane	26.05.09	15	10.5
Currumbin	07.12.09	15	10.5
Adelaide	21.10.09	14	9.8
Ourimabah	05.11.09	11	7.7
Geelong	16.03.10	10	7
Upwey	15.07.10	10	7
Hervey Bay	10.12.09	9	6.3
Port Augusta	03.09.09	6	4.2
Townsville	27.05.09	4	2.8
Lismore	08.06.10	1	0.7
Total		143	100

The tables that follow summarise responses to each of the questions asked of participants. Each table provides the exact wording of the question, the frequency and percentage of participants responding in each response category, and the number of participants (n) on which percentages in the table are based. The ns vary even within a group because not all participants answered all questions. Also included in each table, where appropriate, is the 'Percent Favourable', which is the sum of the percentages in categories that represent a positive response to the question as distinct from those that indicate an undecided or negative response. Whereas the individual percentages indicate the spread across response options, the Percent Favourable indicates the percentage in broad agreement with the proposition of the question.

Participants' perceptions of delivery of the safeTALK workshop

Tables 3 and 4 summarise responses to the two questions about delivery of the workshops.

Table 3.
My trainer was prepared and familiar with the material.

Strongly Agree f %	Agree f %	Partly Agree f %	Disagree f %	Percent Favourable
316 (85.6%)	53 (14.4%)	0 (0%)	0 (0%)	100%

n = 369

Table 4.
My trainer encouraged participation and respected all responses.

Strongly Agree f %	Agree f %	Partly Agree f %	Disagree f %	Percent Favourable
312 (84.8%)	55 (14.9%)	1 (0.3%)	0 (0%)	99.7%

n = 368

As inspection of the tables indicates, the great majority of respondents were in strong agreement that the program was delivered well; none disagreed.

Participants' experiences and changes in their perceptions of their preparedness to help people at risk

The next set of tables indicates the extent of preparedness participants reported after the workshops.

Table 5.
I will recognise signs inviting help.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
115 (51.6%)	101 (45.3%)	7 (3.1%)	0 (0%)	96.9%

n =223

Table 6.

I will approach a person with thoughts of suicide.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
87 (39.2%)	125 (56.3%)	10 (4.5%)	0 (0%)	95.5%

n =222

Table 7.

I will ask directly about thoughts of suicide.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
109 (49.3%)	99 (44.8%)	13 (5.9%)	0 (0%)	94.1%

n =221

Table 8.

I will connect a person with thoughts of suicide to someone who can help them keep safe.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
147 (66.2%)	64 (28.8%)	11 (5%)	0 (0%)	95.0%

n =222

Inspection of Tables 5 to 8 indicates that following the program a very substantial proportion (94 to 97%) of participants reported that they were better able to respond to a person with suicidal thoughts. More (66%) were confident about organising a safety plan than with approaching the person directly (39%), but some reticence is not surprising in such a confronting situation. Just on 50% of respondents indicated that they were much more likely to ask directly about suicide. This is a good outcome for the program. Although a statement of intention only and as such one that might not be borne out by action if the

occasion arises, there is reason to expect a reasonable relationship between intention and action particularly in novel situations (see e.g., Ouellette & Wood, 1998).

Participants' experiences and changes in their perceptions of their preparedness to help people at risk

Questions about feelings of preparedness were asked of Group 1 before and after the workshop but in different ways. Participants were first asked: 'At this time, how prepared do you feel to talk directly and openly to as person about their thoughts of suicide?' After the workshop, they were asked: 'How prepared do you now feel to talk directly and openly to a person about their thoughts of suicide?' Group 2 participants were only asked about their preparedness at the end of the safeTALK workshop. Finally, after the workshop, Group 1 participants were asked whether they would 'recommend this training to others'. In contrast, Group 2 participants were asked to respond to two different questions. The first was a yes/no statement: "I intend to tell others that they will benefit from this training"; the second asked participants to rate the training on a five-point Likert scale from 1 (= not at all helpful) to 5 (= very helpful).

In Group 1, 224 participants responded to both the pre- and post-workshop questions. There was a substantial change in the perceived preparedness of participants, as inspection of 9 indicates.

Table 9.
Participants' preparedness pre- and post-safeTALK – Group 1

	Mostly prepared f %	Well prepared f %	Partly prepared f %	Not prepared f %
Pre-Workshop	71 (31.7%)	20 (8.9%)	53 (23.7%)	80 (35.7%)
Post-Workshop	126 (56.3%)	67 (29.9%)	30 (13.4%)	1 (.4%)

n =224

Whereas slightly less than a third of participants in Group 1 considered they were mostly prepared to interact with a person with suicidal thoughts before the program, this proportion rose to over 50% following the program. More importantly, the proportion who considered they were unprepared fell from over a third (36%) to less than 1%.

Following the safeTALK workshops, Group 2 participants responded to the question: "How prepared do you now feel to talk directly and openly to a person about their thoughts of suicide?"

Table 10 summarises the results.

Table 10.
Participants' preparedness pre- and post-safeTALK – Group 2

Mostly prepared f %	Well prepared f %	Partly prepared f %	Not prepared f %	Percent Favourable
47 (33.1%)	70 (49.3%)	25 (17.6%)	0 (0%)	100.0%

n = 142

Group 1 participants were only asked one question regarding future recommendations. In total, 220 participants responded to the question: "Would you recommend this training to others?" Overwhelmingly, 218 participants (99.1%) said that they would; only 2 participants (0.9%) said they would not.

Group 2 participants were asked two questions regarding future recommendations. In total, 136 participants responded to the statement: "I intend to tell others that they will benefit from this training". The overwhelming majority of participants (134; 98.5%) intended to tell others about the workshop's benefits. Only two participants (1.5%) said they would not tell others. In addition, 141 participants answered the question: "On a scale of 1 = not at all helpful to 5 = very helpful how would you rate this training?" The response was once again overwhelmingly positive, as inspection of Table 11 shows.

Table11.
On a scale of 1 = not at all helpful to 5 = very helpful how would you rate this training?

1 Very helpful f %	2 f %	3 f %	4 f %	5 Not at all helpful f %	Percent Favourable
107 (75.9%)	24 (17%)	9 (6.4%)	1 (0.7%)	0 (0%)	92.9%

n = 141

Comment

As a brief glance through the Percent Favourable indexes accompanying the tables in this section indicates there was very strong support (in the 90% range) for all aspects of the safeTALK workshops on which an opinion was sought from participants.

ASIST Participant Feedback

As with safeTALK, two different types of feedback survey forms were used. Only those questions consistent between both forms were compared. The ASIST participant feedback form only included one question in both pre- and post-workshop sections about participants' feelings of preparedness.

Participants

The participants were those who attended an ASIST workshop as part of Operation *Life* between October 2009 and December 2010, inclusive. There were 13 workshop sites, with two workshops held at the same site. In total, participant feedback forms from 147 participants at 14 workshops were analysed. Not all participants answered every question.

Materials

Participants were asked to provide background information prior to commencement of the ASIST workshop. This included: the date and location of the workshop, participants' main area of work, reasons for attending ASIST, previous suicide prevention training, and previous experiences responding to suicidal people including how prepared they felt in this circumstance. After ASIST, they were asked to respond, using Likert scales, to statements about their perceived capacity to help and their satisfaction with the training and the trainers.

Results

The number of participants by the date and location of the workshop are presented in Table 12.

Table 12. Number (n) of ASIST participants by date and location

Location	Date	n	Percent
Sydney	28.9.10	23	15.6
Adelaide	10.7.10	20	13.6
Townsville		19	12.9
	22.11.10	10	
	06.12.10	9	
Gosford	10.6.10	14	9.5
St. Helens	17.7.10	13	8.8
Maroochydore	01.10.09	11	7.5
Lismore	02.8.10	11	7.5
Melbourne	25.5.10	10	6.8
Perth	05.5.10	8	5.4
Port Augusta	24.2.10	6	4.1
Hervey Bay	06.7.10	5	3.4
Currumbin	03.6.10	4	2.7
Brisbane	01.6.10	3	2
Total		147	100

As inspection of Table 12 indicates, participants from sites across Australia were involved, although less than 10% were from sites in Queensland.

Approximately 50% of participants attended the ASIST workshop in a volunteer capacity; 39% as part of their work; and, 11% for personal reasons. These ASIST participants appeared to primarily work in the areas of welfare/counselling (50.7%), 'other' (16.7%), or defence (12.5%). Other areas of work included: mental health (5.6%); the service industry (2.8%); physical health (2.1%); sport/recreation (1.4%); and, pastoral care/clergy and business/trade (both 0.7%). The majority of the ASIST participants had previously undertaken some form of suicide prevention training. Most had completed courses of 1-2 days duration (43.1%), 13.9% had completed courses of 1-3 hours duration, and 9% had completed longer courses. However, for 34% the ASIST workshop was their first experience with suicide prevention training.

A total of 145 participants responded to the question: 'How many times have you talked directly and openly to a person about their thoughts of suicide?' Of these, 66 participants (45.5%) had talked to someone 2-5 times; 20 participants (13.8%) had talked to someone 6-20 times; the same number

had done so once before; and, 14 participants had talked with a suicidal person more than 20 times before the workshop. In contrast, 25 participants (17.2%) had never spoken to a suicidal person.

Data are summarised in the following tables in the same way as data were earlier presented for the safeTALK evaluation.

Participants' perceptions of the ASIST workshop and the trainer

Before the workshop, participants were asked what they expected to learn from ASIST. Responses to this question (Question 6) included knowing more about suicide prevention and intervention, the desire to provide practical help to a suicidal person, and feeling more confident and comfortable talking to people about suicide. Respondents were asked at the conclusion of the workshop whether their expectations had been met. The results are tabulated in Table 13.

Table 13.
ASIST has met my expectations from question 6.

Strongly agree f %	Agree f %	Partly agree f %	Disagree f %	Percent Favourable
101 (72.1%)	37 (26.4%)	2 (1.4%)	0 (0%)	98.5%

n = 140

Tables 14 and 15 summarise responses to the two questions about delivery of the workshops.

Table 14.
My trainer was prepared and familiar with the material.

Strongly Agree f %	Agree f %	Partly Agree f %	Disagree f %	Percent Favourable
124 (86.1%)	20 (13.9%)	0 (0%)	0 (0%)	100%

n = 144

Table 15.

My trainer encouraged participation and respected all responses.

Strongly Agree f %	Agree f %	Partly Agree f %	Disagree f %	Percent Favourable
123 (85.4%)	20 (13.9%)	1 (0.3%)	0 (0%)	99.3%

n = 144

The great majority of respondents strongly agreed that the trainer was well prepared and encouraged and respected participants' responses.

Participants' perceptions of their own abilities to respond to people at risk of suicide

The tables that follow summarise the results for those questions directed to the capacity of participants to respond to those at risk.

Table 16.

I will recognise signs inviting help.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
93 (65.5%)	44 (31%)	5 (3.5%)	0 (0%)	96.5%

n = 142

Table 17.

I will ask directly about thoughts of suicide.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
98 (68.1%)	43 (29.9%)	3 (2.1%)	0 (0%)	98%

n = 144

Table 18.

I will explore why someone is thinking of suicide and what connects them to living.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
98 (68.1%)	43 (29.9%)	3 (2.1%)	0 (0%)	98%

n = 144

Table 19.

I know how to review immediate suicide risk.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
73 (50.7%)	65 (45.1%)	6 (4.2%)	0 (0%)	95.8%

n = 144

Table 20.

I could take steps to increase the safety of a person at risk.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
92 (64.3%)	48 (33.6%)	3 (2.1%)	0 (0%)	97.9%

n = 143

Table 21.

I am aware of how my attitudes affect helping a person at risk.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
88 (61.5%)	49 (34.3%)	6 (4.2%)	0 (0%)	95.8%

n = 143

Table 22.

I have options for self-care in my helper role.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
75 (52.1%)	58 (40.3%)	11 (7.6%)	0 (0%)	92.4%

n = 144

Table 23.

I will network with others around suicide safety.

Much more likely f %	More likely f %	About the same f %	Less likely f %	Percent Favourable
73 (50.7%)	62 (43.1%)	9 (6.3%)	0 (0%)	93.8%

n = 144

For all the skills involved in working with suicidal people asked about in this set of questions, there was broad support (in many cases up to 100%) for the proposition that participants' perceptions of their capability had improved. In all cases 50% or more indicated that they were now more likely to engage in the activities directed to improving the outcome for a suicidal person.

Participants' experiences and changes in their perceptions of their preparedness to help people at risk of suicide

Questions about participants' feelings of preparedness were asked before and after the workshop but in different ways. Participants were first asked: 'At this time, how prepared do you feel to help a person at risk increase their suicide safety?' After the workshop, they were asked: 'How prepared do you now feel to help a person at risk increase their suicide safety?' Following the workshop, participants were asked whether they would 'recommend this training to others'.

Table 24 summarises the change in preparedness reported by participants as a result of the ASIST workshop they attended. As inspection of the table indicates, the proportion who considered they were mostly prepared increased from just under a third to over a half from pre- to post-workshop, and the proportion who considered they were unprepared decreased from 10% to zero.

Table 24.
Participants' preparedness pre- and post-ASIST

	Mostly prepared f %	Well prepared f %	Partly prepared f %	Not prepared f %
Pre-Workshop	46 (32.2%)	14 (9.8%)	69 (48.3%)	14 (9.8%)
Post-Workshop	80 (55.9%)	59 (41.3%)	4 (2.8%)	0 (0%)

n = 143

Finally, 143 participants responded to the yes/no question: 'Would you recommend this training to others?' Overwhelmingly, 142 participants (99.3%) said they would recommend it; only one participant (0.7%) would not.

Comment

The results summarised here indicate that the participants in ASIST workshops are strongly supportive of the value of the workshops in terms of their overall perceptions of delivery and of the specific attitudes and capacities that are developed. In no instance did broad agreement fall below 92% for the propositions advanced in the questions put to participants.

Summary

This section of the report has considered data gathered from evaluations of safeTALK and ASIST prior to AISRAP's review. The data were drawn from survey forms routinely administered as part of the workshop program. Participants completed the workshops in a number of metropolitan and regional centres across Australia. Although not systematic, the size and spread of the sample provides some basis for considering the results a reasonable reflection of outcomes for the two programs. The number of veterans participating is however unknown. For 68% of participants in the safeTALK workshops it was their first experience of suicide training, but 76% of participants had spoken directly and openly at least once to a person with thoughts of suicide. For participants in the ASIST workshops the respective percentages were 34% and 76%.

In the case of both safeTALK and ASIST the survey results were very favourable in terms of both the delivery of the workshops and the beliefs of participants about their increased capabilities as a result of their participation. With 90% to 100% of participants endorsing positively the questions put to them about the workshop, there can be little doubt that the participants are satisfied with the experience and consider they have learnt something valuable from it.

As noted above, the assessments of outcome are about intentions rather than actions, and what a participant believes they will now do as a result of a workshop is not the same as what they will do when confronted by a person at risk. The intentions asked about were, however, in many cases reasonably specific (e.g., 'I will ask directly about thoughts of suicide') and in these circumstances there is evidence to suggest that intention is a good, although less than perfect, predictor of future behaviour, particularly in novel situations. More information about outcomes is required for a firm view about the impact of the workshops, but endorsement by those who participate in them is itself an essential first criterion of their value.

5. Evaluation of the workshops

Participants and Design

The original plan for the project called for quantitative and qualitative analysis of participation in safeTALK, ASIST, and ASIST Tune Up workshops, with a sample size of approximately 120. Scheduling and attendance difficulties and a substantial drop-out rate (32-44%) resulted in a much smaller data collection than this. During the study period no ASIST Tune Up workshops were scheduled. Final numbers were 19 participants in ASIST and 16 in safeTALK workshops, considerably smaller than expected, and hence generalisation to the larger veteran community must be done cautiously.

The study used a pre-test / post-test design, with a three-month follow-up. Survey data were collected in person at the beginning of the workshop, in person on completion of the workshop, and at three month follow-up surveys were delivered by mail. In addition, telephone interviews were conducted with those willing to participate at three-month follow up.

The results presented here are based on three different workshops attended by two evaluators. These workshops took place during March 2011. The evaluators attended two ASIST workshops and one safeTALK workshop, each at a different site. Attendance at these workshops was organised through DVA and approved by the main trainer.

Participants were informed in advance that an evaluation process would be taking place at their workshop. Consent was obtained for all data collections. The evaluators participated in the workshops.

There were 12 participants, excluding the two evaluators, at one ASIST workshop. One participant only attended on the second day. In this group, there was a fairly equal mix of veterans and their partners, as well as an adult child of a veteran. All the participants knew each other well and many knew the lead trainer as they had previously undertaken a safeTALK workshop.

The ASIST workshop held at the second site had seven participants, all but one of whom were veterans. The other participant closely worked with veterans. There was only one woman in the group. Three of the participants had travelled at least an hour to be there and only three knew each other.

The safeTALK workshop attended by the evaluators had 16 participants, excluding the two evaluators. There was a mix of veterans, partners and community workers. Most of the community workers were also veterans. All the participants knew each other in some capacity, either through their employment or in a more social context.

Survey Instruments

A three-part survey was designed by the evaluators, with separate versions for safeTALK and ASIST participants. The items in each survey were developed directly from the suicide awareness learning objectives within both training manuals, as well as factors identified in research on suicide in veterans. There were two parts to each survey: Perceived Capability and Actual Knowledge. Both parts were completed at the same time. As well, information was sought on participants' gender, age, position/role, experience in helping someone who was suicidal behaviour, and previous suicide prevention training.

The Perceived Capability section consisted of nine Likert scales and took approximately five minutes to complete. The Actual Knowledge test was in three parts, a mix of True/False and short-answer questions, and took about 15 minutes to complete. The actual survey forms appear in Appendix A.

Interviews were semi-structured, audio-taped, and transcribed for analysis.

Results of the Quantitative Analysis

Summaries of the data collected are presented in Appendix B with the results of statistical tests of differences, obtained using SPSS. The present section is concerned with inferences that can be made from these data, first for SafeTalk and then for ASIST. The conventional .05 level has been adopted throughout. Paired sample t tests were used to compare mean response levels at each of the three points (pre-, post-workshop, and follow-up). Where the n for a particular comparison was less than 10 and the t test indicated a statistically significant difference, the decision was checked using the Wilcoxon signed ranks test, a generally less powerful test but one that makes fewer assumptions. Only in those cases where the decisions based on the two significance tests agree, has the judgement been made that there is a difference.

safeTalk

Participants' Perceived Capability was assessed on nine 7-point scales. Scale points 3, 4, and 5 were marked as indicating 'moderately capable' and point 6 and 7 as 'very capable'. As inspection of Tables 1 to 3 in Appendix B indicates, median score on seven of the nine scales moved from the moderately capable range to the very capable range as a result of participation in the workshop and this change was largely maintained at 3-month follow-up. The changes from pre- to post-workshop were statistically significant. The two scales that did not show movement into the 'very capable' range were 'Ability to engage a person with suicidal thoughts or behaviour, in direct and open talk about suicide' and 'Ability to quickly connect a suicidal person with someone who can do a suicide intervention'. However, in both cases there was substantial shift (2 scale score points and 3.5 scale score points, respectively) as a result of the workshop.

Participants' Actual Knowledge was assessed in three ways: a series of True/False questions, a series of short answer questions, and a scenario accompanied by a set of short answer questions. Statistically significant improvements in total score for the True/False questions occurred as a result of participation in the workshop (pre-workshop mean = 8.5; post-workshop mean = 11.71; $t = -3.69$, $N = 14$, $p = 0.003$). Significant improvements were also found when comparing pre-workshop and follow-up scores (pre-workshop mean = 7.43, follow-up mean = 11.86, $t = -6.16$, $N = 7$, $p<0.001$; Wilcoxon $p<.05$). The difference between means for post-workshop and follow-up mean scores was not significant (post-workshop mean = 11.50; follow-up mean = 12.17; $t = -1.19$, $N = 7$, $p = 0.286$). That is, the changes were at least maintained at follow-up.

For the short answer questions assessing Actual Knowledge, statistically significant improvements in scores were found from pre- to post-workshop (pre-workshop mean = 4.43; post-workshop mean = 6.07; $t = -3.74$, $N = 14$, $p = 0.002$). Improvements were also found when pre-workshop and follow-up means were compared but in this case the decision to be reached from the two tests of significance differed (pre-workshop mean = 4.00; follow-up mean = 6.00; $t=-2.74$, $N = 6$, $p = 0.041$; Wilcoxon $p<.05$)). No statistically significant difference was found when comparing the post- and follow-up periods (post-workshop mean = 6.57; follow-up mean = 6.00; $t=0.93$, $p=0.386$). Again the inference is that the gains were maintained at follow-up.

For the scenario section of the Actual Knowledge test, data are summarised in Tables 4 and 5 of Appendix B. These data show no substantial or statistically significant changes as a result of the workshop.

ASIST

Participants' Perceived Capability was assessed on nine 7-point scales with somewhat different content to those used with the safeTalk workshops. Scale points 3, 4, and 5 were again marked as indicating 'moderately capable' and point 6 and 7 as 'very capable'. As inspection of Tables 6 to 8 in Appendix B indicates, median score on all but one of the nine scales moved from the moderately capable range to the very capable range as a result of participation in the workshop and this change was largely maintained at 3-month follow-up. The changes from pre- to post-workshop were statistically significant. The scale that did not show movement into the 'very capable' range was 'Awareness that my personal attitudes can affect how I interact with a suicidal person'. The median for this scale was in the very capable range before the workshop.

For Actual Knowledge, three methods of assessment were used, as in the evaluation of the safeTalk workshop. There was an increase in total score on the True/False questions from pre-workshop to immediately post-workshop, but the difference was not statistically significant (pre-workshop mean = 11.05; post-workshop mean = 13.47; t = -1.89, N = 6, p = 0.075). However, the difference from pre-workshop to follow-up was statistically significant (pre-workshop mean = 10.5; follow-up mean = 14.33; t = -3.21, N = 6, p = 0.024; Wilcoxon p = .05).

For the short answer questions, the difference from pre-workshop to immediately post-workshop was not statistically significant (pre-workshop mean = 4.63; post-workshop mean = 4.31; t = 0.66, N = 6, p = 0.518). The difference from pre-workshop to 3-month follow-up was statistically significant by t test (post-workshop mean = 3.50; follow-up mean = 5.33; t = -3.05, p=0.028), but not according to the nonparametric test (Wilcoxon p>.05).

Tables 9 to 12 in Appendix B summarise the findings with respect to the scenario section of the Actual Knowledge evaluation. In no case were the changes substantively or statistically significant.

Results from the Qualitative Analysis

Transcripts of the interviews were analysed for theme and narrative using NVivo 9. An analysis of the short-answer sections of the surveys was also conducted. Of particular interest were perceptions of the workshops' relevance, appropriateness, and effectiveness.

A total of 13 participants completed the follow-up survey and 6 took part in the interviews. The detail of this analysis is presented in Appendix C. For present purposes the results can be summarised as follows.

In general the response to the workshops was positive.

> *It was more grass-roots-type thing, simple language, simple questioning and so for me it was good. It wasn't…frightening to go to*.
>
> *Things that I didn't know I learnt from*
>
> *I thought it was a great, great session*.

The role playing aspect was commented on quite favourably.

> *I think role playing is a very important thing because then you can look back at it and see what worked and what didn't.*
>
> *A relevant point in the actual course because I think once you can say it to someone and you try and say, play the part it doesn't matter if you're playing a part or not.*

Some who had experience working with suicidal persons found the sessions useful.

> allowed her *to approach the subject of suicide and talk about it openly*
>
> *I sort of made friends with her, better friends, and got a bit further into her mind and eventually got out of her what was going on*

One person however attributed his capacity to experiences other than the workshop.

Discussion

Limitations of the study

The study reported here is limited by the nature and size of the samples employed and by its design. There are three issues of sampling. The first applies only to the quantitative data and the second and third to the quantitative and qualitative analyses. The design issue applies principally to the quantitative data.

The first issue of sampling concerns the confidence that can be placed in the inferences about differences between pre-workshop , post-shop, and follow-up on the various measures employed, given the sample sizes involved. Statistical significance testing was used here to provide a basis for

deciding that differences were not due to chance. Where outcomes reach the conventional level of statistical significance ($p<.05$), it is reasonable to conclude that there is a real difference. Where the samples were particularly small (<10), a conservative approach was adopted, with a second test of significance being employed. Where both agreed, it is reasonable to infer that even though the samples are small the difference is not simply sampling error.

The second issue relates to the generalisation of the observations from the study to the wider population from which the samples were drawn. Because the original samples were not drawn systematically from the population of interest (those who might work with veterans) but were essentially convenience samples (including non-veterans) that were available at the time of the study, there is no statistical basis for concluding the samples are representative and hence that the results found in this study will generalise to the population of interest.

Of equal importance is the third issue, the possible bias that participant attrition during the course of the study may have introduced. Not all of those who completed the original data collection chose to or were available for the subsequent data collections. Those who participated in these later data collections may have been more receptive to the program and for this reason showed changes that might not be seen with other participants.

Limitations of this sort are not unique to the present study but are commonly found in evaluations conducted in community and organisational settings. The best counter to these is replication of the findings with larger and more representative samples drawn from the same population. To the extent that similar results (within the limits of sampling error) are found in subsequent samples there is reason for greater confidence in them. In the meantime, however, some confidence can be had from the fact that results found here are consistent with those reported from previous studies conducted elsewhere. Had the results here been quite at variance with previous findings, it would be difficult on the basis of these results alone to reach any conclusion.

The design issue has to do with lack of a condition with which the effects of the workshop can be compared. All comparisons were from before to after the workshops and not between the workshops and an alternative method of increasing knowledge and capability of how to deal with suicide. Any changes observed from before to after cannot in strict logic be attributed to the content of the workshop. Changes of the same magnitude could have been observed if participants had, for example, been directed to reading material on working with those showing suicidal

behaviour. Against this it can be said that demonstrating change, as in the design used here, is a first requirement and only if this can be shown does the question of the specific effects of the workshop arise. It is also the case that in a practical situation where the best interests of veterans must be served it is difficult to justify employing a condition that might not be as effective as another. However, the design issue means that caution needs to be exercised in attributing any changes to the specific content of the workshops.

Conclusions

Given these limitations, what the results show is that for participants in the present study there were real and substantial improvements following safeTALK in their perceptions of their capabilities in dealing with a person who may be considering suicide and that these improvements did not deteriorate over a three-month period. The differences were statistically significant and in most cases showed practically important levels of change on the scale used to assess them (from 'moderately capable' to 'very capable'). The changes are consistent with those reported in the literature for evaluations of safeTALK (see earlier Section 2) and with previous evaluations conducted in Australia by LivingWorks as analysed in Section 4 of this report.

For changes in actual knowledge of what to do in working with those who might be considering suicide, the results of the present study for safeTALK varied somewhat with the measure used to assess it. Knowledge was examined in three different ways, and for two of these the results were reasonably clear. For the first (answering True/False to questions about what to do) there was improvement that was maintained over time. The change from pre- to post-workshop was statistically significant and of the order of 3 points on a 14-point scale, or on a scale standardised in terms of pre-workshop variability (SD = 2.68) a change of more than one unit. At follow-up three months later, mean score was again significantly higher than pre-workshop. For the second of the two measures of actual knowledge (responses to short answer questions), the change from pre- to post-workshop was again statistically significant and more than one-and-a-half points on the 10-point scale or more than one unit on a scale standardised in terms of pre-workshop variability (SD = 1.22). At follow-up, mean score was again higher than pre-workshop but the results of significance testing in this case were equivocal. For the third of the measures of actual knowledge the results were not statistically significant.

In the case of the ASIST workshops, the results were equivocal. There were substantial (from 'moderate' to 'very capable') and statistically significant changes for most perceived capabilities, but

for actual knowledge the changes were not always statistically significant and in one instance the direction of the change was negative (a lower mean following the workshop). A conclusion with respect to change in actual knowledge as a result of the ASIST workshop must therefore remain open.

No conclusion can be reached with respect to ASIST Tune Up, which was not evaluated.

To summarise:

1. There were substantial increases in participants' perceptions of their capabilities in dealing with those showing suicidal behaviour and substantial increases in their actual knowledge following safeTALK workshops.
2. There were substantial increases in participants' perceptions of their capabilities in dealing with suicidal behaviour following ASIST workshops, but again these need replication.
3. Change in actual knowledge following ASIST workshops needs further demonstration beyond the present study.
4. The effectiveness of ASIST Tune Up has yet to be assessed.

6. Perceptions of the workshops

VVCS and ESO

As part of the evaluation, a focus group was run with members of the VVCS - Veterans and Veterans Families Counselling Service and members of the Ex-Serviceman Organisation (ESO) Reference Group were interviewed. The VVCS helped arrange the evaluators' attendance at Operation *Life* workshops and ESO lent its support to encouraging participation in the evaluation. Only material directly relevant to the evaluation of the workshops is considered here.

Some VVCS Focus Group participants and ESO Reference Group members had completed one or both of the safeTALK and ASIST workshops. They were asked for their own perception of the workshops overall and, more specifically, of the ones they attended. ESO Reference Group members were more willing to give their own perception of the workshops; VVCS Focus Group participants tended to frame their responses in terms of the *world-wide recognition* of the workshops and previously conducted evaluations. One of the ESO Reference Group members said that everything *had been very positive and we wanted to be critical about it* (the workshop).

Both the VVCS and ESO Reference Group placed importance on the need to tailor suicide prevention workshops to the needs of veterans. An ESO Reference Group member gave an example of a previous trainer who had conducted the same type of workshops:

We had to sit down with them initially and give them a brief on the veteran community…what the community's expectations were and how they should handle veterans. Because it's quite different to be handling a veteran who's got chronic PTSD to somebody who has just volunteered from the wider community to be trained in suicide intervention…. There was lots of nuances that they weren't aware of and had to be made aware of during the presentation.

This simple measure was thought to be effective in that the workshops were perceived to be relevant to the veteran community because they spoke to veterans in their language to their needs.

The VVCS Focus Group also discussed the need to ensure the implementation of the suicide prevention workshops took into account the differing levels of mental health among possible participants. This could include participants with no symptoms of mental illness to others suffering from PTSD. Given the potential vulnerability of veterans to mental health issues, one VVCS Focus Group participant argued that people should perhaps be limited to just doing safeTALK unless they

were *doing lots of work with vulnerable people [and] who want more skills*. Only then, would ASIST be an appropriate workshop to undertake. This participant felt that many within the veteran community would neither be interested nor emotionally capable of undertaking a two-day suicide prevention workshop. This was affirmed by an ESO Reference Group member who found that the role-play participation brought *…things that we'd suppressed or haven't thought about for a long time…. some people find it quite hard to complete the day because it's still so confronting*. Despite this, this same member held that *there's not much point in having some namby-pamby thing that doesn't train you properly*.

Both the VVCS and ESO participants reported having received very positive feedback about the workshops from other participants. Both groups qualified this in different ways. The VVCS participants said it was *very positive but it's quite broad*. From the VVCS perspective, it seemed that *in the main, [participants] seem to have an increased awareness of suicide behaviour. There's an aspect of their skill and confidence improvement that they feel they can take intervention in the future*.

An ESO Reference Group member, who had also attended a workshop, qualified his response in terms of those who had been able to complete the course; there was a disclaimer that a few were not able to do so as it was *too stressful for them*. This member commented *that everyone that's come out the other end, I haven't heard of unkind comments about it, except it's hard work and that's not going to do anyone any harm*.

The VVCS Focus Group participants who had attended an Operation *Life* workshop themselves believed that *it really gives you that much greater insight into the programme and how it's received*. Indeed, those VVCS administrative staff who had completed one or both of the workshops felt *more comfortable or confident in terms of being the first point of contact with VVCS*.

Comment

These observations from participants, who might be expected to be more engaged with the workshop program than the average member of the public, could be interpreted as somewhat biased. If one has committed to a workshop program it is not surprising that one would view it positively. The observations are, however, based in several cases on first-hand experience of the workshop program and the commitment is to veterans rather than to particular training programs. The observations reinforce those of participants in the workshops reported in the previous section.

The Evaluators

The two evaluators from AISRAP attended all three workshops and sought to gather the data for the evaluation as objectively as possible. Inevitably they formed their own opinions and those are provided here not as definitive but simply as part of the information base. Both have experience in suicide research and one has professional training in psychology and clinical experience.

safeTALK and ASIST follow a standard procedure with the gate-keeper role strictly scripted. There are several positive aspects to this. First, a script can be easily taught in an accessible manner – the steps are relatively simple and easy to follow. Second, this accessible training helps to reduce the stigma surrounding suicide, which was demonstrated by comments particularly from safeTALK participants. Third, participation in the workshops raised awareness about suicide among the veterans who attended; participants all spoke about their perceived increase in knowledge and openness to talk about suicide.

The workshops are not veteran specific, although the safeTALK workshop included a video of a veteran's experience of suicidal ideation. During one ASIST workshop, the second trainer made a concerted effort to create a more veteran-specific scenario – even checking to make sure it wasn't too close to anyone's real life experiences. This was done subtly, without disrupting the flow of the narrative. As a result, veterans seemed to be able to talk more about issues, such as compensation claims and loss, which had directly affected themselves and others they knew.

Where ASIST participants had previously completed safeTALK they seemed better equipped to respond to the workshop. They had a language at their disposal that helped them process the material more readily.

There are potential risks attached to being a gate-keeper and these may be greater where the gatekeeper and the suicidal person come from an environment where mateship, loyalty and protecting one's own are strongly valued, if they previously served together. This may create a greater burden for the gatekeeper and a greater sense of failure if the outcome of the intervention is not positive.

The use of role-plays in the safeTALK and ASIST workshops were positively perceived by the workshop participants but may pose problems for some participants who themselves are not at the

peak of psychological health. They may trigger flashbacks, a symptom of PTSD, or a level of emotion difficult to control. One trainer commented that, when compared to other groups, veterans seemed to have trouble distinguishing between the role-plays and real life. Screening of participants to judge whether they are emotionally capable of completing a suicide prevention workshop needs further consideration. A VVCS focus group member noted, however, that one difficulty with the screening process was a person's fluctuating state of wellbeing. On the day of screening, they may be well but still experience difficulties during the workshops.

The problems attached to the use of role-plays within the workshops may also be linked to the idea that suicide interventions undertaken within the veteran community may be a matter of the 'sick helping the sicker'. This phrase was used by several veterans during the workshops. People who volunteer for workshops can be the ones who volunteer for many other workshops. They can be both champions (who advocate strongly for care for suicidal people in their community) and constant volunteers (who will always provide care for those more vulnerable in their community). As such they may be susceptible to 'burn-out' or emotional fatigue but their condition may go unnoticed and unsupported.

Effective debriefing after the workshops may be valuable, particularly for those who because of their own military and post-military experiences may be vulnerable or to those who, as noted, may be suffering emotional fatigue. This might be done for all participants a week or so after a workshop by an experienced person by telephone.

There were differences between the workshops observed in the amount of information available about support services to which gatekeepers could refer veterans if this became necessary. Although in one case a detailed list was provided, in the other there was reliance on participants suggesting the names of appropriate organisations and given their limited experience the list was not long and may not have been accurate.

Comment

The overall view of the evaluators was that the workshops were well presented and well received. They had concerns however about aspects of the workshops, including adequacy of screening, potential problems of role plays, and the provision of information about support services.

7. Conclusions and recommendations

The various aspects of this evaluation -- the literature review, the review of materials, the data collections, and the observations of those involved -- all point to ASIST and safeTALK being strongly endorsed by participants and to the impact of these workshops in changing the perceived capabilities of participants. The findings do not go to the question of their effectiveness in reducing suicidal behaviour, a critical but less studied outcome of the workshops, because this was not part of the present brief.

From what is known from the international literature on gatekeeper programs these can be effective, and ASIST is one of the programs that is widely employed and for which there is a good deal of supportive evidence. It was assessed by the Suicide Prevention Resource Center in the United States as meeting the content requirements for best practice in the field. It has not been widely assessed, however, for its relevance to veteran communities. Nor have studies been conducted either generally or for veteran communities that include long-term follow-ups (12 months or more) to determine the point at which knowledge and skill gains are no longer significant. The demonstration of effective skill acquisition is less understood as it requires an observable assessment component, not conducted in the majority of evaluation studies including this study. Nevertheless, the present evaluation with veteran samples in Australia, admittedly limited as previously noted, indicates that the workshops are delivered in a manner consistent with the training manual and in line with international practice and yield results consistent with previous research. As such it supports the effectiveness of both ASIST and safeTALK in changing participants' understanding of suicide and of how best to intervene. Importantly, both workshops are supported by those to whom they are addressed.

This conclusion implies that, on the basis of the present review, the workshops be continued. The literature review indicated that gatekeeper programs are one effective plank in an overarching suicide policy and indicated few alternatives to safeTALK or ASIST and none that would obviously be superior to them for application in a veteran community. There may be issues beyond the scope of this review such as cost and capacity to deliver that bear on a larger evaluation of the workshops but these were not part of the present brief.

If the workshops continue, further consideration should be given to adjustments that may enhance their value. Again there may be factors outside the scope of the present review that make these suggestions impractical.

The first has to do with the scheduling of safeTALK and ASIST. Although these are stand-alone workshops there would be value in having, wherever possible, participation in safeTALK precede participation in ASIST. The first is shorter and has the aim of alerting participants to suicidal behaviour but in doing this it provides a frame of reference and a language that is of benefit in absorbing the content of ASIST. The topic of suicide is confronting for many members of the community and graded exposure may be helpful. A strict comparison of the knowledge and skills of those completing the workshops in the order suggested here versus those who do not complete safeTALK before ASIST is necessary, of course, to provide a factual answer to the question but, in the absence of this, professional judgement suggests the proposed ordering would be beneficial.

The current background material on suicide is, to judge from the dates of publication, not as current as it could be. Reviewing and updating this material would provide a better knowledge base. In undertaking such a process, it would be advantageous to draw on what is known about suicidal behaviour among veterans from the research literature and possibly add to it from a systematic qualitative analysis of veterans' experience. The later would provide a better sense of the phenomenology and context of veterans contemplating suicide and, with the research findings, provide a firmer grounding for the workshops.

Whether even more should be done to make workshops 'veteran specific' could be considered. On the face of it, scenarios and discussions that go to the veteran experience make for greater relevance and therefore engagement. It cannot be assumed however that there are fundamental differences between suicide in veterans and suicide in non-veterans that make different workshops for the two a requirement. Moreover, those preparing to be gatekeepers may find themselves in the presence of a non-veteran and should not consider that they are unprepared for such a situation. While acknowledging the special circumstances and needs of veterans, it may be counterproductive to emphasis difference when human distress has much in common.

The vulnerabilities of veterans and the demands on those who would assist those who might suicide have been touched on earlier. These matters lead to consideration of the benefits of closer screening of participants and subsequent debriefing, particularly in the case of ASIST. The material in

this workshop, notably the role-playing exercise, can be challenging for those who have a history of trauma and distress and may in fact trigger the re-experiencing of events. Some screening for participation is already attempted. It is not immediately obvious how this can be improved, because any assessment at one point in time can lead to errors in accepting some who might be at risk or rejecting some who might not. Given that the number of volunteers for workshops is not high, more stringent screening may be detrimental to the overall aims of the program.

It may be more useful therefore to think of debriefing after the workshops. If there are instances where the workshop has given rise to personal difficulties these might well be picked up in a telephone interview with all participants, say, a week after the workshop. It is difficult to specify the best length of time because problems can develop at different rates for different participants but a one-week interval may be sufficient to include issues that might arise from the workshop as distinct from other sources. Some level of experience is clearly required in those providing follow-up as is some capacity to provide support.

It is important that at all workshops include provision of contact details for services from which help can be sought in the event of a suicidal crisis. This contact list would also be helpful to ensure participants can be referred if required. As noted in Section 5, in one workshop evaluated there was reliance on the participants suggesting appropriate organisations. Although this may be valuable as an exercise, it should be supplemented with a list of appropriate agencies carefully drawn up in advance.

Although originally it was expected that ASIST Tune Up would be included in the evaluation this was not possible as a workshop was not run during the evaluation period. It would be difficult to argue against the value of some form of refresher program. Knowledge and skills can be forgotten over time and re-assurance that gatekeepers continue to have the necessary capacities is of benefit to them and to the sponsoring organisation. Although first-hand information on ASIST Tune Up was not obtained, there is no reason for it not to continue.

Recommendations

In light of the preceding discussion, it is recommended:

1. That the Operation *Life* Suicide Awareness workshops be continued as part of the suicide prevention framework for veterans;

2. That materials for workshops be reviewed (a) to update information on risk and protective factors for suicidal behaviour in veterans, and (b) to provide current information on agencies in the region where a workshop is being held to whom veterans showing suicidal behaviour may be referred, if necessary, by workshop participants;
3. That consideration be given to encouraging veterans who participate in ASIST workshops to first attend a safeTALK workshop;
4. That consideration be given to telephone follow-up of veterans who participate in ASIST workshops approximately one week following a workshop to assess whether they have experienced any adverse effects as a result of the workshop and provide support and assistance as required.

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Appendix A: Survey instruments

Information Sheet
Review of Operation Life Suicide Awareness Workshops
Project Aims and Background Information

The Australian Institute for Suicide Research and Prevention (AISRAP) has been commissioned by the Department of Veteran Affairs (DVA) to undertake an external evaluation of the Operation Life Suicide Awareness Workshops. This evaluation has three aims:

a) To review the safeTALK and ASIST workshops currently being delivered under Operation *Life* to the veteran community;
b) To review the short term impacts of the safeTALK and ASIST workshops; and,
c) To provide recommendations on the status of the evidence-base of Operation *Life* suicide awareness workshops, and on ways to achieve this in line with international literature, theory and best practice guidelines in suicide prevention.

Your Participation

Your participation in this evaluation will provide valuable information on how effective you perceive the workshop you have attended to be in terms of teaching you relevant and practical knowledge about suicide prevention in the veteran community. In this way, recommendations can be made which will ensure that suicide prevention not only remains an important focus of the DVA but that you are provided with the most effective training available.

Your Involvement

If you agree to take part in this evaluation, you will be asked to complete two questionnaires which will be given to you prior to the commencement of the workshop, again immediately following the workshop, and again at 3 months following the workshop. Each questionnaire will take approximately 10 minutes to complete. One questionnaire will focus on your perceived personal capability in responding to a suicidal person. The other questionnaire will focus on your actual knowledge about suicide prevention.

The Information You Provide

All information provided by you in these questionnaires will remain **strictly confidential**.
Individual results will not be released in any way, which means that you cannot be identified. All results will be recorded and communicated as group data only. You will have the right to seek additional information about the project at any time and to raise any concerns or questions with project staff.

The information collected for this project will be electronically-stored on a password-protected PC and hard copies of questionnaires will be kept in a locked filing cabinet at the Australian Institute for Suicide Research and Prevention at Griffith University. Data collected for the project will be retained for five (5) years from project completion.

Further Information

We appreciate your participation in the Review of Operation Life Suicide Awareness Workshops. If you have questions concerning the content or the process of this project, please do not hesitate to contact the research team.

Thank you for your support

If you have any questions, please don't hesitate to contact:

Project Coordinator
Mrs Jacinta Hawgood
Griffith University
Ph: (07) 3735 3394
jacinta.hawgood@griffith.edu.au

Project Officer Ms
Kathy McKay
Griffith University
Ph: (07) 3735 1028
k.mckay@griffith.edu.au

Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Human Research. If you have any concerns or complaints about the ethical conduct of the research project, please contact the Senior Manager, Research Ethics and Integrity on 3735 5585 or research-ethics@griffith.edu.au.

The information collected is confidential and will not be passed to any parties without your consent. For further information consult the University's Privacy Plan http://www.griffith.edu.au/privacy-plan or telephone (07) 3735 5585.

Consent Form
Review of Operation Life Suicide Awareness Workshops

By completing this Consent Form, I confirm that I have read and understood the Information Sheet and, in particular, that:

I agree to participate in the Review of Operation Life workshops;

I understand that there will be no direct benefit to me from my participation in this research;

I understand that my participation in this research will involve taking part in a focus group or telephone interview which will take approximately one hour;

I understand that I will not be personally identified, except by code and individual information will remain confidential and will not be passed to any other parties;

I understand that my participation in this research is voluntary;

I have had any questions answered to my satisfaction and I can contact the research team at any future point in time with any additional questions;

I understand that I am free to withdraw from participating in the research at any time; and,

I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3735 5585 (or research-ethics@griffith.edu.au) if I have any concerns about the ethical conduct of the project.

Name: ____

Address (postal or email): ____

Date: ____

Signed: ____

safeTALK Perceived Capability Survey

safeTALK Perceived Capability Survey

This is a brief survey intended to gather how you perceive your ability to help suicidal people in order to determine:

a) whether the workshop you attended had an impact on knowledge, attitudes and perceived capabilities (before, after, and three months following the workshop); and,

b) the usefulness of training to impact upon attitudes and behaviours regarding enhanced awareness of suicide and the creation of a suicide-safer community.

Your responses are **anonymous** and **confidential** and no person outside of the AISRAP evaluation team will see this individual questionnaire. Data will be collated and used only in an aggregate form to reflect general group responses. The information gathered from this survey will be utilised to:

a) inform future training targeted towards the veteran community; and,

b) enhance awareness of suicide and the creation of a suicide-safer community.

There are two parts to this survey. Part One asks demographic questions. Part Two covers your perception of your capability to help suicidal people.

Completion of the survey should take approximately 10 minutes. Please respond to each question based on your first impressions, which are the most reliable.

Please begin by giving us some brief demographic information about yourself.

Your initials (first and last name) ______________________________
*DOB (of mother or father) ______________________________

*Please remember whether you use the DOB of your mother OR your father since this information is will be required also for both the post-survey and follow-up survey, in order for the researchers to match the data.

CONFIDENTIAL – PERSONAL/DEMOGRAPHIC DETAILS

Gender: Male / Female **Age:** 16-40 ❑ 41-60 ❑ 61+❑

Occupation/role: Veteran ❑ Partner ❑ Son/Daughter ❑ Welfare Officer ❑ Pension Officer ❑ Men's Health Peer Educator Volunteer ❑

Have you ever had experience helping someone who has been suicidal? Yes ❑ No ❑

List your background qualifications (if relevant), and any training/education you have previously received pertaining specifically to suicide prevention:

Qualifications:...
....
....
....

Training/Course (e.g., safeTALK, ASIST, Mental Health First Aid): Date Undertaken:
....
....
....

PERSONAL CAPABILITY

The following section presents a list of some of the skills, knowledge or capabilities that may be relevant when effectively responding to people with suicidal thoughts/behaviour. **Circle the appropriate number from 1 (a low rating) to 7 (a high rating) on each scale to indicate your judgement.**

Personal Capability	My current capability						
	Not at all capable		Moderately capable			Very capable	
1) Awareness of the stigma that surrounds suicide	1	2	3	4	5	6	7
2) Awareness that my personal attitudes can affect how I interact with a suicidal person	1	2	3	4	5	6	7
3) Awareness that opportunities to help a suicidal person can be dismissed or avoided	1	2	3	4	5	6	7
4) Enhanced desire to provide practical support to a suicidal person	1	2	3	4	5	6	7
5) Ability to recognise when a person is having suicidal thoughts	1	2	3	4	5	6	7
6) Ability to engage a person with suicidal thoughts or behaviour, in direct and open talk about suicide	1	2	3	4	5	6	7
7) Alibility to listen to a person's suicidal thoughts to demonstrate their serious nature	1	2	3	4	5	6	7
8) Knowledge of names and contact details of local suicide intervention resources	1	2	3	4	5	6	7
9) Ability to quickly connect a suicidal person with someone who can do a suicide intervention	1	2	3	4	5	6	7

Once again, thank you for your time and support in informing and enhancing our ability to evaluate the safeTALK workshops.

safeTALK Actual Knowledge Survey

This is a brief survey intended to examine your actual knowledge of suicide prevention in order to determine:

a) whether the workshop you attended had an impact on knowledge, attitudes and knowledge (before, after, and three months following the workshop); and,

b) the usefulness of training to positively impact upon attitudes and behaviours regarding enhanced awareness of suicide and the creation of a suicide-safer community.

Your responses are **anonymous** and **confidential** and no person outside of the AISRAP evaluation team will see this individual questionnaire. Data will be collated and used only in an aggregate form to reflect general group responses. The information gathered from this survey will be utilised to:

a) inform future training targeted towards the veteran community; and,

b) enhance awareness of suicide and the creation of a suicide-safer community.

There are three parts to this survey. Part One is a set of statements which you must judge to be true or false. Part Two is a set of short answer questions on suicide prevention in the veteran community. Part Three is a hypothetical story about a suicidal veteran with associated questions.

Completion of the survey should take approximately 10-15 minutes. Please respond to each question based on your first impressions, which are the most reliable.

Your initials (first and last name) ________________________

*DOB (of mother or father) ________________________

*Please remember whether you use the DOB of your mother OR your father since this information is will be required also for both the post-survey and follow-up survey, in order for the researchers to match the data.

PART ONE
Please read each statement and tick 'True', 'False' or 'Don't Know' as applicable.
Please note: it is not expected that you will know all the answers to the following questions if you are answering these questions before your workshop.

1. Almost anyone can have suicidal thoughts.
   True False Don't Know

2. Most people who suicide act impulsively.
   True False Don't Know

3. A person's thoughts of suicide should always be taken seriously.
   True False Don't Know

4. Suicide is not a community problem.
   True False Don't Know

5. Asking about suicide will not put those thoughts into someone's head.
   True False Don't Know

6. People with thoughts of suicide always want to die.
   True False Don't Know

7. safeTALK training will provide me with the skills to intervene with a suicidal person.
   True False Don't Know

8. People need special qualifications or skills to learn about suicide awareness.
   True False Don't Know

9. If they don't know what to look for, even caring people can miss, dismiss or avoid invitations to help.
   True False Don't Know

10. People with thoughts of suicide almost always want to talk to someone.
    True False Don't Know

11. A person's invitation for help can be verbal or non-verbal.
    True False Don't Know

12. My own attitudes about suicide won't affect how I interact with suicidal people.
    True False Don't Know

13. In the presence of a suicide alert helper, people with suicidal thoughts can talk themselves out of a suicidal act.
    True False Don't Know

14. If a person tells me they have suicidal thoughts, I should keep it a secret.
    True False Don't Know

PART TWO

Please answer the following questions.

Please note: it is not expected that you will know all the answers to the following questions if you are answering these questions before your workshop.

1. What does the TALK in safeTALK stand for?

   T____

   A____

   L____

   K____

2. How do you tell when a person has suicidal thoughts?

   ____

   ____

   ____

3. Have you heard of the 'Healthy Warrior' effect? If, so please describe it.

   ____

   ____

   ____

4. Compared to other people, do you think veterans have different risk factors for suicidal behaviour? If so, what are these factors?

   ____

   ____

   ____

5. Why might a veteran who is having suicidal thoughts be reluctant to tell someone?

   ____

   ____

   ____

6. What resources do you know of that are available to help veterans in your community?

   ____

   ____

   ____

7. What is the best way to ask someone if they are feeling suicidal?

   Direct manner   Indirect manner

8. What should you do if you don't believe a person's response?

   Keep asking   Stop talking about it

9. Are male veterans more at risk of dying by suicide than female veterans?

   Yes   No

10. Is mental illness more common among veterans who die by suicide?

    Yes   No

PART THREE

Please read the story below and answer the questions after it. Answers only have to be short and you don't need to use full sentences.

Please note: it is not expected that you will know all the answers to the following questions if you are answering these questions before your workshop.

Your next door neighbour has recently left the army after serving in a number of regions which had been impacted by war. While he refuses to talk about specific events, you know that he experienced several traumatic events during this time. It is a long-standing joke that he was always able to organise a solution for everything, which suited army life, but now he seems at a loss. He still keeps in touch with a few army mates but this is usually through Facebook rather than face-to-face meetings. Recently, you have been concerned about him because he has been drinking more than usual which has been causing arguments with his partner. Yesterday, you saw his girlfriend leave the house after a heated argument. He has come over to your house early the next morning. Normally, he would start to ask if anything in the house needed to be fixed but today he is just silently sitting in the kitchen.

1. Identify the 'invitation' (warning signs).

   ____
   ____
   ____

2. Identify the risk factors.

   ____
   ____
   ____

3. Why might it be easy to dismiss his 'invitation'?

   ____
   ____
   ____

4. What would you do to make sure you didn't avoid his 'invitation'?

   ____
   ____
   ____

5. What would be the most effective way to keep him safe?

   ____
   ____
   ____

ASIST Perceived Capability Survey

ASIST Perceived Capability Survey

This is a brief survey intended to gather how you perceive your ability to help suicidal people in order to determine:

a) whether the workshop you attended had an impact on knowledge, attitudes and perceived capabilities (before, after, and three months following the workshop); and,

b) the usefulness of training to positively impact upon attitudes and behaviours regarding enhanced awareness of suicide and the creation of a suicide-safer community.

Your responses are **anonymous** and **confidential** and no person outside of the AISRAP evaluation team will see this individual questionnaire. Data will be collated and used only in an aggregate form to reflect general group responses. The information gathered from this survey will be utilised to:

a) inform future training targeted towards the veteran community; and,

b) enhance awareness of suicide and the creation of a suicide-safer community.

There are two parts to this survey. Part One asks demographic questions. Part Two covers your perception of your capability to help suicidal people.

Completion of the survey should take approximately 10 minutes. Please respond to each question based on your first impressions, which are the most reliable.

Please begin by giving us some brief demographic information about yourself.

Your initials (first and last name) ___________________________
*DOB (of mother or father) ___________________________

*Please remember whether you use the DOB of your mother OR your father since this information is will be required also for both the post-survey and follow-up survey, in order for the researchers to match the data.

CONFIDENTIAL – PERSONAL/DEMOGRAPHIC DETAILS

Gender: Male / Female **Age:** 16-40 ❑ 41-60 ❑ 61+❑

Occupation/role: Veteran ❑ Partner ❑ Son/Daughter ❑
Welfare Officer ❑ Pension Officer ❑ Men's
Health Peer Educator Volunteer ❑

Have you ever had experience helping someone who has been suicidal? Yes ❑ No ❑

List your background qualifications (if relevant), and any training/education you have previously received pertaining specifically to suicide prevention:

Qualifications:……
……
……
…………………………

Training/Course (e.g., safeTALK, ASIST, Mental Health First Aid): Date Undertaken:
……
……
………

PERSONAL CAPABILITY

The following section presents a list of some of the skills, knowledge or capabilities that may be relevant when effectively responding to people with suicidal thoughts. **Circle the appropriate number from 1 (a low rating) to 7 (a high rating) on each scale to indicate your judgement.**

Personal Capability	My current capability						
	Not at all capable			Moderately capable			Very capable
1) Awareness of the stigma that surrounds suicide	1	2	3	4	5	6	7
2) Awareness that my personal attitudes can affect how I interact with a suicidal person	1	2	3	4	5	6	7
3) Ability to discuss suicide with a person at risk in a direct manner	1	2	3	4	5	6	7
4) Ability to identify risk alerts regarding a suicidal person	1	2	3	4	5	6	7
5) Ability to develop safeplans related to risk alerts identified with a suicidal person	1	2	3	4	5	6	7
6) Ability to appropriately intervene with a suicidal person	1	2	3	4	5	6	7
7) Knowledge of all relevant and effective suicide prevention resources in the community	1	2	3	4	5	6	7
8) Confidence and ability to improve suicide prevention resources in the community	1	2	3	4	5	6	7
9) Awareness to take care of myself and enhance other protective factors as part of enhancing suicide prevention in the community	1	2	3	4	5	6	7

Once again, thank you for your time and support in informing and enhancing our ability to evaluate the ASIST workshops.

ASIST Actual Knowledge Survey

ASIST Actual Knowledge Survey

This is a brief survey intended to examine your actual knowledge of suicide prevention in order to determine:

a) whether the workshop you attended had an impact on knowledge, attitudes and perceived capabilities (before, after, and three months following); and,

b) the usefulness of training to positively impact upon attitudes and behaviours regarding enhanced awareness of suicide and the creation of a suicide-safer community.

Your responses are **anonymous** and **confidential** and no person outside of the AISRAP evaluation team will see this individual questionnaire. Data will be collated and used only in an aggregate form to reflect general group responses. The information gathered from this survey will be utilised to:

a) inform future training targeted towards the veteran community; and,

b) enhance awareness of suicide and the creation of a suicide-safer community.

There are three parts to this survey. Part One is a set of statements which you must judge to be true or false. Part Two is a set of shorter answer questions on suicide prevention in the veteran community. Part Three is a hypothetical story about a suicidal veteran.

Completion of the survey should take approximately 10 minutes. Please respond to each question based on your first impressions, which are the most reliable.

Your initials (first and last name) ________________________

*DOB (of mother or father) ________________________

*Please remember whether you use the DOB of your mother OR your father since this information is will be required also for both the post-survey and follow-up survey, in order for the researchers to match the data.

PART ONE

Please read each statement and tick 'True', 'False' or 'Don't Know' as applicable.

Please note: it is not expected that you will know all the answers to the following questions if you are answering these questions before your workshop.

1. Open and direct talk about suicide should be avoided.
   True False Don't Know

2. My own attitudes about suicide can impact upon how I respond to a suicidal situation.
   True False Don't Know

3. Anyone can be at risk of suicide.
   True False Don't Know

4. People can become vulnerable to suicide when they feel they have lost something very important to them.
   True False Don't Know

5. People who are violent towards others never become suicidal.
   True False Don't Know

6. Listening to a person's reasons for dying won't help in a suicide intervention.
   True False Don't Know

7. I have done enough to help a person with suicidal thoughts if I just listen to their problems.
   True False Don't Know

8. A person with suicidal thoughts is still trying to decide whether to live or die.
   True False Don't Know

9. A caregiver may have to help the same person more than once.
   True False Don't Know

10. The suicidal person does not have to do anything in a suicide intervention.
    True False Don't Know

11. The goal of ASIST is to be able to solve all a suicidal person's problems.
    True False Don't Know

12. Asking whether a person is having suicidal thoughts demonstrates that you care about them.
    True False Don't Know

13. I don't need to follow-up with the suicidal person after we have agreed on a safeplan.
    True False Don't Know

14. Even talking about hurt and pain can lead to life.
    True False Don't Know

15. I always have to be aware of my own safety when I'm helping a suicidal person.
    True False Don't Know

PART TWO

Please answer the following questions.

Please note: it is not expected that you will know all the answers to the following questions if you are answering these questions before your workshop.

1. Please list three possible characteristics of a veteran at risk of suicide.
   a. ______________________________
   b. ______________________________
   c. ______________________________

2. Have you heard of the 'Healthy Warrior' effect as it applies to Veterans? If so, please describe it?
   ____
   ____
   ____

3. How might suicide become acceptable to a veteran?
   ____
   ____
   ____

4. Do you think a safeplan for a suicidal veteran should be different to that for a non-veteran?
   ____
   ____
   ____

5. Why do you need to understand a person's reasons for suicide?
   ____
   ____
   ____

6. Are male veterans more at risk of dying by suicide than female veterans?
   Yes No

7. Is mental illness more common among veterans who die by suicide?
   Yes No

8. What resources do you know of that are available to help veterans in your community?
   ____
   ____
   ____
   ____

PART THREE

Please read the story below and answer the questions after it. Answers only have to be short and you don't need to use full sentences.

Please note: it is not expected that you will know all the answers to the following questions if you are answering these questions before your workshop.

Your neighbour has recently left the army after serving in a number of regions which had been impacted by war. While he refuses to talk about specific events, you know that he experienced several traumatic events during this time. It is a long standing joke that he has always been extremely tidy and organised, which suited army life, but now it seems to be a problem. He gets fixated on seemingly unimportant details like making sure all the carrots are the same length when he cuts them. In the army, he was praised for his physical strength and problem solving abilities but feels bored in a civilian job. He keeps in touch with a few army mates but is always a bit depressed after seeing them as it makes him miss army life even more. However, it appears that re-enlisting in the army is not an option. He won't tell you why but you think he may have been seeing a psychiatrist towards the end of his time in the army. As far as you know, he hasn't sought any help since then. A few weeks ago, he found out that one of his army mates killed himself. He has reacted angrily and is drinking more than usual. He has come over to your house early in the morning. Normally, he would start to ask if anything in the house needed to be fixed but today he is just silently sitting in the kitchen.

1. Identify the 'invitation' (warning signs).

   ____

   ____

   ____

2. Identify the risk factors.

   ____

   ____

   ____

3. How would you 'Connect' him?

   ____

   ____

   ____

4. How would you 'Understand' him?

   ____

   ____

   ____

5. How would you 'Assist' him?

   ____

   ____

   ____

Appendix B: Quantitative survey data

Table 1. Mean scores of pre- and post-workshop Perceived Capability

Perceived Capability		Pre-workshop		Post-workshop			
	N	Mean	Median	Mean	Median	Z-value	p-value
Awareness of the stigma that surrounds suicide	13	4.46	5.00	5.86	6.00	-2.63	**.009**
Awareness that my personal attitudes can affect how I interact with a suicidal person	13	4.92	5.00	5.43	6.00	-1.78	.075
Awareness that opportunities to help a suicidal person can be dismissed or avoided	13	4.15	5.00	5.79	6.00	-2.87	**.004**
Enhanced desire to provide practical support to a suicidal person	13	4.38	4.00	5.79	6.00	-2.56	**.011**
Ability to recognise when a person is having suicidal thoughts	13	3.54	3.00	5.57	6.00	-2.84	**.004**
Ability to engage a person with suicidal thoughts or behaviour, in direct and open talk about suicide	13	3.54	3.00	5.21	5.00	-2.85	**.004**
Ability to listen to a person's suicidal thoughts to demonstrate their serious nature	13	4.54	5.00	5.64	6.00	-2.41	**.016**
Knowledge of names and contact details of local suicide intervention resources	13	2.77	2.00	5.43	6.00	-2.95	**.003**
Ability to quickly connect a suicidal person with someone who can do a suicide intervention	13	3.08	2.00	5.43	5.50	-2.83	**.005**

Table 2. Mean scores of pre-workshop and three-month follow-up Perceived Capability

Perceived Capability		Pre-workshop		Follow-up			
	N	Mean	Median	Mean	Median	Z-value	p-value
Awareness of the stigma that surrounds suicide	6	3.83	4.00	5.29	6.00	-1.84	.066
Awareness that my personal attitudes can affect how I interact with a suicidal person	6	4.33	4.50	5.71	6.00	-1.51	.131
Awareness that opportunities to help a suicidal person can be dismissed or avoided	6	3.83	4.00	5.43	5.00	-1.63	.102
Enhanced desire to provide practical support to a suicidal person	6	4.00	4.00	5.43	6.00	-1.19	.236
Ability to recognise when a person is having suicidal thoughts	6	2.83	3.00	4.86	5.00	-2.04	**.041**
Ability to engage a person with suicidal thoughts or behaviour, in direct and open talk about suicide	6	2.83	3.00	4.71	4.00	-2.04	**.041**
Ability to listen to a person's suicidal thoughts to demonstrate their serious nature	6	3.33	3.00	5.29	6.00	-1.83	.068
Knowledge of names and contact details of local suicide intervention resources	6	2.33	2.00	5.71	6.00	-2.23	**.026**
Ability to quickly connect a suicidal person with someone who can do a suicide intervention	6	2.17	2.00	5.57	6.00	-2.23	**.026**

Table 3. Mean scores of post-workshop and three-month follow-up Perceived Capability

Perceived Capability		**Post-workshop**		**Follow-up**			
	N	Mean	Median	Mean	Median	Z-value	p-value
Awareness of the stigma that surrounds suicide	6	5.67	5.50	5.29	6.00	-1.73	.083
Awareness that my personal attitudes can affect how I interact with a suicidal person	6	4.83	5.50	5.71	6.00	-1.29	.197
Awareness that opportunities to help a suicidal person can be dismissed or avoided	6	5.83	6.00	5.43	5.00	-1.13	.257
Enhanced desire to provide practical support to a suicidal person	6	5.50	5.50	5.43	6.00	-0.82	.414
Ability to recognise when a person is having suicidal thoughts	6	5.17	5.50	4.86	5.00	-0.68	.496
Ability to engage a person with suicidal thoughts or behaviour, in direct and open talk about suicide	6	4.67	5.00	4.71	4.00	-0.14	.888
Ability to listen to a person's suicidal thoughts to demonstrate their serious nature	6	4.83	5.00	5.29	5.00	-.82	.414
Knowledge of names and contact details of local suicide intervention resources	6	5.17	6.00	5.71	6.00	-.38	.705
Ability to quickly connect a suicidal person with someone who can do a suicide intervention	6	4.67	5.00	5.57	6.00	-1.07	.285

Table 4. Changes in the number of correct answers to Part Three of the Actual Knowledge section (case study), pre- and post-workshop

		Pre-workshop		Post-workshop		McNemar's test
	N	Correct	%	Correct	%	p value
Identify the 'invitation' (warning signs).	12	9	75%	5	41.7%	0.289
Identify the risk factors	9	4	44.4%	5	55.6%	1.000
Why might it be easy to dismiss his 'invitation'?	10	3	30%	3	30%	1.000
What would you do to make sure you didn't avoid his 'invitation'?	10	4	40%	8	80%	0.125
What would be the most effective way to keep him safe?	9	2	22.2%	6	66.7%	0.125

Table 5. Changes in the number of correct answers to Part Three of the Actual Knowledge section (case study), pre-workshop and three-month follow-up

		Pre-workshop		Follow-up		Fisher's ex test
	N	Correct	%	Correct	%	p value
Identify the 'invitation' (warning signs).	6	4	66.7%	4	66.7%	0.467
Identify the risk factors	4	1	25%	3	75%	1.000
Why might it be easy to dismiss his ‘invitation’?	4	2	50%	2	50%	0.333
What would you do to make sure you didn't avoid his 'invitation'?	4	0	0%	2	50%	N/A
What would be the most effective way to keep him safe?	5	2	40%	3	60%	0.400

Table 6. Changes in the number of correct answers to Part Three of the Actual Knowledge section (case study), post-workshop and three-month follow-up

		Post-workshop		**Follow-up**		**Fisher's ex test**
	N	Correct	%	Correct	%	p value
Identify the 'invitation' (warning signs).	6	2	33.3%	4	66.7%	0.467
Identify the risk factors	5	2	40%	3	60%	0.400
Why might it be easy to dismiss his 'invitation'?	5	2	40%	2	40%	1.000
What would you do to make sure you didn't avoid his 'invitation'?	5	3	60%	3	60%	0.400
What would be the most effective way to keep him safe?	5	4	80%	2	20%	0.400

Table 7. Mean scores of pre- and post-workshop Perceived Capability

Perceived Capability		**Pre-workshop**		**Post-workshop**			
	N	Mean	Median	Mean	Median	Z-value	p-value
Awareness of the stigma that surrounds suicide	18	5.06	5.00	6.33	6.00	-3.23	**.001**
Awareness that my personal attitudes can affect how I interact with a suicidal person	18	5.28	6.00	6.22	6.00	-2.68	**.007**
Ability to discuss suicide with a person at risk in a direct manner	18	5.17	5.00	6.39	6.00	-3.10	**.002**
Ability to identify risk alerts regarding a suicidal person	18	4.61	4.50	6.11	6.00	-3.58	**<.001**
Ability to develop safe plans related to risk alerts identified with a suicidal person	18	4.11	4.00	5.89	6.00	-3.33	**.001**
Ability to appropriately intervene with a suicidal person	18	4.39	4.00	5.89	6.00	-3.46	**.001**
Knowledge of all relevant and effective suicide prevention resources in the community	18	3.78	4.00	5.78	6.00	-3.55	**<.001**
Confidence and ability to improve suicide prevention resources in the community	18	3.61	4.00	5.56	6.00	-3.56	**<.001**
Awareness to take care of myself and enhance other protective factors as part of enhancing suicide prevention in the community	18	4.56	4.00	6.33	6.00	-3.34	**.001**

Table 8. Mean scores of pre-workshop and three-month follow-up Perceived Capability

Perceived Capability		Pre-workshop		Follow-up			
	N	Mean	Median	Mean	Median	Z-value	p-value
Awareness of the stigma that surrounds suicide	6	4.33	4.00	5.83	6.00	-1.63	.104
Awareness that my personal attitudes can affect how I interact with a suicidal person	6	5.17	5.50	6.00	6.00	-1.29	.197
Ability to discuss suicide with a person at risk in a direct manner	6	5.00	4.50	6.00	6.00	-1.47	.141
Ability to identify risk alerts regarding a suicidal person	6	4.33	4.00	5.67	5.50	-1.81	.071
Ability to develop safe plans related to risk alerts identified with a suicidal person	6	4.17	4.50	5.33	5.00	-1.60	.109
Ability to appropriately intervene with a suicidal person	6	3.83	4.00	5.50	6.25	-2.04	**.041**
Knowledge of all relevant and effective suicide prevention resources in the community	6	2.50	2.00	5.67	7.00	-2.21	**.027**
Confidence and ability to improve suicide prevention resources in the community	6	3.00	3.50	5.00	5.50	-1.80	.072
Awareness to take care of myself and enhance other protective factors as part of enhancing suicide prevention in the community	6	3.83	4.00	6.00	6.00	-1.81	.071

Table 9. Mean scores of post-workshop and three-month follow-up Perceived Capability

Perceived Capability		Post-workshop		Follow-up			
	N	Mean	Median	Mean	Median	Z-value	p-value
Awareness of the stigma that surrounds suicide	6	6.00	6.00	5.83	6.00	-.38	.705
Awareness that my personal attitudes can affect how I interact with a suicidal person	6	6.17	6.00	6.00	6.00	-.58	.564
Ability to discuss suicide with a person at risk in a direct manner	6	6.33	6.00	6.00	6.00	-1.41	.157
Ability to identify risk alerts regarding a suicidal person	6	5.50	5.50	5.67	5.50	-.58	.564
Ability to develop safe plans related to risk alerts identified with a suicidal person	6	5.50	5.50	5.33	6.25	-.58	.564
Ability to appropriately intervene with a suicidal person	6	5.33	5.00	5.50	5.50	-.45	.655
Knowledge of all relevant and effective suicide prevention resources in the community	6	5.33	5.50	5.67	5.50	-.45	.655
Confidence and ability to improve suicide prevention resources in the community	6	5.33	5.50	5.00	5.00	-.38	.705
Awareness to take care of myself and enhance other protective factors as part of enhancing suicide prevention in the community	6	6.00	6.00	6.00	6.00	0	1.000

Table 10. Changes in the number of correct answers to Part Three of the Actual Knowledge section (case study), pre- and post-workshop

	Pre-workshop			Post-workshop		McNemar's test
	N	Correct	%	Correct	%	p-value
Identify the 'invitation'	12	10	83.3%	11	91.6%	1.000
Identify the risk factors	12	5	41.6%	11	91.6%	0.070
How would you "connect" him?	9	5	55.5%	8	88.8%	0.250
How would you "understand" him?	9	4	44.4%	4	44.4%	1.000
How would you "assist" him?	11	6	54.5%	8	72.7%	0.687

Table 11. Changes in the number of correct answers to Part Three of the Actual Knowledge section (case study), pre-workshop and three-month follow-up

	Pre-workshop			Follow-up		Fisher's ex test
	N	Correct	%	Correct	%	p-value
Identify the 'invitation'	6	4	67%	5	83.3%	0.333
Identify the risk factors	6	3	50%	6	100%	N/A
How would you "connect" him?	5	3	60%	2	40%	0.400
How would you "understand" him?	5	3	60%	3	60%	1.000
How would you "assist" him?	5	4	80%	4	80%	1.000

Table 12. Changes in the number of correct answers to Part Three of the Actual Knowledge section (case study), post-workshop and three-month follow-up

	Post-workshop			Follow-up		Fisher's ex test
	N	Correct	%	Correct	%	p-value
Identify the 'invitation'	5	4	80%	4	80%	1.000
Identify the risk factors	5	4	80%	5	100%	N/A
How would you "connect" him?	5	3	60%	2	40%	1.000
How would you "understand" him?	5	2	40%	3	60%	1.000
How would you "assist" him?	5	3	60%	4	80%	0.400

Appendix C: Qualitative data

Workshops and Follow-Up Interviews

The following section examines themes that emerged from the longer answers of the pre/post/follow-up surveys, as well as the follow-up interviews. Only 13 completed the follow-up surveys and six participated in the interview (two from safeTALK and four from ASIST).

The taboo nature of suicide

Throughout the different interviews, words like 'sensitive', 'emotive' and, especially 'confronting' were used by various participants. The trainers spoke intensely about the need to extinguish the stigma around suicide. In the workshops, language use was scrutinised. The use of the words 'success', 'fail' and 'commit' in connection to suicide was discouraged due to their judgemental nature. There was significant debate about how to ask whether a person is suicidal – how direct did the helper needed to be as to whether they had to say the word 'suicide'. The training tells the helper to directly ask a person whether they're thinking about suicide; however, as one participant pointed out, *it's not only a sentence*. The trainers focused on listening to the suicidal person talk through their reasons. An ASIST participant said that she realised suicide prevention could be *…about sitting there and letting silence happen, because as human beings and as welfare officers we want to jump in and help everybody*.

Some ASIST participants appeared to have more entrenched ideas than the safeTALK participants. This was evident in the idea that *suicidal people…eventually go through with it one way or the other*".

One participant, who had no previous knowledge or experience about suicide, found that the safeTALK workshop opened his eyes to the importance of talking about suicide prevention. He found the openness of the other participants unexpected:

…most of the guys when they started talking, they were just talking as if they've been dealing with that sort of situation for ages and it's not hard to talk about. I thought it would be difficult for people to talk about it because I was under that stigma of you don't talk about you know, Uncle Johnny trying to do something to himself 20 years ago. We don't talk about him anymore.

The confidential nature of the safeTALK environment allowed this participant the opportunity to hear about real experiences of suicide; the fact that these stories came from people already within his social group more effectively dismantled his stigma.

A safeTALK participant said that the workshop had made her feel capable of talking to someone she knew about suicide. She was then able to recognise that not everyone would be able to do this: *It's [suicide] been a taboo sort of thing that people don't usually like talking about and try and avoid and pretend that it's not happening to them*. In this way, safeTALK had shaped her attitudes and knowledge about suicide so she was able to see a difference in herself as well as compared to others.

Reasons for attending the workshops

In the follow-up interviews, the reasons given for attending the workshops were similar across the six participants. All wanted to help people in their community, whether this was through their employment role or their personal interactions with others. This was best illustrated in the following response:

…we just wanted to go and learn a bit more about it and hopefully if that sort of thing comes up again we might be able to pick up a few, you know, factors here and there …either our own relative or anyone else that we may come across that we think might be in that situation.

With three of the six follow-up participants, including the one above, this willingness to help people was also tied to their personal experiences of suicide. One participant disclosed that surviving his own suicide attempt had made him realise the vulnerability of others, including other members of his family:

I suppose also looking back at my own life, I think that the saddest thing and the most horrid feelings are when you have your suicide thoughts yourself, and if I can help somebody, family or otherwise, go over that period, that'd be wonderful…. I think one of the worst things in my life was when I finally decided to do away with myself and got everything all prepared and went out in the bush and couldn't do it. It left me in a terrible state, because I didn't know where to turn. So if I can help somebody ease that feeling, that'll be something worthwhile in my life.

A member of another participant's family had attempted suicide which inspired their interest in better understanding suicide prevention. Another participant had dealt with suicidal people through her job and was uncertain as to whether she *had made the right decisions and spoken in the correct manner and done the right thing*.

For one participant, the safeTALK workshop was one of his first experiences of talking openly about suicide:

I went to that workshop because I'd never been to anything like that before…. I never actually came across it before any time in my working career and I suppose I'm old hat where it was frowned up to be suicidal, so people didn't talk about it.

He saw the workshop as an opportunity to learn skills relevant to his career: *I'd just completed a welfare course…. I just thought it would be handy as another tool*.

Specificity of the workshops to veterans

Neither the safeTALK nor ASIST workshops were developed with the unique suicidal vulnerabilities of veterans in mind. However, the delivery process of the workshops allow for some tailoring of different parts to include more relevant aspects to the audience. Additionally, one of the characters in a safeTALK video is a veteran.

Questions the trainer could answer

Trainers need to be clear if they are unsure about the answer to a question (e.g., actual suicide rates of veterans or the hereditary nature of suicide).

The safeTALK and ASIST workshops are very clear on what they are and what they are not in terms of intervention and gate-keeper roles; this was clearly articulated by the trainers at each of the workshops.

The positive perception and realism of the workshops

All the participants gave highly positive feedback about the safeTALK and ASIST workshops. One ASIST participant *felt it was something really worthwhile that I was doing in my life*. Another ASIST participant thought the opportunity to meet other people was a benefit of the workshop. Despite the workshop bringing up some bad memories, one safeTALK participant was able to see benefit in what she had learned:

…it was good to have a bit more information on it [suicide] and review it sort of thing. Not very nice reviewing the bad parts of it but it's the sort of thing that you have to, to get a point across sort of thing. But no, I thought it was a great, great session and I think more people should do it.

It should be noted that two participants (one safeTALK and one ASIST) had differing views on the level of knowledge gained in the workshops. The ASIST participant thought the workshop would suit *people who have never had any experience*. While he didn't appear to gain new knowledge, he found that the workshop *brought more things to the top of the earth…. Things that I didn't know I learnt from. I think group discussions, you learn a lot from them*.

In contrast, the safeTALK participant felt that the workshop had hit the right pitch*: …it wasn't too overbearing, it wasn't too scientificky. It was more grass-roots-type thing, simple language, simple questioning and so for me it was good. It wasn't…frightening to go to*. As the workshop was more accessible than he expected, this participant's knowledge about suicide was increased: *I think I*

learnt to listen more and now knowing a lot of the sign…you can add it all together and then get the person to someone a little more qualified than what I am at least. Indeed, the idea that listening was an important skill was also reinforced by the comment from an ASIST participant who learned *just to let them speak and to have that prolonged silence…because if you jump in really it's taking away from their situation*.

The role-plays tended to be very positively perceived by the participants. The discussion which occurred after the role-plays was found to be beneficial by an ASIST participant: *I think role playing is a very important thing because then you can look back at it and see what worked and what didn't. That was good*. Another ASIST participant who had done ASIST once before and had helped two people in real suicidal crises said *even though it is set up and you do have great scenarios where everything works out, it definitely helps you in real life. Because without that training I would have been floundering a bit I think*.

While one ASIST participant thought the video scenarios were a "cop-out" because the helper knew the at-risk person, he still conceded they were well made. Some participants felt able to help someone they already knew but remained uncertain as to whether they would be able to help a stranger; others sought to help whoever needed assistance within their community. Indeed, the simple narratives of the videos made an intervention look possible.

. In the safeTALK workshop, one of the role-plays involved each participant asking the trainer whether she was thinking about suicide. A safeTALK participant commented:

That was pretty relevant because I think that brought everyone's feelings to the very edge and some people couldn't ask the question where others could. Others asked it quite comfortably, others asked the question but they had reservations sort of thing. So I think that was relevant. A relevant point in the actual course because I think once you can say it to someone and you try and say, play the part it doesn't matter if you're playing a part or not, it's still a hard question to ask even if it's - because that's what I found.

The most difficult aspect of the course to translate into real life appeared to be the structured steps of the interventions. Participants who had not had to intervene in a suicidal crisis talked about the required steps: *You approach the person, the actual TALK: the telling and asking and listening and keeping safe*. In contrast, two participants who had intervened constructed examples of more fluid and flexible processes which adjusted according to the situation.

Further, they both gave examples of situations which were not adequately covered in the workshops. The first was the co-morbidity of depression and substance misuse. The participant was concerned about a safeplan that could adequately protect a suicidal person: *Because you're really dealing with two demons. You're dealing with depression and you're dealing with the substance*. In

her experience, the only adequate safe plan was hospitalisation. The second was a suicidal young person. In this situation, the participant helped provide practical assistance including accommodation, clothing and employment. These measures allowed the suicidal person to reconnect with his family and the community which led to longer term protection.

Disclosure and connectedness

The lack of connectedness was perceived by some veterans to be a significant factor in suicide. One of the ASIST participants who had previously helped people through suicide crises believed: *they [veterans] don't know who to go to for friendship or someone that they can speak openly with. It takes some time to get them to talk openly as well because they're sort of hiding a lot of things with themselves*.

However, it should be noted that talking openly was initially difficult even in the safeTALK workshop where the veterans, and their families, knew each other. One of the participants commented that: *…a couple of the ladies sort of held back on being completely open…. I knew all of those people but I didn't know some of the situations that they'd been throug*h.

How did the training impact on the real experiences of helping a suicidal person?

Three of the people who participated in the follow-up interview had directly helped a suicidal person; one before they participated in the workshop and the others in the three months following the workshop. One had completed safeTALK and the others had done ASIST. The latter had felt that the previous training had allowed her *to approach the subject of suicide and talk about it openly*. She had provided care for two people in suicidal crisis, at different times; one of whom appeared to be a person in acute crisis. This participant had *been very concerned that they were going to actually go and kill themselves that night…. So I actually drove them to their GP and called the CAT team. They ended up at the psych ward at the hospital up here*. She had been able to act as a gatekeeper and find appropriate help, although she didn't strictly follow the ASIST steps: *I mean I didn't say it in my head but I made sure I covered all bases*. However, she had remained uncertain as to whether she had done acted in the most appropriate way: *…I mean as human beings we still need reassurance that we've done the right thing*. In the apparent absence of a supervisor who could provide such reassurance, the ASIST workshop had fulfilled this role.

When he was still actively serving, a participant who attended the ASIST workshop had known *people with suicidal tendencies…. Eventually I got to have a chat to them in a friendly way sort of thing and talked them around*. After he had undertaken the ASIST workshop, this participant also spoke about helping a woman whose suicidal behaviours appeared to be linked to family problems.

In a similar way, he approached this woman with an offer of friendship and conversation: *I sort of made friends with her, better friends, and got a bit further into her mind and eventually got out of her what was going on…. a couple of days later she's a different person altogether*. However, even though the ASIST workshop was positively perceived, he didn't directly link his actions to the training. Instead, he attributed his willingness and ability to help others to his previous military experiences:

I've been around a long time and I think it's a lot of my own experience is in the services where I have seen a lot of this from time to time…. People have tried to cut their wrists and things, well then we go and talk to them as well and find out what caused it. If you see somebody with an injury you want to know how they got it, especially something that looks like they've done damage to themselves. I say that's the experience I've had with it. Where…I see somebody needs help I just give it to them.

In contrast, the participant who had attended safeTALK directly linked his ability to help someone to the training. Prior to safeTALK, he didn't feel at all capable of helping a suicidal person. Afterwards, he felt *quite confident to be able to carry out a reasonable conversation and sort of be able to talk to a person and say to them, look, if you're in a situation where you can't go on anymore, I can get you help. I can get someone who can talk to you, I can do that*.

Care and debrief for distressed veterans

There was no doubt that many of the participants in these workshops found them to be emotional at times. The workshops encouraged open and honest discussion and some participants shared stories for the first time in the safe environment of the workgroups.

One safeTALK participant commented that the promise of confidentiality made her group *more likely to be a bit more open about thing, only to help each other*.

While participants were screened before they came to the workshops, some participants were more vulnerable to distress than others. This vulnerability became more obvious during the ASIST workshop as two days was a substantial period of time, especially as some participants had not completed any other suicide prevention course previously.

One safeTALK participant found the trainer *very comforting in their words and manner*.

One ASIST participant spoke of his difficulties in taking care of himself after helping someone through a suicidal crisis: *I get a bit carried away myself because…I've got a thin nature I suppose you could call it. I'm very easily upset mentally about people's problems. It affects me*.

However, it should be noted that while emotions were brought to the surface during the workshops, this does not necessarily mean that the veterans were too vulnerable to attend. One veteran was able to distinguish between his feelings at a previous suicide prevention course and what he experienced at the Operation *Life* workshop. While he experienced distress both time, the levels were different and his resilience was also stronger the second time:
This time I sort of - it was more down in the subconscious, because at the actual course, I suppose there was a suppressed agitation within me. Like, I wasn't in peace. But at the same time I wasn't distressed. With the [other] course it was very present day things and
this time there were things brought up that happened five, 10, 15, 20 years ago and more, but I didn't actually pull out individual events in my life. With this latest course that I did, it was just a subconscious - at a subconscious level, there was that agitation.

Providing support for people in a suicidal crisis can leave workers *feeling quite drained and emotional*.