The Scottish Government

The Use and Impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: An Evaluation

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THE USE AND IMPACT OF APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST) IN SCOTLAND: AN EVALUATION

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It should be noted that since this research was commissioned a new Scottish government has been formed, which means that the report reflects commitments and strategic objectives conceived under the previous administration. The policies, strategies, objectives and commitments referred to in this report should not therefore be treated as current Government policy.

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ACKNOWLEDGEMENTS

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The members of the Research Advisory Group for this study were:

- Mary Allison (NHS Health Scotland)
- Ciara Byrne (Scottish Association for Mental Health)
- Phil Eaglesham (NHS Greater Glasgow & Clyde / Scottish Government, Choose Life NIST)
- Jacki Gordon (Scottish Government, Choose Life NIST)
- Angela Hallam (Scottish Government, Health Analytical Services Division)
- Liz Martin (Scottish Government, Choose Life NIST)
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EXECUTIVE SUMMARY

Introduction and background (Chapter 1, pp 7-12)

1. This is the report of an evaluation of the impact and effectiveness of Applied Suicide Intervention Skills Training (ASIST) in Scotland and elsewhere, conducted by Griesbach and Associates, on behalf of the Scottish Government. The evaluation was commissioned in March 2007 and all research took place between April and October 2007.

2. Suicide and suicidal behaviour affect all age groups and communities. Suicide rates in Scotland are about two-thirds higher than in England and Wales (Brock *et al* 2006) although since the period 2000-02, the suicide rate in Scotland has begun to fall. ASIST was introduced in Scotland in 2003 under the auspices of Choose Life, the Scottish Government's ten-year strategy and action plan to prevent and reduce suicide.

3. The overall aims of this evaluation were to explore the development and implementation of ASIST in Scotland and to evaluate the impact and effectiveness of the training programme. The evaluation addressed four main questions:

- Why and how has ASIST been implemented in Scotland?
- What is known about the effectiveness of ASIST, both in Scotland and elsewhere?
- How can the impact of ASIST be maximised?
- How can the sustainability of ASIST be ensured in future?

What is ASIST? (Chapter 2, pp 13-21)

4. ASIST is a two-day course that aims to help caregivers (both professionals and lay people) to become more willing, ready and able to recognise and help persons at risk of suicide. ASIST is intended as 'suicide first-aid' training, and is focused on teaching participants to recognise risk and learn how to intervene effectively to reduce the immediate risk of suicide. The course is delivered over two consecutive days in a workshop-type format. Participants develop skills through observation and supervised simulation experiences in large and small groups. All ASIST trainers must attend a five-day 'training for trainers' (T4T) course.

5. ASIST was developed in the early 1980s by four individuals at the University of Calgary in Alberta, Canada. In 1991, these four set up the company, LivingWorks Education (LWE), to market the course outside Alberta.

6. ASIST has now been implemented in a number of countries worldwide. Where ASIST is newly implemented in a country, LWE continues to retain the responsibility for maintaining the standardisation and quality of the T4T and ASIST courses, and for keeping both courses up-to-date. Therefore, LWE Coaching Trainers provide all T4T training. Where a country has achieved International Collaborative Committee (ICC) status, that country then becomes responsible for quality control, and for collecting, recording and responding to feedback on its own courses. Scotland has recently attained ICC status.

7. ASIST is just one of the suicide prevention training programmes offered by LWE. In addition, the short refresher course, ASIST Tune-Up, provides a review of the principles and practices of ASIST for people who have completed the course some time ago. Moreover, in addition to the LWE programmes, there are other suicide prevention training programmes

available in Scotland, including STORM (Skills-based Training on Risk Management). Scotland's Mental Health First Aid (SMHFA), while not a suicide prevention training programme, addresses the possibility of suicide in people who are experiencing mental ill health, and uses risk review material from an earlier version of ASIST.

Methods (Chapter 3, pp 22-31)

8. This was a large and complex study and both quantitative and qualitative methods were used to capture the breadth and depth of views that exist in Scotland in relation to ASIST. The Kirkpatrick model was used as the theoretical framework for the research. This model can be used to evaluate training interventions on four levels: i) participant response; ii) participant learning; iii) applying learning into practice; and iv) organisational / societal impact of the training. For the purposes of this evaluation, the Kirkpatrick model was incorporated into a larger programme logic model.

9. The methods used in the study were: a review of the international literature on ASIST and a limited review of literature on other related training programmes (STORM and MHFA/SMHFA); an analysis of the national ASIST database; a national online survey of over 2000 ASIST participants; interviews and focus groups with national and local stakeholders, ASIST trainers and participants; and in-depth local implementation studies (LIS) in six selected areas/organisations around Scotland.

The implementation of ASIST in Scotland (Chapter 4, pp 32-45)

10. The rationale for introducing ASIST to Scotland was that training people from a range of backgrounds and in a variety of settings would increase the likelihood of intervention and, therefore, have a greater impact on reducing suicide rates. The choice of ASIST was influenced by its community focus and its international reputation and longevity.

11. ASIST began to be rolled out nationally in Scotland in 2004, although there was some implementation of the training in one local area from 2003. The national roll-out was co-ordinated by the Choose Life National Implementation Support Team (NIST), and two posts were created in NIST for this purpose. The subsequent huge demand for the training left little time for the national team to evaluate other potential programmes.

12. There were a number of levers and barriers to the implementation of ASIST at a local level. The barriers to implementation included the cost of ASIST; the length of the training, both for participants and trainers; difficulties in recruiting and retaining trainers; and, in some areas, a lack of a strategic focus on training. Levers included a well-supported national strategy on suicide prevention which highlighted the importance of training; the availability of funding to local areas; proactive involvement of the local Choose Life co-ordinator; and a good supply of trainers.

13. As of September 2007, there have been 576 ASIST workshops completed by 10,477 people. This represents approximately 1 in 500 of the Scottish population. In addition, between April 2004 and November 2007, there have been 12 T4Ts which have trained 271 people to deliver ASIST. However, it is also worth noting that 303 people (3%) who started the ASIST workshop did not complete it, and 77 ASIST trainers (28.4%) are currently inactive and have not delivered a workshop since 2006.

14. ASIST participants have come from voluntary sector projects, housing services, mental health services (NHS, council and voluntary), primary care services, education, police and social work. However, participation by health and social care professionals has varied in different areas.

15. Overall, national and local stakeholders agreed that the implementation of ASIST had raised awareness of suicide, reduced stigma and fear, and that the course had given a range of people the knowledge and skills they need to help those at risk of suicide. Ideas to support future sustainability included the creation of a Scottish LivingWorks. There was also a consensus that, in the future, ASIST should be part of a suite of suicide prevention training programmes.

Kirkpatrick level 1: What do people think about ASIST? (Chapter 5, pp 46-54)

16. The vast majority of ASIST participants reported positive reactions to the training and found it to be useful and relevant. Those who found ASIST to be most useful were likely to be local government and voluntary sector staff (as compared to NHS staff), and individuals who perceived themselves to have low levels of suicide intervention confidence, knowledge and skills prior to attending ASIST.

17. The elements of training thought to be most useful were the discussion of attitudes to suicide prevention, and learning the ASIST suicide intervention model. However, despite the hugely positive reaction to ASIST, there was also evidence of some negative reactions — in particular, negative emotional reactions, dislike of the role-play element, and mixed views on the suicide intervention model and other aspects of ASIST.

Kirkpatrick level 2: What did people learn from ASIST? (Chapter 6, pp 55-63)

18. Participants' self-reported levels of knowledge, confidence and skills in relation to intervening with someone at risk of suicide increased considerably immediately after ASIST and these increases were largely maintained over time. However, the majority of participants also felt that their ASIST skills needed updating.

19. Participants who had intervened with someone at risk of suicide prior to attending ASIST were more likely to have higher levels of pre-course and post-course confidence, skills and knowledge than those who had not intervened prior to ASIST. The findings also suggest that people who have prior experience of intervening are more likely to sustain the gains in skills, knowledge and confidence they acquire in the workshop. An analysis by gender found that male participants consistently perceived themselves as more confident, skilled and knowledgeable than females.

20. We found that ASIST training seemed to be reaching people with no other previous experience of suicide prevention training.

Kirkpatrick level 3: What did people do as a result of the training? (Chapter 7, pp 64-74)

21. We found that the proportion of participants who reported intervening with a person at risk of suicide increased by 20% following their ASIST training. In addition, the vast majority of people who had intervened following training reported having one or more experiences of using ASIST to good effect.

22. The most challenging aspects of using ASIST, according to participants, were asking people directly about whether they were thinking of suicide, and being personally involved with an individual who was thinking of suicide.

23. We found that individuals who applied their learned skills into practice were most likely to be those who had prior experience of suicide intervention and who reported higher levels of confidence knowledge and skills, both before and after training.

Kirkpatrick level 4: What difference has ASIST made? (Chapter 8, pp 75-82)

24. ASIST was reported to have a number of positive impacts including reducing stigma and raising awareness of suicide within organisations and communities. Moreover, it was felt ASIST had made an impact on the development of multi-agency working and information-sharing practices between agencies. However, there was also some evidence that the impact of ASIST had been limited or virtually non-existent in some local areas where, for a variety of reasons, it had been difficult to implement.

25. In some areas, there was a perception that there had been little take-up of ASIST among certain professional groups — in particular, GPs and other primary care staff, NHS hospital staff, ambulance staff and addictions workers. This lack of take-up was often attributed to the two-day commitment required by the ASIST workshop.

Trainers' experiences of ASIST (Chapter 9, pp 83-92)

26. ASIST trainers confirmed that the vast majority of ASIST participants enjoy the course and consider it to be useful. However, they also confirmed that the course sometimes had a negative emotional impact on some people. Other problems included negative attitudes and behaviour among some people who attend the course unwillingly, and a reluctance by some participants to do the role-play. In general, however, trainers felt that ASIST was effective for most participants in increasing knowledge, skills and confidence, and they gave examples, from feedback or personal observation, of people using their ASIST skills.

27. Despite high levels of enthusiasm and commitment, 28% of trainers were no longer delivering ASIST. The reasons included: demands of the "day job", the very structured nature of the course, and lack of organisational support. There were also issues about the level of monitoring and support available to trainers from both NIST and LivingWorks.

28. Overall, trainers from all over Scotland felt that ASIST was an excellent, well-thought-out course, with clear messages. However, they also had some suggestions for improving the effectiveness and impact of the course. These included:

- making more information available in advance about the content of the T4T course, and ensuring that participants have read and understood the information available about the commitment involved in being an ASIST trainer
- making more information available to participants about the content of the workshop
- localising the course — i.e. making it Scottish and more culturally relevant
- modifying the role-play aspect of the course in order to reduce performance anxiety.

The cost of ASIST (Chapter 10, pp 93 – 98)

29. At a national level, the largest part of the cost of ASIST has been related to the costs of training trainers and purchasing materials. Until recently, all Scottish T4T courses have been delivered by LWE Coaching Trainers from Australia, Canada, USA and Ireland. All materials have had to be purchased from LWE. As of January 2008, payments to LWE related to the implementation of ASIST in Scotland have totalled **£538,133**. In addition, there have been hotel costs in relation to the delivery of the 5-day residential T4T course which have totalled **£177,034** since 2004-05.

30. From March 2005, NIST began to charge local areas £1,800 per trainer for T4T. And in April 2005, NIST introduced a pricing policy which had the aim of making the delivery of suicide prevention training sustainable — both at a national and local level. Since the introduction of the charge for T4T training, a total income of **£457,955** has been generated by NIST in relation to ASIST. This includes the sale of training material purchased from LWE and sold on to the Scottish ASIST network.

31. The pricing policy set out guidance to local areas about ways to generate income from the delivery of ASIST by charging participants for attendance. However, most areas continued to subsidise the training with local Choose Life funding. More recently, local areas were starting to consider the possibility of charging fees, although in some cases, the intention was to charge fees only for those who registered for the course and then didn't turn up.

32. Once a country has attained International Collaborative Committee (ICC) status, that country can choose to print its own materials, or can continue to purchase materials from LWE at a significantly reduced cost. Therefore, in November 2007, NIST updated their pricing policy to reflect reductions in the cost of materials which resulted from Scotland attaining ICC status.

33. ASIST was perceived to be an expensive course. There were concerns that, if there was no more funding from Choose Life, it would be difficult or even impossible to sustain ASIST in the long-term. Trainers and Choose Life Co-ordinators from around Scotland had a number of suggestions for how the cost of ASIST could be reduced. In general, these suggestions related to reducing the cost of materials.

Discussion (Chapter 11, pp 99-113)

34. The evidence of effectiveness and impact found in this evaluation strongly suggest that ASIST could have a sustainable future in Scotland. Other factors that support sustainability include the opportunity for ASIST to be part of the roll out of suicide prevention training under Commitment 7 and the focus on mental wellbeing within the developing national policy framework.

35. The evidence also suggests some areas for action that would maximise the impact of ASIST and improve the prospects for sustainability. These include:

- **Reducing the costs of ASIST:** The two issues consistently identified as barriers to sustainability were the costs of T4T and the costs of materials. NIST / Health Scotland should complete negotiations with LWE on the introduction of Scottish training coaches and the production and distribution of materials in Scotland.

- **Creating flexibility in the two-day structure of ASIST:** The requirement to attend for two consecutive days was consistently raised as a barrier to participation by some groups of health and social care professionals. NIST / Health Scotland should discuss options for flexibility with LWE.

- **Developing more robust selection criteria for trainers:** There are problems with both recruitment and retention of trainers in some areas. NIST / Health Scotland should consider, in partnership with local areas: the development of more robust selection criteria which take into account, for example, motivation, previous experience of training, previous knowledge of mental health and / or suicide. They should also consider how to provide more national support for trainers through monitoring, a regular national forum and the availability of advice and support on a one-to-one basis. At local level, more administrative support would help trainers to reduce their workload.

- **Maintaining ASIST skills**: As time goes by, people may need to refresh and update their skills. NIST / Health Scotland should consider promoting more Tune-Up Refresher courses to help people maintain their skills.

36. Finally, one of the key messages from the evaluation was that future sustainability will depend on training the "right" people in the right setting. This reinforces the findings of the evaluation of the first phase of Choose Life. A key area for action, therefore, is in relation to **targeting** of ASIST**.** The evidence from the evaluation suggests that, to make the greatest impact, suicide prevention training should be targeted at those individuals and groups who have most opportunity to use the skills because they work with, or live beside, people from sections of society most at risk of suicide — for example, people living in areas of deprivation and those affected by drug and alcohol problems. NIST / Health Scotland and local partners should consider which individuals and groups would benefit most from ASIST and prioritise those who have greatest contact with the key target groups through their jobs or their role in the community.

References

Brock A, Baker A, Griffiths C, Jackson G, Fegan G & Marshall D (2006) Suicide trends and geographical variations in the United Kingdom, 1991 – 2004. In *Health Statistics Quarterly*, no. 31, pp. 6-22. Available at: www.statistics.gov.uk/downloads/theme_health/HSQ31.pdf.

CHAPTER ONE INTRODUCTION AND BACKGROUND

1.1 This is the report of an evaluation of the impact and effectiveness of Applied Suicide Intervention Skills Training (ASIST) in Scotland and elsewhere, conducted by Griesbach & Associates, on behalf of the Scottish Government.[1] The evaluation was commissioned in March 2007 and all research took place between April and October 2007.

Why do this evaluation?

1.2 Suicide and suicidal behaviour affect all age groups and communities, at enormous personal and economic cost. The Scottish Government's ten-year Choose Life national strategy and action plan aims to prevent and reduce suicide. The delivery of appropriate and relevant training in suicide prevention is one of the main elements of Choose Life.

1.3 ASIST was introduced in Scotland in 2003. Choose Life funding and local co-ordination has enabled it to be delivered widely since then so that, by September 2007, there were over 10,000 ASIST-trained people in every sector across Scotland.

1.4 ASIST has proved immensely popular in Scotland, however, to date there has been limited published evidence of its effectiveness. Given the Scottish Government's commitment to train 50% of key frontline staff in suicide prevention by 2010 (see paragraph 1.15), it is important to evaluate the impact and effectiveness of ASIST in Scotland and to ascertain whether any changes should be made to optimise its impact in the future. This evaluation was conducted therefore, to guide the future development of ASIST across all sectors in Scotland.

Brief epidemiology and policy context

1.5 This section describes the epidemiological and policy context for suicide prevention in Scotland.

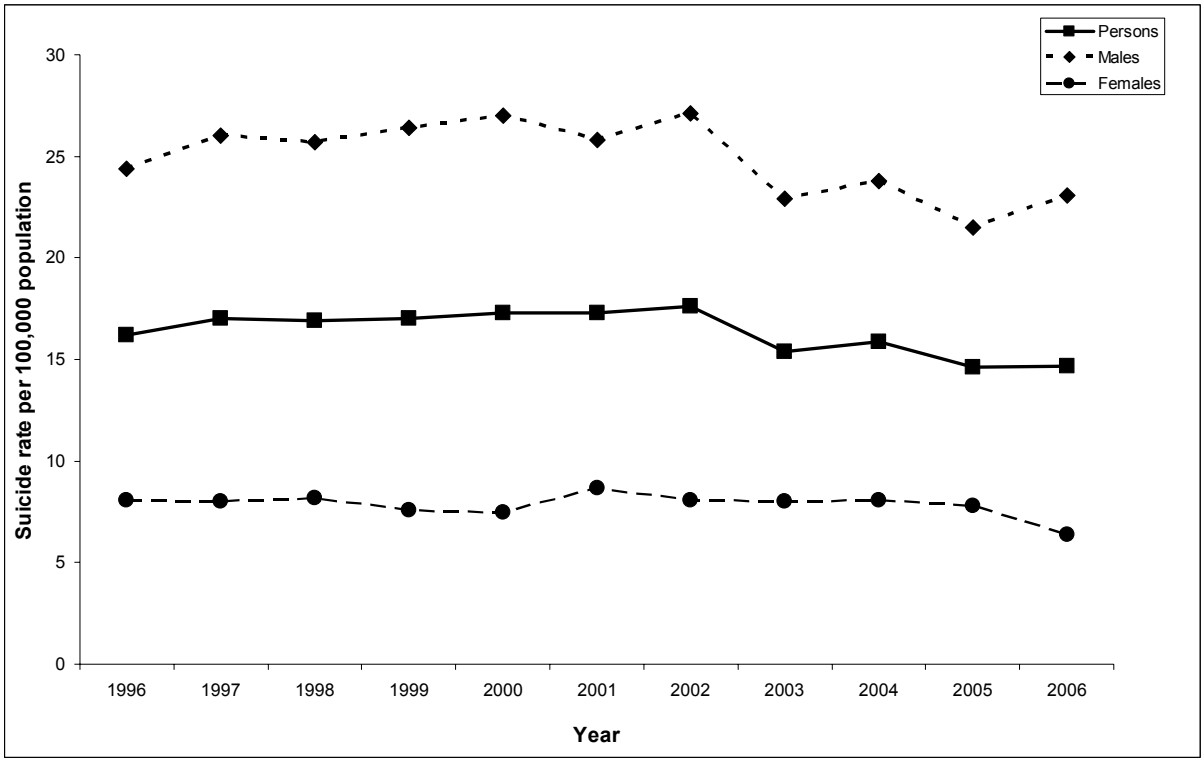
Suicide rates in Scotland

1.6 Since 1970, the suicide rate in Scotland has been consistently higher than in other parts of the UK.[2] Since the period 2000-02, suicide rates in Scotland have started to fall. (See Figure 1.1). However, rates for men and women living in Scotland are still about two-thirds higher than in England and Wales (Brock *et al* 2006).

[1] Called the Scottish Executive prior to September 2007.

[2] See Choose Life website: www.chooselife.net/Statistics/UKComparisons.asp.

Figure 1.1: Suicide rates in Scotland, 1996-2006



Source: Suicide rates from the Scottish Public Health Observatory (www.scotpho.org.uk).

1.7 Recent suicide statistics published by Choose Life[3] show that:

- in 2006, there were 765 suicides in Scotland, equating to an age standardised rate of 14.7 per 100,000
- on average, there are around two suicides per day in Scotland
- around three out of four suicides are by men
- more than half of all suicides in 2006 were of people aged 35-64
- suicide is the leading cause of death in those under 35 years of age
- the risk of suicide in the most deprived areas of Scotland is almost double the Scottish average.

1.8 As well as the serious human cost to families and communities, there is also a significant economic cost. In 2004 alone, the total costs of all completed suicides in Scotland were estimated to be £1.08 billion (Platt *et al* 2006).[4]

[3] See Choose Life website www.chooselife.net/Statistics/Statistics.asp.

[4] These costs include lost waged and non-waged output, intangible human costs and direct costs.

National Programme for Improving Mental Health and Wellbeing

1.9 In 2001, the then Scottish Executive launched a National Programme to improve the mental health and wellbeing of everyone living in Scotland and to improve the quality of life and social inclusion of people who experience mental health problems.

1.10 This programme sits within the government's continuing commitment to improve Scotland's health and reduce health inequalities.[5] The programme is also closely linked to a wide range of other policy initiatives related to social justice, social inclusion, and employability. Suicide prevention is one of the National Programme's four key aims.

Choose Life

1.11 Choose Life is the Scottish Government's ten-year national strategy and action plan to reduce Scotland's suicide rate. It was launched in December 2002 and sets a target of a 20% reduction in suicides in Scotland by 2013. The strategy is part of, and operates under the auspices of, the Scottish Government's work on health improvement and social justice including the National Programme for Improving Mental Health and Wellbeing.

1.12 The Choose Life action plan is being implemented in three phases (2003–06, 2006-08 and 2008-11), and involves action at a national and local level. A total of £20.4 million has been allocated to Choose Life to date. Local effort has been led by the 32 Community Planning Partnerships (CPPs) which have each identified a Choose Life Co-ordinator.

1.13 The delivery of appropriate and relevant training in suicide prevention is one of the main elements of Choose Life. Suicide prevention training has a central role because it is thought to raise awareness of suicide risk within services and in the wider community, provide the skills that people need to intervene contribute to building a solid base of knowledge and skills that can support long-term action on suicide prevention and help with strategic engagement between key agencies in the NHS, local authority and voluntary sectors.

Delivering for Mental Health and Commitment 7

1.14 In 2006, the then Scottish Executive published *Delivering for Mental Health*, which it described as 'an agenda for care delivered in partnership across all settings including the NHS, Local Authority and Voluntary organisations.'

1.15 *Delivering for Mental Health* sets out 14 commitments and three targets to take forward improvements in mental health services.[6] Commitment 7 states that 'key frontline mental health services, primary care and accident and emergency staff will be educated and trained in using suicide assessment tools/suicide prevention training programmes; and 50% of target staff will be trained by 2010.'

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[5] For example, see *Towards a Healthier Scotland,* 1999; *Improving Health: The Challenge,* 2003; *Delivering for Health,* 2005; *Better Health, Better Care*, 2007; *Towards a Mentally Flourishing Scotland: Discussion Paper on mental health improvement 2008-2011,* 2007.

[6] See www.scotland.gov.uk/Topics/Health/health/mental-health/servicespolicy/DFMH.

1.16 Target 2, to reduce suicides in Scotland by 20% by 2013, is the same as the Choose Life target. This target has also been part of HEAT (Health Efficiency Access Treatment) targets, which apply to the NHS.[7] As of December 2007, the training commitment on suicide prevention was rolled into the suicide target in HEAT.

1.17 The developments described above provide an important context for the story of the implementation of ASIST in Scotland, which is described in Chapter 4 of this report.

Aims and objectives

1.18 The overall aims of this evaluation were to explore the development and implementation of ASIST in Scotland and to evaluate the impact and effectiveness of the training programme. The evaluation had four key objectives:

- To review information from previous evaluations of ASIST and distil the lessons which can be learned, particularly in relation to impact and effectiveness
- To obtain the views and theories of change of key stakeholders responsible for introducing ASIST in Scotland, to explore whether and how ASIST should be further rolled out in Scotland for optimal and sustained impact and effectiveness
- To explore participants' experiences of delivering or receiving and using ASIST training, in order to appraise the implementation, impact, and (where possible) the effectiveness of ASIST in Scotland
- To make recommendations about whether and how ASIST should be targeted in the future to optimise impact in Scotland and to identify further research and evaluation activity which could usefully be undertaken to support the implementation process.

1.19 These objectives may be re-framed into four overarching questions:

- How has ASIST been implemented in Scotland?
- What is known about the effectiveness of ASIST, both in Scotland and elsewhere?
- How can the impact of ASIST be maximised?
- How can the sustainability of ASIST be ensured in future?

Important things to note

1.20 Before going on to describe the research methods used in the evaluation, we would like to draw attention to, and define, a number of terms used throughout this report. Firstly, we would like to clarify what is meant in this report by the terms *effectiveness* and *impact.*

1.21 **Effectiveness** is the ability of an intervention to achieve its aims. Therefore, in order to measure effectiveness, one must first ask, "What were the aims of the intervention? What did it intend to achieve?" **Impact**, on the other hand, is about the difference the intervention has made. In the case of a training intervention such as ASIST, there may be impacts on course participants, on trainers, on individual organisations and on communities more widely.

[7] HEAT targets are a core set of Ministerial objectives, targets and measures set for the NHS for a three-year period. Progress towards them is measured through the Local Delivery Plan process.

1.22 Some interventions may be effective, but have little or no impact. For example, in the case of a training intervention such as ASIST, it is possible that the training was *effective,* but that its impact was limited because of an inability to roll out the training in certain areas. Alternatively, the training may have no *impact,* because those who received the training failed to use their skills.

1.23 Secondly we would like to note the following definitions used in this report.

1.24 ASIST **participants** are people who have attended a two-day ASIST training workshop – that is, the trainees.[8] For the purposes of this evaluation, we divided ASIST **participants** further into the following categories, according to the capacity in which they attended ASIST:

- **Professionals -** attended ASIST as a professional (paid) caregiver (in the statutory or voluntary sectors), to help clients, patients, pupils, colleagues or other service users.
- **Volunteers** - attended ASIST in a voluntary capacity (to help members of a community).
- **Informal caregivers** - attended ASIST in a personal capacity.

1.25 We would like to note how we refer to two organisations who have had a key role in the implementation of ASIST in Scotland.

- **LivingWorks Education** or **LivingWorks** are terms used interchangeably in this report to refer to the organisation based in Canada that has developed ASIST training and with whom the Scottish Government has an agreement in relation to the delivery of certain aspects of ASIST (which is described further in Chapter 2).

- The **Choose Life National Implementation Support Team,** referred to as **NIST** throughout this report, is a team set up to support the development and delivery of the Choose Life strategy and action plan, both locally and nationally. Note that wherever "Choose Life" is used in this report, it refers to the whole implementation strategy, whereas "NIST" refers to the national team. The role of NIST is further described in Chapters 4 and 10.

1.26 Finally, we have used September 2007 as the cut-off date for reporting the number of ASIST **participants** trained in Scotland and the number of workshops held, as this was the most up-to-date information available to the evaluation at the time this report was drafted. However, we have used November 2007 as the cut-off date for reporting data on the number of ASIST **trainers** in Scotland and on national expenditure related to ASIST, in order to include the two T4T courses offered in October and November 2007.

Structure of this report

1.27 The remainder of the report is set out as follows.

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[8] It is perhaps worth noting that only those ASIST participants who *completed* an ASIST training workshop were able to take part in this evaluation. We did not have access to contact details for people who did not complete the course.

- **Chapter 2** provides a description of the ASIST workshop.
- **Chapter 3** describes the methods used in this study.
- **Chapter 4** describes the way in which ASIST has been implemented in Scotland, and highlights how implementation has varied from one area to another.
- **Chapter 5** examines participants' reactions to ASIST training.
- **Chapter 6** examines what participants have learned from ASIST training.
- **Chapter 7** looks at the extent to which participants put their ASIST training into practice.
- **Chapter 8** examines what differences ASIST has made in Scotland.
- **Chapter 9** looks at trainers' experiences of ASIST.
- **Chapter 10** outlines the costs of ASIST.
- Finally, **Chapter 11** discusses the findings, draws conclusions and highlights the lessons which can be learned for the future.

CHAPTER TWO WHAT IS ASIST?

2.1 Before discussing the methods used in of this evaluation, it will be useful to first explain exactly what ASIST is.

2.2 ASIST is a two-day workshop which aims to help caregivers become more willing, ready and able to help persons at risk of suicide. According to LivingWorks Education, the term 'caregiver' refers to any person in a position of trust. This may include professionals, paraprofessionals and lay people. It is suitable for mental health professionals, nurses, doctors, teachers, counsellors, youth workers, police and correctional staff, school support staff, clergy, and community volunteers.[9] ASIST is intended as 'suicide first-aid' training, and is focused on teaching participants to recognise risk and learn how to intervene to prevent the immediate risk of suicide.

2.3 The two-day ASIST workshop is currently the most widely used suicide intervention training programme in the world.

Background

2.4 The ASIST programme, including the Training for Trainers (T4T) course was developed in the early 1980s by four individuals at the University of Calgary in Alberta – Richard Ramsay, Bryan Tanney, William Lang and Roger Tierney. In 1991, these four set up the company, LivingWorks Education (LWE), to market the course outside Alberta.[10] (Further information about the history of ASIST is available in Annex 1.)

2.5 ASIST has now been implemented in a number of countries worldwide, including, in Europe: Norway, Ireland, Northern Ireland, Wales and Scotland. Where ASIST is newly implemented in a country, LWE continues to retain the responsibility for maintaining the standardisation and quality of the T4T and ASIST courses, and for keeping both courses up-to-date. This is done through feedback forms which are sent to LWE each time an ASIST course is delivered. Where a country has achieved International Collaborative Committee (ICC) status (see below), that country then becomes responsible for quality control, and for collecting, recording and responding to feedback on its own courses.

Course content

2.6 ASIST is based on adult education principles with less than 15% of the workshop employing a lecture format. The course also makes use of the principles of graduated

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[9] LivingWorks makes a distinction between "designated caregivers" (people who, in the course of their professional training (it was assumed) were prepared to work with people who might be suicidal. Designated caregivers would include people in the medical, psychiatric, nursing and social work professions) and "emergent caregivers" (individuals who were not trained, or expected to know how to respond to someone who might be suicidal, but who might be called upon to do so in the course of their work, or because a person at risk of suicide had approached them for help). (Interview with LivingWorks representative)

[10] Roger Tierney is now deceased, and has been replaced on the Board of Directors of LWE by Tari Kinzel. LivingWorks Education is described as a "public service corporation." However, it operates on a for-profit basis.

learning, continuous reinforcement, and the setting of competency-based objectives. The workshop consists of five learning modules:[11]

- **Preparing**: sets the tone, norms, and expectations of the learning experience
- **Connecting**: sensitises participants to their own and others' attitudes towards suicide
- **Understanding**: provides an overview of the needs of a person at risk – participants gain the knowledge and skills to recognise risk and develop a "safeplan" to reduce the risk of suicide
- **Assisting**: presents a model for effective suicide intervention (SIM) – participants develop their skills through observation and supervised simulation experiences in large and small groups
- **Networking**: generates information about resources in the local community. Promotes a commitment by participants to transform local resources into helping networks.

2.7 The workshop uses a 20-page workbook and two videos. The format of the course is highly structured and prescribed. Trainers are given detailed instructions not only about the precise timing of each part of the course, but also about the layout of seating and the materials to be used at each stage.[12] At the end of the course, participants receive a Suicide Intervention Handbook and a pocket card featuring the main principles of the Suicide Intervention Model to be used as a memory aid. The structure of the workshop is fixed and participants must attend both days consecutively in order to receive a certificate of attendance.

The process of updating the training

2.8 Throughout its history, the ASIST course has been subject to development by LWE. There was a major revision of ASIST in 2002/03 (the current version of ASIST is version 10), and there are plans for another update in 2009.

Dissemination of training

2.9 ASIST is disseminated by local trainers, who have attended a five-day 'training for trainers' (T4T) workshop. Local trainers may be self-employed, or they may be employed within an organisation which agrees to release them from their job to deliver the training. As ASIST requires team teaching, there must be a minimum of two trainers for each workshop.

2.10 Upon completion of the five-day T4T, trainer candidates become provisional trainers. In order to become Registered Trainers, they are required to deliver three workshops within a year of the T4T course. Registration is maintained thereafter by delivering at least one workshop per year.

2.11 LWE has established a hierarchy of trainers, which is based partly on the number of courses the trainer has delivered, and partly on other criteria set by LWE. For example, an

[11] Information taken from the LivingWorks website: www.livingworks.net.

[12] See www.chooselife.net/web/FILES/TrainingFiles/ASIST_Organisers_Guide.pdf for a copy of the ASIST course organiser's handbook.

individual may achieve the status of **Master Trainer** after the delivery of 10 ASIST workshops.

2.12 A **Consulting Trainer** is a Master Trainer with responsibilities for assisting provisional trainers to prepare for and conduct their first workshops. The selection of Consulting Trainers is determined by the local network and by LivingWorks. There are no formal criteria that Consulting Trainers must meet, but they must be perceived by others locally as doing a good job in their delivery of ASIST. In addition, the LWE Coaching Team do their own assessment of the person's abilities and all prospective Consulting Trainers have to apply formally and be approved by LWE. This process requires attending T4T again, as a kind of apprenticeship, and undertaking a number of consultations with less experienced trainers, which involve discussing difficulties, coaching or advising less experienced trainers in relation to aspects of their course delivery. The experience of the consultation process is then written up and submitted to LWE for approval. Ordinarily, trainers are expected to have delivered at least 25 workshops before they can be put forward to be a Consulting Trainer. However, this latter requirement can be waived.

2.13 A **Training Coach** is a Consulting Trainer who is invited to, and successfully completes, a second apprenticeship at T4T and is authorised by LWE to conduct the last three days of a T4T course. A **Senior Training Coach** is authorised to deliver all five days of T4T, and a **Team Leader** is a senior coaching trainer who acts as a representative of LWE and leads T4T taking responsibility for the organisation and running of a T4T programme.

Training for Trainers (T4T)

2.14 The ASIST T4T is a five-day course that prepares individuals to be able to deliver the ASIST workshop within their local communities. During the first two days, candidates participate in the standard ASIST workshop, receiving first-hand experience of the course they will be trained to deliver. The third day focuses on the transition to the Trainer role and includes some coaching sessions. Days 4 and 5 include dress rehearsal presentations of components of the ASIST course combined with more coaching sessions, course debriefing and issues to do with local implementation and marketing.

2.15 Upon completion of the T4T, each trainer receives a range of supporting materials including the Trainer's Manuals, the Organiser's Guide, workshop slides and audio-visuals, participant materials and marketing materials. Trainers also receive suicideTalk and ASIST Tune-Up materials.

2.16 Provisional Trainers sign a contract with LWE, in which they confirm their intention: a) to become a Registered Trainer by "successfully conducting three ASIST workshops within one year" and (b) to maintain their registration status by "presenting at least one ASIST workshop every 12 months following the initial three workshops." Trainers are directly responsible to LWE (rather than their employing organisations) for their delivery of the course. (Further details of the contract signed by Provisional Trainers with LWE is included in Annex 1.)

2.17 LWE does not require any formal qualifications or previous experience from people wishing to become ASIST trainers.[13] However, according to the LWE website, the success of a trainer is greatly enhanced by a combination of skills and characteristics including flexible attitude towards suicide; good interpersonal, communication and helping skills; suicide intervention skills; knowledge about suicide; and established teaching and group leadership skills. The signatures of both the candidate and their employer are needed on the registration form as an indication of their acceptance of the commitments involved in delivering ASIST.

2.18 In Scotland, Choose Life *recommends* that, to become an ASIST trainer, individuals should have:

- completed a two-day ASIST workshop
- familiarity with Choose Life and their local Choose Life activities
- previous experience of delivering training
- support from their employer
- an open mind about suicide and the ability to talk openly about the subject.

International Collaborative Committee (ICC) agreement

2.19 An ICC agreement enables a country to run its own ASIST and T4T programmes. To attain ICC status, countries must meet certain criteria, including having a sufficient number of Consulting Trainers who can assume responsibility for quality control of the ASIST programme in that country, and a team of trainers who can deliver T4T. ICC members must pay an annual renewable licence fee to LWE, and a payment is made to LWE for each ASIST participant and trainer trained. ICC members can arrange for local printing of course handbooks and other materials, or they can continue to purchase them from LWE at a discount (cost + 20%). (Further details of ICC membership criteria are included in Annex 1.)

2.20 Australia and Norway currently have ICC membership status. Scotland has recently attained ICC status, but negotiations regarding the licence fee are still ongoing, and efforts are still underway to set up a Scottish infrastructure for delivering T4T.

Other suicide prevention training programmes

2.21 It is worth noting that ASIST is just one of the suicide prevention training programmes offered by LWE. The others are: (Note that descriptions are quoted directly from the LivingWorks website.[14])

- **suicideTALK:** a 1.5- to 2-hour exploration in suicide awareness. Organised around the question, "Should we talk about suicide?" it provides a structure in which session members can safely explore some of the most challenging attitudinal issues about suicide, and encourages every member to find a part that they can play in preventing suicide.

[13] Some countries have established their own criteria that prospective trainers must meet before they can attend a T4T course.

[14] See www.livingworks.net/.

- **safeTALK:** a 2.5- to 3.5-hour training for everyone in the community, designed to ensure that persons with thoughts of suicide are connected to helpers who are prepared to provide first-aid interventions. safeTALK is designed to be used in organisations and communities where there are already ASIST-trained caregivers.
- **suicideCARE:** a one-day, clinically-oriented exploration of the challenges presented to and the competencies required of the helper who works with persons at risk of suicide on a longer-term basis. ASIST training is a pre-requisite.

2.22 In addition, the short refresher course, ASIST Tune-Up, provides a review of the principles and practices of ASIST for people who have completed the course some time ago.

2.23 A licence fee and materials costs must be paid to LWE for each course (except for suicideTALK and Tune-Up for which there are no fees). In Scotland, a number of local areas and organisations are already making use of suicideTALK, safeTALK and ASIST Tune-Up. (Please note that detailed information about the costs associated with ASIST will be provided in Chapter 10.)

2.24 In addition to the LWE programmes, there are other suicide prevention training programmes available in Scotland. As part of a review of the literature carried out for this evaluation, we undertook a limited review of two other training programmes: Skills-based Training on Risk Management (STORM) and Mental Health First Aid (MHFA), including Scottish Mental Health First Aid (SMHFA). Although, strictly speaking, MHFA / SMHFA are not suicide prevention programmes, they nevertheless address the possibility of suicide in people who are experiencing mental ill health, using risk review material from an earlier version of ASIST. The aim of this review was to try and establish whether there were lessons to be learned from these two programmes that might be relevant to our evaluation of ASIST, particularly in relation to future direction and sustainability.

STORM

2.25 STORM is a suicide prevention training package designed for all front-line health and / or social care staff, criminal justice staff and staff in voluntary agencies, and particularly those working with people at risk of suicide. The aim is to benefit service users by giving staff the skills to provide appropriate risk assessment and risk management.

2.26 STORM has been developed by the University of Manchester. It consists of four teaching modules: Assessment, Crisis Management, Problem Solving and Crisis Prevention. The course is based on Social Learning Theory and delivered through teaching techniques designed to help participants gain and maintain the skills needed to assess a person at risk of suicide and manage the crisis effectively. The main focus is role-rehearsal, using video, self-reflection and feedback. The modular design allows flexibility in delivery, for example in the number of modules delivered to staff with previous knowledge and experience.

2.27 The STORM team uses a cascade model for training. They offer the STORM Facilitators' course (equivalent to ASIST T4T) commercially (not-for-profit). The facilitators' training is usually delivered to a group of four to six staff in an organisation at one time, although organisations may later train additional groups of staff. The trainers then cascade the training to others in their own organisations.

2.28 The cost of training four STORM Facilitators is £6,600 + VAT and expenses. This is a one-off fee for four days of training, the licence to run STORM, three sessions of face-to-face

support and unlimited e-mail and phone support, plus teaching materials and expenses for STORM staff. Costs increase if more staff are trained. There is a new self-injury module which will cost £3,600 + VAT and expenses for training four staff. There will also be a combined package costing £8,000 + VAT and expenses for four staff.

MHFA

2.29 MHFA is a 12-hour course designed to improve mental health literacy. It uses a first aid model to train members of the public in how to support someone in a mental health crisis situation (including someone who is at risk of suicide) or who is experiencing mental health difficulties. The aim is to assist in early intervention or ongoing community support. There is evidence to show MHFA can be useful for people who work in areas that may involve contact with people who have mental health problems.

2.30 MHFA was developed at the Centre for Mental Health Research at the Australian National University by Betty Kitchener and Tony Jorm.[15] From 2005, the course has been based at the ORYGEN Research Centre, University of Melbourne. The underlying philosophy is that people with mental health problems can potentially be helped by people in their social networks.

2.31 MHFA introduces five steps: i) Assess risk of suicide or harm; ii) Listen non-judgmentally; iii) Give reassurance and information; iv) Encourage person to get appropriate help; and v) encourage self-help strategies. The course gives an overview of major mental health problems: depression, anxiety, psychosis and substance use disorders. It teaches symptoms, causes and evidence-based treatments. It is run over four 3-hour sessions usually on two days but not necessarily consecutively

2.32 The instructor training course is five days long. It costs $3,500 (£1,522), which covers the five days training (including lunch and refreshments), an instructor training kit consisting of seven videos / DVDs, teaching notes, Powerpoint CD, six books, additional readings, an MHFA T-shirt and an MHFA bag. Instructors also get ongoing support, regular newsletters and updates from the MHFA office in Melbourne. The fee also covers accreditation. Each course must have a minimum of ten people and a suitable venue available.

2.33 There are criteria for selection of instructors. Anyone who wishes to be trained to deliver MHFA has to be able to demonstrate: substantial knowledge about mental illness and treatments, good teaching and communication skills; positive attitudes towards people with mental health problems; personal or professional experience of people with mental health problems; good knowledge of mental health and community services; and commitment to improve mental health literacy to reduce the stigma surrounding mental illness.

2.34 There are now over 650 instructors in Australia, covering all states and territories. Some instructors are trained and deliver MHFA as part of their job when the workplace manages all aspects the training. In other cases, a workplace may pay an external MHFA instructor to deliver the training. Some MHFA instructors organise the whole course themselves and then charge fees to each participant to cover costs.

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[15] General information about MHFA was taken from the Australian MHFA website: www.mhfa.com.au

2.35 To remain accredited, instructors are required to conduct at least three courses a year and attend the annual MHFA refresher course at least once every three years. Instructors pay the MHFA Australia programme AUD $6.60 dollars for a manual and a certificate per participant in their course.

SMHFA

2.36 The Scottish version of MHFA has been developed since 2003 by NHS Health Scotland, on behalf of the National Programme for Mental Health and Wellbeing, with funding from NIST.[16] The training of instructors is co-ordinated by the Scottish Development Centre for Mental Health. As in Australia, the aim is to improve the level of mental health literacy by training the general public. There are also some specific target groups such as the police, Ambulance Service, Prison Service, primary health and social care staff and voluntary and community groups.

2.37 The main developments of the programme in Scotland have been:

- strengthened criteria for the recruitment of instructors
- a requirement that instructors deliver four courses a year
- the introduction of a self-harm module.

2.38 The cost of training instructors varies from £500 to £1000 between the voluntary and statutory sectors. SMHFA instructors are required to deliver four courses a year. They are responsible for the organisation of courses themselves or with the support of their sponsor organisation. As of November 2007, there were nearly 200 instructors and around 6,000 people across Scotland had been trained. A recently-published evaluation of SMHFA is available from Health Scotland.[17]

Similarities and differences between ASIST, STORM, MHFA and SMHFA

2.39 From our review of the literature on STORM and MHFA / SMHFA, we have identified a number of similarities to, and differences from, ASIST. In broad terms, ASIST and MHFA / SMHFA are similar in that they are both based on the principles of first-aid, i.e. giving knowledge and skills to people in the wider community, as well as health and social care professionals, so that they can help others. STORM is a training package for health and social care professionals and is delivered within an organisation. (STORM is not delivered within the community.)

2.40 Table 2.1 presents the key features of all four programmes. There may be some aspects worth exploring in relation to the future of ASIST.

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[16] The information in this section was taken from the NHS Health Scotland website:: www.healthscotland.org.uk/smhfa/index.cfm. Further details were provided through personal communication with a representative of the Scottish Development Centre for Mental Health.

[17] Evaluation available at: www.healthscotland.org.uk/smhfa/Evaluation_Final.cfm.

Table 2.1: A comparison of different aspects of ASIST, STORM, MHFA and SMHFA

	ASIST	STORM	MHFA	SMHFA
Aim	A "first aid" intervention to help all caregivers become more willing, ready and able to help persons at risk.	To teach risk assessment and risk management through a skill-based suicide prevention training package.	To improve mental health literacy and to train people in supporting individuals in mental health crisis situation.	To increase mental health literacy by giving skills and confidence to help people experiencing mental health problems.
Target audience	All caregivers (including professionals, para-professionals and lay people).	All frontline healthcare, social care, criminal justice staff and staff in voluntary sector.	Members of the public and those in contact with people with mental health problems.	The general public and some key groups: police, ambulance service, primary heath and social care, and voluntary and community groups.
Flexibility in structure	The structure of the workshop is fixed and participants must attend both days.	The modules can be delivered flexibly.	Usually delivered in two days but not consecutively.	Delivered on two consecutive days, or two days over two weeks, or as four 3-hour sessions.
Trainers	Trainers undergo a 5-day T4T course delivered by LWE, which includes the two-day ASIST workshop. Requirement to deliver three courses in first year and, in Scotland, in every subsequent year.	Staff within an organisation who undertake the 4-day Facilitators Training course.	Instructors undertake a 5-day course. They must deliver three courses per year and attend a refresher every three years.	Instructors undertake a 7-day course, which includes the two-day SMHFA course. Required to deliver four courses per year.
Recruitment of trainers	Officially, no formal pre-requisites (apart from having participated in an ASIST workshop).	No criteria	Applicants need to meet criteria including knowledge of mental illness, teaching and communication skills.	Applicants need to meet criteria (strengthened from original MHFA criteria) to include personal or professional experience of mental health, training or teaching and good communication skills.
Funding	Funded by Choose Life and by local areas. National and local organisations also contribute funding.	Offered commercially to health and social care organisations as part of their suicide prevention strategy.	Either fee for service or delivered by an organisation (who pays).	Funded by NHS Health Scotland. Courses may be free, e.g through NHS or instructors or their sponsor organisations may charge a fee.
Implementa-tion	LWE is the central organisation body for ASIST, providing services such as T4T, resource support to local trainers, programme updating.	Offering the package commercially is part of the implementation. STORM is recognised by the Department of Health (England) as a useful training package.	MHFA was initially funded by a grant from the Australian Capital Territory Government but now runs as fee-for-services with continuing demand, particularly from workplaces.	NHS Health Scotland manages SMHFA on behalf of the National Programme and oversees development of training materials. SDC co-ordinates training of instructors.

Summary of Chapter 2

- ASIST is a two-day course that aims to help caregivers (both professionals and lay people) to become more willing, ready and able to recognise and help persons at risk of suicide.
- ASIST is intended as 'suicide first-aid' training, and is focused on teaching participants to recognise risk and learn how to intervene effectively to reduce the immediate risk of suicide. The course is delivered over two consecutive days in a workshop-type format. Participants develop skills through observation and supervised simulation experiences in large and small groups. All ASIST trainers must attend a five-day 'training for trainers' (T4T) course.
- ASIST was developed in the early 1980s by four individuals at the University of Calgary in Alberta, Canada. In 1991, the company, LivingWorks Education (LWE) was set up to market the course outside Alberta.
- ASIST has now been implemented in a number of countries worldwide. Where ASIST is newly implemented in a country, LWE continues to retain the responsibility for maintaining the standardisation and quality of the T4T and ASIST courses, and for keeping both courses up-to-date. Therefore, LWE Coaching Trainers provide all T4T training. Where a country has achieved International Collaborative Committee (ICC) status, that country then becomes responsible for quality control, and for collecting, recording and responding to feedback on its own courses. Scotland has recently attained ICC status.
- ASIST is just one of the suicide prevention training programmes offered by LWE. In addition, the short refresher course, ASIST Tune-Up, provides a review of the principles and practices of ASIST for people who have completed the course some time ago.
- In addition to the LWE programmes, there are other suicide prevention training programmes available in Scotland, including STORM (Skills-based Training on Risk Management). Scotland's Mental Health First Aid (SMHFA), while not a suicide prevention training programme, addresses the possibility of suicide in people who are experiencing mental ill health.

CHAPTER THREE METHODS

3.1 This section will describe the methodology used in this evaluation. This was a large and complex study and the methodology was intended to capture both the ***breadth*** and ***depth*** of views that exist in Scotland in relation to ASIST. Thus, both quantitative and qualitative methods were used. An attempt was made to ascertain not only whether ASIST was effective, but in what conditions and why it is effective, or *not effective*, as the case may be. Moreover, this study looked not only at the experience of ASIST in Scotland, but it also examined studies of the effectiveness and impact of ASIST in other parts of the world where it has been implemented.

Our approach to the evaluation

3.2 In considering the effectiveness and impact of ASIST, the starting point for this evaluation was a model which has been widely used in the evaluation of training interventions — that is, the Kirkpatrick model.[18] The Kirkpatrick model looks at the evaluation of training at four levels (described below):

1. **Reaction:** What did the learner feel about the training? (Includes not only their views of the training itself, but also their views about the facilities, the venue, the quality of the training delivery, etc.).

2. **Learning:** What facts and knowledge did the learner gain? Did the person learn anything new?

3. **Behaviour / performance of the individual:** What changes have there been in the learner's behaviour? Is the learner applying the training, and if so, are they doing so in the way anticipated?

4. **Results (organisational / community change):** What has been the impact of the learner's changed behaviour – on organisations, communities and society?

3.3 While the Kirkpatrick model is useful for examining the outcomes of a training intervention, we felt it did not address *all* the issues that might have a bearing on the effectiveness of a training programme. For example, it doesn't consider what the learner brings to the learning experience (in terms of their motivation, interest, existing skills and background), and how this impacts on the outcomes. Nor does it consider the experience and practice of the trainers – those who are responsible for delivering the training.

3.4 Therefore, we did not wish to limit our approach by adhering too rigidly to the Kirkpatrick model. Indeed, in considering the aims and objectives of this evaluation, we have found it useful to incorporate the Kirkpatrick model into a larger programme logic model.

3.5 A programme logic model is a useful tool for planning the implementation of an intervention (in this case, the ASIST training programme), as well as thinking about the process of evaluation. A well-designed logic model clearly shows the links between the aims,

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

activities, outcomes and impacts of an intervention. It also provides a useful basis for asking questions about different aspects of an intervention — as well as questioning the underlying assumptions of the intervention. Our logic model for ASIST is shown in Table 3.1.

Table 3.1: Logic model for the Applied Suicide Intervention Skills Training (ASIST) programme in Scotland

Aim: To provide training to community caregivers (professionals and others) in order that they might recognise the risk of suicide and provide immediate help to persons at risk.

Assumptions:

- Most people considering suicide share their distress and intent.
- If people are provided with knowledge and skills — and the opportunity to practise those skills — they will be able to intervene effectively to reduce the risk of suicide in people they come in contact with.
- People's attitudes to suicide can affect their willingness to intervene.
- If people are trained, they will be more willing to intervene.
- For suicide prevention training to be effective, it needs to be targeted at a wide range of people.

For whom	• Participants – professionals, paraprofessionals (volunteers) and members of the community. • Trainers – at least two individuals from every local authority and organisations such as SAMH, MoD, Ambulance Service, ChildLine, etc.
Processes / activities	• Provide training for trainers (T4T). • Organise training workshops. • Trainers provide training to course participants. • Provide course materials to participants. • Gather course feedback for continuing evaluation and quality improvement.
Outputs	• ASIST trainers in every local authority in Scotland. • > 10,000 people trained. • > 200 people trained as trainers. • > 400 workshops held. • > 10,000 feedback forms collected & entered into the national database.
Outcomes (short-term)* (incl. Kirkpatrick levels 1 and 2)	• Trainers feel competent to train others. • Participants enjoy the workshops. • Participants have acquired the skill of being able to identify when someone is at risk of suicide. • Participants' knowledge of suicide risks is increased and their attitudes towards suicidal people are changed. • Participants feel confident to help people at risk. • Participants know who to refer people to for help.
Outcomes (long-term) (incl Kirkpatrick level 3)	• Participants use the skills and knowledge they have acquired to intervene with people at risk of suicide. • Participants use their skills to good effect.
Impact (incl Kirkpatrick level 4)	• Organisations and communities in Scotland are more suicide-aware. • Better multi-agency working in relation to supporting people at risk. • Suicide is prevented in particular individuals. • Reduction in suicide rates in Scotland [long term].

* A list of LivingWorks Education's expected caregiver competencies and trainer competencies is included in Annex 1.

Summary of study methods

3.6 The methods used in the study were:

- a review of the international literature on ASIST
- a limited review of other suicide prevention training programmes
- an analysis of the national ASIST database, held and maintained by NIST
- a national survey of ASIST participants
- interviews with ASIST participants
- interviews and focus groups with ASIST trainers
- interviews with key stakeholders, including Choose Life co-ordinators and members of NIST
- in-depth local implementation studies (LIS) in selected areas / organisations around Scotland.

3.7 These methods are described more fully below.

Review of the international literature on ASIST

3.8 This evaluation included a review of all available and relevant English-language literature relating to the ASIST programme up to 2007. The majority of papers included in the review were identified by the commissioners of this evaluation. However, a further search was conducted by the research team to identify any literature relating to ASIST which was not included in the original list. In addition, all Choose Life co-ordinators in Scotland were contacted to confirm whether there were any other published, or soon-to-be published evaluations of ASIST in Scotland which should be included in the review.

3.9 The findings of the literature review were analysed using the Kirkpatrick model as a framework. A full report of the literature review has been published as a separate document. In addition, relevant findings from the literature review are highlighted throughout the report.

3.10 It should be noted, however, that only 15 formal evaluations of ASIST could be identified from the international literature. Moreover, most of these were unpublished. Only five of studies (including one from Scotland) were considered to be good-quality evaluations. The remaining 10 were either of fair or poor standard. Therefore, the extent to which firm conclusions can be drawn about the effectiveness of ASIST from the published literature is limited.

Review of other suicide prevention training programmes

3.11 As well as the international review of the ASIST literature, a limited review of the literature on other types of suicide prevention training was undertaken. Skills-based Training on Risk Management (STORM) was the main programme identified. Owing to the lack of other such programmes, we also looked at Mental Health First Aid (MHFA), including Scottish Mental Health First Aid (SMHFA), which has a suicide prevention component. The aim of this review was to examine the similarities and differences between ASIST and these other programmes; and to identify any lessons for the future development and sustainability of ASIST in Scotland. The primary focus was on similarities and differences in format,

targeting and implementation, rather than comparisons of effectiveness. The findings of this review are included within the main literature review, which is published separately.

Analysis of the national ASIST database

3.12 As part of our effort to evaluate ASIST's impact and effectiveness, we examined the national ASIST database, which is held and maintained by staff within NIST. The database holds information collected by ASIST trainers following each workshop. A standard course evaluation form is used for this purpose. Data include:

- workshop details (time held, place held, number of participants (begun and completed), name of trainer).
- participant feedback (three rating scales asking for: (a) an overall course rating; (b) the extent to which participants feel better prepared to help someone at risk of suicide; and (c) whether participants would recommend the course to others).
- participant comments on the course in free text format.
- participant contact details and basic demographic information.

3.13 The analysis of the ASIST database aimed to:

- find out how many ASIST workshops have been run, how many people have attended from particular areas / organisations and how this has changed over time
- obtain a description of the people who have attended ASIST training in the past (including gender and age profile)
- find out about participants' experiences of the training and their reactions to it (Kirkpatrick level 1 outcome).

3.14 However, our examination of the database uncovered a number of problems. First, we found a high degree of inaccuracy in the data entered in the database. Some information had been entered into the wrong fields; some courses had been entered multiple times; and a large proportion of participant e-mail addresses had been entered incorrectly.

3.15 In addition, there was a substantial amount of missing information in the database. For example, participant demographic data only began to be collected in 2006. However, this information was missing for many courses even in 2006-2007. The information on trainers' experiences of delivering each course was also incomplete and, where it was available, was often difficult to interpret.[19]

3.16 The structure of the database itself also proved to be problematic. For example, there was no way to do very simple analyses of the number of men and women who have attended ASIST training to date. In addition, it was only possible to obtain participant feedback and

[19] Many of the difficulties associated with the ASIST database have been due to a lack of staffing resources within the NIST training team. At the time of the training team's greatest expansion, there was only one admin worker supporting the whole of Choose Life, and no option for providing additional long-term support to the training team. The task of inputting data to the database fell to a series of temporary staff, employed for short periods. These staff had great difficulty interpreting the course evaluation forms, which were often incomplete or illegible, and their contracts were too short to allow them to follow up missing or out-of-date information. The situation was rectified in May 2007 when, following an increase in the training budget, a dedicated admin worker was appointed to the training team.

comments on *one course at a time*. It was not possible to obtain a report on *all* the feedback and comments on several courses held over a period of time in a particular local authority area.

3.17 Because of the poor quality of the data in the national database, we have made only limited use of it for the purposes of this evaluation.

National survey of ASIST participants

3.18 The evaluation included an internet survey of 2,000 former course participants. The purpose of this survey was to find out whether or not respondents believed that they had acquired skills and knowledge in relation to suicide prevention, if they had been able to apply the training and skills in practice, in what circumstances, and why. The survey instrument was developed through focus groups with former ASIST participants. Three focus groups were held for this purpose – in Inverness, Edinburgh and Glasgow.

3.19 The survey sample was randomly selected from the 10,000+ individuals who attended ASIST training to-date. Former participants were contacted using email addresses provided in the database. However, because of the difficulties we discovered in the database (described above), only participants who attended the course between 2005-2007 (according to the database) were invited to take part, since there were no contact details available for participants who attended the course prior to 2005.[20]

3.20 We originally planned to select 1,500 participants for the survey, with the expectation that we might achieve a 30% response rate – or a target sample of 500 responses. However, again, because of the problems with the database, particularly in relation to participant contact details, we took a decision to select 2,000 participants – to account for the fact that many participant email addresses were likely to be incorrect or no longer valid.

3.21 The survey received 568 responses. Following data cleaning, we achieved a final sample of 534. Just over a fifth (21.8%) of respondents were men, and 78.3% were women. Just over three-quarters of respondents (77.9%) had attended the course as a professional caregiver (that is, to help clients, patients, pupils, colleagues or other service users), and of these, the majority represented the voluntary sector (34.5%), social work (16.6%) or NHS primary / community care services (10.9%). There were also a substantial number of respondents from other groups (17.2%) such as the armed forces, local authority housing or community education services, the police and the fire brigade.

3.22 Table 3.2 below provides brief summary information about the survey respondents. A full frequency analysis of the survey responses is available from the research team upon request.

3.23 We checked the representativeness of our sample in two ways. First, we selected a random sample of 15 courses from the ASIST database during the period January 2006 – June 2007. The gender profile of the participants in these 15 courses was 78% female and 22% male – precisely the same as in our survey sample.

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[20] Interestingly, 0.4% (n=2) of respondents to the survey reported that they had attended the training in 2003 and 2.3% (n=12) said they attended in 2004.

Table 3.2: Description of ASIST survey respondents, by gender

	Male*		Female*		All people	
	% of responses	(n)	% of responses	(n)	% of responses	(n)
Year of course completion						
2003	0.0	(0)	0.5	(2)	0.4	(2)
2004	2.7	(3)	2.2	(9)	2.3	(12)
2005	30.4	(34)	28.8	(116)	28.8	(154)
2006	43.8	(49)	48.1	(194)	47.8	(255)
2007	22.3	(25)	16.6	(67)	17.8	(95)
Not sure	0.9	(1)	3.7	(15)	3.0	(16)
Total respondents	100.0	(112)	100.0	(403)	100.0	(534)
Capacity in which they attended the ASIST workshop						
In a personal capacity	1.8	(2)	3.5	(14)	3.0	(16)
As a professional (paid) caregiver	72.3	(81)	79.7	(321)	77.9	(416)
In a voluntary capacity	15.2	(17)	8.7	(35)	10.3	(55)
Other**	10.7	(12)	8.2	(33)	8.8	(47)
Total respondents	100.0	(112)	100.0	(403)	100.0	(534)
Organisations they represented						
Partnership organisation (CHP, etc)	2.0	(2)	4.8	(17)	4.0	(19)
NHS primary or community care	7.1	(7)	12.1	(43)	10.9	(51)
NHS hospital care	1.0	(1)	3.4	(12)	2.8	(13)
NHS other	0.0	(0)	2.0	(7)	1.5	(7)
Drug and alcohol services	6.1	(6)	3.1	(11)	3.6	(17)
Education – primary	1.0	(1)	1.7	(6)	1.5	(7)
Education – secondary	5.1	(5)	5.4	(19)	5.3	(25)
Education – further / higher	2.0	(2)	3.9	(14)	3.5	(16)
Social work	13.3	(13)	17.5	(62)	16.6	(78)
Vol sector / community org	30.7	(30)	34.9	(124)	34.5	(162)
Private sector / self-employed	2.0	(2)	3.9	(14)	3.6	(17)
Church or religious organisation	2.0	(2)	3.1	(11)	2.8	(13)
None	2.0	(2)	0.6	(2)	0.9	(4)
Other***	29.6	(29)	13.8	(49)	17.2	(81)
Total respondents	100.0	(98)	100.0	(355)	100.0	(470)

* 19 participants did not specify their gender. Therefore, the total male respondents + the total female respondents does not equal the total number of respondents (all people).
** "Other" capacities included: students, course tutors, people attending as part of military training, self-employed or volunteer (phone line) counsellors, complementary therapists, or other self-employed persons, ministers of religion, service user group representatives, etc.
*** "Other" organisations included: armed forces, other local authority (non-social work) services such as housing, community education, etc., police, fire brigade, etc.

3.24 We also compared the proportion of respondents who said they completed the course in a particular year, with a breakdown of participants from the database. This comparison is shown in Table 3.3 below.

Table 3.3: Comparison of the percentage of ASIST participants in the national database and the survey, by year of course completion

	Database		Survey	
Year of course completion	%	(n)	%	(n)
2003	0.5	(57)	0.4	(2)
2004	12.6	(1347)	2.3	(12)
2005	31.9	(3425)	28.8	(154)
2006	36.4	(3907)	47.8	(255)
2007*	18.6	(1995)	17.8	(95)
Not sure	--	--	3.0	(16)
Total all years	100.0	(10,731)	100.0	(534)

* Note that the number of participants for 2007 are considerably smaller than for previous years. This is because the figures shown here include ASIST courses only up until September 2007.

3.25 The main differences between the two were in relation to the years 2004 and 2006. The survey included a higher proportion of people who had completed the course in 2006 than the database. Nearly one-half (47.8%) of the survey respondents reported completing the course in 2006, whereas only 36.4% of ASIST participants recorded in the database completed the course in this year. And according to the database, 12.6% of all ASIST participants completed the course in 2004, whereas only 2.3% of the survey respondents reported that they had completed the course in that year. The reason for these differences is partly because email addresses were only available for people who (according to the database) had attended the course from 2005 onwards. Moreover, the contact details available in the database were more likely to be correct for those who attended the course more recently.

3.26 Respondents were asked in the survey if they had made use of their ASIST skills since their training. Those who indicated that they *had* were then asked to provide brief details of this. All respondents were also asked to indicate if they would be willing to share further details of their experience of ASIST with a member of the research team in a one-to-one telephone interview.

3.27 Of the 534 responses, 208 (39%) volunteered to take part in a telephone interview.

Interviews with ASIST participants

3.28 Our plan was to interview 28 ASIST participants in total, so initially, a random sample (every seventh respondent) was selected from the 208. This resulted in a sample of 30 potential interviewees. However, this sample contained few males, and it included a large proportion of people from the west of Scotland (in particular, North and South Lanarkshire and Glasgow), where ASIST had been implemented more widely. Although this sample reflected the gender balance and geography of the survey respondents overall, our intention in sampling was not to achieve statistical representativeness, but rather to capture the diversity of views and experiences that participants might have in relation to ASIST — including those that were less common. Therefore, to achieve a better qualitative sample, we removed seven west-of-Scotland females from the random sample, and substituted seven replacements from other areas of Scotland (outside Lanarkshire and Glasgow). We specifically chose males,

individuals who reported intervening with male non-clients, and individuals who appeared from the survey to have had a less positive experience of ASIST. It was particularly important to include this latter group in order that decisions on future policy and implementation could take their views into account.

3.29 Of the 28 who were selected to be interviewed, we were able to conduct interviews with 22 individuals (7 males and 15 females). Time constraints on the evaluation did not allow us to pursue interviews with the remaining six. However, several of the local implementation studies (described below) also involved interviews and / or focus groups with ASIST participants.

3.30 Our discussions with ASIST participants allowed us to explore participants' experiences of putting their ASIST skills into practice, and any difficulties they found in doing so.

Interviews and focus groups with ASIST trainers

3.31 A combination of telephone interviews, face-to-face interviews and focus groups were held with ASIST trainers from across Scotland. The purpose of these discussions was to explore trainers' experiences of delivering ASIST, to identify the factors that supported and hindered trainers in their role, and to determine the reasons that some people chose not to deliver the training any longer.

3.32 A list of current and former trainers was provided by NIST, and a deliberate attempt was made to select from this a number of trainers who either had never delivered, or were no longer delivering ASIST. We also included trainers who were involved in the first two T4T courses in Scotland, as we thought these individuals would have a useful perspective on the early days of implementing ASIST in Scotland.

3.33 Those selected for interview were contacted initially by email and invited to take part in a 30- to 45-minute telephone interview. Information was provided about the evaluation, what participation would entail and how the results would be used. Those who agreed to participate where then contacted again (by email or phone) to arrange a mutually convenient time for the interview. Detailed notes were taken of telephone interviews, and the data was analysed qualitatively to identify key themes in trainers' experiences of ASIST

3.34 Other interviews and focus groups with trainers were carried out as part of our local implementation studies (see below). Moreover, it should be noted that a number of Choose Life co-ordinators are also ASIST trainers, and the perspectives of these individuals *as trainers* (as well as co-ordinators) were also sought during interviews with them (see below).

3.35 In total, 28 ASIST trainers were interviewed or took part in a focus group as part of this study.

Interviews with key stakeholders

3.36 The evaluation also involved interviews with a large number of stakeholders, at a local, national and international level. The main aim of these interviews was to get people's informed views about why ASIST was introduced in Scotland; how the process of implementation has worked so far; and whether and how it should be rolled out further.

3.37 The stakeholders who were interviewed as part of this evaluation included:

- Twelve (12) Choose Life co-ordinators, selected from areas across Scotland, and including the co-ordinators for the Scottish Prison Service, the Scottish Association for Mental Health and the Ministry of Defence in Scotland. A further seven co-ordinators were also interviewed as part of the local implementation studies.
- Six (6) national stakeholders, including: the Director of the National Programme for Improving Mental Health and Wellbeing; the Head of Implementation, the Operations Manager, and the current national Training Manager from NIST; and the *former* training manager and training co-ordinator, both of whom left NIST before the start of the evaluation.
- A senior representative of LivingWorks Education, based in Canada.

3.38 It is worth noting that, in total, approximately half of Scottish Choose Life co-ordinators were interviewed for this evaluation. These represented geographical areas and organisations which have implemented ASIST and those which have not made much use of ASIST. They also included areas which had chosen other training programmes instead of, or in addition to, ASIST.

3.39 Nine of the Choose Life co-ordinators who took part in the evaluation were also ASIST trainers, and as mentioned above, we explored with these individuals their experiences of delivering the training.

Local implementation studies

3.40 Finally, this evaluation involved six in-depth local implementation studies (LIS). The aim of the LIS was to get a more detailed perspective on the implementation of ASIST and its impact in organisations and communities. This was done through discussions with a range of stakeholders in a single geographical area or, in the case of one LIS, a single organisation.

3.41 The subjects for the local implementation studies were chosen in consultation with the evaluation Advisory Group, so as to maximise the potential learning from the exercise. Five geographical areas – Glasgow, Shetland, Highland, Midlothian and West Dunbartonshire – were chosen. And one organisation – the Scottish Association for Mental Health – was also chosen. Decisions were based on a combination of factors, including: the number of ASIST courses offered, the suicide rate in the area, and the association between suicide rates and deprivation in the area.

3.42 In each area, interviews or focus groups were held with a range of people, including:

- Choose Life Co-ordinator(s) / Development Officer(s) and, in some cases, a former Co-ordinator
- Chair and members of the local Choose Life steering group
- Director of Public Health
- Consultant in public health
- representatives from local strategic planning partnerships, e.g., Community Health Partnerships, Drug and Alcohol Action Teams and Mental Health Partnerships.
- managers of local organisations whose staff have attended ASIST training
- current and (where possible) former trainers
- local ASIST participants.

3.43 A particular effort was made to also interview the individual(s) who had responsibility for local action on *Delivering for Mental Health* in relation to Commitment 7.

3.44 Full reports of the local implementation studies are in Annex 2 of this report.

Summary of Chapter 3

- This was a large and complex study which used both quantitative and qualitative methods.
- The Kirkpatrick model was used as the theoretical framework for the research. This model can be used to evaluate training interventions on four levels: i) participant response; ii) participant learning; iii) applying learning into practice; and iv) organisational / societal impact of the training. For the purposes of this evaluation, the Kirkpatrick model was incorporated into a larger programme logic model.
- The methods used in the study were:
  - » a review of the international literature on ASIST and a limited review of literature on other related training programmes (STORM and MHFA/SMHFA)
  - » an analysis of the national ASIST database
  - » a national online survey of over 2000 ASIST participants
  - » interviews and focus groups with national and local stakeholders, ASIST trainers and participants
  - » in-depth local implementation studies (LIS) in six selected areas / organisations around Scotland.

CHAPTER FOUR IMPLEMENTATION OF ASIST IN SCOTLAND

4.1 In this chapter we describe how ASIST has been implemented in Scotland at: (a) national level and (b) local level. We also explore stakeholders' views of some of the levers and barriers that have influenced the implementation, including aspects of national and local policies and practice, and features of the ASIST workshop itself.

4.2 Our key sources of evidence for this chapter were:

- interviews with national stakeholders, local Choose Life Co-ordinators, members of local Choose Life Steering Groups and early trainers
- reports and guidance documents

Implementation at national level

Why introduce ASIST?

4.3 We explored the "theories of change" behind the introduction of ASIST in our interviews with national stakeholders who had been involved in the decision to promote and support the implementation of ASIST in Scotland. We found that the "theories of change" were based on the following premises:

- Choose Life is primarily a **public health strategy** and suicide prevention is a public health issue. The main focus of Choose Life activity has been, therefore, on (health) promotion and prevention using a community delivery approach.[21]
- There was a need for **suicide prevention training** that would raise awareness and reduce stigma among the public by giving people the knowledge and skills to recognise the signs of suicide and intervene. This need was reinforced by the local plans submitted by each Choose Life area in 2003 which identified: (a) a lack of understanding of suicide and (b) a lack of skills in intervention among the public.
- **Suicide occurs for various reasons** and it is reported that approximately 75% of people who die by suicide were not in touch with mental health services, although they may be in touch with other services.[22]

4.4 The "theory of change" was that **training people from a range of backgrounds** and in a variety of settings would increase the likelihood of intervention and, therefore, have a greater impact on reducing the number of suicides

4.5 National stakeholders reported that there had been some limited exploration of other training programmes, but there was a consensus that there should be national support for ASIST for the following reasons:

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[21] It should be noted that the evaluation of the first phase of Choose Life called for more involvement with clinical services and more focus on specific priority groups.

[22] National Confidential Enquiry into Suicides and Homicides by People with Mental Illness
www.scotpho.org.uk/web/site/home/Healthwell-beinganddisease/suicides/suicide_data/suicide_mental_illness.asp

- It had a credible provenance because it was created by people (Richard Ramsey, Bryan Tanney, William Lang and Roger Tierney) regarded as experts in their field and respected for their work on suicide prevention.
- It had longevity (compared to other programmes) and had been developed and refined over a period of over 20 years.
- It was being used in different countries (e.g. Norway, Australia) and in different settings so, for example, it had been used in both rural and urban settings, which supported its applicability in Scotland.
- The ASIST first-aid model seemed to fit with a public health approach, i.e. the teaching of knowledge and skills accessible to a range of professional, voluntary and community caregivers.
- Four people from Scotland had participated in ASIST in 2003 and trained as trainers (two in Ireland and two in Canada). Their positive feedback was influential. There had also been a seminar about ASIST run by LivingWorks training coaches in Scotland which had received a good response.
- There was access to the LivingWorks infrastructure for the training and support of trainers and the provision of materials; and the availability of complementary programmes, e.g. suicideTALK

4.6 There was also a view that providing national support to ASIST would help to promote a consistent approach to training across Scotland. While this view did not preclude the development of other programmes in the future, it reflected concern about the potential for local areas to develop a wide range of different training at an early stage which would make it difficult to achieve national monitoring and evaluation.

How was ASIST rolled out?

4.7 The then Scottish Executive entered into an agreement with LivingWorks to be the sole conduit for ASIST in Scotland. It was thought that this arrangement would support consistency in implementation which was perceived to be an advantage both to Choose Life and to LivingWorks, who are protective of the integrity of ASIST and the quality of the training. It also allowed for the development of a national monitoring system (through the ASIST database).

4.8 NIST organised two T4Ts as a pilot in April and May 2004, inviting each local area to send two people, since ASIST requires a pair of trainers to run workshops. NIST subsidised the cost of the T4T, but each employing organisation had to agree to release people for the whole five-day course, and to allow them to run three workshops throughout the year.

4.9 The pilot T4Ts attracted many more applications than the 48 places available. In addition, once workshops started being delivered, there was further demand from other areas who also wanted to run ASIST. Two further T4Ts were funded by NIST in autumn 2004, so by the end of 2004 there were 91 trainers in Scotland. The aim was to have at least two trainers in every area.

4.10 Once the decision had been made to roll out ASIST, the biggest factor affecting the implementation was the unexpectedly high level of demand for workshops coming from local areas. The time and attention of the national training staff were almost wholly absorbed in rolling out ASIST. It was this demand, rather than any formal decision, that led to a sole focus on ASIST at national level between 2004 and 2006.

Funding and guidance

4.11 In the meantime, the then Scottish Executive issued guidance on the local implementation of Choose Life Phase 1 in July 2003. This set out the allocation of £9 million funding to local areas over three years. One of the three priorities for action was the development and implementation of local training programmes. The guidance also stated that the training should benefit a range of practitioners and local workers across different agencies, interests and sectors. Further guidance, issued in December 2005, allocated £6.4 million to local areas for 2006-08 (for Phase 2 of Choose Life), and again, training was identified as a key area for action. It asked local areas to work within the proposed national training strategy framework (see paragraph 4.16 below), to produce training plans which would identify target groups and numbers, and to submit plans for sustaining local training activity beyond the end of the Choose Life strategy. The Phase 2 guidance also, for the first time, highlighted the need for training plans to allow for the introduction of new training in the future.

Pricing Policy

4.12 From the beginning of the Choose Life strategy and action plan, there has been a clear focus on making the work sustainable in order that it might continue once national funding had come to an end. This requirement to achieve sustainability provided the impetus for NIST to introduce a pricing policy in relation to ASIST in April 2005 (revised April 2006). The objective was to generate an income by charging local areas an additional "administration" fee for ASIST course materials. The aim was to use the income to part-subsidise places on future T4T courses, national and local training support events, the production of marketing materials and support for a national resource of peripatetic trainers.

4.13 The pricing policy also set out a framework for local areas to begin charging a participant fee for ASIST training. The details of the pricing policy are discussed in Chapter 10 of this report. However, it is worth mentioning here that the policy was (very) unpopular, and only a few local areas attempted to recover the additional costs they paid for course materials by charging a participant fee.

The national training function

4.14 In early 2005, the posts of Training and Development Manager and Training Co-ordinator were created within NIST to support the implementation of ASIST at a national level. From 2006, the training function within NIST was sub-contracted to Right Track, a Scottish charity which offers education, training and employment opportunities to young people and unemployed adults requiring additional support to enter the labour market. Right Track was given the task of delivering all training services on behalf of NIST. This included developing a Scottish suicide prevention training infrastructure and supporting the delivery of training at a local level. The contract with Right Track was £169k in 2006/07 and £200k in 2007/08. These payments included:

- the salaries of the Training Manager and Training Administrator (who were seconded to NIST) and their associated costs, including computing equipment, telephones, etc. (a third employee joined the training team in 2007)
- funding for regional and national training meetings
- sponsorship of trainers to attend training and development events and
- all payments made to LivingWorks for materials and the delivery of T4T.

4.15 However, in 2007, the Right Track board took a decision to terminate this contract with the Scottish Government as the ring-fenced nature of the funding was disadvantaging their charitable status. The remaining funding for 2007 was returned to the Scottish Government. At the same time, plans were underway to move the national training function to NHS Health Scotland from 1 April 2008, and in August 2007, the training team became employees of Health Scotland in anticipation of this. From March 2008, the national training budget will be held by Health Scotland as part of its budget for suicide prevention activities.

4.16 In the meantime, there has been slow progress towards finalising a national training strategy. To move it forward, in 2005 NIST commissioned Richard Ramsey (President of LivingWorks) to develop a questionnaire for a consultation with Community Planning Partnerships on suicide prevention training in their areas. There was only a limited response to this questionnaire (nine out of 32 areas). A draft strategy was published for comment in December 2006. However, further work on the strategy has halted as the new Training and Development Manager (in post from April 2007) was given the task of developing a national training competence framework. This framework will provide the basis for the local response to Commitment 7 in *Delivering for Mental Health* – to train 50% of key front-line staff (primary care, A&E and mental health staff) in suicide prevention.

4.17 The draft version of the national training strategy stressed that Choose Life was an integral part of the Scottish Government's National Programme for Improving Mental Health and Wellbeing. It set out the aim of developing a knowledge base within the Scottish population to give people the "confidence and ability to intervene and support those at risk of suicide". It described the functions of the national training team as: providing guidance on delivering the training strategy; monitoring its effectiveness; evaluating existing programmes; and working collaboratively to identify and introduce new training where gaps exist.

4.18 It also advocated the development of local training plans to complement the national strategy and set out guidance on who should receive training. The focus was on "gatekeeper" professionals or other caregivers who are in a position to give "first-aid assistance" and link to other sources of help. Suggested target groups were:

- community-based groups or individuals (including professionals and lay people – i.e. family, friends, clergy, voluntary organisations and workers, youth workers, teachers, social workers, school teachers, police, etc.)
- primary health care workers (GPs, midwives, public health nurses, etc.)
- mental health professionals (residential, in-patient and community-based)
- emergency department professionals

4.19 The Phase 1 evaluation of Choose Life (Platt *et al* September 2006)[23] outlined the need for a more strategic and targeted approach to national and local training; and a greater clarity about which key front-line services and practitioners should be trained in suicide prevention. The evaluation also recommended combining the existing population and community-based approaches to suicide prevention with a greater focus on those at highest risk (in particular, people with mental health problems, problem alcohol and drug users, and prisoners); and the need to improve national and local connections between Choose Life and mental health, primary care and drug and alcohol services.

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[23] On Choose Life website: www.chooselife.net/web/site/ResearchandReviews/ResearchandEvaluation.asp

Recent developments

4.20 Over the last year criteria have been developed to assist with the selection of trainers, as part of a move to achieve accreditation of the course for trainees – i.e. quality control of trainers is essential for accreditation. As mentioned in the previous chapter, the current selection criteria, listed on the Choose Life website, include:

- previous completion of ASIST
- familiarity with Choose Life and local activities
- previous experience of delivering training
- support from the employer (to be released to deliver the training)
- an open mind in relation to suicide.

4.21 The information for applicants on the Choose Life website also makes it clear that the delivery of the course requires significant preparation time of around 30 hours per course for new trainers. This time may be reduced as they gain experience. The requirement by LivingWorks to do one course a year after the first year has now been extended in Scotland to three a year.

4.22 In October 2006, six experienced Scottish trainers began the process of becoming Consulting Trainers. Another six joined this group in May 2007. (Two previous Consulting Trainers were no longer delivering ASIST in Scotland.) All 12 of this group were self-selected but have been proposed to LivingWorks by NIST on the basis that they met a set of criteria including their personal commitment and their employer's support. Their role will be to provide support to new trainers in delivering their first three workshops. It is also expected that some of this group will have a role in maintaining the quality and consistency of the ASIST course in Scotland, which will require them to undertake additional training.

4.23 As of January 2008, there is one Scottish Training Coach and three further prospective Training Coaches. NIST plans to develop a contract with them directly under the ICC.

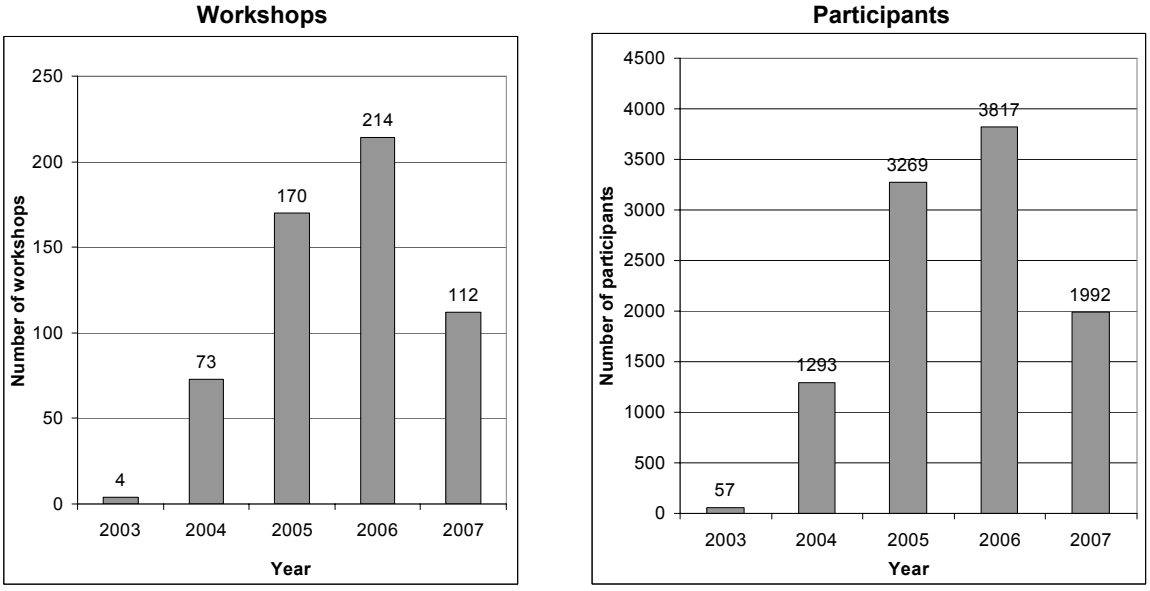
ASIST facts and figures

4.24 In light of the aim to have at least two trainers in each area delivering ASIST, the national implementation can be counted as a success. Indeed, the evaluation of Phase 1 of Choose Life found that ASIST was one of the key elements in the progress made in getting the Choose Life strategy accepted and developed at local level. In addition:

- As of September 2007, there have been 576 workshops completed by 10,477 people. This represents approximately 1 in 500 of the Scottish population.
- As of November 2007, there have been 12 T4Ts.
- There are 271 ASIST trainers, which includes 94 provisional trainers (still to do their first three workshops),12 consulting Trainers and 54 Master trainers.

4.25 Figure 4.1 shows the number of workshops delivered and the number of participants trained in ASIST, by calendar year, since the start of roll-out in 2003 up to September 2007.

Figure 4.1: Number of ASIST workshops delivered and number of completed participants in Scotland, 2003-2007, by calendar year.



Note: The figures shown for 2007 includes data only until September 2007.

4.26 However, it is perhaps also worth noting that:

- According to the national ASIST database, 303 people (3%) who started the ASIST workshop did not complete it.[24]
- As of November 2007, 77 of the 271 ASIST trainers (28%) were inactive – that is, they had not delivered a workshop since 2006.

Implementation at a local level

4.27 We explored with local Choose Life Co-ordinators how ASIST had been implemented locally. Overall, there were a number of common aspects to the implementation of ASIST in the local Choose Life areas. There were also some interesting variations.

Common aspects

4.28 In general, local areas had themselves identified the need for suicide prevention training as part of their Choose Life strategy and implementation. The decision to roll out ASIST at a local level was largely influenced by the strong message which many people perceived NIST had given about its merits and its suitability. The common view was that NIST had reviewed and examined the evidence on suicide prevention training programmes

[24] The actual number of non-completers is likely to be substantially higher than 303, since there was a change in the trainer report forms which were previously used collect this information. The current forms no longer ask for data on non-completions.

and concluded that ASIST was the 'best'. The timing of the invitation to the first T4Ts funded by NIST in early 2004 acted as a catalyst. Some areas (for example, Argyll and Bute) considered other programmes before finally adopting ASIST as the sole programme, or in tandem with other programmes such as STORM. A key factor was the view that the first-aid model of ASIST fitted well with a whole population approach to "skilling-up" communities to prevent suicide.

4.29 A striking feature of local implementation has been that, to a greater or lesser degree, it has focused ASIST on "people who are in contact with people," and most commonly those in the voluntary sector and in communities.[25] This has not precluded participation by health and social care professionals, but the extent to which these groups have attended ASIST appeared to have varied in different areas. ASIST participants have come from voluntary projects, housing services, mental health services (NHS and voluntary), primary care, education, police, fire and ambulance services, social work, and administrative and clerical staff in large organisations such as local authorities. Between 2004 and 2006, many areas experienced a high demand for ASIST, with a peak of 214 courses run in 2006. (See again Figure 4.1.)

4.30 The marketing of ASIST in local areas followed a similar pattern – with flyers, letters and email messages sent to local authority and NHS staff (including administrative staff), voluntary sector projects and community groups, and advertising in the local press. Once courses started running, word-of-mouth recommendation also brought in participants.

Variations

4.31 The **role of the Choose Life Co-ordinator**, and in particular the level of the co-ordinator's interest in, and responsibility for, training, varied across areas. Some co-ordinators were ASIST trainers and, therefore, had a more in-depth knowledge about the aims of the training, its style and content. Having said that, there were also co-ordinators who were not trainers, who were very proactive in rolling out ASIST. A more important factor might be the time available to the co-ordinator. For some, the role of Choose Life Co-ordinator is full-time; for others, the role is "very part-time".

4.32 The role taken by the local **Choose Life Steering Group** also varied depending on the level of priority given to Choose Life in the local Community Planning Partnership (CPP) and health structures. Where the CPP and local partners were more actively engaged with the Choose Life agenda, there was a strategic focus on training and clear decisions about the funding and targeting of the training. There was also a difference between areas on the allocation of funding between projects and training, with some giving little or no money to projects (on the basis that they would not be sustainable in the long term) and others taking the opposite view.

4.33 The **charging policy** was applied differently in different areas, with some areas subsidising ASIST training entirely and other areas charging the maximum fee. There was a perception that the introduction of fees often resulted in a drop in the number of participants. Some areas tried a tiered system of fees, and one area settled on a much reduced fee of £25. Others decided to subsidise free places but to reduce the number of courses offered.

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[25] This precise phrase "people who are in contact with people" was used by a number of the people we interviewed.

4.34 There have been varied experiences in the **recruitment and retention of trainers**. Some areas have attracted a good number of trainers from a mix of disciplines – including mental health staff, social work, education, counsellors and staff from the voluntary sector – while other areas have struggled. The average amount of training activity has also varied between areas from one or two workshops in a year, to one a month. Having said that, the national ASIST database shows that feedback from trainers remains positive, with many trainers holding three workshops per year and some holding ten or more. As mentioned above, NIST now requires trainers to deliver three workshops per year on an ongoing basis.

4.35 In the first couple of years of implementation, the common approach across many local areas was **to target ASIST** quite broadly based on the premise that "suicide is everyone's business." There was also a view that the most productive approach was to try and deliver ASIST to "people in contact with people" recognising that many suicides occur among people not in contact with mental health services or even with any health or social care services. As a result, there has been an effort to recruit a range of participants from voluntary sector agencies who deal with issues such as housing problems, mental health support and drug / alcohol misuse; from statutory health and social care services, and education; local authority clerical staff; care assistants; clergy; and people who work in the community such as taxi drivers, fire and ambulance services and the police.

4.36 In rural areas, the focus on a whole population approach and delivering ASIST in communities was seen as particularly important. However, travelling distance and the cost of accommodation for participants in rural areas were seen as difficulties. In those cases, the workshops are often run with fewer than the recommended number (24).[26]

4.37 Other issues raised in relation to the implementation of ASIST in rural areas included:

- **Concerns about confidentiality:** People attending ASIST from small communities reported that they were unwilling to speak openly in a group where they knew the other participants.
- **The stigma of suicide:** People in rural areas were reported to feel a sense of stigma in relation to suicide and mental health problems. Many aren't willing to seek help from professional services for this reason, which can leave an ASIST-trained person in the position of having to support someone who is feeling suicidal.
- **The impact of suicide:** The impact of suicide in a small communities is often felt across the whole community. It may be partly for this reason that the emotional response to ASIST can be especially strong in these communities.

4.38 On the other hand, it was also reported that small service networks in rural areas have a tendency to promote better integrated working among services.

The views of national and local stakeholders

4.39 Overall, national and local stakeholders agreed that the implementation of ASIST had met most of their expectations**.** In the view of national stakeholders, ASIST has made a major contribution to the Choose Life strategy through:

[26] It is worth noting that the full-time Highland co-ordinator post was created in 2006 with funding from the Scottish Government to look (at a national level) at the particular needs of rural and remote areas.

- promoting public engagement and involvement
- raising awareness and reducing stigma and fear
- giving knowledge and skills to a range of people to help those at risk of suicide.

4.40 While the huge demand caused some problems in the first two years, stakeholders saw the number of trainers and trainees as a significant achievement and they believed there was now a body of people better equipped to identify and address the signs of suicide. They felt that, overall, the central roll-out had been effective but there was also a view that perhaps the national team had not maximised all the opportunities: for example, offered enough guidance about targeting of the training and how it should integrate with other training.

4.41 National and local stakeholders identified a number of factors that had helped and hindered the implementation of ASIST (although not all applied in all areas). These included both strengths and weaknesses of ASIST itself (internal factors) and levers and barriers arising from the national and local implementation (external factors). These are represented in the table below, and are discussed in more detail on the following pages.

	STRENGTHS /LEVERS	**WEAKNESSES /BARRIERS**
INTERNAL	• The "excellence" of the training • The first-aid model is suitable for the wider community but can also be used by professionals • Well-respected internationally and tested in other countries/settings • Strong on attitudes to suicide • People training together – who would not otherwise meet and sharing information • Support available from wider, international ASIST community	• The control exerted by LivingWorks • The Canadian materials – differing views on importance of this • The rigid structure of ASIST • Two-day commitment required • The cost of training and materials • The cost of venues and catering • Lack of evidence of effectiveness • Lack of accreditation • Lack of support for trainers from LivingWorks, e.g. poor response to requests for help and information • Lack of quality control • The money paid to LivingWorks
EXTERNAL	• The Choose Life strategy and funding • The national roll-out and national training support function • The importance given to training in local areas • The supportive role of LivingWorks • A high rate of suicides and interest in training to raise awareness and build capacity. • A good selection of potential trainers • A high level of demand for training • Support from line managers and senior staff, for example to release trainers to deliver workshops and participants to attend • A proactive Choose Life Steering Group and Co-ordinator • The HEAT target to reduce Suicides in Scotland by 20% by 2013 (supported by Commitment 7)	• Unplanned roll out of ASIST • Self-selecting participants • Not enough national guidance / direction • The view of some professionals that it is too basic **or** that it is for the community, not for them • Loss of training capacity through trainers moving post • The cost of employing peripatetic trainers • Lack of administrative support for trainers • The charging policy • The difficulty of engaging with senior clinical staff and management in the NHS • Lack of priority from the CPP and senior managers • The difficulty for staff in getting two consecutive days for the workshops (not all agreed this was a problem)

4.42 In our interviews, it was a recurring theme that the **high quality** and "excellence" of the training were major factors in the success of ASIST. This was the case even when interviewees pointed out aspects of ASIST that they wished to see improved such as the two-day structure, or elements of funding and organisation, such as the charging policy.

4.43 The **role of LivingWorks** attracted both positive and negative views. The positive view was that they were very supportive in the early days of bringing ASIST to Scotland and that there were clear benefits in adopting an internationally recognised programme, with a well-developed infrastructure for training and materials. There was also a view, however, that LivingWorks had identified a good opportunity to be part of a well thought-out, funded national strategy which would generate income for them and, if successful, add to their reputation. There was, partly related to the latter view, some criticism of Living Works based on the understanding of respondents about their role in the management and delivery of ASIST in Scotland. The issue most commonly raised was their perceived inflexibility and high level of control. Specific issues raised were:

- the use of external Coaching Trainers when there were experienced Scottish trainers
- the rigidity of the two-day structure and the requirement that all participants must complete the *entire* course, or else repeat it in order to receive a course certificate
- the content of the course which "cannot be changed"
- the lack of transparency in decisions about who could become a trainer following T4T
- apparent reluctance to sanction changes in the course and materials to make the language and videos more relevant to the Scottish context
- the high costs of materials.

4.44 There were also comments about the unwillingness of LivingWorks to contribute to any programme development costs, such as the development of material for deaf trainees (in Glasgow). We also found problems in two cases where people who had completed the T4T course were then told by the LivingWorks T4T Training Team they could not become an ASIST trainer – with little or no explanation about the reasons why.

4.45 It is important to note that other respondents gave a different view about some of these issues. For example, it was reported to us that delays in the development of a Scottish Coach Training team and the creation of Scottish videos were due at least in part because of earlier decisions on priorities by the then national training team. Moreover, we also understand that Living Works does allow flexibility in the delivery of the course but that this may not have been communicated to trainers attending T4T in the past. According to a senior representative from LivingWorks, trainers have *always* been able to make changes to ASIST to suit their own local circumstances, so long as they keep to the core curriculum:

> *The core curriculum includes the standard procedures for the five sections in the Trainer's Manual and the materials that support them. Within the standard procedures, trainers can shape what they do to fit their presentation styles and experiences. They are expected to include all the steps in the procedures, but they are not required to rigidly follow the example scripts that are provided in their manuals. They can contextualize and shape the workshop experience to fit the circumstances of the workshop participants.*

4.46 Local interviewees in particular consistently raised the **quality and availability of trainers** as key to successful implementation. Overall, they were highly complimentary about the quality of the trainers. However, they identified two issues that have affected implementation: the **reluctance of managers to release trainers** after the first three courses are completed; and the **loss of trainers** moving post; deciding to give up; or becoming inactive because they had not delivered any courses within a year. There has been a 30%

attrition rate. The burden upon trainers of course administration, organisation and marketing was also cited as a factor although some areas provided trainers with support for these tasks. There were some examples of people not delivering any training or giving up quite quickly because they lacked confidence or because they decided that ASIST was not appropriate for them. The views of trainers themselves are explored more fully in Chapter 9.

4.47 There were also concerns about the **monitoring of trainers** both at the T4T stage and later with some suggestion that, on occasion, both NIST and LivingWorks have not responded adequately to concerns about the performance of a trainer. There were also reports of lack **of support for trainers** from LivingWorks when they have asked for help with difficult situations such as participant refusals to take part in role-play or very emotional reactions to the training.

4.48 **The cost of ASIST** was commonly raised as a barrier. While the funding available from Choose Life has been a major factor in supporting the implementation, there was a widely held view that the costs – of T4T, the workshop materials, venues and catering – made ASIST an expensive training programme.

4.49 The pricing policy does not seem to have done much to alleviate the financial burden felt at a local level. Where it was applied, the introduction of fees seems to have had the effect of reducing the number of participants and has in the main been abandoned or continued with a lower level of fee. It is also important to note, however, that there was also some experience of "drop-out" from courses because they were free, i.e. there is no loss attached to non-attendance. There is also some resentment of the administration fee taken by NIST. Overall, there were mixed views about the **pricing policy** with criticism of it as a "half-hearted attempt" which had proved unpopular and which was only patchily implemented. There was also a view, however, that while it had created some resentment, it would ultimately help with sustainability.

4.50 The **two-day structure** of the ASIST workshop was probably the subject of most comment both positive and negative. The positive view was that it is "essential" because of the way that the course is designed to work through "layers and layers" so that it helps participants to acquire the understanding, knowledge, skills and confidence that will enable time to intervene with people at risk of suicide. The more negative view was that the two days created difficulties for the release of staff. There was also a view that this was more difficult for some health and social care professionals, such as NHS hospital-based clinical staff, GP and social workers and for voluntary sector projects that had fewer staff resources.

4.51 By and large, there were no criteria applied to the **selection of participants.** There were views, however, that there were some people for whom the course was not suitable. This included clinical staff who were not receptive to the ASIST approach or who thought that the "first aid" model was insufficient for their needs. There were also concerns about the ability to cope of people who were themselves still suffering from the effects of suicide by family or friends.

4.52 The national stakeholders felt that, in a community-focused, public health approach, there was still scope to **target** key groups who are most likely to be in contact with those at risk of suicide. One issue was how to target men more effectively since the majority of suicides are male, mainly young males, but the training seems to attract a higher percentage of women. There has been limited work done on this. There is also a wide recognition that more

could be done on targeting those who work with people in deprived areas where suicide rates tend to be higher but, to date, there has been limited penetration into these areas.

4.53 The lack of development of **other training programmes** was an issue. The national stakeholders agreed that it had not been the intention for ASIST to be the *only* suicide prevention training programme in Scotland. They now share a view that there needs to be a portfolio or suite of programmes to cater for the needs of different groups – both among professional staff and community caregivers. It was suggested that such a portfolio would include SMHFA, ASIST, ASIST Tune-Up, STORM and other LivingWorks programmes such as safeTALK and SuicideTALK

4.54 There were mixed views about the **engagement of professionals**. Take-up of ASIST among health and social care professionals was reported to be variable and in some places low. In some areas, there had been feedback that professionals saw ASIST as too basic for their needs. In contrast, other stakeholders found that professionals had welcomed ASIST because it offered a different perspective. There was also a view that not all professionals would have done any suicide prevention training. There was some concern about negative attitudes of professionals towards ASIST because of the need to implement Commitment 7. This view was that, while STORM would be an option for professional staff because of its focus on risk assessment and management, ASIST does more to address attitudes towards suicide. There was also some concern that, while accreditation for ASIST either as part of Continuing Professional Development or with SQA was an early ambition, there has been little progress. Accreditation would potentially make ASIST more attractive to some professional staff, for example, GPs.

How could ASIST become sustainable?

4.55 The major barrier to sustainability suggested by stakeholders was money. One interviewee went so far as to say "No money – no sustainability." Interviewees also emphasised, however, that the training that had already been delivered had raised awareness of suicide which, in turn, made more people responsive to the idea of training.

4.56 There were ideas about how ASIST could be made sustainable.

4.57 The consensus was that there should be a move to a **Scottish ASIST or a LivingWorks Scotland**. Stakeholders believed that this would reduce the costs of ASIST by using Scottish Training Coaches to deliver T4T. It would also allow materials more relevant to the Scottish context to be developed and distributed within Scotland. There could be options for more in-house trainers, e.g. in local authorities; trainers could deliver open courses run by LivingWorks Scotland; and trainers could be commissioned by communities or agencies to run courses charging a fee to participants. A lower cost operation could contribute to the sustainability of ASIST. The national stakeholders also recognised that people at a local level would like to see a looser relationship with LivingWorks, if not complete autonomy.

4.58 There was also a consensus that ASIST should now become part of a **suite of programmes**. While all interviewees recognised that Commitment 7 represented a major opportunity, they also recognised that ASIST would not be the only programme used to meet the target set by Commitment 7. Interviewees agreed that the format of the two-day workshop could be a barrier to attendance for some people, and particularly for professionals, such as GPs or clinical staff. They also acknowledged that a more clinically focused model

might be seen as more relevant. As this evaluation progressed, there was more discussion of the use of STORM and safeTALK as well as ASIST, particularly following the initial consultation which took place in September 2007 on the draft competency framework produced by the NIST team. It is important to note, however, that there was some concern that Commitment 7 would lead to suicide prevention training being taken over by the NHS, which many felt would run counter to the wider community focus of Choose Life.

4.59 A broader approach to sustainability was through possible mainstreaming of ASIST, whether or not there is further funding from Choose Life after 2008. There was a general view that an important step would be to get ASIST into the core training programmes of relevant organisations and /or to be embedded in service contracts and job descriptions. This would be likely to include health boards (primary care, mental health services, accident and emergency, GPs, clinical staff) and local authorities (social work, housing, education) but could also include police and fire services. Interviewees recognised, however, that statutory services already face heavy demands to deliver training that is compulsory, for example, training required by the Care Commission.

4.60 Some areas have already taken steps towards making ASIST sustainable by, for example:

- putting suicide prevention into job descriptions
- identifying two people in each area to organise training (rural area)
- using in-house trainers who have training as part of their job description (where the responsibility lies with the post, not the person) and the employing organisation also providing free venues
- trainers delivering three courses free per year and employers waiving replacement costs as a contribution to local implementation.

4.61 Other ideas were:

- do more Tune-Up refresher days to maintain the skills of ASIST-trained people
- keep a focus on the strategic management
- retain the Choose Life co-ordinator post, even at part-time level

4.62 One interviewee cited the example of Glasgow using Mental Health Partnership money to fund ASIST training. Another cited the example of the place of ASIST in the curriculum for nurse training at Bell College in Dumfries (where two lecturers are ASIST trainers). However, it was noted that other colleges in Scotland, while expressing interest, were not prepared to do it without funding.

4.63 Finally, there were no big ideas about financial sustainability. In the short term, there were concerns about what would happen from 2008 onwards. For the longer term, there was a common view that some element of central funding or support would be necessary. There was also a view that some form of charging for ASIST training would be required in the future.

Summary of Chapter 4

- The rationale for introducing ASIST to Scotland was that training people from a range of backgrounds and in a variety of settings would increase the likelihood of intervention and, therefore, have a greater impact on reducing suicide rates. The choice of ASIST was influenced by its community focus and its international reputation and longevity.
- ASIST began to be rolled out across Scotland in 2004, although there was some implementation of the training in one local area from 2003. The national roll-out was co-ordinated by NIST, and two posts were created in NIST for this purpose.
- The support for ASIST at a national level reflected the desire to promote a consistent approach to training across Scotland, which would also facilitate national monitoring and evaluation. This approach was not intended to preclude the development of other training programmes. However, the subsequent huge demand for the training left little time for the national team to evaluate other potential programmes.
- There were a number of levers and barriers to the implementation of ASIST at a local level. The barriers included the cost of ASIST; the length of the training, both for participants and trainers; difficulties in recruiting and retaining trainers; and, in some areas, a lack of a strategic focus on training. Levers included a well-supported national strategy on suicide prevention which highlighted the importance of training; the availability of funding to local areas; proactive involvement from local Choose Life co-ordinators; and a good supply of trainers.
- As of September 2007, there have been 576 ASIST workshops completed by 10,477 people. This represents approximately 1 in 500 of the Scottish population. In addition, between April 2004 and November 2007, there have been 12 T4Ts which have trained 271 people to deliver ASIST. However, it is also worth noting that: 303 people (3%) who started the ASIST workshop did not complete it, and 28% of ASIST trainers are currently inactive.
- ASIST participants have come from voluntary sector projects, housing services, mental health services, primary care services, education, police and social work. However, participation by health and social care professionals has varied in different areas.
- Overall, national and local stakeholders agreed that the implementation of ASIST had raised awareness of suicide and reduced stigma and fear — and that the course had given a range of people the knowledge and skills they need to help those at risk of suicide. Ideas to support future sustainability included the creation of a Scottish LivingWorks. There was also a consensus that, in the future, ASIST should be part of a suite of suicide prevention training programmes.

CHAPTER FIVE KIRKPATRICK LEVEL 1: WHAT DO PEOPLE THINK ABOUT ASIST?

5.1 This chapter summarises information gathered from participants about their reactions to the ASIST training course. Evaluation at this level (Kirkpatrick level 1) attempts to answer questions regarding participants' perceptions of the programme's quality and relevance. Participants' reactions to the training could play a key role in programme improvement. In addition, participants' reactions have important consequences for learning (Kirkpatrick level two). Although a positive reaction does not guarantee learning, a negative reaction almost certainly reduces its possibility.

5.2 According to the national ASIST database, since the introduction of ASIST in Scotland in 2003, 10,780 participants have commenced the training. There was a non-completion rate of 3% (303 participants).

5.3 The evidence for participants' reactions to ASIST training was obtained from our on-line survey of, and telephone interviews with, ASIST participants, information gathered for our local implementation studies, the national ASIST database and our literature review.

5.4 Our analysis of Kirkpatrick level 1 outcomes focuses on participants' reactions to:

- the training overall
- the usefulness and relevance of the training
- the quality of training.

5.5 We also highlight and discuss issues raised where participants gave mixed or negative reactions to the training.

Overall reactions to ASIST

5.6 The ASIST literature consistently reports highly positive participant reactions to the workshop. In all the papers that measured level 1 outcomes in our review (seven international evaluations and six Scottish in-house questionnaires), the vast majority of ASIST participants expressed high levels of satisfaction and generally felt that taking part in the training was worthwhile and beneficial.

5.7 Data gathered for our evaluation provided a similar picture of highly positive participant reactions to ASIST. Here are some illustrative quotes from our survey participants:

> *I found the ASIST training invaluable and it removed many taboo areas and misinformation that I had accumulated over the years.*
>
> *Overall it was challenging, stimulating and beneficial to me both professionally and personally.*
>
> *Rather than seeing people at risk as having an incurable disease, I saw that I could intervene in a positive way so I felt it was quite hopeful.*
>
> *ASIST helps [you] look at things and life in a more positive way!*

This was one of the best and most useful courses I have attended in 30 years of community work.

5.8 We also spoke to ASIST participants as part of our local implementation studies. The reactions we found there were also very positive.

- In one Glasgow focus group, practitioners who had backgrounds of addiction, prison and family suicide, were overwhelmingly positive about the structure and content of ASIST. Participants spoke about its value to them as individuals as well as to their work with clients. They had found ASIST challenging, even "scary" but reported that it was "the best two days of my life".
- In Midlothian, in a focus group with local ASIST participants, they said they valued the multi-disciplinary and multi-agency mix on ASIST courses and the clear suicide intervention model.
- Practitioners employed by the Scottish Association for Mental Health (SAMH) also said it was the best training course they had ever been on.

5.9 At the end of every ASIST workshop, participants are asked to complete a feedback form, which includes (among other things) three questions asking participants to rate various aspects of the course on a scale from 1-10. These include:

- an overall course rating
- the extent to which they feel better prepared to help someone at risk of suicide
- the extent to which they are likely to recommend the course to others.

5.10 Our analysis of this information in the national ASIST database found that ASIST training was highly rated by participants. At a national level, the average overall course rating was 8.2; the average score reflecting the extent to which participants feel better prepared to help someone at-risk was 7.8; and the average score reflecting the extent to which participants are likely to recommend the course to others was 8.6.

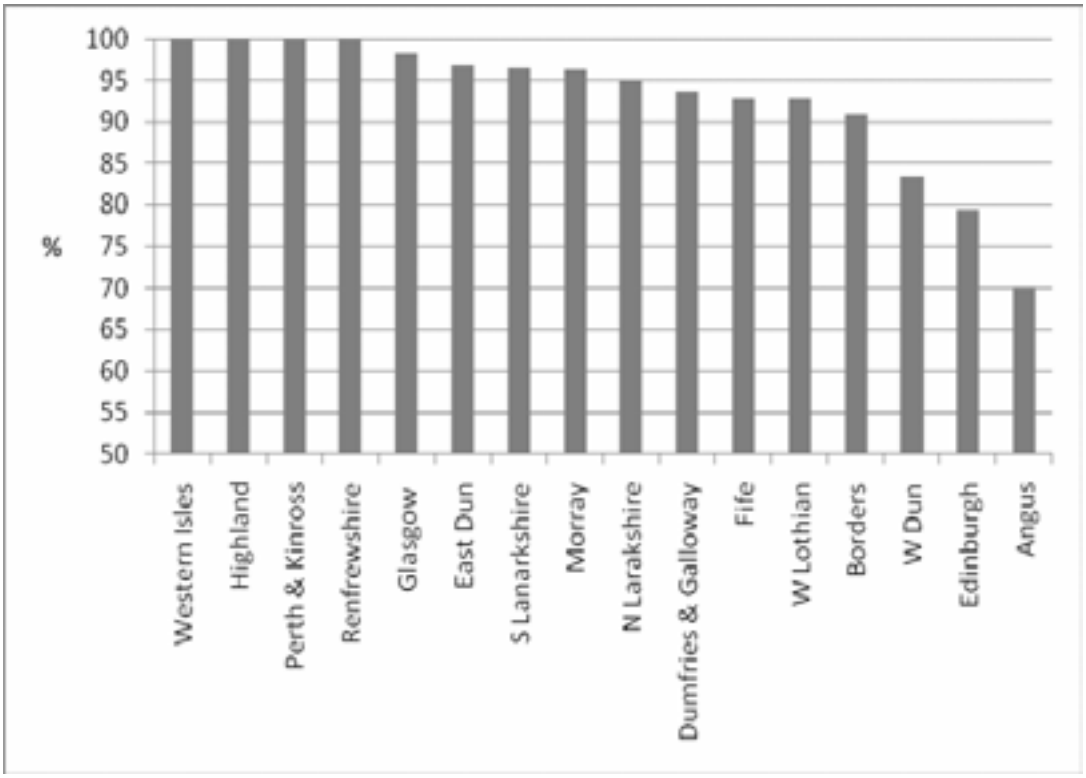
Usefulness and relevance of training

5.11 In our survey of ASIST participants, almost all participants (94.5%) agreed with the statement that going on ASIST training was a good use of their time.

5.12 A comparison by participant employee group (NHS, local government, voluntary sector and informal caregivers) found that, across all groups, almost all (more than 90% in each group) thought that ASIST had been a good use of their time.

5.13 A comparison by local authority found that the majority of participants in all areas of Scotland agreed that ASIST had been a good use of their time. However, as can be seen in Figure 5.1, the level of agreement in the different areas was quite varied, and ranged between 70-100%.

Figure 5.1: Percentage of survey participants who agreed that attending ASIST training had been a good use of their time, by local authority



Note: The figure above includes data only for local authorities for which we had at least 10 survey respondents.

Usefulness of the various elements of ASIST

5.14 We asked survey participants to state how useful they found various elements of the ASIST training. Ratings of 'very useful' and 'somewhat useful' for the various elements are shown in Table 5.1. The most useful elements of the training were perceived to be learning the suicide intervention model and the discussion of attitudes to suicide and suicide prevention. The least useful elements were perceived to be the videos and networking for caregivers. Overall, however, the totals for 'very useful' and 'somewhat useful' added together show that almost all participants found most elements of the workshop useful to some degree. It is notable that 92.1% of participants found the role-play 'very useful' or 'somewhat useful,' although participants often do not enjoy the experience of role-play (see paragraphs 5.24 and 5.25).

Table 5.1: Percentage of ASIST participants rating elements of ASIST workshop as 'very useful' or 'somewhat useful'

Element of ASIST workshop	% participants rating it very useful	% participants rating it somewhat useful	Total % rating it very or somewhat useful
Learning the suicide intervention model (SIM)	79.0	18.6	97.6
Discussion of attitudes to suicide and suicide prevention	76.9	21.6	98.5
The ASIST workbook	64.9	30.9	95.8
The suicide intervention handbook	63.9	31.6	95.5
ASIST wallet sized card	63.4	28.0	91.4
Practice through role-play	62.6	29.5	92.1
ASIST leaflet	46.0	45.2	91.2
Videos	45.2	44.1	89.3
Networking for caregivers	34.0	52.9	86.9

5.15 A comparison of the usefulness of various elements of ASIST between participant employee groups showed that:

- Local government and voluntary sector staff were more likely than NHS staff to give all aspects of the training 'very useful' ratings.
- All employee groups were likely to rate the discussion of attitudes to suicide and learning the suicide intervention model more highly than other aspects of the course.
- In comparison to other groups, informal caregivers gave particularly low 'very useful' ratings to the videos, the networking for caregivers and the ASIST leaflet.

Usefulness as a function of prior confidence, knowledge and skills

5.16 We compared the reactions to ASIST of those who reported their levels of confidence **and** knowledge **and** skills before ASIST as 'low' or 'very low' (n=179), with those who reported that all three were 'high' or 'very high' (n=42). We found that:

- Almost all (97.5%) of the 'low' to 'very low' group agreed that going on ASIST was a good use of their time. All elements of ASIST, except the videos, were rated as 'very useful' by a majority.
- Three-quarters (76.5%) of the 'high' to 'very high' group agreed that going on ASIST was a good use of their time. The discussion of attitudes to suicide and suicide prevention was the only element that was rated as 'very useful' by a majority.

Quality of training

5.17 An examination of participant ratings of individual courses (and individual trainers), as presented in the national ASIST database, revealed that there did not seem to be much variation between areas, although the course ratings in Edinburgh were slightly lower than in other areas. All courses and trainers were rated highly, and there were no examples of trainers rated poorly.

5.18 Participants in the survey and interviews were not asked specifically about their views on the quality of trainers, however, 21 participants commented without prompting. More than half of those commenting were positive about the trainers, for example: trainers were "fantastic," "professional and supportive" and "first class" and the training was "well-facilitated." The remainder were negative, for example: "clearly a novice," "not able to manage and deal with the issues that arose" and "not facilitating the group appropriately and did not work together well as a training team."

5.19 Our findings suggest that, although in the majority of cases participants perceived the quality of training and trainers as good, this perception was not consistent across the various trainers and / or areas.

Mixed and negative reactions to ASIST

5.20 Overall, the reactions of participants to ASIST were hugely positive. However, in our research we also came across some mixed and some negative reactions to ASIST. Whilst relatively small in overall numbers, they are important in considering how to optimise ASIST in the future and to avoid any potential harm arising from ASIST training. We therefore give some detailed commentary and examples of these reactions.

Negative emotional impact

5.21 In our literature review we found that an Australian study (Mikhailovich *et al* 2003), examining the implementation of ASIST in a university setting, raised a concern as to a possible negative emotional impact of the training on participants (especially vulnerable ones). This issue was also raised by participants in a Scottish in-house evaluation from Shetland (Todd 2005). However, both studies stated that, despite any potential negative emotional impact immediately following training, in the longer run training was largely perceived as a positive experience. In response to any possible negative emotional impact of training, an independent Irish evaluation of ASIST (Bookle and Burtenshaw 2004) recommended that participants should be informed in advance of the course content in order to prepare them for the intense nature of the programme.

5.22 In our survey, few participants (5.3%) agreed with the statement that ASIST training 'had a negative effect on me emotionally.' Whilst this is a small percentage in overall terms, if this was generalised to the more than 10,000 people now trained in ASIST in Scotland, it would imply that more than 500 had been affected. However, at the same time, comments by participants in interviews and the survey illustrate that the degree of negative emotional impact ranged from being emotionally draining to being potentially harmful. For some participants, although they found ASIST emotionally difficult, they felt it had helped them deal positively with personal issues. Some illustrative quotations from survey comments and interviews are given below:

ASIST was a valuable training experience although emotionally draining. Attendees should be fully aware of this prior to attendance and should take personal responsibility to ensure that if they request ASIST training, that it takes place at an appropriate time in their personal lives. The trainers fulfilled their responsibilities in relation to this completely. Individuals must also be responsible.

As a service user (mental health) who has tried to commit suicide, I found parts of this course very difficult emotionally, i.e. the role-play and would perhaps not recommend it to other service users. At the end I was VERY upset with the experience. I think the effects of ASIST on vulnerable people should be promoted more.

It made a big impact on me. Part of it was personal. It made me realise that myself and others close to me sometimes have very depressing thoughts. It brought it home in a personal way, how common it was… I felt a bit wobbly and vulnerable at times but they kept you safe. It was not a problem – for me, it made it a good course.

At some point I felt I might need to leave because it was all too much, but at the end it was very beneficial. Found the course to be therapeutic as I've attempted suicide in the past.

5.23 Although ASIST had a negative emotional impact, three-quarters (73.9%) of participants who reported negative emotional impact nevertheless agreed that the course had been a good use of their time. Other characteristics of those who reported a negative impact were that:

- almost all (92%) were female (compared to 73.8% females overall in survey)
- approximately two-thirds (64%) were professional caregivers (compared to 77.9% overall in survey)
- they were from across Scotland and different employment sectors, though the biggest group (42.9%) was from the voluntary sector (compared to 32% overall in survey).

5.24 In our local implementation studies, it was rare for interviewees or focus group participants to report negative emotional impacts from ASIST. A notable exception was in Shetland, where ASIST participants and trainers recounted examples where people had had strong emotional reactions to the material — to the extent that they were openly weeping during the course. However, it was reported that this type of response had lessened as the trainers had grown more confident in delivering the material and had learned how to inject some humour into the course. On the other hand, one individual described a situation where a formal mental health service user had attended the course quite recently, and the experience had left him in urgent need of support afterwards. This was despite the fact that the Shetland trainers always give very clear 'health warnings' to prospective participants prior to the course.

5.25 SAMH managers reported that some staff in the organisation had fed back to them that the course had had a big emotional impact on them, but this was not necessarily perceived to be negative.

Role-play

5.26 There were very mixed reactions to the role-play element of the training. Whilst some people found this a useful way to learn, others found it very difficult and did not like being pressured into role-play. In one workshop described by a participant, three ASIST participants refused to take part in the role-play and eventually did their own role-play, unobserved, in a separate room. The upset this caused had negatively affected the atmosphere for the whole group. Other participants described how the role-play had reminded them of, or "made them relive," personal experiences of suicide and this had been upsetting. This is illustrated by the quotation below:

> *Two women, for whom suicide was very close to home, asked the trainer to sit out on the role-play, but were told they couldn't do that. The result was that when they did the role-play one of the women became very upset and the other had to leave the room. I think that they should allow more flexibility in taking part in the role-play, not forcing people into doing it.*

5.27 Similar comments were made by participants in all our local implementation studies. The role-play was the one aspect of ASIST that people tended to dislike. In SAMH, one individual felt that the role-play had actually detracted from her experience of the course, since, as she said: "I spent the whole second day worrying about it, rather than paying attention to what was being said and discussed in the course." One ASIST participant in Glasgow suggested that more sensitively was needed with people who were reluctant to participate in the role-play. In Highland, it was noted more than once that it would be useful for participants to be given some preparation for the role-play — particularly for those who were unused to it.

5.28 Despite all this, some participants commented that, although they did not like the role-play, they had nevertheless found it useful and beneficial.

The suicide intervention model

5.29 A key part of ASIST training is to teach participants a suicide intervention model which consists of a three-phase process of connecting, understanding and assisting. (A further explanation of the ASIST model was given in paragraph 2.6 of this report.)

5.30 There were mixed views on the model amongst participants who commented about it in the survey and interviews. Some found the model a useful, clear, step-by-step process that helped them to confront the issue of suicide and help the person at risk. However, others felt it was not appropriate for all contacts (for example, those who self-harm, are always suicidal, have learning difficulties or personality disorders), or that it did not fit with their job requirements. In our survey, we found that 13.6% agreed with the statement, 'ASIST is not appropriate for some of the client groups I work with'; and 13.5% said it was not always appropriate for personal contacts.

5.31 Some comments illustrative of these mixed views are quoted below:

> *The model is fantastic and should be compulsory for everyone working with vulnerable adults and children.*

[ASIST] doesn't take account of the complex nature of relationships – that one may be disinclined to get into a long-term intervention if one has an emotionally dysfunctional relationship with the person and feel that by doing so it may pave the way for unreasonable emotional demands.

The model does not always fit into NHS practice as there are formal procedures such as admitting patients which go beyond the form of a safeplan identified in the ASIST programme.

5.32 Some participants reported difficulties with the idea of trying to contract a safeplan. For one participant (from The Samaritans) this was because it was impractical and possibly would be seen as "presumptuous and unwanted" and for another participant:

Sometimes it can be really hard to refer on – i.e. the client has a poor relationship with statutory agencies such as the GP and psychiatric services. Perhaps they have been through this process many times and feel that nothing can help. It really can be hard work and mean that the worker can feel left with a lot of the responsibility.

Other aspects of ASIST

5.33 Other negative reactions to ASIST related to cultural aspects. ASIST was developed in Canada and a few people found the content of the training to be "too Canadianised" or "evangelical." Some of the scenarios were felt to be inappropriate to Scottish culture, for example the scenario of someone threatening to attempt suicide with a gun.

5.34 Some participants commented on other aspects of the videos and scenarios, for example, that the videos were "badly acted" or "very staged". One person thought that the scenarios should represent more common situations, for example, a woman with postnatal depression, rather than a person about to jump off a bridge. One or two people commented that the bridge scenario overlooked risks to personal safety by suggesting that the police should not be called and that individuals should intervene, even if they were lone females.

5.35 A few people commented on the name of ASIST and its similarity to the term 'assisted suicide,' which they felt was unfortunate.

5.36 A small number of participants identified gaps in ASIST training in relation to support. The first was a perceived lack of support during, or immediately after, the workshop for participants who either (anonymously) reported that they had been feeling suicidal during the previous week or who were adversely emotionally affected by the training. The second issue raised was about the absence on the ASIST curriculum of any discussion about support for people who are deploying ASIST skills. One participant said:

If you do ...ASIST and it doesn't work you may be left with terrible, traumatic feelings. Support networks for people intervening were not discussed or addressed at all.

5.37 Whilst some participants liked the highly structured, step-by-step approach of the ASIST training, others found the inflexibility of delivery difficult. For some people, they felt that the inflexibility meant their needs were not met. One person who was blind said that, "No reasonable adjustment was made for my situation." Another said that the "strict

adherence to course curriculum, while important, appeared to alienate people in the training I attended," whilst one thought that ASIST might be less interesting for trainers to deliver than courses which allowed a greater degree of flexibility and responsiveness. One person was concerned about the impact of being discouraged from talking to non-ASIST-trained colleagues about the training, stating:

> *We were encouraged not to discuss the training with anyone who hasn't done it. I belong to a Psychology service where we are deliberately sending everyone on the training over a period of time. We do this with other training too, and we use our staff meetings to keep awareness of the issues current. The effect of the instruction from the training, however, has been to discourage such conversations and I believe has reduced the support we could have been giving each other to keep our training current and share experiences of using the approach.*

5.38 A few people commented on the size of group. One person, who was a trainer within the NHS, thought that 12 was an optimum size for a training course of this nature, whilst some people thought that the role-play would be better performed in small groups of four to five, rather than two groups of 12.

Summary of Chapter 5

- The vast majority of ASIST participants reported positive reactions to the training and found it to be useful and relevant — 94.5% of all participants agreed with the statement that going on ASIST training had been a good use of their time.
- A comparison by participant employee group (NHS, local government, voluntary sector and informal caregivers) found that, across all groups, almost all (more than 90% in each group) thought that ASIST had been a good use of their time.
- Those who found ASIST to be most useful were local government and voluntary sector staff (as compared to NHS staff), and individuals who perceived themselves to have low levels of suicide intervention confidence, knowledge and skills prior to attending ASIST.
- The elements of training thought to be most useful were the discussion of attitudes and learning the ASIST suicide intervention model. The elements of training thought to be least useful were the videos and the networking for caregivers. Although participants often reported that they do not enjoy the experience of role-play, more than 90% rated the role-play as 'very useful' or 'somewhat useful.'
- ASIST training was perceived as a 'good use of my time' by the majority of participants, ranging between 70-100% of participants from various local authorities across Scotland.
- In general, participants perceived the quality of training and trainers as good. However, this perception was not consistent across trainers and / or areas.
- Despite the very positive views on ASIST, there was also evidence of some negative reactions — in particular, negative emotional reactions, dislike of the role-play element, and mixed views on the suicide intervention model and other aspects of ASIST.

CHAPTER SIX KIRKPATRICK LEVEL 2: WHAT DID PEOPLE LEARN FROM ASIST?

6.1 The immediate aim of ASIST is to enhance the suicide intervention knowledge and skills of caregivers, in order that they can recognise and respond to people at risk. This chapter looks at whether and how ASIST participants enhanced their confidence, skills and knowledge in relation to suicide prevention and whether ASIST changed or challenged their attitudes about suicide (Kirkpatrick level 2 outcomes). We also report on participants' learning prior to ASIST and their other activities in relation to suicide prevention post-ASIST.

6.2 The evidence presented in this chapter was obtained from our ASIST literature review, from our participants' comments (on-line survey, trainee interviews), and from comments made by service managers in our local implementation studies who have staff trained in ASIST.

6.3 In our literature review, we found that Kirkpatrick level 2 outcomes were measured in 13 of the 15 papers. All studies found an overall positive change in participants' *self-reported* suicide intervention knowledge, skills and attitudes post-training.[27] Similarly, participants' *self-reported* levels of knowledge, skills and attitudes compared favourably to those of controls (who had not undertaken training).

6.4 These findings were reinforced by five studies that used *direct* (as opposed to self-reported) measures of knowledge, skills and attitudes. Participants who were trained in ASIST registered a significant improvement in both post-workshop simulated scenario exercises[28] (Tierney 1994; Turley *et al* 2000) and paper test scores (post-training compared to pre-training, and trained participants compared to a control group) (MacDonald 1999; ORS 2002; Tierney 1994).

6.5 In our survey of participants, we asked about their levels of skills, confidence and knowledge separately. We also asked participants to report on their levels of skills, knowledge and confidence at three points in time: before ASIST training, immediately after ASIST training and now (at the time of the survey – September 2007). Furthermore, the survey asked participants whether they felt their attitudes had been challenged by ASIST.

6.6 It should be noted that our survey and interview evidence from participants is also largely based on self-reported changes and is not, therefore, independently verified. However, in addition, we obtained the views of managers in our local implementation study areas who have, in some cases, provided a degree of external validation of our findings.

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[27] Knowledge, skills and attitudes have been measured in the various papers as either individual variables or as an overall "readiness" score.

[28] Note that, in one of the two studies which used a simulated scenario measure (Turley et al, 2000), the trainee group had a higher level of baseline experience and competency in suicide intervention than the control group. While acknowledging this weakness in design, the authors claim that this actually highlights the capacity of the workshop to facilitate enhanced suicide intervention competencies even among those who have prior experience and training.

Attitudes

6.7 One of the key elements of ASIST is a discussion of attitudes to suicide which aims to help participants explore their own and other's attitudes to suicide and suicide prevention and consider how these might affect the intervention process. The discussion of attitudes is also one of the features which distinguish ASIST from other suicide prevention training programmes such as STORM. Unlike ASIST, STORM does not directly address attitudes as part of the course.

6.8 Fifty-nine percent (59%) of our survey respondents agreed with the statement that ASIST had challenged their attitudes about suicide. The extent to which ASIST had challenged participants' attitudes varied according to employee group:

- Two-fifths (41%) of NHS staff indicated that ASIST challenged their attitude about suicide.
- More than half (55%) of local government employees indicated that ASIST challenged their attitude about suicide.
- Almost two-thirds (63%) of voluntary sector employees indicated that ASIST challenged their attitude about suicide.
- Nearly three-quarters (72%) of informal caregivers and volunteers indicated that ASIST challenged their attitude about suicide.

6.9 Of the 119 participants (24.8%) who *disagreed* that ASIST had challenged their attitudes, just over three-quarters (77.3%) were professional caregivers, spread across all sectors. Nevertheless, although they stated their attitudes had not been challenged, the majority of this group (61.0%) had found the discussion of attitudes in ASIST useful.

6.10 A small number of participants in the survey commented on the usefulness of the discussions about attitudes. For example, one participant said the training "revisited my beliefs" about suicide and another said that the "training made you confront your own issues and attitudes."

6.11 Some of the participants we interviewed also commented on the attitudes element of ASIST training:

> *I became a lot more aware of my own attitudes. It dispensed with some myths. The army has a lot of aggressive and macho mentality and people don't understand why others might want to kill themselves. It helped temper my attitude.*

> *Very challenging – it forced me to look at my own personal attitudes to suicide as opposed to in a purely professional role. I usually maintain a professional distance when dealing with suicide, which is a good thing, but it taught me a bit more about me and my attitudes.*

Immediate, post-workshop changes in confidence, knowledge and skills

6.12 In our survey the proportion of participants reporting 'high' or 'very high' levels of confidence, knowledge or skills, in relation to intervening with someone at risk of suicide **increased substantially** immediately after the training, compared with before, as follows:

- Few participants (11.3%) said their level of **confidence** was 'high' or 'very high' before ASIST, whereas three-quarters of participants (76.8%) said their level of confidence was 'high' or 'very high' immediately after ASIST.
- Few participants (15.1%) said their level of **knowledge** was 'high' or 'very high' before ASIST, whereas most participants (85.4%) said their level of knowledge was 'high' or 'very high' immediately after ASIST.
- Few participants (11.9%) said their level of **skills** was 'high' or 'very high' before ASIST; whereas three-quarters (75.2%) said their level of skills was 'high' or very high' immediately after ASIST.

6.13 Eight out of the 24 participants we interviewed said that ASIST training had given them the confidence to "ask the question," or "have a conversation" with someone about whether they were feeling suicidal. One participant said:

> *This [confidence] was the main thing I gained. Before, if I thought someone was at risk, I would have been terrified to deal with it, in case 10 minutes after I saw them they did it.*

6.14 The types of skills participants felt they had acquired through ASIST included communication skills and being able to follow through the suicide intervention model, for example, one participant said:

> *Although I use a lot of the skills daily, I didn't have a theoretical model. I now have a better understanding when I'm doing an intervention of where I am in the process and how I can help a person move from one stage to the next.*

6.15 Some participants stated that they felt the skills were applicable to other non-suicide situations, for example:

> *It has allowed me to use areas of the training to address the more serious incidents of self harm.*

> *The techniques are useful even when speaking to someone who is not suicidal but bogged down by a crisis or responsibilities.*

6.16 Some participants with previous experience of dealing with suicide felt that ASIST training had confirmed they were approaching it in the right way already.

6.17 Participants reported gaining knowledge of the signs that someone may be considering suicide, suicide statistics, the suicide intervention model, reasons for suicide, risk factors for suicide and the different organisations and networks that can help. One participant who had a lot of experience dealing with suicide said s/he gained knowledge about asking about reasons for dying, whereas she had always previously focused on asking people about their reasons for living.

6.18 Service managers in four of our LIS areas confirmed that participants in their organisation had gained confidence, skills or knowledge in dealing with clients at risk of suicide since training in ASIST:

- In Midlothian, a team leader in a mental health service noted increased confidence in her ASIST-trained staff in dealing with people at risk of suicide. A service manager in the same organisation thought ASIST training had helped staff deal

with their own issues relating to suicide and learn to separate them from client issues, so that the learning had been on two levels.

- In West Dunbartonshire, a voluntary sector service manager (mental health) commented that ASIST training had made her staff more focused, clear and confident about carrying out a suicide intervention. A second voluntary sector service manager (addictions) said he had seen a difference in his staff's attitudes towards suicide prevention following training. He mentioned one staff member who had previously refrained from talking about suicide with clients as they were worried it might do more damage than good. After going on the ASIST course, the staff member realised that openly talking about it would be helpful to their clients.
- In Shetland, one service manager (addictions) reported that prior to their ASIST training, her staff would *never* have asked someone if they were feeling suicidal. However, this is now something that is routinely asked as part of on-going assessment.
- Similarly, in SAMH, managers in four services said that prior to ASIST training, staff avoided discussion of suicide, both among clients and within teams. However, they now feel much more confident about broaching the subject directly with their service users and discussing the issue openly in team meetings.

Maintaining increased skills, knowledge and confidence over time

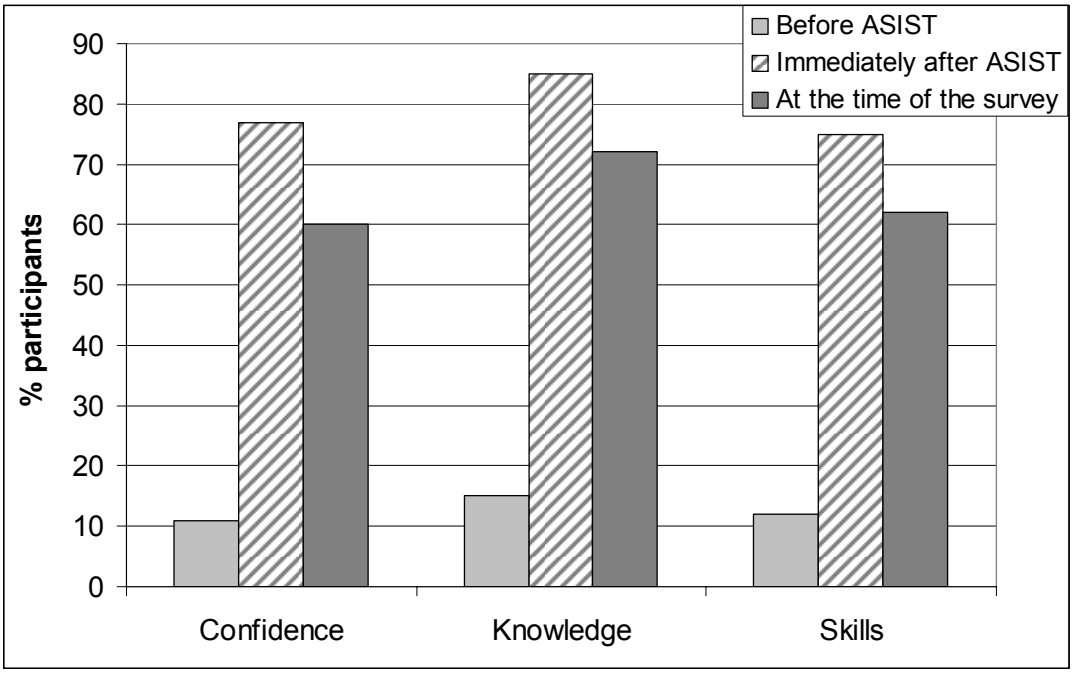
6.19 In evaluating any training programme, it is useful to look at whether people retain what they have learned over time. In our literature review we discovered that evaluations which included follow-up measures had largely found that gains in knowledge, skills and attitudes were maintained at follow-up (typically three to six months post-training).

6.20 Our survey measured self-reported levels of confidence, skills and knowledge, in some cases up to four years after the training. We found that:

- Three-fifths (60.2%) of participants said their level of **confidence** was 'high' or 'very high' at the time of the survey
- A larger majority (71.8%) of participants said their level of **knowledge** was 'high' or 'very high' at the time of the survey
- Just over three-fifths (62.0%) of participants said their level of **skills** was 'high' or 'very high' at the time of the survey.

6.21 Comparing this with the levels reported immediately after ASIST, our findings indicate that, for knowledge and skills, the proportion of people reporting 'high' or 'very high' levels decreased by approximately one-fifth, and for confidence, the proportion reporting 'high' or 'very high' levels decreased by over a quarter. Nevertheless, levels remained much higher overall than before ASIST training. These findings are illustrated in Figure 6.1. Our survey findings support those of the literature review that increases in confidence, knowledge and skills were largely maintained over time, although our survey followed-up participants, in most cases, much longer after training than the literature review studies.

Figure 6.1: Percentages of participants reporting 'high' or 'very high' levels of confidence, knowledge and skills, before ASIST training, immediately after ASIST training, and at the time of the survey



6.22 One American study (ORS 2002) suggested that gains in knowledge and skills over time are most sustainable among participants with less pre-workshop experience of working with suicidal individuals. In order to test this finding from the literature, we compared self-reported levels of confidence, knowledge and skills (rated by our survey participants on a 1 (very low) to 5 (very high) scale) between those who had *not intervened* with someone at risk of suicide *prior* to attending the ASIST workshop (n=181) and those who *had* (n=308). These findings are summarised in Table 6.1. Note that the differences in scores (for confidence, knowledge and skills) between interveners and non-interveners before training, immediately after, and at the time of the survey were all found to be statistically significant at the 0.01 confidence level using the t-test for independent samples.

Table 6.1: Reported levels of confidence, knowledge and skills before training, immediately after, and at follow-up among participates who *had* intervened with a person at risk prior to their ASIST training and participants who had *not*

	Confidence (1-5)*		**Knowledge (1-5)***		**Skills (1-5)***	
	Intervened prior to ASIST	Not intervened prior	Intervened prior to ASIST	Not intervened prior	Intervened prior to ASIST	Not intervened prior
Before training	**2.9**	2.1	**3.1**	2.5	**2.87**	2.0
Immediately after training	**4.0**	3.8	**4.1**	3.9	**4.0**	3.7
At the time of the survey	**3.9**	3.5	**3.9**	3.6	**3.9**	3.5

* Scale: 1=very low, 2=low, 3=moderate, 4=high, 5=very high

6.23 The analysis presented in Table 6.1 highlights three important findings:

- Participants who had the experience of intervening with someone at risk of suicide *prior* to their ASIST training reported higher levels of confidence, knowledge and skills both *before* training, immediately *after* training and at follow-up, as compared with participants who had *not* intervened prior to their ASIST training. This suggests that intervening with a person at risk might increase people's confidence in their ability to carry out an intervention, as well as increasing their perceived levels of suicide intervention knowledge and skills. On the other hand, it is also possible that people who perceive themselves to have high levels of suicide intervention skills are more likely to intervene in the first place, compared with people who believe their suicide intervention skills to be weak.

- For both groups (interveners and non-interveners) the average scores for confidence, knowledge and skills at follow-up were much higher than before they attended the ASIST training. This suggests that the ASIST workshop *does* enhance learning. It also shows that learning (for both interveners and non-interveners) is sustained for the longer term.

- As can be expected, there was a slight drop in scores (confidence, knowledge and skills) for both interveners and non-interveners between the time immediately after training to follow-up time (up to 3 years in our sample). The drop in scores ranged between 0.1-0.2 for people who *had* intervened prior to their ASIST training and between 0.2-0.3 for people who had *not* intervened prior to ASIST. These figures do *not* seem to support the American finding (ORS 2004) that gains in knowledge and skills over time are most sustainable among participants with less pre-workshop experience of working with suicidal individuals. On the contrary, our findings suggest that people who have the experience of intervening with someone at risk of suicide *before* they attend ASIST training are more likely to be able to sustain the gains in knowledge and skills they acquire in the workshop.

Male and female perceptions of their suicide intervention confidence, knowledge and skills

6.24 In order to test for gender differences in participants' workshop learning we compared male and female scores before training, immediately after and at the time of the survey. Findings are reported in Table 6.2.

Table 6.2: Suicide intervention confidence, knowledge and skills scores for males and females before training, immediately after and at follow-up

	Confidence (1-5)*		**Knowledge (1-5)***		**Skills (1-5)***	
	Females	Males	Females	Males	Females	Males
Before training	2.47	**2.82**	2.73	**3.29**	2.47	**2.71**
Immediately after training	3.84	**4.13**	3.99	**4.13**	3.83	**4.03**
At the time of the survey	3.62	**4.01**	3.75	**3.81**	3.66	**3.93**

6.25 As can be seen in Table 6.2 males consistently perceived themselves as more confident, knowledgeable and skilled in suicide intervention than females, both before training, immediately after training and at follow-up. All these difference (bar differences in

knowledge before training and at follow up) were found to be statistically significant at the 0.05 confidence level using the t-test for independent samples.

Whether participants are more likely to intervene

6.26 One of the aims of ASIST is to help front-line caregivers from all disciplines and occupational groups (formal and informal) to become more willing, ready and able to provide practical suicide first-aid to persons at risk.

6.27 In our survey, we asked participants whether they felt that, in their personal life and in their professional life, ASIST training had made them more, or less, likely to intervene with someone at risk of suicide than before the training.

6.28 We found that, in their *professional life*:

- Two-thirds of participants (67.4%) said they were **much more likely** to intervene.
- Few participants (15.5%) said they were **slightly more likely** to intervene.
- Few participants (14.8%) said their likelihood of intervening was **about the same** as before.
- Only two participants (0.4%) said they felt **slightly or much less likely** to intervene.

6.29 In their *personal life*, we found that:

- Just under two-thirds of participants (64.5%) said they were **much more likely** to intervene.
- More than one-fifth of participants (22.1%) said they were **slightly more likely** to intervene.
- Few participants (12.5%) said their likelihood of intervening was **about the same** as before.
- Only four participants (0.8%) said they felt **slightly or much less likely** to intervene.

6.30 Among most participant employee groups, the majority (between 50% and 74%) said they were 'much more likely' to intervene in their professional life and their personal life. The only exception was the NHS group, where less than half said they were 'much more likely' to intervene in their professional life (46.3%) and their personal life (47.1%) than before ASIST. However, a much greater proportion of the NHS group said their likelihood of intervention was about the same as before ASIST training.

6.31 We also compared the self-reported likelihood of intervention between those who had experience of intervening *prior* to ASIST and those who had *not*. Among those who had *not* intervened prior to ASIST, three-quarters (75.6%) of participants said they were 'much more likely' to intervene following ASIST, whereas among those who *had* intervened prior to ASIST, just under two-thirds (64.5%) said they were 'much more likely' to intervene following ASIST. It is interesting to note that the levels are quite high even among those who had intervened prior to ASIST.

Refresher training

6.32 In our literature review we found two exceptions to the overall trend of increased knowledge after ASIST training. Carney (2005) identified two topics for which there was a decrease in knowledge at three months follow-up: (1) the need to encourage a suicidal individual to talk about their wish to die; (2) the need to calmly enquire about what is happening in the suicidal individual's life. Carney suggested that these findings highlight the need for a possible review of how this information is delivered in the ASIST training course, or perhaps the need for regular updating of training.

6.33 In our survey, we found that:

- Just over half of participants (53.5%) agreed that their ASIST skills needed to be updated.
- A slightly larger proportion (58.4%) agreed they needed to be updated on the community resources available in their areas.

6.34 Twenty survey participants added comments about the need for refresher training, for example, one participant said:

> *I have used some things from what I learned on ASIST but not regularly. I do feel a regular refresher would be useful as when I'm not using the skills very often, learning lapses. I had one or more experiences using parts of ASIST that went well, but not using all the skills.*

Other training related to suicide prevention prior to, and following, ASIST

6.35 The majority of participants (67.8%) had not taken part in any of the following types of training in relation to suicide prevention prior to attending ASIST: Mental Health First Aid (MHFA) or Scottish Mental Health First Aid (SMHFA); Skills Training on Risk Management (STORM); SuicideTALK, Samaritans training or other suicide prevention training as part of a professional qualification or delivered to their organisation. This suggests that ASIST is training a large number of people in Scotland who have not previously completed formal training in suicide prevention.

6.36 After ASIST, about three-fifths of participants (59.2%) said they had not undertaken any of a pre-defined list of activities in relation to suicide prevention, including: further related training or becoming involved in a Choose Life steering group. Less than one-third (30.5%) said they had encouraged or enabled other people to do suicide prevention training. A few (7%) had undertaken further training, for example, Tune-Up (not widely available in Scotland yet) or Samaritans training and a few (4%) had trained as ASIST trainers or delivered other training. This suggests that participation in ASIST does not lead to an obvious increase in other suicide prevention-related activities, apart from encouraging others to attend ASIST.

Summary of Chapter 6

- The majority of our survey respondents agreed with the statement that ASIST had challenged their attitudes about suicide. NHS staff were least likely to say that ASIST had challenged their attitudes, and informal caregivers and volunteers were most likely to say that ASIST had challenged their attitudes.
- Participants' self-reported levels of knowledge, confidence and skills in relation to intervening with someone at risk of suicide **increased substantially** immediately after ASIST. These increases were largely maintained over time. However, the majority of participants also felt that their ASIST skills needed updating.
- Participants who had experience of intervening with someone at risk of suicide prior to attending ASIST were more likely to have higher levels of pre-course and post-course confidence, skills and knowledge than those who had not intervened prior to ASIST.
- People who have prior experience of intervening are also more likely to sustain the gains in skills, knowledge and confidence they acquire in the workshop.
- There is evidence to suggest that ASIST enhances learning even for those whose confidence, knowledge and skills are 'high' or 'very high' prior to ASIST training.
- An analysis by gender found that male participants consistently perceived themselves as more confident, skilled and knowledgeable than females.
- Two-thirds of participants reported that they were much more likely to intervene with someone at risk of suicide in their professional or personal life following their ASIST training. An analysis by employee group showed that NHS staff were more likely than other employee groups to say that their likelihood of intervention after ASIST training was about the same as before ASIST training.
- We found that ASIST training seemed to be reaching people with no other previous experience of suicide prevention training.

CHAPTER SEVEN KIRKPATRICK LEVEL 3: WHAT DID PEOPLE DO AS A RESULT OF THE TRAINING?

7.1 The previous chapter explored what participants learned (in terms of confidence, knowledge and skills) from their ASIST training. Changes in learning, however, do not necessarily lead to changed behaviour. This chapter will examine the extent to which participants transfer their ASIST learning into practice in either a professional or personal capacity (Kirkpatrick level 3 outcome).

7.2 In the case of suicide intervention, obtaining direct measures of the application of learned skills into practice (i.e. observing a real life interaction) is both practically and ethically impossible. Therefore, our evidence regarding Kirkpatrick level 3 outcomes is derived mainly from self-report measures (participant online survey and interviews), supplemented by reports from managers whose staff have been ASIST-trained, and other indirect measures reported in the ASIST literature.

7.3 For the purposes of our analysis, we have defined an 'intervention' as the use of *one or more of the elements* of the ASIST suicide intervention model (SIM). The elements include:

- asking someone if they were having thoughts of suicide
- exploring reasons for wanting to live and / or die
- reviewing the person's risk
- making a safeplan.

7.4 We believe that this broader definition of 'intervention' produces a more accurate reflection of the application of ASIST learning into practice, than defining 'intervention' as the use of *all* of the SIM elements. For example, in the case of an ASIST trainee who had asked someone if they were thinking about suicide, but the response was negative: this would still count as an 'intervention' for the purposes of our analysis, as the person had used their ASIST learning to recognise risk and ask directly about suicide.

7.5 This chapter also reports some of the qualitative evidence we gathered in the survey and in local implementation studies which shows how people used the ASIST model (or parts of it) to intervene, as well as situations in which interventions may have not gone well.

Intervening with a person at risk

Intervening before and after training

7.6 In our survey of ASIST participants, more than half (58%) reported they had intervened with a person at risk of suicide *prior* to their ASIST training. The number of participants who reported intervening *following* training rose to over three-quarters (78%). This finding represents a 20% increase in intervention following training.

7.7 A comparison by employee group shows that:

- NHS staff reported an increase in intervention from 70.3% before training to 90.4% following training.

- Voluntary sector staff reported an increase in intervention from 63.8% before training to 86.6% following training.
- Local government employees reported an increase in intervention from 58.4% before training to 76.6% following training.

7.8 Our analysis suggests that the percentage of interventions both before and after training are highest among NHS staff, followed by the voluntary sector and are lowest among local government employees. However, the 20% increase in intervention following training is consistent among all three employee groups.

7.9 The percentage of participants who reported applying their ASIST skills into practice in our survey is higher than the figure reported elsewhere in the ASIST literature. The literature typically reports an average of 50% of participants who say they have used their ASIST skills at least once with a person at risk of suicide following training. The difference between findings from our survey and findings reported in the literature might result from any of the following:

- **Variation in follow-up times:** International evaluations of ASIST have typically obtained follow-up measures within three to six months post-training, whereas our survey sampled participants who have attended the training up to four years ago, hence, having more of an opportunity to apply their skills.
- **Targeting of training:** ASIST participants in Scotland might be individuals who come in contact with people at risk of suicide (in a professional or personal capacity) more often than participants in other places.
- **Measurement:** In our survey we have defined and measured an 'intervention' as the use of *one or more* of the elements of the SIM model. The definition of an intervention in the ASIST literature is vague, and it is not clear whether respondents had understood an 'intervention' to include the use of elements of the model *as well as* following through the model in full.

Intervention outcome

7.10 Eighty-seven percent (87%) of survey participants, who have intervened following training, reported having (one or more) experiences using ASIST when it went well. The following quotes from participant interviewees illustrate how they perceive the effectiveness of their intervention:

> *I did go through the model with him and at some point he said, 'You know what, I couldn't really do this...'. Exploring his ideas with someone else had allowed him to think things through and realise that suicide is not the answer.*
>
> *He continues to present sometimes in a histrionic way and difficulties in family relationships are still apparent. However he has been able to make continuing use of the resources network which he started to build up from after our early discussion.*
>
> *Several weeks later, and lots of chats, she is holding down a trainee position with the organisation that could result in a full time job.*
>
> *The client was going through a period of self harm, there were many factors in her life which led to this. On one occasion when I went to visit her she said*

when I left she was going to take her own life. I spent two hours talking with her. Eventually she agreed to keep herself safe until I could take her to a project the next day that deals with suicide intervention.

I used the model with a couple of other people – a close relative who lost his wife of 60 years and another personal contact who had been out in touch with me. Neither were suicidal but appreciated being asked.

7.11 These quotes illustrate the positive impact that the use of various elements of the ASIST model (exploring invitations, asking directly about suicide, exploring reasons for dying and living, reviewing risk, making a safe-plan, and linking to resources) had on individuals who were perceived to be at risk of suicide.

7.12 Only 4% of survey participants reported having had experiences using ASIST when it did not go well. Here are some quotes from these participants:

I have been in a situation where I asked the right questions, but the person chose to verbally deny that he was thinking about suicide and killed himself a couple of hours later. Nothing prepares you for that and it seems that time and loving friends / family are the only healers.

On the occasion it did not go well, the model was not at fault. Possibly no intervention would have changed the outcome.

Without ASIST I would have felt worse if his suicide attempt had been successful. I know I did the best I could. I now know the change in body language, voice and barrier that accompanies that intention, and know not to take them personally and to persevere with positive intentions.

7.13 The remaining 9% were unsure as to whether their interventions went well or not:

I don't feel I did any harm. Maybe made him aware I was there. There was no reaction from him, either positive or negative, about me asking.

Elements of the model

7.14 Just over a quarter (26%) of survey participants reported having followed *all* stages of the ASIST model in their interventions. More than half (59%) reported having used parts of the model. (Note that this figure includes cases where participants asked someone whether they were feeling suicidal and the answer was 'no'.) The other 15% either used a different model, hadn't used any model at all, or were unable to recall.

7.15 Only one of the 22 ASIST participants we interviewed used the ASIST prompt card in an intervention. Whereas some participants did not feel the need to use the card, others were uncomfortable about using it. Here are some quotes from the interviewees who have not used the prompt card:

No – didn't feel the need.

No – was fairly soon after training and still fresh in my mind. I carry it with me though.

No – I felt that it would seem like I didn't know what I was doing, or that I was trying to quantify her experiences.

No – it was in my handbag and I couldn't stop the conversation to get it. I carry it everywhere though.

Not in front of her or with other people.

No, don't know why. I do carry it in my purse.

Things that work well in putting ASIST into practice

7.16 Participants interviewed for this study highlighted several elements they felt have gone well in their interventions with individuals at risk using the ASIST model. The main elements that were perceived as helpful included:

- being able to recognise the signs in someone thinking of suicide
- having the confidence to ask a person directly whether they are thinking about suicide
- having a structured model to follow through
- being able to establish a "safe plan" and link the person to resources.

Challenges in putting ASIST into practice

7.17 The most challenging aspects of using ASIST, according to participants, are asking people directly about suicide and being personally involved. Here are some quotes from our survey participants and interviewees:

It was difficult to ask the question, but training had given me courage.

Asking the question was the most difficult bit, but it actually helped her and it made it easier to move on in the conversation. It actually reassured me that it's not so difficult to be direct as I had previously thought.

It was hard because I'm personally involved – she's so close to me. It's always easier when you can distance yourself.

7.18 One interviewee found it very difficult to deal with a situation where her patient had refused to let her disclose her suicidal ideation to other staff involved in her care:

She said she had been buying lots of Paracetamol and was going to take it. I asked her how many she's got and she said 12 packets. I asked her permission to talk to the staff and she refused. I was in a big dilemma, as on the one hand I have a duty to tell the staff if someone is threatening to kill themselves, but on the other hand that would break any confidence she has in me, which is the basis for our relationship, and if she finds out I told somebody when she asked me not to, it could drive her over the edge. I decided not to tell anybody and tried to make a safe plan with her – to get rid of the pills in order to avoid temptation.

Reports from managers

7.19 To supplement our findings from participants' self reports, we asked service managers in a number of local authorities and organisations whether they had noticed any changes in the work-related behaviour of ASIST-trained staff members, which could be reasonably connected to the training.

7.20 Several project managers in our LIS areas reported that they had actually observed their staff putting ASIST into practice (either in a face-to-face situation with a client, or on the telephone). In one project in Glasgow, the manager said that she could see the empathy that staff had with clients as a result of ASIST training. They were confident and not afraid to ask the question about suicide intent.

7.21 In Midlothian, a service manager in a mental health service reported having heard stories from staff of their use of ASIST with clients to good effect. She had no doubt that it raised awareness and made people more confident to intervene. However, she felt that participants' confidence may not be sustained if they do not use it regularly.

7.22 Another manager in Shetland reported that their staff discussed their interventions with clients in staff meetings. This was seen to be a marked change directly resulting from workers' attendance on the ASIST training.

7.23 In addition, in our interviews with ASIST trainers (many of whom are themselves service managers), there were quite a number of cases highlighted where ASIST participants had applied their learned skills within 24 hours of completing the training.

Other indirect measures of Kirkpatrick level 3 outcomes

7.24 Our review of international ASIST literature identified two evaluation studies that employed additional indirect measures (other than participant self-reports or reports from managers) for the application of knowledge and skills into practice.

7.25 Perry and McAuliffe (2007) evaluated the implementation of ASIST in a large community hospital in Canada. To complement staff self–report measures, the authors measured: (a) the proportion of clients that staff routinely assessed for suicide risk; (b) identification of suicidal risk among mental health patients in the Emergency Department; and (c) admission rates of suicidal patients presenting in the Emergency Department. All of these measures were taken repeatedly over a four-year period. Following training there was an increase of between 14-21% in the identification of suicidal risk among mental health patients and more staff assessed a higher proportion of their clients for suicide risk. There was also a steady reduction in suicidal patients' admission rates (from 56 to 42%), reflecting (according to staff) the clearer process of exploring reasons for dying and living and an increased focus on strengthening the client's protective factors in the community, which enabled some admissions to be averted. The findings could suggest that knowledge and skills were transferred effectively from the training context to the workplace, however there is no way to ascertain a casual relationship to be attributed to training.

7.26 A second paper evaluated ASIST training which was provided to primary and secondary school staff members in Virginia, USA (Cornell et al, 2006). Over a period of two years, the evaluators measured: (a) the number of referrals to mental health services; (b) the number of students questioned about suicide; and (c) the number of contracts made (not to

engage in suicidal behaviour) with potentially suicidal individuals. The authors carried out two studies: the first compared the above measures before and after training, and the second compared the above measures between ASIST trainees and controls.

7.27 In the first study, the authors found that, following training, trainees made more referrals to mental health services than they did pre-training. However, in the second study, the authors found that, overall, the control group made more referrals than the trainees did. It is not clear whether an increase in the number of referrals to mental health services is interpreted by the authors as being a desirable outcome. On the one hand, it is said to reflect increased awareness of signs of suicide risk, but on the other hand, it is also said to reflect a lack of confidence in one's ability to help individuals who are at risk.

7.28 The number of students questioned about suicide did not differ pre- and post-training. Moreover, when trainees were asked about whether they had wondered if a student might be suicidal but decided not to question that student, they reported this to happen on average 6.7 times a year. For the control group this figure was only 0.7 times a year. This finding may reflect trainees' improved ability to detect suicidal signs, but it does nevertheless suggest that they do not always act on their concern.

7.29 Finally, in the first study, the authors found no significant difference between the number of contracts not to engage in suicidal behaviour made *before* training and three months *after*. However, in the second study the authors found that within two years post-training, trainees had made more contracts with suicidal individuals than did a control group.

7.30 In summary, the international ASIST literature offers some evidence, which does not rely solely on self report measures, to suggest that ASIST participants indeed transfer their knowledge and skills into practice. While this evidence supports and complements participants' reports of their own behaviour, it should be viewed with caution, because:

- Any interpretation of the findings as evidence for the successful transfer of ASIST learning into practice lies on the assumption that measures of admission rates, referrals, assessments, etc, are indeed a reflection of behavioural change in course participants. While this is a possibility, there are likely to be other factors that influence these measures which could not be causally attributed to training.
- The findings from the literature are largely inconclusive and could be interpreted in a variety of ways.

Profile of intervener and non-intervener

7.31 In this section, we outline a profile of the 'intervener' (someone who has intervened with a person they believed to be at risk of suicide following their ASIST training) and a profile of the 'non-intervener' (someone who hasn't intervened following training). These profiles could be useful for reflecting on the *targeting* of future training in order to maximise effectiveness.

7.32 Over three-quarters (n=412) of our survey sample reported that they intervened with a person at risk following their ASIST training. The remaining quarter (n=122) did not intervene.

7.33 A comparison by employee group shows that:

- More than one-third (35%) of interveners worked in the voluntary sector.
- More than a quarter (28%) of interveners were local government employees.
- Less than a fifth (19%) of interveners were NHS staff.
- The remaining (18%) belong to other employee groups.

7.34 These figures closely match the characteristics of the entire sample, and therefore interveners cannot be distinguished from non-interveners by employee group.

7.35 In order to outline the profiles of the intervener and the non-intervener, we compared survey participants who have intervened following training, with participants who have not, on several key features. (See Table 7.1.)

Table 7.1: Key characteristics of people who have intervened following ASIST ('intervener'), people who haven't intervened ('non-intervener'), and the overall sample

	Intervener	Non-intervener	Overall sample
Females	80%	69%	78.3%
Professional caregivers	81%	68%	77.9%
Intervened with a person at risk PRIOR to ASIST training	**66%**	**28%**	58.1%

7.36 These findings indicate that individuals who put their learned skills into practice following training were most typically:

- female
- professional caregivers
- had previous experience of intervening with a person at risk of suicide.

7.37 The first two bullet points above (female, professional caregivers) also represent key characteristics of ASIST participants who have *not* put their skills into practice, and indeed are key characteristics of ASIST participants in general. However, the non-interveners group contained a smaller percentage of female professional caregivers compared to the interveners group.

7.38 The third bullet point is of most interest, as it seems to highlight a key feature differentiating interveners from non-interveners. Over two-thirds of respondents who have intervened following training have had *previous* experience of suicide intervention. In comparison, over two-thirds of respondents who have *not* intervened following training did *not* have previous experience of suicide intervention. A possible explanation is that people who are more exposed to high risk individual have more opportunities to practise ASIST skills once they've attended training. Another possible explanation is that people who have intervened before have more confidence to intervene again.

7.39 In order to find out whether interveners and non-interveners differed in terms of their perceived levels of suicide intervention confidence, knowledge and skills we compared survey participants' scores (on a scale of 1 (very low) to 5 (very high)) before and after training. (See Table 7.2.)

Table 7.2: Perceived levels of suicide intervention confidence, knowledge and skills before training and at the time of the survey among interveners and non-interveners

	Confidence (1-5)*		Knowledge (1-5)*		Skills (1-5)*	
	Intervened since training	Not intervened since training	Intervened since training	Not intervened since training	Intervened since training	Not intervened since training
Before training	**2.6**	2.1	**2.8**	2.2	**2.7**	2.0
At the time of the survey	**3.8**	3.3	**3.9**	3.5	**3.8**	3.3

* Scale: 1=very low, 2=low, 3=moderate, 4=high, 5=very high

7.40 As can be seen in Table 7.2, interveners reported higher levels of confidence, knowledge and skills both before training and at follow-up, than non-interveners. All these differences were found to be statistically significant at the 0.01 confidence level using the t-test for independent samples.

7.41 These findings suggest that having confidence, knowledge and skills in relation to suicide intervention plays a significant role in the likelihood that an individual will intervene with a person at risk. Individuals who have intervened following ASIST reported higher levels of confidence, knowledge and skills, both before and after training, than individuals who have not intervened following ASIST.

Reasons for not intervening

7.42 As stated earlier in this section, less than a quarter (22.8%) of participants in our survey sample had not intervened with a person at risk of suicide following their ASIST training. The vast majority of them (96%) reported the reason for not intervening to be that a situation had not arisen. The remaining 4% gave other reasons for not intervening, such as ASIST was not perceived to be appropriate, they felt their skills were too rusty, or that they had assisted others to intervene.

Intervening with different groups

7.43 One of the factors that might influence whether and how a trainee would apply their learned ASIST skills into practice, is the type of relationship they have with the person at risk. We asked survey respondents to indicate whether they had ever intervened with a client, personal contact or colleague:

- More than three-quarters (77%) had intervened with a client.
- More than one-third (38%) had intervened with a personal contact.
- Few (13%) had intervened with a colleague.

7.44 It appears that the majority of ASIST interventions occur in a professional setting, between a trained staff member (or volunteer) and their client. Slightly over a third of respondents reported intervening with a personal contact, and even less with a colleague.

This is likely to result from having less opportunity to make contact with suicidal individuals in a non-client capacity, but might also reflect the challenges involved in carrying out an intervention with a personal contact or a colleague at work. Moreover, 13% of survey respondents felt ASIST was not always appropriate for use with personal contacts. Here are some illustrative quotes from our participant interviews:

> *There is more tension when it is people you know, if you've got more invested in a relationship with them and you care more. With people in a professional capacity – you might not see them again.*
>
> *With a personal contact it's more difficult – you want to protect them and don't want to believe that anyone close to you can see no way out. You have to not take it as a personal affront and manage your emotions better. I felt confident I could handle it well though, because of training. When it's a professional contact you can maintain your distance.*

7.45 We also asked survey respondents to indicate the age group of the person they have intervened with most recently:

- Less than one-third (29%) had intervened with someone aged between 16-25 years.
- Almost two-fifths (39%) had intervened with someone aged between 26-45 years.
- Less than one-fifth (19%) had intervened with someone aged between 46-64 years.
- The remaining 13% had intervened with under-16s, over-65s, or could not recall the age of the person they had intervened with.

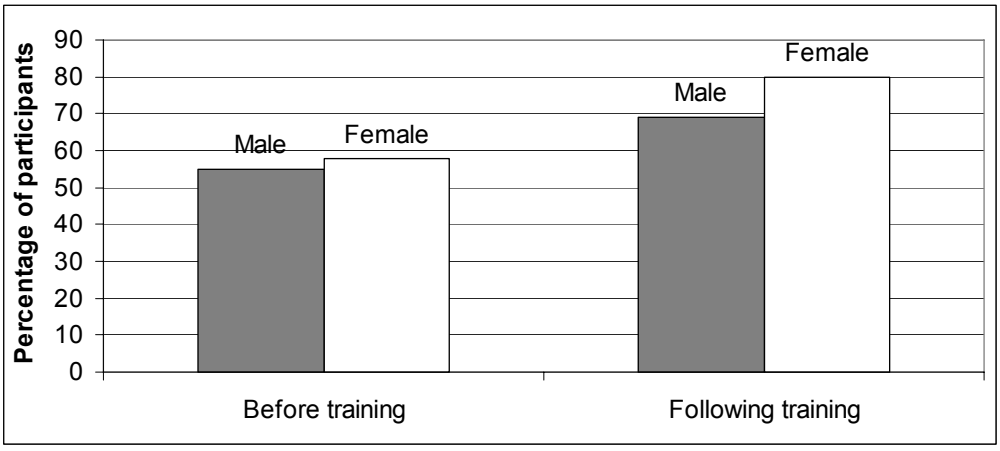
Female vs. male interveners

7.46 The following analyses examine possible differences in the extent and pattern of suicide intervention between female and male participants in our survey.

Intervening before and after training

7.47 We compared the percentage of females and males who had intervened with a person at risk of suicide before and after their ASIST training in order to check whether gender is of importance to suicide intervention. (See Figure 7.1.)

Figure 7.1: Percentage of males and females who had intervened with a person at risk of suicide before and after ASIST training



7.48 The difference between the percentage of females and males who had intervened with a person at risk before ASIST was only 3%. This difference was *not* found to be statistically significant using the chi-square test for independence. Following training, the percentage of interveners had grown for both males and females. However, the gap between males and females has increased to 11% more female interveners following training. This difference was found to be statistically significant at the 0.01 confidence level using the chi-square test for independence.

7.49 Our analysis suggests that while ASIST training increases the likelihood of intervention for both males and females, the increase is significantly higher for females.

Intervening with different client groups

7.50 Additionally, we wanted to examine whether there were any differences between male and female interveners as a function of:

- the gender of the person at risk (male / female)
- the type of relationship with the person at risk (client / personal contact / colleague).

7.51 The findings from our survey of ASIST participants are summarised in Table 7.3.

Table 7.3: Percentage of male and female participants who have intervened with male and female clients, personal contacts and colleagues following ASIST training

	Client		**Personal contact**		**Colleague**	
	Male	Female	Male	Female	Male	Female
Male intervener	80%	72%	33%	32%	11%	10%
Female intervener	63%	77%	34%	39%	7%	13%

7.52 Two main findings come out of the table:

- Consistently, over the three relationship groups, males tend to intervene slightly more with males and females tend to intervene slightly more with females. However, these differences are quite small.
- Overall, it seems that males intervene with clients slightly more than females do, and females tend to intervene with personal contacts and colleagues slightly more than do males do. Again, these differences are quite small.

7.53 Here are some illustrative quotes from female interviewees, talking about the challenges of intervening with males:

> *I would be slightly more concerned about men's responses in the sense that they might be less likely to admit to feeling suicidal and that it would take more work to get there. (Female interviewee)*

Not much of a difference between intervening with men and women – only thing is that I find it harder to watch a man cry, which is something that often happens once you 'ask the question.' (Female interviewee)

Perhaps I would find it more difficult to ask men the question, because of how they might respond. (Female interviewee)

Summary of Chapter 7

- We found that the proportion of participants who reported intervening with a person at risk of suicide increased by 20% following ASIST training. The likelihood of intervening was highest among NHS staff and lowest among local government employees, although the 20% increase in intervention following training was consistent among all employee groups.
- The vast majority of people who had intervened following training reported having one or more experiences of using ASIST to good effect. Only 4% of survey participants reported having had experiences of using ASIST to intervene when it did not go well.
- Just over a quarter of survey participants reported having followed *all* stages of the ASIST model in their interventions. More than half (59%) reported having used parts of the model.
- The most challenging aspects of using ASIST, according to participants, were asking people directly about whether they were thinking of suicide, and being personally involved with an individual who was thinking of suicide.
- Participant reports of putting their ASIST-learned skills into practice were largely confirmed by their managers.
- We found that individuals who applied their learned skills into practice were most likely to be those who had prior experience of suicide intervention and who reported higher levels of confidence knowledge and skills, both before and after training.
- Less than a quarter of participants in our survey had not intervened with anyone at risk of suicide following ASIST training. Among these, the vast majority said the reason they had not intervened was because the situation had not arisen.
- The majority of ASIST interventions occur in a professional setting, between a trained staff member (or volunteer) and their client. Slightly over a third of respondents reported intervening with a personal contact. However, fewer reported intervening with a colleague.
- ASIST training increases the likelihood of intervention for both males and females. However, the increase is significantly higher for females.

CHAPTER EIGHT KIRKPATRICK LEVEL 4: WHAT DIFFERENCE HAS ASIST MADE?

8.1 This chapter will examine the wider impact that ASIST has had in Scotland. It considers the question of whether the training of more than 10,000 individuals has resulted in any benefits – for the organisations they work in and the communities they live in.

8.2 The evidence for this chapter comes from our interviews with Choose Life Co-ordinators and trainers across Scotland, and our local implementation studies in Glasgow, Highland, Midlothian, Shetland, West Dunbartonshire and SAMH.

8.3 ASIST was reported to have an impact in:

- reducing the stigma associated with suicide and raising awareness within organisations and communities
- developing and planning services
- multi-agency working and information-sharing practices between agencies
- developing policies and practices within agencies
- establishing more supportive management and supervisory relationships.

8.4 The previous chapter looked at the perceived impact of interventions on individuals who have been intervened with. However, this section will consider whether ASIST has had any impact on suicide rates in Scotland. In addition, we will consider some of the impacts that interviewees felt had failed to materialise from the implementation of ASIST in Scotland.

8.5 However, first we will look at the impacts of ASIST that were identified in our review of the international literature.

Findings from the review of the international literature

8.6 Only a minority of ASIST evaluations which we reviewed as part of this evaluation (three out of 15 papers) attempted to examine the broader organisational and societal impact of ASIST training. This is not a surprising finding considering the complexity involved in measuring such outcomes. However, it indicates that there is little evidence available from the literature on the impact of ASIST at the level of organisations or communities.

8.7 Hinbest and Associates (2001) evaluated the implementation of ASIST in a Canadian school setting, in which training had been delivered to school and community representatives concurrently. They found that at an organisational level training had an impact in two main areas. First, training facilitated interaction and improved relationships between community agencies, and particularly between school and community representatives. Second, training also actively contributed to the development and articulation of system-wide protocols and school policies.

8.8 Evidence regarding the impact of ASIST in a health care organisation was found in an evaluation of ASIST in a large community hospital in Canada (Perry and McAuliffe 2007). Following a four-year 'Suicide Assessment project' (including staff training in ASIST), the hospital's reputation in the community had been enhanced and it is now identified as a leader in suicide prevention training – regularly receiving training requests from partner mental health agencies and other organisations. In addition, the local community college made the

ASIST programme mandatory for their nursing students. This study provided an example of how an effective implementation of ASIST in an organisation can broaden its impact beyond the walls of the establishment.

8.9 Finally, Walsh and Perry (2000), examined the impact of introducing ASIST in a small rural community in Canada. The authors found that, with over 300 individuals trained in the community, the consensus from both the community-wide Suicide Prevention Team and the Child and Youth Mental Health team was that people in the community recognise potential suicidal individuals earlier, act on their assessment with more comfort and have a good understanding of other supportive resources in the community. They also noted that ASIST provided a common language for suicide assessment and intervention in the community. People referring teenagers to mental health services were better able to provide basic risk estimations and were better able to follow recommendations based on the intervention model.

Suicide rates

8.10 Ideally, the effectiveness of suicide intervention programmes would be able to be demonstrated through a direct reduction in suicide rates. There are, however, substantial difficulties in demonstrating such an impact. For example:

- The reporting of suicidal acts is inaccurate and unreliable.
- Completed suicide is a statistically rare event.
- Interventions, such as training, are indirect (i.e. targeted at helpers, not suicidal individuals).
- The effects of some interventions — training, in particular — may not be seen for many years.
- Furthermore, in the case of training interventions, it is not clear how many people need to be trained — and how much contact they need to have with people who are at risk — in order to result in a reduction in suicides.

8.11 Moreover, it is generally acknowledged that suicide rates are affected by a multitude of societal and individual factors (Beautrais 1998) — not just the suicide intervention programme. Given these complexities, it would be practically impossible to attribute any changes in suicide rates to a single, specific preventive intervention.

8.12 Only one of the studies in our review of the literature had attempted to examine the impact of suicide intervention training on suicide rates (Cornell *et al* 2006). This evaluation was carried out in a number of Virginia schools, which present more contained and controlled environments than the broader community. The control group in the study reported a greater number of students who attempted suicide than did the trainee group (more than three times higher). This might seem a highly promising finding, however, it is impossible to demonstrate a causal effect of training on this outcome, especially since both training and control groups were self-selected.

8.13 In this evaluation, we specifically asked many of our respondents whether *they* thought ASIST had had an impact on suicide rates in their areas – or whether they would have expected it to do so. In general, people were reluctant to attribute any change in suicide rates (whether positive or negative) to ASIST, because as one person said: "How would you know what rates would have been otherwise?"

It's very difficult to see a direct connection between suicide rates and the delivery of ASIST. However, a consistent message from people who have attended the training locally is that ASIST has encouraged them to think differently about suicide and how they can approach someone who may be at risk. This is useful, but you may not see the impact for a long time. It's very intensive training, and is likely to have a long-term impact. (Choose Life Co-ordinator)

In terms of ASIST – you need a critical mass, and it's probably a lot more than you can train over three or four years. You're talking about probably a 20-year cultural change process. (Chair of Community Planning Partnership)

8.14 However, others clearly felt that ASIST *had* had an impact on suicide in their area – mainly because of the stories they heard from ASIST-trained individuals, who had successfully intervened with someone at risk. One individual from the Scottish Prison Service reported that he personally knew of five suicides that had been prevented by former prisoners who were trained in ASIST as part of a larger life-coach training programme. Others said similar things:

I think that ASIST does have an impact on suicide rates because of the stories I hear. Sometimes people have an opportunity to use ASIST on the same day [they attended the course]. (Choose Life Co-ordinator and ASIST trainer)

8.15 At the same time, in one large voluntary sector organisation where two-thirds of staff had been trained in ASIST, we heard that two members of staff had taken their own lives in the past six months. While suicide often has a major impact on the people left behind, the impact of these two suicides appeared to be particularly strongly felt across this entire organisation. One of the ASIST trainers in this organisation reported:

It's thrown up a lot of issues for us. People who were using ASIST with their service users regularly, did not link it with their colleague who was struggling. And lots of people had different parts of information and when you put it together, it made a very big invitation. But it wasn't put together. And people felt bad, because they had been on the training and they didn't see it. And that was an interesting dimension for me, because it's not what we want… People are almost on the lookout for it with their service users, maybe, and maybe they know more about their service users' lives than they do about the person sitting next to them. (ASIST trainer)

8.16 This comment is interesting in light of the findings we reported in Chapter 7 (paragraphs 7.43 and 7.44). When ASIST participants were asked whether they had ever intervened with clients, personal contacts or colleagues following their ASIST training, only 13% said they had ever intervened with a colleague, compared to 77% who said they had intervened with a client and 38% who had intervened with a personal contact.

Reducing stigma and raising awareness in organisations and communities

8.17 One of the main impacts attributed to ASIST by the participants in this study was a perceived reduction in the stigma often associated with suicide. ASIST was also seen to make a significant contribution to raising awareness of the needs of suicidal people within

communities, and to give people in communities the confidence to be more open and willing to talk about suicide.

> *It (ASIST) has done a tremendous job of reducing the stigma associated with suicide – particularly in addressing the problems that people have from a religious point of view. It has helped people to talk about suicide more openly. When you can talk about an issue, it helps to get you the support and help you need. (Chair of Choose Life strategy group)*

> *There's a lot more awareness about suicide prevention locally now. People feel bolder about asking the questions. (Choose Life Co-ordinator)*

8.18 There was also a suggestion by one respondent that ASIST training had been particularly helpful in communities affected by suicide because it addressed feelings of "powerlessness" by providing a structure for understanding a distressing and frightening event.

8.19 In this respect, interviewees commented that ASIST had played a key role in helping to push forward the wider Choose Life agenda, particularly within the community and voluntary sectors where the take-up of training had been greatest. In other areas, there was agreement that suicide prevention was much higher on the agenda than it had been before. This was partly attributed to ASIST, and partly to Choose Life as a whole.

Impacts on service development and planning

8.20 ASIST was also attributed with having a positive impact in terms of service development and planning. For example, in our local implementation study in Midlothian, ASIST was seen to have helped inform thinking in relation to the development of a new Crisis Response and Early Intervention Service for people with mental health problems living in the community. Similarly, in Shetland, there was on-going discussion about establishing a 24-hour crisis support service, with the possibility of involving ASIST-trained individuals in the provision of that service.

Impacts on multi-agency working and information sharing

8.21 We heard reports from service providers across Scotland that the wide implementation of ASIST in their area had been particularly beneficial in giving people a "common language" and framework for discussing the needs of their service users. For example, a clinical psychologist reported on the impact of targeting ASIST to staff in all the young people's services in his area:

> *Our main aim was to get young people's workers [in education, social work and the voluntary sector] to have a better understanding of young people's mental health and how to work together to support young people who may be at risk. I feel we've succeeded in this and there's really good evidence to support this. We get much more useful information now from people who phone us up with concerns about their clients. (Clinical psychologist, CAMHS)*

8.22 We also heard that the networking opportunities provided during the ASIST workshop help to bring together staff from diverse organisations to learn about what each other do.

This results in people feeling more comfortable about raising their concerns about particular individuals with other agencies that may be involved with them. One manager gave this example:

> *The police rang me up one day and said, 'Just thought you should know, we've had this guy in, kept him overnight, and we're about to let him go. We're **very** concerned about him. Can you pick him up?' (Service manager, addictions)*

8.23 It turned out that the police custody sergeant had been trained in ASIST.

8.24 ASIST was also perceived to have an impact on referral procedures between agencies. Managers reported that their ASIST-trained staff were now better able to identify and respond to the needs of clients with suicidal ideation, and that they knew when and how to refer them on if necessary.

Impacts on policies and procedures within agencies

8.25 ASIST was also reported to have had an impact in relation to the development of new policies and procedures within organisations. For example, in some services, assessment procedures and forms had been modified to include a question about suicidal feelings and previous experience of attempted suicide. In another service, the manager reported that staff now routinely respond to any expression of suicidal feelings among their clients with an ASIST intervention – irrespective of how often those feelings are expressed.

> *When someone mentions suicide, you do ASIST. In working with clients who frequently talk about suicide, ASIST is a helpful tool for clarifying exactly what their intentions are. (Service manager, mental health)*

> *ASIST has made the team more aware of when someone might be suicidal. Before they did ASIST training, they would have **never** asked someone if they were having suicidal feelings. Now, that question is included in our assessment form. (Service manager, addictions)*

8.26 One large voluntary sector organisation requires all of its senior management staff to attend ASIST training. The reasons for this were: (a) so that managers can support their ASIST-trained staff as they intervene with service users; and (b) so that managers can support staff who may themselves be feeling suicidal.

Where impacts were limited, unknown, or failed to materialise

8.27 The main focus of our interviews and discussions with people from around Scotland has been on the impacts they have attributed to ASIST. However, in the course of these interviews, we also asked people whether ASIST had met their expectations. While responses to this question were generally very positive, people also identified some ways in which ASIST had perhaps *not* met their expectations.

Within the NHS

8.28 We found evidence from a number of sources, including our national survey of ASIST participants, that ASIST was valued by staff from a range of different agencies, including the

NHS. We heard stories from ASIST trainers, and from Choose Life Co-ordinators, of NHS psychiatric nursing staff, psychologists and even psychiatrists, attending ASIST and finding the course helpful and beneficial to their work. However, in some areas, there was a perception that there had been little take-up of ASIST among certain professional groups – in particular, GPs and other primary care staff, NHS hospital staff, ambulance staff and addictions workers. This lack of take-up was often blamed on the two-day nature of the ASIST workshop: for many of these groups, taking two consecutive days away from work to attend a training course on suicide (which related to just one small aspect of their overall work) was simply seen to be unfeasible.

8.29 However, one senior social work manager suggested that, on a deeper level, there had been a failure by Choose Life to make good links with the NHS "establishment" (for example, the Royal College of Psychiatrists and other mental health professionals). A similar view was expressed by a senior manager in a voluntary sector mental health service:

> *ASIST came out through the Choose Life agenda, and was seen as training that* ***anyone*** *could access. There was never a sense that NHS mental health services were wholly comfortable with the Choose Life approach – putting the money out to local authorities. ASIST has never sat comfortably with the NHS mental health agenda. (Senior service manager)*

Lack of availability of services for people at risk of suicide

8.30 One further issue that arose in a number of places across Scotland was to do with the lack of appropriate support services for people who may be feeling suicidal. The point was made that ASIST teaches individuals how to identify someone who may be at risk of suicide, to assess the level of that risk, and then to make a safe plan with them. In many cases, this safe plan may involve helping the person to seek help. However, in some areas of Scotland, people felt that there was a lack of appropriate mental health support services to refer people on to. It was suggested that this situation could leave the ASIST-trained person as the main source of long-term support for someone who is at risk of suicide, and that in cases where that person is not a qualified mental health professional, this can be difficult. One ASIST trainer echoed this point:

> *The problem with ASIST is that it doesn't actually address the problem of where people go for help when services aren't there – or aren't responsive. It means that people are then left to try to work it out themselves how to support someone who may be suicidal. In our area, there is a problem with the adult mental health services in particular. People will phone up Psychiatry with someone who is genuinely suicidal, and the response from the psychiatrists is, "This is not a psychiatric issue. Go away." If there's no one to send people to for help, what do you do with them?*

In reducing inequalities

8.31 As part of an effort to reduce rural deprivation, two Community Planning Partnerships in very different parts of Scotland were intending to target specific geographically-isolated communities in their area with a number of health promotion and community safety interventions, including ASIST. However, this work was still in the planning stages in both areas.

8.32 We found some examples of ASIST being particularly targeted towards services working with asylum-seekers and refugees (in Glasgow), and with women who had been victims of physical and sexual abuse. However, there was no evidence available about the impact ASIST had had among these groups.

A longer-term view is needed with suicide prevention

8.33 The point was also made by a number of local stakeholders that, as with any public health intervention, it is unrealistic to expect quick results: a longer-term view was needed. One interviewee suggested that a 20- to 30-year period of intervention might be required to change the cultural factors that contribute to high suicide rates in Scotland.

Reduced impact through discouraging the sharing of ASIST learning within teams

8.34 We heard from a number of people that demand for the training is often through word-of-mouth recommendation from a colleague who has been on the training. However, at the same time, both participants and trainers reported that ASIST participants are often discouraged by trainers from speaking to non-ASIST-trained colleagues in any detail about the course. The reason for this was in order that people would come on the training without preconceived ideas of what was going to happen. As mentioned in Chapter 5, one survey respondent expressed particular concern about the (negative) impact of this, and suggested that this practice had reduced the support that people in his / her team had been able to give each other in using the ASIST approach. It should perhaps be noted that we heard conflicting reports about whether trainers had been told in T4T courses to actively discourage participants from speaking about the training to their colleagues.

Reduced impact through failure to put ASIST into practise

8.35 We also heard a report from a senior manager in one mental health agency, who felt there had been some problems in one or two of the projects he was responsible for, in that ASIST-trained staff were not picking up on, what he felt, were obvious signs that a service user was planning suicide. He attributed this to a lack of confidence and a "complacency" among staff who worked with people who were often talking about suicide. This individual suggested that ASIST-trained staff needed managers who also were familiar with the ASIST model, and who could challenge staff when necessary.

8.36 There was also a feeling that if ASIST-trained staff did not use their skills within a relatively short period of time after training (for example, within 6 weeks), they might not ever do so, because they will have forgotten what they learned and lost confidence. Therefore, in order to maximise the impact of ASIST, staff needed to be given regular refreshers.

Summary of Chapter 8

- ASIST was reported to have a number of positive impacts including reducing stigma and raising awareness of suicide within organisations and communities.
- It was felt ASIST had also made an impact on the development of multi-agency working and information-sharing practices between agencies.
- However, there was also some evidence that the impact of ASIST had been limited or virtually non-existent in some local areas where, for a variety of reasons, it had been difficult to implement.
- In some areas, there was a perception that there had been little take-up of ASIST among certain professional groups — in particular, GPs and other primary care staff, NHS hospital staff, ambulance staff and addictions workers. This lack of take-up was often attributed to the two-day commitment required by the ASIST workshop.

CHAPTER NINE TRAINERS' EXPERIENCES OF ASIST

9.1 Throughout this evaluation, the Kirkpatrick model has provided a useful framework for considering the effectiveness and impact of ASIST on a number of levels. However, one of the significant gaps in the Kirkpatrick model, is that it does not consider the experience of training from the perspective of the person(s) delivering the training. In our evaluation of ASIST, we felt this was an important perspective to capture for a number of reasons.

9.2 First, much of the information we have presented in Chapters 5 and 6 in relation to participants' reactions to the training and participants' learning is based mainly on participant self-report. We would expect trainers to provide an extremely useful additional perspective on these questions. In addition, since many trainers also work in organisations with colleagues who are ASIST-trained, they also have a perspective on whether participants are applying their ASIST skills and what the impact of that has been.

9.3 Second, one of the main barriers to the implementation of ASIST in Scotland has been a difficulty in retaining trainers. At the same time, the cost of training trainers has been one of the greatest costs of implementing ASIST. An enormous investment has been made in the training of trainers, and it is crucial to try to find ways to maximise the return on that investment. Therefore, it seemed important, at the very least, to hear from trainers about why they sometimes decided to stop delivering ASIST.

9.4 Third, our logic model for ASIST (presented in Chapter 3) indicates that one of the main outcomes from the ASIST programme is that "trainers are competent to train others." Chapter 5 highlighted comments that ASIST participants made regarding the quality of trainers. This chapter will look at this issue from the trainers' point of view.

9.5 Finally, trainers obviously have a much broader perspective on ASIST than do individual ASIST participants. Thus trainers have a crucial perspective on what works well in the ASIST course and where improvements could be made. This section will end with a brief summary of things that trainers would like to change about the ASIST course.

9.6 It is perhaps worth noting in relation to this latter point that, in general, trainers were very positive about the ASIST course. However, some common themes arose among trainers about difficulties they had with the course. At the same time, there was a very wide spectrum of views expressed about whether, and which aspects of the course needed to be improved or changed. *This point is important. There were few entirely uniform views expressed by trainers about suggested changes to the course.*[29]

9.7 The evidence for this chapter was drawn from our interviews and focus groups with trainers from around Scotland, including a focus group we held with eight of Scotland's 12 Consulting Trainers. We also specifically sought to include trainers who were no longer active as trainers, or who, having attended a T4T course, had *never* delivered an ASIST workshop. However, this chapter will first start with a brief description of Scotland's ASIST trainers.

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[29] This chapter will describe a *selection* of comments made by trainers about the course, but it is not possible to list all of these here. In any case, a close knowledge of the ASIST material would be required in order for many of these comments to make sense. A complete list of trainers' comments can be made available upon request.

Facts and figures

9.8 According to information given to us by NIST, as of November 2007, 271 individuals had successfully completed a T4T course in Scotland, and were eligible to become ASIST trainers. Of these 77 (28%) were classified as "long-term inactive," that is, they had not delivered an ASIST course in over a year. Of these, eighteen had never delivered a course. These individuals completed the T4T training, and then for whatever reason, decided not to deliver the training.

9.9 According to the national ASIST database, the number of courses delivered by individual ASIST trainers since April 2004, ranged from 1 to 33. As of September 2007, one-quarter of trainers (24.5%, n=54) had delivered 10 courses or more, and thus automatically had received the title of "Master Trainer." In addition, as previously mentioned, as of May 2007, there were 12 active Consulting Trainers.

9.10 ASIST trainers come from a variety of backgrounds. Some of those we interviewed in the course of this evaluation included:

- clinical and educational psychologists
- qualified social workers, including care managers and Mental Health Officers
- qualified nurses (both hospital- and community-based), including Registered Mental Nurses and psychiatric nurses
- managers and project workers in voluntary sector mental health and addiction services
- health promotion specialists
- private-sector counsellors
- freelance trainers
- college lecturers.

9.11 Some had a great deal of previous experience of training prior to attending the T4T course, and some had little or none.

Recruitment and selection of trainers

9.12 In terms of the recruitment and selection of trainers, there appeared to be a distinction between people who had been on the T4T course in the early days of ASIST (2004 – 2005), and those who were trained more recently. In the early days, trainers were often self-selected. Email messages were sent round local networks inviting people to come forward for the training, and those who expressed an interest were sent. It was common for trainers who attended the early T4Ts to report that they really had little or no idea what the course was all about prior to attending it. In some cases, prospective trainers "were sent" on the course by their line manager, who also knew little about it except that it was about suicide prevention training.

> *My line manager volunteered me for the training while I was holiday – two weeks before the event. I had no idea what to expect. In fact, I hadn't even realised that it was a training for trainers course; I just thought it was for personal development. My manager said I should go and bring back what I learned and share it with the rest of the team, but she didn't really understand what ASIST was about at the time, either. When I came back and told her what*

the training was all about, she said she wouldn't have let me go if she had realised the time commitment that would be required.

9.13 At the same time, there were also cases where individuals had been on the ASIST training, and very much *wanted* to be trained as a trainer, but were unable to obtain information from NIST about how to do this.

9.14 In the first few years of ASIST, there appeared to be little thought given to criteria for selecting prospective trainers – either at a national level, or at a local level. However, procedures regarding the recruitment and selection of trainers appeared to tighten up considerably as time went on, and many areas and organisations now have formal application procedures and selection criteria. Those who express an interest in being trained generally also have to have written agreement in advance from their line manager to release them for the purposes of delivering the training.

9.15 It also appeared that a number of areas and organisations have begun to adopt a much more strategic approach with respect to the selection of trainers, by including ASIST training in the job descriptions for particular posts. In some cases, these posts have already included a training remit within a local authority or NHS Board area. This has mainly been with a view to making the training sustainable in the future. This process has already been discussed in some detail in Chapter 4.

9.16 However, our discussions with trainers suggest that the personal interest of the trainer also plays a crucial role in the selection of trainers in many areas. Prospective trainers often put themselves forward for ASIST T4T training because they have been personally touched by suicide — through family or friends — or because they have faced the issue in a professional capacity.

Trainers' views on the effectiveness and impact of ASIST – Kirkpatrick levels 1-4

Kirkpatrick level 1: Participant reaction to the training

9.17 In general, trainers confirmed the findings from our participant survey – described in Chapter 5 – that the vast majority of participants enjoy the ASIST course tremendously and consider it to be the best training course they have ever attended.

9.18 However, we also heard from all trainers who took part in this evaluation, that there were some difficulties. Some of these issues have already been mentioned in Chapter 5, but the perspective of trainers confirmed that it was not unusual for ASIST to have a negative emotional impact on some people. Trainers reported experiences of delivering courses where participants were openly weeping and obviously distressed. We heard of cases where participants had to leave the course early because of the distress they were feeling. On the other hand, some trainers confirmed the messages from participants that the emotional impact of ASIST, although difficult, could also sometimes be therapeutic. Trainers responded to these situations as best they could, but some clearly felt more comfortable and qualified than others in doing so.

9.19 In relation to this, there were some particular issues raised in terms of participant reaction to the training in rural areas, where the trainer might be well-known by participants, either professionally or as a member of the community. In one island community, there were

reports that the trainers sometimes received phone calls at home in the evening from ASIST participants needing counselling support after the course.

9.20 At the same time, trainers also reported problems with people who came along on the course (usually because they were sent along by their line manager), but who did not really want to be there. In some cases, this was played out by individuals refusing to participate in the role-play – which could sometimes result in all the other participants following suit. We also heard of participants who were critical of the course, or certain aspects of it, and this often resulted in disrespectful, flippant or even abusive behaviour towards the trainers.

9.21 Like participants, trainers also mentioned the difficulties that many participants had with the role-play aspect of the course. Trainers reported that it was not uncommon for participants to exhibit signs of anxiety – ranging from mild to severe – in anticipation of the role-play. Trainers were frequently asked by participants not to have to participate in this part of the course. Trainers responded to these requests in different ways. Some gently insisted that the role-play was part of the course, and useful for learning, and that participants would have to take part if they wanted a course certificate. Others allowed individuals to sit out the role-play, but said that they would have to request the permission of the group to do so. Others compromised by allowing a group of two or three participants to do their role-play separately in another room, rather than in front of the entire group. We heard of situations where, despite instruction to the contrary, participants ended up playing scenarios that were a little "too close to home," and became upset or distressed.

9.22 While participant reactions to the role-play tended to be mentioned most often, trainers also reported that participants struggled with certain other aspects of the course – or found them confusing, or boring. One experienced trainer suggested that:

> *Not all participants react well to the facilitative approach that's used in the ASIST course. People who are well-informed about suicide, and who are used to going on similar courses, have no problems with it, but for those who don't have that background, I think it's helpful to explain more about why certain things are happening. LivingWorks says it all becomes clear to participants as the course goes on, but I think that if people don't understand how the course works, it can sometimes be a barrier to their learning.*

9.23 It is important to note that, while trainers suggested that these difficulties related to a minority of participants, these situations were by no means isolated problems, relating to only a few trainers. *Nearly every trainer we spoke to had faced these difficulties.*

Kirkpatrick level 2: Participant learning - changes in participants' skills, knowledge, attitudes and confidence

9.24 Once again, trainers largely confirmed the messages we heard from participants, that ASIST was effective, for the majority of participants, in increasing their skills, knowledge, and confidence, and improving their attitudes in relation to suicide.

9.25 However, trainers also reported that they occasionally had difficulties with people who, for whatever reason, "just didn't get it" — that is, they simply did not understand the information in the course. Trainers said that situations like this presented them with a dilemma. On the one hand, they are required by LivingWorks to give *everyone* who completes the ASIST course a certificate of completion. On the other hand, it simply does not

feel right to give people who obviously haven't learned anything, the same certificate that everyone else receives. The point was made by one trainer that this seems to undermine the "quality" of the ASIST course.

9.26 Having said this, trainers also found the opposite problem difficult to deal with — where a participant had obviously engaged with the entire course, but for personal reasons, had to leave early on the second day. Trainers around Scotland reported that, in these situations, the participant not only could not receive a certificate of completion, but according to LivingWorks, was required to re-sit the entire two-day course in order to receive one.[30]

9.27 In addition to the situation described above, where participants seemed to miss the entire point of the course, trainers also said that there were parts of the course that did not work well, and which, as a result, often caused confusion among participants. The section on "ambivalence" is one. This is meant to be an exercise in reflective listening and an exploration of the concept of ambivalence. Participants are asked to paraphrase (i.e. reflect back) statements of ambivalence made by Christina, a character in one of the videos. However, neither the concept of reflective listening nor the concept of ambivalence are explicitly taught. Trainers consistently said that the concepts discussed in this section were among some of the most important in the ASIST course. However, because of the way they were required to teach this section, participants often do not understand it. One trainer commented:

> *There's no discussion of what ambivalence is and why it's important to explore. It becomes an exercise in jumping through hoops. People disengage, because they don't understand the point. Why does one person's paraphrase work, but not someone else's? The whole thing also makes me feel very anxious, because if **I** make a mistake and tell someone that their paraphrase was **good**, when in fact, it was **wrong**, it undermines the whole exercise!*

9.28 We heard reports from a small number of trainers that they had taken a decision to dispense with the course instructions, and taught it in their own way – which they felt made it clearer.

Kirkpatrick level 3: Learning into practice

9.29 Trainers often expressed firm conviction that ASIST makes a difference in people's willingness to "ask the question" of people at risk. For some trainers, this was based on the experience of seeing and hearing their own staff intervening with a service user on the telephone. More often, though, this view was based on feedback they received from people after the course.

9.30 Such feedback is obviously extremely encouraging for trainers. And it is this feedback that makes many trainers so committed and passionate about ASIST, despite the difficulties that have been highlighted above.

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[30] A senior representative from LivingWorks confirmed this and explained that the requirement to re-sit the entire workshop is because of the likely impact that someone would have in dropping into an on-going workshop where trust had already been established in small groups. However, this individual also made the point that trainers have the discretion to assess the circumstances and reasons for a participant's early departure from a course and they can decide what constitutes a participant's full participation.

Kirkpatrick level 4: Impact on organisations and communities

9.31 Finally, trainers confirmed many of the findings discussed in Chapter 8 — that ASIST had had an impact on raising awareness of suicide in communities and promoting better inter-agency working. Trainers also spoke about the "common language" that ASIST gave to professionals working in different sectors in discussing shared clients.

9.32 Trainers who had staff management responsibilities also discussed the impact that ASIST had had on their clients. One trainer said that ASIST had taught her staff how to listen to their service users more carefully, and to review their suicide risk frequently.

9.33 However, trainers felt that the greatest impact of ASIST was on those who had taken part in the training. Trainers strongly felt that ASIST gave people confidence to intervene, and that it had made a difference to participants' willingness to ask people if they are contemplating suicide. One trainer, in discussing the impact of ASIST in her area, said:

> *ASIST participants move from feeling that they **can't** help someone who's feeling suicidal, to understanding that people are **asking** for help, to being comfortable **talking** about the subject with someone who is asking for help. People feel much more comfortable with the idea of intervening and delaying people's decisions to kill themselves. (ASIST trainer)*

9.34 One trainer specifically commented on the impact that ASIST had had among psychiatric nurses in her area: "They feel it gives them a framework in which they can use their skills." The view was expressed by several manager-trainers that, "Staff no longer ignore the issue of suicide with their clients." They address it directly.

Turnover among trainers

9.35 This evaluation found a great deal of enthusiasm and personal commitment among trainers to the ASIST course. Many believed strongly that the training provided people with the skills, knowledge and confidence they needed to save lives, and that it also gave people an opportunity – in some cases, the first opportunity they had ever had – to be able to reflect on their own attitudes towards people at risk of suicide and consider what impact those attitudes might have.

9.36 However, as of November 2007, 28% of people who had completed T4T were no longer delivering the ASIST course. In speaking to former trainers about the reasons for this, we found that the following issues were common:

- The demands of the trainer's "day job" meant they no longer had the time to give to ASIST.
- Trainers moved posts, and their new employer was not willing to release them to deliver the training.
- The demanding nature of the course (the amount of time that was required for preparation, the need to memorise the trainer's manual, the need to keep to script) caused difficulties, and a great deal of anxiety, for some trainers.
- The constraints of the course (in terms of the rigid structure, the content – which "must not be changed" – and the expectation that trainers "stick to the script") caused frustration for some, particularly for individuals who had had a lot of previous experience of facilitative training.

- The *emotionally* taxing nature of the course was also a issue for some (the need to provide emotional support to participants and carefully manage their responses to the course, and the disrespectful attitudes of some participants).
- Many trainers, in addition to delivering the course, were also expected to do all the administration as well – course advertising, marketing, venue hire, arranging catering, registration of participants, etc.
- Some trainers also felt they received little or no support, encouragement or feedback from LivingWorks, from NIST, or from their own local Choose Life group in relation to their delivery of the course.

9.37 In addition, there were also instances where people had gone forward for T4T training without having attended an ASIST course first, and found that they did not like the course, had a strong negative emotional reaction to it, or as was more often the case, they did not like the *style* of the training. In particular, some individuals described the T4T course as "evangelistic," "gung-ho," "cultish," "a big Tupperware party," "too much like the Stepford wives," "like a pyramid sales scheme," "almost brainwashing" and "culturally quite alien."

> *The whole thing feels like a package – if you take this pill, it will all be OK. Go on this course, and you'll get the cap and the bag. We had to see past all this to get to the heart of the model. (ASIST trainer)*

9.38 It is important to make clear that these comments were expressed by ASIST trainers from all over Scotland – including those who are still active trainers. It was *not the case* that only a small minority of trainers had these views. However, while many of the trainers we spoke to were able to "see past all this," others struggled to do so. The style of delivery of the T4T course was clearly a factor for some in deciding not to carry on with the training.

9.39 We also heard of at least two situations in which individuals completed the entire five-day T4T course, and then were told by the LivingWorks T4T Training Team they had, for some reason, not "passed" the course and would not be allowed to become an ASIST trainer. In both cases, it was not clear why. Efforts to get formal feedback from LivingWorks, or to get support from NIST in the matter, reportedly failed. In addition, we also heard of one situation where a trainer had to leave a T4T course a few hours early on the final day of the five-day T4T for compelling personal reasons, and was also told that she would not be allowed to become an ASIST trainer.

9.40 While these reasons were given by people for deciding *not* to deliver the ASIST course any longer, we also heard from current active and very enthusiastic trainers that they felt the need for greater support – both in relation to the delivery of the course and the need to debrief afterwards, but also in relation to the mundane, but very demanding, administrative aspects of the course.

Competence of trainers

9.41 Just as trainers expressed concerns about decisions taken by the LWE Coaching Team to "fail" people who had attended T4T training (including those who had to leave the five-day course a few hours early), concerns were also expressed about trainers who were "passed", but who (in the views of other trainers) were not competent to deliver the ASIST workshop. This situation had become a particular problem in at least two areas, and the trainers who reported these situations expressed frustration that there was no oversight or supervision of trainers who "weren't up to the job". Moreover, once these trainers have delivered 10 ASIST

workshops, they automatically achieve the status of "Master Trainer," even if their delivery of the course is poor.

9.42 Trainers from around Scotland said that they had been told in their T4T course that they would receive on-going feedback from LivingWorks in relation to their delivery of ASIST. However, few said they had ever received any — either from LivingWorks or from the then NIST Training Team — even when they specifically asked for it. Others said the responses they received were not helpful. An example was given by one trainer who attempted to get help from the NIST Training Team regarding a difficult situation that had arisen with a participant. This trainer reported, "We were basically told that, if we had done our jobs better, this situation wouldn't have arisen." She and her co-trainer subsequently wrote a detailed report of the matter and sent it to NIST, who (she assumed) would have sent it to Canada. However, they never received any feedback or support from LivingWorks either.

9.43 A number of trainers expressed a desire to get more regular feedback or support in relation to their delivery of ASIST — particularly where they had had to deal with difficult or vulnerable participants. Some trainers had attempted to set up local trainers' networks for this purpose. For example, in the Scottish Association of Mental Health, 13 members of staff are ASIST trainers. This group meets quarterly to discuss problems and share learning.

9.44 The establishment of a Scottish Consulting Trainers group should begin to address some of the difficulties that trainers have highlighted in relation to a lack of oversight and support, since one of the roles of this group is to provide feedback and support to other trainers, particularly those in their first year of training.

Who should be an ASIST trainer?

9.45 According to some trainers, people who felt most at ease with the ASIST course are those who feel comfortable with the "Socratic method of teaching" advocated by LivingWorks. In other words, if someone asks a question, the trainer does not answer it, but rather encourages the individual to find the answer him / herself.

9.46 It was also suggested by some trainers that people who feel most comfortable with ASIST are those who are willing to "stick to the script."

9.47 The experience of those who attended the T4T course without first having attended the two-day ASIST course separately also would seem to suggest that it is important that trainers attend the course first before going forward to the T4T course, as some people simply do not like the course, or the style of ASIST.

Perspectives on ASIST

9.48 Trainers from all over Scotland felt that ASIST was an excellent, well-thought-out course, with clear messages. In particular, trainers valued:

- the simplicity and very practical nature of the course
- the discussion of attitudes
- the discussion of reasons for living and dying
- the opportunity it gave participants to share information and network

- the focus on making a safe plan with someone who may be feeling suicidal

9.49 It was common for trainers (like participants), to say that ASIST was the best course they had ever experienced, and that they "got a real buzz" from delivering it. However trainers also had some thoughts about how the course could be made better, and expressed frustration that they were not allowed to change it.

Suggestions for improvement

9.50 Trainers from around Scotland had a number of suggestions for improving the effectiveness and impact of ASIST. These included:

- making more information available to prospective trainers in advance about the content of the T4T course, and ensuring they receive, read and understand the information available about the commitment involved in being an ASIST trainer
- making more information available to participants about the content of the ASIST workshop
- localising the course — i.e. making it Scottish and more culturally relevant
- changing the instructions given to trainers about certain sections of the course to make them clearer to participants
- allowing participants to do role-play in pairs or triplets – not in front of the entire group, and providing participants with scenario to play, rather than asking them to make one up.

9.51 In relation to the latter point, it was argued that these changes would do a lot to reduce performance anxiety and make the role-play aspect less stressful for some participants.

9.52 In general, trainers felt strongly that the consecutive, two-day structure of ASIST was necessary and important. However, there was also a feeling expressed by some that, within the two days, there were some aspects of the course that were repetitive and would benefit from being shortened.

Summary of Chapter 9

- ASIST trainers confirmed that the vast majority of ASIST participants enjoy the course and consider it to be useful. However, they also confirmed that the course sometimes had a negative emotional impact on some people. Other problems included negative attitudes and behaviour among some people who attend the course unwillingly, and a reluctance by some participants to do the role-play.
- In general, however, trainers felt that ASIST was effective for most participants in increasing knowledge, skills and confidence, and they gave examples, from feedback or personal observation, of people using their ASIST skills.
- Despite high levels of enthusiasm and commitment, 28% of trainers were no longer delivering ASIST. The reasons included: demands of the "day job", the very structured nature of the course, and lack of organisational support. There were also issues about the level of monitoring and support available to trainers from both NIST and LivingWorks.
- Overall, trainers from all over Scotland felt that ASIST was an excellent, well-thought-out course, with clear messages. However, they also had some suggestions for improving the effectiveness and impact of the course. These included:
  - » making more information available in advance about the content of the T4T course, and ensuring that participants have read and understood the information available about the commitment involved in being an ASIST trainer
  - » making more information available to participants about the content of the workshop
  - » localising the course — i.e. making it Scottish and more culturally relevant
  - » modifying the role-play aspect of the course in order to reduce performance anxiety.

CHAPTER TEN THE COST OF ASIST IN SCOTLAND

10.1 This chapter will present information about the monetary cost of ASIST. It was beyond the scope of this evaluation to undertake a cost effectiveness analysis of ASIST. However, as part of our interviews with stakeholders across Scotland, we gathered data on their views of the costs of ASIST, and asked whether they felt ASIST was worth the investment. We have also included here some suggestions about how the delivery of ASIST could be done more cheaply.

10.2 The evidence presented in this chapter comes from documentation provided by NIST; interviews with national stakeholders and Choose Life Co-ordinators; interviews with trainers; and the local implementation studies.

National costs: payments made to LivingWorks

10.3 At a national level, the largest part of the cost of ASIST has been related to the costs of training trainers and purchasing materials. Until recently, all Scottish T4T courses have been delivered by LWE Coaching Trainers from Australia, Canada, USA and Ireland, and all materials have had to be purchased from LWE.

10.4 As of January 2008, payments to LWE related to the implementation of ASIST in Scotland have totalled **£538,133**. This includes £313,373 for 12 T4T courses (covering the cost of fees, travel and accommodation for the LWE Coaching Trainers), and £225,760 for materials. Table 10.1 provides a breakdown of payments made to LWE for delivery of T4T and for ASIST materials, from 2004 – present. In addition to the costs shown below, £10,000 was paid in 2005-06 to a consultant from LWE to carry out a survey of Community Planning Partnerships in Scotland.

Table 10.1: Payments to LivingWorks Education, 2004-05 to 2007-08, by financial year

2004-05	Four T4Ts in Apr, May, Oct & Nov 2004 (91 participants)	£91,033	
	Two T4Ts in March 2005 (48 participants)	£60,034	
	ASIST materials	£50,438	
	Total for 2004-05	**£201,505**	
2005-06	Two T4Ts in Nov and Dec 2005 (40 participants)	£48,341	
	ASIST materials	£116,750	
	Total for 2005-06	**£165,091**	
2006-07	T4T in Oct 2006 (24 participants)	£29,916	
	ASIST materials	£29,250	
	Total for 2006-07	**£59,166**	
2007-08	Three T4Ts in Apr, Oct & Nov 07 (68 participants)	£83,049	*
	ASIST materials (2500 packs)	£29,322	
	Total for 2007-08	**£112,371**	
	Total	**£ 538,133**	

* The cost of the T4T course in Nov 07 was CAN$100,706.32. This has been estimated, at the rate of exchange on 10 January 2008 as £51,120.

Note that payments made to LivingWorks in 2004 and 2005 were made by the then Scottish Executive through NIST. Payments made in 2006 and 2007 were made by Right Track.

The cost of ASIST materials

10.5 A single participant kit for the ASIST course contains a workbook, the Suicide Intervention Handbook, a prompt card, a certificate of completion and a course evaluation form. The full kit must be purchased for every participant, and the current price of a participant kit for one person is CAN$35. At today's rate of exchange, this is approximately equivalent to £17.50 – or £420 for a box of 24. According to a senior representative from LWE, the cost of the participant kit includes the cost of printing and shipping materials, plus a programme support fee of CAN$19 that covers all "Reader" support services. Also included in the price is a cost for "on-going services" provided by LWE and a contribution towards research and development costs related to ASIST.

How payments to LWE change with ICC membership

10.6 Once a country has attained ICC status, that country can choose to print its own materials, or can continue to purchase materials from LWE at a significantly reduced cost. (The support fee reduces to CAN$14 and the cost of materials reduces to CAN$8.04 (printing cost + 20%).) All other income and expenditure involved in organising ASIST courses, including the cost of T4T, becomes the responsibility of the ICC member country, although in relation to T4T costs, LWE continues to receive CAN$250 per trainer trained under a licence agreement with ICC countries.

Other national costs associated with the implementation of ASIST

10.7 In addition to the payments made to LWE described above, there have also been hotel costs in relation to the delivery of the 5-day residential T4T course. These have totalled £177,034 since 2004-05.

Introduction of NIST pricing policy

10.8 As mentioned in Chapter 4, NIST subsidised 100% of the costs of the first four T4T courses in April / May 2004 and October / November 2004. In addition, each pair of new trainers were given three boxes of 24 participant kits for free. This was done to support local areas in getting ASIST off the ground quickly.

10.9 However, the NIST team were keenly aware that there was an expectation upon them, as there was upon local areas around Scotland, to make Choose Life activity sustainable in the longer term. Therefore, from March 2005, NIST began to charge local areas £1,800 per trainer for T4T. And in April 2005, NIST introduced a pricing policy which had the aim of making the delivery of suicide prevention training sustainable — both at a national and local level.

10.10 The policy set out guidance to local areas about ways they could generate income from the delivery of ASIST by charging participants for attendance. (NIST suggested £200 should be the maximum participant fee, but stressed that local fee structures should not exclude people who could not afford to attend.) In addition, it provided information about new charges that would be levied for ASIST materials — £605 for a box of 24 participant kits. (Materials were no longer to be provided free to new trainers.) In addition, in order to keep costs down, a decision was taken to distribute participant kits in boxes of 24, since 24 was considered to be the most effective group size for an ASIST workshop run by two trainers.

10.11 The £605 charge for materials covered the actual cost of the materials (approximately £420 paid to LivingWorks), and included a £180 administration fee, plus £5 for postage and packing. The administration fee was then used by NIST to part-subsidise the cost of T4T training, which cost a minimum of £2,000 per participant — at least £200 more than the £1,800 charged to local areas. (The cost per participant for T4T was, in fact, variable and depended on the number of participants and the hotel costs. However, local areas were only ever charged £1,800 per participant for the course.)

10.12 Following the introduction of the pricing policy, a few local areas did begin to levy charges for participants attending ASIST. However, most areas continued to subsidise the training with local Choose Life funding. This evaluation found that, more recently, local areas are beginning to consider the possibility of charging fees, although in many cases, the intention is to charge fees only for those who register for the course and then don't turn up. These issues are discussed below.

10.13 In general, the pricing policy was not popular and it contributed to a perception among local areas that ASIST was an expensive form of training. However, the aim of the policy was to make suicide prevention training sustainable in the long run. The policy was underpinned by the principle that any income generated from charging for ASIST would be invested directly back into training, both at a national and local level.

10.14 In November 2007, NIST updated their pricing policy to reflect reductions in the cost of materials which resulted from attaining ICC membership. From July 2007, the cost of a box of 24 participant kits was £319.00, which included £5.00 for postage and packing. In addition, the cost of the T4Ts in October / November 2007 were also subsidised by the Scottish Government in order to help local areas to meet the requirements of Commitment 7 of *Delivering for Mental Health.* Moreover, local areas have now been advised that participant fees should be set no higher than £150 per participant.

Income received by NIST

10.15 Since March 2005, when NIST began charging participants on T4T courses, a total income of **£457,955** has been generated in relation to ASIST. This includes £223,000 for places on T4T courses, and £234,955 for the sale of ASIST materials in Scotland.

10.16 Table 10.2 below shows that, at a national level, once all expenditure and all income was taken into consideration, NIST has spent a total of £159,974 on ASIST since the introduction of the course in April 2004.

Table 10.2: National cost of ASIST, April 2004 – January 2008

Expenditure	
Payments to LWE for T4T	£312,373
Payments to LWE for ASIST materials	£225,760
Hotel costs for delivery of T4T	£177,034
Total expenditure	**£715,167**
Income	
T4T places	£223,000
Sale of materials (includes value of materials in stock)	£234,955
Total income	**£457,995**
Cost of ASIST at a national level	**£257,212**

Local costs: venue hire, catering and trainers' fees

10.17 At the local level, the main costs of ASIST have been related to the cost of training trainers (£1800 per trainer), the purchase of materials (£605 for a box of 24 participant kits), venue hire and catering. In some areas, there have also been costs related to trainers' fees.

10.18 The costs of venue hire and catering have varied from one area to another. In some areas, there have been no venue costs because trainers have been able to use rooms available to them for free within their own organisations. In other areas, workshops have been held in external venues. We heard of at least one area which has, until now, delivered the two-day ASIST course as a residential course (with an overnight stay in the middle). Preferential rates from a local hotel were negotiated for this. At least one other area did not provide lunch to participants; instead participants are asked to purchase or bring their own lunches.

10.19 In most areas, there has been no additional cost related to trainers' fees, since trainers in these areas have generally delivered the course 'for free' as part of their paid employment. However, where there has been a shortage of trainers, some areas have had to buy in trainers. This was done either by paying a fee directly to the trainer (who is effectively self-employed), or by entering into partnership agreements with other agencies. For example, several local authorities, including North and South Lanarkshire, Angus and Glasgow have partnership agreements with the Scottish Association for Mental Health (SAMH). SAMH has a large pool of ASIST trainers who are available to deliver training in these areas.

10.20 It should be noted that in some rural and island areas, participants must often travel great distances to attend ASIST. We heard that in some areas, decisions had been taken to subsidise the cost of travel and overnight accommodation for participants in this situation.

Views on the costs of ASIST

10.21 As mentioned above, ASIST was perceived to be an expensive course. Concerns were expressed by individuals across Scotland that if there was no more funding from Choose Life, it would be difficult or possibly even impossible to sustain ASIST in the long-term.

10.22 There were conflicting views about the benefits of implementing local charges for ASIST training. Some local areas had attempted to do so, but found there was a fall-off in demand for ASIST following this. At the same time, some trainers argued that fees *should* be charged to discourage people from booking on the course and then not turning up on the day.

How the cost of delivering ASIST can be made cheaper

10.23 Trainers and Choose Life Co-ordinators from around Scotland had a number of suggestions for how the cost of ASIST could be reduced. In general, these suggestions related to reducing the cost of materials. However, one individual also argued that the requirement to attend a two-day course was, for some individuals (for example, self-employed taxi-drivers, hairdressers, etc.) a significant expense which involved a loss of income. This individual suggested that the time required for the course could be reduced, and aspects of it delivered via the web or DVD.

10.24 In relation to the cost of materials, many people felt frustrated that all ASIST participant materials had to be purchased in boxes of 24, irrespective of how many kits were

actually needed. One trainer in a rural area reported that because participant numbers on her courses were often less than 24, she and her training partner had been able to stockpile left-over kits, and run a number of courses over the past few years "for free" (i.e. without having to purchase a box of materials for each course).[31]

10.25 There was also a feeling that much of the material in the participant kits could be purchased or produced much more cheaply than was currently possible. For example, the view was expressed that it is unnecessary to provide certificates and feedback questionnaires in all participant kits. These could easily be photocopied at a local level, or downloaded from the web when needed, rather than paying LivingWorks to print one for every participant.

10.26 There was also a perception among trainers that the Suicide Intervention Handbook was little used by course participants. This view was confirmed in some of our interviews and focus groups with ASIST participants. When directly asked if they had ever read the handbook, few participants said they had even looked at it after the training.[32] It was suggested that, where an entire office or project team was trained in ASIST, it was unnecessary (and a poor use of resources) to have one handbook for every person. The feeling was that a single copy of the handbook in the office library would have sufficed for everyone.

10.27 There was also a suggestion that the Suicide Intervention Handbook could be sold separately to participants who were interested in purchasing it, or making it available on CD or even on-line. (The Handbook is, in fact, already available in audio CD format, but the cost of this in Scotland is the same as the cost of the printed handbook.)

10.28 None of these suggestions would undermine the integrity of the course, but would enable it to be delivered more cheaply.

Reducing the costs of trainers

10.29 Some local areas had arranged for the delivery of ASIST to be attached to posts within certain organisations. These posts were often in health improvement or health promotion departments, which had a wider training remit. In general, Choose Life co-ordinators in these areas seemed to perceive the delivery of ASIST as *less* expensive than those areas where there was a high turnover of trainers, or where external trainers had to be brought in to deliver the course.

10.30 Finally, as mentioned in Chapter 9, 77 of the 271 individuals who had completed a T4T course in Scotland were no longer active trainers. At a cost of approximately £2000 per trainer, this represents a significant loss of investment, and it is clearly important in relation to the sustainability of ASIST to find ways of addressing the difficulties that trainers have faced.

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[31] It should be noted that, according to the latest pricing policy document from NIST, individual items of the ASIST participant kit can be purchased separately.

[32] However, this finding would seem to contradict the findings of our participant survey which indicated that 96% of ASIST participants found the Suicide Intervention Handbook 'somewhat useful' or 'very useful.'

Summary of Chapter 10

- At a national level, the largest part of the cost of ASIST has been related to the costs of training trainers and purchasing materials. Until recently, all Scottish T4T courses have been delivered by LWE Coaching Trainers from Australia, Canada, USA and Ireland, and all materials have had to be purchased from LWE. As of January 2008, payments to LWE related to the implementation of ASIST in Scotland have totalled **£538,133**. In addition, there have been hotel costs in relation to the delivery of the 5-day residential T4T course which have totalled **£177,034** since 2004-05.
- From March 2005, NIST began to charge local areas £1,800 per trainer for T4T. And in April 2005, NIST introduced a pricing policy which had the aim of making the delivery of suicide prevention training sustainable — both at a national and local level. Since the introduction of the charge for T4T training, a total income of **£457,955** has been generated by NIST in relation to ASIST. This includes the sale of training material purchased from LWE and sold on to the Scottish ASIST network.
- The pricing policy set out guidance to local areas about ways to generate income from the delivery of ASIST by charging participants for attendance. However, most areas continued to subsidise the training with local Choose Life funding. More recently, local areas were starting to consider the possibility of charging fees, although in some cases, the intention was to charge fees only for those who registered for the course and then didn't turn up.
- Once a country has attained International Collaborative Committee (ICC) status, that country can choose to print its own materials, or can continue to purchase materials from LWE at a significantly reduced cost. Therefore, in November 2007, NIST updated their pricing policy to reflect reductions in the cost of materials which resulted from Scotland attaining ICC status.
- ASIST was perceived to be an expensive course. There were concerns that, if there was no more funding from Choose Life, it would be difficult or even impossible to sustain ASIST in the long-term. Trainers and Choose Life Co-ordinators from around Scotland had a number of suggestions for how the cost of ASIST could be reduced. In general, these suggestions related to reducing the cost of materials.

CHAPTER ELEVEN DISCUSSION

11.1 The evaluation of a training programme, particularly a programme such as ASIST that aims to address a serious and complex problem, is itself complex. There are a number of inter-related factors that can all affect, to some degree, the implementation, effectiveness and impact of the training. The effectiveness and impact, for example, will depend as much on **how** the programme is implemented as on the intrinsic quality of the training. Its wider impact will be closely linked to the national and local **priority** given to the objective of the training. ASIST, for example, has benefited from being part of a high profile national strategy, but that raises the question of what happens when the period of the strategy ends.

11.2 Against that background, in this chapter we will discuss the main themes and issues that have emerged from the information and evidence from our literature review and evaluation. We will use as a basis the four overarching questions we set out in Chapter 1 and look at:

- how ASIST has been implemented in Scotland (and elsewhere) and lessons to be learned
- what we know about its effectiveness
- what we know about its impact
- whether and how ASIST can be sustainable in the future.

The implementation of ASIST in Scotland

11.3 The implementation of ASIST in Scotland took place in highly favourable circumstances. As we described in Chapter 4, there were several supportive factors (levers):

- a well-supported national strategy on suicide prevention which highlighted the importance of training
- the availability of funding to local areas which could be used for training
- the identification by local areas of a lack of skills and knowledge
- the development of a national training function to support the delivery of training.

11.4 There were, in addition, a number of highly motivated and committed "early adopters" who were very influential in bringing ASIST to the attention of NIST initially and in promoting and supporting its implementation at both a national and local level.

11.5 From our interviews with national stakeholders who had been part of the original decision to roll out ASIST, we found that there had been a sense of urgency about getting suicide prevention training underway in local areas to support the Choose Life strategy. The decision to use ASIST was supported by a "theory of change": that training people from a variety of backgrounds would increase the likelihood of intervention and, therefore, have a greater impact on the number of suicides. ASIST was seen to be a good "fit" with the overarching public health approach of Choose Life because it had a community focus but it was also aimed at both professional staff and people who live and work in communities. At a pragmatic level, ASIST was a well-known programme used in a number of countries over a period of time and was supported by an organisation – LivingWorks – that could provide materials and ensure quality control.

11.6 It is also important to note that national stakeholders did comment on the limited evidence base for the effectiveness of ASIST. Although there were some concerns, these were outweighed by the factors noted above and by the international reputation of ASIST and its creators. In addition, there was little evidence available at the time about other suicide prevention programmes.

11.7 One of the interesting points about the early implementation of ASIST was that NIST had not intended it to be the sole suicide prevention training programme in Scotland. This is contrary to the belief held by many people at local level. However, NIST *did* want to try and develop a consistent approach to training across the country. To achieve that, they decided to devote the available time and resources into promoting ASIST as a first step. The huge demand that followed took up all their resources over the next 18-24 months. The result has been that, until recently, there has been little national consideration of the potential role of other programmes, such as STORM, although some local areas have themselves gone ahead and introduced other programmes alongside ASIST.

11.8 Another interesting point is the largely unquestioning response by local areas to the roll-out of ASIST. In many local areas the view was that, if NIST supported ASIST, it was because they were satisfied with its quality and the evidence for its effectiveness. It could be argued that this is a normal response in the case of a national strategy where there is a central implementation team and funding to be spent within a set time frame. The offer of free T4T places in the first year of ASIST was also an incentive. We know that in at least one area (Highland), there were doubts expressed about the evidence base for ASIST although ASIST was rolled out anyway. But we also know that one or two other areas did look at other programmes and did not find anything more persuasive. In addition, a number of people across Scotland had attended a seminar by Tari Kinzel of LivingWorks in 2003 and had been impressed by what they heard, and so were receptive to ASIST.

11.9 Overall, it can be argued that the decision to roll out ASIST and the subsequent concentration of resources on that effort was a sensible and pragmatic response to capitalise on the momentum. The output from that effort to roll-out ASIST as quickly as possible to meet the large demand represents a major achievement: twelve T4Ts, 214 trainers, 576 ASIST workshops and 10,477 people across Scotland who have completed ASIST training as at September 2007.

11.10 Implementation, however, has not been achieved evenly across local areas. In some areas there have been few trainers and few workshops, while in other areas there has been a regular high volume of training and an adequate (or better) supply of trainers. Arguably, all areas should have been able to benefit from the support of a national strategy and the availability of funding, The main factors that seem to have contributed to a higher level of implementation are:

- a proactive Community Planning Partnership (CPP) and local partners
- a proactive Co-ordinator who supported the training
- enthusiastic trainers and a good supply of prospective trainers
- demand for the training
- engagement of senior managers (linked to willingness to release staff as trainers or participants)
- the allocation of all or most of the Choose Life funding to training
- the prioritisation of suicide prevention.

11.11 Where there has been a lower level of implementation this seems variously to have been linked to

- the costs of ASIST (including the costs associated with the T4T course)
- the two-day commitment
- difficulties in recruiting and retaining trainers
- a lower priority given to training
- turnover in the role of Co-ordinator and gaps in filling the post.

11.12 The **cost of ASIST**, in particular, was a constant theme in all our interviews, even among those who were strong advocates of ASIST. The two main issues raised were the cost of T4T and the cost of purchasing full packs of materials for every course. Some made comparisons with STORM since, for STORM, once the materials are purchased they can be photocopied. Many people were also very concerned about the costs of venues and catering.

11.13 The problem of costs was often laid at the door of LivingWorks, although the NIST charging policy was also cited as a factor. It may be that the initial subsidy of places on T4T and the initial supply of materials to newly trained trainers created a false climate of expectation about the costs of ASIST (although it was successful in getting the programme up and running). It appears that once local areas had to meet the costs themselves, they began to question not just the money involved but the payment to a non-UK body. The current levels of concerns about costs now represents, in our view, a considerable barrier in many areas to further roll-out of ASIST. The new arrangements under the ICC may help to reduce some of the costs, but NIST may wish to consider what other action might be appropriate.

11.14 The **two-day structure of the course** was the second constant theme. There were mixed views. Some people strongly advocated the benefits of the structure, but others were adamant that for many front-line staff, and clinical staff in particular, it was too much of a barrier. We did find that engagement of professionals was a significant problem in some, if not all, areas (although that has also been attributed to their attitudes towards ASIST). It could be argued, however, that if the training was a high enough priority for senior managers, key staff would be supported to take the time. Having said that, the two-day commitment has also been cited as a significant barrier for a range of people such as teachers, or staff in small voluntary services, or people who work in the community such as taxi drivers. It would seem to be counter-productive, therefore, not to consider some options for making the delivery of the course more flexible. The flexibility of STORM was often described as a strength. We understand that LivingWorks may be prepared to consider some element of flexibility under the ICC, so an approach may be timely.

11.15 A third theme has been the **difficulty in recruiting and retaining trainers**. Some areas found it difficult to recruit trainers in the first place and some also found it difficult to retain them. **Difficulties in recruitment** seemed to be associated with a lower profile at senior management level for Choose Life and/or for training, together with reluctance on the part of managers to release trainers to deliver the training. A supportive Co-ordinator who had sufficient time for the co-ordination role and / or one who was also an ASIST trainer, seemed to keep the level of enthusiasm and commitment high, which was attractive to prospective trainers. Where the Co-ordinator was very part-time and had little time for the role, or where the Co-ordinator was less directly involved in training, or where there was a

turnover of Co-ordinators, then the profile of training was often low. That affected recruitment of trainers.

11.16 There were a number of reasons for **difficulties with retention** of trainers, which included: lack of motivation; the demands of preparing for and delivering the course; lack of skills or experience to actually deliver; inadequate support and help from LivingWorks and NIST when there were problems; and lack of organisational support. There were also a number of people who completed T4T but did no training, as noted in Chapter 9, often for a variety of reasons, including because they did not like the style of the training. Reluctance of line managers to release trainers led to some becoming rusty and not fulfilling their one course a year requirement. The charging policy also reduced the number of courses in some areas which had a similar effect. It is notable that there are currently 60 inactive trainers on the ASIST database, of whom 18 have never delivered a workshop.

11.17 T4T represents a considerable investment and, in our view, there is a strong case for a more structured recruitment process and robust selection criteria to be developed and applied nationally. We understand that some local areas and organisations have introduced selection criteria and there are suggested national criteria but, given the investment in training, this seems to be an area requiring some immediate attention at national level. More could also be done to ensure that both managers and prospective trainers fully understand the commitment required in being an ASIST trainer, and to obtain the agreement of managers to release trainers.

11.18 We also found, in the course of the evaluation, that there were a number of beliefs held by trainers about the delivery of ASIST that were either not accurate, or which conflicted with beliefs held by other trainers. These included the belief that trainers must stick rigidly to the script without making any adaptations to suit their group. We found that beliefs about the inflexibility of the course delivery made some trainers feel disempowered and contributed to their decisions not to continue. However, the message from LivingWorks Education was that trainers have always had the freedom to modify the course, so long as they stick to the core curriculum. There were also conflicting beliefs in relation to the issue of whether participants must be encouraged not speak to anyone else about the content of the ASIST course. Both these cases highlight a problem in relation to the accuracy of information and communication within T4T courses. It may also be a function of a lack of monitoring of trainers and training practice by LivingWorks and NIST. There may be a need for a more structured national forum for trainers to meet regularly to share practice and express views and problems. The existing Consulting Trainers group may be well-placed to take on some of that role, but their main responsibility is in supporting new trainers, so there may be a place for another group to oversee and support existing trainers.

11.19 Having said that, it is important to emphasise that there are many very good trainers who attract high levels of praise from participants for their skills. They are the public face of ASIST and represent a considerable resource as well as a considerable investment.

11.20 The fourth theme is the **lack of high level, strategic focus** on training. While some areas have chosen to put much of their available Choose Life resource into training because they believe that raising awareness and building capacity will have a greater impact in the longer term, others have given a lower priority to training and instead put their funding into developing services**.** There are also areas where Choose Life had a lower profile. This may be where the CPP or the local structures are not so well-developed or where the CPP has not

given any significant time to consideration of the strategy direction for Choose Life. This is an issue which may need to be addressed at national level.

11.21 Finally, we found in the course of evaluation some problems with the way in which records of training had been collected and stored. We understand that these problems have now been addressed. However, once Scotland is fully operating under ICC status, LivingWorks will not hold any training records for Scotland so there is a need to ensure that robust data collection systems are put in place, and that it is possible to obtain useful and monitoring information from them.

The effectiveness of ASIST

11.22 In assessing the effectiveness of ASIST, we have asked "What were the aims of the intervention? What did it intend to achieve?" The aim of ASIST training, as set out in Chapter 2, is to help caregivers (both professional and informal) to become more willing and able to help persons at risk of suicide by teaching participants to recognise risk and learn to intervene to prevent the immediate risk of suicide.

11.23 From our application of the Kirkpatrick model and our own logic model, we have found that ASIST is, overall, an effective programme. One of the key objectives of this evaluation, however, was to explore whether and how ASIST is sustainable in the future and to make recommendations about it should be targeted to optimise impact in Scotland. We have, therefore identified some issues and some aspects of the course where changes could improve effectiveness.

Do participants enjoy the training?

11.24 It is a key element in creating a learning environment that participants find training enjoyable as well as useful and relevant. We found that ASIST is highly effective in achieving a very positive response from the great majority of participants across a range of sectors. It was common for people to say that ASIST was "the best course they had ever attended." Moreover, a comparison by employee group (NHS, local government, voluntary sector and informal caregivers) found that, across all groups, almost all (more than 90% in each group) thought that ASIST had been a good use of their time.

11.25 There are some issues that arose, however, that suggest changes may be needed to enhance participants' response. The first is that that NHS staff find ASIST useful, but find certain aspects of it less useful than other employee groups. This may be because some groups of NHS staff have greater level of prior knowledge and skills. If that is the case, it may have to be taken into account when deploying ASIST as part of the implementation of Commitment 7.

11.26 The second issue is the identification, albeit by a small number of participants in the online survey, of the need for more support to be available to people who experience some level of emotional distress during the course. While we acknowledge that this experience is not necessarily a barrier to learning, it would be worth considering measures to address it. Information about the content of the course prior to attendance would be one approach. We know that some information is available but it may not be reaching everyone and it may not be detailed enough. Another related issue raised in the survey and in interviews is the need to provide more information about sources of support for people who use ASIST (whether

successfully or unsuccessfully) because of the emotional impact that intervening can have on those who intervene.

11.27 The third issue is that the videos were seen as one of the least useful elements of the training. This seems to be linked to "cultural" issues about the scenarios (some seen as less relevant in the Scottish context), the Canadian language and the "evangelical" approach. This was a recurring theme in our interviews as well as in the online survey. While we acknowledge that many participants do not attach too much importance to this feature of the course, our view is that "tartanising" the course material may remove an unnecessary barrier to effective learning for some. We understand that there is now a dialogue with LivingWorks to achieve this.

11.28 Finally, we noted differing views among participants about the highly-structured approach of the training, which some found unresponsive to their needs. This echoes some of the trainers' concerns and suggests that greater flexibility (e.g. doing role-play in smaller groups, or providing participants with scenarios for role-play), which we understand is possible, may remove a potential barrier to learning for some participants.

Did participants gain anything from the course?

11.29 The evidence from our evaluation and from the literature review shows that ASIST is effective in enhancing the confidence, knowledge and skills of participants. Fewer than a fifth of the respondents to the national participant survey said that their levels of confidence, knowledge and skills were 'high' or 'very high' prior to going on the ASIST course — whereas immediately after the course, more than three-quarters of respondents said their confidence, knowledge and skills were 'high' or 'very high.' And, importantly, the effects were maintained over time.

11.30 Having said that, there was a view in the survey and in interviews that there was also a need for skills updating. We know that some areas have started to run Tune-Up refreshers and we would suggest that future development in this area would get the best value from the investment that has been made in ASIST at a national and local level.

11.31 The majority of participants also reported that the ASIST course changed their attitudes. Others, mainly professionals, did not identify a change but felt that the discussion of attitudes was useful. The inclusion of a session on attitudes in ASIST was frequently highlighted in our interviews as one of the course's key features and one which was important even for mental health professionals. It may be worth considering this particular aspect when considering who can benefit most from ASIST training.

Do participants put ASIST into practice?

11.32 The key to the effectiveness of any intervention is whether it results in changes in practice. We heard many stories throughout this evaluation of situations where individuals had put their ASIST skills into practice — with their service users, their families and friends — and where they felt they had done so to good effect. This was confirmed by our survey which showed a 20% increase in interventions among people who were trained.

11.33 One of the most significant findings of this evaluation, in our view, is that the people who are most likely to intervene with someone at risk of suicide *following* ASIST training are

those who have experience of intervening *prior* to the training. The implication may be that these are the people who have the most opportunity to intervene. We believe that this finding could be important in considering how to optimise the impact of ASIST. Arguably, the best return for the considerable investment required to run ASIST is to target those most likely to use the training. Our profile of "interveners" suggests that they are female, professional caregivers with previous experience of intervening. We would not suggest such a narrow targeting of ASIST but we believe that there is evidence to suggest that those planning the strategic direction of training should consider who, in their area, can benefit most from the training — either because of their job or their role in the community.

11.34 The other interesting finding is that the main reason given by participants for *not* intervening is that the "situation has not arisen." This may also raise issues about the targeting of ASIST if some participants are not likely to have the opportunity in their work or daily lives to encounter people at risk of suicide. Such an approach may seem to run counter to the original public, health approach of Choose Life, although in the intervening years more emphasis has been placed on targeting key groups. The landscape has also changed. There is now a range of other programmes including the shorter safeTALK which could fit the needs of some groups for knowledge and skills rather than offering the more resource intensive ASIST course to all.

What has been the impact of ASIST?

11.35 As we noted in Chapter1 an intervention can be effective in achieving its objectives but still have little or no impact. The question that has to be addressed is: "What difference has it made?" Our evaluation looked at what difference (if any) ASIST has made at a number of levels: individual, organisational, local and national.

11.36 At an individual level, we found that most ASIST participants had used the skills to intervene, often more than once, and that the intervention went well. Since we did not explore the views of recipients of interventions, these are self–reported accounts, but the level of detail suggests a high degree of reliability. In some cases, we had verification from colleagues or managers.

11.37 There was one issue raised by former participants, trainers, and a range of other stakeholders which could reduce the impact of the intervention: that there are sometimes insufficient services available for referral of individuals after an intervention. A lack of (appropriate) services in an area would reduce the impact of an intervention to reduce the risk of suicide. It could also result in the ASIST-trained person continuing to support the individual and they may not be equipped to take on this role. This issue is one which would fall within the remit of local CPP or Choose Life Steering Group to address when planning training.

11.38 At an organisational level, we found that ASIST was felt to be responsible for changes in organisations' assessment and review practices in relation to their clients, and in improvements in communication and information-sharing between services in relation to people at risk of suicide. This is an important contribution to improving service provision for these clients.

11.39 ASIST has clearly had a range of positive impacts in Scotland. There was a consistent view in areas where ASIST had been widely rolled out, that it had been important in raising awareness of suicide, reducing the stigma associated with it, and equipping individuals to

better respond to the needs of people at risk of suicide. However, we also found evidence that the impact of ASIST had been limited or virtually non-existent in some local areas where, for a variety of reasons, it had been difficult to implement. Arguably, this reinforces how important the approach to implementation is to achieving impact even when the intervention is itself effective.

11.40 In Chapter 8 we outlined the difficulties associated with using suicide rates as a measure of impact or effectiveness. Nevertheless we asked many of the respondents in the evaluation for their thoughts on whether ASIST had impacted on suicide rates. Some respondents were reluctant to attribute any change in suicide rates to ASIST, whereas others felt that it had had an impact because of the stories of successful interventions they had heard.

The future of ASIST: whether and how it can be made sustainable

11.41 In the discussion above we have brought together the main themes and key messages from the literature review and our evaluation on the implementation, effectiveness and impact of ASIST. The final, and probably the most important question, is whether ASIST can be sustainable in the future and how that might be achieved.

Factors affecting the future of ASIST

11.42 There are a number of factors that **support** a future for ASIST:

- The evidence that we have gathered shows ASIST to be a **high-quality, effective training programme** that has achieved its aim and made an impact by raising awareness of suicide, and by improving the skills and willingness of a wide range of people to identify and help individuals who may be at risk of suicide.

- The growth of other training programmes such as STORM and safeTALK can be seen as a positive development that increases the profile of suicide prevention training. More importantly, a choice of programmes allows managers to take a strategic view of the appropriate level of training for different staff groups. Indeed, such an approach is currently being taken under the plans for Commitment 7 of *Delivering for Mental Health*, and should allow the widest possible spectrum of staff to receive suicide prevention training. In our view, a future for ASIST is more likely to be secured if it is **part of a suite of programmes which offer options to meet different people's needs and requirements.** It may also encourage a progression to ASIST for people who initially undertake a more basic level of training.

- The **current and developing national policy framework** continues to give priority to tackling health inequalities and health improvement with a clear focus on mental wellbeing. The incorporation of Commitment 7 into the HEAT target of reducing suicides by 20% by 2013 keeps suicide prevention at the forefront of the NHS agenda. The Scottish Government's Discussion Paper *Towards a Mentally Flourishing Scotland* (October 2007) highlights the importance of "preventing mental health problems, mental illness, co-morbidity and suicide". More recently, the Better Health Better Care Action Plan has again put emphasis on mental wellbeing which is one of the topics being addressed by the Ministerial Task Force

in Health Inequalities. Within this climate, there should be scope for a more tailored ASIST to be part of a wider programme of suicide prevention training.

11.43 We have, however, found a number of issues that have emerged during the period of implementation which may affect the prospects for continuation of ASIST training across the wide range of settings where it is currently used. To some extent that is to be expected after the first wave of enthusiasm when people reflect on what is happening in practice. We believe, however, that addressing the barriers described above (costs, two-day structure, trainers' issues and strategic focus) could help to underpin a sustainable future for ASIST. We know that some action has already been taken through the ICC agreement to get agreement on the development of a Scottish Coach Training team and some flexibility on materials; and we believe that the findings from our evaluation offer support for these and other developments. There may also be a need for consideration of the future marketing of ASIST as it is now one of a number of suicide prevention training programmes available in Scotland.

Targeting ASIST

11.44 Future sustainability will depend on training the "right" people in the "right" settings. Initially, the "first aid" model with its community focus conveyed the message that ASIST was suitable for everybody and this fitted well with the overarching public health approach of Choose Life. However, the need for more targeting was highlighted in the evaluation of Phase 1 of Choose Life. It also emerged as an issue from our literature review and, in this evaluation, the question of, "Who would benefit most from ASIST?" was raised by the evidence on effectiveness. One of the issues, therefore, is **targeting**.

11.45 In the course of the evaluation we explored to what extent targeting had taken place. We found little evidence of targeting thus far. There were some exceptions (for example, see Glasgow LIS report in Annex 2) but, by and large, ASIST was seen as a population-level public health intervention which sought to provide as many people as possible with the skills to intervene. It was, therefore, seen as relevant to a wide range of people — whether a professional working in the NHS or voluntary sector, a hairdresser or taxi driver.

11.46 With the experience now gained from four years of rolling out ASIST and the availability of other programmes, it may now be time for NIST and local areas to give more active consideration **to targeting as a way to maximise the impact** of the resource that is required to run the intensive two-day ASIST course. As noted above, this has been built into the draft framework for the implementation of Commitment 7.

11.47 We know that suicide risk does not fall evenly across the population and it makes sense to target training to those who work with, and those who are from, sections of society that are most at risk. Indeed, we heard strong views from some interviewees that the most effective location for ASIST (or perhaps for suicide prevention training more generally) is in communities where, for reasons of deprivation (often associated with problem drug and alcohol use), suicide is not such an unusual event. This suggests that ASIST training should be prioritised for those who have greatest contact with the key target groups, whether professional staff or key people within communities. Having said that, targeting should be informed both by current epidemiological knowledge and by reliable evidence in order to

address issues such as 'suicide contagion.'[33] In addition, training such a wide range of people still needs to be monitored, to ensure that the coverage is not patchy – there should be no big gaps.

11.48 We also found that ASIST participants were predominantly female (around 70-75%) which, interestingly, is also the case with SMHFA and STORM. As young men are the group at highest risk of suicide, this may be an issue. There were differing views about the need to train more men, on the basis that they were more likely to be in contact with other men or more able to make a connection with them. We found no evidence that there had been any significant attempt to attract more men as participants. In our view it could be a fruitful avenue to explore but one which might require some innovative thinking.

11.49 The findings of our national survey of ASIST participants suggest that ASIST might best be targeted at individuals who have had previous experience of intervening with someone at risk of suicide — since these individuals are most likely to make use of their skills after training. This may make ASIST particularly attractive in relation to Commitment 7. However, as mentioned above, NHS staff found certain aspects of ASIST less useful than other employee groups. It may be necessary, therefore, to offer NHS staff a range of suicide intervention programmes, including ASIST, to suit their specific needs.

11.50 To achieve maximum impact there may be a case for the development of local and national strategies for the selection of participants, and for training of trainers although such strategies should be assessed for the impact on equalities groups (homeless people, people with poor literacy or asylum seekers, for example).

Funding and organisation

11.51 There are two other issues that will have a strong influence on the likelihood of a sustainable future for ASIST: **funding and organisation.**

11.52 There was a strong view from a cross section of our respondents that ASIST would not be sustainable in the longer term without some national funding while others thought that its reputation and success to date in raising awareness and increasing skills had created a good basis for the future. We cannot predict what, if any, funding might be available in the future. However, a sustainable future is more likely to be achieved if ASIST (or suicide prevention training more generally) could be incorporated into the mainstream activities of key organisations such as the NHS or local authorities: for example, as part of their training programmes, or become embedded on job descriptions or service contracts. This would also reduce the need for external funding.

11.53 At national level, we identified an arguably even more important issue to address for the future beyond 2013, when the current Choose Life strategy (and possibly funding) may end. Given the evidence that we have gathered about the way in which other countries such as Norway and Australia operate ASIST through a national organisation, and in the light of the pivotal role played by NIST and the national training team in rolling out ASIST, we formed a preliminary view that there should be an organisation at national level with responsibility over managing ASIST and its companion programmes.

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[33] See www.suicideandmentalhealthassociationinternational.org/suiconclust.html.

11.54 During 2007, it was announced that NHS Health Scotland would take on the national implementation support functions for the Choose life strategy from 1 April 2008. In our view, the focus of activity on ASIST should be on:

- overseeing the delivery of T4Ts through Scottish Training Coaches
- setting and monitoring selection criteria for trainers
- supporting and monitoring trainers — ensuring quality control
- monitoring and maintaining course information
- targeting ASIST
- developing and distributing Scottish training materials
- setting and monitoring charging for courses including criteria for free places

Areas for action

11.55 The following section offers some possible areas for action by NIST and its partners in relation to ASIST.

Supporting future implementation

11.56 We have identified some areas for action to support future implementation of ASIST.

- Paying LivingWorks for T4T and materials represents a considerable barrier to the future sustainability of ASIST. NIST should:
  - » complete negotiations with LivingWorks about the timing of the introduction of Scottish T4T Training Team
  - » agree with LivingWorks the Scottish printing of materials and work towards developing Scottish materials
  - » discuss with local partners what level of costs in relation to ASIST would be feasible / acceptable.

- The two-day structure of ASIST was seen as a significant barrier to the participation of some key groups of health, social care and education professionals. NIST should discuss the options for some flexibility with LivingWorks as a matter of urgency to capitalise on the demand for training generated by Commitment 7 of *Delivering for Mental Health*.

- ASIST cannot be sustained, or maintain its high quality, without well-motivated, skilled trainers and there are problems with both recruitment and retention of trainers. NIST should consider, in partnership with local areas:
  - » the development of more robust selection criteria to include, for example, motivation, previous experience of training, previous knowledge of mental health and/or suicide, agreement of employers to the time commitment
  - » the development of more national support for trainers through monitoring, the creation of a regular national forum, and the availability of advice on a one-to-one basis to help with problems. There may also be a need for refresher

courses for trainers. At local level, the creation of local trainer groups would provide a source for sharing good practice and support for problems.

  - » how to provide more administrative support to trainers to reduce their workload
  - » how to improve communication and ensure that accurate information is available to both trainers and employers about the nature of the commitment required to deliver training, and that that information is read and understood
  - » the development of other ideas, such as the creation of full-time trainers, paid trainers, trainers who deliver training as part of their job descriptions and more self-employed trainers.

- A high level commitment to suicide prevention and a supportive infrastructure is necessary for the effective roll out of ASIST. NIST should consider how to address that in local areas where it may be lacking.

- There is a need to ensure that there are good information and monitoring systems in place when Scotland becomes solely responsible for data collection and recording. Effective information and monitoring systems are crucial to ongoing evaluation of the implementation of ASIST. They would also enable the national training team to ensure greater consistency of approach across local areas, and provide an early indication of possible problems.

Enhancing effectiveness

11.57 NIST and local partners may wish to consider the following areas for action to enhance the effectiveness of ASIST.

- To reduce the impact of the emotional distress felt by some participants because of the content of the course, NIST could consider how (and what) information could be provided in advance of the course and how it would most effectively reach prospective participants.

- The use of more flexibility in the delivery of the course to respond to the needs of the group could aid learning. NIST could support better use of existing flexibility and explore with LivingWorks what additional flexibility might be appropriate. In relation to this, much greater transparency is needed both within T4T training and in support given to existing trainers, so that all trainers are aware of what aspects of the course are mandatory and where they can be flexible in delivering ASIST.

- At the same time, structures need to be put in place to monitor the quality of training and ensure that trainers are delivering the core aspects of the course in a consistent manner.

- The Canadian videos and language may be a barrier. There may be scope under the ICC to discuss the development of Scottish material but it may be helpful to prioritise that discussion.

- As time goes on people may need to update their ASIST skills. NIST and local partners should consider how to promote the use of Tune-Up refreshers to help maintain skills.

Improving the impact of ASIST

11.58 We have identified the following areas for action for consideration by NIST and local partners that could improve the impact of ASIST.

- Lack of availability of appropriate services for referral of people at risk of suicide can reduce or negate the impact of the intervention. It may be timely for local areas to consider the range of services available.

- The level of activity on implementation and the supporting structures have a major impact on the success of ASIST. In those areas where implementation has been less successful it may be useful to review the strategic and operational mechanisms that are in place.

Targeting ASIST to the "right" people

11.59 Future sustainability will depend on training the "right" people in the "right" settings to make maximum use of the investment in ASIST training. NIST and local partners should consider which individuals and groups would benefit most from ASIST and prioritise those who have greatest contact with the key target groups through their jobs or their role in the community.

Undertaking future research

11.60 In light of the relatively small number of ASIST evaluations carried out to date, there is a need for further evaluation of ASIST. This should be based on good-quality, independent research that aims to establish the effectiveness of ASIST training on both individuals and the broader community. Following are a number of specific recommendations.

11.61 Evaluations of ASIST rely heavily on self-report measures, which can be influenced by the memory, motivation and subjective perceptions of the individual participants. Hence, although participant self-reports are informative and can offer useful insights, they do not substitute for more direct measures. Following are some suggestions:

- Changes in suicide intervention confidence, knowledge and skills (Kirkpartrick level 2 outcomes) could be measured using pen and paper tests or simulated scenarios.
- The transfer of learning into practice (Kirkpatrick level 3 outcomes) could be measured by carrying out trainee follow-up using observation and/or multi-source, multi-rater performance feedback from a variety of stakeholders in actual life/work situations ("360 degree assessment").

11.62 In order to be able to track and compare participant outcomes there is a need for future evaluative research to be conducted with:

- Baseline measurements
- Longer follow-up periods

11.63 Further research should be conducted to explore, in more depth, the factors and / or circumstances which inhibit ASIST participants from applying their learned skills, as well as

those that promote the application of skills into practice. This information should be utilised to refine the ASIST training programme.

11.64 A more powerful approach to the examination of suicide intervention programmes could be achieved by including a matched comparison (control) group. This would allow testing for any pre-existing differences between people who do, and do not, undertake ASIST training, in terms of their motivation, skills, and knowledge in suicide intervention, hence allowing future studies to draw stronger conclusions about the causal effects of training.

11.65 Future evaluations of ASIST should strive to put more focus on assessing the impact of ASIST on an organisational and community level (Kirkpatrick level 4 outcomes), as well as issues of sustainability and implementation of ASIST. One way in which this could be achieved is by carrying out local implementation studies (as in the present study).

11.66 Further research is needed on the cost-effectiveness of ASIST, which represents a considerable gap in the literature.

11.67 Another gap in the literature relates to the different cultural responses and approaches to suicide intervention in Scotland. Conducting an investigation into this subject-area would help to establish guidelines for the delivery of ASIST in a culturally-sensitive and appropriate manner, as well as the targeting of individuals at risk who come from a variety of cultural and ethnic backgrounds.

Conclusion

11.68 In this evaluation of the use and impact of ASIST training in Scotland we have found that the national and local implementation of ASIST has, overall, been successful in achieving the original aims of raising awareness of suicide and increasing the body of people who have the skill to intervene with individuals at risk of suicide. There is potential to achieve greater effectiveness and impact, and secure a sustainable future within a Scottish-focussed ASIST / suicide prevention training programme by addressing the issues that we have identified about course content and format, and about the management and delivery of ASIST.

Summary of Chapter 11

- The evidence of effectiveness and impact found in this evaluation strongly suggest that ASIST could have a sustainable future in Scotland. Other factors that support sustainability include the opportunity for ASIST to be part of the roll out of suicide prevention training under Commitment 7 and the focus on mental wellbeing within the developing national policy framework.
- The evidence also suggests some areas for action that would maximise the impact of ASIST and improve the prospects for sustainability. These include:
  - » reducing the costs of ASIST
  - » creating flexibility in the two-day structure of ASIST
  - » developing more robust selection criteria for trainers
  - » maintaining ASIST skills.
- The future sustainability of ASIST will depend on training the "right" people in the right setting. A key area for action, therefore, is in relation to **targeting** of ASIST**.** The evidence from the evaluation suggests that, to make the greatest impact, suicide prevention training should be targeted at those individuals and groups who have most opportunity to use the skills because they work with, or live beside, people from sections of society most at risk of suicide — for example, people living in areas of deprivation and those affected by drug and alcohol problems. NIST / Health Scotland and local partners should consider which individuals and groups would benefit most from ASIST and prioritise those who have greatest contact with the key target groups through their jobs or their role in the community.

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ANNEX 1: FURTHER DETAILS ABOUT THE HISTORY OF ASIST, THE CONTRACT BETWEEN PROVISIONAL TRAINERS AND LWE, THE CRITERIA FOR INTERNATIONAL COLLABORATIVE COMMITTEE MEMBERSHIP, AND LWE'S EXPECTED TRAINER AND CAREGIVER COMPETENCIES

History of ASIST

ASIST was originally developed as part of a suicide prevention strategy in the Canadian province of Alberta in the early 1980s. At that time, Alberta had the highest suicide rate of all the Canadian provinces, and one of aims of the new strategy was to develop and deliver a province-wide suicide prevention training programme for front-line helpers / caregivers.

Four individuals based at the University of Calgary in Alberta – Richard Ramsay, Bryan Tanney, William Lang and Roger Tierney – were involved in taking forward this work, and together they became the co-founders and co-developers of the ASIST programme. The ASIST Training for Trainers (T4T) course grew out of this context.

According to a senior representative from LivingWorks Education, the T4T course incorporated a knowledge transfer methodology developed at the University of Michigan in the mid-1970s (Rothman 1980) which enabled a standardised course curriculum to be widely disseminated and quality-controlled. Some of the course materials (in particular, the Suicide Intervention Handbook) and one of the audio-visuals were developed in collaboration with the California Department of Mental Health. California subsequently became the first place outside of Canada where ASIST was rolled out.

Meanwhile, the Canadian Mental Health Association, which had provided the initial funding to develop ASIST, was given the rights to disseminate the programme in Alberta. However, the developers maintained the intellectual property rights and responsibility for maintaining the quality and ongoing development and delivery of ASIST outside of Alberta.[34]

LivingWorks Education

LivingWorks Education (LWE) was established in 1991, as a university start-up company, to commercialise the ASIST programme. According to a representative from LWE, this was the university's first attempt at commercialising an innovation from the "soft sciences."

LWE then became the vehicle through which the ASIST course was marketed outside the province of Alberta. LWE also retains the responsibility for maintaining the standardisation and quality control of the T4T and ASIST courses, and for keeping both courses up-to-date. This is done through feedback forms which are sent to LWE each time an ASIST course is delivered. Where a country has achieved International Collaborative Committee (ICC) status (see below), that country is then responsible for collecting, recording and responding to feedback on its own courses.

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[34] It is worth pointing out that according to the most recent statistics published by Statistics Canada (for 2004), the province of Alberta has continued to have suicide rates which are significantly higher than the average suicide rate for Canada. See the Statistics Canada website for further information: www.statcan.ca.

ASIST was rolled out to Australia and New Zealand in the mid-1990s, and to Norway starting in 1998. In these countries, modifications were made to the programme to account for cultural and, in the case of Norway, language differences. In Norway, the entire ASIST programme was translated into Norwegian, and the ASIST audio-visuals were refilmed using Norwegian actors and culturally-relevant scenarios. These countries now print their own T4T materials, and have full responsibility for the delivery of ASIST through an ICC agreement.

Information about the contract between Provisional Trainers and LWE

Provisional Trainers sign a contract with LWE, in which they confirm their intention a) to become a Registered Trainer by "successfully conducting three ASIST workshops within one year" and (b) to maintain their registration status by "presenting at least one ASIST workshop every 12 months following the initial three workshops."

In addition, this contract asks new trainers to agree to the following "Statement of Principles":

1. To conduct ASIST in a manner consistent with the objectives and content of the ASIST Trainer's Manual and training experiences. Minor variations in style or content consistent with the spirit of the workshop are permitted.

2. To conduct ASIST workshops over a period of two full consecutive days using a minimum of two Registered or Provisional (ASIST Edition 10) trainers and workgroup sizes of 7-15 participants. (Although not preferred, smaller workshops with one workgroup of at least 8-10 participants and two trainers are possible. However, trainers need to demonstrate ability to facilitate their own workgroup by their third workshop.)

3. Not to conduct any ASIST workshops with participants under the age of 16 without prior consultation with LivingWorks and written parental consent.

4. To maintain a safe working environment for participants and be aware of local referral guidelines and resources.

5. To be informed of and comply with local requirements regarding privacy of information.

6. To allow LivingWorks, in the interest of maintaining standards, to observe workshops that trainers present.

7. To not use materials from ASIST in other types of suicide prevention training or to use them in demonstrations or conferences without consultation with LivingWorks.

8. To respect the copyright of ASIST's audiovisuals and other materials.

9. To forward all participant feedback and trainer report forms promptly and directly to LivingWorks (or other designated contact) following each workshop.

10. To use participant materials purchased from LivingWorks and distribute all materials to each participant who completes the workshop.

International Collaborative Committee (ICC) criteria

An ICC agreement enables a country to run its own ASIST and T4T programmes. The following conditions must be met in order for a country to attain ICC status.

- The country must have a sustainable delivery infrastructure for trainers.
- There must be a sufficient number of Consulting Trainers in the country who can assume responsibility for quality control, assuring continuity of the core curriculum of ASIST and provide ongoing support and assistance to the trainer network.
- The country must keep its own record of feedback received on the course, and provide information on a quarterly basis to LWE on how many trainers they have and how many workshops have been delivered.
- There must also be a team of training coaches in the country or be part of an inter-country consortium of coaches who are able to deliver the T4T course. One or more Team Leaders are needed who can take full responsibility for operating the T4Ts in that country.
- LWE and member country formalise an ICC agreement and revised programme support arrangement (i.e. a licence fee). The structure is negotiable but usually takes the form of an annual renewable license and a payment for each ASIST participant and trainer trained. According to LWE, ICC status can commence with items 1-3 in place.

LWE's expected trainer and caregiver competencies

The table below outlines the trainer and caregiver competencies set out by LWE.

Trainer competencies	Caregiver competencies
A **willing** trainer recognises: • participants have wisdom about intervention • ASIST unfolds intervention wisdom • learning intervention and doing interventions have similar processes A **ready** trainer understands: • positive feedback is important • almost everything participants do is a contribution • ASIST increases intervention skills. An **able** trainer: • balances safety and challenge • uses a suicide intervention when needed • is committed to ASIST standards • pursues ongoing learning and engages in self-reflection • supports other trainers • values ASIST training.	A **willing** caregiver: • recognises that their attitudes can affect what they do in an intervention • recognises that an intervention unfolds in response to the needs of a person at risk • values life. A **ready** caregiver: • understands that person at risk likely has reasons for living • understands that first aid interventions focuses upon the immediate situation and a commitment to avoid suicide for an agreed amount of time • understands that there are several possible risk alerts and that each needs to be addressed in the planning for safety. An **able** caregiver: • explores the meaning of things they see, hear, sense or find out about, to see if they are connected to thoughts of suicide • talks openly, honestly and directly about suicide • tries to listen to the reasons for dying before searching for the reasons for living • reviews risk and creates a safeplan for the risk alerts found in the review • involves a person at risk in as much decision-making about their safety as is possible • knows local resources and how to access them • follows up on safeplan commitments.

ANNEX 2: REPORTS OF LOCAL IMPLEMENTATION STUDIES

This annex presents the full reports from our six local implementation studies in selected areas / organisations around Scotland. The aim of each local implementation study was to get a more detailed perspective on the implementation of ASIST and its impact in organisations and communities. This was done through discussions with a range of stakeholders in a single geographical area or, in the case of one study, in a single organisation.

Five geographical areas were chosen for the local implementation studies (Glasgow, Shetland, Highland, Midlothian and West Dunbartonshire), and one organisation (Scottish Association for Mental Health). The choice of these areas / organisation was based on a combination of factors, including: the number of ASIST courses offered, the suicide rate in the area, and the association between suicide rates and deprivation in the area.

Local implementation study areas

Area / organisation	No. ASIST courses (No. of participants) (Jan 2003 – Sep 2007)	Suicide rate per 100,000 (1989-2002)*		Suicide gap*	Other comments
		Males	Females		
Glasgow (p. 120)	74 (1231)	43.6	13.8	Widening	High suicide rates. High levels of worklessness and deprivation. Recently established a new Mental Health Partnership. Are proposing an "intensive ASIST" for areas of deprivation. Priorities for ASIST training in future include staff in agencies working with refugees, asylum seekers and care leavers.
Highland (p. 126)	27 (479)	44.0	10.9	Widening	High suicide rates. Remote and rural area. Has a clear suicide prevention training strategy. Has experience of ASIST, STORM and SuicideTalk.
Midlothian (p. 132)	3 (57)	26.5	9.6	Widening	Have made little use of ASIST.
West Dunbartonshire (p. 138)	18(343)	42.7	8.1	Closing	High suicide rates. Very proactive in implementing ASIST.
Shetland (p. 144)	18 (233)	36.1	12.1	N/A	High suicide rates. First to roll out ASIST. Geographically remote. Has made links to drug and alcohol services.
SAMH (p. 150)	28 (517)	N/A	N/A	N/A	Major provider of ASIST training across Scotland.

* See Platt *et al* (2007) The epidemiology of suicide in Scotland 1989-2004: an examination of temporal trends and risk factors at national and local levels. See www.scotland.gov.uk/Publications/2007/03/01145422/0. The "suicide gap" is the gap between suicide SMRs in the highest and lowest areas of deprivation from 1989-95 to 1996-2002.

All suicide statistics in this appendix are taken from the Scottish Public Health Observatory, *www.scotpho.org.uk/home/Healthwell-beinganddisease/suicides/suicide_data/Suicide_national.asp*.

GLASGOW CITY

Overview

Glasgow is the largest city in Scotland with a population of 580,690. Major employers include the financial and business services, the retail and services sectors and the NHS and the local authority. While unemployment has reduced significantly in recent years, there are still 100,000 people who are economically inactive.

Suicide facts and figures

- In 2006, there were 135 suicides in Glasgow, the highest number since 2000. (See Figure 1.)
- The SMR for suicide in Glasgow among all persons in 2002-06 was 1:29, or 29% higher than the Scottish level. There has been a decline in the SMR for males but a sharp increase for women, who have an SMR of 1:47, or 47% above the Scottish level. (See Figure 2.)
- The suicide rates for Glasgow are consistently among the highest in Scotland for both men and women. There is a strong correlation between suicide and deprivation and Glasgow accounts for over half of Scotland's 5% most deprived areas, and one-third of the 15% most deprived areas.

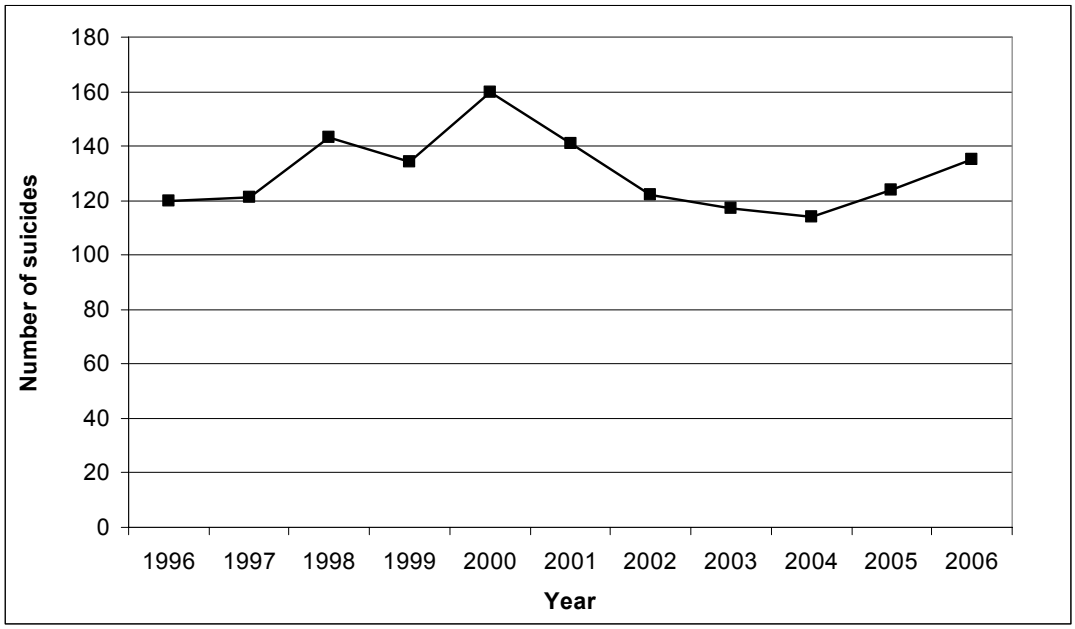
Implementation of ASIST

In Phase 1 of Choose Life (2003-2006), the Glasgow Healthy City Partnership (HCP) co-ordinated the Choose Life programme on behalf of the Choose Life Action Planning Group. The HCP already co-ordinated health improvement activities in Glasgow and had an existing infrastructure. The HCP Lead Officer also took on the role of Choose Life Co-ordinator. There was an initial review of priorities with a range of stakeholders including senior officers from Health, Social Work and the Scottish Prison Service. This group endorsed the national Choose Life priorities and added locally identified priorities including lesbian, gay, bisexual or transgender people; older people; black and ethnic minority people, including asylum seekers; and victims of abuse. The Action Planning Group then identified three main areas of work: programme development through the funding of 11 community and voluntary sector projects; identification of good practice and gaps in service provision; and the implementation of suicide prevention training through ASIST.

The Action Planning Group was pro-active in the implementation of ASIST over the next two years. They sponsored the training of 19 trainers, mainly from the voluntary sector; and required that the first three courses delivered by each pair of new trainers should be free. Training was targeted at organisations providing services to identified priority groups in order to achieve the greatest impact. Most participants came from the voluntary sector but there were some from the NHS and education (the New Learning Communities). The first Co-ordinator believes that ASIST training was provided to people well-placed to use it, including school nurses, agencies working with refugees/asylum seekers and social housing staff.

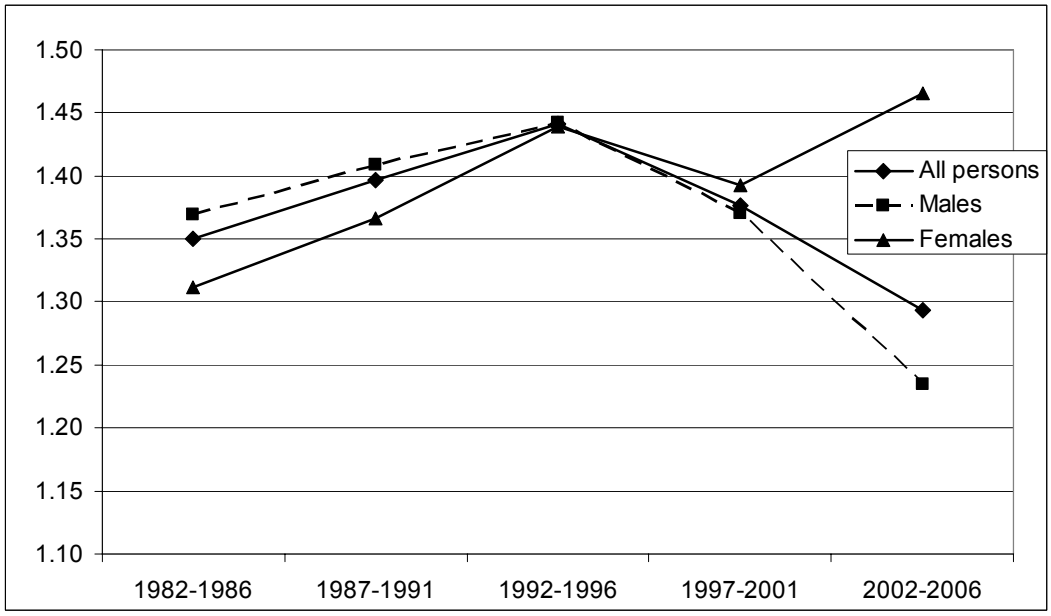
In Phase 2 of Choose Life (2006-8), there has been greater emphasis on the future sustainability of local Choose Life activities and connections with mainstream agendas.

Figure 1: Annual deaths from suicide in Glasgow city (1996-2006)



Source: Scottish Public Health Observatory.

Figure 2: Standardised Mortality Rates for suicides in Glasgow City (Scotland = 1.00)



Source: Scottish Public Health Observatory.

Following a change in the role of the HCP, the Health Improvement and Inequalities Manager for the new Mental Health Partnership for Greater Glasgow and Clyde NHS Board took on the role of Choose Life Co-ordinator for Glasgow City. He has formal reporting and accountability connections with Glasgow City Council on behalf of the Community Planning Partnership. The Action Planning Group membership now includes the new Community Health and Care Partnerships (CHCPs) in recognition of their key role in suicide prevention, and mental health and health improvement more generally. Other members include community and voluntary sector projects, the Scottish Prison Service, Police and Education. There are sub-groups on policy and training.

The new Action Planning Group identified the need for better co-ordination and support to make the most effective use of the skills resource vested in the ASIST trainers. Many of the trainers were delivering training to their own staff, or in partnership with other projects. Two particular issues had arisen. First, most trainers were from voluntary sector projects that could not afford to run training without recovering costs. Different levels of fees were being set by different projects leading to inequity. The NIST charging policy did not reflect the costs associated with higher staff rates, e.g. psychologists. Some projects felt they could not afford to continue to deliver training and some trainers became inactive. The second issue related to an unwillingness among some managers to release trainers.

In response, the Action Planning Group funded a contract for the support of ASIST training across the City with the aim of utilising the skills of the pool of existing trainers and widening access to training. The MHP contributed an additional £20,000 to fund 10 courses targeted at specific groups. The Scottish Association for Mental Health (SAMH) won the contract in February 2007. There are three strands of activity to be completed by March 2008:

- providing co-ordinating, administrative, marketing and other practical support to the ASIST trainers to maximise training opportunities
- organising the MHP-funded courses: five courses for each of the five CHCPs and five courses focused on workers in priority settings – vulnerable young people, homelessness, primary care mental health, addictions and care of older people
- leading discussions to shape the future policy and approach to suicide prevention training in the city.

SAMH has now put in place administrative systems and support for the Glasgow trainers and is working with them to find ways to deliver ASIST to a wider audience.

Meanwhile, the Co-ordinator has developed new links with addictions services who recognise the benefits of ASIST training for their staff. He is also pursuing links with services dealing with vulnerable young people. The five CHCPs all have mental health networks at various stages of development and they are considering how to take forward ASIST or other suicide prevention training programmes. One of the key drivers has been the HEAT target.

According to the national ASIST database, as of September 2007, 74 courses have been completed by 1,231 people (37 did not complete). Approximately 1 in 473 people in Glasgow are now ASIST-trained (compared to the national average of approximately 1 in 500). Seven of the 19 trainers sponsored by the Action Planning Group are now inactive. However, seven new trainers were either funded by other bodies, e.g. the University of Glasgow, or moved to Glasgow from other parts of Scotland, thus bringing the number back to 19 active trainers, of whom three are Master Trainers and four are Consulting Trainers. There are also 13 SAMH trainers available to deliver training in Glasgow.

Impact and effectiveness of ASIST

Kirkpatrick level 1: Participants' reaction to training

There has been very positive feedback from participants with an average score of 9 out of 10 for the training overall; 8 out of 10 for feeling better prepared; and 9 out of 10 for recommending the course to others. Participants have also commented favourably on the course content, the jargon-free, direct language and the benefits of the role-play. There have

been a few comments about the length of the course, but also some comments about having too many breaks.

A focus group with practitioners who regularly use ASIST, and who have backgrounds in addiction, prison and family suicide, was overwhelmingly positive about the structure and content of ASIST. They spoke about its value to them as individuals as well as in their work with clients. They had found ASIST challenging, even "scary" but also said it was "the best two days of my life." They all felt that the two-day structure was essential. Other practitioner interviewees commented on the value of the direct and simple language, and the way in which it helped to find the positive aspects of people's lives. Some interviewees said that the role-play was embarrassing, but that it was well-done and useful. One suggested, however, that there could be more sensitivity when people were reluctant to participate in role-play.

Kirkpatrick Level 2: Changes in confidence, knowledge and skills

All the practitioners interviewed said that ASIST had given them the confidence to ask people about suicide intention. One interviewee had observed increased confidence in colleagues (who had previously thought they knew all about suicide) to ask the question, "Are you feeling suicidal?" She attributed that to the role-play. One manager commented on the increase in confidence that she had seen in staff and observed that ASIST helped them not to take things personally. One trainer spoke about feedback from senior managers who reported that ASIST had raised their awareness of suicide and challenged their professional thinking.

Sixty-six people who trained in Glasgow responded to the national participant survey carried out as part of this evaluation. Sixty said that their levels of confidence, skills and knowledge were moderate or low before ASIST but, both immediately after ASIST and at the time of the survey, the majority reported that levels were high. A substantial majority (55 of the 66 respondents) said that, since ASIST training, they were much more likely to intervene with someone in their professional life and slightly more likely to intervene with someone in their personal life if they thought the individual was at risk of suicide.

Kirkpatrick Level 3: Application of learning into practice

Several interviewees commented on changes in their own behaviour, or the behaviour of staff, following ASIST training. Workers in one project had used ASIST on several occasions and related stories of successful interventions. The team leader of this same project reported that she had actually observed workers putting ASIST into practice (in some cases on the telephone). In another project, the manager said that she could see the empathy that staff had with clients as a result of ASIST training. They were confident and not afraid to ask the question about suicide intent. Three practitioners spoke about using parts of the ASIST model in their work and adapting it or combining it with other training when they were dealing with clients for whom it was not wholly suitable, e.g. clients with schizophrenia.

Other interviewees in the health and social work sectors said that it was too early to comment on ASIST's impact on practice. One senior manager did, however, comment that it was important for senior staff to ensure that there was support for staff to reflect on what they had learned and put it into practice within their teams.

In our survey of ASIST participants, over half of Glasgow respondents (35) said they had intervened with someone at risk of suicide before ASIST training. After ASIST over three-quarters (51) said they had intervened, using all or part of the model.

Kirkpatrick level 4: Organisational / societal impact

The overall view in Glasgow is that ASIST has been an important part of taking forward the Choose Life agenda and particularly in the community and voluntary sector where most of the training has taken place so far. It has helped to raise awareness and increase capacity.

One Social Work manager, who is also on the Action Planning Group, endorsed the value of the training but questioned its impact. He linked that to a failure of Choose Life nationally to make good links with the "establishment," e.g., Royal College of Psychiatrists, and with key services such as addictions. Another senior manager with a joint NHS and Council remit suggested that one barrier to wider roll-out of ASIST was the low profile given to mental health within the CPP agenda.

In the community and voluntary sectors, a report by SAMH on the current and future activities of the Glasgow trainers suggested that ASIST has become embedded in the structure and programmes of a number of projects working with priority groups at risk of suicide.

Cost effectiveness

The cost of ASIST was not the subject of much comment. There was some concern about the cost of materials. Senior managers, however, took the view that training is a cost that has to be met. The feeling was that, if suicide prevention training is seen as a high priority, as is likely because of Commitment 7, the challenge will be to ensure that ASIST (or any other course) is targeted at the appropriate levels of staff to make the best use of resources.

Strengths and weaknesses

All the contributors were positive about the merits of ASIST training and, in particular, the focus on attitudes and ambivalence; the direct and simple language; the networking; and the role-play. It was felt that ASIST was useful for a wide range of practitioners including mental health staff because it "opens the mind to other ways of working."

There were some strong views that the two-day structure was essential because of the way in which the elements of ASIST linked together. In contrast, others suggested that the two days could be a barrier for some people, and cited the drop-out on the second day of the first course targeted at CHCP staff, it was also suggested this might be related to the course being free.

Contributors also identified as areas of concern: the use of Canadian language and scenarios in the course material; the cost of materials; and the perception that Living Works was reluctant to allow adaptation. At an organisational level, the possible reluctance of employers to release trainers may also be a problem.

SAMH has reported on some issues raised by trainers which include the need for more involvement and co-ordination from a senior level within the NHS and the City Council; pricing to be agreed between all agencies including free places for those who could not afford to pay; and more trainer support and quality control.

The future of ASIST in Glasgow

There are a number of factors that may help to secure a future for ASIST in Glasgow: the SAMH contract; the availability of trainers; the CHCP mental health networks; and the new

links with statutory services. The strategic approach of the Action Planning Group to training, including the proposed work on a post-2008 training plan to be taken forward by the training sub-group, is a positive step.

Commitment 7 is also an important driver. It represents a major challenge in Glasgow. The number of staff who require training in order to meet the 50% target is considerable. It is likely, however, that ASIST would be part of a suite of programmes in line with the proposed competence framework developed by the national Choose Life team. Some concerns were expressed about the appropriateness of ASIST. One senior NHS manager commented that his management team thought that ASIST might be pitched at too low a level for some staff, such as nurses. Another manager thought that the focus on attitudes would be valuable for people who normally take a clinical approach.

Several contributors felt strongly that in future ASIST should be delivered within communities where there is a high rate of suicide among young men. They thought that it could help to tackle the "powerlessness" felt by those communities by giving people who live and work there the knowledge and skills to help. Contributors also identified the close link between drug and alcohol dependency and suicide in such communities. It is expected that the closer engagement between Choose Life and the Addictions Service will bring more addictions staff into ASIST training.

Sustainability and mainstreaming

One of the issues in Glasgow is how long it can take for new policies and systems to become embedded because of the scale of the services. The new contract is seen as a way to move towards mainstreaming by increasing the number of people who have experienced ASIST and stimulating the policy debate necessary to support mainstreaming.

Some contributors clearly identified money as an issue that would have a major influence on the future of ASIST, particularly as there is a widely held view that Glasgow had received too low an allocation of Choose Life funding. Although Glasgow has until now put in matched funding and extra investment, there are concerns that the expected reduction in the financial allocations to the Council for the next three years will reduce the money available for suicide prevention training.

Comment

Glasgow has taken a strategic approach to training and has devoted significant time and resources to promoting and supporting ASIST. The focus on communities and the voluntary sector has created a body of ASIST-trained people in some of the city's most deprived communities. The investment in training trainers has provided a good resource and, more recently, the contract with SAMH has been a major step towards ensuring that the skills of the trainers are used more effectively across the city. The current drive to deliver ASIST to more people from statutory services, and the added impetus related to Commitment 7, will be crucial to securing a sustainable future, as has been recognised by the Action Planning Group. The partnership approach in Glasgow which brings together health and social care services, and includes the voluntary sector, should be another supporting factor. In the longer term, the challenge will be how effectively ASIST can be mainstreamed, particularly if resources are constrained, but there is a good foundation in Glasgow to build on.

HIGHLAND

Overview

Highland is the largest and most sparsely populated rural area in the UK. It has a population, swelled in recent years by inward migration, of 215,310. Most people live in small, dispersed communities and there is a limited transport and communication infrastructure which reduces access to services. The main employers are the Council and the NHS while tourism provides around 10% of jobs and agriculture employs a number of people in the rural areas.

Suicide facts and figures

- In 2006, there were 40 suicides in Highland. (See Figure 3.)
- The SMR for suicide in Highland among all persons in 2002-06 was 1:35 or 35% more than the Scottish level. There has been a sharp fluctuation in the SMR for women. (See Figure 4.)
- There is some research to show that men in agricultural occupations are at higher risk of suicide, and more so if they live in rural areas. Specific factors associated with suicide include isolation, stigma, limited access to services, deprivation and access to lethal means. On average, 10% of suicide deaths reported in Highland are of non-residents.

Implementation of ASIST

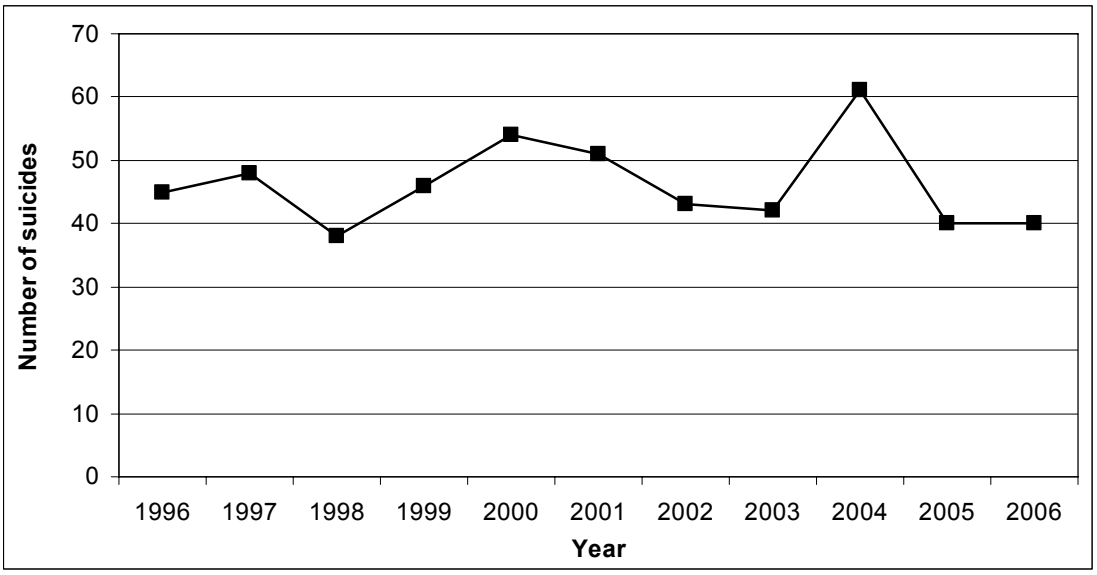
The Highland Choose Life Steering Group, which draws its members from the NHS, Council and voluntary agencies, has taken an active role promoting suicide prevention training. In September 2006, a full-time Co-ordinator was appointed with additional support from NIST to take on a national remit to look at the needs of rural and remote areas. There is also a full-time Training and Development Manager, seconded from NHS Highland, and a part-time Project Support Officer (post currently vacant). These posts are funded until March 2008.

The Steering Group decided early on to direct most of the available Choose Life resources to training because they considered that enhancing the skills of staff would have more impact in the longer term. A sharp peak in the number of suicides in 2004 led to a twin focus on improving the skills levels among professionals, particularly risk assessment and risk management; and raising public awareness.

Highland is unusual in that it rolled out both ASIST and STORM from the early days of Choose Life. STORM was identified first as suitable for NHS and Social Work staff because of its focus on risk assessment and risk management. When NIST began to roll out ASIST in 2004, the Steering Group decided to adopt ASIST as well, but to make a clear delineation between the target groups for ASIST and STORM. They also supported the delivery of SuicideTalk to a range of organisations and community groups to raise awareness of suicide.

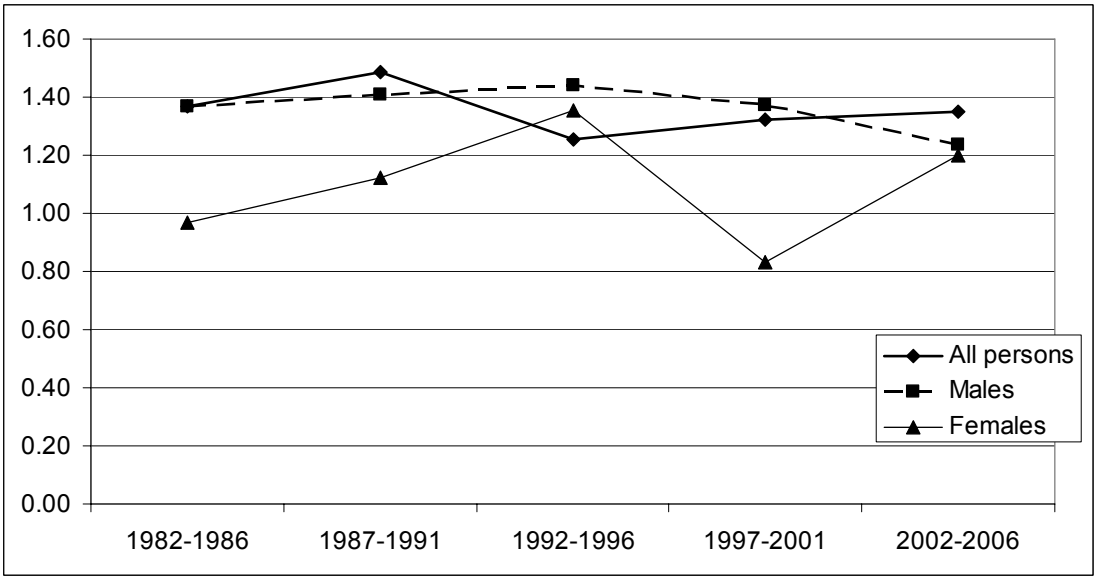
ASIST was targeted at “lay people“, broadly defined as those who might have occasional contact with people at risk of suicide: either as part of their job, for example, clergy, education staff, care assistants, admin/clerical staff; or voluntary agencies, community groups and individuals. ASIST was seen as suitable for this group because it trained them to recognise the signs of suicide, offer immediate help and refer the person to another source of support.

Figure 3: Annual deaths from suicide in Highland (1996-2006)



Source: Scottish Public Health Observatory.

Figure 4: Standardised Mortality Rates for suicides in Highland (Scotland = 1.00)



Source: Scottish Public Health Observatory.

STORM was provided initially to Health and Social Work (registered) professionals, except Mental Health professionals, whose jobs brought them into regular contact with people at risk of suicide and who would be engaged in risk assessment and risk management. Over time, it was agreed that the training would also enhance the skills of Mental Health staff in suicide prevention. As at June 2007, almost equal numbers had been trained in ASIST and STORM.

Highland took advantage of the early T4T courses and was able to begin offering ASIST workshops in 2004. The courses were advertised through NHS Highland and Highland Council networks and word-of-mouth. There was a very positive response in the first two years (2004-6) and there was around one course per month with a waiting list. Participants came from both the statutory and voluntary sectors, and included individuals and community

groups. There was a good take-up from administrative and clerical staff, and from housing services, within the Council.

Highland initially ran ASIST courses for free. When a charging policy was introduced in 2006 (as suggested by NIST), there was a drop in numbers. Local consultation on the charging policy found that people agreed it was reasonable to charge a fee but, in practice, it seemed to be a barrier to participation. Some interviewees suggested that some people would not be able to justify the fee because suicide prevention was not part of their job remit. On the other hand, they also suggested that there might have been a degree of "market saturation" by that time.

According to the national ASIST database, since 2004, there have been 27 ASIST courses in Highland, attended by 479 people. The majority of participants were from the Council, voluntary sector or communities (in line with the targeting policy). At one point, there were six ASIST trainers (all of whom were Mental Health Nurses) who were also STORM-trained. There are now three active Trainers. Highland has also produced a training strategy which sets out the training priorities and plans for Phase 2 of Choose Life (2006-08). The intention for the future is to offer fewer ASIST courses and to promote STORM and Suicide Talk.

Impact and effectiveness of ASIST

Kirkpatrick Level 1: Participants' reaction to training

ASIST has been well received by participants in Highland. The feedback scores recorded in the national database are 9 out of 10 for the course overall, 8 out of 10 for feeling better prepared and 9 out for 10 for recommending the course to others. The content and structure of the course have been singled out for positive comment. There was a range of views about the role-play, with some wanting more and others less. One interesting comment noted more than once, was the desirability of some preparation for the role-play for those who were unused to it.

The NHS and Council managers who were interviewed reported that they had received favourable comments about the training from their workers who had participated.

Kirkpatrick Level 2: Changes in confidence, knowledge and skills

In the national survey of ASIST participants, only three out of the 25 Highland respondents indicated that their levels of confidence, knowledge and skills were high or very high before attending the ASIST training. However, more than two-thirds reported high or very high levels immediately after attending ASIST, and also at the time of the survey in August 2007.

In 2007, the Highland Co-ordinator sent out a survey to 394 people who had attended ASIST training between 2004 and 2006. Out of the 102 people who responded, 46 had used ASIST.

Kirkpatrick Level 3: Application of learning into practice

Out of the 46 respondents to the Highland survey who had used ASIST, 20 had done so between two and five times, and nine had done so on more than five occasions. These respondents identified a number of factors that had gone well including having the confidence to ask, and to talk openly about suicide; the reassurance of having a checklist; the value of

"making the connection" to the person; and the ability to establish a "safe plan." The most challenging aspects had been engaging with the person; listening to the reasons for suicide; dealing with emotions but not getting too personally involved; and keeping focussed.

In our national survey of ASIST participants, 13 out of 25 Highland respondents reported intervening with someone at risk of suicide before doing ASIST training. After ASIST, 22 out of the 25 had intervened. These included people from housing services, a drug and alcohol project, education, an employability service and a careers service.

Kirkpatrick Level 4: Organisational / societal impact

Interviewees felt that there has been a good spread of people trained in ASIST and that it has helped to raise awareness and understanding among the population in Highland. Both Council and NHS managers involved in the roll-out of ASIST believed that suicide is now more openly discussed and more people seem to be seeking help. It is, however, difficult to know how far that is attributable to ASIST.

One contributor expressed the view that ASIST training had been particularly helpful in communities affected by suicide because it addressed feelings of "powerlessness" by giving people a structure for understanding a distressing and frightening event.

Cost effectiveness

Highland has examined the relative costs of ASIST and STORM as part of the development of their Choose Life training strategy. They have concluded that STORM is both cheaper to run and more effective in meeting the needs of the majority of health and social care professionals, and staff in other organisations. The main factors are:

- **Flexibility:** ASIST must be delivered over two consecutive days, while STORM can be tailored to the needs of staff and delivered in 1, 2 or 4 separate modules.
- **The cost of delivering training:** The ASIST charging policy has been difficult to implement whereas STORM trainers deliver training as part of their role within the organisation so there are no fees. There are costs for venues and catering incurred for ASIST courses because it targets a wider target group. In addition, ASIST materials have to be purchased for each course whereas STORM materials can be photocopied.

Strengths and weaknesses of ASIST

The view from all contributors was that ASIST is a very good course which has been very well-attended and well-received by participants. It has a "very solid, firm framework" and is "slick and well put together". Interviewees also highlighted the benefits of the information sharing and networking aspects of ASIST.

Those who had used ASIST highlighted the value of the "safe plan," the directness of the language and the SIM model itself. One of the Highland trainers said that it was the best course he ran and had a "real buzz."

Despite these positive views, contributors also identified a number of weaknesses in the design of the course or in the infrastructure that reduced prospects for future roll-out in Highland:

- The two-day structure: it was felt to be particularly difficult for voluntary organisations to release staff for two days. In addition, distance often means an additional cost for overnight accommodation.

- The rigidity of the course structure was seen as a drawback, e.g. prescribed language, no flexibility to adapt the content or the timing to the needs of participants (although not all agreed that this was a problem).

- Course fees were perceived as a barrier for people who cannot justify the course in terms of their job. The cost of training trainers (currently £1800) and the cost of running courses (e.g. materials, venues and catering) were also felt to be a burden.

Some interviewees identified specific issues for health and social care professionals. One was the lack of differentiation in ASIST between levels of risk. ASIST was described as a good first-aid intervention, but professionals working with clients on a regular basis need more on risk assessment and management. The second issue was the lack of opportunity in the course to reflect on practice.

Highland ASIST trainers also identified the burden of having to do all the administration and organisation for courses. They felt that this burden was at least part of the reason that some trainers had ceased to deliver ASIST. In addition they felt that there should be more support for trainers at a national or, possibly, regional level.

Suggestions for improving ASIST were to "tartanise it," to make it a one day course and to introduce more flexibility in delivery.

The future of ASIST in Highland

Highland has been very proactive in taking forward suicide prevention training and has demonstrated its commitment by developing a training strategy, in consultation with partners, to achieve sustainability for training in the longer term. The focus, however, is on further roll-out of STORM training because feedback has indicated that it is more relevant to practice and more flexible in delivery. It is also considered to be well-equipped to meet the requirements of Commitment 7. Finally, STORM is seen as more cost-effective.

The training strategy, which was ratified by the NHS Direct Services Group, in April 2007, concludes that ASIST is not sustainable in the longer term mainly because of the cost and the time commitment required. In the short term, the Choose Life Steering Group has funded three courses in 2007/8 to be targeted at specific groups, e.g. voluntary staff in remote and rural areas and older adults, faith groups and youth workers. They will also provide training upon request by local stakeholders in line with an agreed charging policy.

Highland Council has put together a draft plan for suicide training of staff across a range of services and has proposed different levels of training depending on the roles and responsibilities of staff. Most of the training will be one or more modules of STORM but a number of staff will also receive SuicidTalk. [There may be scope for a small number of staff to receive ASIST.]

Interestingly, the training strategy includes a commitment to deliver SuicideTalks across Highland in local areas and they are currently recruiting people to do that. In order to become a Suicide Talker, it is necessary to complete an ASIST course and some courses are being planned for that purpose. STORM trainers will also do ASIST T4T so that they can also

deliver ASIST to potential Suicide Talkers. There are plans to do more ASIST refresher courses to reinforce the training while SafeTalk may be considered once the national evaluation of SafeTalk is published.

Comment

In Highland, the decision to deliver STORM to health and social care professionals to meet an identified need for risk assessment and management skills has meant that ASIST has primarily been targeted at other staff groups or the wider community. Although there was a very good response to ASIST in the first couple of years, including from some professional staff, the demand is now less. This seems to be attributable to two main factors

- the introduction of charging
- the increasing adoption of STORM by other organisations, such as the police and fire services, and its flexible use for non-professional staff.

A major theme of the LIS interviews was the significant barrier to future take-up presented by the two-day structure of ASIST and the lack of flexibility of delivery, but this view is not entirely borne out by the success of ASIST in the first two years of its implementation locally. It seems that over the period, people in other organisations may have looked at the level of training that staff actually need to do their jobs and taken the view that it could be met by one or two modules of STORM, rather than the full course of either ASIST or STORM. It may also be that many relevant people have already been ASIST-trained and that, as planned, there should be investment in refresher days. There will, however, be more people trained in ASIST as a precursor to becoming a Suicide Talker.

The current training strategy will see a reduction of ASIST courses and a growth in STORM across a range of organisations in Highland. Without changes at national level to support a more flexible and cheaper delivery, the implementation of ASIST in Highland, beyond March 2008, is in doubt.

MIDLOTHIAN

Overview

Midlothian is a mixed rural-urban area with a population of 79,290. It is the second smallest mainland local authority in Scotland by population. In the past Midlothian's main economic activities were in agriculture, mining and manufacturing, but now services account for almost three-quarters of jobs.

Suicide facts and figures

- In 2006 there were 10 suicides in Midlothian (deaths caused by intentional self harm and events of undetermined intent). In the past 10 years the annual number of deaths from suicide has fluctuated between 6 and 20. (See Figure 5.)
- Midlothian has a standardised mortality ratio for suicides among all persons of 1.12, or 12% above the Scottish level. The SMR for females is 1.40, or 40% above the Scottish level. Midlothian suicide SMRs are rising. (See Figure 6.)

Implementation of ASIST

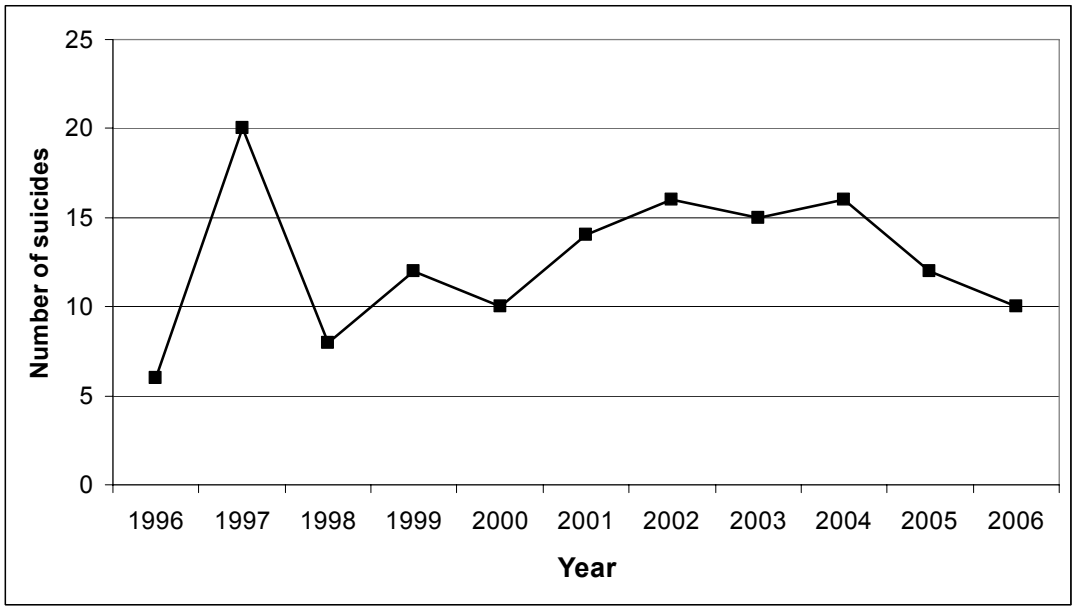
The Midlothian Choose Life Steering Group has a mix of operational and policy representatives from social work; health improvement; voluntary mental health, youth work and health services; clinical psychology; health promotion; and education. There is only one senior operational manager, from the voluntary sector, on the Choose Life Steering Group. The group reports to the Joint Mental Health Planning Group and to the Community Planning Group via the Healthy, Caring and Diverse Partnership Group. Although Choose Life has been linked into these strategic groups, two contributors commented that senior management priorities had focused on the mental health strategy, child protection and inclusion to a greater extent than on suicide prevention.

In Phase 1 of Choose Life, the Choose Life Steering Group decided to fund 10 local projects providing a range of services for people at risk of suicide. In addition, Choose Life funding was allocated to training in ASIST and Mental Health First Aid. One contributor suggested that there has been a focus on funding of projects, to the possible detriment of training and development.

Midlothian has trained approximately 1 in 1400 people (based on total population) in ASIST, compared to approximately 1 in 500 people trained in Scotland as a whole. Three ASIST workshops have been delivered locally, all in 2006, training 57 people. ASIST participants have been drawn evenly from the voluntary sector, health service and local government. The reasons for the low number of ASIST workshops held are described below.

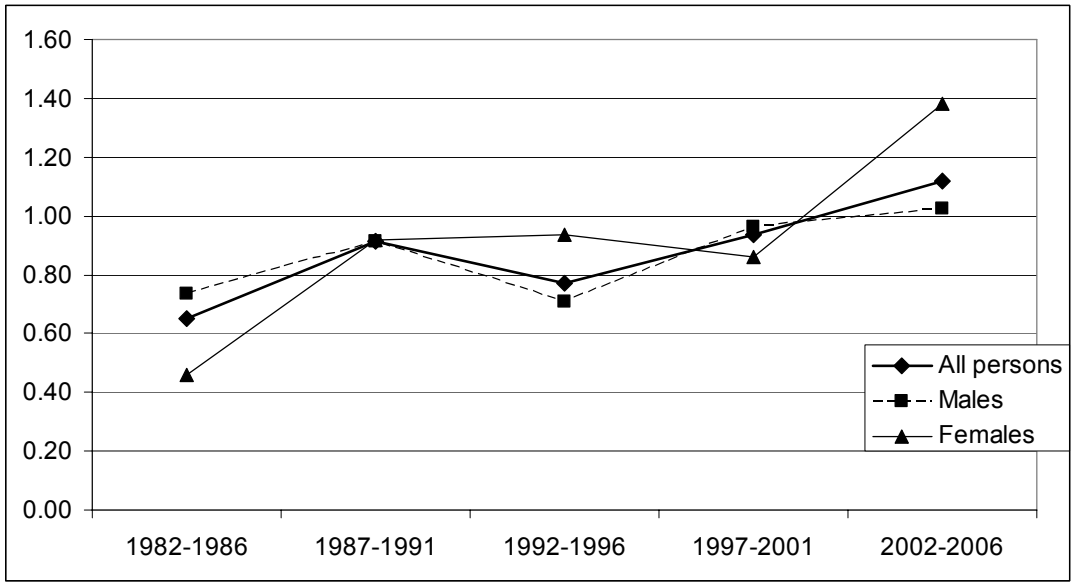
One ASIST trainer (Trainer 1) from Midlothian completed a T4T course in 2004. Not long after he had a three-month period of sickness absence. He felt unable to deliver ASIST for some time after returning because of the demands of the training and the pressure of other work. This trainer had taken on ASIST training as an additional responsibility, but there was no corresponding reduction in his workload and, for this reason, his manager had been reluctant for him to become a trainer. After delivering three ASIST workshops in 2006, Trainer 1 experienced work overload and felt he needed to "take a break" from the demands of ASIST training.

Figure 5: Annual deaths from suicide in Midlothian (1996-2006)



Source: Scottish Public Health Observatory.

Figure 6: Standardised Mortality Rates for suicides in Midlothian (Scotland = 1.00)



Source: Scottish Public Health Observatory.

A second potential trainer started the T4T in 2004, but dropped out after two days because he disliked the style of the training, the lack of evidence-base and the negative emotional impact of the workshop.

Early in 2006, an experienced trainer (Trainer 2) moved to a post in Midlothian from outside the area. Three ASIST workshops were held in Midlothian in 2006. Trainer 2 then went on maternity leave until May 2007 and no further workshops were held until November 2007.

Since 2004, due to the difficulty recruiting local trainers and trainer absence, various options for delivering ASIST in conjunction with external trainers have been explored. However, apart from the three courses in 2006, no training has been delivered because:

- discussions about providing joint training with Scottish Borders trainers proved fruitless, as it was not allowed by Borders management
- in the light of uncertainty over the future of Choose Life funding, it was felt to be too expensive to run courses using two external trainers
- discussions with Edinburgh led to a potential joint trainer completing T4T but, since then, she has been unable to deliver ASIST because of personal issues.

All previous ASIST participants were also canvassed about the possibility of becoming ASIST trainers but there was only one person interested, and this individual was unable to undertake T4T due to the residential requirement.

Trainer 2 has now returned and a further two workshops are scheduled for late 2007 and early 2008. One of these will be run in conjunction with SAMH and the other with East Lothian. Discussions about further joint training are underway with Edinburgh, West and East Lothian trainers, as all areas have experienced a shortage of trainers. In addition, Lothian Health is co-ordinating pan-Lothian developments in relation to Commitment 7.

ASIST was widely advertised to public and voluntary sector workers in Midlothian and there was no specific targeting for the first round of training. Although there was a wide cross-section of participants, there was only one social worker and no substance misuse workers trained. The social work mental health team was, at the time ASIST was offered, significantly understaffed and officers were unable to participate in any training. However, they are now due to attend the next series of workshops. Substance misuse staff have not, so far, attended ASIST training. This is partly because they have been pre-occupied with a review of their joint working and management arrangements during the past year.

Two team leaders in clinical mental health services participated in ASIST to assess its appropriateness for colleagues. They concluded that it was more suitable for newly-qualified staff and people being re-deployed from hospital to community-based services. It was felt that an in-depth, risk assessment-focused course would be more useful for experienced staff. To date STORM has not been offered in Midlothian, however, this option is part of ongoing discussions in relation to Commitment 7.

Strengths and suggested improvements to ASIST

Most contributors had positive views on ASIST training and identified many strengths of ASIST, including the suicide intervention model, learning about reasons for living and dying and asking questions about suicide, the evidence base behind the development of ASIST and that it is regularly reviewed and updated.

Although overall views on ASIST and its implementation were positive, the following suggested improvements were made by some contributors:

- Make ASIST content more relevant to Scottish culture.
- Reduce the length of the course to 1.5 days, with less repetition on day 1.
- Ensure that warnings are provided about the emotional content of ASIST prior to enrolling and that support is offered during workshops to anyone who needs it.
- Publicise ASIST more widely.
- Promote T4T to potential trainers via information sessions, ensuring that they know the level of commitment required and can deliver training as part of their job.
- Improve selection and quality control of trainers at Scottish level.

- Provide dedicated trainers via a national organisation.
- Provide Scottish trainers to deliver T4T.
- Provide e-mail alerts to trainers of updates to ASIST.
- Increase support for trainers, for example, a more regular regional trainers meeting.

Two contributors felt uncomfortable about the anonymous exercise at the start of ASIST where everyone is asked if they had been feeling suicidal in the previous week. In one Midlothian workshop, one person had been feeling this way, but never identified themselves or asked for support. It was felt that it had "hung over" the remainder of the workshop. One participant said it wasn't clear exactly what support was available for anyone feeling this way. In addition, one participant was very concerned about the bridge scenario as she felt that personal safety of the person expected to intervene was overlooked.

Other important mental health developments

The Midlothian Mental Health Strategy has been "an all-consuming focus" for mental health services in Midlothian in the past few years. It has led to a shift from hospital-based care of acutely mentally ill adults to, primarily, community-based care. Three new multi-disciplinary, community-based teams have been established: the Continuing Recovery Team, the Intensive Home Treatment team and an Early Intervention and Crisis Response Service, in addition to a short-term residential facility. Between them they offer a range of round-the-clock care services for people with mental health problems.

In addition, the Midlothian Well-Being Interventions Network (MWIN) has been established to support the development of non-medical, social and psychological interventions for mental health and well-being.

Impact and effectiveness of ASIST

Evidence about the impact and effectiveness of ASIST is limited by the small number of people from any one service who have been trained. One contributor hoped that the impact on practice and policy will grow as more people become trained.

Kirkpatrick level 1: Participants' reaction to training

Overall participant feedback on the workshops in Midlothian has been very good, with average ratings of 7/10 for the training overall, 8/10 for feeling better prepared and 8/10 for recommending it to others. Most comments on the workshop feedback sheets have been very positive. Most concerns related to the length or pace of the training or the amount of repetition, particularly on the first day. However, a few participants also said they thought the workshop would be better spread over a series of days to prevent 'cramming' and to reduce intensity. A small number of participants felt that trainers seemed inexperienced or unfamiliar with the material.

In a focus group with local participants in ASIST, they said they valued the multi-disciplinary and multi-agency mix on ASIST courses and the clear suicide intervention model. Views were mixed on the role-play – some found it very useful and others intensely disliked it.

Kirkpatrick level 2: Changes in confidence, knowledge and skills

Local focus group participants said ASIST training had helped them to ask the right questions and be alert to signs that someone may be considering suicide. One said, "It gave you permission to use the word suicide." They felt that having a process to work through had made them more confident. A team leader in a mental health service noted increased confidence in her ASIST-trained staff in dealing with people at risk of suicide.

Twelve people who currently work in Midlothian and are ASIST-trained responded to the participant survey carried out through this evaluation. The majority said that their levels of confidence, skills and knowledge were moderate or low before ASIST but, both immediately after ASIST and at the time of the survey, the majority reported that levels were high. Half (6) said that since ASIST training, they were much more likely to intervene in their professional life and five said they were much more likely to intervene in their personal life, if they thought someone was at risk of suicide.

A service manager thought ASIST had helped staff to deal with their own issues relating to suicide and to separate these from client issues, so that the learning had been on two levels.

Kirkpatrick level 3: Application of learning into practice

One service manager in a mental health service said that her ASIST-trained staff had better confidence, skills, knowledge and understanding about suicide as a result of ASIST. She had heard stories from staff of them implementing ASIST with clients. She had no doubt that it raised awareness and made people more confident to intervene. However, she felt that participants' confidence may not be sustained if they do not use it regularly.

In the online survey, two-thirds of Midlothian respondents (n=8) said they had intervened before training in ASIST and 10 had intervened since training in ASIST. Nine of the most recent interventions described had used parts of the ASIST suicide intervention model.

Kirkpatrick level 4: organisational /societal impact

There was limited evidence of wider impacts of ASIST. One service manager said her service had reviewed their assessment forms to ask about suicidal thoughts. She said, "We are much more confident about asking." It was reported that ASIST had also helped inform the thinking on the new Crisis Response and Early Intervention Service for people with mental health problems in the community.

One contributor said that suicide prevention was "much higher up agenda than it was before, because of ASIST and Choose Life as a whole." Others said that suicide prevention is now becoming integrated into key plans and strategies, such as the Drug Action Team strategy and action plan, the children's services plan and the joint health improvement plan.

Cost effectiveness

Lack of trainer capacity was identified as the main barrier to implementing ASIST in Midlothian. The demands on trainers are significant, particularly in the first year — trainers are warned by, and sign an agreement with, LivingWorks stating that each workshop requires 30 hours of preparation. One service manager felt that only statutory services could afford to

allow staff to become trainers and that the rigidity of ASIST might put off voluntary sector staff (who may work in the sector because of its flexibility) from becoming trainers.

The main concerns expressed about ASIST related to the length and repetitive nature of the workshop. The length of the workshop makes it difficult for small organisations, particularly those providing front-line services, to release staff to attend. This was partly balanced by the fact that the training had been free of charge.

The future of ASIST in Midlothian

There was local uncertainty about the future funding of ASIST. It is hoped that there will be government funding for training in future and it was suggested that it should be ring-fenced. Concern was expressed about the ability of the voluntary sector to pay for training. However, it was also assumed that the NHS would be funding training required by Commitment 7. One suggestion for income generation was for ASIST to be marketed to local employers and a sliding scale of fees to be introduced to cross-subsidise training. Another suggestion was for online resources to replace course materials.

It is proposed to establish a Lothian-wide pool of trainers who could deliver joint training across local authority boundaries. This would also provide cover for absent trainers. Ideally, more in-house trainers (for example, from social work and the NHS) could also be found in Midlothian, who would be supported by their managers to deliver ASIST as part of their job.

It is planned that a suite of courses will be offered from late 2007: suicideTalk, safeTalk, ASIST and MHFA. ASIST-trained people will be able to deliver suicideTalk, so more of these sessions could be provided and would help to advertise ASIST. At the same time, the Midlothian Wellbeing Interventions Network is establishing a training sub-group for all mental health and wellbeing training. The sub-group will be looking at the training needs of people coming into relevant services and publicising available training.

The plan for Lothian is to continue to offer multi-disciplinary ASIST workshops, with some participants funded via Commitment 7 and others through their local Choose Life partnership.

Comment

The main barriers to delivering ASIST training in Midlothian have been the difficulty in recruiting trainers, the demanding nature of ASIST training delivery, the absence of trainers and lack of cover. There has also been no senior management figurehead from the public sector to drive Choose Life and ASIST, management priorities have lain elsewhere and there was no dedicated staff time to deliver ASIST training until Trainer 2 arrived.

Although only 57 people have been trained, feedback on ASIST training was very largely positive, and plans to deliver joint suicide prevention training across Lothian are being formulated to address the capacity problem.

Although ASIST has not been widely implemented, there have been other important developments in mental illness prevention and the care of people with mental health problems.

WEST DUNBARTONSHIRE

Overview

West Dunbartonshire is situated in the west of Scotland with an estimated population of 91,240. The three main areas of population are Clydebank, Dumbarton and the Vale of Leven. West Dunbartonshire has high rates of poverty, unemployment and drug misuse, and ranks third among local authorities on the Scottish Index of Multiple Deprivation.

Suicide Facts and Figures

- Suicide rates in West Dunbartonshire doubled between the early 1980s and the early 1990s, but have remained at a constant level since.
- In 2006 there were 19 suicides (deaths caused by intentional self harm and events of undetermined intent) in West Dunbartonshire. In the past 10 years the annual number of suicides has fluctuated between 13 and 26. (See Figure 7.)
- West Dunbartonshire has a Standardised Mortality Ratio (SMR) for suicides of 1.36, or 36% above the Scottish level. West Dunbartonshire suicide SMRs are gradually rising. (See Figure 8.)

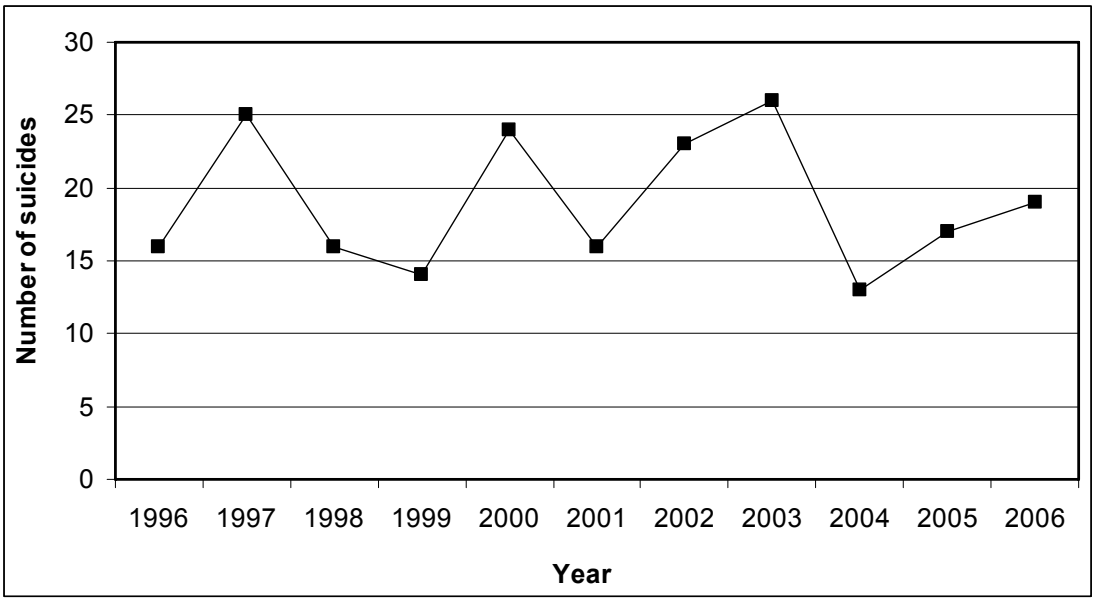
Implementation of ASIST

The CL Advisory Group in West Dunbartonshire includes 11 members representing the Council, NHS, and the police (2 members). There is no representation of voluntary agencies. The group reports to the Health Improvement Strategy Group which is a sub group of the Community Planning Board.

Initially, two part-time Co-ordinators were appointed to provide direction, co-ordinate efforts and oversee the day to day implementation of the local action plan. Currently there is one part-time Co-ordinator in place (the Policy & Training Officer in Mental Health for the Council). In July 2004 a full time Choose Life Development Officer was appointed to provide capacity and focus for the implementation of the local action plan. This post was funded for 3 years (ended in July 2007), and the possibility of appointing a replacement is currently being examined.

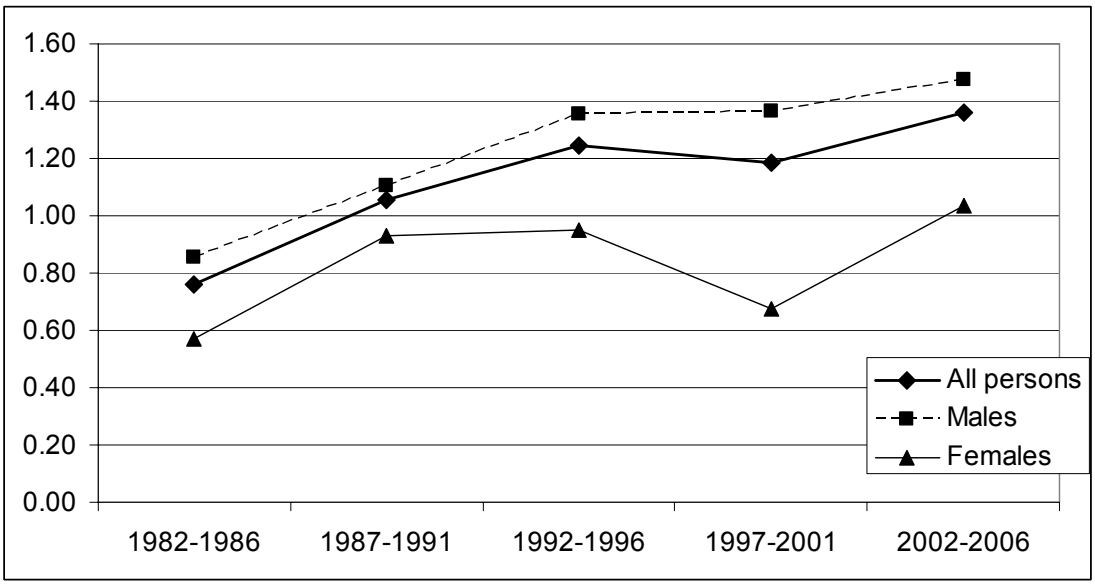
The CL group set its main focus on training as it was seen as having the most potential for achieving long-term benefits and sustainability. Training programmes funded by the CL budget include ASIST, SMHFA, Seasons for Growth and Self Harm awareness. STORM was piloted in 2006 and received with very mixed views. ASIST courses have been regularly advertised by the Development Officer by a variety of means, including an extensive e-mailing list (Council, NHS, voluntary organisations etc'), the Council website, and networking. Workshops are offered to a wide range of agencies and community groups, with priority given to those who have face to face contact with locally identified CL priority groups. There is a very positive response to ASIST locally and courses are almost always run at full capacity with a waiting list. The courses are free of charge for participants and organised by the Development Officer (who was also the lead trainer).

Figure 7: Annual deaths from suicide in West Dunbartonshire (1996-2006)



Source: Scottish Public Health Observatory.

Figure 8: Standardised Mortality Ratio (SMR) for West Dunbartonshire (Scotland =1)



Source: Scottish Public Health Observatory.

ASIST facts and figures for West Dunbartonshire

- Since 2004, 18 ASIST workshops have been delivered locally, training 343 people (an average of 4 courses per year).

- Approximately 1 in 267 people in West Dunbartonshire (based on total population), are ASIST trained. This figure is nearly double the Scottish national average of approximately 1 in 500 people trained.

- The majority of ASIST participants have been drawn from the Council (mainly social work), and the voluntary sector. Health service professionals have attended in small numbers.

- Seven people have trained as local ASIST trainers (T4T). Only three are currently active. The other four have either moved on or are unable to deliver training due to pressures of work or personal issues. Two of them have *never* delivered an ASIST course.

Levers and barriers to implementation

The main lever to the local implementation of ASIST lies in the CL Development Officer post. The decision to employ a person whose full time job is to focus on the implementation of the CL Action Plan has worked well in terms of raising the awareness and profile of ASIST locally. This was further helped by having a very committed individual, with excellent credibility and networking skills, who has successfully introduced, organised and ran ASIST courses in West Dunbartonshire.

Although generally ASIST has been implemented successfully, two main barriers have somewhat hindered local implementation.

- Retention of trainers – West Dunbartonshire lost 4 trainers (more than half), 2 of whom have never delivered an ASIST course. This has created a shortage in trainers and consequently increased the workload for active trainers. Two key issues have been highlighted in interviews with local trainers: (a) Trainers often struggle to find the time away from their regular jobs to deliver the training. Employers, for a variety of reasons, do not always release trainers from their job for that purpose, and in some cases trainers had to take annual leave or unpaid leave in order to deliver 3 courses a year. (b) People who have been trained locally have either not been fully aware or have not taken into consideration the demands of training in terms of time and energy, and the implications these would have on their job and personal lives.

- According to key stakeholders, the rigid two-day structure of the course has been one of the factors contributing to the low representation of frontline NHS staff in ASIST courses, as they find it hard to get time off work for two consecutive days.

Impact and effectiveness of ASIST

In 2005, an independent evaluation[35] of the first 4 ASIST workshops in West Dunbartonshire was commissioned as part of the local Choose Life Action Plan. Questionnaires were sent to the 72 participants from the first four workshops held between June 2004 and February 2005 (43 responded, yielding a response rate of 63%), and further interviews were carried out with a self selected-sample of 13 participants. Findings from this evaluation have been incorporated into this report.

[35] AskClyde (2005). Evaluation of Applied Suicide Intervention Skills Training (ASIST) – West Dunbartonshire. Unpublished report.

Kirkpatrick Level 1: Participants' reaction to training

ASIST has been well received by participants. The feedback scores are 8 out of 10 for the course overall, 8 out of 10 for feeling better prepared and 9 out for 10 for recommending the course to others. Most comments on the workshop feedback sheets and in the focus group have been very positive. The practical aspect of the course (incl. role-play) received special mention, and there was general agreement about the course's high quality content and presentation. The online survey results indicated that participants perceived the most useful elements of the training to be learning the suicide intervention model (SIM), and the discussion of attitudes to suicide and suicide prevention. The independent local evaluation of ASIST (2005) found that the majority of respondents viewed ASIST as highly relevant to their jobs and in some cases their personal lives.

The majority of concerns raised by participants related to the venue and catering facilities. A few participants raised concerns as to the Canadianised teaching materials, and said they would have preferred a British version, and few believed the course could be shortened. One participant found the training to be too structured, in the sense that it did not seem to take into account the needs of individuals in the group. During the training, she disclosed a situation in which a relative committed suicide. Later that day, a similar scenario was used in role-play, which has upset her greatly.

Kirkpatrick Level 2: Changes in confidence, knowledge and skills

By and large participants reported that going on training has increased their confidence, knowledge and skills in undertaking suicide intervention. Two elements that received special mention were greater awareness of the signs of suicide (knowledge) and greater confidence to approach people and ask them whether they were thinking about suicide (confidence).

Twelve people who currently work in West Dunbartonshire and are ASIST trained responded to the online survey. Only a few of them indicated that before ASIST, their levels of confidence, knowledge and skills were high or very high. Immediately after ASIST, and now, the majority reported that levels were high. The majority (10), said that they were much more likely to intervene in their professional life and two thirds (8) said they were much more likely to intervene in their personal life if they thought someone was at risk of suicide.

A voluntary sector service manager (mental health) commented that ASIST training has made her staff more focused, clear and confident about carrying out a suicide intervention. A second voluntary sector service manager (addictions) said he had seen a difference in his staff's attitudes towards suicide prevention following training. He mentioned one staff member who had previously refrained from talking about suicide with clients as they were worried it might do more damage than good. After going on ASIST the staff member realised that openly talking about it would be helpful to their clients.

Kirkpatrick Level 3: Application of learning into practice

The 2005 Independent local evaluation of ASIST reported that the majority of their 43 respondents had had experience of applying their learnt ASIST skills within 6-9 months of training, and with positive outcomes. 10 out of 12 respondents to the online survey reported having used elements of the suicide intervention model with a person at risk, either in a professional or personal capacity (or both). In two of the cases it was a last minute intervention, when the person had already taken active steps to kill themselves. 4 out of the 5

ASIST trainees interviewed, said they have used their training with a person they believed to be at risk of suicide. Two of them said that when they asked the person whether they were considering suicide, the answer was negative. In both cases they felt that it was important for them to ask that question, and that training had given them the courage and confidence to do so.

The two service managers consulted in this study had given examples of staff applying their training into practice. For example, one project worker who had used ASIST felt that she really helped her client, whereas before she would just refer them on to somebody else. She said the training had given her greater insight into how to talk to people about suicide.

Kirkpatrick Level 4: organisational /societal impact

The view of contributors is that there has been a good spread of people trained in ASIST and that it has helped to raise public awareness and understanding among the local population. They believe that suicide is now much higher up on the local agenda, and more openly discussed in West Dunbartonshire.

ASIST has had significant impact on two voluntary sector organisations is West Dunbartonshire in particular. One organisation, providing substance misuse services, set a goal to have all their staff and voluntary workers ASIST trained, and are very close to achieving that goal. They claim ASIST has made a difference within the organisation in terms of staff's confidence and skills in dealing with suicidal individuals. The second organisation, providing mental health services, mainstreams the CL strategy as part of their overall services, and ASIST training will soon be written into staff's contracts. ASIST has had an impact on their referral procedures, and they feel their staff are now better able to identify and respond to the needs of clients with suicidal ideation.

A number of contributors said that suicide prevention is now becoming integrated into key plans and strategies, for example the Integrated Children's Services Plan, the Corporate Action Plan for Alcohol and Drugs, and the Health Promoting School Communities Development Plan

Cost effectiveness

At the moment key stakeholders view ASIST as being very cost effective: the CL budget pays for the training and they use local trainers to deliver the training for free (with contribution from their employers in terms of releasing them). The view of service managers is that ASIST training is a cost-effective use of their staff's time.

Strengths and suggested improvements to ASIST

The view from all contributors was that ASIST is a very good course which has been very well attended and well received by participants. Contributors highlighted many strengths of ASIST, including the direct approach towards talking about suicide and the confidence and tools it provides for carrying out an intervention. In addition to skilling up the workforce, ASIST is perceived to have contributed to awareness raising by getting people to talk about suicide. A voluntary sector service manager commented that ASIST has been "one of the best training programmes that they've had in West Dunbartonshire for a long time".

Two key changes were suggested by contributors to improve ASIST:

- Having a Scottish version of the teaching materials (especially the videos) would make ASIST more relevant to participants.

- Having more flexibility in delivery – sometimes things come up in the course which stray from the set curriculum. The rigidity of delivery does not allow the trainers to discuss them in the way participants would like to, even when it is in line with the underlying aims of the training.

The future of ASIST in West Dunbartonshire

Targeting

The targeting of future training provision could productively be focused on a wider range of professionals than to date, although this would require an increased/ongoing investment in training. Contributors have raised a need for more participation from NHS and Education staff, as well as members of the public (incl. clergy, hairdressers, taxi drivers etc').

Sustainability & funding

The initial local investment in training was based on the assumption that training, by its nature, is very sustainable. Beyond that, there are no concrete sustainability plans for ASIST (or any other suicide prevention training for that matter) in West Dunbartonshire.

The future funding of ASIST is currently unclear and will partially depend on the way commitment 7 is implemented. It is hoped that there will be government funding for training in future. One suggestion for income generation is to introduce a charging policy, however, there are concerns that this will have a negative impact on uptake. In addition, due to a late start in implementing ASIST locally, the Development Officer post can be funded for an additional period of 18 months.

One of the contributors suggested looking at funding from other sources through either the drug and alcohol or mental health forums. For example, the Corporate Action Plan has an implementation fund for addiction services. If three or four agencies come together and put funding towards ASIST training it might be possible to keep the training going once government funding has ceased.

Commitment 7

The Health Board and its partners are responsible for implementing Commitment 7 locally. The local CL group has raised concerns that future funding will only go toward skilling up health professionals, and have recommended that the health board should interpret "front-line staff" in a wide rather than narrow way, to include the voluntary and community sector.

SHETLAND

Overview

Shetland is a group of islands lying in the North Sea approximately 300 miles north of Edinburgh with a population of 21,880. Public administration, the education and health sectors, and the tourism industry are the main employers in Shetland. Agriculture and fishing comprise a small part (4%) of the local economy. Unemployment is low, and educational attainment in Shetland secondary schools is above the Scottish average. Revenue from the oil industry has created a relatively prosperous community and has allowed the local Council to provide excellent roads and other amenities throughout the islands.

Suicide facts and figures for Shetland

- In 2006, there were five suicides in Shetland (deaths caused by intentional self-harm and events of undetermined intent) — three males and two females.
- In the past 10 years, the annual number of suicides has fluctuated between 2 and 8, with peaks in 1997-1998 and again in 2002-2003. (See Figure 9.)
- While the actual number of suicides in Shetland is low, the standardised mortality ratio (SMR) for deaths by suicide is currently 1.37 times the Scottish level. (See Figure 10.)

Implementation of ASIST in Shetland

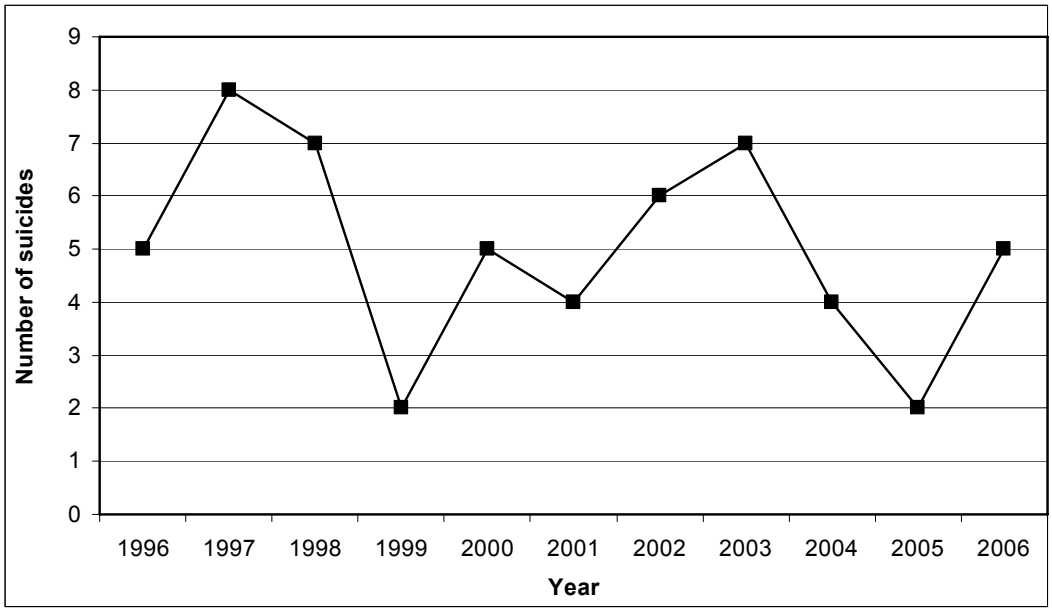
Shetland was the first area in Scotland to roll out ASIST. Implementation of ASIST began in April 2003 – a full year prior to the start of national implementation, and the first two Shetland trainers were trained at a T4T course in Ireland.

ASIST was brought to Shetland initially because of concerns about an increasing rate of suicide and a recognition that, although the actual number of suicides was low, any suicide in a small, island community has a disproportionately large effect on other people. A specific need for training was identified, and one of the original Shetland trainers had been very pro-active at the time in investigating various options for addressing that need.

According to the national ASIST database, between April 2003 and October 2007, there were 18 courses attended by 235 participants (2 of whom did not complete the course). This is an average of 13 participants per course. Just over 1% of the population of Shetland have now been trained in ASIST.

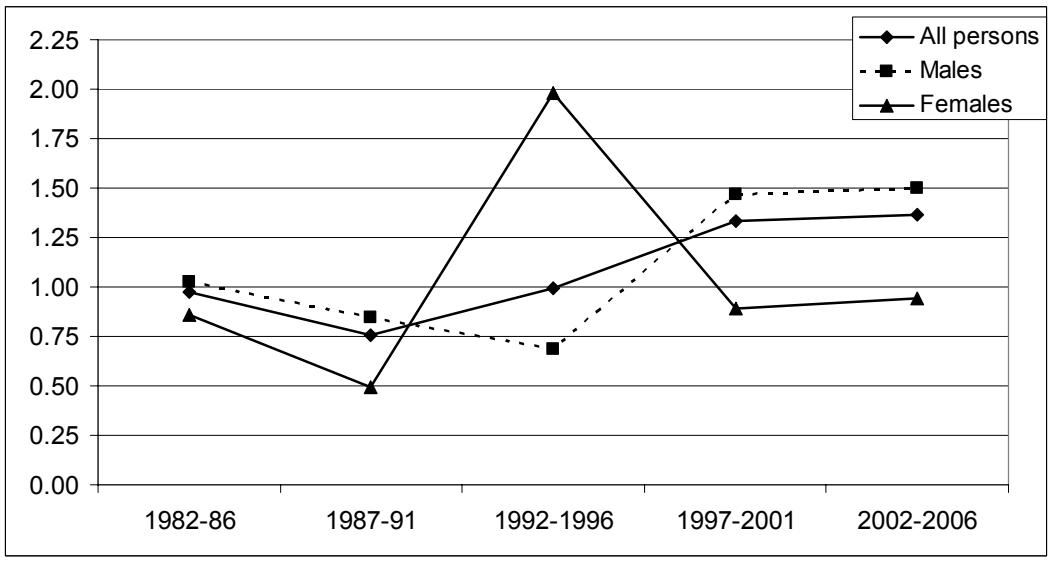
Until now, there has been no specific targeting of ASIST. Courses have been widely attended by professionals working in the NHS, local authority, police and voluntary sectors, as well as the general public. It is particularly notable that nearly all the staff from the Gilbert Bain Hospital A&E department and Ward 3 (the medical ward where patients who have attempted suicide are admitted prior to psychiatric assessment) have been on the course.

Figure 9: Annual deaths from suicide in Shetland, 1996-2006



Source: Scottish Public Health Observatory.

Figure 10: Standardised Mortality Ratio for suicides in Shetland, 1982-86 to 2002-06 (Scotland = 1.00)



Source: Scottish Public Health Observatory.

Factors which have facilitated implementation

There have been several factors that have facilitated implementation of ASIST in Shetland. First, Choose Life funding has allowed the course to be delivered for free. In addition (and perhaps because of this), there has been great demand for the course. The Health Promotion team at NHS Shetland has taken responsibility for co-ordinating the delivery of ASIST (and Mental Health First Aid) throughout Shetland, and there has also been strong support for the course within Shetland's Mental Health Partnership.

In addition, the current Choose Life co-ordinator is a member of all strategic planning groups in Shetland. This individual is also the Alcohol and Drug Development Officer, and this overlap of roles has meant that substance misusers have been identified as a high priority population by the local Choose Life group. Indeed, Choose Life is currently providing partial funding for an outreach service targeted at people who do not access harm minimisation services in Lerwick. All substance misuse workers in Shetland, including the worker who delivers this service, have been trained in ASIST.

It was also suggested by one interviewee that another factor which has facilitated the roll-out of ASIST in Shetland has been a general lack of capacity within specialist mental health services to meet all the needs for support in geographically isolated communities. This had resulted in professionals in other services needing to take more responsibility for supporting people with mental health problems (with advice from the Community Mental Health team), rather than simply referring people on to specialist services all the time. The feeling was that this arrangement worked well.

Barriers to implementation

The main difficulty in implementation has been the turnover / lack of availability of trainers. Shetland initially had two trainers. One of these left the islands. The remaining trainer continued to deliver the training with trainers brought in from the mainland. However, this individual then went on maternity leave and, for a period of about 12 months, no ASIST workshops were offered. However, by autumn 2007, there were two Shetland trainers again (the trainer on maternity leave had returned to work, and a new trainer was trained in May).

Although many of the mental health professionals working in Shetland had attended the course, there was a perception that ASIST was probably less relevant for this group. Feedback from mental health staff suggested that although they found the course interesting, they had not really learned anything new from it. Shetland is currently investigating the possibility of implementing STORM for mental health professionals.

On the other hand, the former consultant psychiatrist for Shetland (who has now left), had attended the course, and reportedly was very impressed with it – but more from the point of view of seeing dozens of other people, with very little mental health training, being trained to intervene with someone who may be suicidal. This individual was reportedly very enthusiastic about trying to find a way for ASIST-trained individuals to provide out-of-hours support on a voluntary basis to people who may be in crisis. The options for this were under discussion as of autumn 2007.

Impact and effectiveness of ASIST

Kirkpatrick Level 1 – Participant reaction

According to trainers and senior managers of staff who had attended ASIST, feedback on the course has been largely very positive. Shetland trainers had the impression that, in general, there were very few things that participants were unhappy with in the course – apart from the role-play.

However, there were some reports of adverse responses to ASIST. Both the trainers and the ASIST participants who were interviewed recounted instances where people attending the course had had strong emotional reactions to the material. Two former participants said that

there were people openly weeping on the courses they had attended. The more experienced of the two current Shetland trainers suggested that this type of response had lessened as the trainers had grown more confident in delivering the material and had learned how to inject some humour into the course. However, one senior manager described a situation where a former mental health service user had attended the course quite recently, and the experience had left him in urgent need of support afterwards. This is despite the fact that the Shetland trainers always give very clear 'health warnings' to prospective participants prior to the course.

The problem of confidentiality was a serious issue among the former ASIST participants who were interviewed in this study. Shetland is a small community where everyone knows everyone else. This has implications for delivering a course which positively encourages the sharing and discussion of very personal matters. Some interviewees who had attended the course reported that they felt extremely uncomfortable about sharing anything personal in the context of the course where there were people they knew. (Partly for this reason, there was a suggestion that separate ASIST courses should be provided in Shetland for people at senior manager level.) At the same time, there was the additional problem that course participants often already knew a great deal about the personal lives of other participants, and this created a dynamic which made it difficult for people to speak openly.

Kirkpatrick Level 2 – Changes in knowledge, confidence, skills and attitudes

The expectation among those in strategic positions in Shetland was that the implementation of ASIST would lead to an improvement in knowledge skills and confidence in the area of suicide prevention. And there was a feeling that it had been largely successful in achieving this. However, as mentioned above, there was a perception that ASIST was less relevant for mental health professionals, as most of those who attended the course had not learned anything new. One senior manager working in the area of substance misuse, also felt there had been nothing new in ASIST for her, but she nevertheless encouraged her staff to attend the course, and they all reported back to her that they had learned a great deal from the course. Another interviewee, who was not a mental health professional, also said that the course hadn't taught her anything new, but it did give her reassurance that she was "doing the right things."

Kirkpatrick Level 3 – Behaviour change

Senior managers had varying reports about the extent to which they had seen their own staff apply their ASIST skills in practice. There was a feeling that, even if ASIST hadn't taught their workers anything new, at least it gave them greater confidence in responding to someone who may be feeling suicidal, as well as a better understanding of how to signpost people to other services.

However, one individual who was responsible for the strategic planning and management of health improvement services in Shetland, reported that she often heard in meetings – which had nothing to do with suicide prevention (the example was given of housing support meetings) – where people were openly discussing how they had used their ASIST skills in particular situations. This individual said: *"I can't think of any other form of training we've been involved in delivering where people have come to me and said, 'I've used **those** skills I learned in **that** course.'"*

One senior manager had a similar experience with her own staff. This individual said that, prior to ASIST, her staff would have *never* asked one of their clients if they were having suicidal feelings. Now, they ask the question all the time – indeed it is now part of their routine assessment of clients – and they also ask other relevant questions about whether the person has a plan, whether they've attempted suicide in the past, etc. This manager strongly believed that if her staff can ask the right questions early enough, they can prevent problems getting worse for their service users.

Interestingly, one former ASIST participant, when asked whether she had ever used her ASIST skills, reported that there was one person in her life whom she simply did not feel comfortable intervening with. This was a close relative who had had suicidal feelings for a long period of time. However, because of the closeness of her relationship with this person, she found she simply could not cope with the knowledge that they wanted to die. However, she had spoken to others (members of the family and friends) about her concerns and knew that others were looking after this person.

Kirkpatrick level 4 – Organisational / societal impact

In terms of the wider organisational or societal impact of ASIST, there was a perception among senior managers that ASIST has had a role in bringing about better integration between services. One example was given of a man who had been arrested and spent a night in police cells. The custody officer (who had been trained in ASIST) had identified that the man might be at risk of suicide, and so phoned the manager of the Drug and Alcohol team the next morning when he was released, to suggest that her team pay him a visit.

The outreach worker in the drugs team has also developed useful working relationships with the ambulance service and staff at the Gilbert Bain Hospital in Lerwick, and she is often the first person contacted (or the second, after the Community Mental Health Team), where a drug user has been identified as having taken an overdose. There have been no completed drug-related suicides since the establishment of this outreach service three years ago – and this was partly attributed to the ASIST training among these professionals.

As mentioned above, questions about suicidal intent and feelings are now included in the routine and on-going assessments of all clients of the drug and alcohol teams.

The future of ASIST in Shetland

It seems likely that ASIST will continue to be delivered in Shetland for some time to come. There was a unanimous view among the participants in this Local Implementation Study that ASIST has been useful, and there was a commitment in place to continue to support delivery of the course at least into the next year. There are not currently concrete plans to support it beyond next year. However, steps are now being taken to increase the pool of trainers and create an infrastructure of people who are able to deliver it. Shetland has attempted to recruit trainers from posts in which the delivery of ASIST will be part of the job. This means that the only real cost associated with the course will be in relation to the cost of materials.

A decision has been taken at this stage *not* to charge participants for attending the course. However, a new policy is being put into place in the new year to start charging people a nominal fee (£50) if they book on the course, and then don't turn up or if they cancel within two weeks of the course. This policy was felt to be fair, since there are often very long waiting lists for courses.

Although ASIST has not been targeted in the past, the intention is to do so in the future. The main target groups will be the fishing, crofting and farming communities, oil workers and people working in small businesses. Drug and alcohol workers in Shetland will also continue to be a priority group for training. In addition, some of the local service delivery groups around Shetland are planning to make more strategic use of ASIST, along with other training programmes such as SuicideTalk, to address the needs for training and awareness-raising in their areas. (For the purposes of service planning, Shetland has been divided into seven localities. Local service delivery groups, comprising representatives from a range of agencies and organisations in the area, are responsible for developing locality plans.) At the same time, the Shetland Training Forum, which consists of representatives from NHS, local authority and voluntary sector agencies, is in the process of developing a training strategy for Shetland's public services workforce. ASIST, Scottish Mental Health First Aid and SuicideTalk are all to be included in this.

SCOTTISH ASSOCIATION FOR MENTAL HEALTH

Overview

The Scottish Association for Mental Health (SAMH) is Scotland's largest mental health charity. It is a major provider of accommodation, support, employability and rehabilitation services to people who experience mental health problems, addictions, homelessness and other forms of social exclusion. Recently, the organisation has begun to work with people with alcohol-related brain damage. The vast majority of SAMH clients fall into groups considered to be at heightened risk of suicide, and a substantial number have a history of self-harm or attempted suicide. Many SAMH projects are based in some of the most economically deprived areas of Scotland.

The organisation employs approximately 900 staff, around 60% of whom are female and 40% male. It is worth noting that a very large proportion of the SAMH staff have experience of losing family or friends to suicide. This has been one of the big drivers for the organisation in rolling out ASIST. The philosophy within SAMH is that, when people are trained in ASIST for their jobs, that training becomes a resource to their community too.

Implementation of ASIST in SAMH

SAMH was among the first organisations in Scotland to implement ASIST, with four members of SAMH staff attending the first two T4T courses in 2004. One of these individuals, who was new in post at the time, now has overall responsibility for SAMH's suicide prevention and intervention strategy, and co-ordination of suicide prevention training across the organisation.

SAMH has made a commitment to deliver ASIST to staff at every level, and their experience can clearly be counted as one of Scotland's success stories. As of July 2007, SAMH had 13 ASIST trainers. These included: two consulting trainers, six master trainers, three registered trainers and two provisional trainers (newly trained but not yet delivered three courses). Within the organisation, prospective trainers have to go through a formal selection process including an interview, and there is an expectation that, once trained, SAMH trainers will deliver six courses in a year (although they may deliver more or less in exceptional circumstances).. The managers of these individuals have agreed to release their staff for 20 days per year for this purpose. In addition, SAMH has two full-time suicide prevention posts. Both post holders are ASIST trainers and both deliver on average one ASIST workshop per month. A formal support network is in place for SAMH trainers, and meetings of this network take place quarterly.

As of July 2007, two-thirds of all staff in the organisation (that is, 600 people) had attended an ASIST workshop. Furthermore, there was a target to train 80% of staff of depute manager grade and above by the end of November 2007. The training of management level staff was felt to be important for three reasons. First, it demonstrated SAMH's commitment to suicide prevention. Second, it provided all staff in the organisation with a common language to talk about suicide and an agreed common approach for intervention. And third, it ensured that managers had the skills and knowledge themselves to be able to encourage and support staff in using the ASIST model and to intervene with staff members who may be at risk of suicide.

ASIST trainers in SAMH are not only responsible for the training of staff internally, but are also actively involved in delivering external training to staff in other agencies and organisations across Scotland. The organisation has entered into partnership agreements with a number of local authorities to provide ASIST training. For example, in North Lanarkshire, SAMH has had full responsibility for the development, co-ordination and management of the area's suicide prevention training programme, which has involved running one ASIST workshop a month over the past three years to a range of multi-participants. Other areas where SAMH has had partnership agreements include South Lanarkshire, Clackmannanshire, Glasgow and more recently Angus and Midlothian.

The nature of each partnership agreement varies, but in general SAMH agrees to deliver a certain number of courses per year, or to deliver training on an *ad hoc* basis (as and when needed). In exchange, the local authority agrees to cover trainers' fees and the cost of all materials. Where partnership agreements have been to deliver 10 or more workshops in a year, the local authority has also covered the full cost of T4T where required. These arrangements have allowed some local authorities to roll out ASIST in their areas where there has been a shortage of local ASIST trainers. SAMH has also delivered ASIST training to other organisations (Glasgow University, for example), in exchange for free places for SAMH staff on the workshop.

SAMH has never received any dedicated Choose Life funding to deliver ASIST internally. However, this has not been a barrier, since the trainers' fees received through external partnership agreements have been used to subsidise any costs associated with internal training. Funding for T4T places for the current 13 SAMH trainers has come from a variety of sources: four places were funded by NIST (in the first year of ASIST), seven by local authorities and two by SAMH.

More recently, SAMH has also begun to deliver SafeTalk, both internally and externally, and one of the SAMH ASIST trainers is qualified to deliver safeTALK training for trainers. As of November 2007, the organisation has also begun to make use of the Tune-up refresher course..

All SAMH staff (including administrative staff) are encouraged to attend ASIST training. In that sense, the organisation has not attempted to target the training in any way. However, the workshop is not mandatory for staff, since it is recognised that it can have an adverse emotional impact on people who may be feeling vulnerable or stressed. The course is deliberately *not* used as induction training for staff who have no background in social care or support work. Rather, all new staff attend the 3.5-hour SafeTalk workshop as part of their induction, and then go on to attend ASIST at a later time.

SAMH has also been actively involved in supporting the implementation of ASIST at a national level. For example, between November 2006 and May 2007, the individual responsible for co-ordinating suicide prevention training in SAMH also held the post of National Training Manager in the NIST team on an interim basis until a new post-holder could be recruited. This individual also chairs the Consulting Trainer Group and is involved in the development of a quality assurance system for ASIST in Scotland, as well as delivering safeTALK T4Ts and providing support to all new Scottish safeTALK trainers to deliver their first three workshops.

Impact and effectiveness of ASIST

Kirkpatrick Level 1 – Participant reaction

In general, SAMH staff who have attended ASIST training reported that they enjoyed the course. Several said it was the best course they had ever attended. Few reported any negative emotional reaction to the course, although several reported that they found it draining and some said that they or others in the course felt upset by the content usually because it reminded them of family or friends who had died by suicide. As in many other areas of Scotland, it was also common for participants in SAMH to say that they had not enjoyed the role-play aspect of the course.

One staff team agreed almost unanimously that they had found the role-play very difficult, and the manager of this team said that for her, the course would have been just as effective without it. In fact, she argued that the role-play had actually detracted from her experience of the course, "*because I spent the whole second day worrying about it, rather than paying attention to what was being said and discussed in the course."* Another staff member agreed with this, saying that he felt *"quite liberated"* when the role-play was over — but this was more a feeling of relief rather than because he found it a useful learning experience. A participant in another SAMH team also said that she did not like the role-play, but that she *did* find it helpful to watch other people doing it. There was a suggestion that the role-play would be just as, if not more, effective if the participants could simply watch the trainers act out one or two scenarios.

SAMH managers reported that they largely received positive feedback, both about the course and the trainers, from their staff who had attended the training. At the same time, some staff fed back to their managers that the workshop had had a big emotional impact on them — as one manager said, *"It struck chords with them."* — but this was not perceived to be negative.

Across all SAMH projects, people who had attended ASIST training said they really had not known what to expect from the course before they attended it and several said they would have liked to have had more information about the course before they went on it.

Kirkpatrick Level 2 – Knowledge, confidence, skills

ASIST participants from across SAMH reported that the workshop had given them knowledge, confidence and skills:

> *It's good to know you don't have to avoid the subject – you can just go straight for it.*
>
> *It made me feel more confident to use the word, suicide, rather than ignoring it.*
>
> *I know what questions to ask, and what's more, I know how to follow on from the answers.*
>
> *I sort of knew that you should explore people's reasons for living, but never knew you should also explore their reasons for dying.*

The course makes you to look at yourself and your own attitudes to suicide.

Senior managers also said that they had observed in their own staff a greater confidence and willingness to talk about suicide. One ASIST participant spoke at length about a client who had made repeated suicide attempts over many years. He discussed his experience of trying to intervene with this client, both before his ASIST training, and then afterwards:

> *ASIST gave me a structure that helped me know how to deal with all these suicide attempts. I had no previous training or experience of dealing with something like this, and before ASIST, I just didn't know what to do… The course helped me to know how to stay focused on what people are really talking about, and what I'm trying to achieve with them.*

Kirkpatrick Level 3 – Behaviour change

Roughly half of ASIST participants from SAMH who took part in this study reported that they had had no opportunity to intervene with someone at risk of suicide since they had attended their ASIST training course. In some cases, participants expressed a need for refresher training as they had attended the course over two years ago. However, one manager expressed concern that members of his staff had appeared not to recognise the obvious signs that a particular client was planning suicide, and suggested that with a client group that is chronically depressed, it can be easy to become complacent.

Other participants, like the one mentioned above, had had multiple opportunities to intervene, sometimes with the same client and sometimes with more than one. Participants also described experiences of intervening with family members or friends.

In a focus group with the management team in one locality area, example after example was given where managers had seen and supported their staff to intervene with clients who were expressing suicidal feelings. These same individuals also described their *own* experiences of intervening with clients – both before their ASIST training and afterwards. In every case, the individuals felt that their interventions after ASIST were more confident, direct and effective.

One former participant said, *"I don't try to divert conversations anymore with one of my clients who is trying to talk about suicide all the time. I'm willing to listen to him now."*

The way in which ASIST taught people to listen was a recurring theme in discussions with SAMH staff. In addition, those who had experience of intervening had valued the clear and simple structure that the ASIST model provided.

Kirkpatrick level 4 – Organisational / societal impact

In interviews and focus groups with ASIST participants and their managers, people repeatedly said that the most significant impact they saw from ASIST training is that it gave people the confidence they needed "to ask the question", to listen to the answer, and thus to successfully intervene to prevent suicide. As one individual said, *"It works."*

In some cases, SAMH staff members reported not only that *they* had found it helpful to work through the ASIST model when intervening with a client, but that they felt the client him / herself had also found it helpful. The individual mentioned above, who had experience of intervening with a client who had made multiple suicide attempts over many years, found

that, over time, as he consistently applied the ASIST model every time the client expressed suicidal feelings, the client began to improve, and in fact, had now not attempted suicide in over a year.

Several individuals also pointed out that they had seen the impact of ASIST on their colleagues' lives outside of work, as they intervened with family members and friends to prevent suicide.

Individuals who had experience of intervening often reported that they had received a great deal of support from their line managers in doing so. This suggests that the SAMH strategy of training all management staff in ASIST is having the benefit intended.

Managers reported that ASIST had also had had other impacts within the organisation:

- It ensured a consistent and effective response to service users who may be feeling suicidal.
- It provided a common language between SAMH staff and other professionals working in the community and in hospitals which could be used when discussing shared clients.
- It provided an excellent opportunity for multi-agency networking during the workshop itself.
- It had raised awareness of suicidal feelings among staff and colleagues and was helpful to managers in supervising and supporting staff who were having personal difficulties.

Senior managers also expressed the view that the number of people trained (both internally and externally) by SAMH trainers was, in itself, quite a significant achievement.

The future of ASIST in SAMH

As SAMH has never received Choose Life funding to deliver ASIST, the prospect of a possible loss of Choose Life funding is less of a concern than it is elsewhere in Scotland. The organisation has already taken steps to ensure the sustainability of ASIST internally, by recruiting a sizeable pool of trainers and giving them the necessary time, support and resources to deliver the training on a regular basis. Throughout the organisation, ASIST training is perceived as a high priority. The successful implementation of ASIST in SAMH can be largely attributed to these factors.

In the past, a number of internal courses have been offered within SAMH where whole teams attended the same course. This was found not to work very well, because participants were sometimes reluctant to fully engage with the course at an emotional level when they were in groups with their co-workers. In the future, the intention is to do less internal training, where the course participants are all SAMH staff, and instead send SAMH staff on ASIST courses that include people from their own local communities. The suggestion was that this would make the course a more valuable experience for staff as it would enable them to meet and engage with others outside their own organisation – and indeed, it would give people in other organisations the opportunity to engage with SAMH staff too.

In the longer term, SAMH would like to have a role in promoting the sustainability of ASIST across Scotland. In particular, they would like to be involved in the mainstreaming of ASIST within professional training for nurses, fire brigade, paramedics, social workers, police, etc.

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