Review and Evaluation of the

Implementation of a Range of Delivery Models of Suicide Prevention Gatekeeper Training

Full Report

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Connecting for Life

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Aim

To undertake a review of the literature (both grey and empirical) on models of gatekeeper training (GKT) for suicide prevention and reported impact/contribution to suicide prevention outcomes commissioned by the National Office of Suicide Prevention (NOSP).

In this study the main research question asked are;

- What are the models of gatekeeper training (GKT) on suicide prevention?
- What has been the impact (contribution) of GKT models to suicide prevention outcomes?
- Which GKT programmes are delivered using a web-based/online platform?

Two types of gatekeepers were explored in the review. Designated gatekeepers are individuals likely to have a professional role that will require them to offer support or assistance. Examples include; teachers, health and social care staff, police, clergy, community or youth workers. Emergent gatekeepers could be members of the public, family members and other individuals, who with the knowledge about signs of emotional distress have the capacity and skills to connect them to someone who could offer the appropriate support.

Methodology

A multi-step process has been undertaken to guide a rigorous review of material (both grey and empirical). This included;

a. identifying a well-defined focused relevant question

b. developing a detailed review protocol with strict inclusion and exclusion criteria

c. systematic literature search of multiple databases and unpublished data (where key sources have been identified in consultation with NOSP)

d. study identification and systematic data abstraction

e. evidence standards framework

Quality of Evidence

Nesta (an innovation organisation in the UK) has produced an evidence toolkit to support evidence informed decision making. It provides detailed description of evidence types, methodologies and sources of evidence that form an evidence hierarchy set against a clear set of defined standards (Puttick & Ludlow, 2012). The Nesta Standards of Evidence Framework is used as a guide to sort and assemble data (including grey material) identified in the literature review.

Findings

A Prisma diagram summarised the studies identified, screened and selected as eligible for inclusion based on the search criteria. This focused on grey and academic material, which referred to GKT programmes, elements or content for adult-to-adult and peer-to-peer (children and young people) populations. A literature review was conducted separately for these cohorts. Where possible systematic reviews examining GKT [Isaac (2009), Yonemoto (2019), Holmes (2019)] were essential sources of reference when examining quality of evidence for studies identified. Through grey material searches, National Registries, Guidelines and rating systems were made known. They offered additional support on quality of evidence based on benchmarks established by these systems (e.g. NICE, UK; National Registry of Evidence-Based Programmes, USA).

Adult GKT Programmes

A total of 11 adult GKT programmes and 24 related studies were included in the final selection and details of GK type (emergent or designated), beneficiary group, programme content, design, quality of evidence and outcomes were summarised. Three programmes currently part of CfL's Education and Training Plan that featured in the review as part of the 11 adult programmes were; safeTALK, ASIST and STORM. The other programmes not listed in the National Plan but identified in the review were;

- MATES/MATES Mobile
- Youth Mental Health First Aid
- ICare
- Kognito Health Simulation
- MHO E Learning
- Three Minutes to Save a Life
- QPR

Distinctions in the approaches of GKT were found in terms of (A) training [dosage/intensity] and (B) response [intervene directly or make a referral]. Furthermore, the context in which GKT takes place and who the target group varied across studies but included educational settings (universities and schools), health and social care, community and workplace settings such as construction sites. Selection of a programme was generally determined by the setting in which GKs were working and likely to have a role to play in supporting individuals displaying mental distress or suicide ideation. Consideration of contextual relevance and cultural sensitivity were rationalised in the selection of programmes and why choices were made for one GKT programme over another.

The review found that GKT programmes included both emergent and designated GKs. Three studies were specific to emergent GKs such as the general community, family members and parents while 20 targeted designated GKs who held professional roles in education, health and social care and community. There was no evidence available that looked at outcomes in terms of GK role.

Peer to Peer GKT Programmes

For peer-to-peer GKT aimed at children and young people, four programmes and eight supporting studies were selected. These included;

- Teen Mental Health First Aid
- Friend2Friend (Kognito health simulation)
- Youth Aware Mental Health (YAM)
- Sources of Strength

Searches for peer led GKT examples narrowed the focus of the search for this cohort. Both emergent and designated gatekeepers were described in the studies with peer leaders or peer educators viewed as having a designated role in a school or youth context. Where a more universal approach was taken, all pupils who took part in the training were considered to have a role in supporting peers that show signs of emotional distress. In this small sample of studies, five are rated at Level 4 of the Nesta Framework with RCT designs and large sample sizes across multiple settings. One study also provided cost benefit information on the economic impact on the use of peer led methodologies in GKT programmes.

The Nesta Framework

The quality of evidence for this and the adult programmes is summarised in the Nesta Framework;

Level	Expectation	How evidence can be generated	Number of GKT studies	
			Adult (n=25)	Peer to Peer (n=8)
1	You can describe what you do and why it matters, logically, coherently and convincingly	You should be able to do this yourself and draw upon existing data and research from other sources	4	1
2	You capture data that shows positive change but you cannot confirm you caused this	Data can begin to show effect but it will not evidence direct causality. You could consider such methods as: pre/post survey evaluation; cohort/panel study; regular interval surveying	11	0
3	You can demonstrate causality using a control or comparison group	We will consider robust methods using a control group that begin to isolate the impact of the product/service. Random selection of participants strengthens evidence at this level and have a sufficiently large sample at hand. Scale is important at this level	2	2
4	You have one+ independent replication evaluations that confirms these conclusions	We are looking for robust independent evaluation that investigates and validates the nature of impact. This might include endorsement via commercial standards or benchmarks. You will need documented standardization of delivery and processes. You will need data on costs of production and acceptable price points for customers	8	5
5	You have manuals, systems and procedures to ensure consistent replication and positive impact	We expect to see use of methods like multiple replication evaluations; future scenario analysis and fidelity evaluation	* Programmes such as ASIST, safeTALK, QPR and Kognito, YAM were manualized with consistent procedures. However, for the purposes of this review, the evidence rating of individual studies is based solely on the methodological design and evidence type	

Conclusion

Findings from studies included in the review suggest gatekeeper training is effective in improving participants' knowledge, skills, self-efficacy and likelihood to intervene when someone is in distress. There is mixed evidence around outcomes that focus on changing participants' attitudes and gatekeeper behaviour. More high-quality studies with longer follow-up periods are required to determine the impact of GK training in improving participants' knowledge, skills, and attitudes towards suicide and gatekeeper behaviour. In addition, studies to explore long-term outcomes such as suicide attempts or behaviour were more infrequent. The multiplicity of response to suicide prevention as outlined in the National Strategy, CfL, reinforces that a singular approach is unlikely to have an attributional effect on its own. As a complex public health issue, it has been argued that suicide prevention interventions are 'rarely delivered in a vacuum' (Dillion et al, 2015).

There is a larger representation of GKT programmes in schools where designated adults are trained to recognise signs and symptoms of distress and have the capacity and confidence to connect the young person to support rather than peer-to-peer examples. Furthermore, there was an overlap in mental health awareness programmes in schools where the objective was to increase knowledge and understanding about recognising signs of mental or emotional distress in oneself and others and raise awareness about how to access help. This was likely to involve offering pathways of support to peers. While not named programmatically as a GKT programme, elements of the objectives speak to the responsibility of peers to support their peers in distress.

The availability of technology based learning and gamification mechanisms used in health simulation approaches was evident in this review with four programmes (three adult and 1 peer to peer) using online learning to deliver training. Evidence supporting these approaches has grown alongside the innovations and applications on social platforms. The use of online training alone was questioned in the literature with arguments made that the most effective use was in behavioural rehearsal for real life interactions.

Application of the Nesta's evidence framework as part of the review methodology provides a recognised framework to rate the quality of evidence, which can be used to inform decisions. In combination with Evidence to Decision Making Frameworks, the selection of a programme is carefully and systematically chosen through a transparent and standardised protocol. This would offer an internationally recognised benchmark for programme selection in future education and training plans.

In addition, having access to a wide range of evidence on outcomes, feasibility, cost effectiveness, context, populations and implementation offers the potential to understand why evidence based or evidence informed programmes are more readily adopted in one context than another (Lewin et al, 2018).

Recommendations

Drawing on the learning from this literature review of GKT programmes and evidence presented across the 24 adult and 9 peer to peer studies, the following recommendations have been put forward for consideration;

- Explore the use of an Evidence to Decision Making Framework such as the WHO-INTEGRATe, GRADE and GRADE-CERQual when selecting a programme in response to the National Suicide Strategy CfL's Education and Training Objectives
- Carry out a worked example of an existing programme using an Evidence to Decision Making Framework
- Pilot the use of a peer-to-peer GKT programme to explore the contextual application of this model of working as a suicide prevention action with young people in school or youth settings.

Part 1: Literature Review

1.1 Aim

To undertake a review of the literature (both grey and empirical) on models of gatekeeper training (GKT) for suicide prevention and reported impact/contribution to suicide prevention outcomes commissioned by the National Office of Suicide Prevention (NOSP).

The subset of deliverables included;

- A desk-based study of literature on models of gatekeeper training for suicide prevention and their contribution to suicide prevention outcomes
- Consideration of training programmes for young people (under 18 years of age) to identify and review gatekeeper training for suicide prevention in this cohort. While this is not under the remit of the NOSP, relevant literature is being explored to provide evidence available that supports or challenges the NOSP's current position
- A clearly articulated literature approach details; sources accessed, depth and breadth of searches, date ranges, source types (grey and empirical, published (academic/non-academic)
- The review will be in a summary format prior to commencing data collection for the remaining objectives.

1.1.1 Context

The purpose of the literature review is to identify, review and curate the current literature on models of GKT for suicide prevention from international and national evidence to inform the National Suicide Prevention Strategy, Connecting for Life (CfL) relating to Goals 2, 3 and 5. In line with Goal 7, Objective 7.1; responsibilities for monitoring and evaluating the effectiveness and cost-effectiveness of suicide prevention education and training, this literature review forms one of three parts of this external evaluation. It is intended to guide NOSP on recommendations of GKT programmes as one part of education and training plan under CfL.

1.1.2 Defining Gatekeeper Training for Suicide Prevention

In the field of suicide prevention, the term gatekeeper refers to "individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine." They may be trained to "identify persons at risk of suicide and refer them to treatment or supporting services as appropriate" (Burnette et al, 2015). As such, GKT has been developed with the recognition that many individuals who have suicidal ideation do not seek help, yet the risk factors for suicide are recognizable and thus identifiable by others (Gould et al, 2003).

GKT programmes can differ in their objectives and learning outcomes. This can vary from general awareness raising with a focus on knowledge and understanding, such as START and SafeTALK, to more skills based training. With programmes such as ASIST and STORM, there is a greater emphasis on participants' capacity to respond and refer when engaging with someone at risk of suicide. These four examples are in the CfL's Training and Education Plan (2019-2020) as part of the suite of standardised and evidence based GKT programmes ranging from an awareness, alertness and intervention level of response to suicide prevention.

Gatekeepers (GKs) are individuals who are likely to have an opportunity to interact with someone vulnerable to suicide. This can be in a designated role such as clinical practitioners or in contact with the general public. As such, role GKs can be either designate or emergent. Examples of the types of GKs who would benefit from GKT in their role are listed below. This is not an exhaustive list. These range across the five tiers of stakeholder type (ranging from general public and concerned communities at Level 1 to HSE Mental Health Services at Level 5.

- General Practitioners
- Clinical Staff
- Counsellors
- Teachers (school)
- College/University staff
- Parents
- First Responders
- Faith Leaders
- Youth Workers
- Social Services Agencies
- Non-Clinical Caregivers
- Community GKs
- Police

While GKT models/programmes were identified through the review process, it is important to highlight the 'dynamic multidimensional environment' these are delivered in (Kelly et al, 2017). It has been argued that understanding the 'interplay between context and an intervention or policy (or more accurately the mechanisms by which the intervention or policy achieves its effect), then they can have only limited confidence in whether they would see the same effect in their own context' (Pawson & Tilly, 1997). As such, decision makers incorporating a complexity perspective into the process, need to know in what circumstances did the programme work, for who, why and how (Booth et al, 2019). In this regard, the evidence included in the literature review, is understood best through a lens adjusted for contextual sensitivity.

1.2 Methodology

The approach followed in this literature review has the key purpose of critically and objectively synthesising available information and evidence regarding models of gatekeepers training for suicide prevention and reported impact (contribution) to suicide prevention. A multi-step process has been undertaken to guide a rigorous review of material (both grey and empirical). This included;

a. identifying a well-defined focused relevant question
b. developing a detailed review protocol with strict inclusion and exclusion criteria
c. systematic literature search of multiple databases and unpublished data (where key sources have been identified in consultation with NOSP)
d. study identification and systematic data abstraction
e. evidence standards framework

1.2.1 Research Questions

In this study the main research question asked are;

- What are the models of gatekeeper training (GKT) on suicide prevention?
- What has been the impact (contribution) of GKT models to suicide prevention outcomes?
- Which GKT programmes are delivered using a web-based/online platform?

Sub-Study Questions

- What are the models of gatekeeper training (GKT) on suicide prevention among young people (under 18 years of age)?
- What has been the impact (contribution) of GKT models to suicide prevention outcomes in young people (under 18 years of age)?

1.2.2 Inclusion and Exclusion Criteria

1.2.2.1 Inclusion Criteria

Based directly on the primary research question the studies had to contain the following in the title and/or abstract;

- Suicide (suicid*)
- Suicide Prevention (suicid* prevent*)
- Gatekeeper
- GKT
- Web-based (online, e-programmes)
- Children/young people GKT programmes
- Peer to peer
- Peer educators

- Peer mentors
- Peer leaders

1.2.2.2 Boolean operators

These use the relationship between different search words to help with the search strategy. Examples are (AND, OR, WITH) which help generate more focused or general results depending on how they are used. For the purpose of this study the Boolean operators are; 'AND', 'OR', 'ON', 'WITH'.

1.2.2.3 Truncation

Truncation has been applied in the searches with use of '*' in the word suicide (suicid*). Each of the key words in the research questions were considered for truncation to determine whether this would be required in the search engines. It was necessary to also apply truncation to contribution (contrib*) to explore contribution of possible impact on suicide prevention outcomes.

1.2.3 Search Databases and Grey Literature

1.2.3.1 Search Databases

Peer reviewed articles were sought through key databases such as; Cochrane Library, PubMed, PsycNet, PsychInfo and Campbell Collaboration.

1.2.3.2 Grey Literature Access

A grey literature search can access unpublished papers, reports, and conference reports, and incorporates studies that are published in a more informal way which are not in an indexed system (Henderson et al, 2010). Grey literature sources purposefully searched in this review included; New York Academy of Medicine Grey Literature Collection (medicine), Bielefeld Academic Search Engine (BASE), CORE, National Institute for Health and Care Excellence (NICE) and The British Library.

Initially, Web of Science, Research Gate, Semantic Scholar and Google Scholar were accessed but due to the 'platform sharing' nature of the sites there was a high level of duplication generated in initial searches. For this reason, grey sources focused primarily on BASE, CORE, NICE and The British Library.

NOSP also played an active role in identifying access routes to grey literature including through networks of contacts in Government and Non-Governmental Organisations (NGOs), partners and other stakeholders with interest or influence in suicide prevention.

1.2.4 Study Identification and Systematic Data Abstraction

The framework set out created a clear pathway for the identification of studies that fitted the inclusion criteria using search databases and grey literature access. The data abstracted was then filtered and ordered into a literature matrix style shown in Table format later.

1.3 GKT Identification

1.3.1 Evidence Based Hierarchies

These hierarchies rank studies (research/evaluation) types based on the rigour (strength and precision) of research methods used (Hoffman et al, 2013). One example from the National Health and Research Council uses a pyramid model to represent how methodologies and study designs are ranked. Well-designed systematic reviews and meta-analyses are at the top of the pyramid while expert opinion and anecdotal experience are at the bottom (National Health and Research Council, 2009). In this respect, the higher up the hierarchy the study design is located, the more rigorous the methodology and with that, the decreased likelihood of bias or the design minimises the effect of bias. Two additional layers are attached to the pyramid;

Filtered information appraises the quality of a study and recommend its application in practice. The critical appraisal of the individual articles has already been carried out. Filtered literature will often provide a more definitive answer than individual research reports. Examples of filtered resources include, Cochrane Database of Systematic Reviews, BMJ Clinical Evidence, and ACP Journal Club.

Unfiltered information are original research studies that have not yet been synthesized or aggregated. As such, they are the more difficult to read, interpret, and apply to practice. Examples of unfiltered resources include, CINAHL and EMBASE.

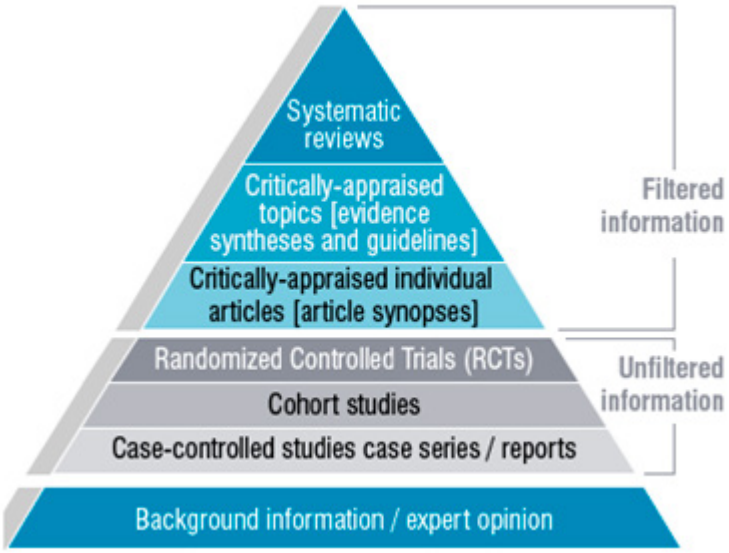


Figure 1: Evidence Hierarchy

Additionally, Nesta (an innovation organisation in the UK) has produced an evidence toolkit to support evidence informed decision making. It provides detailed description of evidence types, methodologies and sources of evidence that form an evidence hierarchy set against a clear set of defined standards (Puttick & Ludlow, 2012).

The Nesta Standards of Evidence Framework is used as a guide to sort and assemble data (including grey material) identified in the literature review (Figure 2).

Figure 2: Standards of Evidence for Impact Investing

1.3.2 Overview of Adult GKT Studies

A two-level data search was conducted using databases containing peer-reviewed papers and grey material searches which includes non-peer reviewed material that contributes to practice and learning. In this specific piece of work, 21 were deemed included in the review process from academic databases and three emerged from grey material searches.

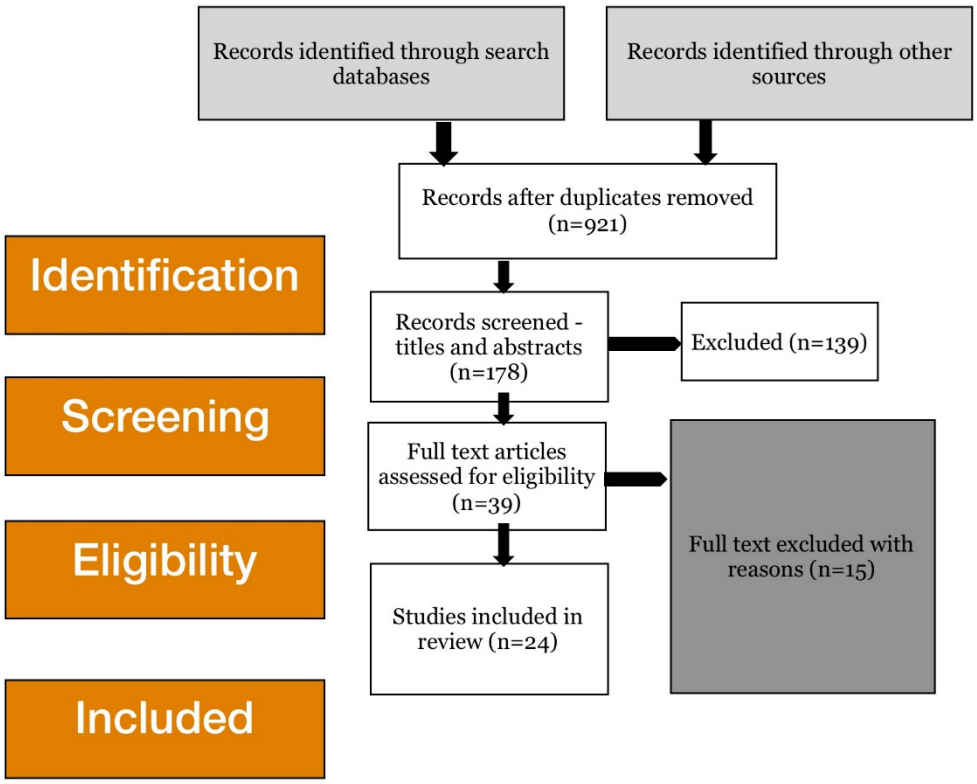
All records were loaded into Mandeley, (a reference management tool) and duplicates removed. Titles and abstracts remaining after the identification process were reviewed. Suitability for inclusion in the literature review was based on the agreed search terms and parameters described in 2.2.

Following comprehensive screening 139 records were excluded. Full texts were then retrieved of records deemed eligible for inclusion (n=39). A further smaller number of records were additionally excluded based on review of full text content (n=15). Figure 3 is a flow chart of all steps in the process with 24 remaining papers included as core papers consulted in exploring GKT models and contribution to outcomes of suicide prevention.

For clarity and ease of presentation, studies identified that refer to GKT for children and young people have been summarised separately (Section 1.3.5).

Figure 3:

PRISMA (Preferred Reporting for Items for Systematic Review and Meta Analyses) Flow Diagram of Review



1.3.3 Literature Matrix of Adult GKT

While the current literature review seeks to explore the implementation of the range of gatekeeper delivery models, there is a deliberate effort to review the standardised programmes outlined in the Education and Training Plan (2019-2020). The Plan sets out a string of programmes and training options across a spectrum of support levels although the focus of this review is at levels one, 2 and 3;

1. Awareness raising
2. Alertness raising
3. Intervention
4. Postvention

A two-stage process of identification followed by quality of evidence filtering resulted in programme ranking to support decision making on selection of GKT choice from a suite of options. Table 1 first gives an overview of the 11 training programmes, which summarises their core tenets in terms of; learning outcomes, objectives, content and structure and GK type. Table 2 provides details of the research studies selected after completion of the review process.

Records accepted for inclusion in the review contained standardised and replicated programmes such as ASIST, STORM and SafeTALK. These featured in CfL's National Education and Training Plan (2019-2020). Additional programmes identified but not listed on the National Plan met the criteria of the review and represented standardised and non-manualised programmes. These were QPR, MATES, ICare, Youth Mental Health First Aid and the Kognito health simulation approach (Appendix 1). A more detailed example of one study for ASIST and QPR GKT programme is provided below:

Gould, et al (2013) explored the impact of ASIST training on individuals who worked as counsellors for the USA National Suicide Prevention Lifeline (n=1507). ASIST is a 2-day face-to-face training, which provides skills to enable the GK to assess risk and develop a plan to increase the safety of the person vulnerable to suicide and make an appropriate referral.

A wait-list control design was used to establish if there was any difference between clients speaking to an ASIST trained counsellor and one without ASIST training. It emerged that the odds that callers would be less suicidal after speaking to an ASIST trained counsellor had increased by 74%.

For this review, there is intentional searching for evidence of outcomes relating to ASIST, SafeTALK and STORM. Additionally, GKT programmes with a delivery mode of online engagement and a web-based platform for delivery were sought out for identification. The review considered programmes first for adults and then for children and young people.

While not currently within the remit of deliverables for CfL's Education and Training Plan (under 18 years of age), NOSP commissioned a scoping of the potential of GKT for this cohort specifically on peer-to-peer delivery. The same process of identification, screening, eligibility and inclusion was applied. A summary discussion of programmes identified and included are set out separately in Section 1.3.5.

Table 1: GKT Programme Overview

Programme type	Training Outcomes for Learner	Programme Objectives	Delivery Details	Type of Gatekeeper
LivingWorks START	Provides knowledge on signs of distress to recognise when someone is thinking about suicide Skill to know when and who to link someone to who appears to be thinking about suicide	Learning the four step model of LivingWorks START to be able to recognise signs and offer pathways to support	One hour online Includes online simulations for learning and skill practice	Emergent GK (13 years plus)
SafeTALK	Improves skills and readiness; Improves skill retention; Learn to recognise when someone is thinking about suicide and connect them to a pathway where support is available; No iatrogenic effects	Reduces suicide stigma in the community Offers a safety network to individuals who need support beyond the safeTALK trainee	Four hour face to face workshop Presentations, skill based rehearsal and audio-visual aids	Emergent GK (15 years plus)
ASIST	Increase general counselling and listening skills Prevent suicide by recognising signs of distress (being suicide alert) Understand the reasons behind thoughts of suicide and reasons for living Assess risk and safety and develop a plan to increase the safety of the person at risk Recognise invitations to help Recognise potential barriers of seeking help Offer support Recognise important aspects of suicide prevention such as self-care and life promotion Apply a suicide intervention model Link with community resources No iatrogenic effects	Increase hope and reduces suicidality	Two day face to face training with two trainers Presentations, skill based rehearsal, discussions and audio-visual aids	Designated GK (18 years plus) where other connectors such as trainees from safeTALK and LivingWorks START can link with

Programme type	Training Outcomes for Learner	Programme Objectives	Delivery Details	Type of Gatekeeper
QPR and Web Based QPR	Increased declarative knowledge Increased perceived knowledge Increased self-efficacy Increased diffusion of gatekeeper training information Increased gatekeeper skills (ability to engage in active listening, ask clarifying questions, make an appropriate referral)	Raise public awareness about suicide and its prevention Provide low-cost, high-tech, effective, basic gatekeeper and intervention skills training to lay persons who may be able to prevent a suicide Provide suicide prevention and intervention training programs for a variety of professionals and for undergraduate, graduate and post-graduate students preparing for careers in the helping professions Reduce morbidity and mortality of suicidal persons served by health care, correctional, workplace, hospital and other institutions and settings through a systems approach to suicide risk reduction that enhances first responder and clinical competencies to detect, assess, monitor, manage and treat persons known to be at elevated risk for suicidal behaviours	Offered both online and in person across Both general QPR and QPR for specialised areas of work is available Content includes; – Videos – Audio – Interactive Practice Challenges – Thought challenges – Interactive Quizzes – Surveys	Designated GKT; Clergy Prison staff Eldercare workers Firefighters and ambulance staff Police Doctors Nurses OT/PT Sports coaches Pharmacists School professionals Targeting alcohol, drugs and suicide Emergent GKs

Programme type	Training Outcomes for Learner	Programme Objectives	Delivery Details	Type of Gatekeeper
Youth MHFA	Recognise warning signs of distress and mental ill-health in pupils Improve mental health literacy Skills and confidence to approach and support young people safely Encourage young person to access support they need Understanding of how to support positive wellbeing and address stigma in society generally	Provide help on a first aid basis to someone in crisis	Two day course face to face MHFA manual provided	Designated (teachers, school personnel)
STORM	Developing & enhancing skills Improving attitudes Increasing confidence in helping someone in distress	To build skills and confidence in talking about suicide and self-harm and challenge the fear of asking people about this	The programmes are based on academic research and best practice with a focus on 'real life' experiences for; – Skills Training in Suicide Prevention (Adults) – Skills Training in Suicide Prevention and Self-Harm Mitigation (Adults) – STORM open courses	Designated Emergent (open courses)

Programme type	Training Outcomes for Learner	Programme Objectives	Delivery Details	Type of Gatekeeper
ICare	College campus interactive GKT programme that aims to increase the knowledge of intervention skills and readiness to detect and respond appropriately to someone showing signs of emotional stress, distress and crisis	Knowledge of support/crisis intervention skills Readiness to use and apply skills Gatekeeper Behaviour Scale (a validated measure of preparedness, likelihood to intervene, and self-efficacy) Valuing care for self and others Feeling connected with the college community Reduction in perceived stigma	3 hour training with an additional online module that use; Experiential activities Learning about emotional processing in increasing participants' comfort and preparedness to intervene in challenging situations and learn about; – College mental health trends – Campus resources – Distinguishing between stress, distress, and crisis – Listening techniques – Crisis intervention skills	Emergent (students) Designated (college staff, counsellors and college paraprofessionals)

Programme type	Training Outcomes for Learner	Programme Objectives	Delivery Details	Type of Gatekeeper
4 Mental Health's Connecting with People (CwP) mental health training programmes	A whole organisational approach to improve the response to people in distress with different a selection of courses available; – Community suicide awareness module – Suicide awareness module for healthcare professionals – Suicide awareness and response for primary care	By completing the module(s) the learner; Develops understanding and compassion Tackles myths, stigma and barriers Introduces concept that suicide is not inevitable – people can be helped, and module includes the latest research and evidence Suitable for everyone, i.e. community members with no previous training Helps trainee understand how distress develops and how people can be best supported Develops common language between community, services and those in distress Gives trainees the confidence and the skills practice of talking to someone in distress Develops a compassionate approach for demanding and time-pressured environments Equips the trainee with the knowledge of how to use www.StayingSafe.net to make their own Safety Plan	The courses use facilitation, lecture style presentation, open discussion and group work The training can be direct to participant or through a train the trainer model for organisations	Emergent (community) Designated (healthcare professionals and primary care professionals)

Programme type	Training Outcomes for Learner	Programme Objectives	Delivery Details	Type of Gatekeeper
CwP Three Minutes to Save a Life	The programme is focused on increasing participant awareness and compassion, eradicating stigma around students experiencing emotional distress and promoting student resilience in developing active strategies to seek help	The programme is aimed at creating a safer and more responsive community, and one that is confident and compassionate towards those who experience mental health difficulties	Face to face programme	Designated (University staff)
MATES and MATES-mobile	Industry based multi-component prevention and early intervention programme General awareness training (GAT) to construction workers on sites Workers completing GAT are provided with a white sticker to wear on their hard hat identifying them as 'GAT-trained'. MATESmobile focuses on two main elements: 1) reinforcing face-to-face training messages over time, and; 2) enabling links to mental health support should people need it Components include; – Connector training for volunteer GKs – ASIST training – MATES field officer who visits sites fortnightly – Case manager to assist workers with a plan to reduce stress and distress	It aims to reduce stigma and encourage help-seeking and help-offering behaviour, and presents suicide as preventable	MATES is a face to face 45 minute suicide awareness session to provide workers with information on signs of distress and increase alertness to suicide risk factors of colleagues	Emergent within the site Designate workers after training, field officers and case managers

Programme type	Training Outcomes for Learner	Programme Objectives	Delivery Details	Type of Gatekeeper
Online Kognito	Participants from the programme are likely to demonstrate significant and sustained increases in attitudinal variables that predict behaviour change including preparedness, likelihood, and self-efficacy to better manage conversations.	Health education evidence based simulation approach incorporates a behavioural change model with game mechanics and learning principles. Virtual rehearsal Contextualised learning Personalised feedback Storytelling Case-based approach	Online virtual environments with virtual humans who act as coaches to support the active construction of knowledge around mental health and suicide prevention for the learner	Designated GK (teachers, school personnel)

1.3.4 Review Findings

A total of 24 were included in the review of GKT programmes are described in this section with additional information provided in Appendix 1.

1.3.4.1 Gatekeeper Types

A distinction between types of gatekeepers are known in the literature as 'Emergent' or 'Designated'. Suicide alert helpers are considered to be members of the community who are trained to recognize signs of stress, distress and crisis (Osteen, 2014). Designated gatekeepers were those in professional roles who are more likely to encounter individuals needing support with mental and emotional ill health (Tsai et al, 2011).

The suite of programmes offered by LivingWorks (safeTALK and ASIST) refer to these roles as 'safety Starters' and 'Safety Connectors' on a continuum of safety skills (LivingWorks.net). Safety Starters have the awareness and identification skills to recognise someone in stress, distress or crisis and refer them to the someone who could connect them to the appropriate support. The Safety Connector then links this person to a Safety Provider who can engage with the individual to create a safety plan. The continuum axis is mapped against an axis called 'depth of skill developed' by taking the training at each stage of the model.

The studies are described in terms of the role of GK (designated or emergent) and the beneficiary group (adults, individuals at risk, students, community members, school pupils).

1.3.4.2 Country of Study

There was an international distribution of countries represented in GKT research and evidence literature. Countries listed in the search include;

- Canada
- UK
- USA
- Netherlands
- Australia

1.3.4.3 Programme Type

A summary table has been populated which provides an overview of studies/records included in the literature review after the identification, screening and eligibility process. These have been set out by;

- Author/Year/Country
- Training programme
- Gatekeeper (role and type [designated or emergent]
- Sample
- Beneficiary
- Design
- Evidence Level*

*The studies are filtered through Nesta's Standard of Evidence, which is intended to gauge the level of confidence attached to findings that indicate the impact of an intervention.

The review found 11 types of GKT programmes for suicide prevention available for selection. These were;

- ASIST (Applied Suicide Intervention Skills)
- QPR/QPR Web based (Question, Persuade, Refer)
- safeTALK
- STORM
- YMHFA (Youth Mental Health First Aid)
- ICare
- Three Minutes to Save a Life
- MATES/MATES Mobile
- MHO (Mental Health Organisation E Learning)
- Kognito Health Simulations

Within this selection, QPR Web based, ICare, Mates Mobile, MHO and Kognito offer use online platforms to deliver training. Kognito has developed a health simulation approach that utilises avatars and virtual reality behaviour rehearsal. They offer multiple options for different contexts and types of GKs.

Some programmes developed extensions for the core programme with tailored content for specific GKs and beneficiaries. These were amended with the target audience in mind to increase the alignment between information and support. In this case the following had GK or beneficiary specific options for the trainee;

- STORM
- Kognito
- QPR

Table 2: GKT Programmes Adult Trainees

Study [country]	Programme	Gatekeeper sample	Gatekeeper (Emergent/ Designated)	Beneficiary	Design	Nesta Quality of Evidence Standard	Outcomes
Sareen et al (2103) Canada	ASIST	First Nations Community (n=31)	Emergent	General population of First Nations Community	RCT	4	Increased skills Reported preparedness to intervene with suicidal behaviour Suicidal ideation Suicide attempt
Shannonhouse et al (2019) USA	ASIST	College staff & counsellors in training (n=54)	Designated	College students	Qualitative analysis	1	ASIST improved the self-perception of college staff at working with students-at-risk of suicide and their skills at performing an intervention.
Gould et al (2013) USA	ASIST	National Suicide Prevention Lifeline Counsellors (n=1507)	Designated	Callers to Lifeline	Wait-list Control	3	If suicidal callers spoke with ASIST-trained counsellors rather than non-ASIST-trained counsellors, the odds that callers would be less suicidal was increased by 74%.
Osteen et al (2015) USA	QPR	Social workers and social work trainees (n=73)	Designated	Families they work with	RCT	4	Results suggest improvements in post-training measures for knowledge, attitudes, self-efficacy, reluctance, and the use of gatekeeper behaviours, but there was no supporting evidence for the presence of mediated effects on behaviour. Only self-efficacy demonstrated a strong direct relationship with gatekeeper behaviours.

Study [country]	Programme	Gatekeeper sample	Gatekeeper (Emergent/ Designated)	Beneficiary	Design	Nesta Quality of Evidence Standard	Outcomes
Cross et al (2011) USA	QPR	School personnel including mental health professionals, teachers and bus drivers Parents (n=147)	Designated	Secondary school pupils	RCT	4	At 3-months following, participants in intervention groups had 77.52% correct response about suicide- related facts compared with 75.79% by participants in control group.
McLean et al (2017) Australia	QPR	University resident assistants (peer leaders)	Designated	College students	RCT	4	The training did not significantly impact RA intervention behaviour
Lancaster et al (2014) USA/Australia	Web-based QPR	Salvation Army volunteers Social workers, probation officers and teachers (n=162)	Designated	Members of the public and youth communities	RCT	4	Participants in the web-based QPR training group showed improvements on knowledge, self-efficacy, and behavioural intentions from T1 to T2, which were similar to the face-to-face QPR training group. However, knowledge, self-efficacy, and behavioural intentions in both groups declined 6 months after the training. Furthermore, a significant increase in gate-keeper referring behaviour from 6 months before to 6 months following the training was observed for both groups.

Study [country]	Programme	Gatekeeper sample	Gatekeeper (Emergent/ Designated)	Beneficiary	Design	Nesta Quality of Evidence Standard	Outcomes
Loftsgaarde et al (2017) USA	QPR	Members of a rural community (n=894)	Emergent	General community	Pre/post response	2	Quantitative outcomes showed statistically significant gains from pre-post training among all cohorts regarding perceived knowledge, attitudes and skill with little between-group variance. Qualitative outcomes further supported and enhanced quantitative results revealing an overarching theme of 'appreciation' (for learning about suicide prevention). Further
Ledvora et al (2017) USA	QPR modified for young people	School teachers	Designated	Pupils aged 13-18 years	RCT	4	Post-test scores were significantly higher compared with pre-test scores in the categories of declarative knowledge about suicide and suicide prevention behaviours, self-perceived confidence in enacting suicide prevention behaviours and self-perceived comfort in enacting suicide prevention behaviours
Kaplan (2018)	SafeTALK	College community (n=693)	Emergent	College students	Pre/post surveys	2	Was associated with increases in suicide prevention knowledge. It was also associated with an increase in the number of students who identified suicidal youth and made mental health referrals, as well as total number of referrals made, over the course of three months. Females reported greater improvement in suicide prevention skills and knowledge post-training than males

Study [country]	Programme	Gatekeeper sample	Gatekeeper (Emergent/ Designated)	Beneficiary	Design	Nesta Quality of Evidence Standard	Outcomes
Eynan (2011) Canada	SafeTALK	Toronto subway staff (n=176)	Designated	General public	Pre/post surveys	2	SafeTALK had positive immediate and long-term effects on participants' knowledge of suicide and suicide prevention, attitudes, and intervention skills. Sustainability is unknown
Gask et al (2017) UK	STORM	University staff	Designated	University students	Pre/post surveys	2	There was evidence of acquisition of skills, improved attitudes and increased confidence
Gask et al (2019) UK-Scotland	STORM	Health and social care staff (n=568)	Designated	Community members	Post training Interviews	1	Confidence in applying a train-the-trainer model and actively engaged in delivering training where needed within Scotland's National Suicide Prevention Strategy
Farmer et al (2014) UK-England	STORM	Clinical staff	Designated	Patients with a first psychosis episode	Qualitative feedback	1	Participants demonstrated increased knowledge, confidence, and skills following the training
Grylewicz et al (2018) USA	YMHFA	School personnel (N=365)	Designated	School pupils	Pre/post surveys	2	Improvements in knowledge, skills and confidence to speak to a pupil and refer to appropriate of support
Jorm et al (2010) Australia	YMHFA	Secondary school teachers (n=16 schools)	Designated	Secondary school pupils	Cluster RCT	4	The training increased teachers' knowledge, changed beliefs about treatment to be more like those of mental health professionals, reduced some aspects of stigma, and increased confidence in providing help to students and colleagues. There was an indirect effect on students, who reported receiving more mental health information from school staff.

Study [country]	Programme	Gatekeeper sample	Gatekeeper (Emergent/ Designated)	Beneficiary	Design	Nesta Quality of Evidence Standard	Outcomes
Borrill & Kuczynska (2013) UK-England	YMHFA	School professionals (n=224)	Designated	Young people	Pre/post-test design	2	Increased confidence in, likelihood of, and comfort with helping a young person in emotional distress or crisis were also reported post-training compared to pretraining
Reiff (2019) USA	ICare	University community including students (n=1800)	Designated and Emergent	University students	Pre/post-test design	2	Demonstrated significant increases in knowledge of intervention skills and readiness to intervene from pretraining to post-training. Knowledge and readiness remained significantly higher than preworkshop for the entire follow-up evaluation period, extending 15 months post-training
Dickens & Guy (2019) UK	'Three minutes to save a life' CwP	Mental health wellbeing coordinators	Designated	University students	Theoretical	1	Suggest the programme is focused on increasing participant awareness and compassion, eradicating stigma around students experiencing emotional distress and promoting student resilience in developing active strategies to seek help
Ross et al (2020) Australia	MATES	Construction workers (n=2260)	Emergent	Construction workers	RCT	4	Findings indicated that MATES reviewed using a longitudinal design found sustained learning and behaviour in terms of suicide awareness and help-seeking intentions
Ghoncheh et al (2016) Netherlands	Mental health organisation programme MHO (E-Learning)	Professionals working with adolescents (n=190)	Designated	Adolescents	RCT	4	The programme had a positive effect on knowledge and perceived confidence in skills dealing with suicide prevention amongst participants attended the training compared to those in the control group

Study [country]	Programme	Gatekeeper sample	Gatekeeper (Emergent/ Designated)	Beneficiary	Design	Nesta Quality of Evidence Standard	Outcomes
Robinson-Link et al (2019) USA	Online Kognito programme	School teachers (n=5019)	Designated	Adolescents	Pre/post-test design	2	Teachers significantly increased their beliefs (i.e., preparedness and self-efficacy) and behavioural intention (i.e., likelihood) to intervene with at-risk students. However, teachers did not change suicide intervention behaviours. Natural gatekeeper status (i.e., teachers approaching students at baseline) impacted number of referrals over time (in the opposite direction we predicted); however, natural gatekeeper status did not have an impact on proportion of students approached. Self-efficacy change, however, preceded change in proportion of students approached, but not referred

Study [country]	Programme	Gatekeeper sample	Gatekeeper (Emergent/ Designated)	Beneficiary	Design	Nesta Quality of Evidence Standard	Outcomes
Albright et al (2018)	Kognito's 'At Risk' for High School Educators'	Secondary school teachers (n=22,132 secondary school teachers across 43 States)	Designated	Secondary school pupils	Pre/post design	2	Three months after training it emerged that; A statistically significant increase ($p<0.01$) in Total Mental Health Skills; (1) identify when a student's behaviour or appearance is a sign of psychological distress, (2) discuss concern with a student, (3) motivate a student to seek help, and (4) discuss a referral to mental health support services Participants reported an increase of 27% in the number of students they approached to discuss concerns with and 16% in the number of students they referred to support services 56% of participants reported an increase in the number of conversations they had with other adults in their school about students they were concerned about

Study [country]	Programme	Gatekeeper sample	Gatekeeper (Emergent/ Designated)	Beneficiary	Design	Nesta Quality of Evidence Standard	Outcomes
Albright & Shockley (2018) USA	Kognito's 'At Risk' for Faculty and Staff	University personnel (n=163 Universities across 33 States)	Designated	University students	Pre/post design	2	Three months after training it emerged that; A statistically significant increase ($p<0.05$) in Total Mental Health Skills (as described above) Behaviour Change Participants reported an increase of 47% in the number of students they approached to discuss concerns with and 42% in the number of students they discussed a referral to support services with Speaking with Colleagues about At-Risk Students 60% of participants in the study reported an increase in the number of conversations they had with other faculty, staff, and administrators about students they were concerned about.

1.3.4.4 Delivery Details

A multi-modal training structure was a recurrent feature of programmes. Knowledge transfer and capacity building were promoted through individual and group active learning techniques, case study examples, role-play and behavioural rehearsal. Training tools such as presentations, booklets, worked examples and experiential techniques were described as key facets of the programmes structure and delivery mechanisms.

Where online learning was used as a platform for dissemination and learning, training was always an individual endeavour. This meant training was self-paced but defined by a set of actions required for completion.

The Kognito suite of programmes represented the only example where health simulation technology was employed. Game mechanics and learning principles form the basis from which trainees engage in role-play conversations in a virtual learning environment with emotionally responsive virtual humans.

1.3.4.5 Type of GK

Studies included in the review have both types of GKs represented. There are examples where the training programme had different modalities to allow trainees to be from either emergent or designated categories. These programmes had a multi-modal structure that either offered targeted training dependent on the role of the trainee or was more universal in nature and could accommodate a variety of potential GKs. Of the studies included 20 were aimed at designated GK, three were emergent GKs and one study had both types. It should be noted that these were study specific as some approaches have designed training options for emergent or designated or both.

1.3.4.6 Outcomes and Quality of Evidence

Evidence gathered during the review has been furthered sorted according to the Nesta framework to provide the NOSP with information on what is known about GKT and where this research sits on an evidence hierarchy. Systematic reviews carried out to date on GKT have formed a central part of this review in line with good practice.

Both quantitative and qualitative research designs were used to explore outcomes of GKT programmes. This ranged from; case studies, reflective feedback, pre/post surveys and feedback forms, standardised tests, repeated measures follow up, quasi-experiential design and randomised control trials. Indicators of change were measured in terms of GK behaviour, attitude, confidence, skill, self-efficacy and helping behaviour. Studies were more likely to have designs that explored changes in GKs rather than at the target group receiving support. However, the methodological challenge of examining the possible contribution of GKT to suicide prevention outcomes has been acknowledged (Holmes et al, 2019).

Findings across the 24 studies predominantly recorded improvements in trainee knowledge and understanding of identifying signs of emotional distress, confidence to speak to someone in need of support, attitude towards suicide and self-harm, behavioural intentions to support and refer to appropriate services and support pathways. Collectively the studies suggested an increase in preparedness and readiness to support a person in distress. Almost all designs included a follow up period after training ranging from 6 weeks to 15 months. Retention of outcomes at follow up periods suggested mixed results, which would require further research to address sustainability of the training objectives.

Outcomes of GKT programmes were measured at an individual (GK and person likely to be helped) and system level changes following this type of suicide prevention. As stated earlier, there was a greater emphasis in researching programme outcomes in terms individual characteristics such as GK knowledge, benefits and attitudes about prevention, reluctance and stigma and the level of self-efficacy to intervene. Contribution to suicide rates by examining connections between GKT and suicides were much less likely to be featured. Systematic reviews of GKT indicated this area of research was absent in the literature but the complexity of suicide makes it difficult to explore a causal link to GKT programmes and reduction in rates (Holmes et al, 2019). The Nesta framework has linked assumptions (how the evidence was generated) against each expectations (requirements) (Table 1). This was central to organising GKT programmes listed in the review.

A key document identified in this review was the NICE guideline document (2018): 'Preventing suicide in community and custodial settings: Information, advice, education and training' (www.nice.org.uk). The aim of this review is to determine the effectiveness and cost-effectiveness of non-clinical interventions to help staff and members of the public recognise and respond to signs of distress or crisis that may indicate someone is contemplating suicide, and to determine the effectiveness of non-clinical interventions to support people who are at risk of suicidal acts (NICE, 2018).

There was a predominance of Level 2 and 4 evidence in studies included in the review. Research on GKT that incorporated RCT designs accounted for eight records included in the review. Outcomes were primarily measured in terms of knowledge change, self-efficacy, help-giving behaviour and attitudes of GKs to supporting individuals in distress. The remainder of studies were non-RCT in design and met expectations on the Nesta framework at Level one or three (Table 3).

Table 3: Nesta Standards of Evidence (n=24)

Level	Expectation	How evidence can be generated	Number of GKT studies
1	You can describe what you do and why it matters, logically, coherently and convincingly	You should be able to do this yourself and draw upon existing data and research from other sources	4
2	You capture data that shows positive change, but you cannot confirm you caused this	Data can begin to show effect, but it will not evidence direct causality. You could consider such methods as: pre/post survey evaluation; cohort/panel study; regular interval surveying	10
3	You can demonstrate causality using a control or comparison group	We will consider robust methods using a control group that begin to isolate the impact of the product/service. Random selection of participants strengthens evidence at this level and have a sufficiently large sample at hand. Scale is important at this level	1
4	You have one+ independent replication evaluations that confirms these conclusions	We are looking for robust independent evaluation that investigates and validates the nature of impact. This might include endorsement via commercial standards or benchmarks. You will need documented standardization of delivery and processes. You will need data on costs of production and acceptable price points for customers	9
5	You have manuals, systems and procedures to ensure consistent replication and positive impact	We expect to see use of methods like multiple replication evaluations; future scenario analysis and fidelity evaluation	* Programmes such as ASIST, safeTALK, QPR Kognito were manualized with consistent procedures. However, for the purposes of this review, the evidence rating of individual studies is based solely on the methodological design and evidence type

1.3.4.7 Return on Investment Evidence

A smaller number of studies that reported associated economic benefits from a GKT programme were identified and included in the review. Programmes aimed at preventing suicide in the construction industry in Australia calculated the potential impact of the programmes MATES in Construction (MIC or MATES) (Ross et al, 2016). It has a multifaceted structure made up of general awareness training, connector training and ASIST. The analysis suggests that MIC could potentially avert 0.4 suicides, 1.01 suicide attempts resulting in full incapacity and 4.92 suicide attempts resulting in a short absence from work. A subsequent study calculated that cost from suicide and non-fatal suicide in this industry to the Government was AU $6.73 billion in New South Wales. The implementation of MIC identified a cost ratio of 1.5:1 resulting in a saving estimate of AU $61.26 million across Australia (Kinchin & Doran, 2017).

The online Kognito suite of programmes calculated the ROI of implementing Kognito's At Risk Simulations on student retention rates (Kognito, 2017). The paper also presented a behavioural change multiplier over a 12 month period that suggested with every 100 university staff trained an additional 162 students would be approached to discuss concerns and a further 135 students would be referred for support. Furthermore, for every 100 students given support for depression, six university dropouts could be averted.

In the UK, economic analysis of a GP suicide prevention education programme projected that between 603-706 suicides would be avoided over a 1-5-10 year interval after training was completed. In cost terms, this was a saving of £1,573, £2,044 and £2,924 over one, 5 and 10 years respectively (Knapp et al, 2011).

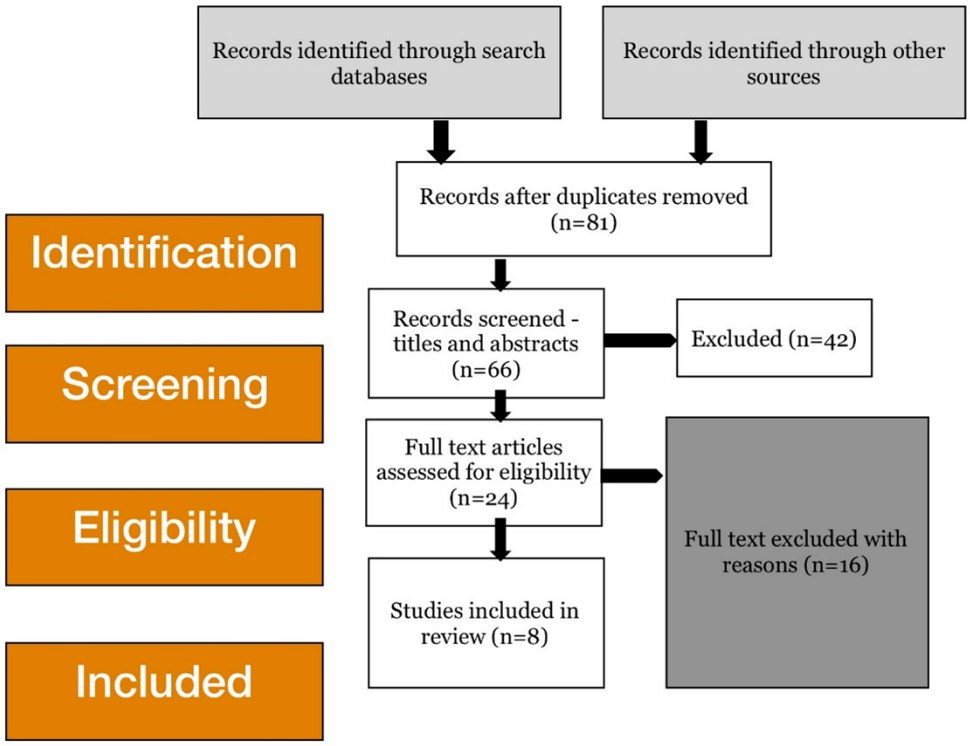
Together they linked programmatic implementation to potential cost saving compared to suicide response spend. These studies argued the health economics of two specific GKT programmes.

1.3.5 Children and Young People GKT Programmes

Following the same format in the previous sections, programmes identified for children and young people have been reviewed, sorted and filtered through Nesta's evidence framework (Table 3). These programmes focused specifically on peer-to-peer examples. Studies where the context was a school setting and/or the target group was under 18 years of age, were included in the general GKT review process (Section 1.3.1). A stringent search criteria was applied in this literature search and as such, a smaller number of peer-to-peer GKT programmes for this age cohort emerged. The PRISMA diagram is presented in Figure 4 with an overview of the programme content and objectives summarised in Table 4. Additional information on the programmes is also available in Appendix 2.

Figure 4

PRISMA (Preferred Reporting for Items for Systematic Review and Meta Analyses) Flow Diagram of Review



1.3.5.1 Overview of GKT Studies of Peer to Peer Trainees

Following the same protocol used for adult trainees, records were stored in Mandeley and duplicates removed. Titles and abstracts remaining after the identification process were then reviewed. Suitability for inclusion in the literature review was based on the agreed search terms and parameters described in 1.2.2 with the focus on peer-to-peer programmes. At the completion of the search and review process, 139 records were excluded. Full texts were then retrieved of records deemed eligible for inclusion (n=39). A further smaller number of records were additionally excluded based on review of full text content (n=16). Figure 3 is a flow chart of all steps in the process with eight remaining papers included as core papers consulted in exploring GKT models and contribution to outcomes of suicide prevention.

1.3.5.2 Data Sources

Both peer reviewed papers and grey material searches were used. In this sub-study, seven were from academic databases and one emerged from grey material searches.

1.3.5.3 Programme Types

In the context of this review and within the criteria set, peer-to-peer delivery of GKT approaches for suicide prevention referred to programmes with peer mentors or peer leaders in children and young people under 18 years of age.

The literature has suggested the peer group of a young person with poor mental health or who is showing signs of distress, can be a source of great support, comfort and information (Rickwood et al, 2005). Studies on help-seeking behaviour in young people suggest the decision to seek help, to engage in appropriate treatments and follow the treatment course are strongly influenced by the attitudes and suggestions of the social network or peer group (Yap et al, 2013). It has been argued that providing young people with the knowledge of how to support someone and how to seek out appropriate help offers a potential avenue for increasing early intervention and reducing untreated mental illness in young people (Hart et al, 2016).

Four GKT programmes emerged from this review, which offered a peer-to-peer delivery mode to young people under 18 years of age;

- YAM (Youth Aware Mental Health)
- tMHFA (Teen Mental Health First Aid)
- Friend2Friend
- Sources of Strength

All of these with the exception of Friend2Friend were face to face in school or youth settings. Friend2Friend is Kognito's young person's programme where peer avatars are used to provide information on how to support someone in distress while offering virtual rehearsal opportunities online. Localised resources are made available to give a customised network of support and context specific referral pathways.

1.3.5.4 Gatekeeper Type

As the purpose of the sub-study exclusively sought out peer-to-peer GKT programmes all the studies included in Table 4 are peer-based approaches. However, there are adult input whether it is to initiate the process, offer mentoring or co-facilitate part of the delivery. This aspect was clearly defined as a secondary role in the programme with the main responsibility given to peer mentors or leaders. All programmes described though the safety measures taken to meet the legal duties of a school or youth organisation.

Table 4: Peer-to-Peer Children and Young People's GKT Programmes

Programme type	Training Outcomes for Learner	Programme Objectives	Delivery Details	Type of Gatekeeper
Youth Aware of Mental Health (YAM)	Increased confidence in supporting peers in need of help or in distress Capacity to participate in an inclusive and youth led dialogue about mental health Enhances solidarity among young people	Youth driven approach (with the support of two adult YAM instructors) The programme argues it has adaptability to cultural/geographical contexts	Five one hour classroom sessions over three weeks with role-play, slides, posters and a personal booklet for each pupil	Emergent (pupils)
Teen Mental Health First Aid	How to identify signs of mental distress and substance misuse among their peers Skills to have supportive conversations with friends and connect someone to a trusted and responsible adult to get help	Young people will be able to apply the Teen MHFA action plan; Look for warning signs Ask how they are Listen Help them connect to an adult	Three interactive classroom sessions of 90 minutes or six of 45 minutes per session for 16-18 year olds Content included; A didactic PowerPoint presentation; video presentations, role-plays, group discussion and small group activities. A student booklet was provided for each participant, for use in sessions and for reference after course completion	Emergent (pupils)

Programme type	Training Outcomes for Learner	Programme Objectives	Delivery Details	Type of Gatekeeper
Friend2Friend	Health simulation GK model to improve understanding of mental health and drives change in skills and attitudes towards seeking help for a friend or themselves.	Learn about mental health and wellness while reducing stigma Identify warning signs of psychological distress, including verbal, behavioural, and situational clues Build skills in how to approach a peer in a manner to motivate them to access support Become comfortable asking a friend if they are thinking about suicide	25 minute simulation training that includes; Fully-hosted solution deployed to users in less than one week Technical assistance and outreach templates to drive adoption; Usage reports and customizable online surveys to support program evaluation; Customizable list of local and national mental health resources; Lesson plan and discussion guide to facilitate integration with mental health curriculum or group discussion	Emergent (school pupils)
Sources of Strength	Changes peer group norms that influence coping practices and problem behaviours Promotes protective factors that are linked to overall psychological wellness and reduced suicide risk Reduces the acceptability of suicide as a response to distress Increases the acceptability of seeking help Improves communication between youth and adults Develops healthy coping attitudes among youth	The program aims to enhance protective factors and reduce suicide. It engages peer leaders to change peer norms related to help-seeking and developing strengths It is built on a universal school-based suicide prevention approach designed to build socioecological protective influences across a full student population	Peer leaders spend 15–50 hours during a 3–6 month program, which includes an initial training, although the program is designed to last multiple year	Emergent (school pupils)

Table 5: Peer to Peer GKT studies

Study	Programme	Population	Gatekeeper (Emergent/ Designated)	Beneficiary	Design	Nesta Quality of Evidence Standard	Outcomes
Wasserman et al (2016) 10 European countries	Youth Aware of Mental Health (YAM)	School teachers School pupils	Designated	School pupils	RCT	4	YAM was associated with significant reduction of incident suicide attempts and severe suicidal ideation compared to control group at 12-months follow-up
Hart et al (2016) Australia	Teen Mental Health First Aid (tMHFA)	School pupils (16-18 years)	Emergent	School pupils	Wait-list control and follow up	3	Teen MHFA program appears to be associated with statistically significant improvements in mental health literacy, decreases in stigmatising attitudes, confidence in providing tMHFA to a peer, increases in intentions to seek help and improved student mental health
Hart et al (2018) Australia	Teen Mental Health First Aid (tMHFA)	School pupils (16-18 years)	Emergent	School pupils	Cluster randomised crossover trial	4	tMHFA resulted in significantly improved supportive first aid intentions and mental health literacy and significantly decreased stigmatising attitudes among adolescents

Study	Programme	Population	Gatekeeper (Emergent/ Designated)	Beneficiary	Design	Nesta Quality of Evidence Standard	Outcomes
Kognito.com USA	Friend2-Friend	Young people (13-18 years)	Secondary schools, youth programmes, juvenile justice	Young people (13-18 years)	Case studies\ Evaluation reports	1	Students who complete the training will have increased knowledge of: Signs of psychological distress including verbal, behavioural, and situational clues How to communicate with peers and motivate them to seek help Habits for mental wellness National crisis and mental health resources and local resources and referral points
Wyman et al (2010) USA	Sources of Strength	School pupils	Emergent	School pupils	Wait-list control and follow up	3	Training improved the peer leaders' adaptive norms regarding suicide, their connectedness to adults, and their school engagement, with the largest gains for those entering with the least adaptive norm The intervention increased perceptions of adult support for suicidal youths and the acceptability of seeking help
Calear et al (2016) Australia	Sources of Strength	School pupils (12-15 years)	Emergent	School pupils (12-15 years)	Two-arm cluster RCT	4	Outcomes not yet available

Study	Programme	Population	Gatekeeper (Emergent/ Designated)	Beneficiary	Design	Nesta Quality of Evidence Standard	Outcomes
Petrova et al (2015) USA	Sources of Strength	School pupils	Emergent	School pupils	RCT	4	Positive impact on school-wide help-seeking norms, but did not ascertain which aspects of peer messaging was effective
Pisani et al (2013)	Sources of Strength	School pupils	Emergent	School pupils	RCT	4	Peer leader presentations had a greater impact for suicidal students on enhancing help-seeking acceptability and perceptions that natural protective factors help in coping, adults help suicidal youth, and adults are engaged and caring The study could not separate out the effects of the messenger and the message content and structure

1.3.5.5 Delivery Details

An emphasis was placed on developing GKT programmes for peers with interactive and engaging content and structure. Multiple learning techniques were described to promote individual and group based participation in the training. This involved; role-play, discussions, debating, personal booklets, planning tools and virtual environments and avatars. A systematic review of 34 interventions delivered via technology to children and adolescents found a small effect in favour of technology delivered interventions compared to a waiting list control (Grist et al, 2018). With a growing reliance and use of technology in education as well as the prominence of gaming in social platforms, this route of training is one that offers many benefits in preparing a young person to recognise and offer support to their peers.

1.3.5.6 Outcomes and Quality of Evidence

Out of the eight studies included in the peer-to-peer GKT review, all but one was at Level 3 and 4 in the Nesta Framework. Five were RCT designs with large sample sizes (Table 6).

1.3.6 Cost Effectiveness

A small number of studies included or focused on cost benefit methodologies to understand return in investment of suicide prevention GKT programmes. One study cited emerged from large scale, multi-site and country comparisons. In this regard, it is necessary to be cautious when considering the direct fiscal implications of expenditure on GKT and health economics of these programmes.

A full cost-effectiveness analysis on the SEYLE study used incremental cost-effectiveness ratios which suggested that YAM has the lowest incremental cost per 1% per point reduction in incident for both outcomes and per quality adjusted life year (QALY) versus the control group. It emerged that YAM was most cost-effective intervention (Arnberg et al, 2014; Ahern et al, 2018).

Table 6: Nesta Standard of Evidence (n=8)

Level	Expectation	How evidence can be generated	Number of GKT studies
1	You can describe what you do and why it matters, logically, coherently and convincingly	You should be able to do this yourself and draw upon existing data and research from other sources	1
2	You capture data that shows positive change, but you cannot confirm you caused this	Data can begin to show effect, but it will not evidence direct causality. You could consider such methods as: pre/post survey evaluation; cohort/panel study; regular interval surveying	0
3	You can demonstrate causality using a control or comparison group	We will consider robust methods using a control group that begin to isolate the impact of the product/service. Random selection of participants strengthens evidence at this level and have a sufficiently large sample at hand. Scale is important at this level	2
4	You have one+ independent replication evaluations that confirms these conclusions	We are looking for robust independent evaluation that investigates and validates the nature of impact. This might include endorsement via commercial standards or benchmarks. You will need documented standardization of delivery and processes. You will need data on costs of production and acceptable price points for customers	5
5	You have manuals, systems and procedures to ensure consistent replication and positive impact	We expect to see use of methods like multiple replication evaluations; future scenario analysis and fidelity evaluation	* Despite evidence of manuals, system and procedure for replication, the design of the specific study is used to designate the quality of evidence rating

1.4 Conclusion

This literature review identified, screened and included systematic reviews, individual trials, research papers and grey material (non-peer reviewed) on GKT programmes for suicide prevention. The findings from this review explored the contribution of GKT to suicide prevention. A sub-study also considered peer to peer GKT for children and young people (18 years and under) and their role in suicide prevention in this population.

For the purposes of reporting, conclusions drawn from the review have been divided into adult GKT and peer-to-peer GKT for children and young people. Key messages, which emerged overall, have been put forward and recommendations made for consideration by the NOSP for future planning of CfL's Education and Training Strategy.

1.4.1 Adult GKT

To date there have been three systematic reviews examining GKT [Isaac (2009), Yonemoto (2019), Holmes (2019)]. Together these suggest it is difficult to determine the role these programmes (standardised and bespoke) have on impacting suicidal behaviour outcomes and as such mean limited conclusions can be drawn about GKT as a single strand in CfL. However, one of the most recent reviews (Holmes et al, 2019) indicates that GKT is a 'valid method in improving the knowledge and self-efficacy of gatekeepers' although reiterated that knowledge itself is not enough to improve and sustain suicide identification behaviour but rather it is attitudinal change in individual GKs.

1.4.1.1 Gatekeepers

Programmes targeted both emergent and designated GKs with the intention of supporting a variety of different types of potential beneficiaries. Emergent GKs are individuals such as members of the public or family members who may come into contact with someone in distress. With knowledge, understanding and skills gained through GKT programmes, they are able to act as a safety starter and connect the person with someone who has the skills to know where to seek the most appropriate help. Designated on the other hand are likely to be individuals in a formal role in healthcare, education or community.

There is an absence of studies that examine outcomes in terms of emergent or designated GKs. The review was overrepresented by designated roles such as university staff, teachers, health and social care professionals. One of the largest studies with emergent GKs was the Australian MATES and MATES Mobile programme, which focused on the construction industry. This was considered a peer-to-peer approach with people on building sites given the knowledge and skills to recognise when a colleague might need support. Clear referral pathways were communicated on multiple sites with all workers required to take training when coming to a site for the first time.

There was a lack of clarity in the literature that distinguished mental health literacy and GKT. This resulted in programmes with educational elements on mental health, signs of mental ill health and referral strategies being included in searches for GKT. Following the review process where papers were excluded, it was possible to be clearer on the relevance of the study to meet the inclusion criteria. It does suggest an overlap in the material in awareness raising and help-seeking actions set out within GKT.

1.4.1.2 Programme Type

Standardised programmes, which have been replicated in different contexts and/or with different GK groups and audiences, represented eight of the studies identified. Bespoke or non-standardised programmes featured less in the review (n=3). However, there was a growth in computerised and e-learning approaches to GKT, such as Kognito health simulations and Web-based QPR.

1.4.1.3 Programme Structure and Content

There was a common framework in the structure of programmes with an emphasis on participant engagement and active participation in the learning. This meant multiple learning tools and opportunities for behavioural rehearsal through role-play, simulated discussions and group planning.

Content across programmes while each describing the key features of their specific model tended to focus on knowledge, understanding, capacity building, behavioural intent and confidence to act when a situation arises that requires action. The unique selling point of particular programmes was based on the arrangement and dissemination of material and the methods to engage the trainee.

The most distinct approach to GKT was the virtual simulation techniques used in the Kognito suite of programmes. This blended gamification mechanisms and social learning principles to offer an innovative and digitally different learning experience.

1.4.1.4 Evidence of Outcomes

Outcomes identified in the NOSP Education and Training Plan (2019-2020) were commonly explored in the studies included in the review. The findings from the literature review support what has been identified as benefits of GKT in the Educating and Training Plan including;

- Improved knowledge of risks associated with suicide
- Positively shaping attitudes to suicidal behaviour
- Improved awareness of the signs of a person at risk of suicide
- Increased knowledge, enhanced positive attitudes towards and confidence in dealing with people who self-harm
- Confidence in addressing the issue of suicide and communicating about suicide
- Increased confidence in dealing with people at risk of suicide
- Increased confidence and ability to connect a person at risk of suicide with services.

Quality of evidence was determined by an evidence hierarchy framework produced by the Nesta Quality of Evidence Framework. The evidence of 24 studies was filtered through the framework which took account of research design and outcomes described in the paper. Three RCTs were recorded at Level 4 in the Nesta standards while six were at Level 3, 11 at Level 2 and 4 at Level 1.

From this perspective, Nesta offered a standardised and hierarchical tool to inform decisions. This represents a critical step in taking forward decisions on developing a response to complex health and social issues. Using an Evidence to Decision Making Framework alongside the Nesta ranking, affords organisations such as NOSP the confidence to explain why certain programme were selected to be part a National Education and Training Plan.

Furthermore, programmes identified in the review have been awarded a designation as a 'Programme with Evidence of Effectiveness' by the Suicide Prevention Resource Centre, USA and included on SAMHSA's National Registry of Evidence-Based Programmes where evidence ratings are awarded on a scale of 0-4. As of May 2020, the following programmes which are identified in this review are;

1. Online training
    - Kognito At-Risk for High School Educators
    - Kognito Suicide Prevention Simulations for College and University Students
    - QPR Web-based
2. Face to face
    - ASIST
    - QPR
    - safeTALK

A point of note is that other programmes were listed on the US National Registry, but they were outside the time period of the review (2010-2020) or clearly described as suicide prevention rather than GKT.

1.4.1.5 Caveats in the Literature

Difficulties in evaluating suicide prevention approaches are entwined in the necessitated design of national and local strategies. There is a need for multi-modal, multi-stakeholder strategies to respond fully to a complicated public health issue.

In a recent editorial which considered progress and challenges of National Suicide Prevention Strategies, it was suggested that the 'insufficient or conflicting evidence concerning the effectiveness of components' should be considered carefully GKT was (Platt et al, 2019). They also argued that this in turn increases the likelihood of model misspecification, where confounders and covariates influence attribution to positive outcomes of CfL (Platt, et al, 2019)

In this regard, the complex structure of responses and actions required by a national plan, create challenges in attributing changes in the national suicide rate to a particular intervention (Dillion et al, 2015). The study suggested that suicide prevention interventions are 'rarely delivered in a vacuum', which brings substantial challenges in attributing change or outcomes in national suicide rates to a specific prevention programme such as GKT.

Despite the interrelated challenges in evaluating elements of a national strategy such as CfL, the role of education and training in suicide prevention models across the world is central to increasing alertness and awareness about suicide and providing skills to develop or enhance capacity to respond to someone in distress in a safe and appropriate manner. This review describes GKT programmes according to type (alertness raising, awareness raising and intervention) and standard of evidence (Nesta framework). It identified contextually tailored approaches to standardised, replicated and scaled programmes that have robust evidence to support their contribution to suicide prevention outcomes. GKT programmes currently delivered by NOSP under the Education and Training Plan (2019-2020) are supported by evidence ranging from Level 1 to Level 3.

1.4.2 Children and Young People Peer to Peer GKT

The same steps were used in the review process of children and young people's peer-to-peer GKT. The key difference in this approach was the capacity of young people to have the knowledge, skills and confidence to notice signs of distress in someone of a similar age to themselves and be able to guide them towards appropriate and accessible supports. As peer educators, leaders or mentors, the programmes identified facilitated peer-to-peer GKT in the context of a school or youth setting.

It should be noted that within the literature there was an overlap in terminology between mental health literacy/awareness programmes. Searches revealed that programmes deemed as suicide prevention were also considered as mental health literacy approaches, for example, MHFA. A difficulty in the review, therefore, was separating out with exact clarity, GK specific and mental health promotion type programmes. However, where programmes were described as having GKT elements or modalities, these have not been excluded in the review process. This resulted in four programmes fitting the criteria and eight studies offering supporting evidence of their implementation.

1.4.2.1 Gatekeepers

Given the deliberate search for peer to peer GKs in the sub-study, participants who received training were young people under 18 (ranging from 13-17 year of age). Some programmes such as Sources of Strength maximised the role of peer leaders in school, others such as tMHFA applied a more universal approach where all young people in the school who received training could be considered an emergent GK. This programme is designed to build socioecological protective influences across an entire school student population and focuses on enhancing help-seeking norms, youth-adult communication, and coping skills to promote help-seeking behaviour (Hart et al, 2018).

1.4.2.2 Programme Type

Four peer-to-peer GKT programmes were included in the review. YAM specifically was subject to a large multi-country RCT with cost benefit analysis included in the protocol. All peer-to-peer GKT presented in the review has been manualised and replicated in other studies.

1.4.2.3 Programme Structure and Content

Different modalities of engagement were used in various settings. These included; face-to-face, online/computerised and blended programmes. It has been argued that use of the Internet to deliver adolescent depression and suicide prevention programmes seems a practical and acceptable manner to provide prevention services to adolescents (Gladstone et al, 2015). It has been suggested that digital technology may be particularly appealing to adolescents who are typically early adopters and regular users of new technologies (Johnson et al. 2015). A dominant feature of online programmes and gamification technology is 'behavioural rehearsal' or role-play. This has been cited as a critical element in changing gatekeeper behaviour by increasing skills and confidence through practice and instant feedback from an expert coach (Cross et al, 2011).

1.4.2.4 Evidence of Outcomes

Overall, the sub-study included eight studies, which were filtered through the Nesta Standards of Evidence Framework. One is at Level 1 with case a study design used as the methodology. Two have a ranking at level three and 5 at Level 4. No study could be placed at the top tier of the framework based on the

research design although each of these described manualised materials and evidence of replication of outcomes.

There was less available evidence on cost-effectiveness with one study (YAM) using cost-benefit formulae to explore return on investment or projected budget savings. The findings suggested savings in the short and long term but stated more economic appraisals of studies are needed particularly with the role of young people as peer educators, mentors and leaders in a gatekeeping function (Ahern et al, 2018).

1.4.2.5 Caveats in the Literature

Standardised programmes from children and young people such as Kognito's Friend2Friend and TeenMHFA have been developed on learning from adult studies and programmes. Adaptions from an adult to adolescent or child population were researched and tested to develop GKT and suicide prevention methods for young people in school settings. However, there is a greater level of evidence available on adult GKT for the 'parent' programme than for children and young people populations. The focus of the methodologies appears to be on the validity of extending its application to this cohort.

1.4.3 Key Messages

There was an overlap in descriptions of GKT programmes and mental health awareness raising generally. While initially papers appearing to have GKT elements were identified, the screening and review of full text papers facilitated the exclusion of studies where there was an absence of GKT features. This raised a question around programme content that offers knowledge to identify signs of someone in need of help and referral mechanisms versus the intention of GKT programmes per se. Likewise, other programs that have been designed to improve mental health literacy and help-seeking, they do not address the issue of peer-to-peer disclosure of mental health problems which has been argued to be an important initial step on a support pathway (King et al, 2018).

1.4.3.1 Gatekeepers

The review found that GKT programmes included both emergent and designated GKs. Three studies were specific to emergent GKs such as the general community, family members and parents while 20 targeted designated GKs who held professional roles in education, health and social care and community. There was no evidence available that looked at outcomes in terms of GK role. Studies explored learning outcomes as a primary research objective with positive findings on improved knowledge, self-efficacy, and intentions to help and confidence to support someone in distress. STORM and ASIST both represent intervention programmes and as such their inclusion in the review means there will be by default designated GKs in their studies.

1.4.3.2 Programme Type, Content and Structure

Programmes identified in this review were recognised in international suicide prevention strategies; National Strategy for Suicide Prevention (USA) and Connecting for Life (Ireland) and rated by quality standards such as NICE Guidelines (UK) and the National Registry of Evidence-Based Programmes and Practices (USA). The inclusion of these programmes, which were subject to additional review processes within these systems, adds further evidence of their role in suicide prevention. This also reinforces the selection of approaches within a decision-making process and their alignment to recognised standards internationally.

With the exponential rise in access to online learning, advantages of digital technologies include greater reach to geographically isolated populations, flexible access, increased convenience, fewer visits to specialist clinics, greater privacy and anonymity, enhanced treatment fidelity, rapid scalability; and low-cost delivery (Clarke et al, 2015; MacDonell & Prinz, 2017). However, the merits of online platforms for GKT and suicide prevention tools have to be balanced against concerns about an absence of a strong motiving and supportive relationship, high rates of attrition and data security (Lal & Adair, 2014). It was suggested that technological booster applications were important to maintain gatekeeper skills over time (Cross et al, 2011).

1.4.3.3 Methodological Design and Quality of Evidence

There was a recurrent use of outcome indicators across studies included in the review. These were likely to be aligned to the learning objectives of the programme and used specifically designed tools to measure change following participation in training. Post-test periods ranged from immediately after training to 15 months follow-up.

- Knowledge
- Gatekeeper skill and capacity
- Attitude towards suicide
- Self-efficacy
- Likelihood to intervene
- Gatekeeper behaviour
- School Based GKT

1.4.3.5 Peer to Peer Programmes for Young People

Peer support can be informal where a culture of empathy, listening, conflict resolution and encouragement is fostered in a school environment. Formal examples of peer support generally involves 'children and young people helping each other in a planned and structured way, with training to enable them to fulfil their roles' (www.mentallyhealthyschools.org.uk). Benefits of being part of a formal peer structure or approach includes developing and strengthening young people's social and emotional skills to contribute to a whole support system. By doing so, confidence, resilience, empathy and interpersonal skills are bolstered.

Peer to peer GKT represent an example of a formal support system in which specific knowledge and skills are nurtured through instructional facilitation by school staff to enable students to have the confidence to act in a GK role when required. There was a small number of examples identified in this review in comparison to adult GKT where young people are the beneficiaries. Without a dearth of research on peer to peer GKT programmes, it was difficult to draw clear and reliable conclusions from publications to date. However, positive findings are reported with strong evidence emerging from RCTs that point to the potentially significant role of peers as GKs.

1.5 Recommendations

Drawing on the learning from this literature review of GKT programmes and evidence presented across the 24 adult and 9 peer to peer studies, the following recommendations have been put forward for consideration;

- Explore the use of an Evidence to Decision Making Framework such as the WHO-INTEGRATe, GRADE and GRADE-CERQual when selecting a programme in response to the National Suicide Strategy CfL's Education and Training Objectives
- Carry out a worked example of an existing programme using an Evidence to Decision Making Framework
- Pilot the use of a peer to peer GKT programme to explore the contextual application of this model of working as a suicide prevention action with young people in school or youth settings

Part 2: Stakeholder Consultation

2.1 Introduction

The NOSP have strategic responsibility and fiduciary duty for the implementation of Strategic Goal 2 of CfL, which aims to 'Support local communities' capacity to prevent and respond to suicidal behaviour'. Under this Goal, Objective 2.3 focuses on the provision and delivery of training and education programmes on suicide prevention to community based organisations including those who are likely to have a role as gatekeeper in their community.

Aligned to this is Goal 5, which intends to 'Ensure safe and high quality services for people vulnerable to suicide'. Key to achieving this is the implementation of training programmes that are accredited, and evidence based. Under the Training and Education Plan, these are; SafeTALK, ASIST and Understanding Self-Harm.

The structure for education and training delivery commitments under Cfl is based on localised implementation across nine CHO areas and their Resource Officers for Suicide Prevention (ROSP). The ROSP is the person designated with articulating the translation of CfL objectives into a localised response that is contextualised by the community profile of that specific CHO.

Since the completion of this report, a Training and Education sub-group was formed to, action points raised from the survey findings. One aspect of the sub-group's work has directly informed the commissioning of the external review of GKT, particularly to explore the sustainability of the current training model.

2.1.1 Aims

- To identify and articulate the various models of delivery of CfL gatekeeper suicide prevention training in use currently by: engaging in a collaborative process with relevant stakeholders, to identify the current models being implemented (by the HSE NOSP and strategic partners)
- To evaluate the implementation of these models of delivery of gatekeepers suicide prevention training by: identifying and evidencing implementation outcomes of training models (e.g. acceptability, adoption, appropriateness, cost, feasibility, fidelity, penetration, and sustainability) identifying implementation enablers and barriers to the delivery of suicide prevention training in Ireland
- To determine the most appropriate and sustainable models of delivery of gatekeepers' suicide prevention training for on-going implementation on a national scale by:
- Identifying how these models can be reproduced in a range of local and national settings.
- Identifying the most appropriate models to target specific CfL priority groups.

2.2 Methodology

2.2.1 Design

A cross sectional design was used to capture experiences, insights and learning from a cohort of key informants engaged in GKT as indicated by CfL's priority groups and the related Training and Education plan (2018-2020). Semi-structured interviews were created with questions directly linked to the objectives of the GKT review. An additional strand explored a potential change to the current policy on delivering suicide prevention training to 16-18 year olds.

2.2.2 Sample

Key informants were identified by NOSP and included ROSPs across the CHOs, members of the Education and Training sub-group, training organisations and representatives of external organisations who have received or delivered GKT (Defence Forces, TUSLA, An Gardaí Síochána, GAA, Department of Social Protection, The Prison Service).

Nineteen stakeholders received a request explaining the purpose of the review and 18 took part in interviews conducted by Zoom or by telephone. Interview questions were sent in advance of the interview. These ranged from 1-2 hours in duration and were recorded (where possible) with consent of each participant. These were stored in an encrypted file before review for analysis purposes.

2.2.3 Analysis

Responses gathered from all participants were collated and ordered under each question for review. These were prepared for inclusion in a thematic table following analysis using the framework method. Themes and sub-themes identified, informed the narrative outlined under the key objectives for this review.

A descriptive account of budgets for training and education in local area action plans were reviewed and an overview presented in Section 2.3.5.

2.3 Findings

2.3.1 CfL GKT Models of Delivery - Overview

The current National Education and Training Plan (2019-2020) sets out an action plan for implementation where the models of training are intended to be 'sustainable, efficient and cost effective'.[1] These models represent the process by which evidence based education and training programmes are delivered across the various CHO areas. The document describes two types;

2.3.1.1 Cascade Model (Model 1)

The intention from the plan is to work 'in partnership with the HSE, government departments, agencies and professional bodies', where trainers will be identified from within their own structures to be trained in relevant suicide prevention programmes. This will facilitate a comprehensive training for trainers and cascade model of training within those departments and agencies most likely to come into contact with people who are vulnerable to/at risk of suicidal behaviour'.[2] This means delivery of GKT forms one part of their role and their salary.

The delivery of training in these contexts will follow protocols in responding to suicide under CfL set out in goal 3, objective 3.1, action 3.1.2.

2.3.1.2 Externally Contracted Trainers Only (Model 2)

This refers to trainers or a training organisation who have a contract with either NOSP or ROSPs to deliver GKT on their behalf in line with the targets and priorities of CfL and the Education and Training Plan. These are paid trainers who have been accredited in programmes such as safeTALK and ASIST who are not linked to an organisation where a CASCADE model is being implemented. Furthermore, there are HSE training officers attached to a small number of CHOs whose sole function is to deliver training under CfL.

2.3.1.3 Hybrid Model (Model 3)

This involves the delivery of training by external trainers or training agencies outside of the organisations described above who are contracted by the ROSP in a CHO area. The ROSPs themselves may also deliver suicide prevention training or in a small number of cases, have training officers attached to that ROSP office. A combination of internal and external trainers results in a hybrid model of implementation of GKT.

Examination of CHO funding applications for 2020, local action plans and information provided by interviewees, served as the basis by which models of training are described in the following section. These are initially disaggregated by CHO area and then summarised in terms of national coverage.

1 https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/national-education-and-training-plan-updated.pdf

2 Ibid 2

2.3.2 CHO Models of Training

It was clear from inspection of information derived from the sources mentioned above and details provided by ROSPs, that there was a predominance of a hybrid model of GKT across nine CHOs. This meant implementation of programmes such as safeTALK and ASIST were carried out by trainers from within the organisation (e.g. HSE staff or ROSPs) or by external partners such as Mental Health Ireland, Breaking Through or Aware. There were variations in how this was compartmentalised between internal trainers (through a cascade approach) and externally contracted trainers/partners.

Table 7: GKT Models by CHO Area

CHO Area	Cascade Model	Externally Contracted Trainers Model	Hybrid Model
CHO1 Cavan and Monaghan			
CHO1 Donegal			X
CHO1 Sligo and Leitrim			X
CHO2			X
CHO3			X
CHO4			X
CHO5			X
CHO6		X	
CHO7		X	
CHO8 Laois			X
CHO8 Longford			X
CHO8 Louth and Meath			X
CHO9			X

2.3.3 Key Partners

Each local action plan is aligned not only to the strategic objectives of the National Education and Training plan, but also to its guiding principles. One of these is a collaborative approach, where suicide prevention is viewed as a collective responsibility. In practice, the intention is to plan and deliver suicide prevention programmes in partnership with key strategic partners across relevant sectors and Government Departments.

Table 8 details the various partners each CHO area works with to deliver training, whether universally or in a targeted manner to priority groups identified in their action plans. Partners were also offered the opportunity to develop a cascade model where training of trainers could build the internal capacity of an organisation to deliver suicide prevention programmes such as safeTALK or ASIST. Where relevant, training at the intervention level, with for example the programme STORM, was a further opportunity to have staff upskilled to respond in the event of someone presenting as suicidal.

The diversity of partners identified in local area action plans under strategic objectives 2.3.2 and 5.4 reinforces the importance of collaboration to strengthen and support local communities' capacity to prevent and respond to suicidal behaviour. These ranged from HSE departments, Government agencies, Community and Voluntary organisations, City Councils, Resource Centres, Priority group representatives and other community gatekeepers.

Training delivered as part of a job role within the HSE for example, was the primary example of what was described as an 'unpaid trainer' [salaried trainer]. The co-existence of trainers contracted by the ROSP and paid specifically for their time, as an accredited trainer of safeTALK, ASIST or STORM, was the most commonly articulated model in interviews with ROSPs. In reference to the 'pool' of trainers available, there was a preference for paid trainers over trainers where training was one aspect of their role in an organisation such as the HSE. The reasons for this are presented and discussed later.

2.3.4 External Models of Delivery (e.g., Defence forces, An Garda Siochana, Tusla, DSP)

Under the Education and Training Plan Objective 1, Action 1.1 (under CfL Goals 2 (Objective 2.2) and five (Objective 5.4.2), NOSP have developed partnerships with Government Departments and Agencies. The intention is to build internal trainer capacity across these organisations to strengthen the capacity of their staff to respond in a best practice manner, to those vulnerable to suicide who they may come into contact with. Identified relevant professional groups are the Gardai training college, the Department of Defence and Tusla. However, these models of working have also been transferred in a contextualised manner to other sectors such as the Department for Social Protection and the Prison Service.

Table 8: CfL Strategic Goal Alignment: Objective 2.3 abd 5.4

Local Actions	Lead	Key Partners
CHO1 Donegal	HSE Mental Health Service	TUSLA, C&V Organisations, Community Health Forums, HSE Primary Care Teams, LYIT, Youthreach, Donegal Youth Service, Foroige, Water Safety, Armed Forces, Farming organisations etc.
CHO1 Sligo and Leitrim	ROSP	HSE MH, HSE H&W, Other statutory agencies, C&V Orgs, MHI, HSE MH, HSE H&W, Other statutory agencies, C&V Orgs
CHO1 Cavan and Monaghan	ROSP	Cavan: Local community based organisations, including: – Youth services – Family Resource Centres – Cavan Traveller Women's Primary healthcare Project – Sporting organisations – Church based organisations Monaghan: Local community based organisations, including: – Youth services – Family Resource Centres – Sporting organisations – Church based organisations
CHO2 Galway, Mayo and Roscommon	ROSP	HSE MH, FRCs, PPNs, MHI, Community & Voluntary organisations, Youth Work Ireland Galway, Foroige, GAA, Grow, GELS, Kinvara Alive, CAATCH, Comhdháil Oileáin na hÉireann
CHO3 Mid-West	ROSP	All non-statutory, community and voluntary organisations, communities, groups and members of the public
CHO4 Cork and Kerry	ROSP, NCS/ CIPC	HSE MH, Local Media, Community and Voluntary organisations, HSE H&W, Community Health Workers/ Safe Talk and ASIST Tutors, FRCs, Haz and CWD
	ROSP, HSE Health & Wellbeing	Community and Voluntary organisations, Children and Young People's Services Committee, Dept. Agriculture, Cork City & County Councils SafeTALK/ASIST/ USH Tutors
CHO5 Wexford	ROSP	Wexford Education Centre, Wexford County Council, Public Participation Network, C&V sector, HSE Primary Care
CHO5 Carlow	ROSP	C&V Sector, HSE Primary Care, HSE Social Care, Tusla
CHO5 Waterford	Training Officers	Waterford Area Partnership, Waterford City and County Council, Public Participation Network, C&V Sector, Implementation Steering Group, HSE Divisions
CHO5 Kilkenny	ROSP	All lead and partner organisations
CHO6 Dublin South East, Dun Laoghaire and East Wicklow	ROSP	Mental Health Ireland, TUSLA, C&V organisations, HSE Primary Care, HSE Mental Health, ROSP, Youthreach, UCD, Institute of Art, Design and Technology, National Rehabilitation Hospital, Acute Hospitals, Gardaí, youth services, farming organisations, carers of older people, carers of people with chronic illness, disability.

Local Actions	Lead	Key Partners
CHO7 Kildare and West Wicklow	ROSP	C&V Organisations
CHO7 Dublin South	ROSP	NGOs, C&V Organisations
CHO8 Midlands, Louth and Meath	ROSP	CfL Education, Community & Voluntary, Youth & Children, Mental Health Support Services, Health, Justice, Traveller, LGBTI+ and Drugs and Alcohol Partners
CHO9 Dublin North City and County	ROSP	HSE Mental Health, HSE Health & Wellbeing, HSE Primary Care, HSE Social Care, TUSLA, Fingal County Council, Dublin City Council, HSE Acute Hospitals, An Garda Siochana, Irish Coast Guard, Community & Voluntary Partners, Education Sector

2.3.5 Programme Monitoring and Evaluation

Data dashboards were produced by the monitoring and evaluation team in NOSP for each of the GKT programmes based on self-report information provided by training participants in each course. These were generated for each CHO over a certain time point and detail the findings from baseline and follow-up analysis of key indicators aligned to reach a specific programme. For ASIST these are; knowledge and understanding (attitudinal factors); knowledge (risk factors and intervention strategies) confidence and competency. For safeTALK, the indicators are; attitudes (attitude towards suicide prevention), confidence and stigma (using the Stigma of Suicide Scale [SOSS subscales]. Related indicators measured in safeTALK include; levels of exposure to suicide, suicides considered preventable and suicide literacy and understanding.

2.3.5.1 Target and Training and Education Budgets

Details provided by NOSP of the proposed budgets for 2020 and summary comparisons between 2019-2020 training and education budgets were reviewed.

Proposed Targets

Each CHO sets targets for the delivery of both courses and attendance levels. Figures 1 and 2 illustrate these projections. Inspection of target courses for 2020 shows variations between areas, ranging from 13 (CHO4) at its lowest to 84 (CHO5) at the highest. Cumulatively this amounts to 579 proposed GKT courses delivered over a 12-month period (safeTALK, ASIST and STORM).

Budgets

Budget allocation from NOSP for local implementation of CfL Training and Education plans are based on annual CHO specific funding applications. Funding decisions in 2019 results in an allocated budget of €338,854 compared to requests for a total of €635,290 in training and education funding across all CHOs. This is a €219,261 increase on the year prior. Given the unexpected impact of a public health pandemic, implementation of programmes did not take place under Government guidelines and restrictions.

Budget variations were linked to the local area action plans and were affected by a number of variables. These included;

- Providers
- Statutory bodies
- Presence and proportion of CfL priority groups
- Connections with community groups
- Delivery model (cascade or paid model).

2.3.6 Evaluation of the Implementation of CfL GKT Models

2.3.6.1 Motivation for Suicide Prevention Training

The requests for training were generally in three categories as described by ROSPs and trainers; response to an incident; the need to complete this training as a requisite of the organisation or wanting to be preventative rather than reactive. All respondents believed it was often a mixture of reactive and proactive with a definite number carrying out a 'tick box exercise'. There was a sense that over time there has been an increase in requests being motivated by a greater realisation of the importance of preventing poor mental health. One interviewee, stated that; *"I believe the work of the ROSPs locally and greater emphasis on positive wellbeing and proactive factors that promote good mental health have driven the public's understanding of acting early....of course this is still a lot of work to be done, but we are making a difference through training and education" (ROSP)*

In terms of a reactive request due to a death by suicide, ROSPs were very clear on how this is managed and the preferred response. This was explained as any request for training after a suicide other than bereavement support is postponed for a year. Interviewees spoke about best practice to give time for mourning and prepare individuals for the emotional readiness needed to attend suicide prevention training following a death by suicide. ROSPs expressed an understanding for the motivation to seek guidance, help, information when a suicide has occurred but they saw it as their role to signpost them to bereavement training also available through the ROSP office.

"It is our responsibility to meet the person where they are at but know from professional best practice that it is postvention not prevention that is needed at that time. This is how we can help and then later return to programmes like safeTALK or ASIST when the time is right".

Interestingly, it was noted, that through bereavement training, other training such as suicide prevention is sought. The circumstances by which this gateway to training is opened was fully recognised. However, the reality of the need for postvention work as well as intervention programmes meant that suicide prevention upstream needs to continue to be able to have an impact further downstream; *"Knowing that people attending safeTALK has arisen due to a suicide is not something we take lightly, but instead motivates us even more to push for suicide prevention to be the initial engagement with our service, not the last".*

2.3.6.2 Prioritising Suicide Prevention Training

This was a recurring theme across discussions with all respondents when asked about the motivation for requesting suicide prevention. In particular, the emphasis on prioritising training in suicide prevention for frontline mental health staff and frontline healthcare staff was described as 'poor' and 'weak'. Engagement was described as 'difficult', 'challenging' and 'unwanted'. The experience of ROSPs and trainers delivering to frontline mental health staff across CHO areas was one where they believed staff perceived the training as 'below their paygrade', 'too simplistic' and 'not valued'.

ROSPs understood the reality of scheduling training in professions and organisations were there were competing priorities. However, the value of suicide prevention and its place in awareness raising and early intervention, meant interviewees equally recognised the essential input the training could have on professional practice and personal wellbeing. One comment from this discussion emphasises this point by saying; *"It has been notoriously difficult to get in front of frontline health staff especially mental health staff without them dismissing the level safeTALK and ASIST is pitched at. They believe they are trained to do this work so do not need to receive this training. We need to work on this engagement and communicate the value of the training".*

2.3.6.3 Support for Suicide Prevention Training

There was full agreement among respondents that the greater the support from management or senior officials from within an organisation, community group or Government agency/department, the more likely suicide prevention will be prioritised and sustained. The recurrence of training within an organisation was linked to management valuing the skills and knowledge gained through the training; "you find that community groups or organisations are keen to have training for new staff or members if they have had GKT previously". The quality of the programmes and responsiveness to safeTALK and ASIST were viewed as key drivers in retaining attendance at suicide prevention training across CHOs. Respondents suggested that the structure and content of the programmes offered trainers' confidence in implementation despite one suggestion around updated examples that are based on an Irish rather than Canadian context.

Organisations that tried to embed a cascade model within their structures were recommended by ROSPs and trainers to make an investment in sustained support for trainers. This was described as; *"having allocated time for training delivery and continuing development", "recognition of their role as a suicide prevention trainer", "firm agreement between the organisation and NOSP to give dedicated time to training"* and *"mentoring from a ROSP who is a trainer or external trainer".* Without the leadership support, formalised agreements and ongoing mentoring, interviewees questioned how the cascade model could show a return in investment that would be worthwhile and cost effective.

2.3.6.4 Enablers and Barriers for Suicide Prevention Training

Through discussions with each interviewee and analysis of their responses, it was possible to isolate the key drivers and barriers to the implementation of GKT in suicide prevention. Together they forge and challenge the delivery of planned targets, but when understood, they can create opportunities for redesign and rethinking of actions to adapt the delivery of education and training across CHOs. These are listed below and vary in the extent to which these are influencing factors in each of the CHOs; however, they were recurring points raised during discussions with ROSPs and trainers.

Enablers

- National framework and strategy for suicide prevention and education and training
- Evidence based programmes that are consistently applied across all CHOs
- Localised action plans and response to CfL objectives for suicide prevention training
- Quality of trainers
- NOSP and ROSP support to other organisations who have developed a cascade model of training within their structures (e.g., Defence Forces, Department for Social Protection, An Gardai Siochana, The Prison Service)
- Where there is senior management buy-in and ongoing support

Barriers

- Unreliability of trainers who deliver training as part of their job role
- Primarily a request driven delivery model (waiting on a request for training)
- The programmatic structure of safeTALK and ASIST in terms of language and directness of the discussions
- Lack of support from management where a cascade model was introduced
- Need for higher levels of management to prioritise this training

2.3.7 Learning from current practices and models of delivery for adults by the NOSP

2.3.7.1 Models of Training

Variances in GKT models were not confined to the distinction in paid and unpaid trainers but also saw variability in the degree to which ROSPs themselves were engaged in direct delivery of the programmes. As one stakeholder said, *"There is no consistent model, in terms of who or what external or internal organisation delivers training, to what extent and for what purpose. There needs to be stability across the country and this will not happen until you have a dedicated training officer in each CHO".* This view was supported by other ROSPs and trainers who argued that the benefits of consistency, quality and fidelity would only improve when a uniform nationally agreed but locally implemented training and education framework is agreed.

The achievement of this suggestion was viewed as having a number of challenges. These were articulated mainly by ROSPs who do not deliver training as they described an already demanding workload. By having the professional skills of external trainers from organisations such as Breaking Through, GROW and Aware, it was reported that consistency and quality could be obtained without the direct involvement of a ROSPs; *"We have built up a bank of trainers who we have full confidence in their commitment, approach and training style, this has been ongoing work which should not be dismissed"*. The variation in models of delivery across the nine CHOs suggests that a familiarity and comfortableness had developed around training and education models in each specific area. In this regard, changes to these were welcomed by some but not by all. This reluctance was expressed more in areas where ROSPs did not deliver training. It should be noted that, full agreement across all ROSPs interviewed was in the need to move away from the cascade model and the unreliable reliance on trainers within organisations who fulfil this duty as part of their role.

"Until we can be absolutely sure trainers are committed, available and supervised for quality assurance, where suicide prevention training is a priority, then this type of model is going to remain inefficient and unstable"

2.3.7.2 Delivery Approach and Training Style

The quality of evidence-based programmes such as safeTALK and ASIST were not questioned during any interview in this review. However, the way in which the programme was delivered and training style of the facilitator were frequently highlighted as key determinants of participant engagement and learning. The nature of the topic and sensitivities likely to accompany discussions during training were taken seriously by the trainers. One trainer said; *"It is an honour and privilege to do this work which you cannot take lightly. You have to have the emotional skills not just knowledge to deliver these programmes".* Another reaffirmed this point by saying; "*it takes a certain type of trainer to be able to hold a room and be fully ready to respond to something that might arise as every group is different. You cannot take for granted what people bring to a group; you just need to be ready to respond respectfully".*

By contrast, trainers raised concerns that there needed to be greater oversight on the delivery style of trainers and keeping fidelity to the programmes. This was particularly in relation to those who do not deliver frequently but provide one or two courses to maintain their accreditation for these programmes. In this respect, three different trainers shared the same concern and made similar suggestions on how to address this; *"We cannot have a high quality training service with such a large range of trainers and training models without firm oversight, agreed nationally and implemented locally across the CHOs".* The requests for mentoring, refresher training and minimum delivery in a year were all proposed as responses to this issue.

2.3.8 External Model of GKT (e.g., Defence forces, An Garda Siochana, Tusla, Department of Social Protection, The Prison Service, GAA)

2.3.8.1 Introducing GKT to External Agencies

Each external agency described their own particular path in bringing suicide prevention training to the organisation. A common thread in this journey, was the recognition by members of a specific department (training, human resources, health and wellbeing) that suicide prevention should be available to staff to support them in their roles and for their own personal wellbeing. In this case, the motivation for these external agencies was clearly embedded in an understanding of the need for the training and its potential impact. The respondents articulated the degree of consideration in designing and planning training in order to maximise the cascade of learning across the organisation. A pertinent step in achieving this was investing in a 'trainer of trainers' approach. This would mean having internal capacity to deliver suicide prevention programmes. In addition, aligned to this was the ability to monitor, respond and reassure colleagues in situations where suicide was a concern. An example given by one respondent clarified this by sharing; *"Not only do we make sure the safeTALK and ASIST is delivered across the organisation especially to frontline staff, we also focus on keeping ourselves up to date with T4Ts and any refresher training we can take".* Recognition of the importance of support for those leading the training was highlighted in interviews and opportunities to share with peers formally and informally were detailed.

Organisations, who required a response at the intervention level, by having training such as STORM, spoke in equal terms of the importance of evidence-based programmes supported by NOSP and the local ROSPs. The collaborative approach and joined up thinking was viewed as essential for partnership working. The input from both offices was described as providing quality assurance, clinical governance and oversight.

2.3.8.2 Leadership and Management

Driving internal investment and commitment to GKT was viewed as a necessary part of the role in order to maintain and sustain its visibility as a priority action. Allotting importance to suicide prevention among other competing training requirements was agreed by all interviewees from external agencies as needing leadership and senior management endorsement.

"Without top-down understanding of why this training adds to the role of our [colleagues], the value of preparedness in responding to others in distress by having suicide prevention language, awareness and skills, then bottom-up commitment will be very difficult to sustain"

For some they were open about the reality of requiring progress to be made on this issue. This was attributed to a lack of appreciating what really takes place during a training session and difficulty therefore in seeing the potential impact of having these skills. Suggestions were made that all staff especially senior management should take the programmes as a way to increase buy-in; "*You have to be open to learn about yourself and this takes courage and willingness to shift attitudes not just at a personal level but at a cultural level in the organisation, unfortunately this takes time and there is no time to waste on this matter"*. One interviewee expressed frustration about struggling to keep suicide prevention a priority in the organisation but could see practice based changes in real life responses. This respondent described how there are more frequent examples of newer staff having not only the skills but also confidence to manage a situation where someone is vulnerable to suicide. This was amplified by a longer serving colleague, recognising they did not have the capacity to respond in the same way.

"You know the training is having an impact when a shift in practice is seen in day to day situations where the outcome changed because someone you trained asked the question and knew what to do to follow up"

Where leadership was a feature in introducing and sustaining GKT, the experience of cascading the learning and building a bank of trainers was much easier. There were examples of senior officials in primary positions who led the initiative to bring suicide prevention programmes to the organisation. When these were described, words such as '*valued*', '*insight*', '*forward thinking*' and '*holistic*' were used to indicate how senior management viewed this type of training and its impact. This positive response was not underestimated or taken for granted, with interviewees acknowledging that changes in personnel and indeed leadership, could result in a redistribution of priorities; *"It is great right now we have had so much support from the leadership of the organisation but we must keep focused on the work on the ground and maintaining the message in both directions, bottom-up and top-down, that suicide prevention training matters to us and who we work with".*

2.3.8.3 Partnering with NOSP

There was an overwhelming positive description of external agencies' experience of engaging with NOSP to introduce GKT. Respondents welcomed the openness by which NOSP received enquiries around suicide prevention training in their organisation. This was made in reference to their willingness to work together with them to configure a training model that is suitable to their specific environment, context and cultural; "This is not an easily understood system with many regulations that required NOSP to grapple from the outside, how to help us implement something new and challenging to our cultural norms". By working alongside with flexibility, experience and expertise, respondents routinely referred to this engagement as a *"genuine and valuable partnership"*.

The planning, implementation and support processes that were required in bringing a model of GKT into the structures of an external agency were highly rated by interviewees. Examples of comments made in discussion about the role of NOSP included; *"they are always there for us with their expertise and experience"; "they have brought a skill set that combines knowledge, research, and evidence gathering skills and connections to other agencies"; "their flexible and accessible approach has strengthened our partnership which we believe will continue for a long time".*

Requests for continued engagement from NOSP was framed by the understanding that GKT will be an ongoing part of their work. As such, guidance and input from NOSP, whether it is by trainers, T4Ts, refresher training or research support, was seen as essential in creating and maintaining suicide prevention training. The degree to which training had been embedded appeared to be a factor in the degree of support organisations perceived that they needed going forward. For example, where there was a history of training delivery, fewer suggestions were put forward about what NOSP or ROSP could do beyond what they were already providing. Interestingly, the direction of engagement was one issue raised by a number of interviewees who stated; *"If anything, we should be more proactive on our end as NOSP come to us looking to help, which is a great partner to have". Another emphasised the importance of promoting the work on a bigger scale; "There needs to be greater promotion of what they have helped us achieve and how this partnership could be a model in so many other sectors".*

2.3.9 Models of working going forward with relevant, responsive and sustainable practices

2.3.9.1 Sustainability and Scalability of CfL GKT Models

Issues of reliability were a predominant theme in the discussions about GKT models. This was described as 'disruptive', 'challenging' and 'uncontrollable' in terms of organisations' capacity to release staff to deliver GKT programmes. In considering the sustainability of the current models where there was a reliance on 'unpaid trainers', respondents from the ROSP, were adamant this was not fit for purpose for the long term implementation of suicide prevention training;

"When you have organised the logistics to bring a group come together for training and then find out the day before that trainer has been given a priority task that means they cannot deliver training, everything could fall apart if you did not have a back-up of paid trainers"

In this respect, there was no disagreement among ROSPs across seven of the nine CHO areas that either a model with only paid trainers or a model with predominantly paid trainers would ensure a reliable, consistent and quality assured delivery of GKT across the country. One ROSP adds to this by saying; *"Coordination and delivery at a local level is critical to maintaining local visibility and developing ongoing responses that includes training and education but at the local level"*. There were only two ROSPs who suggested the possibility of bringing training under a national remit, whether by an external training organisation, reporting to NOSP or through national trainers operating from NOSP. With this came the realisation that without training and education responsibilities, the role of the ROSP would be significantly diminished; "*Planning for training and coordinating training is a significant part of a ROSP role, without it, especially for those who do not directly deliver training, it would question what exactly they would do"*.

This aspect of training delivery by ROSPs divided opinion. While all ROSPs have a responsibility for the local action plans and the aligned actions for training and education implementation, not everyone in this role delivered training directly. For those in this group, this meant responding, planning and coordination of training was the predominant responsibility. Where ROSPs have a training input to organisations in the community, there was a perception that it gave them insights into issues being presented in groups and an understanding of local needs across a variety of settings.

One of these trainers qualified this by saying; *"It is all about managing the room in an empathetic and emotionally invested way, so you don't see it just as training. It is more than, without this part of the job it seems like you are missing out on a connection to the work and the community you engage with"*.

2.3.9.2 Recruitment and Selection of Gatekeeper Trainers

Creating a cascade model in organisations with in-house trainers was described as one of the main learning points derived from the implementation of training and education in CfL. The initial recruitment was viewed as less problematic than the ongoing engagement and reassurance that training would continue where required in the organisation. To this point, stakeholders shared experiences where investment is made in training at the beginning both time and effort, then this is not filtered through the organisational structures afterwards. One interviewee recalled; "*We worked significantly with an agency to support their internal to provide suicide prevention training then to find out not a single course was rolled out after our withdrawal"*. Frustration and disappointment were expressed in this and other circumstances culminating in a collective questioning around return of investment. This was articulated in the context of national spending on cascade models without guaranteed sustainability to upskill and build an internal knowledge bank on how to respond to colleagues or clients/customers/members of the

public in distress or vulnerable to suicide. Another respondent stated; *"We cannot continue to assume just because training was sought and brought into an organisation does it mean it will definitely continue".* The recommendations put forward to address this issue included;

- Clear and defined structures of implementation
- Agreed pathways of support and continued mentoring from external training consultants
- Formularised arrangements that increase the likelihood of a commitment to sustained implementation
- Prioritisation by leadership and support for initiating and continuing suicide prevention training
- Communication strategy to promote messages of the role of suicide prevention in mental health promotion

Whether it is a trainer within a cascade model, one that delivers on behalf of an external organisation or a ROSP/trainer, their skills, facilitation style, knowledge and experience was seen as needing to be filtered through a stringent selection criteria. It was noted this process at a national level has become more robust over the years, but ongoing surveillance of appointed trainers was necessary across all CHOs. They were described as the "conduit" by which the evidence programmes are delivered and engagement achieved. For this reason, participants strongly emphasised having a recruitment, selection, training and ongoing monitoring framework that captured the work of all trainers, irrespective of the model they work under. One suggestion that stressed this point was; *"we cannot underestimate the role of the trainer and as such whether this is good or not so great, there is a responsibility to the public which we at ROSP and especially the NOSP must fully commit to".*

2.3.9.3 Models of Support

There were examples of peer-to-peer support among trainers and ROSPs but not in every case. The importance of support, whether formal, informal or both, was emphasised by all interviewees who delivered training. This was cited as not only good practice but important in personal care. Opportunities to share experiences as a group of trainers to discuss working contexts, challenges, given examples of working practices and receive updates on training information were all viewed as beneficial to programme delivery.

Co-facilitation as a delivery method offered an opportunity to debrief following GKT. It was also viewed as a peer support mechanism by working symbiotically to create a space for the sensitive delivery of training on suicide prevention. One comment on this highlighted the value of working together in a shared learning environment; *"The connection and working relationship between both trainers can have a positive or negative influence on the experience of those attending training. This is why it is vital to have trainers who know how best to co-facilitate in a training context that is more than just distributing information".* Equally the benefits to the trainers themselves were emphasised; *"Until you have delivered this type of suicide prevention training and worked in this area, you won't appreciate the value of helping each other plan, delivery and debrief afterwards".*

2.3.9.4 The Role of NOSP in GKT

To the point above, the national coordination of CfL and the Education and Training plan, which this review is examining, are primary responsibilities of this office. Interviewees understood the strategic positioning of NOSP's role in CfL, which included education and training. Given the office's national connectedness to public policy and policy implementation, it was suggested NOSP could more actively promote the work of the CHOs. This was qualified by saying the work of NOSP itself should be given greater visibility and recognition. One interviewee suggested; *"The National Office and CHOs across the country do such great work but sometimes we are all too busy in the midst of this that we don't see the benefit of raising our public profile".* Another agreed that by doing so; *"the messages around suicide prevention, intervention and postvention would be bolstered through this platform to share evidence of the work that is being done".*

In relation to training, the recently formed Education and Training Working Group that emerged from findings of a trainers' survey in 2018, were seen as a positive step in linking national and local interests. The defined and delicate role of delivering suicide prevention training was viewed as critical to the intentions of CfL and the Training and Education Plan. To this end, it was suggested by some trainers and ROSPs that an understanding and familiarity with the role of trainers should be a prerequisite for anyone responsible for education and training in NOSP. They specifically recommended that this mean undertaking and becoming a suicide prevention trainer. By doing so, respondents who made this suggestion, believed it would bring validity and awareness from a practice viewpoint that could only amplify strategic diligence on the localised delivery of CfL objectives and actions.

"With such an emphasis on training and education, one of the most important things the National office could do is to have team members become registered trainers of safeTALK and ASIST. This would really enhance the connections between ROSP and NOSP beyond strategy to understanding the nuances of practice in suicide prevention".

2.3.10 Delivering GKT to 16-18 year olds in Ireland

Currently, suicide prevention training under the remit of NOSP is not available to anyone under 18 years of age. The decision was informed by findings from the Department of Children and Youth Affairs (DCYA) when safeTALK was first introduced to Ireland. However, with updated evidence on GKT programmes and changing contexts for young people, this review explored what a change to this position would mean for service delivery and suicide prevention education and training.

All stakeholders who took part in interviews were asked about the possibility of delivering GKT such as safeTALK to 16-18 year olds, the considerations needed, implications, responsibilities and barriers to activating this change. Interviews were conducted with stakeholders who have direct engagement with young people such as National Youth Council of Ireland, the GAA and Tusla, who have a statutory duty for children and young people.

The question of this cohort receiving suicide prevention training was more divisive than anything else asked as part of the review. Respondents overall, whichever their viewpoint, were firm about how, who, why and why not GKT should be available to this age group.

2.3.10.1 Requests for GKT for 16-18 Year Olds

ROSPs and NOSP trainers who took part in the review noted that requests for training to be delivered to young people had reduced over the years. They suggested that this decline in enquiries was due to an awareness around the remit of the ROSP and delivery to 18+ only. When queries were made, officers and trainers redirected this to other organisations such as youth work, community and voluntary sector groups and education who had experience of delivering mental health promotion to young people.

Conversations with other stakeholders who engage directly with this age group and younger, did not have experience of suicide prevention training being delivered but did speak about other initiatives and activities under the auspices of health and wellbeing, resilience and mental health promotion using a universal approach. Support for priority groups of young people involved the implementation of a more targeted strategy. These included; looked after children (LAC), LGBTQI youth, young people with mental health presentations and addictions. In this regard, services and support were consumed within existing statutory structures such as TUSLA, CAMHS, Youth Services and Juvenile Justice.

Discussions in general focused on universal delivery rather than targeted with the exception of contributions from Tusla, Addiction Services and An Gardai Siochana. Overall, there was a recognition and agreement of the need to equip young people with the knowledge, skills and capacity to navigate stressful situations and environments, which are more and more likely to arise in current contexts. One respondent made the point that; *"There is no denying that the world young people live in today is very demanding, fast paced and has high expectations of them, no matter their age".* This view was often accompanied with a further acknowledgement that this age group are already have an awareness of the issue of suicide and may have already had direct or indirect experiences of a death by suicide. In this regard, stakeholders stated; *"it was not useful to pretend otherwise'"* and *"to think young people are not already talking about this or have concerns about a friend would be very naïve".*

2.3.10.2 Considerations and Concerns

The Implications of Discussing Suicide

Interviewees expressed fear and worry about the ramifications of placing 'this level of responsibility' on young people. This was in reference to a disclosure to them, subsequent actions needed and ramifications of outcomes, particularly if suicide was completed. The other dominant concern reported in the discussions was the likelihood of increasing suicide ideation or suicide (iatrogenic effect), including creating a contagion where suicide has occurred in the group. It should be noted that despite raising these concerns, there was an acknowledgment that the absence of information and support may also be having negative impacts, especially where suicide has occurred in the peer group. As one respondent stated; *"This is not like general mental health promotion, it is a much more serious conversation and do we really need to be placing this additional responsibility on young people who already have so many demands on them".*

Duty and Responsibility after a Disclosure

Linked closely to concerns of additional and serious burdens being placed on young people, were the expectations a young person might place on themselves in the event of a disclosure. This worry was inflated by the possibility of that peer completing suicide and the implications of this on the mental health of that young person. The risk of this becoming a reality was considered too great to take when balanced against equipping young people to have a role to 'hold a space for friends during tough times'. The difference between mental health promotion strategies and suicide prevention approaches was described as the directness of asking 'the question' about being actively suicidal. This key action and subsequent actions if the answer is affirmative, was the primary barrier reported by stakeholders in implementing GKT.

"These are very difficult and different conversations to have with a young person and then to ask them to have with their friends if the situation should arise is even more delicate. With all the transitions that go on at this stage, is this another layer we want to put on top of that?"

When asked further about responsibility, some stakeholders asked *'who would have the duty of care for 16-18 year old's in the context of suicide prevention work'*? This point arose from debating where the suicide prevention training is most appropriately delivered and in what context. This led to questions about the implications of teachers having this role, but by being educators not youth or social workers, were would the duty of care start and end? Another asked; *"should it be everyone's responsibility?"*. In reality, discussions focused on having transparent structures, legal duties and familiar territories for young people to take these types of training programmes.

Support Mechanisms

Central to the question of delivery to 16-18 year old's was the way in which they would be supported, before, during and after. One trainer suggested that whatever or whoever held responsibility for GKT to this cohort, the same due diligence in preparation, support and follow-up would have to be taken, as is used currently in other programmes such as safeTALK and ASIST.

The type, degree and duration of support all featured in the comments made by respondents. Reviewing the question of GKT for this age group almost always came back to how delivery of a programme would have to be framed in a very secure and full framework of support pathways. This was a driver of implementation or a driver of the barriers to implementation. Reticence expressed by interviewees was primarily based on the concern for the young person and how they should be supported if given this

responsibility. One trainer involved in Incident Debriefing has directly engaged with 16-18 year old's for this purpose. His experience of this group has been one where "*maturity and insightfulness*" were prominent presentations by the young people. This was in the context of a recent suicide and as such brought an emotionally charged energy to the situation. Despite this the trainer went on to say; *"We need to give young people credit for their knowledge and independent skills to be able to listen, respond and build their own resilience, otherwise how is this supposed to happen".*

2.3.10.3 Barriers

Programme Types

A recurring point by trainers in particular was the duration of the training and that lack of appeal to a younger audience who are unlikely to engage for 3-4 hours. An example of safeTALK delivered to young people in Canada, described a format where there was a triad style approach. This is where 10 young people, 10 parents or caregivers and 10 teachers attended a shorter version lasting 45 minutes. This was viewed as a possible alternative for delivery but still brought the focus back to an educational context. Finding a range of appropriate options of programme type was suggested as at least one-step in the right direction in exploring GKT to this group. There was an openness by those willing to explore the possibility of suicide prevention training, who asked the question; *"What does the research tell us now about these programmes"* and *"What changes has there been that take account of engaging young people as active citizens with agency?"*

Suicide Ideation

One of the greatest fears given by those not in favour of GKT for 16-18 year olds was the prospect of any 'iatrogenic effects'. This means concern that chances of a suicide occurring are increased if the topic is discussed or explored. Any risk that this might happen was enough for the smaller number of interviewees to warn against any change in this policy. There was no question about evidence to support this finding from those who challenged this proposal.

This reason was also raised in relation to potential 'gatekeepers' of young people who may prevent someone attending this training, who could include, parents, school principals, teachers or other family members. In all of the discussions, the only people to ask 'what would young people want in this situation and what would it look like?', were those from a youth organisation or agency. In this respect, the voices of young people were not represented.

The Role of ROSPs

There was a predominant view among ROSPs that suicide prevention training to 16-18 year olds was not and should not be the responsibility of NOSP and by alignment, ROSPs. If this responsibility is placed on ROSPs, their current viewpoint could potentially make the transition in the change of policy challenging. There was a recognition among ROSPs that this kind of alteration to policy would require significant investment in time, expertise, policy infrastructure and programmes. Added to cultural and attitudinal shifts, they voiced their reservations clearly and firmly.

2.3.10.4 Preferred Model of Delivery

"I really don't think this is the role of NOSP to be delivering suicide prevention to young people and not in schools, but at the same time, you have to think about what is actually available given we know suicide does occur in this age group"

While in general respondents did believe this was the time to consider suicide prevention for 16-18 year old's, the biggest divergence in opinion was around who should have responsibility and how best to deliver training through a youth based lens. By this they meant, delivery by an organisation such as the youth sector who are in 'tune' with the culture, language and experiences of young people in Ireland at this time; "It is crucial the right organisation who can engage easily and how have an understanding of the stresses and demands placed on young people, led this response". Questions were raised about the role of schools and education as a primary provider by stakeholders when discussing responsibility for GKT to 16-18 year olds. While a small number believed teachers are more likely to have a familiarity with this group and a connection that supported any follow up questions or concerns, this very point, was the reason other stakeholders believed GKT should not be part of a teacher's role; *"the education environment is too focused on formal learning and is not best placed to create a space that encourages young people to feel comfortable to explore these issues".*

Organisations working directly with youth such as the GAA, the Order of Malta, Youth Services and Comhairle na nOg were suggested as suitable organisations in which training could take place or be guided by. It was proposed that GKT programmes suitable for young people were delivered by external trainers from the youth sector or by staff from within those organisations who have received the appropriate training.

Delivery Model

"Suicide prevention training should only take place in the context of added containment, scaffolding, safety measures and a clear understanding of why the programme is being provided and screening for those who are taking part". This was one suggestion put forward that reflects the agreement among interviewees that whatever GKT takes place, there must be a strong framework of working in place that reflects the preparation, delivery and follow up required to promote a safe experience for the young person. In a similar approach to the implementation of safeTALK or ASIST, it was recommended that a checklist of requirements for delivery be developed and followed. For example, it was suggested, if this was in a school setting or a youth setting, then these protocols should be reinforced by the lead agency and agreements put in place prior to the delivery of any programme.

Part of the debate in considering lowering the age of GKT, was around the quality and evidence base of the provision of programmes to schools and youth around mental health and wellbeing. A point was raised about around having access to and agreement on delivering standardised, evidence based programmes for suicide prevention that have been validated for young people. This also included the use of online platforms that were integrated with in person supports; *"with so much engagement done online by young people, we should explore what is available and evidenced that brings a digital option to this work".* However, online learning was seen as only being acceptable where a blended learning approach was taken with adult and peer led supports in place to create additional space for discussions.

Clarity was sought in the interviews about whether GKT to 16-18 year olds should be peer led training or adult to young person training. Where there was a hesitancy around GKT to this age group, peer led was dismissed as an option. For those stakeholders who wanted to see an introduction to GKT, they suggested

delivery that was co-facilitated with a peer group member trained in the programme with an adult trainer. This was based on the belief that engagement and buy-in from young people was likely to be increased with a peer champion or trainer involved. With the relevant training, support and supervision involved, it was suggested this model of working might be the best way to promote the active role of young people in supporting their peers in times of distress.

"We need to give young people a role so they do not see it as yet another thing adults are telling them to do, they need to have ownership and peer led training is an excellent way to do this"

Suicide prevention was viewed as being suitable for this group if it equipped them with the right messages, information and skills to signpost someone to receive help or escalate a concern.

2.4 Conclusions

2.4.1 Key Lessons-Adult GKT Programmes

Reflection on the synthesis of findings that emerged from this external evaluation have pointed to a number of lessons that can directly inform the Training and Education Plan for 2020-2022. These include;

- The reasons behind requests for suicide prevention training were grouped into three; reactive response to a suicide or attempted suicide; a genuine interest in prevention and being proactive and finally, needing to complete the training as a requisite action.
- There was a high degree of variance in how the training response was planned and delivered with each CHO having its own CfL Local Area Action Plan.
- The variance occurred across a number of factors;
    - Delivery model
    - Groups engaged in training
    - Costs associated with training (trainer costs, venue hire, materials, travel)
    - Number of programmes delivered
- Common to all CHO areas was the implementation of evidence-based programmes such as safeTALK, ASIST and STORM.
- The autonomous role of ROSPs to reflect the individual landscape of each CHO, may be affecting the degree to which strategic cohesion is achieved with respect to CfL outcomes.
- Enablers of implementation of GKT across the CHOs ranged from; the policy framework of CfL, evidence based programmes, trainer engagement, planning approaches and ongoing support from senior management.
- One of the largest barriers reiterated by the majority of ROSPs and trainers with responsibility for coordinating GKT, was the unreliability of trainers who had an adjunct role to deliver suicide prevention training.
- Reliance on HSE trainers was a major factor cited in interviews that significantly interrupted the coordination and scheduled delivery of training within communities and across CHOs.
- ROSPs strongly questioned the stability and efficiency of using a model where HSE trainers are a core part of the delivery mechanic.
- Reliance on trainers from within organisations, who perform this duty as part of their role, was strongly recommended as a model of working that is no longer fit for purpose.
- For the sustainability of GKT across CHOs therefore, ROSPs highly recommended a paid trainer model rather than a hybrid approach.
- Responses from ROSPs suggested there was a disconnect operationally between the local focus of CfL and strategic direction at the national level.
- It was unclear to what extent targeting CfL priority groups was a primary driver of GKT in CHO areas.
- One of the most difficult groups to access for GKT was frontline mental health staff. There was a

perception expressed by ROSPs that the training was set at a standard below their professional education.

- The degree of penetration in the implementation of CfL strategic priorities under its Training and Education Plan, was not evidenced in Local Area Action Plan outcomes.
- Out of the three models currently operating in the delivery of suicide prevention GKT, the hybrid model (internal and external providers of training), was most frequently adapted.
- The majority of ROSPs favoured a paid trainer model due to logistical ramifications in planning, coordinating and delivering training. Using internal trainers from the HSE had often created a vulnerability in having assurances that GKT would go ahead.
- ROSPs believed that suicide prevention GKT was not viewed as a priority in HSE departments where internal trainers were based. It was suggested that was due to a lack of senior management commitment and buy-in with regards to GKT.
- The cascade model within organisations listed under CfL Objective 1 (Action 1.1), was viewed highly positively by respondents from agencies where this has been supported by NOSP.
- Considerations for the sustainability of external partnership models included;
    - Resource prioritisation
    - Maintaining trainer input for ongoing implementation
    - Investment and belief from the leadership layers of the organisation
    - Cultural openness to increase capacity and confidence in supporting themselves, their colleagues and those they engage with who may experience vulnerabilities to suicide.
- A total allocation of €1,122,850 was set against the CfL objective of capacity building through education and training outputs for 2020. This took account of all CHO budget projections, national training delivery, T4T days, development of quality assurance days, licences and materials.
- There was a large degree of variance in the distribution of costs associated with CHO local area education and training plans. This was the case across all budget lines and subsequently, total costs proposed for 2020.
- Trainer costs are increased when the external model is adopted. This potentially has significant influence in decision making about the long term sustainability of GKT and preferred models of implementation.
- There are definite ramifications for budgetary allocation in choosing an exclusive approach that has a higher cost per person. It would be essential that strong evidence from local area action plans would be produced to ensure CfL priority groups were targeted more strategically through GKT.

2.4.2 Key Lessons-GKT Programmes for 16-18 year olds

- In considering suicide prevention training for this age group, a delicate balance between providing information and skills and placing further responsibilities on them is needed.
- Concerns about 'burden', 'stress', 'guilt' and 'anxiety' were terms used by those stakeholders who did not favour GKT below the age of 18.
- Questions were raised about responsibility for young people to deliver suicide prevention training. These focused on which agency or organisation had the resources, knowledge, access and sustainability for GKT to this age group.
- It was suggested instead that the focus remain on mental health promotion messages, help seeking behaviour and building resilience as part of a prevention strategy rather than suicide prevention.
- The reality of the lives of young people with colliding demands both in and outside of school and their access to digital information sources on a large scale, were described as key factors in needing to deliver suicide prevention training.
- Providing evidence based relevant and timely information to young people in a format and language that speaks to them was reiterated across the respondents in favour of the change in policy.
- Respondents strongly recommending having the voices of young people in the planning and development stages by providing opportunities to have discussions and arrive at co-produced decisions about, if, how and when suicide prevention education should take place.
- With an existing emphasis on promoting mental health and wellbeing through pastoral care strategies and public health campaign, the platform to move towards training for suicide prevention knowledge and skills has already been built.
- Findings from the literature review conducted as part of this review found that there were a small number of examples of peer-to-peer GKT compared to adult led training. With some positive trends emerging from studies with controlled designs, the contribution of peers to GKT in their age group is promising.

Part 3: Recommendations

These set of recommendations have emerged directly from the analysis of responses by key stakeholders in this review of suicide prevention training. They are framed in the evidence presented in the literature review of GKT models. The intention is to inform the NOSP's Training and Education Plan for 2021-2022. These are defined in terms of short, medium and long-term goals. GKT recommendations for 16-18 year old's have been proposed separately.

3.1 Short-term goals

3.1.1 A review of CHO CfL actions for targeting priority groups named in CfL should be undertaken as a matter of urgency to describe the nuances in CHOs that influence the Local Area Action Plans with respect to training and education.

3.1.2 Consideration is given to the features and priorities of the role of a ROSP to meet strategic targets for CfL. This should include understanding about the extent to which autonomy is required to develop and activate local plans while aligning to the outcomes of the national strategy.

3.1.3 Budgetary differences need to be better understood fully, to account for the variation in costs across CHOs. This will directly inform decisions on the extent of exclusivity in having a paid trainer led model.

3.1.4 Consistency and sustainability of GKT would be improved by following a designated trainer model across all CHOs that is underpinned by ongoing quality assurance through intentional monitoring and mentoring. This means moving away from a reliance on trainers where training is submerged into their role and salary. Before making this transition, it is critical that due diligence is carried out with respect to cost and return on investment. This would mean;

- Having a transparent understanding of the CHO landscape and variables that lead to variances in training outputs, costs, targeting and CfL alignment
- Agreements with ROSPs that there is a strategic focus in training decisions that are evidence through reported outcomes
- There is a quarterly surveillance of outcomes to prevent ongoing misalignment through reporting mechanisms to NOSP
- An action review approach is taken whereby changes are made to maintain strategic focus on CfL priority groups.

3.1.5 A communication strategy for CfL suicide prevention training should be developed to address;

- The motivation of organisations and individuals to support GKT where it is currently a function, to raise its priority listing as one of the organisation's responsibilities
- The understanding between operationalising a strategy such as CfL and having strategic oversight for its implementation
- Raising the profile of NOSP and the work of ROSPs nationally through sharing examples of practice, evidence of outcomes and planned actions
- The engagement of front line mental health service staff to support them to recognise their identification as a priority group in CfL and how GKT can strengthen their capacities and mitigate their risks as a group vulnerable to suicide.

3.2 Medium-term goals

3.2.1 A framework for recruiting trainers should build on the current recruitment process but include a national repository of trainers who are required to maintain their position locally by committing to the requisites of being a suicide prevention trainer.

3.2.2 External Partnership Models

Learning from the development of partnership working for the purpose of creating an external delivery mechanism for GKT, should be harnessed and recreated with contextual awareness and sensitivity to new environments. NOSP should;

- Develop a guideline document that details steps needed in considering, preparing, planning and delivering GKT within an external organisation
- Clearly articulate the support package offered by NOSP to external agencies
- Where a cascade model is requested by an organisation, there is a nominated mentor with the responsibility of supporting the introduction, implementation and sustainability of the training.
- Promote examples of good practice in external models to recruit and engage with other relevant organisations.

3.3 Long-terms goals

3.3.1 The investment in cascade models should be subject to a return on investment agreement whereby a specific number of trainings are delivered throughout the year on a ratio to staff size calculation.

3.4 GKT for 16-18 year olds

Suicide prevention programmes should be considered for delivery by a youth based organisation with the support of NOSP and ROSPs to equip young people with the awareness and skills to respond to peers who present with suicide ideation. This should be done in the context of;

- Developing a framework for delivery that incorporates the key principles of CfL
- Considering the evidence based programmes identified in this review for this age group
- Creating a cross-sectoral, multidisciplinary team who have responsibility for children and young people
- Appointing advocates who can articulate and represent the views and needs of the diversity of young people's experience living in Ireland today
- Considering the impact of COVID-19 on young people, their family, friends, peers, social, educational and emotional health as a risk factor for suicide
- Actively engaging and representing the voices of young people in the consideration, planning and delivery of GKT programmes to this age group.

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Appendix 1: CfL Education and Training Plan

Level	CfL	Literature Review
Awareness	safeTALK	MHO E-Learning Kognito MATES and MATES Mobile safeTALK Youth Mental Health First Aid ICare CwP Three minutes to save a life
Intervention	ASIST STORM	ASIST STORM QPR

Appendix 2: Peer to Peer GKT

Author (year)	Programme type	Sample	Design/Measures	Country	Outcomes Level (NESTA Framework)
Wasserman et al (2018)	QPR & YAM (Youth Aware Mental Health)	14-16 year olds (n=11110)	RCT	10 EU Countries	4
Hart et al (2018)	Teen Mental Health First Aid (tMHFA)	Adolescents 14-18 years (n=1942)	Cluster RCT	Australia	4
Hart et al (2016)	Teen Mental Health First Aid (tMHFA)	School pupils 16-18 years (n=	Wait-list control and follow up	Australia	4
Kognito.com	Friend2Friend	Adolescents 13-18 years	Evaluation and Case Study	USA	2
Wyman et al (2010)	Sources of Strength	School pupils (n=3128)	Wait-list control and follow up	USA	3
Calear et al (2016)	Sources of Strength	School pupils 12-15 years	Two-arm cluster RCT	Australia	4
Petrova et al (2018)	Sources of Strength	School pupils (n=706)	RCT	USA	4
Pisani et al (2013)	Sources of Strength	School pupils (n=7,978)	RCT	USA	4

Connecting for Life

Seirbhís Sláinte Níos Fearr á Forbairt

Building a Better Health Service