Review and Evaluation of the

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

Summary Report

August 2021

Connecting for Life

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Executive Summary

The National Office for Suicide Prevention (NOSP) has strategic responsibility for the implementation of Strategic Goal 2 of Connecting for Life (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.

This review comprised of a literature review and a stakeholder consultation of gatekeeper suicide prevention models. For the purpose of reporting, the findings from each part are presented separately.

- **Part 1** presents the review of the literature (both grey and empirical) on models of gatekeeper training (GKT) for suicide prevention and the relevant recommendations.
- **Part 2** presents the findings from the stakeholder consultation which set out to articulate and evaluate the implementation of the various models of delivery of CfL gatekeeper suicide prevention training and to identify implementation enablers and barriers to the delivery of suicide prevention training in Ireland
- The literature review informed the consultation process and frames the conclusions and recommendations that are drawn directly from an analysis of the responses of engaged stakeholders. **Part 3** of this summary report presents the recommendation.

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).

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.

1.2 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)

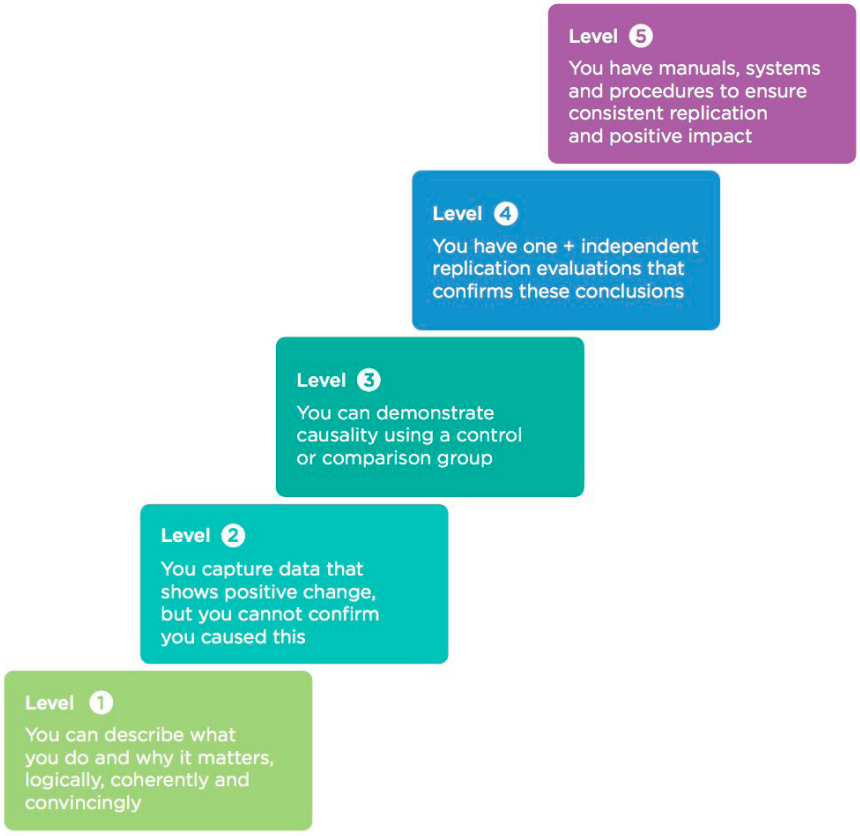
d. study identification and systematic data abstraction

e. evidence standards framework

1.3 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.

The Nesta Framework



1.4 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).

1.4.1 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.

1.4.2 Peer to Peer GKT Programmes

For peer-to-peer GKT aimed at children and young people, 4 programmes and 8 supporting studies were selected. These included;

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

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.

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	

1.5 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, 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).

1.6 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 Aims

The aims of the stakeholder consultation were threefold;

- 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
- 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 and;
    - Identifying the most appropriate models to target specific CfL priority groups.

2.2 Methodology

The experiences, insights and learning from a cohort of key informants (n=19)[1] engaged in GKT as indicated by CfL's priority groups and the related Training and Education plan (2018-2020) participated in the review using semi-structured interviews. Additionally, a potential change to the current policy on delivering suicide prevention training to 16-18 year olds was considered in this review.

2.3 Findings

Three types of GKT models were identified through the review. These were;

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 GKT forms one part of their role and their salary.

1 ROSPs across the CHOs, members of the Education and Training sub-group, training organisations and representatives of external organisations NOSP who have received or delivered GKT such as Defence Forces, TUSLA, An Gardai Siochana, GAA, Department of Social Protection, The Prison Service

2 Ibid 2

Externally Contracted Trainers Only (Model 2); This refers to trainers or a training organisation that have a contract with either NOSP or a ROSP 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.

Hybrid Model (Model 3): This involves the delivery of training by external trainers or training agency outside of the organisations described above who are contracted by the ROSPs 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.

It was clear from inspection of information derived from the sources mentioned above and details provided by ROSPs, that there was a predominance of the hybrid model of GKT across the 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 operationalised between internal trainers (through a cascade approach) and externally contracted trainers/partners. 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.

2.3.1 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 5 (Objective 5.4.2), NOSP has 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 include 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.

2.4 Conclusions

2.4.1 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 with 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 interrupts 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.
- It is essential for the effectiveness of the CfL outcomes to emphasise the importance of the link between the strategic vision of the NOSP with the operational responsibilities of CHOs through the delivery of local area action plans. Showcasing good practice examples of national policy directives being implemented at a local level will highlight the connectedness between strategic priorities and operational objectives.

- It is critical that the role of the education and training manager remains at a strategic level to support the operationalisation of CfL as a key vehicle in realising the CfL vision.
- 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 positive 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 €575,656 was set against CfL objective of capacity building through education and training outputs for 2019. This took account of all CHO budget projections, national training delivery, T4T days, development of quality assurance days, licences and materials. The figures for 2019 were used given the impact of COVID-19 on face-to-face training delivery.
- 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 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 was 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 ROSP 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.

Connecting for Life

Seirbhís Sláinte Níos Fearr á Forbairt

Building a Better Health Service