The Efficacy of a Self-Harm Awareness Training Programme

Report of an Independent Evaluation

Dr. Ella Arensman
Ms. Claire Coffey

National Suicide Research Foundation

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Commissioned by the National Office for Suicide Prevention

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This study was commissioned by the National Office for Suicide Prevention

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Foreword

Reach Out, The National Strategy for Action on Suicide Prevention sets out the evidence based actions to address the public health problem of suicide and self-harm in contemporary Ireland. Much of our focus understandably, is in relation to suicide prevention, but we know from the research evidence that there is a strong link between repeated self-harm and suicide.

Our response to presentations of self-harm must therefore be consistent, thorough and speedy. This report commissioned by The National Office for Suicide Prevention seeks to evaluate the impact of specific self-harm training on those who have contact with people who self-harm.

The findings which are set out in this report offer an important insight into the value of training and provide a benchmark for the potential national roll out of this or a similar programme.

I am grateful to all the trainers in the HSE West and HSE South who were prepared to subject their training programmes to the rigour of this evaluation.

I want to thank the project management team for their robust and challenging reflections on the methodology, the evaluation process and the report findings. I particularly want to thank Ella Arensman and Claire Coffey and colleagues from the NSRF who undertook the evaluation with scientific rigour, application and good humour in responding to the challenges raised through the research.

This report represents another significant building block in our collective efforts to address self-harm and suicide in Ireland

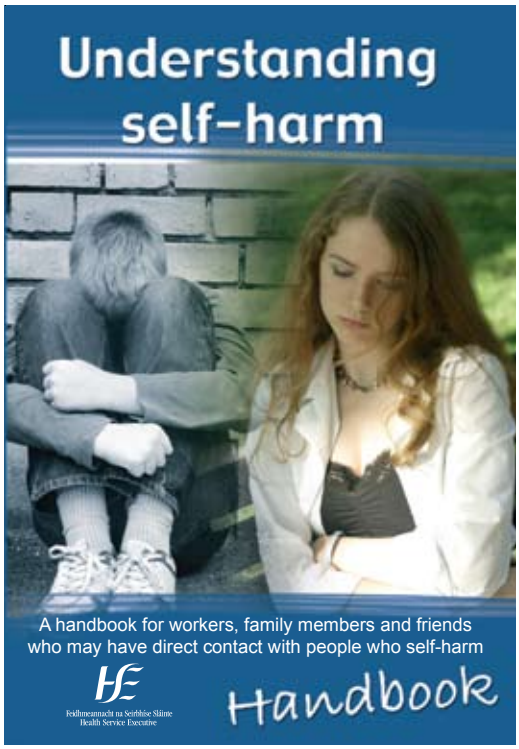
Geoff Day
Director
National Office for Suicide Prevention

Foreword

Over the many years that I have worked in the area of self-harm I have become more and more aware that staff who come into contact with people who self-harm have identified the need for training to help them in what is often a difficult and challenging aspect of their work. The literature based on the views of people who self-harm also identifies the training of staff as being a crucial element in the improvement of services to them. The NICE guidelines picked up on this as a central theme in improving services for those who self-harm. I think it is very telling that, after two years of extensive research, focus groups and expert evidence, the first two key priorities for implementation of the NICE guidelines are that people who self-harm should be treated with the same care, respect and privacy as any patient, and that; "Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed."

In the light of this I was delighted to have been able to work with colleagues in the Republic of Ireland to help them develop a training programme about self-harm. It was very rewarding to work with such a highly motivated and dedicated group of people who wanted to develop, in a systematic way, a training resource that could be delivered to significant numbers of people. It is extremely important that there has now been an independent evaluation of this training. The results of this evaluation, contained within this report, will be of interest to many people and helps to build on the evidence base of what is effective when working with people who self-harm.

Richard Pacitti
Chief Executive, Mind in Croydon
NICE Self-Harm Guideline Development Group Member



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We would like to acknowledge the trainers of the self-harm awareness programme, all of whom facilitated the work of the report.

Ms. Ber Downey
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Ms. Rose Lynch
Ms. Louise Ryan
Ms. Marian Walsh

We would further like to sincerely acknowledge the input from all individuals who contributed to this study. Their contributions and time are greatly appreciated.

We would like to thank Richard Pacitti from Mind in Croydon for his helpful advice.

Executive Summary

The independent evaluation of the self-harm awareness training was commissioned to the National Suicide Research Foundation by the National Office for Suicide Prevention (NOSP) in line with action 12.4 of *Reach Out* – National Strategy for Action on Suicide Prevention 2005-2014 (HSE, 2005, p. 33): the need for *"basic awareness training for all levels of hospital staff on suicidal behaviour,"* and the development and delivery of a *"specialist intervention, skills-based training for the appropriate staff as part of a national training programme"*.

The report consists of four parts: 1) a literature review, 2) a quantitative evaluation of the self-harm awareness training programme, 3) a qualitative evaluation of the self-harm awareness training programme, and 4) a review of the training programme and material. The literature review revealed twelve relevant papers including one review. Five papers reported on studies addressing self-harm as a primary topic and included an evaluation. The quantitative evaluation was conducted along two concurrent strands to include both prospective and retrospective evaluation. In order to determine pre-post training changes among participants of the self-harm awareness training programme, semi-structured self report questionnaires were administered among participants immediately before (pre) and after (post) training. A 4-month follow-up was conducted in order to investigate changes after the 1st follow-up (post-training) and to enable investigation of sustainability of training effects. Qualitative interviews were conducted with participants, trainers and key stakeholders involved in the self-harm training programme. The quality of the training programme and materials was also reviewed as part of the independent evaluation. The handbook and slides included in the training programme were reviewed. The review was conducted using internationally validated criteria to assess the quality of training programmes

Key outcomes and recommendations include:

- Research into the efficacy of self-harm awareness training programmes consistently shows significant positive effects in terms of knowledge, attitudes and confidence in dealing with people who engage in self-harm, in particular in the short term.

- Independent evaluation of the efficacy of this self-harm awareness training programme revealed greater awareness of self-harm following the training. Significant positive changes pre-post training were observed in terms of increased knowledge, enhanced positive attitudes towards and confidence in dealing with people who engage in self-harm.

- The evidence base obtained in the current study supports the wider implementation of the self-harm awareness training programme.

- Considering the enhanced effects of the self-harm awareness training programme when participants had been involved in previous training, it would be recommended to promote the self-harm awareness training programme as part of a series of training programmes to optimise the effects.

- It is recommended that the evidence base obtained in the current study informs guidelines to improve the assessment and care for people who engage in deliberate self-harm, e.g, the clinical guideline on self-harm by the National Institute for Clinical Excellence in the UK.

- Based on the outcomes of both the independent evaluation of the self-harm awareness training programme and international research, it would be recommended to conduct further research into the sustainability of training effects in the long term and the identification of the unique effects of self-harm awareness training programmes.

Introduction

Suicide rates have increased worldwide by 60% in the last 45 years (WHO). With 1.5% of the global burden of disease attributed to suicide, this is a considerable public health issue (Kapur & Gask, 2009; Mann et al., 2005). Furthermore, rates of deliberate self-harm (DSH) are also increasing, with repetition more likely to occur than was previously observed (McAuliffe et al., 2007). DSH is considered a significant risk factor for suicide (Hawton & van Heeringen, 2009). Developing resources for an effective response in the health services for people who present to services having engaged in DSH has been identified as crucial in the development of a targeted approach to reducing the risk of suicidal behaviour among high risk groups and vulnerable people as part of the *Reach Out: National Strategy for Action on Suicide Prevention 2005-2014* (Health Service Executive (HSE), 2005).

DSH refers to a wide range of behaviours with varying levels of intent occurring across all age-groups and socio-economic demographics (Skegg, 2005). Self-harm is considered a major public health concern in Ireland, presenting significant challenges to the health care system (Corcoran et al., 2003; McMahon et al., 2010; Morey et al., 2008). The National Registry of Deliberate Self-harm recorded 11,966 presentations to hospitals nationally for the year 2009 involving 9,493 individuals (National Suicide Research Foundation, 2010). Furthermore, there was a significant increase (5%) in the national person-based rates of DSH in 2009, with a rate of 209 per 100,000 up from 200 per 100,000 in 2008. This represents the third successive increase in the national rate of hospital-treated deliberate self-harm.

Objective 12.4 of *Reach Out* (HSE, 2005, p. 33) clearly states the need for *"basic awareness training for all levels of hospital staff on suicidal behaviour,"* and the development and delivery of a *"specialist intervention, skills-based training for the appropriate staff as part of a national training programme"*. In 2007, the Regional Suicide Resource Office in Waterford established a working group to develop and deliver an awareness training programme on self-harm. The training programme, *"Understanding Self-Harm",* was developed by staff of the Regional Suicide Resource Office in Waterford. The delivery of the training has been supported by the HSE South and HSE West through the Regional Suicide Resource Office in Waterford, the Mental Health Resource Office in Cork and the Suicide Prevention Office in Limerick since 2007.

Understanding Self-Harm

Aims of the training

- To develop participants' knowledge and understanding of self-harm and the reasons underlying such behaviour
- To consider the needs of people who self-harm

Objectives

At the end of this programme participants will be able to:

- Be informed upon definitions of self-harm and consider the relationship with suicide
- Understand the prevalence of self-harm across different age groups and genders
- Be familiar with the functions, motivations and meanings underlying self-harm
- Demonstrate improved sensitivity and awareness of the needs of those people who self-harm
- Be aware of 'treatments' and helpful responses in responding to those people who self-harm

The National Office for Suicide Prevention in collaboration with the HSE South and West areas has commissioned an independent evaluation in order to ascertain the effectiveness of the self-harm training programme currently delivered throughout the HSE South, HSE South East and HSE West. The evaluation is further intended to inform the delivery of a national awareness training programme.

The research was granted ethical approval by both the HSE Mid-Western Area Research Ethics Committee and the HSE South-Eastern Area Research Ethics Committee.

Extract from the self-harm awareness training programme

Understanding Self-harm – Why?

Feeling unreal and distant, disconnected with life,
I pick up my razor blades,
Relieved at the sight of them I cry,
Not totally aware I cut into the skin,
Jolted back into reality by the act,
Checking that I'm still alive, that I'm still real,
For a short while I am in control, for a short while I am at peace.

(Gardner, 2001, p. 3)

Aims and Objectives

- Complete a review of the literature on the efficacy of self-harm training programmes

- Complete a review of the training programme and material in line with defined benchmarking criteria, including comparison with international programmes and similar learning methodologies

- Explore uptake of the training programme among its target audience

- Complete a quantitative and qualitative evaluation of self-harm awareness training as it is currently delivered in the HSE South and HSE West areas in order to identify how the programme is meeting its aims and objectives, including:
    - Whether the training changed participants' knowledge and if this knowledge was retained following the training
    - Whether following the training there was a change in attitude of the participants towards people who self-harm
    - Whether the training impacted on participants' awareness of the needs of those who self-harm
    - Whether the training impacted on participants' confidence and work practices in working with individuals who self-harm

- Explore trainers' experience of the self-harm training programmes

- Identify the resources required by a local co-ordinating site to ensure the optimal delivery of an awareness programme

- Identify potential indicators of successful implementation of the training to inform the national roll out process of the programme, including indicators related to capacity building and sustainability

- Identify potential barriers to successful implementation of the training programme

- Identify processes by which the training may be delivered nationally

Part 1: Literature review on the efficacy of self-harm awareness training programmes

1.1 Background

The National Institute for Clinical Excellence (NICE, 2004) recommends that training in awareness and understanding of deliberate self-harm should be provided to all clinical and non-clinical staff who have contact with people who self-harm. Knowledge and attitude change are frequently used as intermediate outcome measures in the context of suicide prevention initiatives (Althaus & Hegerl, 2003). Although the link between knowledge and attitudes and rates of suicide or self-harm is yet to be definitively established, changes in knowledge and attitudes in people who come into contact with individuals who self-harm may potentially influence the pathway to suicidal behaviour, for example by facilitating early access to appropriate treatment (Wrigley et al., 2005), increasing patients' willingness to engage with services (Patterson et al., 2007), and reducing negative attitudes which may decrease quality of care or increase the chance of missing an important opportunity to reduce the risk of future repetition of suicidal behaviour (Pompili et al., 2005).

Prevention research depends on evidence-based scientific knowledge that facilitates the dissemination and implementation of effective prevention programmes (Elliott & Mihalic, 2004). Therefore, it is crucial that any efforts to implement a nationwide delivery of self-harm awareness training are in line with evidence-based best practice, based on a systematic evaluation of available programmes. It is within this context that a literature review of the available evidence on the efficacy of self-harm awareness programmes was conducted.

1.2 Methods

Literature search

A literature search was carried out using the following electronic bibliographic databases: PubMed, PsycINFO, Science Direct and Current Contents. A computer based search was carried out using a wide range of key words including *deliberate self-harm, self-injury, suicide, awareness, prevention, knowledge, attitudes, training, education, intervention, gatekeeper, evaluation, efficacy, effectiveness and review.* Reference lists of available reviews and studies were also screened.

Inclusion criteria

Study reports were included if the following inclusion criteria were met:

(a) The study report included a training or educational programme addressing self-harm as primary or secondary topic.

(b) The study report included an evaluation: pre-post or post only, controlled or non-controlled.

Methodological quality

Reviewing the outcomes of the available studies, the methodological quality of the studies was taken into account, such as sample size, power, recruitment of sample, use of validated instruments, status of evaluation: independent or not, length of follow-up period, consideration of previous training effects, and appropriate statistical analyses conducted without violation of the assumptions of the selected tests.

1.3 Results

The literature search revealed twelve relevant papers including one review. Five papers reported on studies addressing self-harm as a primary topic and included an evaluation. The methodological aspects of the primary studies are presented in Table 1.1. The target populations varied from medical professionals e.g. A&E/MAU nurses to non-medical professionals, such as school welfare staff, and one study targeted parents of children and adolescents presenting to emergency departments. The number of training participants varied from 13 to 213 and none of the studies had conducted a power analysis to determine the minimum number of participants required in order to detect a training effect. The content of the training programmes varied across the studies. However, there were a number of common elements. In three of the five training programmes, risk assessment of self-harm was included and four programmes covered therapeutic interventions for self-harm. The length of the training programmes varied from 2 hours to 12 days and in one study (Kruesi et al., 1999) this was not specified. All studies included a pre-post design and two studies included a control group (Kruesi et al., 1999; Patterson et al., 2007). The length of the follow-up period varied from 2.4 to 48 months and two studies (Holdsworth et al., 2001; Commons Treloar et al., 2008) conducted only one follow-up immediately following the training. Four studies used validated measurement instruments to investigate the efficacy of the training on knowledge, skills and attitudes related to self-harm. In four studies the evaluation was conducted independently from the training and this was not specified in the study by Holdsworth et al. (2001). Only two

studies had taken into consideration possible effects of previous training programmes. In four studies the relatively small numbers of participants caused a limitation in conducting the appropriate statistical analyses. This may be related to the absence of power analyses in all of the five studies.

All five studies consistently reported positive changes pre-post training in terms of participants' increased knowledge in relation to self-harm, increased confidence in dealing with people who engage in self-harm and more appropriate attitudes towards self-harm and prevention. In the two studies that investigated the efficacy of training in the months and years following the training, some evidence was found for the sustainability of the positive effects. Robinson et al. (2008) found that positive changes in knowledge, attitudes, confidence and skills in dealing with people engaging in self-harm immediately following the training were sustained at 6 months follow-up. Participants who had received previous training showed a greater positive attitude change than those who had not. In a controlled prospective study Patterson et al. (2007) reported significantly lower levels of antipathy, assessed by the Self-Harm Antipathy Scale (SHAS) immediately after the training, and this was followed by a further significant decrease at the second follow-up at least 18 months later.

In the six secondary studies, awareness of self-harm was addressed as one of many other topics in training programmes targeting a variety of populations. Considering the diversity of the training programmes, populations and methods, comparison of the study outcomes is difficult. Two studies investigated the efficacy of gatekeeper suicide prevention training programmes among secondary school staff (Tompkins et al., 2009; Wyman et al., 2008). Both studies reported significant positive changes pre-post training in terms of increased knowledge and more appropriate attitudes towards suicidal behaviour and its prevention. Wyman et al. also found evidence for enhanced gatekeeper's appraisals of efficacy. Two studies focused on the efficacy of mental health first aid training; one study was conducted with teachers (Jorm et al., 2010) and one involved the general public (Kitchener & Jorm, 2002). Both studies reported significant positive changes pre-post training in terms of mental health literacy, stigma related to mental health and confidence in helping behaviour. In both studies, the positive changes were sustained at six months follow-up. Gask and colleagues (2006) conducted an independent evaluation of the Skills Training On Risk Management (STORM) involving 458 mental health professionals. Significant positive changes pre-post training were found for staff members' attitudes towards suicide and its prevention and confidence in dealing with suicidal people. However,

no information was obtained on sustainability of the immediate training effects long term. An independent evaluation of a suicide awareness programme among community volunteers revealed significant positive pre-post training effects in terms of increased awareness of suicide warning signs (Tsai et al., 2010). Again, sustainability of training effects in the long term was not addressed.

Isaac and colleagues (2009) conducted a systematic review of studies evaluating the efficacy of suicide prevention gatekeeper training among a wide range of populations, such as military personnel, school staff, clinicians, peer helpers etc. A number of the gatekeeper training programmes reviewed included modules on self-harm. The review revealed consistent evidence supporting the efficacy of suicide prevention gatekeeper training in terms of significant positive changes relating to knowledge, skills and attitudes of participants towards suicide prevention. Large-scale prospective studies also reported significant reductions in suicidal ideation and non-fatal and fatal suicidal behaviour.

Overall, the literature review revealed consistent evidence supporting the efficacy of self-harm awareness training and related training programmes, in particular regarding short-term effects. However, there is a need for more randomised controlled studies including long term follow-up assessments. In addition, further research is required to identify the unique effects of gatekeeper training on rates of self-harm and suicide.

Table 1.1 Methodological aspects of primary studies evaluating the efficacy of self-harm awareness training

Authors	Target group and N	Content of the training programme	Programme duration	Study design	Length of follow-up period	Use of validated instruments	Status of evaluation	Consideration of previous training effects	Use of appropriate statistical analyses
Kruesi et al. (1999)	Parents of children adolescents presenting to A&E deemed by staff to be at-risk (N=41)	• Information on self-harm and suicide risk • Information on means of self-harm and lethality • Educating parents using problem-solving interventions	Not specified	Pre-post-controlled	Mean number of months: 2.4 (SD 1.7)	√	Independent	x	√ (Relatively low N)
Holdsworth et al. (2001)	Accident and emergency nurses and medical admission unit nurses (N=13)	• Assessment of self-harm and suicide risk • Responses to repeated DSH • Risk assessment instruments and documentation • Practice feedback reflection • Locus of control and relevant legislation	5 half day sessions	Pre-post	Pre-post training only	x	Not specified	x	Due to the limited N only absolute numbers were presented
Patterson et al. (2007)	Qualified healthcare professionals (N=69)	• Explanations and causes of self-harm and suicide • Forms and functions of the behaviour • Exploring possibilities for prevention • Responses to the behaviour • Assessment methods and processes • Interventions and management of care • Professional practice issues	78 hours (12 days)	Pre-post-controlled	Between 18 - 48 months	√	Independent	x	Limited number at last follow-up

Table 1.1 contd. Methodological aspects of primary studies evaluating the efficacy of self-harm awareness training

Authors	Target group and N	Content of the training programme	Programme duration	Study design	Length of follow-up period	Use of validated instruments	Status of evaluation	Consideration of previous training effects	Use of appropriate statistical analyses
Commons Treolar & Lewis (2008)	Mental health and emergency medicine practitioners (N=99)	• Research findings on attitudes to BPD • Prevalence rates of DSH and suicide, and aetiological factors • DSM-IV diagnostic criteria • Therapeutic interventions to BPD	2 hours	Pre-post	Pre-post training only	√	Independent	√	Limited number in some subgroups
Robinson et al. (2008)	School welfare staff (N=213)	• Epidemiology of DSH • Relationship between DSH and suicide • Evidence based interventions • Recognition and assessment of risk • Risk management planning • Benefits and challenges of working with families • Individual interventions for young people and specialist services • Signs and symptoms of mental disorder • Therapeutic interventions • Policies and procedures in schools	7-14 hours (1 or 2 day packages)	Pre-post	6 months	√	Independent	√	√

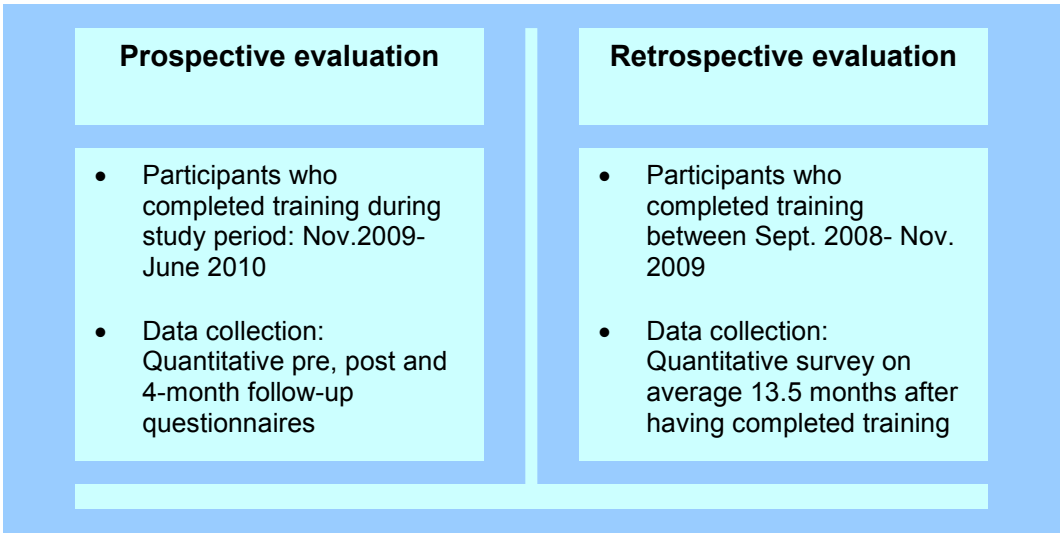
Part 2: Independent evaluation of the self-harm awareness training programme - Quantitative

2.1 Methods

Design

The evaluation was conducted along two concurrent strands to include both a prospective and retrospective evaluation (Figure 2.1). In order to determine pre-post training changes among participants of the self-harm awareness training programme, semi-structured self report questionnaires were administered among participants immediately before (pre) and after (post) training. A 4-month follow-up was conducted in order to investigate changes after the 1st follow-up (post-training) and to enable investigation of sustainability of training effects.

Figure 2.1 Design of the quantitative evaluation



Sample

In connection with the prospective evaluation, all people who attended the self-harm awareness training programme in the HSE South East and HSE Mid West between November 2009 and June 2010 were invited to participate in the quantitative evaluation. No training programmes were delivered in the HSE Southern during the prospective evaluation time period.

In order to detect a medium difference between two independent sample means at the 5% level of statistical significance (i.e. p-value < 0.05) with 80% statistical power, 64 participants were required in each group.

The sample included in the retrospective evaluation comprised people who attended the self-harm awareness training programme in the HSE Southern, HSE South East and HSE Mid West between September 2008 and November 2009.

It is important to note that the intervention sites differ in several respects (Table 2.1).

Table 2.1 Intervention sites

	HSE Southern	HSE South East	HSE Mid West
Number of deliberate self-harm episodes (2009)*	1433	1234	1076
Trainers of the self-harm awareness training programme	2 CNS/Liaison Nurses Total: 2	6 CNS/Liaison Nurses 2 Training & Development Officers Total: 8	1 Suicide Resource Officer 1 Training & Development Officer Total: 2
Length of training programmes offered	3 hours	3 hours	8 hours
Administrative support for the programme	Part time	Yes	Part time

**National Registry of Deliberate Self-Harm 2009 Annual Report (NSRF, 2010)*

Procedure

Prospective evaluation

A standardised procedure was used to collect data from participants attending the training programmes in the HSE South East and HSE Mid West. At the start of each of the training programmes, a sealed envelope was handed out to all participants including a letter introducing the independent evaluation, a consent form and the baseline questionnaire. Immediately after the training programme, a second envelope, including an explanatory letter and first follow-up questionnaire, was handed out to those who had agreed to participate. Participants were also invited to give consent to be contacted for a further second follow-up questionnaire. Participants who had completed the training programme between November 2009 and February 2010 (taking into account the time scale of the study period) and who had consented to be contacted for the 2nd follow-up received an explanatory letter and 2nd follow-up questionnaire 4 months after the 1st follow-up either by post (83%) or email. For participants who had not returned the 2nd follow-up questionnaire within 3-6 weeks, a reminder message was sent out by e-mail.

Retrospective evaluation

The retrospective evaluation was also conducted according to a standardised procedure. Contact details of all participants who had completed the self-harm awareness training programme in the HSE South and HSE West between September 2008 and November 2009 and who had consented to be contacted for the purpose of the evaluation, were obtained from the training co-ordinator. Between February and April 2010 a letter introducing the independent evaluation, a consent form and the questionnaire were sent out to 553 participants. In total 177 participants had not provided their postal address, but their e-mail address. Therefore, 376 letters were sent out by post with a further 177 messages sent by e-mail.

Data items and measurement

For both the prospective and retrospective evaluation, the content of the semi-structured questionnaires was largely similar (Appendices I - IV). The questionnaires included standard socio-demographic items, length of the training programme (i.e. 3-hour versus 8-hour format), previous experience of training in self-harm and related topics, satisfaction with the self-harm awareness training, knowledge of self-harm, attitudes toward self-harm, confidence in dealing with patients who self-harm and feedback on the training programme.

Knowledge of self-harm was assessed using a measure specifically designed to measure service providers' knowledge of self-harm (Jeffery & Warm, 2002). The Knowledge of Self-Harm Scale includes 20 statements, such as *"self-harm is a failed suicide attempt" and "self-harm expresses emotional pain*". Responses are scored on a five-point Likert scale, ranging from strongly disagree (1) to strongly agree (5). Statements related to myths about self-harm (e.g. *"self-harm is a female problem"; "self-harm is attention-seeking"*) are negatively scored, allowing an overall knowledge score to be calculated, ranging from 20 (poor understanding of self-harm) to 100 (good understanding of self-harm). Internal consistency of the scale from the original study was good (Cronbach's alpha: .75) with a split half reliability of .84. In this sample, the Cronbach's alpha for the scale was .71 (reliability indicators for all scales calculated at baseline).

Attitudes towards self-harm were assessed using the Attitudes Towards Deliberate Self-Harm Questionnaire (ADSHQ; McAllister et al., 2002). The ADSHQ consists of 33 items, such as *"self-harm clients are just using ineffective coping mechanisms"* and *"I often feel helpless in dealing with the problems of DSH clients"*. Responses are scored on a four-point Likert scale, ranging from strongly disagree (1) to strongly agree (4). Four subscales have been identified in the ADSHQ: *perceived confidence in assessment and referral; ability to deal effectively with clients; empathetic approach; and ability to cope effectively with legal and hospital regulations that guide practice.* Subscale reliability for each dimension ranged

from sufficient (α=.57 to α =.74). In this sample, a Cronbach alpha of .64 was found for the total scale with scores for the subscales ranging from .48 to .70. The scale has been used previously to evaluate attitude changes pre-post educational training in self-harm (Commons Treolar & Lewis, 2008).

In order to take the wide range of participant occupation roles into account (i.e. individuals who work in both clinical and non-clinical settings), it was proposed that the ADSHQ scale be amended for participants who do not come into contact with self-harm in a clinical setting. For these non-clinical participants (e.g. youth workers or representatives of community groups), items included in the subscale *"ability to cope effectively with legal and hospital regulations that guide practice"* were removed from the questionnaire to ensure relevancy across all groups while still allowing insight into changes specifically relevant to participants working in clinical settings (e.g. psychiatric nurses).

Confidence in dealing with self-harm patients was assessed by two items included in the Confidence Scale, developed by Morriss et al. (1999). The items assess confidence in: *"I feel confident that I could relate and instill help seeking behaviour to someone who self-harms" and "After seeing a person once, I would be confident that I could recognise potential suicide risk".* The items are scored using two 10cm visual analogue scales. A minimum score indicates being "not at all confident" whereas a maximum score indicates being "very confident".

The phrasing of some items was amended and some extra items were included based on the strand of the evaluation (retrospective vs. prospective) or the time period in which the questionnaire was completed (i.e. baseline, 1st follow-up or 2nd follow-up). For example, in both the retrospective questionnaires and the 2nd follow-up questionnaires, extra items were included in relation to the handbook and whether or not participants noticed a difference in relation to how they dealt with people who self-harm or are at risk of self-harm since the training programme. Furthermore, a 12-item training programme evaluation section was included in both the 1st follow-up and retrospective questionnaires.

Data analysis

The data were entered in Excel and data analyses were conducted using SPSS. Continuous data, such as data obtained from the Knowledge of Self-Harm Scale, the Attitudes towards Deliberate Self-Harm Questionnaire and Confidence Scale were analysed using t-tests, and mean differences in order to examine differences by demographic characteristics, such as age, gender, profession, years of education and work experience, and whether participants had attended previous training or not. T-tests were also used to analyse differences between baseline and 1st follow-up and between 1st and 2nd follow-up.

In the prospective evaluation, a limited number of clinical professionals (N=6) participated in the self-harm awareness training programme. Therefore, the ADSHQ subscale 4: *Ability to cope effectively with legal and hospital regulations that guide practice* was not included.
Due to the relatively low response rate at the time of the 2nd follow-up, comparisons could not be made for subgroups in terms of changes between 1st and 2nd follow-up.

2.2 Prospective evaluation results

Response

Between November 2009 and June 2010, 275 participants attended 21 training programmes. In total 270 participants completed the baseline questionnaire giving a response rate of 93%. Of the participants who completed baseline, 244 completed the 1st follow-up (post-training) questionnaire, a response rate of 95%. In total, 94 participants consented to be contacted for the 2nd follow-up, 4 months after the training. Of these, 29 returned a completed questionnaire, a response rate of 31%.

Socio-demographic characteristics

The majority (80.9%) of participants involved in the prospective evaluation were females and the mean age of the total sample was 39.5 years (SD 11.6). Nearly two thirds (61.0%) of the sample were younger than 45 years and 39.0% were 45 years and older.
In terms of the number of years involved in education including primary, secondary, higher education and courses, the average number of years was 16.2 (SD 4.5) with a maximum of 29 years. The majority (40.1%) of the participants were working in the social care sector, followed by 15% in the education sector, 13.1% in counselling, 10.5% in health services and 8.6% in community agencies. The remaining 12.7% were involved in a variety of work areas (e.g. An Garda Siochana, financial advisors, business managers etc.) The average number of years of work experience was 8.6 (SD 8.2), ranging from 1 to 53 years.

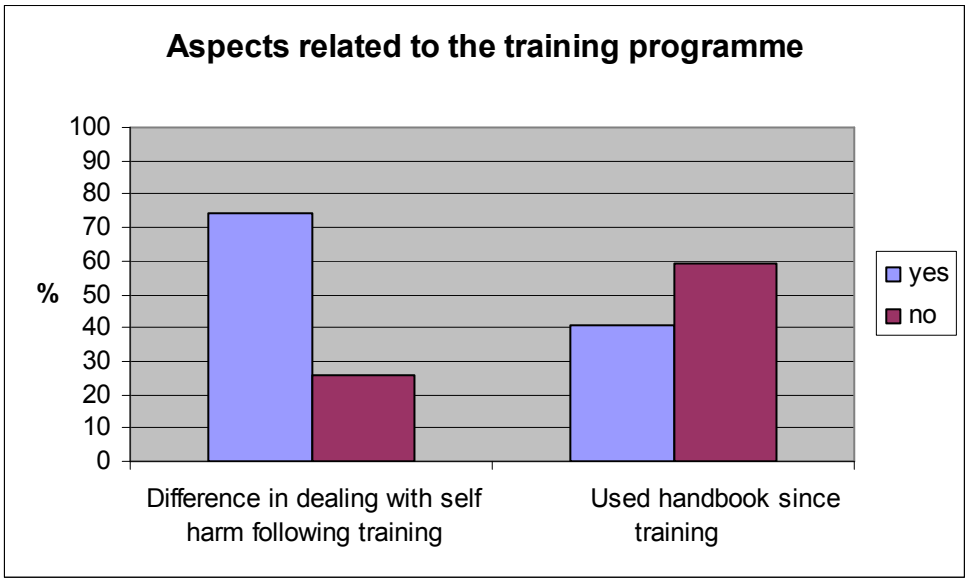
Previous training

Most of the participants involved in the prospective evaluation had completed training in a relevant mental health area prior to the self-harm awareness training programme. The majority of participants had completed previous training on crisis intervention (64.9%) and 61.4% had been involved in training on suicide or suicide prevention. Just over half (53.5%) had received training on depression and 30.5% had been involved in a previous training programme on self-harm.

Aspects related to the training programme

The majority of participants (78%) had followed the 3-hour training programme and 22% had followed the 8-hour programme. At the four month follow-up 41% of the participants reported having used the handbook. Most participants (74%) indicated that the training has made a difference in how they are dealing with self-harm following the training (Figure 2.2).

Figure 2.2 Proportion of participants indicating differences in dealing with self-harm and use of the handbook at 4-month follow up



In general, participants provided positive comments for the open-ended questions at both the 1st and 2nd follow-up. The course was consistently described as "informative" with reference to the participatory nature of the workshop.

> *"I found the course very beneficial and it certainly added to my skills and understanding of this complex area"*

> *"A great enlightenment on self-harm and a great help in my work place"*

A number of the participants referred to the duration of the training programme and the potential for the training to include more skill-based elements.

> *"Probably needs more time as some issues are complex and need more discussion"*

"The title of the programme was "understanding self-harm" and this was delivered. However I would have liked some information on management/dealing with a crisis incident."

At 2nd follow-up, participants provided comments on the handbook, with most agreeing that the book is useful and contains clear and relevant information. Some participants also described how they had made use of the handbook.

"Read some of it to friends and work colleagues the day after the training"

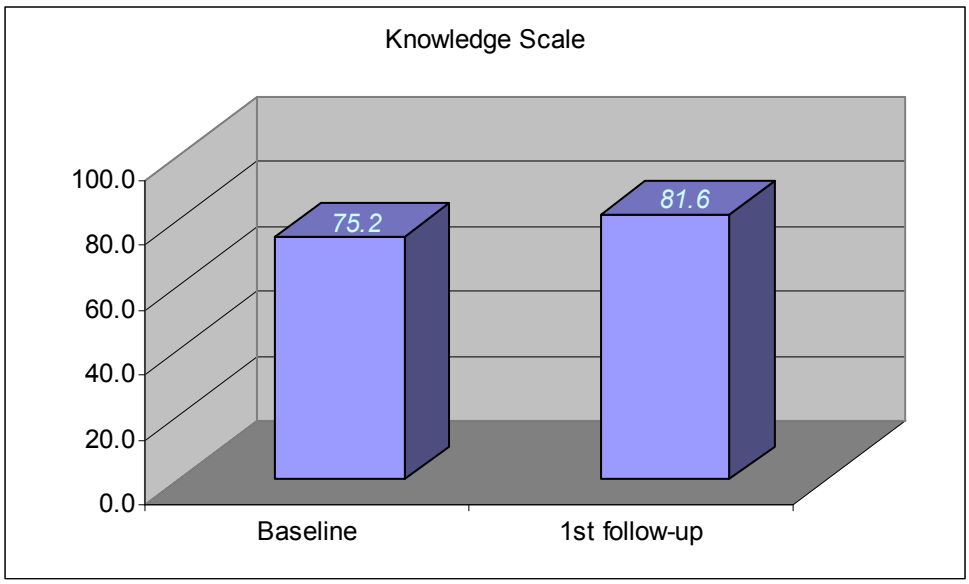
"I have used the handbook to keep refreshed the skills I learned during the training"

Baseline versus follow-up

Knowledge of self-harm

Comparing baseline to first follow-up directly after having completed the self-harm awareness training programme, a significant positive change was observed in the mean total self-harm knowledge score from 75.2 (SD 6.5) to 81.6 (SD 6.3) (t=-10.1, df 407, p<.001) (Figure 2.3). The relatively high baseline score is of note.

Figure 2.3 Mean total scores on the *Knowledge of Self-Harm Scale* at baseline and 1st follow-up



In terms of the magnitude of change between baseline and 1st follow-up, a significantly greater change in knowledge of self-harm was found for participants who had not received any previous training on self-harm awareness (Table 2.2). A trend towards significance was found for participants who had not previously been involved in training on depression awareness. No significant differences were found for gender, age group, years of work

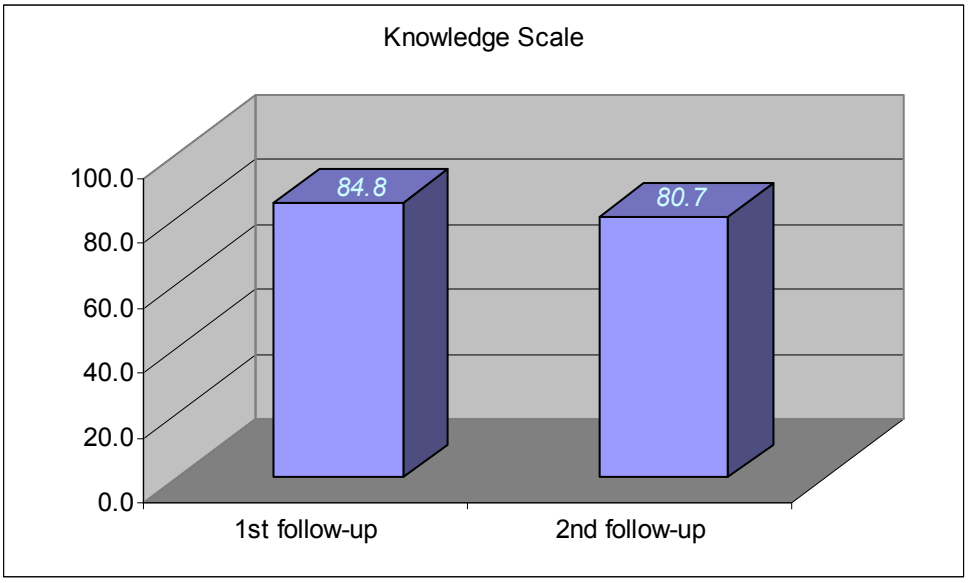
experience, years of education and previous training on crisis intervention and suicide/ suicide prevention.

Table 2.2 Magnitude of change in relation to the *Knowledge of Self-Harm Scale* between baseline and 1st follow-up

	Mean change Baseline – 1st Follow-up	Std. Dev.	t	p
Previous self-harm awareness training				
Yes	4.2	9.1	2.4	<.02
No	7.4	8.8		
Previous depression training				
Yes	5.3	8.9	1.7	<.08
No	7.5	9.1		

Comparing participants who had completed both the first and second follow-up questionnaires (i.e. four months after having completed the training programme), a significant reduction was found in the mean total knowledge score from 84.7 (SD 6.1) to 80.7 (SD 7.0) (t=2.5, df 17, p<.02) (Figure 2.4).

Figure 2.4 Mean total scores on the *Knowledge of Self-Harm Scale* at 1st and 2nd follow-up



Attitudes towards self-harm

Significant positive changes were observed on the total score of the Attitudes to Deliberate Self-Harm Questionnaire (ADSHQ) and two subscales when comparing baseline to first follow-up (Figures 2.5-2.8). The ADSHQ mean total score increased from 56.0 (SD 4.2) at baseline to 59.3 (SD 4.7) at first follow-up (t=7.1, df 380, p<.001) (Figure 2.5). Comparing

the magnitude of change from baseline to first follow-up for all subscales of the ADSHQ, the greatest change was observed for subscale 2: *Dealing effectively with DSH clients* (Baseline: M=14.6, SD 2.5; 1st follow-up: M=16.7, SD 2.1) (t=9.6, df 432, p<.001) (Figure 2.7). The mean score for subscale 3: *Empathic approach* increased from 15.7 (SD 1.8) to 16.1 (SD 1.8) (t=2.2, df 468, p<.02) (Figure 2.8). Even though no significant effect of the training was found for subscale 1: *Perceived confidence in assessment and referral of DSH clients*, the average total score at first follow-up (M=26.3, SD 2.8) was slightly higher compared to baseline (M=25.8, SD 2.2) (Figure 2.6).

Figure 2.5 Mean total scores on the *Attitudes Towards Deliberate Self-Harm Questionnaire* at baseline and 1st follow-up

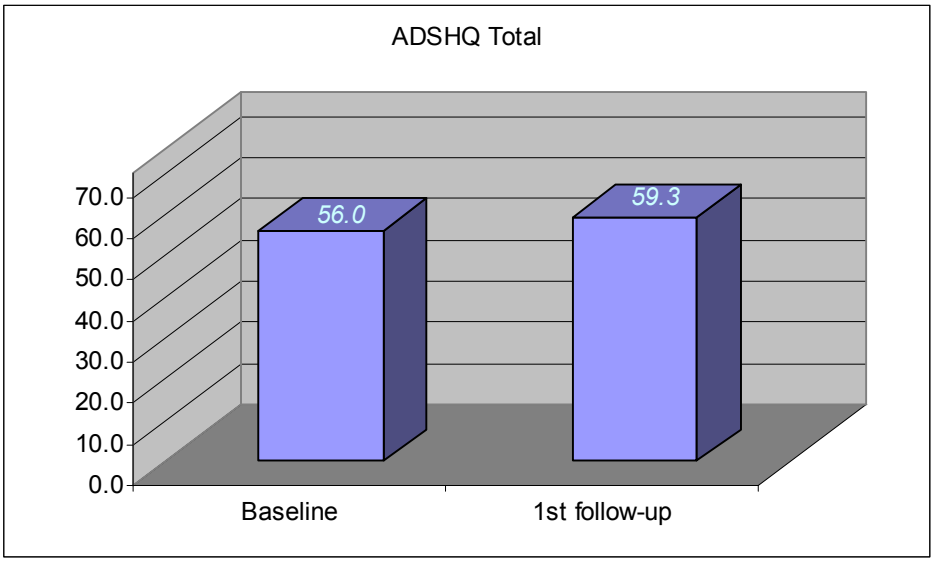


Figure 2.6 Mean total scores on ADSHQ subscale 1: *Perceived confidence in assessment and referral of DSH clients* at baseline and 1st follow-up

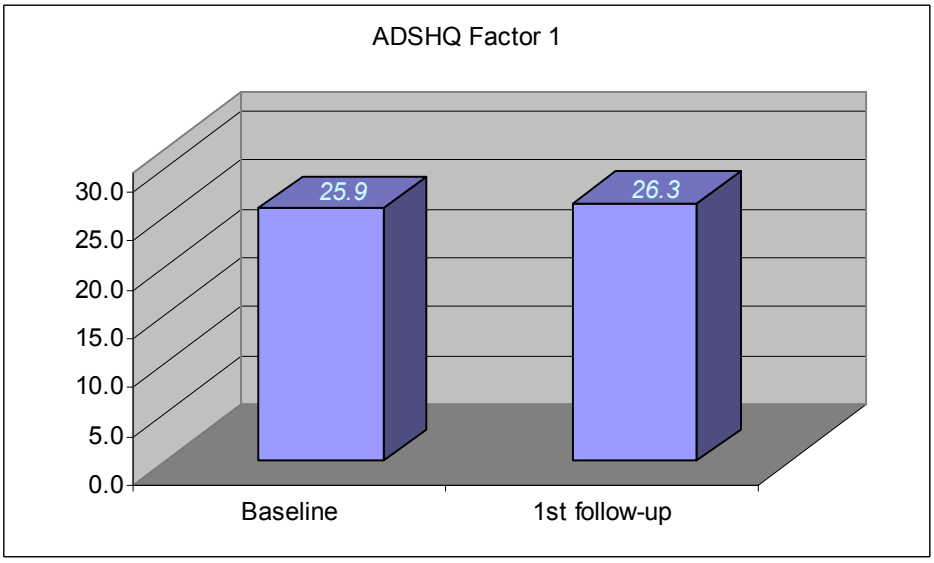


Figure 2.7 Mean total scores on ADSHQ subscale 2: *Dealing effectively with DSH clients* at baseline and 1st follow-up

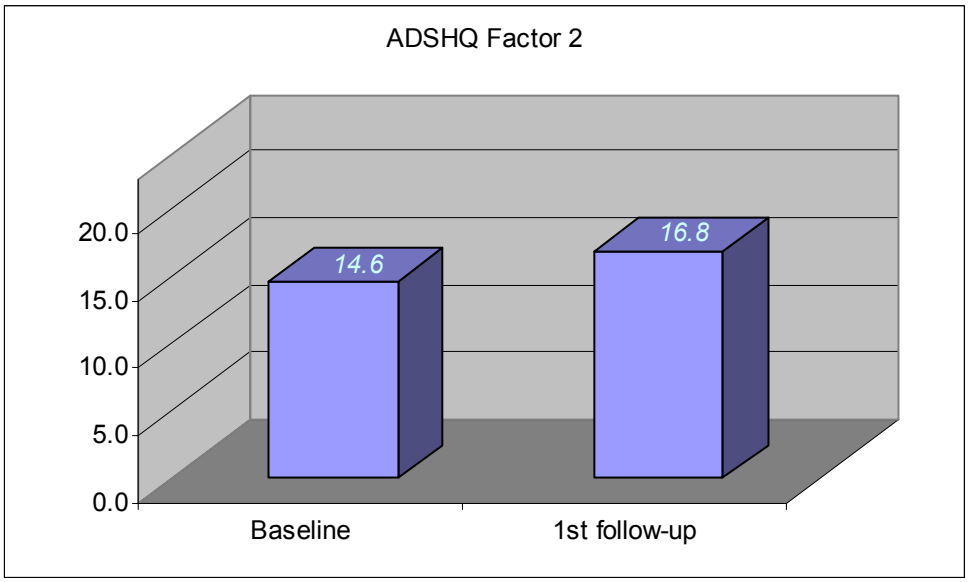
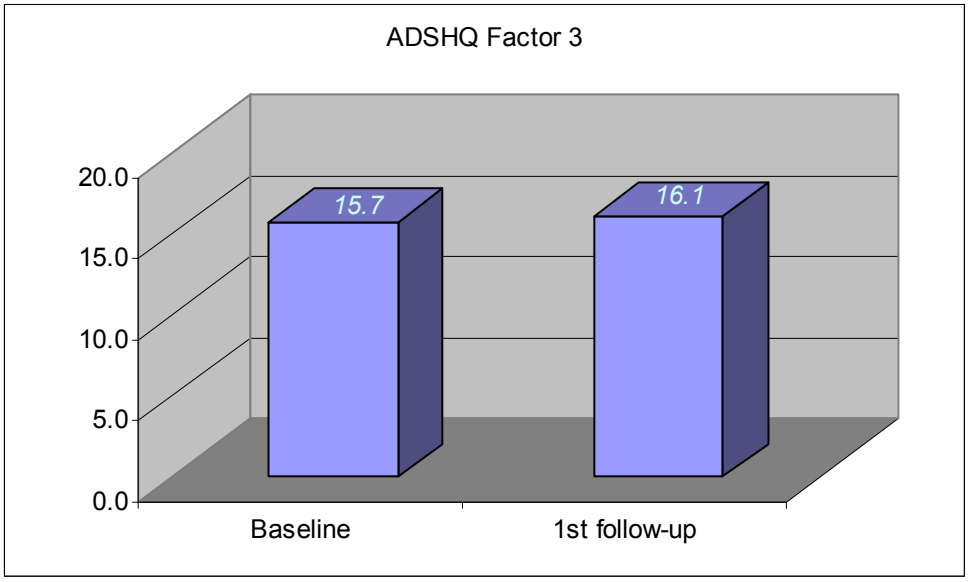


Figure 2.8 Mean total scores on ADSHQ subscale 3: *Empathic approach* at baseline and 1st follow-up



Comparing changes on the mean total ADSHQ score between baseline and first follow-up by socio-demographic characteristics and previous training, a number of significant differences were identified (Table 2.3). A significant positive change on the mean total ADSHQ score was found for women but not for men, which may be partly related to the smaller number of male participants. Participants with 15 or more years of education showed a significantly positive change on the mean total ADSHQ score while for those with less than 15 years education we only found a trend towards significance, which again may be partly explained by the lower number in the latter group. The pre-post training changes

did not vary in terms of direction and significance by age, years of work experience and previous training.

Table 2.3 Changes on the mean total ADSHQ score between baseline and 1st follow-up by socio-demographic characteristics and previous training

	ADSHQ scores							
	Baseline			Follow-up				
	n	Mean	Std. Deviation	n	Mean	Std. Deviation	T	p
Gender								
Males	38	56.9	4.5	40	58.7	5.78	1.5	<.134
Females	150	55.8	4.2	152	59.5	4.38	7.4	<.001
Length								
3 hours	140	56.0	4.0	148	59.1	4.86	5.8	<.001
One day	42	56.0	4.6	43	60.1	4.1	4.4	<.001
Depression Training								
Yes	103	56.8	4.5	103	59.6	4.5	4.4	<.001
No	84	55.1	3.9	91	59.1	5.0	5.9	<.001
Self-Harm Training								
Yes	62	57.2	4.7	74	60.1	4.4	3.7	<.001
No	126	55.5	4.0	120	58.9	4.8	6.1	<.001
Suicide Training								
Yes	117	56.8	4.4	121	59.7	4.6	4.8	<.001
No	71	54.8	3.7	72	58.9	4.8	5.7	<.001
Crisis Training								
Yes	128	56.6	4.3	132	59.3	4.8	4.8	<.001
No	60	55.0	3.9	62	59.5	4.5	5.9	<.001
Age								
<45 yrs age	115	56.0	3.9	114	59.5	4.4	6.3	<.001
≥45 yrs age	53	55.6	4.8	80	59.1	5.1	4.0	<.001
Years Experience								
<15 years	147	56.0	4.2	133	59.2	4.8	5.9	<.001
≥15 years	27	56.6	4.6	29	59.4	4.5	2.3	<.024
Years Education								
<15 years	38	56.1	5.1	37	58.2	5.4	1.7	<.092
≥15 years	150	56.0	4.0	127	59.7	4.6	7.0	<.001

In terms of the magnitude of change between baseline and 1st follow-up, a significantly greater change in perceived confidence in assessment and referral of DSH patients (ADSHQ subscale 1) was found for participants who had not received previous training in crisis intervention, and a trend towards significance was found for the ADSHQ total score (Table 2.4). Participants with 15 or more years of education showed a significantly greater change in perceived confidence in assessment and referral of DSH patients compared to those with less than 15 years of education.

No significant differences were found for gender, age group, years of work experience, previous training on depression, self-harm awareness and suicide/ suicide prevention.

Table 2.4 Magnitude of change in relation to the *Attitudes Towards Deliberate Self-Harm Questionnaire* between baseline and 1st follow-up

	Mean change Baseline – 1st Follow-up	**Std. Dev.**	**t**	**P**
	ADSHQ Total			
Previous crisis intervention training				
Yes	2.7	6.4	1.8	<.07
No	4.5	5.9		
	ADSHQ Subscale 1			
Previous crisis intervention training				
Yes	0.1	3.6	1.9	<.05
No	1.1	3.3		
	ADSHQ Subscale 1			
Years of education				
< 15 years	-0.65	3.8	2.1	<.04
≥ 15 years	0.69	3.4		

Comparing participants who had completed both the 1st and 2nd follow-up questionnaires, no significant reductions were found for the total ADSHQ and subscale scores (Figures 2.9 - 2.12). For ADSHQ subscale 3: *Empathic approach* a slight increase was found from 15.9 (SD 1.7) to 16.3 (SD 1.9). Due to the relatively low numbers at the time of the 2nd follow-up no analyses could be conducted for subgroups.

Figure 2.9 Mean total scores on the *Attitudes Towards Deliberate Self-Harm Questionnaire* at 1st and 2nd follow-up

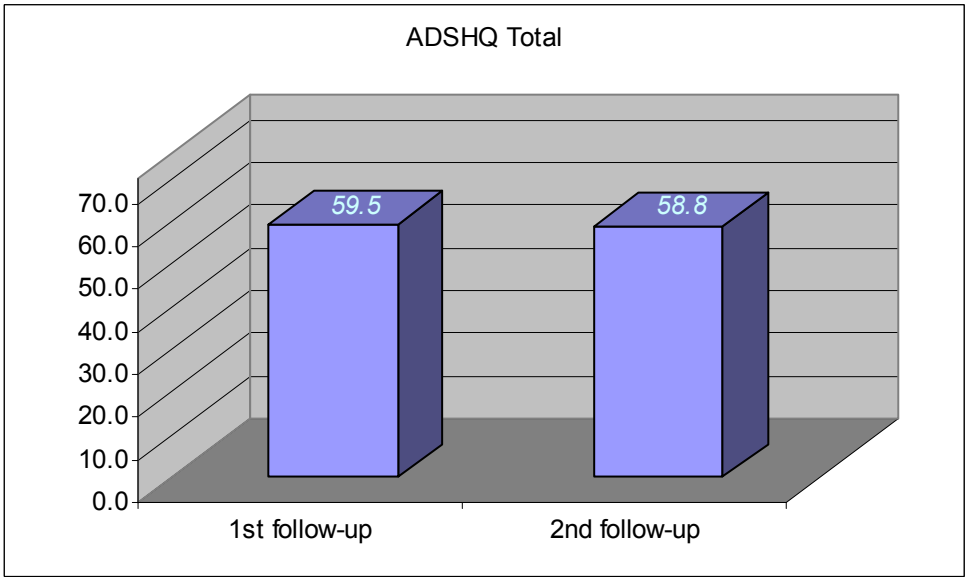


Figure 2.10 Mean total scores on ADSHQ subscale 1: *Perceived confidence in assessment and referral of DSH clients* at 1st and 2nd follow-up

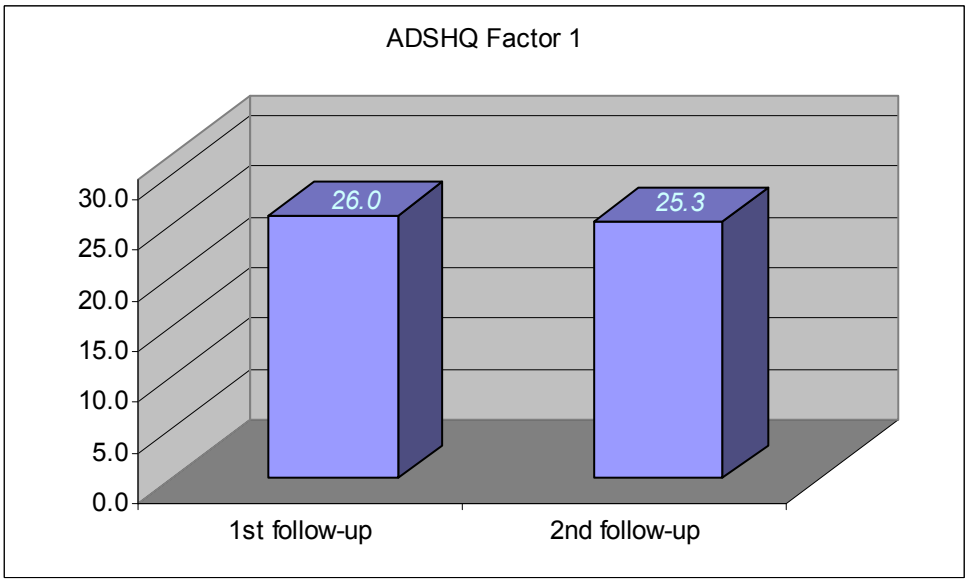


Figure 2.11 Mean total scores on ADSHQ subscale 2: *Dealing effectively with DSH clients* at 1st and 2nd follow-up

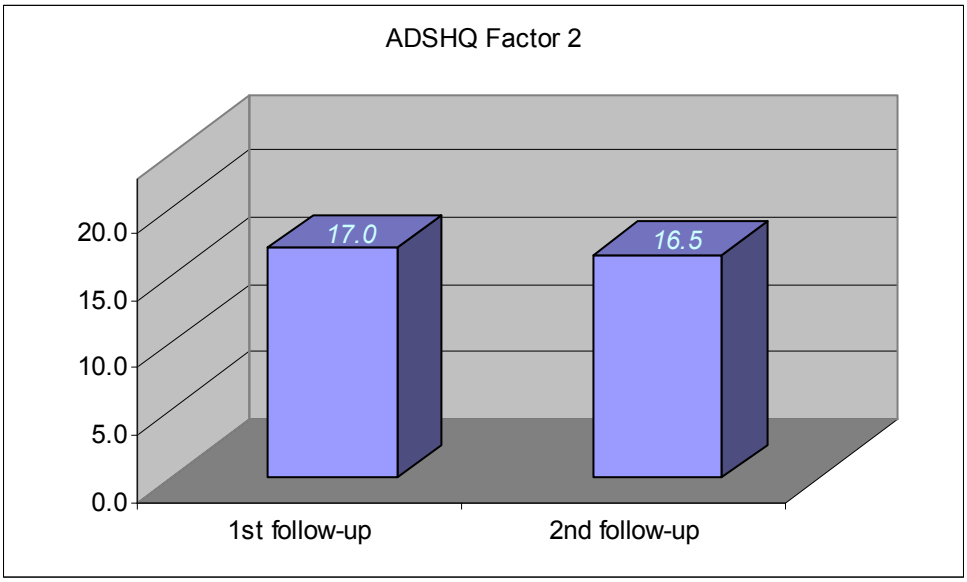
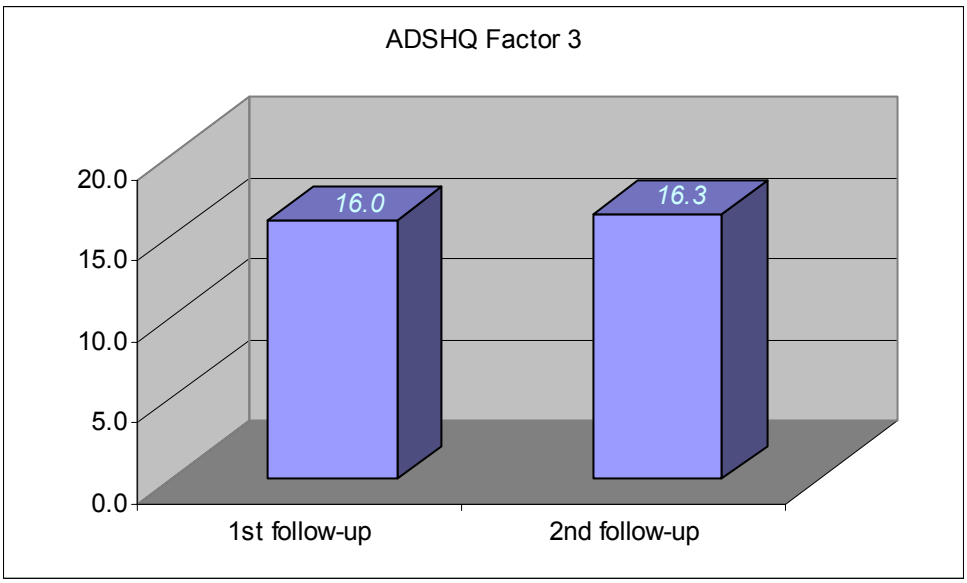


Figure 2.12 Mean total scores on ADSHQ subscale 3: *Empathic approach at* 1st and 2nd follow-up



Confidence in dealing with people who self-harm

The study revealed significant positive changes in relation to participants' confidence in dealing with people who self-harm pre-post training (Figures 2.13 – 2.14). With regard to the statement: *"I feel confident that I could relate and instil help seeking behaviour to someone who self-harms"* the average total score increased from 5.4 (SD 2.0) at baseline to 6.8 (SD 1.7) at first follow-up (t=8.4, df 514, p<.001). A similar effect was observed for the statement: *"After seeing a person once, I would be confident that I could recognise potential suicide risk"* (Baseline: M=4.2, SD 2.5; Follow-up: M=5.3, SD 2.3) (t=5.2, df 513, p<.001).

Figure 2.13 Mean total scores on Confidence Scale item 1 at baseline and 1st follow-up

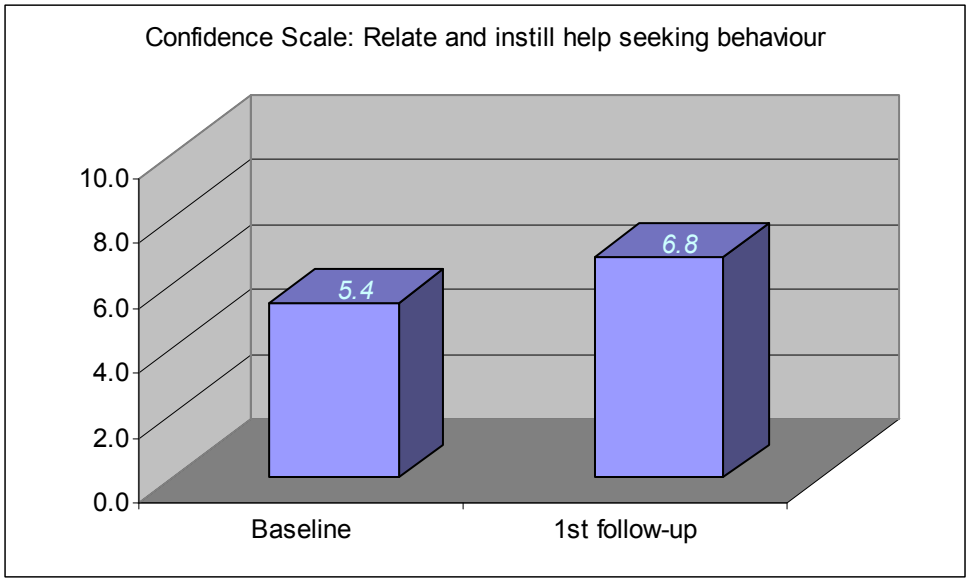
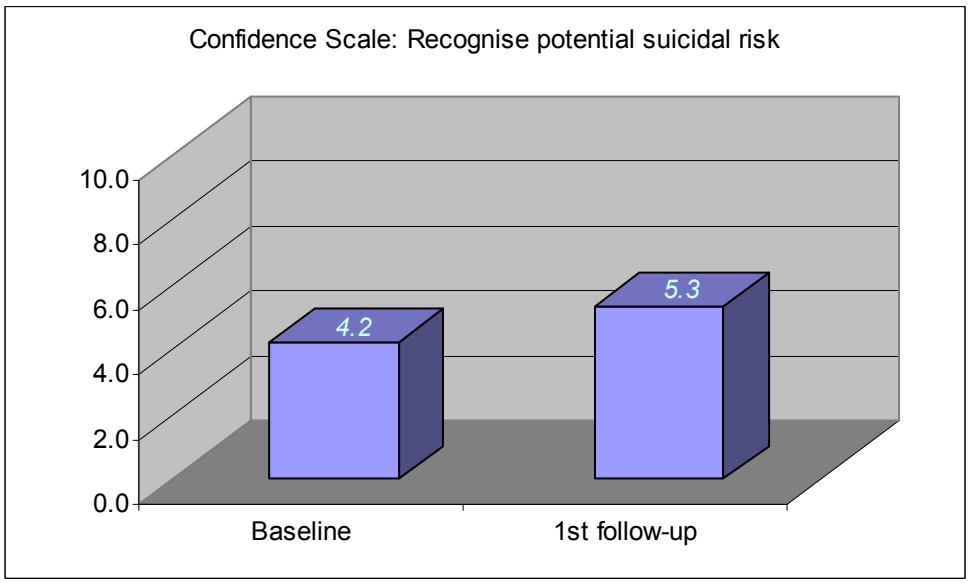


Figure 2.14 Mean total scores on Confidence Scale item 2 at baseline and 1st follow-up



With regard to the statement: *"I feel confident that I could relate and instill help seeking behaviour to someone who self-harms"* the magnitude of change between baseline and follow-up was significantly greater among participants who had not received self-harm awareness training prior to participating in the present training programme (M=1.6, SD 2.7) compared to those who had (M=0.9, SD 2.2) (t=2.2, df 193, p<.02) (Table 2.5). Participants who had received the 8-hour training programme showed a greater magnitude of change on the Confidence Scale *"After seeing a person once, I would be confident that I could recognise potential suicide risk"* than those who had been involved in the 3-hour programme (M=1.80, SD 3.0 versus M=0.90, SD 3.4) reflecting a trend towards significance (t=1.7, df

244, p<.08). No significant differences were found for gender, age group, years of education, years of work experience, previous training on crisis intervention, depression and suicide/suicide prevention.

Table 2.5 Magnitude of change in relation to the *Confidence Scale* between baseline and 1st follow-up

	Mean change Baseline – 1st Follow-up	**Std. Dev.**	**t**	**P**
	Confidence Scale: Relate and instil help seeking behaviour			
Previous self-harm awareness training				
Yes	0.9	2.2	2.2	<.02
No	1.6	2.7		
	Confidence Scale: Recognise potential suicide risk			
Previous crisis intervention training				
3 hour	0.9	3.4	1.7	<.08
8 hour	1.8	3		

Comparing participants who had completed both the first and second follow-up questionnaires, participants' level of confidence in instilling help seeking behaviour to someone who self-harms had remained fairly stable (M=6.7, SD 2.2 versus M=6.3, SD 1.8) (Figure 2.15). However, a significant reduction was observed in participants' confidence in recognising potential suicide risk after seeing a person once (Figure 2.16). The average total score had decreased from 5.3 (SD 2.5) to 4.6 (SD 2.1) (t=2.1, df 24, p<.04).

Figure 2.15 Mean total scores on *Confidence Scale* item 1 at 1st and 2nd follow-up

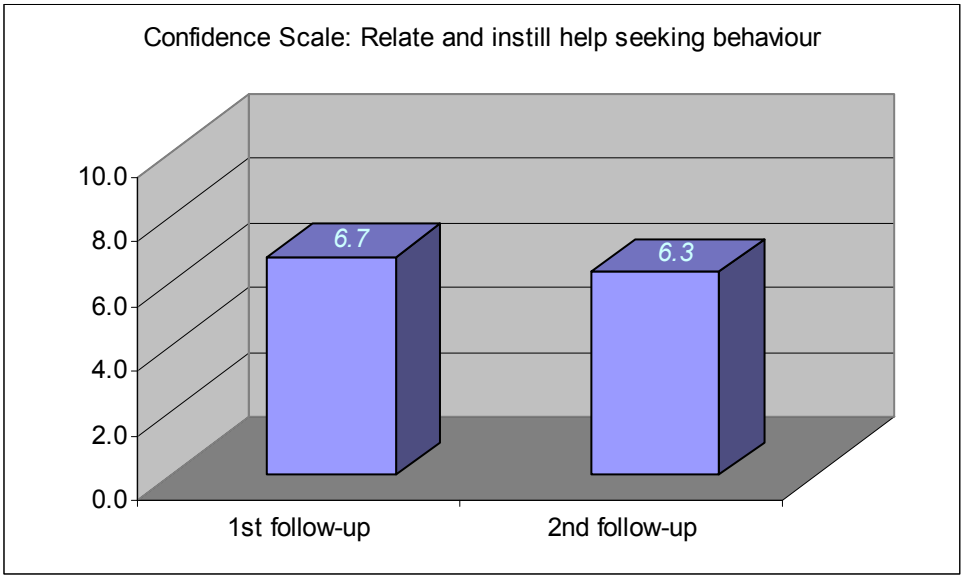
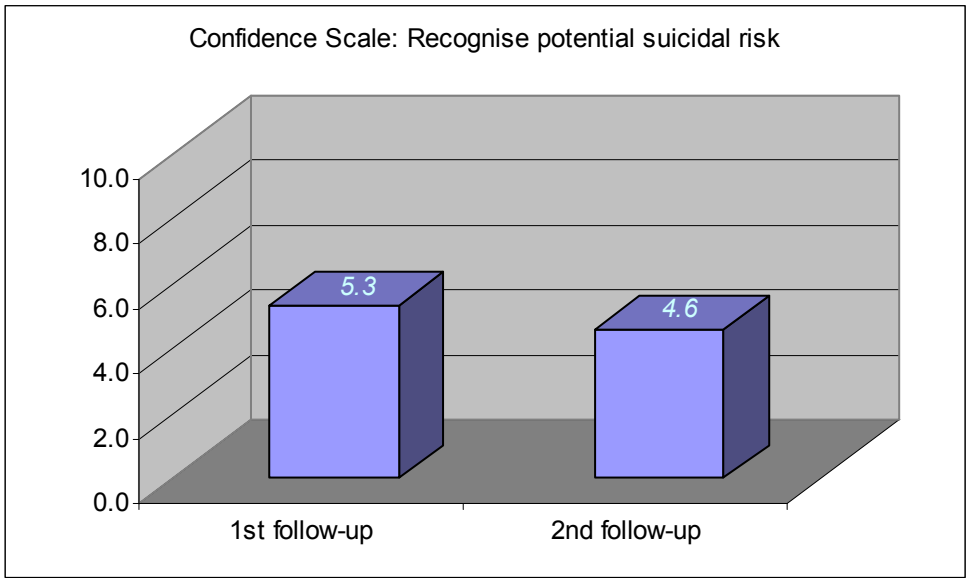


Figure 2.16 Mean total scores on *Confidence Scale* item 2 at 1st and 2nd follow-up



2.3 Retrospective evaluation results

Response

In total, 619 participants who had completed the self-harm awareness training programme between September 2008 and November 2009 consented to being contacted for the purpose of evaluation. Postal or e-mail addresses were available for 553 participants (89.3%). After sending out the letter and self-report questionnaire, 21 packs were returned due to incorrect address details. Of those who received the questionnaire (N=532), 120 returned a completed questionnaire, giving a response rate of 22.6%. The average time between completion of the training programme and completion of the questionnaire was 13.5 months (Range 5-18).

Socio-demographic characteristics

Among participants involved in the retrospective evaluation, the majority (80%) were females and the mean age of the total sample was 41.7 years (SD 10.5). Over half (56.6%) of the sample was younger than 45 years and 43.4% were 45 years and older.

In terms of the number of years involved in education, the average number of years was 16.0 (SD 4.8) with a maximum of 28 years. The majority (44.1%) of the participants were working in the social care sector, followed by 16.1% in community based agencies and 13.6% in the health services. Ten percent were working as counsellors or helpline workers and 5.5% were employed in the education sector. The remaining 10% were involved in a variety of work areas. The average number of years of work experience was 11.1 (SD 9.0), ranging from 1 to 38 years.

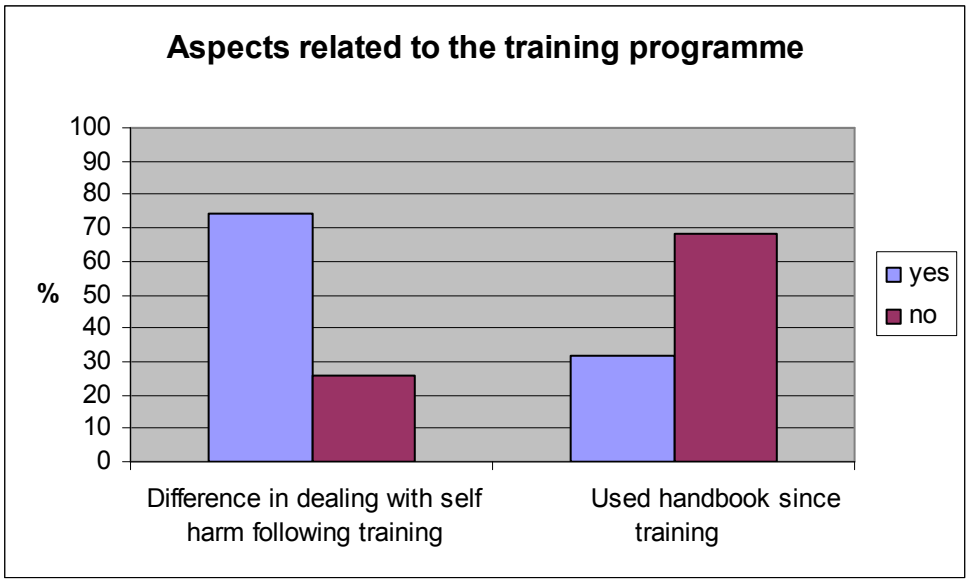
Previous training

The majority of participants involved in the retrospective evaluation had completed training in a relevant mental health area prior to the self-harm awareness training programme. The vast majority (75.4%) of participants had completed previous training on crisis intervention, 62.2% had been involved in training on suicide or suicide prevention, 54.2% had received training on depression and 37.5% had been involved in a previous training programme on self-harm.

Aspects related to the training programme

The majority of participants (70.2%) had followed the 3-hour training programme and 29.8% had followed the 8-hour programme. Close to one third (31.8%) of the participants reported having used the handbook. The majority (74.1%) of participants indicated that the training had made a difference in how they are dealing with self-harm following the training (Figure 2.17).

Figure 2.17 Proportion of participants in retrospective evaluation indicating differences in dealing with self-harm and use of the handbook since the training



Knowledge of self-harm

Participants had an average total score of 78.5 (SD 5.8) on the Self-Harm Knowledge Scale. Women showed a significantly higher score (M=79.2, SD 5.6) than men (M=76.0, SD 5.9) (t=-2.2, df 92, p<.03). A slightly higher score was found among participants who had completed the 8-hour training programme (M 78.9, SD 6.4) compared to those who had completed the 3 hour programme (M=78.5, SD 5.6), reflecting a trend towards significance (p<.08). This is in line with the outcomes of the prospective study. A significantly higher

score on the Self-Harm Knowledge Scale was found among participants who had used the handbook (M=80.6, SD 5.6) versus those who had not (M=77.6, SD 5.9) (t=2.2, df 86, p<.03). Among participants who had noticed a difference in how they dealt with people who self-harm or who are at risk of self-harm since they had completed the self-harm awareness training, a slightly higher knowledge score (M=79.2, SD 5.6) was found compared to those who had not noticed a difference (M=76.9, SD 5.9). However, this was not significant.

Comparing participants who had completed any previous training programmes prior to the self-harm awareness training versus those who had not, no significant differences were found in relation to knowledge of self-harm. Similarly, the number of years of work experience and years of education had no effect on knowledge of self-harm.

Attitudes towards self-harm

The average total ADSHQ score and average total scores on the four subscales are presented in Table 2.6. Considering the maximum score of 100, both the total ADSHQ and subscale scores reflect a moderately positive attitude to deliberate self-harm.

Table 2.6 ADSHQ: Mean, standard deviation and range of total scale and subscales

ADSHQ	Mean	Std. Dev.	Range
Total scale	73.5	4.5	63-88
Subscale 1*:* Perceived confidence in assessment and referral of DSH clients	25.6	2.0	22-31
Subscale 2: Dealing effectively with DSH clients	15.6	2.2	11-21
Subscale 3: Empathic approach	15.6	1.7	11-20
Subscale 4: Ability to cope effectively with legal and hospital regulations that guide practice	16.2	2.1	11-21

Participants who were working in the social sector had a significantly higher total ADSHQ score (M=74.8, SD 4.4) and they scored higher on subscale 4 (M=16.9, SD 1.7) compared to those working in non-social sectors, respectively 72.1 (SD 1.7) (t=2.4, df 57, p<.02) and 15.5 (SD 2.4) (t=2.6, df, p<.009). Participants who had received previous training on suicide or suicide prevention scored higher on the subscale reflecting how well participants believe they deal with clients with self-harm compared to those who previously had not received this previous training (M=15.9, SD 2.1 vs. M=14.8, SD 2.4) (t=2.2, df 86, p<.03). Participants who had completed previous training on self-harm were significantly more empathic towards self-harm clients than those without previous training on self-harm (M=16.1, SD 1.7 vs.

M=15.3, SD 1.7) (t=2.0, df 92, p<.04). Participants who had previously received training in depression scored significantly higher on scales measuring how well participants believed they dealt with clients who self-harm (M=16.3, SD 2.1 vs. M=14.9, SD 2.2) (t=3.0, df 86, p<.02) and empathic attitude (M=16.0, SD 1.7 vs. M=15.1, SD 1.7) (t=2.4, df 85.9, p<.02).
No significant effects were found for gender, age group, number of years of education, number of years work experience and length of training programme on participants' attitudes to self-harm.

Confidence in dealing with people who self-harm

Regarding participants' confidence in "*instilling help seeking behaviour to someone who self-harms"*, the average total score was 5.9 (SD 1.7), with a range from 1.0 to 9.2. A slightly lower average total score was found for the statement: *"After seeing a person once, I would be confident that I could recognise potential suicide risk"* (M=4.1, SD 2.2, range: 0 – 9.0).
Confidence in recognising potential suicide risk was significantly higher among participants who had completed the 8-hour training programme (M=4.9, SD 2.3) compared to those who had received the 3-hour programme (M=3.9, SD 2.1) (t=2.3, df 111, p<.02). Confidence in instilling help seeking behaviour was slightly higher among participants who had completed the 8-hour programme (M=6.3, SD 1.8) compared to those who had received the 3-hour programme (M=5.7, SD 1.7), but this was not significant.
In terms of previous training, participants who had been involved in previous training on depression or suicide/prevention showed significantly higher levels of confidence in dealing with people who self-harm on both scales (Table 2.7).

Table 2.7 Effect of previous training in depression or suicide prevention on *Confidence Scales*

Confidence scale: Ability to relate and instil help seeking behaviour					
	Mean	**Std. Dev**	**T**	**df**	**Sig.**
Previous depression training					
Yes	6.3	1.6	2.5	115	<.02
No	5.5	1.8			
Previous suicide prevention training					
Yes	6.3	1.5	3.4	116	<.01
No	5.3	1.8			

Table 2.7 contd. Effect of previous training in depression or suicide prevention on *Confidence Scales*

Confidence scale: Ability to recognise potential suicide risk					
Previous depression training					
Yes	4.7	2.3	3.1	115	<.01
No	3.5	1.9			
Previous suicide prevention training					
Yes	4.6	2.2	3.1	116	<.01
No	3.4	2.0			

Confidence in instilling help seeking behaviour was significantly higher among participants with less than 15 years work experience (M=6.1, SD 1.65) compared to those reporting 15 years or more (M=5.2, SD 1.8) (t=2.5, df 113, p<.01). Confidence in recognising potential suicide risk was slightly higher among participants with less than 15 years work experience (M=4.2, SD 1.2) compared to those reporting 15 years or more (M=3.8, SD 2.0). However, this was not significant. Years of education had no effect on the level of confidence in dealing with people who self-harm.

3.1 Methods

Qualitative interviews were conducted with participants, trainers and key stakeholders involved in the self-harm training programme. Semi-structured interview schedules for each group were developed by the NSRF and approved by the Project Management Team to explore key areas including the experience of participating in or delivering training programmes, the resources required by a local coordinating site to ensure the optimal delivery of an awareness training programme, potential barriers to the local delivery of an awareness training programme, opportunities and challenges inherent in the roll out of a programme nationally and possible processes required for implementation of the training programme at national level. The interview schedules were considered flexible in order to allow exploration of themes that arose during the course of the interviews.

All interviews were recorded using a digital device and recordings were transcribed, with all identifying information removed from transcriptions. Thematic analysis was conducted on the transcripts with recurrent themes and sub-themes agreed upon between two independent researchers.

For participant interviews, transcripts were analysed according to the four main themes from evaluation framework developed by Kirkpatrick (2006):

1. Reaction: how did the learner feel about the training?
2. Learning: what knowledge and skills did the learner gain?
3. Behaviour change: has the learner applied the training in practice?
4. Organisational change: what have been the outcomes at an organisational level?

Participants:

Ten out of the ninety four participants who had completed training programmes between November 2009 and June 2010 and who had indicated an interest in being contacted for a follow-up evaluation were randomly selected. Letters introducing the qualitative study were sent to these 10 participants, with an option to contact the NSRF by email or telephone if they did not wish to receive further communication. Follow-up emails were sent approximately ten days following these letters, inviting participants to take part in the qualitative interviews. One participant was organised through a stakeholder who had

facilitated staff to attend the training programme. Insofar as possible, interviews were conducted at a location convenient to the participant (N=3) or by telephone if preferred by the participant (N=1). All participants were assured of confidentiality and given assurances that the information obtained would only be used for the purpose of this study. Contact details were given if they had any further questions or concerns.

Trainers:

Letters introducing the qualitative study were sent to trainers detailing times and locations for the interviews. Follow-up telephone calls were made approximately 10 days following these letters if no response was made, inviting trainers to take part in the qualitative interviews. All trainers involved in the self-harm training programme consented to participate in the study (n=10). Seven of the interviews were carried out in the Suicide Resource Offices in Limerick and Waterford. Due to unforeseen circumstances, one interview was carried out by telephone. Two interviews were conducted in the participant's office. All trainers were assured of confidentiality and given assurances that the information obtained would only be used for the purpose of this study. Contact details were given if they had any further questions or concerns.

Stakeholders:

Stakeholders were identified through consultation between the NSRF and the Project Management Team. Letters introducing the qualitative study were sent to 18 identified stakeholders, detailing a date and location for those based in the HSE South or HSE West. A follow-up telephone call was made to participants if no response was made, inviting stakeholders to take part in the qualitative interviews. Thirteen stakeholders agreed to take part in the interviews. One joint interview was conducted with two stakeholders, the remainder were individual interviews. Seven interviews were conducted in the Suicide Resource Office in Waterford, 1 in the Suicide Prevention Office in Limerick, and 2 in locations convenient to stakeholders in Dublin. One stakeholder preferred a telephone interview and one stakeholder resided outside Ireland and therefore had to be interviewed by telephone. All stakeholders were assured of confidentiality and given assurances that the information obtained would only be used for the purpose of this study. Contact details were given if they had any further questions or concerns.

3.2 Results

Overall, interviews conducted in person lasted 34.4 minutes on average. Telephone interviews were 34.5 minutes on average.

The perspective of participants

On average, the interviews with participants lasted 18 minutes. The interviews ranged from 12 to 22 minutes.

1. Reaction

- Positive experience

All participants reported generally positive feedback about the training programme.

> *"I think that in building a general awareness among professionals it was quite effective".*

- Importance of prior expectations about the training programme

Three of the participants had attended the training expecting an element of skills-based learning. In some cases, this was because the participants did not have a lot of information about the course before attending although in most cases information is sent to participants before the training. This lack of knowledge regarding the programme tended to affect their overall experience of the programme

> *"I would have expected some form of interaction with greater knowledge and information on how to work with somebody".*

- Target programme content to audience

Participants consistently reported that there was a need for the content to be targeted for the particular group in attendance, either for professionals or for people with no previous experience of working with self-harm.

> *"I would have liked to have had more of an opportunity to tease out that whole thing. The psychiatrist in front of me, well he understood it totally and wondered why somebody was asking a basic question you know".*

- Length of programme

Participants consistently reported that three hours was adequate time for the content covered within the training programme.

> *"For what was given it was enough"*

One participant felt that the time was too limited to cover the content of the programme for people who had no previous experience with or training in the area of self-harm.

> *"Just that it was a little bit rushed because we had so much to cover. For somebody who has no knowledge there was an awful lot to take on"*

Participants felt that they would be released to attend a programme of longer duration if necessary.

- Practicalities

Of the participants who completed the training outside of their own work setting, there were consistent reports relating to the impact of the facilities on their experience of the training.

> *"The room was very small…Too small for the number of people who were there"*

- Handbook

Participants who had used the handbook since the training agreed that this had been helpful.

> *It was good, it had a lot of point form information which was easy to read".*

2. Learning

- Useful information provided

Participants consistently appreciated the information they received from the course. Particular reference was made to the provision of information on statistics and available services.

> *"I thought it was quite useful. I liked the general approach and view of self-harm it was taking. I think there was a deliberate attempt not to view it as something pathological which I would have appreciated and I think that in building a general awareness it was quite effective"*

- Need to incorporate a skills-based element

There was agreement among participants regarding the need for more skills based training aspects to be incorporated in the programme.

"From a learning perspective I would like to have had more knowledge in dealing with and working with somebody who's self-harmed to get some information on the best way to work with them and the best way to deal with them. I felt that that was lacking"

- Sustaining the benefits of the training programme

Participants also highlighted the importance of efforts to sustain the benefits of the training programme.

"Almost like a focus group. Almost like what you are doing now, coming back and seeing how people are getting on…I think that would be (helpful) because as I have said and I am not alone in saying that, that a lot of us would struggle dealing with somebody who self-harms"

3. Behaviour change

Although only one participant had encountered self-harm since they completed the training, all felt that they would be able to handle such a situation better if the need were to arise.

"Well, if I ever come across somebody who is self-harming I would be a lot more comfortable"

The suggestions from the programme in relation to alternatives to self-harm had also been implemented following the training. However, the decision to introduce some of these techniques was reversed as a result of negative consequences.

"Well we did but we had to take some of that away because we were finding that the rubber band technique was being abused and they were making more damage than expected"

4. Organisational

Although none of the participants had evidence that changes had been made at the organisational level as a result of the training, participants who worked within a mental health setting felt that the training could be of relevance to policy development.

"But I think that you know training a particular service together might be helpful because you, know that…people are sharing information but there's also the expectation within the service that things might be done in a particular way"

The perspective of trainers

On average, the interviews lasted 43.2 minutes. The interviews ranged from 19 to 65 minutes.

Self-harm training and daily responsibilities

There was a general consensus that the time needed to run training programmes was sometimes difficult to balance with daily responsibilities and workload, in particular for those working on a daily basis in a clinical capacity.

> *"Sometimes if you have to go back to work in the afternoon it can be difficult. Now I've never negotiated that but it can be quite draining if you have to come back because you sort have to go from one mode into the other where you haven't been in there all morning"*

However, a recurrent theme across the interviews was that despite difficulties with time, there were many benefits to being a trainer.

> *"And I suppose it kind of challenges you to get different kinds of people asking different kinds of questions from different perspectives. You get teachers asking and nurses asking and doctors asking so it's all kind of different types of questions there, I suppose it keeps you thinking about it"*

Train-the-Trainer programme

Although there was general agreement that the two day Training for Trainers programme was adequate, some areas which could have been useful were highlighted across the interviews. In particular, trainers who did not have a background in training felt that some emphasis on dealing with difficult situations within groups would have added to their experience.

> *"What I liked about it really was that it was an open programme if you like that we could tailor to suit I suppose the audience and the needs of our participants. So yeah, we kind of looked at that, there was a lot of scope I think to, if you like, I won't say to change the programme but certainly to refocus the programme depending on what participants needed".*

A recurrent theme throughout the interviews was the need for the development of a formalised Train-the-Trainer programme and manual if the training is to be rolled out nationally.

> *"I think it's a great support for the trainer when they go away. It formalises everything. And I realise it would be a huge piece of work but well worth doing if it would be rolled out nationally"*

Organisation of training programmes

There was a general consensus across interviews in the South East that having the administration tasks associated with running the training programme carried out by the Suicide Resource Office was effective and a great benefit for those working in a clinical setting.

> *"I think the fact that it's run from here is quite good, from the one base it's good""*

Experiences of delivering the training programme

In general, there was a consensus that delivering the programme was typically a positive experience. Across the interviews, trainers described their own experiences of the effects the training programme can have for participants.

> *"For me I suppose, and it would come back in the feedback and I suppose people would say it at the end of the training that they feel far more comfortable with the subject, they feel much more knowledgeable"*

A theme which recurred throughout the interviews was the sometimes challenging situation of having people share their personal experiences of self-harm within the training programme.

> *"The only problem I would find sometimes, and it has happened, that somebody may be engaging in self-harm, or has a family member, and maybe is coming to the training with a different perspective of what that person is going to learn. Sometimes that is in conflict with what we're delivering and the perception and that person maybe can try to take over and make the personal agenda into the talk. Now that can be difficult to deal with. But then that's up to yourself, you have to deal with that"*

Among trainers who did not have a training background, there was a general consensus that they did not have enough training to deal with these types of situations within a training session. However, they also felt that they had the personal skills and abilities to manage such occurrences.

> *"It would have given you more confidence because in-group you don't want to embarrass somebody by saying the wrong thing, or saying it sharply maybe. You know you don't want to do that, yeah, absolutely. That would have been, yeah, we didn't ever really…People would tell you yeah, do this. But I suppose until you encounter the situation as well you know, you don't realise that maybe an odd gesture or an odd word, you know sometimes it just doesn't work"*

The importance of good group facilitation skills was highlighted throughout the interviews in light of the sensitive nature of the topic of self-harm.

> *"A lot of people are afraid coming to training, they don't know what to expect, they don't know how they are going to be hearing about this stuff or maybe they have had an experience. So just having a kind of openness in the group, taking and sharing and supporting each other and setting that climate right from the beginning. So safety is really important and that the balance and how much challenge the group is facing, you as a trainer have to watch that"*

A recurrent theme throughout the interviews was the relevance of experience in the area of self-harm to the trainer's role on the self-harm awareness programme.

> *"I think it's about having credibility so that if you are going out there you're not just reading, you have ownership of it. You work in the field, you work in the area of self-harm and suicide, you're resourced in the area of self-harm and suicide. You're out there talking about self-harm but equally people know that you work in the area of self-harm. I think that gives a lot of credibility"*

Self-harm and suicide

A number of the respondents felt that the self-harm awareness training is an important addition to the broader context of suicide prevention activities.

> "*I felt there was a need for it…because everything was around suicide and yet we know that self-harm is broader than just suicide"*

With regard to clarifying the link between deliberate self-harm and suicide for participants, trainers reported different views.

> *"I think sometimes people actually think self-harm is something much bigger. And I'm not downplaying self-harm because it is a serious issue of concern, but people would actually associate self-harm with suicide, they think it's all the one. So for people it's really about I suppose breaking that down and people feel much more comfortable dealing with self-harm and it's breaking away the stigma and the taboo around it"*

> *"And as well to be really clear about what is the link between what is self-harm and suicide. People are not aware of those statistics about the increased risk of suicide if you deliberately self-harm. People aren't aware of that, that's news…People think that people who continuously self-harm aren't going to kill themselves and that's the one piece of information in this entire thing that stands out"*

Length of programme

There was general agreement across interviews that a development of the 3-hour programme into an 8-hour programme could be of benefit both from a resource point of view and to allow more time to explore issues.

> *"Well I think ya the one thing we need to look at expanding is maybe making it a one day training and into an afternoon...Then you could look at the interventions a little bit more and that would be helpful I think yeah"*

An additional programme or the development of the existing programme to include a skills-based element was also a recurrent theme throughout the interviews.

> *"It would be more intense probably, more practice orientated and hopefully people will feel they will go away with more than just information and knowledge but that they feel that they will go away with the practical skills so that they will be able to intervene with someone who is harming."*

Materials

Not all of the trainers reported using props such as the cards. However, in general the trainers were happy with the props they use.

"I'm comparing to other programmes that I deliver I'd see huge areas of improvement material wise and delivery wise, whereas with this, no I wouldn't have too much concern"

- DVD

Across the interviews, there was consensus that the content of the DVD is quite effective.

"At the moment it does what it needs to do which is to give participants a chance to hear a number of people who are self-harming and say what that is like and to talk about what kind of response they have got in terms of service"

Most participants also referred to the quality of the DVD.

"The DVD, the quality of the DVD isn't great. And then it depends maybe on the quality of your speaker and the size of the room… I've done it in other rooms where it can be a bit lost"

- Handbook

A recurrent theme throughout the interviews was the value and the quality of the handbook. The handbook was seen as an important element of the training programme.

"It's very good. I think it lends a whole air of professionalism to the whole thing. It's not just a photocopied handout. I think it's really good, I think people were very impressed by it"

Service user involvement

In general, the trainers felt that having a service user involved in the training would be of benefit to the training programme, although there was a recognition that the service user view is at the centre of the training programme.

"Somebody who has experience of self-harm, you know, involved in the planning and indeed possibly the roll out I think would be very beneficial"

There was also an awareness of a number of challenges inherent in involving service users in the implementation of the training.

> *"You'd have to have somebody attached to the training programme yeah. But then all the ethical issues with that. They'd have to be well mentally themselves to be able to do it. You'd have all the confidentiality issues, ethical issues that would go along with that"*

Importance of resources required to do the training

Trainers referred to the importance of having resources such as a laptop, projector, etc. available to them to be able to do the training.

> *"I think we had a bit of difficulty, we had, getting the equipment, and we were expected to source that ourselves. Yeah we found that difficult now, where were we going to pull it from. And it was difficult at the time. Yeah that was a difficulty"*

Trainers also highlighted the importance of commitment from the co-ordinators of the training programme and line managers.

> *"I would say that for each trainer there needs to be somebody identified who's going to co-ordinate the programmes. And run with them"*

Debrief/Supervision

There was a consensus across the interviews that the trainers recognised and appreciated informal opportunities to debrief following training programmes.

> *"I suppose what we have here would be quite an informal kind of structure but it works because we would get on very well and we'd support each other continually".*

The need for a formal structure for debriefing or supervision was also highlighted throughout the interviews.

> *"Because if you don't then you stumble on until the next one and you think oh God I must talk to somebody about that and then it's gone. Whereas you put it on an agenda if you have a dedicated time"*

Integration of knowledge into daily work

The trainers' own ability to integrate their own learning from the training programme with their daily responsibilities was a recurrent theme throughout the interviews.

> *"Everything you do kind of makes you more familiar with the topic, you know? So like I said, from an informational point of view probably. And yeah, I suppose it has made me more confident"*

There was also an awareness of and insight into the impact the training programme can have for patients or clients.

> *"They're able to relate to them better, they can talk to them, they can talk to the patient about it. And when I would come and do my assessment they would talk about the great care of the staff, that they were kind. And that all impacts down the road then. That it is having a huge positive effect"*

Sustainability of programme

Resources were highlighted throughout the interviews as key to ensuring the sustainability of the training programme into the future.

> *"Lots of money, lots of time, lots of planning! Again I think buy in and commitment from lots of different stakeholders because there are so many different groups and it's about bringing them together. And for people to have a common language I suppose like other programmes because otherwise you go down the road of having different programmes with different meanings"*

National implementation

There was consensus across the interviews that the programme would be suitable for a national roll-out and an appreciation of the benefits of such an expansion of the programme.

> *"No matter where you work you're getting the same training and from that point of view I think it would be very good"*

The perspective of stakeholders

On average, interviews lasted 32 minutes. The interviews ranged from 12 to 83 minutes.

Relevance of the training programme

A recurrent theme across the interviews was recognition of the need for a self-harm awareness training programme and it's relevance to broader suicide prevention initiatives.

> *"There has to be a multi-response to the whole issue for self-harm, which would include psycho-educational input, raising awareness, assessment functioning, a whole range of interventions really which would include a counselling intervention. So within that continuum of intervention, it clearly has a very important role to play"*

This recognition was also related through interviews with representatives of organisations which had staff attend the training.

> *"As part of the management team we would have seen it as a necessary training…then we would be trying to ensure that the staff would attend that training"*

Content of the training programme

- Theoretical content of the programme

In general, there was an acceptance across the interviews that the training is intended primarily to understand self-harm from the service user's point of view.

> *"When you are able to explain some of the functions of why people do these things it's passing on information and it gives people confidence to look at the situation in a different way for those who self-harm or those who are presented with it"*

However, there was also a perception that the content did not fully reflect the range of clinical implications of self-harm.

> *"The emphasis in the programme (is on) validating the person self-harming to avoid stigmatising and antagonism and sometimes I think we need to address it and define it as being a problem…self-harm can't be discussed in isolation as a problem in itself, it's a tip of an iceberg related too often with mental health problems and introduces the opportunity to talk about those problems and I think long term, resolving self-harm is about resolving the underlying problem"*

- Relevance of the distinction between self-harm and suicide

Across the stakeholder interviews, there was a view that a significant message of the self-harm awareness training was a distinction between self-harm and suicide.

> *"The first step is awareness and maybe questioning what self-harm means in patients rather than assuming it is a suicidal gesture"*

> *"You begin to see what's going on for the person instead of labelling them and fitting them into a category. It becomes less about the act and more about the person I think"*

In interviews with stakeholders who had organised for staff to attend training, a recurrent theme was that staff responded to self-harm differently in line with this distinction.

> *"They were all positive and actually remarked that they are now more relaxed around the area of self-harm since doing the training and they contributed that directly back to the training. Their attitude towards it has relaxed in that they feel less scared of it as a direct link to suicide which I think they brought to their training as one of their biggest fears, perhaps it was always linked, and that's probably one of the biggest changes in their own work with (individuals who self-harm)"*

- Length

In general, there was an appreciation that a programme of short duration facilitated people being released from work for the training.

> *"The other key factor is the amount of time that people have to give to a training programme. So if it's a half day or a one day it means that people will be more likely to be released. If it's two day, that's much more problematic for people"*

- Provision of information on local support services

The importance of the training programme as an avenue for dissemination of information on local support services was consistently highlighted by the stakeholders, with local trainers seen as key.

"We would certainly see local people delivering that training locally as the best people because they're familiar with the services and how services can be accessed locally"

Current limitations of the training programme

A recurrent theme across the interviews was recognition that the content of the current training programme may not address or meet the needs of people working in clinical settings.

"If they're primarily there to work in the area of self-harm, the training programme that we provide down here is not a high enough of a standard for them to be engaging with people who are self-harming from a clinical perspective"

Safety issues

The importance of strategies to maintain the safety of the individuals attending the training programme was highlighted across the interviews.

"I suppose certain people coming from certain groups, they may be coming in 'raw' as we would say, they would have no experience or they might think it's something that it's not or they might think it's therapy or they might think that they're actually going to get all the answers"

Targeting the training session to the needs of the audience

A recurrent theme across the interviews was the suggestion of targeting training programmes to the specific needs of each group.

"I think a key thing would be to research the group or audience it is being presented to and to tailor it to their experiences and needs and where I gave some examples of the programme being very good it could have been enhanced with this group by anticipating the typical self-harm experiences they meet. Because if you want that buy in, then you need to make the programme as relevant to the real world experience of the people as possible so perhaps before coming to deliver the programme to do some initial exploration in to what self-harm do people experience and what difficulties does it cause to them and to tailor the programme to answer those questions for them"

There was also a view that targeting training programmes in such a way maximises the use of resources.

> *"Because of the resources involved in delivering training, I don't think it's good enough to just target it at everybody…there is only so much resources available to deliver training so the key is to reach the right people with the right course because even if something is inexpensive to deliver in itself it still takes up considerable human resources to deliver it"*

Effects of the training programme for participants

Throughout the interviews, there was an awareness and an appreciation in relation to the possible effects of the training programme.

> *"I think one of the ones is it would enable people who are self-harming to disclose it and get help if they feel that the response would be less punitive or critical. So I think it probably enables doctors to enquire more openly about it"*

Some of the stakeholders who had organised for staff to attend the training programme were also able to describe situations in which the self-harm training was felt to have an impact on interactions in relation to self-harm.

> *"We definitely would up our supervision etc and be more I suppose mindful of interacting with (them) and I suppose exploring more with them what was going on for them rather than being afraid if you know what I mean, of saying the wrong thing in case you escalated a situation or whatever which I think a lot of staff were afraid of"*

Effects of the training programme for organisations

A recurrent theme throughout the interviews was the impact the self-harm awareness training can have on organisations whose employees attend the programme.

> *"So I think those can be very helpful things as well as a sort of indirect outcome of the training that actually gets organisations and individuals to sit down and think about the subject and what their responses ought to be"*

Resources

The relatively low cost of implementing the self-harm awareness training was highlighted across the interviews.

> *"really the cost is minimal compared to…the financial cost isn't that great. I don't think that's a barrier"*

Trainers

There was a general consensus that clinical experience was an important requirement for trainers.

> *"The clinical expertise you can't beat. Having dealt with it and understanding exactly where we're coming from makes a big difference and you need that in a trainer"*

A training background or group facilitation skills were also identified as important for trainers.

> *"Individuals who come from a training background or who have facilitation skills is key to being a successful trainer"*

Support for the trainers was also highlighted throughout the interviews.

> *"I think trainers having a back up, having the support, I think has to make a difference"*

Importance of strong administrative support

Stakeholders consistently highlighted the importance of strong administrative support. This was considered crucial to supporting the needs of the trainers.

> *"Administration support…who knows the programme inside out, has done the programme and can link in with all of the different organisations but can also take the queries, can do the recruitment which I suppose releases the trainers out of having to do that, that's critical"*

Centralised co-ordination of the training programme

A recurrent theme across the stakeholder interviews was that a national implementation of the self-harm awareness training would require centralised co-ordination of the programme to oversee the logistics and organisational elements of the scheme.

> *"Work around that needs to be done at a national level"*

However, there was also a strong emphasis on the necessity of maintaining the day-to-day co-ordination of the training programme at local level.

> *"You need regional co-ordinating sites to co-ordinate at a local level because…you need to identify the key people who would co-ordinate courses, who would organise trainers, who would know who would be suitable in their area, you know the logistics, the day-to-day operational logistics"*

The importance of recruitment conducted at local level was also a recurrent theme.

> *"The recruitment side can't really be done at a national level because you wouldn't have the contacts with the individuals who need it"*

Future development of the programme

- Train the Trainer

The need for a formal structure for the training of trainers was consistently reported by the stakeholders.

> *"If this programme is going to be rolled out nationally I think there needs to be a formal T for T and there needs to be a trainers' manual."*

There was also recognition of the resources which would be required for the establishment of such a system.

> *"If it's going to become a national programme you have you know you will have to have a Train-the-Trainer and that in itself can be quite problematic because you have to find well who is going to be the Train-the-Trainer and the time involved in organising a Train-the-Trainer programme is quite resource intensive as well"*

- Inclusion of information on evidence-based treatments

A consistent suggestion across the interviews was for a development of the programme to incorporate an element of skills based learning.

> *"Continue doing the awareness absolutely but have another for the area around intervention and assessment of risk and those type of areas and that they should be kind of consistent across services"*

The need to incorporate information on evidence-based treatments for self-harm was also highlighted throughout the interviews.

> *"…I think to maybe look at integrating an understanding of the techniques of DBT (dialectical behaviour therapy) into managing self-harm because DBT would be a longer term approach to this problem than simply helping the person cope with the immediate effects of self-harm"*

- Integration of the training programme into curricula

Across interviews, stakeholders felt that the self-harm awareness training could and should be incorporated into curricula of professional training programmes.

> *"I think it's essential and should be not just at the graduate level but undergraduate level I think"*

- Ongoing monitoring/evaluation of the training programme

The importance of an ongoing system of monitoring for the self-harm awareness training programme was consistently reported by the stakeholders.

> *"Feedback of the impact of the training programme from a local level back up to national level really gives…strength to say this programme should continue.It's really important, it's actually the key thing"*

- Service user involvement

An awareness that buy in and involvement from service users is of value to the development of the self-harm awareness training was apparent across the interviews. However, there was also an awareness that such involvement would need to be well thought out, with the issues inherent in supporting services users involved in a safe way also a recurrent theme.

"I think from the whole issue of involving and supporting vulnerable people in the delivery of training where they're to some extent having to use their lived experiences as part of the training is something you have to think very carefully about, and the support that you give to people. So I would say in principle it's a good idea…it needs to be thought through and I think involving service users in perhaps writing the training materials and putting stuff on film and video my be a way of getting the service user input into it, other than just thinking "oh we've got to train service users to deliver it"

National roll-out of the training programme

Across the interviews, there was agreement that the training programme should be rolled out on a national level.

"I think that it should be made more widely available from the point of view that there's no single answer to the issue of self-harm reduction, there has to be a multi-response"

A recurrent theme in relation to ensuring the sustainability of such a roll-out of the programme was that it would require targeted and intensive efforts to integrate the training programme into existing systems.

"Getting it embedded in the culture of the organisation rather than bringing it as an add-on thing and give it longevity"

Accreditation from the relevant bodies was consistently highlighted as important to a roll out of the training programme.

"The other key thing around national delivery of programmes is that if they are accredited, it makes it so much easier…so it makes sense, it adds value to it. It means that people can stand over the training"

Buy in from national stakeholders from both within and outside the health services was consistently identified as a crucial element to a national roll-out of the self-harm awareness training programme.

"For it to be successful…the commitment of other service managers to release and to allow their staff who have been trained to continue to deliver the training"

Part 4: Review of the training programme and material

4.1 Methods

The quality of the training programme and materials was reviewed as part of the independent evaluation. The quality of the training programme and trainers was evaluated on the basis of nine statements that were rated by the participants as part of a specific section on the evaluation of the training programme included in the quantitative evaluation and involving both the prospective and retrospective sample. For each of the statements the participants were asked to indicate whether they "strongly agreed" – "agreed" – "were unsure" – "disagreed" – "strongly disagreed". The handbook and slides included in the training programme were reviewed by two independent raters with expertise in developing and implementing self-harm/suicide awareness training programmes and who had not been involved in preparing the handbook. The review was conducted using internationally validated criteria to assess the quality of training programmes that were rated from 0 (insufficient) to 4 (excellent) (International Training and Education Centre on HIV, 2004). Eight criteria were used for the rating of the quality of the slides included in the training programme. Nine criteria were used for the rating of the quality of the handbook. Considering the difference between the 3-hour and 8-hour training programme in terms of the total number of slides included (42 versus 60), the two sets of slides were assessed separately.

Data analysis

Considering the relatively low numbers in some of the response categories, the 5 categories were collapsed into 3: "agreed", "unsure" and "disagreed". Frequencies were obtained for both the prospective and retrospective sample. Based on the outcomes of the rating of the handbook and slides by the two independent raters, average scores were calculated. A comparison was made between the 3-hour and 8-hour training programme in terms of the outcomes of the quality of the training programme and the sets of slides used.

4.2 Results

Quality of the training programme

As part of the prospective evaluation 240 (92%) participants completed the section on the evaluation of the training programme at the 1st follow-up immediately after the training programme. The majority of the participants were positive about all aspects of the training programme and the delivery of the programme by the facilitators (Figure 4.1). The outcomes

indicate that a small subgroup of the participants disagreed with the statements (range: 5% - 13.2%) or were undecided (range: 7.4% - 11.5%). Thirteen percent indicated that there was not enough time for discussion. This percentage was higher among participants who had received the 3-hour training programme compared to those who completed the 8-hour programme (7.7% versus 14.8%) (Figures 4.2, 4.3). Among participants who received the 8-hour training programme, consistently 86.5% agreed with four of the nine statements referring to comprehensive introduction, clear communication, well structured and target-oriented programme and familiarity of the facilitators with the topic. This was slightly higher among participants who received the 8-hour programme compared to those who received the 3-hour programme. Among participants who completed the 3-hour programme a higher proportion of participants were undecided when responding to the statements (range: 7.9% - 13.2%) compared to those who had received the 8-hour programme (range: 1.9% - 5.8%).

Figure 4.1 Prospective evaluation of the training programme

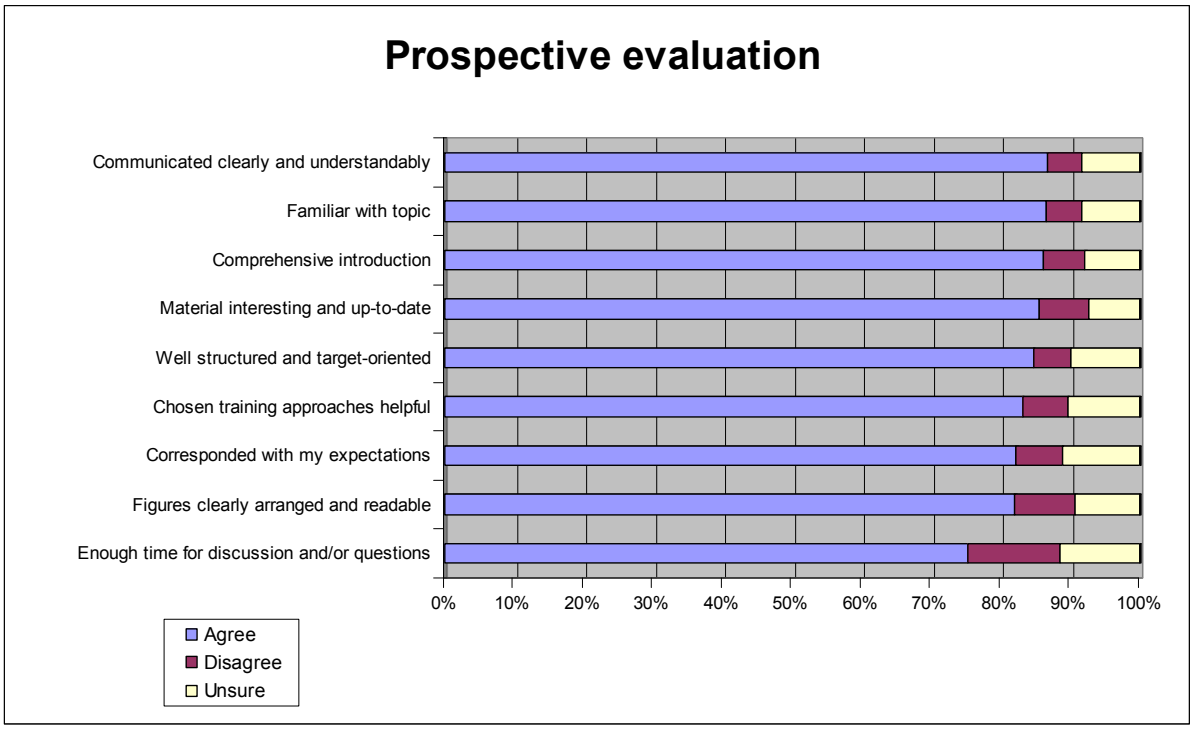


Figure 4.2 Prospective evaluation of the 8-hour training programme

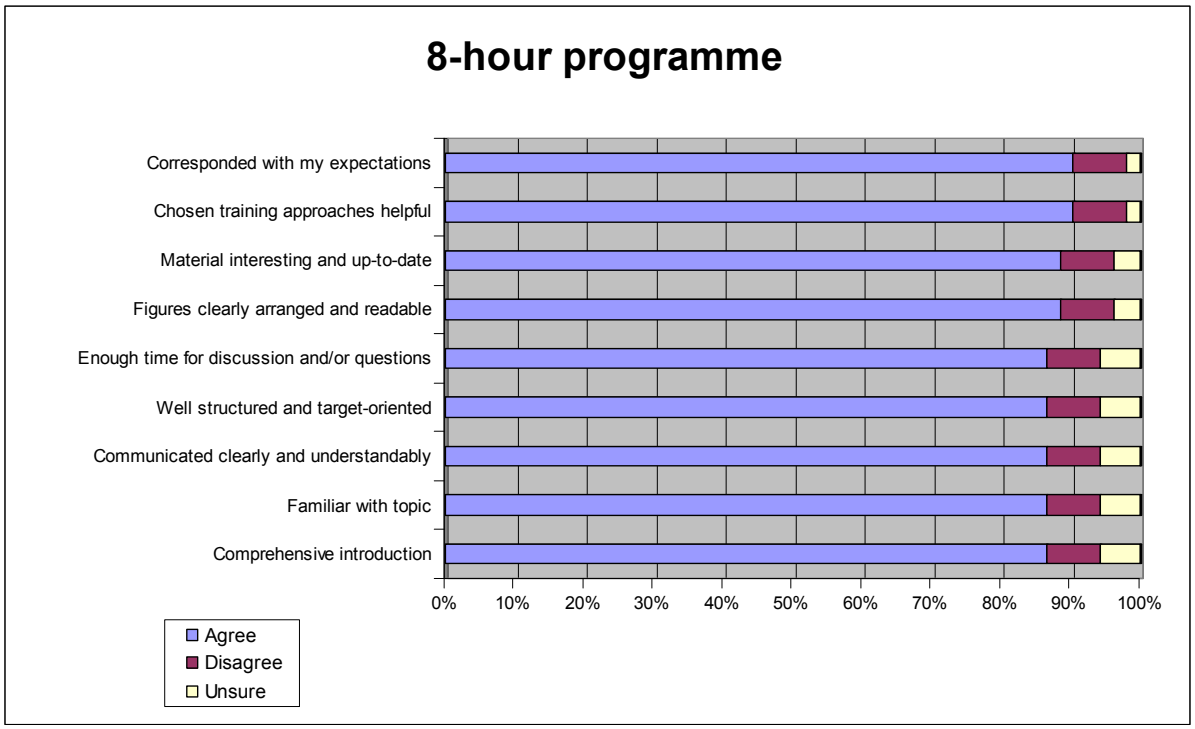
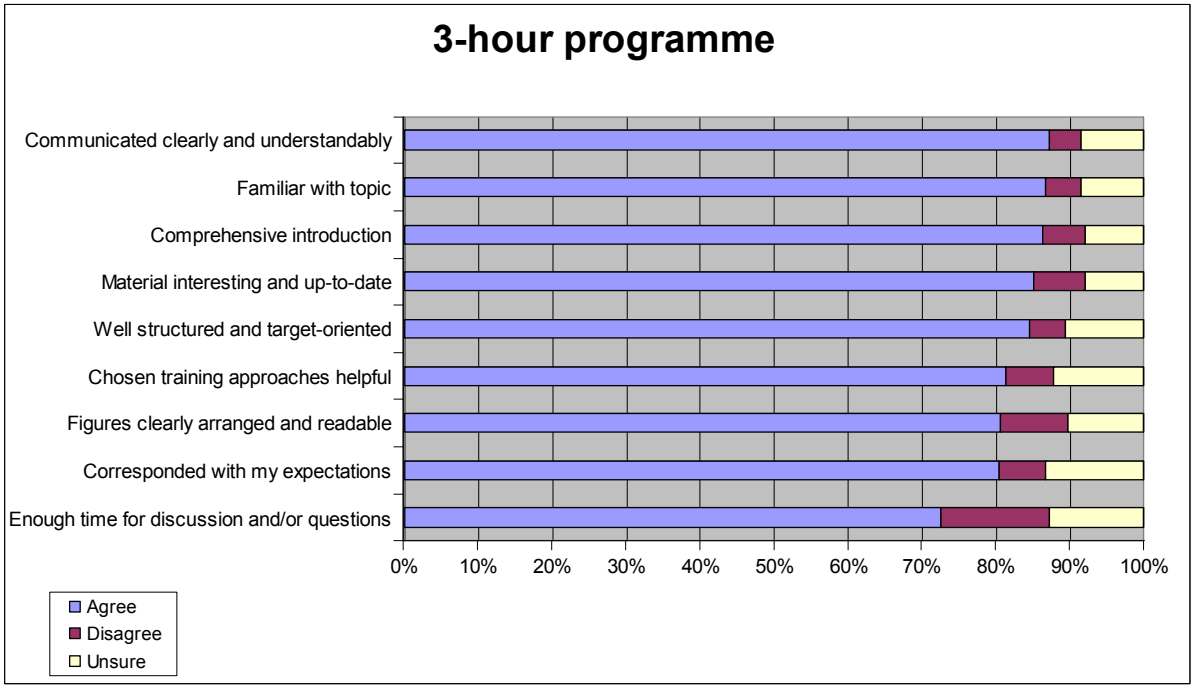


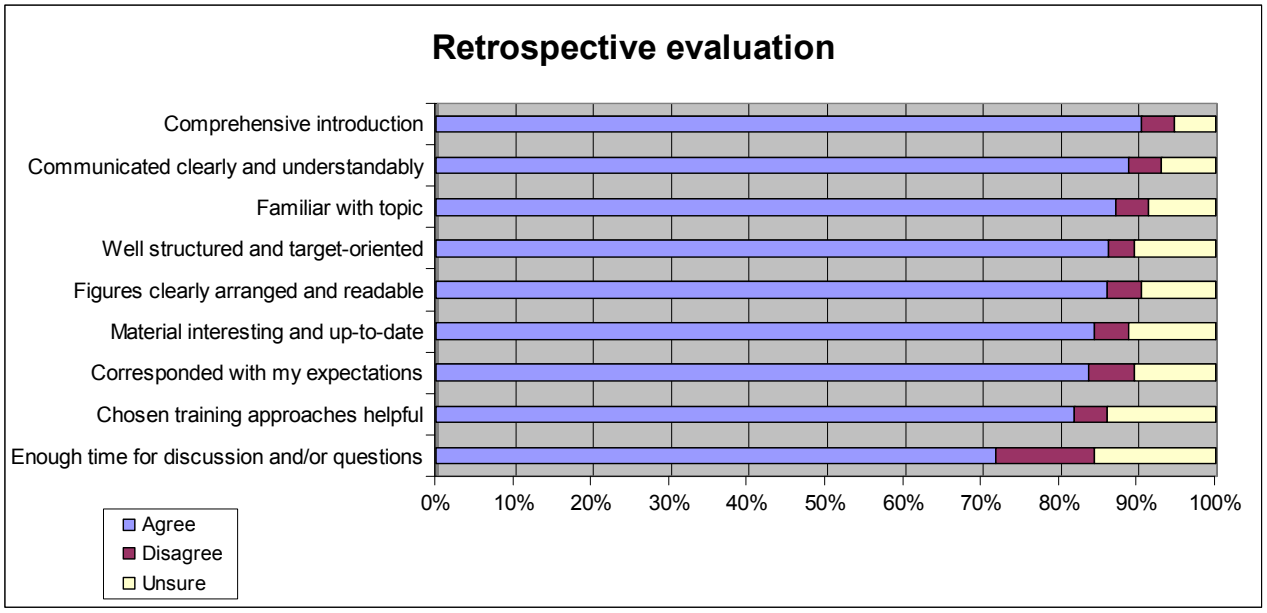
Figure 4.3 Prospective evaluation of the 3-hour training programme



Overall, the outcomes of the retrospective evaluation (N=116) were in line with the prospective evaluation (Figure 4.4). However, for most statements there was a higher proportion of participants who were undecided (range: 5.2% - 15.4%) compared to those involved in the prospective evaluation (range: 7.4% - 11.5%).

Considering the relatively low number of participants who had completed the 8-hour training programme retrospectively, it was not possible to conduct analyses by length of training programme.

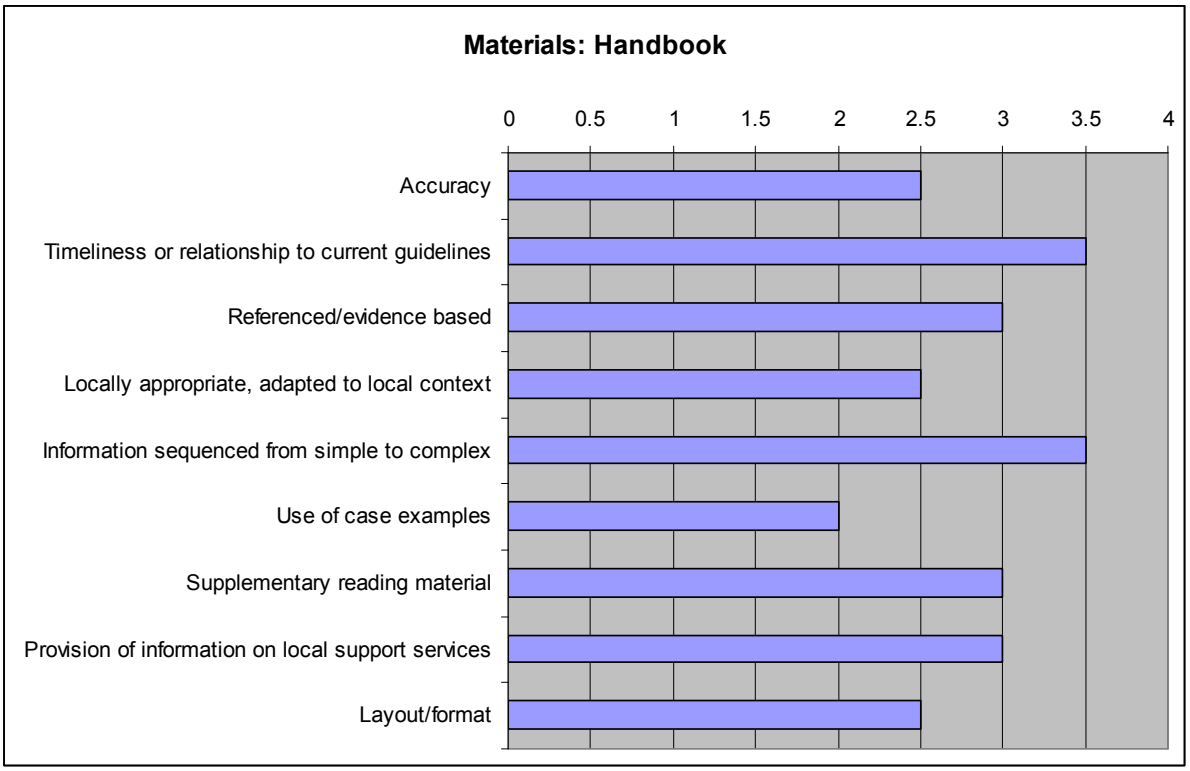
Figure 4.4 Retrospective evaluation of the training programme



Quality of the training materials

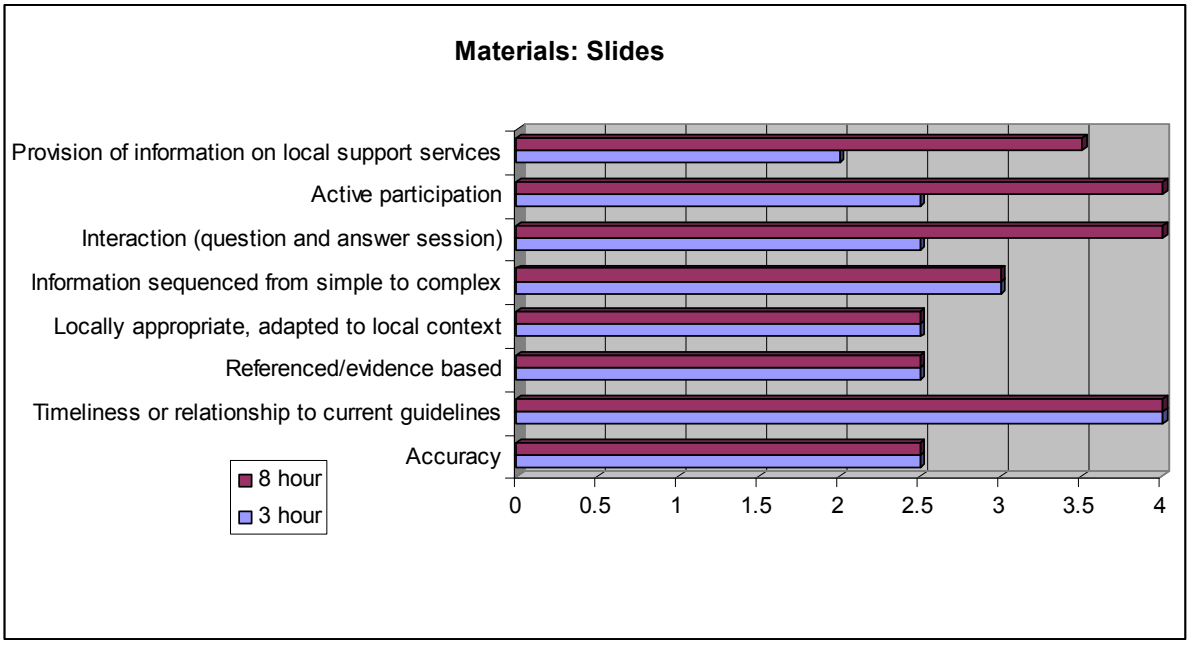
The rating of the handbook revealed a score of 3 or 3.5 (maximum 4) on 5 of the 9 criteria. The scores reflected current relevance and relationship to current guidelines, information being adequately sequenced from basic to specialised, evidence based approach, adequate provision of supplementary reading material and adequate provision of information on local support services (Figure 4.5). The criterion in relation to accuracy of information was rated 2.5 with the recommendation to update the information on risk factors associated with self-harm in young people, inclusion of information on self-harm among men, and inclusion of a wider range of effective treatments for self-harm. The criterion referring to the use of case examples was rated 2 due to the absence of any case examples in the handbook.

Figure 4.5 Review of the training handbook



The evaluation of the quality of the slides included in the training programme revealed a number of differences between the slides used in the 8-hour programme versus those used in the 3-hour programme. Overall, the slides in the 8-hour programme were rated slightly higher than the slides used in the 3-hour programme (Figure 4.6). The criteria representing interaction and active participation were scored 4 for the 8-hour programme versus 2.5 for the 3-hour programme which is related to available time. In terms of accuracy of information presented for the slides in both training programmes it would be recommended updating and optimising the information by referring to recent publications and including more publications relevant to the Irish situation. It would also be recommended updating the information on evidence based treatments for self-harm. In terms of adaptation of the information to the local context, it would be recommended to include more information on self-harm in young people since this is the group at highest risk of self-harm in Ireland, which applies to the slides for both training programmes. Regarding information on local support services, it would be recommended to conduct a regular update of the handbook and services at least every two years.

Figure 4.6 Review of the slides included in the training programme by length of training programme



Literature review on the efficacy of self-harm awareness training programmes

- Research into the efficacy of self-harm awareness training programmes consistently shows significant positive effects in terms of knowledge, attitudes and confidence in dealing with people who engage in self-harm, in particular in the short term.

- These findings are in line with positive effects of other types of gatekeeper training programmes implemented among a wide range of health care professionals and community facilitators.

- Further research is required in order to verify sustainability of positive effects in the long term and to enhance insight into the unique effects of self-harm awareness training programmes.

Independent evaluation of the self-harm awareness training programme – Quantitative

Prospective evaluation

- Independent evaluation of the efficacy of the self-harm awareness training programme revealed greater awareness of self-harm following the training. Significant positive changes pre-post training were observed in terms of increased knowledge, enhanced positive attitudes towards and confidence in dealing with people who engage in self-harm.

- Both the 3-hour and the 8-hour training programmes were shown to positively affect knowledge, attitudes and confidence in dealing with people who engage in self-harm.

- The pre-post training effects in terms of increased knowledge and attitude change were greater among participants who had not received previous training on self-harm or related topics, such as crisis intervention.

- The pre-post training effects in terms of increased confidence in dealing with people who engage in self-harm were greater among participants who had not received previous training on self-harm.

- The pre-post training effects in terms of increased confidence in dealing with people who engage in self-harm were greater among participants who completed the 8-hour training programme.

- The positive pre-post training effects in terms of attitudes towards self-harm and participants' confidence in instilling help seeking behaviour were sustained four months after having received the training programme.

- At 4-months follow-up, a significant reduction was observed in knowledge of self-harm and confidence in recognising potential suicide risk. However, the knowledge and confidence levels at four months follow-up were still higher compared to baseline levels.

Retrospective evaluation

- The retrospective evaluation identified good awareness of self-harm amongst people who had completed the training. Based on the retrospective evaluation, the majority of participants indicated that the training had made a difference to how they were dealing with self-harm following the training programme.

- Comparing the outcomes of the retrospective evaluation with the outcomes of the 1st follow-up of the prospective evaluation, overall higher scores were found among participants who had completed the prospective 1st follow-up questionnaires. The differences may be related to the longer time period between time of training programme and time of completing questionnaires for the purpose of the retrospective evaluation.

- On all measures, higher scores were found among participants who had received the 8-hour training programme compared to those involved in the 3-hour programme, which reached statistical significance for confidence in recognising potential suicide risk.

- A significantly higher score for knowledge was found among participants who reported having used the handbook since the training.

- Having completed previous training on suicide/suicide prevention contributed to a more effective attitude in dealing with self-harm clients and higher levels of confidence in dealing with self-harm clients compared to those who had not.

- Participants who had completed previous training on self-harm were more empathic towards people who engage in self-harm compared to those who had not.

- Having completed previous training on depression contributed to higher levels of confidence in dealing with self-harm clients.

- Confidence in instilling help seeking behaviour was higher among participants with less than 15 years work experience, which may be related to a stronger emphasis on educational programmes increasing awareness of self-harm and suicide training in recent years.

Independent evaluation of the self-harm awareness training programme – Qualitative

The perspective of participants

- All participants reported generally positive feedback about the training programme.

- Positive aspects reported by the participants included:
  - 3-hour programme was considered sufficient taking into account its current content
  - The handbook being a helpful tool
  - Relevance of the information included in the training programme
  - Enhanced competence in dealing with people who engage in self-harm
  - Importance of the training programme for the purpose of policy development

- Adjustments to the training programme suggested by the participants:
  - Content of training programme should be geared to target group
  - Potential interest in longer training programme
  - Improving the facilities for the delivery of the training, e.g. bigger room

- Inclusion of more skills based training aspects
- Add sessions in order to sustain the benefits of the programme
- Consideration of negative effects of alternatives to self-harm

The perspective of trainers

- There was general agreement among the trainers that being involved in the delivery of the self-harm awareness training was beneficial.

- Positive aspects reported by the trainers included:
  - Overall positive feedback from participants
  - Positive effects of training in terms of increased knowledge and confidence
  - Assistance in administrative tasks sufficient
  - Positive attitude towards extending the length of the training programme from 3 to 8 hours
  - Positive attitude towards involvement of service users in the training
  - Positive view on the content of training materials
  - Positive experience with informal opportunities for debriefing
  - Positive attitude towards national implementation of the self-harm awareness training programme

- Adjustments to the training programme suggested by the trainers:
  - In terms of a Train-the-Trainer programme, there is a need for the development of a formalised programme and manual if the training is to be rolled out further.
  - In the Train-The-Trainer programme, more emphasis on dealing with difficult situations such as participants sharing their self-harm experiences
  - More emphasis on the relevance of trainers having clinical experience
  - The training could be optimised by expanding the 3-hour training programme to an 8-hour programme
  - Consideration of challenges when involving service users in the training programme
  - Trainers underlined the benefits of a formal structure for debriefing
  - In terms of sustainability of the training programme, trainers highlighted the need for further funding and increased commitment from key stakeholders
  - Access to resources, e.g. laptop, LCD projector should be improved
  - The quality of the DVD should be improved

- Trainers reported different views in relation to clarifying the link between deliberate self-harm and suicide for participants

The perspective of stakeholders

- There was general agreement among the stakeholders regarding the need for a self-harm awareness training programme and it's relevance to broader suicide prevention initiatives.

- Positive views and aspects reported by the stakeholders included:
  - An understanding of self-harm from the service user's point of view is a key objective of the self-harm awareness training programme
  - Short duration of 3-hour training programme will facilitate people being released from work for the training
  - Involvement of local trainers will facilitate access to local services
  - Stakeholders had observed positive effects of the training among staff members who had received the training and recognised positive effects of the training on organisations
  - Positive attitude towards involvement of service users in the training
  - Relatively low costs of implementing the self-harm awareness training
  - Agreement among stakeholders to roll out the training programme at national level

- Adjustments to the training programme suggested by the stakeholders:
  - Consideration to include wider range of clinical implications of self-harm
  - In targeting people working in clinical settings it would be required to adjust the content of the training programme to this group
  - Considering the diversity of the participants involved, strategies should be put in place to maintain the safety of participants
  - Stakeholders considered it important to target the training to the needs of the audience in order to maximise the use of resource
  - According to stakeholders, support and safety issues should be taken into account when involving service users
  - According to stakeholders, a training background and clinical experience are important requirements for trainers

- Stakeholders highlighted the importance of support/debriefing for trainers and administrative support
- Stakeholders underlined the importance of incorporating evidence-based treatments for self-harm in the training programme
- Stakeholders underlined the importance of incorporating the training into curricula of professional training programmes

- According to the stakeholders, the relevance of the distinction between self-harm and suicide was associated with making people feel more comfortable with self-harm.

- If the self-harm awareness training programme would be implemented nationally, the stakeholders suggested a number of additional requirements:
  - Buy in from national stakeholders both within and outside the health services
  - Accreditation of the self-harm awareness training programme by the relevant professional bodies
  - The self-harm awareness training programme should be integrated into the curricula of professional training programmes and should be delivered on an ongoing basis
  - National implementation of the training programme would require centralised co-ordination of the programme with local responsibility for the day-to-day co-ordination and recruitment of trainers at local level
  - National implementation of the training programme would require a formal structure for the Train-The-Trainer programme and adequate resources.

Review of the self-harm awareness training programme and materials

- The majority of the participants were positive about all aspects of the self-harm awareness training programme.

- Participants who had received the 8-hour training programme were slightly more positive about a number of elements of the training compared to those who had received the 3-hour programme, including the introduction, communication and structure of the programme and familiarity of the facilitators with the topic.

- Among participants who had received the 3-hour training programme, a higher proportion indicated that there was not enough time for discussion compared to those involved in the 8-hour programme.

- Participants who had received the 3-hour training programme were more often undecided in their responses compared to those who had been involved in the 8-hour programme.

- The outcomes of the retrospective evaluation were in line with the prospective evaluation in that the majority were positive about all aspects of the training programme. However, the retrospective evaluation revealed a higher proportion of those who were undecided.

- Overall, the quality of the handbook was rated positive, with recommended updates on specific information and use of case examples.

- Evaluation of the quality of the slides revealed a number of differences between the slides used in the 8-hour versus the 3-hour programme. Higher scores were obtained for the slides used in the 8-hour programme in relation to active participation and interaction, which is likely to be associated with available time. Provision of information on local support services was also rated higher for the slides used in the 8-hour programme compared to the 3-hour programme.

Recommendations

1. The evidence base obtained in the current study supports the wider implementation of the self-harm awareness training programme.

2. In order to enhance the sustainability of the training effects, it would be recommended to consider implementing refresher courses or other low cost initiatives such as regular contact by e-mail.

3. Considering the enhanced effects of the self-harm awareness training programme when participants had been involved in previous training, it would be recommended to promote the self-harm awareness training programme as part of a series of training programmes to optimise the effects.

4. It would be recommended to either target the programme more specifically to clinical professionals or develop a separate programme to meet their needs.

5. The efficacy of the self-harm awareness training programme could be enhanced by extending the 3-hour programme to 8 hours and including more elements of skills-based learning.

6. In terms of the content of the materials used in the self-harm awareness training programme, it would be recommended to update information on risk factors associated with deliberate self-harm and evidence based interventions reducing or preventing self-harm.

7. It would be recommended to address the quality of the DVD and access to resources for trainers.

8. In order to enhance consistency among trainers in relation to key messages of the programme, in particular regarding self-harm and suicide, it would be recommended to regularly update all trainers on the evidence base.

9. From the point of view of safety and learning for the trainers involved in the self-harm awareness training programme, it would be recommended to develop a formal structure for support and debriefing for trainers.

10. Considering the overall positive effects of the self-harm awareness training programme, it would be recommended to roll out the training at national level. This process would be facilitated by:
    a) buy in from national stakeholders both within and outside the health services,
    b) accreditation of the training programme by relevant professional bodies,
    c) integration of the programme into the curricula of professional training programmes,
    d) centralised co-ordination of the programme with local responsibility for the day-to-day co-ordination and recruitment of trainers at local level
    e) a formal structure for the Train-The-Trainer programme and adequate resources.
    f) a system for continuous evaluation of the training programme with dedicated resources for updating content and materials in light of emerging evidence.

    We would recommend that the implementation process will be coordinated by the National Office for Suicide Prevention in collaboration with the Mental Health Directorate.

11. It is recommended that the evidence base obtained in the current study be considered for guidelines to improve the assessment and care for people who engage in deliberate self-harm, e.g, the clinical guideline on self-harm by the National Institute for Clinical Excellence in the UK.

12. Based on the outcomes of both the independent evaluation of the self-harm awareness training programme and international research, it would be recommended to conduct further research into sustainability of training effects in the long term and identification of the unique effects of self-harm awareness training programmes.

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Appendix I: Retrospective questionnaire

Questionnaire ID number: ☐☐☐
All details given will be treated as confidential.

Participant Questionnaire

Section 1

Please fill in the following details. It is **Not** necessary to fill in your name or address on any part of this questionnaire.

Thank you for your help in filling out this questionnaire.

County of residence ☐☐☐☐☐☐☐☐☐☐☐

GENDER: Male ☐ Female ☐ AGE ☐☐

Where did you complete the self-harm training programme?_____

Length of self-harm training programme: 3 hours ☐ One day ☐

How many years in total did you spend studying in school, college or university? ☐☐
(including primary school, secondary school, college/university)

What is your area of care work? e.g. health care, social care, teaching, youth work, voluntary care, pastoral care, housing, etc.

Position if applicable

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

How many years experience do you have in this area? ☐☐

Have you previously received any training related to aspects of depression?

YES ☐ NO ☐

Have you previously received any training related to self-harm?

YES ☐ NO ☐

Have you previously received any training related to suicide or suicide prevention?

YES ☐ NO ☐

Have you previously received any training related to responding to a crisis?

YES ☐ NO ☐

In the past 12 months, have you had experience with self-harm or suicide *in a personal/professional capacity*?

Never ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Daily ☐

If YES

Please describe the standard route of care which you recommend for clients/patients with deliberate self-harm:

_____

_____

Have you noticed a difference in how you deal with people who self-harm/are at risk of self-harm since the training programme?

Yes ☐ No ☐

If yes, can you indicate what changes have occurred since the training programme?

_____

_____

_____

Section 2

The following are short statements about self-harm. Based on your knowledge of self-harm, to what extent do you agree or disagree with these statements? Please answer the following questions by placing an X in the box under your response.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1) Self-harm is a form of communication					
2) Self-harm is a sign of madness/mental illness					
3) Self-harm provides a way of staying in control					
4) Self-harm provides distraction from thinking					
5) People who self-harm will "grow out of it" eventually					
6) Self-harm is a manipulative act					

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
7) Self-harm can obtain/promote feelings of euphoria					
8) Self-harm is a "woman's problem"					
9) Self-harm is a release for anger					
10) Self-harm is an expression of emotional pain					
11) The best way to deal with people who self-harm is to make them stop					
12) People who self-harm have been sexually abused					
13) Self-harm is a failed suicide attempt					
14) Self-harm helps individuals deal with problems					
15) Self-harm is a coping strategy					
16) Self-harm is attention seeking					
17) Self-harm helps a person maintain a sense of identity					
18) Everybody who self-harms suffers from Munchausen's Disease (self-inflicted injuries that are calculated to produce specific symptoms that will lead to medical hospital admissions)					
19) Self-harm provides escape from depression					
20) People who self-harm should be kept in psychiatric hospitals					
21) Self-harm is a form of suicide					
22) Self-harm is a precursor to suicide					
23) Individuals who self-harm are suicidal					
24) Self-harm is distinct from suicide					

Section 3

The following are short statements about contact with individuals who self-harm. Based on your experience of contact with individuals who self-harm, to what extent do you agree or disagree with these statements? Please answer the following questions by placing an X in the box under your response.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1) Overall, I am happy with the control I have in dealing with deliberate self-harm clients in my unit/care				
2) There is really no way I can help solve some of the problems the deliberate self-harm patient has				
3) I often feel helpless in dealing with the problems of deliberate self-harm				
4) Sometimes I feel used by the hospital system				
5) I feel useful when working with deliberate self-harm patients				
6) The way the hospital system works encourages repetition of deliberate self-harm behaviour				
7) Self-harm clients just clog up the system				
8) Knowledge of referral sources is important when dealing with deliberate self-harm clients				
9) Dealing with self-harm clients is a waste of the health care professional's time				
10) I deal effectively with deliberate self-harm clients				
11) The hospital system impedes my ability to work effectively with deliberate self-harm clients				
12) Clients who deliberately self-harm have been hurt and damaged in the past				
13) Ongoing education and training would be useful in helping me deal appropriately with deliberate self-harm clients				
14) Risk assessment is an important skill for me to have				
15) Clients who deliberately self-harm are just attention seekers				
16) Sometimes when all other actions have failed, I feel the need to go to extremes when dealing with deliberate self-harm clients				

	Strongly Disagree	Disagree	Agree	Strongly Agree
17) I have the appropriate counselling skills to help deliberate self-harm clients				
18) Referral of deliberate self-harm patients to external consultant services for further assessment or treatment is an effective course of action				
19) Self-harm clients are just using ineffective coping mechanisms				
20) I have the appropriate communication skills to help deliberate self-harm clients				
21) Providing deliberate self-harm clients with information about community support groups is a good idea				
22) Self-harm clients are clients of some other social problems				
23) Clients who deliberately self-harm are in desperate need of help				
24) The legal system impedes my ability to work effectively with deliberate self-harm clients				
25) I feel that clients who self-harm are treated less seriously by the medical staff than clients with medical problems				

Section 4

The following questions are about how confident you are in dealing with people who self-harm.

Please, indicate a point on each line with an X, as shown below, which best reflects your opinion.

Example

Not at all confident ***Very confident***

----------X----------

0 1 2 3 4 5 6 7 8 9 10

I feel confident that I could relate and instill help seeking behaviour to someone who self-harms.

Not at all confident: **Very confident**

---

0 1 2 3 4 5 6 7 8 9 10

After seeing a person once, I would be confident that I could recognise potential suicidal risk.

Not at all confident **Very confident**

0 1 2 3 4 5 6 7 8 9 10

Section 5: Workshop Evaluation

Using the following rating scale, to what extent would you agree or disagree with the following statements:

1 = Strongly disagree
2 = Tend to disagree
3 = Neither agree nor disagree
4 = Tend to agree
5 = Strongly agree
6 = Don't know

1	The facilitators gave a comprehensive introduction into the workshop	1	2	3	4	5	6
2	The facilitators were familiar with the topic	1	2	3	4	5	6
3	The facilitators communicated the topic clearly and understandably	1	2	3	4	5	6
4	The training was well structured and target-oriented	1	2	3	4	5	6
5	All shown figures were clearly arranged and readable	1	2	3	4	5	6
6	Chosen training approaches (e.g. DVD, case studies, small group work) were helpful	1	2	3	4	5	6
7	The training improved my knowledge	1	2	3	4	5	6
8	The overall impression of the training corresponded with my expectations	1	2	3	4	5	6
9	Presented material was interesting and up-to-date	1	2	3	4	5	6
10	There was enough time left for discussion and/or questions	1	2	3	4	5	6
11 What did you like about the training course?							
12 What should be done differently next time?							

13 Since the training, have you used the handbook that was given out?

Yes ☐ No ☐

If yes, please offer some brief details of sections referred to or how you have used the handbook.

14_ Do you have any comments regarding the handbook?

Please provide any extra comments if you wish.

Thank you for taking the time to complete this questionnaire.

Appendix II: Prospective baseline questionnaire (non clinical)

Questionnaire ID number: ☐☐
All details given will be treated as confidential.

Participant Questionnaire

Section 1

Please fill in the following details. It is **Not** necessary to fill in your name or address on any part of this questionnaire.

Thank you for your help in filling out this questionnaire.

County of residence ☐☐☐☐☐☐☐☐☐☐☐

GENDER: Male ☐ Female ☐ Age ☐☐

Where did you complete the self-harm training programme?_____

Length of self-harm training programme: 3 hours ☐ One day ☐

How many years in total did you spend studying in school, college or university? ☐☐
(including primary school, secondary school, college/university)

What is your area of care work? e.g. health care, social care, teaching, youth work, voluntary care, pastoral care, housing, etc.

Position if applicable

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

How many years experience do you have in this area? ☐☐

Have you previously received any training related to aspects of depression?

YES ☐ NO ☐

Have you previously received any training related to self-harm?

YES ☐ NO ☐

Have you previously received any training related to suicide or suicide prevention?

YES ☐ NO ☐

Have you previously received any training related to responding to a crisis?

YES ☐ NO ☐

In the past 12 months, have you had experience with self-harm or suicide *in a personal/professional capacity*?

Never ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Daily ☐

If YES

Please describe the standard route of care which you recommend for clients/patients presenting with deliberate self-harm:

_____

_____

Section 2

The following are short statements about self-harm. Based on your knowledge of self-harm, to what extent do you agree or disagree with these statements? Please answer the following questions by placing an X in the box under your response.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1) Self-harm is a form of communication					
2) Self-harm is a sign of madness/mental illness					
3) Self-harm provides a way of staying in control					
4) Self-harm provides distraction from thinking					
5) People who self-harm will "grow out of it" eventually					
6) Self-harm is a manipulative act					
7) Self-harm can obtain/promote feelings of euphoria					
8) Self-harm is a "woman's problem"					
9) Self-harm is a release for anger					
10) Self-harm is an expression of emotional pain					
11) The best way to deal with people who self-harm is to make them stop					

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
12) People who self-harm have been sexually abused					
13) Self-harm is a failed suicide attempt					
14) Self-harm helps individuals deal with problems					
15) Self-harm is a coping strategy					
16) Self-harm is attention seeking					
17) Self-harm helps a person maintain a sense of identity					
18) Everybody who self-harms suffers from Munchausen's Disease (self-inflicted injuries that are calculated to produce specific symptoms that will lead to medical hospital admissions)					
19) Self-harm provides escape from depression					
20) People who self-harm should be kept in psychiatric hospitals					
21) Self-harm is a form of suicide					
22) Self-harm is a precursor to suicide					
23) Individuals who self-harm are suicidal					
24) Self-harm is distinct from suicide					

Section 3

The following are short statements about contact with individuals who self-harm. Based on your experience of contact with individuals who self-harm, to what extent do you agree or disagree with these statements? Please answer the following questions by placing an X in the box under your response.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1) Overall, I am happy with the control I have in dealing with deliberate self-harm clients in my unit/care				
2) There is really no way I can help solve some of the problems the deliberate self-harm patient has				

	Strongly Disagree	Disagree	Agree	Strongly Agree
3) I often feel helpless in dealing with the problems of deliberate self-harm				
4) I feel useful when working with deliberate self-harm patients				
5) Self-harm clients just clog up the system				
6) Knowledge of referral sources is important when dealing with deliberate self-harm clients				
7) Dealing with self-harm clients is a waste of the health care professional's time				
8) I deal effectively with deliberate self-harm clients				
9) Clients who deliberately self-harm have been hurt and damaged in the past				
10) Ongoing education and training would be useful in helping me deal appropriately with deliberate self-harm clients				
11) Risk assessment is an important skill for me to have				
12) Clients who deliberately self-harm are just attention seekers				
13) I have the appropriate counselling skills to help deliberate self-harm clients				
14) Referral of deliberate self-harm patients to external consultant services for further assessment or treatment is an effective course of action				
15) Self-harm clients are just using ineffective coping mechanisms				
16) I have the appropriate communication skills to help deliberate self-harm clients				
17) Providing deliberate self-harm clients with information about community support groups is a good idea				
18) Self-harm clients are clients of some other social problems				
19) Clients who deliberately self-harm are in desperate need of help				

Section 4

The following questions are about how confident you are in dealing with people who self-harm.

Please, indicate a point on each line with an X, as shown below, which best reflects your opinion.

Example
Not at all confident ***Very confident***

----------X----------
0 1 2 3 4 5 6 7 8 9 10

I feel confident that I could relate and instill help seeking behaviour to someone who self-harms.

Not at all confident: **Very confident**

---
0 1 2 3 4 5 6 7 8 9 10

After seeing a person once, I would be confident that I could recognise potential suicidal risk.

Not at all confident **Very confident**

---
0 1 2 3 4 5 6 7 8 9 10

Please provide any extra comments if you wish.

Thank you for taking the time to complete this questionnaire.

Appendix III: Prospective 1st follow-up questionnaire (non-clinical)

Questionnaire ID number: ☐☐
All details given will be treated as confidential.

Participant Questionnaire

Section 1

Please fill in the following details. It is **Not** necessary to fill in your name or address on any part of this questionnaire.

Thank you for your help in filling out this questionnaire.

County of residence ☐☐☐☐☐☐☐☐☐☐☐

GENDER: Male ☐ Female ☐ Age ☐☐

Where did you complete the self-harm training programme?_____

Length of self-harm training programme: 3 hours ☐ One day ☐

How many years in total did you spend studying in school, college or university? ☐☐
(including primary school, secondary school, college/university)

What is your area of care work? e.g. health care, social care, teaching, youth work, voluntary care, pastoral care, housing, etc.

Position if applicable

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

How many years experience do you have in this area? ☐☐

Have you previously received any training related to aspects of depression?

YES ☐ NO ☐

Have you previously received any training related to self-harm?

YES ☐ NO ☐

Have you previously received any training related to suicide or suicide prevention?

YES ☐ NO ☐

Have you previously received any training related to responding to a crisis?

YES ☐ NO ☐

In the past 12 months, have you had experience with self-harm or suicide *in a personal/professional capacity*?

Never ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Daily ☐

If YES

Please describe the standard route of care which you recommend for clients/patients presenting with deliberate self-harm:

_____

_____

Section 2

The following are short statements about self-harm. Based on your knowledge of self-harm, to what extent do you agree or disagree with these statements? Please answer the following questions by placing an X in the box under your response.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1) Self-harm is a form of communication					
2) Self-harm is a sign of madness/mental illness					
3) Self-harm provides a way of staying in control					
4) Self-harm provides distraction from thinking					
5) People who self-harm will "grow out of it" eventually					
6) Self-harm is a manipulative act					
7) Self-harm can obtain/promote feelings of euphoria					
8) Self-harm is a "woman's problem"					
9) Self-harm is a release for anger					
10) Self-harm is an expression of emotional pain					
11) The best way to deal with people who self-harm is to make them stop					

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
12) People who self-harm have been sexually abused					
13) Self-harm is a failed suicide attempt					
14) Self-harm helps individuals deal with problems					
15) Self-harm is a coping strategy					
16) Self-harm is attention seeking					
17) Self-harm helps a person maintain a sense of identity					
18) Everybody who self-harms suffers from Munchausen's Disease (self-inflicted injuries that are calculated to produce specific symptoms that will lead to medical hospital admissions)					
19) Self-harm provides escape from depression					
20) People who self-harm should be kept in psychiatric hospitals					
21) Self-harm is a form of suicide					
22) Self-harm is a precursor to suicide					
23) Individuals who self-harm are suicidal					
24) Self-harm is distinct from suicide					

Section 3

The following are short statements about contact with individuals who self-harm. Based on your experience of contact with individuals who self-harm, to what extent do you agree or disagree with these statements? Please answer the following questions by placing an X in the box under your response.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1) Overall, I am happy with the control I have in dealing with deliberate self-harm clients in my unit/care				
2) There is really no way I can help solve some of the problems the deliberate self-harm patient has				

	Strongly Disagree	Disagree	Agree	Strongly Agree
3) I often feel helpless in dealing with the problems of deliberate self-harm				
4) I feel useful when working with deliberate self-harm patients				
5) Self-harm clients just clog up the system				
6) Knowledge of referral sources is important when dealing with deliberate self-harm clients				
7) Dealing with self-harm clients is a waste of the health care professional's time				
8) I deal effectively with deliberate self-harm clients				
9) Clients who deliberately self-harm have been hurt and damaged in the past				
10) Ongoing education and training would be useful in helping me deal appropriately with deliberate self-harm clients				
11) Risk assessment is an important skill for me to have				
12) Clients who deliberately self-harm are just attention seekers				
13) I have the appropriate counselling skills to help deliberate self-harm clients				
14) Referral of deliberate self-harm patients to external consultant services for further assessment or treatment is an effective course of action				
15) Self-harm clients are just using ineffective coping mechanisms				
16) I have the appropriate communication skills to help deliberate self-harm clients				
17) Providing deliberate self-harm clients with information about community support groups is a good idea				
18) Self-harm clients are clients of some other social problems				
19) Clients who deliberately self-harm are in desperate need of help				

Section 4

The following questions are about how confident you are in dealing with people who self-harm.

Please, indicate a point on each line with an X, as shown below, which best reflects your opinion.

Example
Not at all confident ***Very confident***

----------X----------
0 1 2 3 4 5 6 7 8 9 10

I feel confident that I could relate and instill help seeking behaviour to someone who self-harms.

Not at all confident: **Very confident**

---
0 1 2 3 4 5 6 7 8 9 10

After seeing a person once, I would be confident that I could recognise potential suicidal risk.

Not at all confident **Very confident**

---
0 1 2 3 4 5 6 7 8 9 10

Section 5: Workshop Evaluation

Using the following rating scale, to what extent would you agree or disagree with the following statements:

1 = Strongly disagree
2 = Tend to disagree
3 = Neither agree nor disagree
4 = Tend to agree
5 = Strongly agree
6 = Don't know

1	The facilitators gave a comprehensive introduction into the workshop	1	2	3	4	5	6
2	The facilitators were familiar with the topic	1	2	3	4	5	6
3	The facilitators communicated the topic clearly and understandably	1	2	3	4	5	6
4	The training was well structured and target-oriented	1	2	3	4	5	6
5	All shown figures were clearly arranged and readable	1	2	3	4	5	6
6	Chosen training approaches (e.g. DVD, case studies, small group work) were helpful	1	2	3	4	5	6
7	The training improved my knowledge	1	2	3	4	5	6

8	The overall impression of the training corresponded with my expectations	1	2	3	4	5	6
9	Presented material was interesting and up-to-date	1	2	3	4	5	6
10	There was enough time left for discussion and/or questions	1	2	3	4	5	6
11 What did you like about the training course?							
12What should be done differently next time?							

Please provide any extra comments if you wish.

Would you be willing to be contacted by mail/email in 4 months time to determine how the training met your needs?

Yes ☐ **No** ☐

If yes, please list your preferred contact information below:

Name: _____

Email: _____

Address: _____

_____

_____

Thank you for taking the time to complete this questionnaire.

Appendix IV: Prospective 2nd follow-up questionnaire (non-clinical)

Questionnaire ID number: ☐☐
All details given will be treated as confidential.

Participant Questionnaire

Section 1

Please fill in the following details. It is **Not** necessary to fill in your name or address on any part of this questionnaire.

Thank you for your help in filling out this questionnaire.

County of residence ☐☐☐☐☐☐☐☐☐☐☐

GENDER: Male ☐ Female ☐ Age ☐☐

Where did you complete the self-harm training programme?_____

Length of self-harm training programme: 3 hours ☐ One day ☐

How many years in total did you spend studying in school, college or university? ☐☐
(including primary school, secondary school, college/university)

What is your area of care work? e.g. health care, social care, teaching, youth work, voluntary care, pastoral care, housing, etc.

Position if applicable

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

How many years experience do you have in this area? ☐☐

Have you previously received any training related to aspects of depression?

YES ☐ NO ☐

Have you previously received any training related to self-harm?

YES ☐ NO ☐

Have you previously received any training related to suicide or suicide prevention?

YES ☐ NO ☐

Have you previously received any training related to responding to a crisis?

YES ☐ NO ☐

In the past 4 months, have you had experience with self-harm or suicide *in a personal/professional capacity*?

Never ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Daily ☐

If YES

Please describe the standard route of care which you recommend for clients/patients presenting with deliberate self-harm:

_____

_____

Have you noticed a difference in how you deal with people who self-harm/are at risk of self-harm since the training programme?

Yes ☐ No ☐

If yes, can you indicate what changes have occurred since the training programme?

_____

_____

_____

Section 2

The following are short statements about self-harm. Based on your knowledge of self-harm, to what extent do you agree or disagree with these statements? Please answer the following questions by placing an X in the box under your response.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1) Self-harm is a form of communication					
2) Self-harm is a sign of madness/mental illness					
3) Self-harm provides a way of staying in control					
4) Self-harm provides distraction from thinking					
5) People who self-harm will "grow out of it" eventually					
6) Self-harm is a manipulative act					
7) Self-harm can obtain/promote feelings of euphoria					

8) Self-harm is a "woman's problem"					
9) Self-harm is a release for anger					
10) Self-harm is an expression of emotional pain					
11) The best way to deal with people who self-harm is to make them stop					
12) People who self-harm have been sexually abused					
13) Self-harm is a failed suicide attempt					
14) Self-harm helps individuals deal with problems					
15) Self-harm is a coping strategy					
16) Self-harm is attention seeking					
17) Self-harm helps a person maintain a sense of identity					
18) Everybody who self-harms suffers from Munchausen's Disease (self-inflicted injuries that are calculated to produce specific symptoms that will lead to medical hospital admissions)					
19) Self-harm provides escape from depression					
20) People who self-harm should be kept in psychiatric hospitals					
21) Self-harm is a form of suicide					
22) Self-harm is a precursor to suicide					
23) Individuals who self-harm are suicidal					
24) Self-harm is distinct from suicide					

Section 3

The following are short statements about contact with individuals who self-harm. Based on your experience of contact with individuals who self-harm, to what extent do you agree or disagree with these statements? Please answer the following questions by placing an X in the box under your response.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1) Overall, I am happy with the control I have in dealing with deliberate self-harm clients in my unit/care				
2) There is really no way I can help solve some of the problems the deliberate self-harm patient has				
3) I often feel helpless in dealing with the problems of deliberate self-harm				
4) I feel useful when working with deliberate self-harm patients				
5) Self-harm clients just clog up the system				
6) Knowledge of referral sources is important when dealing with deliberate self-harm clients				
7) Dealing with self-harm clients is a waste of the health care professional's time				
8) I deal effectively with deliberate self-harm clients				
9) Clients who deliberately self-harm have been hurt and damaged in the past				
10) Ongoing education and training would be useful in helping me deal appropriately with deliberate self-harm clients				
11) Risk assessment is an important skill for me to have				
12) Clients who deliberately self-harm are just attention seekers				
13) I have the appropriate counselling skills to help deliberate self-harm clients				
14) Referral of deliberate self-harm patients to external consultant services for further assessment or treatment is an effective course of action				
15) Self-harm clients are just using ineffective coping mechanisms				

	Strongly Disagree	Disagree	Agree	Strongly Agree
16) I have the appropriate communication skills to help deliberate self-harm clients				
17) Providing deliberate self-harm clients with information about community support groups is a good idea				
18) Self-harm clients are clients of some other social problems				
19) Clients who deliberately self-harm are in desperate need of help				

Section 4

The following questions are about how confident you are in dealing with people who self-harm.

Please, indicate a point on each line with an X, as shown below, which best reflects your opinion.

Example

Not at all confident ***Very confident***

----------X----------

0 1 2 3 4 5 6 7 8 9 10

I feel confident that I could relate and instill help seeking behaviour to someone who self-harms.

Not at all confident: **Very confident**

---

0 1 2 3 4 5 6 7 8 9 10

After seeing a person once, I would be confident that I could recognise potential suicidal risk.

Not at all confident **Very confident**

---

0 1 2 3 4 5 6 7 8 9 10

Section 5:

Since the training, have you used the handbook that was given out? Yes ☐ No ☐ If yes, please offer some brief details of sections referred to or how you have used the handbook.
Do you have any comments regarding the handbook?

Please provide any extra comments if you wish.

Thank you for taking the time to complete this questionnaire.

National Suicide Research Foundation

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