Evaluation of SafeTALK Training in a Convenience Sample of 500 Niagara Region Residents, Health Professionals and Volunteers

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Summary:

- Suicide is a serious issue in the Niagara Region.

- A 2011 report found that Niagara residents were ready for, and would benefit from suicide awareness programs; in particular males and young people.

- SafeTALK workshops (developed by Livingworks) are effective in teaching the practical skills necessary for actively evaluating and responding to individuals having thoughts of suicide.

- Suicide awareness programs (such as SafeTALK) can be effective strategies for inducing positive changes towards the prevention of suicide.

- The regional roll-out of the SafeTALK program to professional and lay groups supports Niagara Suicide Prevention Coalition’s (NSPA) mandate to develop and maintain a suicide-safe Niagara.

- The SafeTALK workshops were delivered to 500 individuals who either resided, volunteered or worked in Niagara.

- These workshops were evaluated utilising a series of quantitative and qualitative questionnaires.

- The main results indicated that the SafeTALK participants believed the SafeTALK training program was useful and practical.

- The majority of those surveyed after the training program felt prepared to openly ask an individual about thoughts of suicide.

- Results from the qualitative feedback found that participants believed the SafeTALK training was most useful for lay groups, volunteers with no health background and young people; but least useful to those experienced health professionals who dealt with crisis mental health situations on a regular basis.

- More research needs to be undertaken to attempt to ascertain whether this type of training is indeed specifically linked with reduced rates of suicide attempts or deaths by suicide in Niagara as the evidence base in relation to this regard is inconclusive.
What is SafeTALK?

SafeTALK is a three-hour training program (developed by LivingWorks) that prepares helpers to identify persons with thoughts of suicide and connect them to suicide first aid resources. Most people with thoughts of suicide, either directly or indirectly, invite help to stay safe. Alert helpers know how to identify and work with these opportunities to help protect life. Training methods include powerful videos illustrating both non-alert and alert responses, and discussion and practice to stimulate learning.

Who can attend?

Anyone who is interested in helping those with thoughts of suicide; minimum age 15 years.

Learning Outcomes:

By the end of the training, participants will be better able to:

• Move beyond common tendencies to miss, dismiss, or avoid people with thoughts of suicide
• Identify people who have thoughts of suicide
• Apply the TALK steps (Tell, Ask, Listen and KeepSafe) to connect a person with thoughts of suicide to a suicide first aid intervention caregiver
Introduction:

Suicide is the act of intentionally killing one’s self. In 2004, the overall costs in Canada for deaths by suicide was 2.4 billion dollars (Smartrisk, 2009). Furthermore, in the province of Ontario, suicide and self-harm* accounted for 79% (886 million dollars) of the total cost for intentional injury.

Most people with thoughts of suicide invite help, and often these opportunities are missed, dismissed or avoided—leaving people more alone and at greater risk of a suicide attempt. However, a preventative program, SafeTALK (developed by Livingworks), prepares individuals to intervene using the elements of TALK (Tell, Ask, Listen and KeepSafe) to identify, approach, and engage with people who are having thoughts of suicide and, to connect them with further help and support.

* Distinguishable from suicide, self-harm refers to the act of intentionally causing bodily harm to one’s self without the intent of suicide.

Recent National Demographics

In 2011, there were approximately 3,728 deaths by suicide throughout Canada, which translates to 11 deaths for every 100,000 population (Statistics Canada). Moreover, the Public Health Agency of Canada (2012) reported that suicide was the leading cause of injurious death in Canada in 2007 for individuals between the ages of 25 and 69 years, and the second leading cause of injurious death for youths and young adults between the ages of 0 and 24 years. In 2009, 35% of all suicides occurred between the ages of 15 and 39, 45% between the ages of 40-59, and 19% in those aged 60 and older (Statistics Canada, 2012). Men were three times more likely than women to die from suicide (17.9 versus 5.3 per 100,000 population), and the risk for suicide is exacerbated for marginalized populations such as people with mental illness, Canada’s First Nations, victims of bullying, and the LGTBQ community (Dickerson et al., 2014; Mustanski & Liu, 2013; Statistics Canada 2011; Weir, 2001).

Provincial Demographics

In 2011, the province of Ontario had the leading number of deaths by suicide per year (1,185); and consistent with the national rate, men were three times more likely than women to die from suicide: 12.6 versus 4.3 per 100,000 population (Statistics Canada, 2011). That is, for every 100,000 Ontarians, approximately 5 of them will die by suicide (Statistics Canada, 2014).

Regional Demographics

Between 2000 and 2004, suicide was the leading cause of injury-related death within Niagara (Niagara Region, 2011). Specifically, of the 604 injurious deaths reported in Niagara between 2000 and 2004, 29% (175) of these were deaths by suicide (Niagara Region Public Health, 2010). These results indicate that on average, 44 Niagara residents die as a result of suicide each year. Also, according to Ontario Student Drug Use and Health Survey, 9.9% of students in Niagara (12 – 17y old youth) have seriously considered suicide (OSDUHS, 2011).
Strategy for a Suicide-Safe Niagara

In order to develop and maintain a suicide-safe Niagara, 25 local community agencies established a partnership in 2003: The Niagara Suicide Prevention Coalition (NSPC). The NSPC applies a multimodal approach to implement prevention, intervention, and post intervention strategies: public awareness, media education, access to services, means reduction, training, and evaluation/research. A recent approach was taken in order to explicate the strategy surrounding the implementation of an effective suicide awareness program in Niagara. The Niagara Suicide Prevention Coalition (NSPC) in partnership with the Niagara Region Public Health (NRPH) conducted a survey to determine the extent to which Niagara residents would be receptive to educational programs about the phenomenon of suicide. Gauging residents' degree of comfort, attitude, knowledge, and responsiveness to suicide was an integral part in the successful development and implementation of effective suicide awareness programs.

Specifically, a Niagara region-wide study was carried out in 2011 (internal report; Alexander & Masse, 2011) and the overall results showed that Niagara residents were ready for, and would benefit from suicide awareness programs. A majority of the respondents (91%) reported that they would perceive suicidal comments as a serious statement, and 90% of them disagreed with the statement, “I feel it is none of my business if someone wants to kill him or herself.” Approximately 82% of the participants indicated that suicide was indiscriminate; that anyone can be at risk for suicide, and 76% agreed that most suicides can be prevented. Only 36% of Niagara residents believed that people who are suicidal give clear signs that they want to die.

An overwhelming number of Niagara residents (88 %) reported that they were comfortable talking about suicide and that they would ask an individual if he or she was having thoughts of suicide. However, one-quarter of the responses suggested that Niagara residents would not know how to respond to an individual who was having thoughts of suicide and, 40% of the participants indicated that they would not seek out emergency services if someone was at risk for suicide. Moreover, 27% of the participants reported that they would not be comfortable talking with someone who had attempted suicide, with the youngest age group (18-34) expressing the most discomfort (34%).

Finally, the results of the Niagara region-wide study indicated that there were sex differences in how residents perceive and respond to suicide; with males having significantly more negative attitudes about suicide compared to females. Specifically, compared to female participants, a greater percentage of young males agreed to the statement, “I think people who die by suicide are taking the easy way out,” and that it was none of their business should an individual choose to take his or her own life.

These findings suggest that Niagara residents are ready for awareness programs about suicide, and that training is necessary for educating Niagara on how to recognize, communicate, and connect with individuals having thoughts of suicide.

Evidence Supporting Suicide Awareness Programs

Previous research has shown that some suicide awareness programs are effective in preventing deaths by suicide (Cigularov, Chen, Thurber, & Stallones, 2008; Gullestrup, Lequertier, & Martin, 2011; McLean, Schinkel, Woodhouse, Pynnonen, & McBryde, 2007; Mellonby et al., 2010). McLean et al. (2007) and Mellonby et al. (2010) have shown that SafeTALK workshops are effective in teaching the practical skills
necessary for actively evaluating and responding to individuals having thoughts of suicide. For example, Mellanby et al. (2010) conducted a SafeTALK workshop with third-year veterinary students, and the results indicated that there was a positive relation between workshop attendance and suicide awareness. Eighty-eight percent of the respondents who had participated in the workshop reported that they were either more likely or much more likely to recognize, approach, ask, and connect individuals that were having thoughts of suicide. Similarly, McLean et al.’s (2007) study found that over 80% of the participants who attended a SafeTALK workshop were either more likely or most likely to employ the elements of TALK in situations involving suicidal ideation: Tell, Ask, Listen, and Keepsafe.

Gullestrup et al. (2011) found significant intervention effects between participants who attended a suicide awareness training program and a comparison group, in that participants who attended the program were shown to have a greater awareness and understanding about suicide compared to those who had not participated in the suicide awareness training program. Similarly, Cigularov et al. (2008) tested the efficacy of suicide education programs with 779 high school students and found that compared to a control group, the treatment group had significantly higher scores on both, the measures of knowledge and attitude about suicide, and the perceived ability to approach individuals who might be at risk for suicide. The same findings were shown when comparing the treatment group’s pre (Time 1) and post (Time 2) training scores – there was a significant increase in scores from Time 1 to Time 2 on measures of knowledge, attitude, and approach behaviour.

These results strengthen the premise that suicide awareness programs can be effective strategies for inducing positive changes towards the prevention of suicide: knowledge, attitude, and responsivity. Therefore, it is crucial that a proactive approach is taken to ensure the safeguarding for those at risk of suicide. Preventative measures such as awareness programs and interactive workshops may also help to reduce the stigmatization that is so prevalently associated with suicidal ideations.

**SafeTALK Initiative:**

In response to the rates of suicide in Niagara, the pervasive nature of stigmatization associated with pathological behaviours, and research findings that have shown the efficacy of suicide awareness programs; the Distress Centre of Niagara, in partnership with the NSPC, obtained a $10,000 grant in order to roll out the SafeTALK training to professional and voluntary groups in Niagara only (e.g., EMS, NRP and other groups within the community), as well as for high-risk populations; specifically, males between the ages of 18 and 24 years. The average cost of training was approximately $20 per person.

The main objective was to improve knowledge, skills and attitudes towards suicide in Niagara by (a) successfully implementing the SafeTALK interactive workshop for individuals who wanted to prevent suicide, including, but not limited to: volunteers, front line workers, law enforcement, teachers, parents, youths, and emergency response groups; and (b) increasing awareness and comfort in discussing topics surrounding suicide, so that people would take an active approach in evaluating and connecting with individuals having thoughts of suicide.

SafeTALK is a suicide awareness training program developed by LivingWorks Education. Certified facilitators use a multimodal learning approach during the workshop training. For example, video clips are used to illustrate both, alert and non-alert responses to suicide, in conjunction with the practical application of the recently learned skills through the use of role play. This standardized training program educates individuals about (a) the various warning signs that indicate there is a risk for suicide,
(b) the importance of recognizing these signs, (c) communicating with the individual who is at risk, and (d) connecting him or her to suicide "first aid" intervention caregivers to assist with keeping him or her safe.

**Learning Objectives of SafeTALK:**

1. Move beyond common tendencies to miss, dismiss, or avoid suicide
2. Identify people who are having thoughts of suicide
3. Apply the elements of TALK (Tell, Ask, Listen, and Keepsafe) to connect a person with thoughts of suicide to suicide first aid intervention caregivers.

SafeTALK is one of eight programs in the United States which are considered gatekeeper suicide prevention programs for high schools, higher institutions of learning, and the community at large (Eynan, 2011). Gatekeeper training teaches specific groups of people to identify people at risk for suicide and then to manage the situation appropriately (Ubido & Scott-Samual, 2014). Various gatekeeper training packages exist, including ‘Applied Suicide Intervention Skills Training’ (ASIST), ‘Skills Training on Risk Management’ (STORM) and SafeTALK. The other programs include ASIST (Applied Suicide Intervention Skills Training). Both SafeTALK and ASIST have been utilized by the Niagara Region. Living Work INC. suicide education and intervention programs are used world-wide. Given the international reputation and common use across Canada, the Niagara Suicide Prevention Coalition decided to market Safe Talk in Niagara. While these programs address specific goals of the National Strategy for Suicide Prevention in the US and have been reviewed by a panel of experts and found to meet standards of accuracy, safety, and programmatic guidelines, the programs were not reviewed for evidence of effectiveness (Eynan, 2011).

**Aims of this report:**

The regional roll-out of the SafeTALK program to professional and lay groups supports NSPC’s mandate to develop and maintain a suicide-safe Niagara. This report aims to evaluate the roll out of the SafeTALK training in Niagara as it is acknowledge that there is a lack of robust evidence for the effectiveness of SafeTALK (Ubido & Scott-Samual 2014). This was achieved by evaluating participants’ knowledge, beliefs, attitudes and skills in relation to suicide in general and on the SafeTALK program pre and post training, utilizing both quantitative and qualitative means.
Methods:

The SafeTALK Working group met and discussed the steering and management of this project and the preferred groups to target. The main target groups as identified by the previous unpublished report were males and young people. Therefore the working group contacted a variety of organizations and explained the concept of SafeTALK. Emergency Medical Services (EMS) and the Niagara Region Police Service (NRPS) were two specific organizations which were targeted due to the ratio of male to female staff and asked if they wished to participate. Other groups who were invited to participate included Family and Children Services (FACS) Niagara staff, the John Howard Society summer staff (staff who work with at risk-youth) and Med Plus students at Brock University.

SafeTALK half day interactive workshops were held in a variety of locations across Niagara.

Questionnaires utilized to gather information on SafeTALK were developed by the Niagara Region Epidemiologist. Previous studies which had evaluated SafeTALK were consulted and samples of questions which were most suited to the Niagara SafeTALK evaluation were utilized or created. The SafeTALK Working Group then approved the final draft of the questionnaire. Four data collection tools were created and can be found in the appendix.

1. **A pre-questionnaire (mainly quantitative)** which identified knowledge, beliefs and attitudes in relation to suicide and dealing with suicidal individuals. This questionnaire was handed out to participants when they arrived at their training location and had to be completed before the SafeTALK training commenced.

2. **A post-questionnaire (mainly quantitative)** which identified knowledge, beliefs, attitudes and skills in relation to suicide and dealing with suicidal individuals. This questionnaire was handed out to participants when they had completed their SafeTALK training and had to be returned to the SafeTALK trainer on that particular day.

3. The SafeTALK Steering Committee decided that in order to obtain insightful feedback, participants would be asked to provide information on whether they had actually utilized their SafeTALK knowledge and skills. Therefore a **three month post-SafeTALK training (semi-quantitative)** questionnaire was developed and utilized Remark software as a means of creating an online survey. Only participants who agreed to be contacted (and who had provided their email address) were emailed the link to this online survey.

4. **A three month post SafeTALK training telephone interview (qualitative)** was developed and only the participants who had provided their phone numbers were contacted to find out more in depth details as to the perceived strengths and weaknesses of the SafeTALK training. These telephone semi-qualitative interviews were carried out by a trained operator at the distress centre, as it was felt that this person had the best knowledge and skills to cope with any issues which might arise from these more detailed conversations.

Once completed, questionnaire 1 & 2 were checked, sorted, scanned into the OMR software and cleaned. The data were then imported into the statistical analysis package SPSS and were analyzed using descriptive statistics. Data from questionnaire 3 was downloaded from the Remark Software into SPSS, and was cleaned and analyzed using descriptive statistics. Finally, the qualitative information from the phone interviews was summarized, themed and reported. The flow chart below summarizes this information.
Ethical approval was not required as subject identifiers were not created and no personal identifiable information was recorded. Therefore the results of the pre and post SafeTALK evaluations are reported in aggregate format. As the majority of these questions were categorical in nature, percentages were utilized to best describe the results.

**Results: Pre and post results on the day**

**Demographics:** Over half (56%) of the participants were male and approximately 45% were aged between 18 and 29 years. The majority of participants were from St. Catharines, followed by Niagara.
Falls and Welland. Almost a fifth attended SafeTALK for volunteering/personal reasons. Of those who attended for work purposes (Figure 2), those working as paramedics were the largest group in attendance followed by those within the Mental Health professions and those who worked within organizations dealing with Child Welfare and Physical Health. Almost half the participants did not have previous training in relation to suicide risk (Figure 1).

**Figure 1**

![Previous Suicide Risk Training](image)

**Figure 2**

![Where do you work?](image)

*The ‘other’ category consisted mainly of EMS/Paramedics although other workplaces of note were Public Health, Social Services and those working with the homeless.*
Participants were asked ‘How many times have you talked openly to a person about their thoughts of suicide?’ (Figure 3). The majority (almost half) had had this conversation more than twenty occasions. Approximately 1 in 8 had never talked about suicide and almost a tenth had only had that conversation once.

**Beliefs, Attitudes and Behaviours:** Participants were asked how they would respond to a friend/colleague/relation presenting with thoughts of suicide. (‘You are having a conversation with a friend/colleague/relation and within the conversation he or she expresses thoughts of suicide (e.g. ‘I just do not think I can do this anymore’ or ‘I would be better off dead’). How would you respond?

The overall results of the percentages of those who agreed and strongly agreed with the statements (Table 1) identify that the ‘I would keep it to myself’ and ‘I would try to convince them life wasn’t so bad’ scores went in the expected direction (i.e. the scores decreased from pre to post). The ‘I would not take the comment seriously’ score increased from pre to post while the ‘I would ignore the comment’ pre and post scores remained very low.

**Table 1**

<table>
<thead>
<tr>
<th></th>
<th>Not take the comment seriously</th>
<th>Keep it to myself</th>
<th>Convince them that life wasn’t so bad</th>
<th>Ignore the comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PRE</td>
<td>POST</td>
<td>PRE</td>
<td>POST</td>
</tr>
<tr>
<td>Overall</td>
<td>7.6</td>
<td>11.3</td>
<td>6.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Male</td>
<td>9.8</td>
<td>15.2</td>
<td>9.7</td>
<td>2.6</td>
</tr>
<tr>
<td>Female</td>
<td>4.6</td>
<td>6.8</td>
<td>4.5</td>
<td>2.3</td>
</tr>
<tr>
<td>18 - 39</td>
<td>6.3</td>
<td>10.3</td>
<td>7.3</td>
<td>1.5</td>
</tr>
<tr>
<td>40+</td>
<td>10.8</td>
<td>13.2</td>
<td>5</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Participants were asked pre SafeTALK training and post SafeTALK training their level of agreement with the statements listed in Table 2. Overall these scores increased in the expected direction; that is 54% of
those surveyed pre SafeTALK training thought that most suicides could be prevented and this figure increased to 60% post SafeTALK training. The biggest increase was noted in the 40y + age group (an increase of 20%). There was also a large increase in the pre and post scores in relation to ‘I think people who are suicidal give signs they want to die’ from 40% pre SafeTALK training to 64% post SafeTALK training. Again the largest increase in scores was noted in the 40y+ age group (an increase of 30%). Although only baseline data were available, those who indicated that they were paramedics (EMS; and especially those who were aged 40y +) were least likely to agree with the statement that ‘most suicides can be prevented, while non EMS aged 40+ were most likely to believe that most suicides can be prevented.

Table 2

<table>
<thead>
<tr>
<th>% who agreed and strongly agreed with the statements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think that most suicides can be prevented</td>
</tr>
<tr>
<td>PRE</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>Overall</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>18 - 39</td>
</tr>
<tr>
<td>40+</td>
</tr>
<tr>
<td>EMS 18 - 39</td>
</tr>
<tr>
<td>EMS 40+</td>
</tr>
<tr>
<td>Non EMS 18 - 39</td>
</tr>
<tr>
<td>Non EMS 40+</td>
</tr>
</tbody>
</table>

NA = Data not available due to the lack of question in the post questionnaire asking about areas in which the participants worked or volunteered.

Participants were also asked how prepared they felt to talk openly about suicide pre and post the SafeTALK training. Figure 4 demonstrates that only 12% of participants felt well prepared before the training while more than half felt well prepared after the training and almost 40% felt mostly prepared. Further investigation found that those working as a paramedic (18 – 39y) were most likely to feel well prepared to talk openly about suicide (21.8%) pre SafeTALK training; Post SafeTALK training data for this particular question is not available.
Participants were asked pre SafeTALK whether they were aware of organizations they could advise someone who has expressed suicidal thoughts to contact. 325 out of 486 (67%) participants wrote a response(s) and the majority of these indicated the Distress Centre (n = 69) as their first preference, followed by COAST (n = 65) and the Crisis Helpline (n = 27). Participants were also asked post training whether they would have recommended SafeTALK to others, and 88% stated that they would.

Participants were also asked post training their intentions regarding applying the SafeTALK training to appropriate situations (table 3). On average, 80% of participants stated that they would recognize the signs inviting help (highest in the females and those aged 40+ y categories). Three-quarters of participants would approach a person with thoughts of suicide and would ask directly about thoughts of suicide and 82% would connect a person with thoughts of suicide to someone who could keep them safe.
Table 3

<table>
<thead>
<tr>
<th></th>
<th>I will recognize signs inviting help</th>
<th>I will approach a person with thoughts of suicide</th>
<th>I will ask directly about thoughts of suicide</th>
<th>I will connect a person with thoughts of suicide to someone who can help them keep safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>80</td>
<td>73.5</td>
<td>76.5</td>
<td>82.2</td>
</tr>
<tr>
<td>Male</td>
<td>75.8</td>
<td>70</td>
<td>73.4</td>
<td>80.3</td>
</tr>
<tr>
<td>Female</td>
<td>84.1</td>
<td>82.9</td>
<td>85.2</td>
<td>87.5</td>
</tr>
<tr>
<td>18 - 39</td>
<td>77.8</td>
<td>72.6</td>
<td>74.1</td>
<td>79.8</td>
</tr>
<tr>
<td>40+</td>
<td>84.1</td>
<td>75.2</td>
<td>80.7</td>
<td>86.7</td>
</tr>
</tbody>
</table>

Participants were also asked ‘*How could this training be more effective in preparing suicide alert helpers?’*. Ninety-one participants responded (19% of the total sample) to this semi-qualitative question. The responses fell into two main categories; comments in relation to the content of SafeTALK (figure 5) and comments in relation to the delivery (figure 6) of SafeTALK.

Figure 5: Summarized themes/supporting comments on the delivery of SafeTALK (Qualitative)
Figure 6: Summarized themes/supporting comments in relation to the content of SafeTALK (Qualitative)
3 month post interviews – Quantitative and Qualitative Results

Of the 100 individuals who provided contact details, 34 completed the online survey. 46% were male and more than half of respondents were in the 18 – 34 year old age category.

More than 90% of this group felt that the SafeTALK training was useful and that the objectives were met i.e. (1) to identify persons with thoughts of suicide and (2) to connect persons with thoughts of suicide to suicide intervention care givers. More than half of this particular group had used the SafeTALK (Tell, Ask,
Listen & Keepsafe) since they had undertaken the training and had used it in a variety of situations (mainly in their personal life, at work with a client and where they volunteered). More than half of this group felt well prepared in terms of talking directly and openly to a person about their thoughts of suicide. No-one felt unprepared.

Figure 7: What was the most useful aspect of SafeTALK? (Qualitative: Main themes identified)

Almost two thirds stated that this course affected the way they thought about suicide and the majority of these comments were of a positive nature. These comments were mainly in relation to an increased knowledge of the burden of suicide in societies, an acknowledgement of the fact that it made them more understanding of suicidal persons and the fact that they felt more empowered to ask directly whether a person was contemplating suicide. The majority of those surveyed referred people onto the Distress Centre and to COAST.

There were some negative comments & constructive criticism in relation to the SafeTALK training (see below)

Least useful aspects of SafeTALK (individual comments)

* ‘I think it is silly to connect people to 3 people (SafeTALK, Alert person, and then a professional), I know I
wouldn’t want to feel passed on 3 times’

• ‘No opinion on this question. It’s the patient’s refusal to buy into the system that makes it less effective. This varies with each scenario.’
• ‘Not much knowledge on current communication methods, ie: texting’
• ‘Saying do you want to commit suicide? Most patients tell you right away’
• ‘Telling people that they should be looking for signs. You do not want people evaluating everyone they meet.’
• ‘The inability to help the individual beyond just connecting them with a resource. A de-escalation method would have been used.’
• ‘The initial few pages of the SafeTALK Resource Book could be formatted in a more easy to follow way’.
• ‘The length of the training or out dated videos’
• ‘There was a lot of information given in a short period of time’.
• ‘There were a lot of videos and some technical issues, so maybe if there were fewer videos and more interactive activities (ex: breaking off into groups of 4 and re-enacting a real life example).’

3 month post interviews Qualitative Results (n = 15)

Seventeen individuals also provided their phone number and of these, 15 telephone interviews were held. All of those who took part in the telephone interview felt that the objectives of the SafeTALK trainings were met.

1. SafeTALK objective 1: To identify persons with thoughts of suicide:

The majority of people surveyed agreed with this statement for example;

‘Could already identify signs but the training would help others’.

‘Many demonstrations of seeing signs and signals. Emphasis on the importance of asking even when not sure there is a crisis.’

‘Identify persons who may have thoughts of suicide by showing videos which included examples.’

‘Become comfortable in speaking to people about serious issues and asking them about thoughts of suicide.’

‘Training great for the average community member to understand and identify concerning signs and behaviours.’

‘Provided examples on how a person may say they are suicidal without saying the actual words.’

‘A great refresher.’

‘Provided clues and hints to look for when someone is having thoughts of suicide.’
SafeTALK objective 2: To connect persons with thoughts of suicide to suicide intervention care givers

The majority of people agreed with this statement for example;

‘Emphasis on dealing with the immediate crisis and then passing them onto an assist trained individual. Emphasis on not being able to solve the entire problem immediately, nor is it your responsibility.’

‘We were given a long list of resources available within our region’/’Yes the list of organisations was great’

‘Yes but I do think that more examples on how to connect with resources would be helpful.’

However one individual stated that ‘the system is convoluted and difficult to navigate and we’ve seen too many times that connecting to ‘suicide intervention care givers’ has proven ineffective.

2. How has this course affected the way you think about suicide?

Five people had had previous training and stated that their thoughts had stayed the same. The other respondents stated that they became more ‘sensitive’ and ‘compassionate’ to the issue ‘Realize that suicide is real and not people looking for attention’ and were not as likely to ‘dismiss’ someone with thoughts of suicide. Three people stated that they were more open-minded to the issues of mental health and suicide and were more attentive to the signs of suicide.

Your ability to recognize signs of suicide?

Some of those surveyed had already completed the ASIST course. However for those who had not completed this course/completed other training they reported that they were now better able to recognize the subtleties of suicidal ideation and had a heightened awareness of the signs of suicide. Increased attentiveness when working with clients ‘increased my ability to better identify those with signs about suicide and to identify invitations’

The way you respond when you think someone may be thinking of suicide?

The responses indicated that these participants responded positively to having a useful template provided to them, and were more vocal, more comfortable/confident about asking about suicide, more sensitive to the signs of suicide and not as quick to be dismissive, and will not dismiss them, ‘more willing to be open, up front and bold in addressing the conversation’.

3. Do you feel confident that you can connect persons with thoughts of suicide to people trained with additional suicide intervention skills?
The majority of those questioned said yes and listed organizations such as COAST, the Distress Centre, other urgent support services.

4. **Have you used the SafeTALK (Tell, Ask, Listen, Keepsafe) since you have taken the safeTALK training?**

Eight out of the 15 participants had used SafeTALK since their training and the main themes emerging from these encounters were that they had used the TALK steps and to connect the person to other contacts/organizations.

5. **What did you think was the most useful aspect of SafeTALK?**

- The application of the TALK
- Good working template
- Openness and mindfulness around talking about suicide/ Open discussion
- Generating awareness
- Increased comfort level; video of ‘real stories’; professional participants providing their expert stories; trainers did a good job/ The examples in the seminar
- Role Play; Excellent refresher/ Interactive workshop
- Learning to assess the signs of suicide rather than dismiss it
- Ok to ask a person about suicide even when there are only minimal signs, since it is best to ask than just ignore or dismiss.
- Becoming more aware of how many people are affected by suicide and increasing comfort level discussing suicide.
- Ability to better identify invitations and increase the confidence to asking the simplest yet toughest question ‘are you thinking about suicide’.
- It initiated a necessary conversation with our staff team. It alerted us to the fact that we need the assist training
- Card that has the SafeTALK steps
- Nothing/I cannot think of any/All useful/Do not change anything/Suicide is ALWAYS an important topic

**What do you think was the least useful aspect of SafeTALK?**

- Not comfortable with the in-class scenario but I do realize the need in order to create familiarity
- Need more specific info on youth suicide
- Not all suicides can be prevented and frontline workers need to be taught to not take it personally when a client carries out a suicide.
- Repetitive
- Course should include mental health piece
- Videos
- Not useful for seasoned, tenured’ crisis, emergency workers/Too basic for our team
- Didn’t really demonstrate how to communicate but this might be more for ASSIST trained individuals.
• Lack of information on the ability to help someone beyond building a connection with a professional.

Discussion:

The resounding evidence from the quantitative and qualitative evaluation of SafeTALK found that most participants saw the value in the SafeTALK training; if not for themselves, then for others. The majority of those surveyed after the training felt prepared to openly ask an individual about thoughts of suicide. Qualitative feedback indicated that the TALK steps (Tell, Ask, Listen, Keepsafe) were found by participants to be extremely useful, practical and easy to follow. Eight out of the 15 participants who completed a telephone evaluation interview had used the ‘TALK’ steps in the 3 months since their training and had been able to connect the person with thoughts of suicide to other contacts & organizations.

Undertaking the SafeTALK training led to a better understanding of suicide as an issue; and positive changes in relation to beliefs and attitudes towards those who expressed suicidal thoughts as evidenced
by the results in Table 1, Table 2 and Table 3 and within the qualitative feedback. This was also evidenced in the recent rapid review by Ubido & Scott-Samuel (2014). Respondents stated that they became more ‘sensitive’ and ‘compassionate’ to the issue of suicide in the general population and ‘Realize that suicide is real and not people looking for attention’ and were not as likely to ‘dismiss’ someone with thoughts of suicide. Also participants were very positive about the fact that they were able to practice talking about suicide ‘SafeTALK taught me how simple yet important it is to get over the initial desire to avoid uncomfortable conversations with someone who is exhibiting signs of suicide and ask them questions’; ‘I now think suicide should be open to conversation. There should not be a taboo or uncomfortable feeling around talking about suicide openly. It should be discussed and should not be ignored or avoided’.

The overall results of those who agreed and strongly agreed with the statements (Table 1) identify that the ‘I would keep it to myself’ and ‘I would try to convince them life wasn’t so bad’ scores went in the expected direction (i.e. the scores decreased from pre to post in line with the teachings of SafeTALK). However, there was an unusual result, whereby those who agreed with the ‘I would not take the comment seriously’ score increased from 7.6% pre SafeTALK training to 11.3% post. One of the main messages of the SafeTALK to avoid dismissal of individuals comments in relation to suicide. This unusual result could be a result of the manner in which the question was displayed in the questionnaire and participants could have unwittingly chosen the wrong response (i.e. agree’ when they meant to choose ‘disagree’) and care should be taken in future evaluations to ask participants to ensure they are filling out their chosen response; and this could be further explored within qualitative evaluations.

Participants were asked pre SafeTALK training and post SafeTALK training their level of agreement with the statements ‘I think most suicides can be prevented’ and ‘I think people who are suicidal give signs that they want to die’. The results were in the expected direction i.e. that participants had higher levels of agreement with these statements after the training. However it is interesting to note that although higher levels existed after the training (approximately 60% agreement with the statements); this still indicates that 40% of participants did not agree with these statements even after completing the SafeTALK training. This may be based on previous experience (for example those who identified themselves as paramedics were least likely to agree that most suicides can be prevented) and is a point which could be explored qualitatively in more detail in future evaluations.

Although most participants believed the SafeTALK training was valuable, some groups who undertook the training found it to be less useful to their work than others as identified by the qualitative results. A proportion of those who were already trained as health professionals (particularly those with a paramedicine background) did not find SafeTALK as useful for them ‘Not useful for seasoned, tenured’ crisis, emergency workers/too basic for our team’ or ‘Content needs to be tailored to a specific audience’. However it was acknowledged by participants that this training would be very useful as a refresher or for other population groups – especially for youth groups and for the general public who had no prior knowledge/skills of this type of training. The videos utilized within the SafeTALK training received mixed reviews, with some participants finding them boring ‘Stop using the co-trainer very gimicky and boring’, while others found them extremely useful ‘The videos were helpful and made it easier to see what SafeTALK would look like in real life situations’.

Strengths and Weaknesses of this study
Strengths: Large scale evaluations of gatekeeper training (i.e. SafeTALK is considered a gatekeeper training) are rare. In a recent rapid review carried out by Ubido & Scott-Samual (2014), gatekeeper training was successful at imparting knowledge, building skills, and molding the attitudes of trainees, as was identified in the Niagara SafeTALK results.

The current study is one of the few evaluations which attempted not only to ascertain changes in knowledge and attitudes of participants but also attempted to ascertain whether the newly acquired knowledge and skills of participants were utilized in the months following the SafeTALK training. The current study also obtained the views of approximately 500 male and female participants from a variety of age-groups, workplace and volunteer settings. Finally, the current student was also grounded in local evidence that Niagara Region respondents were ‘ready’ for a suicide awareness intervention.

Weaknesses: From a study design perspective, ethical approval was not required as the pre and post questionnaires were not linked with a subject id. Therefore only aggregate data could be provided. Questionnaires should have been linked pre and post to allow the use of more meaningful statistics and produce trend data over time. The numbers completing the three month post questionnaire were small and again the data were not linked, and these results should be interpreted with caution as they are most likely not representative of the original sample of n = 500. Also, the three month post-questionnaires were only circulated via email/online questionnaire and could have been produced as a paper copy/postal survey to boost the response rate. All the results are entirely descriptive and the current study design means that it is impossible to link increased attendance in SafeTALK training to decreased rates of suicide attempts or deaths in Niagara. Overall in the literature, there is generally a dearth of studies showing effectiveness in terms of increased SafeTALK/other gatekeeper training versus decreasing suicide ideation, suicide attempts or deaths by suicide (Isaac et al, 2009).

Trainer's reflective statement:

‘Being able to facilitate the Safe TALK program has been a privilege for our Niagara Safe Talk Trainers. Being able to provide a structured approach to a taboo multifaceted topic such as suicide has been very rewarding. This program provides participants a sound outline on how to help a friend/family member or a colleague struggling with life events’. After debriefing informally with the eight trainers who participated in the research project, all trainers discussed that participants reactions/feedback during the training echoed the results found in the report: that they found the SafeTALK Program to be a useful, structured program that allowed SafeTALK “helpers” to feel more comfortable and confident in identifying a person at risk of suicide and help keep them safe by referring them on to appropriate individuals, organizations and agencies. In addition, the trainers were able to reflect upon the challenge of presenting a structured program to a wide variety of participants from health care providers to individuals who has never had a suicide prevention training. Trainers felt the importance of knowing the type of audience pre-training and being able to tailor the program to meet their needs. In addition, the importance of providing ASIST training for people whose role will be “intervening” was noted.
**Recommendations:**

**Recommendations for Research:**

- To continue to evaluate the SafeTALK training via quantitative and qualitative methods and to further modify the questionnaires to ensure that they are fit for purpose.

- To ensure that ethical approval is obtained in order to link surveys both pre and post training to compare knowledge, beliefs, attitudes and skills using more sophisticated statistical analyses.
• To consider the creation of a survey/RRFFS module in due course to ask whether Niagara residents have heard of SafeTALK/to ascertain whether the knowledge, skills from this training are filtering down to the general population.

• To consider liaising with local Emergency Departments in the Niagara Region to ascertain whether those who have attempted suicide have had any exposure to individuals who are SafeTALK/ASIST/any other suicide prevention training before their suicide attempt(s).

• To continue to monitor data from IntellHealth to identify trends in suicide rates/attemptsed suicides within the Niagara Region

Recommendations for Practice:

• To offer incentives (gift cards/entry into a draw) to ensure a better response rate in post evaluation surveys and to ensure that surveys are disseminated to SafeTALK participants in a variety of ways (online and paper copy).

• To continue to offer SafeTALK training to young people and lay people as highlighted by the survey responses.

• To consider modifying the SafeTALK for other professional groups (paramedics/police/health professionals) to ensure it is fit for purpose and practice or to offer ASIST training instead.

• Other research indicates that gatekeeper suicide training is effective with GP and military populations. Therefore these groups could also be approached in Niagara to ask if they might be interested in the SafeTALK training.

• To feed the results from this report back to Livingworks and to ask for their comments and feedback.

• To feed the results of this survey back to other agencies mandated to deal with Suicide in Niagara and to ascertain their feedback on this particular training.

• To run the SafeTALK program at a reduced cost for volunteer agencies/Niagara residents.

Conclusions:

Systematic reviews of gatekeeper training found they were generally successful in imparting knowledge, building skills and molding the attitudes of trainees Ubido & Scott-Samual (2014). These findings were echoed in this current Niagara report. Although there was some criticism of this SafeTALK training being too basic for certain individuals with a background in health, the resounding feedback was that those undertaking the training found it extremely useful if not for themselves, then for others (especially young people and general lay groups). More research needs to be undertaken to attempt to ascertain whether this type of training is indeed specifically linked with reduced rates of suicide attempts or deaths by suicide in Niagara as the evidence base in relation to this regard is inconclusive.


References:


Appendices:

SafeTALK 1 (Pre-QUESTIONNAIRE)

Please take a few moments to complete this questionnaire. This will take about 10 minutes to complete and your participation is voluntary. Any information you give will be kept confidential and will be safely stored in a data file. Your information will never be shown on its own and you will not be identified in any report or survey results.
<table>
<thead>
<tr>
<th>Are you</th>
<th>O Male</th>
<th>O Female</th>
<th>O Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>How old are you?</td>
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<tr>
<td>O 18 – 24</td>
<td>O 45 – 49</td>
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<td>O 25 – 29</td>
<td>O 50 – 54</td>
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<td>O 30 – 34</td>
<td>O 55 – 59</td>
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<td>O 35 – 39</td>
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<tr>
<td>O 40 – 44</td>
<td>O 65 +</td>
<td></td>
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</tbody>
</table>

In which municipality do you currently live?

| O Fort Erie |
| O Grimsby |
| O Lincoln |
| O Niagara Falls |
| O NOTL |
| O Pelham |
| O Port Colborne |
| O St Catharines |
| O Thorold |
| O Wainfleet |
| O Welland |
| O West Lincoln |
| O Other |
Is your main interest in attending this program related to?

O Work  O Volunteering  O Personal

Which best describes the area in which you work or volunteer? (please choose one)

O Mental health
O Physical health
O Education/training
O Child Welfare/counseling
O Corrections/police
O Defense
O Sport and recreation
O Pastoral care / clergy
O Business /trade
O Service industry
O Other (please specify)

I think most suicides can be prevented

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
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<td>O</td>
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<td>O</td>
</tr>
</tbody>
</table>

I think people who
are suicidal give signs they want to die

I think if you ask someone about suicide, they will be more likely to attempt suicide

What training in helping a person at risk of suicide have you had before (*please use the box(s) to briefly describe your previous training)*?

- None
- 1-3 hours
- 1-2 days
- Longer course(s)

How many times have you talked directly and openly to a person about their thoughts of suicide?

- Never
- Once
In the following question, we are interested in finding out how you would respond to a friend/colleague/relation presenting with thoughts of suicide.

‘You are having a conversation with a friend/colleague/relation and within the conversation he or she expresses thoughts of suicide (e.g. ‘I just do not think I can do this anymore’ or ‘I would be better off dead’). How would you respond? (please select one option per question)

<table>
<thead>
<tr>
<th>Response</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would not take the comment seriously</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I would keep it to myself</td>
<td>O</td>
<td>O</td>
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<tr>
<td>I would try to convince them that life wasn’t so bad</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I would ignore the comment</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

At this time, how prepared do you feel to talk directly and openly to a person about their thoughts of suicide?

<table>
<thead>
<tr>
<th>Preparation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Well prepared</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mostly prepared</td>
<td>O</td>
<td></td>
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<tr>
<td>Partly prepared</td>
<td>O</td>
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<tr>
<td>Not prepared</td>
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</table>

Are you aware of any organizations you could advise someone who has expressed suicidal thoughts to contact (please list)?
Thank you for your time

SafeTALK 2 (QUESTIONNAIRE: Feedback on the day)
Please take a few moments to complete this questionnaire. This will take about 10 minutes to complete and your participation is voluntary. Any information you give will be kept confidential and will be safely stored in a data file. Your information will never be shown on its own and you will not be identified in any report or survey results.

Are you
O Male
O Female
O Other

How old are you?
In which municipality do you currently live?

- [ ] Fort Erie
- [ ] Grimsby
- [ ] Lincoln
- [ ] Niagara Falls
- [ ] NOTL
- [ ] Pelham
- [ ] Port Colborne
- [ ] St Catharines
- [ ] Thorold
- [ ] Wainfleet
- [ ] Welland
- [ ] West Lincoln
- [ ] Other

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Partly Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My trainer was prepared and familiar with the material.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>My trainer encouraged participation and respected all responses</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Somewhat disagree</td>
<td>Somewhat agree</td>
<td>Agree</td>
</tr>
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<td>-------------------</td>
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</table>

I think most suicides can be prevented

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
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</table>

I think people who are suicidal give signs they want to die

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Somewhat agree</th>
<th>Agree</th>
<th>Strongly agree</th>
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</tbody>
</table>

I think if you ask someone about suicide, they will be more likely to attempt suicide

At this time, how prepared do you feel to talk directly and openly to a person about their thoughts of suicide?

<table>
<thead>
<tr>
<th>0</th>
<th>Well prepared</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Mostly prepared</td>
</tr>
<tr>
<td>0</td>
<td>Partly prepared</td>
</tr>
<tr>
<td>O</td>
<td>Not prepared</td>
</tr>
</tbody>
</table>

In the following question, we are interested in finding out how you would respond to a friend/colleague/relatin presenting with thoughts of suicide.

‘You are having a conversation with a friend/colleague/relatin and within the conversation he or she expresses thoughts of suicide (e.g. ‘I just do not think I can do this anymore’ or ‘I would be better off dead’). How would you respond? (please select one option per question)
Niagara Region
Evaluation of SafeTALK

<table>
<thead>
<tr>
<th>I would not take the comment seriously</th>
<th>O</th>
<th>O</th>
<th>O</th>
<th>O</th>
<th>O</th>
<th>O</th>
<th>O</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would keep it to myself</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<td>O</td>
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</tr>
<tr>
<td>I would try to convince them that life wasn’t so bad</td>
<td>O</td>
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<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I would ignore the comment</td>
<td>O</td>
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</table>

**Compared to where I was before the SafeTALK training:**

<table>
<thead>
<tr>
<th></th>
<th>Much more likely</th>
<th>More likely</th>
<th>About the same</th>
<th>Less likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will recognize signs inviting help</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I will approach a person with thoughts of suicide</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I will ask directly about thoughts of suicide</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I will connect a person with thoughts of suicide to someone who can help them keep safe</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

Would you recommend this training to others?

O        Yes        O        No

How could this training be more effective in preparing suicide alert helpers?
We would like to contact you in two to three months to find out whether you have used any of your newly-acquired SafeTALK knowledge and skills in your work (paid or volunteering) or personal life.

Please select your preferred communication method below. Individual results will not be personally identifiable.

<table>
<thead>
<tr>
<th>I do not wish to be contacted</th>
<th>O</th>
</tr>
</thead>
<tbody>
<tr>
<td>I wish to be contacted via email to complete a short questionnaire (&lt;10min)</td>
<td>O</td>
</tr>
<tr>
<td>I wish to be contacted via telephone to complete a short (10 – 15 minute) interview</td>
<td>O</td>
</tr>
</tbody>
</table>

*Once the questionnaire has been completed/telephone interview has taken place, your email address/phone number will be deleted from the file. We will not pass your contact details on to anyone else.*

Thank you for your time

SafeTALK 3 (QUESTIONNAIRE-Quantitative – entered into the Remark Software)

Two to three months after the training: Quantitative questionnaire via email)

When answering these questions, please think about the time between the SafeTALK training and now.
1. **In your opinion, were the objectives of the SafeTALK training met?**

   a. To identify persons with thoughts of suicide?
      
      O Yes  
      O No  
      O Don’t know

   b. To connect persons with thoughts of suicide to suicide intervention care givers?
      
      O Yes  
      O No  
      O Don’t know

2. a. Have you used the SafeTALK (Tell, Ask, Listen, Keepsafe) since you have taken the Safe TALK training?

      O Yes  
      O No  
      O Don’t know

   b. Where did you use the SafeTalk training?
      
      O At home  
      O At work  
      O Where I volunteer  
      O Sports related area  
      O Other ________________________________

3. **How useful did you think the safeTALK training was? (please click one box)**
   
   very useful 1 2 3 4 5 not useful at all

   What did you think was the most useful aspect of the SafeTALK?
   
   ____________________________________________________________
   
   ____________________________________________________________

   What was the least useful aspect of SafeTALK?
   
   ____________________________________________________________
   
   ____________________________________________________________

4. **At this time, how prepared do you feel to talk directly and openly to a person about their thoughts of suicide?**
o Well prepared  
o Mostly prepared  
o Partly prepared  
o Not prepared

5. **Has the course affected the way you think about suicide?**

  - O Yes  
  - O No  
  - O Don’t know

If yes; please describe:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

After the SafeTALK training, how able were you at recognizing/identifying people at-risk of suicide?

1. **Not at all**  
2. A little  
3. Somewhat able  
4. Able  
5. Very able

After the SafeTALK training, how able were you at engaging a patron at-risk of suicide in direct and open talk about suicide?

1. **Not at all**  
2. A little  
3. Somewhat able  
4. Able  
5. Very able.

After the SafeTALK training, how competent did you feel you were at intervening with a suicidal person?

1. **Not at all**  
2. A little  
3. Somewhat competent  
4. Competent  
5. Very competent

After the SafeTALK training, how comfortable were you intervening with a suicidal patron?

1. **Not at all**  
2. A little  
3. Somewhat comfortable  
4. Comfortable  
5. Very comfortable

In the following question, we are interested in finding out how you did respond to a friend/colleague/relation/individual presenting with thoughts of suicide.

‘You were having a conversation with a friend/colleague/relation and within the conversation he or she expresses thoughts of suicide (e.g.’I just do not think I can do this anymore’ or ‘I would be better off dead’) OR the subject of suicide came up. How did you respond (please tick one option per question?"
Evaluation of SafeTALK

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I didn’t take the comment seriously</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. I kept the comment to myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. I would tried to convince them that life wasn’t so bad</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. I ignored the comment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Compared to where I was before the training...</th>
<th>Much more likely</th>
<th>More likely</th>
<th>About the same</th>
<th>Less likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I recognized signs inviting help</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I approached a person(s) with thoughts of suicide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I asked directly about thoughts of suicide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I connected a person with thoughts of suicide to someone who can help them keep safe</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Need a list of the Safe connections here (tick all that apply)

**SafeTALK 4 (QUESTIONNAIRE - Qualitative)**

Two to three months after the training: Semi-qualitative questionnaire via a phone interview

(Prompt) **Main objectives of the SafeTALK training:**

- Identify persons with thoughts of suicide
- Connect persons with thoughts of suicide to a keep safe connections community resource.
1. In your opinion, were the objectives of the SafeTALK training met?

   a. To identify persons with thoughts of suicide? Yes/No (please circle) and reasons why
      ______________________________________________________________
      ______________________________________________________________
      ______________________________________________________________
      ______________________________________________________________

   b. To connect persons with thoughts of suicide to suicide intervention care givers? Yes/No (please circle) and reasons why
      ______________________________________________________________
      ______________________________________________________________
      ______________________________________________________________
      ______________________________________________________________

2. How has the course affected:

   the way you think about suicide? (write N/A if not applicable)
      ______________________________________________________________
      ______________________________________________________________
      ______________________________________________________________
      ______________________________________________________________

   your ability to recognize signs about suicide? (write N/A if not applicable)
      ______________________________________________________________
      ______________________________________________________________
      ______________________________________________________________
      ______________________________________________________________

   the way you respond when you think someone may be thinking of suicide? (write N/A if not applicable)
      ______________________________________________________________
      ______________________________________________________________
      ______________________________________________________________
      ______________________________________________________________

3. Do you feel confident you can connect persons with thoughts of suicide to with people trained with additional suicide intervention skills (ASIST) or community resources? Yes/No (please circle)
If not why not?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
If yes, which keep Safe connections
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

4. Have you used the SafeTALK (Tell, Ask, Listen, Keepsafe) since you have taken the Safe TALK training? Yes/No (please circle)

If no, why not?
______________________________________________________________________________
______________________________________________________________________________

If yes, can you please describe the situation and what you did (any person identifiable information will not be included in the questionnaire)
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

(Prompts: Confidence/skill in recognizing suicide? Confidence to approach someone with thoughts of suicide? Referring people to ASIST trained helpers or others with intervention skills)