Response to Suicide Prevention Training Bill Consultation

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Defining suicide prevention training

Suicide prevention training is not defined in the consultation and there are many different types of training. In this response, I consider several different types of training, however I would be happy to provide more focused guidance regarding any specific type of training or training package.

In this new Bill it is vital that we have a clear definition of "suicide prevention training". The term "training" implies the acquisition of knowledge and skills. It is important that there are clear goals and targets for change, for example in knowledge, attitudes and/or behaviour. In this context it could be to help lay members of the public identify subtle communications and behaviours which may indicate suicidality. It could additionally refer to skills so that a trainee can have helpful conversations to support that person (this may or may not reduce the likelihood of suicide) and possibly signpost people to sources of support and interventions. The training may also aim to raise awareness by improving knowledge about suicide, and/or combat myths about suicide such as the idea that suicide cannot be prevented, or that people who talk about suicide do not go on to attempt suicide. The goals of training may therefore be to raise awareness, have helpful conversations, to help a person get support, to signpost a person to services, or to deliver an intervention which reduces the risk of suicide. It is my view that the Bill needs to state clearly what this training would achieve, and in addition, the mechanism by which it would lead to a reduction in suicide deaths. Clarity regarding the frequency of training and updates would also be helpful. I will consider each of the "types" of training, however it is important to add that some of the established training programmes address more than one area, in varying levels of depth.

Suicide awareness and signposting training

The Zero Suicide Alliance provides free online suicide awareness training. This programme is based on "see, say, signpost" and whilst it includes coached scenarios for how to approach someone who may be at risk, it does not provide trainees with specific intervention skills. Furthermore, the training is generic, rather than addressing specific settings, however there are versions for colleges, veterans and neurodiversity. Trainees would need to have information about local services for the signpost element of the training so that they can signpost people to effective support. The training package includes a warning that this is a sensitive topic and recommends that there is a supportive person nearby. The Towards Zero Suicide (TZS) programme in NI's mental health services includes this training (https://www.zerosuicidealliance.com/training) and TZS also incorporates the provision of safety planning interventions as part of a care pathway for people who are in receipt of

Mental Health services. Feedback indicates that this training improves trainees' confidence in recognising the signs of suicide and confidence in talking to someone about suicide. The signposting element is crucial as the training does not provide the trainee with skills in addressing the factors influencing suicidal thoughts and behaviours, and the types of interventions (e.g. safety planning) which are likely to impact on the risk of suicide. This training is a low-cost (potentially free if staff can undertake the training in their free time) way of improving understanding of suicide and it could help increase the numbers of people who access suicide prevention services. It would not however be accurately described as suicide prevention training.

Suicide prevention training

The term suicide "prevention" training implies that the training includes skills, perhaps in therapeutic conversations or interventions with people who are suicidal, this could be for example, assisting them in the development of safety plans, or problem-solving interventions. Safety planning interventions are designed to help people manage and reduce suicidal thoughts and behaviours. They involve collaboratively developing a personal plan, outlining strategies to cope with suicidal urges and access professional support during a crisis. There is some evidence showing that this type of intervention can lead to reductions in suicidal thoughts and behaviour. The research studies supporting the use of these training packages are generally in particular population groups using tightly defined manualised intervention programmes. This type of training is costly, and it is vital that trainees should have clear pathways of support themselves in delivering these interventions. This is because intervening with individuals who are suicidal can lead to feelings of responsibility for that person's wellbeing that is inappropriate, or it can trigger negative or suicidal thoughts in the person who is helping. This is a particular risk for trainees who have prior exposure to suicide, and good quality programmes have highly skilled trainers who are able to spot the signs when the training could have a negative impact on the trainee. This type of training is therefore not suitable for everyone, those with a history of trauma may experience triggering and a negative impact and may not opt out themselves. Training programmes are designed to be undertaken on a voluntary basis, and trainees need to be able to consent to adhere to the principles of the training.

A range of good quality suicide prevention (or gatekeeper) training programmes are available including; Applied Suicide Intervention Skills Training (ASIST), Question Persuade and Respond (QPR), STORM, 4 Mental Health. These programmes have different approaches, and whilst they all focus on identifying the signs of suicide and keeping the person safe; some focus on providing skills to connect and refer or signpost, whilst others include training in the assessment of risk, how to support someone in crisis, and elements of a safety plan.

A recent review of reviews of the impact of QPR, ASIST and community gatekeeper training programmes (Kingi-Uluave et al., 2024) concluded that these training programmes can lead to improvements in knowledge, attitudes, stigma, and skills. However, few studies have examined whether these effects are maintained over time. Furthermore, it is unclear whether short sessions are sufficient to change deeply ingrained attitudes and beliefs. In addition, behaviour change is rarely addressed in these studies, so it can be difficult to ascertain whether any changes in knowledge, attitudes, stigma and skills leads to a change in the way that people who undertake training engage with people who may be suicidal. I am not aware of any evidence showing that this type of training has resulted in fewer suicide attempts or deaths. However, such events are relatively rare in a population, and research studies in this area would not typically have large enough population sizes to detect such a change.

If training is to encourage individuals to intervene and support people who are suicidal then it is absolutely vital that they themselves have a robust support system to share experiences and receive support themselves. Trainees who are in contact with individuals who subsequently die by suicide may experience distress and feelings of guilt and blame; they need to be able to access support. Staff in specific sectors outside of health (e.g. schools, colleges, youth workers) may benefit from the training but again, they need to have support systems and links with services in place to be able to use the training in a way that would reduce the risk of suicide in others whilst working within the boundaries of their role. Training in suicide prevention in young people should be tailored to reflect differing presentations and legal issues (e.g. neurodivergent young people, consent and safeguarding).

Costs

The cost of the good quality training programmes described can range from £6-10,000 per group of 12-15. This does not include the cost of time off work, which can be 2-3 days, room booking and support for trainees and replacements. It is not possible to undertake a robust cost effectiveness analysis in terms of deaths prevented, as the extent to which the training reduces the deaths from suicide has not been established (and may well be dependent on the other services available). We therefore need to consider whether the current resources for suicide prevention should be allocated to training, and weigh this against the impact of using the funding for other aspects of our Suicide Prevention Strategy. Given that it is essential that trainees are able and willing to signpost people to effective crisis intervention services, which include formal safety planning and other effective interventions. These services need to be expanded, particularly the safety planning interventions to those who are not under the care of mental health services (and not included in TZS). The suicide prevention measure with the strongest evidence base for cost effectiveness is the restriction of access to methods of suicide and this also needs to be a priority area for the strategy funding allocation.

The funding for training health care and primary care providers, beyond what is covered in the Towards Zero Suicide Programme (which is again in mental health services), may well be drawn from the Department of Health budgets, thereby reducing the funding available for crisis services. The funding for training teachers and staff in schools may also be drawn from the budget for the components of the Emotional Health and Wellbeing in Education Framework, which delivers evidence-based cost-effective early interventions which are demonstrated to reduce the risk of poor mental health and suicidality.

Recommendations

Neither suicide awareness training nor suicide prevention as defined above should be mandatory (even with an opt out clause). The Zero Suicide Alliance's free online suicide awareness training programme should be promoted for those working in health, education and in public services. Public awareness campaigns to address stigma and misinformation and encouraging connection and signposting may also be helpful and cost effective. They should focus on the everyday things that we can all do to help people who are vulnerable and raise awareness of existing services such as Lifeline.

Despite the lack of evidence regarding the impact on suicide deaths, I would consider the suicide prevention training with quality assurance, connections to services and safeguards described above, to be a helpful element of a broader suicide prevention strategy. This type of suicide prevention training is already provided in NI as part of the PL2 Suicide Prevention Strategy, and in sectors such as in universities and workplaces. Public sector/front line workers who show an interest in suicide prevention training should be supported and encouraged to explore this training using existing personal development/CPD avenues. The availability of suicide prevention training could be more widely advertised, and any public sector/front line worker should have access (and line manager support in terms of being given time to participate) to the training if they want to participate.

The evidence shows that crisis services and restriction of access to means are cost effective ways of preventing suicides. The Regional Crisis Intervention Service needs to be delivered in full as a matter of urgency, particularly one to one suicide prevention (safety planning) interventions for people who do not need to attend statutory MH services. The Executive also need to focus on reducing inequality and eradicating poverty to address the root causes of despair. In terms of training, ACEs and trauma awareness programmes such as the Solihull approach are important, evidence based and should be provided more widely to improve societal understanding of mental health and trauma. The school curriculum should include child development, social and emotional learning, and relationships education. The Framework for Emotional Health and Wellbeing should be delivered in all schools so that all young people have access to early intervention and tailored support. The Mental Health

Strategy needs to be funded in full to transform mental health services to meet the needs of the population and deliver support and interventions at an earlier stage.

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