Evaluation of TouchPoints Workshop

Final Report

Presented to

Roses in the Ocean

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Acknowledgements and commemorations:

We wish to acknowledge the lived experience suicide prevention workforce, for their tenacity, determination, insight, and invaluable contributions towards saving lives and for the representative participants in this study. We would also like to acknowledge Roses in the Ocean for their financial support to undertake this important evaluation work.

In commemoration of the 10-year anniversary of Roses in the Ocean (2011-2021), we wish to dedicate this report to the loving memory of Mark, brother of CEO and founder of Roses in the Ocean, Bronwen Edwards. Further, we want to acknowledge the remarkable leadership, compassion, and contributions to suicide prevention of Ms Edwards who has dedicated her life to changing the way suicide is understood, discussed, and prevented, and to empowering those with a lived experience of suicide to contribute with their wisdom and insights to suicide prevention.

1 Background

1.1 Roses in the Ocean

Roses in the Ocean was founded in 2011 by the organisations' CEO, Ms Bronwen Edwards, who lost her brother Mark, to suicide. Roses in the Ocean was initiated with a purpose of building a safe, well-trained, and supported lived experience "workforce" equipped with the expertise and skills needed to bring the voice of lived experience to all aspects of suicide prevention. Roses in the Ocean is an organisation that empowers people with a lived experience of suicide to change the way suicide is spoken about, understood, and prevented. Their focus is on 'driving system reform, co-designing innovative services, and affecting cultural change' (Roses in the Ocean, 2022) to contribute to the suicide prevention evidence base. In doing so, they offer a suite of capacity building workshops which support the four pillars of Roses in the Ocean activities: Lived experience workforce, Community capacity building, Sustainability, workplace and industry engagement, and Thought Leadership (Roses in the Ocean, 2022). Roses in the Ocean's signature innovations include their capacity building training workshops designed by people with a lived experience of suicide to empower people to engage meaningfully in suicide prevention activities. The suite of training workshops has been developed to a) build the capacity of individuals with personal lived experience of suicide to effectively and safely communicate their stories to increase awareness and effect change and b) to build capacity of community members, groups, and workplaces in suicide prevention, including supporting and responding to those in suicidal distress.

Roses in the Ocean is committed to continual development of the evidence base of their activities, which includes undertaking evaluation of all programs offered. To date, Australian Institute for Suicide Research and Prevention (AISRAP) and Black Dog Institute (BDI) have evaluated Our Voices in Action and Voices of In-Sight workshops for their impact and effectiveness (Hawgood et al., 2019; 2021). The current evaluation report represents the findings of the most recent engagement of AISRAP by Roses in the Ocean, to evaluate TouchPoints workshop; a lived experience-designed and delivered 'Lifekeeper' (gatekeeper training) workshop. The 4-hour interactive workshop is designed specifically to build the capacity and confidence of people to better understand and respond to suicide and is based on evidence-based gatekeeper content and principles (Roses in the Ocean, 2020).

2 TouchPoints workshop

TouchPoints workshop was developed by Roses in the Ocean to equip individuals within communities with the appropriate knowledge, attitudes, and practical tools to identify and support someone who may be experiencing a suicidal crisis using a compassionate and person-centred approach. Individuals who are positioned within communities, and who have face to face contact with large numbers of community members as part of their usual routine, and who can recognise someone at risk, identify possible suicidal distress, and safely engage the person in conversation to access further help is referred to as a 'TouchPoint of contact' (Roses in the Ocean, 2020). Within the suicide prevention training field, such individuals are generally referred to as community gatekeepers (Burnette et al., 2015; Isaac et al., 2009). The main difference between TouchPoints and general suicide prevention gatekeeper training is that TouchPoints includes evidence-based content integrated with the expertise of those with a lived experience of suicide (Roses in the Ocean, 2020).

Touchpoints workshop is delivered over an interactive, four-hour training session. The *overall aim* of the workshop is to enhance, participant knowledge around suicide (including prevention, intervention, and bereavement), positive attitudes, motivation/intent to intervene, self-confidence and sense of control to influence decision-making, and the importance of self-care.

The *specific learning outcomes* of TouchPoints workshop include:

1. Attained deeper understanding and appreciation of the complexity of suicide
2. Understanding of commonly held suicide myths
3. Increased awareness of warning signs and invitations for help
4. Increased confidence and capacity to engage with people in crisis
5. Improved confidence to connect a person at risk of suicide with support
6. Attained practical skills to support someone bereaved by suicide
7. Attained practical skills to support staff following a suicide in the workplace
8. An appreciation of the importance of self-care and practical tools to implement

Importantly, TouchPoints workshop is specifically designed to provide participants with insights into supporting people experiencing suicidal distress from the lens of those who have a lived experience of suicide. As the workshop has been created by people who have been personally impacted by suicide, the content includes reference to what people with their own lived experience found to be helpful, what may not have work so well, and how they were best supported. Finally, the skills-based components involve practicing conversations and receiving guidance from people

who have been impacted by suicide themselves, to build participants' confidence in being able to initiate discussions and apply these strategies outside of the training workshop.

3 Training evaluation components

3.1 Gatekeeper competencies

Burnette and colleagues (2015) posited that individual characteristics influence gatekeeper behaviour in terms of ability and willingness to intervene, support or respond to the suicidal person. Their conceptual model of gatekeeper training, based on Bandura's Social Cognitive theory (Bandura, 2001), includes key variables or factors which if targeted by gatekeeper training, are expected to influence intervention behaviours of gatekeepers (Burnette, 2015, p 4). These factors include knowledge about suicide (perceived and declarative), attitudes about suicide and suicide prevention, reluctance to intervene, and self-efficacy (self-confidence). Other factors suggested to influence effective outcomes of gatekeepers have also emerged as important targets for gatekeeper training programs including preparedness to act and perceived self-control (Albright et al., 2016), willingness to intervene (Aldrich et al., 2014), and more recently, understanding of lived experience and the importance of self-care when working with those in suicidal distress (Hawgood et al., 2021). Hawgood et al (2021) recommend that evaluators of gatekeeper training programs measure these variables to determine the impacts of training believed to alter them, with the overall intent of enhancing effective gatekeeper interventions.

3.2 Trainer fidelity

An important component rarely assessed in evaluation studies of gatekeeper training, despite the widespread understanding of potential influences on training delivery, is *trainer fidelity* (Cross, 2014; Cross & West, 2011). Trainer fidelity is the extent to which trainers or facilitators adhere to the training content and delivery mechanisms espoused in the programs' training schedule/manuals. An additional aspect of fidelity is trainer competency (knowledge and specific content- and skill-related expertise) (Cross & West, 2011). The assumption is that training effectiveness cannot be surpassed by either a) adherence to the standardized training delivery schedule, and b) the competency (knowledge, skills etc) of the trainers delivering them (Cross & West, 2011). Of relevance to the current evaluation study is trainer fidelity regarding *program adherence*. That is, we are interested in the way the trainer delivers the espoused training content according to the workshop schedule/manuals. Specifically, we want to know whether there is potential alignment with or drift from the manualised training content and objectives, which is believed to influence training effectiveness (Cross & West, 2011).

3.3 Enhancing trainer fidelity

Importantly, in the field of suicide prevention training, it is possible for trainers to experience discomfort towards initiating conversations about suicide as well as fear of exacerbating distress in workshop participants through difficult conversations. This discomfort may result in trainers' drifting from the schedule, avoiding content or spending too much emphasis on selected topics. Heavy coverage of additional content areas outside of the workshop schedule due to inability to stay on task may become a key barrier to effective standardised delivery of the scheduled material. One method of reducing potential barriers to 'trainer adherence' is implementing train-the-trainer programs for facilitators, which includes 'knowledge-based learning and practice-based skills' to reach optimal trainer standards and outcomes. Roses in the Ocean ensure all facilitators or trainers for their entire suite of programs have undertaken train-the-trainer workshop procedures (including original 'participant' training, train the trainer and shadowing processes) before reaching optimal competency as facilitators. Facilitators are trained to not only adhere to the workshop schedule but to simultaneously attend to the safety of participants, resulting in safe, standardised workshop delivery. In addition to paying attention to participant safety, facilitators are trained to manage the potential processes and dynamics that may arise in discussions around suicide. Evaluation of trainer fidelity for any gatekeeper program, is an essential component of good quality assurance while also ensuring optimal training program outcomes for participants (Hawgood et al., 2018). The following sections of this report provide a description and analysis of the evaluation of Touchpoints workshop.

4 Aims

The aims of this evaluation are to:

1. assess the immediate impacts of Roses in the Ocean TouchPoints workshop from before to after the workshop on learning objectives,
2. examine the application and utility of training outcomes for participants after the workshop, in respect of the skills applied supporting people in suicidal distress/crisis over the short- to medium-term (1 month to 6 months),
3. examine trainer fidelity of TouchPoints workshop (i.e.., facilitator adherence to deliver the TouchPoints workshops in line with the standardised TouchPoints workshop schedule and trainer guidelines).

In line with these aims, we hypothesized the following:

Aim 1. Based on the gatekeeper training theory of Burnette et al (2015) we expected that TouchPoints workshop would be associated with significant improvements (from pre to post workshop) in participant learning outcomes such as perceived confidence in suicide prevention, knowledge in safe suicide terminology, suicide literacy, suicidal crises support responses, and self-care; and a sense of hope in ability to initiate and action planned goals.

Aim 2: This was an exploratory aim. Based on the inconclusive literature supporting short to medium-term impacts of applied gatekeeper training learnings (Holmes et al., 2019), we did not hypothesize about whether participants would utilize their gained skills in the 'real world' over time.

Aim 3: Based on the works of Cross et al (2014) we expected variability in trainer fidelity – or adherence to the TouchPoints workshop trainer schedule. We did not hypothesize differences between trainers or across workshops as this was a preliminary/exploratory component of the current evaluation.

5 Governance

While lived experience of mental illness has long been acknowledged and validated as a critical component of consumer care, the purposeful inclusion of lived experience in suicide prevention activities is a more recent concept – for policy, practice (service provision) and research. Evaluation methodology must be reflexive and sensitive to potential impacts on those who are suicidal, carers, and those bereaved by suicide. To ensure that the voice of lived experience is privileged and valued. Despite being an externally commissioned evaluation, the methodology, and all surveys and evaluation processes were collaboratively reviewed and discussed with lived experience advisers from within Roses in the Ocean before implementation.

6 Development of Training Impact Evaluation Surveys for Workshops

6.1 Identifying key indicators

To identify key measurable indicators of learning outcomes for this evaluation, AISRAP reviewed the key workshop materials of the TouchPoints workshop which included workshop overview, aims/objectives, and learning outcomes as well as associated modules, topics and learning materials (inclusive of facilitator schedule and guidelines). The following documents were obtained: Facilitator Handbook, PowerPoint slides, Workshop program (schedule), advertisements etc.

AISRAP reviewed the TouchPoints workshop materials (above) to identify learning outcomes and delivery mechanisms (for trainer fidelity measurement), as well as to gain context for interpreting findings and drawing evaluation conclusions. AISRAP liaised with Roses in the Ocean to establish appropriate evaluation measures that were aligned with espoused aims/learning outcomes. Only two of the six measures identified for this evaluation were obtained from the existing literature. The remaining four measures were designed by the research team and lived experience experts and involved collaborative discussion and negotiation to ensure consensus was achieved between the researchers (JH and MG) and lived experience expertise from Roses in the Ocean (KP).

6.2 Design of the Training Impact Evaluation Survey

Socio-demographic items were included in the first section of the pre-workshop evaluation survey (e.g., items on occupational background and settings, previous training in suicide prevention etc). Additionally, to ensure the matching of participant surveys at different time points (pre-, post-, and 6-month follow-up), participants were asked to provide a 'secret non-identifying code' (e.g., what was "the street name that you first recall living in"?). Post-surveys included not only the same measures of the pre-workshop survey but two demographic items (e.g., age, gender) for 'back-up' assistance with 'matching' of participant codes in the potential event of common and reoccurring street names or errors in re-writing codes.

Validated standardised measures previously used in peer-reviewed publications were utilised only where such measures matched the identified learning indicators (see below measures 4 and 6). The measures constructed by the research team and lived experience expertise were developed through detailed re-examination of the program materials, to adequately capture training effects. Co-author and lived experience expert from Roses in the Ocean staff (KP) contributed to the selection of questionnaire items and advised on the suitability and safety of the survey and the accompanying support and risk information provided to participants. Some survey measures developed in this study were also co-designed with another lived experience expert (MM) for application in a recent evaluation study for Roses in the Ocean (Hawgood et al., 2021). All survey measures were compiled into a unified word document for (the Evaluation Survey) for ease of administration and participant response; and this document was administered to trainees in hard-copy survey before and after the program. An online version of this evaluation survey was compiled for the 6-month evaluation follow-up.

6.3 Measures of the Training Impact Evaluation Survey

Specific descriptions of these measures appear below and measures themselves appear in the full Training Impact Evaluation survey in Appendix A:

1. *Confidence in Support Tasks:* This 11-item scale, designed by the research team, measures perceived confidence associated with the workshop objectives and outcomes. Participants were asked to rate their current level of confidence on a 5-point Likert Scale ranging from 'Not confident at all' (1) to 'Extremely confident' (5) with regards to skills in connecting and intervening with people experiencing suicidal crises. Item examples include *'Using safe language when talking about suicide'* and *'Reaching out to people with a person-centred approach.'* Total scores ranged from 11-55. The internal validity in the current study sample was adequate, $\alpha = 0.96$ (N = 104)].
2. *Safe Suicide Language Scale:* This 5-item scale, designed by the research team, measures safe language and terminology knowledge. A dichotomous response format was used in which participants are asked to choose the safest terminology between two alternative statements or phrases related to suicide language. Item content was drawn from guidelines on discussing and reporting suicide (Beaton et al., 2013) which were included in the workshop. An overall score was calculated by totalling one (1) point for all the correct answers and zero (0) for incorrect answers.
3. *Literacy of Suicide Scale (LOSS) (Calear et al., 2012):* This 12-item scale measures knowledge of suicide and suicide-related warning signs, and includes items associated with a range of commonly reported myths or misconceptions around suicide. Participants are presented with statements about suicide with corresponding True/False/Don't Know response options. An overall total score is calculated by totalling one (1) point all the correct answers and zero (0) for incorrect answers.
4. *Suicide-related Crisis Support Scale:* This 11-item scale, designed by the research team, measures knowledge about skills for supporting a person in suicidal distress. Participants are presented with two statements or phrases and are asked to select the most appropriate alternative when supporting someone dealing with suicidal thoughts. Items were adapted from the workshop content. They assess understanding on topics including providing advice, acknowledging feelings, and avoiding confronting language. An overall score was calculated by totalling one (1) point for all the correct answers and zero (0) for incorrect answers.

5. *Adult Hope Scale (Snyder et al., 1991):* This 12-item scale includes items scored on an 8-point Likert scale ranging from Definitely False (= 1) to Definitely True (=8) , to produce a total maximum hope score of 64); and two subscales 'agency' (belief in one's capacity to initiate and sustain actions or goal directed energy) and pathways (ability to generate routes by which goals may be reached or planning to accomplish goals). Each sub-scale is scored from a minimum of 8 and maximum score of 32. The Adult Hope Scale is one the most widely used positive psychology instruments and has previous use in lived-experience intervention evaluations (Cook et al., 2012). The internal validity in the current study sample was adequate, $\alpha = 0.88$ (N = 81)].
6. *Self-Care Knowledge Scale:* This 9-item scale, designed by the research team, measures factual/knowledge-based learning objectives using multiple choice item response format. Items were adapted from the workshop content and assessed understanding on key self-care related topics including understanding what is or isn't self-care and recognising potential signs for focussing further on self-care strategies. One (1) point was given for correct answers and zero (0) for incorrect answers. Total scale scores were calculated from the sum of responses.

7 Training Outcomes Utility survey

7.1 Training Outcomes Utility survey

A survey was developed collaboratively between AISRAP researchers and Roses in the Ocean, to explore whether and how participants applied TouchPoints workshop training outcomes in the real world after attending the workshop (between 1 to 6 months duration post-workshop). The Training Outcomes Utility survey asked participants whether they had supported someone experiencing a suicidal crisis or emotional distress since the workshop, and if so, how they had supported them. Specifically, they were asked whether they had applied the skills/actions taught in the workshop including items such as: 'You noticed invitations for help,' 'You directly asked about suicide' and 'You listened without judgement.' The survey also asked participants for their perceptions about the use of workshop acquired capabilities via an open-ended, free-text response format. The questions asked were 'Do you have any feedback about giving assistance?' and 'Do you have any further feedback on the knowledge or skills that you have learned and/or used from the workshops?'. Participants were emailed the link to this online survey at each month from one to six months after attending the workshop (See Appendix B.).

8 Training Fidelity

8.1 Trainer Fidelity Checklist

The Trainer Fidelity Checklist was based on the work of Hawgood et al (2018) and designed collaboratively between AISRAP researchers and Roses in the Ocean. The Trainer Fidelity Checklist is a 37-item measure, measuring the degree of adherence by facilitators to the training content (during delivery) in four domains specifically aligned with the training schedule and trainer guidelines for TouchPoints workshop (See Appendix C). The four domains of this checklist include: Workshop organisation (7 items); Subject matter (17 items); Presentation/style (7 items); Group management (6 items). All questions required the rater to provide an answer on a 5-point Likert scale, where 1 = very dissatisfied, 3 = neutral, and 5 = very satisfied.

9 Survey administration and data collection procedures

9.1 Participants

All attendees of TouchPoints workshops delivered between December 2020 and May 2022 (N=347) were invited to participate in all components of this evaluation study. Study sample information appears under the Results section below.

9.2 Data collection time points

All participants (N=347) were asked to complete the *Training Impact Evaluation Survey* at pre- and post- workshop, and at 6 months post-workshop. Due to the project timeframes and limited scope for gaining larger sample responses at 6 months post-workshop, together with natural attrition experienced over this period, we were unable to collate enough data for conducting 6-month follow-up point analyses (the total participant response rate to the 6-month survey was 6.91% (N = 24). As reported under results section, the number of pairs able to be matched from this small follow-up sample was only 50% of responses to it (N=12). As such, only the pre- and post- survey data was used for the immediate impact evaluation in the current report.

The *Training Outcomes Utility survey* was sent to all participants of the TouchPoints workshops (N=347) every month between 1 to 6 months after the original TouchPoints workshop to explore how participants applied the skills and knowledge gained from the workshop over time.

The *Trainer Fidelity Checklist* was administered at four different TouchPoints workshops. As reported earlier, effectiveness of the same training program at different workshops can be influenced by trainer fidelity. At each workshop, the facilitator was assessed independently by two

raters who observed whether the facilitator covered items listed on the Trainer Fidelity Checklist. Two raters were used to increase reliability of the observations made using the checklist, and so inter-rater reliability calculations could be performed.

9.3 Data collection procedures

All pre- and post- surveys were hard copy, paper-based surveys administered at the time of the workshops. This was a preferred method of data collection compared to online survey method due to the higher likelihood of completion by participants based on prior experience of the researchers with such workshops (Hawgood et al., 2020). All follow-up surveys, including both the 6-month follow-up survey, and the utility survey administered between 1 and 6 months after the original workshop were administered online by emailing participants the links to related online surveys. The Griffith University Ethical approval for this study required that Roses in the Ocean directly invite participants to undertake the surveys by either providing them at the workshops or emailing the online surveys using the embedded link for these follow-up-surveys, to reduce potential access by AISRAP researchers to personally identifying information of participants.

10 Ethics

Ethical clearance for this study was obtained from the Griffith University Human Research Ethics Committee (GU HREC), GU Reference Number: 2018/315.

11 Participants

11.1 Training content evaluation sample size

TouchPoints workshops were delivered between December 2020 and May 2022 to a total of 347 participants who were all administered the impact survey. A total of 159 pre- and post-surveys were received (response rate of 45.82%). Of these surveys, a total of 117 pairs were able to be matched for analysis. Of the 24 x 6-month follow-up impact surveys received, only 12 surveys were able to be matched for analysis rendering any meaningful analysis of data unviable. Therefore, as mentioned earlier, only pre-, and post-workshop analyses were conducted for this current report.

For many measures, participants did not complete all items, or did not complete all measures at both pre- and post- time points. As such there is considerable variation in the number of matched pairs for each measure. The Literacy of Suicide Scale was the measure most infrequently completed in entirety with only 23 participants completing both pre- and post-data collection points. Pairwise deletion was used to retain as many completed measures as possible for the analysis.

11.2 Participant Demographics

Table 1. TouchPoints Evaluation survey participants

		N	%
Gender	Male	26	22.4
	Female	89	76.7
	Non-binary	1	.9
	Did not specify	1	.9
Age	20-29	12	10.3
	30-39	19	16.2
	40-49	27	23.1
	50-59	30	25.6
	60-69	12	10.3
	70-79	7	6
	80-89	1	.9
	Did not specify	9	7.7
Sexual Orientation	Heterosexual	80	68.4
	Gay	2	1.7
	Lesbian	1	.9
	Bisexual	2	1.7
	Queer	1	.9
	Transgender	1	.9
	Asexual	1	.9
	Did not specify	29	24.8
Aboriginal and/or Torres Strait Islander		18	15.4
Culturally and Linguistically Diverse		5	4.3
Occupation	Education	12	10.3
	Health	24	20.5
	Retail	1	.9
	Community	35	29.9
	Business	4	3.4
	Welfare	11	9.4
	Emergency	1	.9
	Religious	1	.9
	Home	2	1.7

	Studying	4	3.4
	Other	15	12.8
	Did not specify	7	6
Prior training in suicide prevention	Question-Persuade-Refer (QPR)	5	4.3
	Wesley Lifeforce	6	5.1
	Applied Suicide Intervention Skills Training (ASIST)	13	11.1
	SafeTALK	4	3.4
	Mental Health First Aid for the Suicidal Person	20	17.1
	Screening Tool for Assessing Risk of Suicide (STARS)	6	5.1
	Other	13	11.1
	No previous training	69	59

As seen in Table 1., the majority of participants were female, and over half (57%) were aged between 40 and 60 years. The community sector was the occupational setting where most (35%) participants worked, followed by the health sector (24%). Just over 15% of participants identified as Aboriginal and/or Torres Strait Islander, while less than 5% identified as coming from cultural and/or linguistically diverse backgrounds. More than 6% of participants reported gender and/or sexual diverse identities, and a quarter (24.8%) did not reveal this this demographic information. More than two thirds of all participants (59%), had not received prior suicide prevention training, indicating that TouchPoints workshop was the first suicide prevention training they had received.

12 Data analysis

For this training intervention evaluation, the recommended methodological approach is to perform matched pair sample analyses where the pair is the unit of analysis, and the focus is on the difference in measured variables within each pair. In other words, the sample size is the number of distinct pairs formulated within the sample. Therefore, in the current study, we conducted matched pair sample analyses between the pre and post surveys, and between the pre- and follow-up surveys.

13 Evaluation Survey Results

13.1 Confidence in Support Tasks

As seen in Figure 1, after attending the workshops attendees reported feeling significantly more confident on all the key skills and tasks of the TouchPoints workshop. The most reported increase in confidence after the workshop was for the learning objectives: *'Challenging misconceptions or myths about suicide'*, and *'Recognising invitations for help or warning signs for someone who may be experiencing a suicidal crisis'*. The overall mean confidence gains for participants (N=104) from pre- to post-workshop also increased significantly from 32.34 to 42.54 (t = 11.72(103), p < .001).

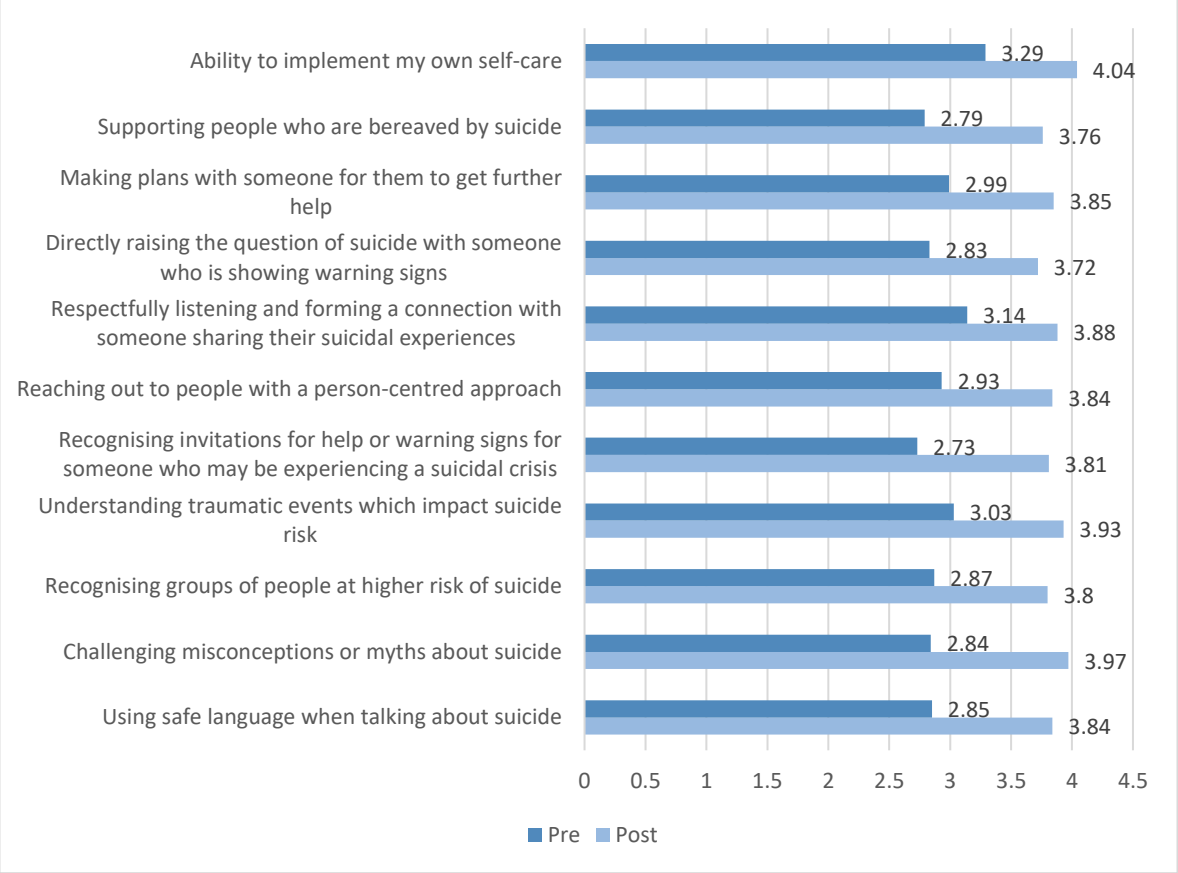

Figure 1. Comparison of mean Confidence in Support Tasks scores from pre to post workshop

13.2 Safe Suicide Language Scale

As seen in Figure 2 below, the total mean scores for the total sample (N=90) on the Safe Suicide Terminology Scale increased significantly from pre to post workshop from 4.06 to 4.76, (t = 5.32(89), p < .001).

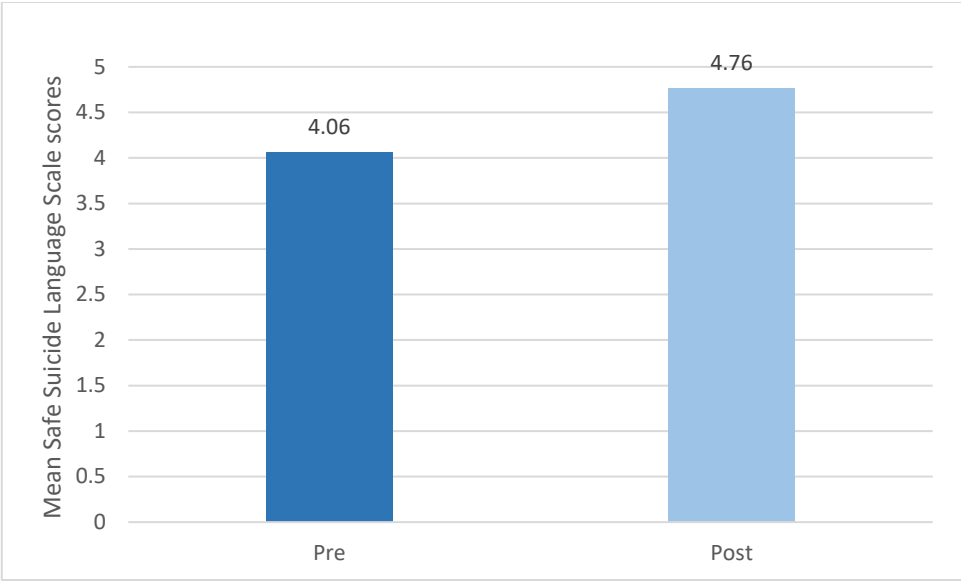

Figure 2. Comparison of mean Safe Suicide Language Scale scores from pre- to post workshop

13.3 Literacy of Suicide Scale (LOSS)

While the average total number of correct participant answers (N=23) on the LOSS from pre- to post- workshop rose from an average value of 10.57 to 10.96, this difference was not statistically significant (t = 1.62(22), p = .119) (see Figure 3).

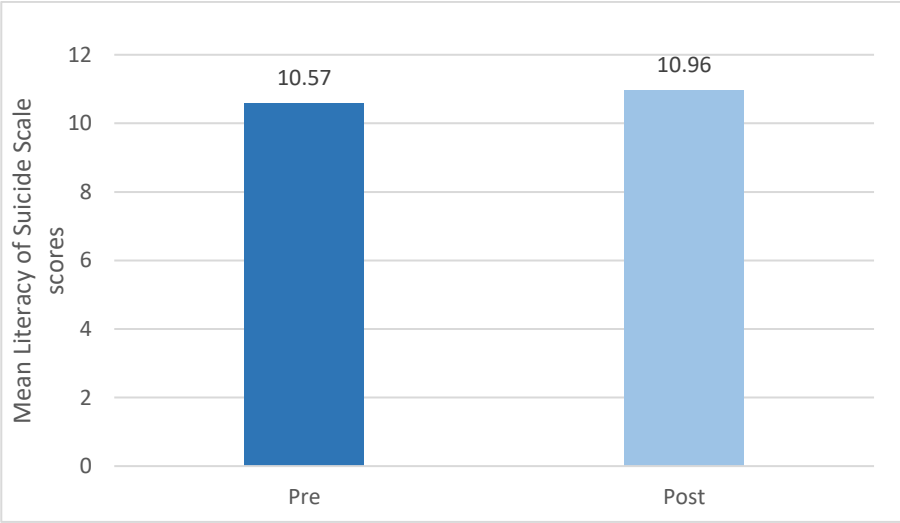

Figure 3. Comparison of mean Literacy of Suicide Scale scores from pre to post workshop

13.4 Suicide-related Crisis Support Scale

Figure 4 below presents the pre- to post mean group score comparison for participants on the Suicide-related Crisis Support Scale. Participants (N=70) answered significantly more correct

answers after compared to prior to the workshop, with the average total number of correct answers arising from an average value of 8.64 to 9.54 (t = 5.75(69), p < .001).

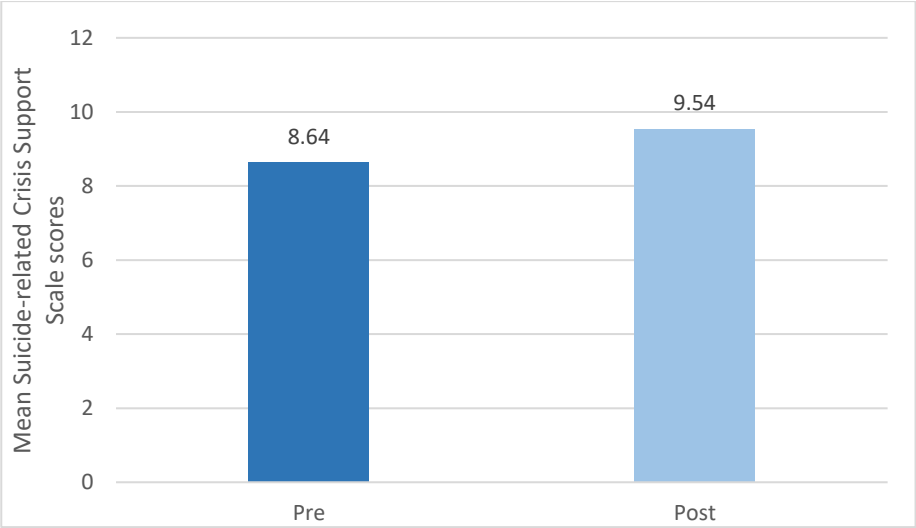

Figure 4. Comparison of mean Suicide-related Crisis Support Scale scores from pre to post workshop

13.5 Adult Hope Scale

As displayed in Figure 5 below, participants' (N=81) sense of hope (self-perceptions of capability to plan towards and achieve desired goals), increased significantly from pre- (51.28) to post workshop (52.79) (t(80) = 3.69, p < .001).

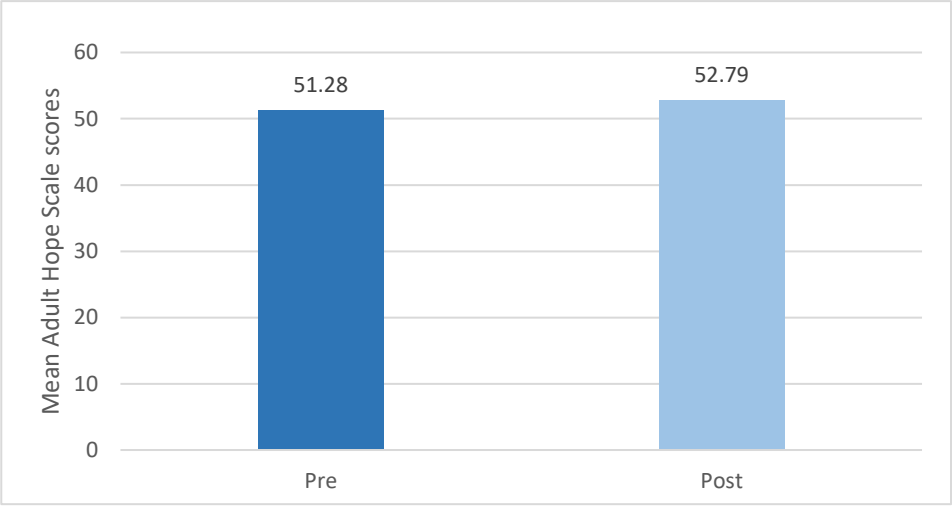

Figure 5. Comparison of mean Adult Hope Scale scores from pre- to post-workshop

13.6 Self-Care-Knowledge Scale

As displayed in Figure 6, while not significant, the mean total number of correct scores on the Self-Care Knowledge Scale decreased from an average value of 6.83 at pre-workshop to 6.96 post-workshop (t = 1.11(79), p = .272).

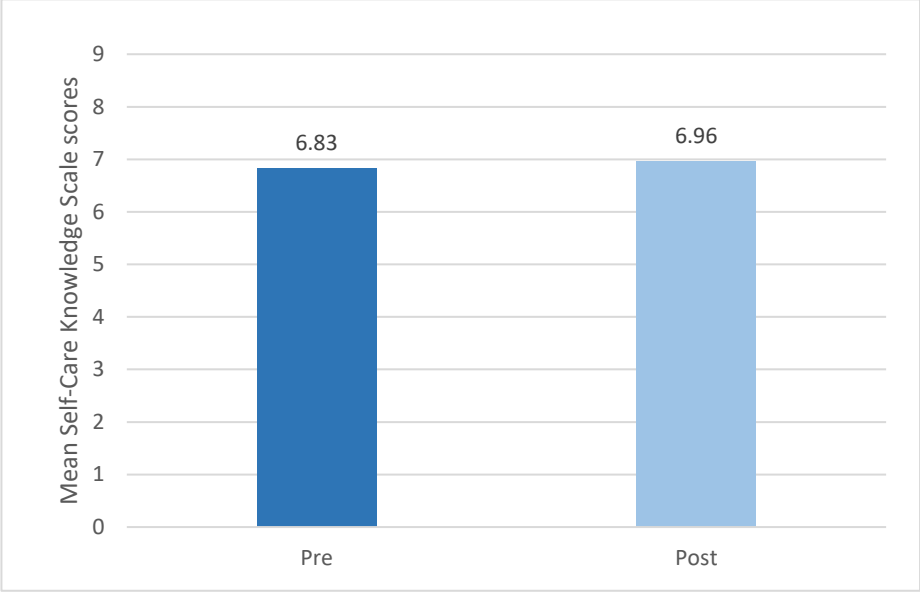

Figure 6. Comparison of mean Self-Care Knowledge Scale scores from pre to post workshop scores

The following Table 2., presents a summary of all measures within the TouchPoints workshop impact evaluation survey.

Table 2. TouchPoints Workshop Evaluation surveys: Results Summary

Scale	Pre-Workshop Mean	Post-Workshop Mean	*t(df)*	sig
Confidence in Support Tasks	32.34	42.54	11.72(103)	<.001*
Safe Suicide Language Scale	4.06	4.76	5.32(89)	<.001*
Literacy of Suicide Scale (LOSS)	10.57	10.96	1.72(22)	.119
Suicide-related Crisis Support Scale	8.64	9.54	5.75(69)	<.001*
Adult Hope Scale	51.28	52.79	3.69(80)	<.001*
Self-Care Knowledge Scale	6.83	6.96	1.11(79)	.272

** Indicates p < .05*

14 TouchPoints Outcomes Utility Survey results

14.1 Participants

TouchPoints Outcomes Utility survey measured participants' application of TouchPoints workshop learnings afterwards in the 'real world'. As participants were emailed the survey link to complete every month from one month to six months after attending the workshops, individuals may have responded to any number between 1 to 6 of the monthly survey administrations (whereby maximum number of surveys to be completed by any one individual equalled 6). A total of 193 surveys were returned from participants who attended the Touchpoints workshops between December 2020 to May 2022. Eleven incomplete surveys were removed from analysis, resulting in a total of 182 completed participant surveys retained for analysis. Preliminary data cleaning identified that the 182 surveys were completed by 125 different individual participants retained for analysis, with 88 people completing the survey at only one time point and 37 people completing more than one (further seen in Table 5.)

The majority of the 125 respondents who completed the Utility survey were female (82.4%). Twenty (16%) identified as Aboriginal or Torres Strait Islander persons (as seen in Table 3).

Table 3. TouchPoints Outcomes Utility Survey: Participants

		N	%
Gender	Men	22	17.6
	Women	103	82.4
Age	Under 18	2	1.6
	18-24	4	3.2
	25-34	13	10.4
	35-45	27	21.6
	45-54	32	25.6
	55-64	34	27.2
	65+	12	9.6
	Did not specify	1	0.8
Aboriginal and/or Torres Strait Islander persons		20	16
Total		**125**	**100**

14.2 Training outcomes utility data collection timepoints

As seen in Table 4., nearly 50% of the surveys received were completed within the first two months after the TouchPoints workshop. The least likely proportion response was at 4 months post-workshop (9.3%), closely followed by the 6-month follow-up point (9.8%).

Table 4. Training Outcomes Utility Survey completions

Post workshop follow-up Timepoint	Surveys completed (N)	%
1 month	49	25.4%
2 month	47	24.4%
3 month	32	16.6%
4 month	18	9.3%
5 month	28	14.5%
6 month	19	9.8%
Total	**182**	**100%**

As seen in Table 5, although participants were sent the online surveys to complete each month between one and six months after attending the TouchPoints workshop, most participants completed the survey at only one time point throughout the 6-month period (N = 88, 70.4%). However, 37 participants (26.6%) completed the survey at more than one timepoint. The pattern of survey completion at the consecutive data collection time points (months 1-6) can be seen in Appendix D.

Table 5. Timepoints at which participants completed the TouchPoints Outcomes Utility Survey

Surveys completed	Participants (N)	%
1 timepoint	88	70.4%
2 timepoints	26	20.8%
3 timepoints	7	5.6%
4 timepoints	3	2.4%
5 timepoints	0	0%
6 timepoints	1	0.8%
Total	**125**	**100%**

14.3 Supporting people experiencing suicidal crisis or emotional distress

Out of the 125 participants who completed the Training Outcomes Utility survey, 56.8% (N=71) responded 'yes' to the first survey item; asking about whether they had provided assistance to someone experiencing a suicidal crisis or emotional distress since attending the TouchPoints workshop. Through the data cleaning process, another five individuals who responded 'no' to this initial survey item, also answered positively on subsequent survey items indicating that they had applied some of the specific skills (such as directly asking about suicide or helping people decide what to do next) suggesting either misunderstanding or misinterpretation in reading of the first item. The research team concluded that due to misunderstanding or misinterpretation of the first survey item, these five participants must have incorrectly answered 'no' to it, as their subsequent responses indicated otherwise. As a result, after consensus was reached by the research team, these five participants were included with the total number of participants who answered 'yes' to having 'provided support or assistance' since their participation in the TouchPoint workshop. As such, a total of 76 participants (out of 125 participants who completed the Training Outcomes Utility survey; 60.8%) were identified as providing support or assistance post TouchPoints workshop or 117 (64.3%) of all 182 responses received (Figure 7.).

At all data collection timepoints, more responses were observed for participants' providing support in the context of suicidal crises or distress compared to responses indicating that no support was provided. However, as seen in Figure 7, across all time-points, the largest proportion of responses where participants provided support was at the three month point post-workshop data collection. Chi-square analysis found that the association between data collection time-points and providing support over the 6-month period post workshop was not significant, $X^2(5) = 8.5$, $p = .113$. This means that there was no relationship between support provided to those in suicidal distress and the specific time-point between one to six months following TouchPoints workshop.

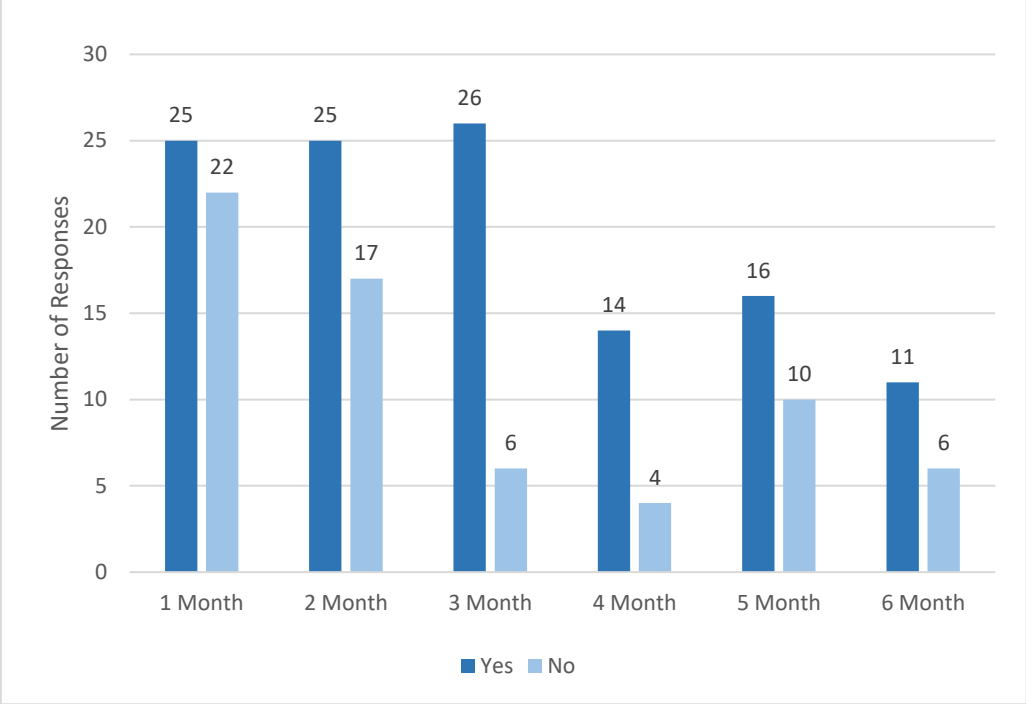

Figure 7. Support provided across one- to six months after TouchPoints workshop (N=182)

As seen below in Figure 8., a larger proportion of responses indicated that support *had* been provided versus *not* having been provided to people experiencing suicidal distress during the four-to-six-month period compared to the first three month period after the Touchpoints workshop. However, a chi-square analysis found that this difference was not significant, $X^2(1) = .341$, $p = .558$.

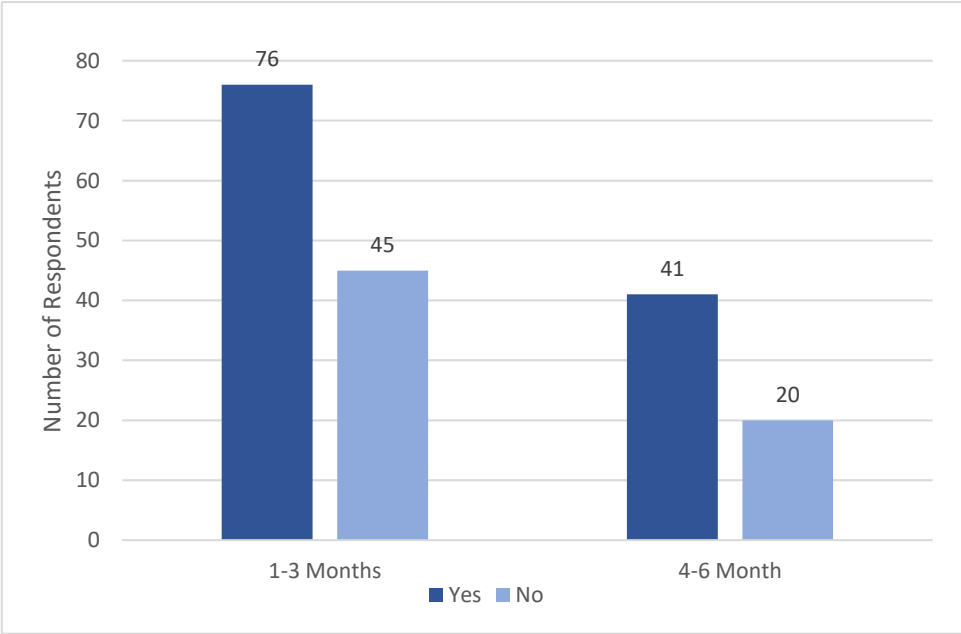

Figure 8. Support provided at one-to-three and four-to-six months after TouchPoints workshop (N = 182)

14.4 Utility of workshop skills and actions

Of the participants who reported that they had provided support to people experiencing a suicidal crisis (N = 76), four out of five (80.3%) had listened without judging and 60.5% had supported someone to get help (Table 6). Approximately half (51.3%) reported that they asked someone about suicide and 48.7% had assisted someone to decide on the next steps they should take. Just over a quarter (26.4%) of participants had noticed invitations for help. On average, participants (N = 76) each reported providing support to two people experiencing a suicidal crisis or emotional distress (*M* = 2.46, *SD* = 2.41) over the 6 months follow-up period.

Table 6. Training Outcomes Utility Survey: Implemented support skills/actions

Support skills/actions	Participants (N)	%
Listened without judgement	60	78.9%
Supported to get help	46	60.5%
Asked about suicide	39	51.3%
Helped someone decide next steps	37	48.7%
Noticed invitations for help	32	42.1%

N = 76

As seen in Figure 9., listening without judgement was the most frequently reported skill used at all six timepoints. At all timepoints the majority of participants who had provide support to people reported that they had listened without judgement and supported someone to get help. The equal least frequently used skills for months 1, 2, 3 and 5 were noticing invitations for help and asking about suicide. These two skills in addition to helping someone decide their next steps were equally the least frequently used at 4 and 6 months.

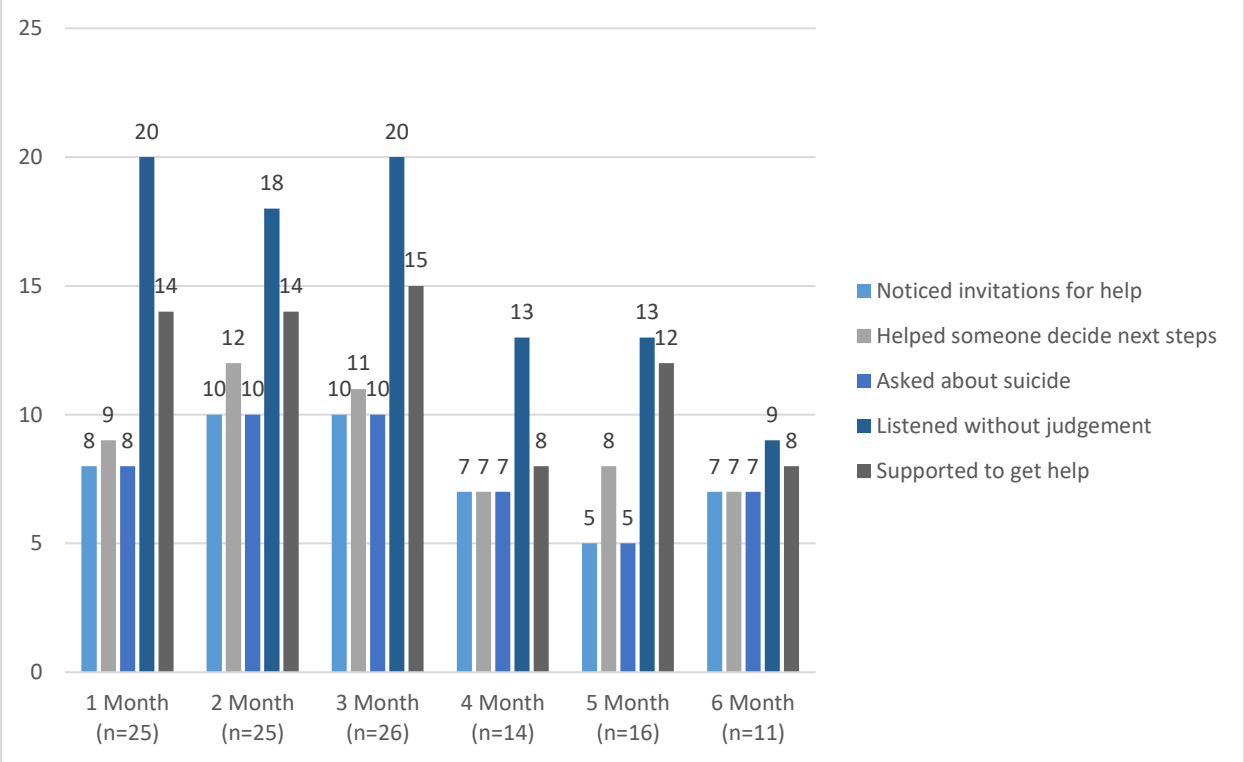

Figure 9. Utility of skills applied -one- to six months after TouchPoints workshop (N = 182)

14.5 Matched pair analysis of utility of skills/actions applied since TouchPoints workshop

A total of 25 participant pairs were able to be matched to compare the utility skills/actions used in the first three months with utility in the final four to six months after TouchPoints workshop. Due to the limited and sporadic response rate by participants on this survey over the six timepoints, it was not possible to 'match' enough surveys across the timepoints to compare month by month analyses of the application of skills. Therefore, we merged the first three months utility data (months 1-3) to compare with the final three months (months 4-6), justified by the predominant dichotomised clustering of responses at either end of the data gathering period. The proportion of skills/actions applied were calculated and compared for the 1-3- and 4-6 months periods.

As seen in Figure 10., out of the 25 participants able to be matched, one additional person reported providing assistance to someone experiencing suicidal crises that had not within the first 3 months after the workshop.

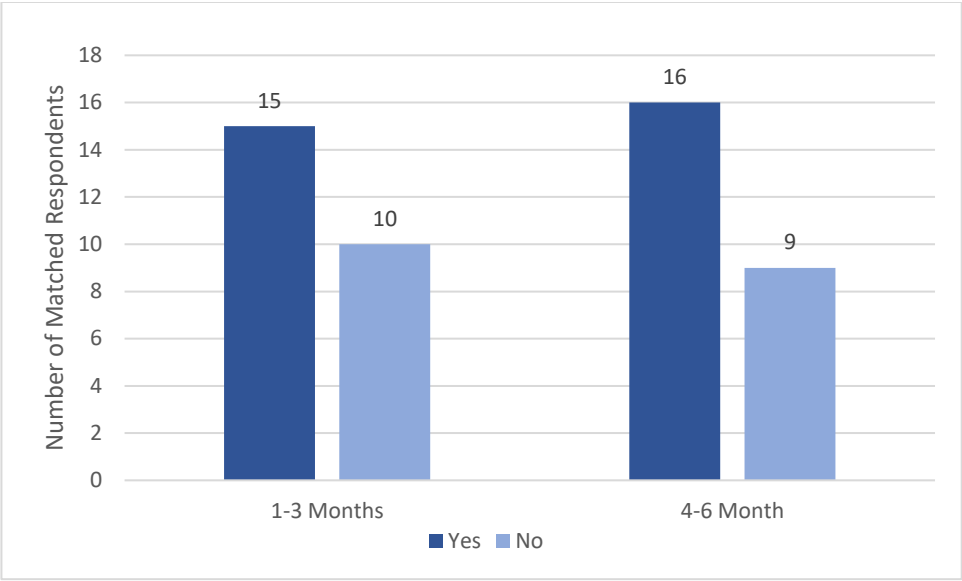

Figure 10. Support provided at one-to-three and four-to-six months after TouchPoints workshop in matched participants (N = 25)

In four of the five key utility skills/actions, more participants reported using these skills at 4-6 months as compared to the first 3 months after the workshop. Surprisingly one participant, reported that they had supported someone to get help in the survey completed in the first 3 months, but then provided a different response in their survey after 4 months indicating that they didn't provide this support. As seen in Table 7., McNemar's tests revealed that none of these differences were significant in the sample of 25 matched participant samples, (ranging from $p = .453$ for noticing invitations for help to, $p = 1$ for listening without judgement, supporting people to get help, and helping people decide next steps).

Table 7. Matched sample TouchPoints utility skill/actions application

Support Skills/Actions	1-3 Months	4-6 Months	McNemar's Test *(p)*
Listened without judgement	16 (64%)	17 (68%)	1
Supported to get help	15 (60%)	14 (56%)	1
Asked about suicide	9 (36%)	11 (44%)	.687
Helped someone decide next steps	8 (32%)	9 (36%)	1
Noticed invitations for help	5 (20%)	8 (32%)	.453

N = 25

14.6 Participant Feedback

14.6.1 Training workshop experiences

Of the 182 surveys completed, 124 (or 68.1%) did not provide any response in the open-ended experience components of the survey. Thirty-one (or 53.4% of the 58 total responses received) were regarding the workshops and the content. Thirteen of the workshop specific comments (41.9% of workshop-specific comments) were either broad positive comments, such as "It was great training" and "Well-presented session" or reported that the respondent felt that no modifications were needed to improve the workshops.

Five participants (16.1% of workshop comments) elaborated further with positive feedback most frequently in support of the necessary nature of these skills and knowledge taught, and two (6.5%) noted that the workshops provided the opportunity to gain insight, provided them with "a different perspective to other suicide prevention workshops" (e.g. "helps with the discussion between the people in the room of experiences"). Finally, participants positive endorsed the TouchPoints workshop facilitators (N = 5, 16.1%), with one describing the facilitators style as "heart-warming and considerate"

14.6.2 Training utility of skills/application

Approximately two-thirds (65.5%) of all responses received (N = 38) described the experiences of applying the skills and knowledge gained from TouchPoints workshop. Three participants from these respondents (7.9%) reported that since attending the Touchpoints workshops they were more aware and compassionate in their approach to people experiencing suicidality or related distress. Fifteen (39.5%) reported that they felt more comfortable or confident in their abilities to talk to people and enquire about suicidal thoughts, for example "I'm not afraid to talk about suicide now. We need to ask." Three participants (7.9%) reported that they now had necessary skills to engage in conversations while two other participants (5.3%) articulated they now know how to respond to such conversations.

14.6.3 Suggestions for future workshops

Only three participants made suggestions for potential improvements or changes to the TouchPoints workshop. Suggestions included a) a requirement for more time (length of workshop) to adequately engage with the content, b) negotiation of the cost of the workshop (cost was identified as a barrier preventing people in communities and organisations attending, and c) despite valuing the workshop content, there is a need to attend to the workshop presentation style of presenters/facilitators who may be too emotional (e.g. the degree to which the presenter spoke

about their own lived experience and the [facilitator's] apparent distress in discussing their lived experience).

15 Training fidelity Results:

15.1 Trainer adherence to training schedule and inter-rater reliability

Results below are organized in four sections that follow the structure of the survey, as outlined in the method section of this report. Scores assigned by the two raters were averaged, where 1 represents the lowest score (suggesting the rater was very dissatisfied with the facilitator's performance on that item, and 5 suggests the rater was very satisfied).

15.1.1 Workshop organisation

Table 8. Average scores on items regarding Workshop organisation

ITEM	Trainer A	Trainer B	Trainer C	Trainer D
Facilitator arrived on time.	3.5	5.0	5.0	4.0
The room was set up appropriately, with workbooks, stationery and wellbeing Wi-Fi documents neatly set up for each participant.	3.0	5.0	5.0	3.5
Check sheets / sign in sheets were available for participants.	4.5	5.0	5.0	4.0
Room temperature was checked and comfortable.	3.5	5.0	5.0	0.0
Evaluation of toilet facilities and fire escapes was undertaken.	4.0	4.0	4.0	0.0
Morning / afternoon tea was set up and functional.	3.5	5.0	5.0	0.0
Technology was checked to work appropriately.	3.0	5.0	5.0	0.0
TOTAL	**3.6**	**4.9**	**4.9**	**1.6**

Trainer B and Trainer C received very high scores on most items within this domain of the questionnaire, suggesting the various elements that went into the preparation of the space, resources and organisation of the workshop were executed nearly perfectly. Trainer A's scores across the 7 items on this domain suggest some lacking in terms of checking technology and setting up the room and resources. Trainer D received good scores on 3 out 7 items, however, judging from zeros on the remaining four items, seemed to perform very poorly with setting up morning/afternoon tea, evaluation toilet facilities and fire escape, did not check the room temperature nor technology.

15.1.2 Subject matter

Table 9. Average scores on items regarding Subject matter

ITEM	Trainer A	Trainer B	Trainer C	Trainer D
Appropriate introduction to the workshop and completion of acknowledgements.	2.0	4.0	0.0	0.0
Capacity to articulate the Roses in the Ocean story / beginnings.	1.0	3.0	0.0	0.0
Setting up the room and holding conversations about safety / self-care.	2.5	5.0	5.0	0.0
Have a discussion with the group around factors on our decision making	/	5.0	1.5	0.0
Explanation of TouchPoints and associated behaviours	2.0	0.0	3.5	0.0
Hold a conversation about language and unhelpful sayings.	2.0	4.0	3.0	0.0
Well run Myths and Misconceptions activity, with strong engagement.	2.5	5.0	0.0	0.0
Can articulate current statistics, along with a few other pertinent stats.	1.0	4.0	0.0	0.0
Able to explain crisis and trauma and its impact on suicide.	1.0	4.0	4.5	0.0
Can hold a discussion about warning signs, including LE stories.	2.0	0.0	4.0	0.0
Managed conversation on both case studies and brought out insights.	2.5	4.0	0.0	0.0
Holds practical and helpful discussion on the Lifeline 5 step model.	2.0	5.0	1.5	0.5
Able to show the differences with the crisis intervention model.	2.0	3.0	3.0	0.0
Can explain suicide bereavement and how it differs from other grief.	1.5	3.0	0.0	0.0
Brings LE stories to the discussion about grief associated with suicide.	1.0	2.5	0.0	0.0
Able to explain self-care and demonstrate active SC behaviours.	3.0	0.0	3.5	0.0
Concludes the content professionally.	1.5	5.0	5.0	0.0
TOTAL	**1.8**	**3.3**	**2.0**	**0.0**

As above, Trainer B on average received highest scores on items within the domain of subject matter, receiving an average score of 3.3, which was considerably higher than the remaining facilitators. It is worth noting, that three items received a score of zero (total absence of knowledge on this topic, or more likely, the fact that this element of the training did not get addressed during the workshop). The items were related to the explanation of touchpoints and associated behaviours; holding a discussion about warning signs; and the ability to explain self-care and demonstrate self-care behaviours. Trainer A's scores ranged between 1.5 and 3.0, demonstrating relatively poor expertise on most elements measured within Subject matter. Trainer C's scores ranged from 1.5 (suggesting she did not have a good discussion with the group around factors in our decision making) and 5 (on items related to holding conversations about safety / self-care and concluding the content professionally). She did, however, received zeros on seven of the 17 items on this domain. Trainer D's scores were almost consistently zeros across all items.

15.1.3 Presentation / style

Table 10. Average scores on items regarding Presentation style

ITEM	Trainer A	Trainer B	Trainer C	Trainer D
Fluent and comprehensive presentation of content.	1.5	5.0	3.5	0.0
Appeared confident and in charge of the content delivery and process.	1.5	5.0	3.5	0.0
Maintained professional appearance and conduct during the workshop.	3.0	5.0	5.0	0.0
Established a warm and engaged connection with participants.	4.0	5.0	5.0	0.0
Used appropriate stories to illustrate key ideas and points.	2.5	3.0	4.0	0.0
Maintained the safety of the room and all participants.	3.5	4.5	4.5	0.0
Acknowledged and validated the responses of participants.	4.0	4.0	4.5	0.0
TOTAL	**2.9**	**4.5**	**4.3**	**0.0**

Trainer B and Trainer C received high scores on most items measured as part of Presentation/style, with the only item where Trainer C did not seem to demonstrate satisfactory performance being around the use of appropriate stories to illustrate key ideas and points. There were certain elements of Trainer A's presentation/style that were rated as above average (namely, establishing a warm and engaged connection with participants, acknowledging and validating their

responses, and maintaining the safety of the room and participants). On all other items, however, she was scored relatively poorly. Trainer D's scores were zeros across all items.

15.1.4 Group management

Table 11. Average scores on items regarding Group management

ITEM	Trainer A	Trainer B	Trainer C	Trainer D
Welcomed people in a warm and friendly way.	4.0	5.0	5.0	4.0
Informed people as to what would be happening in the workshop.	3.0	5.0	5.0	0.0
Started and finished the workshop on time.	4.0	3.5	3.5	0.0
Allowed space and time for group and individual interaction.	3.5	4.0	4.0	0.0
Encouraged and welcomed input from the participants.	4.0	5.0	5.0	0.0
Managed the timing, content, and activity interaction.	2.5	3.5	3.0	0.0
TOTAL	**3.5**	**4.3**	**4.3**	**0.7**

Regarding Group management, Trainer B and Trainer C received the same scores on all items, and an average score of 4.3 which suggested strong skills on this domain. Trainer A's scores ranged between 2.5 (suggesting somewhat poor managing of the timing, content and activity interactions) and 4 on items related to welcoming the participants in a warm and friendly way and encouraging their input during the workshop. Trainer D appeared to have welcomed people in a warm and friendly way, though failed to deliver skills measured through the remaining items on this domain.

15.1.5 Total scores per facilitator

Table 12 shows the average scores assigned to each facilitator on the four domains, as well as their total scores.

Table 12. Mean domain and total facilitator scores

DOMAIN	Trainer A	Trainer B	Trainer C	Trainer D
Workshop organisation	3.6	4.9	4.9	1.6
Subject matter	1.8	3.3	2.0	0.0
Presentation / style	2.9	4.5	4.3	0.0
Group management	3.5	4.3	4.3	0.7
TOTAL	**2.6**	**4.0**	**3.3**	**0.4**

Results showed that Trainer B received highest average scores on all domains across all facilitators, matched by Trainer C's scores on Workshop organisation and Group management. When averaged across all domains, Trainer B also achieved the highest score of 4.0, followed by Trainer C (3.3), and Trainer A (2.6). Trainer D's total score of 0.4 indicated very low level of competency across all domains, most notably on Subject matter and Presentations/style where both raters assessed complete lack of required skills.

It is also worth noting that when comparing scores received by each facilitator, all four received their highest scores on the domain of Workshop organisation, and lowest scores on Subject matter.

15.1.6 Inter-rater reliability (IRR) calculations

Two independent observers / raters were used to increase reliability of the observations made using the checklist. Inter-rater reliability (IRR) coefficients were calculated to demonstrate the reliability of the observations made by the raters, by examining the level of alignment between their scores. Cohen's kappa (κ) is a measure of inter-rater agreement for categorical scales when there are two raters. Kappa results are typically interpreted as follows:

≤ 0.01 - no agreement
0.01 – 0.20 - none to slight agreement
0.21 – 0.40 - fair agreement
0.41 – 0.60 - moderate agreement
0.61 – 0.80 - substantial agreement
0.81 – 1.00 - very strong agreement

Table 13 shows Cohen's kappa values for the raters' scores assigned to each facilitator, for individual domains on the scoring questionnaire as well as totalled across all domains.

Table 13. Levels of Cohen's kappa: measure of IRR between observer-raters

DOMAIN	Trainer A	Trainer B	Trainer C	Trainer D
Workshop organisation	1.000**	1.000**	1.000**.	0.741**
Subject matter	1.000**	0.922**	0.571**	/
Presentation / style	1.000**	0.731**	0.125	/
Group management	1.000**	0.250	0.429	1.000**
TOTAL	1.000** **Fair agreement**	0.793** **Substantial agreement**	0.591** **Moderate agreement**	0.754** **Substantial agreement**

*Note: * level of statistical significance p<.05; ** level of statistical significance p<.001; / Kappa could not be calculated due to too little variance in data*

Substantial variations can be observed between levels of agreement between raters regarding individual domains. For example, statistically significant high levels of Kappa coefficients were observed on domains of Workshop organisation and Subject matter across all four facilitators (with the lowest of 0.571 recorded for Trainer C's Subject matter, and even this suggested moderate level of congruence). On the other hand, only slight level of agreement was noted on the domain of Presentation/style for Trainer C, and low level of agreement on Group management for Trainer B.

Kappa coefficients assigned to the total questionnaire were seen to range from the highest of 1 (total alignment between scorers) when rating Trainer A, to lowest of 0.591 (moderate agreement) regarding Trainer C's ratings. All total Kappa scores reached a level of statistical significance at level 99%. These results confirm that, on the whole, the observer ratings reflect an objective assessment of facilitators' workshop organisation, knowledge on the subject matter, presentation/style, and group management.

16 Discussion

The overall aim of this evaluation was to determine the effectiveness of TouchPoints workshop on identified learning outcomes for attendees during December 2020 to May 2022. To achieve this we outlined three specific aims associated with important elements of evaluation of training as specified in the literature (Hawgood et al., 2021; Cross et al., 2014; Cross & West, 2011). These aims were to determine a) immediate (pre- to post-workshop) impacts on learning outcomes (including perceived confidence in suicide prevention, knowledge of suicide safe terminology, suicide literacy, suicide-related crisis support scale, sense of hope and self-care); b) application and utility of workshop learning outcomes over the short to medium term (1-6 months post workshop); and c) trainer fidelity - adherence to training content and scheduled content delivery.

For the first aim, it was expected that TouchPoints workshop would be associated with significant improvements (from pre to post workshop) on all participant learning outcomes. This hypothesis was supported for gains on perceived confidence in suicide prevention, knowledge in safe suicide terminology, suicidal crises support responses, and a sense of hope in ability to initiate and action planned goals. However, knowledge of self-care and suicide literacy gains were not significantly different from pre to post, likely a result of the ceiling effect observed from high pre-training scores on these measures. Our exploratory aim was to examine the application and utility of TouchPoints skills in the short to medium term post-workshop. Findings revealed a trend for increased average use of skills over time (short to medium term) in the group of respondents.

However, there was no significant change in the mean group application of skills between 1-3- and 4-6-months post workshop. However, importantly, there was no evidence of attrition in self-reported skill application for the group. We are unable to report on individually matched outcomes over time due to the small number of respondents able to be matched across all time points. Nevertheless, that most participants reported utility of skills for up to 6 months post workshop, is a promising finding for the influence of TouchPoints workshop. Finally, the expectation of variability in trainer fidelity was supported, with results ranging from very low level of adherence to training content across several domains of the training schedule by one facilitator through to the highest adherence, near perfect alignment by another facilitator across all domains. Results of raters appeared to be reliable and consistent in terms of observations overall, reflecting an objective assessment of the facilitator adherence to TouchPoints workshop delivery. A comprehensive discussion of the findings associated with each of the three evaluation aims is outlined in the sections below (16.2-16.5).

16.1 Overall sample findings

The broad range of occupation fields of the TouchPoints participants reflect that Roses in the Ocean were effective at recruiting widely throughout workplaces and within key workplace settings for potential opportunities for gatekeeper conversations – including community services, education, and welfare supports. Approximately two-thirds of all participants had not attended any suicide prevention training previously, suggesting the workshop targeted a diverse range of learning needs, including a majority with limited education in suicide prevention. Further, approximately 15% of participants identified as Aboriginal and/or Torres Strait Islander persons. Taken together, these findings suggest that Roses in the Ocean has effectively recruited from priority demographics as well as targeting those who have not been educated in such training previously; thus influencing a key group of potential 'LifeKeepers' for suicide prevention. Further, as First Nations people are overrepresented in suicide mortality, increasing capacity of people in communities to confidently engage in conversations about suicide is an important action within Australia's national suicide prevention priorities (Department of Health, 2021).

Since a quarter (24.8%) of participants did not feel comfortable to provide information about gender or sexual orientation in the demographic identification item, it is not possible to adequately examine the effectiveness or reach within LGBTIQA+ communities, another priority group within suicide prevention. However, this may be possible in larger evaluation samples or within more targeted LGBTIQA+ workforces in the future.

16.2 TouchPoints workshop impact

In support of our first hypothesis, findings revealed significant immediate positive effects of TouchPoints workshop on four of the six key learning outcomes. Firstly, all gatekeeper capabilities on the *confidence in support tasks measure* increased significantly; but the greatest gains were observed for 'Challenging misconceptions or myths about suicide', and 'Recognising invitations for help or warning signs for someone who may be experiencing a suicidal crisis'. Perceived confidence in suicide prevention knowledge and skills has been found to predict utilisation of skills outside of the training workshop (Rossetto et al., 2016). Further, positive perceptions of ones' capabilities may motivate and enhance intentions to intervene in suicide prevention (Hawgood et al., 2021). Furthermore, findings revealed that participants made significant knowledge gains on understanding of *safe suicide terminology* after attending the TouchPoints workshop. Participants had greater understanding of safe language to use when discussing suicide and when supporting someone dealing with suicidal thoughts. These findings are consistent with the positive increases observed for 'safe suicide terminology' outcomes in the Our Voices in Action (OVIA) training evaluation (Hawgood et al., 2021).

Participant gains on the *suicide literacy scores* (as measured on the LOSS) from pre to post workshop were not significant. This finding contrasts with findings of a recent evaluation of the OVIA program (albeit training specifically targeted at those with a lived experience of suicide) (Hawgood et al., 2021). The OVIA evaluation found not only immediate significant gains in suicide literacy, but these gains were maintained at 3-months and up to 12 months post training. Although the participant response rate for LOSS in the current study was low (n=23; 19.7%), it is not dissimilar to the sample size of Hawgood et al's (2021) study at the 3-month follow-up. Therefore, this finding is most likely explained by the high pre-existing literacy levels in our current sample, which left little room for knowledge gains, resulting in a 'ceiling effect' where observation of significant effects is limited.

Participants also made significant immediate gains on the *Suicide-related crisis support scale* which suggests that the TouchPoints workshop may play an important role in participants' acquisition of knowledge associated with supporting someone in suicidal distress. These gatekeeper capabilities have been consistently highlighted in the literature as being positively enhanced by training (Hawgood et al., 2021; Holmes et al., 2019). Our findings concerning application and utility of such knowledge after the training (see below) appear to support the invaluable impacts of this knowledge uptake and its translation to the real world as a result.

The construct of *hope* in the suicide prevention literature has only recently received attention as an important factor for contributing to health, psychological and social well-being and other areas of mental health outcomes (Di Gasbarro et al., 2020; Snyder2002). In our study, we conceptualised and measured hope as a cognitive, goal-directed response whereby people identify pathways towards achieving their defined goals, as well as ways to stay focused and motivated on achieving them. We found significant increases in this construct from pre to post the TouchPoints workshop which may reflect positive influences of the workshop on goal-related motivations of participants. This finding is meaningful to the extent that increased motivation and desire to achieve positive outcomes in support of those in distress may be an important influencer of effective intervention behaviours. Further studies are required to elucidate the relationship more fully between hope, training impacts and intervention behaviours related to TouchPoints workshop and other gate-keeper trainings.

Unexpectedly, participant's knowledge about self-care did not change significantly from pre to post TouchPoints workshop. Closer examination of the results suggests that, like the LOSS measure findings above, the pre-existing high levels of knowledge on this construct have resulted in a ceiling effect. Specifically, any room for change in scores post training was limited, effectively reducing any potential significant findings. In particular, the pre-workshop scores on one item; 'Ability to implement my own self-care', achieved the highest mean confidence score. It is also possible that individuals drawn to work in this field enter with pre-existing expectations about the 'challenging type of work' and potential 'impacts on the worker', and this preparedness may entail existing self-care knowledge and abilities.

16.3 Training utility and application

Few gatekeeper training studies have assessed the translation of applied skills employed over the medium-term post original training (Hawgood et al., 2021). This is despite the importance of knowledge/skill acquisition if the aim of the training is to change participant intervention behaviour working with those in suicidal distress. Consequently, the literature is inconclusive around short to medium term impacts of training (Holmes et al., 2019). We therefore aimed to determine utility of participants' gained knowledge and skills using a proxy measure of *actual observation* post TouchPoints workshop. We used a self-report survey of applied skills administered monthly (for 1-6 months following the workshop) to try to capture reported utility of skills 'in the moment', over time.

Findings revealed that the majority of participants supported someone experiencing a suicidal crisis or emotional distress within the six months after participating in the TouchPoints

workshop. The self-reported skills most applied by participants included listening without judgement when someone was in distress, followed by supporting someone to get help. These findings suggested the positive influence of TouchPoints workshop on actual real-world application of acquired knowledge and skills; critical for effective gatekeeper outcomes (Hawgood et al., 2021).

Interestingly, approximately half the participants applied their gained knowledge and skills within the first two months post the workshop, with a notable increase at three months, and a slight decrease in application five to six months post workshop. While this increase in utility of the measured skills increased from the short term (1-3 months) to the medium term (4-6 months) post workshop, this increase was not significantly different. Nevertheless, the upward trend observed in utility of skills over time is promising but requires further analysis in larger follow-up samples. Similarly, retention of acquired skills is not commonly reported beyond three months post training or over the medium to long term in the gatekeeper literature (Holmes et al., 2019). Use of larger samples in the future may allow for more pronounced significant changes in skill utility over time. Further, longer follow-up and testing of applied skills (e.g., up to 12 months post training) are required to demonstrate longer term impacts of TouchPoints workshop.

16.4 Participant feedback about the workshop

Workshop feedback about facilitator delivery and skill application was diverse. Majority of the feedback was positive concerning facilitation delivery and workshop content, indicating high satisfaction with nature of content and the facilitation. Regarding facilitation, while one participant reported that they found the emotional nature of one facilitator's lived experience discussion uncomfortable, majority of participants reported the facilitation as warm, engaging and as a new way to approach suicide prevention training. The content was necessary and important providing increased insight and new perspectives for some around suicide intervention.

Regarding application and utility of the knowledge and skills gained from TouchPoints, the most frequent participant feedback related to enhanced confidence and comfort in being able to have conversations with people, feeling less afraid to talk about suicide, and being more aware and compassionate in approaching those in suicidal distress. These qualitative statements reflect the positive influences of TouchPoints workshop on those who provided support over the medium term. Equally important were participant suggestions for modifications or improvements to the workshop, including increasing the length of the workshop, reducing costs for those unable to afford it, and reducing facilitator self-disclosure where it is inappropriate or overly emotional. These findings are also worth interpreting in the context of the trainer fidelity results discussed below.

16.5 Training Fidelity

We expected variability in the findings concerning trainer fidelity and adherence to the TouchPoints workshop content. This is because in the literature, there is little known about trainer adherence to and competency in standardised delivery of training schedules for suicide prevention gatekeeper training despite great acknowledgement of the need to address this (Cross et al., 2014). The underlying assumption appears to be that trainers of all programs deliver the 'same' training program comparable to what they were originally taught (in Train-the-trainer or other facilitator education programs). Yet, little assessment of this construct is reported upon in the literature, limiting interpretation of evaluation training outcomes (Hawgood et al., 2018; Hawgood et al., 2021). As discussed, lower adherence to training schedules can impact an otherwise effective intervention, potentially diluting effects of the intervention per se (Cross et al., 2014, p. 2). Thus, we aimed to determine the level of trainer fidelity or adherence by facilitators to understand the evaluation results in context.

Over the four domains of adherence that we assessed (workshop organisation, subject matter, presentation style and group management), Trainer B received the highest average scores out of all facilitators. However, Trainer C matched her scores on domains of workshop organisation and group management. In terms of 'highest scores' (as opposed to average overall scores), Trainer B, followed by Trainer C performed at the highest level consistently; and then Trainer A performed relatively at an expected level of performance with the second least adherence across all domains compared to all other facilitators. Trainer D's total score indicated the least adherence for all domains but significantly for subject matter and presentation style. This variation in facilitator adherence is critical for interpretation of workshop evaluation findings. As said, it can be assumed that lack of adherence by one facilitator particularly, has diluted to some extent the TouchPoints workshop impacts on participants. The actual effectiveness of the workshop on meeting different learning outcomes may have therefore been undermined (most evidence on the domains of subject matter and presentation/style), thwarting the opportunity for participants to have acquired the respective knowledge and skills. Future train-the-trainer workshops and processes delivered by Roses in the Ocean should ensure strict attention is paid to measurement and rehearsal of the key jointly defined workshop domains of adherence and competency (as measured in this study). That is both training for the facilitators and selection of facilitators could be aligned with achievement of these domains to reduce potential for dilution of future evaluation impacts.

Finally, noteworthy was the fidelity checklist domain achieving the least and the highest adherence by all facilitators; these were 'subject matter' and 'workshop organisation' respectively. Studies have found that lower-level fidelity and adherence is associated with more experience and prior training, explained by the potential resistance to trying 'new' content or training material, or the 'primacy effect' whereby previous learning interferes with uptake/internalisation of different learning (Cross et al., 2014). Unfortunately, we did not measure the prior experience or training of facilitators, this important information so cannot draw conclusions about potential explanations from the current findings. However, this information should be gathered in future evaluations of trainer fidelity. We did, however, provide inter-rater reliability measurement to the trainer fidelity assessments. While variability among raters was found across the different domains for different facilitators, the overall ratings reflected very good inter-rater reliability suggesting an objective assessment of trainer fidelity/adherence. To this end, our findings concluding the potential influence of trainer impacts on evaluation findings is supported.

17 Evaluation Study Limitations

As in all survey-based evaluations, our evaluation is limited by self-report data, which is open to bias, but particularly so due to the use of 'researcher developed' surveys which have yet to be rigorously validated. Further, there was a potential for retrospective recall bias with our 6-month follow-up surveys (also limited by low response-rate). Regarding measurement of skill application and utility over time, our main strategy to reduce recall bias was to collect data monthly over time (for 6-months post workshop). However, due to the small number of responses received from the same individual over the 6-month data collection period, our interpretations were limited. Consideration must also be given to the potential inaccuracy of self-reported skill application for the utility survey outcomes. It is understood that practitioners with less skill and experience tend to overestimate their expertise and application of skills in self-report measures (approximately two thirds of our sample entered the workshop with no prior training) (Scheerder et al., 2010).

While we limited the potential for retrospective recall in our data, by administering monthly surveys to obtain more 'current' experiences, the additional unavoidable bias was that participants who engaged with those in distress compared to those who had not applied their skills post workshop, were more likely to have completed these surveys. It is also possible that the researcher-developed utility survey was not entirely clear from the outset in the wording of its first question (asking about whether participants had supported someone in distress or not). We found that participants who reported that they *did not* support anyone experiencing suicidality or distress, still

completed subsequent items confirming they had asked about suicide or supported someone to get help. While we exercised consensus and agreed to include this data in the analyses (see results), it is recommended that the terminology in the survey be clarified for future evaluations.

Regarding methodology, we predominantly collected quantitative data, which did not allow for deep understandings around 'real world' skill application and intervention dynamics between support/interventionist and person in suicidal distress. Qualitative methods are suggested to explore and understand the different experiences in context and toalidate quantitative findings from our study. Interview studies could be used to better understand training participants experiences both in attending training delivered from a lived experience perspective and applying the skills and knowledge to support people in community post workshop.

Finally, our measurement of trainer fidelity only included a measure of adherence, as opposed to comprehensive assessment of both adherence and competency of the trainer. Therefore, understandings about overall facilitator competence and the true effects on training outcomes are not known. We also did not include demographics of facilitators in our fidelity checklist which means we were unable to infer potential influencing variables on the facilitator adherence scores. Future studies should include these elements of measurement and expand observations/rater assessments of individual trainers over several workshops to account also for sustained trainer influences on training outcomes.

18 Recommendations for future program deliveries and evaluations

Our evaluation of the TouchPoints workshop yielded important findings. The following recommendations are drawn from these findings to inform future workshop delivery and evaluations:

- Given the observed positive uptake of participants from First Nations and LGBTIQ+ communities, continue existing recruitment strategies for future TouchPoints participants across community groups, workplaces.
- Embed implicit data gathering processes as an ongoing quality assurance mechanism to ensure longer term large enough samples for future robust evaluation designs, including longer follow-up studies to detect capability retention and attrition points with participants.
- Administer pre-workshop surveys in enough time to undertake pre-workshop observations of particularly 'self-care' and 'literacy' scores to identify any 'ceiling effects' where participants enter with significantly high scores. This will enable slight change in emphasis

on these modules where scores are particularly high; suggesting refresher focus only, enabling more time to be spent on other modules.

- Future evaluation studies should be conducted to elucidate the emerging relationship between hope, training impacts and intervention behaviours related to TouchPoints workshop.
- Continue to collect trainee utility data to determine the application of skills over time with greater samples to detect more robust findings around what is applied by whom and in what contexts for different experiences of suicidal distress.
- Future evaluation methodologies should include qualitative methods to better understand training participants' experiences applying the skills and knowledge to support people in community post workshop.
- Future studies should include trainer fidelity measurement and expand observations/rater assessments of individual trainers over several workshops to account also for sustained trainer influences on training outcomes.

19 Conclusion

This is the first evaluation study to explore the effectiveness of a gate-keeper training (LifeKeeper training) designed and delivered by people with a lived experience of suicide. The TouchPoints program successfully increased all learning outcomes on the training impact evaluation survey except self-care and literacy measures. Importantly, participants were more confident in all abilities or key actions required to perform gatekeeper or 'touchpoint' roles with people potentially experiencing suicidal distress post workshop. Participants also felt more confident and hopeful about their abilities more broadly. Regarding use of the training knowledge and skills post workshop, the majority of survey respondents had supported someone experiencing suicidal crises or emotional distress and of those more than a third had directly raised questions of suicide and took action to support someone in distress. These findings may have been diluted to some extent as suggested by our trainer fidelity checklist outcomes which demonstrated objectively that there was diversity amongst facilitators with specific weaknesses in facilitator subject matter and presentation style, both known to influence negatively participant uptake on the capabilities taught.

As mentioned previously, due to the sample sizes collected during the project timeframes, continued data collection is required to explore TouchPoints workshop impact more robustly on skills translation effects and knowledge retention over time. Nevertheless, the preliminary findings

are impressive. Further qualitative research will also be important and substantially enhance the confidence in the findings thus far concerning participant utility of the acquired TouchPoints learning outcomes.

This evaluation has provided unique and novel findings contributing to our understanding the impacts of a lived experience designed workshop for gatekeepers (Lifekeepers) within the suicide prevention sector in Australia. If implemented, the recommendations from the present study can inform other lived experience suicide prevention training evaluation methodologies and program development. It is essential that rigorous research on the effectiveness of training programs delivered by those with a lived experience of suicide build on these learnings to continue to explore participant learnings and experiences to safely and effectively guide suicide prevention policy, practice, and research.

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Appendix A. TouchPoints Evaluation Survey

Evaluating the impact of *Roses in the Ocean* 'Touchpoints' workshops

Introduction

You are invited to take part in a study examining the impact of the Touchpoints workshop which helps people in the community to feel more capable and confident to support someone at risk of suicide or bereaved by suicide. Surveys will be conducted before and after the workshop and again at six months following the workshop.

The Australian Institute for Suicide Research and Prevention (AISRAP, Griffith University) has been contracted by *Roses in the Ocean* to evaluate the impact and effectiveness of the 'Touchpoints' workshop.

What would you be asked to do if you agree to participate?

You will be asked to answer questions about your age and other details such as education, and employment status; your confidence in implementing skills associated with the workshop, your behaviours towards someone who you think might be at risk of suicide, and your knowledge of suicide prevention. The survey will take approximately 10 minutes to complete and less time for the post survey and follow up survey 6 months after the workshop.

Benefits

While we intend that this research furthers knowledge and may improve suicide prevention, it may not be of direct personal benefit to you.

How will your privacy be protected?

All the information collected from you for the study will be treated confidentially, and only the researchers named will have access to it. The study results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in such a presentation; only group data will be provided with all data de-identified.

Consent

Before beginning this survey, you will need to provide your consent to participate in it (see immediately below). Your consent to participate may be withdrawn at any time. Please know that we value your feedback and the survey results will be used to inform improvements to the *Roses in the Ocean* training programs.

Risks

It is not expected that you will be exposed to any risks as a result of participation in this study. However, you may potentially find some of the questions about the topic of suicide prevention upsetting. If you become distressed or upset during your participation in this study, please do seek help using the support contacts provided in the survey (on this page and at the bottom of each survey page), OR, discontinue the survey. Should you require emotional support either prior to, during or post undertaking this survey, please utilise the following support contact details or contact the Chief Investigator of this study (Jacinta Hawgood at Jacinta.hawgood@griffith.edu.au) who can provide assistance in referrals to suit your needs.

There are several 24-hour phone lines available if you need to get help, get a referral, or just want to talk to someone:

- **Lifeline**: 13 11 14 www.lifeline.org.au
- **Q Life: 1800 184 527**
- **BeyondBlue**: 1300 22 4636 www.beyondblue.org.au
- **Suicide Call Back Service**: 1300 659 467 www.suicidecallbackservice.org.au
- **MensLine Australia:** 1300 789 978
- **Emergency/Crisis:** 000 (ask for Police or Ambulance)

How do you receive further information?

If you would like to receive further information about this study, you may contact the Chief Investigator of this study, Jacinta Hawgood at Jacinta.hawgood@griffith.edu.au.

I consent to participate in the research study

_____ **(signature & date)**

Australian Institute for Suicide Research and Prevention

Before taking this survey

Please note that in order to determine any changes in your learning from this workshop, we will need to compare your initial pre-workshop survey responses with those you provide after the workshop and again at 6 months after the workshop. Therefore, we are required to match your answers across three different time points. To do this successfully, we need to 'match' your survey responses over time in a way that doesn't identify who you are. Therefore, immediately below we ask for you to provide a 'secret password' (or matching code).

Secret Password - First street you recall living on.*_____

Please note the location of the workshop you areattending _____

Gender (please circle one)**:**

Male	Female	Non-Binary	Different Identity (please state)

Age (age turned this year) _____

What ethnicity best describes you? (e.g., Caucasian, African, South-East Asian, Polish)

_____

What language/s do you usually speak at home?

- English
- English and other language (please specify) _____
- Other language only (please specify) _____

Are you of Aboriginal or Torres Strait Islander origin?

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander
- Yes, both Aboriginal and Torres Strait Islander

If applicable**, how you identify?**

- Gay
- Lesbian
- Bisexual
- Transgender
- Heterosexual
- Intersex
- Queer
- Or have we missed how you identify:_____

What pronouns do you use?

- He/him/his
- She/her/hers
- They/them/theirs
- Or have we missed yours:_____

Occupation/work/profession

Please indicate below your occupation or position of current employment (if employed) against sector fields, or note unemployed (and provide any relevant information):

Sector/field of work/occupation	Specify (e.g. position/role/type etc)
Education	
Health	
Retail	
Hospitality	
Community	
Business	
Welfare	
Emergency	
Business	
Religious	
Home	
Studying	
Other	

Prior education/training in suicide prevention

Have you completed any of the following suicide prevention training courses? (please indicate yes/no)

Training/education program	Yes/No
Question-Persuade-Refer (QPR)	
Wesley Lifeforce (Community, Relationship Counsellor, Aged Care Nursing, GP)	
Applied Suicide Intervention Skills Training (ASIST)	
SafeTALK	
Mental Health First Aid for the Suicidal Person	
Screening Tool for Assessing Risk of Suicide (STARS)	
Other (please specify)_____	

Confidence in knowledge domains of suicide prevention

Please rate your confidence in the following areas:

	Not confident at all	Somewhat confident	Uncertain	Confident	Extremely confident
Using safe language when talking about suicide					
Challenging misconceptions or myths about suicide					
Recognising groups of people at higher risk of suicide					
Understanding traumatic events which impact suicide risk					
Recognising invitations for help or warning signs for someone who may be experiencing a suicidal crisis					
Reaching out to people with a person-centred approach					
Respectfully listening and forming a connection with someone sharing their suicidal experiences					
Directly raising the question of suicide with someone who is showing warning signs					
Making plans with someone for them to get further help					
Supporting people who are bereaved by suicide					
Ability to implement my own “self-care”					

Which of the following is **NOT** an example of person-centred connection? (Please **select one** by ticking the adjacent blank space)

	Expressing sympathy and that you feel sorry for someone's experiences
	Communicating understanding of someone's feelings
	Asking questions so you can better understanding their experiences

When supporting someone dealing with suicidal thoughts, which statements are most appropriate? (Please **circle one in each line**)

1.	"There is help available"	"Keep busy, everything will be ok"
2.	Tell them they will feel differently tomorrow and not to worry about their thoughts	Tell them thoughts of suicide are common and do not need to be acted on
3.	Ask direct questions about possible thoughts of suicide	Avoid confronting language like "suicide" or "wanting to die"
4.	Direct the conversation away from suicide to a less distressing topic	Continue and ask about any previous suicidal thoughts or attempts
5.	Talk about alternative actions or steps you can take together	Give advice on how they can remove some of their stressors to not feel suicidal anymore
6.	Promise that you will keep their suicidal thoughts a secret	Ask who else could help talk with them or persuade them to get help
7.	Discuss an appropriate diagnosis for what they are experiencing	Discuss services where they have got support in the past
8.	Explain support service options and involve them in decisions about where to contact	Immediately book an appointment for them with the service you feel is most appropriate
9.	Define the problem by adhering to the risk level results of risk assessment tools	Define the problem by asking their priorities and the support they need right now
10.	Acknowledge their feelings by letting them sit with the pain of their experiences	Focus on problem-solving and addressing the main trigger of the crisis

Which terminology is safest when discussing suicide?

(Please **circle one in each line**)

1.	He died by suicide	He committed suicide
2.	She completed suicide	She ended her life
3.	They took their own life	There was a successful suicide
4.	She had an unsuccessful suicide	She attempted to end her life
5.	There were several failed suicide attempts reported	There were several non- fatal attempts at suicide

Which of the following is ***not*** an example of self-care? (Please **select one**)

	Always putting yourself before others
	Knowing your role and limitations
	Finding ways to unwind and manage stress
	Being aware of how work can impact your wellbeing

Please read each sentence and **indicate if you think it is a potential sign for the NEED to focus on self-care** (perhaps indicative of neglected self-care)

	Yes	No	Don't Know
Becoming more likely to make poorer decisions or emotional responses			
Feeling more negative about your capacity to manage the challenges in front of you			
Being less able to come up with creative ways to meet the challenges you face			
Finding hobbies, activities and leisure activities changing overtime			
Drinking many cups of coffee everyday			
Feeling more lethargic			
Changes in emotional wellbeing			
Occasional forgetfulness			

Please read the following statements and **indicate whether you think they are true or false**

	True	False	Don't Know
People who have thoughts about suicide should not tell others about it			
Seeing a psychiatrist or psychologist can help prevent someone from suicide			
Most people who suicide are psychotic			
Talking about suicide always increases the risk of suicide			
A suicidal person will always be suicidal and entertain thoughts of suicide			
Not all people who attempt suicide plan their attempt in advance			
Very few people have thoughts about suicide			
If assessed by a psychiatrist, everyone who kills themselves would be diagnosed as depressed			
Men are more likely to die by suicide than women			
People who talk about suicide rarely kill themselves			
People who want to attempt suicide can change their mind quickly			
There is a strong relationship between alcoholism and suicide			

Using the scale shown below, **please circle the number next to each item that best describes you.**							
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Definitely False	Mostly False	Somewhat False	Slightly False	Slightly True	Somewhat True	Mostly True	Definitely True

1 2 3 4 5 6 7 8	1. I can think of many ways to get out of a jam.
1 2 3 4 5 6 7 8	2. I energetically pursue my goals.
1 2 3 4 5 6 7 8	3. There are lots of ways around any problem.
1 2 3 4 5 6 7 8	4. I can think of many ways to get the things in life that are important to me.
1 2 3 4 5 6 7 8	5. Even when others get discouraged, I know I can find a way to solve the problem.
1 2 3 4 5 6 7 8	6. My past experiences have prepared me well for my future.
1 2 3 4 5 6 7 8	7. I've been pretty successful in life.
1 2 3 4 5 6 7 8	8. I meet the goals that I set for myself.

Should you require emotional support during or post undertaking this survey, please utilise the following support contact details or contact the Chief Investigator of this study (indicated also below).

- **Lifeline**: 13 11 14 www.lifeline.org.au
- **Q Life: 1800 184 527**
- **BeyondBlue**: 1300 22 4636 www.beyondblue.org.au
- **Suicide Call Back Service**: 1300 659 467 www.suicidecallbackservice.org.au
- **MensLine Australia:** 1300 789 978
- **Kids Helpline:** 1800 551 800
- **Emergency/Crisis:** 000 (ask for Police or Ambulance)

Chief Investigator of this study (GU ref no: 2018/315): Jacinta Hawgood (Jacinta.hawgood@griffith.edu.au).

Thank you for participating in this research. Your input will help to further improve the quality of its training program.

Griffith UNIVERSITY

Australian Institute for Suicide Research and Prevention

Appendix B. Training Outcomes Utility survey

Roses in the Ocean

stemming the tide of suicide

Community TouchPoints Participant Survey

Please tell us a little bit about you

Thank you so much for taking the time to complete this survey. Your input is very much appreciated and will help us continue to improve our workshops.

* 1. First Name

2. Email address

* 3. Where do you live?

- ◯ Queensland
- ◯ New South Wales
- ◯ Northern Territory
- ◯ Tasmania
- ◯ Western Australia
- ◯ South Australia
- ◯ Victoria
- ◯ Australian Capital Territory

4. What is your home address post code?

5. What's your age (age turned this year)?

* 6. Gender: Do you identify as

- [ ] Woman
- [ ] Man
- [ ] Non-binary
- [ ] Prefer not to say

My identity is not in this list. I identify as

* 7. If applicable, how do you identify?

- [ ] Gay / Lesbian
- [ ] Bisexual
- [ ] Transgender
- [ ] Heterosexual
- [ ] Intersex
- [ ] Queer

My identity is not in this list. I identify as

* 8. Do you identify as an Aboriginal and/or Torres Strait Islander person?

- [ ] No
- [ ] Aboriginal
- [ ] Torres Strait Islander
- [ ] Both Aboriginal and Torres Strait Islander

* 9. What languages do you speak at home?

- [ ] English
- [ ] English and other languages (please let us know)
- [ ] Other languages only (please let us know)
- [ ]

5. What ethnicity or culture best describes you?

Have we missed anything about your cultural background that you'd like us to know about? For example, are you Maori, Pacific Islander, of Asian descent or another cultural group?

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Community TouchPoints Participant Survey

Please tell us about your experience since attending the TouchPoints workshop

* 8. Which workshop did you attend?

- ◯ Dubbo, NSW | 1 September 2020
- ◯ Tamworth, NSW | 3 September 2020
- ◯ Moree, NSW | 30 November 2020
- ◯ Tamworth, NSW | 1 December 2020
- ◯ Orange, NSW | 7 December 2020
- ◯ Dubbo, NSW | 8 December 2020
- ◯ Armidale, NSW | 17 December 2020
- ◯ Glen Innes, NSW | 8 February 2021
- ◯ Narrabri, NSW | 24 February 2021
- ◯ Dubbo, NSW | 9 March 2021
- ◯ Warialda, NSW | 16 March 2021
- ◯ Gilgandra, NSW | 6 April 2021
- ◯ Nyngan, NSW | 20 April 2021
- ◯ Walcha, NSW | 21 April 2021
- ◯ Perth South, WA | 22 April 2021
- ◯ Bingara, NSW | 27 April 2021
- ◯ Warren, NSW | 4 May 2021
- ◯ Bathurst, NSW | 1 June 2021
- ◯ Manilla, NSW | 1 June 2021
- ◯ Blayney, NSW | 15 June 2021
- ◯ Orange, NSW | 29 June 2021

* 9. Since attending the TouchPoints workshop, have you assisted anyone in suicidal crisis or emotional distress?

- ◯ Yes
- ◯ No

10. Since attending the TouchPoints workshop (or since completing your last survey), how many people have you assisted?

11. While providing assistance, did you use the knowledge and skills gained from the workshop?

- ◯ Yes
- ◯ No

12. Please select any of the following that you have applied:

- ☐ You **noticed invitations** for help
- ☐ You **directly asked about suicide**
- ☐ You **listened** without providing judgement
- ☐ You **recognised warning signs** of someone who may be experiencing a suicidal crisis
- ☐ You **helped them decide what to do** next to stay safe
- ☐ You **supported them to get help**

13. Did you apply any other knowledge or skills that we have not listed above? (If yes, please indicate what these are here):

14. Did you experience any challenges when providing assistance?

15. Do you have any feedback regarding your experiences of providing assistance?

16. Do you have any further feedback on the knowledge or skills that you have used from the workshops?

Thank you very much for your contributions which will assist us to understand the impact of our Touchpoints Training.

- **Lifeline**: 13 11 14 www.lifeline.org.au
- **Q Life: 1800 184 527**
- **BeyondBlue**: 1300 22 4636 www.beyondblue.org.au
- **Suicide Call Back Service**: 1300 659 467 www.suicidecallbackservice.org.au
- **MensLine Australia:** 1300 789 978
- **Kids Helpline:** 1800 551 800
- **Emergency/Crisis:** 000 (ask for Police or Ambulance)

Appendix C. Trainer Fidelity Checklist

Facilitator Evaluation – Touchpoints

The following evaluation areas form part of the development process for potential facilitators. It should be used to provide positive feedback in relation to areas of competence, whilst assisting a potential facilitator to understand areas for improvement. It is the intent of the evaluator to be as specific as possible in the process, whilst acknowledging the subjective nature of the evaluation. The evaluator should also provide additional information where necessary or requested by the facilitator.

Very Satisfied = 5 **Satisfied = 4** **Neutral = 3** **Dissatisfied = 2** **Very Dissatisfied = 1**

WORKSHOP ORGANIZATION					
Facilitator arrived on time.	1	2	3	4	5
The room was set up appropriately, with workbooks, stationery and wellbeing Wi-Fi documents neatly set up for each participant.	1	2	3	4	5
Check sheets / sign in sheets were available for participants.	1	2	3	4	5
Room temperature was checked and comfortable.	1	2	3	4	5
Evaluation of toilet facilities and fire escapes was undertaken.	1	2	3	4	5
Morning / afternoon tea was set up and functional.	1	2	3	4	5
Technology was checked to work appropriately.	1	2	3	4	5

SUBJECT MATTER					
Appropriate introduction to the workshop and completion of acknowledgements.	1	2	3	4	5
Capacity to articulate the Roses in the Ocean story / beginnings.	1	2	3	4	5
Setting up the room and holding conversations about safety / self-care.	1	2	3	4	5
Explanation of TouchPoints and associated behaviours.	1	2	3	4	5
Hold a conversation about language and unhelpful sayings.	1	2	3	4	5
Well run Myths and Misconceptions activity, with strong engagement.	1	2	3	4	5
Can articulate current statistics, along with a few other pertinent stats.	1	2	3	4	5
Able to explain crisis and trauma and its impact on suicide.	1	2	3	4	5
Can hold a discussion about warning signs, including LE stories.	1	2	3	4	5

Managed conversation on both case studies and brought out insights.	1	2	3	4	5
Holds practical and helpful discussion on the Lifeline 5 step model.	1	2	3	4	5
Able to show the differences with the crisis intervention model.	1	2	3	4	5
Can explain suicide bereavement and how it differs from other grief.	1	2	3	4	5
Brings LE stories to the discussion about grief associated with suicide.	1	2	3	4	5
Able to explain self-care and demonstrate active SC behaviours.	1	2	3	4	5
Concludes the content professionally.	1	2	3	4	5

PRESENTATION / STYLE					
Fluent and comprehensive presentation of content.	1	2	3	4	5
Appeared confident and in charge of the content delivery and process.	1	2	3	4	5
Maintained professional appearance and conduct during the workshop.	1	2	3	4	5
Established a warm and engaged connection with participants.	1	2	3	4	5
Used appropriate stories to illustrate key ideas and points.	1	2	3	4	5
Maintained the safety of the room and all participants.	1	2	3	4	5
Acknowledged and validated the responses of participants.	1	2	3	4	5

GROUP MANAGEMENT					
Welcomed people in a warm and friendly way.	1	2	3	4	5
Informed people as to what would be happening in the workshop.	1	2	3	4	5
Started and finished the workshop on time.	1	2	3	4	5
Allowed space and time for group and individual interaction.	1	2	3	4	5
Encouraged and welcomed input from the participants.	1	2	3	4	5
Managed the timing, content, and activity interaction.	1	2	3	4	5

ADDITIONAL NOTES

Appendix D. Participant survey response pattern

ID	1m	2m	3m	4m	5m	6m
1	x			x		
2		x	x			
3				x	x	
4		x		x		
5		x			x	
6	x	x		x		
7	x	x				
8	x					x
9			x		x	
10	x				x	
11	x	x	x			
12					x	x
13	x	x	x			
14	x		x	x	x	
15			x			x
16		x	x	x	x	
17	x	x				
18			x		x	
19	x	x		x		
20			x		x	
21	x				x	
22		x	x			
23	x		x			
24		x			x	
25	x	x			x	
26	x	x			x	x
27			x			x
28		x	x			
29	x	x	x	x	x	x
30	x	x				
31			x		x	x
32	x		x			
33			x			x
34		x		x		
35	x		x			x
36	x		x			
37	x				x	