

Athlone Institute of Technology

SafeTALK

*A participant's review of the experience and learning from
participating in the SafeTALK Course*

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Declaration

**I declare that this dissertation and the research involved in it are entirely
the work of the author**

Signature: _____ **Date:** _____

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For Darren

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Abstract

Suicide is a significant public health concern in Ireland. In response to this the National Office of Suicide Prevention has been the forerunner in the development of standards for training in suicide prevention. This training entails the SafeTALK (Suicide Alertness For Everybody – Tell, Ask, Listen, Keep-safe), and the ASIST (Applied Suicide Invention Skills Training). The aim of these programs is to improve and enhance the skill levels and confidence of people within the community in responding to people in suicidal crisis.

The purpose of this study is (1) to investigate the perceived knowledge and attitude towards those who engage in suicidal ideation before and after completion of the SafeTALK; (2) To explore the perceived skill of participants in dealing with a person with a suicidal ideation before and after completing the SafeTALK course, and (3) to investigate any perceived strengths and limitations of the course from the perspective of course participants. It is expected that the research will lead to recommendations for the implementation for future suicide prevention initiatives which will be relevant both on a national and international level, and will also lead to a model of best practice for Athlone Institute of Technology which will ultimately lead to a high bench mark being set by the college being so proactive in suicide prevention in Ireland.

Literature Review

2.1. Introduction

The last century in Ireland and abroad has witnessed significant change in attitude and knowledge of suicide, and suicidal ideation. This is most notable in the growing literature written by key authors such as Joiner, Shneidman, Marx, Keir and Orbach on understanding the causes and nature of suicide. Within Ireland the decriminalisation has resulted in significant changes in policy, service provision and the growth of educational programmes such as SafeTALK.

This literature review explores changes to attitude and knowledge through a historical lens while investigating the causes that attribute to suicide, followed by an in-depth exploration of one such programme, namely SafeTALK.

The mere thought about suicide and the idea that somebody would chose to end their life can cause deep uneasy feelings in many. The subject can arouse potent emotions. Keir (1986) suggests “We do not, in truth, really want to know” because “contemplation of the deed itself, the manner of its execution – the overdose, the drowning, the hanging –fills us with horror”.

In 2008, the Centre for Disease Control (CDC) stated that “suicide does not discriminate”. It impacts families, communities and people of all ages. It equally affects racial and ethnic groups, genders and creeds (Jacobson, Osteen, Sharpe and Pastoor, 2012). Unlike other issues pertaining to mental health, suicide has given rise to significant concern globally over the past two decades (Allen, 2005).

Of note it is worth mentioning that between genders statistics indicate that males die by suicide more frequently than do females; however, reported suicide attempts and suicidal ideation are more common among females (Crosby *et al*, 2011). Further to this, Schrijvers (2011) informs us that the difference in suicide rates for males and females is partially a result of the methods employed by each gender. Females are far more likely to attempt suicide; however, they are more likely to use methods that are less violent or immediately lethal. Males frequently complete suicide through more violent and high mortality actions such as firearms, carbon-monoxide poisoning, and hanging. Females tend to rely on drug overdosing which can take more time.

O'Donnell and Wilkinson (2011) state that globally suicide has become a significant public health problem; from estimates and projections from the World Health Organisation (WHO) over one million people die by suicide every year, a rate that translates to one death every forty seconds. In 1998 suicide represented 1.8% of global death and is now predicted to increase to 2.4% by 2020 (Bertolote and Fleischmann, 2009).

This sharp increase in suicide rates has led researchers to explore causal explanation for the striking rise, especially in young men. Nordt (2015); Webb (2015) and Warnke (2015) debate that the worlds' economic circumstances are a key factor in the notable increases in suicide rates. A prominent example of spiralling suicide rates can be seen across Europe, notably Greece. As a result of the economic recession strategies of austerity were imposed on the nation which resulted in mass unemployment. Fountoulakis et al (2014) composed a study to calculate the instances of parasuicide and completed suicide per annum in Northern Greece from the years 2000-2012 and to compare the correlations with unemployment. Their results illustrate a significant rise in the suicide rates in 2007 from 328 to 477 in 2011, which marks a 45% increase in suicide rates attributable to worsening economic conditions (Fountoulakis et al, 2014).

Helliwell (2004) states that the decrease in social capital and reductions in income that are associated with economic recession lead to higher rates of suicide. In terms of Ireland Corcoran and Arensman (2010) found that between 1996 and 2006 those who were unemployed were at a much greater risk of dying by suicide than their employed counterparts. They proposed that the stability in suicide rates in the past ten years was extremely likely to change due to increasing unemployment and this is particularly the case for tradesmen.

Further to this, Arensman et al (2013) found that individuals that were employed or had been employed within the construction or production sector accounted for 40% of suicide between September 2008 and June 2012. Farmers and agricultural workers accounted for 13.2% and those that worked in sales or business 8.9%.

In support of this, Durkheim (1897) proposes that in his theory of anomic suicide that social change provides uncertainty. Durkheim further proposes other sociological theories to account for suicide namely the lack of assimilation of the individual into society results in this type of suicide. He believed that the more dependent the person had to be on his own

resources rather than have external outlets for support the larger the suicide rate in the society.

Suicide is also associated with social factors such as critical illness, recent hospital discharge, living in isolation and a person having a history of substance abuse and experience of self-harm (Appleby, Amos and Parsons *et al*, 1999).

Nonetheless suicide can never be simplified with a single identifiable cause; instead, it is normally the culmination of a complex interplay of events or factors in a persons' life (Appleby, Amos and Parsons *et al*, 1999).

More recently, Allen (2005) puts forward a similar view arguing that the increase of individualism, family breakdown, the loss of religious faith and community solidarity, substance abuse, unemployment, or conversely, 'Celtic Tiger' affluence (Allen, 2005).

Regarding the risk of suicide in mental disorders a recent meta-review of meta-analyses of suicidal risk in mental disorders, particularly high rates of suicide were found in borderline personality disorder. Risk of suicide was estimated at forty five times that of the general population, depression twenty times greater risk, bipolar disorder seventeen times greater risk, schizophrenia thirteen times greater risk, anorexia nervosa thirty one times greater risk and alcohol misuse or dependence sixteen times greater risk (Chesney *et al*, 2014). It is therefore undeniable that there is a strong association between psychological factors and suicide.

Kalmar (2013) found in his meta-analysis of the protective and risk factors for suicide in adolescents, states that there are numerous reasons why a person would take their own life. They include life history; demographic systems e.g. gender, age and ethnicity; philosophical and theological e.g. the values associated with their culture and; psychodynamic e.g. a person's feelings or emotions. Further to this, Kalmar argues that despite the already recognised background factors, it is often unlikely to know the precise reasons behind suicide due to its multi-causal nature. Kalmar affirms that, while the aforementioned variables have a major role in suicidal ideation; suicide is also determined by biological factors. In other words, Kalmar appears to be proposing a bio-psychosocial model to explain suicide.

2.2 Suicide in Ireland

Smyth *et al* (2003) state that historically, attitudes in Ireland have always been influenced by the Catholic ethos and the act of suicide was seen as a mortal sin. Suicide went against the fifth commandment of “Thou shalt not kill”. The Catholic Church rejected suicide and from its earliest days denied funeral rites to those who had died from suicide. The ultimate indignity for a Catholic Irish family was to have their loved one buried in un-consecrated grounds thus suicide was a great source of embarrassment to a family and was often covered up as accidental death (Smyth *et al*, 2003).

Suicide statistics in Ireland highlight an increasing problem. In 2012 suicide mortality was reported to be 507 persons, of whom 81% were male. The issue of suicide is significant across the country in both rural and urban contexts as rates remain high each year with minor fluctuations in total figures (NOSP Annual report, 2012). The rate for 2012 was 19.3 per 100,000 amongst Irish men and the female rate returned a rate of 3.7 per 100,000 (Meagher, 2013).

Up until 1993, suicide was seen as a crime in Ireland and was legislated for under section 9 of the Summary Jurisdiction Act 1871. The Act was repealed in July 1993 and was replaced by The Criminal Law (Suicide) Act which states that the act of attempting suicide or completing suicide is not a crime but it is a criminal offence to help another person to end their life carrying a penalty of fourteen years (Doolan, 1999).

The introduction of the amending Act reflected changing attitudes towards the causes of suicide and as Minister Maire Geoghegan Quinn (1993) pointed out, the introduction of the Act removed suicide from the range of criminal law and put it firmly in the area of mental health.

It is worth acknowledging that since the decriminalisation of suicide in 1993 there has been a notable increase in the annual rates of reported suicide, however, Swanwick and Clare (1997) propose that the rise in suicide deaths, specifically in young men is attributable to a real increase in suicide deaths rather than improved reporting procedures. This pointed toward the need within Ireland to address this growing problem.

The decriminalisation of suicide paved the way for national health promotion initiatives to combat the growing problem. In 1995 the Irish Government established the National

Taskforce on Suicide (NTOS). The Taskforce sought to research and develop recommendations for tackling suicide.

Two key recommendations of the report of the NTOS (1998) saw the emergence of two key structures; the first of which was the National Suicide Review Group (NSRG) which was established by the Chief Executive Officers of the then Health Boards, now known as the Health Service Executive (HSE). The second was the implementation of appointed resource officers for suicide prevention into the regions that the Health Boards were then split into.

The work carried out by these offices have systematically lead to a shift in attitudes towards suicide and it prevention, a quote from the then President of Ireland, Mary McAleese (2005) Suicide isn't "someone else's problem", "it is everybody's problem" is indicative of the momentous shift in societies attitudes towards the subject of suicide.

More recently, resource officers within the NOSP work with voluntary organisations, dedicated individuals and academics, as a result of a growing recognition to develop a specialised skill-set to deal with the issue of suicide [to] "Develop and implement information and education campaigns to increase awareness of mental health and suicide prevention, and second, [to] build capacity through the implementation of a national training programme on suicide prevention" (NOSP, Annual report 2010). The two mediums that are used to enhance society's knowledge and skills are the suicide prevention and awareness courses such as SafeTALK (Suicide Alertness For Everybody: Tell, Ask, Listen & Keepsafe) and ASIST (Applied Suicide Intervention Skills Training). The ASIST began being run across Ireland in 2004, and in 2006 the NOSP began facilitating the SafeTALK programme.

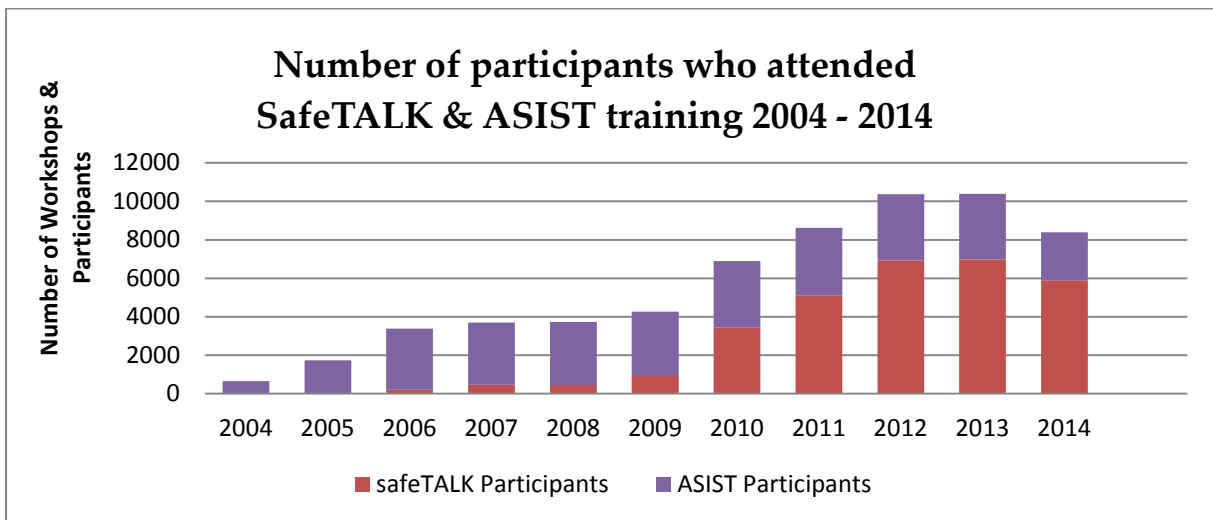
Table 1, presents an overview of the number of workshops co-ordinated and the number of participants that attended for training between the years 2004 – 2014. A total of 30,364 attended SafeTALK and 31,740 attended ASIST training.

Table 1: Number of workshops and number of participants 2004 - 2014

| | SafeTALK Workshops | SafeTALK Participants | ASIST Workshops | ASIST Participants |
|------|-------------------------------|----------------------------------|----------------------------|-------------------------------|
| 2004 | 0 | 0 | 30 | 641 |
| 2005 | 0 | 0 | 80 | 1724 |
| 2006 | 11 | 200 | 150 | 3184 |
| 2007 | 30 | 473 | 151 | 3219 |

| | | | | |
|--------------|--------------|---------------|--------------|---------------|
| 2008 | 31 | 443 | 152 | 3279 |
| 2009 | 58 | 915 | 159 | 3348 |
| 2010 | 199 | 3439 | 158 | 3461 |
| 2011 | 282 | 5100 | 162 | 3525 |
| 2012 | 326 | 6921 | 156 | 3444 |
| 2013 | 379 | 6982 | 154 | 3406 |
| 2014 | 319 | 5891 | 114 | 2509 |
| Total | 1,635 | 30,364 | 1,466 | 31,740 |

Figure 1: Number of participants who attended SafeTALK and ASIST training



To date: 1 in every 113 individuals over 18 yrs of age completed SafeTALK training and 1 in every 109 individuals completed ASIST training

(NOSP, 2015)

2.3. SafeTALK

The programme at the centre of this study ‘SafeTALK’ aims to dispel the taboo elements of asking open and direct conversation about suicide. The course has been utilised by the Irish Health Services since 2006 and to date approximately 30,000 people have been trained across the Ireland. Venues where the course can be facilitated range from parish halls, colleges, and local jobs clubs and beyond.

The course is a mix of multimedia presentations that convey scenes where suicide may be present, as well as information delivered by the course facilitator. Within the training there are also a number of role play style scenarios where participants can practice “being suicide alert” (McLean *et al*, 2007).

The SafeTALK Trainer Manual (2009) defines the programme as a “Gate-Keeper” course that is suitable for the majority of a community. Snyder (1971) coined the term ‘gate-keeper’ and defines it as “any person to whom troubled people are turning to for help”. SafeTALK is designed to fill a gap that appears in most communities. The gap is specifically a lack of individuals that can help and want to help somebody with suicidal ideations by; 1) “recognising that a person might be having thoughts of suicide, 2) engaging them in open and direct talk about suicide, 3) moving quickly to connect them with someone who is able to do a suicide intervention (SafeTALK Trainer manual, 2009).

It is a half-day training course which some people use as a stand-alone course or alternatively as a precursor for entering the more in-depth suicide intervention course ASIST. The focus is on training and awareness where participants are taught to recognise other individual in crisis and subsequently enable the trained person to bridge the gap between the person(s) at risk and a community resource that can help them more effectively (McLean *et al*, 2007).

As previously stated SafeTALK is an abbreviation of “Suicide Alertness For Everyone”- Tell, Ask, Listen, and Keepsafe. The TALK refers to the steps that a trained SafeTALK individual carries out to effectively. Each of the steps has specific directions to follow (SafeTALK resource book, 2010).

Issac *et al*. (2009) focused on systematic review of gatekeeper training in suicide prevention, the conclusion of this study highlighted that Gatekeeper training imparts knowledge, builds skills and can adjust the attitudes of trainees.

We will now examine at the TALK steps as they are explained in the resource material distributed in the course.

2.4. The SafeTALK steps

(a) Tell

Tell pertains to what the person with thoughts of suicide does. It is rare that a person will tell in the clearest possible way; however it does happen at times. It refers to the way the person with thoughts might disclose their feelings indirectly (SafeTALK trainer manual, 2009).

Following the presentation, the trainer then speaks about not connecting such situations with suicide and then the concept of ‘invitations’ is explored. Essentially ‘invitations’ are what people make see, hear, sense and learn from another individual that might give rise to suspicion of suicidal ideations or that the individual is trying to communicate something much deeper, for example “could suicide be involved here?”(SafeTALK trainer manual, 2009).

Chehil and Kutcher (2012) reinforce these psychiatric symptoms through their association with suicide risk. They list an extensive number of correlating signs in their work such as depression, hopelessness, anxiety, isolation, impaired reasoning, rigid thinking and displaying verbal and non-verbal clues toward suicide.

(b) Ask

Within the DVD presentation we are told that the most effective way of finding out if a person is suicidal is to ask them directly “are you thinking about suicide? This action gives rise to the noteworthy question of if you ask a person if they are suicidal, will it then put the idea of suicide into their head. Essentially are you influencing them or giving them an idea that was not already there? The answer to this is No, for dual reasons, firstly because human beings are not that easy to influence. An example contained within the presentation is if you asked another person to give you 40% of their life’s income would they then consider doing so? And secondly, asking such a serious question in an open and direct way lets the other person know that you are genuinely concerned and are taking their issues seriously (SafeTALK trainer manual, 2009).

Gray (2013) states that asking a patient directly about suicide does not increase the risk of suicide. Further to this she advocates that people that are having thoughts of suicide are in a state of distress and are often willing to discuss the issue if approached in the proper manner and asked directly about it.

(c) Listen

SafeTALK Trainer Manual (2009) explains that once the question has been asked it is not difficult to respond to the now obvious request for help. It is stated that the person with thoughts of suicide does not really want to die, but rather does not want to live as they currently are. Further to this listening acknowledges the pain, creates empathy, allows for a release of emotions and makes the person feel less alone. The Trainer Manual (2009) explores the helpful and unhelpful characteristics that are important whilst engaged with the person with thoughts of suicide such as being sensitive, non-judgmental, calm and sensitive.

Such characteristics are similar to that of the theory of have ‘unconditional positive regard’. Unconditional positive regard is a phrase coined by the humanist psychologist Carl Rogers (1962) who suggests that the concept promotes that a helper should have acceptance of the other persons problem, even if the helper agrees or disagrees with the person’s thoughts or actions. It is the acceptance of the natural value of that person. Ultimately the helper should reserve judgement.

(d) KeepSafe

The final step is the KeepSafe. This step is concerned with linking the person having thoughts of suicide to a connection that can help them effectively and carry out a suicide intervention. One factor is heavily reinforced within this step and that is the importance of “keeping yourself safe” and that the helper should never put themselves in any danger. At this point of the course the trainer asks the participants to list off a number of ‘keepsafe’ connections that are relevant to their local environment. Having a number of varied connections is often important as it will give the person having thoughts of suicide a choice in who they can talk to. From here the helper should try put the person with thoughts in direct contact with the person that can carry out the suicide intervention. Once this step is done all SafeTALK steps are complete (SafeTALK Trainer Manual, 2009).

2.5. The language of Suicide

Of note, SafeTALK challenges the language that is typically used to describe acts of suicide. For example, the term “committed” suicide is no longer favoured. The term that is now used is “Suicided” and there are legalistic, proceduralistic and policy reasons behind this (See Beaton, Forster and Maple, 2013 for further information). Johnstone, MJ (2009, p. 307)

explains that the term ‘committed’ is misleading and unhelpful, as it implies the commission of a sin or breaking the law, which suicide is neither.

While there have been a number of evaluations on suicide prevention programmes across the world, there has been limited evaluations specific to SafeTALK; namely the Scottish Pilot Evaluation (2007) and, the evaluation of the Australian Suicide Prevention Strategy for Army Veterans (2012).

The outcomes of the evaluations have almost always yielded positive results, however in some cases there have been cultural disparities echoed in the research. For example in the evaluation of the Scottish SafeTALK pilot (McLean, et al, 2007) course participants were interviewed following their completion of SafeTALK; it was found that 70% of the sample stated that the course helped them to recognise the warning signs for suicide and had made them more attuned to reading between the lines when dealing with people with suspected suicidal ideations. It was also found that 40% of the sample stated that the content be more localised to fit the Scottish population. One participant stated “it just wasn’t the right theme for Scotland” and that it was “obviously an old video”. Others echoed similar sentiments stating that the videos were too “sanitised” and made the asking experience look too easy and didn’t include any of the complexities and unexpected responses.

More recently, McKay, Hawgood, Kavalidou et al (2012) evaluated suicide prevention courses provided for within the framework for Operation Life; an Australian suicide prevention strategy for army veterans. SafeTALK was included within the evaluation. Participants of the study were asked to rate their views on whether or not the training was helpful, the response yielded 92.9% favourable towards its helpfulness; however as with the Scottish evaluation, the topic of the courses’ suitability was raised. The sample involved put emphasis on the need to tailor the course to the needs of the veteran community. One participant outlined an example from an instance of having to brief a previous trainer on the community’s expectations and how they should approach veterans, he stated “it’s quite different to be handling a veteran who had chronic Post Traumatic Stress Disorder to somebody who had just volunteered from the wider community to be trained in suicide prevention” and that “trainers need to be informed of the multitude of nuances that they would not have been aware of before the course”.

2.6 Rationale for research

SafeTALK has not been formally evaluated in the Irish context. The aim of this body of work is to evaluate the experience and learning from participating in SafeTALK within AIT before and after completing the course. The objectives of which are:

1. To investigate the perceived knowledge and attitude towards those who engage in suicidal ideation before and after completion of the SafeTALK.
2. To explore the perceived skill of participants in dealing with a person with a suicidal ideation before and after completing the SafeTALK course.
3. To investigate any perceived strengths and limitations of the course from the perspective of course participants.

The author proposes the hypothesis that the course will be found to be effective, however, like similar evaluations that have taken place across the world, it is believed that the issues of cultural suitability will be reflected within the sample used. It is hoped that following the collation of the results, a series of recommendations can be outlined that may aid in more effective delivery of the SafeTALK course.

Methodology

3.1. Introduction

Creswell (2012, p.3) defines research as a systematic process used to analyse and collect information to enhance the understanding of a topic or issue. Further to this, he states that there are three steps: posing a question, collection of data to answer the question and presenting an answer to the question.

The following chapter will outline the methodological approach and research design used in the study. The summary of the study demonstrates the background and forms the aims and objectives of the research. The chosen methodology needs to reflect the inquisitive nature of the research.

After consideration of the study's aim, the most apposite methodology to carry out the study was determined to be quantitative measures. The instrument utilised was a pre and post questionnaire. The research used Athlone Institute of Technology as a population to investigate the perceived effectiveness of the SafeTALK course.

Within this section, there is an explanation of the method, procedure, sample and participants used in the study in addition to a breakdown of the methods used for data analysis and ethical implications that needed to be considered before commencement of the study.

3.2. Summary of study

The research is designed to study the views of participants of the SafeTALK Course. To explore the views of the course participants, one SafeTALK course were facilitated in Athlone Institute of Technology. Questionnaires were distributed to all course participants that consented to taking part in the study before and after the SafeTALK course.

3.3. Research Aim

The aim of the research is to:

- To investigate the perceived knowledge and attitude toward those who engage in suicidal ideation before and after completion of the SafeTALK evaluate the experience and learning from participating in the SafeTALK. course within AIT before and after completing the SafeTALK course.

- To explore the perceived skill of participants in dealing with a person with a suicidal ideation before and after completing SafeTALK.
- To investigate any perceived strengths and limitations of the course from the perspective of course participants.

Findings from the study may inform further suicide prevention courses. A formal evaluation of the SafeTALK course has not yet been carried in Ireland although the course has been funded for delivery by the National Office for Suicide Prevention since 2004 and over 30,000 people have been trained in the course in the Republic of Ireland.

3.4. Methodological considerations

Designing a study gives rise to consideration of adopting a quantitative approach or qualitative approach depending on what method(s) is suitable for the study. The author opted for a quantitative method for the purposes of gathering data.

Athlone I.T. was chosen as the basis for the population because since its introduction to the I.T. over 600 students and staff have been trained on the course. Courses are ongoing, an average of five take place each academic year. The course caters to 32 participants at a time and as a result an average of 150+ students and staff receive training per year.

In order to carry out the research successfully a sample group from the population needed to be defined. This group contained incumbent students and staff members that had not yet completed SafeTALK training who completed a pre-training and post-training.

3.5. Process

The Students' Union and the Healthy Campus Office organise several SafeTALK courses throughout the academic year. The Students' Union advertised the SafeTALK course, and the scope to be part of the research through their Class Representative Meetings, internal college email, social media and through posters at key locations across the college. On the day of the SafeTALK course, all attendees were asked, if they would like to be part of the proposed research. A clear explanation of what it entailed was given verbally and in writing, and attendees were informed that they were under no obligation to participate and that non-participation would not have any negative consequences.

3.6. Research site

The research took place in Athlone Institute of Technology on __ April 2015. Rooms were allocated by the Bookings Department in AIT. Those that completed both the pre and post questionnaires did so in the same room that was allocated for the course.

3.7. Sampling

The author used convenience sampling within this research in that all course participants on a particular day were invited to participate in the research. The invitation to become part of the research was advertised by the AIT Students' Union in their emails, posters and social media postings in the run up to the course. On the day of the course, attendees were asked if they would like to be part of the research by completing a pre and post questionnaire, before and immediately after the training was complete. They were told at this juncture that they were under no obligation to participate. The participants comprised a wide range of students from Athlone Institute of Technology varying from mature students to international students to younger students alongside the general public and staff. This ensured a varied response as the participants came from a number of differing ages, creeds, cultures and socio-economic backgrounds. The use of this group was key to exploring the articulated changes, if any, in attitude to, and levels of knowledge, if any, of suicide prevention of the course participants after course completion, in addition to exploring their opinion of the elements of the SafeTALK course.

3.8. Limiting bias

Firstly the researcher was aware of the need to formulate neutral questions when designing the questionnaire. The piloting of the questionnaire represented an anti-bias safeguard. Following the piloting and testing of the method the researcher was satisfied that the study remained unbiased and that the information gathered was consistently valid.

Secondly, the author is a SafeTALK trainer but refrained from facilitating the courses in Athlone Institute of Technology through the research period to ensure a level of objectivity.

3.9. Ethical issues

The Ethics committee of Athlone Institute of Technology were given two submissions before approval was obtained. The central topic of the study is based around suicide prevention and due to the sensitive nature of this the committee proposed a number of amendments to the

original application. The committee advised a Gatekeeper should be used in inviting participants of the course to take part in the study. It was recommended that a backup counselling resource be put in place.

Attendees that volunteered to participate were then given a consent form and extra information outlining the nature of the study, and additionally a list of contacts, both local and national, that deal exclusively with mental health and suicide in the unlikely event of the questionnaire evoking any bad feelings for them. The National Suicide Prevention Officer was also present on that day to ensure that the research did not cause any distress to any participants. This was done to ensure that no malfeasance occur with any research participant. Upon completion, it was once again emphasised that participants could opt out of the study at any point by contacting the author via an email address given to them by the author. Finally it was then explained that their contributions would be coded and included within the final piece of work, but that their responses would be 100% anonymous and unidentifiable.

The issue of data handling had to be given ethical consideration also so the author needed to ensure that all data be handled in accordance with the Data Protection Act. All information received from the group was held in encrypted folders which were only accessible by the research student and supervisor.

3.10 Limitations

The setting of the study was within a 3rd level institution which meant that the sample was varied in terms of ages, professional backgrounds and ethnicities however as diverse a population that the Institute has there are many backgrounds and socio-economic backgrounds that are not part of the cultural melting pot of Athlone Institute of Technology, in other words the sample is unlikely to be representative of the population being studied. This undermines the authors' ability to make generalisations from the research sample to the population in general. If the research was to look beyond the chosen population there may have been scope to investigate the attitudes and experiences of participants from other dominant backgrounds in Ireland to attain a more in-depth exploration of the course experience. Other factors perspectives that may have been explored are; those from a Traveller background, Asylum seekers, the elderly, young people under the age of 18, established and working professionals.

It would also be of significant relevance to carry out such a longitudinal study on how the same participants that took the initial questionnaire apply their learning's over a period of 2-3 year. It would then be possible to measure their initial perceived opinions on the effectiveness of the course against their experiences of suicide awareness and prevention since course completion.

3.11. Data Analysis

The research employs both quantitative and qualitative sampling which will return two different forms of data. The quantitative data will be presented with the use of graphs, charts and statistics. The qualitative component will be extensively illustrated in the results by using specific themes drawn from the objectives.

Presentation of results

4.1. Introduction

The following is the presentation of the results of this study. The results are presented in two sections. The first results are of the questionnaire distributed to participants before the course commenced. Following this is the analysis of the post course questionnaires. Both of which took place in Athlone Institute of Technology.

4.2 The Pre-Course Questionnaire

4.2.1. Demographics

The questionnaire was distributed to all participants of the SafeTALK. A response was received from the full population of the course (n= 30). The sample was comprised of 20 females (67%) and 10 males (33%). The majority of the sample was students (18,) another portion (11) was made up of people in employment, and the remaining (1) was unemployed. Of the thirty participants the ages ranges were 18-25yrs (12), 26-35yrs (5), 36-45yrs (11), 46-55yrs (1), 56+ (1).

4.2.2 Peoples' motivations for taking the course

Participants were asked to outline in their own words why they decided to be trained in SafeTALK. The majority of responses conveyed peoples concerns about suicide becoming a greater problem. Examples of the actual responses were:

“I want a better understanding of the why, what and how to prevent suicide in my community and for my own awareness”.

“To seek knowledge, advise others and increase consciousness of my own environment”.

“With suicide on the rise in Ireland I thought it would be helpful to learn about the matter”.

“Because I have children and in the society we are in today, it is very good to be alert to suicide, for too many teens nowadays commit suicide without seeking help”.

A number of participants also mentioned that they will eventually be working within the social care area, and while the majority mentioned the fact that they were attending the training to learn more about the topic several stated responses such as:

“I am doing a degree in social care and I feel the training will be of great help”

“I am a social care student and feel that the course would be beneficial to me and for future employment”.

“I am studying social care and I feel this would help with more experience”.

4.2.3. Previous Suicide Prevention Course experience

Participants were then asked if they had attended/completed any suicide prevention courses in the past. None of the 30 participants had attended any in the past.

4.2.4. Peoples’ Understanding of Suicidal Ideation

A question was posed to identify if participants understood the term ‘suicidal ideation’. The majority of the cohort had a very clear idea of what the term meant returning responses such as:

“When a person decides to take their own life”.

“It is the mindset of a person who wants to end their own life”.

“A consistent thought of suicide regardless of mental state”.

Six members of the group did not understand the term ‘ideation’ and marked their responses as “Don’t know”.

4.2.5. Participants’ Opinions on Why People Have Suicidal Thoughts

Participants were asked to outline why they felt people have suicidal thoughts, many reasons were given as to why people engage in suicidal activities; the responses received are as follows.

“Because they think that the problems they are facing can’t be resolved or are shameful to them”

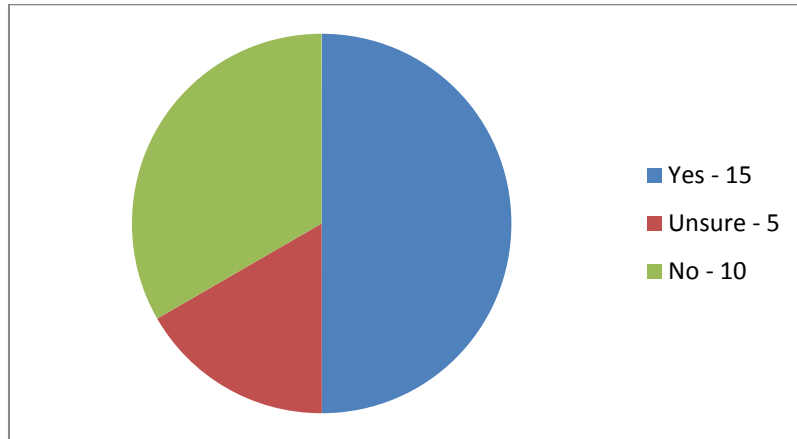
“Depression; they feel like everybody else’s lives would be better without them, feel not as important as others and that they will not be missed”.

“Because of their frustrations in life, and their lack of skills to deal with them”.

“Because they feel it is the best escape for them”

“They have not or cannot speak to people about their problems”.

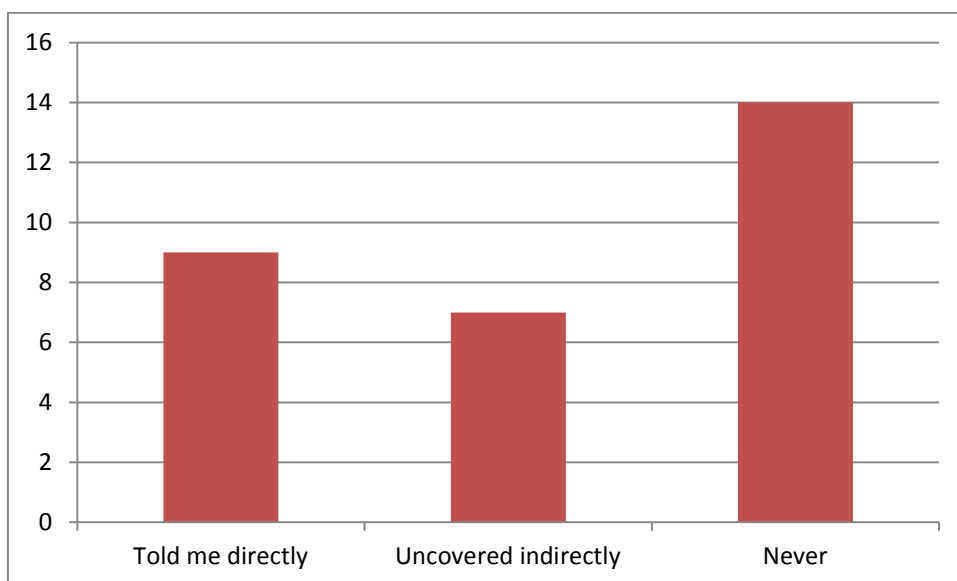
4.2.6. If participants had encountered any occasions where a person was experiencing thoughts of suicide



(Fig.1)

The above pie chart highlights the fact 50% of the surveyed population have encountered instances where they found somebody that was experiencing thoughts of suicide, but 16% were unsure whether suicide was a factor.

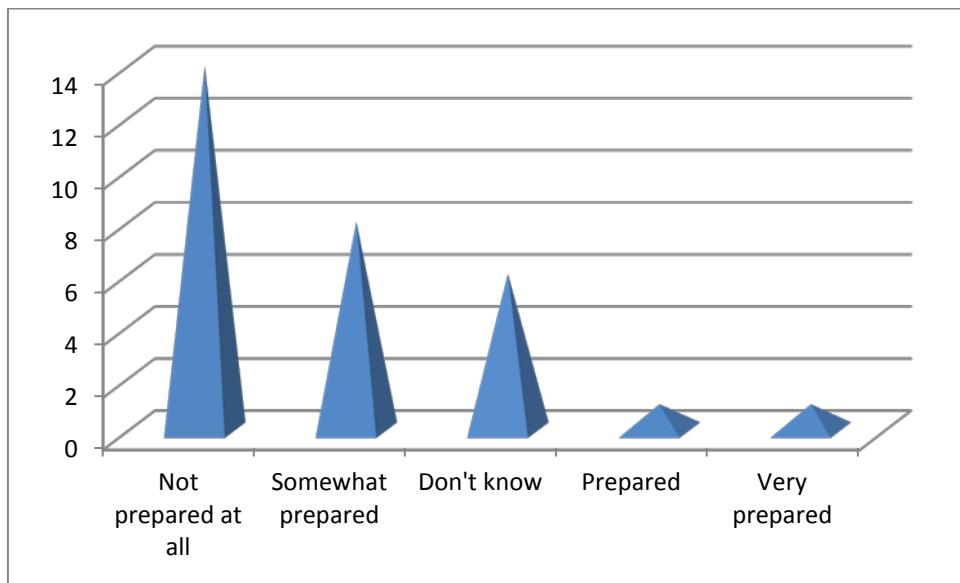
4.2.7. If that person disclosed their thoughts of suicide to the participant, directly, indirectly or not at all



(Fig.2)

The bar chart outlines that almost 50% of the population that had encountered a person experiencing thoughts of suicide did not have any form of disclosure made to them, in contrast to 33% of participants that were told directly. The remaining 17% had found out about the suicidal ideation indirectly.

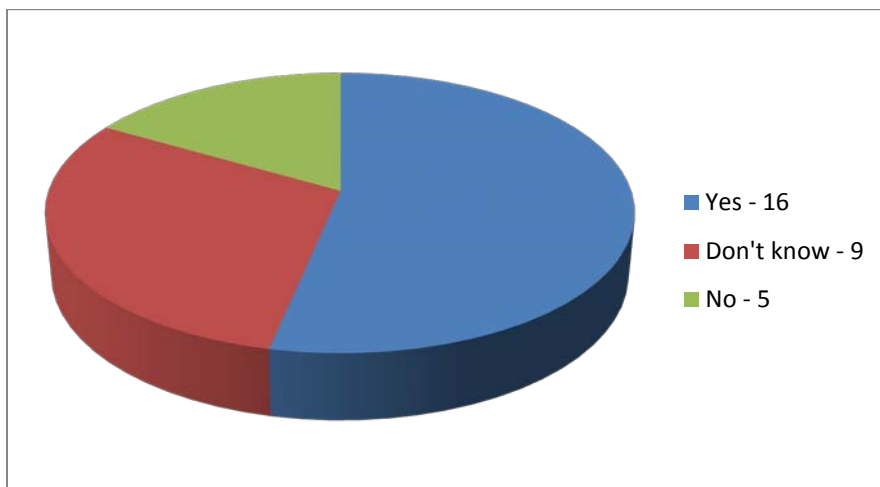
4.2.8. Participants perceived preparedness in dealing with a suicidal crisis



(Fig.3)

In terms of people perceived preparedness only 7% of the sample agreed that they would be prepared or very prepared to deal with a suicidal crisis, 23% stated that they were somewhat prepared. 47% did not feel prepared in any way and the remaining 23% did not know if they were prepared at all.

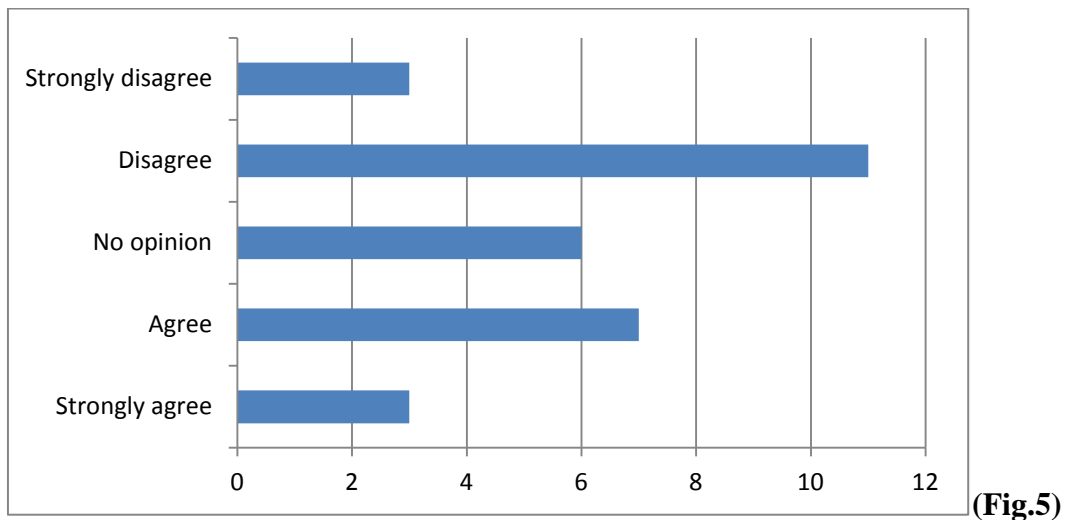
4.2.9. Do people think a person with thoughts of suicide would tell somebody?



(Fig. 4)

53% of the sample believed that a person with thoughts of suicide would tell somebody, in contrast 17% did not believe that a person with thoughts of suicide would tell anybody and the remaining 30% did not know.

4.2.10. Would you agree or disagree with the statement “the majority of suicides are impulsive”?

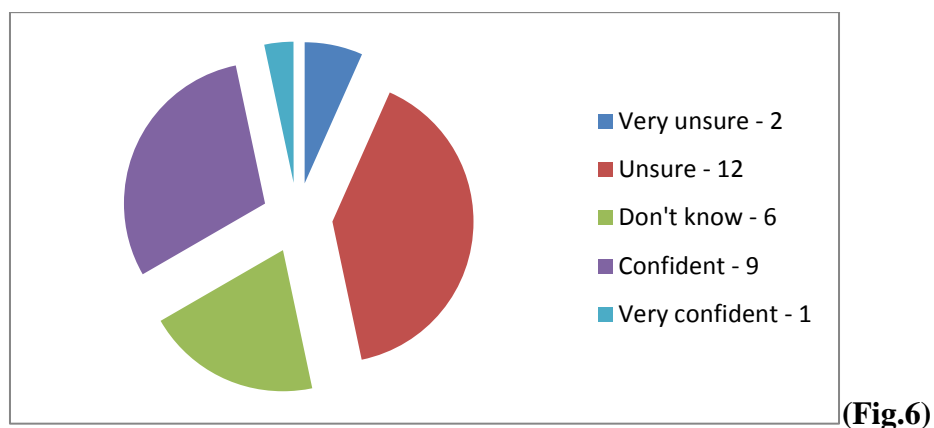


33% of the sample believed that “the majority of suicides are impulsive”, 47% of the group disagreed with this idea and 20% did not have an opinion on the matter.

4.2.11. Are people with thoughts of suicide open to help?

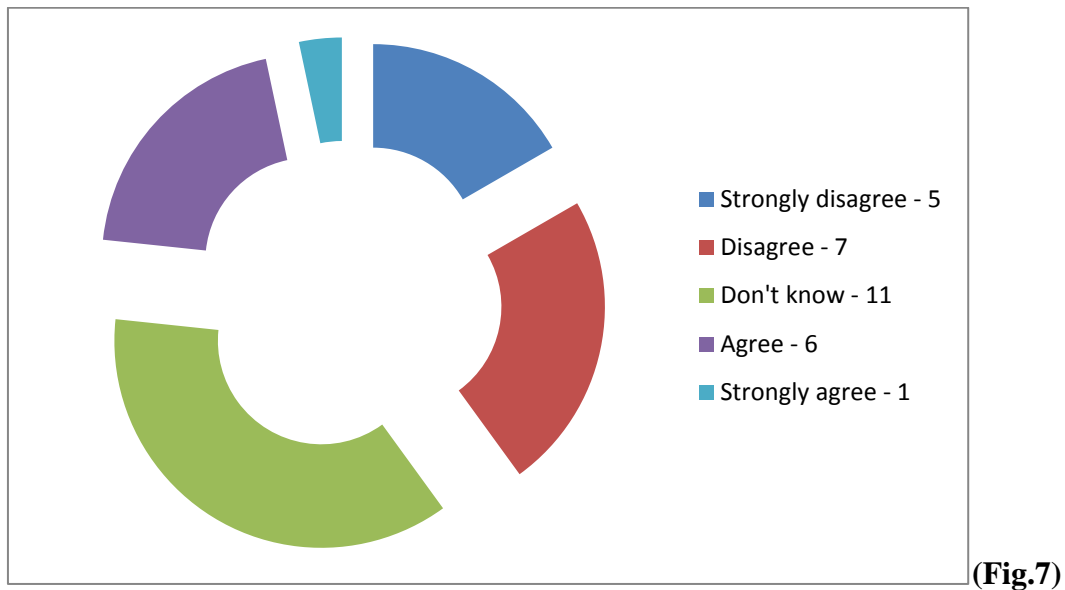
53% of participants believed that people with thoughts of suicide are open to help. 20% of the group stated that such people were not open to help and the remaining 27% were unsure. This highlights the fact that only half the group felt that suicidal people were open help.

4.2.12. Hypothetically, if a person discloses thoughts of suicide to you, to what extent would you consider yourself confident in dealing with the person?



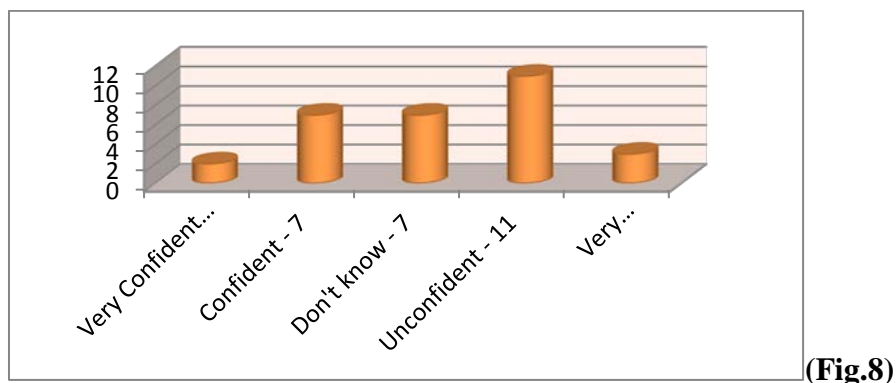
Some 66% of participants either did not know or were unsure about their confidence levels in dealing with a person that had disclosed a suicidal ideation, leaving the remaining 34% responding as feeling confident in their abilities to deal with a person with a suicidal ideation.

4.2.13. To what extent do you agree or disagree that asking the question “are you thinking about suicide?” would cause harm to the person or encourage a person to begin thinking in a suicidal manner?



23% of the participants felt that asking a person if they were thinking about suicide could lead that person to begin thinking in a suicidal way. 37% did not know if asking such a question would “cause harm to the person or encourage the person to begin thinking in a suicidal manner”. 40% of participants disagreed that asking such a question would cause any harm.

4.2.14. To what extent do you consider yourself confident in asking a person if they are considering suicide?



Overall 30% deemed themselves confident to ask a person if they were considering suicide. The remaining 70% did not know or felt unconfident in asking a person if they having thoughts of suicide.

4.2.15 Participants were then presented with a list of statements and asked to circle ‘Agree or Disagree’ as they saw fit.

| Statement | Agree | Disagree |
|--|--------------|-----------------|
| Suicidal people want to die | 10 | 20 |
| Suicidal people want to live | 23 | 7 |
| Suicidal people want to talk to somebody | 24 | 6 |
| Suicidal people rarely give a sign that they want to die | 14 | 16 |
| Suicidal people never ask for help either directly or indirectly | 12 | 18 |
| Once a suicidal person has decided to end their life they cannot be helped to change their mind | 7 | 23 |
| When people that talk about dying by suicide, they are not serious and will not go through with it | 4 | 26 |
| Once a person has made a serious suicide attempt, that person is then unlikely to make another | 4 | 26 |
| Talking about suicide can put the idea into somebody’s head | 8 | 22 |

(Fig.9)

The results now move to the questionnaire responses from directly after course completion.

4.3. Post – Course Questionnaire

4.3.1 Participants understanding of ‘suicidal ideation’

All participants defined suicidal ideation as a person having thoughts of suicide. Some examples of the responses are as follows:

“It is when somebody has ideas and/or thoughts of dying by suicide”

“It is where somebody might not want to live anymore”

4.3.2. Participants were then asked to what extent they agreed or disagreed with the following statements:

| | Strongly disagree | Disagree | Don’t know | Agree | Strongly agree |
|---|-------------------|----------|------------|-------|----------------|
| The course has prepared me in dealing with a person with thoughts of suicide | 0 | 0 | 1 | 17 | 12 |
| People with thoughts of suicide would tell somebody directly or indirectly | 0 | 2 | 3 | 16 | 9 |
| A person with thoughts of suicide is open to help | 1 | 2 | 1 | 16 | 10 |
| It would be easy to miss the idea of suicide | 0 | 9 | 2 | 14 | 5 |
| It would be easy to dismiss the idea of suicide | 2 | 3 | 3 | 16 | 6 |
| It would be easy to avoid the idea of suicide | 1 | 3 | 2 | 16 | 9 |
| Asking a person “Are you thinking about suicide?” would cause harm and/or encourage the person to begin thinking in a suicidal manner | 12 | 14 | 2 | 2 | 0 |
| I now feel confident in asking a person if they are considering suicide | 0 | 0 | 3 | 23 | 4 |
| Almost all people that have had thoughts of suicide told somebody in one way or another | 1 | 3 | 3 | 19 | 4 |
| Impulsive suicides are not that common and the majority of suicides are pre-meditated | 0 | 3 | 5 | 14 | 8 |
| It would be difficult to connect a person to a “keep-safe” connection (A person qualified to help) | 9 | 15 | 4 | 2 | 0 |
| Talking and listening to the person with thoughts of suicide about their issues can really help in discouraging them | 0 | 1 | 0 | 13 | 16 |

| | | | | | |
|---|---|---|---|----|----|
| from suicide | | | | | |
| It is important to be nosey when it comes to asking people about possible suicidal thoughts | 2 | 1 | 2 | 14 | 11 |
| The course is suitable for the entire Irish population over the age of 16 | 1 | 0 | 2 | 10 | 17 |
| It is applicable to college students | 1 | 0 | 1 | 11 | 17 |
| It is applicable to members of the travelling community | 1 | 0 | 1 | 11 | 17 |
| It is applicable to immigrants (whose first language is not English) | 2 | 1 | 4 | 9 | 13 |
| It is applicable to older people | 1 | 0 | 0 | 13 | 16 |
| I now feel comfortable talking about suicide openly | 0 | 0 | 3 | 17 | 10 |
| I feel confident in dealing with a person with thoughts of suicide | 0 | 0 | 3 | 16 | 11 |

(Fig.10)

On analysis of the previous statements it is shown that 97% of the participants agreed that the course had prepared them in “dealing with a person with a suicidal ideation”.

84% now believed that a person with an ideation would “tell somebody either directly or indirectly”; 7% disagreed that there would be some form of disclosure, either “directly or indirectly”.

86% stated that “a person with thoughts of suicide is open to help”, however 10% did not feel “a person with thoughts of suicide was open to help”.

30% of the sample disagreed that it would be “easy to miss the idea of suicide”, however 64% agreed that it could be “easy to miss”.

73% agreed that it would be easy to “dismiss the idea of suicide”, in contrast 17% disagreed with the statement; the remaining 20% were unsure.

84% believed it would be easy to “avoid the idea of suicide” whereas 13% disagreed with the notion that it would be easy to “Avoid the idea of suicide”.

7% held onto the belief that asking the question “Are you thinking about suicide?” would cause a person to begin thinking in a suicidal manner. 87% now agreed that asking the question would not cause harm or lead the person to have thoughts about suicide.

90% stated that they now felt confident in asking a person “if they were considering suicide”. The remaining 10% were not sure if they felt confident.

77% of participants agreed that persons with thoughts of suicide had “told somebody in one way or another” 14% of the group disagreed with the statement. 9% were unsure.

73% responded that the majority of suicides are premeditated and that “impulsive suicides” are not that common. 10% disagreed with the statement. 17% stated they did not know.

80% of the sample stated that it would not be difficult to “connect a person to a keep-safe connection (a person that can help)”, 13% were unsure and 7% stated that it would be difficult to connect a person with somebody that could help them.

97% reported that talking and listening to a person with suicidal ideations would really “help in discouraging them from suicide”. 3% disagreed that talking and listening would help.

9% disagreed that “being nosey” would benefit the person with suicidal ideations. 83% agreed that “being nosey” would help the person; the remaining 8% were unsure.

In terms of the courses’ suitability for “the entire Irish population over the age of 16” 90% stated that it was suitable, 3% disagreed about its suitability and the remaining 7% did not know.

93% of the surveyed group stated that the course was suitable for both college students and member of the travelling community. The responses on each of these questions aligned with each other with 3% being unsure and a further 3% stating that it was not suitable for either group.

10% of the participants stated that the course might not suitable for immigrants (whose first language isn’t English), however 73% felt it was suitable, and 17% were uncertain if it was suitable.

97% agreed that the course was applicable to older people; 3% disagreed on its applicability towards the group.

90% of respondents agreed that they now felt confident in “talking about suicide openly” and 10% were uncertain.

In terms of confidence in “dealing with a person with thoughts of suicide” 90% now agreed that they felt confident whereas 10% still felt unsure.

4.3.3. Participants were then presented with a list of statements and asked to circle ‘Agree or Disagree’ as they saw fit.

| Statement | Agree | Disagree |
|---|-------|----------|
| Suicidal people want to die | 4 | 26 |
| Suicidal people want to live | 29 | 1 |
| Suicidal people want to talk to somebody | 29 | 1 |
| Suicidal people rarely give a sign that they want to die | 4 | 26 |
| Suicidal people never ask for help either directly or indirectly | 1 | 29 |
| Once a suicidal person has decided to end their life they cannot be helped to change their mind | 0 | 30 |
| When people that talk about dying by suicide, they are not serious and will not go through with the suicide | 1 | 29 |
| Once a person has made a serious suicide attempt, that person is then unlikely to make another | 5 | 25 |
| Talking about suicide can put the idea into somebody’s head | 3 | 27 |

(Fig.11)

When asked to agree or disagree with the above statements we can see that 87% of participants disagreed that suicidal people want to die.

97% stated that suicidal people want to live and that 97% of people with suicidal ideations would want to talk to somebody.

87% believed that a person with thoughts of suicide give a sign of their intentions, but 13% disagreed that a person would exhibit signs.

97% now believe that a person would seek help either directly or indirectly. ,

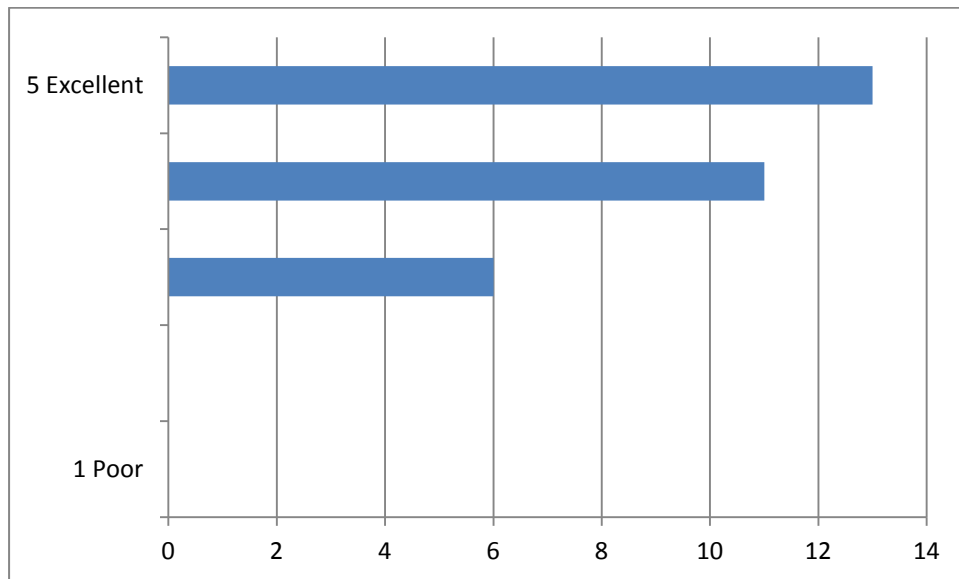
100% of the sample were now of the opinion that a suicidal person that has decided to end their life can be helped to change their mind.

Of the group 97% stated that they disagreed with the notion that if a person were to talk about dying by suicide that they should not be taken seriously.

83% of the participants were not in agreement that if a person has attempted suicide in the past, that they are likely to make another attempt.

10% of the sample still believed that talking about suicide can “put the idea in somebody’s head”.

4.3.4. Rating the content of the DVD component of the course on Likert scale (1 = Poor, 5 = Excellent)



(Fig.12)

Participants were then asked to outline reasons for the answer. The majority of responses spoke in favour of the DVD content stating that:

“It was quite clear in communicating the message.”

“It was very clear and concise.”

“It was easy to follow and very informative”.

In contrast a small number of the group outlined a number of grievances about its content; for example:

“Some of the clips felt unrealistic but were still good”

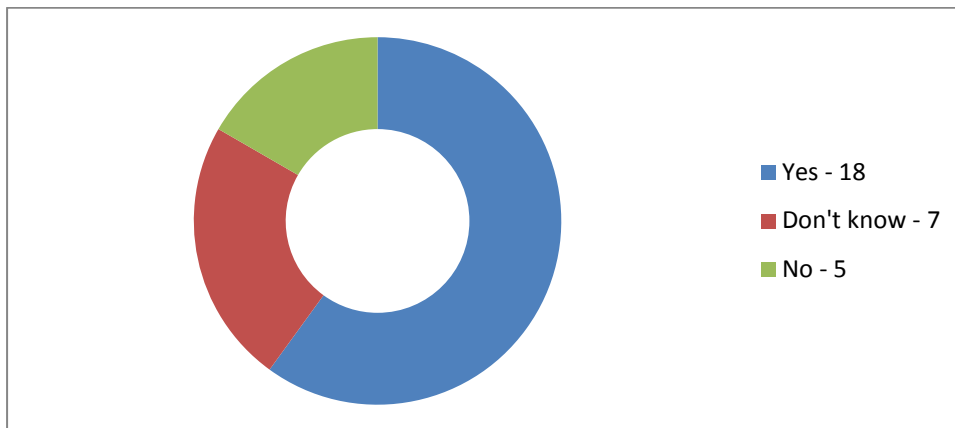
“It was too general; it would be more effective if the scenarios were more specific to Ireland”

“The message was good but the actors were unconvincing”

“The videos are obviously very old and I think they could use more up to date scenarios, maybe include something about teens and cyber-bullying”

Overall 80% rated the content as being good or excellent, with the remaining 20% rating its as average or fair.

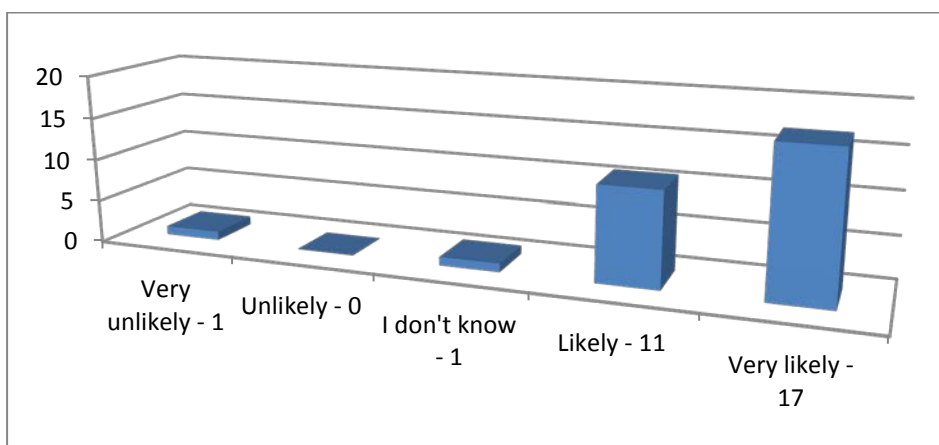
4.3.5. Do you think the examples contained within the programme are realistic and pertinent to contemporary Ireland?



(Fig.13)

60% of the participants stated that the examples contained within the programme were realistic and pertinent to modern day Ireland; 17% felt they were unsuitable, and 23% were unsure.

4.3.6. The extent to which participants are likely to attend similar courses in the future



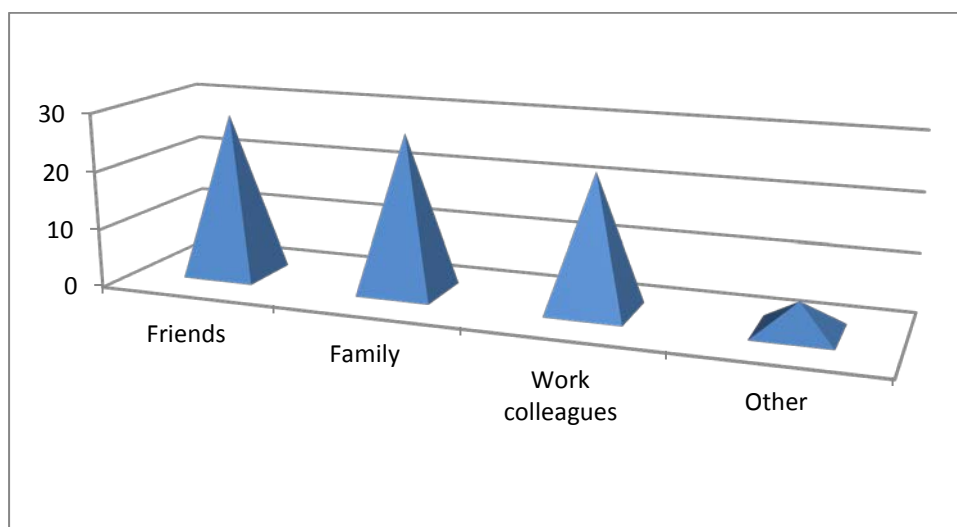
(Fig .14)

Out of all the participants attending the course 94% stated that they would be likely or very likely to attend similar courses in the future, 3% were unsure and a further 3% said they would not attend any similar course(s).

4.3.7. Likelihood of recommending the course to others

The majority of participants stated that they would be likely (11) or very likely (18) to recommend the course to others, overall 97%. One participant (3%) stated that they would be very unlikely to recommend the course to anybody.

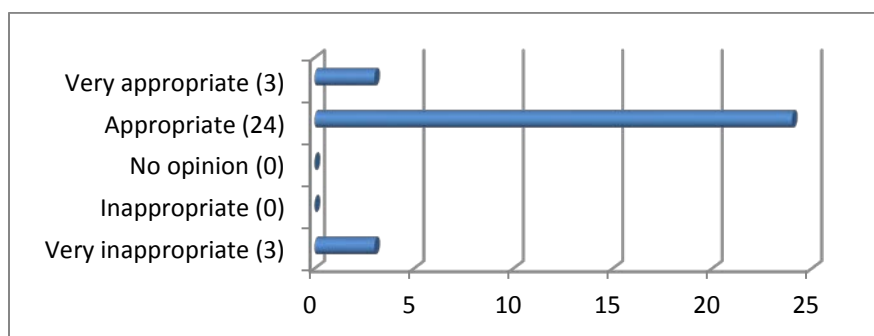
4.3.8. The question was then posed “who would you recommend the course to? Participants were instructed to tick as many boxes as they felt it applied to:



(Fig.15)

Some of the “others” that were mentioned as to whom participants would recommend the course to were as follows; older people with illnesses, students, and people living in direct provision style accommodation.

4.3.9. Participants views on the appropriateness or inappropriateness of the presentation



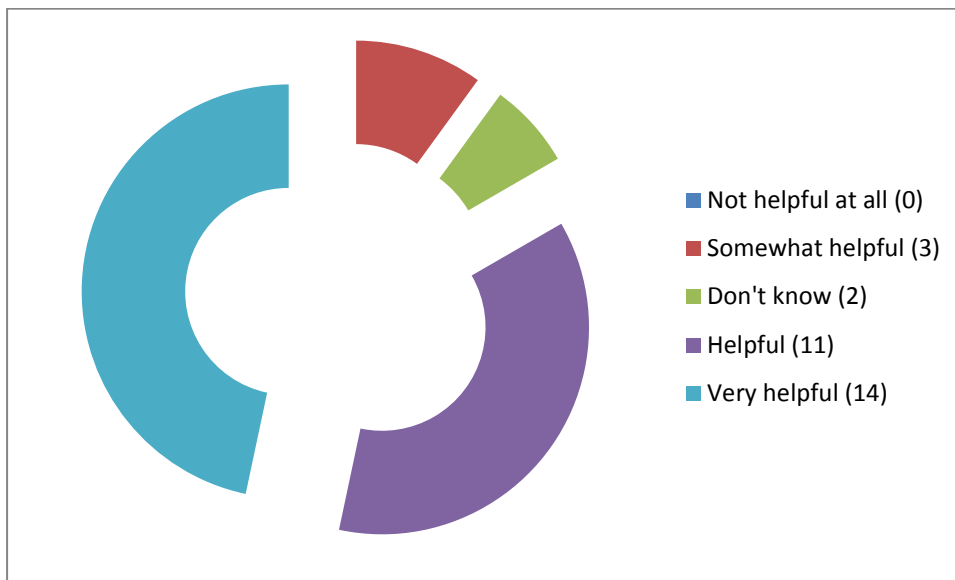
(Fig.16)

Overall 90% of participants felt the presentation of the course was appropriate, however 10% felt it was very inappropriate.

4.3.10. Participants were then asked if the course had gotten the key messages right, or was there something that should have been emphasised more?

17 participants (56%) agreed that the course covered all the key messages; 9 participants (30%) stated that the course covered enough of the key messages; 2 (7%) did not know and the remaining 2 (7%) stated that the course missed some key messages.

4.3.11. How helpful the course has been in helping participants in assessing risk and understanding the difference between acute and chronic risk:



(Fig.17)

84% of participants stated that the course had been helpful or very helpful in assessing risk and understanding the difference between acute and chronic risk. 10% found the course “somewhat helpful” and 6% were unsure.

4.3.12. Can the course be aimed at the entire Irish population?

22 participants (74%) stated the course could indeed be aimed at the whole Irish population; 5 participants (17%) were unsure and the remaining 3 (9%) stated that it could not be aimed at the entire Irish population.

4.3.13. Does the course address the needs of those from different ethnicities?

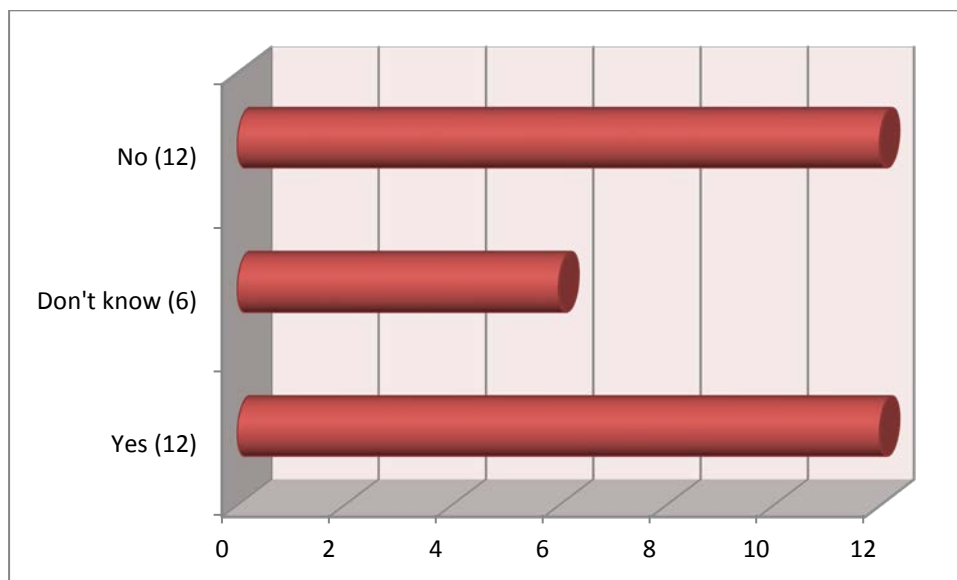
18 participants (60%) felt that the courses addresses the needs of those from differing ethnicities; 9 (30%) participants were unsure and the remaining 3 (10%) did not feel the course was addressed the needs of people from other ethnicities.

The participants that responded “No” were then asked to outline the reasons for their answer:

“Ethnicities often hold different religions and many religions have differing beliefs about suicide.”

“Different groups have different problems and a lot of the course was too general.”

4.3.14. Participants were then asked if they felt a need for more cultural sensitivities in the course:



(Fig.18)

When asked about the need for more cultural sensitivities 40% stated that there was no need, 40% stated there was a need and a further 20% were unsure.

Those that answered “No” were then asked to outline their reasons; the following are examples of why:

“If you are sensitive, you are avoiding the issue.”

“Suicide is everywhere.”

“The same general issues apply.”

“The situations were applicable to most cultures.”

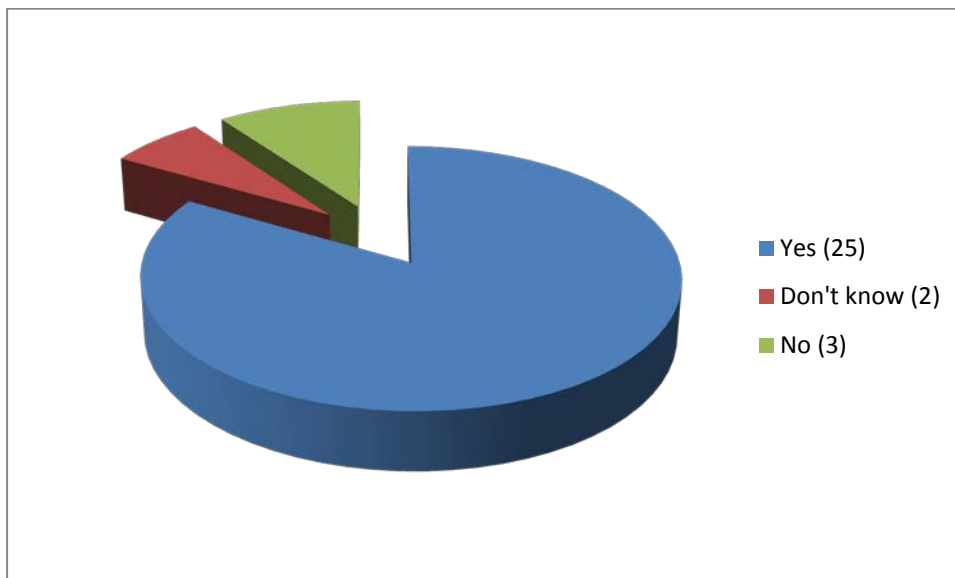
4.3.15. If you feel the programme is not aimed at the entire Irish population, why?

Only 2 participants (7%) gave a response for this question.

“The content is very American as were the scenarios and even the voices and actors were a little bit distracting because of it.”

“Topics discussed may not apply to people with different cultures and social set-ups.”

4.3.16. Do you think that attitudes and beliefs come into play when dealing with a disclosure of suicidal ideation?



(Fig.19)

83% of the participants felt that attitudes and beliefs come into play when dealing a disclosure of suicidal ideation, 10% did not believe that they were factors, and the remaining 7% stated that they did not know.

Participants were then asked to elaborate on their answer:

“Stigma and pride are big things in Irish people.”

“People are afraid of being labelled with the idea of suicide.”

“Past experiences of suicide can present stigma so people may be reluctant to disclose.”

“Men may think that people will think them to be less of a man.”

4.3.17. Do you think there is enough awareness around the practice of SafeTALK?

13 participants (43%) thought there was not awareness around the programme; 14 (47%) stated that there was some awareness; and the remaining 3 (10%) felt there was enough awareness.

4.3.18. Participants were then ask to consider any possible improvements to the programme:

33% of the sample proposed possible improvement. The following are the responses.

“Make it suitable for secondary school kids and those under the age of 16 years.”

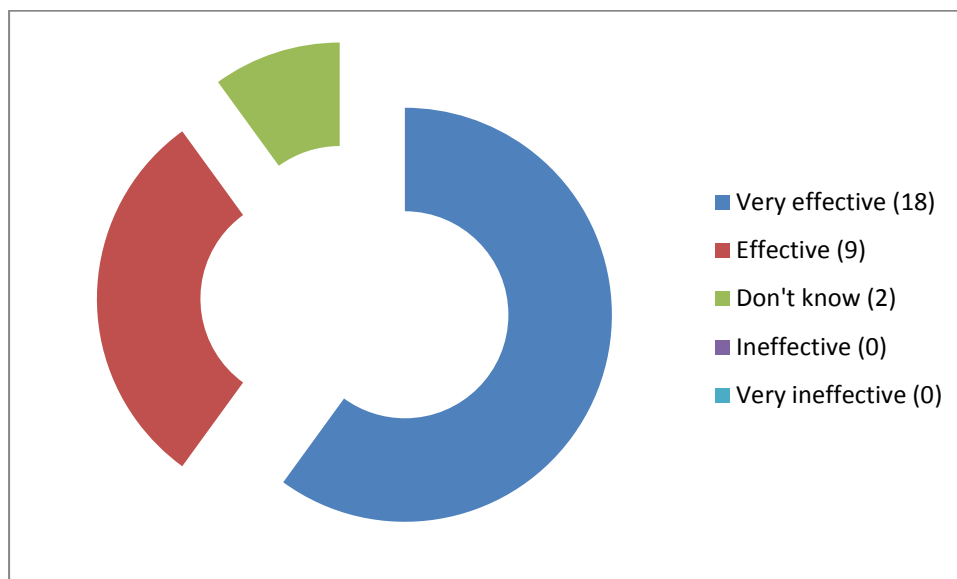
“Create more awareness around how to access the course.”

“Encourage more feedback within the course.”

“Tailor it for different cultures.”

“Include more information on suicide in Ireland.”

4.3.19. Participants overall opinion of the effectiveness of the course



(Fig.20)

90% of participants stated that the course was effective/very effective; 7% were unsure of its effectiveness and one participant left the question blank.

4.4 Summary of results

It is apparent that from this study that all participants had varying attitudes and knowledge of suicide and suicide prevention before participating in the SafeTALK course. Many participated in the course to get a better understanding of the topic of suicide and be a part of suicide prevention in their local environments and communities. The student participants also stated en masse that they were taking part in the course due to a dominant trend, that being that the majority of students were training to work at the coalface of the community within the social care sector. There was a resounding belief that the course would be of benefit to them in the working environment also.

Participants had a strong understanding of what suicidal ideation was, and also on why and how people become suicidal. Half of the group had experienced instances where a person was having thoughts of suicide which may account for the extensive knowledge that the majority of the group had. Participants reported, before course commencement that the majority did not feel prepared to deal with a suicidal crisis but aligning with that was the belief that the person suspected of having thoughts of suicide would give out signals that they were having suicidal ideations. The finding that 53% believed that a person with thoughts of suicide is open to help was substantive as ultimately, it is the premise of the SafeTALK course. Participants' pre-course confidence levels reflected that two thirds of the group were no confident in dealing with a person suffering from a suicidal ideation.

Another substantive finding that came from the pre-course questionnaire was that almost one third of the group sampled believed that talking about suicide would put the person at greater risk of harming themselves or put the idea into their mind, however a common thread throughout the pre-course questionnaire was that suicidal people did not want to die and that they were at times seeking help either directly or indirectly.

The post course questionnaire presented a number of substantive changes in attitude and knowledge of suicide and suicide prevention. Participants reported a greater perceived awareness of the signs of suicidal ideation in people. The majority of the sample conveyed that they now believed that open and direct discussion about suicide with a person with a suspected ideation would not do harm or impel the person to start beginning in a suicidal

manner. There was a noted increase in perceived comfort and confidence in dealing with a person with thought of suicide. Comparatively 87% reported they now believed that a person with a suicidal ideation was open to help, an increase of 34%. Another significant increase recorded was that 90% now perceived themselves as having the confidence to deal with a person with thoughts of suicide, compared to 94% feeling unconfident prior to completing the SafeTALK course.

The theme then turned to participants of the course content – the multimedia component of the course was noted as either excellent or good by the majority of respondents, however as the questions around the multimedia content became more specific there was a noted record of certain perceived inadequacies that participants highlighted. Examples of the perceived inadequacies are as follows: participants stated that many of the scenarios were not pertinent to Irish society and that some of the scenes were unrealistic and needed to be more culturally appropriate. One fifth of the sample reported that the scenes and examples were not realistic and/or pertinent at all.

Finally the findings outlined the course experience and perceived efficacy, the vast majority reported that they had found the course to be effective and worthwhile, and when asked if they would recommend the course to others only one member of the group said that they would not recommend the course to others.

All of these findings will be explored in greater detail in the next chapter.

Discussion

5.1. Introduction:

The aim of this study was to evaluate the experience and learning from participating in the SafeTALK course. The research question sought to; investigate the perceived knowledge and attitude towards those who engage in suicidal ideation before and after completion of the SafeTALK course; explore the perceived skill of participants in dealing with a person with suicidal ideation before and after course completion, and; an investigation of any perceived strengths and limitations from the point of view of the course participants.

This chapter will focus on the findings from the research process, with reference being made to the information gathered in the literature review. The findings from the quantitative study will be compared to the published studies and literature highlighted in the literature review. The findings will be discussed through the meta-themes that emerged from the results. The conclusion of the chapter will propose recommendations for prospective research.

5.2. Summary of discussion:

This study did not uncover any specific new information when compared to other SafeTALK evaluations carried out and mentioned within the literature review. The study largely confirms recorded theory and commentary pertinent to the research question. Perhaps this may be due to the study being located with on specific context. Specifically it uncovered several meta-themes, namely:

- (a) Levels of confusion and stated lack of preparedness before the course and changes to these levels post-course.
- (b) Participants' perceptions of the presentation and content of SafeTALK, with emphasis on the cultural suitability of the course.
- (c) The perceived efficacy of the course from participants that complete SafeTALK.

To briefly summate the results we can see that the course is instrumental in changing attitudes and approaches to open and direct talk about suicide. It is apparent that the course instils a new level of confidence and comfort in participants to approach people that that may be dealing with suicidal ideation. However, with similar evaluations, for example the evaluation of the Scottish SafeTALK pilot (McLean et al, 2007) and the more recent evaluation of SafeTALK within the framework for Operation Life in Australia (McKay,

Hawgood and Kavalidou et al, 2012) the issue of cultural suitability came for the fore and was highlighted by significant portions of the sampled population. Some 97% of the sample reported a positive experience of the course as a whole, the majority of whom stated that the course had prepared them to help others and would have no problem in recommending the course to others.

5.3. Knowledge and attitudes toward suicidal ideation

It is important to note that none of the sample had participated in a suicide prevention course previous to completing SafeTALK. The term “suicidal ideation” was clearly understood by 80% of the sample in the pre questionnaire; however following completion of the course the full sample reported a full understanding of the term in the post course questionnaire.

When asked about their opinion on why people have suicidal thoughts the participants outlined a range of issues around depression, having poor coping skills, personal history and not being able to communicate their emotions effectively; such issues are reinforced by Amos, Appleby and Parson et al (1999) where they state that there is no one single identifiable cause for suicide, rather it is a culmination of a complex interplay of factors in a persons’ life.

Hogg and Vaughan (2005, p.150) tell us that “an attitude is a relatively enduring organisation of beliefs, feelings and behavioural tendencies towards socially significant objects, groups, events or symbols”, essentially experiences can shape attitudes and from analysis of the findings it was uncovered that at least half of the sample had experienced an occasion where a person was having thoughts of suicide. This is a substantial finding as it can be aligned with the growing suicide rates in Ireland as outlined in the National Office for Suicide Prevention, Annual Report (2012). The SafeTALK programme also tells us that on any one day at least 5% of the population may be thinking about suicide (SafeTALK, 2009). Another reason for the high instance of participants that have had the experience of dealing with a person that was having thoughts of suicide could also be explained by initiatives such as the ReachOut strategy. One of the strategies within the framework is to highlight the necessity to create more awareness around mental health and suicide through education and promoting open and direct talk about suicide, ultimately trying to break down stigmatising beliefs and removing the idea that suicide and mental health are taboo subjects (ReachOut, 2005).

The growing awareness and promotion of open and direct discussion around suicide may also correspond with the fact that out of the fifteen participants that had the experience of dealing with a person presenting suicidal ideation sixty percent stated that they had been told directly whereas uncovered in indirectly by picking up on what the SafeTALK Trainer Manual (2009) refers to as “invitations” which can be defined as what people “ see, hear, sense and learn from another individual that might give rise to suspicion of suicidal ideation, or that the individual is trying to communicate something much deeper”.

In the pre-questionnaire the concept of impulsive suicide was raised and it was found that only half of the sample disagreed with the statement “the majority of suicides are impulsive”, however this belief has been discredited by notable academics such as Swann, Dougherty, Pazzaglia and Pham et al (2005) where they purport that impulsivity and suicide are more often connected with people suffering from Bi-Polar disorder due to the illnesses tendency toward rapid and unplanned responses to crises and events.

Another substantive finding conveyed that only 53% of the sample believed that people with suicidal ideation were open to help. The author found this statistic somewhat contradictory as the majority of participants had outlined their wishes to “help a person in crisis” etc when initially asked about their motivations for participating in the SafeTALK course. Research carried out by the LivingWorks organisation advocates that suicidal people are very much open to help. In the SafeTALK presentation we are reminded that “suicide is not about wanting to die, it is about now wanting to live”, i.e. being unable to cope with what a person is dealing with at that moment in time (SafeTALK DVD, 2009). Gray (2013) advocates that people that are having thoughts of suicide are very much open to help, and, if they are approached in the correct manner and are then asked direct questions about suicide. In comparison, in the post course questionnaire 87% now stated that they believed that a person with a suicidal ideation was open to help. This did however leave 13% of participants uncertain as to whether such a person could be helped.

Further to that Gray (2013) goes on to say that asking somebody if they are thinking about suicide does not increase the risk of suicidal ideation of behaviour. The premise of SafeTALK is to “engage them (the person(s) with suicidal ideation) in direct and open talk about suicide (McLean et al, 2009). On analysis of the findings only 40% disagreed that asking the question “are you thinking about suicide?” would pose a risk that the person would begin thinking in a suicidal manner, however in the questionnaire post-course there was a

significant increase in the percentage of people that disagreed with the notion that asking “are you thinking about suicide?” would pose a risk or put the idea of suicide into somebody’s head.

5.4.Perceived Skills

Prior to course commencement only 7% of participants felt prepared to deal with a suicidal crisis, however following participation in the course 97% of the group had a perceived preparedness in dealing with the same type of situation. The change represents perceived changes to skills and due to the limitations of this study gauging the actual skill enhancement was not possible. It is however noteworthy that perceived preparedness in their approaches to dealing with a person presenting with a suicidal ideation has significantly increased. This finding bodes well for the courses overall efficacy as it reflects a number of the courses primary aims as outlined by McLean et al (2007) as [SafeTALK] aims to empower participants to recognise a person who might be having thoughts of suicide, engage them in open and direct talk about suicide, listen to the person’s feeling about suicide to show them that they are being taken seriously, and to move quickly to connect them to somebody trained in suicide intervention.

Similarly there was a clear increase in people’s perceived confidence levels in asking a person if they were having thoughts of suicide. Initially only 30% stated that they would be confident in asking, however upon course completion the figure had risen sharply to 90%. Again it is worth noting that the responses reflect perceived confidence levels but ultimately demonstrate that the message within the course is getting through to the participants. The findings of both perceived preparedness and confidence align with two similar evaluations , namely; The Review of the Operation Life Suicide Awareness Workshops carried out by McKay and Hawgood et al (2012) and The Evaluation of the Scottish SafeTALK Pilot by McLean et al (2007). Each of these evaluations found at the baseline stage that participants confidence and preparedness was low but following completion of the SafeTALK course participants nearly always reported a very contrasting difference in their confidence and preparedness.

While the reported results demonstrate a notable change in knowledge, attitude and skills it is not scientifically possible to quantify people’s perceptions of alterations to their own skill-set in terms of suicide prevention ability. If, however the participants opinion on the effectiveness of the course can be used as a measure, then SafeTALK can be seen as a highly

effective course that empowers participants with a set of skills that can enable them to try keep a person safe from suicide.

5.5. Perceived strengths and limitations of the course

5.5.1. Strengths

When participants were asked to rate the content of the DVD component the majority rated it on the Likert Scale as being good or excellent. Participants echoed that the message was “clear in communicating the message” and that it was also “concise”. Over half of the group stated that the multimedia had been beneficial in demonstrating how to ask people about possible thoughts of suicide and mentioned the ease at which many of the signs could be missed by not be alert to the possibility of suicide. One respondent noted and praised the multimedia as one part had provoked a course wide conversation which opened up a discussion on differing attitudes to suicide prevention. The respondent added that had the multimedia clip not sparked the discussion that many participants would have been more reluctant to engage more fully in the course. 83% of the respondents stated that the course had gotten what they deemed to be the right message, across. A number of these participants stated that they found the steps easy to remember and that the language used for “miss, dismiss and avoid” was easy to remember. The perceived strengths as reported by the participants are almost parallel to those found in the Evaluation of the Scottish SafeTALK pilot (McLean et al, 2007).

5.5.2. Limitations

Not surprising the notion of cultural suitability came to the foray which participants were asked to express their opinions on the limitations of the course. Even though there was a high praise for the multimedia content a significant portion (40%) stated that the content was not realistic or pertinent to contemporary Ireland, however only two participants gave rationale for their answer. One stated that the content was very American, that the scenarios, voices and actors were hard to relate to; and the other stated that the topics discussed would not apply to persons of varying ethnicities, cultures and social backgrounds. 40% also stated that the course did not address the needs of those from different ethnicities; their reasons being that ethnicities often hold different religions and many religions hold different beliefs around suicide; additionally, different groups have different problems and a lot of the course was found to be too general. These finding once again draw parallels with the Scottish Evaluation (McLean et al, 2007) where respondents reported that the complexities of life were not been

shown and that the content was at times too sanitised and non relatable. Similarly in the Australian Evaluation (McKay and Hawgood et al, 2012) the issues around cultural suitability were also noteworthy. Participants and trainers felt that the content was also too broad and polished, and that for mostly it did not suit everybody.

Following on from the limitations of the course participants were then asked to consider any possible improvements to the programme. Once again the issue around cultural suitability arose and 33% of the participants stated a need for the programme to be tailored to different cultures and/or ethnicities to improve its suitability to a diversifying Ireland. Other suggestions included a tailoring of the course for young people under the age of 16. Participants proposed more feedback within the course itself and to include a lot more information around suicide and suicide prevention in Ireland. One final proposal was to create far more awareness about the course as the individual had only attended because a friend had expressed an interest in attending it.

5.6.Conclusion

The findings of this study aim to add to what is a limited body of knowledge surrounding the efficacy of suicide prevention courses. Although the study did contain limitations and a small sample the findings will hopefully bring a better understanding of the Irish participant of the SafeTALK course and promote best practice within the provision of SafeTALK facilitation and other such suicide prevention strategies for the population of Ireland. The sample used was broad and reflects the needs of a diversifying contemporary Ireland. This study indicated that all participants had a very good understanding of the nature of suicide, yet before taking part in the SafeTALK course would have been very reluctant to confidently approach or ask a person about their suspected suicidal ideation. The results highlight the fact that the SafeTALK course is very beneficial in helping people reach a level of preparedness to act as a person that can be a part of a referral pathway process. While the experience of participating in the course was a very positive one for the majority the issues around cultural suitability of the DVD content and some components of the presentation may need more intensive research, or a move away from the “one size fits all” approach that the SafeTALK programme uses. The Safe in SafeTALK is an acronym for “Suicide Alertness For Everybody”, however the findings of this study would contradict this idea as it has with similar evaluations with Scotland and Australia.

Recommendations

6.1. Improve cultural suitability

It is evident that the cultural issues are important to many of the participants across the world, and it is worth noting that there are facets of the programme that can be tailored to suit varying demographics but the author would advocate an overhaul of the video content in an effort to make it more specific to the countries in which the programme is being delivered., Having characters and scenarios that participants can relate to would help greatly in the overall efficacy of the programme.

6.2. Inclusion of more localised information and statistics

Questions regarding a certain countries statistics, initiatives and strategies are commonplace from the participants of SafeTALK and such information is not always known by the facilitators. The course endeavours to make people realise that suicide is everybody's problem. If participants are armed with a wider knowledge of what is happening on their own doorstep in term of suicide mortality and awareness campaigns it would be expected that there would be more long term interest from participants in the long term.

6.3. Creating a SafeTALK style programme for minors

SafeTALK is suitable for anybody over the age of 16 years, however in recent years we have seen growing spikes in the incidence of suicide at earlier ages. The author believes it is crucial that younger teens been empowered with a similar skill set to prepare them for any mental health issues hat may arise in later life.

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Telephone: 057 93 57807.
Mobile: 086-8157850.

Appendix 1

HSE Dublin Mid-Leinster,
Suicide Prevention
HSE Block

2nd Feb 2015

TO WHOM IT CONCERNS:

The Postgraduate Student, John Madden, approached our organisation a number of months ago outlining a research proposal for his Masters Degree thesis titled SafeTALK – A participants review of course effectiveness '. The aim of this research proposal is to investigate the effectiveness of the SafeTALK course from the perspective of participants in a real-world setting. We are happy to allow this piece of work to proceed and look forward to exploring the findings.

John has also asked if he can use the names of the various organisations and training courses within his study. We see no issue with this as terms such as NOSP (National Office for Suicide Prevention), HSE (Health Service Executive), LivingWorks, ASIST (Applied Suicide Intervention Skills Training) and SafeTALK (Suicide Alertness for Everyone) would be important to outline and identify within the literature to disambiguate the work being carried out.

Should you have any queries or require further clarification, please do not hesitate to contact me.

Yours sincerely,

A handwritten signature in black ink that reads "Josephine Rigney".

Josephine Rigney

Suicide Prevention Resource Officer.

Appendix 2



10th March 2015

Participants Consent Letter

To whom it concerns,

My name is John Madden and I am a post graduate student in Athlone Institute of Technology. As part of my Master's research I am seeking participants to take part in a study relating to the effectiveness of the SafeTALK course by investigating the following objectives:

Aim:

To evaluate the experience and learning from participating in the SafeTALK course within AIT before and after completing the SafeTALK course.

Objectives:

1. To investigate the perceived knowledge and attitude towards those who engage in suicidal ideation before and after completion of the SafeTALK.
2. To explore the perceived skill of participants in dealing with a person with a suicidal ideation before and after completing the SafeTALK course.
3. To investigate any perceived strengths and limitations of the course from the perspective of course participants.

Participants are chosen by their initial registration to the course and will then be asked if they will complete a questionnaire pre and post interview that will explore their experience of the course.

Participation in the research is completely voluntary and participants can opt out at any time.

All information will be deleted upon completion of research. All responses will be anonymous and confidential thus making all contributors unidentifiable. The only people that will have access to the individual questionnaires will be the researcher and research supervisor, Bernadette Naughton.

It is hoped that this research may contribute to improvements in the SafeTALK course. It is anticipated that a series of recommendations will be developed from the research. If you feel you would like to contribute to this research, please complete the consent form below. Should you have any queries or concerns, please do not hesitate to contact me.

Thank you for your time,

Email: jmadden@research.ait.ie

Supervisor Email: bnaughton@ait.ie

Appendix 3



Participant Consent Form

I, _____ (print) agree to participate in this study. I am aware that my contribution will be anonymous and that any information I provide will be used for research purposes only, free from any identifiable information.

I am aware that I am free to withdraw my participation at any stage, without any negative consequences.

I am informed of the nature of the study and aware that I can ask questions regarding the research at any time.

Signature _____

Date _____

Appendix 4



Dear participant,

Firstly thank you for agreeing to participate in this body of research. It is hoped that this will serve to create improvements in the areas of suicide prevention in Ireland. Given that the topic can be a sensitive one for many i hope that it has not raised any issues for you that may be personal to you. If a situation arises that you feel overwhelmed by what we have discussed and would like to talk to somebody about the issues please see relevant contact numbers for staff within the Institute that can help and also some external resources that are available to you. Always remember talking is a sign of strength and there is always somebody there to help you.

Kind regards,

AIT contacts:

| | |
|-----------------------------------|-------------|
| College Chaplain (Fr. Shay Casey) | 0906 468065 |
| College Counsellor (Teresa Fox) | 0906 468064 |
| Students' Union | 0906 468067 |
| Students Services | 0906 468139 |

External resources:

| | |
|--------------------|--------------|
| Suicide or survive | 1890 577 577 |
| Pieta House | 01 601 0000 |
| Samaritans | 116 123 |
| SOSAD | 041 9848 754 |