Evaluation of the
Suicide Risk Assessment Australia
Suicide Prevention for Leaders Program
(previously Managers as Gatekeepers)

Final Report

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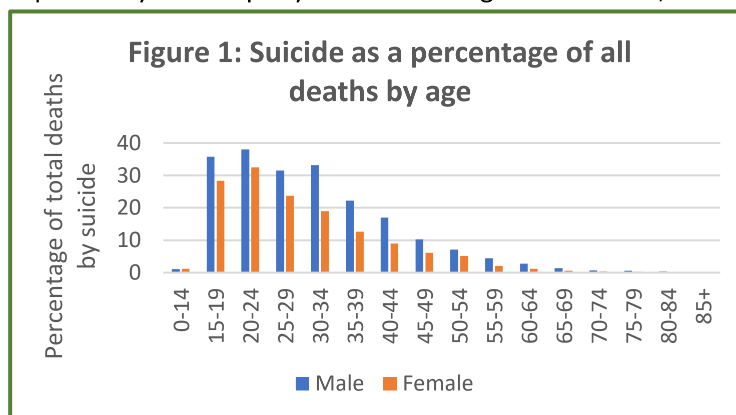
1. Executive Summary

The Suicide Prevention for Leaders successfully achieved goals consistent with gatekeeper training. The outcomes evaluations at the initial and six-week follow-up periods demonstrated an increased knowledge of suicide, development of positive attitudes and beliefs about suicide, willingness and motivation to intervene and increased self-efficacy. While there were some areas of ongoing training need and gatekeeper support identified, this report provides some practical recommendations to address some of the areas. Unfortunately, challenges with administering assessments repeatedly to a busy workforce limited the ability to assess the maintenance of gatekeeper behaviour and knowledge over time and it is recommended that this be addressed in further investigations of outcomes. However, it is noted that this analysis represents a unique and successful approach to examining program outcomes through case vignettes to assess learning outcomes specific to program goals.

2. Literature Review

Suicide is the leading cause of death for Australians between 15 and 44 years of age[1] and the World Health Organisation reports 800,000 people die by suicide per year across the globe[2]. In 2017, the Australian Bureau of Statistics (ABS)[3] released updated data on suicide in Australia. Noting some of the challenges associated with suicide and attempted suicide reporting rates[i4], figure 1 shows the percentage of deaths by suicide by age. Although there are peaks of suicide rates for people in their early adulthood, it remains a problem across the lifespan. The ABS statistics indicate that suicide was three times higher in males than females, with the most common form of suicide for both males and females being hanging[5].



2.1 Suicide in the context of work

Employment is a source of personal growth for individuals. It can offer a sense of belonging, confidence, and self-esteem, along with the other practical outcomes of work, such as financial stability. However, statistics indicate that workplace stress can be life-threatening with a significant level of work-related suicide and suicide attempts. Although some professions are identified as high risk for trauma and stress (e.g. first responders), suicidality affects all industries at all levels[6]. In the US, between 2003 and 2010, 1,804 suicides were reported, representing 38.4% of all workplace deaths[7], noting that the figure may be higher as not all suicide deaths for work-related reasons are classified as work injuries. There are no current statistics on workplace suicide in Australia, although a study in Victoria in 2012 identified 642 work-related suicides over a seven-year period[8].

The most common stressors that impact employees are deaths affecting the workforce and redundancies[9]. The latter can impact employee confidence, promotional opportunities, job security and higher workloads. Fatalities, particularly suicides, can have a strong impact on the mental health

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and emotional state of co-workers and managers and raise the likelihood of suicide clusters[10]. In addition, there are a multitude of other work-related causes of psychological distress including the increasing demand for flexibility, business difficulties, conflict, recent or previous work injury, fear of termination or demotion, poor work conditions, bullying, lack of recognition, emphasis on financial results, and lack of support[11,12,13,14,15].

The economic cost of suicidal behaviour in the workforce is great. A recent Australian study, examining both suicide and self-injurious behaviour in the workforce, estimated the cost to be $6.73 billion in one year, suggesting that the economic benefit of implementing a universal workplace strategy would considerably outweigh the cost of the strategy[16].

2.2 Suicide prevention

Suicide and self-injurious behaviour occur as a result of psychological, biological, social and cultural factors, combined with life experiences that shape decisions. For example, psychological disorders are a major contributing factor in suicidality and self-injurious behaviour, but they are not the sole cause[17,18]. Other contributory factors include access to lethal means, substance abuse, lack of access to psychological treatment, attitudes to suicide, physical illness and an absence of help-seeking behaviour[19,20]. There has been significant research about how these factors combine to create a risk for suicide and self-injurious behaviour, and various models have particularly focused on preconditions necessary to move from ideation to action. This includes the Interpersonal-Psychological Theory of Suicide[21] or the Three-Step Theory of Suicide[22].The result of these theoretical and research advancements in recognising that suicide and self-injurious behaviour are multifaceted phenomena is that suicide prevention is a complex problem without a singular solution. As a result, there are several suicide prevention approaches, including:

- Education and awareness programs (e.g. gatekeeper training).
- Pharmacotherapy (e.g. antidepressants, antipsychotics).
- Psychotherapy (e.g. Dialectical Behaviour Therapy, Suicide Prevention - Cognitive Behavioural Therapy).
- Physical restriction (e.g. restrict access to means).
- Media reporting guidelines for suicide.

Suicidal and self-injurious ideation and behaviour is highly likely to be present in any employee population. Effective, evidence-based interventions for suicide are needed. There have been various approaches to suicide prevention that focus on reducing risk factors for suicide and increasing the availability and accessibility of support services[23]. Programs have had mixed results in term of efficacy in reducing suicidality and there is yet to be a definitive, effective evidence-based approach to suicide intervention[24]. However, gatekeeper training has emerged as a promising suicide prevention approach[25].

2.3 Gatekeeper training

Gatekeeper training teaches specific groups of people to identify people who are at risk of suicide, assess the level of risk, and then act to manage the situation appropriately. Gatekeepers are defined as "*individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine*"[26].

The premise of gatekeeper training is the notion that people who are most at risk of suicide often do not seek help, but that recognisable warning signs exist that can help identify these individuals.

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Gatekeeper training is not time-intensive, and although the time investment varies, the average gatekeeper training is two days in length[27].

In a recent effort to develop an empirically based model for gatekeeper training, four common factors addressed during gatekeeper training were identified across a systematic review of 53 studies[28]:

1. **Knowledge about suicide**, which includes knowledge about suicide, depression, and resources available for at-risk individuals.
2. **Beliefs and attitudes about suicide prevention** refers to whether individuals believe suicide is considered preventable, whether it is important or appropriate to intervene with at-risk individuals, and whether seeking help for mental illness is a form of self-care.
3. **Reluctance to intervene** refers to perception's individuals may have that it is not their responsibility or that it is inappropriate to intervene; stigma of mental illness is one reason for gatekeeper reluctance.
4. **Self-efficacy to intervene** reflects the extent to which the individual feels comfortable and competent to identify, care for, and facilitate referral for a person at risk of suicide.

The model, based on Bandura's social cognitive theory[29], posits that gatekeeper training attempts to address these four factors, which then leads to appropriate intervention behaviour (figure 2) [30]. This theory also notes that the impact of social context and individual characteristics can affect the efficacy of gatekeeper training.

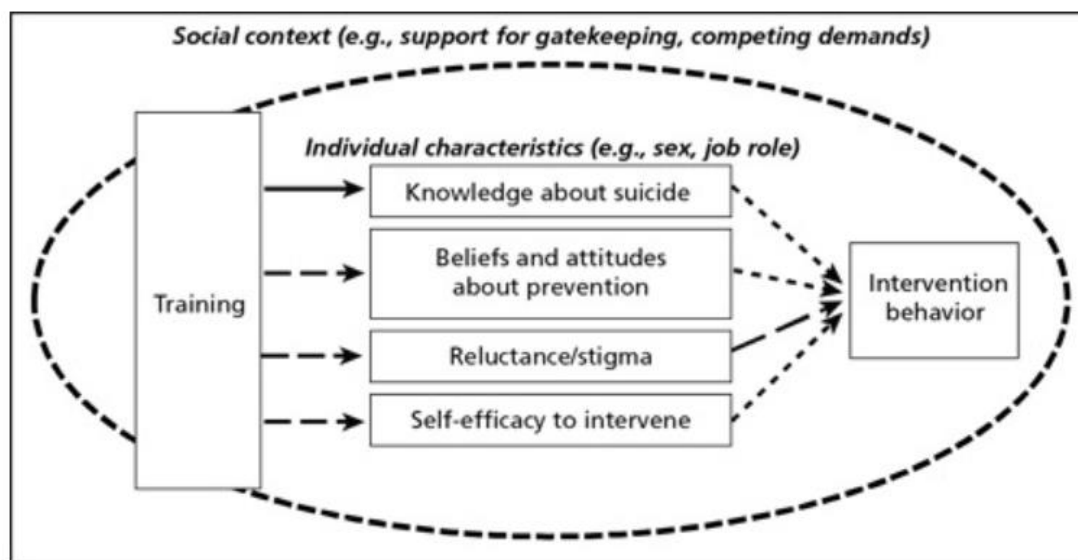

Figure 1: Model of Gatekeeper Training (Burnette et al., 2015)

2.4 Efficacy of gatekeeper training

Unfortunately, there are limitations to examining the effectiveness of gatekeeper training. This is influenced by gatekeeper training often existing in a broader suicide prevention program and the challenges of identifying an appropriate control group. In addition, there are limited studies with robust experimental design, which makes identifying the causal relationship between training (improved knowledge and skills) and reduced suicide risk difficult to ascertain. Thus, it is difficult to identify and attribute successes specifically to the gatekeeper training. However, there has been some encouraging research.

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In a systematic review of the efficacy of gatekeeper training across a variety of community situations (e.g. military populations, indigenous communities, primary care physicians), the authors note a large-scale investigation into the impact of suicide prevention training, including gatekeeper training, within the US Air Force[31]. Unfortunately, gatekeeper training was not exclusively studied, but they reported a 33% reduction in risk in suicide, compared with a prior no-intervention cohort. In a Swedish study examining suicide following gatekeeper training for General Practitioners (GPs), they found a reduction in suicide for females only and that the suicide rate returned to pre-training levels after three years[32]. This suggests an ongoing training need for gatekeepers. Following gatekeeper training, another study identified a decrease in suicidal behaviour of 24% over two years, compared with a control region[33]. One study found that just a one-hour community gatekeeper training for suicide prevention administrative and support staff resulted in positive outcomes[34]. These positive outcomes were defined as increasing participants' knowledge about suicide warning signs, how to intervene with a colleague in distress, and developing self-efficacy in dealing with people who are suicidal.

Examining the model of gatekeeper training, the authors considered evidence for each facet of training. They cite substantial evidence that training leads to increased **knowledge about suicide**. For example, people who complete gatekeeper training are better able to identify warning signs and choose effective intervention strategies, as compared to those who have not completed the training[35,36,37,38]. Further, research indicates that interactive training methods are more effective in increasing knowledge than self-study methods, such as reading pamphlets[39].

Within the model of gatekeeper training, **beliefs and attitudes about suicide prevention** cover an individual's beliefs about prevention, intervention and help-seeking. There is some evidence of more adaptive beliefs following gatekeeper training[40,41]. However, the relationship between attitudes about suicide prevention and intervention and risk reduction remains unexamined, mostly due to research limitations[42].

This model also identifies **reluctance to intervene** and **stigma** as an area for development in gatekeeper training. Studies have found that this reluctance (caused by discomfort) and stigma (negative stereotypes of people with mental health issues) reduces following training[43,44]. However, further research is needed to explore whether development in this area leads to significant changes in gatekeeper behaviour and/or a reduction in suicidal behaviour.

Finally, **self-efficacy** is defined as "*the belief in one's capabilities to organise and execute the courses of action required to manage prospective situations*"[45]. When self-efficacy is high, people feel confident and this creates a sense of control. Studies have identified increases in self-efficacy following gatekeeper training[46,47]. However, there is limited evidence of the relationship between self-efficacy gains in gatekeepers and intervention and/or suicide reduction[48].

Overall, research supports a significant link between gatekeeper programs and increased knowledge about suicide warning signs, increased understanding of suicide prevention strategies and improved self-efficacy. However, the link between participation in gatekeeper programs and decreased suicidal behavior has not been conclusively established[49,50]. Further robust studies to specifically examine gatekeeper training are required.

2.5 Gatekeeper behaviour assessment Tool

To address some of these research issues, the Gatekeeper Behaviour Scale (GBS) was developed to provide a robust and valid assessment tool that that examines the impact of training on the behaviour of both the gatekeeper and the person at risk for suicide[51]. Recognising that gatekeeper

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training aims to enable action through identifying, motivating, and referring people who may be at risk of suicide, this tool is based in theories of motivation. In developing the GBS and exploring different factor models, the data indicated a three-factor model of **preparedness** (underlying beliefs and attitudes), **likelihood** (probability of acting versus reluctance to intervene), and **self-efficacy** (perceived control to engage in a behaviour). These three factors are consistent with the model of gatekeeper training. Empirical investigations indicate that the GBS provides significant predictive ability for gatekeeper behaviour. They also note that use of the GBS is an appropriate tool for assessing behaviour change.

3. Project Background

In a large multinational organisation of 24,000 employees, a needs assessment was conducted in 2016 regarding suicide prevention, following the identification of several critical incidents relating to suicide within the workplace.

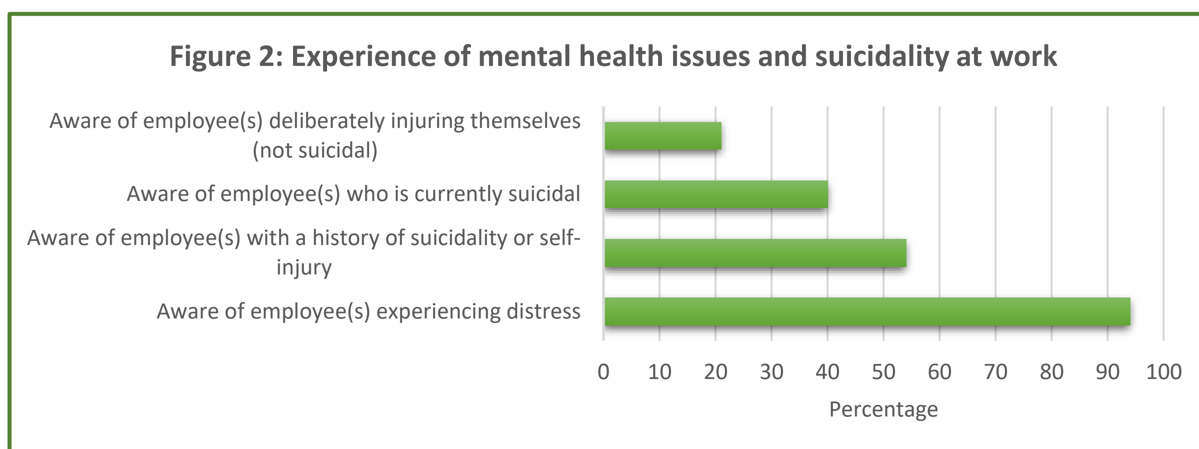
Over 100 employees (primarily leaders and employees with support functions) were invited by email to respond to an online survey examining their responses to employees presenting with mental illness and/or suicidality. The average time taken to complete the survey was 15 minutes. Seventy-two responses were received, constituting approximately 6% of people within the leaders and support function roles.

The needs analysis explored experience, awareness of mental health and suicide, confidence in providing support, awareness of support strategies, and ability to direct to appropriate services.

3.1 Awareness of mental health and suicidality in the workplace

A large percentage of participants had been aware of distressed employees in the workplace. Significantly, over 50% were aware of an employee who had a history of suicidality or self-injury, with a large number also having been aware of an employee who is currently suicidal (figure 2).

Figure 2: Experience of mental health issues and suicidality at work



In examining participant's understanding of warning signs for suicidality and self-injury (both physical and psychological), some participants (6%) were unfamiliar with the term 'warning signs'. However, most (72%) were familiar with the concept of a warning sign and were able to identify a variety of potential physical, behavioural and emotional warning signs for suicide (figure 3). The most commonly identified warning signs were depressed mood, mood changes, withdrawal and isolation, and talking about suicide or making threats. No participants identified prior suicidal behaviour as a risk factor for future behaviour, suggestive of a lack of knowledge about suicidal behaviour.

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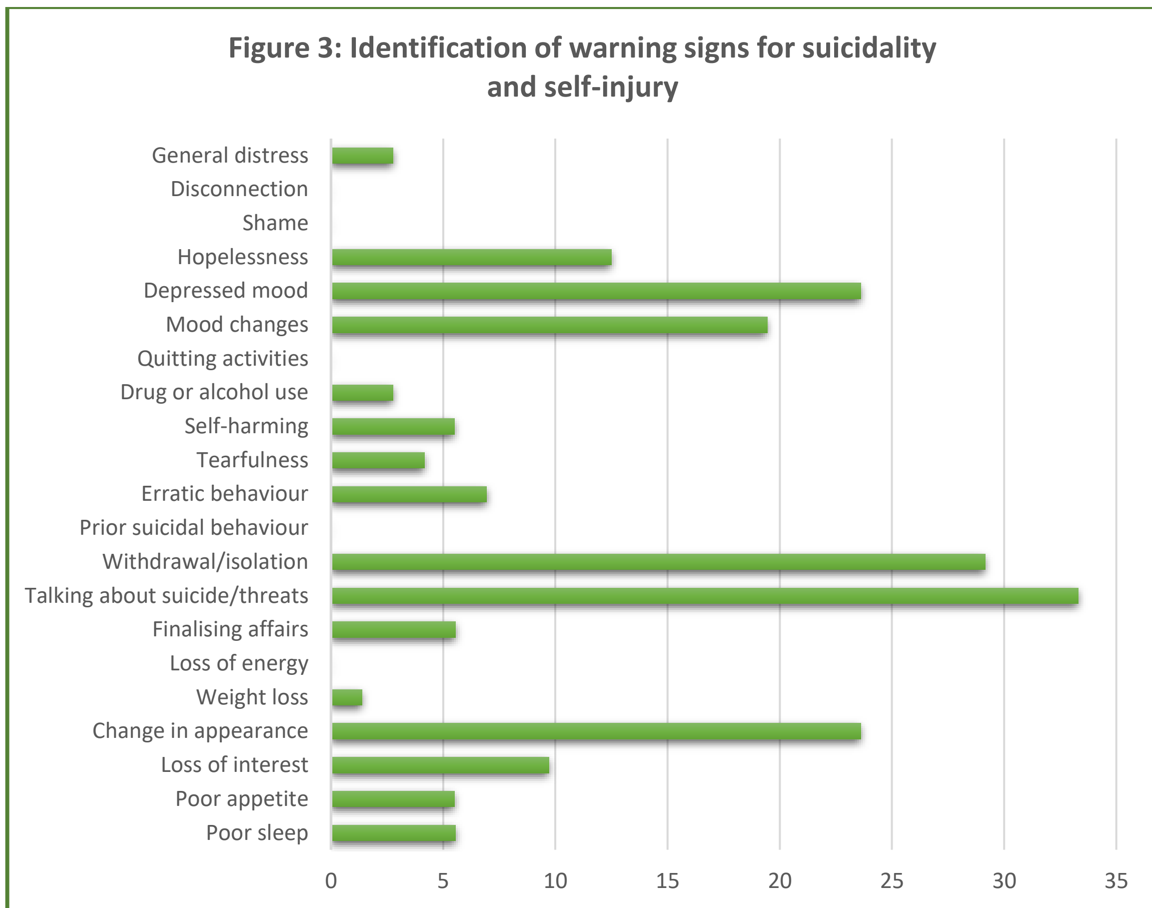
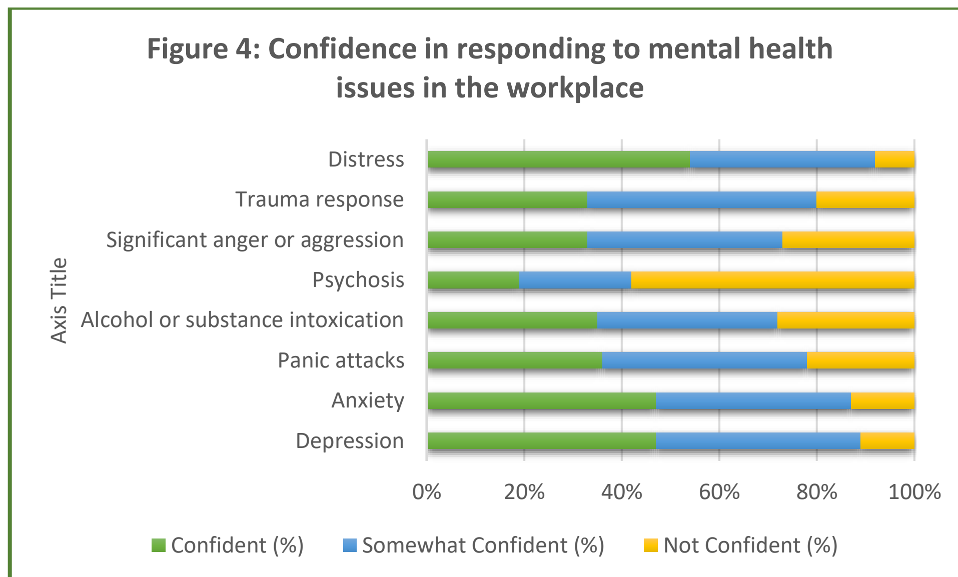


3.2. Confidence in responding to mental health issues, suicidality and self-injury

For the most common mental health presentations, participants identified feeling 'confident' or 'somewhat confident' in responding appropriately (figure 4). The 'somewhat confident' responses suggested there is room for development of skills. For the less common psychological presentations, there is a significant training need with the workforce identifying that they feel mostly ill-equipped in dealing with psychosis.



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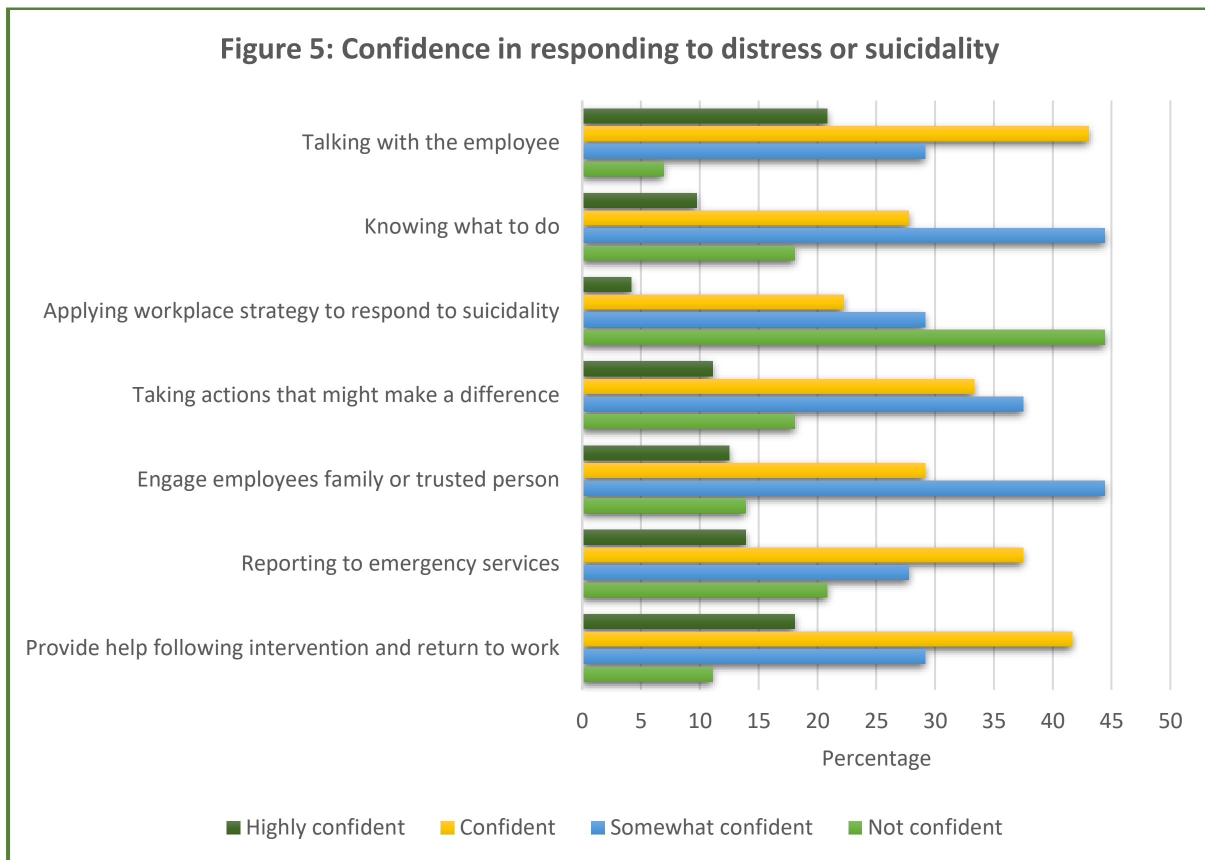
The survey explored this confidence further, examining confidence in employing specific strategies to assist employees. Under half (42%) of all participants identified that they knew how to support an employee who faced mental health difficulties.

Figure 5 describes the most frequent methods of support that participants felt confident in using – the most common was engaging with the employee. This suggested a proactive and responsible approach to managing issues in the workplace. However, 22% of participants reported being unaware of any support mechanisms or appropriate actions, while 36% said their ability to support employees depended on a range of factors. These included concerns about the severity or complexity of the mental health issue, openness of the employee and availability of support mechanisms, particularly in rural areas. In addition, there was a significant lack of confidence (44% not confident) in applying the workplace suicide prevention strategy in responding to suicidality, suggesting a training deficit or lack of knowledge.



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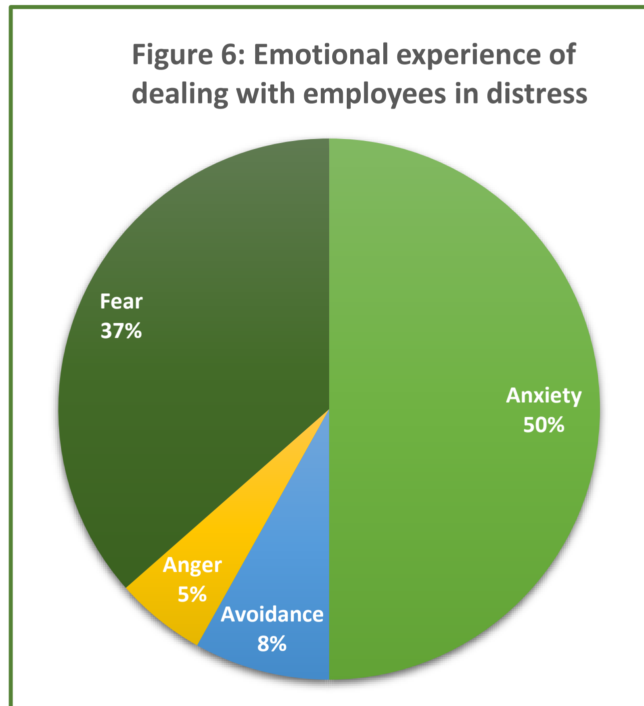
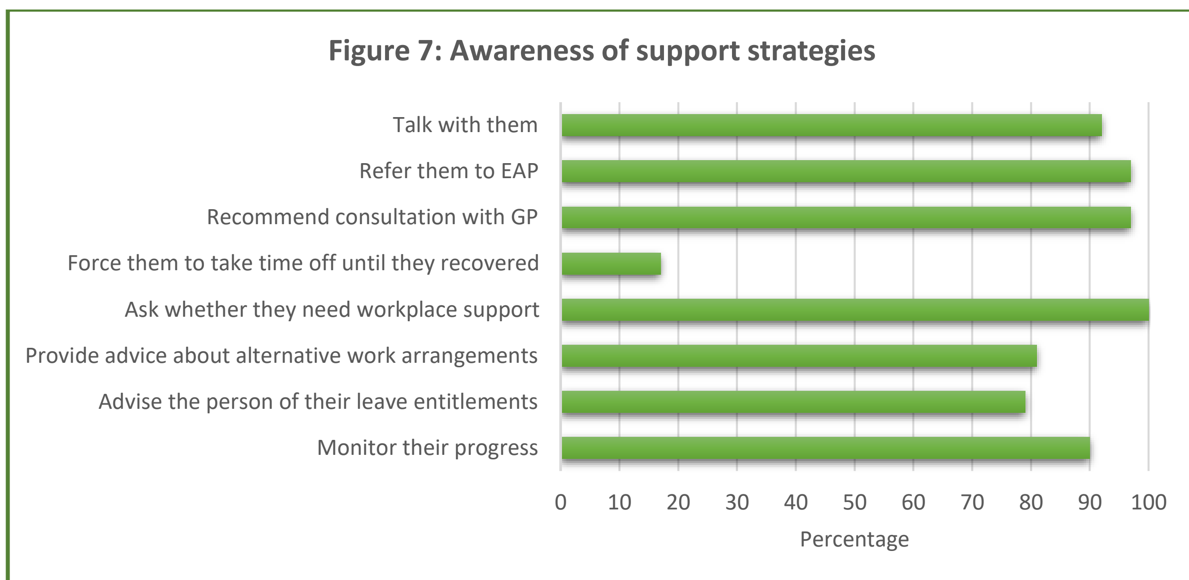
When asked about their emotional response to assisting people who are suicidal or self-injurious, 40% of the participants identified that they would not feel concerned about working with an employee in distress. The remaining 60% identified experiencing some negative emotions as a result of dealing with employees in distress (figure 6). For half the participants, anxious feelings were present when dealing with employees experiencing mental health or suicidal issues. This suggests a significant need for providing support to gatekeepers.



3.3 Awareness of support strategies

Most participants were aware of a variety of ways to provide support. Most participants did not consider forcing someone to take time off to be an appropriate way of supporting an employee with mental health issues (figure 7). The supportive actions that participants were most familiar with included offering organisational support, talking to the employee, referring them to the Employee Assistance Program (EAP) or General Practitioner, and monitoring employees.



3.4 Ability to direct to appropriate services

Of those participants who had been concerned for a colleague or employee and have responded with action, the most common form of action was asking the employee's friends or colleagues to monitor them, as well as directly approaching the topic of suicide with the employee. Figure 8 shows the range of strategies employed. It also shows the frequency in which certain strategies are employed – most notably contacting EAP is used most regularly as a strategy but the overall level of using EAP was still less than 30%. These results suggest that strategies are infrequently used, despite the previously identified high level of distress in the workplace.

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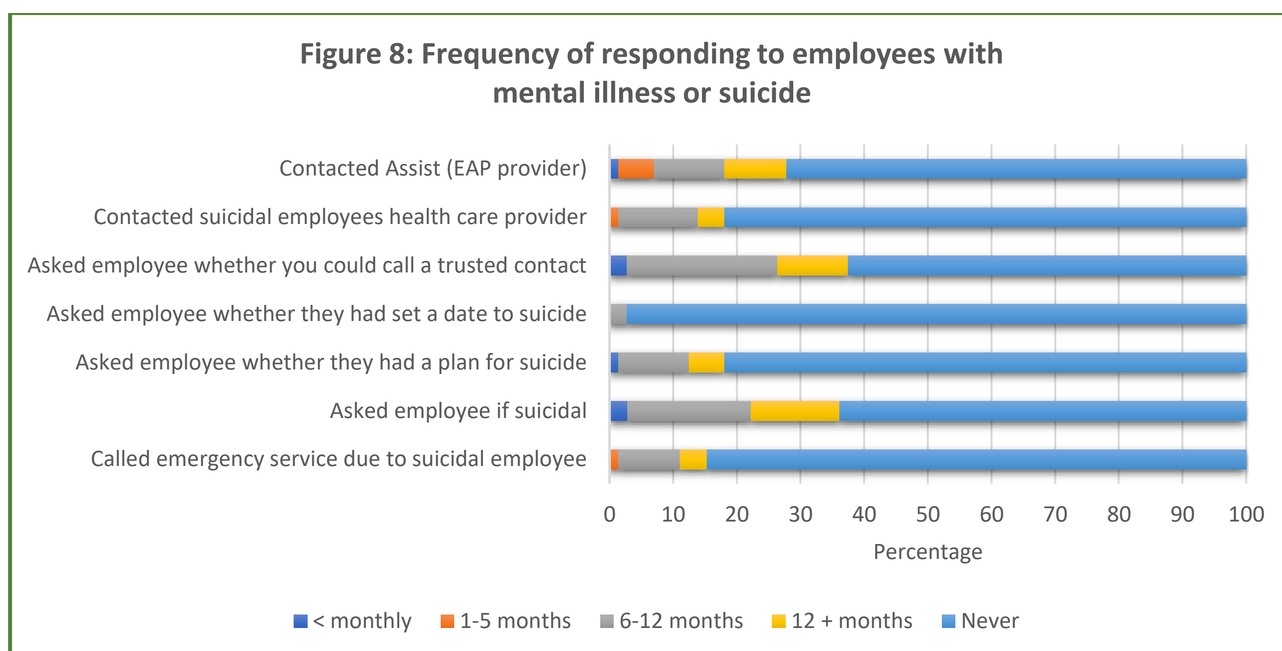

3.5 Outcome of needs assessment

It was evident from the needs analysis that mental health difficulties, suicidality and self-injury are not isolated events but are present across the workforce, and that people perceive they have a responsibility in addressing these concerns. There were some key areas of training and development need identified through these responses, which were consistent with the four factors of gatekeeper training and the factors assessed by the Gatekeeper Behaviour Scale (see table 1).

Identified training need	Gatekeeper training factor	Gatekeeper Behaviour Scale factors
Understand warning signs (physical, emotional and behavioural) for suicide and self-injurious behaviour	• Knowledge about suicide	• Preparedness
Develop resilience and confidence in providing support and help to employees in distress	• Self-efficacy • Reluctance to intervene/ stigma	• Preparedness • Likelihood • Self-efficacy
Understand and feel confident to apply strategies for suicide prevention	• Beliefs and attitudes about suicide prevention • Self-efficacy • Reluctance to intervene/stigma	• Preparedness • Likelihood • Self-efficacy
Promote and understand the workplace suicide prevention strategy and how it supports all staff.	• Beliefs and attitudes about suicide prevention • Reluctance to intervene/ stigma • Self-efficacy	• Preparedness • Self-efficacy

Table 1: Needs assessment outcomes and gatekeeper training factors

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4. The Program: Suicide Prevention for Leaders

The Suicide Prevention for Leaders (previously known as Managers as Gatekeeper Training) was developed by Suicide Risk Assessment Australia (SRAA) in recognition of the important placement and role of workplaces in identifying suicidality. Strong workplace initiatives can inspire and empower workplaces to address and assist employees and provide a workplace culture that supports people with mental health issues.

This workshop teaches key factors essential for nominated employees – gatekeepers – to work with peers experiencing distress, who may be in crisis or who are reporting suicidality, with the goal of reducing the potential risk for suicide. The program is presented through a combination of didactic formal presentations, video presentations and experiential exercises and training areas include:

Self-care. Recognising the importance of self-care in resilience, and the role of resilience in providing support to others, the program addresses the need for self-care, self-care strategies and increasing comfort in discussing suicide.

Suicidality and self-injury psychoeducation. This focuses on having an increased understanding of the facts and appropriate terminology, as well as exploring the relationships between mental health and suicidality and the critical role of a positive and supportive workplace culture.

Leadership roles. This explores the roles and functions of individuals in leadership or gatekeeper roles, particularly focussing on identifying the role of gatekeepers and leaders and to enable the provision of providing support through empirically derived actions that aim to increase help-seeking and reduce risk.

Preparing for gatekeeping. This component focusses on applying theory through the practice and development of behavioural engagement techniques, whilst also facilitating engagement through environmental adjustments and strategies to enhance personal preparedness.

Safety planning. Through role playing hypothetical scenarios, participants collaborate with their 'suicidal worker' to develop a Safety Plan consistent with the Stanley and Brown (2012) model[52]. This demonstrates transparency and focuses on the need for an individual approach, while also harnessing the available workplace resources.

Resources and documentation. This component provides support to leaders and gatekeepers through identifying internal workplace resources and external services, discussing policies and procedures that support actions, and understanding duty of care, consent and other relevant documentation requirements.

5. Project Scope and Aim

The aim of this project is to explore learning outcomes and program efficacy following the implementation of a gatekeeper training program within a large workplace. This will have a focus on knowledge acquisition, capacity and ability to apply knowledge and engagement in the program, specifically examining whether the workplace needs have been addressed through the delivery of the gatekeeper training, Suicide Prevention for Leaders Program.

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6. Evaluation Process

Following from the initial needs analysis, 150 employees participated in the SRAA Suicide Prevention for Leaders, with workshops delivered nationally between October 2017 to March 2018. All participants were invited to partake in the evaluation study, which was sent via email. Of these participants, 66 employees completed the initial post-workshop survey (within 48 hours of training completion) and 74 employees completed a case study-based evaluation six weeks post-workshop.

In the initial evaluation, a validated measure, the Gatekeeper Behaviour Scale (GBS) was utilised[53] (see Appendix). The survey evaluated people's attitudes towards suicide prevention training, their preparedness to engage with a potentially suicidal employee, the likelihood to respond and self-efficacy, their confidence and capacity to respond with workplace-specific and evidence-informed strategies. It is noted that the term 'student' in the original GBS was replaced by the term 'employee' for this specific cohort.

Due to organisational constraints, it was not possible to re-administer the GBS at the six-week follow-up. However, a case study assessment approach was utilised in order to identify areas of skill, attitude or knowledge development that maintains or dissipates over time and highlight any potential need for refresher training. Efforts were made to engage participants after 12 weeks, 6 months and 12 months. Unfortunately, employee retention, organisational change management and restructuring resulted in significant disruption to the workforce's engagement with the program, which was not foreseen prior to the projects initiation.

The workplace was not able to capture data related to the frequency or prevalence of workplace suicidal and self-injurious events. Therefore, no evaluation was possible regarding any changes in this data post-training.

7. Results

7.1 Initial post-workshop evaluation

7.11 Motivation

One potential barrier to the effectiveness of gatekeeper training is a lack of interest and investment in recognising the need for suicide prevention[54]. Additionally, underpinning any knowledge acquisition, capacity and ability to apply knowledge and engagement in suicide prevention is empathy and motivation. The survey responses indicated that all participants felt they had an important role in the workplace suicide prevention strategy.

7.12 Preparedness

Preparedness as a construct relates to an individual's knowledge and potential to respond to a person who may be suicidal. Preparedness taps into the participant's knowledge of suicidality and identification of suicide warning signs, strategies for engaging an employee, as well as resources and the intent to link the person with appropriate support services. Figure 9 indicates that post-training, all participants felt able to recognise warning signs and engage and motivate an employee in distress. In fact, most participants felt that they had the knowledge and potential to respond to a suicidal or self-injurious individual. This is in contrast to the identified lack of confidence in dealing with a person with suicidal behaviour in the needs assessment, whereby there was a lack of

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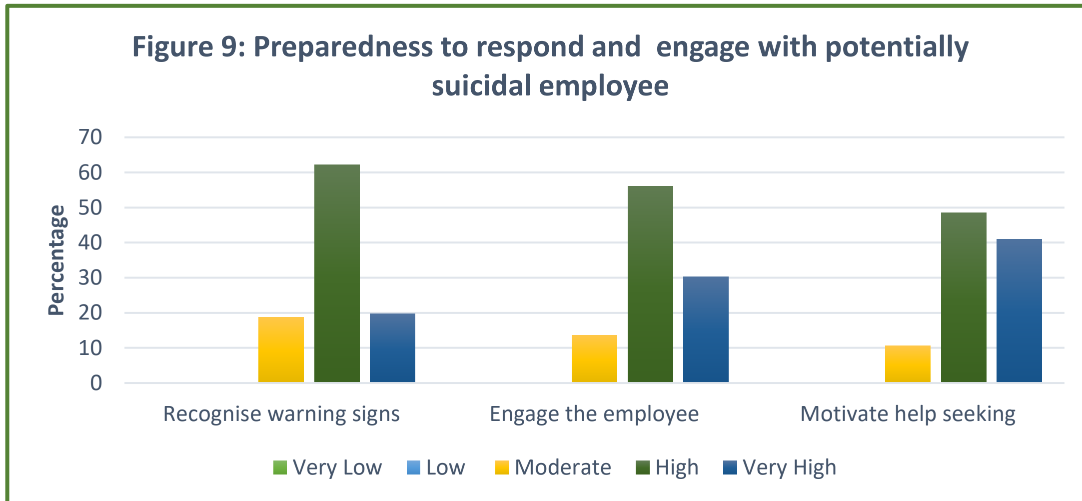
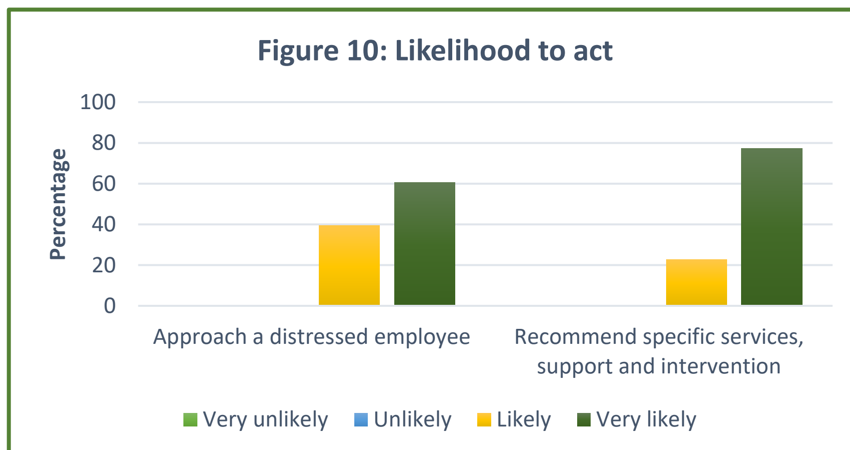
confidence in applying the workplace suicide prevention strategy and where negative emotions strongly impacted a person's ability to feel prepared with the distress of an employee.



7.13 Likelihood

The construct of likelihood relates to a participant's beliefs around their perceived probability of engaging in suicide prevention activity with another person. This construct extends from preparedness whereby the more knowledge and resources available, the greater the likelihood for action. In surveying participant's beliefs around their perceived likelihood of acting, they reported a high probability that they would engage in suicide prevention activity with a person presenting with suicidal behaviour. In fact, 100% of participants indicated a strong likelihood of both approaching a distressed employee to enquire about suicidality, as well as recommending services to support them (figure 10).



7.14 Self-efficacy

Self-efficacy pertains to the belief that a person can achieve their goals. The questions in the survey pertaining to self-efficacy explored how capable a person feels in achieving effective action regarding people with suicidal behaviour.

Following training, all participants indicated that they felt confident and capable of discussing support options and taking action, as well as confidence in the workplace services and suicide prevention strategy (figure 11). Compared to the needs analysis where 44% of participants identified

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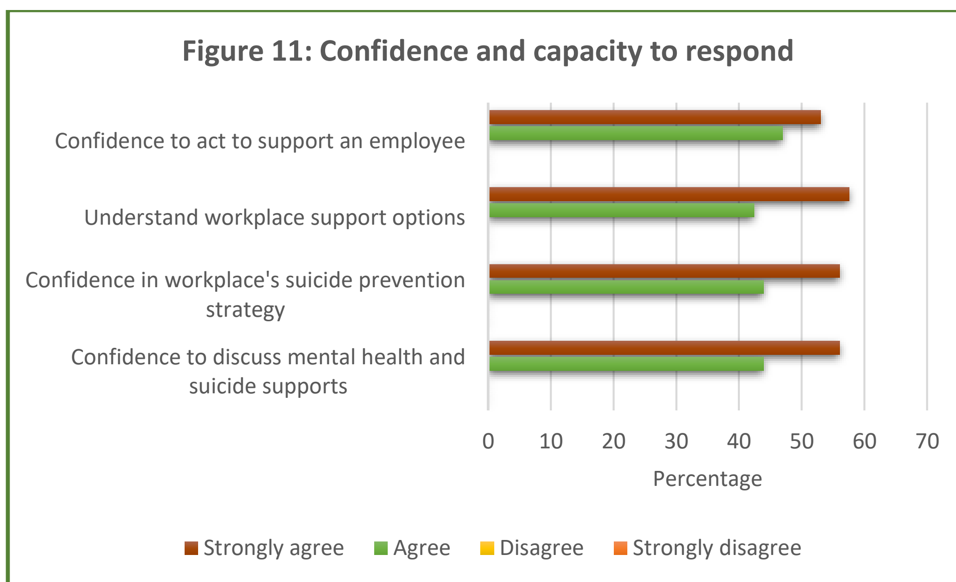
a lack of confidence in applying the workplace strategy in suicide prevention, this suggests a development of skills and an increased sense of self-efficacy.



7.2 Six-week follow-up survey

There were six areas of assessment included in the case study evaluation (text box 1). All the responses aimed to identify the maintenance of learning and highlight potential further development needs regarding to implementing the workplace mental health and Crisis Response Table[ii]. This table outlines appropriate actions based on the presentation severity of an employee.

The initial question asked participants to provide an open-ended response, while the other five questions provided multiple choice responses, each with a correct option. Each are described below.

Text Box 1: Case Study (six-week evaluation)

Sarah is usually a diligent employee and has been with you for the past five years. You have noticed that she is somewhat withdrawn and generally not herself. Her performance has deteriorated significantly over the past week, where there was a major error noted. Two of her team members have approached you expressing concern that she is depressed, becomes teary or agitated and on one occasion, she said that she "wishes she was dead". You decide to call her in for an informal meeting, to better understand what is happening for her, and to offer her support.

7.21 Application of Crisis Response Table

This question was open-ended and provided the brief case study, asking participants to identify how they would respond. This question examined participant's familiarity and ability to utilise the Crisis Response Table. Unfortunately, only 20 participants responded to this question and this limits any extrapolation of conclusions to the wider group. However, from the responses, it appears that participants can identify appropriate courses of actions and the range of potential responses is identified in Figure 12.

[ii] The Crisis Response Table used for this organisation was adapted from the SRAA and is protected under the workplace agreement. However, the SRAA Crisis Response Table is attached in the appendix for reference.

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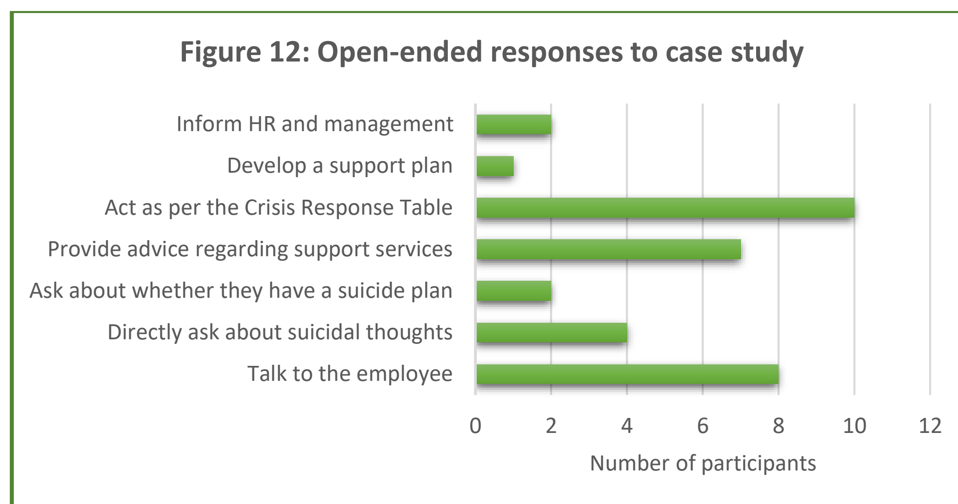

7.22 Taking immediate action

All participants (*N* = 74) responded to all remaining questions. Four questions focussed on participant's knowledge of taking appropriate immediate action. The results showed that 96% of participants were aware of the need for preparation, as well as appropriate resources available for preparation, prior to talking with an employee. Further, 98% of participants recognised the need for asking about plans of suicide directly.

One question explored how participants would deal with the distressed employee who stated that they are not suicidal and then identify appropriate next steps. While all participants recognised the significance of the distress in the case study, only 45% of participants selected the correct response, correctly following the Crisis Response Table guidance. In fact, over 50% of participants perceived that the situation did not require as significant an intervention as was indicated by the presentation of the employee. This highlights challenges posed when situations are unclear or ambiguous (the case study implies that the employee is clearly distressed but denies suicidal intent), and that participants responses currently suggest a tendency to minimise the seriousness of the event. This indicates a further training where cases are complex or ambiguous.

The final action question explored participant's knowledge of introducing the concept of a safety/support plan to the distressed employee. This suggests knowledge of the Crisis Response Table and understanding appropriate next steps. Eighty percent of participants identified correctly that the appropriate action would involve introducing the safety/support plan, including identifying appropriate supports, such as EAP or contacting a GP. While 19% of participants identified introducing a range of online support services that could be helpful indicates good intent, this is not consistent with the Crisis Response Table and best-practice suicide prevention.

7.23 Who to notify

One question measured participants knowledge regarding who to notify in response to an employee talking about their suicidality. Ninety-nine percent of participants correctly identified the requirement to consult and collaborate with appropriate leadership, management and human resources.

7.3 Participant feedback

Feedback was sought regarding experiences during the workshop, including potential limitations or adjustments to the workshop. Feedback was received from 143 participants. Overall, the program

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achieved a Net Promotor Score of 9.4/10, with an overwhelming majority awarding a score of 10/10 for their likelihood to recommend the training to others.

The feedback provided is summarised below, within themes. It should be noted that some participants offered suggestions which extend across the multiple themes.

7.31 Role plays

Several participants commented on the need for more role plays and opportunity to work through case examples. It was suggested that demonstrating a variety of strategies to initiate 'lead in' conversations could also be helpful. One respondent asked for real case examples to be role played.

7.32 Content

A few participants requested additional content inclusions, such as discussion of discrimination. Additionally, greater focus or specificity regarding mental illness, such as suicide rates, trends, "triggers" for mental illness, and anxiety and depression was requested. In addition, there were some requests for more opportunities to examine examples using the workplace suicide prevention strategy guidelines, particularly focusing on complex situations, such as remote or overseas locations.

There were a range of comments that highlighted strengths in the content and structure of the program. These ranged from one participant noting that it was "*candid yet compassionate*" and another reporting it was "*confronting enough to realise the importance of the issue*". Other participants described the program as "*interactive, informative without being overwhelming*" and that the "*delivery of the presentation that kept me interested*" was a strength. Of note, multiple participants highlighted the consolidation of learning through role plays was valuable, despite wanting additional time for more experiential learning. One participant explained that *"… the real-life scenarios that were discussed and practical 'what to do' examples were strengths*".

One participant described feeling "*empowered to help in a situation where previously I would have been cautious, and overthought things before acting. Also, it is unfortunate that so many of us as Leaders in the room had been confronted by these situations, however, knowing that this is the case makes me feel confident that I can rely on my colleagues for support and understanding should I need it*". They also described "*building confidence*", "*knowing what to look for and what we can do*", "*there is no need to feel inadequate and unable to assist someone*" and "*having examples to illustrate points*", as empowering their capacity to act.

7.33 Course duration and delivery

Several participants noted that a lot of information was delivered in a short period of time, and that discussions of complex and specific experiences raised by trainees limited time further. In addition, two participants commented that providing the training at the end of a working week impacted their energy levels and focus during non-work time.

7.34 Course attendance

Feedback was provided that some trainees were observed to be conducting non-training activities during the sessions. For example, one respondent asked that people are directed to attend and that no phones are allowed as this was distracting.

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7.35 Ongoing Support

Several participants requested follow up regarding how to apply the gatekeeper skills, such as through one-on-one sessions, peer support sessions/communications (e.g. app-based) or additional workshops.

7.36 Presenter

There were numerous comments noting that the depth of knowledge and the capacity to respond to specific questions was a strength from SRAA. It was also observed that the facilitation of participant engagement and inclusion through contributions and questions were strengths.

8. Discussion

The purpose of this current review is to examine this gatekeeper model with regards to knowledge acquisition, capacity and ability to apply knowledge, and engagement in the SRAA Suicide Prevention for Leaders program. Each of these will be discussed below.

8.1 Knowledge acquisition

The workplace needs assessment identified significant knowledge gaps in understanding warning signs (physical, emotional and behavioural) for suicide and self-injurious behaviour, and in the application of the workplace suicide prevention strategy. In addition, the pre-training assessment indicated a need for the development of confidence and resilience in providing support to employees exhibiting suicidal or self-injurious behaviour.

Following participation in the Suicide Prevention for Leaders program, most participants were able to identify warning signs and felt that they had the knowledge and potential to respond to a suicidal or self-injurious employee. This indicates a knowledge acquisition regarding understanding suicide indicators, as well as a development in confidence. However, there were some remaining participants who felt only moderately prepared to deal with a suicidal employee, suggesting that knowledge acquisition and associated confidence may remain an issue for some participants. This is in line with some of the individual feedback, which highlighted requests for additional content regarding mental health and suicide, as well as more experiential learning, case-driven discussions, and follow-up support.

As per the model of gatekeeper training, it appears that this program was successful in developing knowledge about suicide, which is a positive indicator for preparedness for action.

8.2 Capacity and ability to apply knowledge

Following the program, all participants reported a strong likelihood of both approaching a distressed employee to enquire about suicidality, as well as feeling able to engage and motivate them. Participants also identified a strong likelihood of recommending services to support them, the ability to identify appropriate courses of action, and the requirement to consult and collaborate with appropriate leadership, management and human resources. This suggests that participants likely feel prepared enough such that they feel confident in acting. Again, this indicates an improvement following training specific to capability and ability to implement a suicide prevention plan. While already discussed, the improvement in feelings of self-efficacy by participants is likely to have a positive impact on their perceived capacity and ability to apply knowledge in suicide prevention.

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In the needs assessment, over half of the participants identified negative emotions, such as anxiety and fear, impacting their ability to support an employee with suicidal behaviour. Importantly, in the initial follow-up, almost all participants identified the need to discuss suicide directly with an employee and felt confident in their ability and capacity to respond. This is likely the combination of acquired knowledge, self-efficacy and confidence, as well as the actual ability to support a distressed employee guided by the workplace Crisis Response Table.

Results indicated that while participants could identify possible immediate actions, there was some difficulty in accurately identifying the level of the suicidal behaviour as per the workplace Crisis Response Table. This has an impact on decision-making regarding actions, notification and documentation. The results suggested that participants had difficulty in distinguishing between the urgency of required response.

Individual feedback highlighted that further development in applying skills through either individual sessions, peer support sessions or additional workshops may further enhance capability and ability to act, and would likely have a positive impact on confidence and self-efficacy.

These outcomes suggest that participants experienced greater self-efficacy, positive attitudes about suicide prevention and overcame reluctance to intervene and stigma. These are indicators of greater preparedness and likelihood of acting. Further training on assessment, particularly in correctly applying the Crisis Response Table in ambiguous or complex cases, may be of benefit.

8.3 Engagement

Both at the initial post-training and six-week follow-up, it appears that participants perceived that they had an important role in the workplace suicide prevention strategy. There was a positive consensus that participants would recommend the training to others. Results suggested a high degree of confidence to approach and support a distressed employee across all survey participants, as well as an ability to identify an appropriate method of support. This indicates a strong motivation within the group be an active participant in the workplace suicide prevention strategy. The responses suggest that not only do participants feel that it is their role to be an active participant, but that they also feel capable, confident and resilient.

9. Recommendations

Based on the outcomes of surveys and participant feedback, as well as current empirical literature, some potential training developments could enhance learning outcomes further. These recommendations include:

- Utilise robust data collection methods to obtain and record suicidal or self-injurious behaviour within the workforce, in order to monitor the frequency and prevalence.
- Provision of refresher training and follow-up support options. This addresses concerns about the currency of knowledge, which has been shown to dissipate over time. Provision of short refresher training not only ensures that participant's skills and confidence remain current, but that the workplace continues to promote mental health as a priority. Aspects of refresher training could be delivered online.
- Provision of refresher training immediately following any suicidal or self-injurious behaviour to ensure appropriate individual and workplace responses.
- Minor recommendations to the format and content of the existing program:
    - Enhanced use of role-plays to further develop experiential learning and practice.

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- Increase the depth and range of content, enabled through extending the training. This is consistent with the average gatekeeper training being of approximately two days[55].
- Timetable the training to accommodate work schedules and/or breaks.
- Timetable the training to enhance participant's energy and interest levels.
- Ensure presence and attentiveness of participants through ground rules.
- Additional training on assessment, particularly focussing on ambiguous or unclear cases.

10. Limitations of Evaluation

There are several limitations associated with the outcome evaluation methods that have restricted the ability to undertake quantitative analysis of learning outcomes following the Suicide Prevention for Leaders program. This includes the absence of a valid pre- and post-measure, different sample populations over the course of the three assessment points, limited follow-up over time, and a lack of responses to the open-ended question. The lack of a robust data collection method relating to suicide and self-injurious behaviour in the workplace also limits any quantitative analysis of post-intervention outcomes.

The use of case vignettes to assess learning outcomes is unique and provides valuable data to assess specific program objectives. Recommendations for further evaluation in the future would be to develop a data collection method regarding critical incidents of suicide or self-injurious behaviour, and to employ a robust and valid measure over time (pre, post, six-week follow-up and six-month follow-up) to properly gauge knowledge gains and skills acquisition over time. Further, in addition to using a valid measure (such as the Gatekeeper Behaviour Scale), using surveys specific to enacting workplace suicide prevention policy and plans that involve multiple-choice questions but cover a range of case studies, including those that are more ambiguous or unclear will measure maintenance of knowledge over time.

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APPENDIX – Crisis Response Table

Urgency of response	Postvention	Time Critical	Urgent	Suffering	Coping/Adaptive	Thriving
Observed &/or reported	Current/Former Employee • Suicide attempt/self injury reported by employee or other party • Suicide death has been reported	• Suicide/self injury reported as imminent • Violence to others reported or imminent • Access to weapon or method/s for suicide identified • Acute distress (including while intoxicated)	• Acute distress/poor coping • Suicide, self injury &/or violence reported (plan & intent) • Access to weapon or method/s for suicide identified • Isolated/burdensomeness/ self hate/despair/shame /defeat/pain/ substance abuse/dependence • Resources fatigued/ exhausted/unavailable	• Distress observed yet reports & demonstrates coping • Warning signs for suicide identified • History suicide attempt &/or self harm • Readily agitated, angered, impulsive • Harmful substance use pattern or dependency • Requesting support	• Typical functioning, may be punctuated with periods of suffering or difficulty coping • No suicide warning signs • No history of suicide attempt or self harm	• Individual reports and is observed to be motivated, engaged and energised • Healthy, well and achieving desired goals • Finds meaning in purpose in life • No concern expressed by others
Response	**Depending on who completed the notification:** • Immediately offer support/ condolences to the person notifying • Discuss with NoK or person their request for how/what detail to be communicated with the team • Be conscious that legal processes may complicate family/clients' expectations • Document communications **Advise team** • Confidentiality continues after death. No disclosures without consent • Notes/ documents may be subpoenaed and must be handled according to policy • All communication must be conducted according to privacy stipulated by family/employee	• Immediate referral to Ambulance &/or Police **000** • Contact trusted others/family immediately • Facilitate method restriction/ removal if reasonable If safe, stay with client until ambulance/police arrive • Review/Develop Safety Plan with client **Documentation** • Case note observations & actions • GP & treatment providers including sharing Safety Plan • Correspondence with other Leaders/Executive • Notification to identified 'at risk' individuals if violence indicated, with or without consent	Immediate referral to Crisis Assessment Team/s **INSERT LOCAL NUMBERS** • Support client in the room if possible, during calls • Engage with trusted others • Review/Develop Safety Plan **Documentation** • Case note observations & options/actions taken • GP & treatment providers including sharing Safety Plan • Correspondence with other Leaders/Executive • Notification to identified 'at risk' individuals if violence indicated, with or without consent	**Develop Safety Plan** • Make appt with GP &/or treatment providers • May include support from **INSERT LOCAL NUMBERS** • Engage trusted others in collaborative care • Establish regular review/contact/support plan **Documentation** • Ensure consent to engage NoK/trusted others on file • Case note observations and options/actions taken • Communicate with GP & treatment providers • Correspondence re: Safety/ Support Plan with nominated others, only with consent	**Develop Safety/Support Plan** • Establish regular review/contact plan • Ensure collaborative approach with treatment providers & trusted others/Next of Kin in rehab strategy **Documentation** • Ensure consent to engage NoK/trusted others on file • Case note observations only as required for duties/performance • Correspondence with GP and nominated others re: Support Plan if employee requests it	**Support strategies** • Allow autonomy while offering support if needed • Remain engaged but verbalise observations of self efficacy, achievements and opportunities **Documentation** • Hold information consent on file if present, but do not seek explicit consent unless required for role • Case note observations only as required for duties/performance
Self care/staff wellbeing	• Debriefing – opt in and not compulsory. May be facilitated by manager, but may be better provided by external provider, skilled in critical incident debriefing • Access to timely supervision/support, as a group or one-on-one. This is recommended as an ongoing clinical performance strategy. • Proactive strategies must recognise that difficulties can emerge following suicide specific critical incidents, regardless of resilience, competence and experience. • Employee Assistance Program or Suicide Call Back Service – debriefing after hours and professional support in understanding potential suicidality					

✓ Action Guide must be supported by internal policy and procedures specific to suicide prevention in the workplace and/or workplace mental health ✓ Review and update referral numbers relevant to your local area, contacts and collaboration partners ✓ **All** vulnerable employees are supported with a Safety (or Support) Plan to know strategies to cope or reach out, in crisis

APPENDIX: Gatekeeper Behaviour Scale (Albright, Davidson, Goldman, Shockley, & Timmons-Mitchell, 2016).

Gatekeeper Behavior Scale

This tool is freely available for noncommercial use and dissemination. See current citation at bottom of page.

Please select the number that corresponds to the label that most represents you.

Subscale	Number	Item	Response Scale
Preparedness		**How would you rate your preparedness to:**	
	1	Recognize when a student's behavior is a sign of psychological distress	1- Very Low 2- Low 3- Medium 4- High 5- Very High
	2	Recognize when a student's physical appearance is a sign of psychological distress	
	3	Discuss with a student your concern about the signs of psychological distress they are exhibiting	
	4	Motivate students exhibiting signs of psychological stress to seek help	
	5	Recommend mental health support services (such as the counseling center) to a student exhibiting signs of psychological distress	
Likelihood	6	How likely are you to discuss your concerns with a student exhibiting signs of psychological distress?	1-Very Unlikely 2-Unlikely 3- Likely 4-Very Likely
	7	How likely are you to recommend mental health/ support services (such as the counseling center) to a student exhibiting signs of psychological distress?	
Self-Efficacy		**Please rate how much you agree/disagree with the following statements:**	
	8	I feel confident in my ability to discuss my concern with a student exhibiting signs of psychological distress	1- Strongly Disagree 2- Disagree 3-Agree 4-Strongly Agree
	9	I feel confident in my ability to recommend mental health support services to a student exhibiting signs of psychological distress	
	10	I feel confident that I know where to refer a student for mental health support	
	11	I feel confident in my ability to help a suicidal student seek help	

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