



Suicide and Self-Harm Prevention Cymru

Training Needs Analysis Survey 2023: National Report

NHS Wales Executive
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Summary

This report details the findings of the Suicide and Self-harm Prevention Training Needs Survey 2023. In response to the objectives of the national suicide and self-harm prevention strategy the national suicide and self-harm prevention programme deployed a survey to explore the learning and development needs of workers across a wide range of agencies. A series of questions were asked that covered a) demographics, b) responding to people affected by suicide or self-harm, and c) training and development. The survey was distributed to employers across a variety of employment sectors.

The survey found that many reported that they had either never received training in suicide and self-harm or not recently. The majority of those who had received training reported that it either fully or partially met their needs. Many indicated that they were not confident in responding to a range of situations involving suicide and self-harm. Levels of confidence were shown to be related to how recently training had been received.

The findings show clear need to increase learning and development offers across all sectors, delivered in different ways, by experienced tutors. Respondents were interested in both gaining knowledge and increasing their level of skills. There was a demand for knowledge of practical skills and tools and for how to provide an appropriate response. Despite generally good levels of satisfaction with training there are gaps in providing training that fully meets users' needs. Many indicated that they wished to be better informed with a greater depth of content. There was a demand for training to be developed by experts in the field, with relevance to real life situations. A need was identified for a national 'training the trainer' programme to be developed or development of existing courses to increase the skills of those who train others.

The following recommendations are made.

- Access to learning and development is increased across all sectors through a range of delivery methods.
- The outputs of the survey should be communicated with training providers to help inform the design and delivery of training offers.
- Offers should be increased in areas where the survey indicated provision is low.
- Opportunities should be highlighted for those who train others to attend 'training the trainer' courses.
- A national model of learning is developed that includes learning in the workplace. Development of resources for informing front line practitioners of support offers.
- Make the survey tool or adaption of it available to other organisations.

Introduction

Suicide and self-harm affect people of all ages, and from all backgrounds. Suicide is described as a phenomenon, and a serious public health problem, and is often considered to be preventable¹. For every person who dies by suicide, many more attempt suicide, and more again have suicidal thoughts or feelings. While very few people who self-harm go on to take their own life, a history of self-harm is one of the strongest risk factors associated with subsequent suicide². Due to stigma, or fear of doing harm, many people do not feel confident talking about suicide and self-harm, including those whose work is public facing and brings them into contact with people who are vulnerable in this way.

In light of this, one of the key objectives of the national suicide and self-harm prevention strategy for Wales is to:

Increase awareness, knowledge, skills and understanding of suicide and self-harm amongst i) the public, ii) individuals who frequently come into contact with people at risk of suicide and self-harm and iii) professionals.

As part of this workstream, the national suicide and self-harm prevention programme deployed an anonymised survey to explore further the learning and development needs of workers across all agencies, to add deeper insight to the anecdotal feedback being received through different routes across the system. Partner agencies who participated included police, housing, education, social services, health, youth services, and voluntary agencies.

The survey was aimed at those individuals who frequently come into contact with people at risk of suicide and self-harm, be they professionals, lay-workers, or volunteers.

We wanted to have a better understanding of:

- the extent and frequency with which people receive training
- whether the training they attend provides them with what they need,
- their levels of confidence when responding to people affected by suicide and self-harm
- the areas of learning that they feel are most important to help them strengthen their confidence and capability
- preferences relating to delivery format and content for in-service training

¹ [Suicide \(who.int\)](https://www.who.int)

² [Self-harm presentation across healthcare settings by sex in young people: an e-cohort study using routinely collected linked healthcare data in Wales, UK \(bmj.com\)](https://www.bmj.com)

We also wanted to establish a baseline from which to monitor increased access to learning, and the building of confidence across the workforces.

This report details the findings of the survey and identifies actions that are being taken, and further actions that could be taken, in response to the needs identified, to strengthen the response provided by workforces across Wales with regard to suicide and self-harm prevention.

Methodology

The survey was designed and developed by the Suicide and Self-harm Prevention (SSHP) programme team and the Health Intelligence Service based in the NHS Wales Executive. The Public Health Wales National Advisory Group (NAG) for Suicide and Self-harm Prevention provided oversight for the development of the survey and supported its deployment.

The survey was previewed and tested by stakeholders from March 2023 up to final release, through national, regional, and local multi-agency partnership groups. This was to test both the wording of the questions, and the formatting, to ensure that subsequent data analysis and visualisation would optimise on the knowledge gained. The survey was modified in response to several rounds of testing.

The survey was targeted at a range of employment sectors that were known to have staff working with people affected by suicide and self-harm. The survey was anonymous and made clear to respondents that neither they, or their employing organisation would be identifiable in any subsequent reporting, to encourage the most open and candid responses.

The survey was accessible on-line in both English and Welsh and released during the six weeks leading up to the end of the summer school term in 2023, prior to anticipated periods of extended annual leave or family care demands (between 14th June and 31st July). The survey was distributed via email to stakeholder groups asking them to publicise the survey and distribute more widely through their own communication channels. Large employers were also contacted directly, for example local authorities and police forces.

The survey was also publicised on the SSHP Digital Training Hub³ and the NHS Executive intranet, which is visible to all NHS Wales employees.

The survey was broken down into three sections:

- A. Demographics
- B. Responding to people affected by suicide or self-harm (this section asked questions about people's confidence and capability)
- C. Training and Development

There were 26 questions in total, but respondents were not required to answer all questions. Some questions were limited to a particular subset of respondents based on filtering from previous questions.

³ [Welcome to the Suicide and self-harm Prevention Cymru Training Hub \(sshp.wales\)](https://sshp.wales)

Questions 24 and 25 are excluded from this report as they were focussed on the specific training requirements of (self-identifying) mental health professionals. The insights gained from these questions will be processed internally to inform ongoing service improvement work across health and care.

While efforts were made to minimise the number of open-text responses, four questions invited more generalised qualitative data. As this was the first time that the survey was being conducted there were areas of enquiry where the lack of existing insight prohibited the design of categories or response options without the risk of pre-determining what the responses might be.

The open-text responses have been analysed by manually grouping responses into themes. These themes can support the development of more structured questions when the survey is repeated. Responses that were considered not to answer the question and therefore invalid were removed from the analysis.

Strengths and Limitations

Strengths:

- There was a high level of responses from a wide range of employment sectors.
- The anonymity of the survey encouraged candid responses.
- The survey contained variables that allowed cross linked analysis to be carried out.

Limitations:

- Respondents volunteered to complete the survey, so it cannot be viewed as a representative sample of the workforce.
- As the survey was not targeted at specific individuals it is not possible to calculate a response rate.
- Some sectors were better represented than others. The distribution of the survey relied in many cases on organisations distributing the survey details to their employees. The SSHP programme team had no control over how this was carried out within other organisations.
- Some geographical areas were less represented than others.

Data Reporting

Data used in the report are rounded up or down to the nearest percentage point. This means that the total of percentages will not always add up to 100%.

Findings

A total of 2045 responses were completed from across Wales from a range of employment sectors. An accessible infographic on the headline findings has been published on the SSHP Digital HUB⁴

Headlines

Headline findings are:

- Of all respondents, 83% said that they respond directly to people affected by suicide and self-harm in the course of their work.
- Almost a third (30%) stated that they had never received training in suicide and self-harm.
- A further quarter (26%) reported that while they had attended training in suicide and self-harm, this had occurred over two years ago.
- Almost two-thirds (64%) stated that the training they had attended delivered what they needed, whilst only 5% stated that the training did not deliver what they needed.
- When asked about their levels of confidence in responding to people affected by suicide and self-harm, a fifth of respondents (21%) stated that they were 'not confident' in responding appropriately to a range of situations involving people affected by suicide and self-harm.
- One in four (36%) of respondents stated that they were 'Always or usually confident' in responding appropriately to a range of situations involving people affected by suicide and self-harm.
- One in ten respondents (10%) stated that they delivered training in suicide and self-harm prevention as part of their role.
- Of those that delivered training, six out of ten (63%) stated that they had never attended a 'training the trainer' course, and of those 78% said they would be interested in attending 'training the trainer' training.
- Considering the design and delivery of training, eight out of ten (81%) valued the access to 'Experienced tutors' as most important.

⁴ [Documents - NHS SSHP](#)

- Considering areas most relevant to day-to-day work, 86% chose 'Understanding, and responding to people who have thoughts of suicide'.
- Considering topics for webinars or workshops the most popular choice of respondents was 'Trauma informed and compassionate approaches' selected by 82%.

A. Demographics

The survey asked respondents which area of Wales their role covers, what employment sector they worked in, and what their role was.

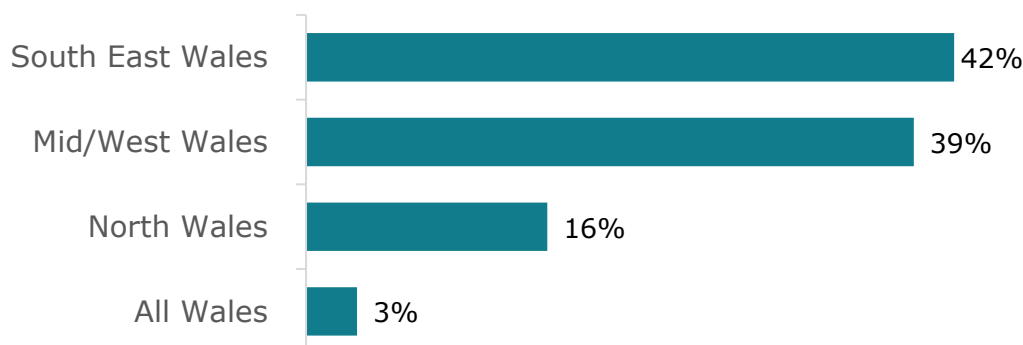
The work of the SSHP team covers three regional areas, each with a dedicated lead (health board and local authority areas covered by the region are shown in brackets):

- North Wales (Betsi Cadwaladr UHB) (Gwynedd, Isle of Anglesey, Conwy, Denbighshire, Flintshire, Wrexham)
- Mid and West Wales (Hywel Dda, Swansea Bay, and Powys UHBs) (Powys, Pembrokeshire, Carmarthenshire, Ceredigion, Swansea, Neath Port Talbot)
- South East Wales (Aneurin Bevan, Cwm Taf Morgannwg, and Cardiff and Vale UHBs), (Bridgend, Rhondda Cynon Taf, Vale of Glamorgan, Cardiff, Merthyr Tydfil, Caerphilly, Blaenau Gwent, Torfaen, Newport)

Q1	Which region does your work apply to? 2045 responses
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Respondents were asked which of the three regions their work applied to. This question also included a further option of 'All Wales' for those who had a national remit or worked Wales-wide. The two largest number of responses were from South East Wales (42%) and Mid and West Wales (39%). North Wales received a smaller portion of 16%. Three percent chose 'All Wales'.

Figure 1. Q1. Which region does your work apply to?



To gauge the strength of representation for each region, a comparison was made between the proportions of respondents for each region with the regional proportion of the national population. From this it was observed that some areas were better represented than others. Those respondents that chose 'All Wales' for question 1 were excluded from this analysis.

Mid and West Wales was the region best represented with the percentage of respondents 12 percentage points higher than the percentage of total population. By contrast both North Wales and South Wales were less represented to the same degree, both with the percentage of respondents six percentage points lower than the percentage of total population.

Table 1. Proportions of respondents compared to proportions of population for each SSH region

Region	Population 2020 ⁵	Percentage of total	Responses	Percentage of responses	Difference in percentage
Mid/West Wales	913,698	29%	804	41%	12%
North Wales	703,361	22%	318	16%	-6%
South East Wales	155,2527	49%	856	43%	-6%
Total	3,169,586	100%	1978	100%	

Q2	What sector do you work in? 2045 responses
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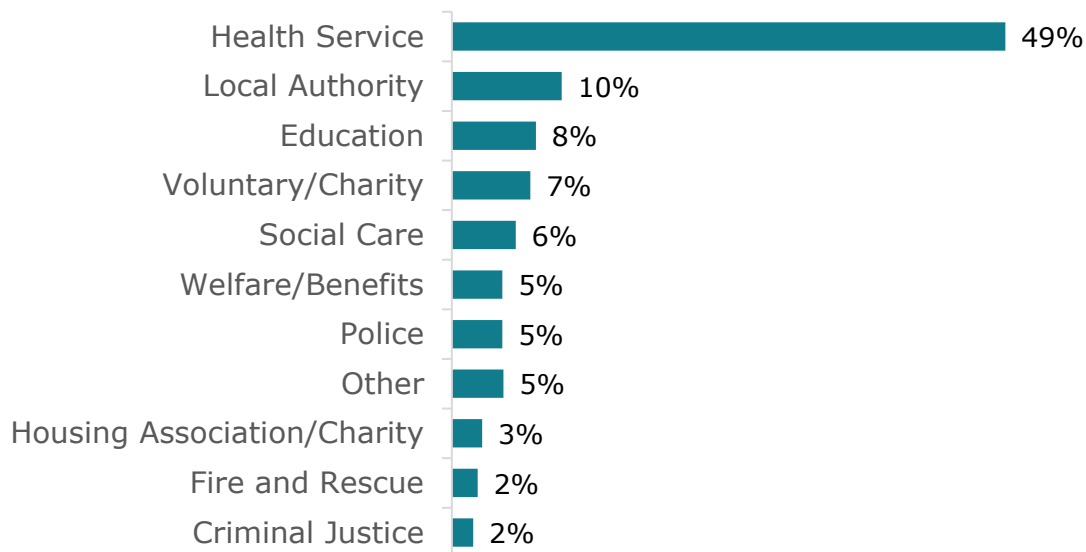
Respondents were asked to select their employment sector from a drop-down list. A further option of 'Other' allowed text responses. Larger sectors (local authority, education, health service and police) were asked a further question to indicate which part of the sector they were working from.

Almost half (49%) of respondents were working in the National Health Service (NHS). The second largest group, Local Authority, had a significantly smaller proportion with 10%.

The 'Other' category included Civil Service (and, more specifically, DWP), coastguard, counselling, drug and alcohol services, RNLI, substance misuse and youth services. However, some respondents did select 'Other' when one of the available options would have been appropriate.

⁵ Office of National Statistics (ONS) mid-year estimate

Figure 2. Q2. What sector do you work in?



When analysed by role, notably for 'Mental health professional' the percentage of workers in the NHS rose to 78%. For 'Front-line workers' the percentage of workers in the NHS was lower at 43%.

Q3	Which service area (within LA) do you work in? 201 responses
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Within the Local Authority sector 29% of respondents stated that they worked in Social Services, followed by 26% Other, 25% in Housing, and 10% in Community Services, 8% in Education and 2% in Resources.

('Other' included economic development, homeless services, occupational health, public health, public protection, waste management, and youth service.)

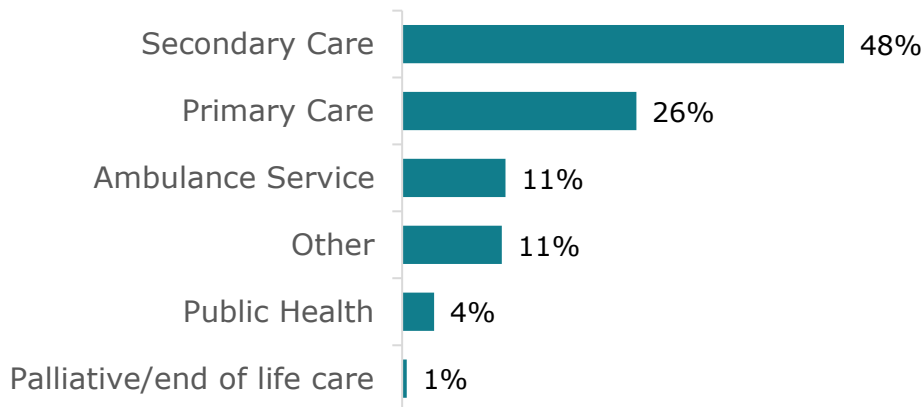
Q4	Which educational sector? 154 responses
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With regard to the educational sector, older learner groups were better represented with University and Higher Education highest with 49%, followed by Further Education, Tertiary with 31% and Secondary 17%. Primary education was less well represented, by 4%.

Q5	Which health service sector? 1011 responses
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Amongst the Health sector, 'Secondary care' was the most represented subsector with 48%. This was notably higher than the next most selected option, 'Primary care' with 26%.

Figure 3. Q5. Which health service sector?



Q6	Which police force area? 92 responses
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This information will not be published here as this will identify individual organisations. However, responses were received from all four forces in Wales.

Q7	What is your role? 2045 responses
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Respondents were asked to identify their role from four options:

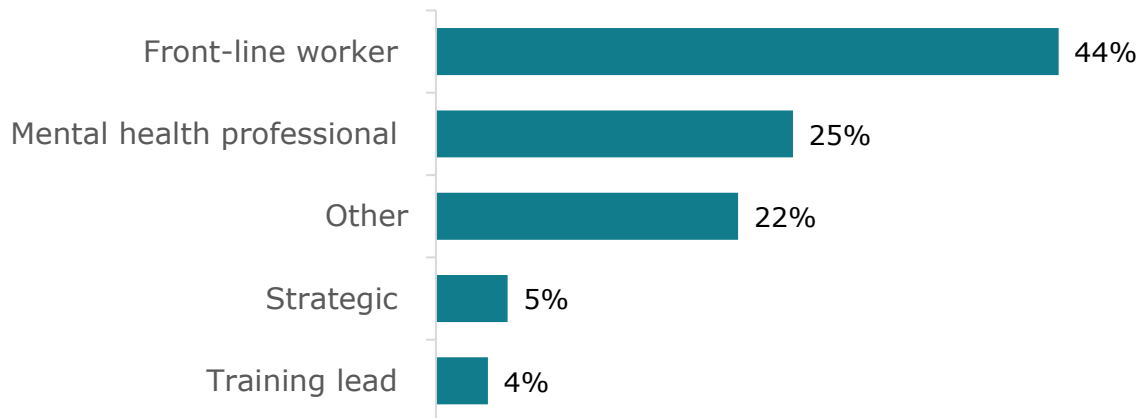
- Mental health professional (social worker, psychiatric nurse, psychiatrist, psychologist)
- Training lead (organisation, department, or team)
- Strategic (implementation of plans, policies)
- Front-line worker (public facing)

Over four out of ten stated their role as 'Front-line worker' (44%). A quarter chose 'Mental health professional' (25%). The remaining categories had far smaller proportions: 'Strategic' with 5% and 'Training lead' with 4%. 22 percent chose 'Other'.

The 'Other' category contained a wide range of roles including, administrator, benefits officer, support worker, employment advisor, union officer, human

resources officer, occupational therapist, police officer, RNLI crew, substance misuse worker, welfare rights advisor and youth worker.

Figure 4. Q7. What is your role?



B. Responding to people affected by suicide or self-harm

An important objective of the survey was to gauge the level of confidence in the workforce when involved in situations relating to suicide and self-harm. This section considers the level of confidence in dealing with a range of situations.

The questions contained in this section of the report were limited to respondents whose work required them to work directly with people affected by suicide and self-harm.

Q8	<p>Does your work require you to respond directly to people affected by suicide and self-harm?</p> <p>2045 responses</p>
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This question was used to filter respondents for the questions that followed (9 and 10).

Overall, over eight out of ten (83%) said that their work required them to respond directly to people affected by suicide and self-harm. This confirms that the targeting of the survey successfully reached the people for whom the survey was designed.

Analysing by role, the percentages of those working directly with people affected by suicide and self-harm were 95% of 'Mental health professionals', 84% of 'Front-line workers', 74% of 'other' and 58% of strategic.

Q9	Thinking about the following situations involving people affected by suicide or self-harm, how confident are you that you would be able to respond appropriately? 1686 responses
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Respondents that stated in Question 8 that they *did* respond directly to people affected by suicide and self-harm were then asked to state their level of confidence in responding appropriately to a range of situations involving people affected by suicide and self-harm. For each statement respondents could choose one of the following options.

- Always or usually confident
- Sometimes confident
- Not confident
- Not applicable to my role

This analysis excludes responses where the respondents selected 'Not applicable to my role' for all situations.

To find the statements for which respondents were the *least* confident, the percentages of 'Always or usually confident' were ordered with the lowest first:

- 'Responding to someone who has been impacted or bereaved by suicide' (32% always confident and 21% not confident).
- 'Responding to someone who is supporting others who self-harm' (35% always confident and 21% not confident).
- 'Responding to someone who is working with those who are vulnerable to suicide' (37% always confident and 18% not confident).

Conversely, the statements with the highest percentages of respondents that selected 'Always or usually confident' were:

- 'Responding to someone who is experiencing thoughts of suicide' (46%).
- 'Signposting someone to other agencies or services who can help regarding issues of self-harm, thoughts of suicide, and suicide bereavement' (45%).
- 'Responding to someone experiencing self-harm' (44%).

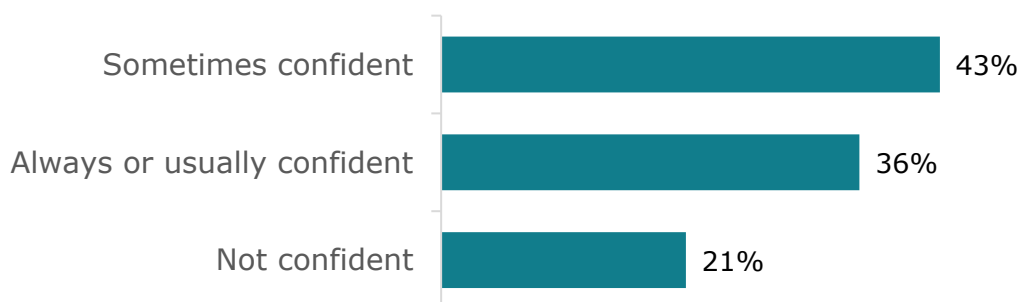
Less than half of respondents chose 'Always or usually confident' for any statement, with the highest percentage being 46% for 'Responding to someone who is experiencing thoughts of suicide'. Even for this statement, over one in ten chose 'not confident' (14%).

Figure 5. Q9. Thinking about the following situations involving people affected by suicide or self-harm, how confident are you that you would be able to respond appropriately?



Looking at overall levels of confidence, based on the percentage of total responses for all situations, only 36% were 'Always or usually confident', and 21% 'Not confident'.

Figure 6. Overall levels of confidence (from Q9)



Analysing overall levels of confidence by role, those identifying as 'Mental health professional' had a significantly higher percentage for 'Always or Usually confident' than all other roles of 47%, 12 percentage points higher than the next highest, 'Other' (35%).

('Other' included: administrator, benefits officer, support worker, employment advisor, union officer, human resources officer, occupational therapist, police officer, RNLi crew, substance misuse worker, welfare rights advisor and youth worker.)

Notably, 'Front-line worker' had the lowest percentage who were 'Always or usually confident' of 30%. This role also had the highest percentage that were 'not confident' of 26%.

Figure 7. Overall levels of confidence (from Q9) by role



Q10	When you interact with people affected by suicide and self-harm, what aspects do you need most help with? (Optional) 1105 responses
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This question was open-ended text and analysed by grouping into one or more themes. Responses that were considered invalid were excluded from the analysis.

The question was restricted to respondents who stated that their work required them to respond directly to people affected by suicide and self-harm in question 8.

The three most commonly occurring themes were 'Signposting and referral', 41% of responses, 'Appropriate response' (36%) and 'Risk management' (8%).

The table below shows all themes listed in order of the percentage of unique respondents per theme.

Table 2. Q10. When you interact with people affected by suicide and self-harm, what aspects do you need most help with?

<i>Theme</i>	<i>Definition</i>	<i>Percentage of respondents</i>
Signposting/referral	Agencies and organisations offer support, referral pathways.	41%
Appropriate response	How to respond appropriately to a person in crisis. Communication skills. Language. Empathy.	36%
Risk management	How to assess and manage risk.	8%
Practical skills/tools	Skills and tools to support a person having suicidal thoughts or self-harming. Safety planning.	6%
Staff support	Support for staff, wellbeing, debriefing.	5%
Self-harm	Training relating to self-harm.	4%
Up-to-date information	Up-to-date information on resources. Refresher training.	4%
Bereavement	How to support people bereaved by suicide.	3%
Supporting family/carers	Support for family and carers when a person is suicidal or is self-harming (not bereavement).	3%
All aspects	Interested in all aspects of training, or specific area not stated.	3%
Awareness	Recognising signs of suicidal ideation. Understanding the psychology behind feelings. Dispelling myths	2%
Other		2%

Selected responses for each theme are shown below.

Signposting/referral:

- *"Signposting information/referral pathways"*
- *"Lack of services to signpost to when the risks are higher"*

- *"Knowledge of the services available to help them – such as a directory of all services (including NHS, local authority, charity, religious groups etc.)"*

Appropriate response:

- *"What steps to take when dealing with someone threatening suicide or harm"*
- *"Something like a 'do's' and 'don'ts' for suicide and self-harm' and 'know what questions and responses to use"*
- *"Confidence to realise that I'm working within the correct boundaries and procedures – it would be great to have a specific framework'- and – 'having a clear protocol to follow; knowing what exactly to say"*

Staff support

- *"Understanding that the organisation will support me and that there are systems in place for me to get support "*
- *"Time to debrief/ have supervision to process others' distress."*
- *"Being able to de-brief so that I don't absorb all of the issues myself and become affected myself."*

Up to date information:

- *"Having the correct and up-to-date information"*
- *"I think it is always good to refresh/recap on all aspects. Keeping up to date with new services and their offers/different ways of working."*
- *"I need to refresh any former training and update on current procedures"*

Self-harm:

- *"Whilst confident in dealing with someone who might be feeling suicidal, I have no training on self-harming and have struggled to find relevant training available"*
- *"Self harm training, there is training for suicide awareness and mitigation but no training for self harm"*
- *"I have never had training on self-harm so wouldn't know what I need to ask the client or what I could tell them."*

Bereavement:

- *"How to support someone who has lost someone to suicide"*
- *"Knowledge of the services available to help them – such as a directory of all services (including NHS, local authority, charity, religious groups etc.)"*
- *"Helpful/appropriate language, where is help to be found, how to help the bereaved, what do people find helpful?"*

Supporting family/carers:

- *"More training on the wider impact and psychological harm to the families"*
- *"Also appropriately raising the anxiety [sic] of parents who are not taking suicidal ideation seriously can be difficult and support or advice with this would be great."*
- *"Supporting parents to find ways of talking to their children about loss of a sibling to suicide"*

All aspects

- *"Having had no training it is difficult to know what I don't know"*
- *"All of it, our training is extremely limited. I use own experiences to help others and that's not always helpful."*
- *"All aspects. adequate training not just teams training for 3 hours would be beneficial"*

Awareness

- *"Recognising suicidal tendencies, who to refer to if needed"*
- *"Awareness of conditions and recognizing signs and symptoms"*
- *"Ok with Dealing with Suicide Ideation but sometimes struggle with things that might be causing this."*

C. Training and development

One of the objectives of the survey was to establish a baseline of the training status of the workforce, in terms of when respondents had last received training, or if they had received training at all.

Respondents were then asked for their views on the training that they had received, what areas of suicide and self-harm prevention are most relevant to their work, and in what format they would like to see training delivered.

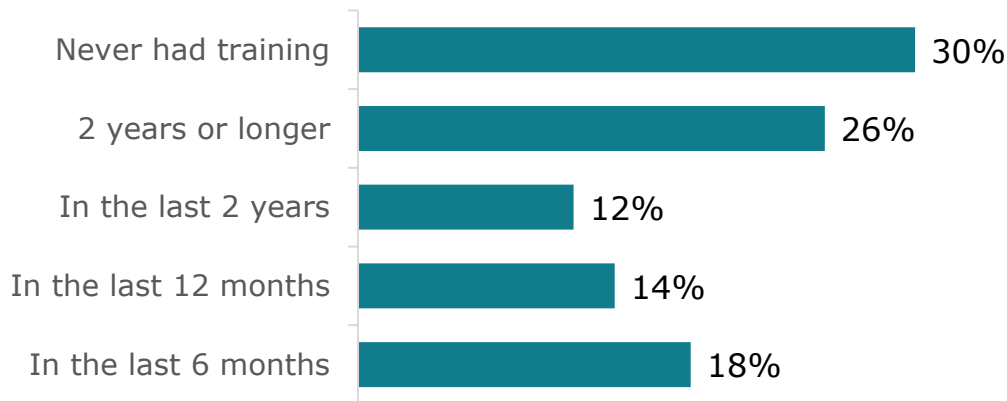
Additionally, there were questions for those who delivered training as part of their role, considering how well equipped they are for this role.

Q11	When did you last attend or access any training on suicide and/or self-harm? 2045 responses
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All respondents were asked if they had received training, and when, in suicide or self-harm. Generally, there was lower than expected training uptake reported with a significant proportion either not having had training at all, or not having had training within the last two years.

Three out of ten (30%) stated they had never received training. Over a quarter (26%) last had training two years ago or longer. A total of 44% stated that they had received training at some point during the previous two years.

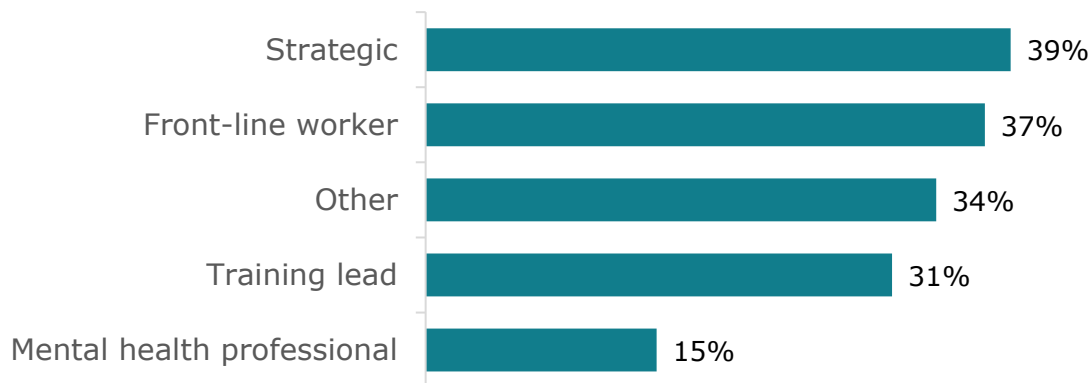
Figure 8. Q11. When did you last attend or access any training on suicide and/or self-harm?



This question was further analysed by role. For all roles except 'Mental Health professional', over 30% stated they had 'never had training'. For those who identified as mental health professionals (across sectors) training levels were noticeably better with just 15% stating they had had never received training.

('Other' included: administrator, benefits officer, support worker, employment advisor, union officer, human resources officer, occupational therapist, police officer, RNLi crew, substance misuse worker, welfare rights advisor and youth worker.)

Figure 9. Respondents who had 'never had training' (from Q11) by role



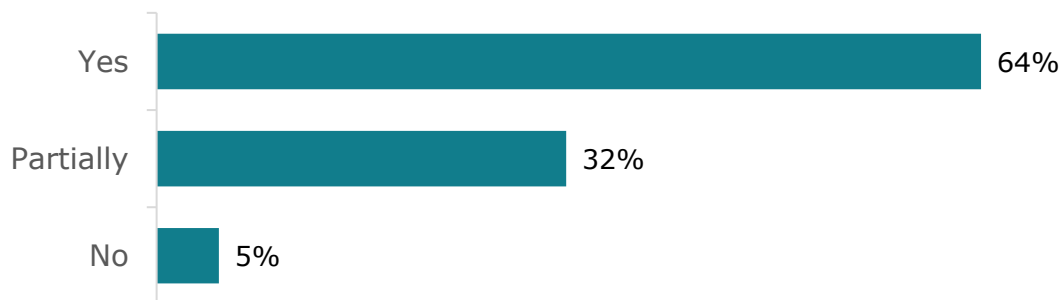
Q12	Did the training meet your needs, or deliver what you needed? 1422 responses
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Those respondents who stated they had received training in question 11 were asked if the training met their needs, or delivered what was needed.

Generally, a reasonably high level of satisfaction with training received was reported.

Almost two-thirds (64%) stated that the training delivered what they needed, whilst only one in twenty (5%) stated that the training did not deliver what they needed. Almost a third (32%) stated that the training partially delivered what they needed.

Figure 10. Q12. Did the training meet your needs, or deliver what you needed?

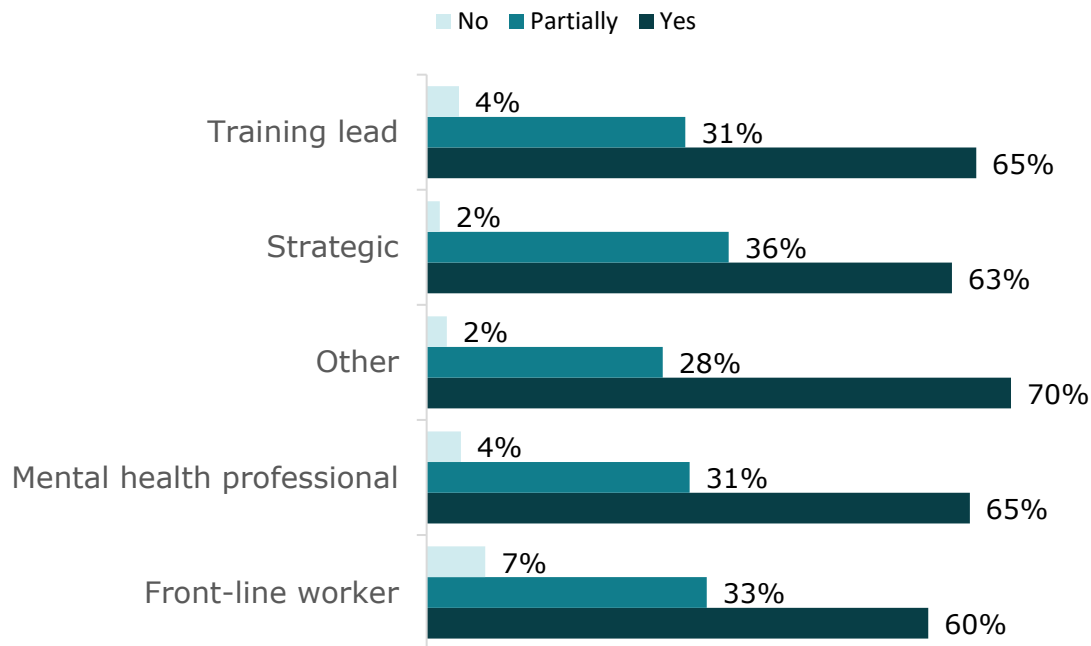


Analysing by role, the level of satisfaction was consistent across all roles with 60% and over for all roles stating that the training met their needs.

For 'Front-line worker' 7% said that the training had not met their needs. This is notably higher compared to 4% for 'Mental health professional' and 'Training lead', and 2% for both 'Strategic' and 'Other'.

(Roles found under 'Other' included administrator, benefits officer, support worker, employment advisor, union officer, human resources officer, occupational therapist, police officer, RNLI crew, substance misuse worker, welfare rights advisor and youth worker.)

Figure 11. Q12. Did the training meet your needs, or deliver what you needed? (by role)



Q13	What did you think was particularly good about the training you received? 776 responses
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This question was open-ended text. Individual responses were grouped into one or more defined themes. Responses that were considered invalid were excluded from the analysis.

The most commonly occurring themes were 'Practical skills/tools', selected by 16% of respondents, 'Appropriate response' (14%) and 'Informative' (13%).

The table below shows all themes identified, listed in order of the percentage of unique respondents per theme.

Table 3. Q13. What did you think was particularly good about the training you received?

Theme	Definition	Percentage of respondents
Practical skills/tools	Skills and tools to support a person having suicidal thoughts or self-harming. Safety planning.	16%
Appropriate response	How to respond appropriately to a person in crisis. Communication skills. Language. Empathy.	14%

<i>Theme</i>	<i>Definition</i>	<i>Percentage of respondents</i>
Informative	Informative, useful (specific area not stated).	13%
Delivery	Quality of delivery, including clarity, conciseness, format.	12%
Risk Management	How to assess and manage risk.	9%
Awareness	Recognising signs of suicidal ideation. Understanding the psychology behind feelings. Dispelling myths.	8%
Experienced trainer	Trainer was experienced in their subject field.	7%
Subject coverage	Level of detail, range of subjects covered.	6%
Discussion/Interactive	Training included discussion or interactive content.	5%
Relevant	Relevant to role, sector, region.	5%
Increased Confidence	Increased level of confidence as training outcome.	4%
Real life examples	Real life examples or lived experience.	4%
Role play/scenarios	Training including role play and scenarios.	4%
Signposting/referral	Agencies and organisations offer support, referral pathways.	4%
Up-to-date information	Up-to-date information on resources. Refresher training.	4%
Self-harm	Training relating to self-harm.	2%
Other		1%
Psychological Approaches	Psychological approaches or therapies. Formulation.	1%
Staff support	Support for staff, wellbeing, debriefing.	1%
Statistics/evidence base	Data and evidence relating to suicide and self-harm.	1%

Selected responses for the top three themes are shown below.

Practical skills/tools:

- *"Always good to have tools to take away from training. I no longer ask, can you keep yourself safe. I now say, you have the capacity to keep yourself safe."*
- *"Coping strategies for those dealing with people with suicidal ideation."*
- *"Good explanation of safety planning- considering the immediate needs of that person."*

Appropriate response:

- *"Helped with what key words to use when dealing with suicide."*
- *"Gave ideas for starting off conversations with the patient, and ideas for directing the conversation"*
- *"Encouraging sensitive use of appropriate language/ terminology"*
- *"It de-stigmatised conversations around suicide, it increased confidence around the early explorations discussions"*

Informative:

- *"Increased my knowledge of pathways"*
- *"Felt confident that I had been equipped with the information required to provide useful support"*
- *"It was thorough and informative, with examples given and a place to discuss specific issues that may have arisen for us"*

Q14	What was missing from the training for you? 429 responses
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This question was open-ended text. Individual responses were grouped into one or more defined themes. Responses that were considered invalid were excluded from the analysis.

The most commonly occurring themes that were considered missing from training were 'Appropriate response' and 'Subject coverage', both with 20% of respondents, followed by 'Signposting/referral' with 14%.

The table below shows all themes listed in order of the percentage of unique respondents per theme.

Table 4. Q14. What was missing from the training for you?

<i>Theme</i>	<i>Definition</i>	<i>Percentage of respondents</i>
Appropriate Response	How to respond appropriately to a person in crisis. Communication skills. Language. Empathy.	20%
Subject coverage	Level of detail, range of subjects covered.	20%
Signposting/referral	Agencies and organisations offer support, referral pathways.	14%
Relevant	Relevant to role, sector, region.	9%
Self-harm	Training relating to self-harm.	8%
Other		7%
Up-to-date information	Up-to-date information on resources. Refresher training.	7%

<i>Theme</i>	<i>Definition</i>	<i>Percentage of respondents</i>
Face-to-face training	Preference for face to face or classroom training.	5%
Real life examples	Real life examples or lived experience.	5%
Risk management	How to assess and manage risk.	5%
Practical skills/tools	Skills and tools to support a person having suicidal thoughts or self-harming. Safety planning.	3%
Supporting family/carers	Support for family and carers when a person is suicidal or is self-harming (not bereavement).	2%
Bereavement	How to support people bereaved by suicide.	1%
Psychological Approaches	Psychological approaches or therapies. Formulation.	1%
Staff support	Support for staff, wellbeing, debriefing.	1%

Selected responses for the top three themes are shown below.

Appropriate Response:

- *"Advice on wording / responses on what to say when someone discloses they are contemplating suicide and correct procedure"*
- *"Direct strategies or 'talk through' tips to address their needs holistically and ensure that I have not missed anything."*
- *"How to deliver empathy and wrap up a conversation with respect in the 10 minutes allocated to me"*

Subject coverage:

- *"More in-depth training - the training attended was for Mental Health First Aid and felt that some topics did not give enough depth, the trainer did not seem to be able to step outside the PowerPoint slides."*
- *"Just needs to be more in-depth - I cover duty calls which is literally people calling in crisis and need to feel confident in how I respond to this."*
- *"It was rushed, lots of elements skipped over and not provided by subject experts."*

Signposting/referral:

- *"Advice on where to signpost people for help."*
- *"Lack of pathway/signposting material and avenues."*
- *"Referral pathways. Information regarding further help outside organisations - i.e in the community"*

Q15	Who is your preferred training provider, or providers, on the management and prevention of suicide and self-harm prevention? (if you have a preference) 138 responses
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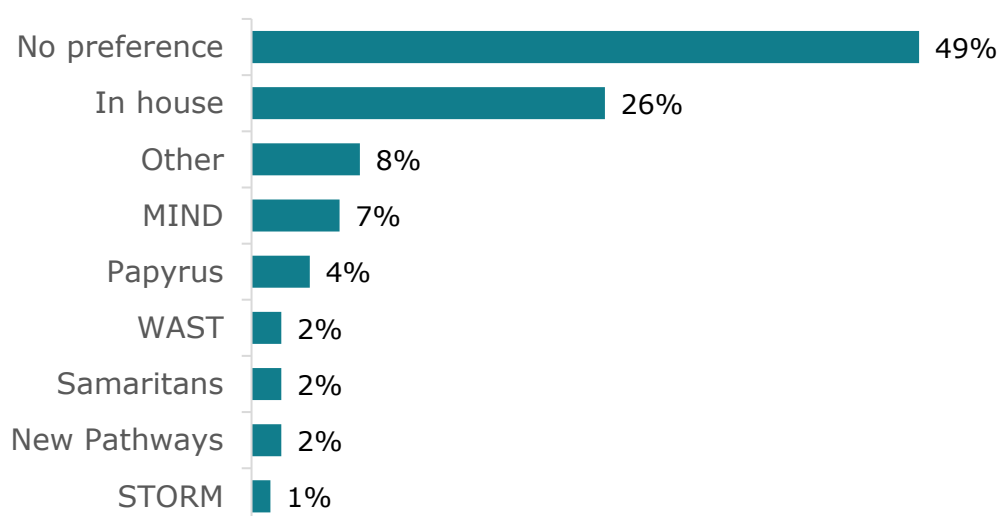
This was an open-text question. Individual responses were grouped into one or more defined themes. Responses that were considered invalid were excluded from the analysis. However, it was decided that those that stated that they had no preference should be retained.

'No preference' was the most frequent category, with almost half (49%) of all responses. This suggested that the 'provider' is less important than the need to have people delivering the training who are experts in the area, and that it reflects real-life experience – something that cannot be delivered by just delivering a set of slides.

The most frequently identified provider was in-house training with over a quarter (26%) of the 278 responses. However, this did not necessarily indicate a preference as many respondents were simply stating who actually delivered training.

8% of respondents chose 'Other', followed by MIND with 7% and Papyrus, 4%. Other providers mentioned were WAST, Samaritans and New Pathways, all with 2%, and STORM, 1%.

Figure 12. Q15. Who is your preferred training provider, or providers, on the management and prevention of suicide and self-harm prevention? (if you have a preference)



Examples of comments for this line of enquiry include:

"Only received in house training from other colleagues, would like to see HB use regular external trainers – there will be a less medical approach and move the narrative away from this just being the business of mental health services"

"Nothing in particular but local teaching and working together may be useful"

"Preferably an organisation who specialises in this field rather than a trainer who just delivers a training programme"

"For CYP training in particular, its felt there needs to be strong links with safeguarding and training providers who appreciate and can deliver on this"

"I have only had inhouse training – it would be good to have a multi-networking event for this"

Q16	Do you deliver any training in suicide and self-harm prevention as part of your role? 2045 responses
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One of the aims of the survey was to find out how well-equipped staff are to deliver in-house training, and if there is a need for more 'training the trainer' training.

The survey asked all respondents if they delivered training as part of their role. Overall, one in ten of respondents (10%) reported that they did.

Analysed by role, as expected there was a wide variation in percentages of those that stated that they delivered training. Excluding Training Lead, 'Mental Health Professional' was highest with 18%. Strategic was 14%, Other 11% and 'Front-line worker' was 4%.

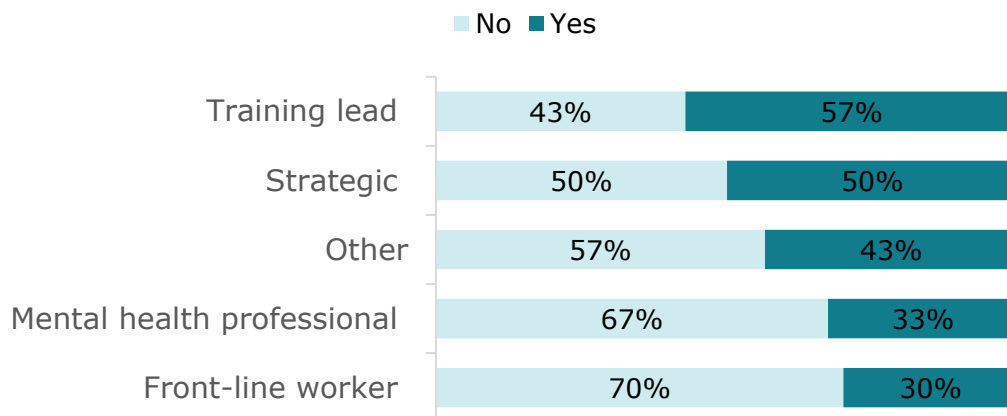
Q17	Have you attended a 'training the trainer' course? 209 responses
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Of those that stated that they delivered training in question 16, almost two-thirds (63%) stated that they had not attended a 'training the trainer' course, with 37% reporting that they had.

This was further analysed by role. For all roles except 'Training lead', at least half of respondents had not attended a 'training the trainer' course. The role with the highest percentage that had not attended a course was 'Front-line worker', with 70%, closely followed by 'Mental health professional' with 67%.

'Training lead' was the role with highest proportion of respondents who had attended a training the trainer course, but notably over on in four (43%) reported that they had not.

Figure 13. Q9. Have you attended a 'training the trainer' course? (by role)



Q18	Which training the trainer programme did you attend and when? 72 responses
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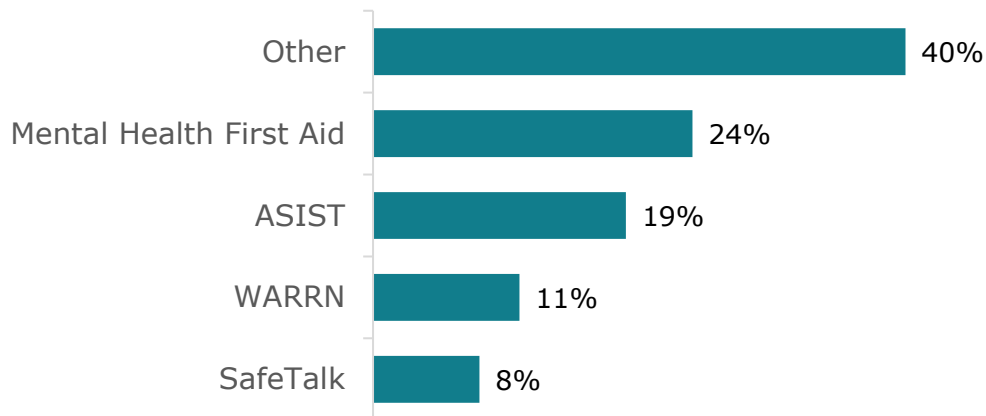
This was an open-ended text question. Individual responses were grouped into one or more defined themes. Responses that were considered invalid were excluded from the analysis.

There was little consistency in the responses to this question, but a number of respondents identified programmes such as Mental Health First Aid (both CYP and Adult), WARRN (risk assessment training within the NHS in Wales), although often many years ago, and the international Living Works ASIST programme⁶.

40% of response were grouped under 'Other'. This is because the programme referred to was not mentioned by any other respondents, or by too small a number of respondents, to form its own group.

⁶ [LivingWorks ASIST - LivingWorks](#)

Figure 14. Q18. Which training the trainer programme did you attend and when?



Q19	Would you be interested in attending a 'training the trainer' programme? 131 responses
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Those that had delivered training, but not attended a 'training the trainer' course were asked if they were interested in doing so. Nearly eight out of ten (78%) answered Yes.

This figure was consistently high when analysed by role, with 'Other' 89%, 'Mental Health Professional' 80%, 'Front-line worker' 68% and 'Strategic' 57%.

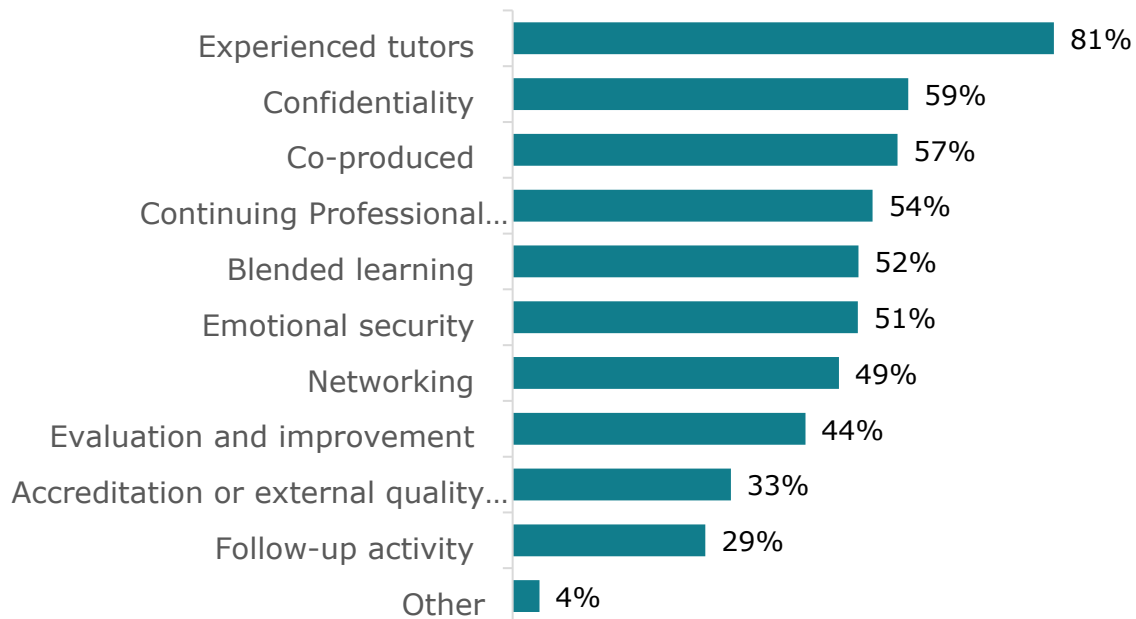
Q20	What are your primary requirements regarding the design and delivery of training on suicide and self-harm management and prevention? (select all that apply) 2045 responses
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When asked for primary requirements regarding the design and delivery of training, 'experienced tutors' was notably the most popular option, selected by eight out of ten respondents (81%).

Other options all chosen by over half of respondents were Confidentiality (59%), Co-produced (57%), Continuing Professional Development (CPD) recognition (54%), Blended Learning (52%) and Emotional Security (51%).

There was another category for 'Other' responses. Themes included face to face training, flexibility of access for part-time workers, regular or refresher training, training in the Welsh context and separate training for suicide and self-harm.

Figure 15. Q20. What are your primary requirements regarding the design and delivery of training on suicide and self-harm management and prevention?



When broken down by role, 'Experienced tutors' was notably the most frequently occurring option for every role (Front-line worker 78%, Mental health professional 86%, Other 80%, Strategic 79%, Training lead 77%).

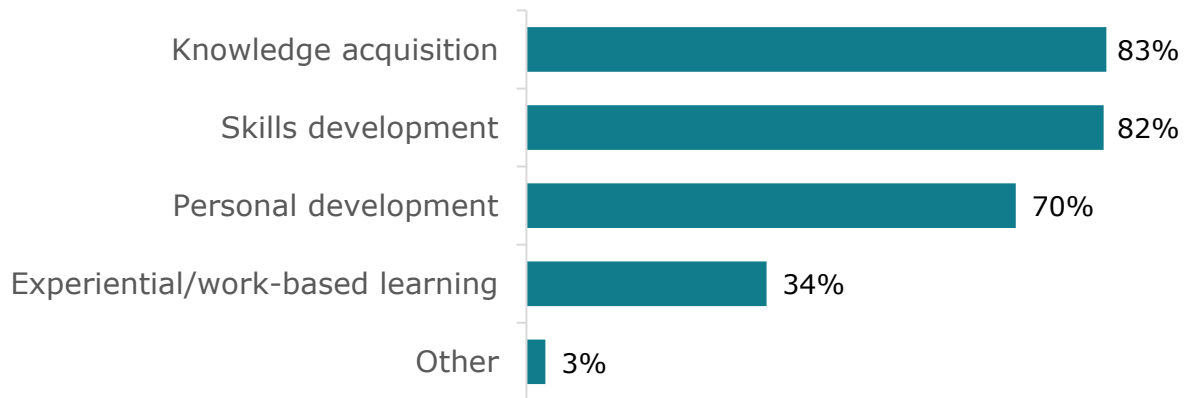
Q21	<p>What would you be looking to gain from training on suicide and self-harm management and prevention? (select all that apply)</p> <p>2045 responses</p>
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Overall, of the top three most selected options, 'Knowledge acquisition' was chosen by over eight out of ten respondents (83%), as was 'Skills development' (82%). Seven out of ten selected 'Personal development' (70%).

Notably, 'Experiential/work-based learning' was less popular, chosen by just over a third (34%).

A text answer was required for the 'Other' category. Themes were generally about more specific learning outcomes, including increased confidence, knowing where to refer to for support, how to respond to people in crisis and supporting families.

Figure 16. Q21. What would you be looking to gain from training on suicide and self-harm management and prevention?



When broken down by role, the order of popularity was the same for all roles. However, mental health professionals showed more appetite for 'Experiential/work-based learning', chosen by 39%, compared to 34% for all roles.

Q22	If webinars and workshops are made available, what would you like them to address? (select all that apply) 2045 responses
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This question asked about subject areas for webinars and workshops.

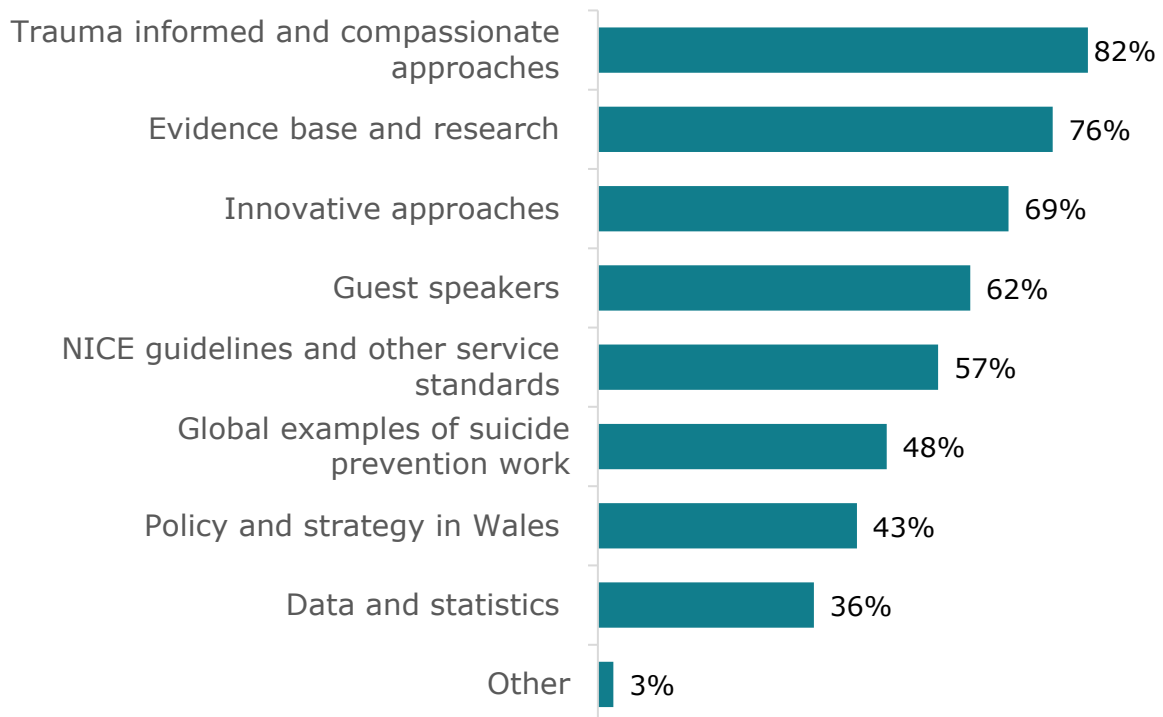
Trauma informed and compassionate approaches was selected by over eight out of ten respondents (82%). 'Evidence base and research' was the second most selected area (76%). 'Innovative approaches' was the third most frequently selected (69%).

Except for the 'Other', 'Data and Statistics' was the least selected option across all roles. For all respondents it was 36%. All other categories were selected by over 40% of respondents.

Other accounted for just 3% of respondents. Responses included:

- Information on resources, signposting.
- Managing wellbeing of self and colleagues after dealing with difficult situations.
- Strategies and methods for helping clients.
- Working with cultural diversity.
- Neurodiversity and suicidal thoughts.

Figure 17. Q22. If webinars or workshops are made available, what would you like them to address?



This question was further analysed by role. Notably the top three topics were the same across all roles. 'Trauma informed and compassionate approaches' was most popular with 88% for 'Mental Health professional', 81% for Other, 84% for Strategic, and 80% for Training Lead.

Q23	What areas of suicide and self-harm management and prevention are most relevant to your day-to-day work? (select all that apply) 2045 responses
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The survey asked respondents which areas of suicide and self-harm prevention and management are most relevant to their day-to-day work. The aim of this question was to identify the most relevant topics for training and development.

The most frequently identified area was 'Understanding, and responding to people who have thoughts of suicide' selected by 86% of all respondents.

The second most frequently identified area was 'De-escalating distress, or managing emotionally charged conversations, with people experiencing self-harm or suicidal thoughts' with 78% of respondents.

The third most frequently identified area was 'Responding to people who self-harm' with 74%.

There was generally an appetite for all areas of training and the least selected options were still identified by over one in four of all respondents (46%): 'Delivering a suicide intervention' and 'Understanding and implementing relevant national and organisational policies, protocols, standards, legislation and ethical considerations'.

Table 5. Q23. What areas of suicide and self-harm management and prevention are most relevant to your day-to-day work? (select all that apply)

<i>Option</i>	<i>Percentage of respondents</i>
Understanding, and responding to people who have thoughts of suicide	86%
De-escalating distress, or managing emotionally charged conversations, with people experiencing self harm or suicidal thoughts	78%
Responding to people who self-harm	74%
Recognising, understanding, and managing risk in relation to self-harm and suicide	73%
Understanding self-harm	72%
Understanding the experiences of people who are exposed, affected, or bereaved by suicide	69%
Responding to people who are exposed, affected, or bereaved by suicide	68%
Understanding suicide	68%
Establishing and managing compassionate conversations	67%
Communicating with people of different ages or development levels, or through communication barriers, applying evidence-based interpersonal techniques	57%
Managing, supporting, and developing workers who are in frequent contact with people experiencing self-harm, thoughts of suicide, suicide attempts, or deaths by suicide	48%
Delivering a suicide intervention	46%
Understanding and implementing relevant national and organisational policies, protocols, standards, legislation and ethical considerations	46%

This was further analysed by role. Notably the most popular theme 'Understanding, and responding to people who have thoughts of suicide' scored most highly for all roles, for 'Front-line worker' 89%, 'Mental Health Professional' 91%, 'Other' 80%, 'Strategic' 71% and 'Training Lead' 77%.

Q26	Please provide further information about your training and development needs, and how you'd like those needs to be met, if not already addressed earlier in the survey (optional) 340 responses
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This question was open-ended text. Individual responses were grouped into one or more defined themes. Responses that were considered invalid were excluded from the analysis.

The most frequent theme was 'All aspects' with 17% of respondents. 16% of respondents were grouped as 'Appropriate response.' The third most popular theme was 'Awareness' with 13%.

Table 6. Q26. Please provide further information about your training and development needs, and how you'd like those needs to be met, if not already addressed earlier in the survey

<i>Theme</i>	<i>Definition</i>	<i>Percentage of respondents</i>
All aspects	Interested in all aspects of training, or specific area not stated.	17%
Appropriate response	How to respond appropriately to a person in crisis. Communication skills. Language. Empathy.	16%
Awareness	Recognising signs of suicidal ideation. Understanding the psychology behind feelings. Dispelling myths.	13%
Up-to-date information	Up-to-date information on resources. Refresher training.	12%
Signposting/referral	Agencies and organisations offer support, referral pathways.	11%
Risk management	How to assess and manage risk.	8%
Other		7%
Self-harm	Training relating to self-harm.	7%
Staff support	Support for staff, wellbeing, debriefing.	7%
Psychological Approaches	Psychological approaches or therapies. Formulation.	6%
Face-to-face training	Preference for face to face or classroom training.	6%
Practical skills/tools	Skills and tools to support a person having suicidal thoughts or self-harming. Safety planning.	4%
Knowledge sharing	Knowledge sharing, continued support.	3%
Bereavement	How to support people bereaved by suicide.	3%

<i>Theme</i>	<i>Definition</i>	<i>Percentage of respondents</i>
Supporting family/carers	Support for family and carers when a person is suicidal or is self-harming (not bereavement).	3%
Online training	Preference for online training or webinars.	2%

Relationship Between Training and Confidence

Q9 and Q11	Cross tabulation between levels of confidence and how recently people had received training.
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A further analysis involved looking at the relationship between whether training had been received, and for those that had received training how recently the training was received, and levels of confidence. This involved a cross-tabulated analysis of the following questions.

Question 9: Thinking about the following situations involving people affected by suicide or self-harm, how confident are you that you would be able to respond appropriately?

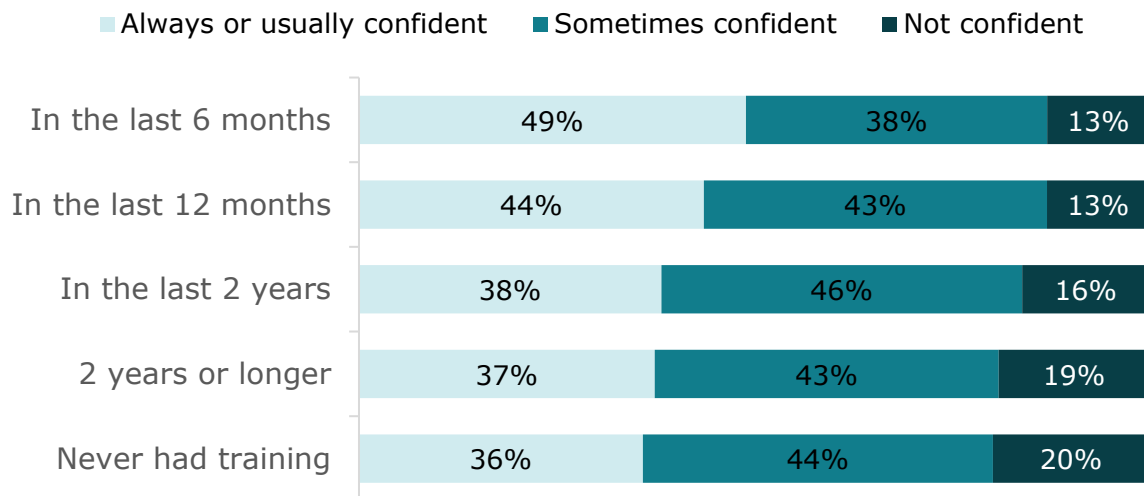
Question 11: When did you last attend or access any training on suicide and/or self-harm?

Those respondents that indicated that none of the situations in question 9 were applicable to their role were excluded from the analysis.

It was observed that there was a relationship between confidence and when training had been received. When looking at the overall levels of confidence, based on the percentage of total responses for all situations, the more recent the training the higher the percentage for 'Always or usually confident' (up to a maximum of 49% the last 6 months). Those that had never had training had the lowest percentage for 'Always or usually confident' (36%).

Conversely, those that had had training most recently (either within the last 6 months or the last 12 months) had the lowest percentage of 'Not confident' (13%). The percentage of 'Not confident' increases the longer the time since training was received, up to 20% for those that had not received training.

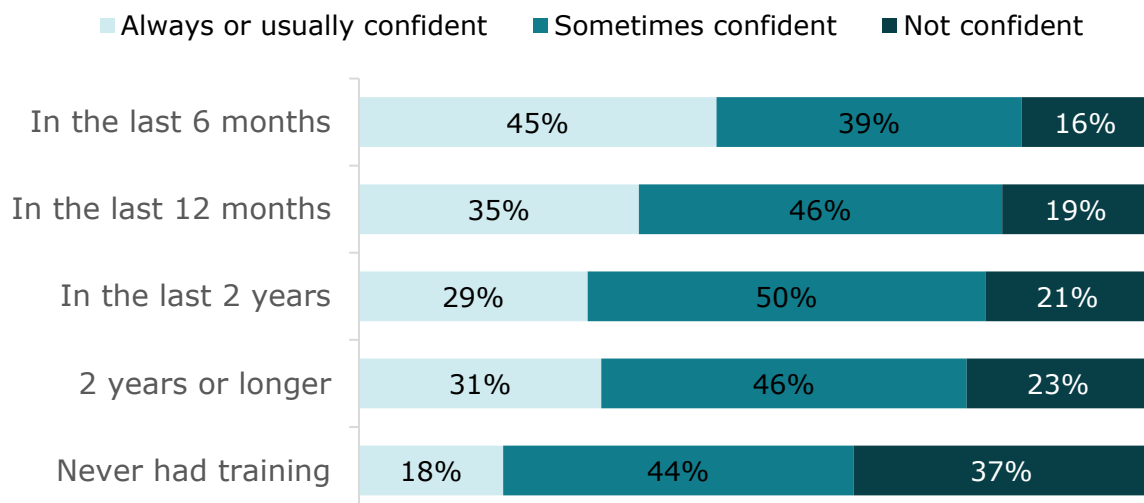
Figure 18. Overall level of confidence (Q9) cross-tabulated with when training was last received (Q11) (1267 responses)



This was further analysed by role, where generally the same relationship was observed.

For 'Front line worker', the increase in 'Always or usually confident' was more striking than the figures for all respondents, ranging from just 18% for those that had never had training, up to 45% for those that had had training in the last 6 months.

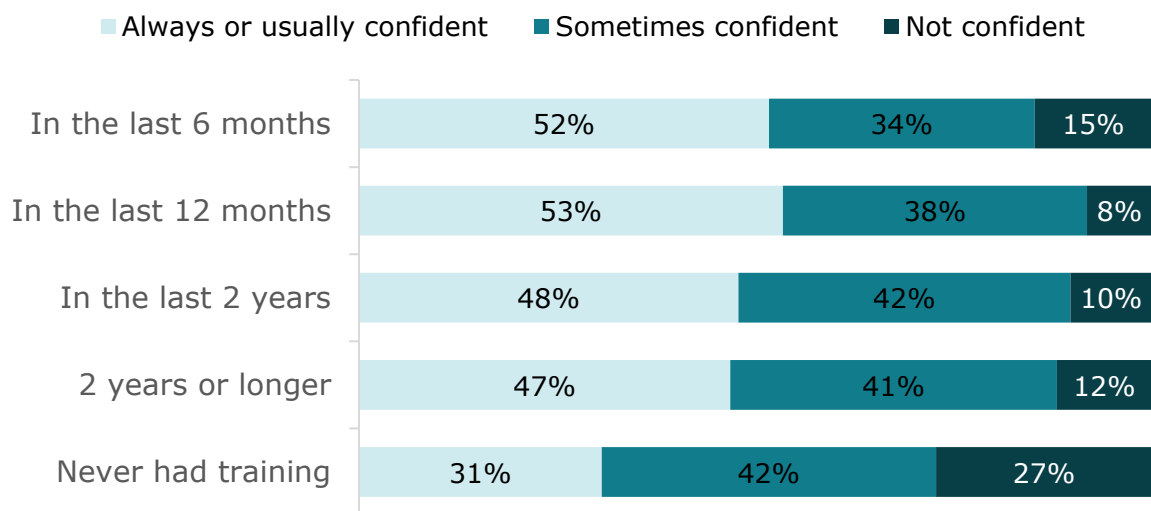
Figure 19. Overall level of confidence (Q9) cross-tabulated with when training was last received (Q11) ('Front line worker', 1342 responses)



The figures for 'Mental health professional' also showed a more significant change in 'Always or usually confident', ranging from 31% for never had training, up to 52% for 'in the last 6 months'.

The relationship was not so clear for 'Not confident', but 'Never had training' had a notably higher percentage compared to those that had attended training, with 27%.

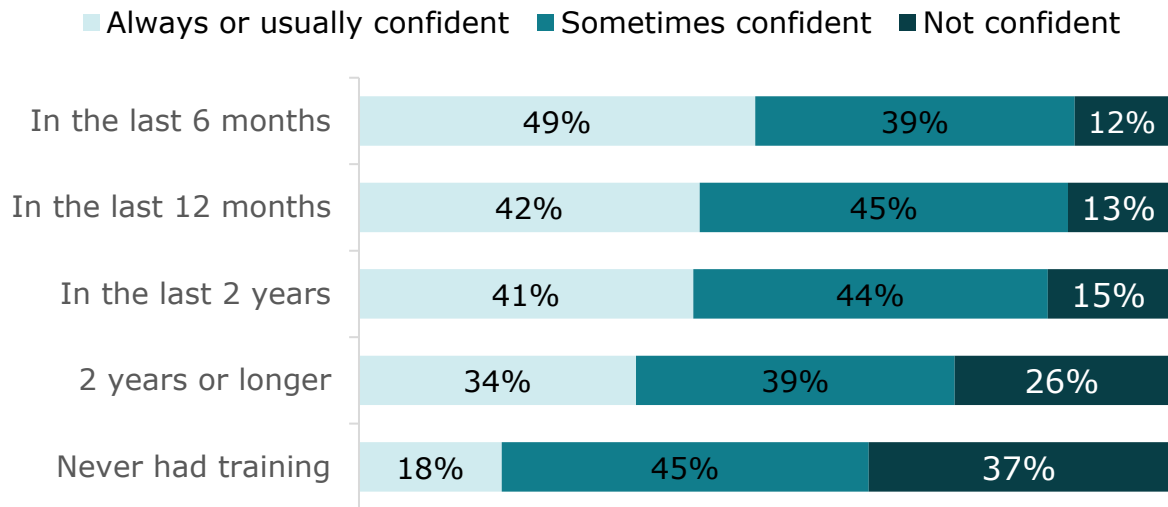
Figure 20. Overall level of confidence (Q9) cross-tabulated with when training was last received (Q11) ('Mental health professional', 883 responses)



Those that identified as 'Other', showed a consistent relationship with 'Always or usually confident' ranging from 18% for 'Never had training' up to 49% for 'In the last 6 months'. 'Not confident' ranged from 12% for 'In the last 6 months' to 37% for 'Never had training'

('Other' included: administrator, benefits officer, support worker, employment advisor, union officer, human resources officer, occupational therapist, police officer, RNLI crew, substance misuse worker, welfare rights advisor and youth worker.)

Figure 21. Overall level of confidence (Q9) cross-tabulated with when training was last received (Q11) ('Other' 581 responses)



The findings were not so conclusive for 'Strategic' (105 responses), and 'Training Lead' (87 responses), not helped by the limited number of responses for these roles. However, there were some notable observations.

For 'Strategic', just 11% of those that had never received training said that that they were 'Always or usually confident'. This contrasted with 41% of those that had received training in the last 6 months.

For 'Training lead' only 8% of those that had never received training said that that they were 'Always or usually confident', with 50% stating that they were 'Not confident'. This contrasts with those that had received training in the last 6 months, where 50% were 'Always or usually confident', and 13% were 'Not confident'.

Discussion

The number and profile of respondents to the survey (2045) suggest that the aim to reach those working directly with people affected by suicide and self-harm was achieved (83% of respondents, question 8).

Rationale for increased provision

Responses to question 11, that show that almost a third of respondents have never received training in suicide and self-harm prevention, indicate that there is a clear need to increase access to learning and development offers across all sectors. There is appetite for this learning to be delivered in a range of different ways, with a clear requirement for 'experienced tutors' to be delivering that training, if it is to be valued (question 20).

Cross-analysis of questions 9 and 11 shows a correlation between access to training and confidence in working with people affected by suicide and self-harm, with those receiving training most recently expressing greater confidence in their work, indicating the potential impact of training.

What people are looking for in training

Respondents showed equal appetite for the acquisition of knowledge and the development of skills, acknowledging the importance of both of these aspects of learning relating to suicide and self-harm prevention (question 21). There is demand for practical help for people in their different roles.

While the level of satisfaction was consistent across all roles with 64% stating that the training they have accessed meets their needs (question 12), it remains that for almost four in ten (37%) there is room for additional learning to be gained to help them in their work.

When asked what they found most useful about training they'd already attended, respondents most frequently identified i) practical skills/tools, ii) how to deliver an appropriate response, and iii) feeling generally better informed (question 13).

When asked what was missing from training they'd attended, respondents referred to learning about the need for greater depth in what was delivered and providing an 'appropriate response' (question 14).

Some of the responses to the open text questions (questions 15 and 18) raised the requirement for the delivery of training from people expert in the field, with relevance to real-life situations and events, and with mixed-disciplines attending the training to mitigate the tendency for this area of work to be perceived as the domain of mental health professionals or services only.

Training the trainers

A notable cohort of respondents (10%) currently deliver training in suicide and self-harm within their organisations. Of these, 63% had not attended a 'train the trainer' programme, 78% of whom, would like to attend a 'train the trainer' programme (questions 16-19).

This would suggest demand to warrant the development of a train the trainer programme for those who are providing training in suicide and self-harm, or an increased profile of existing courses in adult education/life-long learning such as the Level 3 Award in Education and Training (AET)⁷, that can be delivered by a range of providers in Wales⁸. There is also scope for this cohort to constitute a 'community of practice'⁹ to support their training role going forward.

How people learn

Question 20 asked respondents what their requirements were regarding training. The least favoured option (29%) was for follow-up by the training provider regarding learning application. Similarly, question 21 asked respondents what they would be looking to gain from training and 'experiential/work-based learning' was the least favoured option (34%). This suggests that respondents place higher value on more formalised training offers away from the workplace. There may be a number of reasons for this, that were not explored in the survey, so it is not known whether this is because there is a preference for classroom-led/off-site learning generally; if it reflects the level or quality of learning they feel they currently gain within the workplace; or for other reasons.

Specialist training organisations often reference the 70/20/10 model of learning developed during the 1980s by researchers working with the Centre for Creative Leadership¹⁰. The evidence base for the model is often questioned, none-the-less, it is still used globally as a general guideline by organisations looking to

⁷ [Teaching Learning Courses | Adult Learning | Wales](#)




⁸ [Education and Training Level 3 Award \(HABC\) | Course Search \(gov.wales\)](#)

⁹ <https://www.wenger-trayner.com/introduction-to-communities-of-practice/>

¹⁰ [The 70-20-10 Rule for Leadership Development | CCL](#)

optimise their learning and development programmes¹¹. The model describes the processes through which people derive their learning in relation to their work, and therefore their performance at work. Workers will always be acquiring the majority of their learning 'on-the-job'.

Figure 22. The 70/20/10 model of learning

70%	20%	10%
		
On-the-job experience (challenging experiences and assignments carried out during the workflow)	Developmental relationships (other people)	Courses and training

This model recognises that all organisations have a learning culture, whether it wants one or not, and the organisational norms are transmitted to the workforce in this way¹² It recognises that 'work is learning, and learning is work' where learning is less an intervention separate from work, and more about continual engagement embedded 'in-the-flow' of work¹³

To achieve alignment with requirements of the 'business', such as improving services, it is important to identify what we require the workforce to do. By asking many of them via this training and development survey, we have invited them to tell us what they feel they need to be able to do to be more responsive to the people that present to them with a range of needs. Working with commissioners and employers, we now need to respond by providing both the learning opportunities, and the resources, to enable the learners to become better equipped to deliver better services.

Many of the responses received through this survey, particularly where respondents have been able to express their needs through open-text responses, has shown that while there are clear preferences for expert-led training offers, there is also a plea for experiential-based learning, set in real-life contexts, with a focus on the practical challenges of supporting people affected

¹¹ [What is the 70:20:10 Model for Learning & Development? \(growthengineering.co.uk\)](https://www.growthengineering.co.uk/what-is-the-70-20-10-model-for-learning-and-development/)

¹² How People Learn: designing education and training that works to improve performance, Nick Shackleton-Jones, Kogan Page Publishers, 2019

¹³ Driving Performance Through Learning: develop employees through effective workplace learning, Andy Lancaster, Kogan Page publishing, 2020

by suicide and self-harm. This is accompanied by requests for clear guidance and support from employers regarding expectations when responding to people presenting with self-harm and suicidal thoughts, through policy, protocols and frameworks.

Over half of respondents to the survey (52%) expressed a preference for blended learning approaches (question 20), and 57% would value co-produced training offers. Almost half (49%) also identified 'networking' as a support to learning. This provides scope for the development of a learning system that can support learning on and off the job, through a range of delivery options, offering the potential for continual engagement e.g. through communities of practice.

Current developments that support the needs identified in the survey

Since the recruitment of a SSHP programme team (2020), a number of offers to support learning and development in suicide and self-harm prevention have been designed and developed. These include:

SSHP Digital Hub

The SSHP Training Hub was launched in the autumn of 2022 as a response to the many queries being received about the training and development offers that are available. The platform was developed through agile approaches to digital development that engaged potential users, including front-line workers and training providers.

The Hub provides short-cuts to free on-line offers available from a range of providers within Wales and beyond; a 'knowledge base' where the basic essentials around suicide and self-harm can be found, including use of language, myths, and evidence-base; and a search area, with filters, to help people to find training providers/offers that will meet their needs.

This platform is available in Welsh and English:

[Welcome to the Suicide and self-harm Prevention Cymru Training Hub \(sshp.wales\)](https://sshp.wales)

Basic Suicide Awareness e-module

During 2022/23 a suicide awareness module was developed through collaboration and co-production with potential users and people with lived experience. This e-module focuses on suicide only and is designed for a universal audience (everyone). This was initiated by the need to replace an out-of-date unit already available to all NHS employees on the NHS Electronic Record System (ESR), the portal where all NHS workers can complete their statutory and mandatory training, as well as other non-mandatory modules.

While the initial intention was to update the provision for NHS workers, it quickly became evident that the universal pitch of the module lent itself to other

sectors. It has therefore been made available via learning@wales¹⁴ that is accessed by a wide range of agencies across Wales

The open access version of the module is available on the SSHP Digital HUB, and a partner universal module in self-harm awareness will be developed during 2024/25

AGORED accredited units/qualification in responding to people affected by suicide or suspected suicide

Through the postvention (support after suicide) workstream, national guidance has been developed setting out a system-response to those bereaved, exposed, or affected by suicide in Wales¹⁵. One of the pillars of this response is workforce development. During 2023/24, the SSHP programme team have worked closely with GRASSROOTS suicide prevention¹⁶ to develop a set of units in responding to people affected by suicide or suspected suicide, and a 'training the trainer' module to equip trainers across Wales to deliver the units. The 'Train the Trainers' (TtT) was piloted in April 2024 and is currently being refined for roll-out. Over 200 (10%) of respondents to the survey said they delivered training in suicide and self-harm, while 63% of those had not received 'train the trainer' training.

Respondents to the survey were asked about their levels of confidence regarding different interactions, and the area where people had the *least* confidence was in responding to people impacted or bereaved by suicide (question 9). These units place particular emphasis on the need for trauma-informed and compassionate approaches. This was the area most frequently selected (82%) in the survey when respondents were invited to identify their priorities for learning (question 22).

The units can be found on the AGORED website:

[Qualification \(agored.cymru\)](https://agored.cymru)

Undergraduate Learning in Suicide and Self-harm Prevention

During 2022/23 the SSHP programme team led a number of engagement activities to test the appetite for the development of curriculum guidance for

¹⁴ <https://learning.nhs.wales/>

¹⁵ <https://www.gov.wales/draft-guidance-responding-people-affected-suicide>

¹⁶ [Grassroots Suicide Prevention | Educating, Connecting, Campaigning \(prevent-suicide.org.uk\)](https://grassroots-suicide.org.uk)

Higher Education Institutions (HEIs) who provide undergraduate/pre-registration training for health and care professionals in Wales. Attendees to these events included university lecturers and programme leads, student representatives, work-based supervisors and front-line practitioners, professional body/regulatory body representatives, Health Education and Improvement Wales (HEIW), Social Care Wales (SCW), and people with lived experience.

This proposal has gained traction, and working with Skills for Health, a set of learning outcomes and delivery guidance is currently has been developed ready for implementation across HEI's in Wales. A link to the work is available on the Skills for Health website:

[Developing Undergraduate and Pre-registration Learning for the Prevention of Suicide and Self-harm | Skills for Health](#)

Delivery guidance in this learning resource discusses the important tripartite relationship between the learner/student, the work-based supervisor/employer, and the education institution (HEIs). This acknowledges that learning occurs in both classroom and work-based settings, and the important contribution of 'on-the-job' learning.

The delivery guidance also places emphasis on the health and wellbeing of staff working with people affected by suicide and self-harm prevention, and the potential for learning in this area of work to be delivered in multi-professional forums and across disciplines.

Recommendations

The survey findings suggest the following actions:

- Increase overall access to learning and development opportunities available to all sectors, including 'refresher' or 'top-up' offers. These offers should:
 - be made available through a range of modes/delivery methods;
 - be clear in the learning that they can realistically deliver in relation to the modes of delivery e.g.: awareness raising, acquisition of knowledge or factual information, introduction and development of skills.
- Communicate the outputs from the survey to training providers registered with the national SSHP Training HUB¹⁷ to inform the design and delivery of current training offers, and the development of new offers that reflect the needs expressed in the survey.
- Support the increased availability, development/co-production and dissemination of learning and development offers in areas where current provision appears to be low e.g.: self-harm, suicide bereavement/support after suicide, de-escalating distress, trauma-informed and compassionate practice. Links could be drawn to the Trauma Informed Wales¹⁸ programme and any associated training offers that might be developed from that.
- Identify opportunities for those who train others to develop and validate their expertise in training adult/delivering work-based learning, through attendance to 'train the trainer' offers such as the Level 3 AET Award
- Identify a national model of learning and development that is sustainable, and ensures that quality learning is taking place in the workplace, as well as through specific programmes of study/courses
- Develop mechanisms for the development of tools and resources for front-line practitioners to help them to understand what is available, providing up-to-date and relevant information to enable responsible signposting to range of support offers in their locality, as resources to support learning and development offers.
- Consider making the survey tool itself, or an adaptation of it, available to organisations across Wales for them to assess their own learning and

¹⁷ [Training Hub | SSHP Cymru Training Hub](#)

¹⁸ <https://traumaframeworkcymru.com/>

development needs with regard to how their staff respond to those affected by suicide and self-harm. The national programme team could advise and support this activity within the regions. (An area in England has already requested use of the survey tool to deploy in their area). The survey/audit tool could potentially form part of a wider package for employers and workplaces who would consider working towards a 'suicide-aware organisation' status, should such a programme be developed.

Appendix: Survey Questions

Suicide and Self-harm Prevention Training Needs Survey 2023

* Required

Demographics

1. Which region does your work apply to? *

- North Wales (Isle of Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire, Wrexham)
- Mid/West Wales (Powys, Ceredigion, Pembrokeshire, Carmarthenshire, Swansea, Neath Port Talbot)
- South East Wales (Bridgend, Rhondda Cynon Taf, Merthyr Tydfil, Vale of Glamorgan, Cardiff, Caerphilly, Torfaen, Newport, Blaenau Gwent, Monmouthshire)
- All Wales (National role)

2. What sector do you work in? *

- Criminal Justice Education
- Fire and Rescue
- Health Service
- Local Authority
- Housing Association/Charity
- Police
- Private/Commercial
- Social Care
- Voluntary/Charity
- Welfare/Benefits
- Welsh Government
- Other

3. Which service area do you work in? *

- Education
- Social Services
- Housing
- Resources
- Community Services
- Other

4. Which educational sector? *

- Primary (up to age 11)
- Secondary (age 11 to 16)
- Further Education, Tertiary (age 16 and over)
- University or Higher Education

5. Which Health Service sector? *

- Primary Care
- Secondary Care
- Ambulance Service
- Public Health
- Palliative/end of life care
- Other

6. Which Police Force area? *

- North Wales
- Dyfed/Powys
- South Wales
- Gwent
- All Wales

7. What is your role? *

- Mental health professional (social worker, psychiatric nurse, psychiatrist, psychologist)
- Training lead (organisation, department or team)
- Strategic (implementation of plans, policies)
- Front-line worker (public facing)
- Other

Responding to people affected by suicide or self-harm

8. Does your work require you to respond directly to people affected by suicide or self-harm? *

- Yes
- No

9. Thinking about the following situations involving people affected by suicide or self-harm, how confident are you that you would be able to respond appropriately? *

	Always or usually confident	Sometimes confident	Not confident	Not applicable to my role
Responding to someone experiencing self-harm				
Responding to someone who is experiencing thoughts of suicide				
Responding to someone who has been impacted or bereaved by suicide				
Responding to someone who is supporting others who self-harm				

	Always or usually confident	Sometimes confident	Not confident	Not applicable to my role
Responding to someone who is working with those who are vulnerable to suicide				
Signposting someone to other agencies or services who can help regarding issues of self-harm, thoughts of suicide, and suicide bereavement				

10. When you interact with people affected by suicide and self-harm, what aspects do you need most help with? (Optional)

Your answer will help to inform the development of new training offers

(Free text)

Training and Development

11. When did you last attend or access any training on suicide and/or self-harm? *

- In the last 6 months
- In the last 12 months
- In the last 2 years
- 2 years or longer
- Never had training

12. Did the training meet your needs, or deliver what you needed? *

- Yes
- No
- Partially

13. What did you think was particularly good about the training you received? *

(Free text)

14. What was missing from the training for you? *

(Free text)

15. Who is your preferred training provider, or providers, on the management and prevention of suicide and self-harm (if you have preferences)?

16. Do you deliver any training in suicide or self-harm prevention as part of your role? *

- Yes
- No

17. Have you attended a 'training the trainer' course? *

- Yes
- No

18. Which 'training the trainer' programme did you attend and when? *

(Free text)

19. Would you be interested in attending a 'training the trainer' programme? *

- Yes
- No

20. What are your primary requirements regarding the design and delivery of training on suicide and self-harm management and prevention? (select all that apply) *

- Blended learning (delivered in a blended way: for example self-directed modules, online group activity, face-to-face sessions)
- Experienced tutors (who have experience of working in a role supporting people affected by suicide and/or self-harm)
- Co-produced (people with lived experience are involved in the programme design or take part in the training)
- Emotional security (support offered should issues arise due to the sensitive content and nature of the training)
- Confidentiality (people's experiences and disclosures are respected throughout and not shared outside of the training against their wishes)
- Networking (you can link with other people who work in similar fields, for shared learning, and follow-up connections)
- Evaluation and improvement (the training is regularly evaluated and the outcomes of that evaluation are shared)
- Accreditation or external quality assurance (training is accredited by a named external organisation or part of a recognised external quality assurance process)
- Continuing Professional Development (CPD) recognition (the training provides CPD points with a known CPD organisation for your personal or professional development)
- Follow-up activity (the training provider contacts you after the training to help you to apply what you have learned)
- Other

21. What would you be looking to gain from training on suicide and self-harm management and prevention? (select all that apply) *

- Knowledge acquisition (to improve your knowledge and understanding of the issues)
- Skills development (to learn new, and to develop existing skills, with an opportunity to practice them, or to receive feedback or coaching)
- Personal development (opportunity to reflect on practice, learn from colleagues or other practitioners or attendees)
- Experiential/work-based learning (with supervision and tutorship 'on-the-job')
- Other

22. If webinars or workshops are made available, what would you like them to address? (select all that apply) *

- Policy and strategy in Wales (what it sets out to achieve and how)
- Evidence base and research (understanding risk and those most at risk, information about effective interventions and approaches to prevention)
- NICE guidelines and other service standards (that should be informing practice)
- Innovative approaches (services or projects going on in other areas of Wales)
- Global examples of suicide prevention work (for example Australia, New Zealand, Canada and developing countries)
- Guest speakers (who are recognised leads on suicide and self-harm management and prevention)
- Trauma informed and compassionate approaches (to managing supportive conversations with people affected by suicide and self-harm)
- Data and statistics (relating to suicide and self-harm, sources and limitations)
- Other

23. What areas of suicide and self-harm management and prevention are most relevant to your day-to-day work? (select all that apply) *

- Understanding suicide (basic knowledge and awareness)
- Understanding, and responding to people who have thoughts of suicide
- Understanding the experiences of people who are exposed, affected, or bereaved by suicide
- Responding to people who are exposed, affected, or bereaved by suicide
- Delivering a suicide intervention
- De-escalating distress, or managing emotionally charged conversations, with people experiencing self-harm or suicidal thoughts
- Understanding self-harm
- Responding to people who self-harm
- Communicating with people of different ages or development levels, or through communication barriers, applying evidence-based interpersonal techniques
- Establishing and managing compassionate conversations
- Recognising, understanding, and managing risk in relation to self-harm and suicide
- Managing, supporting, and developing workers who are in frequent contact with people experiencing self-harm, thoughts of suicide, suicide attempts, or deaths by suicide
- Understanding and implementing relevant national and organisational policies, protocols, standards, legislation and ethical considerations (safeguarding, confidentiality, capacity, collaborative inter-disciplinary approaches)

24. Are you a mental health professional? (For example, social worker, psychiatric nurse, psychiatrist, psychologist, occupational therapist) *

- Yes
- No

25. Thinking about the areas of suicide and self-harm management and prevention that you most frequently encounter in your day to day work, how do you feel about your level of training and development? *

	Well trained and equipped	Further training would be of benefit	Not equipped and require training	Not part of my role
Fostering and maintaining a good therapeutic alliance with someone				
Working to organisational policies, protocols, legislation				
Undertaking a collaborative assessment of risk, needs, and strengths				
Conducting a psychosocial assessment				
Working alongside someone in a safety planning process				
Developing a formulation				
Conducting a mental state examination				
Delivering specific psychological interventions such as CBT, DBT, EMDR				
Liaising with others to manage transitions of care within and across services				

Further Comments

26. Please provide further information about your training and development needs, and how you'd like those needs to be met, if not already addressed earlier in the survey. (Optional)

(Free text)