SafeSide InPlace Workshop Evaluation Data Summary

Prepared for: Department of Defence Pilot

Introduction

This Data Summary presents real-time data from pre- and post-evaluations completed following six pilot sessions held for Mental Health and Primary Health within the Departmetn of Defence in Feb and March 2022.

- Aggregate post-evaluation data is reported for all constructs.
- Pre- and post-evaluation comparison graphics for Knowledge, Self-Efficacy, and Systems Perspectives on Suicide prevention are **only** presented for data from participants who completed both the pre- and post-evaluation (i.e., matched responses).
- For your convenience, this report is downloadable as a PDF.

If you have any questions, please contact support@safesideprevention.com.

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Section 1. Evaluation Completions Overview

Evaluation	Completions
How many people have completed pre-workshop evaluations?	48
How many people have completed post-workshop evaluations?	47
How many people have completed a pre- AND post-evaluation?	39

Role of Respondents

Role	Choice Count
Clinical service	14
Other (please specify)	11
Nurse	9
Health service	7
Administrator	2
Other service	2
Administrative/Support Staff	1
Medical Doctor (MD)	1

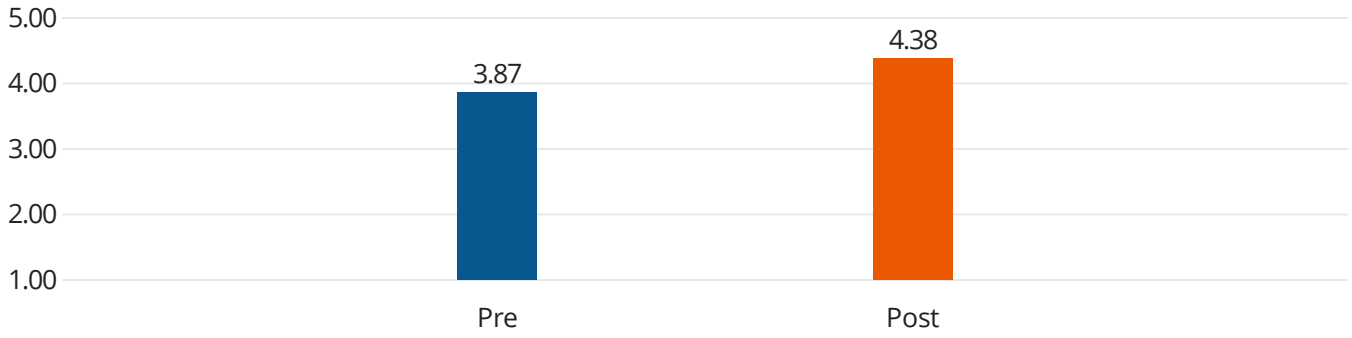
Section 3. Self Efficacy

These seven items, adapted from other studies (Connor et al, 2013; Pisani et al., 2012), are asked in the pre- and post-evaluation to measure self-efficacy in suicide prevention skills. Self-efficacy is the person's belief or confidence in their ability to engage in a behavior (Bandura, 1977). People reporting higher self-efficacy are more likely to use a skill in their day-to-day work (Cross et al., 2010; Osteen et al., 2014; Osteen et al., 2017).

How did self-efficacy change from before to after the workshop?

*NOTE: Reflects only participants who completed the pre- and post evaluation

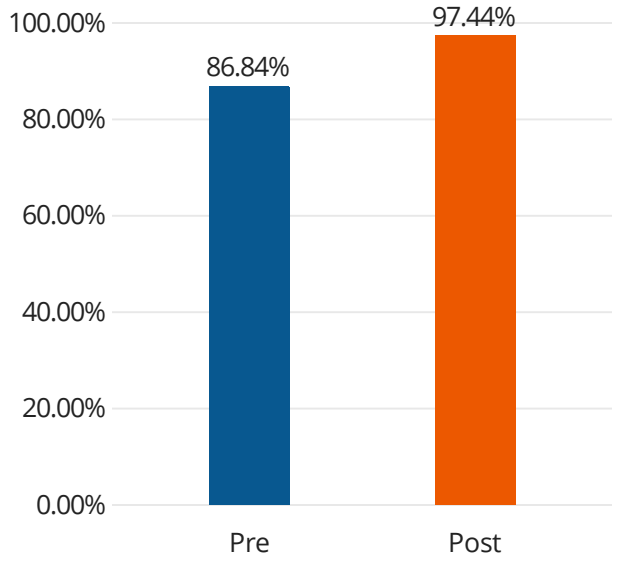
How did the average score on all self-efficacy items change from before to after the workshop? (Min 1; Max 5)



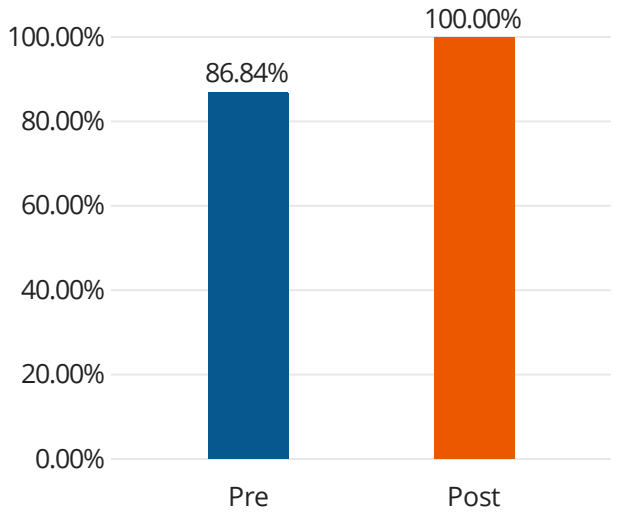
How did the percentage of participants endorsing "Agree" or "Strongly Agree" on each self-efficacy item change from before to after the workshop?

I feel confident in:

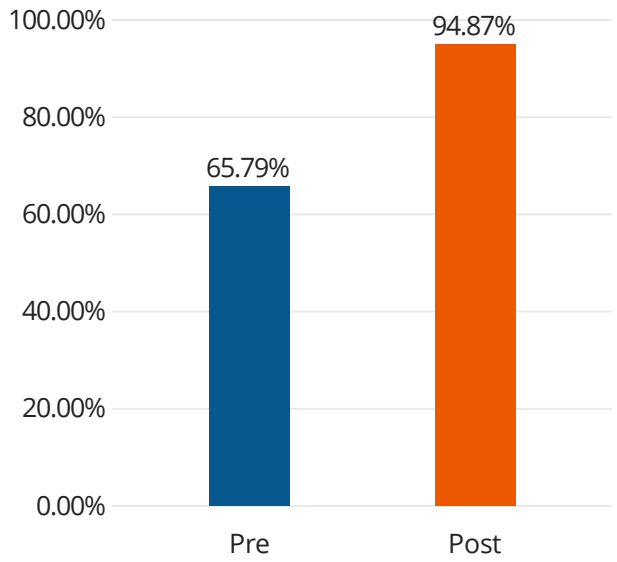
My ability to ask about suicide.



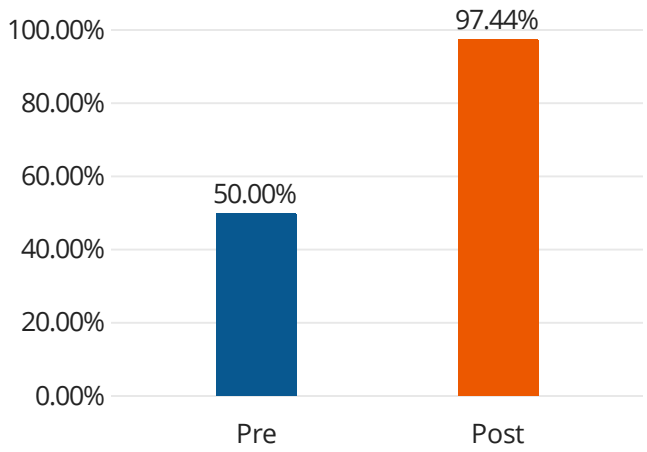
My ability to contribute to assessments of suicide risk within my role.



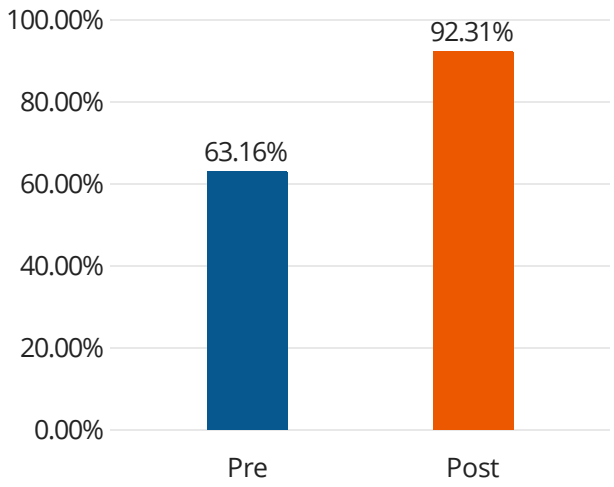
My ability to link risk assessments to person-specific plans.



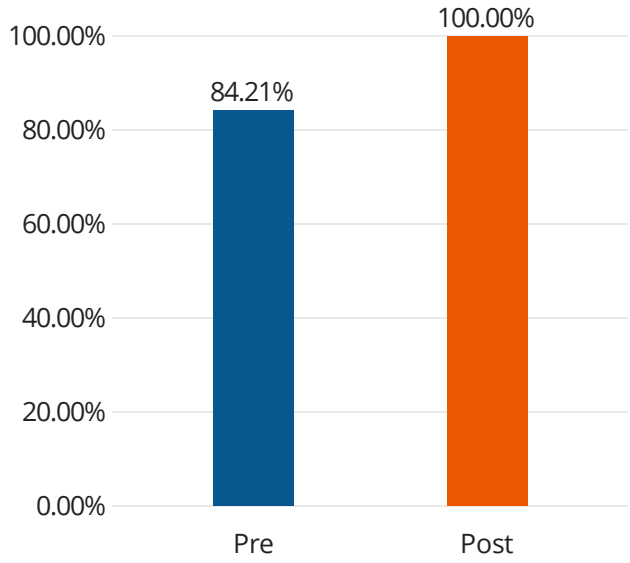
My ability to develop person-specific safety plans that include means safety and plans for specific life events that would increase risk.



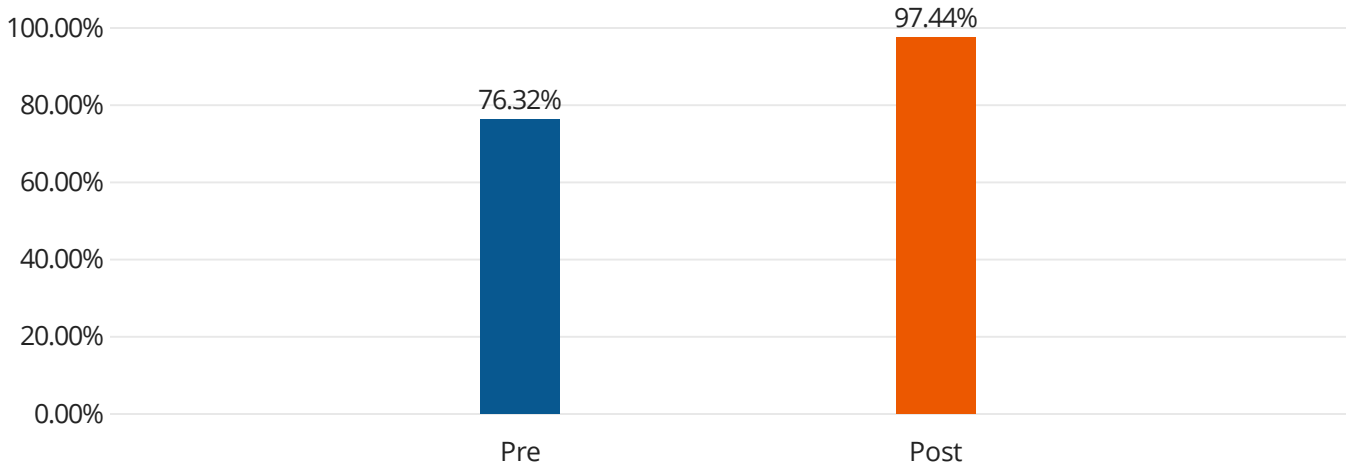
How I can extend support to people at risk beyond the time when I am in contact with them.



What to do when I encounter a person with suicide concerns.



My ability to convey and maintain a hopeful stance when someone feels hopeless.

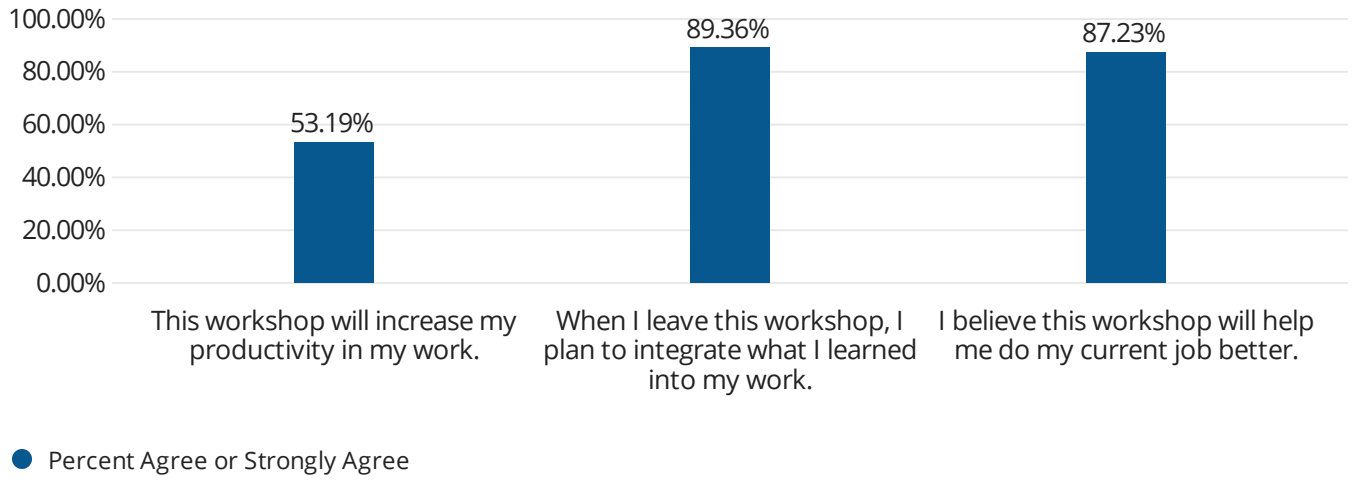


Section 4. Learning Transfer

Learning transfer is a construct that helps us better understand the likelihood that a person will use key suicide prevention skills in their day-to-day work with people at risk. These post-evaluation items, adapted from learning transfer items used in other studies (Cross et al., 2019; Pisani et al., 2012; Pisani et al., 2021) measure perception of how well the training content will transfer into practice (Holton et al., 2000). The stronger the endorsement of learning transfer, the more likely it is the person will use the skills in their day-to-day work.

Motivation to Transfer: the participant's report of their motivation or persistence of effort toward using new skills on the job.

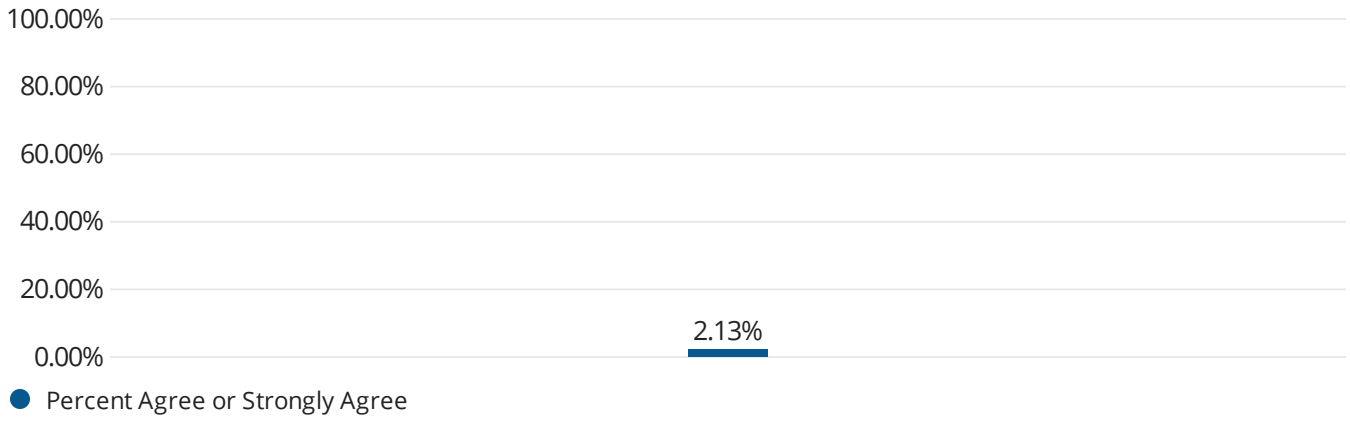
What percentage of participants endorsed "Agree" or "Strongly Agree"?



Personal Capacity for Transfer: the extent to which participants feel they have the time and energy to transfer their learning into practice in their job.

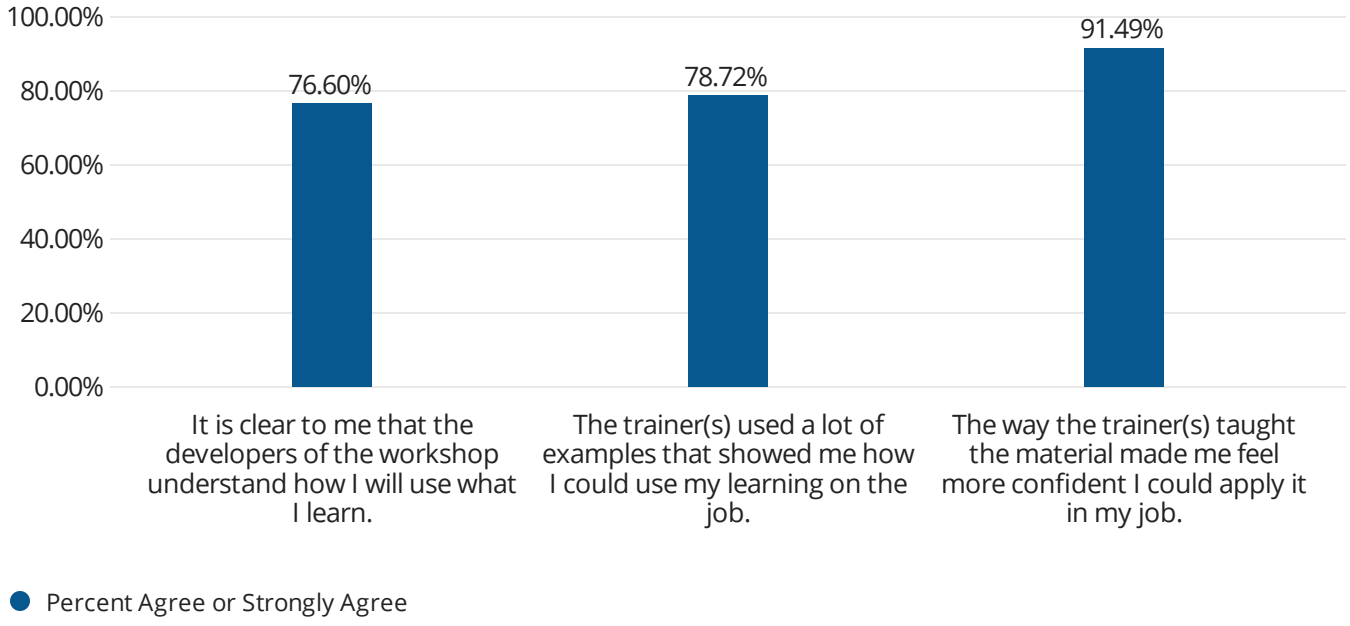
What percentage of participants endorsed "Agree" or "Strongly Agree"?

Trying to use this framework will take too much energy away from my other work.



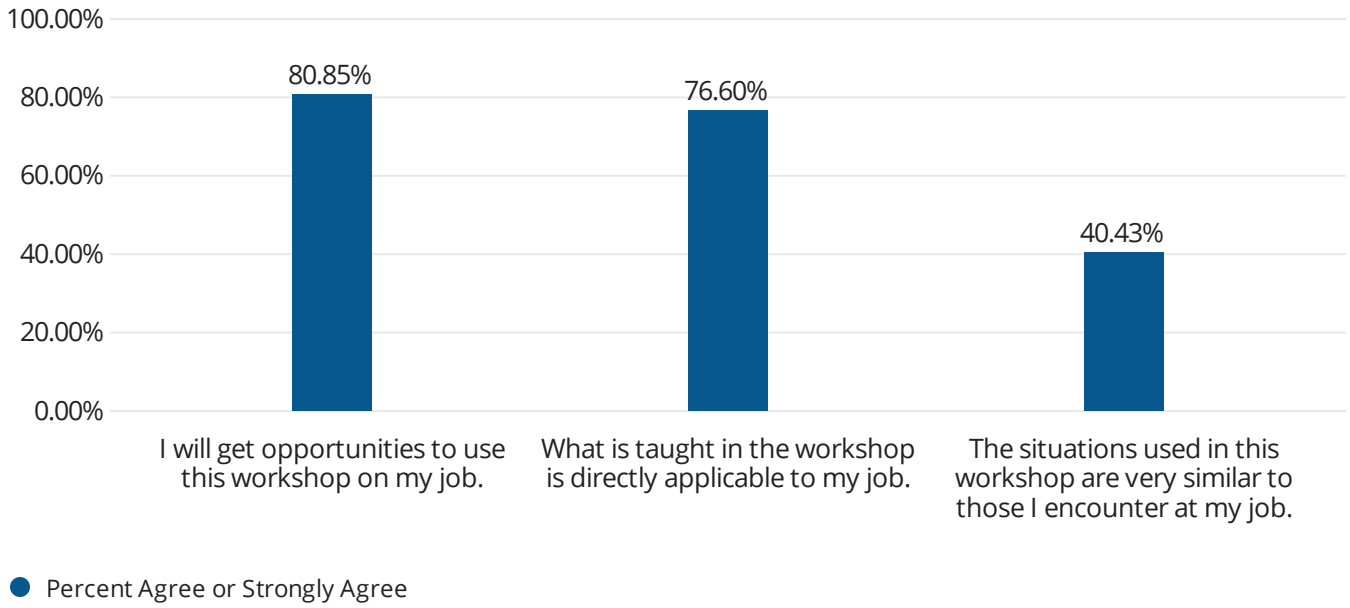
Transfer Design: the extent participants feel the training was designed and delivered to facilitate learning transfer on the job.

What percentage of participants endorsed "Agree" or "Strongly Agree"?



Opportunities to Use Learning: the extent to which participants state they were given resources to enable them to use newly learned skills on the job.

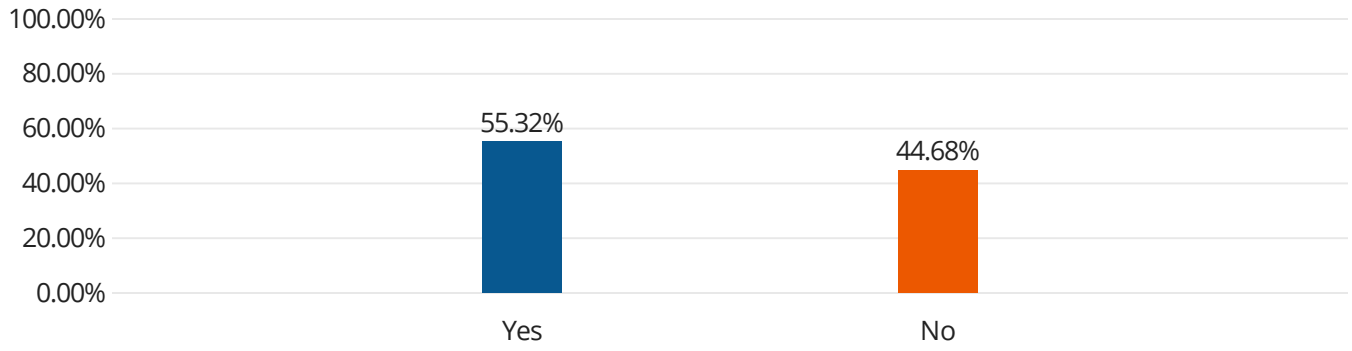
What percentage of participants endorsed "Agree" or "Strongly Agree"?



Section 6. Impact

These items, asked after completing the workshop, help us understand how the participant feels participating in the InPlace Workshop will impact their work. This includes asking about **immediate impact**, like if the workshop has impacted their perception of their role in preventing suicide and what is one thing they will take into their everyday work. We also ask about **longer-range impacts**, such as how they think using the SafeSide Framework will impact the care provided and if they anticipate participating in opportunities for continued learning and engagement with SafeSide, like Office Hours.

Has this workshop impacted your perception of your role in suicide prevention?



Tell us how it impacted your perception.

Excerpt of most recent responses.

I can make a difference through things like mini-intervention.
Expanded skill set
Trying to understand the underlying risk factors
That it is ok to be truthful - to say "I don't know what to say"
Made me more confident that I haven't been doing or saying the wrong things
It made me realise how much of this I already do
More understanding of the role an RC may play within the Assess / Respond framework.
How broad and involved many people/resources can be
Impacted how I approach people who are thinking about suicide, I needed further structure

It helped me connect the dots with other (non-clinical) approaches

Given a structure of questions/items to ask and to have continuity with other health care professionals.

It has reinforced the benefit of included a broad range of supports and applying them specifically to a situation

More confident extending response

Framing it in a more holistic way

Emphasised that everyone has a role

Provided me with a more comprehensive framework which can be implemented in the workplace

The framework reinforced my teachings when i studied clinical psychology. The next challenge I face now is implementing this in practice noting that there will be layers of policy that will need to be considered first.

Greater commitment to recover and less “processing and pushing through current risk management processes

move beyond initial consultation, more future-focused, not all about suicide but the feelings behind it

Structure /framework

Giving me tools to help respond to suicide ideation in a hopeful, supportive way

it has widened the scope for me wrt suicide prevention - the mini interventions, and in-depth safety planning that involves specific steps when triggered is a good extension of my work in suicide prevention.

Reinforced the importance the structure how we work

The follow up piece and family safe plan giving concrete examples

What's one thing you will take into your everyday work?

Excerpt of most recent responses.

mini-intervention, contingency plan for foreseeable changes

Language re contingency planning, framework theory, adapting strategies and skills to Defence

Some of the other ways of asking questions.

a more structured approach

The framework

I will take the 8 factor assessment tool into my clinical handovers, and how I document some of my patient interactions.

confidence and confirmation of my knowledge in suicide prevention

as above -

Focusing more on extending the care

Use of mini interventions when people discussed their mental health symptoms.

compassion and empathy are crucial

Furhter understanding of the research someone has done into suicide options

Looking for foreseeable triggers

Picking 2 specific scenarios to target contingency planning

The assessment

assessing risk and responding

Contingency plans

Mini-interventions like sitting with and frequency of asking "are you okay" can be very useful.

The best plan is "to do with... not to do to"

How to assess risk, and respond.

The plans part was good. Being able to come up with a plan that is mutually agreed upon and followed up.

The specific use of anticipating foreseeable changes and contingency planning

The importance of consistency and structure in an organisational model of risk assessment.

Identifying future risks/triggers and plans

The use of the risk status and state framework which I really like.

more involvement of family in ongoing support plan

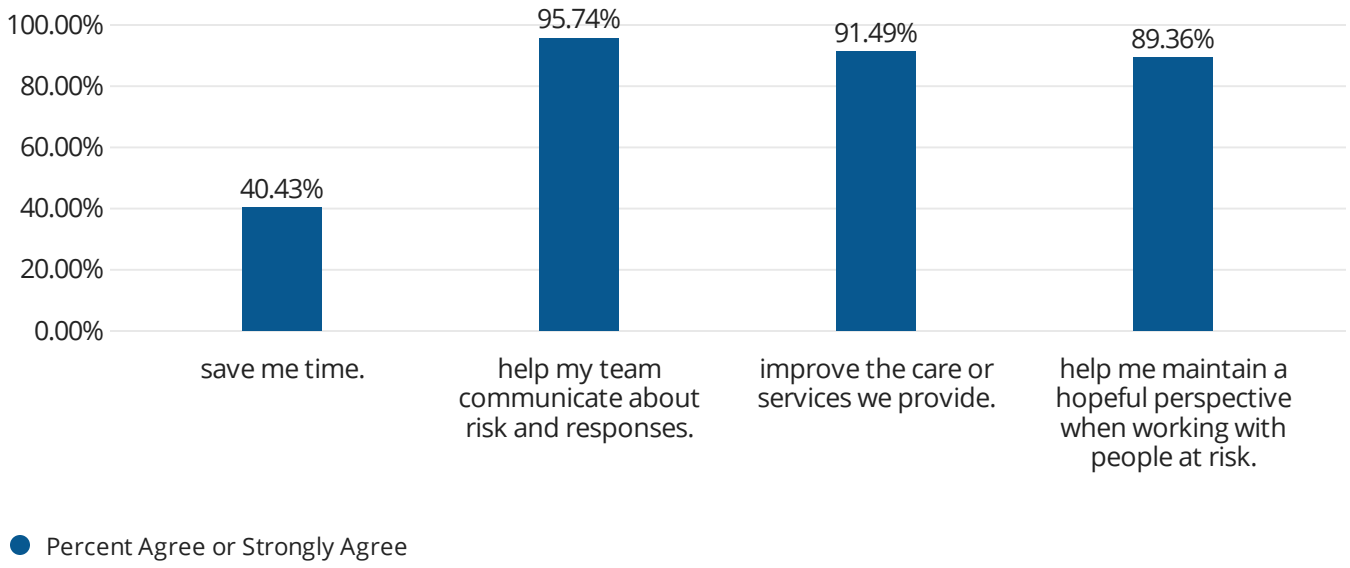
Immediate contingency plans and foreseeable triggers

Liked the strengths based approach, the framework: need to work with my staff on Extend (and with other community based organisations and DVA on how to improve warm hand offs etc)

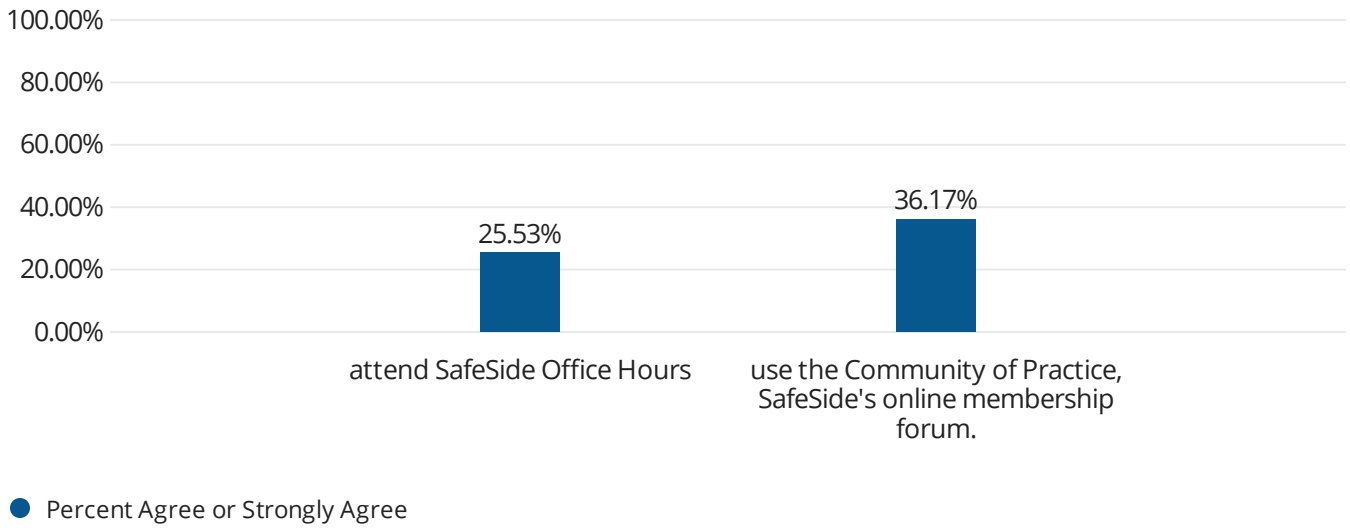
Keeping the structure in mind when undertaking complex case management, supervision and case reviews. Plus the time expectations to appropriately apply the framework for clinicians
I like the emphasis on managing the risk rather than classifying it.
Extend - has it worked and where adjustments are required
The intent to streamline communication and simplify the language we use when discussing the topic of suicidal ideation and behavior
I liked the positive language and decision document
foreseeable risk identification and contingency planning
Using the same risk assessment language with the client as other professionals.
The extension was useful (commitment from family members)
Clinical outline - succinct
Confidence to help somebody in crisis connect with appropriate mental health support
Working on the concepts of mini interventions in all my work and encouraging it amongst the people I supervise, to extend suicide prevention interventions currently being taught in my work.
Importance of follow through after assessment and planning
Shared language when speaking with health teams e.g at Unit Welfare Boards
Strength of individuals and my row is to help them find hope
the framework / assess structure
More family based interventions

What percentage of participants endorsed "Agree" or "Strongly Agree"?

Using the SafeSide Framework will:



In the next 3 months I plan to:



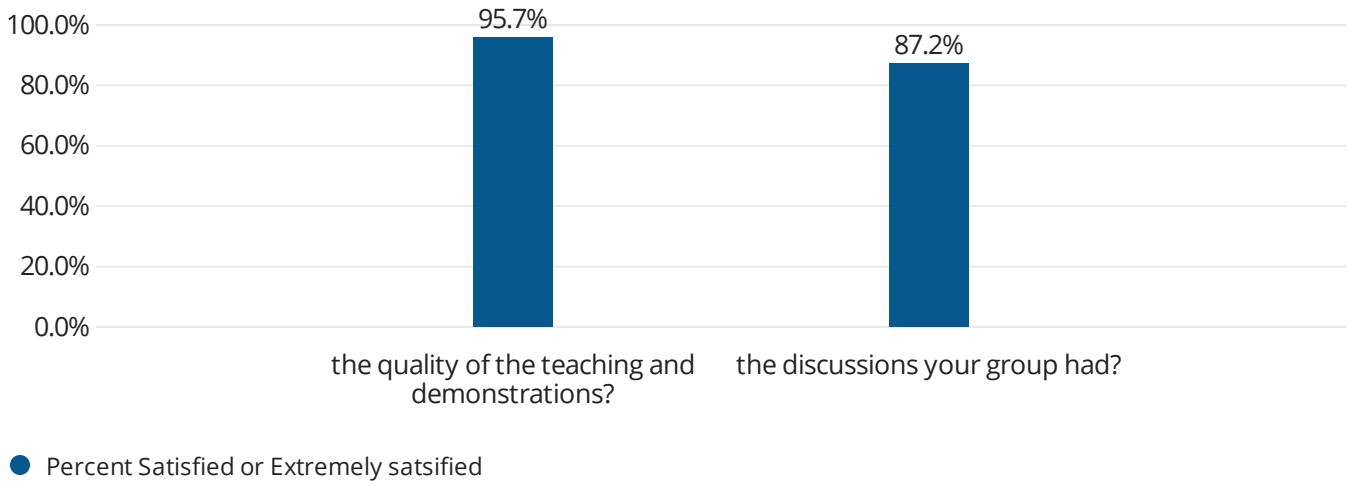
Section 7. Satisfaction

We ask about satisfaction regarding the video-guided instruction and demonstrations **and** live group discussions. We then aggregate the responses to those items to understand overall satisfaction. Overall satisfaction is shared on a 5-point scale (1 being extremely dissatisfied, 5 being extremely satisfied).

We also provide a Net Promotor Score (NPS), which is a standard customer experience metric across many industries.

Open-ended feedback about how the workshop experience could be improved is also invited.

How satisfied are you with:



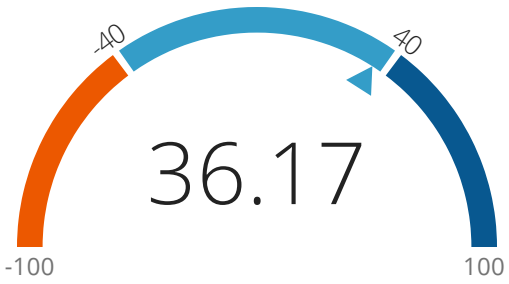
Average Total Satisfaction (5 = Extremely satisfied)

NET PROMOTER SCORE (NPS)

What's an NPS? Net Promoter Score is a rigorous rating of what proportion of participants are enthusiastic fans (Promoters, 9 and 10) with a heavy discounting for the proportion who are neutral to negative (Detractors, 6 or less out of 10). People who are positive but not hugely enthusiastic (Passives, rating a 7 or 8 out of 10) are not included in the equation. This helps focus an organization on exceeding expectations as well as reducing anything resembling a negative experience. NPS range from -100 to +100, with a higher NPS being more desirable.

An NPS greater than 0 is considered good and above 20 is considered favorable.

NPS: How likely are you to recommend this workshop to a colleague or peer?



How is NPS calculated?

Respondents answer this question: How likely are you to recommend this workshop to a colleague or peer? (0 = Not at all likely; 10 = Extremely likely). Responses are then categorized as Promoters (9 or 10), Passives (7 or 8), or Detractors (6 or less).

NET PROMOTER SCORE (NPS) = % PROMOTERS - % DETRACTORS

What would you improve about your workshop experience?

Learnt some very useful strategies, however this workshop is probably more tailored to clinicians who are likely to encounter / manage patients with suicidal risk on a day to day basis. Also the examples in this workshop applies to the wider community in America, and at times bears little relevance to the Australian setting (eg. guns and ammunitions) and the ADF setting.

Needs to be put into context for defence. Lots of room for improvement.

Getting the team to be more interactive by using breakout rooms

I think that tailoring the workshop to meet ADF specific examples and audiences would greatly improve it for people working in similar roles to myself.

more context specific to australian defence

Just using more defence related language and context for the role plays

more specific examples to my workplace

More applicable scenarios for the population

Examples tailored to ADF context and policy

Differentiate between health professionals and non health professionals

As stated in the evaluation document, more ADF specific examples with some consideration in application through the Chain of Command network is definitely required.

A little more pre-workshop info from our internal people to give better context to the training and the target audience.

Cant wait to see it rolled out :)

It was a long time to be in a virtual group- perhaps 2 half days instead of one whole day would be better

needs Defence context and link into policy

I have a slightly different service delivery role which includes not only current Defence members, but more commonly transitioned members and families. It would be helpful to have been able to discuss some if the additional challenges around managing suicidal ideation across these various groups as much of the group discussion understandably assumed that everyone was linked into the Defence MH care system. There is also quite a silo approach between we Defence MH services and other service delivery arms within Defence- although the fact that I could participate in this workshop was a good start to addressing this

Discussion in smaller groups as well as the larger group
See attached feedback form
Freeloaders need to be drawn into discussion
Demonstrations from facilitators
see feedback form
My feedback may seem less positive than is anticipated, but there are only very minor differences to how we already assess risk. The 'extend' section is an improvement on what we already do. And the intervention section is much more limited than what I would already do. Otherwise, it is the same as what we already do, but structured a little differently and with different words. What would I improve? I think risk status and risk state need a lot more work to be employed in Defence.
ADF / link to policy
It would be easier to do the activities in smaller break out groups
More job specific examples
Defence specific examples and scenarios
Contextualising to Defence which is part of this session and understanding how fits within policy will be important
issues around privacy and policy requirements. case studies. actual medico legal documentation advice - good vs bad examples.