NO MORE SUICIDE: COMMUNITY TRAINING

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The content of this report represents the independent work of the research team of Liverpool John Moores University.

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Executive Summary

Background

Suicide represents a major global public health crisis, with approximately 700,000 deaths annually worldwide. Communities play a critical role in suicide prevention by providing social support and reducing stigma. The NO MORE Suicide community-based training programme was developed to enhance community members' knowledge, confidence, and skills in suicide prevention across Liverpool.

Method

This mixed-methods evaluation employed pre-post surveys and semi-structured interviews. Quantitative data were collected from 58 community training attendees using validated scales, with 16 completing both pre- and post-training assessments. Two facilitator interviews and three participant interviews provided qualitative insights. Analysis included paired-samples t-tests and thematic analysis.

Results

Quantitative analysis showed the training improved general suicide knowledge ($p < .05$) and confidence supporting suicidal individuals ($p < .06$). The qualitative analysis identified three key themes: 1) skills development and outcome of the training, 2) personal connection and 3) training evaluation and future development. Participants preferred face-to-face delivery over online formats.

Limitations

Small sample size (n=16) limited statistical power, while high attrition prevented long-term follow-up analysis. Participants were primarily from mental health or social support organisations, limiting broader community representation.

Recommendations

Future research should focus on evaluating the long-term impact and establish refresher training on suicide prevention. Community training should emphasise face-to-face formats incorporating case studies rather than role-play activities. Outreach strategies must engage underrepresented professionals, such as hairdressers and taxi drivers.

Table of Contents

Background

Suicide is a major public health problem, both internationally and in the UK (World Health Organisation [WHO], 2023). Approximately 700,000 individuals die by suicide each year. Globally, suicide is among the three leading causes of death in those aged 15-44 years, and the second leading cause of death in 10-24 years old (WHO, 2023). However, these figures do not include non-fatal suicidal behaviours, such as self-harm, which are up to 20 times more frequent than completed suicide (WHO, 2023). There are indications that for each adult who dies of suicide there may be more than 20 others attempting suicide. The impact on families, friends and communities is devastating and far-reaching, even long after persons dear to them have taken their own lives. Social, psychological, cultural and other factors can interact to lead a person to suicidal behaviour and the stigma attached to suicide means that many people feel unable to seek help.

Many suicides occur in areas of deprivation where resources and services are often scarce, limiting early identification, treatment, and support for people in need (Biddle et al., 2023; Office for Health Improvement & Disparities, 2024). These striking facts, paired with the limited availability of timely interventions, make suicide a serious global public health problem demanding urgent action (World Health Organization [WHO], 2023). Communities can play a critical role in suicide prevention by providing crucial social support to vulnerable individuals, engaging in follow-up care, reducing stigma, and supporting those bereaved by suicide (Higgins et al., 2022; Morrissey et al., 2024). Research indicates that community spaces and peer support are particularly valuable in these contexts, fostering connection and healing (Higgins et al., 2022; Morrissey et al., 2024). Such community involvement can enhance individuals' sense of belonging and connectedness, known protective factors against suicide (WHO, 2023). Lastly, communities can implement evidence-based suicide prevention strategies tailored to their unique local circumstances—and engaging communities directly in planning is considered a best practice platform by WHO and others (WHO, 2023; Nicholls et al., 2024). While governments are responsible for leading comprehensive, multisectoral suicide prevention efforts, empowering community-level engagement allows these

broader policies to be shaped and enacted in ways that meet local needs, priorities, and contexts (WHO, 2023; Nicholls et al., 2024).

As part of the Cheshire and Merseyside Suicide Prevention Strategy, community organisations have delivered the *No More Suicide* training to build local capacity for early intervention. Using a train-the-trainer model, the programme equips frontline staff and volunteers with skills to recognise suicide risk, initiate supportive conversations, and signpost individuals to appropriate help (Cheshire & Merseyside Suicide Prevention Partnership, 2020). Since its launch, hundreds of trainers have cascaded half-day sessions across diverse settings—including schools, housing, probation, and voluntary services—reaching thousands of participants. Research to date shows significant improvements in confidence and preparedness to engage in suicide prevention, alongside strong satisfaction ratings, highlighting the value of community-led approaches in complementing statutory services (Cheshire & Merseyside Suicide Prevention Partnership, 2020; Higgins et al., 2022).

Aim: To gain the views and experiences of people attending the NO MORE Suicide community-based suicide prevention course.

The main objectives were to:

- Compare attendees' knowledge of suicide, attitudes towards helping people feeling suicidal, and confidence speaking about suicide before and after training.
- Explore attendees' experience of the NO MORE Suicide community training.
- Examine attendees' use of the training content and changes in behaviour post-training.

Methodology

Design

A mixed-methods approach was used for this study. Quantitative survey data and qualitative interview data were collected and analysed to evaluate the effectiveness of the NO MORE Suicide training programme in community settings in Liverpool. A longitudinal pre-post survey design was used to track changes in attendees' knowledge, confidence, and attitudes toward suicide following the training. Semi-structured interviews were conducted with attendees and the facilitators who provided the training to gain a comprehensive understanding of the NO MORE Suicide training.

Participants

Quantitative data was collected from 22 cohorts of NO MORE Suicide training attendees between 26th July 2023 to 25th January 2025 (n=132). Qualitative data was elicited through five in-depth interviews: three with attendees of the NO MORE Suicide between 26th May and 25th April 2024, and two with training facilitators between 28th November and 9th December 2024.

Procedure for quantitative data collection

Data were collected at three timepoints; before attending the training, immediately after the training, and three months post-training. Data was collected via online surveys using the QuestionPro survey platform. Participants ticked a consent box before beginning the surveys to indicate explicit consent. Demographic data were collected from the attendees including age, gender, level of education, occupation, and years of experience in current job role. Then, the validated scales listed below were used to evaluate the training.

At all-time points:

Landschoot et al.'s (2017) measure of knowledge confidence, and attitudes. The measure uses four scales, each of which have been shown to be valid and reliable measures. These include:

- ***Self-perceived knowledge****:* A subscale of the Dutch translation of the *Question, Persuade, and Refer* (QPR) measuring how participants rate their own understanding of suicide warning signs and prevention strategies. This is a 7-item questionnaire assessing self-perceived knowledge around suicide. Participants respond to each item (e.g. suicide warning signs) ranking their knowledge on a 5-point Likert scale ranging from 1 (very low) to 5 (very high). Responses were summed to give a total score ranging from 7 to 35, with higher scores indicating higher levels of knowledge. The QPR has been shown to be a reliable measure of self-perceived knowledge of suicide prevention.
- ***Objective knowledge****:* The *Suicide Information Test* (SIT), an eight-item true/false measure assessing factual understanding of suicide risk factors and warning signs. This is an 8-item questionnaire measuring knowledge of facts and myths around suicide. Participants agree (score 1) or disagree (score 0) with each statement (e.g. everyone who dies by suicide is depressed), resulting in a total score from 0-8. Higher scores indicate higher knowledge.
- ***Provider confidence:*** A subscale from the *Confidence and Beliefs Questions* (CBQ), which gauges self-assessed confidence in managing suicidal behaviour (e.g., "I am confident in my ability to successfully treat a suicidal patient"), rated on a 5-point Likert scale. This 3-item scale (e.g. I am confident in my ability to successfully signpost someone who is feeling suicidal) measured on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Responses are summed to give a total score from 3-15, with higher scores indicating higher confidence in caring for someone who is feeling suicidal.
- ***Attitudes toward suicide prevention****:* A three-item subscale derived from the *Attitudes Towards Suicide Questionnaire* (ATTS), specifically measuring willingness to help suicidal individuals (e.g., "It is a humane duty to try to stop someone from dying by suicide"), rated on a 5-point Likert scale. Responses are

summed to give a total score from 3-15, with higher scores indicating more positive attitude towards caring for suicidal individuals.

At T2 (immediately post-training) and T3 (three months post-training):

- The Behavioural Change Questionnaire version 1.2 – a 12-item scale assessing the impact of the training on behaviour. The scale consisted of 12 items using a 10-point Likert scale from 1 (I want to make this change) to 10 (Definitely not). The questionnaire specifically measures factors influencing professional practice rather than general attitudes towards change, with higher scores indicating a greater readiness and capacity to integrate new approaches into their job role and professional practice.

Quantitative data analysis

Data were analysed using SPSS 26. To examine attendees' outcomes, repeated measures t-tests were used to compare pre- and post- training data. The three-month follow up had an insufficient sample size for inferential tests, and so was excluded from the analysis.

Procedure for qualitative data collection

Prior to the interviews all participants verbally consented to confirm participation. The interviews were conducted online via Microsoft Teams. Interviews were transcribed automatically by Microsoft Teams and checked for accuracy by a research assistant. Attendees were asked about their experience of the NO MORE Suicide training, their use of the training since attending, any changes they would suggest, and whether they would recommend the training to others. Training facilitators were asked about their role, perception of engagement, logistics of delivering the training, any changes they would suggest, and any ways the training benefitted them. Interview times ranged from 20-60 minutes.

Qualitative data analysis

Thematic framework analysis was used to analyse the interview transcripts. This was selected as an appropriate method to explore the interview data as it facilitates a deeper understanding of the content (Richie and Spencer, 1994; Braun & Clarke, 2021). SW conducted the five interviews, and listened back to the audio-recorded interviews to check transcripts for accuracy and become familiar with the whole data set. RL cross-checked the anonymised transcripts to form a consensus. PS, SW and RL conducted thematic analysis of the anonymised transcripts. Initially, the qualitative responses were coded and organised into themes independently, and the generated themes cross-checked by PS, SW and RL to form a consensus (Braun & Clarke, 2021).

Data interpretation

The findings from the quantitative and qualitative data analysis were triangulated to understand the NO MORE Suicide community training within Liverpool.

Ethical Approval

Ethical approval was granted by the Liverpool John Moores University Research Ethics Committee (Reference: 23/PSY/053).

Findings

Participants

Overall, 58 people completed at least one of the three surveys. 16 completed both T1 and T2. No participants completed all three time points. Because the participants who completed T3 did not complete T1 or T2, T3 could not be analysed as longitudinal data to test the longer-term effects of the interventions. Thus, the analysis focuses on pre- (T1) vs post- (T2) training comparisons.

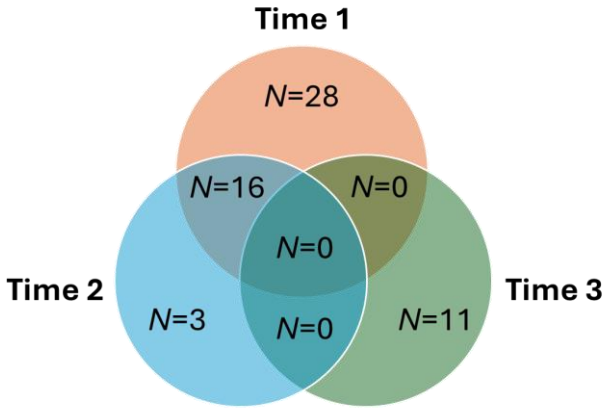


Figure 1: Data completion at 3 timepoints

Demographics

Overall, participants ranged in age from 23-65 years, with a mean age of 45. 72.4% (*n*=42) were female and 25.9% (*n*=15) were male. One participant did not give their gender.

Participants' years in practice ranged from <1-40, with a mean of 6.49 (*SD*=7.752). In total, 32 different job roles were given by 57 participants, with one participant not giving an answer. The most common category of job role was Support or Social Worker (*n*=17), followed by a managerial or leadership role (*n*=11).

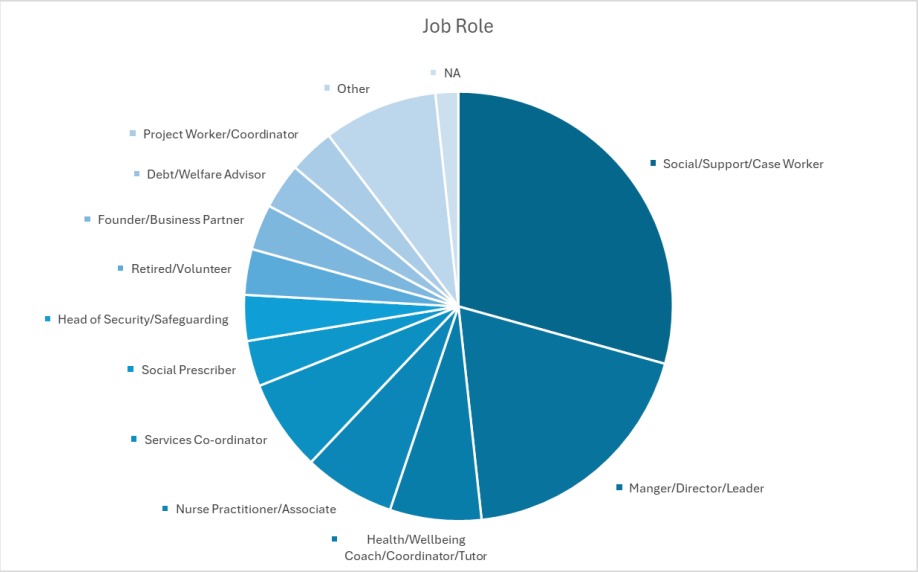
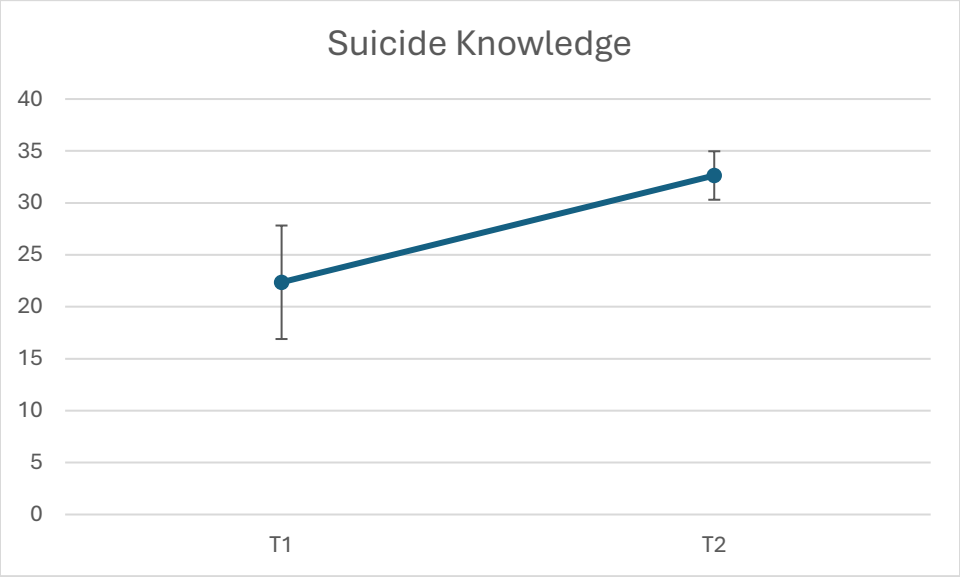


Table 1: Job Role

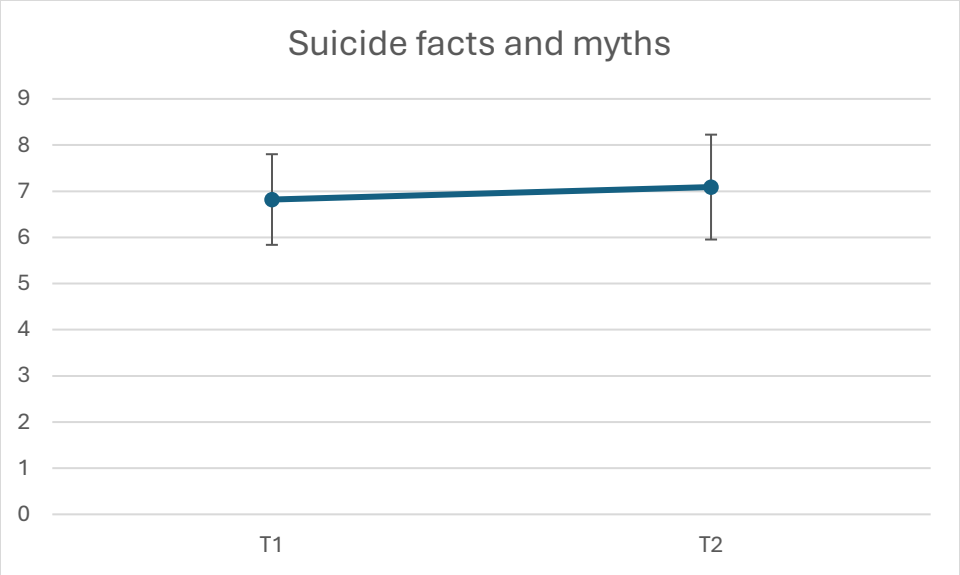
Job Role	***N***
Social/Support/Case Worker	17
Manger/Director/Leader	11
Health/Wellbeing Coach/Coordinator/Tutor	4
Nurse Practitioner/Associate	4
Services Co-ordinator	4
Social Prescriber	2
Head of Security/Safeguarding	2
Retired/Volunteer	2
Founder/Business Partner	2
Debt/Welfare Advisor	2
Project Worker/Coordinator	2
Young People's Advocate	1
Community Engagement Worker	1
Probation Officer	1
MS	1
Bus driver	1

Knowledge, Self-Confidence, and Attitudes

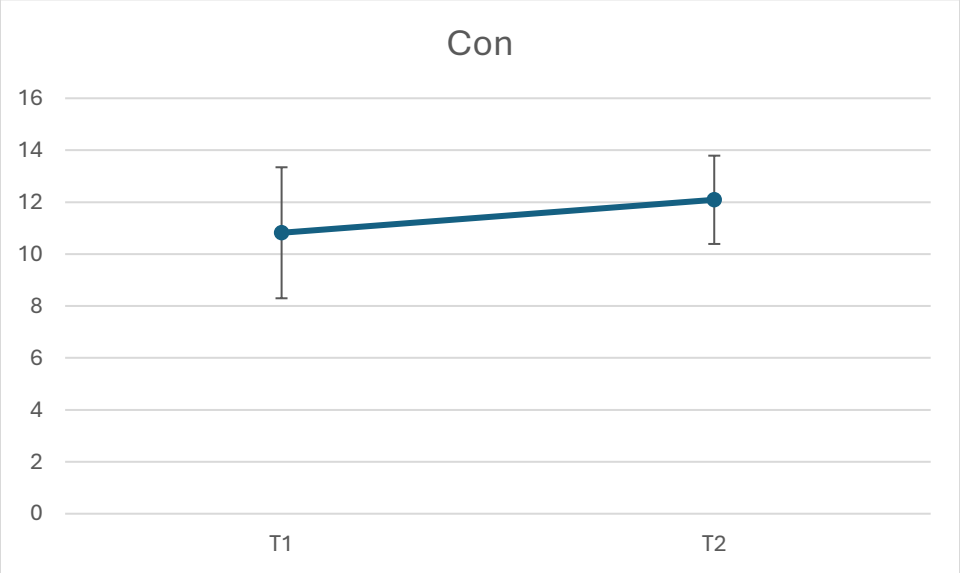
In the first knowledge scale, measuring knowledge around the topic of suicide, participants scored higher at T2 (*M* = 32.64, *SD* = 2.335) than T1 (*M* = 22.36, *SD* = 5.464). A paired-samples t-test found the increase in suicide knowledge from T1 to T2 was statistically significant (*t(10)*=-6.021, *p*=<.001). This suggests that participants' general knowledge of suicide significantly improved after the training.



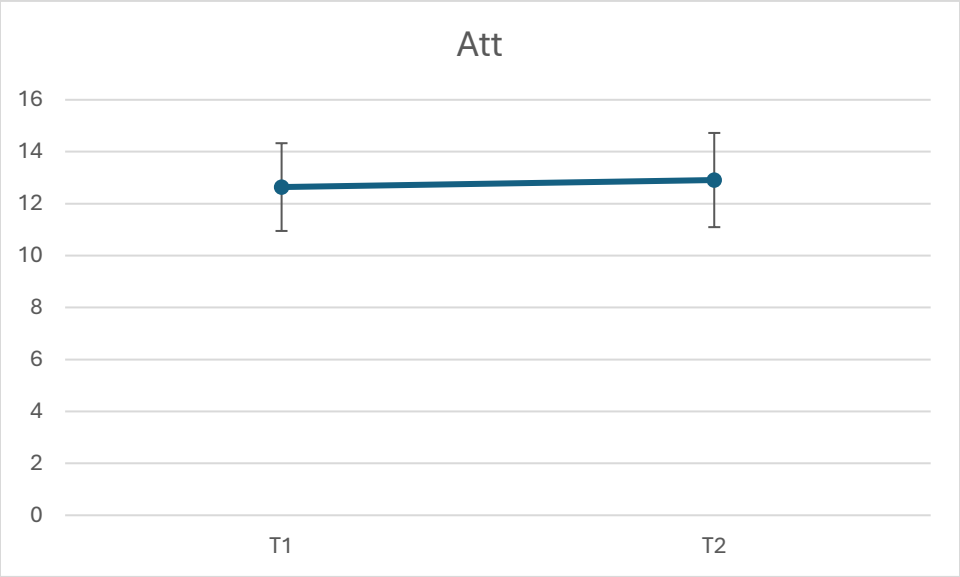
In the second knowledge scale, measuring knowledge of suicide facts and myths, participants scored similarly across T1 (*M* = 6.82, *SD* = 0.982) and T2 (*M* = 7.09, *SD* = 1.136). A paired-samples t-test showed no statistically significant change in knowledge of suicide myths and facts between T1 and T2 (*t(10)*=-.760, *p*=.465).



Participants appeared more confident in their ability to speak to and support someone feeling suicidal at T2 (*M* = 12.09, *SD* = 1.700) compared to T1 (*M* = 10.82, *SD* = 2.523). A paired-samples t-test comparing T1 and T2 trended towards significance (*t(10)*=-2.219, *p*=.051).



Participants' attitudes towards suicide showed little change between T1 (M = 12.64, SD = 1.690), T2 (M = 12.91, SD = 1.814). A paired-samples t-test showed no significant difference between T1 and T2 ($t(10)$=-.521, p=.614).



Interview data

Based on comprehensive interview data from five interviews, including two facilitator interviews and three interviews from individuals who attended the NO MORE Suicide training, three key themes were identified (see figure 2 below): 1) skills development and outcomes, 2) personal connection, and 3) training evaluation and future development.

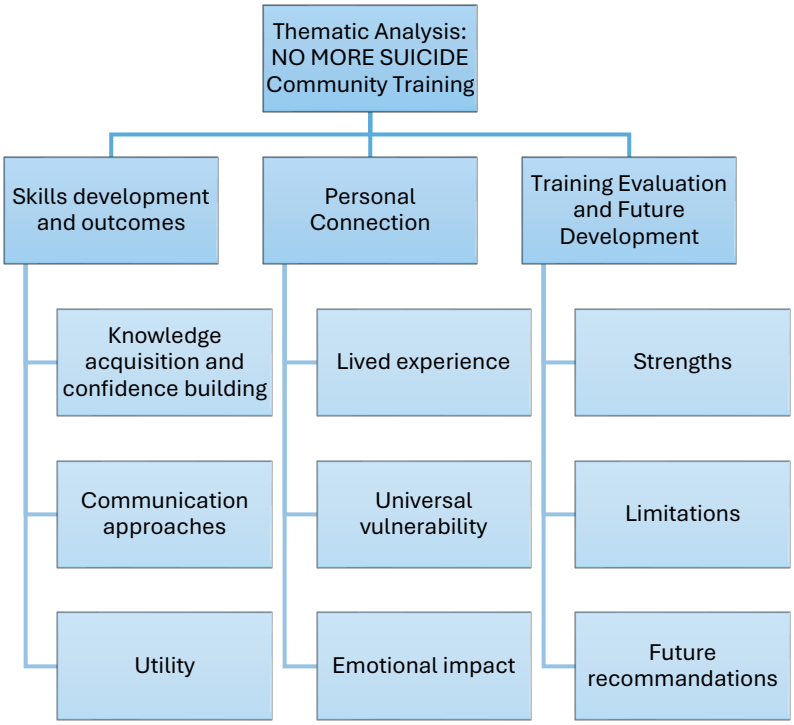


Figure 2: Themes and sub themes from the interview data

1) Skills Development and outcomes

a) Knowledge acquisition and confidence building

Both groups acknowledged an improvement in their skills related to suicide prevention following the training. Attendees reported improved knowledge about suicide, enhanced confidence in addressing suicide concerns, and practical skills in risk assessment and safety planning.

"*I had more confidence and having that conversation… it wasn't so fearful. It wasn't so far away from the realms of my world. There was a certain amount of relief from the training as well*

because I understood about it [the topic] a little bit more. I understood it a bit more and it wasn't so fearful.. [I learnt] putting it into a certain ways for it to be professional, like in my professional setting…." (Participant 2)

Facilitators also noticed increased confidence in those who attended the training.

"*They really recognise something about how suicide is horrible and it's painful and it's difficult, so they upskill themselves and give themselves more confidence."* (Facilitator 1)

b) Communication approaches

Both facilitators and attendees highlighted the importance of using direct and clear language rather than euphemisms when addressing suicidal thoughts. Facilitators saw this as an important theme in their delivery of the training and placed focus on teaching specific questioning techniques for inquiring about suicidal ideation.

"We bust the myth of, you know, you can't make someone suicidal by talking to them about suicide that… So, I think people feel less fearful of being direct and can see the value of being direct" (Facilitator 2)

"We offer this structure… the PHEMPO structure [Permission, History, Exposure, Method, Plan, Out of situation] which is a very clunky acronym but does what it needs to if somebody does say that thye're feeling suicidal, and highlight what kind of information does someone want to gather to identify how immediate and significant that risk is" (Facilitator 1)

Facilitators also placed emphasis on teaching attendees to balance direct questioning with compassion, creating an environment where difficult conversations about suicide could take place effectively without increasing risk or discomfort.

We are trying to, in a positive way, promote really the good culture around supporting people that might be suicidal or have made suicide attempts…. sort of having those warm conversations, but also being quite direct about asking if people did have a plan (Facilitator 2)

As well as being a key focus of facilitators, language and communication was also reported by attendees as being one of the most useful aspects of the training.

"I think being able to think about the questioning and what to say and what not to say, what's helpful and what's not helpful has been my main sort of learning from this training." (Participant 1)

"[The learning] of having a warm conversations but also being quite direct about asking if people did have a plan was helpful." (Participant 2)

As well as language and directness, attendees also reported terminology as one of their key learnings from the training.

I felt terrible about using the term commit suicide and [now] I'm very aware of not using that term. Um… you know [I've] reflected massively on suicide related terminology and the awareness (Participant 3)

c) Utility

Training attendees reported feeling better equipped to respond to potential suicide situations in their communities. They mentioned the training bridged theoretical understanding with practical application.

...since the training, I've changed positions, actually... I've since changed to support worker, so it's now face to face. So this training put me in good stead- well, I would say it has actually put me in a really good stead for face-to-face contact with clients as well as over the phone. (Participant 3)

2) Personal Connection

a) Lived Experience

A significant theme that was identified from the interviews was the personal connection many participants had to the topic of suicide. Both trainers and attendees often brought lived experience to the training, which influenced their engagement and motivation.

To begin with, I found this topic a bit hard because personally, I've had two people umm…end their life and obviously that took a long time to recover from.. so, I took the training very seriously… (Participant 4)

b) Universal vulnerability

The training emphasised the universal vulnerability to suicide, helping break down stigma by recognising that suicidal thoughts can affect anyone regardless of their background. Attendees left the training with an increased awareness of both the rates of suicide and the universal, invisible nature of suicide.

"Actually you don't know who sat next to you… you don't know what's going on in people's lives... the person sat next to you, the person on the bus, it's everywhere… and it's getting worse, unfortunately... actually the statistics are scary…" (Participant 2)

c) Emotional impact

Participants frequently mentioned the emotional weight of engaging with the topic of suicide, which was often heightened by their personal experience. Attendees reported that the training felt intense and tiring not due to the amount of content, but the emotional impact of the topic.

"*It was- it was quite tough actually, it's- I found it quite emotional, I suppose I would say. Not tough as in hard, but it- it's a hard- it's a hard subject to approach, for me…" (*participant 3*)*

Facilitators were aware of the emotional impact of the topic, and placed emphasis on attendees' own well-being. Facilitators felt it important that the training included teaching attendees how to take care of themselves both during the training and when implementing the training to help others.

"the whole topic can raise people's own vulnerability and anxiety. We facilitate them to stay grounded in themselves and able to just listen and not get pulled by their own anxiety, into either trying to fix or into rushing too quickly or just being overwhelmed by somebody else's distress." (Facilitator 2)

3) Training evaluation and future development

a) Strengths

The structure and content of the training received mixed feedback. Attendees appreciated the relevance of the material, appropriate timing and pace, and the mindfulness-based approaches within the training. They reported that the framework provided practical tools while maintaining sensitivity to the subject matter.

"It was well facilitated and enhanced knowledge and confidence. The resources were good, and the balance of self-directed learning was effective…The reiteration on helpful, open questions, the acronym and approaches to situations involving suicide risk was really beneficial." (participant 1)

b) Limitations

However, limitations were also identified, particularly around discomfort with role-play components which some found challenging. Attendees expressed a preference for face-to-face training over online delivery, believing the in-person format better supported the sensitive nature of the content. Many suggested enhancing the training with additional video content and more scenario-based learning opportunities.

"The role plays were quite difficult... I think it was difficult for someone to get into a role play situation with people that you didn't know so much… I probably would have preferred to see more videos and examples of how that had planned out, and maybe been asked in an open group, what type of questions could you ask, or how would you respond…" (participant 4)

c) Future recommendations

The need for continued support emerged as an important theme. Participants identified refresher sessions as crucial for maintaining skills and confidence over time

"I don't think it should be a one-off course because it'd be nice to have that reminder… because it probably will go from my mind… it should be something like you do first aid. It should be like a

yearly thing… I think that would be a really good idea actually to do that. Not to teach new tricks or anything, but just as a reminder, a refresher…" (participant 4)

The interviews further revealed the need of targeting outreach strategies to improve engagement in underrepresented sectors (i.e. roles outside of mental health support services) who are also working with vulnerable individuals. It was observed the attendees primarily came from sectors closely linked with charities and other organisations related to suicide prevention.

"The majority of participants are individuals who work within supportive organisations, some of which may be affiliated with or funded by the council. But we are not reaching professions such as taxi drivers and hairdressers who are also working with vulnerable people, even though the training is open to them. Instead, we are getting people whose networks have identified this training is suitable for them. So may be something [to do to] broaden the scope to include these people as well…" (Facilitator 2)

Discussion

Key Points

• Participants showed an improvement in general suicide knowledge and confidence supporting suicidal individuals, indicating the training was effective in knowledge transfer.
• The training did not have an effect on staff knowledge of suicide myths and facts nor their attitudes towards suicide.
• Both trainers and participants complimented learning the use of direct, clear language when discussing suicide, with participants feeling more confident using them in sensitive conversations.
• Many participants brought lived experience with suicide to the training, which both motivated their engagement yet made the content emotionally demanding.
• Participants valued structured approaches (e.g. the PHEMPO framework) for risk assessment and safety planning.
• Participants preferred face-to-face training over online delivery and found role-play activities challenging, suggesting alternative learning methods would be effective.
• A clear preference emerged for refresher sessions, with participants recommending annual or by annual follow-up training.

Overview of findings

The evaluation of the NO MORE Suicide community-based training programme suggests the training is effective in enhancing participants' knowledge, confidence, and practical skills in suicide prevention. The mixed-methods approach revealed significant improvements in general suicide knowledge and trends toward increased confidence in supporting individuals experiencing suicidal ideation. Qualitative findings identified three key themes: skills development and outcomes, personal connection, and training evaluation and future needs. This served to provide insights into the mechanisms through which community-based suicide prevention training operates.

The findings of this study align with the growing body of evidence supporting community-based suicide prevention interventions. Cross et al. (2011) demonstrated that community-based gatekeeper training programmes can effectively increase knowledge and

confidence in identifying and responding to suicide risk. Similarly, Isaac et al. (2009) found that brief educational interventions for community members led to sustained improvements in attitudes toward suicide and help-seeking behaviours. The current study extends this evidence base by examining a comprehensive training programme in a UK context, addressing the need for culturally and contextually appropriate interventions (Hogan & Schmidt, 2002).

The improvement in general suicide knowledge observed in this study is consistent with previous evaluations of suicide prevention training programmes. For instance, Wyman et al. (2008) reported similar knowledge gains following their Question, Persuade, Refer (QPR) training, whilst Tompkins et al. (2010) demonstrated that brief gatekeeper training programmes consistently produce measurable improvements in suicide-related knowledge across diverse community populations.

There is evidence of the training improving confidence which is supported by the interview findings. Similar findings have been previously reported by Burnette et al. (2015) who found confidence building to be a more gradual process than knowledge acquisition, requiring reinforcement through practice and ongoing support. The importance of follow-up sessions and continued professional development was also seen as vital.

The emphasis on direct communication about suicide, highlighted by both facilitator and attendee interviews, reflects best practice guidelines established by the International Association for Suicide Prevention (Mishara & Kerkhof, 2013). The move away from euphemistic language toward clear, direct questioning aligns with evidence that direct inquiry about suicidal thoughts does not increase suicide risk and may facilitate help-seeking (Dazzi et al., 2014). The PHEMPO framework employed in the training provides a structured approach consistent with evidence-based risk assessment protocols (Hagan et al., 2001).

The prevalence of lived experience among participants reflects broader patterns in suicide prevention work, where personal connection to the issue often motivates professional involvement (Survivors of Suicide Loss Task Force, 2015). In his book on

suicidal behaviour, McKeon (2009) emphasised the valuable contributions of individuals with lived experience whilst noting the importance of appropriate support and boundaries. The emotional impact reported by participants aligns with literature on secondary trauma in suicide prevention work (Cerel et al., 2013), highlighting the need for ongoing supervision and self-care strategies.

Strengths and Limitations

The use of mixed-methods within this study enabled triangulation of findings, providing both quantitative evidence of training effectiveness and qualitative insights into attendee and facilitator experiences. The use of validated scales and systematic thematic analysis strengthens the reliability of the findings. The evaluation was conducted within community settings, enhancing the external validity and practical applicability of findings. Findings show that the training addressed multiple domains identified as crucial in suicide prevention literature, including knowledge, attitudes, confidence, and practical skills (Burnette et al., 2015). Further, the findings highlight the importance of the incorporation of structured and accessible approaches such as PHEMPO and evidence-based practices provides a solid foundation for sustainable skill development.

The study carries some limitations. The small sample size completing both pre- and post-assessments (n=16) limits statistical power and generalisability of quantitative findings. However, we were still able to detect improvements in the domains of knowledge and confidence. The inability to conduct longitudinal analysis due to participant attrition represents a limitation, preventing assessment of sustained training effects. Participants were primarily from organisations already engaged in mental health or social support work, potentially limiting generalisability to broader community populations. This difficulty is a common limitation in research conducted in this area (Patel et al., 2017). The lack of three-month follow-up data from participants who completed initial assessments however, prevents evaluation the long-term impact of the training, a crucial factor in determining programme effectiveness (Cross et al., 2011).

Implications for Research and Practice

Future evaluations should prioritise retention strategies to enable assessment of training effects over extended periods. Understanding the long-term impact of the training is crucial for determining optimal refresher schedules and ongoing support needs.

The UK's suicide prevention strategy (HM Government, 2023) highlights the need for community engagement. The findings of this study add to the current body of evidence that demonstrates the effectiveness and impact of community-based suicide prevention training, and supports the need to extend these training programmes beyond mental health professionals and support services. It also highlights the importance of extending training programmes to include refresher sessions to reduce degradation of skills and knowledge.

Focusing on the delivery of the programme, this study suggests a clear preference for face-to-face training over online delivery which should inform programme planning in future, particularly for sensitive content requiring interpersonal connection and support. Given discomfort with role-play activities, alternative learning methods such as video case studies, structured discussions, or simulation exercises are recommended. Furthermore, strategies to engage underrepresented groups, including hairdressers, taxi drivers, and other community-facing professionals, should be developed to maximise the impact.

Conclusion

This evaluation provides evidence for the effectiveness of community-based suicide prevention training in enhancing knowledge, confidence, and practical skills among diverse professional groups. The mixed-methods approach revealed both quantitative improvements and important qualitative insights about participant experiences and programme enhancement needs.

Whilst limitations around sample size and follow-up data prevent a definitive conclusion about long-term effectiveness, our findings support continued investment in community-based approaches to suicide prevention. The emphasis on direct communication,

structured assessment approaches, and ongoing support aligns with evidence-based best practices and participant preferences. The NO MORE Suicide training programme therefore demonstrates promising potential as a component of comprehensive suicide prevention efforts, warranting continued development and rigorous evaluation to optimise impact.

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