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Nottingham and Nottinghamshire WAVE 4 SUICIDE PREVENTION Evaluation Report

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Date: January 2025 (Final)

CONTENTS

1. INTRODUCTION

The Wave 4 Suicide Prevention Programme, funded by NHS England, represented a transformative initiative within the Nottingham and Nottinghamshire Integrated Care System (ICS) aimed at reducing suicide rates and improving population mental health and well-being. With an annual budget of £209,161 allocated over three years (2021–2024), the programme was governed by the Public Health teams of Nottingham City Council and Nottinghamshire County Council, with the latter assuming lead responsibility for operational delivery.

Governance was provided by the Nottingham and Nottinghamshire Suicide Prevention Strategic Steering Group (SPSSG), which was established by the ICS Mental Health Board and the Health and Wellbeing Boards of both Nottinghamshire County and Nottingham City. The SPSSG is tasked with overseeing system-wide suicide prevention efforts, monitoring trends, and coordinating responses to emerging challenges.

As a key component of the local overarching Suicide Prevention Strategy and Action Plan, the programme embraced principles of engagement, co-production, and collaboration. It adopted a holistic approach to addressing identified risk factors for suicide, ensuring that the initiative was both inclusive and impactful in its efforts to improve mental health outcomes.

The local programme identified four priority areas to maximise the impact of the Wave 4 funding:

- **Priority One: Training.** Enhancing the skills and compassion of professionals in statutory and non-statutory services to support individuals at risk of suicide.

- **Priority Two: Communications and Public Awareness.** Establishing a unified local identity and narrative through the development of a suicide prevention communications campaign.

- **Priority Three: Real-Time Surveillance (RTS) Data System.** Strengthening the local RTS system with advanced tools for data management and insights. [Not part of the evaluation project].

- **Priority Four: Prevention Support for Higher-Risk Groups.** Implementing small-scale, test-and-learn projects, a small grants programme, and reviewing pathways to better support those experiencing challenges associated with suicide risk.

The evaluation of the Wave 4 programme, conducted primarily between March and August 2024, was commissioned to assess its reach, effectiveness, and impact while capturing key learnings to shape future suicide prevention efforts. This report aims to provide a comprehensive overview of the programme, highlight key achievements and areas for improvement, and offer evidence-based recommendations to inform the post-Wave 4 strategy.

The evaluation process has been guided by a combination of quantitative and qualitative methodologies, including engagement with stakeholders, people with lived experience, and the general public. The findings will inform system-wide priorities, ensuring a sustainable and impactful approach to suicide prevention beyond the current funding period.

2.   PRIORITY ONE - TRAINING

Aim: **Suicide prevention training / skills development for statutory and non-statutory services, particularly those who support people in at risk groups, to increase compassion, competency, knowledge and skills.**

2.1. Background

The training component of the Wave 4 Suicide Prevention Programme was a cornerstone initiative aimed at enhancing the local workforce's skills and confidence in addressing suicide prevention. This initiative was underpinned by a Training Needs Analysis (TNA) conducted by the University of Nottingham between January and March 2022. The TNA identified a critical gap in suicide prevention training, particularly when compared to the availability of broader mental health training. This gap informed the subsequent commissioning process and the design of the training framework.

Nottinghamshire County Council took the lead in commissioning Harmless CIC – a local provider with a national presence that offers support and training around self-harm and suicide prevention – to deliver the training, following a competitive tendering process. The framework agreement established covered four core modules: suicide prevention, self-harm awareness, suicide bereavement, and mental health awareness[1].

Harmless CIC were also commissioned separately in Year 2 under Priority Four to develop and deliver bespoke sessions tailored to specific needs, such as those of local organisations or marginalised communities as seen in Year 2 including: Boys and Men; LGBTQIA+; Gypsy, Roma, and Traveller; Relationship Breakdown; Suicide Bereavement Training for Services (such as funeral directors, bereavement counsellors and bereavement support services); and Children & Young People[2].

Training was developed with an emphasis on co-production, involving stakeholders and insights from the TNA. For the bespoke training sessions delivered as part of Year 2 activities, Harmless CIC tailored its content to specific community needs, addressing barriers such as language and trust, in the following training packages (as per Eventbrite titles):

- Wave 4: Boys and Men: Self Harm & Suicide Prevention (Nottingham/shire)

- Wave 4: LGBTQIA+ Self Harm & Suicide Prevention (Nottingham/shire)

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[1] *Note:* The mental health awareness training was not considered or discussed as part of this evaluation project as it was funded from other sources.

[2] *Note:* Unless otherwise noted, the findings presented in this section encompass both the core training modules and the bespoke sessions delivered under the programme, as the themes and outcomes apply equally to both. For further details on the Year 2 Pre-Training Engagement, refer to the Priority Four section below.

- Wave 4: Gypsy Roma & Traveller SH & Suicide Training (Nottingham/shire)

- Wave 4: Relationship Breakdowns as a Suicide Risk Factor (Nottingham/shire

- Wave 4: Suicide Bereavement Training for Services (Nottingham/shire) Suicide bereavement training for funeral directors, bereavement counsellors and bereavement support services across Nottingham and Nottinghamshire.

- Wave 4: Children & Young People - Self Harm Prevention (Nottingham/shire)

Despite the robust planning, challenges arose in implementation – early mobilisation delays, logistical complexities, and the varying needs of diverse audiences required adaptive approaches. Harmless CIC incorporated iterative feedback and adjustments to align the training with participants' expectations and the commissioners' objectives.

The training's impact was measured through pre-and post-session evaluations, showing significant increases in participant confidence and knowledge. However, limitations in follow-up evaluation mechanisms were noted, with low response rates for behavioural change assessments. These findings highlight the programme's success in addressing immediate learning outcomes while identifying areas for improvement in long-term impact evaluation.

2.2. Methodology

The primary question guiding this evaluation was: **"How well did the priority area deliver against its aim?"** This was supported by several sub-questions aimed at exploring different dimensions of the priority area's implementation and impact:

1. Who did we reach with the training? Was this who we intended to reach?

2. Who didn't we reach that we intended to reach and why? How can we improve this for future training?

3. How has the training improved compassion, competency, knowledge and skills across the system?

4. What has been the impact of the training (e.g., knock on reach of training on service users)?

A multi-faceted approach was employed, utilising a combination of qualitative and quantitative methods. These activities were designed to assess the achievements and limitations of the campaigns and inform actionable recommendations for improving future public awareness efforts.

2.2.1. Evaluation Activities

- **Commissioner and Provider Interviews.** Semi-structured interviews were conducted with two commissioners, three members of the provider (Harmless CIC) development and delivery team, one additional trainer, and the marketing lead. These interviews explored topics such as commissioning processes, performance management, training development and testing, promotion and delivery, quality assurance, and the embedding of training into practice.

- **Activity and Feedback Data Review.** The evaluator reviewed performance monitoring information provided by Harmless CIC, including immediate post-session feedback and new follow-up evaluation data. The focus of the review aligned with Kirkpatrick's model of training evaluation, primarily addressing Level 1 (Reaction) and Level 2 (Learning), while exploring Level 3 (Behaviour) and Level 4 (Results). A participant follow-up survey, designed with the evaluator's input, aimed to assess longer-term application of learning and return on investment. Despite a low response rate, the findings are considered indicative of the most engaged participants, offering valuable insights into best-case scenarios.

- **Stakeholder Network Meeting:** Attendance at the Nottingham and Nottinghamshire Suicide Prevention Stakeholder Network meeting on 18 June 2024 provided an opportunity for open discussion with eight stakeholders. The participants, representing a range of sectors – including local government, public health, Voluntary and Community Sector organisations, health and social care, and education – shared diverse perspectives on the programme's implementation and outcomes.

- **Stakeholder Workshop.** A broader workshop held on 26 June 2024 at County Hall (see Appendix One for more details) brought together public sector representatives, Voluntary and Community Sector organisations, individuals with lived experience, and other stakeholders. This forum enabled collective reflection on the training's effectiveness and facilitated collaborative action planning to inform future developments.

All data were thematically coded and analysed to align with the evaluation sub-questions. The qualitative data from interviews, surveys, and workshops underwent thematic analysis to identify recurring patterns, while quantitative data were statistically analysed to explore trends, awareness levels, and demographic variations. This dual-method approach provided both numerical insights and rich, contextual understanding, ensuring a balanced and in-depth evaluation.

One notable limitation was the lack of representation from certain organisations or sector stakeholders in the evaluation process. This could be, in part, due to challenges in engagement, including competing priorities, resource constraints, and varying levels of awareness or buy-in

regarding the programme's relevance to their work. Additionally, some stakeholders may have lacked the capacity or confidence to contribute meaningfully to the evaluation. Their absence limited the breadth of perspectives (both diverse and supportive validation), which could have provided a more comprehensive understanding of the programme's impact. To address this, future evaluations should include more targeted outreach and tailored support to encourage participation from these underrepresented groups, ensuring a more balanced and inclusive range of responses.

2.3. Key Findings

2.3.1. Commissioner and Provider Interviews

The key findings from these interviews demonstrate a collaborative approach to addressing training needs through sensitive and tailored delivery.

2.3.1.1. Contracting and Performance Management

- **Contracting.** The core training was commissioned in response to a clear gap identified through the Training Needs Analysis, with a focus on high-risk groups and system-wide needs. Nottinghamshire County Council led a competitive tender process that prioritised co-production and cultural sensitivity; and emphasise flexibility in delivery to tailor training to the needs of different organisations and communities.

  > *"It was all driven by the TNA – we knew the gaps and were able to commission directly to address them ... The tender really focused on how the provider would adapt the training to meet the needs of diverse audiences."*

- **Challenges in Mobilisation.** Initial delays in mobilisation to the core and bespoke training created pressure to deliver within tight timelines. This required strong collaboration between the commissioners and Harmless CIC to address early teething issues.

- **Performance Management.** Harmless CIC provided core training performance updates, including data on delivery metrics, participant feedback, and reach. This ensured commissioners could track progress and address any emerging issues. Feedback mechanisms captured Kirkpatrick Level 1 (reaction) and Level 2 (learning). While immediate outcomes indicated positive shifts in knowledge and confidence – meeting core objectives of the training – mechanisms for evaluating long-term behaviour change and systemic impact were limited.

  At the time of this report, performance management data for the bespoke training sessions had not been provided, creating a gap in understanding their effectiveness and impact.

Follow-up evaluation was specified as a contractual requirement but was not systematically implemented. As part of this evaluation project, follow-up questions were developed and distributed to capture longer-term insights, though low response rates constrained the ability to draw conclusive findings.

> *"The provider gave us regular updates, so we could see where we were hitting targets and where there were gaps ... The immediate feedback was great – we could see people felt more confident, but longer-term impact was harder to assess."*

> *"You could see the difference – people left the sessions feeling more confident to have those difficult conversations."*

> *"We know anecdotally it's making a difference, but we can't quantify it [the real-world impact] without better data."*

- **Iterative Adjustments.** Feedback loops allowed the provider to refine training content and delivery approaches, ensuring alignment with participant needs. Interviewees felt that the emphasis on co-production for the bespoke training enriched those sessions' content, but the time and resources required to engage with lived experience representatives / professional groups were greater than anticipated (see Priority Four Year 2 Professional Engagement Pilot for more details).

> *"The provider was great at adapting – they really listened to what participants needed and made changes."*

> *"Co-production added so much value but took longer than anyone expected – you have to commit to doing it properly."*

- **Balancing Flexibility and Scalability.** The bespoke nature of some training sessions enhanced relevance but created challenges in achieving consistency and scalability.

> *"Tailored sessions were great for local needs, but they made it harder to scale the programme overall."*

The contracting and performance management of the training effectively addressed immediate learning needs and filled critical gaps. However, stronger mechanisms for follow-up evaluation, coupled with clearer contractual provisions and resource allocation, are necessary to sustain and measure long-term impact. Themes of collaboration, adaptability, and responsiveness were evident throughout but must be matched with a strategic approach to monitoring and scaling for future iterations.

2.3.1.2. Development, Promotion and Delivery

- **Training Development.** In addition to the core training called-off through the Framework Agreement, Harmless CIC designed six bespoke training sessions for marginalised communities, with a focus on cultural sensitivity and lived experience, under Priority 4 Pilot Projects. The training content underwent extensive consultation with stakeholders, including commissioners, advocacy organisations, and service users, to ensure relevance and inclusivity. This approach was reflected in the use of culturally tailored content, case studies, and high-quality supplementary materials.

  Challenges included tight timelines, with content development overlapping other project activities, such as stakeholder engagement. As noted, *"The content was created just before Christmas, leaving only three months to deliver 33 sessions,"* highlighting the compressed timeframe for the programme.

  Flexibility in delivery and trainer reflection logs allowed iterative content refinement based on delegate feedback. Trainers noted that this process enhanced their confidence and knowledge: *"The reflective learning log was a really helpful exercise … it made everyone feel more equipped for preparation for the unknowns"*. Additionally, the inclusion of service user voice through audio clips and videos enriched the sessions, ensuring alignment with community needs while acknowledging the limitations of not having trainers from every represented community.

- **Promotion.** Promotion efforts targeted both specific marginalised groups and general audiences. The marketing team at Harmless CIC utilised a combination of outreach strategies, including bespoke advertising materials, social media campaigns, and newsletters. Specific visual cues, such as sports imagery for Boys and Men or gypsy motifs for GRT communities, were employed to resonate with target audiences.

  Direct contact with organisations, such as funeral directors or leisure centres, proved more effective than social media campaigns, especially for groups less likely to engage digitally. Low attendance in some sessions, particularly among funeral directors, reflected difficulties in booking due to time constraints or ineffective cascade models (e.g., no overarching infrastructure organisation for funeral directors that could be promoted through). However, the provider was able to balance capacity and activity across the various training sessions noting, *"We reduced the planned sessions for funeral directors due to low bookings, which allowed us to allocate resources to higher-demand areas"*.

  Promotional materials were consistently refined to ensure clarity and alignment with intended audiences. Post-training brochures designed by the Marketing Lead at Harmless CIC tailored to each community provided a valuable resource, featuring definitions, support contacts, and additional reading.

- **Delivery.** Training sessions were delivered online accommodating various learning styles and participant needs. Trainers used interactive techniques such as breakout discussions and audio-visual aids to engage participants. Despite these efforts, online delivery presented challenges, such as reduced participant interaction when cameras were off. Trainers adapted by incorporating smaller group discussions and varied formats to maintain engagement.

  Interviewees highlighted that offering face-to-face training sessions could provide significant value for certain groups, enhancing the dissemination and retention of content due to the relational and interactive nature of in-person learning. However, they also acknowledged that implementing this approach would be constrained by practical challenges, such as venue availability and resource limitations.

  In line with commissioner requirements, trainers demonstrated significant commitment to participant well-being, particularly when addressing disclosures. Of note, the integration of Harmless CIC's clinical services enabled immediate support for participants in crisis: *"Having clinical support available during sessions provided reassurance and confidence to trainers, enhancing participant safety"*.

Overall, the training achieved notable success in aligning training content with the needs of marginalised communities, leveraging diverse promotional strategies, and ensuring dynamic delivery methods. However, challenges such as tight timelines, low uptake for specific groups, and the complexities of online engagement underscore areas for future refinement.

2.3.2. Pre / Post Session Survey (NCC Evaluation Database)

Five performance management spreadsheets, covering core training sessions from January 2023 to September 2024, provide detailed session-level data, including breakdowns by organisation, demographics, and outcomes. The spreadsheets are segmented by timeframe, with four-month periods represented consistently until the final two, which cover January to March 2024 and April to September 2024, respectively. This variation in reporting periods makes direct comparisons across all datasets more challenging.

The granular data offers valuable insights into session delivery and participant engagement, enabling an analysis of attendance trends, sectoral representation, and training outcomes throughout the programme. However, the current format is not readily accessible for commissioners, as it lacks an overarching cumulative dashboard or routine summaries that consolidate key insights for easier reference and decision-making.

To address this, the headline findings have been consolidated and analysed by the evaluator to provide both quarterly and cumulative trends and insights. This consolidated information has been shared with the evaluation commissioners to enhance accessibility and usability, ensuring the data can better support ongoing programme improvements and strategic planning. However, it should be noted that there were some minor inconsistencies between supplied

datasets e.g., 'total number of attendance' vs. 'total number of attendance' based on location data.

2.3.2.1. Suicide Prevention and Intervention Training

The headline figures reflect a significant engagement effort across the sessions. 76 sessions delivered between January 2023 and September 2024, showcasing a robust programme aimed at reaching a wide audience. 2,040 bookings, a strong indication of interest and demand. However, cancellations (290) and no-shows (404) resulted in attendance of 1323, meaning approximately 35% of bookings did not convert into attendance – a figure the evaluator understands is typical of online training.

Attendee Location

The geographical spread highlights areas of strong and weaker representation:

- **City-based attendees (483)** represented the largest proportion, suggesting high urban engagement.

- Among the districts, **Mansfield (130)** had the strongest attendance, followed by **Ashfield (107)**, **Newark & Sherwood (106)**, and **Bassetlaw (92)**.

- The comparatively lower attendance from **Gedling (65)**, **Broxtowe (62)**, and **Rushcliffe (67)** highlights potential areas to target for increased engagement. However, this may also reflect the socio-economic profiles of these areas, as they are generally less deprived compared to others such as Mansfield or Ashfield. Lower levels of deprivation may correspond with reduced prioritisation of suicide prevention training or a lower perceived need for community-focused support initiatives. This observation suggests a need for tailored outreach strategies that emphasise the universal relevance of suicide prevention, irrespective of deprivation levels, while also acknowledging the specific needs and contexts of less deprived areas.

- A notable **227 attendees** were marked as representing **multiple locations**, and **53 were county-wide** (including the city), emphasising cross-county interest but also potential challenges in pinpointing super-local representation.

Attendee Sector

The sector breakdown provides insight into the reach and diversity of participants:

- **Charity / Third Sector (468; 35%) and Local Authority (480; 36%)** accounted for the largest proportions, highlighting strong engagement from community-focused and government bodies.

- **NHS / Health sector (212; 16%)** participation is notable but could benefit from broader engagement, given the critical relevance of mental health and suicide prevention within healthcare services.

- **Education (147; 11%)** attendees reflect a strong group, underscoring the importance of training and awareness in schools and colleges.

- **Emergency Services (13; 1%) and Private Sector (7; 0.5%)** attendance were relatively low, representing an area to address in future sessions, especially given the critical role these sectors can play in early intervention and support.

- Only five attendees was recorded under the **'Other'** category, potentially due to limited engagement with unconventional or uncategorised sectors.

Pre- and Post-Training Scores

Analysis of evaluation forms for the training sessions show a significant increase in scores from pre-training to post-training with all post-training scores:

Statement (On a scale of 1 – Strongly Disagree to 5 – Strongly Agree)	Pre-Training Weighted Average Score	Post-Training Weighted Average Score	Difference
I have a good understanding of the topic of suicide	3.37	4.49	1.12
I have a good knowledge of suicide risk factors, high-risk groups and warning signs	3.31	4.56	1.25
I understand why suicide bereavement is a unique risk factor for suicide	3.29	4.49	1.20
I feel confident talking to people about their suicidal thoughts / actions	3.15	4.29	1.14
I am aware of evidence-based strategies to help someone who is thinking about suicide	2.76	4.32	1.56
I know a range of local and national services to signpost to	3.21	4.42	1.21
I understand the relationship between self-harm, mental health and suicide	3.59	4.56	0.97
I understand the importance of recovery	3.78	4.56	0.78
I understand the importance of maintaining my own self-care and wellbeing when supporting someone who is thinking about suicide	4.04	4.65	0.61

Based on the above data, the suicide prevention training was highly effective, with participants reporting significant improvements in knowledge, confidence, and awareness across all key areas. The largest gains were observed in understanding evidence-based strategies to help someone thinking about suicide (1.56 difference), highlighting the practical and actionable focus of the session.

Substantial improvements were also noted in participants' knowledge of suicide risk factors, high-risk groups, and warning signs (1.25 difference), as well as their confidence in discussing

suicidal thoughts and actions (1.14 difference), demonstrating the training's success in addressing both foundational knowledge and personal hesitancy around sensitive conversations.

Smaller, yet still notable, improvements were recorded in understanding the relationship between self-harm, mental health, and suicide (0.97 difference) and the importance of recovery (0.78 difference.

Pre-training scores were already high in recognising the importance of maintaining self-care and wellbeing when supporting others, resulting in a smaller increase (0.61 difference), though this reflects pre-existing awareness among participants. Overall, the training excelled in equipping attendees with the tools and confidence needed to address suicide prevention, while future sessions could place greater focus on long-term recovery strategies, and tailored content for specific professional and personal needs.

Qualitative Feedback

Positive feedback overwhelmingly dominates the 785 responses to the 'Any other comments' question on the session feedback form. These comments provide insight into what worked well and areas for potential improvement. Key strengths include:

- **Facilitator Performance (~175 comments).** Trainers were frequently praised for their knowledge, engagement, and authenticity. The sharing of personal lived experiences by trainers made the training impactful and relatable.

- **Content Relevance (~110 comments).** The training content was described as informative, insightful, and practical. Many respondents mentioned that the course helped them feel more confident in discussing suicide and supporting individuals experiencing suicidal thoughts.

- **Impact on Practice (~100 comments).** Respondents reported an increase in awareness, confidence, and understanding of tools and strategies to intervene effectively. The session was considered highly applicable to both professional and personal contexts.

- **Interactive Elements (~90 comments).** Breakout rooms, group activities, and quizzes were appreciated for promoting interaction and breaking up the session. These elements helped make the session more engaging and dynamic.

- **Structure and Flow (~70 comments).** Frequent breaks were appreciated, especially for such an intense topic. Many respondents noted the session was well-paced and balanced, though some felt the timing could be adjusted.

Areas for improvement include:

- **Session Length (~80 comments).** The four-hour duration was described as too long by many respondents, especially for an emotionally heavy topic. Suggestions included splitting the session into two shorter segments or providing a longer break in the middle.

- **Rushed Content (~60 comments).** Some respondents felt the second half of the session, particularly on interventions and safety planning, was rushed. A more balanced allocation of time between theory and practical application was recommended.

- **Breakout Rooms (~50 comments).** While valued overall, some respondents felt breakout rooms were too long, with discussions occasionally stagnating due to group size or lack of diversity. Rotating attendees or providing more structured prompts might improve engagement.

- **Delivery Format (~45 comments).** Online delivery was effective but not universally preferred. Several respondents suggested face-to-face training for such a sensitive and complex topic. Technical issues, like platform distractions (e.g., chat notifications), were also highlighted.

- **Specific Content Requests (~25 comments).** Respondents suggested more focus on practical tools, such as role-playing or scenario-based exercises for safety planning; content tailored for specific audiences, like neurodivergent individuals, children and young people, or those working with individuals with cognitive impairments; and addressing psychosis, substance misuse, and non-verbal communication techniques in future sessions.

- **Content Overlap (~15 comments).** Some respondents who had attended other related sessions felt there was repetition, particularly in foundational concepts like risk factors and statistics.

2.3.2.2. Self-Harm Awareness Training

A total of 36 sessions were held, resulting in 1,001 bookings, of which 160 (16%) were cancelled and 232 (23%) were marked as Did Not Attend (DNA). This left 658 attendees, achieving a booking-to-attendance conversion rate of 66%, which is reasonable outcome for online training.

Attendee Location

- **City (248; 38%)** had the highest representation, indicating strong engagement from urban areas.

- **Mansfield (74; 11%)**, **Bassetlaw (62; 9%)**, and **Newark & Sherwood (53; 8%)** were notable contributors among district locations.

- **Gedling (44; 7%)**, **Broxtowe (48; 7%)**, and **Rushcliffe (49; 7%)** had comparatively lower attendance, which aligns with patterns seen in the other training and may reflect the generally lower deprivation in these areas.

- Attendees from **multiple locations (95; 14%)** and **County-wide (30; 5%)** efforts suggest cross-area collaboration and broader engagement beyond localised settings.

Attendee Sector

- The **Charity / Third Sector (269; 41%)** and **Local Authority (154; 23%)** once again accounted for the largest proportions, emphasising robust involvement from community-focused and government entities.

- **Education (125; 19%)** attendees reflect strong interest in addressing self-harm in educational settings, which is critical given the prevalence of self-harm behaviours among young people.

- **NHS / Health sector (90; 14%)** participation is noteworthy, but there remains room for broader engagement within this sector, particularly given the relevance of self-harm prevention in clinical settings.

- **Emergency Services (9; 1%) and Private Sector (5; 0.8%)** participation was minimal, representing an opportunity to target these sectors more effectively in future training.

- Only one attendee was recorded under the **'Other'** category, potentially due to limited engagement with unconventional or uncategorised sectors.

Pre- and Post-Training Scores

Analysis of evaluation forms for the training sessions show a significant increase in scores from pre-training to post-training with all post-training scores across all areas:

Statement (On a scale of 1 – Strongly Disagree to 5 – Strongly Agree)	Pre-Training Weighted Average Score	Post-Training Weighted Average Score	Difference
I have a good understanding of self-harm	3.49	4.55	1.06
I understand the different functions of self-harm	3.25	4.54	1.29
I understand the stigma associated with self-harm, and how to challenge this	3.47	4.55	1.08
I have a good understanding of evidence-based interventions to support someone who self-harms	2.84	4.40	1.56

I have the skills needed to provide effective support to someone who is self-harming	2.98	4.35	1.37
I feel confident responding to someone who self-harms	3.07	4.36	1.29
I feel confident understanding and managing self-harm risk	2.98	4.28	1.30
I understand what self-harm recovery can look like	2.97	4.46	1.49
I know where to signpost someone who is self-harming	3.29	4.56	1.27

The largest improvement was observed in understanding evidence-based interventions to support individuals who self-harm (1.56 difference), underscoring the training's focus on providing actionable and practical knowledge. Participants also showed notable gains in understanding what recovery looks like (1.49 difference) and developing the skills needed to provide effective support (1.37 difference), reflecting a strong emphasis on fostering both technical expertise and empathetic engagement. Confidence in responding to self-harm (1.29 difference) and managing self-harm risk (1.30 difference) also improved significantly, equipping attendees with the ability to handle sensitive and potentially critical situations. Additionally, the training effectively addressed key areas such as understanding the different functions of self-harm (1.29 difference) and challenging stigma (1.08 difference), promoting more compassionate and informed approaches.

Pre-training scores were lowest in areas like understanding evidence-based interventions (2.84) and managing risk (2.98), indicating these as key knowledge gaps that were successfully addressed, with post-training scores exceeding 4.20 in these domains.

Participants entered the sessions with relatively higher baseline knowledge of signposting (3.29), yet still experienced meaningful improvement (1.27 difference), reinforcing the value of updated information on available resources.

Overall, the training has proven to be highly effective in equipping participants with the knowledge and skills needed to support individuals who self-harm, while fostering confidence and reducing stigma.

Qualitative Feedback

Positive feedback overwhelmingly dominates the 310 responses to the 'Any other comments' question on the session feedback form. These comments provide insight into what worked well and areas for potential improvement. Key strengths include:

- **Trainer Expertise and Delivery (~40 comments).** Trainers were praised for their knowledge, passion, and sensitivity in delivering the training. Respondents found the trainers engaging, empathetic, and respectful when discussing a challenging subject. Use of personal experiences by trainers helped humanise the content and reduce stigma.

- **Practical Strategies and Tools (~35 comments).** Techniques such as the "10-minute rule," distraction strategies, and safety planning were highly valued, as was the clear guidance on how to respond to disclosures and support individuals effectively.

- **Content and Relevance (~30 comments).** Comprehensive coverage of self-harm, its causes, and interventions was appreciated. Respondents noted the relevance of the training to their roles, particularly in education, health, and community support.

- **Lived Experience Integration (~25 comments).** Inclusion of lived experiences, either through trainers or recorded stories, was considered impactful and inspiring. This helped attendees relate the training to real-life scenarios and their personal experiences.

- **Session Structure (15+ comments).** Hourly breaks were seen as well-timed, helping respondents process the intense subject matter. Many found the training well-paced and easy to follow.

- **Confidence Building (20~ comments).** Respondents reported feeling more confident and equipped to support individuals who self-harm. Reassurance about their existing practices and newly learned techniques boosted their competence.

Areas for improvement include:

- **Session Format and Length (~30 comments).** Four-hour online sessions were considered too long and mentally taxing for some attendees i.e., approximately 10% of 'Any other comment' responses. Suggestions included shorter sessions (e.g., 2–3 hours) or splitting the content over multiple days. Requests were made for more face-to-face options for better engagement.

- **Pacing and Rushed Sections (~20 comments).** Respondents felt some sections, particularly on interventions and recovery, were rushed. There was a desire for more time to explore practical strategies and support systems in depth.

- **Interactivity and Engagement (~15 comments).** While breakout rooms were appreciated, some respondents wanted more interactive tasks and small group discussions. Requests were made for clearer instructions for breakout sessions to maximise participation.

- **Content Overlap Across Trainings (~10 comments).** Repetition of material across Harmless training sessions (e.g., the suicide prevention training) was noted. Respondents suggested clearer differentiation between training topics during registration.

2.3.2.3. Suicide Bereavement Training

A total of 24 sessions were held, with 674 bookings recorded. 135 cancellations (20% of bookings) and 147 no-shows (22% of bookings) resulted in an overall attendance rate of 388 participants, equating to 58% of bookings, the lowest attendance rate of the three training sessions analysed.

Attendee Location

- **City (154 attendees)** accounted for the largest share (40%), indicating a strong urban engagement.

- Rural and less urbanised areas such as **Ashfield (32)**, **Bassetlaw (29)**, **Gedling (21)**, **Broxtowe (19)**, and **Rushcliffe (22)** had lower participation, collectively making up 33% of attendees. This may reflect fewer available services, lower population density, or less prioritisation in these areas.

- **Mansfield (41)** and **Newark & Sherwood (32)** showed moderate engagement.

- The **'Multiple' (75) category** (19%) and **County-wide (11)** participants highlight a cross-county engagement.

Attendee Sector

- **Charity / Third Sector (137 attendees, 35%)** and **Local Authority (117 attendees, 30%)** dominated participation, reflecting strong engagement from community-focused and governmental organisations.

- **Education (67 attendees, 17%)** demonstrated a positive turnout, indicating awareness and prioritisation of self-harm support in schools and colleges.

- **NHS / Health (57 attendees, 15%)** participation was relatively lower, given the relevance of self-harm to mental health services, suggesting a potential gap to address.

- **Emergency Services (5 attendees, 1%) and Private Sector (3 attendees, <1%)** had minimal representation, highlighting key areas for targeted outreach.

- No participation was recorded under the **'Other'** category, potentially due to limited engagement with unconventional or uncategorised sectors.

Pre- and Post-Training Scores

Analysis of evaluation forms for the training sessions show a significant increase in scores from pre-training to post-training with all post-training scores:

Statement (On a scale of 1 – Strongly Disagree to 5 – Strongly Agree)	Pre-Training Weighted Average Score	Post-Training Weighted Average Score	Difference
I have good knowledge around suicide awareness	3.56	4.52	0.96
I understand the magnitude of suicide in the UK and locally	3.68	4.66	0.98
I understand suicide loss as a unique form of 'complicated' bereavement	3.90	4.66	0.76
I understand the difference between suicide exposure and suicide bereavement	3.04	4.61	1.57
I recognise the wider impact of bereavement on those exposed to or affected by suicide	3.65	4.63	0.98
I can identify the stigma and shame surrounding suicide and suicide bereavement	3.74	4.66	0.92
I understand why suicide bereavement is a unique risk factor for suicide	3.47	4.61	1.14
I feel confident responding to someone who has been bereaved by suicide	3.11	4.41	1.30
I feel confident providing support to someone who has been bereaved by suicide	3.10	4.40	1.30
I have the relevant skills necessary to respond and support someone who is bereaved by suicide	3.02	4.36	1.34
I am aware of guidance and research on best practice in shaping services to incorporate suicide bereavement support	2.73	4.44	1.71
I can identify local and national support services to help those bereaved by suicide	3.15	4.53	1.38
I recognise recovery is possible, and that suicide bereavement support is important in suicide prevention	3.72	4.64	0.92

The most significant improvement was in awareness of best practices for supporting those bereaved by suicide (1.71 difference), highlighting the training's effectiveness in addressing a critical pre-training knowledge gap. Similarly, understanding the distinction between suicide exposure and bereavement saw a marked improvement (1.57 difference), ensuring participants could better tailor their support. Confidence and skills to respond to and support individuals bereaved by suicide also improved significantly (1.30 difference and 1.34 difference respectively), indicating the training provided practical tools for real-world application. Notable gains were also seen in participants' awareness of available support services (1.38 difference), enabling better signposting to appropriate resources.

Overall, the training demonstrated its success in bridging knowledge gaps, fostering confidence, and equipping participants to provide effective and empathetic support to those bereaved by suicide.

Qualitative Feedback

Positive feedback overwhelmingly dominates the 256 responses to the 'Any other comments' question on the session feedback form. These comments provide insight into what worked well and areas for potential improvement. Key strengths include:

- **Trainer Expertise and Delivery (~90 comments).** Trainers were consistently praised for their knowledge, sensitivity, and ability to handle a difficult topic with care and professionalism. Personal experiences shared by trainers enhanced the session's impact and relatability. Trainers were described as approachable, empathetic, and engaging, making the training impactful and memorable.

- **Content and Relevance (~60 comments).** The training was seen as highly informative, addressing a topic that is often overlooked. Respondents appreciated the balance between theory, research, and practical application. Emphasis on the unique nature of suicide bereavement was considered valuable and enlightening.

- **Practical Strategies and Tools (~40 comments).** Respondents highlighted the value of practical advice, such as language to use when supporting someone bereaved by suicide and scripts for opening conversations. The focus on postvention strategies and recognising the risks for bereaved individuals was particularly well-received.

- **Structure and Session Management (~35 comments).** The training was commended for being well-structured, with regular breaks allowing participants to process the emotional content. The use of breakout rooms and interactive elements fostered discussion and connection among attendees.

- **Confidence Building (~20 comments).** Many respondents reported feeling more confident in supporting individuals affected by suicide bereavement after the training. Respondents also found reassurance that their existing practices aligned with best practices helped reinforce their competence.

- **Personal and Professional Impact (~25 comments).** Respondents found the training beneficial for both their professional roles and personal lives, with some noting its relevance to their own experiences with suicide bereavement. Increased awareness of the ripple effects of suicide and the importance of tailored support was frequently mentioned.

Areas for improvement include:

- **Session Length and Format (~50 comments).** Four-hour sessions were considered too long and difficult to sustain, especially online. Suggestions included breaking the content into shorter sessions or spreading it over multiple days, with some requests for more face-to-face sessions for greater engagement.

- **Pacing and Content Depth (~20 comments).** Some respondents felt that sections, particularly on interventions and support strategies, were rushed.

- **Interactivity and Engagement (~15 comments).** While breakout rooms were appreciated, some respondents wanted more interactive tasks and small group discussions. Suggestions included incorporating more personal stories and lived experiences from a broader range of individuals.

- **Tailoring and Customisation (~5 comments).** Respondents suggested more tailored content to meet the needs of different professional roles and knowledge levels. Requests for introductory and advanced-level training options.

- **Emotional Intensity (~5 comments).** The emotionally heavy nature of the subject was highlighted, with some attendees finding it difficult to process in a single session. Recommendations included incorporating more support mechanisms for participants processing their own experiences.

2.3.2.4. Overarching Observations

Across the three training types, a number of overarching themes emerge, reflecting both the strengths of the programme and opportunities for further development.

Urban areas demonstrated consistently strong engagement, with city-based attendees accounting for the largest proportion of participants across all training types. In contrast, rural and less urbanised districts such as Gedling, Broxtowe, and Rushcliffe had lower attendance rates, aligning with patterns of lower deprivation and potentially reduced perceived need for training in these areas. Tailored outreach efforts and messaging that emphasise the universal relevance of these topics could help improve engagement in such regions.

Sector representation was dominated by the Charity / Third Sector and Local Authority, reflecting strong participation from community-focused and governmental organisations. NHS / Health sector participation, while notable, was lower than expected given the relevance of all three training types to clinical and mental health services. Emergency Services and Private Sector representation were minimal, highlighting key opportunities for targeted outreach and tailored training to engage these sectors more effectively.

Each training type demonstrated significant improvements in participant knowledge, confidence, and skills, as reflected in the pre- and post-training survey results. The greatest gains were consistently observed in practical and actionable areas, such as understanding evidence-based interventions, recognising unique risk factors, and developing confidence to respond effectively to individuals in crisis.

Respondents also reported high levels of knowledge acquisition in specific areas such as responding to suicide bereavement, managing self-harm risk, and understanding the stigma surrounding both topics. While pre-training knowledge was generally higher in areas like self-care and the importance of recovery, post-training scores reflected meaningful improvements, particularly in areas where participants had identified initial knowledge gaps.

The expertise of the trainers was universally praised, with participants commending their knowledge, empathy, and ability to deliver emotionally challenging content with sensitivity. The inclusion of lived experiences was frequently cited as a key strength, making the training relatable, impactful, and memorable.

Participants also valued the practicality of the training content, which provided actionable tools and strategies directly applicable to both professional and personal contexts. Interactive elements, including breakout rooms, group discussions, and quizzes, helped foster engagement and allowed participants to process the material more effectively. Additionally, the session structure, with regular breaks, was noted as being well-suited to the intense nature of the topics.

Despite its effectiveness, the programme faced consistent feedback regarding session length and format. Four-hour sessions, particularly in an online setting, were described as overly long and mentally taxing. Many participants suggested splitting sessions into shorter segments or spreading the content over multiple days. Face-to-face delivery was also preferred by some, as it offers a greater sense of connection and support.

Pacing and content depth emerged as another area for refinement. Participants often felt that certain sections, particularly those on practical interventions and recovery strategies, were rushed, limiting the time available to fully explore these critical areas. Some noted overlap in content across the related training sessions, suggesting a need for clearer differentiation between topics during registration.

There was also a call for greater tailoring of the content to specific professional roles and target populations. Respondents suggested the inclusion of training options tailored for educators, healthcare workers, emergency responders, and those working with children, neurodivergent individuals, or people with cognitive impairments.

Organisational Representation

The attendee lists across the training sessions demonstrates a rich and diverse representation of organisations, reflecting a strong commitment to mental health, social care, and community support across Nottingham and Nottinghamshire. Public sector participation is particularly notable, with significant involvement from Nottinghamshire County Council, Nottingham City Council, NHS Trusts, District Councils, and the Police, showcasing institutional dedication to addressing mental health and social wellbeing. Healthcare providers, including GP Alliances and Mental Health Trusts, further highlight the integration of mental health into broader health

systems. Education is well represented, with schools, colleges, and universities such as Nottingham Trent University and the University of Nottingham engaging in efforts to support youth mental health. The voluntary sector, exemplified by organisations like Change Grow Live, Home-Start Newark, and Turning Point underscores the vital role of grassroots and community-focused groups in this work.

Support for vulnerable groups is evident through the presence of Juno Women's Aid, Nottinghamshire Sexual Violence Support Services, and LGBT+ Service Nottinghamshire, demonstrating a commitment to inclusivity and safeguarding. Children and family services, including children's centres and early help teams, reflect a prioritisation of safeguarding and family wellbeing. Overall, the attendee list offers a strong foundation for fostering cross-sector collaboration and driving impactful mental health and social care initiatives.

While the training brought together a diverse and substantial range of organisations, there are some notable gaps in representation that could provide opportunities for future engagement. In the area of workplace and employment support, organisations such as Jobcentre Plus or larger employers from high-stress industries could have complemented the contributions from Futures Advice and Inspire College, offering a deeper understanding of the intersection between unemployment, workplace stress, and mental health.

Similarly, while some faith-based organisations were present, such as St. Martin's Church and Trent Vineyard, broader representation from a range of faith and cultural groups could strengthen culturally sensitive approaches to mental health and suicide prevention, particularly for underrepresented communities.

In terms of youth-focused organisations, while groups such as Base 51 and YMCA Robin Hood made valuable contributions, the inclusion of other regional youth charities or youth engagement groups like Scouts or Guides could have further enriched discussions on supporting young people at risk.

Lastly, in criminal justice, although representatives from probation services and Nottinghamshire Police attended, the involvement of additional services such as youth offending teams or prison representatives could deepen the understanding of mental health and suicide risks within the justice system.

However, it is worth acknowledging that some organisations may be delivering their own internal training, which could account for lower representation in the sessions. For example, conversations with East Midlands Ambulance Service revealed that they are conducting in-house training for their staff. Similar arrangements might exist within other organisations, which could explain their absence from external training sessions. This highlights an opportunity to explore partnerships or alignment with these internal programmes to ensure consistent messaging and complement existing efforts.

2.3.2.5. Priority Four: Tailored Training

Unfortunately, no performance management spreadsheets have been supplied with respect to the bespoke training sessions delivered as part of the Year 2 Pilot Projects.

2.3.3. Follow-Up Survey

The follow-up evaluation survey conducted by Harmless CIC for the purposes of this report garnered 58 responses from participants representing a wide range of sectors, roles, and organisations across Nottinghamshire. Analysis of the responses revealed no discernible differences when filtering results by specific training courses or trainers. This consistency suggests a uniform experience among participants, irrespective of the course content or facilitator.

Q1. Which sector do you work in?

Responses reveal a diverse range of participants from various sectors, demonstrating cross-sectoral engagement with the training programme. Education professionals accounted for a significant portion of respondents. Health services, including 0-19 services, CAMHS, and adult mental health services, were also well-represented, indicating alignment with the training's focus on addressing mental health and suicide prevention across the life course. Other key sectors included the voluntary sector, police, children's social care, early help services, and community-focused roles such as housing and pastoral care. The inclusion of police and community health professionals highlights the training's reach into frontline and community safeguarding roles. This broad representation of respondents underscores the programme's ability to engage a wide range of practitioners, fostering a multidisciplinary approach to suicide prevention. However, the relatively higher presence of education and health professionals suggests potential gaps in ongoing engagement from other sectors, such as justice or private organisations, which could be targeted in future outreach efforts for follow-up feedback.

Q2. What is your role?

Responses highlight the breadth of professional roles that engaged with the training, reflecting its relevance across a wide spectrum of service areas. Many participants hold frontline positions, such as social workers, health visitors, police constables, family mentors, and counsellors, indicating the training's direct applicability to practitioners working closely with vulnerable populations. Roles like Designated Safeguarding Leads (DSLs), crisis care practitioners, and family support coordinators underscore the training's focus on equipping professionals who address safeguarding, mental health, and crisis intervention.

There is a notable representation from education-focused roles, including trainee education mental health practitioners, study assistants, and safeguarding campus leads, reflecting strong uptake within learning environments where mental health issues are prevalent. Similarly, roles within health services, such as child psychiatrists, paediatric nurses, and specialist public

health practitioners, highlight the training's alignment with healthcare professionals addressing mental health and suicide prevention.

The participation of police officers, neighbourhood policing teams, and housing managers demonstrates the training's reach into community-facing roles, reinforcing a multidisciplinary approach to suicide prevention. Additionally, the inclusion of pastoral care coordinators and peer trainers reflects engagement with roles that emphasise relational and supportive practices.

This diversity underscores the training's relevance across sectors, particularly for those in direct contact with at-risk individuals. However, the responses suggest an opportunity to further extend reach into underrepresented roles or sectors, such as justice services, private employers, and non-health-related public services, to broaden the impact of suicide prevention initiatives.

Q3. Which organisation do you work / volunteer for?

The responses highlight the diverse range of organisations represented by participants, demonstrating the training's broad appeal and relevance. A significant proportion of respondents are from healthcare settings, including Nottinghamshire Healthcare NHS Foundation Trust, CAMHS, and Daybrook Medical Practice, underscoring the alignment of the training with health services that frequently engage with mental health and suicide prevention.

Education institutions also feature prominently, with participants from organisations such as the University of Nottingham and Vision West Nottinghamshire College. This reflects the training's relevance within learning environments where safeguarding and mental health support for students are critical.

The presence of public service organisations, such as Nottinghamshire County Council, Nottingham City Council, and Nottinghamshire Police, highlights the uptake of training by professionals in frontline roles addressing community safety, crisis response, and social services. Voluntary and community organisations, including Survivors of Bereavement by Suicide, and Juno Women's Aid, further illustrate the training's applicability to those supporting vulnerable populations through direct services and advocacy.

This organisational diversity demonstrates the training's effectiveness in attracting a multidisciplinary audience. It also points to its potential for creating collaborative approaches to suicide prevention across health, education, public safety, and voluntary sectors. However, it suggests an opportunity to deepen engagement within smaller or specialised organisations, particularly those that may lack in-house capacity for mental health training, to further expand the programme's impact.

Q4. Which Suicide Prevention Training have you attended?

The training attended by participants reflects a diverse engagement across several targeted modules under the Wave 4 programme. Key findings and percentages based on the responses are as follows:

- Wave 4: Boys and Men: Self-Harm and Suicide Prevention: 21 responses (37.5%)
- Wave 4: Gypsy, Roma, and Traveller Self-Harm and Suicide Training: 18 responses (32.1%)
- Wave 4: LGBTQIA+ Self-Harm and Suicide Prevention: 10 responses (17.9%)
- Suicide Prevention and Intervention Training: 9 responses (16.1%)
- Suicide Bereavement Training (Nottinghamshire and Nottingham): 6 responses (10.7%)
- Self-Harm Awareness Training (Nottinghamshire and Nottingham): 5 responses (8.9%)
- Wave 4: Children and Young People - Self-Harm Prevention Training: 4 responses (7.1%)
- Wave 4: Relationship Breakdown as a Suicide Risk Factor Training: 3 responses (5.4%)

The range of training modules and the diversity of participants (as analysed in previous questions) indicate that the programme effectively catered to varied professional needs across Nottingham and Nottinghamshire.

The high response rate for modules targeting Boys and Men, Gypsy, Roma, and Traveller communities, and LGBTQIA+ individuals (in total 87.5% of responses) may highlight the programme's effectiveness in reaching high-priority and at-risk groups. However, this trend raises further questions about the underlying factors contributing to the response rates:

- **Higher Popularity or Demand.** The tailored nature of these modules may have resonated more strongly with participants, reflecting a higher demand or perceived relevance compared to the core training.

- **Engagement and Investment.** Participants in training programmes may have felt more engaged or invested, possibly due to the targeted approach addressing specific needs or contexts, making them more inclined to respond to surveys.

- **Recency of Training.** The timing of the bespoke training could also play a role, as more recent sessions may have been fresher in participants' minds, leading to higher response rates.

These factors suggest the need for further analysis to better understand whether the response rates indicate the success of the bespoke training approach or a combination of demand, engagement, and timing. Such insights could help refine future training and evaluation strategies.

While more targeted modules were well-represented in responses, general modules like Suicide Prevention and Intervention (16.1%) and Self-Harm Awareness (8.9%) were also valued, suggesting a balance between broad and niche training offerings.

Modules such as Children and Young People (7.1%) and Relationship Breakdowns (5.4%) had relatively lower response rates, suggesting potential gaps in outreach or lower demand for / engagement with these specific topics.

Q5. When did you attend the training?

With nearly 70% of respondents having completed training within the past three months, this follow-up evaluation is well-timed to capture immediate reflections and initial changes in behaviour or practice.

Q6. On average, how many individuals do you support on a weekly basis in your professional role? (Please use a number estimate)

Responses range from 0 to 100+ individuals. Many respondents support between 5–30 individuals weekly with a median caseload of approximately 15 individuals per week. A few respondents indicated either very low caseloads (0–2) or exceptionally high caseloads (e.g., 50+ and 100+), suggesting diverse professional roles and levels of interaction.

Q7. Approximately how many of the individuals you support have benefited from the skills and knowledge you gained from the training? (Please use a number estimate)

The number of individuals reported as benefiting from training ranges from 0 to all individuals supported. Many respondents estimate 1-10 beneficiaries, with several indicating "all" or most of their caseloads. A small number of respondents (e.g., 0 beneficiaries) either have not yet applied the training or do not work directly with clients in relevant contexts. Several responses include vague estimations or comments like "unsure" and "cannot answer."

For respondents who provided estimates, the average proportion of their caseloads benefiting from the training appears to be 25–50%. Some reported 100% application, particularly those in counselling or support roles, suggesting the training's immediate relevance to their practice.

Respondents with higher weekly caseloads (e.g., 50+) often report applying the training to only a subset of their clients, likely due to the training's focus on specific scenarios (e.g., suicide prevention or self-harm). For those with smaller caseloads, the training appears to influence a higher proportion or all of their clients, reflecting its integration into intensive one-on-one work.

Respondents who reported "0 beneficiaries" or were unsure often cited contextual factors, such as their role not aligning with the training's focus, or a lack of opportunities to implement new knowledge so far. This highlights a need for ongoing support to encourage and monitor the application of training.

Q8. How has the training impacted your approach to supporting others around suicide prevention?

The training has had a significant positive impact on participants' approaches to supporting individuals around suicide prevention, with recurring themes of increased confidence, awareness, and practical skills. Many respondents noted greater confidence in discussing sensitive topics such as suicidal ideation and self-harm, overcoming fears of triggering negative reactions. Enhanced awareness of risk factors and signs, particularly in specific populations like males, LGBTQ+ individuals, and Gypsy, Roma, and Traveller communities, was frequently mentioned. Participants also highlighted improved understanding of how to approach conversations effectively and collaboratively, including using tools like safety plans.

Several respondents shared how the training has informed their advocacy efforts and improved their ability to signpost to appropriate resources. For some, the training reinforced existing knowledge as a refresher, while others expressed that it opened their eyes to previously unconsidered cultural or contextual factors. While the majority found the training beneficial and applicable, a few respondents indicated limited immediate impact due to the nature of their roles or lack of relevant opportunities post-training. Overall, the training appears to have equipped participants with the knowledge, confidence, and tools necessary to enhance their practice in supporting individuals around suicide prevention.

Q9. What are the biggest challenges you have faced in applying new skills or knowledge from the training in the workplace?

The biggest challenges participants reportedly faced in applying new skills and knowledge from the training stemmed from a combination of systemic, situational, and personal factors. One of the most common barriers was time constraints, which limited the ability to integrate new practices into daily roles. For some, the nature of their work or the low frequency of relevant cases further reduced opportunities to apply their learning.

Participants also highlighted challenges in engaging certain populations, such as males or Gypsy, Roma, and Traveller communities. Difficulties included overcoming ingrained societal misconceptions, client reluctance to engage with support, and the stigma surrounding discussions about suicide and self-harm.

Professional challenges were another key theme. Some respondents reported struggles in navigating environments where colleagues or other agencies failed to take concerns seriously or where escalation pathways were unclear. These systemic issues often left participants feeling unsupported when attempting to apply their training.

On a personal level, building confidence to ask direct questions about suicide and addressing unconscious biases were frequently mentioned. These challenges reflect the internal work required to implement sensitive training in real-world scenarios.

Despite these barriers, many participants expressed gratitude for the training. They noted that it provided them with valuable tools to address these obstacles and prepared them for future situations, even if their current roles limited immediate application. These findings underscore the need for ongoing professional development, organisational support, and systemic change to enable effective implementation of training outcomes.

These findings imply that training should not be a one-time event for practitioners but instead part of an ongoing professional development cycle. The challenges reported suggest that regular refresher training – perhaps annually or every three years – could help reinforce knowledge, sustain confidence, and keep practitioners equipped with the latest tools and insights. This approach would ensure a consistent standard of support and better prepare practitioners to address challenges as they arise.

Q10. Can you provide a brief case study or example where the training helped you support someone more effectively? Please include details on the situation, your actions, and the outcome.

The responses to the request for case studies illustrate the impact of the training on practitioners' ability to support individuals in challenging circumstances. Most examples reflect how the training improved practitioners' confidence, communication skills, and ability to identify and address risks. Several respondents highlighted enhanced capacity to approach conversations about self-harm and suicide without fear of exacerbating the situation, often leading to better outcomes for individuals in distress. Key themes from responses include:

- **Increased Confidence and Communication Skills.** Practitioners consistently reported feeling more confident addressing sensitive topics. They employed training techniques to ask direct questions, use appropriate language, and explore coping mechanisms collaboratively.

- **Application in Crisis Situations.** Several examples involve practitioners supporting individuals in immediate distress, from a young person self-harming in a residential home to a service user who stated their intention to self-harm. Training enabled practitioners to intervene effectively, provide emotional support, and create safety plans.

- **Cultural and Demographic Awareness.** Training on specific communities, such as Gypsy, Roma, and Traveller (GRT) groups or LGBTQIA+ populations, was cited as helping practitioners adapt their approach to be culturally sensitive and relevant.

- **Practical Tools for Long-Term Support.** Many practitioners used safety plans, resource referrals, and multi-agency collaboration to help individuals transition from crisis to stability, demonstrating the broader application of training skills.

Some example case studies are provided below – these case studies have been anonymised and summarised to ensure the privacy and confidentiality of individuals involved while retaining the essence of the examples provided. These examples highlight the tangible impact of the Wave 4 suicide prevention training, illustrating the practical application of skills in diverse and challenging scenarios. They reflect the importance of cultural competency, direct communication, and collaborative planning in supporting individuals at risk.

1.   Supporting a Young Person in Crisis.

Situation: A young person in a residential home had tried several times in the past to take their own life.

Action: The practitioner, initially hesitant to discuss suicide, used training insights to ask direct questions about their feelings and actions. They worked with the young person to review their safety plan, focusing on distraction techniques and support networks.

Outcome: The practitioner built a stronger rapport with the young person, enabling open discussions about their mental health and establishing a clearer pathway for future support.

2.   Crisis Intervention in the Workplace.

Situation: A service user stated they intended to take their own life.

Action: The practitioner engaged them in conversation to divert focus from their feelings and provide immediate emotional support.

Outcome: The individual was calmed and directed towards appropriate support services, demonstrating the practitioner's ability to de-escalate a high-risk situation.

3.   Supporting a Male Patient with Cultural Barriers.

Situation: A male patient struggled with mental health issues compounded by cultural expectations and lack of family support.

Action: The practitioner, using cultural sensitivity learned in training, worked with the patient to explore their struggles and identify appropriate coping mechanisms while navigating cultural stigma.

Outcome: The patient felt understood and supported, leading to a more open discussion about their mental health and the development of strategies to address their challenges.

4.   **Enhancing Family Communication.**

      Situation: A young person and their family were struggling to discuss self-harm and suicide openly.

      Action: The practitioner facilitated a conversation between the parent and child, using training-based language to create a safe environment for dialogue.

      Outcome: The family developed a stronger understanding of the young person's needs, fostering better communication and a shared plan for support.

5.   **Practical Support Following Self-Harm.**

      Situation: A person, following distressing news, self-harmed in a private room.

      Action: The practitioner intervened calmly, assisted the individual with first aid, provided emotional support, and guided them toward solutions for the situation that had triggered their distress.

      Outcome: The individual felt supported and calmed, enabling a constructive conversation about coping strategies and next steps.

Q11. On a scale of 1 (Strongly Disagree) to 5 (Strongly Agree), to what extent do you agree with the statement: "The training has been beneficial to me personally."

Most respondents (87%) either agreed or strongly agreed that the training had been personally beneficial. This reflects a high level of satisfaction with the content, delivery, and relevance of the training to their professional and personal contexts.

A small proportion of respondents (10.8%) were neutral, indicating that while they did not find the training directly unhelpful, its personal benefit may not have been as immediately evident or relevant to their role.

Only one individual disagreed, suggesting a very low rate of dissatisfaction.

The strong agreement likely reflects the training's ability to enhance participants' confidence, awareness, and practical skills in addressing issues related to self-harm and suicide. The personal nature of the subject matter may have also fostered reflection, making the content resonate on a deeper level.

Q12. On a scale of 1 (Strongly Disagree) to 5 (Strongly Agree), to what extent do you agree with the statement: "The training has been beneficial to me professionally.

Nearly all respondents (95.4%) either agreed or strongly agreed that the training was professionally beneficial, indicating that the content and delivery met or exceeded professional expectations.

Almost half (49.2%) strongly agreed, suggesting the training had a significant and tangible impact on enhancing professional skills, confidence, and application.

A very small proportion of respondents (4.6%) were neutral, implying the training may not have directly aligned with their immediate professional responsibilities or roles.

The positive feedback reflects the training's relevance to professional practices, particularly in roles involving mental health, safeguarding, and direct support. Participants highlighted gains in confidence, awareness, and strategies for addressing self-harm and suicide-related challenges.

Q13. On a scale of 1 (Strongly Disagree) to 5 (Strongly Agree), to what extent do you agree with the statement: "Attending the training was worth my time and effort."

Every respondent agreed or strongly agreed that attending the training was worth their time and effort, with nearly 60% strongly agreeing. This indicates the training provided a meaningful and practical return on participants' investment in terms of time and engagement.

The overwhelmingly positive feedback aligns with earlier questions indicating that participants found the training both professionally and personally beneficial. The consistent agreement highlights its relevance to their roles and its direct application in practice.

The absence of any neutral or negative responses reinforces the perceived effectiveness of the training design, delivery, and content.

Q14. Would you recommend this training to others? Please state why / why not.

The responses overwhelmingly indicate that participants would recommend the training to others, with many explicitly endorsing it as "Highly Recommended" (53.7%) or "Recommended" (46.3%) with no respondents not recommending the training to others.

Q15. Please give a reason for the previous answer.

While most responses focused on the training's relevance, confidence-building impact, and high-quality delivery, a small subset pointed to areas for improvement, particularly regarding the content's alignment with advanced professional roles. These findings highlight both the broad value of the training and opportunities for refinement to meet specific audience needs. Key themes include:

- **Informative and Relevant Content (19 responses).** Participants found the training highly informative and relevant to their roles, with the content tailored to specific communities and demographics relevant to their role. Many highlighted the breadth of knowledge gained, including risk factors, cultural insights, and practical strategies for suicide prevention.

- **Confidence Building (15 responses).** A recurring theme was the training's ability to boost confidence, particularly in addressing sensitive topics like suicide and self-harm. Participants noted feeling more equipped to ask difficult questions and provide effective support. Several responses referenced overcoming fears or misconceptions about discussing suicide, emphasising the training's empowering effect.

  > *"The training was comprehensive and helpful, giving me confidence to approach sensitive subjects."*

- **High-Quality Delivery (13 responses).** The quality of facilitation was frequently praised, with participants describing trainers as knowledgeable, engaging, and empathetic. Many appreciated the balance between professionalism and human connection. Real-life examples and personal experiences shared during sessions were highlighted as adding depth and relatability to the training.

  > *"Highly relevant topic and delivery was exceptionally high quality— professional yet human, which is rare to achieve."*

- **Practical Application (12 responses).** Responses pointed to the practical utility of the training, with many mentioning new skills, tools, and strategies they could apply immediately in their roles. Examples included creating safety plans, addressing misconceptions within teams, and engaging with communities in culturally sensitive ways.

- **Awareness Raising (10 responses).** Participants valued the focus on raising awareness of suicide risks, underreporting, and barriers to accessing mental health support, especially within marginalised communities. The training was seen as a tool to challenge stereotypes and foster greater understanding of cultural or demographic nuances.

  > *"The session challenged misconceptions and raised awareness of barriers within the Traveller community."*

- **Universal Importance (7 responses).** Several participants recommended the training for a wide audience, including professionals, parents, and community members, citing the universal relevance of suicide prevention skills.

- **Room for Tailoring (3 responses).** A small number of participants suggested that the content could be better tailored for specific professional audiences, such as those with advanced mental health expertise.

> *"Not highly recommended as some of the info is pitched too low for MH professionals."*

Q16. Any other comments?

Overall, the handful of comments received in response to this question reflect a high level of satisfaction with the training, with participants noting its relevance, delivery quality, and applicability. Key themes include:

- **Positive Feedback and Gratitude (8 responses).** Many participants expressed thanks and appreciation for the training, emphasising its value and their satisfaction with the experience. Comments such as *"Thank you very much for this training"* and *"Really pleased I attended the training"* highlight the positive reception of the sessions.

- **Call for More Training Opportunities (4 responses).** Participants expressed a desire for continued or expanded training, with some noting they were unable to attend all sessions but found the topics beneficial.

- **Preference for In-Person Training (1 response).** One participant noted the effectiveness of in-person training over online formats, citing greater impact and engagement potential, albeit acknowledging the logistical and cost challenges.

- **Feedback on Content Specificity (1 response).** A detailed critique raised concerns over specific terms and examples used in the training, particularly around transgender terminology and scenarios. While acknowledging the overall usefulness of the training, the participant suggested more clarity and sensitivity in examples to ensure alignment with lived experiences and current discourse.

The training commissioner and provider should acknowledge isolated comments, such as those with a single response, but should prioritise changes only when they align with broader trends and recurring concerns. A preference for in-person training has emerged as a theme across multiple evaluation activities, warranting exploration. In contrast, a critique of specific language usage has not surfaced as widespread feedback, suggesting that while it should be noted, it does not necessitate immediate action. However, language norms are constantly evolving, and inclusivity remains a critical consideration. If future evaluations indicate a growing pattern of language-related feedback, a more comprehensive content review may be warranted to ensure that training materials remain current, sensitive, and reflective of best practices.

2.3.3.1. Overarching Observations

The follow-up evaluation survey underscores the positive impact of the Wave 4 suicide prevention training, with participants reporting significant benefits both personally and professionally. The training was widely regarded as informative, relevant, and empowering, with a high-quality delivery that enhanced participants' confidence and practical skills. Engagement across diverse sectors and roles highlights the programme's reach and multidisciplinary relevance, though there are opportunities to further tailor content for advanced professionals and extend outreach to underrepresented sectors.

Recommendations from the follow-up evaluation include:

- **Integrate Training into Organisational Structures.** Work with organisations to explore making suicide prevention training a mandatory component of professional development plans, onboarding processes, and training schedules. Embedding the training into organisational frameworks ensures consistent knowledge dissemination, increases uptake, and reinforces the priority of suicide prevention across sectors.

- **Develop a Refresher Training Cycle.** Introduce periodic (and shorter) refresher training to reinforce knowledge, sustain confidence, and update participants on evolving best practices in suicide prevention.

- **Expand Training Formats.** Explore in-person training options alongside online delivery to cater to different learning preferences and enhance engagement where feasible.

- **Enhance Content Tailoring.** Adjust training materials to better align with the needs of advanced professionals, including more specialised content, terminology and scenarios e.g., clinical professionals that already have an established mental health knowledge and / or who may encounter complex scenarios in their caseloads.

- **Explore Follow-Up and Application Support.** Explore the provision of post-training support, such as access to resources or community forums (e.g., Knowledge Hub), to assist participants in applying skills and addressing challenges in their roles.

2.3.4. Stakeholder Network

Contributions at the Stakeholder Network related to training included:

- **Positive Feedback on Current Training.** Existing training by Harmless CIC received widespread praise, underscoring its effectiveness and value. Participants who attended noted its high quality and practical impact.

- **Recognition of Gaps and Needs.** Neurodiversity was highlighted as a specific area requiring tailored communication approaches for suicide prevention. Stakeholders suggested developing a bespoke training package to address these needs. A significant gap in suicide prevention training for newly qualified social workers was identified. Suggestions included incorporating this training into mandatory sessions for new hires and as part of ongoing professional development frameworks.

- **Barriers to Participation.** Timing and scheduling were noted as barriers, particularly for organisations with "fixed working hours" i.e., those services who operate on a schedule outside of standard working hours that makes it challenging to attend traditional weekday courses. For example, the Nottinghamshire Sexual Violence Support Service operates based on limited opening hours during the daytime (10.00am – 1.00pm) and evenings (4.30pm to 7.30pm). On-demand or flexible training access was recommended as a solution.

- **Demand for Variety in Delivery Formats.** Stakeholders expressed a preference for a mix of face-to-face and online training, with some disengaging from virtual platforms like Teams. The value of more intensive training, such as ASIST, was also noted as desirable if resources permit.

Recommendations from the Stakeholder Network attendees included:

- **Enhance Training Accessibility.** (1) Develop self-paced training modules to address scheduling challenges i.e., materials such as pre-recorded videos, interactive e-learning and downloadable resources allowing participants to access and complete the training at their convenience. (2) Expand the scope of mandatory training to include suicide prevention for sectors like social work, public health, and HR.

- **Integrate Lived Experience.** Engage individuals with lived experience from the pilot projects (Priority Four) in the development and delivery of training to ensure relevance and authenticity.

2.3.5. Stakeholder Workshop

The Stakeholder Workshop (Appendix One) served as a valuable platform to explore key insights and learnings from this priority area with stakeholders during the first World Café session. In the second World Café session, participants engaged in conversations about action planning for the future. Detailed exploration was made possible through the supply of provider materials / reports and attendance and input from the Training Lead at Harmless.

A write up of the flip chart and post-it notes from the workshop can be found in Appendix One. Based on these notes and their involvement in the workshop, the insights from this workshop can be summarised as:

- **Trauma Informed Approach.** Participants were curious as to the links to trauma-informed practice and whether this could be strengthened further in the training, or whether the links could be made at a promotional level.

- **Diverse Training Needs.** Participants recognised the need for more diverse training options for different participant groups. In addition to the targeted training for higher risk groups that had been developed and delivered, participants referred to refugees and minority ethnic groups for example. One participant suggested linking targeted training in line with suicides locally i.e., leveraging the local suicide Real Time Surveillance system to inform training efforts.

- **Attendance and Inclusivity.** Men, especially in male-dominated industries, show low engagement and attendance in training. Actionable recommendations include the development of targeted outreach and training programmes to engage men, such as male-only training sessions and involving male community leaders. A potential City project for men working in construction was referenced as an opportunity given the prevalence of suicide in that industry. There was also an interest in involving 'street outreach workers' in the training recognising the need to offer flexible schedules that better accommodate their availability.

- **Training Content and Delivery.** The 20-minute Zero Suicide Alliance (ZSA) training was recognised as a useful first step for awareness training, but there's a recognised need for more comprehensive and diverse training content. Participants recognised the graduated approach to suicide prevention training that has been offered because of the Wave 4 programme. However, it was felt that more could be done in terms of developing a clearer training pathway with e-learning and modular options.

- **Mandatory Training and Certification.** Making training mandatory (e.g., through addition to competency frameworks) could enhance participation and universal adoption by the "wider Public Health workforce"[3]. An assessment could be used to certify completion alongside recognition of the training as contributing to Continuing Professional Development (CPD) hours for certain workforces.

- **Commitment and Pledges.** It was felt that participants should be encouraged to make personal and organisational pledges post-training to enhance accountability. This could be linked to the Nottingham and Nottinghamshire Suicide Prevention Charter developed by the Suicide Prevention Strategic Steering Group[4].

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[3] The wider public health workforce refers to individuals and organisations that contribute to public health outcomes, even if public health is not their primary role or focus. This workforce encompasses professionals and volunteers across various sectors who play a part in promoting health, preventing disease, and addressing health inequalities through their roles.
[4] https://www.nottinghamshire.gov.uk/media/v0edu3xd/suicidepreventioncharterinformationpack.pdf

- **Endorsements and Real-Life Examples.** Real-life endorsements are recognised as motivation for others to participate. Use of testimonials and real-life examples to illustrate training benefits and encourage uptake should be included in promotional efforts. One suggestion was the creation of short videos for use on social media based on *"I'm a [role] that's done the suicide prevention training. It was important to me because [reason] and I've used it [this way]."*

- **Integration into Contracts and Policies.** Embedding training into contracts and policies ensures broader implementation. This could be extended to include training requirements within all public health and local authority contracts, induction programmes, and stronger links with safeguarding and stigma reduction initiatives among the local authority and its partners.

- **Promotion and Uptake.** Broader promotion can increase training uptake. There should be more strategic and active promotion through various channels, including GP practices and other primary care settings, that encourage uptake, especially among men. One specific suggestion was to deliver a 1-hour training session to the Health and Wellbeing Boards and Councillors, recognising that they hold community surgeries.

- **School and Youth Engagement.** Strengthening connections with schools and youth services can enhance support for young people and their families. Tailoring the development and delivery of suicide prevention training to their needs.

2.4. Conclusion

The Wave 4 suicide prevention training programme has made excellent progress in addressing identified gaps in workforce skills and confidence. It effectively supported the aim of equipping statutory and non-statutory service providers with the knowledge, compassion, and tools required to support at-risk populations, with overwhelmingly positive feedback from participants.

Evaluators who attended training sessions for observational purposes affirmed the quality of delivery, highlighting its practical relevance, sensitivity, and engaging format; noting that the session outperformed comparable national offerings, showcasing the training's strength in meeting local needs through bespoke and co-produced content.

- **Training Reach.** The training successfully engaged a wide range of sectors, including health, education, voluntary and community services, and local authorities. However, certain groups – such as justice services, private employers, and faith / community leaders – were underrepresented. While the training was broadly representative of the wider public health workforce, targeted outreach to address gaps (e.g., men in male-dominated industries, and frontline roles in social care) could enhance sectoral diversity and impact.

- **Improving Future Training.** The programme's strengths lie in its culturally tailored content, interactive delivery methods, and co-produced approach. Nonetheless, opportunities for improvement include:

  o   Expanding in-person sessions to complement online offerings.

  o   Refining follow-up evaluation mechanisms to capture long-term behavioural changes.

  o   Addressing barriers such as scheduling conflicts and creating modular or 'on demand' training options for increased accessibility.

  o   Enhancing outreach to smaller and underrepresented sectors, leveraging local data (e.g., suicide surveillance systems) to prioritise need.

- **Compassion, Competency, Knowledge and Skills.** The training measurably improved participant confidence, awareness, and practical skills. Pre- and post-training evaluations demonstrated significant gains in understanding suicide risks, recovery, and intervention techniques. The inclusion of lived experience stories and culturally sensitive materials fostered compassion and empathy, reinforcing the programme's focus on relational support. Despite these successes, further skill- and confidence-building opportunities, such as refresher training or advanced modules, would help sustain competency gains over time.

- **Training Impact.** Participants widely reported that the training enabled them to provide more effective support to individuals at risk of suicide or self-harm. Case studies revealed tangible outcomes, such as improved safety planning, de-escalation in crisis situations, and enhanced family communication. However, addressing challenges like stigma and systemic barriers in some settings remains critical for amplifying long-term impacts.

2.5. Key Recommendations

- **Embed Training into Organisational Structures.** Integrate suicide prevention training into mandatory professional development and induction programmes. Explore CPD accreditation and competency framework alignment to ensure sustainability.

- **Develop Refresher Training Cycles.** Offer periodic refresher sessions and shorter modular formats to reinforce learning and adapt to evolving best practices.

- **Target Underrepresented Sectors.** Focus outreach efforts on justice services, private sector employers, and faith and community leaders, as these groups remain

underrepresented despite their potential influence in suicide prevention and self-harm awareness.

Prioritise engagement with male-dominated industries such as construction, where suicide rates are disproportionately high, by developing targeted training sessions or tailored approaches that address sector-specific needs and cultural sensitivities. Collaborate with industry bodies, unions, and local community networks to ensure the training is accessible, relevant, and impactful.

- **Expand Training Formats.** Include a mix of online, in-person, and asynchronous training options to cater to diverse preferences and logistical constraints.

- **Strengthen Routine Follow-Up Evaluation.** Enhance post-training surveys and introduce qualitative feedback mechanisms to better capture long-term impacts and participant application of learning.

  Additional strategies could be employed to provide a more comprehensive understanding of long-term impacts, overcoming the reach and depth limitations of surveys alone. For example, Longitudinal qualitative methods such as interviews or focus groups at multiple intervals post-training; action research or reflective practices where participants document how they apply their learning in real-word scenarios over time, creating a reflective journal or log; or engage stakeholders in partner organisations to track outcomes indirectly e.g., collecting insights from supervisors or team leads on observed changes in workplace behaviours or practices post-training.

- **Integrate Lived Experience.** Involve individuals with lived experience in training design and delivery to maintain relevance and authenticity.

- **Enhance Promotion and Uptake.** Leverage testimonials, case studies, and endorsements to drive uptake. Deliver introductory training to key influencers, such as councillors and health boards, to champion the programme's importance.

3. PRIORITY TWO – COMMUNICATIONS AND PUBLIC AWARENESS

Aim: **Develop a local identity, narrative and communications campaign for suicide prevention.**

3.1. Background

The communications activity was a coordinated effort focused on suicide prevention and awareness, executed through a structured process involving branding, consultation, and materials development for a modest budget of £14,000.

The activity was a collaboration between the city and county councils, involving contributions from multiple stakeholders, including public health teams, communications experts, and external design consultants. Key partners included the Integrated Care Board (ICB), public health colleagues, and council teams.

An established three-phase design process – **Discovery, Development, and Delivery** – was employed to establish a unified branding approach led by Esme Macauley, an established Marketing and Communications Officer at Nottingham City Council on behalf of the partnership.

Extensive consultation was undertaken to co-produce the branding. This involved professionals, service users, and individuals with lived experience. Design feedback was collected through workshops, presentations, and one-on-one consultations.

The final brand – developed by Elaine Draper from the Little Green Box Design – included logos, social media graphics, posters, and a brand toolkit. A significant focus was on ensuring the branding resonated across diverse audiences, though its primary aim was in reaching professionals due to resource limitations and costs associated with universal roll-out to the general population.

3.2. Methodology

The primary question guiding this evaluation was: **"How well did the priority area deliver against its aim?"** This was supported by several sub-questions aimed at exploring different dimensions of the priority area's implementation and impact:

1. How effectively has the local brand been used and adopted across the system? How have the campaigns been perceived?

2.   What was the reach of communication campaigns?

3.   How can the reach and impact of communication campaigns be improved in the future, for target groups / populations?

4.   How should we measure awareness and impact moving forward?

A multi-faceted approach was employed, utilising a combination of qualitative and quantitative methods. These activities were designed to assess the achievements and limitations of the campaigns and inform actionable recommendations for improving future public awareness efforts.

3.2.1. Evaluation Activities

- **Stakeholder Interviews.** Interviews were conducted with members of the 'Communications Working Group', including public health representatives, marketing experts, and designers, such as Lucy Jones (Nottinghamshire Senior Public Health and Commissioning Manager), Steph Knowles (Nottinghamshire Public Health and Commissioning Manager), Esme Macauley (Nottingham City Council Marketing and Communications), Elaine Draper (freelance graphic designer), and Rachel Lees (Clinical Lead for Suicide Prevention and Self-Harm).

  Additional Working Group members were approached to take part in this evaluation but either did not engage or were no longer in post, reflecting the time lapse between the branding process (2021-2022) and this evaluation (2024). Despite this, existing documentation and email trails provided sufficient insight into the branding process.

- **Engagement with People with Lived Experience.** Despite intentions to involve individuals with lived experience for feedback on materials and messaging within this evaluation project, efforts to secure their participation through Harmless CIC were unsuccessful. This reflects broader challenges across Wave 4 projects in engaging this key audience. This absence represents a significant limitation in gaining a reflective, qualitative depth on campaign perceptions and effectiveness. Future evaluations must address the gatekeeping issue to ensure the inclusion of this critical perspective. However, it should be noted that people with lived experience were included as part of the wider design consultation.

- **General Population Survey.** An anonymous survey targeting the general population was conducted via SurveyMonkey, with the incentive of two £50 supermarket e-gift cards to encourage participation.

The survey included equality, diversity, and inclusion (EDI) questions to allow analysis of responses across demographic groups. While no direct question addressed deprivation, inferences could be made based on respondents' districts / boroughs.

Participants were also asked whether they had lived experience of suicide, allowing the evaluation to capture insights from individuals with varying degrees of lived experience. This approach provided some understanding of how the campaigns resonated with those most directly impacted by the issue, even in the absence of direct interviews or focus groups with people with lived experience.

The survey was promoted through Harmless CIC networks, the County Council communications team, and the County Citizens Panel but lacked support from City Council communications due to resource constraints.

With 195 responses, the survey achieved a low sample size, and its representativeness is uncertain. A limited evaluation budget precluded in-person canvassing, which could have improved reach and diversity.

- **Professional Stakeholder Survey.** A separate survey targeted professionals across the system to gauge their awareness, recognition, and usage of branding and campaigns.

  This survey, distributed via the Nottinghamshire and Nottingham Suicide Prevention Network, yielded 18 responses. While not comprehensive, the responses are likely reflective due to broad representation across sectors and geographic areas.

- **Stakeholder Network Meeting.** Attendance at the Nottingham and Nottinghamshire Suicide Prevention Stakeholder Network (18 June 2024) allowed for an open discussion with eight stakeholders. Participants represented diverse sectors, including local government, public health, Voluntary and Community Sector organisations, health and social care, and education.

  The group's expertise spanned frontline service delivery, strategic oversight, and policy development, ensuring a wide range of perspectives to inform findings and recommendations.

- **Stakeholder Workshop.** A broader workshop held on 26 June 2024 at County Hall (see Appendix One for more details) brought together public sector representatives, Voluntary and Community Sector organisations, individuals with lived experience, and other stakeholders. This forum provided an opportunity to share insights from the campaigns and engage stakeholders in action planning.

- **Follow-Up Interviews.** Four follow-up interviews with stakeholders further explored branding adoption and campaign dissemination across the system.

All data were thematically coded and analysed to align with the evaluation sub-questions. Qualitative data from interviews, surveys, and workshops underwent thematic analysis, which identified recurring patterns and insights to provide a comprehensive assessment of the campaigns' outcomes and implications. For quantitative data collected through surveys, statistical analysis was conducted to examine trends, measure awareness levels, and assess variations across different demographic groups. This dual approach of statistical and thematic analysis has ensured that both numerical trends and rich, contextual insights inform the evaluation's findings and recommendations.

3.3. Key Findings

3.3.1. Design Interviews

The key findings from these interviews highlight the strengths of a collaborative and structured branding process, challenges in co-production and implementation, and opportunities for strategic improvement in communication efforts.

- **Collaborative Process.** The branding initiative fostered collaboration among city and county councils, public health teams, and external stakeholders. The structured process helped align diverse perspectives under a unified vision. However, organisational priorities occasionally clashed, making it challenging to maintain momentum and secure consistent contributions. These tensions highlight the inherent challenges of cross-organisational initiatives, particularly when resources are constrained.

    "If you're asking people to dovetail under an umbrella brand, that's good for the service user holistically but harder for the organisations that want recognition."

- **Strengths of the Approach.** The branding development was methodical and well-organised, following a clear and established "3Ds" design process – Discovery, Development, and Delivery. This structured approach ensured clarity and consistency.

    "Having a clear process from the outset helps... It needs to be done with people on the journey with you."

    The resulting materials, such as logos, social media graphics, and event resources, are considered to have been well-received and provided a consistent professional image at events and in public settings.

- **Challenges in Co-Production.** Involving people with lived experience (PWLE) was a key ambition but proved resource-intensive and slow due to the sensitivity of the topic

and difficulties in identifying appropriate groups. While valuable feedback was gathered from this group, some groups – like men – were underrepresented, limiting the diversity of input.

> *"Co-production with people with lived experience can't be entered into lightly. It slows things down but is necessary for safe engagement."*

- **Implementation Gaps.** The branding outputs provided a strong foundation, but the absence of a funded, comprehensive implementation phase has limited reach. Without a dedicated push for dissemination, the branding's full potential remains untapped.

> *"We emailed materials to the Steering Group and partners, but I'm not sure how well others have used our branding."*

- **Missed Opportunities in Strategic Communication.** A broader communication strategy, encompassing campaign planning, implementation, and evaluation, was not part of the initial commission. This omission underscores the need for a phased approach to maximise the impact of branding efforts.

> *"Maybe the thing that should have been commissioned was a bigger, more holistic journey… a greater sense of strategy."*

Recommendations from these interviews include:

- **Develop a Comprehensive Communications Strategy.** Build on the branding foundation by commissioning a long-term campaign strategy that outlines specific objectives, key audiences, and tailored messaging. This strategy should include phases for implementation and evaluation to ensure sustained impact.

> *"You'd want targets for awareness, engagement … specific measurements for each stage of the customer journey ... measurement and monitoring are critical to know how we're doing against indicators."*

- **Enhance Co-Production Efforts.** Allocate dedicated resources and plan carefully to involve PWLE safely and effectively. This includes targeted outreach to underrepresented groups, such as adult males, as communications materials are developed further.

- **Targeted Campaigns for Key Demographics.** Focus communication efforts on specific groups identified through evidence-based insights. Tailored messaging and strategic placement in channels that resonate with these groups will enhance reach and impact within a set budget.

- **Secure Resources for Implementation.** Invest in the next phase of communication, including partnerships with local organisations and paid advertising. A robust implementation plan should include scalable approaches, such as digital campaigns for broader audiences, complemented by in-person initiatives like workshops or local events, to ensure messages resonate across diverse demographics.

3.3.2. Population Survey

The population survey garnered 195 responses, providing a valuable initial temperature check on perceptions of the Suicide Prevention communications materials. While the response rate warrants some caution in interpretation, this represents the first-time feedback has been gathered from this audience for this purpose. The findings offer insights into awareness, engagement, and areas for improvement.

Responses have been filtered by key characteristics, such as lived experience and EDI considerations, to identify themes and observations, which are detailed in the relevant sections. Quotes from respondents have been included to illustrate these themes and enrich the analysis. Appendix Three provides copies of the materials presented during the survey.

Q1. Have you seen this image [Suicide Prevention logo] before?[5]

Out of 195 respondents to the general population survey, awareness of the Suicide Prevention logo appears limited. Only 28.72% reported recognising the logo, while a majority (57.44%) indicated they had not seen it before, and 13.85% were unsure. These findings suggest that the logo has relatively low visibility among the general population, potentially limiting its impact as a recognisable element of the Suicide Prevention Programme.

This highlights an opportunity to increase public awareness through enhanced promotional efforts, such as wider distribution of materials, targeted campaigns, and integration of the logo across various community platforms. Improving the visibility and recognition of the logo could strengthen its association with suicide prevention efforts and encourage broader engagement with the programme.

Q2. If you answered 'Yes' to the question above, where did you see it? Please be as detailed as possible.

The responses to this question reveal a broad but varied presence of the Suicide Prevention logo across multiple platforms and locations:

- **Digital Platforms.** Many respondents cited platforms like Facebook, Twitter, and Instagram as places they had seen the logo, suggesting strong online engagement. Others noted its appearance on websites, email footers, and stakeholder newsletters.

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[5] A copy of the logo can be found in Appendix Three of this report.

Specific mentions include the Nottinghamshire County Council website and GP surgery websites, indicating targeted digital promotion aligned to programme ownership (i.e., public sector healthcare).

- **Physical Locations.** The logo was prominently seen in hospitals, GP surgeries, and psychological consultation spaces, reflecting its integration into healthcare environments (e.g., specific mentions of Beeston and Sherwood Oaks Hospital were given). It was also noted by some respondents on bus stops, billboards, and signage in city centres, ensuring visibility in community-facing areas.

  However, commissioners were unable to confirm the exact locations where materials had been distributed. This discrepancy may stem from misattribution of branding, perception or memory errors, or secondary exposure – where individuals assume they have seen the logo in certain locations based on familiarity.

  This highlights the need for more precise tracking of logo placement, public encounters, and awareness levels. A more structured implementation plan, incorporating routine monitoring and evaluation processes, would ensure greater accuracy in assessing reach and impact. Aligning evaluation efforts more closely with campaign activities could provide clearer insights into effectiveness and audience engagement.

- **Workplaces and Educational Settings.** Respondents observed the logo in workplaces, particularly on email signatures, staff lanyards, and posters. Its presence on a university campus was specifically mentioned, aligning with the known involvement of a university lead actively promoting the Suicide Prevention agenda through the Stakeholder Network.

- **General Uncertainty.** Several respondents were unsure or provided vague answers, such as "online," "not sure," or "can't remember," reflecting a gap in recall or consistent exposure.

The logo has achieved visibility across digital, physical, workplace, and educational mediums, with strong promotion in healthcare settings and specific recognition from a university actively supporting the agenda. However, fragmented mentions and uncertainty highlight a need for a more consistent, strategic branding approach to reinforce public recognition and association with the Suicide Prevention Programme. Strengthening its visibility through coordinated campaigns could enhance its impact across these varied channels.

Q3. What do you <u>think</u> when you see the above Suicide Prevention poster? Please share your thoughts or reactions.[6]

Responses to the Suicide Prevention poster reveal a mix of positive feedback, constructive criticism, and emotional reactions, highlighting both its strengths and areas for improvement.

- **Strengths.** Many respondents praised the clarity of the message, noting that it communicates the importance of talking about suicide and provides clear contact details for support. The inclusion of a text messaging option was highlighted as particularly beneficial for younger audiences or those anxious about speaking on the phone. The statistic that "1 in 5 people have had suicidal thoughts" was seen as impactful, helping to normalise these feelings and reduce stigma. - Some found the design eye-catching and informative, appreciating its focus on local support and its potential to encourage conversations about a difficult topic.

    "I hadn't appreciated that 1 in 5 people had had suicidal thoughts. I had thought it was something like 1 in 100."

- **Weaknesses.** Several respondents found the poster too text-heavy or the design elements, such as the yellow-highlighted 'I's in "suicide," confusing or distracting. Some felt the design lacked emotional resonance or did not align well with the gravity of the subject matter. Accessibility concerns were raised, with the heavy text posing challenges for individuals with dyslexia, English as an Additional Language (EAL), or those in a state of crisis. Suggestions included breaking up the text, using simpler language, and incorporating more visually engaging elements. The colour scheme received mixed feedback. While some found the yellow bright and attention-grabbing, others felt it was not appropriate for a topic as serious as suicide, suggesting more sombre tones. The call to action was considered unclear by some, with ambiguity about whether the message was aimed at individuals in crisis or those supporting them.

- **Emotional and Personal Reactions.** Respondents expressed a range of emotions, from sadness and shock at the statistic to reassurance that support is available. Some shared personal connections to the issue, highlighting the poster's potential to resonate deeply with its audience.

    "I think of my brother and how this may have helped him stay alive."

    "Being someone who has had and survived suicidal thoughts during a difficult time in university … I feel it should be talked about more. The poster above makes people feel seen and important."

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[6] A copy of the poster can be found in Appendix Three of this report.

However, a few respondents expressed scepticism about the effectiveness of such initiatives, citing personal experiences with 'inadequate' support services – criticising the quality, availability, or responsiveness of the support services, rather than the campaign leading to unrealistic expectations for the support services.

> *"I relate to it as my son gets suicidal, but my eyes roll as regardless of campaigns, groups there really is no help whatsoever until someone attempts to take their own life."*

While the campaign itself may not need changes for this audience, the responses suggest a need to recognise and address improvements in service delivery. Strengthening the linked support services would ensure that campaigns better achieve their intended impact, and fosters trust among the audience.

While the poster has clearly been effective in raising awareness and normalising discussions about suicide, refinements could help address accessibility and usability concerns. However, it's essential to approach changes thoughtfully, avoiding "design by committee" while recognising the value of diverse perspectives. Ultimately, the aim is to create materials that resonate with a wide audience without undermining the integrity of the original design process.

Q4. In your own words, what is the message asking you to do?

The responses to this question highlight varied interpretations, reflecting both the clarity and ambiguity of its messaging. Key themes include:

- **Encouraging Help-Seeking (Majority Response).** Most respondents interpreted the poster as encouraging individuals experiencing suicidal thoughts to contact crisis services via phone or text for support.

- **Uncertainty About Audience.** Some respondents expressed confusion over whether the poster targets individuals in crisis, their friends and family, or the general public.

  > *"It's not clear whether the same applies if I'm concerned about the wellbeing of someone else."*

  > *"I'm not sure if it's for people feeling like taking their life or for survivors or for family or friends affected by it."*

- **Encouraging Conversations.** Some interpreted the message as a call to normalise discussions around suicide and reduce stigma.

  > *"Asking to start a conversation about suicide, to normalise that conversation instead of it still being a taboo subject."*

- **Criticism of Clarity.** A few respondents found the message unclear or misinterpreted its intent.

  "Just think about suicide – it's not inviting me to seek help."

  "I see this as asking me to volunteer to be a phone listener."

- **Emotional Reactions and Scepticism.** Some responses reflected emotional engagement or frustration, highlighting barriers to trust in available support.

  "Call for help... but what actual help is available after the call is over?"

  "Get help, but there isn't any."

The poster's core message of encouraging help-seeking is clear to many respondents, particularly those who view it as an invitation to contact crisis services. However, significant ambiguity regarding the intended audience – whether it targets those in crisis, individuals supporting them, or the general public – without the recognition that it can be everyone. This confusion could reduce its effectiveness in motivating action.

Additionally, while the message to "talk" about suicide is positively received by some, a small number found it insufficiently actionable or even misinterpreted as asking for volunteers. Emotional responses, particularly from those sceptical of available support, highlight the importance of ensuring follow-through on promises of help to maintain trust.

Q5. How does the poster make you <u>feel</u>? Describe any emotions or feelings this material evokes.

Responses to how the poster makes people feel reveal a wide spectrum of emotions, ranging from reassurance and hope to sadness, frustration, and indifference. These varied reactions highlight the poster's impact while also pointing to areas for potential improvement.

- **Positive Reactions.** Many respondents felt comforted by the poster, appreciating its message of support and availability of help.

  "It makes me feel supported, that it is ok to not feel 'right' and that help is at hand."

Some expressed gratitude for the services promoted and felt encouraged by the focus on suicide prevention.

  "Happy that this is normalised. That people in this position can see that they are not alone."

Responses often reflected a deep empathy for individuals experiencing suicidal thoughts.

> *"Moved – makes me think of all the people struggling."*

- **Negative or Neutral Reactions.** A significant number of respondents felt sadness or unease, reflecting the emotional weight of the topic.

> *"It makes me feel heartbroken, because it's awful to know we now live in a world where suicide rates are on the rise."*

> *"The poster makes me feel uncomfortable as it's easy to prefer not to think about it."*

Some expressed scepticism about the effectiveness of services or frustration with systemic issues.

> *"Cynical, to be honest, due to my previous experiences with local mental health services."*

> *"Pissed off with the system and not getting the help people need."*

A smaller group felt indifferent or found the poster unengaging.

> *"No feelings or emotions at all."*

> *"Not a lot – it's very bland."*

- **Criticism of Messaging and Design.** Some respondents felt the message lacked clarity, particularly regarding its intended audience or specific actions.

> *"It doesn't prompt me, doesn't feel very personable, a bit demanding more than empathetic."*

The colour scheme and visual elements evoked mixed reactions, with some finding them calming while others felt they trivialised the topic.

> *"I just don't like the yellow. Uncomfortable. 'Prevent suicide' sounds too much like some mission statement."*

Some found the poster impersonal or lacking human connection, suggesting a need for more relatable or emotionally resonant imagery and language.

It's clear the poster evokes a range of emotions, with many finding reassurance, hope, and a sense of support. However, the mixed reactions underscore the challenge of addressing a complex and deeply personal issue with a universal message.

Q6. What three words would you use to describe the style of the brand and poster?

Following standardisation of words to handle variations and duplicates, frequency analysis identifies some themes among respondent submissions to this question. The majority (59.1%) of descriptions align positively with the poster's design objectives, suggesting that it resonates well with a significant portion of the audience. However, the critical feedback (40.9%) highlights opportunities to refine elements such as emotional resonance, tone, and the balance of text and visuals to better engage a wider audience.

- **Positive.** Many respondents appreciated the straightforward design and messaging, describing it as clear, simple, direct, and informative. Words like eye-catching, bold, and impactful were frequently mentioned, indicating that the poster succeeds in drawing attention. Some described the style as reassuring, supportive, and compassionate, reflecting the poster's intent to provide hope and encouragement.

- **Critical.** Some respondents found the design uninspiring, repetitive, or lacking personality, with descriptions like bland, boring, corporate, and outdated. Words like busy, wordy, and unclear suggest that some respondents found the design too crowded or lacking in focus. Some felt the style was too light-hearted or mismatched for the topic, using terms like childish, patronising, and too joyful. Words like judgemental, clinical, and unsophisticated suggest that some respondents felt the poster lacked empathy or personal connection.

Q7. How could the brand / message by improved?

The feedback on how the brand and message could be improved provides diverse and actionable insights, grouped into key themes.

- **Clarity and Accessibility.** Many respondents suggested making the message more direct and less text-heavy, especially in the bottom section. Suggestions also included making the phone and text numbers larger, bolder, or using colour to ensure they stand out.

- **Tone and Emotional Connection.** Respondents emphasised the need for a more empathetic and welcoming tone, focusing on "you" language and reassurance. Several respondents raised concerns about fears of judgment or consequences when seeking help.

    "Mention that the service is anonymous (if that's true)."

"I might not want to talk for fear professionals will take over and I won't be in control of my care or life."

- **Visual Appeal.** Feedback indicated mixed feelings about the yellow and black scheme, with some finding it effective and others suggesting it lacked emotional resonance or accessibility. Respondents suggested incorporating relatable visuals, such as images of people or symbolic elements like a tree, hand, or face, to make the poster feel less corporate.

- **Inclusivity and Reach.** Suggestions included ensuring the message appeals to men, older individuals, and people without access to technology. Also, including translations to reach diverse populations.

- **Distribution and Branding.** Respondents wanted the message displayed in more public spaces, such as bus shelters, parks, and toilets. Some felt the numerous organisational logos detracted from the message and suggested reducing or removing them.

Q8. Do you have lived experience of suicide?

The survey highlights a significant prevalence of lived experience of suicide among respondents, with 75.94% reporting some form of direct or indirect connection to the issue. The most reported experience was having suicidal thoughts, with 40.64% of respondents identifying in this category. Additionally, 16.04% had survived a suicide attempt, and 25.67% had supported a loved one through a suicidal crisis. A further 17.11% had been bereaved by suicide, while 18.18% had professionally supported someone with lived experience of suicide. Only 24.06% of respondents reported no direct lived experience, underscoring the widespread impact of suicide across communities.

These findings reveal the multifaceted and interconnected nature of suicide-related experiences. Many respondents likely fall into multiple categories, such as having suicidal thoughts while also supporting others or processing bereavement. This overlap underscores the need for campaign messaging to address both personal struggles and the broader impact on loved ones and professionals. By recognising this complexity, materials can better resonate with audiences and provide more meaningful support.

The variety of experiences also highlights the importance of tailored resources and interventions. Individuals in crisis may require immediate and accessible support, while those supporting loved ones or grieving a loss may benefit from resources that focus on coping strategies and navigating their roles.

Finally, the 24.06% of respondents with no direct lived experience represent an opportunity for outreach and education. For this audience, campaign messaging should focus on raising awareness of suicide's prevalence and the importance of fostering a supportive environment.

Balancing this educational focus with empathetic and actionable support for those with lived experience will help the campaign connect with a diverse audience and encourage meaningful action toward suicide prevention.

Filtering responses by those self-reporting as having 'suicidal thoughts' – the primary audience for these communication materials – revealed awareness and sentiments similar to the overall response set.

Q9. What area of Nottingham or Nottinghamshire do you live in?

The distribution of respondents across Nottingham and Nottinghamshire reveals varied levels of representation, with Mansfield accounting for the highest proportion of participants at 21.93%. Other areas, including Gedling, Rushcliffe, and Nottingham City, each contributed 11.76%, followed by Broxtowe at 10.70%. Lower representation was seen in Ashfield (9.09%), Bassetlaw (8.56%), and Newark & Sherwood (8.56%), while 5.88% of respondents preferred not to disclose their location.

Respondents from Nottingham City have slightly higher awareness of the logo (31.82% compared to 28.72% in the general population), but also a higher level of no awareness (59.09% compared to 57.44%) – the difference being more certainty about their exposure. Similarly, City respondents appear more critical of the campaign's tone, with words like "corporate" and "uninspired" recurring more frequently. However, they also use terms like "modern" and "balanced" more often, suggesting an appreciation for its alignment with current mental health messaging trends.

Respondents from Mansfield and Ashfield – the two most deprived boroughs in the County – had awareness levels slightly lower compared to the general population, with a higher proportion reporting no awareness. While there are similarities in sentiment between respondents from these boroughs and the general population, respondents in Mansfield and Ashfield were more likely to use terms like "childlike" or "millennial," suggesting a perception that the campaign does not fully address the needs of older or more deprived audiences. Emotional terms like "hope" and "friendly" were also more prevalent in these boroughs, potentially reflecting a deeper connection to the campaign's purpose.

Q10. What is your gender?

The survey responses indicate a majority of participants identified as female (66.84%), with male respondents making up 30.48%. A small proportion identified as non-binary (1.07%), other (0.53%), or preferred not to disclose their gender (1.07%).

This gender distribution suggests that women are more engaged with or responsive to the survey and its focus on suicide prevention. The lower representation of men aligns with broader trends in health and wellbeing surveys, where men are often less likely to participate. However, given

the higher rates of suicide among men, this highlights a need for targeted efforts to engage male audiences in future outreach and prevention initiatives.

Respondents identifying as men displayed a slightly lower rate of recognition of the logo compared to the general population. Among male respondents, 26.32% had seen the logo before, slightly lower than the general population's 28.72% recognition rate. A majority (61.40%) of male respondents had not seen the logo, and 12.28% were unsure, close to the general population's 13.85%.

Male respondents provided a broader mix of reactions, with a notable presence of emotionally charged terms like "shock" and "empathy." They also had a higher concentration of critical terms like "judgemental" and "patronising" compared to the general population. This could stem from several interrelated factors, including societal norms around masculinity and the ways men are socialised to express or suppress emotions, suggesting a need to adjust or tailor tone and relatability for this demographic.

Older men (50–64) have significantly lower awareness of the campaign compared to all men (16.67% vs. 26.32%). Additionally, a higher percentage of older men are unsure if they've seen the logo (16.67% vs. 12.28%). This suggests that outreach efforts may not be effectively targeting older men, despite their at-risk status. Similarly, older men are more likely to perceive the campaign as impersonal or overly directive, using terms like "judgmental" and "grim" more frequently than the broader male population. They also express discomfort with the starkness of the design and language.

The differences in awareness and sentiment among older men compared to younger demographics and all men reflect a broader generational divide often seen in responses to mental health and wellbeing campaigns. Older men's lower awareness of the campaign and their critical feedback highlight a generational disconnect in how mental health messages are received.

This pattern aligns with a common generational difference in attitudes toward mental health. Older generations may have been socialised in environments where discussing mental health was stigmatised or seen as a sign of weakness. As a result, modern campaigns with open, inclusive, and emotionally focused messaging can sometimes feel alienating or uncomfortable. These responses often mirror a resistance to what may be perceived as a shift in cultural norms rather than the core message itself.

Younger generations, who have grown up amid increasing awareness of mental health, often respond more positively to the same campaigns. The emphasis on emotional openness and supportiveness aligns with their lived experiences and societal attitudes. For older men, however, messaging may need to be reframed to bridge this gap – focusing on strength-based narratives, practical solutions, and dignified support rather than emotional appeals.

This observation suggests that campaigns like this, and mental health messaging more broadly, must adapt to generational differences. Tailoring communication to address these divides – without compromising the openness and inclusivity that modern audiences expect – will be key.

Q11. What is your sexual orientation?

The majority of respondents identified as heterosexual (78.49%), with smaller proportions identifying as bisexual (8.60%), gay or lesbian (5.91%), or selecting other (1.08%). A further 5.91% preferred not to disclose their sexual orientation. These findings indicate a predominantly heterosexual respondent base, but with notable representation from LGBTQ+ communities.

Respondents identifying as LGBTQ+ displayed a higher rate of recognition of the logo compared to the general population. 37.04% had seen the logo before, compared to 28.72% in the general population. A smaller proportion (48.15%) reported not having seen the logo, compared to 57.44% in the general population, and 14.81% were unsure, slightly higher than the 13.85% in the general population. This suggests that awareness of the logo is higher within the LGBTQ+ group than among the general population. This could reflect a stronger connection to mental health and suicide prevention initiatives, which may resonate more deeply within LGBTQ+ communities given their elevated risks for mental health challenges.

LGBTQ+ respondents also provided a more diverse range of emotional and nuanced responses to the What Three Words question compared to the general population. While the general population's responses tended to be split between positive and critical reactions, LGBTQ+ respondents often added an emotional dimension, highlighting the campaign's relevance to their experiences.

Q12. What is your age?

The age distribution of respondents shows the largest group falling within the 51-64 age range (34.76%), followed by 25-34 (24.06%) and 35-50 (16.58%). A smaller proportion were aged 65 and over (14.97%), with even fewer in the 18-24 range (8.02%) or under 18 (0.53%*. Only 1.07% of respondents preferred not to disclose their age.

Q13. What is your ethnicity?

The majority of respondents identified as White (83.51%), with smaller proportions identifying as Black or Black British (4.79%), Asian or Asian British (2.66%), Gypsy, Roma, or Traveller (2.66%), and Mixed or Multiple Ethnic Groups (1.06%). An additional 2.66% selected "Other," and 2.66% preferred not to disclose their ethnicity. Unfortunately, the limited representation from minority ethnic groups means the response sets are too small to draw meaningful conclusions about their perspectives or experiences.

Q14. Do you consider yourself to have a disability or health condition?

The survey responses indicate that 45.41% of participants identify as non-disabled, while a significant portion report having a disability or health condition. The most common conditions include mental health conditions (15.68%) and long-term or chronic conditions (11.35%), followed by hearing impairments (4.86%), physical disabilities (2.70%), and cognitive or learning disabilities (2.70%). Visual impairments were reported by 2.16% of respondents, while 9.73% selected "Other," often providing detailed descriptions of complex circumstances. A further 5.41% preferred not to disclose their status.

Respondents with self-reported mental health conditions displayed a slightly higher rate of recognition of the logo compared to the general population. 31.03% of this group had seen the image before, compared to 28.72% in the general population survey. However, a majority (62.07%) had not seen the image, and 6.90% were unsure. This suggests that awareness of the campaign is somewhat higher among those with mental health conditions, but there is still significant room for improvement in reaching this audience effectively.

In addition, respondents with mental health conditions provided a more emotionally complex and nuanced range of reactions to the What Three Words question, blending recognition of helpfulness with critiques of tone and design. The general population's responses were more evenly split between positive and critical reactions, without as much emphasis on emotional resonance or personal relevance.

3.3.2.1. Overarching Observations

The survey provides an initial temperature check on public awareness and perceptions of suicide prevention materials in Nottingham and Nottinghamshire. Awareness of the logo and campaign remains limited, with varied recognition across demographics. Themes of clarity, tone, and accessibility recur, emphasising the need for inclusive, empathetic, and relatable communications to maximise impact and engagement.

Filtered responses suggest that suicidal ideation itself is not the primary factor shaping responses to the campaign. Instead, the findings indicate that responses are more influenced by individual characteristics and social factors, such as age, gender, ethnicity, and sexual orientation.

This observation aligns with broader trends in public engagement, where factors like social norms, cultural upbringing, and personal experiences with mental health messaging plays a larger role in shaping perceptions. For example:

- **Age.** Older respondents often critique tone and design, reflecting generational differences in attitudes toward mental health and visual communication. This is less about personal experiences with suicide and more about how they interpret and process public health campaigns.

- **Gender.** Men, particularly older men, have been observed to view messaging as "patronising" or "judgemental," reflecting traditional gender norms around emotional expression and mental health.

- **Ethnicity.** Responses may reflect cultural differences in how mental health is discussed and the perceived appropriateness of certain communication styles or imagery.

- **Sexual Orientation.** LGBTQ+ respondents tend to have a stronger emotional connection to the messaging, possibly due to a higher prevalence of mental health challenges in their community, but also exhibit distinct critiques tied to cultural and aesthetic preferences.

This highlights the importance of tailoring the campaign to demographic and cultural nuances, recognising that a one-size-fits-all approach may not resonate equally across diverse groups. Messaging must do more than convey information – it should represent and reflect the identities and experiences of the audience to foster a sense of attachment and connection.

For many individuals, particularly those from underrepresented or marginalised groups, seeing themselves reflected in a campaign can validate their experiences and increase trust and engagement. This reinforces the need for targeted outreach that not only addresses the unique challenges faced by different communities but also ensures their inclusion in the campaign's visuals, language, and tone. By incorporating representations of diverse people and experiences, the campaign can better resonate with its intended audiences and make its messaging more inclusive and impactful.

Recommendations from the Population Survey include:

- **Increase Visibility.** Broaden public awareness of the logo and materials through targeted campaigns and distribution in high-traffic areas such as healthcare settings; transport hubs; educational institutions; community spaces; retail and commercial areas; public and sporting events etc.

- **Enhance Accessibility.** Adapt designs to meet diverse needs, including sensory and language barriers. Use clear, concise calls to action and relatable visuals to improve engagement.

- **Target High-Risk Groups.** Tailor materials for older men, LGBTQ+ individuals, and deprived communities to ensure relevance.

3.3.3. Professionals Survey

This survey aimed to gather professional insights into the use and impact of branding materials developed to support the Suicide Prevention programme. With 18 responses collected, the survey provided an initial understanding of how these materials are being utilised across organisations. However, the analysis revealed notable gaps in feedback, particularly from the 13 respondents currently using the materials, as none completed the second page of the survey. Consequently, key questions regarding the consistency of branding usage, its perceived impact on engagement with suicide prevention, and its effect on the programme's visibility and reputation remain unanswered within this activity.

Filtering responses by categories such as workplace, sector, or role did not yield any additional meaningful insights, suggesting that these variables may not significantly influence perceptions of the materials.

Q1. What area of the city or county do you work / volunteer in?

The survey asked respondents to identify the areas of the city or county where they work or volunteer, revealing a notable concentration of engagement in Nottingham City, with 72.22% of respondents indicating activity in this area. Moderate representation was seen in Newark & Sherwood (38.89%), Broxtowe, Gedling, and Mansfield (33.33% each), while lower engagement was reported in Ashfield and Rushcliffe (27.78%) and Bassetlaw (22.22%).

These patterns may reflect the geographic distribution of the Suicide Prevention Stakeholder Network's membership rather than programme reach or activity. The higher representation in Nottingham City suggests it serves as a hub for members of the network, while lower engagement in areas like Bassetlaw and Ashfield could indicate either fewer network members based there or reduced engagement with the survey in these regions.

Q2. What sector do you work in?

The survey responses highlighted strong engagement from Adult Services (38.89%) and the Voluntary Sector (27.78%), indicating that the branding materials are resonating with professionals working primarily with adult populations. An additional 22.22% of respondents selected "Other"" representing a mix of roles in community safety, adult mental health, local authority, and community work, demonstrating cross-sectoral reach.

In contrast, there was minimal representation from Early Help (5.56%), Education (5.56%), and no responses from Children's Social Care, 0-19 Health Service, or Police (0.00%). This suggests a potential gap in engagement with child-focused and protective services, which could warrant targeted outreach to these sectors in future efforts depending on the intended targeted outreach of communication efforts.

Q3. What is your role, team / department, and organisation?

A significant number of respondents are from therapeutic, counselling, and mental health support roles, suggesting strong alignment with suicide prevention objectives; and the range of organisations includes local authorities, healthcare, education, and voluntary sectors, indicating cross-sectoral engagement. This analysis demonstrates a strong engagement from professionals in counselling and therapeutic fields, with opportunities to broaden the Stakeholder Network (through which the communications materials and this survey were promoted) to include other relevant sectors.

Q4. How would you describe your role within your organisation? (Select all that apply)

The survey responses indicate a workforce heavily focused on frontline practice, with 61.11% of respondents working directly with clients, customers, or service users. This highlights strong representation from professionals engaged in hands-on service delivery. Supervisory roles account for 27.78%, while 22.22% of respondents hold managerial positions, and an equal proportion are involved in strategic or executive roles, demonstrating significant engagement from leadership tiers. Support roles, such as administrative or research assistance, are less represented at 11.11%, suggesting a focus on practitioners and decision-makers. Additionally, 16.67% selected "Other," reflecting roles that may not fit neatly into the predefined categories. This distribution emphasises a balance between direct service delivery and leadership influence, with limited input from support staff.

The role distribution among respondents has implications for the adoption and usage of communication materials. The strong representation of frontline practitioners suggests that adoption and consistent usage of the materials will largely depend on how accessible, practical, and relevant they are for those directly engaging with clients or service users. If the materials are designed to support hands-on delivery, they are likely to gain traction within this group. The presence of supervisory, managerial, and strategic / executive roles indicates an opportunity to leverage leadership to champion the use of the materials, ensure alignment with organisational priorities, and embed them into standard practices. Managers and strategic leaders can play a pivotal role in promoting adoption by integrating the materials into training, protocols, and broader organisational strategies. However, the limited representation of support roles might indicate a gap in operational or administrative integration, which could impact consistency in usage across teams. Without sufficient engagement from these roles, materials might lack logistical support, reducing their visibility and accessibility. Overall, adoption and consistent usage of communication materials will depend on their perceived relevance to frontline work, endorsement from leadership, and the availability of support structures to facilitate their implementation. Addressing these areas will be key to maximising their impact. Addressing these areas will be crucial to maximising the impact of the communication materials, highlighting the importance of a tailored approach rather than a one-size-fits-all strategy for their promotion and adoption.

Q5. Do you support any of the following communities / groups?

The survey responses highlight broad support for diverse communities, often as part of a wider client base rather than through direct or exclusive services. The LGBTQ+ community (82.35%) and Boys and Men (76.47%) received the highest levels of support, reflecting a congruence between the interests of those engaged in suicide prevention (i.e., Network Members) and the groups of service users they support. Similarly, those experiencing relationship distress or breakdown (64.71%), children and young people (58.82%), and Gypsy, Roma, Traveller communities (58.82%) are also well-represented, indicating inclusive engagement with a range of at-risk populations. A small proportion of respondents (11.76%) indicated "Not applicable," suggesting limited direct interaction with these groups, while 23.53% noted "Other," pointing to additional communities not captured by the predefined categories. This alignment between respondent focus areas and suicide prevention goals underscores the relevance of their involvement in the Network and highlights opportunities to develop tailored strategies for specific community groups.

Q6. How involved are you in the suicide prevention agenda?

The survey responses indicate that all participants are at least slightly involved in the suicide prevention agenda, with 33.33% reporting occasional involvement, 55.56% indicating regular involvement, and 11.12% (combined) describing their roles as primarily or entirely focused on suicide prevention. No respondents identified as being uninvolved in the agenda. This level of engagement aligns with expectations for members of the Suicide Prevention Stakeholder Network, representing a pre-engaged audience already brought into the agenda. These findings highlight the network as a key target group for adopting, using, and cascading communication materials and messages to amplify their reach and impact.

Q7. On a scale of 1 (very poor) to 5 (excellent) how would you rate the different aspects of the branding materials?

The branding materials received generally positive feedback, with high ratings for consistency of materials (weighted average 4.50), clarity of message (weighted average 4.39), and alignment to the goal (weighted average 4.06), indicating that they effectively focus on encouraging discussions about suicide and highlighting key sources of support. Clarity of call to action (weighted average 4.00) and visual and emotional appeal (weighted average 3.67) were rated slightly lower, suggesting room for improvement in these areas.

Comments reflected mixed perspectives: while some found the materials clear, concise, and locally relevant, others noted limitations such as perceived suitability primarily for young people, unclear calls to action, and limited inclusion of contact details across materials. Overall, the materials were praised for their strong, simple messaging and focus on local support, but ensuring they resonate across diverse age groups and clarifying their intended calls to action could enhance their effectiveness further.

Q8. Which of the following materials are being used in your team / department / organisation?

The survey responses show that the most widely used branding materials are posters and flyers (66.67%), followed by the logo (27.78%), email footer (27.78%), and MS Teams or Zoom backgrounds (11.11%), with 11.11% (2 respondents) indicating no use of the materials.

Comments suggest varied engagement, with some respondents linking the materials to broader partner agency work or using them for specific initiatives, such as distributing suicide prevention business cards and wallet cards. However, some noted a lack of clarity on the expectation to use the materials within their own organisation or were unaware of their usage. This highlights a potential gap in communication, suggesting that clearer guidance and expectations for Stakeholder Network members to adopt and promote the materials within their organisations could enhance their usage and impact.

Q9. Why aren't the materials being used in your team / department / organisation?

The responses highlight that the primary reason for not using the branding materials by these 2 respondents is a lack of awareness (100%), suggesting that some stakeholders are either unfamiliar with their existence or unaware of how to access them (50%). Additionally, insufficient internal management support (50%) and competing priorities with other campaign materials (50%) were identified as barriers.

Notably, there were no indications of perceived irrelevance, difficulty in using the materials, or challenges aligning them with organisational branding. These findings suggest that increasing awareness and improving communication about the materials' availability, relevance, and importance – along with securing internal buy-in – are critical steps to enhancing their adoption and usage across organisations.

3.3.3.1. Overarching Observations

The survey findings provide valuable insights into the use and perceptions of branding materials within the Suicide Prevention Stakeholder Network when read alongside the other evaluation activities within this priority area.

While the materials are generally well-received, with high ratings for clarity, consistency, and alignment to their goals, gaps in awareness, engagement, and communication limit their full potential. Strong representation from frontline practitioners and leadership roles underscores the network's readiness to adopt and cascade these materials, but the lack of clarity on expectations and limited use by support roles highlight areas for improvement. The alignment between the respondents' focus areas and suicide prevention goals affirms the relevance of the Stakeholder Network as the key audience for these materials.

Recommendations from the Professionals Survey include:

- **Increase Awareness and Accessibility.** Address the lack of awareness about the materials by ensuring all Network Members are routinely informed of their existence, purpose, and how to access them.

- **Clarify Expectations.** Provide clear guidance on the expected use of the materials within member organisations, outlining their role in supporting the suicide prevention agenda and encouraging consistent application across teams.

- **Engage Leadership.** Leverage managerial and strategic leaders to champion the use of materials by integrating them into organisational strategies, training, and protocols, ensuring alignment with broader goals.

- **Target Underrepresented Sectors and Roles.** Expand outreach efforts to child-focused and protective services, support staff, and underrepresented geographic areas to ensure broader and more inclusive engagement with the materials – aligned to the 'new' Communications Plan.

3.3.4. Stakeholder Interviews / Focus Groups

3.3.4.1. Stakeholder Network

The discussions at the Stakeholder Network revealed several key issues and opportunities concerning the communication strategy. While some organisations were effectively leveraging materials, such as conversation-prompt lanyards and resource cards, others were either unaware of the branding or inconsistently using the resources. This highlights gaps in both awareness and the structured dissemination of suicide prevention materials.

Recommendations from the Stakeholder Network include:

- **Need for Regular Updates**. Attendees recommended strengthening mechanisms for keeping all members updated on available resources and ensuring that new network members receive materials when they join.

- **Strengthen Communications Infrastructure.** Ensure the branding is included in the launch of the Suicide Prevention Strategy and Charter. This would act as a central reference point for stakeholders and increase alignment in messaging.

- **Facilitate Collaboration and Sharing.** Establish a platform or dedicated network group for stakeholders to share best practices, case studies, and communication materials. Include communications updates as a standing agenda item in regular stakeholder meetings to ensure consistent dissemination and awareness.

- **Embed Lived Experience.** Actively involve individuals with lived experience in developing and refining communication materials. Attendees offered to engage their contacts to support this process, enhancing the relevance and authenticity of the resources.

- **Track Resource Effectiveness.** Implement simple tracking mechanisms to monitor the routine distribution and usage of materials. For example, QR codes on printed resources that link to digital platforms, and feedback forms or surveys to assess how materials are being used and perceived by target audiences.

- **Focus on Practical Tools.** Continue producing accessible, user-friendly tools like lanyards with conversation prompts and small resource cards. These were highlighted as effective in encouraging engagement and normalising conversations about suicide prevention.

3.3.4.2. Stakeholder Workshop

A write up of the flip chart and post-it notes from the workshop can be found in Appendix Two. Based on these notes and their involvement in the workshop, the insights from this workshop can be summarised as:

- **Visibility and Reach of Messaging.** Current materials, while professional and consistent, are not considered widely visible to the general public, especially with its noted absence in schools, GP practices, libraries, and other community spaces. Attendees made several recommendations about expanding the visibility of messaging to public spaces such as bus shelters, parks, council vehicles, food banks, and train stations; leveraging media like Nottinghamshire TV, local radio, and podcasts to enhance reach; and distribute materials in accessible formats (e.g., fridge magnets, beer mats, badges, and QR codes on mirrors or tables).

- **Breaking the Stigma Around Suicide.** Nervousness about using the word "suicide" persists, but attendees believe that clear, bold messaging helps normalise conversations and break taboos. Attendees made several recommendations that embrace the messaging and attempt to tackle stigma directly. This includes promoting more personal stories (e.g., "Stories of Hope") to make the message relatable and impactful; and encouraging campaigns with visible slogans and identifiers (e.g., badges) for those completing the associated training.

- **Audience-Specific and Community Engagement.** Attendees recognised that different communities and audiences require tailored approaches depending on their cultural context and how suicide is viewed. Recommendations included developing culturally sensitive campaigns with input from community leaders and trusted figures, such as Gypsy, Roma, Traveller and Asian communities. Similarly, focus should be

given to settings frequented by target demographics, such as sports clubs for men, gaming platforms, and barber shops suggesting that collaboration with industry health champions is required to spread the message organically.

- **Leveraging Technology and Digital Platforms.** Attendees recognised that technology can improve accessibility and reach of messages, but its current use is inconsistent. Recommendations included using social media reels, TikTok, and other high-engagement platforms to target specific groups like younger men; and incorporating communication efforts into platforms like the NottAlone website and Integrated Care System WhatsApp channels.

- **Integration with Training and Programmes.** Attendees felt that training efforts could be better connected with communication strategies. Recommendations included providing communication materials as part of training packs (e.g., ZSA and Harmless) to reinforce messaging; encouraging participants to make and share public pledges post-training to amplify the message; and linking suicide prevention communications with existing initiatives like Making Every Contact Count (MECC) and rental agreements through housing associations.

- **Creative Campaign Approaches.** Attendees reported that innovative and unconventional methods capture attention and engage diverse audiences. Recommendations included using creative ideas like "Donuts for Suicide Prevention," stickers, branded pens, coffee shop promotions, and local sporting events (e.g., cricket or hockey games) to engage people informally.

- **Sustaining Momentum.** Maintaining consistent communication over time is recognised as a challenge. Attendees felt that developing a long-term communications and marketing strategy is required to ensure sustainability. Similarly, that using trusted institutions like the Citizens Advice Bureau, Job Centres, and housing associations would keep the message alive; as would having local authorities and elected members endorsing and supporting communication efforts at regular intervals.

- **Measurement and Evaluation.** Attendees recognised that improved evaluation of communication efforts is needed to assess their effectiveness. Recommendations included implementing mechanisms to track the impact of campaigns, such as audience reach, engagement metrics, and behavioural changes. Various Boards and Partnerships were suggested who could provide feedback and support these efforts.

3.3.4.3. Stakeholder Interviews

The series of four 1-2-1 conversations with individuals responsible for dissemination in their setting offered valuable insights into the communication efforts under the Wave 4 Suicide Prevention programme. Interviewees included:

- Senior Media Relations Officer, Nottinghamshire County Council

- Student Health Development Officer, Nottingham Trent University

- Trust Lead for Self-Harm and Suicide Prevention, Nottinghamshire Healthcare NHS Trust

- Communications and Campaign Manager, Nottingham & Nottinghamshire Integrated Care Board

Interviewees reported that the communications work under Wave 4 has demonstrated innovative approaches to promoting suicide prevention, particularly through its multi-channel strategies and inclusive branding efforts. Several themes and examples emerged:

- **Quality of Campaign Materials.** The branding was recognised as impactful and professional, with feedback noting that the co-produced design process had enhanced its relevance and resonance. Interviewees appreciated the "simple, clear, and eye-catching" nature of the materials.

  > *"There was a lot of checking back in and getting ideas … conversations about messages, colours, and what we wanted to do with that"*

  > *"For a health messaging artwork, it's really eye-catching and got a lot of attention"*

- **Effective Use of Resources.** Posters in strategic locations, such as university campuses, were a practical and low-cost method for normalising conversations about mental health and suicide prevention. For example, Nottingham Trent University used clip-frame posters in toilet areas across multiple campuses, reflecting a focus on visibility in spaces with high footfall.

- **Engagement with Specific Audiences.** Efforts had been made by the interviewees to target specific groups using the communications materials, such as male students and underrepresented ethnic communities. However, barriers such as stigma and cultural resistance persist in engaging groups like Gypsy, Roma, Traveller and West African communities. Peer-led approaches were highlighted as particularly effective in university settings, where students supporting fellow students created relatable and approachable avenues for discussion.

- **Integration and Consistency.** Campaign materials had been used across multiple sites and tied into key dates like World Suicide Prevention Day, creating a cohesive narrative and consistent presence. The resources were also integrated into wider health promotion campaigns, such as mental health training and local partnerships.

- **Challenges.** Capacity constraints, particularly in the City's communications team, limited the consistent reach and frequency of campaign activities. This highlights the importance of sufficient resources for campaign implementation to ensure continuity and long-term impact. Interviewees reported that engagement with professionals and organisations outside the 'core network' proved inconsistent, with some noting a lack of clarity on how best to use the materials provided.

- **Innovation and Practicality.** Creative suggestions for communication, such as using air fresheners in tractors or beer mats in pubs, were discussed as ways to reach hard-to-access groups like farmers and men in manual trades. Social media reels created by student mental health champions were cited as a modern, impactful way to normalise conversations and engage younger audiences.

Recommendations from these conversations include:

- **Broadening Reach.** While the campaign effectively utilised digital and physical channels, more focused efforts are needed to engage underrepresented groups. For instance, integrating culturally tailored messaging and building relationships with community leaders could help address stigma in ethnic minority groups like Gypsy, Roma, Traveller and West African communities as well the neurodiverse community.

    "It's important to work on and develop the relationships so that you have the right to speak to people about such sensitive things"

- **Improving Usage Guidance.** Interviewees called for clearer guidance on how to effectively use the campaign materials. A "crib sheet" or case studies illustrating successful use could increase confidence among organisations new to the campaign.

    "A crib sheet … and guidance around when to use certain materials would provide some reassurance that what we're doing is okay."

- **Maximising Partnerships.** Greater collaboration with larger employers, schools, and health providers could extend the campaign's impact. For example, incorporating suicide prevention training into workplace wellness programmes or safeguarding initiatives were suggested as a way to embed the message across different sectors.

- **Communications Resource Allocation.** Capacity challenges within the City communications team underline the need for sustainable funding and staffing. Similarly, continued support for a dedicated Wave 4 coordinator role was viewed as essential for maintaining the campaign's momentum and ensuring alignment across stakeholders.

    "There is an ongoing need for that resource and drive"

- **Routine Evaluation and Feedback.** Interviewees noted a lack of systematic evaluation measures, particularly around the campaign's broader public impact. Building in mechanisms to measure engagement, such as routinely tracking and reporting on website traffic or social media analytics, would provide valuable insights for future campaigns. However, communications team members noted limited resources and staffing, which hinders their ability to conduct in-depth or routine evaluations.

  > *"Take a step back for the next phase implementation ... let's have a sense about what we want to specifically achieve."*

3.4. Conclusion

The Wave 4 communications campaign has played an important role in strengthening suicide prevention efforts across Nottinghamshire. By developing a cohesive brand identity and engaging key stakeholders, the campaign has created a strong foundation for raising awareness and encouraging conversations about suicide prevention. However, evaluation findings indicate that while the branding and communication materials have been well received, their reach and strategic implementation require further enhancement to maximise impact.

- **Establishing a Strong Brand and Communications Strategy.** A key outcome of this work has been the development of a structured communications strategy and brand guidelines, which provide a framework for maintaining consistency in messaging and coordinated outreach efforts. These resources were designed to ensure that suicide prevention messages remain clear, professional, and accessible across different sectors and audiences. However, their adoption has been inconsistent, with some organisations integrating them into their work while others remain unaware of their availability or unclear on how to use them effectively.

  To address this, steps are already being taken to appoint a communications expert who will drive more targeted engagement, ensuring that messaging is adapted to different audiences and settings. Additionally, embedding the resulting communications strategy into broader suicide prevention activities will help sustain and expand the campaign's impact beyond the initial Wave 4 funding period.

- **Addressing Gaps in Reach and Engagement.** Despite the campaign's successes in branding and stakeholder engagement, evidence gathered suggests its visibility and impact among high-risk groups, particularly older men and those in deprived communities, remain limited. While the campaign has achieved good traction in healthcare settings and digital platforms, its presence in everyday community spaces – such as GP surgeries, transport hubs, workplaces, and leisure venues – needs to be strengthened.

Future communication efforts should focus on targeted messaging that reflects the specific needs and concerns of different communities. This means building on the existing brand guidelines to develop tailored campaign strands that incorporate personal stories and lived experiences, making messaging more relatable and engaging. Additionally, partnerships with trusted institutions and local networks will be essential in ensuring that suicide prevention messaging reaches those most in need.

- **Enhancing Strategic Implementation and Evaluation.** One of the key limitations identified in this evaluation is the lack of structured monitoring mechanisms to assess the effectiveness of the communication efforts. While anecdotal feedback suggests that the branding has increased awareness, more robust evaluation methods – such as tracking branding adoption, social media analytics, and engagement metrics – are needed to provide clearer insights into what is working and where improvements are required.

  By embedding a structured evaluation framework into the ongoing communications work, organisations can ensure that the communications strategy remains responsive to emerging needs. Routine tracking of engagement data, coupled with stakeholder feedback, will enable continuous refinement of messaging and outreach approaches.

By taking these steps, the campaign can move beyond initial brand establishment and toward long-term impact, ensuring that suicide prevention messaging remains a visible, accessible, and effective tool for reaching those who need it most.

3.5. Key Recommendations

These recommendations aim to build on the solid foundation established under Wave 4, ensuring that the campaign grows in reach, depth, and impact.

- **Develop a New Communications Implementation Strategy.** To build on the strong foundation established through the Wave 4 programme, it is crucial to ensure that suicide prevention messaging continues to evolve and reach wider audiences. This requires developing a new implementation strategy and embedding the communications materials into everyday practice by ensuring that the brand guidelines are consistently applied across all suicide prevention (and peer) initiatives. Providing clear guidance and support to organisations on how to integrate the communications materials into their work will help maintain consistency. Additionally, aligning branding and messaging with future strategic initiatives will ensure sustainability beyond the Wave 4 funding period.

- **Strengthen Targeted Communications.** Strengthening targeted communications is essential in reaching high-risk groups such as older men and deprived communities. Developing tailored messaging based on insights from lived experiences, such as

those gathered through community engagement, can make the campaign materials more effective. The newly appointed communications expert should focus on creating adaptable materials that resonate with different demographics. Expanding partnerships with trusted local institutions, such as community groups, housing associations, and GP networks, will help increase outreach effectiveness and ensure messaging reaches the right audiences.

- **Increase Visibility in Community Spaces.** Increasing visibility in community spaces is necessary to extend the campaign's reach beyond digital platforms and healthcare settings. Expanding the presence of campaign materials into GP surgeries, public transport hubs, leisure venues, and workplaces will ensure the message is seen in everyday settings. Innovative, low-cost distribution methods such as posters in public restrooms, QR codes on receipts, and engagement through local events can further enhance visibility. Collaborating with local businesses, universities, and sports clubs will also broaden community-level engagement.

- **Enhance Evaluation and Feedback Mechanisms**. Enhancing evaluation and feedback mechanisms is critical for assessing the impact of communication efforts. Implementing simple, scalable tracking tools such as QR codes, social media engagement metrics, and pass-through information from the communications materials to the crisis line will provide valuable data on effectiveness. Developing a structured evaluation framework to measure the adoption and impact of branding materials will help refine future campaigns. Routinely collecting stakeholder feedback will ensure messaging remains aligned with community needs. Additionally, assessing behavioural outcomes such as increased awareness, help-seeking behaviours, and professional engagement will help measure the long-term success of the campaign.

4. PRIORITY FOUR – PREVENTION SUPPORT FOR HIGHER RISK GROUPS

Aim: **Enhance delivery of support to people at risk of suicide experiencing challenges that are known risk factors / antecedents to suicide through small test-and-learn projects and a small grants programme.**

4.1. Background

4.1.1. Year 1 Pilot Projects

Year 1 activities of the Wave 4 Suicide Prevention Programme included three pilot projects, funded by a contract variation to Harmless CIC, aimed at providing targeted support to high-risk groups over-and-above those clients already supported in through existing provision.

Pilot #1 **Men and Older Boys in Suicide Crisis.** This pilot focused on creating accessible, non-judgemental spaces to address mental health and suicide risk in men (particularly those aged 30-34 and 50-54) and older boys (age 15-18). Activities were held in typically male-oriented settings, such as sports clubs, skateparks, and community cafés, aiming to foster engagement through informal and proactive approaches. Structured group discussions complemented these settings, providing opportunities for participants to share experiences, reduce feelings of isolation, and learn coping strategies. Activities were designed to reduce stigma, build trust, and encourage help-seeking behaviours, while psychoeducation elements focused on understanding mental health and navigating available support systems.

Pilot #2 **Parent and Carers Group.** This pilot focused on supporting parents and carers of children and young people at risk of self-harm. The initiative sought to address key challenges faced by parents, including emotional burnout, feelings of isolation, and the need for practical guidance in responding to their child's self-harm behaviours. The project combined psychoeducation, peer support, and structured interventions to empower parents and carers while promoting their own well-being.

Pilot #3 **Training and Support for Primary Care.** This pilot was initially designed to provide targeted training for Primary Care Networks (PCNs) to better support individuals presenting with self-harm and suicide risk. Efforts were made to pivot the training towards NHS Talking Therapies providers, but complications arose when the incumbent provider opted not to re-bid for the new service tender, limiting opportunities for engagement due to a lack of capacity.

In early 2024, renewed efforts focused on identifying a PCN interested in hosting training. While one PCN expressed interest, their preference was for external practitioners to directly deliver support rather than receiving training themselves. From February 2024, opportunities arose to integrate self-harm awareness into Practice Learning Time sessions within the PCN, and plans were made for Harmless CIC, to deliver a short talk on self-harm to a wider audience. Although the original objectives of the pilot were not fully realised, these adaptations highlighted the importance of flexibility and responsiveness to changing stakeholder needs and capacity constraints.

4.1.2. Year 2 Engagement Project

Year 2 activities of the Wave 4 Suicide Prevention Programme included an engagement project that sought to address suicide risks and stigma through bespoke engagement and training initiatives targeting those professionals / volunteers working with at-risk communities. This commenced with project planning and database creation i.e., a comprehensive understanding of services supporting at-risk communities in Nottingham, Nottinghamshire and nationally. This involved early collaboration between the Public Health leads and Harmless CIC – notably their Service User Care and Experience Lead, and Training Service Lead – to map out services, creating a robust database / resource hub that would inform subsequent engagement and training activities.

A needs survey was created and circulated amongst various Nottingham and Nottinghamshire professional groups that support at-risk communities to gauge their general knowledge on self-harm and suicide prevention, identify perceived barriers, and assess their training needs. The Service User Care and Experience Lead then engaged with various community groups and locations emphasising personal outreach and telephone follow-ups to secure responses. On closure, survey data was analysed to understand community-specific needs and barriers leading to the creation of culturally sensitive training materials and bespoke training packages that would resonate with each community's unique context and needs.

The bespoke training packages that would then be delivered as part of the Year 2 activities include (as per Eventbrite titles):

- Wave 4: Boys and Men: Self Harm & Suicide Prevention (Nottingham/shire)

- Wave 4: LGBTQIA+ Self Harm & Suicide Prevention (Nottingham/shire)

- Wave 4: Gypsy Roma & Traveller SH & Suicide Training (Nottingham/shire)

- Wave 4: Relationship Breakdowns as a Suicide Risk Factor (Nottingham/shire

- Wave 4: Suicide Bereavement Training for Services (Nottingham/shire) Suicide bereavement training for funeral directors, bereavement counsellors and bereavement support services across Nottingham and Nottinghamshire.

- Wave 4: Children & Young People - Self Harm Prevention (Nottingham/shire)

Note: The evaluation of engagement activities is the focus of this section, while the evaluation of bespoke training packages is addressed alongside core training in Priority One earlier in this report.

4.1.3. Wave 4 Small Grants Programme

The proposals for the Wave 4 suicide prevention grant included the development of a small grants process to support community groups with small scale but high impact projects under the theme of prevention support for high-risk groups. The scheme was managed by Nottingham City Council on behalf of Suicide Prevention Strategic Steering Group with grants open to organisations or groups who provided activities across Nottingham and Nottinghamshire. Original plans were for three rounds of grants, each focusing on a different group:

Round 1: For projects to benefit men aged 35-64 who may be at risk of suicide open March 2022.

Round 2: For project to benefit people who experiencing financial or employment difficulties open July 2022.

Round 3: For projects to benefit people aged over 65 who may be at risk of suicide open November 2022.

The first round of the small grants fund ran as planned in March 2022. Maximum grants of £500 were available with a total budget of £3,000. Five grant applications were received each of which was successful distributing a total of £2,395.80.

Subsequent rounds were delayed due to capacity constraints within the commissioning team and the second (and final) round of the small grants fund instead ran in summer 2024. However, following reflection on the original round, funding was increased to £500 to £6,000 per grant (supplemented from unallocated Wave 4 funding) and broadened to include mental well-being. Similarly, the second round was coordinated by Nottinghamshire County Council Public Health leads due to greater capacity within their team. However, it was noted that while their capacity was relatively higher, it was still very limited.

As with the first round, grants were widely publicised across a range of local networks including the Suicide Prevention Stakeholder Network. Nottinghamshire District and Borough colleagues were briefed on the grants and proactively promoted the opportunity across Nottinghamshire communities. Information about the grants was also promoted in Nottingham City e.g., through

their mental health collaborative. Written information was provided to potential applicants and the County and City Public Health leads delivered online information sessions, of which a total of 40 organisations attended. Information provided to potential applicants advised that the commissioners anticipated awarding 10 to 15 grants.

168 applications were received in total, significantly greater than expected. An initial screen was completed to ensure applications met the essential criteria with 22 applications rejected at this stage. An assessment panel was established consisting of three City and County Public Health Managers and one Public Health Practitioner. Applications were divided between panel members and assessed and scored independently. Due to the high number of applications, partial funding was considered for applications meeting a 60% or more scoring threshold. Priority was given to those applications aimed at priority target groups. The panel also looked at the spread of applications and ensured that there was an equal spread of applications across City and County areas and across target at-risk groups.

23 applications were approved, with many projects receiving partial funding. 114 applications were declined highlighting the competitive nature of the programme and a misalignment between submissions and scoring criteria i.e., *"there weren't really any bad applications, they just didn't fully meet our criteria so scored lower"*.

In recognition of this, nine organisations that applied for training-related funding will instead be offered support via the Training Framework Agreement. Additionally, some unsuccessful applicants were signposted to alternative funding opportunities, and both City and County Public Health leads are reviewing unsuccessful applications to explore potential support through other internal funding streams, such as County Public Health reserves and the City Healthier Communities Fund. This approach ensures that while not all applications could be funded through this programme, organisations still have access to relevant resources and potential funding opportunities to support their work.

4.2. Methodology

The primary question guiding this evaluation was: **"How well did the priority area deliver against its aim?"** This was supported by several sub-questions aimed at exploring different dimensions of the priority area's implementation and impact:

1.   What was the reach of the pilot projects?

2.   How effective were the pilot projects in generating new learning?

3.   How effective were our approaches in disseminating learning across the system?

4.   How has learning from the pilots been used and adopted across the system?

5.   What was the reach and impact of the small grants programme?

The planned approach included a series of evaluation activities that sought to contribute evidence to one or more of the sub-questions listed above. These activities were designed to provide a deep understanding of the projects' impacts, the challenges encountered, and the successes achieved, informing targeted recommendations for enhancing the scope and effectiveness of suicide prevention efforts.

4.2.1. Evaluation Activities

- **Desk-based Review of Objectives and Outcomes.** A detailed comparison was conducted between the planned outcomes and actual achievements of the pilot projects. This activity employed outcome mapping to track changes in behaviour, relationships, activities, or actions influenced by the programme, alongside gap analysis to identify discrepancies and their contributing factors.

  Data sources included:

  - Project reports prepared by service providers and project managers.

  - Records maintained by project staff, documenting operations and participant interactions (where available).

  While most data were presented as summative information (rather than raw datasets), the evaluation team relied on the accuracy and validity of the reports provided.

- **Semi-Structured Interviews with Commissioners and Delivery Teams.** To gain deeper insights into the implementation and effectiveness of the pilot projects, semi-structured interviews were conducted with the commissioners and pilot project delivery teams.

  Delivery team interviews were designed using the 4-D Appreciative Inquiry model, which focuses on identifying strengths, envisioning future possibilities, planning improvements, and implementing changes. The stages included:

  Discover: Identifying what works well in the projects.

  Dream: Envisioning what might be possible in the future.

  Design: Planning and prioritising actions that might improve the project outcomes.

  Destiny: Implementing the proposed improvements to realise the full potential of the projects.

This approach not only allowed for a positive focus on successes but also encouraged a collaborative dialogue about potential improvements.

- **Focus Groups with Pilot Project Participants.** Focus groups were planned to gather qualitative insights into the effectiveness and impact of both Year 1 and Year 2 pilot projects. These sessions aimed to complement provider-supplied evaluation reports with first-hand accounts from participants.

    - **Year 1** focus groups targeted participants to explore their experiences, perceived impact, and challenges, offering a reflective perspective approximately one-year post-involvement.

    - **Year 2** focus groups were intended to gauge professional perspectives on engagement processes, bespoke training utility, and the influence of projects on organisational culture and practice.

    Unfortunately, these focus groups could not proceed as planned due to a lack of access to participants. This limitation restricted the ability to incorporate deeper lived experiences and insights into the evaluation. Such input could have added valuable depth to the evaluation by presenting more immediate, personal insights to complement the structured findings from provider reports.

- **Stakeholder Engagement and Learning Adoption.** Initial plans included focus groups or surveys to assess how stakeholders across the system adopted and utilised learnings from the pilot projects. However, logistical challenges delayed the sharing of pilot reports:

    - **Year 1** reports were not widely disseminated beyond the Nottingham and Nottinghamshire Suicide Prevention Strategic Steering Group.

    - **Year 2** reports were shared with commissioners in late June 2024, limiting the timeframe for broader feedback collection.

    To address this, the **Stakeholder Workshop** held on 26 June 2024 at County Hall (see Appendix One for more details) became a platform for sharing insights and initiating action planning. Harmless CIC representatives informally shared their findings at the workshop, with table conversations about 'learning adoption'.

All qualitative data were coded and thematically analysed to align with the evaluation's sub-questions. Themes were identified through recurring patterns and insights, providing a comprehensive understanding of project impacts and implications.

4.3. Key Findings

4.3.1. Desk-Based Review

4.3.1.1. Year 1 Pilot Projects

Based on the two final pilot project reports authored and supplied by Harmless CIC:

The **Males and Older Boys in Suicide Crisis** pilot successfully highlighted barriers and engaged men, though outcomes were modest relative to ambitions. Engagement efforts in familiar male-oriented settings were effective, but stigma limited deeper conversations. While the test-and-learn approach identified practical insights (e.g., effective outreach strategies), addressing deeply rooted stigma requires sustained, multi-pronged efforts. Headlines include:

- **Reach.** Consultations engaged 153 individuals, surpassing the target of 145 mentioned in the 'service specification'. These consultations identified key barriers such as stigma, toxic masculinity, and the need for more accessible information.

- **Engagement.** Male referrals increased by 4%, with 37% of those engaging in 1:1 support. Informal outreach in spaces such as cafés proved particularly effective.

- **Barriers.** Text-based support, while preferred by men, had low utilisation. Persistent stigma and lack of awareness hindered deeper conversations and broader uptake.

The pilot effectively tackled a difficult demographic but faced challenges. Greater focus on long-term relationship-building and targeted follow-ups (such as those undertaken by Harmless in Year 2) should enhance future outcomes. Scaling up informal outreach and integrating consistent support structures is also critical.

The **Parent and Carer Group** pilot successfully delivered tailored support through 15 facilitated support groups and 26 drop-in sessions, collectively designed to support up to 216 parents and carers[7]. The sessions achieved meaningful outcomes for many, such as increased confidence and reduced isolation. However, gaps in male participation and unresolved feelings of guilt and shame among some participants highlight areas for improvement. Flexibility in session design and scheduling—offering both online and in-person options—was critical to accessibility and should remain a focus in future iterations. Headlines include:

- **Positive Outcomes.** Parents reported increased confidence in addressing self-harm, improved well-being, and reduced isolation. Lived experiences shared within groups fostered connection and validation.

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[7] However, it should be noted that actual attendance figures for the groups / sessions are missing from the supplied report, rather they present the capacity they were designed to accommodate.

- **Challenges.** Male participation was limited, with stigma identified as a barrier[8]. Long group sessions initially caused disengagement, prompting a reduction to 1½-hour sessions.

- **Accessibility.** Online sessions were popular for their convenience, though some participants missed the connection of face-to-face meetings.

This pilot demonstrated the value of peer support and psychoeducation in addressing the needs of parents. Future iterations should prioritise increasing male / father engagement, refining content to address unresolved emotional challenges, and exploring peer-led approaches for sustained support.

Our observations across both Year 1 pilots are that while the activities are well-documented, the evaluation lacks detailed quantitative data on the impact of these activities. Metrics such as changes in suicidal ideation / crisis among the target group and long-term engagement data (as suggested in the commissioner-supplied log frame matrix) would provide a clearer understanding of effectiveness.

Developing simple Theory of Change documents and identifying clear outcome indicators during a pilot's development phase would support systematic monitoring and evaluation throughout the project's lifetime. Similarly, including service user perspectives in future provider reports would provide richer insights into lived experiences and the interventions' real-world impact.

4.3.1.2. Year 2 Engagement Project

The Year 2 Engagement Project sought to address suicide risks and stigma through bespoke engagement and training initiatives targeting those professionals / volunteers working with at-risk communities. Based on the Wave 4 Suicide Prevention Engagement and Bespoke Training project report and accompanying infographic authored and supplied by Harmless CIC. It should be noted that no further breakdown or other documentation was provided by the provider to the commissioner or evaluator regarding the Year 2 professional engagement or bespoke training activities. While the project's objectives and engagement strategies were referenced in discussions (see further below in this report), a lack of access to formal documentation – e.g., the 'engagement database' and granular training performance reporting – limits the evaluator's ability to further assess the pilot's implementation, impact or reach.

The **engagement activity** seemingly reached a large number of stakeholders with 548 organisations "engaged with" (although there is no clarity on how this is defined), 40 outreach events attended, and 231 'training needs / service barriers' surveys distributed, leading to 132

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[8] Extract from the Harmless report: "When speaking with one of the male participants who attended the six-week groups. Their feedback highlighted that a barrier for males attending the group is due to the stigma associated with males being 'dominant' and 'strong' and potentially internalising the thought of not needing the support."

responses. These efforts informed tailored strategies and materials such as bespoke pamphlets for at-risk groups – of which 212 were circulated – and training content.

The **bespoke training activity** resulted in the development of six new bespoke courses and the delivery of 33 sessions to 472 individuals from 95 organisations. The report states that "Those trained support over 2,925 individuals across Nottingham/shire with their mental health needs every week" demonstrating the significant reach and potential impact of the training within existing caseloads. The report also states that there was "an average shift from 51.0% to 99.7% of delegates who agreed / strongly agreed that they have a good understanding of self-harm and suicide in the community they attended training for." These headline figures highlight the value of equipping professionals who are already embedded in their communities with the knowledge and tools to address suicide prevention and self-harm risks, ensuring that the training has a broad and meaningful influence on mental health support delivery.

After outlining the headline outcomes, the report delves into key learning points from the engagement and training activities that echo findings from other evaluation efforts with respect to the importance of cultural competency, trust-building, and tailoring approaches to the unique needs of different at-risk groups. This includes recognising the distinct challenges faced by each group as well as addressing systemic barriers such as stigma, resource constraints, and the limitations of short-term funding models. The report underscores the value of co-production, accessible materials, and sustained engagement to maximise impact and ensure that interventions effectively reach these communities and the professionals that support them.

Finally, the report provides recommendations for future practice, including offering modular training, expanding cultural awareness training, simplifying resources, and aligning efforts with broader suicide prevention strategies to ensure sustainability and long-term impact. It emphasises the need for innovative engagement methods and robust follow-up mechanisms to evaluate and enhance the programme's effectiveness – all recommendations the evaluator would agree with.

Based on these documents, the Year 2 Pilot Project demonstrates the value of tailored engagement and training in addressing suicide risks within diverse, at-risk communities. The report offers clear, practical examples (page 12, Future Practice) of how Harmless CIC, the pilot project provider, has adapted and enhanced its practices based on experiences and recommendations from the pilot. These evolving practices provide valuable insights and models that can inform and improve suicide prevention efforts in other contexts.

4.3.1.3. Wave 4 Small Grants Programme

The **evaluation forms** for Round 1 projects provide insights into the diverse projects supported by the Small Grants programme. Each project focussed on addressing suicide risk factors through tailored community-based initiatives. Whilst the forms are limited in detail, key findings are as follows:

- **Active Minds CIC (Sutton-in-Ashfield).** The "Fight the Stigma Sessions" project by Active Minds CIC used boxing and fitness as innovative tools to support mental health, build confidence, and provide a safe, inclusive space for participants to focus on their well-being. The sessions offered a constructive outlet for managing stress and mental health challenges, harnessing the well-documented benefits of physical activity for mental well-being. Participants reported enhanced mental health, increased confidence, and a renewed sense of purpose through regular engagement. The project also addressed barriers to accessing fitness opportunities, offering participants a chance to engage in physical activity that might otherwise have been out of reach due to financial or logistical constraints. By breaking down these barriers, the initiative created a positive and empowering environment for its participants. Over the course of the project, 10 individuals actively participated.

- **Hetty's (Mansfield Woodhouse).** Hosted a weekly Monday night football evening for individuals of all ages and abilities, supported by social media content promoting mental well-being. The project reported helping individuals with isolation build lasting relationships, raise awareness of suicidal ideation, low mood, low self-esteem and helped participants understand emotional resilience. 150 people were engaged with throughout the project (although it is unclear how this is split between in-person attendance and social media interaction).

- **Jigsaw Support Scheme (Mansfield and Bassetlaw).** Operated a weekly mental well-being support group facilitated by counsellors. No additional information was provided in relation to the delivery, impact, or reach of this project.

- **Military Community Network Group (Kirkby-in-Ashfield).** Contributions to the organisation a horticultural therapy allotment project and promoted a Veterans' Breakfast Club to support ex-service personnel. The allotment and Breakfast Club provided consistent opportunities for social interaction and connection, fostering a sense of belonging and community needs. The project illustrates the power of community-led holistic support in addressing the unique challenges of an at-risk community. By combining structured activities like horticultural therapy with informal gatherings the Network Group has created a multi-faceted programme. 886 people were engaged with throughout the project.

- **The Newark Co-production Mental Health and Well-being Groups (Newark and Ollerton).** The funding contributed to a project that provides a range of community-based activities in Newark and Ollerton to support mental health and foster social connection. These groups were co-designed to address isolation and improve well-being, particularly for individuals who had experienced mental health challenges, including the project lead who shared their personal journey of recovery. The project facilitated weekly groups, including allotment sessions, music groups, walking groups, and craft / social groups e.g., "coffee and craft" and "knit and natter" sessions.

Over the past eight years, the project has engaged approximately 250 individuals on a revolving basis, offering ongoing support for regular members while welcoming new participants. The funding was specifically allocated to purchase essential allotment equipment, including compost bins, a water butt, and tools; procure music equipment, such as cables and a second-hand guitar; and cover general running costs, including free refreshments for all sessions.

Local authority records supplied for the evaluation demonstrate a robust and formal process for promoting, assessing, and awarding grants. Key insights from the **Round 2 Small Grants Outcome Spreadsheet** are outlined below:

- Applications Approved: 23
- Total Amount Requested: £105,595.43
- Total Amount Awarded: £55,699.00
- Average Amount Requested: £4,591.11
- Average Amount Awarded: £2,421.70

The programme demonstrated a strategic approach to fund allocation, with many projects receiving partial funding to maximise the number of beneficiaries within the available budget. However, the total funding awarded (£55,699) represented just over half of the total requested (£105,595.43), underscoring the significant demand for financial support among community and voluntary sector organisations.

The programme achieved a fair distribution across Nottingham City, Nottinghamshire County, and priority groups, with some projects targeting multiple geographies and at-risk populations. However, limited representation was observed in less deprived boroughs like Gedling, Rushcliffe, and Broxtowe. This likely reflects fewer applications from these areas due to lower levels of deprivation and perceived need. Expanding outreach efforts in underrepresented areas may help address this in future rounds.

The high number of declined (114) and rejected (22) applications may suggest some challenges in aligning with funding criteria. However, commissioners noted that this is primarily due to limited funding availability rather than application quality. The original intention was to fund 10–15 projects, but demand far exceeded available resources. A review of scoring sheets showed that 64 applications scored 50% or more, making full funding financially unviable. As a result, funding decisions prioritised applications scoring 60% or higher (29 applications).

This highlights the high level of competition rather than a fundamental misalignment with criteria. Future rounds could benefit from clearer guidance on funding priorities and capacity-building support for smaller organisations to help refine proposals. Additionally, offering further assistance in navigating the application process and meeting administrative requirements could improve accessibility. However, the primary challenge remains the high demand exceeding available resources.

Approved projects demonstrate strong alignment with the programme's priorities, often addressing multiple high-risk groups. Examples include men experiencing financial distress, autistic individuals, and those at risk of self-harm. This reflects the programme's emphasis on addressing diverse and intersectional needs, ensuring that the funding supported impactful and meaningful mental well-being / suicide prevention interventions.

4.3.2. Interviews

4.3.2.1. Year 1 Pilot Projects

Two interviews were conducted with Year 1 Pilot Project leads from Harmless CIC to gather their reflections. Key findings from these conversations are:

- **Engagement.** Interviews with the stakeholders provided insights into the geographic and demographic reach of the pilot projects. Interviewees reported that the "Male and Older Boys" pilot project had made a noticeable difference by increasing the engagement of men in crisis services, which was an encouraging development over the months following the project's implementation. Whilst this is an indirect benefit, or outcome, of the programme the positive impacts of men engaging in core self-harm and suicide prevention services are significant in improving both individual and community health outcomes. There was also an emphasis on the success of repeated group sessions, particularly with parents / carers, noting better engagement in structured settings than in drop-ins. Teams reflected on underestimating the resource demands for community events, affecting their reach and sustainability. Challenges were also noted in engaging specific groups primarily due to the "difficult-to-engage" nature of these groups, the topics being discussed and the limited time to build rapport with these communities.

Appreciative Inquiry Findings

Discover: Reach was extended through strategic use of resources and community-focused initiatives.

Dream: Increase the scope and scale of the projects to reach a wider audience, including more of those that don't typically engage easily. There was recognition that this involves more funding and broader worker involvement to maximise reach.

Design: Building collaborative strategies and strengthening partnerships between local authorities and Harmless CIC were seen as vital for enhancing project impact in the future.

Destiny: Immediate actions recommended included applying the successful strategies more broadly and ensuring continuous improvement through regular feedback and project adjustments.

- **Generating Learning.** Across all interviews, respondents detailed the effectiveness of the pilot projects in generating new learning through structured group interactions, where significant learning involved understanding suicidal ideation and self-harm in target groups. The repeated nature of sessions and provision of handouts were critical in reinforcing learning with one interviewee suggesting that extending project timelines would enhance learning absorption, particularly for hard-to-reach groups like men and boys, whose engagement was shown to improve significantly over extended periods.

  The limited lead-time for relationship-building emerged as a consistent barrier to maximising learning from the target groups. This challenge reflects the broader impact of fixed-term funding models, which often impose tight deadlines for implementation and spending, leaving insufficient time for essential preparatory work. Service provider feedback highlighted that more time to engage with target groups before delivery would have enhanced trust, strengthened relationships, and improved project outcomes, ultimately contributing to more sustainable and impactful results.

  Appreciative Inquiry Key Findings

  Discover: Repeated group sessions were more effective than drop-ins, fostering stronger community and peer support.

  Dream: Envisioned an enhanced pilot projects with more flexible session timings to increase participation.

  Design: Proposals included maintaining a blend of online and face-to-face sessions and involving more experienced parents in future sessions.

  Destiny: Funding and dedicated administrative support were identified as necessary for implementing these improvements.

- **Disseminating Learning.** Interviewees highlighted that the effectiveness of direct contact methods like presentations at strategic group meetings for disseminating learnings. They noted that engaging presentations followed by discussions helped in better absorption of the information shared. One interviewee noted that *"self-harm and suicide prevention is much broader than a 'healthcare' or 'public health' issue and must involve wider stakeholders"* suggesting that the wider public health workforce – e.g., adult social care or housing etc. – should also be considered in dissemination efforts.

  Appreciative Inquiry Findings

Discover: Successful dissemination was achieved through presentations supported by direct interactions, which facilitated deeper conversations and understanding.

Dream: Ideal dissemination would involve more extensive community involvement and innovative communication strategies like documentaries or short films.

Design: Recommendations included using varied communication methods and enhancing partner engagements to spread learning more effectively.

Destiny: Regular meetings and training sessions were suggested to maintain engagement and continuously share learnings.

4.3.2.2. Year 2 Engagement Project

Interviews with the provider leads for Year 2 engagement and training efforts took place throughout May 2024. The conversations highlighted a comprehensive approach to engagement and training that has clearly yielded valuable insights and laid a strong foundation for ongoing initiatives across diverse communities.

- **Comprehensive Database Creation.** Spending time upfront to establish a detailed database of services supporting at-risk communities provided a solid foundation for targeted engagement. This enabled a well-informed approach to outreach, ensuring that efforts were directed towards relevant and supportive services.

- **Robust Engagement Strategies.** Employing varied engagement methods, such as emails, phone calls, and in-person visits, helped ensure a broad and inclusive audience. Engagement extended beyond traditional settings to include grassroots organisations, unconventional venues (e.g., strip clubs, comic stores), and personal follow-ups ensured a broad audience. This approach was particularly effective in reaching underrepresented groups and gathering diverse perspectives on mental health barriers and training needs.

- **Tailored Survey Design.** Customising survey questions for organisations working with different communities demonstrated sensitivity to the unique contexts and knowledge levels of the at-risk communities they support. This enhanced the relevance and resonance of survey questions, particularly for LGBTQ+ and Gypsy, Roma, Traveller communities, leading to higher engagement and more insightful responses.

- **Cultural Sensitivity and Trust-Building.** The project allocated time for building trust with organisations supporting higher-risk communities (notably Gypsy, Roma, Traveller groups) through sustained engagement efforts. This included the development of

culturally appropriate materials that organisations could use to enhance their work with these communities.

- **Incorporation of Lived Experiences.** Integrating lived experiences from each higher risk group into their training programme makes the content more relatable and impactful. As seen earlier in this report, the feedback is that lived experiences provide a touchpoint for attendees to foster empathy and a deeper understanding of mental health issues including self-harm and suicide.

"Emotions are powerful in training, having that empathy is important."

In terms of lessons learned, interviewees felt that:

- **Survey Design and Format.** Open-ended survey questions may have been intimidating or too time-consuming for organisations and groups supporting Men & Boys, particularly those with less established knowledge or confidence around the subject matter. Simplifying the survey format with more closed-ended questions and tick-box options could have lowered the barrier to participation and increased response rates. This also highlights a broader challenge – organisations themselves can be just as difficult to engage as the communities they serve. Relationship-building with these organisations requires targeted engagement efforts to ensure they feel equipped and supported to contribute meaningfully to the work.

    "On reflection, we could have formatted the survey differently – we got lots of responses from LGBTQIA+ and Gypsy Roma Traveller but found it more difficult to engage with Men & Boys groups – asking about self-harm and suicide can be difficult for those who aren't in that mindset."

- **Engagement with Men & Boys.** It could be difficult engaging Men & Boys due to time constraints and the recreational nature of their activities. Tailoring messaging to emphasise the ease and minimal time commitment of training, as well as the importance of mental health awareness, could improve engagement. Additionally, offering training sessions during convenient times (e.g., weekends or evenings) and in familiar settings might have increased participation.

- **Resource Allocation and Prioritisation.** It was challenging to balance efforts across multiple organisations with varying levels of engagement and response. Prioritising resources based on initial response rates and feedback could ensure more focused and effective engagement. For example, investing more time in organisations who work with specific communities with higher potential impact or greater initial interest. However, it's important to also implement a systematic follow-up process to gather feedback from those who did not respond to the survey and gather valuable insights into non-participation reasons and help refine future engagement strategies.

- **Training Accessibility and Flexibility.** There were perceived barriers to training participation, such as time commitment and responsibility concerns. Developing more flexible training options, such as online modules, brief workshops, and informational pamphlets, could make training more accessible. Emphasising the non-expert nature of the training and the simple steps involved in supporting mental health might alleviate concerns about responsibility.

  > *"I went anywhere men and boys went to … there was a perceived fear about them [the organisation / group working with men and boys] being responsible for that person's mental health."*

- **Cultural and Terminology Barriers.** Addressing cultural differences and the appropriate use of terminology emerged as a challenge for the bespoke training, which focused on engaging professionals and services who work with at-risk / minority communities. For professionals who are not part of these communities, equipping them with cultural competency training and culturally sensitive materials would enhance their capacity to engage effectively and build trust with a community. On the other hand, if professionals engaged in the project were also members of 'the community', additional considerations might include supporting them in navigating dual roles and addressing any unique challenges they face when bridging formal services and their community's needs. Recognising and addressing both scenarios would strengthen the training's overall impact and inclusivity.

  > *"For the training, we created materials that used symbols with simplified language and their iconography – the Gypsy Roma Traveller wheel arch that demonstrates safety."*

  > *"Services have to be ready for these communities. We have done lots of work to be LGBTQAI+ friendly but Gypsy Roma Traveller was new … it's opened up my eyes to who's missing from the service and how we can bridge that gap … we're taking this learning into other parts of the service."*

- **Sub-Group Specific Strategies.** Generalised approaches may not resonate with all higher-risk community sub-groups, even when engaging professionals and organisations working with these groups. Tailored strategies for different sub-groups within each community (e.g., specific age groups or cultural backgrounds) could improve the relevance and effectiveness of training and resources provided to professionals. For instance, equipping professionals with tailored materials and training sessions to address the diverse needs of younger vs. older men in the Men & Boys group or recognising the specific challenges within the Gypsy, Roma, Traveller community. One interviewee reflected:

  > *"What was interesting with the Gypsy Roma Traveller community is that you need time to ingratiate yourself with the them as they are very untrusting and*

fearful of services ... within that community there are multiple cultures, languages, and terms. What you learn is the differences are so vast it's important to never amalgamate them together."

- **Sustained Engagement and Relationship Building.** Short-term engagements with organisations supporting at-risk communities may not lead to lasting impact. Long-term relationship-building with these organisations is crucial for strengthening their capacity to engage effectively on suicide prevention. Regular check-ins, follow-up sessions, and ongoing support help maintain momentum and ensure that organisations feel equipped to continue their work in this area.

  Sustained engagement also requires dedicated time and resources, which should be factored into funding decisions. Integrating continuous engagement strategies into project plans will help ensure that organisations can develop deeper, more meaningful connections with the communities they serve.

  "We learned very quickly that to build trust you need time."

  "[The project] has opened up more doors for us about accessibility in communities in Nottinghamshire. We are doing some work with the Big Issue, a massive percent of their workers are from the Roma community – what do we need to learn from them?"

4.3.2.3. Commissioner Interviews re. Pilot Projects

Multiple interviews were conducted with four commissioner representatives from Nottingham City Council and Nottinghamshire County Council. These interviews provided insights into Priority Four of this evaluation, focusing on the Wave 4 Pilot Projects. Key findings are outlined below:

- **Coordination and Partnership. Collaboration as a Strength**: The strong partnership between commissioners and organisations such as the Integrated Commissioning Board and Harmless CIC was pivotal, particularly in navigating complexities during Year 2 specification development. Personal and professional compatibility among the team members facilitated smoother progress and effective decision-making.

  "It's about people. It's worked well in how we have worked together, we're quite similar in our approaches."

- **Stronger Test-and-Learn Approach in Year 2.** Year 2 prioritised a "test-and-learn" culture, encouraging flexibility and adaptation. Commissioners worked collaboratively to develop specifications, aiming to foster ownership among the delivery teams.

"We set expectations much more clearly around test-and-learn in Year 2. We spoke about how it's okay if delivery doesn't go well ... it's about the learning."

- **The Importance of Dissemination.** Interviewees consistently emphasised the critical role of dissemination in ensuring the system-wide impact of the Pilot Projects. A well-written report, featuring clear findings and actionable recommendations, was identified as a cornerstone for effective learning and adaptation. Additionally, creating dedicated time and space for collective reflection and planning was seen as vital to embed learnings into practice and inform future strategies – i.e., dissemination not merely as an end-of-project task but as an ongoing process for the Wave 4 Steering Group to own.

  "The big thing for me is dissemination ... I'd like to see a proper programme of dissemination and how we share it."

4.3.2.4. Wave 4 Small Grants Programme

One group interview with three Public Health Commissioners and one Public Health Practitioner from Nottingham City Council and Nottinghamshire County Council provided valuable insights into the Wave 4 Small Grants Programme. The discussion highlighted key learnings, challenges, and successes from the programme, with a focus on its implementation, outcomes, and future potential:

- **Implementation and Reach.** The first round of the Small Grants Programme offered grants of up to £500 but received only five applications. Interviewees attributed this to the small funding amount and restrictive criteria, which were closely tied to suicide prevention. In response, the second round expanded funding to between £500 and £6,000 and broadened its focus to mental health and well-being. These changes significantly increased interest, with 168 applications submitted.

  "The first round felt too limited, but the changes in the second round opened the door for a lot of organisations to engage."

- **Adaptability.** The team demonstrated their capacity to learn and adjust, with the broader framing of "mental well-being" in the second round enabling greater inclusivity. The flexibility in implementation timelines, which allowed projects 12 months to deliver from receipt of funds regardless of the financial year, also mitigated some potential implementation challenges.

  "We learned a lot from the first round in terms of our process. That was the added value from our perspective as a team."

- **Administrative Challenges.** Delays in approving applications and distributing funds were recurring issues, with interviewees acknowledging that such delays had the

potential to undermine project effectiveness. However, the flexibility offered in implementation timelines ensured that grantees were still able to deliver on their commitments. While these delays have not negatively impacted projects, they highlight the need for streamlined local authority processes to better support grantees and avoid unnecessary bottlenecks.

- **Accessibility.** Grassroots organisations faced significant hurdles, particularly due to administrative requirements like needing a legal entity or dedicated bank account. This was identified as a missed opportunity to engage highly localised, community-led initiatives. The programme's flexibility in the second round, including partial funding and the identification of alternative grant pots for unsuccessful applicants, improved accessibility. Interviewees also recognised the need to balance objective decision-making with a broader, community-focused approach, though the pressures of accountability and risk aversion remain.

  > *"The paperwork requirements make it hard for smaller groups to engage, even if they have great ideas."*

- **Capacity Building.** The inclusion of suicide prevention training and resources alongside the funding was noted as a significant strength of the programme. It ensured grantees were not just financially supported but also equipped with the skills to deliver impactful projects. Capacity building was further identified as a key opportunity for future support, with plans to co-design evaluation and monitoring templates as part of a small grants celebration in February 2025 to help grantees identify and evidence impact.

- **Outcomes.** The outcomes of the first round of grants demonstrated meaningful, if not robust, impact. While the funding amounts were small, they achieved their aims for the organisations involved, aligning with modern commissioning principles that embrace flexibility and community-driven approaches. This approach aligns with Asset-Based Community Development (ABCD), prioritising community strengths over traditional, rigid evaluation frameworks.

  > *"Looking at the feedback from round one, it's proportionate to the scale of the grants – it's not robust, but it's achieved its aims."*

- **Sustainability Concerns.** Sustainability emerged as a recurring challenge. One applicant in round two declined a partial grant that could not cover their ongoing operational costs, underscoring the tension between funding innovation versus maintaining existing, initiatives and groups. The commissioners acknowledged the need for a balance, recognising the long-term value of small-scale, community-led projects and the importance of operational funding to sustain their efforts.

Overall, interviewees reflected positively on the small grants programme, expressing optimism about its potential to empower communities and improve lives. The commissioners acknowledged the need to embrace the unique dynamics of grant funding, recognising its limitations while celebrating its ability to support transformative, grassroots-led change. The second round was particularly praised for showcasing the value and impact of community-led initiatives.

> *"It was humbling, seeing the work people do to improve the lives of others in their communities. From a corporate perspective, we couldn't achieve the outcomes or benefits they do in their communities … and I think there is a growing recognition of that within our local authorities."*

Based on the discussion, it is recommended that the application process be simplified, with additional support provided for smaller organisations, such as mentorship or partnership models, to help them navigate administrative requirements and improve accessibility. To enhance sustainability, the programme could explore offering multi-year funding or operational grants, enabling projects to grow and establish themselves within their communities. Subject to funding, future rounds should continue to adapt and refine the programme, employing a co-production approach to integrate grantee feedback and evaluation findings into its design. Finally, fostering a network of grantees to share learning and collaborate on shared challenges could amplify the programme's reach and create a legacy of sustained community-led impact.

4.3.3. Stakeholder Workshop

Initially, the plan had been to assess how learnings from the pilot projects have been used and adopted by stakeholders. However, early conversations highlighted it was not practical for this activity to take place. This was because the Year 2 pilot project reports were shared with commissioners late June, and that the Year 1 pilot project reports had not been circulated (a) widely outside of the Nottingham and Nottinghamshire Suicide Prevention Strategic Steering Group, or (b) with a clear ask around adoption of learning.

As such, the Stakeholder Workshop presented an opportunity to share key insights and learning from the priority with stakeholders (World Café Session One) and explore action planning for the future (World Café Session Two). The provider reports and representation from Harmless (CM and LM from who had led on the Year 2 pilot projects) provided an opportunity to explore this in detail.

A write up of the flip chart and post-it notes from the workshop can be found in Appendix Two. Based on these notes and their involvement in the workshop, the insights from this workshop can be summarised as:

- **Relational Practice.** Effective community engagement requires substantial time and effort to build trust and meaningful relationships within the groups and organisations

who work with targeted communities. Successful relational practice demands a long-term commitment from stakeholders, recognising that quick fixes are insufficient.

- **Communication and Coordination.** There's a need for better coordination and communication among services to ensure a cohesive approach to suicide prevention messaging. Encouraging the sharing of best practices and insights is important to foster a collaborative environment. Communicating insights in a clear, concise manner will facilitate easier adoption by various stakeholders e.g., visual tools like infographics. Ensuring clear communication that respects cultural nuances and avoids loss of meaning in translation is important to building trust and ensuring clarity. However, it was recognised that better communication and community engagement (i.e., increased awareness and signposting) may lead to greater access of support service with the unintended consequence of creating longer waiting lists; resources must be planned accordingly.

- **Adoption and Implementation of Learning.** There are questions about whether stakeholders will, or are able to, implement learning from the pilot programmes and change their services. Developing effective metrics to assess the impact of implemented changes and community engagement efforts. However, this requires coordination for example: professionals and organisations will soon be able to pledge their support and commitment to the 'Suicide Prevention Charter' and 'Self-Harm and Suicide Strategy', but how is this followed up to ensure 'compliance'? There is a need to balance support and enforcement, for example a balanced approach that could be taken might involve restorative supervision or Action Learning Sets to implement learning that supports staff while ensuring accountability. One attendee suggested incorporating mental health / suicide prevention promotion into roles more formally, thereby expanding the reach and impact of initiatives.

- **Innovative Approaches.** Adopting creative and inclusive methods to engage with various community groups, recognising their unique needs and contexts, is essential. This requires providing accessible services, such as drop-in clinics, to facilitate ongoing interaction and support. Action plans should include capturing and leveraging the experiences of those with lived experiences for deeper, more meaningful engagement.

- **Sustaining Initiatives.** There are concerns about the discontinuation of pilot funding highlighting the need for longer-term resource allocation to pilot new, and sustain successful, initiatives. Engagement and co-production are important activities in their own right that should be included in strategic plans. One suggestion was for commissioners to learn from how earlier Waves have sustained their initiatives. It is important to note that each area developed its own, often very different, approaches to Wave funding. Therefore, while lessons can be drawn, direct comparisons may not always be applicable.

The combined insights from World Café Sessions One and Two emphasise the need for sustained commitment, effective collaboration, and strategic planning to implement and sustain impactful suicide prevention initiatives. True co-production requires ongoing engagement, innovative approaches, and continuous learning. Addressing cultural sensitivities, reducing stigma, and ensuring resource allocation are pivotal in creating a supportive and effective environment for mental health discussions and interventions. By focusing on these areas, stakeholders can work towards a more cohesive and sustainable approach to suicide prevention in at-risk communities.

4.4. Conclusion

The Priority Four Pilot Projects have contributed to enhancing support for individuals at risk of suicide due to known antecedents, showcasing innovative strategies and adaptability in addressing complex challenges. The projects generated practical insights into engagement and support mechanisms, particularly for high-risk groups, but challenges in execution, dissemination, and sustainability underscore the need for further refinements to maximise long-term impact.

Key findings include:

- **Reach of the Pilot Projects.** The projects successfully engaged with high-risk groups, particularly men and boys and parents / carers (Year 1) and professionals and communities supporting them (Year 2) as demonstrated by the uptake in bespoke training. However, gaps remain in reaching more isolated or less responsive demographics, suggesting the need for more sustained and tailored engagement strategies.

- **Effectiveness in Generating Learning.** Practical insights were developed, particularly around engagement strategies, cultural competency, and the value of sustained relationships. Year 2's emphasis on a test-and-learn culture fostered adaptability and deeper understanding. However, learning was constrained by short timelines and the absence of service user voices in evaluation data.

- **Dissemination of Learning Across the System.** Dissemination efforts have been limited, with presentations to the Suicide Prevention Strategic Steering Group providing some value but lacking mechanisms for ensuring adoption. Future efforts must include a structured dissemination framework with actionable recommendations and dedicated activities to embed learnings into practice.

- **Adoption of Learnings Across the System.** Evidence of systemic adoption is limited, reflecting gaps in follow-through from dissemination and a lack of accountability mechanisms. While pilot learnings have informed ongoing projects and strategies within the Strategic Steering Group and public health teams, sustained and widespread

system-level change is not yet evident. However, the Stakeholder Workshop highlighted a clear appetite for system-wide adoption of these insights. Participants demonstrated an interest in applying learnings and fostering collaboration across sectors. To realise this potential, future efforts must focus on structured dissemination, actionable guidance, and accountability frameworks that ensure learnings are embedded in practice and inform strategic priorities across the system.

- **Reach and Impact of the Small Grants Programme.** The initial round of the Small Grants Programme saw limited uptake, with only 5–6 grants awarded. However, the programme showcased significant potential for engaging Voluntary and Community Sector organisations and addressing the needs of high-risk groups. The lessons learned from the first round informed meaningful adjustments in the second round, including broader eligibility criteria and increased funding, which substantially enhanced participation and reach. To fully realise and demonstrate the programme's impact, a more robust and systematic impact assessment framework is needed. This would provide a clearer understanding of outcomes, enable the evaluation of long-term sustainability, and strengthen the case for expanding similar initiatives in the future.

4.5. Key Recommendations

By addressing these areas, future suicide prevention efforts can build on the learning from the Pilot Projects, achieving more impactful, sustainable, and inclusive outcomes for at-risk communities.

- **Addressing the Lack of Service User Voice in Evaluation Findings.** While this evaluation gathered valuable insights, the absence of direct input from People with Lived Experience (PWLE) remains a gap. Without hearing directly from those affected by suicide prevention efforts, evaluations risk overlooking key perspectives on what works, what doesn't, and what needs improving.

    To ensure future evaluations fully reflect lived experiences, organisations involved in the Suicide Prevention agenda should collectively explore how to progress on the 'ladder of co-production', embedding a stronger, ongoing feedback loop into their work. These insights should be shared across the Suicide Prevention Network to build collective learning and improvement. General steps for strengthening PWLE involvement include:

    o **Integrate PWLE Involvement from the Start:** Allocate time, funding, and appropriate methodologies to engage PWLE in meaningful ways. Use focus groups, case studies, or co-designed evaluation activities to ensure participation is genuine and structured.

    o **Use Practical and Participatory Evaluation Methods:** Move beyond traditional metrics and incorporate methods that reflect lived experiences

and social outcomes, such as: Routine service user feedback sessions to capture direct experiences. Social Value or Social Return on Investment (SROI) to measure real-world / subjective benefits. Social Network Analysis (SNA) to understand how service users interact with support systems, identifying strengths and gaps.

o   **Prioritise Co-Creation:** Work with service users, not just for them. Ensure they have a say in what is measured, how success is defined, and how findings are used. Make co-production a standard approach and primary focus of a project, not an afterthought.

o   **Ensure Findings Lead to Action:** Service user feedback should inform and shape future service design rather than being collected for reporting purposes only. Regularly share insights and lessons learned with the Suicide Prevention Network to strengthen collective impact.

By embedding lived experience into evaluation and decision-making, organisations can ensure that their suicide prevention efforts are more effective, responsive, and aligned with the needs of those they seek to support.

- **Strengthen Upfront Project Planning.** To enhance the effectiveness of pilot projects and ensure robust routine evaluation, sufficient time must be allocated at the outset for the development of comprehensive pilot project Theories of Change and indicator identification. This work should outline the desired outcomes, pathways of change, and measurable indicators to track progress. By establishing a clear formative evaluation framework, projects can ensure a balanced focus on both breadth and depth of findings while providing a structured basis for accountability to the commissioner and clear expectations for performance reporting to the provider.

- **Invest in Relationship Building.** The ongoing adoption of a test-and-learn approach would encourage flexibility, experimentation, and adaptation, ensuring that pilot projects remain responsive to emerging challenges and opportunities. By embracing the potential for learning from what doesn't work, as well as from successes, commissioners and providers can foster a more dynamic, solutions-focused approach to addressing complex issues such as suicide prevention. Central to this is prioritising relational practice, which recognises the importance of trust, collaboration, and shared understanding between stakeholders. Interviews and project reflections highlighted the significant role of compatible personalities and aligned working styles in the success of Year 2 pilot projects. Investing in strong relationships between commissioners and delivery teams from a project's outset encourages open communication, transparency, and mutual support, which are critical for navigating challenges and driving meaningful change.

Additionally, extending the timescales for pilot projects is crucial to achieving their full potential. Short project durations in Year 1 limited the ability to build trust with hard-to-reach communities and gather comprehensive data. Longer timescales would enable deeper engagement, particularly with marginalised or hesitant groups, and provide more time to assess the sustainability and ripple effects of interventions. This would also allow pilot projects to demonstrate their impact more convincingly, supporting wider adoption and funding continuity.

By maintaining a test-and-learn ethos, fostering relational approaches, and allocating adequate time for pilot projects, future initiatives can better balance innovation with thorough evaluation. This approach will ensure that projects not only meet immediate objectives but also contribute to the long-term development of effective and sustainable suicide prevention strategies.

- **Develop a Structured Dissemination Framework.** Create a comprehensive dissemination plan for Pilot Project learning that includes:

  o   Clear, actionable recommendations tailored to different audiences.

  o   A variety of formats, such as infographics, executive summaries, and detailed reports.

  o   Dedicated dissemination activities, such as workshops, webinars, and follow-ups, to ensure learnings are applied across the system.

  o   Mechanisms to track and evaluate the adoption of disseminated learnings.

- **Enhance Targeting and Tailored Approaches for At-Risk Groups.** Design community-specific engagement plans that maximise the relevance and impact of interventions for their population. Account for barriers faced by different groups, such as stigma among men and boys or language and cultural challenges for Gypsy, Roma, Traveller communities. Explore the utilisation of the Wave 4 Real Time Surveillance system and stakeholder consultation to identify and strategically target at-risk groups within a limited budget.

- **Secure Ongoing Funding.** To ensure the continuity and sustainability of successful initiatives, secure long-term funding for core programmes, including the pilot projects and community grants; capacity-building initiatives for Voluntary and Community Sector organisations; and dissemination and follow-up mechanisms to embed learnings across the system (e.g., management and coordination resource). Sustained funding – even a small amount so long as it is ring-fenced for these purposes – ensures that impactful programmes and momentum are not lost due to resource constraints, allowing for long-term change and organisational resilience within the system.

- **Expand and Refine the Small Grants Scheme.** Small community grants should be particularly cost-effective as they empower Voluntary and Community Sector organisations that are already embedded within local communities. These organisations often have existing trust and relationships with at-risk groups, making them uniquely positioned to deliver tailored, culturally appropriate, and impactful interventions. By their very nature, small grants allow for bespoke and innovative interventions that address the specific needs of diverse communities; whilst a test-and-learn approach fosters creativity and reduces the risk of 'under-performance' by attaching success to learning, not traditional provider outcomes – something that can disinhibit local Voluntary and Community Sector organisations that may not be accustomed to navigating rigid performance metrics tied to large-scale funding. These grants also act as seed funding, enabling organisations to establish initiatives that could later attract additional investment or become self-sustaining, thus contributing to long-term sustainability within the suicide prevention ecosystem.

5. OVERALL CONCLUSION

The Nottingham and Nottinghamshire Wave 4 Suicide Prevention Programme effectively addressed its key priorities, demonstrating significant progress in enhancing skills, awareness, and support mechanisms for suicide prevention.

Priority One: Training

The programme successfully delivered high-quality training aimed at improving compassion, competency, knowledge, and skills among statutory and non-statutory service providers. Training was impactful, culturally tailored, and well-received, with measurable improvements in participants' confidence and ability to support at-risk individuals. However, gaps in engagement with certain sectors (e.g., justice services, faith leaders) and the need for stronger follow-up mechanisms to measure long-term behavioural changes were noted. Recommendations include targeted outreach to underrepresented groups, expansion of training formats (e.g., refresher courses), and embedding training into professional development frameworks.

Priority Two: Communications and Public Awareness

The communications campaign successfully developed a cohesive local identity for suicide prevention, leveraging professional branding and stakeholder collaboration. While materials were widely praised, public awareness of the brand and logo remains limited. This highlights the need for enhanced dissemination and strategic campaigns tailored to diverse audiences. Recommendations include a comprehensive communications strategy, targeted outreach to high-priority groups, and better integration of lived experience in campaign design.

Priority Four: Prevention Support for Higher Risk Groups

Small test-and-learn projects supported groups experiencing known risk factors for suicide. Innovative approaches addressed barriers such as stigma and cultural sensitivities, though resource and engagement challenges constrained reach. Future efforts should expand on these successes by aligning the small grants scheme with real-time surveillance data and scaling interventions that demonstrate measurable impacts.

Impact on Suicide Rates

While this evaluation did not directly measure changes in suicide rates, the programme's initiatives contributed to enhanced prevention infrastructure and workforce preparedness. Notably, the suicide prevention communications campaigns have demonstrated measurable impact through increased engagement with support services, such as crisis lines and online resources[9]. Data from monitored campaign activities, including website traffic spikes and

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[9] Source. Email from Nottinghamshire Senior Public Health and Commissioning Manager dated 30-Jan-2025 re. World Suicide Prevention Day 2022 and 2023 campaigns. The provided statistics substantiate the measurable impact of the

increased interactions with targeted digital content, indicate a positive shift in awareness and help-seeking behaviours. Future evaluations should build on these insights by incorporating robust analytical methods, such as regression analysis, to better attribute changes in suicide rates to specific activities and interventions. Additionally, intermediate indicators should be routinely used as key measures of programme effectiveness.

6. OVERALL RECOMMENDATIONS

- **Strengthen Voice and Routine Evaluation.** Centre the voices of people with lived experience in all stages of the programme activities, ensuring their input continues to inform planning, delivery, and evaluation. Co-production should be prioritised as a foundational approach, with feedback from the general population and service users treated as essential to shaping and improving initiatives. Establish a robust evaluation framework using a Theory of Change and clear impact indicators to measure success. Approaches like social network analysis can assess the broader impact of suicide prevention activities.

- **Sustain and Develop Training Initiatives.** Continuing suicide prevention training is vital to embedding the programme's principles and practices, with scope for adaptation and development depending on funding. Training content should emphasise follow-up mechanisms to assess changes in behaviour and real-world impact, sharing examples of success to motivate professionals and highlight lived experiences. These stories should also feed into other programme areas, such as communications materials, to ensure alignment and relevance. Expanding content to reflect feedback and new insights will ensure the training remains current and impactful.

- **Enhance the Communications Campaign.** The communications campaign should be further developed to target high-risk groups while also maintaining the existing universal approach. Materials must be provided to the Stakeholder Network with clear expectations for dissemination and guidance on promoting consistent messaging. Integration with other programme initiatives, such as training, pilot projects, and the Real Time Surveillance (RTS) system, can enable proactive and responsive messaging. A phased implementation plan should align with available budgets, ensuring sustained engagement and scalability. Feedback loops should be established to inform continuous improvement and maximise campaign reach.

- **Leverage the Small Grants Programme.** The small grants programme offers a valuable opportunity to strengthen community engagement and co-production, treating relational practice as both a process and an outcome. By maintaining a manageable scale, the programme can focus on fostering local insights while minimising administrative burdens through simple reporting tools like learning logs. Insights gained through the programme should directly inform other areas of suicide prevention, such as tailored communications and enhanced training content, ensuring alignment and mutual reinforcement across the programme.

- **Encourage Alignment Across Priorities.** Aligning all areas of the Suicide Prevention programme under a cohesive strategy is critical to maximising collective impact. Activities such as pilot projects, training initiatives, RTS data, and communications

campaigns should inform and reinforce one another, ensuring strategic coherence and amplifying outcomes. The Self-Harm and Suicide Prevention Strategy and Suicide Prevention Charter should act as central pillars, guiding efforts while enabling integration. This approach will ensure that the whole is greater than the sum of its parts, achieving meaningful and sustained change across Nottingham and Nottinghamshire's communities.

7. NEXT STEPS

These next steps are for the Nottingham and Nottinghamshire Suicide Prevention Strategic Steering Group to operationalise the findings and recommendations from this evaluation. As the group responsible for overseeing the Wave 4 programme and continuing to lead the new Suicide Prevention Strategy and action plans, the following actions are suggested to ensure effective uptake and application:

- **Action Planning Workshop(s).** Organise workshops to review the evaluation findings and recommendations in collaboration with key stakeholders. These sessions should focus on identifying SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) actions that align with the current funding environment and broader strategic priorities. Workshops can also provide a space to discuss the feasibility and practicalities of proposed actions, ensuring realistic planning and accountability.

- **Distilling and Socialising Key Messages.** Due to the length and detail of this report, concise summaries or targeted briefings should be prepared for dissemination to different stakeholder groups. Tailored materials, such as infographics, executive summaries, or slide decks, can make the findings accessible and relevant for professionals, service users, and community groups. This ensures that all stakeholders can engage meaningfully with the evaluation outcomes and apply them to their areas of work.

- **Feedback Loops with Participants.** Complete the feedback loop with those involved in the evaluation to demonstrate the value of their input. This could include sharing a "you said, we did" summary to highlight actions taken based on their contributions or explaining decisions where suggestions were not adopted. This process fosters trust, ensures participants feel their input was valued, and encourages continued engagement in future initiatives.

By taking these steps, commissioners can ensure that the recommendations are prioritised, disseminated effectively, and embedded into the wider Suicide Prevention Strategy, creating a foundation for sustainable improvements and meaningful impact.

The evaluator remains available to support this process through guidance on the design and facilitation of workshops and the preparation of communication materials.

8. APPENDIX ONE: STAKEHOLDER WORKSHOP OVERVIEW

The Nottingham and Nottinghamshire Suicide Prevention Evaluation Project – Action Planning Workshop, held on 26 June 2024 at County Hall, was designed to foster collaboration, engage stakeholders, and identify actionable insights for the evaluation and enhancement of the Wave 4 suicide prevention programme. The workshop used the World Café methodology, structured around small group rounds with facilitated discussions to ensure an open and productive exchange of ideas. Contributions and outputs from the workshop have been captured and analysed as part of this final evaluation report.

8.1. Workshop Structure

Introduction and Context Setting

Participants were welcomed, introduced to the workshop goals, and briefed on the programme's evaluation objectives and early findings.

World Café Session 1 - Identifying Insights

Participants engaged in group discussions across three thematic tables: Training, Communication and Public Awareness, and Support for Higher-Risk Groups. Key questions explored successes, challenges, evidence of outcomes, and unintended effects.

World Café Session 2 - Action Planning

Discussions focused on recommendations for enhancing training, improving communication strategies, and supporting high-risk groups. Groups prioritised recommendations and proposed actionable next steps.

Summary and Next Steps

Insights were shared, roles and responsibilities for follow-up actions were clarified, and participants reflected on their overall experience.

8.2. Workshop Participants

- Acting Director of Public Health – Nottinghamshire County Council
- Children, Families and Cultural Services – Nottinghamshire County Council
- Coordinator – Survivors of Bereavement by Suicide
- Detective Sergeant – Nottinghamshire Police

- Evaluation Consultant – Billson Consulting Ltd (facilitator)
- Representative – Lived Experience / Charter Group
- Public Health and Commissioning Manager, Domestic Abuse – Nottinghamshire County Council
- Public Health and Commissioning Manager, Mental Health and Suicide – Nottinghamshire County Council (Priority One table facilitator)
- Public Health and Commissioning Manager, Suicide Prevention – Nottinghamshire County Council (Priority Four table facilitator)
- Public Health Manager – Nottingham City Council (Priority Two table facilitator)
- Quality Health Inequalities Lead – Nottinghamshire Integrated Care Board (ICB)
- Senior CYP Commissioning Manager – Nottinghamshire County Council
- Senior Media Relations Officer – Nottinghamshire County Council
- Senior Mental Health Commissioning Manager – Nottinghamshire ICB
- Senior Public Health and Commissioning Manager – Nottinghamshire County Council
- Service User Care and Experience Lead – Harmless
- Student Health Development Officer – Nottingham Trent University
- Training Service Lead – Harmless
- Trust Lead for Self-Harm and Suicide – Nottinghamshire Healthcare NHS Trust

8.3. Reflections on the Workshop

The reflections shared by Wave 4 Suicide Prevention leads, who served as table leads for the evaluation, has provided the following insights into the dynamics and outcomes of the workshop.

The workshop provided a valuable platform for engagement, with participants highlighting its relational nature and effective group dynamics. Attendees noted the benefit of coming together in person, which fostered stronger connections and allowed for richer, more meaningful conversations. For some, such as the Integrated Care Board Communications Lead, it was the first in-person opportunity to engage with the group, underscoring the importance of relational practice in building trust and collaboration.

Despite initial challenges in securing engagement, the workshop achieved strong attendance with a diverse representation of roles and organisations. Participants were keen and actively contributed, creating an atmosphere of collective effort and genuine dialogue. Conversations were described as "proper," with participants showing clear interest and willingness to engage in practical discussions. This included individuals like the Nottinghamshire County Council Communications Team representative, who initially doubted their ability to contribute but found the session valuable, sharing insights from their West African community and exploring actionable ideas.

Notably, the workshop created a space for lived experience voices to be heard, with one Person with Lived Experience representative playing a key role. They offered substantial contributions,

particularly around opportunities to engage schools, and posed challenging and thought-provoking questions. Attendees recognised that while that individual was the most overt representative of lived experience, many others in the room brought their own, often unspoken, lived experiences to the discussion. This highlighted the pervasive nature of suicide and its impact across professional and personal spheres.

Discussions on future actions and improvements dominated the workshop, with participants eager to explore ways to enhance training reach and impact. There was limited reflection on past activities, which some of the Wave 4 leads attributed to assumptions about attendees' familiarity with the Wave 4 programme. This suggested a potential learning point: ensuring adequate pre-session dissemination of programme information to enrich reflective discussions. However, other Wave 4 leads noted that focusing on forward-looking conversations might have been more productive and appropriate given the session's aims.

The workshop reinforced the view that embedding initiatives like Wave 4 into business-as-usual processes takes time. Wave 4 leads collectively recognised that a three-year programme is a relatively short timeframe for creating sustained change, and achieving deeper systemic integration might require a decade or more. Starting co-production efforts early was identified as a critical enabler for long-term success.

Overall, the workshop demonstrated the value of inclusive, action-oriented discussions and highlighted the potential for practical, future-focused collaboration to drive meaningful change in suicide prevention.

9. APPENDIX TWO: FLIPS CHARTS FROM STAKEHOLDER WORKSHOP

9.1. Table 1: Training

9.1.1. World Café Session One: Insights and Learning

- Is there a link to trauma informed?
- Bereavement training accessed mainly
- Do we need more options for different training for different groups of participants?
- Low attendance of men and male dominated industry
- Evaluate who / what most suitable for
- What can go in the Practice Development Unit (PDU)?
- Street outreach workers?
- Time commitment
- Zero Suicide Alliance (ZSA) training useful first step, helpful to break taboos!
- Difference e.g., language to use
- Challenge: supporting someone in a virtual space, is this covered in training?
- Develop e-learning offer
- One [graduated] offer ZSA, Harmless, NHFT (Specialist)
- Impactful training, okay to ask for support
- Training needs analysis, who needs what
- Challenge: need different levels
- Confusion re. who can / cannot attend the training
- Reach young people, whole family approach?
- Increased confidence and understanding
- How do we train people who will be in contact with men? (Not services)
- We must work it into contracts / commissioning. Induction for new starters? Link with safeguarding? Impact re. stigma?

9.1.2. World Café Session Two: Action Planning

- Making ZSA mandatory. Have questions at end to get certificate. Appropriate objective. Make it 'count' as CPD.
- Ask people who have completed the training to make a commitment / pledge for what they personally are going to do as a result (alongside organisation pledge). Could also be used for communications
- Funding?
- Go where men go / what they do > targeted

- Would be useful to hear from someone who has helped someone following training > endorsement
- It's in our Public Health contracts as a CV – maybe we can provide feedback to evaluation via this?
- More pro-active promotion
- Give examples of who and what they can do with it [the training]?
- ZSA – make everybody's business
- Future – pastoral care in schools, student support etc.
- Short videos for social media on "I'm a …, I've done the training, it was important to me because … I've used it [this way]"
- Consider male only training
- Bereavement training earlier – before bereaved?
- Harmless 1 hour training to Councillors and Health and Wellbeing Board
- Rationale – potential reticence to discuss in mixed forum
- City project for construction workers?
- One offer on a page: ZSA, Harmless, NHFT
- Engage more men
- MECC – potential levels, MECC practitioners
- How do we encourage people to do all three [levels of training]?
- Cultural consideration, someone from the community delivering the training
- Consider training for how to engage with males
- Look at the training audience in line with suicides locally
- Tailored training for male staff, co-production "like me" in Sam's name, links to male communities and sports clubs, male training champions
- Evidence review re. engaging men in training, East Midlands Suicide Prevention Forum
- Do the training!! Send to GPs, Protected Learning Time (PLT), GP Champions, email out
- Primary Care Pack
- Have other areas "cracked" this – broader uptake in males?
- Construction workers report
- MP briefing around suicide prevention training
- Role of electoral members and training (MPs hold surgeries)
- Strengthen connections with schools and commissioned children and young people services e.g., MHSTs. Tailor the offer, families with their own mental health challenges, how to engage with them?
- Relatable training

9.2. Table 2: Communications

9.2.1. World Café Session One: Insights and Learning

- Leaflets good but don't have them anymore
- Not seen in the City
- I am aware of the branding as I work in Public Health. Seen in email signatures
- Improved measures of evaluation of comms programmes needed
- Consistent messaging and branding
- Should link with other campaigns like the Norwich video – helps to emphasise the message
- Breaks down the stigma of the word suicide
- Not seen in schools, GP, libraries etc.
- Seen on Teams backgrounds and roller banners
- Does the message connect with the target audience?
- Even within the linked public sector organisations it's not displayed a lot
- The message encourages conversation
- We don't need to be protective about the message
- There is nervousness about putting the word suicide out there
- It's clear and looks professional
- Seems visible to professionals in the area
- The lanyards are very visible
- Stories of Hope – makes a differences and hits home – can impact anyone
- Sent screen savers re. suicide to GPs due to reluctance for paper. But gaps if they don't have screens or people aren't attending their GP practice
- People can seem okay so the materials are good to increase conversations and people will feel less alone
- Visible at place-based / NHS level
- Visible in rural communities
- Getting the word 'suicide' out there is important, takes away the taboo, don't skirt around it
- There can be reluctancy / barriers to talking about it
- The QR codes link to good information
- Recognisable outside the sector – yellow and black with speech bubble
- Brand developed is consistent – build on it to tie the identity together
- Taking the materials to International Men's Day
- Haven't seen in the wild as a member of the public it's not visible

9.2.2. World Café Session Two: Action Planning

- Include in Integrated Care System WhatsApp channel
- When complete Harmless training should get pack with communications materials and information
- Take one pass it on – in community
- Wear yellow
- Hockey games
- Famous people support
- Learning from sexual health as similar in terms of stigma
- Badge – it's okay to talk about – for completing training
- Family courts – both sides and children support
- Solicitors
- TikTok – can hit male audience
- Make suicide prevention messaging more visible in local authority buildings
- Bus shelters
- Incorporated into training
- Balance cost of 'advert' versus cost of 'treatment'
- Everybody's business so needs to be in all areas
- Bus adverts better value
- Thinking about timing on when approaching organisations – what are their priorities?
- On stands have image on laptop – people can take pictures of QR code. Make better use of technology
- Nottinghamshire TV, podcasts, radio stations
- Put on screens
- Mental Health Partnership Board can endorse / commit at an organisation level to support messages and communications
- Fridge magnets at university
- Share suicide message on Suicide Prevention Day, put on Facebook
- Blogs / social media – pinned on Harmless website
- Integrate communications with NottAlone website
- Subtle QR code on tables / barber mirrors etc.
- Share at taxi ranks, train stations, food banks etc.
- Promote through DWP and housing
- Where are your audience? Online, gaming, toilets, scrolling on phone
- More use of media channels at local groups, newsletters, elected member, residents, department specific briefings
- How to keep the momentum going that it is okay to talk about mental health
- Using social media more
- Video reels get more attention
- On beer mats
- Reaching other industry – do they have health champions that we could connect with

- Sports clubs – mental health / suicide prevention champions in council
- On toilet doors with QR codes
- Pens, badges, assets etc.
- Link into Making Every Contact Count (MECC)
- Include information in new rental agreements through housing association
- 'Donuts for Suicide Prevention'
- On bin trucks etc. council vehicles
- Use general public to spread the word organically
- Coffee shops
- Be brave
- After training (ZSA) make pledge build in communications
- Everywhere a person is
- Communications and marketing strategy – best reach for money
- Different communities starting at different point – depending on how suicide is viewed / discussed
- Public spaces like parks, outdoor gyms etc.
- Linked to RTS findings
- Waiting well contact checking in – can we upskill to have conversations re. suicide
- Citizens Advice Bureau
- Job Centre training and well-being incorporated
- Cricket
- Gaming – safety conversations
- Stickers
- Tennant Newsletter – get information in it for free
- Social prescribers
- Having broader communications campaign but tailored towards more intense support where appropriate
- Engaging with trusted person, leaders for some groups and adapting approach – GRT, Asian community etc.

9.3. Table 3: Prevention Support for Higher Risk Groups

9.3.1. World Café Session One: Insights and Learning

- Might not get the people can transfer in a service organisation
- We're not as joined up as we sometimes think we are
- Will people take the learning to change their services?
- How do we measure any difference?
- Definitely changed things at Harmless

- Balance between support and enforcement
- Stigma and continued talking about it
- How do we train the right people in the right service?
- Raised awareness
- Wider ICS support (bereavement specification)
- How do we help people know where to get information?
- Translation of words – may lose meaning
- Language
- Amount of time it takes to engage
- Being creative in approach to communities e.g., strip clubs!
- CPD session on building trust, not just around mental health
- Drop ins as part of services
- Lots of learning on how to approach groups – how do we share this?
- Pilot funding stops!!
- Taboo and culture

9.3.2. World Café Session Two: Action Planning

- Peer support from people with lived experience
- "Aspirations" rather than "recommendations"
- Sharing learning in very succinct way
- Getting much further / earlier in prevention
- Restorative supervision
- Common core theme for all areas
- Focus on males and self-harm for young people
- "What if" for professionals based on the learning
- Use Nott Alone website to house resources
- How do we maintain and build on the engagement with groups? How do we support them?
- Infographics (with document as separate attachment)
- Challenge of increased signposting leading to increased waiting lists.
- What have previous Waves done to sustain activity?
- Difficult to work with lots of different groups at the same time
- Pledges but who follows this up?
- University buy in. To be part of the Health Promotion Officers role. Could have an action plan!!
- Action Learning Set approach to the findings (combine with listening project)
- Recommendation and action to signpost to organisations plus timeframe

9.4. Appendix Three: Communication Materials

9.4.1. Suicide Prevention Logo

9.4.2. Suicide Prevention Poster

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