Report on the evaluation of the We-Yarn project

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Abstract

This report summarises the evaluation of six We-Yarn workshops conducted between 1 December 2016 and 30 June 2017 in rural New South Wales. Workshops were designed and facilitated by the Good SPACE project team, part of the Centre for Rural and Remote Mental Health at the University of Australia. A mixed methods evaluation of the workshops drew on baseline surveys (n=91), endline surveys (n=81), in-depth interviews (n=9) and observations of three workshops to examine the relevance and impact of the workshops. The evaluation found that the content of the workshop was considered culturally appropriate and valuable to participants in understanding how to identify and respond to someone who may be at risk of suicide. Participants engaged well with the facilitators, particularly drawing on their lived experiences and stories. Health and allied health professionals tended to bring existing knowledge and skills in suicide prevention and required more clinical strategies and skills. The workshop was valued by participants for starting an important conversation in their communities and providing them with an improved understanding of links between cultural strengths, social and emotional wellbeing and suicide prevention. There were missed opportunities for follow-up actions in communities after the workshop, and it did not, nor did it intend to, overcome challenges associated with lack of access to appropriate and effective support services.

Keywords

Aboriginal health, social and emotional wellbeing, suicide prevention, evaluation

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Introduction

Suicide in the context of Aboriginal people and their history

Aboriginal people's presence in Australia dates back 45,000 to 50,000 years, and with this strong traditional culture come strengths and resources in holistic approaches to social and emotional wellbeing that draw together "life, community, spirituality, culture and country" (Dudgeon, Wright, Paradies, Garvey, & Walker, 2014, p. 26). The Gayaa Dhuwi (Proud Spirit) Declaration states that:

> Aboriginal and Torres Strait Islander peoples connect their mental health to strong Indigenous identities, to participation in their cultures, families and communities, and to their relationship to their lands and seas, ancestors, and the spiritual dimension of existence. This holistic concept of health that includes mental health is referred to as social and emotional wellbeing. (National Aboriginal and Torres Strait Islander Leadership in Mental Health, 2015, p. 2)

Despite this multi-dimensional framework and traditional strengths, within a context of systemic and historical colonisation, denial of human rights and transgenerational grief, Aboriginal people in Australia tend to experience poorer health outcomes than non-Indigenous Australians, including poorer mental health outcomes (Dudgeon et al., 2014). Suicide is a substantial concern for all populations within Australia. However, the overall rate of suicide for Aboriginal and Torres Strait Islander peoples has been reported to be twice that of non-Indigenous people (Australian Bureau of Statistics, 2012).

Gatekeeper training

'Gatekeeper' training – training which trains key members of a community with suicide prevention skills so that they can support other people within their community – has been posited as one strategy that may contribute to suicide prevention (Coppens et al., 2014; Matthieu, Cross, Batres, Flora, & Knox, 2008; Quinnett, 2012). There is limited evidence to demonstrate the relevance and effectiveness of gatekeeper training programs for addressing suicide within Australia's Indigenous populations, and there are limited robust evaluations of social and emotional wellbeing interventions to support Indigenous Australians (Day & Francisco, 2013). Clifford, et al. (2013) systematically reviewed suicide prevention interventions targeting indigenous peoples in Australia, United States, Canada and New Zealand and found that there was a need for more rigorous evaluations of preventative interventions, noting that coherent, community-level approaches show promise. Nasir, et al. (2016) found, in a systematic review of gatekeeper training for indigenous communities, that in general programs led to beneficial changes in knowledge and attitude, but had little demonstrable impact on behaviour. They also found that there is a need for more rigorous,

controlled study of these programs to identify impact, but that it is clear that these types of gatekeeper programs need "to be tailored to the target population" (Nasir et al., 2016, p. 6).

An evaluation of a gatekeeper training targeting the Aboriginal and Torres Strait Islander population of one New South Wales region demonstrated that, with a consultative approach, a program was implemented that contributed to an increase in participants' knowledge and confidence in identifying and supporting people who were thinking about suicide (Capp, Deane, & Lambert, 2001). Two years on, participants in this program continued to report high confidence to identify someone at risk of suicide and intention to help, and 15 out of the 40 participants had helped someone at risk of suicide since the training (Deane et al., 2006). Furthermore, it has been shown that mental health interventions seeking to support Aboriginal Australians must incorporate a culturally appropriate mental health framework (Vicary & Westerman, 2004).

The We-Yarn workshop

The We-Yarn workshop was developed as a tool for providing culturally safe and appropriate suicide prevention skills training for Aboriginal people and for people who work with Aboriginal people and communities. The program was developed with acknowledgement of the strengths and resources within Aboriginal people and communities that nurture social and emotional wellbeing and a holistic conceptualisation of health. As a new program in an area where there is little evidence, this evaluation was important to understand the impact and relevance of We-Yarn workshops and to examine whether participants felt more able to address and respond to suicide in their communities.

We-Yarn workshops were developed and delivered by staff of the Good SPACE program, part of the Centre for Rural and Remote Mental Health at the University of Newcastle. The Good SPACE program (previously known as Farm-Link) provides training to improve the level of skills and resources available to support people experiencing mental distress in rural communities, mainly through Suicide Prevention Skills Workshops (SPSWs). In 2015, in response to high numbers of suicides amongst Aboriginal communities within the Good SPACE program's target region, Good SPACE staff were approached to deliver an intervention to support Aboriginal communities in recognising, responding to, and preventing suicides. In consultation with local Aboriginal Community Controlled Health Services, elders and community representatives, the SPSW was adapted into a culturally relevant suicide prevention program and was piloted with three communities prior to April 2016. This program was then named We-Yarn and rolled out in rural New South Wales.

The evaluation of We-Yarn workshops sought to build on the limited evidence base supporting gatekeeper training approaches to suicide prevention, to better understand how this type of training may, or may not, support and empower people in rural New South Wales to support Aboriginal people who may be at risk of suicide. It considered whether participation in We-Yarn workshops contributed to changes in participants' knowledge and attitudes regarding suicide and suicide prevention, how participants used the skills and knowledge in their daily lives, the relevance of the We-Yarn workshops to communities and whether participants practice effective self-care strategies.

Aboriginal Community Controlled Health Organisations were invited to partner in the research to evaluate the impact and effectiveness of We-Yarn workshops. Armajun Aboriginal Health Service, Walhallow Aboriginal Health Corporation, Orange Aboriginal Medical Service and Tamworth Aboriginal Medical Service partnered in this evaluation and evaluated workshops were conducted at Tamworth, Tingha, Tenterfield, Walhallow and two workshops at Orange.

Methods

The six workshops included in this evaluation were conducted between 1st December 2016 and 30 June 2017. Each We-Yarn workshop was delivered over six hours on the one day, and all workshops were presented by the same two facilitators. One facilitator is an Aboriginal person with lived experience of suicide and with personal experiences in building social and emotional wellbeing, and the other is an experienced Good SPACE facilitator of suicide prevention training activities who also has lived experience of suicide. Topics discussed during the workshop included an open discussion about suicide, social and emotional wellbeing drawing on seven domains of connection (Gee, Dudgeon, Schultz, Hart, & Kelly, 2014), a discussion on holistic health, theory on why people die by suicide (Joiner, Van Orden, Witte, & Rudd, 2009) and the use of the Good SPACE Suspect, Connect, Act, Refer, Follow-up (SCARF) action plan to assist some at risk of suicide.

This mixed methods evaluation examined whether, and how, participation in a We-Yarn workshop impacted upon a person's knowledge, attitudes and practices regarding support to people experiencing mental distress and its effectiveness in contributing to culturally and locally relevant mental health strategies. Seven Aboriginal Community Controlled Health Organisations across rural New South Wales were invited to partner in the project – to support the coordination of local workshops and to provide consent to the research being conducted in target communities. Four Aboriginal Community Controlled Health Organisations consented to partner in this research, and six We-Yarn workshops were evaluated across the sites covered by these organisations.

Data collection

All participants in the six workshops were invited to complete a brief, hard-copy survey immediately before and immediately after the training, in which they self-rated their capacity and confidence to identify and respond to a person at risk of suicide, on a scale where 1 = strong disagree and 5 = strongly agree. The survey also included open-ended responses about expectations for the workshop, recommendations for improvement and the highlight of the workshop. The survey did not collect any demographic data about participants, as it was considered that people would be more likely to complete a survey that collected as little personal or sensitive data as possible.

Three workshops (at two different sites) were observed by two members of the research team, who were introduced to, and sat in the room with, participants for the duration of the workshop. Observers individually took de-identified notes regarding the workshop environment, participants' engagement and responses to the facilitators and content. Participants in the workshops, who were willing for their anonymised contributions to be observed and noted, provided written consent. For those people who did not consent to the observation no notes were recorded regarding their participation, and an option was available to the group to ask observers to leave the room at any point (although this was not taken up).

Participants in all six evaluated workshops were invited to complete a consent form to participate in an interview or focus group (depending on their preference) approximately three months after completing the workshop. Interviews were conducted by telephone or face-to-face depending on the preference and availability of the participant and each interview lasted approximately 20 to 40 minutes. Interviews were audio-recorded with the participant's consented, transcribed and de-identified. Where the participant did not consent to audio-recording, the interviewer took handwritten notes, which were then de-identified. Interviews explored the participants' experiences of the workshop, implementation of learning and attitudes regarding social emotional and wellbeing and suicide. Interview participants were provided with a $40 gift voucher in recognition of their time and expertise in contributing to the interviews.

Data analysis

All quantitative analyses were undertaken using IMB SPSS (version 24; Armonk, NY, USA). Independent samples t-tests were used to compare mean scores at baseline and endline. Open-ended survey questions were coded and grouped thematically using Microsoft Excel (Office 2016). Qualitative data were coded thematically using QSR International's NVivo 10 Software. Initial thematic codes reflected the research questions, and a second coding explored additional emerging themes.

Ethical approval

This evaluation was approved by the Aboriginal Health and Medical Research Council of New South Wales (Approval number 1197/16) and the University of Newcastle's Human Research Ethics Committee (Approval number H-2016-0309). Participation in the evaluation was voluntary and people's decision regarding participation in the evaluation did not affect their participation in the We-Yarn program in any

way. All respondents received a Participant Information Statement about each part of the evaluation (interview, observation and survey) and observations and interviews were only conducted where the individual first provided written consent. Pseudonyms have been used and identifying features, including names of towns and communities, have been changed or deleted to protect the anonymity of respondents.

Findings

Participants

Baseline surveys were completed by 91 participants in We-Yarn workshops and 81 participants completed endline surveys. 48 participants and two facilitators consented to participate in the observations across three different We-Yarn workshops. Nine participants took part in interviews; seven in individual telephone interviews, and two in a face-to-face interview together, comprising Aboriginal and non-Aboriginal community members and staff, and at least one person was interviewed from each of the workshops.

Table 1 Description of interview participants

Name of interview participant (pseudonym)	**Description**
Larissa	Aboriginal community member and staff at health or community service organisation
Nicholas	Aboriginal community member and staff at Aboriginal Medical Service
Sharnie	Aboriginal community member
Mark	Aboriginal community member
Jarred	Non-Aboriginal health staff at Aboriginal Medical Service
Harry	Non-Aboriginal health staff at Aboriginal Medical Service
Karla	Non-Aboriginal staff at health or community service organisation
Meredith	Non-Aboriginal staff at health or community service organisation
Yasmin	Non-Aboriginal staff at health or community service organisation

Workshops were conducted with interested Aboriginal community members, and Aboriginal and non-Aboriginal staff of Aboriginal Medical Services and other health and community services.

Table 2 Description of workshop participants at each site

Workshop	**Participants**

1.	Aboriginal and non-Aboriginal staff from one Aboriginal Medical Service (health and allied health staff)
2.	Aboriginal community members, Aboriginal and non-Aboriginal staff from various health and community service organisations
3.	Aboriginal and non-Aboriginal staff from one Aboriginal Medical Service (health, allied health and administration staff)
4, 5, 6	Aboriginal community members, Aboriginal and non-Aboriginal staff from the local Aboriginal Medical Service and various health and community service organisations

Expectations and relevance of the workshop

There were 72 responses to the question 'What do you hope to gain from taking part in this workshop today?' Survey respondents at the baseline, generally wanted to learn skills and strategies that would help them to help others. Most of the expected outcomes identified by participants were key parts of the course, but some, such as learning clinical skills, were not a part of this workshop.

Table 3 Expectations of the workshop

Expectations of the workshop	**Number of respondents**	**Was this a focus of the training?**
Learn strategies for talking about, preventing or responding to suicide and how to help people	41	Yes
Be able to identify the signs that a person needs help, six people wanted to learn about services and resources that could help	7	Yes
Learn about culturally appropriate or safe approaches to suicide prevention	6	Yes
Improve therapeutic and clinical skills	4	No
Learn specifically about how to help adolescents and young people	3	No
Concerned about their own or a family member's mental health	2	Partially

At the endline all respondents agreed or strongly agreed that the training was helpful and relevant for them. There were 64 responses to the question 'What are the most important things that you learned today that you will go away and use?' summarised below (some respondents provided more than one answer).

Table 4 Important things learned at the workshop

Important things learned	Number of respondents
Identifying signs and responding	18
How to talk to and help someone	12
Importance of asking direct questions and how to ask questions	11
Cultural aspects (including social and emotional wellbeing model)	8
Everything, all the information	8
Interpersonal theory of suicide	3
Refreshment/validation of existing knowledge and skills	3
Suspect, Connect, Act, Refer, Follow-up	2
Referral pathways/where to get help	2
Lived experience of presenters	1

Interview participants discussed the importance of building skills to help others. Mark attended the workshop because he had experiences of losing family and close community members to suicide, and wanted to be able to tell if someone is thinking about suicide. He was disappointed that he didn't feel clearer about the signs that someone may be thinking about suicide after the workshop, and felt that some of the warning signs and risk factors hadn't been apparent in the people he'd known who had died by suicide. Nicholas felt that the workshop would help in his professional capacity as an Aboriginal Health Worker, in supporting people dealing with mental health problems and he also found that the workshop was beneficial in a personal capacity "because I had a brother that was going through a little bit of sort of depression, mental illness and just him being my brother, I knew that there was something". Larissa and Sharnie saw the workshop as an opportunity to learn more about issues such as depression and suicide and how to help someone who is having a hard time.

> I guess my expectation was to have a bit more of an understanding of people who are struggling with depression and what the effect of suicide is and the different process, how you get to that point. (Larissa)

While Larissa felt that the workshop had been useful, she was disappointed that there was no follow-up activity after the workshop and that the discussions generated on the day had not led to any action in the community.

> There was always a lot of talk. One of the health workers put together a goal for each age group. So there was the younger generation, the middle age and then elders and how we'd all get them

> to connect with each other and start building that rapport again but there hasn't been any follow-on from that.

Three interview participants who identified as being non-Indigenous health professionals said that they attended the workshop because they wanted to gain a deeper understanding of the issues of suicide as they specifically relate to Aboriginal people, and to build skills in culturally appropriate practice, and they felt that these expectations had been met.

> I'm very conscious of trying to be culturally appropriate, given I am a non-Indigenous Australian. ….I think one of the main things I got from the workshop was being comfortable, knowing I didn't really have to change too much in how I was asking those questions around suicide in Indigenous populations. But, then also, I think, secondly to that, having a much greater understanding of how potentially damaging social upheaval and/or disconnection from country, can be for Indigenous Australians during a time of being down. (Harry)

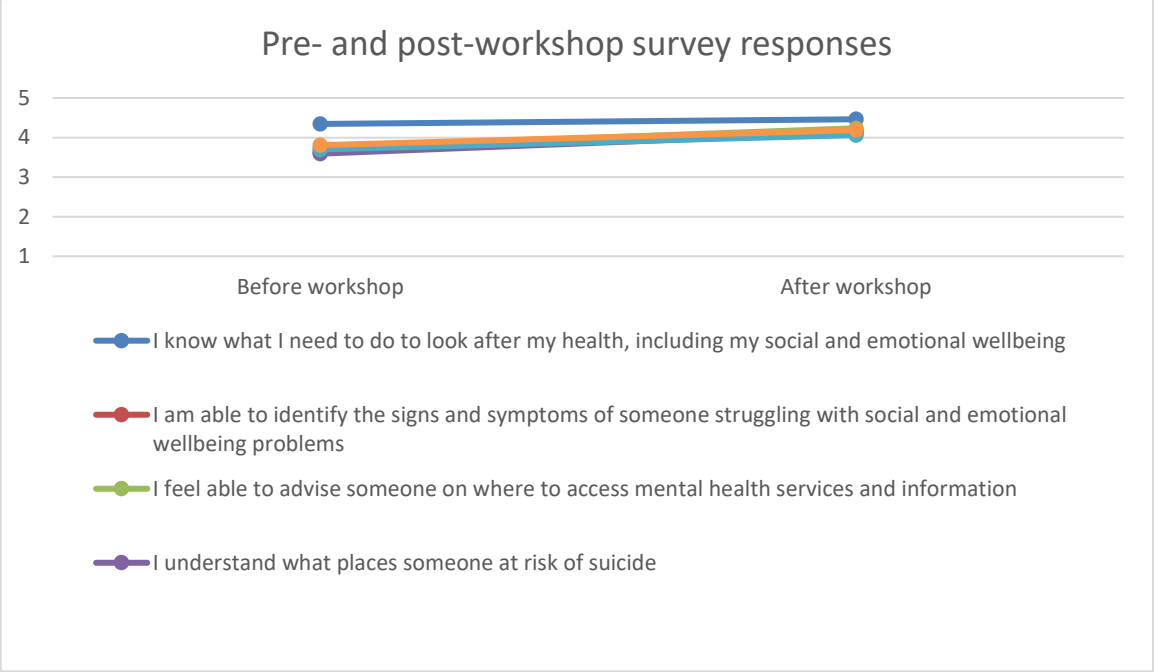
Jarred, a non-Indigenous health professional was hoping to gain more skills in therapeutic interventions and felt that the workshop had not provided the "counselling kind of tools" that he was hoping to learn about, although he still found the workshop useful.

Participants generally found the workshop relevant, and that it started a conversation about an important issue in an accessible and culturally appropriate way. For Nicholas, the discussions with family members continued after the workshop – "we sort of had a conversation about it after the workshop when we went home and we were saying 'That's a good idea to use in that situation'". Jarred found that "it was very relevant to my learning and my education, especially around the cultural side of mental health and the cultural side of suicidality, and talking about the social determinants and historical determinants". Health and allied health professionals Karla and Harry considered that the workshop was important and useful, but found that much of the content regarding suicide risk and response was already known to them through their previous education and training. They recognised that there were different levels of knowledge and experience amongst the workshop participants, and that the content was new for some people, but in their cases it was more of a refresher.

Changes to knowledge, attitude and practice

Changes to participants' knowledge and self-identified abilities in supporting social and emotional wellbeing in the short-term were measured via the pre- and post-workshop survey. Participants tended to start with a fairly high level of self-identified knowledge and ability, which increased after the workshop.

Figure 1 Changes to self-reported knowledge and ability before and after the workshop



Respondents reported a significant increase in feeling able to identify the signs and symptoms of someone experiencing social and emotional wellbeing problems between baseline (M=3.6278, SD=.91664) and endline (M=4.1728, SD=.90540), p=.000. Significant increases were also reported for feeling able to advise someone on where to access mental health services and information between baseline (M=3.7473, SD=1.09131) and endline (M=4.2346, SD=.96529), p=.002, and in understanding what places someone at risk of suicide from baseline (M=3.5934, SD=1.03256) and endline (M=4.1250, SD=1.02346), p=.001. Respondents also reported a significant improvement in feeling able to assist someone at risk of suicide to get the help they need between baseline (M=3.8077, SD=1.01042) and endline (M=4.1875, SD=.95591), p=.013.

There was no significant change in respondents' self-reported knowledge about what to do to look after their health, between baseline (M=4.3444, SD=.96175) and endline (M=4.4625, SD=.87067), p=.405. There was no significant difference reported regarding respondents' feelings able to ask someone directly about suicidal thoughts between baseline (M=3.7, SD=1.24927) and endline (M=4.0625, SD=1.19168), p=0.55.

Three interview participants identified that the most important aspect of their learning from the workshop was understanding the relationship between suicide and social and cultural connections, with participants specifically responding to the seven domains of connection discussed in the training (Gee et al., 2014).

> I really liked that wheel, that circle …. connection to land, and spirituality, and mental health, talking all about connection and, you know, the cultural, social and political aspects of that … I find that's a really good tool to have and to look at often. (Jarred)

Two participants found the discussion on the interpersonal theory of suicide (Joiner et al., 2009) particularly useful and two people strongly connected with the personal stories of the facilitator and the sharing that came from others in the group, with Sharnie recalling that "a lot of people opened up to do the talking, how they felt". One person highlighted the importance of having a plan to follow with language to use, one recollected the importance of understanding that someone who had attempted suicide previously may be at ongoing risk of suicide, and another person noted the importance of understanding the challenging and complex nature of depression. Karla noted that the training had reinforced the importance of asking a person a direct question about suicide, stating that:

> I think one of the things I got out of that was probably something I already knew, that to just straight out ask them, don't, like, dilly dally around the subject, just ask them straight up if they have any thoughts.

Two interview participants felt that the training had changed or shifted their attitude towards people who think about or die by suicide, with Sharnie and Larissa identifying that it helped them realise the connections to issues such as grief, environment and the importance of role modelling. The other interview participants found that the workshop reinforced or built on their existing attitudes, as their previous personal and experiences had already given them some insights into the complexities of why people think about or die by suicide. Yasmin said, "I don't know if it so much influences my opinion because I've probably been dealing with it probably for too long but I like the package as a whole."

Harry reported that the training reinforced and validated existing work practices. Meredith said that the training influenced her to check in more about clients' safety in her work and Jarred noted that:

> …it put an emphasis on the importance of connection and, like, to keeping people – trying to maintain – supporting people with getting connections, whatever that might be, to family, to the community, to their health. So that was one thing that I really took from it, and that I have really tried to implement in my practice, establishing connections and knowing who people feel connected to when they're feeling unwell or at risk…

Seven of the interview participants had used the skills and knowledge from the workshop in supporting someone at risk of suicide or experiencing mental distress. Larissa said:

> I did and actually it came in handy …one of my staff members had lost her niece to suicide that week, but it was actually that week that you ran that workshop and it came in handy to be able to pass on some information that you gave me.

Harry had used the skills and knowledge during his professional practice, noting:

> I did use the approach …I should point out that this was a non-Indigenous person, but I did have the conversation with them about how, you know, the fact that they were feeling this way was not relating to them as a person, but it was relating to the illness, and really trying to set, to differentiate that for them.

Referral and support options

The workshop aimed to build participants' capacities to refer a person to support for their social and emotional wellbeing. Interview participants were asked about their knowledge and use of service and referral pathways for a person experiencing problems with their social and emotional wellbeing. Five participants who worked in health or community services were able to describe a process for referring people if they were concerned about their social and emotional wellbeing or risk of suicide, including physical services and telephone lines, also describing their organisations' internal referral support mechanisms, which was information that they had prior to the workshop:

> So if someone is wanting to seek psychological support through a psychologist, we can make that connection right here at our service. But we also have a list of other providers. (Jarred)

However, the capacity to actually implement the referral pathways was hampered by the limited services available in their rural communities, particularly specialist services.

> There is no public psychiatrist in [name of town]. So, to see a psychiatrist you either wait six to twelve months to see the private psychiatrist, if they haven't closed their books. You get admitted to … the local mental health hospital, or there's a visiting psychiatrist to community mental health one or two days a month.

Three participants identified that there were no services available to help, or that those available were limited and not well trusted by the community and one person was not able to identify any services or resources to which he would refer someone for help. Larissa said that, "I can refer to services, it's just finding the services that they trust. They're not always available either." Sharnie identified a lack of services and activities for supporting young people in particular, noting, "We need people that are going to sit and listen to either a dad, teenagers, adults or kids. Let them have their say."

Self-care

The workshop aimed to build skills in participants regarding self-care and to highlight the importance of 'gatekeepers' looking after their own social and emotional wellbeing. Interview participants recognised that their roles in providing support and care for people struggling with their social and emotional wellbeing could have an impact on their own levels of distress and wellbeing. They were able to reflect on a range of strategies for self-care, but did not attribute these strategies to things they had learned in the workshop – rather they were existing life skills. Those participants who were trained as health and allied health workers reported that they had learned self-care skills in their formal training and through their experience, and those people working in health and welfare agencies had formal processes in their organisations for supervision and debriefing.

> …even before I started in this role, I don't think I was ever uncomfortable with just asking people about that sort of thing. It could come with the degree that we have done, I don't know. (Karla)

Interview participants also explained that they drew on support from family and friends to maintain their own social and emotional wellbeing. Nicholas emphasised that he needed to draw clear boundaries around his work, such as not taking calls about work at night and that he tends to "just go home and just clear my head for a little bit and then I'll go and have a play around with the son or have a yarn with the daughters".

Having personal interests and hobbies outside their formal or informal caring roles were also considered important, with strategies for self-care including participation in sport, music and walking the dog.

Engagement and feedback on the workshop

Respondents to the endline survey were generally positive about the workshop, using language such as "informative" and "helpful" in open-ended comments. Recommendations for improving the workshop included being more interactive or using powerpoint slides less (n=3), having more information about culture and strengths of Aboriginal people (n=3), with individual respondents making suggestions such as a workshop for youth, having a separate workshop for health professionals, and having more information about depression.

Observation of the workshops indicated that participants were particularly engaged when the facilitators discussed their personal experiences and stories about social and emotional wellbeing and suicide. Engagement varied between the observed groups. In one group where there was a mix of community members and representatives of various agencies, and one group with all employees of an Aboriginal Medical Service, participants were reluctant to contribute at the start of the workshop, relying on one or two people to do most of the talking. Participation and engagement increased throughout the

workshop. At another workshop comprising employees of a different Aboriginal Medial Service, participants were engaged and contributed from the start of the workshop.

Meredith, an allied health professional who had participated in a number of different suicide prevention trainings during her career, identified this as the best suicide prevention training she had ever attended because:

> …it was so interactional. I've done loads of suicide training, different things, but to me that was more, because that was people talking about their own experiences… within their communities…

Interview participants had few recommendations for improvement, but Larissa did note that it would helpful to have more work in the community before the training, and more opportunities for follow-up to ensure that goals discussed during the workshop were actioned, stating that: "There was no follow-through with the in-house services". She also felt that more young people needed to attend the training and that it needed to be advertised more widely.

Discussion

Relevance and appropriateness

The content of the workshop, particularly the discussion on the multiple domains of social and emotional wellbeing, was perceived by participants to be culturally appropriate and to connect with a holistic model of health, reflecting the importance of an appropriate cultural framework (Vicary & Westerman, 2004). Aboriginal and non-Aboriginal participants found value in exploring the connections between a culturally-connected model of social and emotional wellbeing, issues related to suicide and skills in suicide prevention. In fact, the evaluation demonstrated that this holistic approach to exploring suicide prevention within a social and emotional wellbeing framework had applications for participants across all the groups and people they worked with.

The ability of the facilitators to connect with participants and share their own experiences was key to engaging participants in a safe, relevant and meaningful way. The facilitators – their stories and their capacity to communicate, empathise and inform participants – was much more important to learning than the training tools used, including the powerpoint slides and workbook.

The relevance and impact of the workshop varied based on each participant's profession and background. For participants who were trained and employed in health and allied health roles, the workshop provided an opportunity to refresh skills and knowledge or to validate existing practices. Some health and allied health workers found that the training did not quite meet their expectations in building

clinical or therapeutic intervention skills. However, for community members who had little experience with formal training in the area of social and emotional wellbeing or suicide prevention, the workshop content was appropriately targeted and offered new insights and strategies.

Impact and follow-up

The findings demonstrate that participants generally felt more knowledgeable and skilled immediately following the training, reinforcing the limited evidence base that demonstrated short-term gains in knowledge and attitude (Capp, Deane, & Lambert, 2001; Nasir, et al., 2016). For those people, particularly health and allied health professionals, who had contact with a person at risk of suicide after the training, they were able to integrate new knowledge from the training, such as the interpersonal theory of suicide and the seven domains of social and emotional wellbeing into their practice.

For community members, while the learnings from the training were valuable in instigating important discussions about suicide, there was little evidence that it had led to changes in practice or actions within communities. There had not been any follow-up activity after the workshops, despite participants' perceiving that the workshops had started an important conversation about a critical issue for their communities.

While the workshops included some information about services and resources for referring someone who may be experiencing problems with social and emotional wellbeing, participants, especially those working in health or community services, already brought knowledge about these referral pathways to the workshop. There was a feeling that potential to implement the support and referral processes advocated in the We-Yarn workshop was limited due to the insufficiency of services and resources on the ground in communities. Structural issues regarding the accessibility and appropriateness of support services limited gatekeepers' capacity to help.

Influencing attitudes and practice

There were some improvements to participants' self-perceived knowledge and capacity to support someone struggling with social and emotional wellbeing problems. These improvements were moderated by the fact that many participants already had knowledge and attitudes in line with the aims of the workshop before participating. The workshops tended to attract people who already had an interest in, and some knowledge of, the importance of social and emotional wellbeing and suicide prevention. As such, the workshops were valuable in strengthening their knowledge and providing opportunities to discuss and explore different frameworks and approaches for culturally appropriate suicide prevention strategies.

Limitations

This evaluation drew on a fairly small sample size, within a particular geographic location in Australia. It was intended to be an exploratory study. The diversity across Aboriginal peoples throughout Australia, and across Indigenous peoples throughout the world means that care must be taken in generalising these findings. The evaluation collected limited demographic data about participants, and this paired with the small sample size makes it difficult to describe relationships between participants' characteristics and the effectiveness of the training. However, key lessons about the processes and approaches to engaging on the topic of suicide prevention in culturally appropriate ways may have relevance to a wide audience.

Not all Aboriginal Community Controlled Health Organisations invited to collaborate on this project were able to do so, for a variety of important reasons, including recent grief or loss in the community and multiple complex demands on the organisations. A small number of participants took part in interviews. This perhaps suggests that participating in the We-Yarn workshop about sensitive and complex issues related to suicide was, for many participants, already a substantial commitment, without the additional participation in an interview. It also suggests the competing demands and priorities on people's times, particularly those people who are engaged, passionate advocates and carers in their communities. Further, the people who did participate in this evaluation tended to be fairly well-informed about issues related to social and emotional wellbeing, particularly as many of the participants were already working in health and community services, and, given this fairly high baseline level of knowledge, it was unlikely that the workshop was going to result in large shifts in attitude or knowledge.

Conclusions and recommendations

This evaluation highlights that participants representing a range of perspectives valued the We-Yarn workshop as a tool for discussing and building on knowledge about social and emotional wellbeing. Frameworks such as a holistic health model, particularly one which draws on connections to spirituality, family, community, culture and land were considered appropriate and relevant for this type of training. More so than specific content within the workshop, it was the facilitators , through their shared experience, culture and mutual respect, who were vital to opening up the discussion and connecting with workshop participants.

In order to increase, and sustain, the impact of these workshops as a starting point for opening up discussions about suicide and promoting social and emotional wellbeing, it is recommended that the focus of the We-Yarn workshops be extended beyond the single workshop. By adopting a more developmental approach – and potentially doing *more* in *less* communities – the We-Yarn team could spend time in community, and with relevant Aboriginal Community Controlled Health Organisations before, and after, the workshop to understand the local context, support planning for particular referral pathways, and work with the Aboriginal Community Controlled Health Organisations to support follow-up activities. There may

also be opportunities to explore how the workshop builds on, or connects with, existing social and emotional wellbeing activities in the area, and for advocacy regarding the enhancement of support services.

Consideration should be given to developing, and delivering, separate workshops for health and allied health professionals and community members, so that training content can be delivered at the most appropriate and relevant level. This may require engaging an agency or individual with experience in culturally appropriate frameworks for building strengths-based therapeutic skills in supporting social and emotional wellbeing.

An ongoing challenge for the We-Yarn project, as with many other projects of this nature, is how to engage a more diverse group of people. Particularly those people who may gain greater benefit from attending a workshop, that is those whose interest and knowledge regarding suicide prevention is low, but who may be likely to interact or communicate with someone struggling with their social and emotional wellbeing. Liaising with a diverse range of community groups, and spending some time in the community before the workshop may enable improved recruitment of participants, but it is likely to be an ongoing challenge not unique to this program.

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