Connecticut Suicide Prevention Initiative

Local Evaluation Report

UCONN HEALTH
CENTER FOR PUBLIC HEALTH AND HEALTH POLICY

July 2014

Garrett Lee Smith
Connecticut Suicide Prevention Initiative

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Sara Wakai, PhD
Co-Investigator
Assistant Professor, Department of Medicine
Assistant Director of Public Health Research
UConn Health | Center for Public Health and Health Policy

Eric Horan, JD, MPA
Research Assistant
UConn Health | Center for Public Health and Health Policy

Elizabeth Schilling, PhD
Statistician
UConn Health | Center for Public Health and Health Policy

Robert H. Aseltine, Jr., PhD
Principal Investigator
Professor, Division of Behavioral Sciences and Community Health
UConn Health

UConn Health
Center for Public Health and Health Policy
263 Farmington Avenue, MC 6030
Farmington, Connecticut 06030

Acknowledgment

The principal investigator and co-investigator would like to thank Andrea Duarte, MSW, MPH, LCSW, Project Director of the Connecticut Suicide Prevention Initiative (CSPI) at the Department of Mental Health and Addiction Services (DMHAS), for the opportunity to conduct this evaluation. We are also very grateful to Connecticut Center for Prevention, Wellness and Recovery for their leadership and administrative support: Judith Stonger, Cathy Sisco, Corrine King, and Heather Clinger. In addition, we greatly appreciate the expertise of Laurel Buchanan at the Center for Public Health and Health Policy, for preparing and monitoring the SPEAKS-S (Student Version) and SPEAKS-F/S (Faculty/Staff Version). Connie Cantor impressed us again with her editing and formatting talents.

A special thank you goes to the representatives of the sub-recipient campuses, Regional Action Councils, and mini-grantees who, among numerous other responsibilities, facilitated trainings and prepared for the administration of SPEAKS-S, SPEAKS-F/S, and NCHA on their campuses. Thank you to the CSPI and Connecticut Suicide Advisory Board members who attended meetings, completed surveys, and contributed their time and knowledge to this evaluation.

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Executive Summary

Background and purpose of the program

The Center for Public Health and Health Policy (CPHHP) at the University of Connecticut Health Center (UCHC) conducted the local evaluation of the Connecticut Suicide Prevention Initiative (CSPI). The CSPI was funded by the Connecticut Department of Mental Health and Addiction Services (DMHAS), with the support of the federal Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Mental Health Services (CMHS) Garrett Lee Smith Suicide Prevention Program (GLS Program).

The purpose of the CSPI was to develop and implement comprehensive, evidence-based suicide prevention/early interventions on college campuses and in communities impacting youth and young adults age 10-24 statewide. Building on Connecticut's existing suicide prevention infrastructure, the proposal's goal and objectives are as follows:

Goal: Reduce suicide contemplation, attempts and deaths of youth and young adults ages 10-24 years attending college and residing in communities in Connecticut.

Objective 1: Strengthen Connecticut town and campus capacity and infrastructure in support of mental health promotion and suicide prevention.

Objective 2: Develop, enhance, implement and sustain evidence-based, culturally competent suicide prevention practices on college campuses and in communities across the state for youth and young adult students age 10 to 24.

Objective 3: Conduct a process and outcome evaluation of the initiative to determine whether progress towards objectives is being achieved and/or adjustments are needed.

In furtherance of Objectives 1 and 2, DMHAS incorporated SAMHSA's Strategic Prevention Framework (SPF) and the national Suicide Prevention Resource Center (SPRC)/JED Foundation's Comprehensive Approach to Suicide Prevention and Mental Health Promotion (Jed Model) into its design of the CSPI. The evidence-based suicide prevention and mental health promotion practices associated with these frameworks were employed to build campus and community infrastructures and increase capacity to address recommendations identified in the National Strategy for Suicide Prevention; the National Prevention Strategy; the Connecticut Comprehensive Suicide Prevention Plan; and by the CTSAB.

Further, using state data, DMHAS noted that some populations have either higher rates of suicide attempts and deaths or face challenges related to accessing mental health services distinct from challenges faced by the greater student community. As such, DMHAS selected four priority populations for the CSPI:

- students with mental health disorders
- veterans and military personnel
- students who are lesbian, gay, bisexual or transgender
- Hispanic or Latino students

DMHAS awarded CSPI grants to four campus sub-recipients and five Regional Action Councils (RACs) with statewide reach. The four campuses were awarded up to $75,000 to be used over a three-year period (March 1, 2012 to June 30, 2014). The sub-recipient campuses were:

- Connecticut College: New London, Connecticut
- Manchester Community College: Manchester, Connecticut
- Norwalk Community College: Norwalk, Connecticut
- Sacred Heart University: Fairfield, Connecticut

The Regional Coordinators received up to $60,000 over two years to build community capacity and infrastructure to prevent suicide and promote mental health, prioritizing, but not limited to, youth and young adults 10-24 years-old. The RACs provided relevant trainings and also administered mini-grant programs, awarding up to $2,500 to campuses and communities to support the development or enhancement of evidence-based suicide prevention, intervention and response strategies listed on the SPRC Best Practices Registry (BPR). In all, the RACs awarded 34 mini-grants. The sub-recipient RACs were:

- Region 1: Southwest, Regional Youth/Adult Social Action (RYASAP)
- Region 2: South Central, Greater Valley Substance Abuse Action Council (VSAAC)
- Region 3: Eastern, Southeastern Regional Action Council (SERAC)
- Region 4: North Central, Capital Area Substance Abuse Council (CASAC)
- Region 5: Northwest, Housatonic Valley Coalition Against Substance Abuse (HVCASA)

DMHAS contracted with Wheeler Clinic's Connecticut Center for Prevention, Wellness and Recovery (CCPWR) to provide administrative support for the CSPI, and provide evidence-based training and technical assistance to the sub-recipients.

The GLS Program requires grantees to participate in two distinct evaluations: a national evaluation called the cross-site evaluation, and a local evaluation. The purpose of the cross-site evaluation is to obtain consistent data across grantee sites so they can be analyzed to provide a national-level assessment of program effectiveness. SAMHSA selected ICF International (ICF), a research and evaluation consulting firm, as the contractor to design and conduct the cross-site evaluation, and provide technical assistance and training for State/Tribal grantees in implementing the cross-site evaluation. CPHHP conducted the local evaluation.

Local Evaluation

Consistent with CSPI Objective 3, this local evaluation consists of a process and outcome component. The purpose of the process evaluation was to track and measure CSPI programmatic activities at the State, campus and community levels. The purpose of the outcome evaluation was to measure direct effects of the CSPI. CPHHP selected three outcomes to measure: 1) statewide suicide prevention infrastructure; 2) sub-recipient campus suicide prevention infrastructure, including programs offered, student knowledge of suicide prevention services, and general campus atmosphere about using those services; and 3) sub-recipient campus student suicide contemplation, attempt and death.

Methods

For the process evaluation, CPHHP used several data collection methods including professional development satisfaction surveys and cross-site assessment tools collected by ICF to track programmatic activities during the grant period. It also employed several surveys, such as the Grant Recipient Survey, to elicit feedback from the campus sub-recipients and mini-grantees. CPHHP, DMHAS, CCPWR, and the sub-recipient campuses administered several surveys to measure the three selected outcomes. These surveys were sent to institutions of higher education state-wide, CSPI sub-recipients, and students and faculty/staff at sub-recipient campuses.

Results

Process Evaluation: CCPWR hosted two special events (the CSPI Kick-Off and closing event) and 13 professional development meetings. CCPWR and the sub-recipients offered 239 training sessions, which were attended by an aggregate total of 7182 attendees. Most sub-recipients indicated satisfaction with the

CSPI overall, though they indicated that there is room to improve the application process.

Outcome Evaluation: Campuses statewide offered more mental health promotion and suicide prevention trainings near the close of the grant period than at its beginning. QPR was particularly popular. On the sub-recipient campuses, every college offered more programs in 2014 than 2012, and nearly all of them offered more services individually tailored to the CSPI-identified priority populations. The proportion of students indicating an awareness of suicide prevention resources on the campuses generally increased from 2012 to 2014. The atmosphere on campus regarding the acceptability of using suicide prevention services was comparable in 2012 and 2014; in both years a majority of students indicated that they and the larger campus community supported help-seeking behavior. Finally, the proportion of students indicating that they had seriously considered or attempted suicide within the prior 30 days or the prior two weeks decreased slightly from 2012 to 2014.

Connecticut Suicide Prevention Initiative

Local Evaluation Report

Introduction

The purpose of the Connecticut Suicide Prevention Initiative (CSPI) was to develop and enhance sustainable evidence-based, culturally competent suicide prevention and mental health promotion policies, practices and programs at institutions of higher education and communities statewide with the goal of reducing suicide contemplation, suicide attempts and suicide deaths of youth and young adults ages 10-24 years in Connecticut. The CSPI was funded by the Connecticut Department of Mental Health and Addiction Services (DMHAS), with the support of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) (Grant No.: SM06039601).

Background

Connecticut Suicide Prevention and Mental Health Promotion

The State of Connecticut has played an active role in suicide prevention since at least the late 1980s. In 1989, the legislature mandated that public school curriculums include a component of "mental and emotional health, including youth suicide prevention." This provision is now codified at Connecticut General Statutes section 10-16b. The same year, the legislature created a Youth Suicide Advisory Board (YSAB), and located it within the state department that is now the Department of Children and Families (DCF). The YSAB is tasked with serving as a "coordinating source for youth suicide prevention."[1]

Connecticut's Department of Public Health (DPH) organized an informal group among the state agencies to discuss suicide-related issues following a conference on preventable injuries in June, 2000. This group was called the Interagency Suicide Prevention Network (ISPN). Inspired in part by the promulgation of the National Strategy for Suicide Prevention in 2001 and by the recommendations of an earlier state Blue Ribbon Commission on Mental Health, the ISPN drafted Connecticut's first Comprehensive Suicide Prevention Plan in 2005. The plan took a lifespan approach to suicide prevention.

The Connecticut Suicide Advisory Board (CTSAB) was established in January 2012. As of July 2014 it has 204 members from institutions of higher education, state agencies, community organizations, hospitals, military, mental health facilities, and survivors of attempts and death. The CTSAB was formed as a merger of the YSAB and the ISPN. The mission and vision of the CTSAB are:

Mission: The CTSAB is a network of diverse advocates, educators and leaders concerned with addressing the problem of suicide with a focus on prevention, intervention, and health and wellness promotion.

Vision: The CTSAB seeks to reduce and eliminate suicide by instilling hope across the lifespan and through the use of culturally competent advocacy, policy, education, collaboration and networking.

The CTSAB meets monthly for programmatic and strategic planning to address issues related to suicide

[1] CGS §17a-52.

in Connecticut. It is co-chaired by one member of DCF and one member of DMHAS.[2] The CTSAB has developed and disseminated the Connecticut suicide prevention campaign, "1 Word, 1 Voice, 1 Life: Be the 1 to start the conversation" (1 Word), which promotes the National Suicide Prevention Lifeline.

Garrett Lee Smith Memorial Act

At the national level, the Garrett Lee Smith (GLS) Memorial Act was passed to provide funds to states, Native American tribes, and institutions of higher education to develop suicide prevention and intervention programs on October 21, 2004. The GLS Program pursuant to the statute is currently administered by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)/ Center for Mental Health Services (CMHS), which is housed within the federal Department of Health and Human Services (HHS).

The State of Connecticut received a three-year grant through the GLS Program in 2006. This grant was used to fund the Connecticut Youth Suicide Prevention Initiative (CYSPI), which was administered by DMHAS. The program included many components, touching upon several areas of youth and community suicide prevention services. The Center for Public Health and Health Policy (CPHHP) at the University of Connecticut Health Center (UCHC) conducted a local evaluation that focused on four components of the CYSPI: Middle School, High School, College, and programs for high-risk youth.[3]

Connecticut Suicide Prevention Initiative

SAMHSA awarded Connecticut a second three-year grant from the Garrett Lee Smith Suicide Prevention Program on August 1, 2011. The state program funded by this grant, the Connecticut Suicide Prevention Initiative (CSPI), is the focus of this local evaluation. The initial overall goal of the CSPI was to develop and enhance sustainable evidence-based, culturally competent suicide prevention and mental health promotion policies, practices and programs at institutions of higher education statewide to reduce suicide contemplation, attempts and deaths of students attending college in Connecticut, with a focus on students ages 18 to 24. It was later decided to expand efforts through the Regional Action Councils (RACs) and subsequently through the mini-grantees to facilitate programming in the community to the full age range of the GLS Program of 10 to 24 year olds.

DMHAS, which administered the grant at the state level, contracted with Wheeler Clinic's Connecticut Center for Prevention, Wellness and Recovery (CCPWR) to provide administrative support for the CSPI and evidence-based training and programmatic guidance. This guidance was conducted in collaboration with the national Suicide Prevention Resource Center (SPRC), the official technical assistance provider to federal GLS grantees. DMHAS also contracted for the services of CPHHP to conduct the local evaluation of this initiative. A sub-committee of the CTSAB, the CSPI Advisory Committee, provided strategic and operational guidance to grant staff and partners to ensure that the initiative addressed the needs of youth and young adults at risk and satisfied the requirements of the federal grant.

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[2] Report to the Public Health and Education Committees of the Connecticut General Assembly on School Based Health Centers, submitted by the Commissioner of the Department of Public Health (January 2012), available at: http://www.ctschoolhealth.org/images/SBHC_Advisory_Committee_Report_Final_2012.pdf (accessed October 24, 2014).

[3] Institute for Public Health Research, Center for Public Health and Health Policy (August, 2010). Connecticut Youth Suicide Prevention Initiative Local Evaluation: Final Report.

CCPWR established and co-manages several listservs, which were used to facilitate CSPI-related communication. The CTSAB listserv and CSPI Advisory Committee listserv were developed on January 30, 2012. CCPWR established the CSPI Campus Sub-Recipient listserv in April 2012, to focus on communication specifically related to the CSPI grantees. The CSPI also collaborated with the Connecticut's Healthy Campus Initiative (CHCI), a group of more than 40 institutions of higher education in Connecticut that serves as a catalyst for creating and sustaining healthy campus and community environments, and CSPI helped to expand the mental health component of the CHCI. Campus-related CPSI communications were also distributed via the CHCI Coalition listserv and the CHCI Informational listserv, both of which predate CSPI, to provide professionals in mental health, and alcohol and other drugs prevention (AOD) with information and funding opportunities on suicide prevention, intervention, and postvention and to support integration of suicide prevention and mental health promotion and substance abuse prevention (Table 1).

Table 1

CSPI-Related Listserv Membership (as of July 2014)

Listserv	Number of members*
CTSAB	204
CSPI Advisory Committee	28
CSPI Campus Sub-Recipient	16
CHCI Coalition	168
CHCI Informational	228

* An individual email address may appear on multiple listservs.

The CSPI used SAMHSA's Strategic Prevention Framework (SPF) and the national Suicide Prevention Resource Center (SPRC)/JED Foundation's Comprehensive Approach to Suicide Prevention and Mental Health Promotion (Jed Model). Evidence-based suicide prevention and mental health promotion practices associated with these frameworks were employed to build campus and community infrastructures and increase capacity to address recommendations identified in the National Strategy for Suicide Prevention; the National Prevention Strategy; the Connecticut Comprehensive Suicide Prevention Plan; and by the CTSAB. DMHAS identified some populations as having either higher rates of suicide attempts and deaths or facing other challenges related to accessing mental health support that are distinct from those faced by other youth and young adults. As such, DMHAS selected four priority populations for the CSPI:

- students with mental health disorders
- veterans and military personnel
- students who are lesbian, gay, bisexual or transgender
- Hispanic or Latino students

DMHAS created a state grant program, primarily funded by the federal grant, through which local colleges could fund suicide prevention and mental health promotion strategies and activities. In January 2012, DMHAS released the Request for Proposals (RFP) for The Connecticut Campus Suicide Prevention Initiative: Promoting the Mental Health of Young Adults. The RFP was distributed via the prevention listservs managed by CCPWR. Individuals who received the notice were asked to forward the RFP announcement to other potentially interested parties. The proposals were reviewed in February 2012 by the CSPI Advisory Committee. DMHAS announced the sub-recipients in March 2012, and awarded funds to four college campuses. In addition, in July 2012 DMHAS implemented a statewide, community-based

component via five lead Regional Action Councils representing each of the five DMHAS service regions.

College Campus Sub-recipients. Four campuses were awarded up to $75,000 each to be used over a three-year period (March 1, 2012 to June 30, 2014). The campus sub-recipients included two community colleges and two private, four-year liberal arts colleges. The campuses utilized the SPF, JED model, and SPRC Best Practices Registry (BRP) to identify strategies and activities to address suicide and mental health on their campuses and promoted the 1 Word campaign. The sub-recipient campuses were:

- Connecticut College: New London, Connecticut
- Manchester Community College: Manchester, Connecticut
- Norwalk Community College: Norwalk, Connecticut
- Sacred Heart University: Fairfield, Connecticut

RAC Sub-recipients. Five RACs were identified to receive awards to function as Regional Suicide Prevention Coordinators who would oversee community-based mini-grants and provide evidence-based training and strategic guidance. The Regional Coordinators received $60,000 over two years to build community capacity, infrastructure and services to prevent suicide and promote mental health. The RACs utilized the SPF, JED model, and SPRC BPR, and made communities and campuses aware of them, in order to identify strategies and activities to address suicide and mental health in these locations, as well as promote the 1 Word campaign. Each participating site received a mini-grant up to $2,500 for a six-month period for a total of 34 mini-grants to campuses and communities throughout Connecticut.

The sub-recipient RACs were:

- Region 1: Southwest, Regional Youth/Adult Social Action (RYASAP)
- Region 2: South Central, Greater Valley Substance Abuse Action Council (VSAAC)
- Region 3: Eastern, Southeastern Regional Action Council (SERAC)
- Region 4: North Central, Capital Area Substance Abuse Council (CASAC)
- Region 5: Northwest, Housatonic Valley Coalition Against Substance Abuse (HVCASA)

GLS Grantee Meetings and Activities. Members of the CSPI team, which included representatives from DMHAS, CCPWR, the CTSAB and CPHHP, attended annual federal GLS grantee meetings over the course of the grant period and participated in group calls and webinars.

GLS Grantee Meetings 2012-2014. The 2012 GLS Grantee Meeting was held in Baltimore April 16–18, 2012 and provided an opportunity for technical assistance and training. Three CSPI team members attended the plenary and break-out sessions and met with the Suicide Prevention Resource Center (SPRC) liaison, an ICF liaison, and the SAMHSA-GLS project officer. The 2013 GLS Grantee Meeting was held in Washington, DC, June 11–13, 2013. Four CSPI team members, representatives from three college sub-recipients, a representative from one RAC sub-recipient, and one member of the CTSAB attended. The event provided an opportunity for technical assistance and training. Andrea Duarte, DMHAS, and Corrine King, CCPWR, spoke at a breakout session: Building Statewide Infrastructure to Support and Sustain Mental Health on Campus. The title of their presentation was Sustaining Connecticut GLS Campus Efforts. CCPWR hosted a table at the Networking Fair during two evenings and distributed the CTSAB suicide prevention campaign materials. The 2014 GLS Grantee Meeting was again held in Washington DC, from June 9 through June 11. Three members of the CPSI team, consisting of representatives from DMHAS, CCPWR, and CPHHP attended the conference. Andrea Duarte presented at one of the breakout sessions, Moving Forward on Substance Abuse Prevention and Treatment Collaborations. The CSPI hosted

a table each year at the Networking Fair and distributed the CTSAB 1 Word statewide suicide prevention campaign materials.

American Association of Suicidology Annual Conference 2012-2014. The three CSPI team members who attended the GLS Grantee meeting in 2012 also attended the American Association of Suicidology Annual Conference in Baltimore April 18-21, 2012. They participated in several workshops including Evaluating Suicide Prevention Programs for Evidence of Effectiveness; Blending Public Health and Behavioral Health Approaches in a Statewide Suicide Prevention Program: A Model for Successful Collaboration; Building a Comprehensive Campus Suicide Prevention Program; Genetic Risk Factors for Suicidal Behavior; and Connect Training. With the support of CSPI and Mental Health Block Grant dollars, the same CSPI staff, the DCF Co-Chair of the CTSAB, and a CTSAB Project Consultant from the UConn School of Social Work all attended the AAS Conference in Austin, TX in April 2013, and participated in multiple workshops. A state team from the CTSAB, including the CSPI Project Director and CPHHP Evaluators, co-presented a day-long pre-conference workshop with the SPRC and SAMHSA at the 2014 AAS Conference in Los Angeles, CA on Statewide Suicide Prevention Planning and Evaluation.

Evaluation of the CSPI. All GLS grantees and their sub-recipients are required to participate in the cross-site evaluation that was designed to obtain consistent process and outcome data across grantee sites so they can be analyzed to provide a national-level assessment of program activities and effectiveness. The CSPI Project Staff worked with ICF as the Cross-site Evaluator and technical assistance provider to ensure accurate utilization of cross-site evaluation tools and data entry into the web-based Suicide Prevention Data Center (SPDC). The GLS also called for a local evaluation, which in Connecticut captures process and outcome results. The two evaluation levels are intended to balance the needs for national uniformity and adaptability to local context.

Cross-Site Evaluation

SAMHSA selected ICF as the contractor to design the cross-site evaluation tools and data collection procedures and provide related technical assistance and training for State/Tribal grantees. The cross-site evaluation tools and instruction manuals are housed on the Suicide Prevention Data Center (SPDC) website. This is also where the cross-site data is entered and maintained. The following is a list of the cross-site evaluation tools:

- Early Identification, Referral and Follow-up (EIRF)
  - » Tracks program early identification activities, referrals and follow-ups
- Early Identification Referral and Follow-up (EIRF) Aggregate Form
  - » Tracks program early identification activities, referrals and referral follow-ups during a group evaluation
- Prevention Strategies Interventions (PSI)
  - » Catalogues prevention strategies, describes target population and budget
- Training Exit Survey Cover Page (TES-CP)
  - » Identifies number and types of trainings, describes participants
- Training Utilization and Prevention Survey (TUPS)
  - » Surveys GLS-funded training attendees three months after the training
- Training Utilization and Prevention Survey (TUPS) Consent Form
  - » Gathers names for ICF to contact to deliver the TUPS

Local Evaluation

The local evaluation allows grantees to examine their particular programs operating in their specific local contexts. It also allows grantees to tailor their evaluations to address grantee-specific needs and interests. The local evaluation was conducted by CPHHP in conjunction with other CSPI Project Staff. Strategies and activities included ongoing monitoring and evaluation to: a) determine if the prevention performance outcomes desired are achieved; b) assess program effectiveness and service delivery quality; and c) conduct continuous quality improvement. The local evaluation design consisted of two components - process and outcome - and involved a variety of local tools and approaches.

Institutional Review Board Submission

An application was submitted to the UCHC Institutional Review Board (IRB) to request approval of the CSPI local evaluation. The UCHC IRB determined that CPHHP's role in the evaluation did not constitute human subjects research. The campus sub-recipients were informed that UCHC could not be the IRB of record and they would need to pursue Human Subjects approval through the appropriate mechanism on their individual campuses as needed. The RACs did not engage in any activities for which IRB approval was necessary. IRB technical support was provided by the CPHHP evaluator and CCPWR coordinator via in-person training, telephone conversations, and email correspondence.

Data Sharing Agreements

Pursuant to the campus RFP, sub-recipients were required to submit written documentation in the form of data sharing agreement letters to allow CPHHP, DMHAS, and CCPWR access to program-related data. Sub-recipients reviewed sample data sharing agreement letters, made modifications as needed, obtained signatures from authorized personnel, and submitted letters to CPHHP.

Technical Assistance

Technical assistance for the CSPI evaluation was provided by an ICF liaison, and programmatic assistance was provided by a SPRC liaison. The SAMHSA/CMHS Government Project Officer (GPO) also provided guidance to CSPI Project Staff. CSPI Project staff provided sub-recipients with program and evaluation support.

- *GLS Project Planning Meeting and ICF Site Visit.* ICF technical assistance liaisons provided an initial six-hour on-site training in November 2012. During the morning session, the liaisons provided an introduction to the Garrett Lee Smith grant, overview of the SAMHSA Strategic Initiatives and ICF's technical assistance model. The afternoon was spent reviewing the GLS cross-site assessment tools, local evaluation materials, and resources. The SAMHSA GPO joined the last hour of the meeting via telephone for a discussion on Strategic Integration.

- *Connecticut Campus Sub-recipient Meetings.* April 2012, following a CSPI Kick-Off Celebration, the CSPI Project Staff, ICF liaison, and SAMHSA GPO provided an on-site evaluation training for the campus sub-recipients. The ICF liaison reviewed the cross-site evaluation tools and the SPDC website. The CPHHP evaluator created local evaluation protocols, examples of letters of support, time lines, etc., and reviewed those documents and the local evaluation tools. CSPI Project Staff created binders for each of the participants which included information and documents necessary to implement the cross-site and local evaluations (e.g., acronyms, contact information, evaluation matrix, training checklist, assessment tools, SPDC coding key, etc.). Additional technical assistance was provided at periodic sub-recipient meetings throughout the project period as needed.

- *RACs and Mini-grantees.* The CSPI Project Director met with the RACs monthly between fall 2012 through spring 2014 as a group to review CSPI program and evaluation tasks, progress and address challenges. The group also co-developed and released the mini-grant RFA. Once funded, each RAC met with their mini-grantees on an individual, and sometimes on a group-basis to provide operational guidance, information and resources.

Evaluation Design

The purpose of the CSPI was to develop and implement comprehensive, evidence-based suicide prevention/early interventions on college campuses and in communities impacting youth and young adults age 10-24 statewide. Building on Connecticut's existing suicide prevention infrastructure, the proposal's goal and objectives are as follows:

Goal: Reduce suicide contemplation, attempts and deaths of youth and young adults aged 10-24 years attending college and residing in communities in Connecticut.

Objective 1: Strengthen Connecticut and campus capacity and infrastructure in support of mental health promotion and suicide prevention.

Objective 2: Develop, enhance, implement and sustain evidence-based, culturally competent suicide prevention practices on college campuses and in communities across the state for youth and young adult students age 10 to 24.

Objective 3: Conduct a process and outcome evaluation of the initiative to determine whether progress towards objectives is being achieved and/or adjustments are needed.

Process Evaluation

The purpose of the process evaluation was to record programmatic activities at the state, campus and local levels related to implementing the objectives of the CSPI. The CSPI hosted special sub-recipient meetings, grant management meetings, and sponsored/co-sponsored several state, campus and community-level trainings and educational opportunities for laypersons through professionals. The process evaluation focused on these programmatic activities. The state's first census of QPR Gatekeeper Trainers was conducted in 2013. The results of this are reported in Appendix B. The campus sub-recipients and mini-grantees completed the locally developed Connecticut Garrett Lee Smith Grant Recipient Survey near the close of the CSPI grant period, in which they were invited to, among other things, provide feedback on the grant application and implementation process.

Table 2

CSPI Programs, Professional Development, and Community Training Attendance

Event	Date	Attendance
CSPI Special Events		
♦ Connecticut Suicide Prevention Initiative Kick-Off	April, 2012	71
♦ Celebrating Today & Promoting Tomorrows: Suicide Prevention and Mental Health Promotion in Connecticut	May, 2014	115
CSPI – CHCI Professional Development Sessions		
♦ Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment - *Tip 50*; and Connecticut Liquor Laws	April, 2012	30
♦ How to Gain Support From College Administrators	May, 2012	21
♦ Addressing Cultural Competence for Collegiate Professionals	Sept., 2012	23
♦ Active Duty and Veteran College Students' Substance Abuse and Mental Health	Nov., 2012	31
♦ Interactive Screening Programs / Fresh Check Day	Dec., 2012	28
♦ LGBTQI Culture	April, 2013	24
♦ Developing a Comprehensive Campus Approach to Prevention: The Jed Foundation	May, 2013	53
♦ Empowering the Next Generation of Latino Students	Sept., 2013	41
♦ The Value of Evaluation	Oct., 2013	28
♦ A Taste of Motivational Interviewing	Nov., 2013	22
♦ Onset of Mental Health Disorders	Dec., 2013	41
♦ Essentials of Motivational Interviewing	Feb., 2014	35
♦ Keep the Problem out of Gambling	March, 2014	24
♦ Positive Social Norms Marketing: From Theory to Practice	April, 2014	29

CSPI Special Events

Connecticut Suicide Prevention Initiative Kick-Off. On April 4, 2012, the CCPWR hosted the Connecticut Suicide Prevention Initiative Kick-Off. The CCPWR invited guests from institutions of higher education, state agencies, and community organizations via its prevention listservs. Seventy-one guests attended the event. Carol Meredith, Director, Prevention and Health Promotion Unit, DMHAS, welcomed the audience and introduced the CSPI and the implementation of the Jed Model. The Keynote presentations included: An overview of the Jed Foundation and the Love is Louder campaign by John MacPhee, Executive Director, Jed Foundation; a discussion on the comprehensive approach to suicide prevention and mental health promotion by Victor Schwartz, Medical Director, Jed Foundation; and a presentation of the Student Support Network, an evidence-based approach to supporting at-risk students on the SPRC Best Practices Registry, by Charles Morse, Director of Student Development and Counseling, Worcester Polytechnic Institute. Andrea Duarte, DMHAS, CSPI Project Director, provided an overview of the CSPI and introduced the Garrett Lee Smith grant campus sub-recipients.

At the conclusion of the event, attendees were asked to complete a brief satisfaction survey to provide

feedback on the quality of the content and presentation at the Kick-Off. Twenty-six attendees completed the survey for a response rate of 37 percent. The satisfaction survey consisted of ten closed-ended questions with responses on a scale of one (strongly disagree) to five (strongly agree), two open-ended questions, and an opportunity to offer additional comments. The respondents reported that they were very satisfied with the presentation. All of the respondents agreed or strongly agreed with the items "The content was relevant to my work on mental health promotion and suicide prevention," "I will share the knowledge I have learned with others," "The presentation included teaching methods that were effective," and "Mastery of the topic was demonstrated in the presentation." Information of greatest value to participants included the Jed Model, resources, training, programs directed at specific groups of students, and the Love is Louder campaign. Participants reported they planned to use the information they gained from the Kick-Off by sharing information with staff, enriching their current programs, and enhancing their initiatives.

CSPI Closing Ceremony: Celebrating Today and Promoting Tomorrows: Suicide Prevention and Mental Health Promotion in Connecticut. The closing ceremony for the CSPI was held on May 1, 2014 at the Sheraton Hotel in Rocky Hill. The CSPI hosted this meeting for all sub-recipients and mini-grantees to celebrate their successes and promote sustainment of their efforts. All campus, RAC and mini-grantees, and grantee community coalition members, as well as CTSAB members, CHCI members, state legislators and the Governor, were invited. The event attracted 115 participants. Commissioner Patricia Rehmer, DMHAS, and CSPI Project Director Andrea Duarte, DMHAS, opened the event and welcomed the guests. A. Kathryn Power, SAMHSA Regional Administrator, delivered the Keynote Address, Behavioral Health is Essential to Health: Prevention Works, Treatment is Effective, People Recover. For the remainder of the morning, campus sub-recipients and mini-grantees presented highlights of their accomplishments using grant funding. The final presentation was by Michael Dutko, Connecticut Army National Guard, and entitled Suicide Prevention and Postvention Achievements with the support of the CSPI. The event closed with a Recognition of Achievement where each sub-recipient and mini-grantee received a framed certificate, followed by an opportunity for participants to informally network and share their thoughts and experience about the CSPI and mental health promotion and suicide prevention in Connecticut. The agenda and presentations may be found at this link: http://www.preventsuicidect.org/files/2014/06/agendamay1.pdf

Professional Development CSPI-CHCI Meetings

Between spring 2012 and spring 2014, CCPWR and the CHCI steering committee co-sponsored several professional development meetings. The professional development meetings were designed to integrate suicide prevention, mental health promotion and substance abuse prevention, as well as increase the understanding of the unique needs of the special populations at increased risk of suicide. Professional development meetings were facilitated by guest speakers who provided training on topics identified as important by CHCI and CSPI members. The professional development meetings were scheduled for three-hour time periods and included presentations, group activities, and discussions.

At the conclusion of each professional development meeting, members were asked to complete a satisfaction survey. The satisfaction survey consisted of ten closed-ended questions with responses on a scale of one (strongly disagree) to five (strongly agree), two open-ended questions, and an opportunity to offer additional comments. A majority of respondents reported satisfaction or strong satisfaction with the professional development presentations (Appendix E).

April 2012: Tip 50/Connecticut Liquor Laws. At the April joint CHCI-CSPI professional development meeting, Maureen Pasko, Suicide Prevention Coordinator, VA Connecticut Healthcare, presented "Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment - Tip 50" and

distributed a Tip 50 manual. The training consisted of video vignettes focusing on suicide assessment and intervention in substance abuse treatment settings. The second portion of the April meeting focused on the Connecticut liquor laws presented by Jack Suchy from the Liquor Control Commission. Both presentations allowed time for group discussions, questions and answers.

May 2012: How to Gain Support from College Administrators. In May, the professional development topic was "How to Gain Support from College Administrators." Three college administrators from diverse types of institutions (e.g., public, 4-year, 2-year) shared their experiences on ways they have collaborated with a variety of entities to promote prevention efforts on their campuses.

September 2012: Cultural Competence. In September, the professional development meeting topic was "Addressing Cultural Competence for Collegiate Professionals." Marc Chartier from the Multicultural Leadership Institute (MLI) presented on multiculturalism focusing on the importance of cultural awareness when hosting trainings/events and while counseling students. After Chartier's presentation, a representative from the Connecticut Council on Problem Gambling informed the coalition about their poster design contest.

November 2012: Active Duty and Veteran College Students. In November, members of the VA Connecticut Healthcare and the Connecticut Army National Guard (CTARNG) Behavioral Health Team presented on "Active Duty and Veteran College Students' Substance Abuse and Mental Health." Latonya Hart, from the VA, shared information on the VA's suicide prevention programs and Todd Perkins presented on the substance abuse treatment programs offered by the VA Hospital. Major Javier Alvarado, Dr. Lisa Miceli, Susan Tobenkin, Michael Dutko, Specialist Kristy Soucy, and Sergeant First Class Claude Campbell shared information on the substance abuse trends and suicide and substance abuse prevention programs the military has available. All speakers provided coalition members with materials and resources to assist active duty and veteran students.

December 2012: Interactive Screening Program. In December, Kimberly Gleason from the American Foundation for Suicide Prevention (AFSP) presented on the foundation's Interactive Screening Program (ISP). Gleason provided an overview of the ISP, demonstrated the tool and shared funding opportunities available through the local AFSP chapter. Dr. Meredith Yuhas from the University of St. Joseph highlighted ways the implementation of the ISP has been successful on her campus. CCPWR led a discussion of the online screening and education programs available for substance abuse prevention. A representative from the Jordan Matthew Porco Memorial Foundation presented on their Fresh Check Day and discussed participation requirements for campuses interested in the program.

April 2013: LGBTQI Culture. Robin McHaelen, Executive Director of True Colors presented on LGBTQI culture. True Colors is a non-profit organization that works with other social service agencies, schools, organizations, and within communities to ensure that the needs of sexual and gender minority youth are both recognized and competently met. McHaelen discussed the increased risk for substance abuse and suicide among LGBTQI students. Following the presentation, a panel of campus professionals gave an overview of their LGBTQI programs.

May 2013: A Comprehensive Campus Approach: The Jed Foundation. John MacPhee, Executive Director and Victor Schwartz, MD, Medical Director from the Jed Foundation presented "Developing a Comprehensive Campus Approach to Prevention." The presenters introduced the JedCampus, an

online survey to help colleges assess their mental health and suicide prevention programs. Following the presentation, participants implemented a cross-walk activity designed to develop a comprehensive plan to address substance use, mental health and suicide prevention on campus.

September 2013: Empowering the Next Generation of Latino Students: Challenges and Opportunities Using a Holistic Approach of Mente, Cuerpo y Alma (Mind, Body and Soul). Fany DeJesus Hannon, Director of the Puerto Rican / Latin American Cultural Center (PRLACC) at UConn, and Graciela Quinones-Rodriguez, LCSW, from Counseling and Mental Health Services at UConn, delivered a presentation and led a discussion on issues, challenges and successes facing Latino/a students.

October 2013: The Value of Evaluation. Sara Wakai, Ph.D, Director of Evaluation at the Center for Public Health and Health Policy discussed the importance of program evaluation and provided attendees with basic steps to design and implement small scale evaluations on college campuses and in other settings.

November 2013: A Taste of Motivational Interviewing (MI). Chip Tafrate, Ph.D., a psychologist at the Criminology and Criminal Justice Department at Central Connecticut State University, presented on "Motivational Interviewing (MI)." MI fosters behavior change by helping individuals explore and resolve their own indecision. MI emphasizes reasons for change rather than skills or techniques used to bring change about. This approach seeks to make individuals active participants in directing change, values freedom of choice over compliance with external norms, and focuses on the individual's own reasons for change rather than presenting advice from others.

December 2013: Onset of Mental Health Disorders in College Students. Barbara Greenberg, Ph.D., a clinical psychologist focusing on the mental health of teens and young adults, discussed signs of emerging mental health disorders among college students. Her presentation included a discussion of eating disorders, depression, suicidality, and violence.

February 2014: Essentials of Motivational Interviewing.[4] Chip Tafrate, Ph.D., a psychologist at the Criminology and Criminal Justice Department at Central Connecticut State University, presented "Motivational Interviewing (MI)," a two-day training, on February 27 and February 28, 2014 at Central Connecticut State University. The MI approach seeks to encourage individuals to be active participants in directing change; it values freedom of choice over compliance with external norms; and it focuses on the individual's own reasons for change rather than presenting advice from others. The two-day training was thematically related to the CSPI-CHCI introduction to MI offered in November, 2013, but was more in-depth and open to non-CSPI-CHCI members.

March 2014: Keep the Problem Out of Gambling. Cheryl Chandler and Elizabeth McCall from the Connecticut Council on Problem Gambling presented on warning signs of high-risk gambling and the relationship between gambling and other risky behaviors. Jonathan Pohl, PhD from CCSU's gambling prevention program and Joe Turbessi, author of Into the Muck: How Poker Changed My Life discussed gambling addiction among college students.

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[4] The regular CHCI-CSPI professional development meeting for February was cancelled due to weather. "Essentials of Motivational Interviewing" was offered outside of the regular professional development framework in response to the popularity of the professional development "A Taste of Motivational Interviewing (MI)" that was offered at the November, 2013, CHCI-CSPI meeting.

April 2014: Positive Social Norms Marketing: From Theory to Practice. Tracy Desovich, MPH and Elizabeth Pratt, MPH, Technical Assistance Providers from the Massachusetts Technical Assistance Partnership for Prevention (MassTAPP) presented on the theory and practice behind positive social norms marketing, the steps to effectively implement a campaign, how to include students in a campaign, and how to sustain a campaign.

Community Training

The CSPI funded several mental health promotion and suicide prevention trainings. The trainings were offered between April 2012 and June 2014. Initially, the trainings that were selected for CSPI funding were Recognizing and Responding to Suicide Risk in Primary Care on Campus; Question, Persuade and Refer Training of Trainers; and Connect Prevention / Postvention Model Training, and Assessing and Managing Suicide Risk and Motivational Interviewing. Later, the CSPI grant was used to fund the additional trainings of Campus Connect, the DORA College Program (Depressions OutReach Alliance) and the Student Support Network.[5]

Recognizing and Responding to Suicide Risk in Primary Care. Recognizing and Responding to Suicide Risk in Primary Care (RRSR-PC) is designed for primary care physicians, physician assistants and others who work in primary care settings. Among other things, RRSR-PC assists attendees determine ways to incorporate suicide risk screening into routine practice, document the results of suicide risk assessments, interpret risk assessment results, and manage patients who are at risk for suicide.[6]

Question, Persuade and Refer Training of Trainers. The Question, Persuade and Refer Training of Trainers (QPR TOT), from the QPR Institute, is an evidence-based, widely used gatekeeper training. The curriculum uses data, warning signs and simple steps to train individuals, called gatekeepers, in suicide prevention: Question someone exhibiting signs of suicide by asking "Are you thinking about killing yourself"; Persuade an individual who responds affirmatively or appears at risk to seek treatment; and Refer the individual to appropriate resources. At the August training, Dave Denino became a master trainer, allowing him to train others to become QPR gatekeeper trainers.

Connect. The Connect program addresses suicide prevention, intervention, and postvention. It views suicide as a public health problem and focuses on the community as a whole to address it. It encourages the members of the community to work across systems to build a safety net for people at risk. The curriculum was developed and is operated by National Alliance on Mental Illness (NAMI) – New Hampshire and uses lecture, interactive case scenarios, activities, facilitated discussion, and printed materials. Its trainings are divided into three broad categories, prevention/intervention, postvention, and SurvivorVoices, which focuses on helping bereaved individuals understand and manage their grief. Connect has developed specialized training for the following areas: Clinicians; cultural factors; developing a community suicide postvention plan; ethical concerns: working with at-risk individuals; healing works: speaking safely about suicide; media, safe messaging and suicide

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[5] Additionally, the campus sub-recipients hosted and sent representatives to attend several additional trainings which were not funded by the CSPI, during the grant period. These trainings discussed as part of Outcome II: Sub-recipient Campus Infrastructure, below.

[6] Recognizing and Responding to Suicide Risk in Primary Care (RRSR-PC) (no date), http://www.sprc.org/bpr/section-III/recognizing-and-responding-suicide-risk-primary-care-rrsr%E2%80%94pc (accessed October 28, 2014).

prevention; social medical; and reporters and journalism students. Additionally, each of the areas can be customized for 16 different target audiences, including colleges, military, and community gatekeepers, and for training of the trainer sessions.[7]

Assessing and Managing Suicide Risk. Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals (AMSR) is a one-day workshop designed for social workers, licensed counselors, psychologists, psychiatrists and other mental health professionals. It is taught by the SPRC Training Institute, which is a part of the Suicide Prevention Resource Center.[8]

Tip 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse and Treatment. Tip 50 was created by SAMHSA to serve as a manual to provide guidelines to assist substance abuse treatment counselors work with suicidal adult clients.[9]

Campus Connect: A Suicide Prevention Training for Gatekeepers. Campus Connect was developed at the Syracuse University Counseling Center. It was developed to assist college faculty, staff and students identify and assist college students who may be at risk of suicide.[10]

The DORA College Program (Depressions OutReach Alliance). The DORA College program was developed to reduce student isolation and increase social support, by assisting peer mentors recognize signs of student depression and provide them tools to assist students who may be suffering from depression or social isolation. The training itself is designed to be largely facilitated by peer mentors, under the guidance of campus professionals.[11]

Student Support Network (SSN). SSN was developed by the Worcester Polytechnic Institute Counseling Center. It is designed to train college students to identify other students who may be suffering from mental health or behavioral health issues and provide them with skills to successfully assist the students identified.[12]

Data on the programs described above was recorded using the Training Exist Survey Cover Page (TES-CP), a cross-site evaluation tool. It was collected by ICF using the TES-CP cross-site evaluation tool, and shared with CPHHP. Among other things, the TES-CP captured the number of trainings by trainer and by type of training, the location of the training, and the number of attendees at each training. A coding system was devised to track the entity facilitating the training and the type of training offered. The system assigned a number (0-9) to each of the trainings initially chosen for CSPI funding: QPR, QPR TOT, Connect Prevention, Connect Pstovention, Connect TTT, AMSR, RRSR-PC, and Tip 50 trainings (QPR

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7 Connect: Training Professionals & Communities in Suicide Prevention & Response, http://www.theconnectprogram.org/ (accessed October 28, 2014).

8 SPRC Training Institute: Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals, http://www.sprc.org/training-institute/amsr (accessed October 28, 2014).

9 SPRC Best Practice Registry: Addressing suicidal thoughts and behaviors in substance abuse treatment: A treatment improvement protocol TIP 50, http://www.sprc.org/bpr/section-II/addressing-suicidal-thoughts-and-behaviors-substance-abuse-treatment-treatment-improv (accessed October 28, 2014).

10 SPRC, Campus Connecticut: A suicide prevention training for gatekeepers, http://www.sprc.org/bpr/section-III/campus-connect-suicide-prevention-training-gatekeepers (accessed October 28, 2014).

11 SPRC, The DORA College Program (Depression OutReach Alliance), http://www.sprc.org/bpr/section-III/dora-college-program-depression-outreach-alliance (accessed October 28, 2014).

12 SPRC: Student Support Network, http://www.sprc.org/bpr/section-III/student-support-network (accessed October 28, 2014).

was assigned two numbers, and an additional number was reserved for "special population" training sessions, thus all numbers between 0 and 9 were assigned). When training entities offered a training session they were to enter into the TES-CP, among other things, the training code and a text description of the training. This system was not entirely adhered to. The other trainings were added later and entered with codes previously assigned to one of the initial trainings. Further, QPR and Connect Train-the-Trainer sessions were not coded as prescribed. Several other entry errors are described below. To attempt to correct for the data entry inconsistencies, CPHHP examined the titles of the trainings provided and attempted to identify the particular type of training involved based on the text description. As a result, the data reported here may differ substantially from data reported by the cross-site evaluator, if the cross-site evaluator relies on the data coding system alone.

There were 239 training sessions entered into the TES-CP database. Of those, 28 training session text descriptions lack any indication of the type of training. In each of these 28 cases, it was assumed that the training types were properly coded and the training was counted according to its coding. There were 26 instances of the text description matching a training code other than the training code entered. In all 26 of these cases, the training was counted in accordance with its text description. Finally, there were 11 cases where the training had no appropriate training code. These other trainings included DORA, SSN, Campus Connect, Campus Connect TOT, and three trainings that could not be identified. Additionally, DHMAS notified CPHHP that, with three exceptions, all of the QPR and Connect trainings hosted by CCPWR were TOT/TTT sessions. Thus, every such case was assumed to be a TOT/TTT training even when the accompanying text description did not describe it as such.

Table 3 lists all of the CSPI suicide prevention and mental health promotion trainings conducted by CCPWR and the CSPI sub-recipients. Accompanying this list is the total number of training attendees. The number of attendees is an aggregation of the attendees at each individual event. Because particular individuals may have attended multiple trainings, this number may be more than the total number of individuals who attended the various types of trainings. Overall, the sub-recipients report offering 239 training sessions during the course of the CSPI grant period. The first such session was offered by HVCASA–DMHAS Region 5 on March 6, 2012; it was a QPR Gatekeeper Training. The final training session entered into the TES-CP database was provided by CCPWR on June 13, 2014. This, too, was QPR-related, a QPR TOT session. In total, there was an aggregate of 7,182 training attendees who attended the 239 trainings.

QPR was by far the most popular of the CSPI suicide programs. The sub-recipients report offering a total of 181 QPR-related trainings during the grant period. This constitutes approximately three-quarters of all CSPI funded training sessions appearing in the TES-CP database. Prospective QPR Gatekeepers were offered 164 trainings at various times and throughout the state. QPR TOT sessions were offered 17 times. While it is unclear how many QPR trainers resulted from these training sessions, the QPR Gatekeeper Trainer Survey, which was administered in the spring of 2013, showed that as many as three-fourths of the state's QPR trainers at that time, or approximately 85 individuals, may have been trained since the initiation of the grant.[13] At that time, March 2013, the TES-CP data shows that there had been only ten QPR TOT training sessions funded by the grant. By the conclusion of the grant period, there had been seventeen QPR TOT sessions, suggesting that there may have been well over 100 certified trainers after the completion of

[13] The response rate was 69 percent. The number of respondents who indicated that they had become QPR trainers since March, 2012, was 59, or 77.6 percent of respondents. Assuming 77.6 percent of non-responders were also trained between March 2012 and March 2013, this yields the estimate of 85 individuals. For more detail on the QPR Gatekeeper Trainer Survey, see Appendix B.

the grant period and, potentially, multiple hundreds of gatekeepers. In addition, two QPR Master Trainers, David Denino and Thomas Steen became master trainers during the grant period. Master trainers are certified to lead QPR TOT sessions.

Table 3

Number of Trainings and Attendees (by type of training)

Name of Training	Number of Trainings	Number of Attendees
QPR	164	5429
QPR TOT	17	411
Connect	39	871
Connect TTT	5	125
RRSR-PC	1	48
AMSR	1	16
TIP 50	1	30
DORA	2	57
SSN	3	62
Campus Connect	2	39
Campus Connect TOT	1	17
Other	3	77
Total	239	7182

There were ten entities that hosted trainings as part of the CSPI: CCPWR, the four campus sub-recipients and the five RAC sub-recipients. All of the CSPI training entities offered at least one CSPI suicide prevention or mental health promotion training during the period of the grant. DMHAS RAC Region 2, the Valley Substance Abuse Action Council (VSAAC), offered the most trainings, at 44, while DMHAS RAC Region 4, the Capitol Area Substance Abuse Council (CASAC), had the highest attendance, with an aggregate of 2,632 attendees at its 42 trainings.

Table 4

Trainers, Trainings, and Attendees

Trainers	Number of Trainings	Attendees
CCPWR	29	744
Sub-recipient campuses	66	1,281
RYASAP-DMHAS Region 1	21	646
VSAAC-DMHAS Region 2	44	1093
SERAC-DMHAS Region 3	30	631
CASAC-DMHAS Region 4	42	2632
HVCASA-DMHAS Region 5	7	155
Total	239	7182

A CSPI-funded training was provided in each of Connecticut's eight counties. Hartford County had, by far, the most trainings, accounting for nearly one-third of them. Hartford County houses one fourth of the state's population and is the home of Manchester Community College and the CCPWR. The next two counties with the highest CSPI trainings were New Haven County and Fairfield County, the latter of which

is home of Norwalk Community College and Sacred Heart University. The counties with the most reported attendees were Hartford (2,882), New Haven (2,750) and New London (1,170) Counties, the last of which is home to Connecticut College.

Table 5

Location of Trainings (by county)

County	Frequency	Attendees
Hartford	81	2882
New Haven	42	1170
Fairfield	41	993
New London	37	1175
Middlesex	18	411
Tolland	8	310
Litchfield	7	139
Windham	4	77
Location Missing	1	25
Total	239	7182

Mini-Grantee facilitated programs

The Grant Recipient Survey was distributed to campus sub-recipients and mini-grantees in late May, 2014, near the conclusion of the CSPI grant period. An email was sent to the campus sub-recipients and mini-grantees with a link to the survey on SurveyMonkey; data was collected until the end of July. The survey gathered information on many aspects of the CSPI programs and processes. The Grant Recipient Survey was returned by 34 of the 38 potential respondents, for a response rate of 89.5 percent. The respondents included the four campus sub-recipients and 30 mini-grantees (25 towns and five campuses). It should be noted that not all respondents answered every question, therefore the response rate varies by question.

The mini-grantee responses were examined to investigate the type and extent of training mini-grantees offered since this information was not collected in the TES-CP, as was the case for the campus sub-recipients. An overwhelming majority of the mini-grantees who responded, 83.3 percent, reported using their funding to host QPR training sessions. Collectively, they reported the QPR training sessions attracted 5,595 attendees. Connect Postvention training was offered by six of the mini-grantees, who reported an aggregate of 80 attendees. Mini-grantees also reported offering other types of suicide prevention and mental health promotion training to their respective communities, including Mental Health First Aid, Signs of Suicide, Student Support Network (SSN), Campus Connect, and Depression OutReach Alliance (DORA). Additionally, about two-thirds of the mini-grantees reported receiving the Connect Prevention trainings with 378 participants.

Question, Persuade, and Refer Gatekeeper Trainer Survey

CCPWR created the QPR Gatekeeper Trainer Survey as part of the CSPI. The survey was developed to establish the number of QPR gatekeeper trainers in Connecticut and to develop a directory of them. More details on the survey are provided in Appendix B.

Sub-recipient Feedback

The campus sub-recipients and mini-grantees were given various informal opportunities to provide feedback

to DMHAS, CCPWR and, in the case of the mini-grantees, the RACs during the grant period. In addition, some or all of the sub-recipients were given an opportunity to formally provide input during and at the completion of the CSPI, see Table 6. The sub-recipients, all of which were invited to participate in the CSPI-CHCI monthly professional development meetings, were invited to suggest meeting topic ideas and provide other feedback through the CHCI Meeting Survey, 2013. CCPWR amended the MHPS in 2014 to allow campus sub-recipients to provide open ended comments on the 1 Word Campaign and other aspects of the CSPI. Finally, DMHAS and CPHHP developed the Grant Recipient Survey, and invited campus sub-recipients and mini-grantees to provide feedback on a number of areas related to their experiences with the grant program.

Table 6

CSPI feedback sources

	Date Administered	Respondents
CHCI Survey 2013	June, 2013	53
Mental Health Promotion Survey 2014	April, 2014	21
Connecticut Garrett Lee Smith Grant Recipient Survey	June, 2014	28

The Grant Recipient Survey gave campus sub-recipients and mini-grantees the opportunity to provide feedback on the grant application process, sectors represented, populations served, the grant implementation process, and the usefulness of the 1 Word Campaign.

Over half (59.4 percent) of the respondents reported that the grant application process was "very clear." All of the respondents were at least somewhat satisfied with the assistance available to them during the application process, with 77.4 percent of them answering that the assistance available was adequate and the remainder indicating it was somewhat adequate. More than two-thirds (71.0 percent) of respondents believed the goals of the grant were clear. Four-fifths of the respondents, 83.9 percent, were very satisfied with the level of assistance available to them during the grant program implementation.

The campus sub-recipients and mini-grantees were required to have at least five sectors represented by members of their task force or coalition to help guide local efforts on campuses or in communities. As noted in Tables 7 and 8, campus sub-recipients and mini-grantees reported having a wide range of sectors suggesting the presence of a strong infrastructure. In the case of towns, the vast majority of respondents reported having representatives from school systems, youth services agencies, law enforcement, mental health and substance abuse prevention entities, and several others. The vast majority of campus respondents identified task force/coalition representatives from counseling center/mental health clinicians, student affairs, student organizations and government and substance abuse center/counselors as would be expected. However, the campus respondents also identified administration, police and safety services, and health center staff illustrating a breadth of representatives involved.

Table 7

Towns: Sectors Represented by Members of Task Force/Coalition

Sectors	n (%)
School System	22 (95.7)
Youth Services Agencies	21 (91.3)
Law Enforcement	18 (78.3)
Mental Health and Substance Abuse Prevention Providers/Organizations/Chapters	18 (78.3)
Social Service Department /Providers/Organizations	17 (73.9)
Mayor/Town Manager/Selectman	16 (69.6)
Mental Health and Substance Abuse Treatment Providers/Organizations/Chapters/ Support Groups	15 (65.2)
Faith-Based Organizations	15 (65.2)
Fire Department	6 (26.1)
Emergency Mobile Crisis Services/Paramedic	5 (21.7)
Other	8 (34.8)

Table 8

Campuses: Sectors Represented by Members of Task Force/Coalition

Sectors	n (%)
Counseling Center/Mental Health Clinicians (campus and community)	8 (100.0)
Student Affairs	7 (87.5)
Student Organizations and Government	7 (87.5)
Substance Abuse Center/Counselors	7 (87.5)
Administration	6 (75.0)
Police/Safety Services (campus and community)	6 (75.0)
Health Center Staff	5 (62.5)
Residence Directors/Assistants	4 (50.0)
Judicial Affairs	4 (50.0)
Faith-Based Organizations	3 (37.5)

Respondents were asked to identify populations that they addressed with CSPI funding (Table 9). The majority of respondents reported that they served youth ages 10-17 (71.0 percent) and young adults in town ages 18-24 (51.6 percent). Almost half (48.4 percent) of the respondents reported serving college students through age 24. Approximately one-third or fewer of the respondents served other priority populations (e.g. LGBT, individuals with specific mental health conditions, Hispanic/Latino(a), military personnel/veterans).

Table 9

Population(s) Grant Addressed

Populations	n (%)
Youth 10-17	22 (71.0)
Young adults in town 18-24	16 (51.6)
College students through age 24	15 (48.4)
Individuals who are Lesbian, Gay, Bisexual or Transgender	11 (35.5)
Individuals with specific mental health condition	9 (29.0)
Individuals who identify as Hispanic or Latino(a)	7 (22.6)
Military personnel/Veterans	6 (19.4)

As a requirement of receiving a sub-grant the mini-grantees and sub-recipients were required to participate in Connecticut's suicide awareness campaign, "1 Word, 1 Voice, 1 Life…Be the 1 to start the conversation." Three-fourths of the respondents thought that the objectives of the 1 Word campaign were very clear. The overwhelming majority of respondents, 87.1 percent, thought the materials produced by the campaign (brochures, wallet cards, posters and other items) were very accessible, and 74.2 percent of the respondents also thought that these materials were "very useful" in their community. Highlighting the importance of people in providing support, nearly two-thirds of the respondents, 67.7 percent, indicated that their RAC contacts were their primary means of accessing the 1 Word campaign, whereas only 23.1 identified the website as the primary means of accessing the campaign.

Finally, the survey asked whether the participants, if given the chance, would go through the grant process again. Specifically, they were asked: "Were a similar grant made available in the future, with similar requirements and conditions, might your town or campus apply?" A large majority of respondents, 80.8 percent, answered this would be very likely.

Outcome Evaluation

CPHHP collected survey data to assess three selected outcomes: State-wide suicide prevention infrastructure; sub-recipient campus suicide prevention infrastructure; and sub-recipient campus student suicide contemplation and attempt. The various survey instruments are listed below and brief descriptions are provided.

Instruments: Description, Administration, and Response Rates

The Mental Health Promotion Survey (MHPS)

CCPWR created the MHPS to measure campus suicide prevention and mental health promotion infrastructure. The survey elicited information on the types of programs offered on college campuses across the state; the populations offered suicide prevention and mental health promotion training; the settings in which the trainings are offered; and whether there are services available specifically tailored to the CSPI priority populations. CCPWR made several minor changes to the survey in 2014. For example, the number of specific programs listed on the survey expanded from 2011 to 2014, from 15 answer items to 28.

CCPWR administered the MHPS on-line via SurveyMonkey during the fall semester, 2011, and again in spring of 2014, near the completion of CSPI activities. Campuses were invited to return the survey regardless of whether they were formal participants in the CSPI. For the first administration, the survey link was active from September 30, 2011, to January 18, 2012. Valid responses were received from 27 campuses

state-wide. For the second administration, the survey was open from April 2 to May 12, 2014. Valid responses were received from 21 campuses in 2014.

Table 10

MHPS Response Rates, 2011 and 2014

Year	Institutions Contacted	Institutional Responses	Valid Institutional Responses	Valid Response Rate
2011	[35]*	29	27	[77.1]*
2014	35	23	21	62.9

** The records containing the number of schools contacted in 2011 were unavailable at the time of this evaluation. For the purpose of calculating the response rate for 2011, it has been assumed that as many schools were sent the survey in 2011 as in 2014.*

In both years, multiple individuals were contacted from each campus. The MHPS included a screening question that asked whether the individual respondent was involved in suicide prevention or mental health promotion on the respective campus. In the fall, 2011 administration of the survey, 38 individuals from 29 campuses returned responses. Two of the 38 individuals did not indicate with which campus they were associated. Several institutions had multiple individual respondents, but in each such case, only one individual satisfied the screening requirement of being involved with the campus's suicide prevention services. Additionally, for two campuses, only one individual returned a response, and that individual failed to satisfy the screening requirement. These two campuses, then, did not return valid responses and are not included in the analyses below.

There were 23 campuses that submitted responses, but two did not include substantive answers and were eliminated, leaving 21 campuses represented in 2014. Of the 21 campuses sending valid responses, 17 had also returned the MHPS in 2011. Six campuses had multiple individuals send a response in 2014. Unlike 2011, however, most of the individual respondents in 2014 satisfied the screening requirement, and, therefore, several institutions had multiple individuals send substantive answers. Further, in all six instances, the different individuals provided inconsistent responses for the respective campus. In each case, we selected one individual respondent per campus to "speak for the institution." The selection process included examining the employment titles provided by the individual respondents and selecting the individual with the title that appeared to be most closely connected to suicide prevention activities.

EIRF

The EIRF was developed by ICF as a web-based, GLS grantee cross-site data collection tool and is managed by the Suicide Prevention Data Center (SPDC). The EIRF collects individual-level information about youth identified as at-risk for suicide by a gatekeeper or through a screening tool. Information on the EIRF includes demographics (i.e. age, race), identification information (i.e. setting, location), referral information (i.e. mental health referral, non-mental health referral). Program staff at the sub-recipient campuses were responsible for completing the EIRF and entering the data on a quarterly basis.

Institution of Higher Education Demographic Survey (IHEDS)

The IHEDS is an institutional survey developed by the American College Health Association. The survey is five pages and asks respondent institutions of higher education to provide basic background information about the institution itself and demographic information about the student population. ACHA requires

campuses administering the NCHA to complete the IHEDS. Each of the four campus sub-recipients completed the survey and results were provided to CPHHP. CPHHP used the IHEDS data to compare total student population demographic data of the sub-recipient campuses with the demographic data of the respondents to the student surveys.

The Suicide Prevention Exposure, Awareness and Knowledge Survey-Student (SPEAKS-S); the Suicide Prevention Exposure, Awareness and Knowledge Survey-Faculty and Staff (SPEAKS-F/S); and the National College Health Assessment II (NCHA)

The SPEAKS-S is a survey for college students. It consists of 59 questions and takes about 20 minutes to complete. The survey asked the students to provide information about, among other things, the general atmosphere on campus regarding mental health and their own view about mental health and suicide prevention services provided on their campus.

The SPEAKS-F/S is a survey for college faculty and staff. It consists of 54 questions and takes about 15 minutes to complete. The survey is designed to measure faculty and staff perspectives of suicide prevention programs as well as awareness and knowledge of suicide risk factors.

The NCHA was developed by the American College Health Association (ACHA). It is a survey designed for college students that focuses on student health habits, behaviors, and perceptions. It consists of 66 questions and takes approximately 25 minutes to complete. The NCHA provided data on whether students had attempted or contemplated suicide.

The SPEAKS-S, SPEAKS-F/S and NCHA surveys were administered as part of the CSPI pretest in 2012, and again as part of the posttest in 2014. A detailed description of the pre- and post-test administration of, and response to, these surveys appears in Appendix C. All surveys were administered on-line. The total valid response rate did not exceed 20 percent for any of the surveys either year. The surveys from the pretest had slightly higher response rates than the posttest. These are summarized in Table 10. Because the response rates to the student surveys are so low, caution should be exercised in making decisions about the larger student population at the sub-recipient campuses based on the answers provided by the respondents. Due to the low response rates, CPHHP analysts determined that the responses were too unreliable to conduct significance tests or other statistical analyses when comparing responses from 2012 to those from 2014.

Table 11

Summary of Student and Faculty/Staff Survey Response Rates

Sub-Recipient	Valid Response Rate, Fall 2012	Valid Response Rate, Spring 2014
SPEAKS-S	12.3	9.9
SPEAKS-F/S	19.9	11.4*
NCHA	9.8	8.5

**CPHHP did not have the number of surveys distributed to faculty and staff in 2014 for all of the campuses at the time of this evaluation. Where 2014 information was lacking, CPHHP assumed that as many surveys were distributed to faculty and staff in 2014 as was the case in 2012.*

Statewide

Outcome I: State-wide Suicide Prevention Infrastructure

One of the aims of the CSPI was to strengthen the suicide prevention infrastructure statewide. To measure this, representatives of institutions of higher education from across the state were asked to complete the Mental Health Promotion Survey, wherein they provided some basic information about the suicide prevention and mental health promotion programs offered on their campuses. They were asked to provide this information during the fall semester, 2011, and again in spring of 2014, near the completion of the grant period. Twenty-seven campuses submitted valid responses in 2012 and 21 campuses did so in 2014.

In the fall of 2011, half of the responding campuses participated in the National Depression Screening Day, a program that was included as part of CYSPI, Connecticut's previous GLS funded suicide prevention initiative. A similar percentage of respondents in spring of 2014 reported National Depression Screening Day participation. Another CYSPI focus program, QPR, also remained popular among responding institutions. In the earlier initiative, the QPR Gatekeeper training program was offered at the four Connecticut State Universities. By the time of the 2011 administration of the MHPS, nine of the respondent schools, or about one-third of them, offered some form of the program. In 2014, 15 campuses reported using QPR, which constituted 71.4 percent of the responding institutions. The College version of the Signs of Suicide (SOS), another program featured in the CYSPI, was discontinued in 2010 and, therefore, not offered during the CSPI.

The programs initially selected for CSPI funding were QPR, Connect Postvention, Connect Prevention/ Intervention, AMSR, RRSR-PC, and Tip 50. None of the campuses reported using any of these programs, other than QPR, in 2011. In 2014, four of the campuses used AMSR, two campuses reported using Connect Postvention, and one campus used Connect Prevention. Of the three other trainings that were funded by the CSPI grant, DORA, SSN and Campus Connect, only DORA was used in 2011. In 2014, one campus reported using DORA, four campuses used Campus Connect and two reported using SSN.

Table 12

Mental Health Promotion and Suicide Prevention Training

	Fall 2011		Spring 2014	
	Frequency	Percent	Frequency	Percent
Active Minds	8	29.6	8	38.1
Applied Suicide Intervention Skills	1	3.7	2	9.5
Assessing and Managing Suicide Risk (AMSR)	0	0.0	4	19.0
At-Risk for College Faculty and Staff	2	7.4	0	0.0
At-Risk for College Students	1	3.7	0	0.0
Campus Connect	0	0.0	4	19.0
College Response	3	11.1	1	4.8
Connect Postvention	0	0.0	2	9.5
Connect Prevention	0	0.0	1	4.8
Counseling on Access to Lethal Means (CALM)	0	0.0	0	0.0
Depression OutReach Alliance (DORA)	2	7.4	1	4.8
Fresh Check Day	0	0.0	4	19.0
Half of Us	0	0.0	3	14.3
Mental Health First-Aid	2	7.4	4	19.0
Mental Health Edu	0	0.0	0	0.0
National Alcohol Screening Day	0	0.0	9	42.9
National Depression Screening Day	13	48.1	10	47.6
National Eating Disorder Screening Day	0	0	5	23.8
Personal Health Questionnaire 9 (PHQ 9)	0	0	4	19.0
Question, Persuade, Refer (QPR)*	9	33.3	15	71.4
Recognizing and Responding to Suicide Risk in Primary Care (RRSR-PC)	0	0	0	0.0
Reconnecting Youth for Young Adults	0	0	0	0.0
Safe TALK	0	0	0	0.0
Signs of Suicide Prevention Program (SOS)	2	7.4	0	0.0
Student Support Network	0	0	2	9.5
Tip 50	0	0	0	0.0
Ulifeline	0	0	6	28.6
Yellow Ribbon Project	2	7.4	2	9.5
None of the Above	7	25.9	0	0.0

Italicized type indicates answer options new to the 2014 survey.
*In MHPS 2012, QPR was divided into two items, QPR facilitated and QPR online. In MHPS 2014, the items were combined into one. The 2012 responses have been combined in the table to facilitate comparison with 2014.

Respondents also provided information on the different groups on campus to which suicide prevention and mental health trainings are directed and the settings in which those trainings are offered. Nearly half of the respondents indicated that faculty and staff were offered such training at orientation and in-service trainings in 2011. Nine campuses offered training to these groups in 2014. More than one-third, 35.7 percent, stated

that student residence assistants received such training. More than half of the respondents reporting in 2014 did so, though this seemingly large percentage increase may be due to the small number of respondents. Only one more campus reported offering the training to RAs in 2014 than 2011. Fewer than ten schools in each year offered training in any of the other individual settings listed.

Table 13

Mental Health and Suicide Prevention Trainee Groups

	Fall 2011		Spring 2014	
	Frequency	**Percent**	**Frequency**	**Percent**
Upper Level Management (2011) *Senior Management (2014)*	4	14.8	6	28.6
Faculty and staff at orientation or in-service	13	49.1	9	42.9
Faculty and staff through online training	3	11.1	1	4.8
Professional residence life or hall directors staff	12	44.4	11	52.4
Graduate assistants	6	22.2	4	19.0
Peer advocates/ educators	8	29.6	8	38.1
First-year students in a first-year experience class	5	18.5	4	19.0
Student residence life/ residence assistants training	10	37.0	11	52.4
Students at campus-wide events	NA	NA	9	42.9
Students at student orientation	3	11.1	3	14.3
Students in classes for credit	3	11.1	4	19.0
Students in classes not for credit	1	3.7	1	4.8
Students through online training	0	0.0	0	0.0
Students through residence life or student activities programming*	9	33.3	10	47.6
None of the above	6	22.2	2	9.5

*This is how the question appeared in the 2011 version. It was split into two items in the 2014 survey, one asking about residence life programming and the other about student activities programming. For purposes of comparison, the responses from 2014 were combined. A school is counted once if it offers both residence life and student activities programming.

Italicized type indicates new answer options for 2014.

Respondents were also asked whether their campuses provided training specifically tailored to meet the needs of any of the student groups that DMHAS identified as being "priority populations" for the purposes of the CSPI. These groups include students with mental health disorders, Hispanic students, veterans and military personnel, and LGBT students. More than half of the respondents indicated that their campuses provided specific services for students with a mental health disorder. A little more than a third offered such services to LGBT students, and another third indicated that they did not provide services specifically tailored to any of the priority populations. A similar number of campuses indicated offering specially tailored programs in 2014 as 2011, though, because of the smaller number of respondents, the percentages are somewhat higher for most groups in 2014. Somewhat fewer campuses reported offering programs specifically tailored to students with mental health disorders in 2014, though this is probably reflective of a change in respondents, rather than evidence of a discontinuation of service.

Table 14

Mental Health or Suicide Prevention Services for CSPI Priority Populations

	Fall 2011		Spring 2014	
	Frequency	**Percent**	**Frequency**	**Percent**
Active Military	5	18.5	7	33.3
Veterans	8	29.6	7	33.3
Hispanic / Latino (a)	8	29.6	8	38.1
LGBT	10	37.0	8	38.1
Mental Health Disorders	16	59.3	12	57.1
None of the Above	9	33.3	6	28.6

Another source for measuring infrastructure development can be found in the Grant Recipient Survey. The survey included several questions related to ways the grant influenced a town or campus's capacity, ability and support related to suicide prevention, intervention and postvention. Table 15 presents the number and percent of respondents who indicated an improvement or increase in the various topics. The results are displayed by type of grant and affiliation (i.e., town mini-grantee, campus mini-grantee and campus). Responses related to suicide prevention indicated that all or the vast majority of the respondents viewed their town/campus's suicide prevention capacity, ability to implement suicide prevention efforts and level of support for suicide prevention increased due to the grant. Similarly, findings related to suicide intervention suggest that the majority of towns and campuses increased their capacity to assist individuals at risk, ability to implement response efforts and level of support for response efforts to assist individuals at risk following a suicide attempt as a result of the grant. When examining the total responses, nearly half of the respondents reported that the grant had a positive impact on their town or campus's response capacity, ability and level of support for suicide prevention/sudden death efforts. However, on closer examination, campus sub-recipients report greater gains in postvention activities than the mini-grantee recipients.

Based on the responses, the CSPI provided the respondents with many networking opportunities with others interested in suicide prevention (48.4 percent) particularly for the campuses. In addition, CSPI greatly increased the respondents' ability to access suicide prevention materials (80.6 percent).

Table 15

Influence of Grant on Mini-Grant Towns Mini-Grant Campuses and Campus Sub-recipients

Item	Mini-Grant Towns n (%)	Mini-Grant Campuses n (%)	Campus Sub-recipients n (%)	Total n (%)
Capacity of suicide prevention in town/campus increased as a result of grant	23 (100.0)	5 (100.0)	3 (100.0)	31 (100.0)
Ability of town/campus to implement suicide prevention efforts improved due to grant	21 (91.3)	5 (100.0)	2 (66.7)	28 (90.3)
Level of town/campus support for suicide prevention efforts increased due to grant	20 (87.0)	3 (60.0)	2 (66.7)	25 (80.6)
Capacity of town/campus to assist individuals at risk following a suicide attempt increased in as result of grant	16 (69.6)	3 (60.0)	2 (66.7)	21 (67.7)
Ability of town/campus to implement response efforts to assist individuals at risk following a suicide attempt improved due to grant	12 (52.2)	2 (40.0)	3 (100.0)	17 (54.8)
Level of town/campus support for response efforts to assist individuals at risk following a suicide attempt increased due to grant	11 (47.8)	3 (60.0)	2 (66.7)	16 (51.6)
Capacity of town/campus suicide postvention/ sudden death response increased as a result of grant	10 (43.5)	1 (20.0)	3 (100.0)	14 (45.2)
Ability of town/campus to implement suicide postvention/sudden death response efforts improved due to grant	10 (43.5)	1 (20.0)	2 (66.7)	13 (41.9)
Level of town/campus support for suicide postvention/sudden death efforts increased due to grant	10 (43.5)	1 (20.0)	3 (100.0)	14 (45.2)
Grant provided many networking opportunities with others interested in suicide prevention	10 (43.5)	2 (40.0)	3 (100.0)	15 (48.4)
Grant greatly increased ability to access suicide prevention materials	17 (73.9)	5 (100.0)	3 (100.0)	25 (80.6)

Sub-Recipient Campuses

Outcomes 2 and 3 relate specifically to the sub-recipient campuses. CSPI took a baseline measure of the campus infrastructure in 2011-2012, and the use of that infrastructure, and also student inclinations towards suicide contemplation, attempt and deaths. Five survey instruments were used to collect the needed data: Institution of Higher Education Demographic Survey, National College Health Assessment, Mental Health Promotion Survey, Suicide Prevention Education Awareness and Knowledge Survey–Student, and Suicide Prevention Education Awareness and Knowledge Survey–Faculty and Staff.

Demographic Information

Sub-recipient Campuses and Student Survey Respondents

In order to gain a sense of whether the respondents to the student surveys were similar to the student body as a whole, CPHHP compared demographic information about the students attending the four sub-recipient campuses with similar demographic information of the survey respondents. The aggregate demographic composition of the sub-recipient campus student populations was based on information from the ACHA Institution of Higher Education Demographic Survey, which the campus sub-recipients were required to complete before administering the NCHA. The IHEDS data was augmented with publically available data from the National Center for Educational Statistics (NCES).[14] Each of the survey instruments collected race information somewhat differently. More detail on this, and the process used to create the summary information in Table 17, may be found in Appendix A.

The combined population of all the sub-recipient campuses is approximately 58 percent female and 42 percent male. Female students appear to have completed both of the surveys at higher rates than their male classmates. For the pretest in 2012, the respondents to the SPEAKS-S were 68.9 percent female and the respondents to the NCHA were 73 percent female. For both surveys, an even larger proportion of respondents were female in the 2014 posttest than the 2012 pretest. The proportions increased to 73.6 percent female for the SPEAKS and 75.3 percent female for the NCHA. If male and female college students have systematically different views or needs with regard to suicide, the large difference between the gender composition of the student body and the respondents may affect the representativeness of the results.

Students who identify as White also seem to have answered the two surveys at higher rates than students who identified with other race categories. White students constitute 55 percent of the entire student body, but were 72.3 percent of the SPEAKS-S respondents and 70.5 percent of the NCHA respondents in 2012. For the posttest, the proportion of NCHA respondents who identified as White increased to 75.1 percent of the total, though reduced somewhat for the SPEAKS-S to 67.6 percent of respondents indicating a racial identification. In part, this difference may be related to the varying response rates between the campuses, each of which has a somewhat different racial composition.

Response rates to the student surveys varied considerably across the four sub-recipient schools. In 2014, for example, the response rates for the SPEAKS-S ranged from 20.3 percent to 4.6 percent. This raises questions regarding the reliability of the aggregate student results to represent the experiences of students at all of the individual campuses.

[14] The campus-wide data does not include student ages. It is probable that students are included in this data who are not between the ages of 18 and 24 and, therefore, not included in the two students surveys. This lessens somewhat the comparability of the campus-wide data and the survey sample data.

Table 17

Summary Demographic Information on NCHA and SPEAKS-S Survey Respondents Compared to Total Undergraduate Enrollment

	Total Enrollment 2012	NCHA 2012	NCHA 2014	SPEAKS-S 2012	SPEAKS-S 2014
Population or sample size	20440	618	516	798	633
	Percent	Percent	Percent	Percent	Percent
Female	57.9	73.0	75.3	68.9	73.6
Male	42.1	26.7	24.3	30.3	25.8
Transgendered/Other	NA	0.3	0.4	0.6	0.6
No response (count)		14	14	154	133
White, Non-Hispanic	55.2	70.5	75.1	72.3	67.6
Black, Non-Hispanic	12.3	6.3	4.8	5.9	5.2
Hispanic	16.5	11.7	12.3	15.1	18.0
Asian or Pacific Islander	3.7	3.8	2.2	5.1	6.4
Native American or Alaskan Native	0.2	0.2	0.0	0.2	0.4
Other	11.3	1.0	1.0	NA	NA
Multiracial	NA	6.6	4.6	1.6	2.4
No response (count)		12	13	167	133
International	1.2	8.6	8.5	4.6	3.8
No response (count)		13	14	162	137

Priority Populations

DMHAS has selected four priority populations for the purpose of the CSPI: Hispanic students, LGBT students, students who are active or former military personnel, and students with mental health disorders. Neither instrument collected data on all four of the priority populations distinctly; nevertheless, each survey yielded information on at least some of the priority populations.

The SPEAKS-S does not ask generally whether the students have ever had a mental health disorder, but it does ask whether students have received mental health services at their particular campus, a useful proxy, for which 13.9 percent answered that they had in 2012 and 20.6 percent in 2014. It also asks students whether they are Hispanic, to which 15.1 percent answered in the affirmative in 2012 and 18.1 percent in 2014. The instrument does not collect data on student sexual orientation; it does ask whether a student is transgender, but there are too few cases to report in light of students' privacy interests. The SPEAKS-S does not ask about military involvement.

Table 18

CSPI Priority Populations, SPEAKS-S

	2012		2014	
	Frequency	**Percent**	**Frequency**	**Percent**
Received Mental Health Services on Campus	90	13.9	103	20.6
Hispanic Students	95	15.1	90	18.1

The NCHA survey also collects demographic information. It asked whether students are transgender and whether they are lesbian or gay, bisexual, or unsure, to which 11.9 percent answered in the affirmative in 2012 and 11.2 percent in 2014. The NCHA also asked whether students were Hispanic (11.7 percent in 2012 and 12 percent in 2014) and whether students had been diagnosed within the past 12 months by a professional for: anorexia, anxiety, attention deficit and hyperactivity disorder, bipolar disorder, bulimia, depression, insomnia, other sleep disorders, obsessive compulsive disorder, panic attacks, phobia, schizophrenia, substance abuse or addiction, other addiction, or other mental health disorders. 26.5 percent of the respondents reported having been diagnosed or treated with at least one of these conditions within the last 12 months in 2012 and 26.7 percent in 2014. Finally, the survey collected data on whether students were affiliated with the military, but there were too few in the sample each year to analyze their responses separately in this report.

Table 19

CSPI Priority Populations, NCHA

	2012		2014	
	Frequency	**Percent**	**Frequency**	**Percent**
Hispanic Students	71	11.7	62	12.0
Mental Health Disorder	161	26.5	138	26.7
Lesbian, Gay, Bisexual, Transgender or Unsure	71	11.9	58	11.2
Military Affiliated	8	1.3	4	0.8

Outcome II: Sub-recipient Campus Infrastructure

One of the aims of the CSPI was to assist the sub-recipient campuses develop their suicide prevention infrastructure. CPHHP collected data near the beginning of the grant period, 2012, on the types of services the sub-recipient campuses offered; student and faculty/staff perceptions of the availability of such services; and a general sense of the atmosphere on the campuses regarding use of these services. Similar data was collected near the end of the grant period, in the spring of 2014.

The MHPS was relied upon to gather data regarding the types of trainings offered at the campuses, and whether these trainings were tailored to the CSPI priority population, and to whom the trainings were offered. Evidence of the accessibility of these programs to faculty/staff and students, and the general atmosphere on the campuses regarding help seeking was collected using the SPEAKS-S, SPEAKS-F/S and the NCHA.

Campus Infrastructure

Information was elicited on the types of programs offered at the sub-recipient campuses; whether there were services available specifically tailored to the identified CSPI priority populations; and the populations to which trainings were offered. Faculty, staff, and a sample of students were invited to provide their beliefs regarding their ability to assist a student in need. Faculty and staff were also asked whether they had ever provided such assistance.

Two of the sub-recipient campuses did not offer any specific mental health promotion or suicide prevention programs in 2011. The other two campuses offered the program "Active Minds" and participated in the National Depression Screening Day. "College Response," "Depression OutReach (DORA)," "Question, Persuade andRefer (QPR)," and "Signs of Suicide (SOS)" were each implemented by one or the other of these sub-recipients. The campus implementing QPR was the only sub-recipient campus to use a CSPI selected program at the time of the pretest.

At the time of the posttest, spring 2014, all four sub-recipient campuses reported having offered QPR training. Further, two campuses offered AMSR, one offered Connect Prevention, and one offered Connect Postvention, all of which were CSPI selected trainings. The other two CSPI selected trainings, RRSR-PC and Tip, were not administered on any of the campuses. In addition to QPR, all four campuses reported using the National Depression Screening Day. Other popular programs included Active Minds and the National Alcohol Screening Day, both of which were offered by three campuses. Each of the sub-recipient campuses reported using at least one mental health promotion or suicide prevention program during the CSPI period.

Table 20

Mental Health Training Programs used by Sub-Recipient Campuses Fall, 2011 and Spring, 2014

	Fall 2011		Spring 2014	
	Frequency	**Percent**	**Frequency**	**Percent**
Assessing and Managing suicide Risk (AMSR)	0	0	2	50
Connect Prevention	0	0	1	25
Connect Postvention	0	0	1	25
Question, Persuade, Refer (QPR)*	1	25	4	100
Recognizing and Responding to Suicide Risk in Primary Care (RRSR-PC)	0	0	0	0
Tip 50	0	0	0	0
Active Minds	2	50	3	75
Campus Connect	0	0	1	25
College Response	1	25	1	25
Depression OutReach Alliance	1	25	1	25
Fresh Check Day	0	0	2	50
Mental Health First-Aid	0	0	2	50
National Alcohol Screening Day	0	0	3	75
National Depression Screening Day	2	50	4	100
National Eating Disorder Screening Day	0	0	1	25
Personal Health Questionnaire 9 (PHQ9)	0		2	50
Signs of Suicide Prevention Program (SOS)	1	25	0	0
Student Support Network (SSN)	0	0	1	25
Ulifeline	0	0	2	50
None of the Above	2	2	0	0
Other	0	0	0	0

Italicized type indicates answer options new to the 2014 survey.
Other programs identified by the MHPS, but which were not used by the sub-recipient campuses, include Applied Intervention Skills; At-Risk for College Faculty and Staff; At-Risk for College Students; Reconnecting Youth for Young Adults; Safe TALK; and the Yellow Ribbon Project, Counseling on Access to Lethal Means (CALM), Half of Us, and Mental Health Edu.
*In MHPS 2012, QPR was divided into two items, QPR facilitated and QPR online. In MHPS 2014, the items were combined into one. The 2012 responses have been combined in the table to facilitate comparison with 2014.

Source: Mental Health Promotion Survey, Fall 2011 and Spring 2014.

The sub-recipients were also asked whether they offered suicide prevention or mental health promotion services that are tailored specifically to one or more of the priority populations. As shown in Table 21, in 2011, one of the campuses did not provide services specifically tailored to any of these groups. Another sub-recipient selected "other," but provided a non-response and so, presumably, also did not offer services specifically tailored to the priority populations. Two of the sub-recipients reported offering services tailored to students with mental health disorders. Services for Veterans, Hispanic students, and LGBT students were each offered by one or another of these sub-recipients.

More campuses offered programs specifically tailored to the CSPI identified priority populations at the time of the second MHPS administration in 2014, though one campus continued to report no special programs. At the later date, specifically tailored programs were offered for students active in the military, Hispanic students, LGBT students, and students with mental health disorders at three of the campuses. Two campuses reported having programs for veterans.

Table 21

Mental Health or Suicide Services for Priority Populations

	Fall 2012		Spring 2014	
	Frequency	**Percent**	**Frequency**	**Percent**
Active Military	0	0	1	25
Veterans	1	25	2	50
Hispanic / Latino(a)	1	25	3	75
LGBT	1	25	3	75
Mental Health Disorders	2	50	3	75
None of the Above	1	25	1	25
Other	1	25	0	0

Additionally, the sub-recipient campuses were directed to state which groups on campus are regularly offered trainings in programs focused on suicide prevention. Both of the campuses that reported offering suicide prevention training in 2011 provided that training to professional residence life staff. One or the other of these campuses also offered training to faculty and staff, upper level management, peer advocates, and other students at various times and in various settings.

More campuses offered more groups training in 2014 than 2011. In 2014, all four of the sub-recipient campuses offered mental health or suicide prevention training to faculty and staff at orientation or in-service sessions; to peer advocates; and to students generally through residence life or student activities programming. Table 22 lists the populations to which, and settings in which, training was provided. Only programs offered by at least one of the sub-recipient campuses is included.

Table 22

Mental Health and Suicide Prevention Trainee Groups at the Sub-Recipient campuses

	Fall 2012		Spring 2014	
	Frequency	**Percent**	**Frequency**	**Percent**
Upper Level Management (2011) *Senior Management (2014)*	1	25	2	50
Faculty and staff at Orientation or In-Service	1	25	4	100
Faculty and staff through online training	0	0	0	0
Professional residence life or hall directors staff	2	50	2	50
Graduate assistants	0	0	0	0
Peer advocates/ educators	1	25	4	100
First-year students in a first-year experience class	1	25	1	25
Student residence life/ residence assistants training	1	25	2	50
Students at campus-wide events	0	0	3	75
Students at student orientation	1	25	1	25
Students in classes for credit	1	25	1	25
Students in classes not for credit	1	25	0	0
Students through online training	1	25	0	0
Students through residence life or student activities programming*	1	25	4	100
None of the above	2	50	0	0
Other	0	0	0	0

Italicized type indicates new answer options for 2014.

*This is how the question appeared in the 2011 version. It was split into two items in the 2014 survey, one asking about residence life programming and the other about student activities programming. For purposes of comparison, the responses from 2014 were combined. A school is counted once if it offers both residence life and student activities programming.

Source: Mental Health Promotion Survey

As another measure of infrastructure, CPHHP examined the beliefs of faculty, staff and a sample of students regarding their confidence in being able to assist students who may be suicidal. In 2012, about half of the student respondents indicated that they were confident that they could recognize the warning signs of suicide in their fellow students. Sixty percent of students were confident that they could connect such a suicidal student to appropriate resources. Less than half, however, felt confident that they would ask the fellow student whether he or she was thinking about suicide. Respondents in 2014 provided answers that were largely similar to those in 2012, though slightly higher proportions of students believed they could confidently complete each of the three of the items.

Faculty and staff were asked a similar set of questions as the students. While roughly two-thirds of faculty and staff were confident that they could connect a suicidal student to appropriate help, far fewer were confident that they could either recognize a suicidal student or be able to ask a student whether he or she were thinking about suicide. In 2012, less than 30 percent of faculty and staff reported they were confident they could recognize a suicidal student and 38.3 indicated that they would be able to ask. The proportion

of faculty and staff reporting that they could confidently complete both of these items increased slightly in 2014, to 34.5 and 41.3 percent, respectively.

Table 23

Students

	2012		2014	
Item	**Frequency***	**Percent***	**Frequency***	**Percent***
I would be able to recognize the warning signs of suicide in students	372	49.1	291	49.5
I would be able to ask someone who was exhibiting the warning signs of suicide if they are thinking about suicide	320	42.4	261	44.8
I would be able to connect or refer a student at risk for suicide to resources for help (e.g., hotline, counseling, ER, etc.)	455	60.3	373	63.6

Source: SPEAKS-S

*answering "very confident" or "confident"

Table 24

Faculty/Staff

	2012		2014	
Item	**Frequency***	**Percent***	**Frequency***	**Percent***
I would be able to recognize the warning signs of suicide in students	159	29.7	141	34.5
I would be able to ask someone who was exhibiting the warning signs of suicide if they are thinking about suicide	204	38.3	169	41.3
I would be able to connect or refer a student at risk for suicide to resources for help	367	68.8	257	63.0

Source: SPEAKS-F/S

* answering "very confident" or "confident"

Finally, faculty and staff were asked whether they had actually assisted any students who were suicidal or had other mental health issues. In 2012, half of faculty and staff answered that they had referred at least one student to the campus counseling center, though not necessarily for suicide intervention. About a quarter of faculty and staff respondents indicated that they had identified a student as at risk for suicide. Fourteen percent had provided a student with the number of a suicide prevention hotline. It is unclear whether the remaining faculty and staff who identified an at-risk student took other measures to assist the student. The percent of faculty and staff respondents who engaged in these activities increased slightly in 2014 as compared to 2012.

Table 25

Faculty

Item	2012		2014	
	Frequency*	Percent*	Frequency*	Percent*
Have you ever referred a student to campus or community counseling services?	256	50.7	209	54.0
Have you ever identified a student who was at risk for suicide?	128	25.4	112	28.9
Have you ever provided someone the number to a hotline (e.g., national suicide prevention lifeline)?	70	13.8	332	14.7

Source: SPEAKS–F/S

*answering "Yes"

The EIRF data indicate that the campus sub-recipients identified 259 individuals as at-risk for suicide during the grant period. Of those individuals, 205 were referred for additional services. In 2012-2013, 129 individuals were referred and 76 individuals were referred in 2013-2014, which is a reduction in the number of referrals of approximately 41 percent. In both years over 80% of the referrals were made to Mental Health only entities.

Table 26

Referrals of students to suicide prevention services

Referred to:	Academic Year 2012-2013 n (%)	Academic Year 2013-2014 n (%)	Total 2012-2014 n (%)
Mental Health and Non-Mental Health Services	9 (7.0)	9 (11.8)	18 (8.8)
Non-Mental Health Only	1 (0.8)	0 (0)	1 (0.5)
Mental Health Only	116 (89.9)	66 (86.8)	182 (88.8)
Neither Mental Health or Non-Mental Health	3 (2.3)	1 (1.3)	4 (2.0)
Total	129	76	205

Access to Suicide Prevention and Related Services

The data used to form a baseline of current student awareness and use of suicide prevention and related services was collected from three survey instruments, the SPEAKS-S, SPEAKS-F/S, and the NCHA survey. Detailed results are provided in Appendices E and F, where the data is displayed by survey instrument; and frequencies of responses and number of missing responses are provided.

Most of the faculty/staff and students who completed the survey at the pretest indicated that they could find their campus's counseling center, with 83 percent of faculty/staff and 64 percent of students answering this item in the affirmative in 2012. A similar percentage of faculty/staff and students indicated that they were aware of at least one resource to which they could refer someone who might be at risk of completing a suicide. Far fewer faculty/staff and students reported being exposed to any suicide prevention materials on their campus. Less than half of both groups reported this in the affirmative on the SPEAKS-S (31.7%) and SPEAKS-F/S (43.2%) in 2012. The NCHA survey also asked students whether they had received information on suicide prevention. This was answered in the affirmative 38.2 percent of the time. Both the SPEAKS-S and NCHA surveys asked students whether they had received mental health services of any type

from their campus counseling center. Both surveys reported an affirmative response of a little more than ten percent at the posttest.

Among the student respondents, proportionally more students answered in the affirmative in the posttest than the pretest for every item listed in Table 26. Large majorities of the students reported knowing the location of the counseling center (70.9 percent) and being aware of local suicide resources (72.2 percent). The proportion of students indicating that they had received information on suicide prevention at their campus increased to nearly half. The proportion of students who stated that they had directly participated in suicide prevention activities on campus nearly doubled, though still remained below ten percent. The largest proportional increase, however, was among those answering that they had received mental health services on campus; more than doubling from 11.2 percent in 2012 to 26.4 percent in 2014. Faculty and staff expressed a similar level of awareness of suicide prevention services in 2014 as in 2012, with some increase in the proportion of them who reported being exposed to suicide prevention materials.

Table 27

Awareness and Use of Suicide Prevention Services

	Student		Faculty/Staff	
	2012	**2014**	**2012**	**2014**
Item (with affirmative answers)	Percent	Percent	Percent	Percent
Exposed to suicide prevention materials on campus*	31.7	43.0	43.4	51.8
Received information from college or university about suicide prevention**	38.2	48.9	NA	NA
Participated in suicide prevention activities on campus*	5.3	9.3	16.8	22.2
Aware of at least one local resource to refer someone at risk for suicide*	65.4	72.2	83.3	81.4
If you knew a student that was thinking about suicide, where would you refer him / her? (list up to four)*	+	+	++	++
Do you know where to find the counseling center on your campus?*	64.4	70.9	83.2	82.5
Have you received mental health services from your campus counseling center?*	13.9	20.6	NA	NA
Have you ever received mental health services from the campus health center?**	11.2	26.4	NA	NA
Know other students who have received psychological/ mental health services from current college/ university counseling/health services*	32.2	41.9	NA	NA
Have you ever referred a student to camps or community counseling services?*, +++	NA	NA	50.7	54.0

+ In 2012, 424 student respondents (53 percent) supplied at least one resource; 74 (9 percent) supplied four resources. In 2014, 366 respondents (57.8 percent) supplied at least one resource; 63 (10 percent) supplied four resources.
++ In 2012, 421 faculty/staff respondents (75 percent) supplied at least one resource; 97 (17 percent) supplied four resources. In 2014, 317 respondents (75 percent) supplied at least one resource; 85 respondents (20.1 percent) supplied four resources.
+++ answering "very confident" or "confident"
*Source: SPEAKS-S, SPEAK-F/S
**Source: NCHA

Students received information on other mental health topics with somewhat higher rates than suicide prevention. Half of them reported receiving information on stress reduction, and nearly half, information on depression and anxiety management. About one-third reported receiving information on how to help others in distress. At the time of the posttest, fall 2014, more students continued to receive information about these other mental health topics than suicide prevention. As was the case with exposure to suicide material, a larger proportion of the 2014 respondents received information on depression or anxiety, helping others in distress, and stress reduction than the 2012 respondents.

Table 28

Received information from college or university about…

	2012		2014	
Item	**Frequency**	**Percent**	**Frequency**	**Percent**
Depression or Anxiety	299	48.8	311	60.5
How to help others in distress	219	36.0	248	48.7
Stress reduction	308	50.3	350	68.1

Source: NCHA

Less than half of the students who indicated in 2012 that they had used mental health services on their campus reported having been exposed to suicide prevention materials. Less than one-third of Hispanic students reported being presented with such materials. On the other hand, nearly all students who had received mental health services knew where to find a counseling center on campus. More than two-thirds of Hispanic students knew where such a center was located.

In 2014, the proportion of students answering in the affirmative to nearly all of the items listed in Table 28 increased from 2012. The one exception is that a somewhat smaller proportion of Hispanic students indicated that they knew where to find their campuses counseling center in 2014 (60.0 percent) than in 2012 (67.4 percent). Due to the very low response rate, this apparent decline may not reliably reflect the entire student population. Nearly all of the respondents who received mental health services knew where the counseling center was located on campus (98.1 percent) and indicated that they were aware of at least one local resource for suicide prevention (93.1 percent). Hispanic students continued to report slightly less interaction with, and knowledge about, student mental health facilities in 2014 than the total student population. Less than two-thirds (60 percent) knew where to find the counseling center of campus, and only a few more (63.3 percent) knew of a local suicide prevention resource. Further, less than half (40 percent) reported that they had been exposed to suicide prevention materials, and less than 10 percent directly participated in suicide prevention activities.

Table 29

Student Access (Student mental health service recipients and Hispanic students)

Item	Mental Health Service Recipients, percent yes		Hispanic Students, percent yes	
	2012	2014	2012	2014
Have you been exposed to any materials on your campus related to suicide prevention?	44.4	61.2	28.7	40.0
Have you directly participated in any suicide prevention activities sponsored by your campus?	7.8	18.4	3.2	7.8
I am aware of at least one local resource to which I could refer a student who seemed at risk for suicide	88.9	93.1	60.6	63.3
Do you know where to find the counseling center on your campus?	96.7	98.1	67.4	60.0
Have you ever received psychological or mental health services from your current college	100.0	100.0	8.4	12.2
Do you know other students who have received psychological or mental health services from you current college?	76.7	82.4	20.0	28.9

Source: SPEAKS-S

Campus Atmosphere

CPHHP examined campus atmosphere, that is, students' and faculty/staff's view on seeking suicide prevention services. The SPEAKS-S and SPEAKS-F/S elicit information about campus atmosphere by asking respondents to give their personal reaction to a series of statements, with a second series of parallel statements that ask the respondents to give their impression of the general campus attitude. The statements themselves each express a negative attitude toward suicide help seeking behavior. Respondents provided their reaction to the statements, choosing from five answer options ranging from "strongly disagree" to "strongly agree." Overall, substantial majorities of students and faculty/staff disagreed with all of the statements in both years.

The first statement is: "I think it is a sign of personal weakness or inadequacy to receive treatment for suicidal thoughts and behaviors." In 2012, the overwhelming majority of both students and faculty/staff respondents indicated some level of disagreement with this statement. Students disagreed/strongly disagreed at a rate of 83 percent, and faculty/staff at the even higher rate of 94 percent. The parallel statement was: "On my campus … [it] is a sign of personal weakness or inadequacy to receive treatment for suicidal thoughts and behaviors." A majority of students and faculty/staff in 2012 reported they disagreed/strongly disagreed with the statement: 78 percent of the students and 87 percent of staff and faculty.

The other two sets of questions in this series asked the respondents to react to a statement that a student would appear less favorable if others knew he or she received suicide prevention treatment and a statement that it is advisable for a student to hide the fact that he or she received suicide prevention treatment. The same patterns identified above, that is, faculty/staff indicating more acceptance of suicide help-seeking behavior than students, and both students and faculty/staff indicating less acceptance by their campuses than themselves, are present in all of the responses to these series of questions.
The responses from the 2014 administration of the SPEAKS-S and SPEAKS-F/S indicated that the

atmosphere on the campuses was comparable to what it had been in 2012. While a somewhat smaller proportion of faculty/staff and students answered that they "strongly" disagreed with the various statements, the changes are too small to indicate a change in the general perception of suicide help-seeking behavior. In 2014 and 2012, both students and faculty/staff indicated more personal support for suicide help-seeking than they thought was generally the case on campus, though both groups report a generally favorable atmosphere for such behavior.

Table 30

	Student		Faculty / Staff	
	2012	**2014**	**2012**	**2014**
Item	Percent	Percent	Percent	Percent
Personally				
I think it is a sign of personal weakness or inadequacy to receive treatment for suicidal thoughts and behaviors				
Strongly Disagree	64.3	62.8	78.9	75.6
Disagree	18.8	22.6	15.5	19.2
No Opinion	9.7	7.8	4.3	3.5
Agree	6.6	4.3	1.2	1.2
Strongly Agree	0.5	1.8	0.2	0.5
On my campus				
It is a sign of personal weakness or inadequacy to receive treatment for suicidal thoughts and behaviors				
Strongly Disagree	56.1	52.9	62.4	57.7
Disagree	21.9	25.2	24.8	26.5
No Opinion	15.4	11.2	9.9	13.8
Agree	5.6	7.2	3.0	1.8
Strongly Agree	1.0	1.3	0.0	0.3

Source: SPEAKS-S, SPEAKS-F/S

As another measure of campus atmosphere, the survey asked student respondents whether they would seek help if they were having suicidal thoughts with an option of "I would not seek help." Respondents were also provided a list of types of individuals from whom they might seek help, such as mental health professionals, parents, and friends (Table 30). The options were listed individually, and the answers were not mutually exclusive. Because of the presumably speculative nature of this question for the majority of respondents, students were invited to state the degree of confidence they had in the answer they were providing. Of the students who responded to this item in 2012, 17 percent indicated that they would likely or very likely not seek help from anyone. Three-quarters of respondents answered that they would likely/very likely seek help from a friend. Nearly a third of the students in 2012 indicated that they would likely/very likely seek help from a mental health professional or school counselor.

A larger proportion of respondents reported they would likely/very likely seek help from a mental health professional or school counselor if having suicidal thoughts in 2014 (39.1 percent) than in 2012 (29.9 percent). Conversely the proportion of students who indicated that they would likely/very likely not seek help from anyone decreased slightly from 17 percent in 2012 to 15.7 percent in 2014.

Table 31

If having suicidal thoughts, would seek help from…	2012		2014	
	Likely	Very likely	Likely	Very likely
Friend not related to you	41.4	34.0	40.8	38.8
Mental Health professional or school counselor	21.4	8.5	29.2	9.9
I would not seek help	12.6	4.4	11.4	4.3
Parent	35.1	33.3	33.5	31.0
Other relative/ family member	5.2	3.6	4.4	3.3
Doctor / general practitioner	16.5	4.7	18.8	5.3
Clergy member	7.9	3.0	8.4	2.9

Source: SPEAKS-S

The SPEAKS-S collected data that allowed CPHHP to identify the respondents who belonged to two of the CSPI priority populations: Hispanic students and students who had received mental health services on campus (Table 28). A majority of respondents in both of these groups reported that it is not a sign of personal weakness to receive treatment for suicidal thoughts in both the pretest and the posttest. A somewhat higher proportion of students in 2014 (70.6 percent) who had received mental health services on campus reported that they "strongly disagreed" with the statement than in 2012 (64.4 percent). The proportion of Hispanic students strongly disagreeing remained virtually the same, at 58.9 percent in 2012 and 57.3 percent in 2014. The percent of respondents from the two priority populations who strongly disagreed with the assertion that help seeking is a sign of weakness was very similar to the responses from the general student population in 2012 and 2014.

The perceptions of general campus acceptance of help-seeking behavior were similar between these two priority groups and the respondents as a whole. In 2012, 54.4 percent respondents who had received mental health services and 59.6 percent of Hispanic students strongly disagreed with the statement that help seeking behavior was viewed as a weakness on their campus. Overall, there was little change in these items in the responses from 2012 to 2014 among the priority populations. For both groups, a slightly lower percent of respondents answered that they "strongly disagreed" with the statement in 2014 than 2012, decreasing from 54.4 percent to 49.0 percent among mental health service recipients and from 59.6 percent to 53.3 percent among Hispanic students.

Table 32

Item	Mental Health Service Recipient		Hispanic students	
	2012	2014	2012	2014
	Percent	Percent	Percent	Percent
Personally				
I think it is a sign of personal weakness or inadequacy to receive treatment for suicidal thoughts and behaviors				
Strongly Disagree	64.4	70.6	58.9	57.3
Disagree	20.0	18.6	23.2	23.6
Neither Agree nor Disagree	4.4	4.9	9.5	12.4
Agree	8.9	3.9	7.4	6.7
Strongly Agree	1.1	2.0	0.0	0
No Opinion	1.1	0.0	1.1	0
On my campus				
It is a sign of personal weakness or inadequacy to receive treatment for suicidal thoughts and behaviors				
Strongly Disagree	54.4	49.0	59.6	53.3
Disagree	27.8	24.5	21.3	22.2
Neither Agree nor Disagree	14.4	13.7	10.6	12.2
Agree	11.1	10.8	3.2	5.6
Strongly Agree	0.0	2.0	2.1	1.1
No Opinion	2.2	2.0	3.2	5.6

Source: SPEAKS-S

The majority (60.7 percent) of student respondents in 2012 who received mental health services on campus indicated that they would likely/very likely seek assistance from mental health professionals were they to have suicidal thoughts in the future (Table 32). Nearly one out of five (18.4 percent) of these students responded that they would likely not seek help from anyone if they were to have suicidal thoughts. One quarter of Hispanic student respondents (24.7 percent) stated that they would likely/very likely seek assistance from a mental health professional. About one-fifth (21.8 percent) of these respondents would not see help from anyone.

In 2014, proportionally more mental health service recipients stated that they would likely/very likely seek help from school counselors (increasing from 60.07 percent in 2012 to 63.6 percent in 2014) and, more substantially, from friends (increasing from 68.2 percent in 2012 to 78.8 percent in 2014). There was an accompanying decrease in the proportion of students who said they would not seek help from anyone.

There was a noticeable increase in the proportion of Hispanic students who answered that they would likely/very likely seek help from a friend were they having suicidal thoughts in 2012 (63.4 percent) as compared with 2014 (77.0 percent). In 2014, Hispanic students were almost as likely as the campus population in general to indicate they would seek help from a friend. The proportion of Hispanic students answering that they would likely/very likely seek help from a school counselor also noticeably increased, from 24.7 percent in 2012, to 36.4 percent in 2014. In 2014, the percent who indicated they would likely/very likely seek help from a school counselor was nearly as high as the student population in general (36.4 compared to 39.1 percent).

Table 33

If having suicidal thoughts, would seek help from…

	Mental Health Service Recipients		Hispanic Students	
	2012	2014	2012	2014
Friend not related to you	Percent	Percent	Percent	Percent
Very Likely	30.7	41.4	25.8	34.5
Likely	37.5	37.4	37.6	42.5
Neither Likely nor Unlikely	10.2	10.1	10.8	6.9
Unlikely	5.7	9.1	11.8	9.2
Very Unlikely	15.9	2.0	14.0	6.9
Mental health professional or school counselor	Percent	Percent	Percent	Percent
Very Likely	18.0	21.2	7.5	8.0
Likely	42.7	42.4	17.2	28.4
Neither Likely nor Unlikely	16.9	15.2	16.1	13.6
Unlikely	15.7	18.2	29.0	27.3
Very Unlikely	6.7	3.0	30.1	22.7
I would not seek help from anyone	Percent	Percent	Percent	Percent
Very Likely	3.9	2.2	6.9	3.6
Likely	14.5	8.6	14.9	15.7
Neither Likely nor Unlikely	18.4	16.1	20.7	14.5
Unlikely	14.5	20.4	24.1	16.9
Very Unlikely	48.7	52.7	33.3	49.4

Source: SPEAKS-S

Outcome III: Student Suicide Contemplation, Attempt, and Death

The overarching goal of the CSPI was to reduce the incidence of campus suicide contemplation, attempt, and death. The evaluation has attempted to gain some basic information regarding the level of suicide contemplation and attempt on the sub-recipient campuses, both before and near the end of the grant period. We have not located any information on the incidence, if any, of suicide deaths at the sub-recipient campuses.

The NCHA asks students if they had ever seriously considered, or actually attempted, suicide. Nearly a quarter of respondents answered that they had seriously considered suicide at some point in their lives. Of those students who responded that they had either seriously considered or actually attempted suicide, a majority answered that this occurred more than 12 months earlier. Respondents were not asked, nor given space to provide, whether these contemplations and attempts preceded their entry into college. Slightly over two percent of respondents indicated that they had seriously considered suicide within the two weeks preceding the administration of the survey, and 6.1 percent offered that they had considered suicide within the preceding year (because of the format of these questions, the answers are mutually exclusive).

The responses from 2014 were largely comparable to the previous survey responses, though for all categories,

a somewhat smaller proportion of students answered that they had seriously considered or attempted suicide. The proportion of students who reported having seriously considered suicide in either the last 30 days or the last two weeks (which are mutually exclusive answers in the survey) decreased slightly, from 3.8 to 3 percent.

Table 34

Have you ever…

		No, never	No, not in last 12 months	Yes, in last 12 months	Yes in last 30 days	Yes, in last 2 weeks
Seriously considered suicide?	2012	74.1	15.0	6.1	1.7	2.1
	2014	77.0	14.5	5.7	1.2	1.8
Attempted suicide?	2012	86.6	10.7	1.3	0.5	0.8
	2014	91.0	7.6	1.0	0.2	0.2

Source: NCHA

The NCHA survey collected information on sexual orientation and gender; mental health disorders; and whether the student identifies as Hispanic. Therefore, CPHHP has information on whether individuals in these priority groups reported having contemplated or attempted suicide. The results are displayed in Table 34. Of the Hispanic respondents, 80 percent reported in 2012 that they have never seriously considered suicide and over 90 percent have never attempted it. Both of these rates indicate less suicidality than in the population as a whole. Students who report having been diagnosed with a mental health condition, however, reported higher incidents of both suicide contemplation and attempts than the population as a whole, with more than a third responding in 2012 that they had considered suicide at some point in their lives. A higher percentage of LGBT respondents also reported having seriously contemplated or attempted suicide than the general population. Nearly half of LGBT respondents reported that they had seriously contemplated suicide at some point in their lives, and a quarter reported having attempted it; approximately 16 percent of these students reported that they had attempted suicide within the year preceding the survey.

The proportion of Hispanic students indicating that they had never seriously considered suicide decreased noticeably from 80 percent in 2012 to 71.0 percent in 2014. The proportion of Hispanic students indicating that they had never seriously attempted suicide also decreased slightly, from 91.4 percent in 2012 to 85.5 percent in 2014. Generally, though, Hispanic respondents in 2014 continued to report a somewhat lower incidence of suicidality than the general population. Students with diagnosable mental health needs and LGBT students continued to report higher incidences of suicidality than the general population in 2014. Slightly more students with mental health needs indicated that they had seriously considered suicide in 2014 (44.7 percent) than 2011 (48.2 percent), but a slightly lower proportion of them had indicated having actually attempted suicide in 2014 (18.8 percent) than 2011 (26.9 percent). Somewhat smaller proportions of LGBT students reported either having seriously considered suicide or actually attempted it in 2014 than 2012.

Table 35

Have you ever…

	Hispanic Students		Students with Mental Health Disorders		LBGT Students	
	2012	**2014**	**2012**	**2014**	**2012**	**2014**
…seriously considered suicide?	Percent	Percent	Percent	Percent	Percent	Percent
No, never	80.0	71.0	55.3	51.8	52.9	57.9
No, not in last 12 months	12.9	21.0	27.7	24.1	27.1	28.1
Yes, in last 12 months	2.9	3.2	9.4	16.8	14.3	7.0
Yes, in last 30 days	1.4	0.0	3.8	2.2	4.3	1.8
Yes, in last 2 weeks	2.9	4.8	3.8	5.1	1.4	5.3
…attempted suicide?	Percent	Percent	Percent	Percent	Percent	Percent
No, never	91.4	85.5	73.1	81.2	73.2	84.8
No, not in last 12 months	8.5	11.3	23.1	13.8	22.5	15.5
Yes, in last 12 months	0	1.6	2.5	3.6	2.8	1.7
Yes, in last 30 days	0	0.0	1.3	0.7	1.4	0.0
Yes, in last 2 weeks	0	1.6	0	0.7	0	0.0

Source: NCHA

Program and Evaluation Challenges

The fall of 2012 marked the launch of many CCSPI grant requirements including cross-site assessment tools and three local surveys. Although detailed technical assistance was provided, demands placed on the sub-recipients were substantial. To obtain feedback from the sub-recipients, a sub-recipient meeting was scheduled for February, 2013 to discuss grant-related procedures, specifically administering the local surveys. An important challenge for the CCSPI evaluation, and the majority of the northeast, was the devastation caused by Hurricane Sandy. In preparation of the hurricane, Governor Malloy signed a Declaration of Emergency on October 26, 2012 closing all state highways and evacuating many cities. Sandy made land fall on October 29, 2012 and caused widespread damage including flooding and power outages across the state. Three of the four sub-recipient campuses were closed for two to eight days. The storm coincided with the anticipated administration of the NCHA, SPEAKS-S, and SPEAKS-F/S and caused an estimated two- to three-week delay in the survey administration and other grant-related activities.

Additionally, due to the varying degrees of readiness and support available at the colleges, the implementation of the strategies was slower than anticipated. In particular, the community colleges had challenges engaging students and necessary stakeholders and did not implement as many activities as anticipated. One of the larger schools experienced delays in progress of their work plan. To address these issues, technical assistance was scheduled with each campus to develop a monthly timeline of activities to meet the goals of the projects.

During the 2013-2014 academic year, CSPI experienced a few program and evaluation challenges. A primary challenge was related to personnel changes. A few of the campus sub-recipients experienced staff

turnover which initially affected the oversight of some grant activities. There was also staff turnover of key stakeholders working with the campuses on their coalition. A staff member at one of the RACs who had received the Connect Prevention TTT training resigned from her position. As a result, the region lacked a trainer and the new staff member had to do self-directed QPR TOT. Additionally, the CCSPI program coordinator at CCPWR resigned.

Due to varying experience in suicide-related programs, some of the mini-grantees had difficulty implementing their plan. For example, one mini-grantee struggled to identify which strategic area in the Jed Model to focus on as many seemed relevant. With some technical assistance provided by CSPI they were able to prioritize one area, and address other areas to a lesser degree. A few of the mini-grantees experienced multiple diverse challenges pertaining to grant submission, start-up, capacity, readiness and community support resulting in varied implementation efforts. One mini-grantee in particular had difficulty at the initial implementation phase when personnel were not as available as anticipated.

Another challenge was the low response rates to the outcome surveys (i.e. SPEAKS-S, SPEAKS-F/S, and NCHA). One explanation for the low response rate may be due in part to the burden of multiple surveys being administered on the campuses. In addition to the CCSPI required surveys administered in spring 2014, CHCI also administered the Core Alcohol and Drug Survey and the Faculty and Staff Environmental Alcohol and Other Drug Survey on the same campuses during the same time period. The over-saturation of the CSPI, CHCI and potentially other surveys may have affected the amount of interest on the part of students, faculty and staff.

Summary

Consistent with Objective Three of the CSPI, this local evaluation consists of two evaluation components: process and outcome.

The purpose of the process evaluation was to track and measure the provision of CSPI programmatic activities at the state, campus and community levels. The CSPI funded two special events, the CSPI Kick-off in spring 2012 and a closing event in May 2014 and 13 professional developments, which were offered in collaboration with the CHCI, a related college-focused behavioral health intervention. The CCPWR, sub-recipients and mini-grantees hosted 239 training sessions, which were attended by an aggregate total of 7,182 attendees. These trainings were offered in every county of the state and on both college campuses and in other community locations. Among these trainings were several Training of Trainers sessions for the programs Question, Persuade and Refer and Connecticut Prevention / Postvention. Attendees have generally reported that they are satisfied with the quality and relevance of each of the trainings and professional developments. Several surveys of various types were administered to individuals and institutions to support the CSPI. The campus sub-recipients and mini-grantees generally indicated satisfaction with the CSPI overall, and the professional development sessions individually, though they did suggest that there were opportunities to improve the CSPI grant application process.

The outcome evaluation component was designed to measure the direct effect of CSPI activities. The CPHHP focused on three selected outcomes: statewide suicide prevention infrastructure; sub-recipient campus suicide prevention infrastructure; and sub-recipient campus student suicide contemplation and attempt. In 2011 and 2012, baseline information was collected on the three outcomes and similar information was then collected in 2014. Campuses statewide offered more mental health promotion and suicide prevention trainings near the close of the grant period that at its beginning. QPR was particularly popular. Each of the sub-recipient campuses offered more services individually tailored to the needs of the identified priority populations in 2014 than 2012. The proportion of students indicating an awareness of suicide prevention resources on the campuses generally increased from 2012 to 2014. The atmosphere on campus regarding the acceptability of using suicide prevention services was comparable in 2012 and 2014; in both years a majority of students indicated that they and the larger campus community supported help-seeking behavior. Finally, the proportion of students indicating that they had seriously considered or attempted suicide in the prior 30 days or two weeks decreased slightly from 2012 to 2014.

Appendix A

Demographic Table

The various instruments used to collect data from students at the four sub-recipient campuses collected demographic data in slightly different ways. As such, it was necessary to re-categorize some of the data, to some extent, so that the demographic data collected by the surveys might be compared with each other and to the demographic composition of the larger campus populations. The procedure described in this section was applied to both the pretest and posttest data.

Most of the sub-recipient campus demographic data displayed in Table 14 was collected using the Institution of Higher Education Demographic Survey (IHEDS). The IHEDS was developed by the American College Health Association and the college sub-recipients were required to complete it as part of the survey administration process. The IHEDS asked the campuses to provide, among other things, total undergraduate enrollment, gender composition, racial composition and percentage of students who are international. The sub-recipient campuses completed this survey for the Fall 2012 semester. The results of this survey were supplemented with publically available information provided by the National Center for Educational Statistics (NCES).

There are some limitations to the IHEDS instrument. The IHEDS elicits information on student status as "international" or not in such a way that this option appears to be an alternative to the racial categories and some of the colleges appear to have reported students as "international" as if it were a race category, exclusive of the other categories (i.e., the percentages of the race categories plus "international" sum to 100 percent), and other campuses did not. The two sample surveys both treat international status as separate from the race categories.

The IHEDS provides schools with two options for the question about gender, male and female. The NCHA and SPEAKS-S surveys offer three options for gender: male, female or transgender.

The three instruments yielding student information, the IHEDS, the NHCA survey, and the SPEAKS-S, categorized demographic information on race in different ways. The IHEDS provides six race categories which, apparently, are mutually exclusive. There is no multiracial option. There is, however, an option for "Other." The NCHA survey, which, like the IHEDS, is created by the ACHA, has seven race categories and allows students to select as many provided categories as they deem appropriate. There is also an explicit "Biracial or Multiracial" option and an "Other" option. The SPEAKS-S lacks an explicit multiracial option, but it also allows respondents to select as many of the provided options as applicable. The SPEAKS-S does not have an "Other" race option.

Further conceptual inconsistencies arise when comparing Hispanic to non-Hispanic students across the three surveys. The IHEDS treats the term "Hispanic" as being interchangeable with the race categories "Black," "White," "Asian," etc. Black and White explicitly exclude "Hispanic" in the options; the other racial categories, "Asian or Pacific Islander" and "American Indian or Native Alaskan" do not. Some ambiguity may arise if there is a student who identifies as both Native American and Hispanic; or Asian and Hispanic. The NCHA also lists the category Hispanic alongside its other racial categories, making it appear conceptually equivalent to, and substantively exclusive of, them, though in this survey, as noted above, respondents are invited to select as many categories as they wish. The SPEAKS-S survey treats the category of Hispanic as conceptually distinct from the race categories. The term Hispanic is not included as a possible answer to its race question (Q. 55), but rather appears as a separate question entirely (Q. 54).

Table A-1

The race categories as listed in the IHEDS, NCHA, and SPEAKS-S surveys.

IHEDS (Question 3)	NCHA (Question 54)	SPEAKS-S (Questions 54 and 55)
White, non-Hispanic	White, non Hispanic (includes Middle Eastern)	White
Black, non-Hispanic	Black, non Hispanic	Black or African American
Hispanic or Latino	Hispanic or Latino/a	Hispanic or Latino
Asian or Pacific Islander	Asian or Pacific Islander	Asian
Native American or Alaskan Native	American Indian, Alaskan Native, or Native Hawaiian	American Indian or Alaska Native
		Native Hawaiian or Other Pacific Islander
	Biracial or Multiracial	
Other	Other	

In order to compare the demographic information in the surveys, some reordering was necessary. The IHEDS race categories were not altered, and the final demographic table above largely follows the race categories established in that instrument.

The NCHA provided several race options, including Hispanic, and invited respondents to "mark all that apply." One of the options was "Biracial or Multiracial." The survey also provided an option of "Other." To create Table 17, any respondent who identified as "Hispanic" was counted in that category, regardless of whatever other option or options the respondent may also have chosen. This was to make the information comparable to the IHEDS, which treats the category Hispanic as equivalent to the race categories. When respondents who did not identify as Hispanic selected multiple options, they are counted as multiracial in the table and are included with those who selected only the option "Biracial or Multiracial."

The SPEAKS-S categories were also reorganized to create Table 17. First, the number of respondents answering both questions 54, which asked whether the respondent is Hispanic, and 55, which asks with what race the respondent identifies, as well as those responding only to question 54 or only to question 55, was determined. Respondents who answered they were not Hispanic in question 54, but who failed to answer question 55 were dropped for the purpose of calculating the figures in Table 17.

Cases were then examined to determine which contained only one selected answer between the two questions, and which contained multiple. All respondents selecting "yes" to question 54 were included in the Table 17 as Hispanic, regardless of what other racial option or options they may have also selected. This was so the SPEAKS-S data could be compared to the campus-wide information from the IHEDS. Any other respondent who selected multiple race answers were included in the "multiracial" row in Table 17, although there is no explicit multiracial option in the SPEAKS-S.

Appendix B

Question, Persuade and Refer Gatekeeper Trainer Survey Report

Question, Persuade and Refer (QPR) is one of the most commonly used suicide prevention programs on campuses in Connecticut. The program largely relies upon local "gatekeepers" who are trained to notice students who may be at risk for suicide. As part of the Connecticut Suicide Prevention Initiative (CSPI), the first census of individuals in the state who are certified to instruct QPR gatekeepers, called gatekeeper trainers, was taken.

QPR is an educational program developed by the QPR Institute for Suicide Prevention, a private firm with headquarters in Spokane, Washington. The program is listed on the National Registry of Evidence-based Programs and Practices, which is maintained by the federal Substance Abuse and Mental Health Services Administration.[15] The basic QPR program has been modified for several different types of communities, including college campuses. The main objective of the program is to enable "gatekeepers" to notice individuals in their community who might be contemplating suicide and empower them to assist a potentially suicidal individual find suicide prevention resources where appropriate. Gatekeeper training is not primarily aimed at mental health professionals, but rather nonspecialists, such as teachers, coaches, emergency personnel and caseworkers, who are positioned to notice individuals exhibiting signs of suicide in their communities. Staff from the QPR Institute sometimes provide training to gatekeepers. Additionally, mental health specialists and others in the community may seek certification from the QPR Institute to become gatekeeper trainers.

QPR may have first been introduced on a college campus in Connecticut in 2003, when it was adopted by Southern Connecticut State University.[16] The program was incorporated into Connecticut's initial GLS-funded suicide prevention program, the Connecticut Youth Suicide and Prevention Initiative, the college component of which was administered on the four Connecticut State University campuses from 2006 to 2009. Pursuant to that program, at least one mental health professional was certified as a gatekeeper trainer on each of the four campuses.[17] Since that time, the number of QPR gatekeepers and the number of certified QPR gatekeeper trainers in the state has increased. As part of Connecticut's second GLS-funded suicide prevention program, CSPI, the Connecticut Center for Prevention, Wellness, and Recovery (CCPWR) at the Wheeler Clinic, on behalf of the state Department of Mental Health and Addiction Services (DMHAS), created and administered the Question, Persuade, Refer Gatekeeper Trainer Survey. The purpose of the survey was to establish a directory of, and verify the contact information for, all of the certified gatekeeper trainers in the state. The survey also requested information concerning, among other things, the location of the trainers, the communities with which they worked, and their intention to remain active gatekeeper trainers.

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[15] QPR Gatekeeper Training for Suicide Prevention, NREPP SAMHSA's National Registry of Evidence-based Programs and Practices (updated March 30, 2014), available at: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=299 (accessed April 17, 2014).

[16] Department of Mental Health and Addiction Services, "Connecticut Youth Suicide Prevention/Early Intervention Initiative, August 2, 2006 update.

[17] Institute for Public Health Research, Center for Public Health and Health Policy "Connecticut Youth Suicide Prevention Initiative Local Evaluation" p. 43, available at: http://www.publichealth.uconn.edu/assets/uchcfinalreport.pdf (accessed April 17, 2014).

QPR Gatekeeper Trainer Survey Administration

CCPWR administered the QPR Gatekeeper Trainer Survey online via SurveyMonkey. A link to the survey was emailed to 107 individuals in Connecticut who were believed to be certified QPR gatekeeper trainers; contact information was obtained from the QPR Institute. The survey was distributed by email on March 19, 2013 and closed on April 16, 2013. Seventy-six individuals returned the survey, for a response rate of 69 percent.

Question, Persuade, Refer Gatekeeper Trainer Responses

The 76 responding gatekeeper trainers were located in every county in the state. Hartford County had the largest number of gatekeeper trainers, at 23. Only one trainer was located in Windham County, which had the fewest. The vast majority of the trainers, 73, indicated that they were interested in providing further gatekeeper trainings. These results are represented in Tables B-1 and B-2.

Table B-1

Are you still interested in providing QPR trainings?

	Frequency	Percent
Yes	73	96.1
No	3	3.9

Table B-2

Location of QPR Gatekeeper Trainers by County

County	Number of Respondent Trainers
Hartford	23
New Haven	15
Tolland	15
Fairfield	12
Litchfield	4
Middlesex	3
New London	3
Windham	1

The survey was administered in late March and early April, 2013. At that time, most trainers in the state responded that they had only recently received QPR gatekeeper trainer certification. The majority, 77.6 percent, had received certification within the previous twelve months, that is, after the time of the CSPI April 2012 Kick-Off. More than a third, 39.5 percent, had received their training within the prior three months. Eight trainers, roughly ten percent of the respondents, however, reported having received their certification more than three years prior to the survey administration date.

Table B-3

When did you become a certified QPR Trainer?

Months prior to survey	Frequency	Percent
0-3 months	30	39.5
4-6 months	15	19.7
7-11 months	14	18.4
12-18 months	3	3.9
19-24 months	0	0
25-36 months	6	7.9
37 months or more	8	10.5

A little less than half of the respondents, 34, provided information on the number of trainings they had offered, and the number of attendees they had trained, in the six months prior to the survey. Of those responding, half reported hosting one or two training sessions. Two indicated providing more than 10 trainings, with one respondent reporting 25 training sessions in the prior six months. The results are summarized in Table B-4 below. Most of the trainers report having trained 30 or fewer individuals in the prior 6 months. The range of individuals trained by the trainers ranged from a low of 7 to a high of 480. These results are summarized in Table B-5.

Table B-4

In the past six months, how many QPR trainings have you provided?

Number of trainings	Frequency	Percent
1-2	17	50.0
3-5	12	35.5
6-10	3	8.8
More than 10	2	5.8
Mean	3.94	
Standard Deviation	5.23	
Range	1 to 25	

Table B-5

In the past six months, how many people have you provided QPR training to?

Number of trainees	Frequency	Percent
1-30	18	52.9
31-100	9	26.5
101-200	4	11.8
201-500	3	8.8
Mean number of people trained	80.5	
Standard Deviation	114.9	
Range	7 to 480	

Most of the respondents provided information about the geographical area in which they could provide QPR training. Of those who answered, the majority, 62.3 percent, could provide gatekeeper training at any location statewide. The remaining trainers were limited to specific geographic areas within the state. The majority of respondents reported feeling confident that they could provide training directly to college students and college faculty and staff. Somewhat fewer than half of the trainers, 47.3 percent, believed they were competent to provide training to mental health providers and about a third reported that they could confidently provide training to military personnel. See Table B-7.

Table B-6

Can you provide QPR training statewide?

	Frequency	Percent
Yes	33	62.3
No	20	37.7

Table B-7

Please select the population [to which] you feel competent to provide QPR training

	Frequency	Percent
College or University Students	45	59.2
College or University Faculty & Staff	43	56.6
Community Teens	41	53.9
Social Services providers	37	48.7
Mental Health providers	36	47.3
Military personnel	26	34.2
Other*	1	1.3

*The provided response was: "Community Coalitions (mixed groups of people)"

Summary

The QPR Gatekeeper Trainer Survey, administered by CCPWR, was the first state-wide census of certified QPR gatekeeper trainers conducted in the state of Connecticut. The response rate was fairly high; nearly seventy percent of the known or suspected certified QPR gatekeeper trainers returned responses. Overall, the responses showed that the overwhelming majority of certified QPR trainers intend to continue training QPR gatekeepers in the foreseeable future. The survey also revealed that trainers reside throughout the state and, assuming the six months reported in the survey are typical, have trained hundreds if not thousands of QPR gatekeepers. The results show that a sizable majority of the respondents were comfortable providing gatekeeper training to college communities, but that only a third believed they were competent to provide training to gatekeepers associated with military communities.

Appendix C

SPEAKS-S, SPEAKS-F/S, AND THE NCHA SURVEY ADMINISTRATION AND RESPONSE RATES

Two surveys were administered to students and one survey administered to faculty and staff on the sub-recipient campuses to help measure the atmosphere on the campuses regarding suicide prevention and mental health promotion issues and services. The student surveys were also used to measure student rates of suicide contemplation and attempt. The surveys were administered as a part of a "pretest" of the CSPI in the fall semester of 2012-2013, and were administered a second time, as a "posttest," near the completion of the grant period in the spring of 2013-2014. The two surveys administered to students were the Suicide Prevention Education, Awareness, Knowledge Survey, student version (SPEAKS-S) and the National College Health Assessment II (NCHA). Staff and faculty were invited to take the Suicide Prevention Education, Awareness, Knowledge Survey, faculty and staff version (SPEAKS- F/S).

The sub-recipient campuses administered the SPEAKS-F/S to all faculty and staff with email addresses and the SPEAKS-S and NCHA surveys to randomly selected samples of students. The surveys were administered electronically; there was not an option to complete paper versions.

For the student surveys, CPHHP provided the sub-recipients assistance in determining sample size. CPHHP also provided some assistance in choosing the samples. For the pretest, CPHHP asked the sub-recipient campuses to use two non-overlapping random student samples for the SPEAKS-S and the NCHA to eliminate the possibility of burdening a student with requests to complete both surveys. CPHHP assisted two of the campuses in generating their samples. The other two campuses reported that they generated random samples on their own. All campuses selected their own samples for the posttest.

The surveys were administered approximately concurrently both years. On each campus, a senior campus administrator emailed prospective respondents to both surveys informing them that the institution was participating in the CSPI and that it supported the administration of the surveys. Students receiving either survey also received a cover letter that provided the following information:

- Completing the survey is voluntary.
- Participants may stop filling out the survey at any time. Participants are allowed to omit questions they do not want to answer.
- Participants must be 18 years of age or older to participate in the survey.
- Participants may complete the survey once in the fall of 2012 and once in the spring of 2014.
- Responses will be kept confidential and the survey cannot be linked to a participant's name or other sources of personal identification.
- By participating in the NCHA or SPEAKS-S, students have the option to enter into a drawing for a chance to win a gift as an incentive.
- Campuses that allowed incentives for faculty and staff, provided an option to enter into a drawing for a chance to win one $100.00 gift card at the end of the SPEAKS-F/S.

NCHA Administration

The NCHA survey was distributed to 6,326 students at the sub-recipient campuses for the pre-test and 6,068 students for the posttest. For both the pre- and posttests, ACHA emailed students a link to the survey with an access code. The link to the survey was kept active for a two to three week period. At the end of

the data collection periods, ACHA selected one winner for the incentive gift. ACHA sent the email address of the winners to the CSPI campus coordinator, who contacted the students.

SPEAKS-S and SPEAKS-F/S Administration

SPEAKS-S and SPEAKS-F/S were programmed by a researcher at CPHHP to be administered electronically via SurveyMonkey. For both the pre- and posttests, CPHHP sent each campus contact person one link for the SPEAKS-S and one link for the SPEAKS-F/S. The campuses reported distributing the SPEAKS-S to a total of 6,497 students and 2,180 faculty and staff in the first year and to 6,381 students and an estimated 3,073 faculty and staff in the final year.

The survey administration period varied from campus to campus for the SPEAKS-S and SPEAKS-F/S. Both surveys became available for the pretest on all campuses in November, 2012. Most of the campuses closed the SPEAKS-S and SPEAKS-F/S pretests by the end of that month. Two of the campuses kept the SPEAKS-F/S open into until December.

For both the pre- and posttests, students and eligible faculty and staff who responded to the SPEAKS were offered the opportunity to enter into a drawing for a prize. For the pretest each campus offered students a chance to win one $100.00 gift card. Faculty and staff at campuses that allowed them to participate in the drawing also had a chance to win one $100.00 gift card. For the posttest, the incentive items were similar in value to those of the pretest, but the actual items varied by campus. Once the administration of the survey was complete, one student name and one faculty/staff name (of those who are allowed to participate in the drawing) were randomly selected and the names were given to the CSPI campus coordinator, who contacted the winners.

Data Entry and Management

The electronic survey responses for the NCHA went to an ACHA database. Electronic survey responses for SPEAKS-S and SPEAKS-F/S were submitted to a SurveyMonkey database. Respondents' identifying information was not linked to responses and respondents were not tracked from 2012 to 2014.

At the close of the SPEAKS-S and SPEAKS-F/S administration, data were retrieved from the SurveyMonkey database and stored on a UCHC server. CPHHP sent each campus a data file with only responses from their campus. ACHA sent NCHA data files directly to each of the campuses who then forwarded the data files to CPHHP.

Response Rates

Overall, response rates to the SPEAKS-S and NCHA in 2012 were quite low. The final response rate, once ineligible cases were dropped, for the SPEAKS-S was 12.3 percent. The final response rate for the NCHA survey was 9.8 percent. Further, there was considerable variation in item response rates among SPEAKS-S questions, from 779 to 581 completed responses, resulting in even lower response rates to several questions for that survey. The response rates for the 2014 posttest were even lower than the pretest. In 2014, 9.9 percent of the invited student sample responded to the SPEAKS-S, and 8.5 percent of the NCHA sample did so.

Faculty and Staff response rates were below 20 percent each year. In 2012, 19.9 percent of faculty and staff responded to the SPEAKS-F/S. In 2014, the proportion fell to 11.4 percent.

There were 804 students who consented to take the SPEAKS-S and 625 who consented to take the NCHA survey in 2012. Because the study was designed to include only students aged 18 to 24, respondents who did not meet the age criteria were eliminated for purposes of the outcome evaluation. For the NCHA survey, examination of the data revealed that seven respondents indicated that they were older than the upper age criterion, and nine did not report an age. Of those who were older than the upper age limit, five were 25 years old, suggesting that they had had recent birthdays, and may have been 24 at the time the sample was selected. Of the 625 respondents, then, only two appear to have been improperly invited to participate. In light of the very low known error rate, CPHHP decided to include the nine cases where there was no age provided, on the assumption that it was highly probable that most or all of these students actually met the age criteria. The final response rate for the NCHA is 9.8 percent.

Of the 804 respondents to the SPEAKS-S, six listed ages that did not meet the age criteria. All six cases were within a year of either the minimum or maximum age limit. These cases were eliminated for the purpose of this analysis. Further, 165 respondents failed to list any age. While the incidence of missing ages is quite high for this survey, the low known age error rate for this instrument combined with the low error rate for the NCHA responses, suggested that there was a high probability that most or all of the 165 respondents who failed to supply their age met the age criteria, and, therefore, they were included in the analyses. The final response rate for the SPEAKS-S is 12.3 percent.

Table C-1

Summary of Final Response Rate to student and faculty/staff surveys

Instrument	Surveys distributed	Surveys completed	Respondents meeting age criteria	Final response rate (%)
Pretest (2012)				
NCHA	6326	625	618	9.8
SPEAKS-S	6497	804	798	12.3
SPEAKS-F/S	2810	558	+	19.9
Posttest (2014)				
NCHA	6068	517	516	8.5
SPEAKS-S	6381	635	633	9.9
SPEAKS-F/S	3703*	449	+	11.4*

*CPHHP did not have the number of surveys distributed to faculty and staff in 2014 for all of the campuses at the time of this evaluation. Where 2014 information was lacking, CPHHP assumed that as many surveys were distributed to faculty and staff in 2014 as was the case in 2012.

+There were no age criteria for faculty and staff.

The rate of item non-response varied between and within the surveys in 2012, in some cases substantially lowering the response rate for particular questions.[18] Overall, the NCHA survey had a fairly low item non-response rate. About a quarter of the items had 10 or fewer non-responses. Over 90 percent of the items had 20 or fewer non-responses. The average incidence of item non-response was 13, for an average item non-response rate of 2.1 percent. Two questions, one about fighting (Q5a) and one about non-consensual

[18] Several items either asked for respondents to volunteer qualitative answers or were contingent upon the answer to prior items; these are not included in the following discussion.

intercourse (Q5b), were answered by all of the respondents. A question asking about relations with transgendered partners (Q20c) had the highest non-response, 75 respondents skipped it. Thus, the non-response rate ranged from 0 to 12 percent.

There were 80 items on the SPEAKS-S survey that elicited independent, quantitative answers, including one item created to aggregate all of the responses to the several race questions. The average number of missing responses for all of the items was 127, yielding an average item non-response rate of 15.9 percent. The non-response for the typical question was 117. There was substantial variation throughout the survey, however. The question "Have you been exposed to any materials on your campus related to suicide prevention" had the lowest incidence of item non-response; only 25 respondents failed to answer this question. The item asking students to respond to the comment "I would not seek help from anyone," were they to be faced with suicidal thoughts, had 223 missing responses. Thus, item non-response ranged from 4 percent to 36.1 percent. A visual inspection of the data reveals an apparent pattern of increase in non-responses as the survey progresses. The item mentioned with only 25 non-responses was the first substantive question in the instrument. The question with 223 non-responses was question 48i (there are 56 numbered questions on the survey, but several have multiple parts). Further, all questions from 1 to 14 have fewer than 100 non-responses, while all questions after this have more than 100 non-responses; all questions after 47 have more than 150 non-responses.

The average item non-response rate for the SPEAKS-F/S was 9 percent with an average of 50 missing responses. The question asking whether the faculty/staff had been exposed to any campus materials had the lowest miss rate, at 3.4 percent; 19 respondents did not answer this. The question that appeared to offer the most trouble to faculty/staff was question 51, "What is your age?" One hundred two respondents decided to skip this question, for a non-response rate of 18.3 percent.

Due to time constraints, a close examination of the item non-responses was not conducted after the posttest. A quick visual inspection, however, suggests similar non-response patterns in the posttest as was present in the pretest.

Table C-2

Item non-response (2012)

Instrument	Survey Response	Min. item non-response	Max. item non-response	Average item non-response
NCHA	625	0	75	13
SPEAKS-S	804	25	223	127
SPEAKS-F/S	558	19	102	50

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Appendix D

Responses to CCPSI Kick-Off Satisfaction Survey

Table D1

CCSPI Kick-Off, April, 2012 (n=26)

Question	Mean	SD
The presented information broadened my understanding of mental health promotion and suicide prevention.	4.58	0.58
The content was relevant to my work on mental health promotion and suicide prevention.	4.65	0.49
This opportunity has helped me connect with other mental health promotion and suicide prevention professionals.	4.15	0.88
I will share the knowledge that I have learned with others.	4.77	0.43
The presentation was well organized.	4.54	0.58
The presentation included teaching methods that were effective.	4.58	0.50
The presentation included an interactive style to engage participants.	3.85	1.01
Mastery of the topic was demonstrated in the presentation.	4.77	0.43
Differences of opinion were respected throughout the presentation.	3.96	0.86
The presentation was culturally sensitive.	4.19	0.80

Range: 1 (strongly disagree) to 5 (strongly agree)

Appendix E

Professional Development Satisfaction Surveys Responses

Table E1

Tip 50 Professional Development, April, 2012 (n=19)

Question	Mean	SD
The presented information broadened my understanding of mental health promotion and suicide prevention.	4.16	0.76
The content was relevant to my work on mental health promotion and suicide prevention.	4.16	0.69
This opportunity has helped me connect with other mental health promotion and suicide prevention professionals.	4.05	0.78
I will share the knowledge that I have learned with others.	4.47	0.70
The presentation was well organized.	4.39	0.50
The presentation included teaching methods that were effective.	4.22	0.81
The presentation included an interactive style to engage participants.	3.41	1.00
Mastery of the topic was demonstrated in the presentation.	4.41	0.71
Differences of opinion was respected throughout the presentation.	3.89	0.90
The presentation was culturally sensitive.	4.00	0.84

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E2

Connecticut Liquor Laws, April, 2012 (n=8)

Question	Mean	SD
The presented information broadened my understanding about underage drinking prevention.	4.50	0.76
The content was relevant to my work on underage drinking prevention.	4.50	0.53
This opportunity has helped me connect with other underage drinking prevention professionals.	4.12	0.83
I will share the knowledge that I have learned with others.	4.38	0.92
Was well organized.	4.62	0.52
Used teaching methods that were effective.	4.25	1.04
Used an interactive style to engage participants.	4.12	1.13
Demonstrated mastery of the topic.	4.75	0.46
Respected differences of opinion.	4.14	0.90
Demonstrated cultural sensitivity.	4.14	0.90

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E3

How to Increase Administrator Support for Campus Prevention Efforts: Round Table Discussion, May, 2012 (n=9)

Question	Mean	SD
The presented information broadened my understanding about mental health promotion and suicide prevention.	3.89	0.78
The content was relevant to my work on mental health promotion and suicide prevention.	4.33	0.71
This opportunity has helped me connect with other mental health promotion and suicide prevention professionals.	4.44	0.73
I will share the knowledge that I have learned with others.	4.44	0.73
Was well organized.	4.56	0.53
Used teaching methods that were effective.	4.22	0.67
Used an interactive style to engage participants.	4.78	0.44
Demonstrated mastery of the topic.	4.67	0.50
Respected differences of opinion.	4.56	0.73
Demonstrated cultural sensitivity.	4.33	0.87

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E4

Addressing Cultural Competence for Collegiate Professionals, September, 2012 (n=14)

Question	Mean	SD
The presented information broadened my understanding about multiculturalism.	3.50	1.22
The content was relevant to my work.	3.93	0.92
This opportunity has helped me connect with other prevention professionals.	3.71	0.99
I will share the knowledge that I have learned with others.	3.29	0.99
The speaker was well organized.	3.79	1.05
The speaker used teaching methods that were effective.	3.64	1.08
The speaker used an interactive style to engage participants.	3.64	1.01
The speaker demonstrated mastery of the topic.	3.86	1.17
The speaker respected differences of opinion.	4.00	1.04
The speaker demonstrated cultural sensitivity.	3.79	1.31

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E5

Active Duty and Veteran College Students' Substance Abuse and Mental Health, November, 2012 (n=10)

Question	Mean	SD
The presented information broadened my understanding of mental health or prevention.	4.70	0.48
The content was relevant to my work in mental health or prevention.	4.60	0.52
This opportunity has helped me connect with other mental health or prevention professionals.	4.80	0.42
I will share the knowledge that I have learned with others.	4.80	0.42
The presentation was well organized.	4.80	0.42
The presentation included teaching methods that were effective.	4.80	0.42
The presentation included an interactive style to engage participants.	4.60	0.52
Mastery of the topic was demonstrated in the presentation.	5.00	0.00
Differences of opinion were respected throughout the presentation.	4.50	0.71
The presentation was culturally sensitive.	4.90	0.32

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E6

Online Screening Programs, December, 2012 (n=13)

Question	Mean	SD
The presented information broadened my understanding of mental health or prevention.	4.46	0.52
The content was relevant to my work in mental health or prevention.	4.54	0.52
This opportunity has helped me connect with other mental health or prevention professionals.	4.62	0.51
I will share the knowledge that I have learned with others.	4.67	0.49
The presentation was well organized.	4.77	0.44
The presentation included teaching methods that were effective.	4.62	0.51
The presentation included an interactive style to engage participants.	4.69	0.48
Mastery of the topic was demonstrated in the presentation.	4.69	0.48
Differences of opinion were respected throughout the presentation.	4.69	0.48
The presentation was culturally sensitive.	4.38	0.65

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E7

LGBTQI Culture, April, 2013 (n=16)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	4.69	0.48
The content was relevant to my work in mental health or suicide prevention.	4.62	0.62
This opportunity has helped me connect with other mental health or prevention professionals.	4.69	0.48
I will share knowledge that I have learned with others.	4.81	0.40
The presentation was well organized.	4.94	0.25
The presentation included teaching methods that were effective.	4.75	0.58
The presentation included an interactive style to engage participants.	4.88	0.34
Mastery of the topic was demonstrated in the presentation.	4.94	0.25
Differences of opinion were respected throughout the presentation.	4.81	0.40
The presentation was culturally sensitive.	4.94	0.25
The panel gave me a better understanding of LGBTQI campus programs.	4.81	0.40

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E8

Developing a Comprehensive Campus Approach to Prevention: The Jed Foundation, May, 2013 (n=30)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	4.36	0.56
The content was relevant to my work in mental health or suicide prevention.	4.46	0.58
This opportunity has helped me connect with other mental health or prevention professionals.	4.64	0.56
I will share knowledge that I have learned with others.	4.68	0.48
The presentation was well organized.	4.62	0.49
The presentation included teaching methods that were effective.	4.41	0.63
The presentation included an interactive style to engage participants.	4.41	0.57
Mastery of the topic was demonstrated in the presentation.	4.52	0.57
Differences of opinion were respected throughout the presentation.	4.24	0.74
The presentation was culturally sensitive.	3.93	0.75

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E9

Latin@Culture, September, 2013 (n=29)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	4.66	0.48
The content was relevant to my work in mental health or suicide prevention.	4.59	0.57
This opportunity has helped me connect with other mental health or prevention professionals.	4.28	0.70
I will share knowledge that I have learned with others.	4.69	0.47
The presentation was well organized.	4.62	0.56
The presentation included teaching methods that were effective.	4.62	0.62
The presentation included an interactive style to engage participants.	4.69	0.60
Mastery of the topic was demonstrated in the presentation.	4.93	0.26
Differences of opinion were respected throughout the presentation.	4.68	0.35
The presentation was culturally sensitive.	4.93	0.26

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E10

The Value of Evaluation, October, 2013 (n=18)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	3.94	0.64
The content was relevant to my work in mental health or suicide prevention.	4.28	0.75
This opportunity has helped me connect with other mental health or prevention professionals.	4.39	0.61
I will share knowledge that I have learned with others.	4.11	0.76
The presentation was well organized.	4.61	0.50
The presentation included teaching methods that were effective.	4.39	0.61
The presentation included an interactive style to engage participants.	4.61	0.50
Mastery of the topic was demonstrated in the presentation.	4.56	0.62
Differences of opinion were respected throughout the presentation.	4.50	0.71
The presentation was culturally sensitive.	4.12	0.86

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E11

A Taste of Motivational Interviewing, November, 2013 (n=18)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	4.67	0.49
The content was relevant to my work in mental health or suicide prevention.	4.82	0.39
This opportunity has helped me connect with other mental health or prevention professionals.	4.78	0.43
I will share knowledge that I have learned with others.	4.53	0.72
The presentation included teaching methods that were effective.	4.89	0.47
The presentation included an interactive style to engage participants.	4.94	0.24
Mastery of the topic was demonstrated in the presentation.	4.89	0.32
Differences of opinion were respected throughout the presentation.	4.65	0.61
The presentation was culturally sensitive.	4.28	0.96

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E12

Emergence of Mental Health Disorders, December, 2013 (n=37)

Question	Mean	SD
The presented information broadened my understanding of mental health or prevention.	4.59	0.60
The content was relevant to my work in mental health or prevention.	4.65	0.54
This opportunity has helped me connect with other mental health or prevention professionals.	4.61	0.60
I will share knowledge that I have learned with others.	4.66	0.59
The presentation was well organized.	4.38	0.68
The presentation included teaching methods that were effective.	4.22	0.79
The presentation included an interactive style to engage participants.	4.46	0.65
Mastery of the topic was demonstrated in the presentation.	4.59	0.64
Differences of opinion were respected throughout the presentation.	4.59	0.55
The presentation was culturally sensitive.	4.32	0.75

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E13

Keep the Problem Out of Gambling, March, 2014 (n=14)

Question	Mean	SD
The presented information broadened my understanding of mental health or suicide prevention.	4.64	0.63
The content was relevant to my work in mental health or suicide prevention.	4.71	0.47
This opportunity has helped me connect with other mental health or prevention professionals.	4.64	0.63
I will share knowledge that I have learned with others.	5.00	0.00
The presentation was well organized.	4.79	0.43
The presentation included teaching methods that were effective.	4.50	0.76
The presentation included an interactive style to engage participants.	4.71	0.47
Mastery of the topic was demonstrated in the presentation.	4.86	0.36
Differences of opinion were respected throughout the presentation.	4.64	0.74
The presentation was culturally sensitive.	4.29	0.83

Range: 1 (strongly disagree) to 5 (strongly agree)

Table E14

Positive Social Norms Marketing: From Theory to Practice, April, 2014 (n=21)

Question	Mean	SD
The presented information broadened my understanding of mental health or prevention.	4.67	0.48
The content was relevant to my work in mental health or prevention.	4.86	0.36
This opportunity has helped me connect with other mental health or prevention professionals.	4.43	0.68
I will share the knowledge that I have learned with others.	4.76	0.44
The presentation was well organized.	4.76	0.44
The presentation included teaching methods that were effective.	4.62	0.59
The presentation included an interactive style to engage participants.	4.52	0.60
Mastery of the topic was demonstrated in the presentation.	4.76	0.44
Differences of opinion were respected throughout the presentation.	4.75	0.55
The presentation was culturally sensitive.	4.60	0.75

Range: 1 (strongly disagree) to 5 (strongly agree)

Appendix F

Community Training Satisfaction Survey Results

RRSR-PC

Table F1

Recognizing and Responding to Suicide Risk in Primary Care on Campus, May, 2012 (n=29)

Item	Frequency	Percent
Profession or Current Practice		
Physician	0	0.0
Physician Assistant	0	0.0
Nurse	26	89.7
Other	3	10.3
Highest Degree		
MD	0	0.0
Masters	13	46.4
Bachelors	8	28.6
Other	7	25.0
Setting of Primary Practice		
Private Practice	0	0.0
Hospital	0	0.0
Out-patient Clinic	1	3.4
Employee Assistance Program	0	0.0
Group Home/Other Residential Facility	1	3.4
Jail, Prison, or Other Correctional Institution	0	0.0
College or University	27	93.1
Other	0	0.0
Number of Years in Practice		
Less Than 5 Years	0	0.0
Between 5 and 10 Years	4	13.8
Between 11 and 15 Years	4	13.8
More than 15 Years	21	72.4
Program Met Expectations		
As expected	6	20.7
More than expected	13	44.8
Exceeded	10	34.5
Current Learning Needs		
Too Basic	1	3.4
Just About Right	28	96.6
Too Advanced	0	0.0

Table F2

Recognizing and Responding to Suicide Risk in Primary Care on Campus, May, 2012 (n=29)

Item	Mean	SD
Learned skills from training	3.48	0.51
Competency After Course	3.48	0.51
Course Objectives Clearly Stated	3.72	0.45
Learning Objectives Defined	3.76	0.44
Interactive Sections Appropriate	3.60	0.50
Pocket Card Useful	3.79	0.41
Resource Sheets Appropriate	3.90	0.31
Facilitator Demonstrated Knowledge and Understanding	3.86	0.35
Facilitator Presented Information Clearly	3.97	0.19

Range: 1 (completely disagree) to 4 (completely agree)

Overall Impression (Range: 1-Poor to 5-Outstanding)	4.48	0.51
Program Met Expectations (Range: 1-Not at all to 5-Exceeded)	4.14	0.74
Amount of Time Scheduled (Range: 1-Much too short to 5-Much too long)	2.97	0.57

Competency Before Course	6.69	2.05
Able to Initiate and Discuss Suicide	8.68	1.11
Able to Use Algorithm to Identify Patients at Risk	8.52	1.28
Able to Apply Crisis Management	8.33	1.71
Able to Deliver Intervention	8.41	1.70

Range: 1 (disagree) to 10 (agree)

QPR TOT

Table F3

Question Persuade Refer (QPR) – Training of Trainers, August, 2012 (n=29)

Item	Mean	SD
Overall Program Organization	4.74	0.45
Program Content	4.79	0.42
Program Presentation	4.82	0.39
Overall Value	4.75	0.44
Course met expectations	4.75	0.44
Instructor demonstrated thorough knowledge of subject	4.86	0.36
Instructor's presentation of material	4.82	0.39
Degree course provided practical applications for work	4.86	0.36
Overall evaluation of course	4.77	0.42

Range: 1 (poor) to 5 (outstanding)

Table F4

Question, Persuade, Refer (QPR) – Training of Trainers, January 9, 2013 (n=29)

Item	Mean	SD
Overall program organization	1.39	0.50
Program content	1.32	0.61
Program presentation	1.29	0.53
Overall value to you	1.36	0.62
How well did the course meet your expectations?	1.28	0.59
Did the instructor demonstrate a thorough knowledge of the subject matter?	1.03	0.19
How would you rate the instructor's presentation of the material?	1.21	0.41
To what degree did the course provide practical applications for your work?	1.38	0.62
What is your overall evaluation of this course?	1.28	0.45

Range: 1 (outstanding) to 5 (poor)

Table F5

Question, Persuade, Refer (QPR), January 10, 2013 (n=26)

Item	Mean	SD
Overall program organization	1.40	0.58
Program content	1.60	0.71
Program presentation	1.48	0.65
Overall value to you	1.48	0.59
How well did the course meet your expectations?	1.60	0.65
Did the instructor demonstrate a thorough knowledge of the subject matter?	1.20	0.41
How would you rate the instructor's presentation of the material?	1.32	0.56
To what degree did the course provide practical applications for your work?	1.56	0.65
What is your overall evaluation of this course?	1.48	0.59

Range: 1 (outstanding) to 5 (poor)

Table F6

Question Persuade Refer (QPR) – Training of Trainers, June 13, 2014 (n=25)

Item	Mean	SD
Overall Program Organization	1.56	0.65
Program Content	1.48	0.65
Program Presentation	1.60	0.71
Overall Value to You	1.48	0.65
How well did the course meet your expectations?	1.56	0.65
Did the instructor demonstrate a thorough knowledge of the subject matter?	1.52	0.65
How would you rate the instructor's presentation of the material?	1.64	0.64
To what degree did the course provide practical applications for your work?	1.48	0.65
What is your overall evaluation of this course?	1.64	0.66

Range: 1 (outstanding) to 5 (poor)

Connect Prevention / Postvention

Table F7

Connect Prevention – Campus Community Training, June, 2012 (n=24)

Question	Mean	SD
The trainers' knowledge of the training topics?	3.83	0.63
The trainer's presentation of the training topics?	3.71	0.75
The building where the training was held?	3.26	0.75
The location of the training?	3.22	0.79
Your overall training experience?	3.63	0.82

Table F7a

Connect Prevention – Campus Community Training, June, 2012 (n=24)

	Percent		
Item	Like	Neutral	Dislike
Activities and Case Scenarios	96	4	0
Amount of Material Covered	75	13	13
Atmosphere of Training	83	17	0
Data and Statistics	79	13	8
Discussion and Interaction	96	0	4
Handouts or Other Materials Provided	92	0	8
Instructor or Trainer	96	4	0
Length of Training	58	25	17
Number of Breaks	79	21	0
Opportunity to Ask Questions	96	0	4
Pace of Training	79	4	17
Resource Information	92	4	4

Table F8

Connect Prevention – Social Services Training, August, 2012 (n=19)

Question	Mean	SD
The trainers' knowledge of the training topics?	3.84	0.37
The trainer's presentation of the training topics?	3.68	0.58
The building where the training was held?	3.42	0.69
The location of the training?	3.42	0.60
Your overall training experience?	3.63	0.49

Table F8a

Connect Prevention – Social Services Training, August, 2012 (n=19)

	Percent		
Item	Like	Neutral	Dislike
Activities and Case Scenarios	100	0	0
Amount of Material Covered	89	11	0
Atmosphere of Training	72	28	0
Data and Statistics	89	6	6
Discussion and Interaction	94	6	0
Handouts or Other Materials Provided	94	6	0
Instructor or Trainer	100	0	0
Length of Training	75	25	0
Number of Breaks	56	44	0
Opportunity to Ask Questions	94	6	0
Pace of Training	72	22	6
Resource Information	89	11	0

Table F9

Connect Postvention – Social Services Training, January 2013 (n=25)

Question	Mean	SD
The trainers' knowledge of the training topics?	3.96	0.20
The trainer's presentation of the training topics?	3.88	0.33
The building where the training was held?	3.32	0.85
The location of the training?	3.54	0.51
Your overall training experience?	3.83	0.38

Table F9a

Connect Postvention – Social Services Training, January 2013 (n=25)

	Percent		
Item	Like	Neutral	Dislike
Activities and Case Scenarios	100	0	0
Amount of Material Covered	88	12	0
Atmosphere of Training	68	20	12
Data and Statistics	88	12	0
Discussion and Interaction	92	8	0
Handouts or Other Materials Provided	100	0	0
Instructor or Trainer	100	0	0
Length of Training	80	20	0
Number of Breaks	88	12	0
Opportunity to Ask Questions	100	0	0
Pace of Training	88	12	0
Resource Information	96	4	0

[Note: No satisfaction survey was conducted for the training Assessing and Managing Suicide Risk (AMSR)]

Table F10

The Essentials of Motivational Interviewing, February 27 and 28, 2014 (n=32)

Question	Mean	SD
The presented information broadened my understanding of motivational interviewing.	4.94	0.25
The content was relevant to my work.	4.59	0.56
This opportunity has helped me connect with other mental health or prevention professionals.	4.53	0.67
Materials (including visual, handouts etc) were helpful in reinforcing content.	4.50	0.67
The presentation included teaching methods that were effective.	4.84	0.37
The presentation included an interactive style to engage participants.	4.88	0.34
Mastery of the topic was demonstrated in the presentation.	4.78	0.42
Differences of opinion were respected throughout the presentation.	4.53	0.62
The presentation was culturally sensitive.	4.41	0.80

Range: 1 (strongly disagree) to 5 (strongly agree)

Appendix G

National College Health Assessment (NCHA) Responses (n=618 / 516)

Table G1

Q2. Received information from college or university

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Depression/Anxiety				
No	314	51.2	203	39.5
Yes	299	48.8	311	60.5
Missing	5	*	2	*
How to help other in distress				
No	389	64.0	261	51.3
Yes	219	36.0	248	48.7
Missing	10	*	7	*
Stress reduction				
No	304	49.7	164	31.9
Yes	308	50.3	350	68.1
Missing	6	*	2	*
Suicide prevention				
No	376	61.8	262	51.1
Yes	232	38.2	251	48.9
Missing	10	*	3	*

Table G2

Q3. Interested in receiving information from college or university

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Depression/Anxiety				
No	279	46.3	185	36.3
Yes	324	53.7	324	63.7
Missing	15	*	7	*
How to help others in distress				
No	280	46.2	166	32.7
Yes	326	53.8	341	67.3
Missing	12	*	9	*
Stress reduction				
No	222	36.6	132	25.9
Yes	384	63.4	378	68.3
Missing	12	*	7	*
Suicide prevention				
No	345	57.4	243	47.7
Yes	256	42.6	266	52.3
Missing	17	*	7	*

Table G3

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q16. Last 12 months, seriously considered suicide when drinking alcohol				
N/A, Don't drink	162	26.8	76	15.0
No	426	70.5	416	81.9
Yes	16	2.6	16	3.1
Missing	14	*	8	*
Q32. Ever diagnosed with depression				
No	457	76.9	382	75.8
Yes	137	23.1	122	24.2
Missing	24	*	12	*
Q35. Received psychological/mental health services from college/university counseling/health services				
No	538	88.6	374	73.6
Yes	69	11.4	134	26.4
Missing	11	*	8	*
Q36. Would consider seeking help from mental health professional in future				
No	187	31.1	117	23.1
Yes	414	68.9	390	76.9
Missing	17	*	9	*

Table G4

Q30. Have ever	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Felt things were hopeless				
No, never	187	31.1	160	31.2
No, not in last 12 months	102	17.0	78	15.2
Yes, in last 2 weeks	123	20.5	95	18.6
Yes, in last 30 days	57	9.5	51	10.0
Yes, in last 12 months	132	22.0	128	25.0
Missing	17	*	4	*
Felt overwhelmed				
No, never	57	9.4	37	7.2
No, not in last 12 months	33	5.5	15	2.9
Yes, in last 2 weeks	294	48.6	277	53.9
Yes, in last 30 days	117	19.3	91	17.7
Yes, in last 12 months	104	17.2	94	18.3
Missing	13	*	2	*
Felt exhausted				
No, never	87	14.4	61	11.9
No, not in last 12 months	50	8.3	23	4.5
Yes, in last 2 weeks	278	45.9	268	52.3
Yes, in last 30 days	109	18.0	76	14.8
Yes, in last 12 months	82	13.5	84	16.4
Missing	12	*	4	*
Felt very lonely				
No, never	128	21.1	110	21.4
No, not in last 12 months	91	15.0	84	16.4
Yes, in last 2 weeks	181	29.9	121	23.6
Yes, in last 30 days	89	14.7	72	14.0
Yes, in last 12 months	117	19.3	126	24.6
Missing	12	*	3	*
Felt very sad				
No, never	115	19.0	103	20.1
No, not in last 12 months	92	15.2	83	16.2
Yes, in last 2 weeks	181	29.9	121	23.6
Yes, in last 30 days	96	15.9	73	14.3
Yes, in last 12 months	121	20.0	132	25.8
Missing	13	*	4	*

Q30. Have ever	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Felt so depressed difficult to function				
No, never	251	41.4	225	43.9
No, not in last 12 months	135	22.3	95	18.5
Yes, in last 2 weeks	78	12.9	51	9.9
Yes, in last 30 days	48	7.9	36	7.0
Yes, in last 12 months	94	15.5	106	20.7
Missing	12	*	3	*
Felt overwhelming anxiety				
No, never	199	32.9	147	28.7
No, not in last 12 months	84	13.9	46	9.0
Yes, in last 2 weeks	147	24.3	129	25.1
Yes, in last 30 days	76	12.6	57	11.1
Yes, in last 12 months	99	16.4	134	26.1
Missing	13	*	3	*
Felt overwhelming anger				
No, never	225	37.1	193	37.9
No, not in last 12 months	135	22.3	104	20.4
Yes, in last 2 weeks	86	14.2	61	12.0
Yes, in last 30 days	61	10.1	44	8.6
Yes, in last 12 months	99	16.3	107	21.0
Missing	12	*	7	*
Intentionally injured self				
No, never	477	78.8	397	77.4
No, not in last 12 months	81	13.4	75	14.6
Yes, in last 2 weeks	16	2.6	7	1.4
Yes, in last 30 days	12	2.0	8	1.6
Yes, in last 12 months	19	3.1	26	5.1
Missing	13	*	3	*
Seriously considered suicide				
No, never	449	74.1	394	77.0
No, not in last 12 months	91	15.0	74	14.5
Yes, in last 2 weeks	19	3.1	9	1.8
Yes, in last 30 days	10	1.7	6	1.2
Yes, in last 12 months	37	6.1	29	5.7
Missing	12	*	4	*

Q30. Have ever	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Attempted suicide				
No, never	524	86.6	467	91.0
No, not in last 12 months	65	10.7	39	7.6
Yes, in last 2 weeks	5	0.8	1	0.2
Yes, in last 30 days	3	0.5	1	0.2
Yes, in last 12 months	8	1.3	5	1.0
Missing	13	*	3	*

Table G5

Q31. In last 12 months, diagnosed or treated by a professional	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Anorexia				
No	594	98.2	507	99.4
Diagnosed no treatment	7	1.2	1	0.2
Treated w/ medication	0	0.0	0	0.0
Treated w/ psychotherapy	4	0.7	2	0.4
Treated w/ medication and psychotherapy	0	0.0	0	0.0
Other treatment	0	0.0	0	0.0
Missing	13	*	6	*
Anxiety				
No	509	84.0	420	82.2
Diagnosed no treatment	17	2.8	16	3.1
Treated w/ medication	30	5.0	22	4.3
Treated w/ psychotherapy	15	2.5	17	3.3
Treated w/ medication and psychotherapy	33	5.4	32	6.3
Other treatment	2	0.3	4	0.8
Missing	12	*	5	*
ADHD				
No	565	93.5	478	93.4
Diagnosed no treatment	7	1.2	5	1.0
Treated w/ medication	21	3.5	19	3.7
Treated w/ psychotherapy	4	0.7	1	0.2
Treated w/ medication and psychotherapy	6	1.0	8	1.6
Other treatment	1	0.2	1	0.2
Missing	14	*	4	*
Bipolar disorder				
No	592	97.9	506	98.8
Diagnosed no treatment	5	0.8	1	0.2
Treated w/ medication	5	0.8	0	0.0
Treated w/ psychotherapy	0	0.0	0	0.0
Treated w/ medication and psychotherapy	3	0.5	4	0.8
Other treatment	0	0.0	1	0.2
Missing	13	*	4	*

Q31. In last 12 months, diagnosed or treated by a professional	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Bulimia				
No	599	98.8	509	99.6
Diagnosed no treatment	4	0.7	1	0.2
Treated w/ medication	0	0.0	0	0.0
Treated w/ psychotherapy	3	0.5	0	0.0
Treated w/ medication and psychotherapy	0	0.0	1	0.2
Other treatment	0	0.0	0	0.0
Missing	12	*	5	*
Depression				
No	523	86.0	442	86.3
Diagnosed no treatment	14	2.3	13	2.5
Treated w/ medication	22	3.6	17	3.3
Treated w/ psychotherapy	18	3.0	11	2.1
Treated w/ medication and psychotherapy	30	4.9	25	4.9
Other treatment	1	0.2	4	0.8
Missing	10	*	4	*
Insomnia				
No	577	95.7	488	95.5
Diagnosed no treatment	11	1.8	10	2.0
Treated w/ medication	15	2.5	7	1.4
Treated w/ psychotherapy	0	0.0	2	0.4
Treated w/ medication and psychotherapy	0	0.0	2	0.4
Other treatment	0	0.0	2	0.4
Missing	15	*	5	*
Other Sleep Disorder				
No	585	96.7	496	97.6
Diagnosed no treatment	8	1.3	6	1.2
Treated w/ medication	3	0.5	1	0.2
Treated w/ psychotherapy	1	0.2	2	0.4
Treated w/ medication and psychotherapy	5	0.8	0	0.0
Other treatment	3	0.5	3	0.6
Missing	13	*	508	*

Q31. In last 12 months, diagnosed or treated by a professional	2012		2014	
Item	Frequency	Percent	Frequency	Percent
OCD				
No	587	96.7	494	96.1
Diagnosed no treatment	7	1.2	7	1.4
Treated w/ medication	5	0.8	4	0.8
Treated w/ psychotherapy	3	0.5	4	0.8
Treated w/ medication and psychotherapy	5	0.8	5	1.0
Other treatment	0	0.0	0	0.0
Missing	11	*	2	*
Panic Attacks				
No	547	90.4	470	91.8
Diagnosed no treatment	15	2.5	11	2.1
Treated w/ medication	12	2.0	8	1.6
Treated w/ psychotherapy	13	2.1	9	1.8
Treated w/ medication and psychotherapy	16	2.6	12	2.3
Other treatment	2	0.3	2	0.4
Missing	13	*	4	*
Phobia				
No	590	97.4	507	98.8
Diagnosed no treatment	6	1.0	3	0.6
Treated w/ medication	1	0.2	1	0.2
Treated w/ psychotherapy	7	1.2	2	0.4
Treated w/ medication and psychotherapy	1	0.2	0	0.0
Other treatment	1	0.2	0	0.0
Missing	12	*	3	*
Schizophrenia				
No	600	99.3	512	100
Diagnosed no treatment	0	0.0	0	0.0
Treated w/ medication	0	0.0	0	0.0
Treated w/ psychotherapy	1	0.2	0	0.0
Treated w/ medication and psychotherapy	2	0.3	0	0.0
Other treatment	1	0.2	0	0.0
Missing	14	*	4	*

Q31. In last 12 months, diagnosed or treated by a professional	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Substance abuse/addiction				
No	596	98.5	503	98.4
Diagnosed no treatment	2	0.3	6	1.2
Treated w/ medication	0	0.0	0	0.0
Treated w/ psychotherapy	3	0.5	2	0.4
Treated w/ medication and psychotherapy	2	0.3	0	0.0
Other treatment	2	0.3	0	0.0
Missing	13	*	5	*
Other addiction				
No	600	99.3	510	99.6
Diagnosed no treatment	0	0.0	0	0.0
Treated w/ medication	0	0.0	0	0.0
Treated w/ psychotherapy	2	0.3	2	0.4
Treated w/ medication and psychotherapy	0	0.0	0	0.0
Other treatment	2	0.3	0	0.0
Missing	14	*	4	*
Other mental health condition				
No	589	97.2	497	97.1
Diagnosed no treatment	3	0.5	3	0.6
Treated w/ medication	2	0.3	1	0.2
Treated w/ psychotherapy	6	1.0	7	1.4
Treated w/ medication and psychotherapy	5	0.8	2	0.4
Other treatment	1	0.2	2	0.4
Missing	12	*	4	*

Table G6

Q33. In last 12 months, the following has been traumatic or very difficult to handle	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Academics				
No	331	54.7	264	51.6
Yes	274	45.3	248	48.4
Missing	13	*	4	*
Career related issue				
No	454	75.2	370	72.4
Yes	150	24.8	141	27.6
Missing	14	*	5	*
Death of family member/friend				
No	479	79.2	424	82.7
Yes	126	20.8	89	17.3
Missing	13	*	3	*
Family problems				
No	379	62.5	362	70.8
Yes	227	37.5	149	29.2
Missing	12	*	5	*
Intimate relationships				
No	396	65.7	345	67.3
Yes	207	34.3	168	32.7
Missing	15	*	3	*
Other relationships				
No	412	68.2	360	70.3
Yes	192	31.8	152	29.7
Missing	14	*	4	*
Finances				
No	352	58.2	339	66.5
Yes	253	41.8	171	33.5
Missing	13	*	6	*
Health problem of family member/partner				
No	473	78.2	410	80.2
Yes	132	21.8	101	19.8
Missing	13	*	5	*

Q33. In last 12 months, the following has been traumatic or very difficult to handle	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Personal appearance				
No	422	70.0	375	73.2
Yes	181	30.0	137	26.8
Missing	15	*	4	*
Personal health issue				
No	456	75.4	407	79.6
Yes	149	24.6	104	20.4
Missing	13	*	5	*
Sleep difficulties				
No	444	73.3	372	72.9
Yes	162	26.7	138	27.1
Missing	12	*	6	*
Other				
No	528	88.1	440	87.6
Yes	71	11.9	62	12.4
Missing	19	*	14	*

Table G7

Q34. Ever received psychological or mental health services from . . .

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Counselor/psychologist				
No	343	57.0	246	48.1
Yes	259	43.0	265	51.9
Missing	16	*	5	*
Psychiatrist				
No	495	82.2	417	81.8
Yes	107	17.8	93	18.2
Missing	16	*	6	*
Other medical provider				
No	505	84.0	413	81.0
Yes	96	16.0	97	19.0
Missing	17	*	6	*
Clergy				
No	556	93.3	482	94.7
Yes	40	6.7	27	5.3
Missing	22	*	7	*

Table G8

Q37. Level of stress in last 12 months

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
No stress	12	2.0	10	2.0
Less than average stress	53	8.8	27	5.3
Average stress	233	38.6	198	38.7
More than average stress	243	40.2	227	44.4
Tremendous stress	63	10.4	49	9.6
Missing	14	*	5	*

Appendix H

Suicide Prevention Exposure, Awareness, and Knowledge Survey - Student Responses (n=798 / 633)

Table H1

Student Survey Responses

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q1. Exposed to suicide prevention materials on campus				
Yes	245	31.7	259	43.0
No	398	51.1	249	42.3
Don't Know	130	16.8	225	16.4
Missing	25	*	30	*
Q2. Participated in suicide prevention activities on campus				
Yes	41	5.3	56	9.3
No	724	93.7	528	87.7
Don't Know	8	1.0	18	3.0
Missing	25	*	31	*
Q6. Aware of at least one local resource to refer someone at risk for suicide				
Yes	491	65.4	418	72.2
No	260	34.6	161	27.8
Missing	47	*	54	*

Table H2

Student Survey Responses

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q3. Can recognize warning signs of suicide in another student				
Not confident	64	8.5	51	8.7
Somewhat confident	299	39.5	227	38.7
Confident	268	35.4	198	33.7
Very confident	104	13.7	93	15.8
Don't know	22	2.9	18	3.1
Missing	41	*	46	*
Q4. Would ask someone exhibiting warning signs of suicide if thinking about suicide				
Not confident	153	20.3	131	22.5
Somewhat confident	256	33.9	172	29.5
Confident	204	27.0	155	26.6
Very confident	116	15.4	106	18.2
Don't know	26	3.4	19	3.3
Missing	43	*	50	*
Q5. Would connect or refer student at risk for suicide to resources				
Not confident	101	13.4	71	12.1
Somewhat confident	177	23.4	117	20.0
Confident	236	31.3	190	32.4
Very confident	219	29.0	183	31.2
Don't know	22	2.9	25	4.3
Missing	43	*	47	*

Table H3

Student Survey Responses

Q48. If I were having suicidal thoughts, I would seek help from:	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Friend not related to you				
Very Likely	219	34.0	193	38.8
Likely	267	41.4	203	40.8
Neither	46	7.1	32	6.4
Unlikely	61	9.5	44	8.8
Very Unlikely	52	8.1	26	5.2
Missing	153	*	135	*

Q48. If I were having suicidal thoughts, I would seek help from:	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Mental Health professional or school counselor				
Very Likely	55	8.5	49	9.9
Likely	138	21.4	145	29.2
Neither	116	18.0	71	14.3
Unlikely	192	29.8	151	30.4
Very Unlikely	143	22.2	81	16.3
Missing	154	*	136	*
I would not seek help from anyone				
Very Likely	26	4.4	20	4.3
Likely	74	12.6	53	11.4
Neither	114	19.4	61	13.1
Unlikely	112	19.0	101	21.8
Very Unlikely	163	44.7	229	49.4
Missing	209	*	169	*

Table H4

Student Survey Responses	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Personally				
Q9. Think it is a sign of personal weakness or inadequacy to receive treatment for suicidal thoughts and behaviors				
Strongly Disagree	469	64.3	348	62.8
Disagree	137	18.8	125	22.6
Neither Disagree nor Agree	63	8.6	43	7.8
Agree	48	6.6	24	4.3
Strongly Agree	4	0.5	10	1.8
No Opinion	8	1.1	4	0.7
Missing	69	*	79	*
Q10. Would see person as less favorable if knew he or she received treatment of suicidal thoughts and behaviors				
Strongly Disagree	500	68.9	393	70.9
Disagree	147	20.2	97	17.5
Neither	39	5.4	33	6.0
Agree	31	4.3	19	3.4
Strongly Agree	6	0.8	6	1.1
No Opinion	3	0.4	6	1.1
Missing	72	*	79	*

Student Survey Responses	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q11. Think it is advisable for person to hide that he or she has been treated for suicidal thoughts and behaviors				
Strongly Disagree	375	51.7	293	53.0
Disagree	162	22.3	123	22.2
Neither	104	14.3	83	15.0
Agree	50	6.9	30	5.4
Strongly Agree	13	1.8	6	1.1
No Opinion	21	2.9	18	3.3
Missing	73	*	80	*
On my campus				
Q12. It is a sign of personal weakness or inadequacy to receive treatment for suicidal thoughts and behaviors				
Strongly Disagree	397	56.1	287	52.9
Disagree	155	21.9	137	25.2
Neither Disagree nor Agree	92	13.0	61	11.2
Agree	40	5.6	39	7.2
Strongly Agree	7	1.0	7	1.3
No Opinion	17	2.4	12	2.2
Missing	90	*	90	*
Q13. People would see person as less favorable if knew he or she received treatment for suicidal thoughts and behaviors				
Strongly Disagree	311	44.2	220	40.7
Disagree	168	23.9	129	23.9
Neither	116	16.5	78	14.4
Agree	79	11.2	90	16.7
Strongly Agree	14	2.0	8	1.5
No Opinion	16	2.3	15	2.8
Missing	94	*	93	*
Q14. It is advisable for person to hide that he or she has been treated for suicidal thoughts and behaviors				
Strongly Disagree	312	44.1	219	40.5
Disagree	171	24.2	139	25.7
Neither	126	17.8	90	16.6
Agree	55	7.8	60	11.1
Strongly Agree	14	2.0	11	2.0
No Opinion	29	4.1	22	4.1
Missing	91	*	92	*

Table H5

Myths	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q15. People often attempt suicide without warning and out of the blue				
True	198	28.9	138	26.2
False	402	58.8	329	62.5
Don't Know	84	12.3	59	11.2
Missing	114	*	107	*
Q16. People who have attempted suicide are less likely to attempt suicide in the future				
True	42	6.1	31	5.9
False	584	85.4	438	83.3
Don't Know	58	8.5	57	10.8
Missing	114	*	107	*
Q17. Sometimes a minor event (like a bad exam grade) can push an otherwise normal person to attempt suicide				
True	358	52.4	290	55.0
False	193	28.3	146	27.7
Don't Know	132	19.3	91	17.3
Missing	115	*	106	*
Q18. People who are depressed are more likely to attempt suicide				
True	604	88.3	463	88.2
False	42	6.1	26	5.0
Don't Know	38	5.6	36	6.9
Missing	114	*	108	*
Q19. Majority of people who commit suicide do not have psychiatric or substance use disorders				
True	250	36.6	199	37.8
False	239	35.0	170	32.3
Don't Know	194	28.4	158	30.0
Missing	115	*	106	*
Q20. Someone who has aggressive or impulsive tendencies is a lower risk for suicide attempt				
True	44	6.4	22	4.2
False	522	76.3	397	75.5
Don't Know	118	17.3	107	20.3
Missing	114	*	107	*
Q21. If a person attempted suicide, their situation was probably so bad that death was the best solution				
True	96	14.1	85	16.1
False	516	75.7	389	73.8
Don't Know	70	10.3	53	10.1
Missing	116	*	106	*

Myths	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q22. Reducing access to firearms and other lethal weapons reduces the risk of suicide				
True	219	32.0	206	39.1
False	376	55.0	254	48.2
Don't Know	89	13.0	67	12.7
Missing	114	*	106	*
Q23. People who talk about or threaten suicide don't do it				
True	53	7.8	39	7.4
False	535	78.6	411	78.0
Don't Know	93	13.7	77	14.6
Missing	117	*	106	*
Q24. If someone is exposed to suicide (family, friends, other students) this increases their own risk for attempting suicide				
True	329	48.1	274	52.1
False	160	23.4	104	19.8
Don't Know	195	28.5	148	28.1
Missing	114	*	107	*
Q25. People who really want to die will find a way; it won't help to try and stop them				
True	83	12.2	63	12.0
False	551	81.1	418	79.6
Don't Know	45	6.6	44	8.4
Missing	119	*	108	*
Q26. People who are using alcohol more than usual or abusing substances are at greater risk for attempting suicide				
True	486	71.5	371	70.7
False	101	14.9	66	12.6
Don't Know	93	13.7	88	16.8
Missing	118	*	108	*
Q27. A person with a family history of suicide is at lower risk for attempting suicide				
True	33	4.8	31	5.9
False	535	78.3	381	72.7
Don't Know	115	16.8	112	21.4
Missing	115	*	109	*
Q28. Hopelessness is a risk factor for attempting suicide				
True	577	84.7	447	85.3
False	41	6.0	24	4.6
Don't Know	63	9.3	53	10.1
Missing	117	*	109	*

Myths	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q29. You should not talk to depressed people about suicide; it might give them the idea or plant a seed in their minds				
True	117	17.2	97	18.5
False	448	65.8	338	64.5
Don't Know	116	17.0	89	17.0
Missing	117	*	109	*
Q30. A fellow student with sleep problems is at increased risk for attempting suicide				
True	267	39.3	226	43.2
False	202	29.7	126	24.1
Don't Know	211	31.0	171	32.7
Missing	118	*	110	*
Q31. People with both mental health problems and substance problems are at even greater risk of attempting suicide than those with either mental health or substance problems alone				
True	462	67.9	358	68.3
False	93	13.7	66	12.6
Don't Know	125	18.4	100	19.1
Missing	118	*	109	*
Q32. Majority of suicides are among people of lower socioeconomic status				
True	99	14.5	97	18.5
False	352	51.6	258	49.3
Don't Know	231	33.9	168	32.1
Missing	116	*	110	*
Q33. Suicides occur in the greatest numbers around the holidays like Thanksgiving and Christmas				
True	356	52.2	282	54.0
False	77	11.3	66	12.6
Don't Know	249	36.5	174	33.3
Missing	116	*	111	*
Q34. Social isolation/ withdrawal is a factor				
True	583	85.5	449	86.3
False	35	5.1	24	4.6
Don't Know	64	9.4	47	9.0
Missing	116	*	113	*
Q35. Most suicidal people never discuss their problems with others				
True	345	50.8	238	45.5
False	194	28.6	185	35.4
Don't Know	140	20.6	100	19.1
Missing	119	*	110	*

Myths	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q36. The experience of physical, sexual and/or emotional abuse puts one at greater risk for attempting suicide				
True	607	89.1	463	88.7
False	22	3.2	19	3.6
Don't Know	52	7.6	40	7.7
Missing	117	*	111	*
Q37. A fellow student who has a sexual identity conflict or is uncertain about their sexual identity is at greater risk for suicide attempt				
True	500	73.6	379	72.5
False	65	9.6	40	7.6
Don't Know	114	16.8	104	19.9
Missing	119	*	110	*
Q38. Many people who talk about suicide just want attention				
True	105	15.4	64	12.2
False	461	67.7	390	74.6
Don't Know	115	16.9	69	13.2
Missing	117	*	110	*
Q39. Suicide is the leading cause of death among college students				
True	215	31.6	199	38.2
False	194	28.5	139	26.7
Don't Know	272	39.9	183	35.1
Missing	117	*	112	*
Q40. Risk for suicide attempt is not associated with police or law enforcement (arrest or incarceration) contact				
True	138	20.4	105	20.1
False	241	35.5	180	34.4
Don't Know	299	44.1	238	45.5
Missing	120	*	110	*
Q41. Most suicide attempts occur late at night or early morning				
True	270	39.6	237	45.4
False	80	11.7	60	11.5
Don't Know	331	48.6	225	43.1
Missing	117	*	111	*

Table H6

Student Survey Responses

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q47. Know where to find counseling center				
Yes	416	64.4	354	70.9
No	226	35.0	141	28.3
My campus does not have a counseling center	4	0.6	4	0.8
Missing	152	*	134	*
Q48. Received psychological /mental health services from current college/university counseling/health service				
Yes	90	13.9	103	20.6
No	555	85.9	394	78.6
My campus does not have a counseling center	1	0.2	4	0.8
Missing	152	*	132	*
Q49. Know other students who have received psychological/mental health services from current college/ university counseling/health services				
Yes	208	32.2	208	41.9
No	435	67.4	285	57.3
My campus does not have a counseling center	2	0.3	4	0.8
Missing	153	*	136	*

Appendix I

Suicide Prevention Exposure, Awareness, and Knowledge Survey – Faculty/Staff (Response =558 / 423)

Table I1

Faculty/Staff Survey Responses

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q1. Exposed to suicide prevention materials on campus				
Yes	233	43.4	214	51.8
No	251	46.7	165	40.0
Don't Know	53	9.9	34	8.2
Missing	21	*	10	*
Q2. Participated in suicide prevention activities on campus				
Yes	90	16.8	92	22.2
No	443	82.5	323	77.8
Don't Know	4	0.7	0	0.0
Missing	21	*	8	*
Q6. Aware of at least one local resource to refer someone at risk for suicide				
Yes	445	83.3	332	81.4
No	89	16.7	76	18.6
Missing	24	*	15	*

Table I2

Faculty/Staff Survey Responses

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q3. Can recognize warning signs of suicide in another student				
Not confident	106	19.8	112	27.5
Somewhat confident	257	48.0	143	35.0
Confident	97	18.1	89	21.8
Very confident	62	11.6	52	12.7
Don't know	13	2.4	12	2.9
Missing	23	*	15	*
Q4. Would ask someone exhibiting warning signs of suicide if thinking about suicide				
Not confident	157	29.5	123	30.1
Somewhat confident	157	29.5	107	26.2
Confident	107	20.1	78	19.1

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Very confident	97	18.2	91	22.2
Don't know	15	2.8	10	2.4
Missing	25	*	14	*
Q5. Would connect or refer student at risk for suicide to resources				
Not confident	53	9.9	50	12.3
Somewhat confident	107	20.0	98	24.0
Confident	159	29.8	111	27.2
Very confident	208	39.0	146	35.8
Don't know	7	1.3	3	0.7
Missing	24	*	15	*

Table I3

Faculty/Staff Survey Responses

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Personally				
Q9. Think it is a sign of personal weakness or inadequacy to receive treatment for suicidal thoughts and behaviors				
Strongly Disagree	408	78.9	304	75.6
Disagree	80	15.5	77	19.2
Neither Disagree nor Agree	19	3.7	12	3.0
Agree	6	1.2	5	1.2
Strongly Agree	1	0.2	2	0.5
No Opinion	3	0.6	2	0.5
Missing	41	*	21	*
Q10. Would see person as less favorable if knew he or she received treatment of suicidal thoughts and behaviors				
Strongly Disagree	399	77.2	291	72.6
Disagree	87	16.8	84	20.9
Neither Disagree nor Agree	24	4.6	14	3.5
Agree	5	1.0	8	2.0
Strongly Agree	1	0.2	3	0.7
No Opinion	1	0.2	1	0.2
Missing	41	*	22	*
Q11. Think it is advisable for person to hide that he or she has been treated for suicidal thoughts and behaviors				
Strongly Disagree	285	55.2	227	56.9
Disagree	112	21.7	82	20

Item	2012 Frequency	2012 Percent	2014 Frequency	2014 Percent
Neither Disagree nor Agree	88	17.1	65	16.3
Agree	21	4.1	16	4.0
Strongly Agree	2	0.4	4	1.0
No Opinion	8	1.6	5	1.3
Missing	42	*	24	*
On my campus				
Q12. It is a sign of personal weakness or inadequacy to receive treatment for suicidal thoughts and behaviors				
Strongly Disagree	317	62.4	226	57.7
Disagree	126	24.8	104	26.5
Neither Disagree nor Agree	38	7.5	44	11.2
Agree	15	3.0	7	1.8
Strongly Agree	0	0.0	1	0.3
No Opinion	12	2.4	10	2.6
Missing	50	*	31	*
Q13. People would see person as less favorable if knew he or she received treatment for suicidal thoughts and behaviors				
Strongly Disagree	212	41.7	146	37.2
Disagree	140	27.6	108	27.6
Neither Disagree nor Agree	85	16.7	75	19.1
Agree	54	10.6	49	12.5
Strongly Agree	3	0.6	3	0.8
No Opinion	14	2.8	11	2.8
Missing	50	*	31	*
Q14. It is advisable for person to hide that he or she has been treated for suicidal thoughts and behaviors				
Strongly Disagree	213	41.8	166	42.6
Disagree	141	27.7	97	24.9
Neither Disagree nor Agree	104	20.4	79	20.3
Agree	32	6.3	25	6.4
Strongly Agree	5	1.0	3	0.8
No Opinion	14	2.8	20	5.1
Missing	49	*	33	*

Table I4

Faculty/Staff Survey Responses

	2012		2014	
Item	Frequency	Percent	Frequency	Percent
Q42. Know where to find counseling center				
Yes	422	83.2	320	82.5
No	80	15.8	66	17.0
My campus does not have a counseling center	5	1.0	2	0.5
Missing	51	*	35	*
Q43. Identified a student at risk for suicide				
Yes	128	25.4	112	28.9
No	376	74.6	275	71.1
Missing	54	*	36	*
Q44. Referred a student to campus or community counseling				
Yes	256	50.7	209	54.0
No	249	49.3	178	46.0
Missing	53	*	36	*
Q45. Provided number to hot-line				
Yes	70	13.8	57	14.7
No	438	86.2	332	85.3
Missing	50	*	34	*
Q46. Received training in suicide prevention				
Yes	121	24.0	108	27.8
No	383	76.0	281	72.2
Missing	54	*	34	*

Appendix J

The content for Appendix J was developed solely by NAMI New Hampshire.

Connect Prevention/Postvention Evaluation Reports

J1. Connect – Prevention – Campus Community Training. June 13, 2012.

Prevention – Campus Community Training

June 13, 2012

Plainville, CT

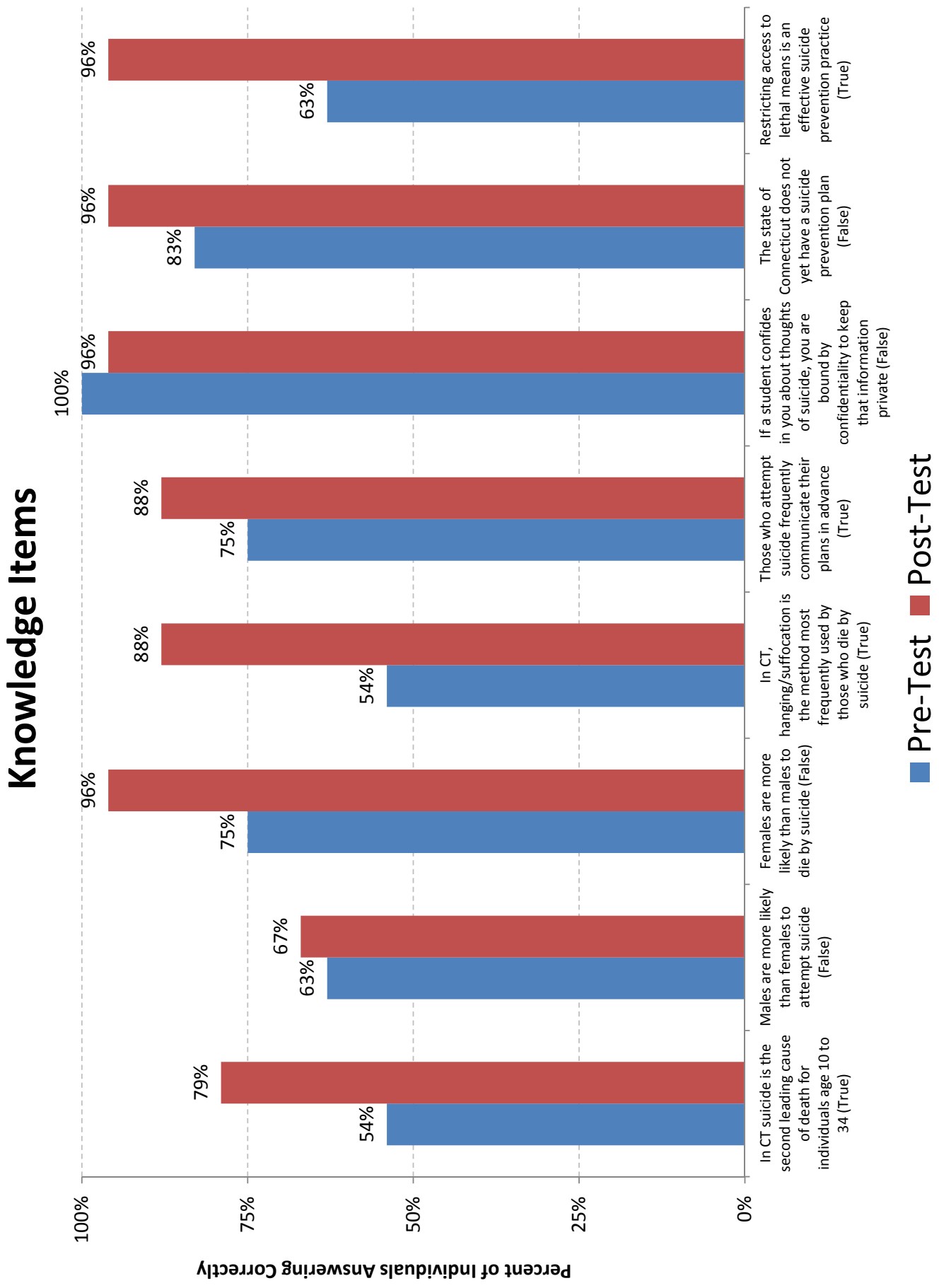
Ann Duckless and Julie Golkowski

Summary:

There were a total of 24 participants in training who completed an evaluation booklet. From the pre-test to the post-test, training participants demonstrated a change in mean number of knowledge items correct from 5.67 at pre-test to 7.0 at post-test (maximum score possible =8). This change was statistically significant at the 0.001 level.[1] Participants also exhibited the desired changes on items related to attitudes, with eight of the changes being statically significant. Lastly, participants exhibited a decrease in scores on the stigma scale. This change means that participants reported lower levels of stigma towards Mental Health and Help-Seeking following the training.

The mean scores from the Training Exit Survey ranged from 3.43 to 3.61 on a four point scale (1 to 4). The highest scoring item was "The training materials I received will be very useful for my suicide prevention efforts" (3.61) and the lowest score was tied between two items (3.43). The overall rating was 3.63. 83% of participants felt that the training was at their skill level.

[1] Please note: This is a relatively small sample. Any conclusions based on the statistical analyses should be made with caution.


Knowledge Items
Percent of Individuals Answering Correctly
100%
75%
50%
25%
0%
79%
54%
67%
63%
96%
75%
88%
54%
88%
75%
100%
96%
96%
83%
96%
63%
In CT suicide is the second leading cause of death for individuals age 10 to 34 (True)
Males are more likely than females to attempt suicide (False)
Females are more likely than males to die by suicide (False)
In CT, hanging/suffocation is the method most frequently used by those who die by suicide (True)
Those who attempt suicide frequently communicate their plans in advance (True)
If a student confides in you about thoughts of suicide, you are bound by confidentiality to keep that information private (False)
The state of Connecticut does not yet have a suicide prevention plan (False)
Restricting access to lethal means is an effective suicide prevention practice (True)
Pre-Test
Post-Test

Knowledge Items

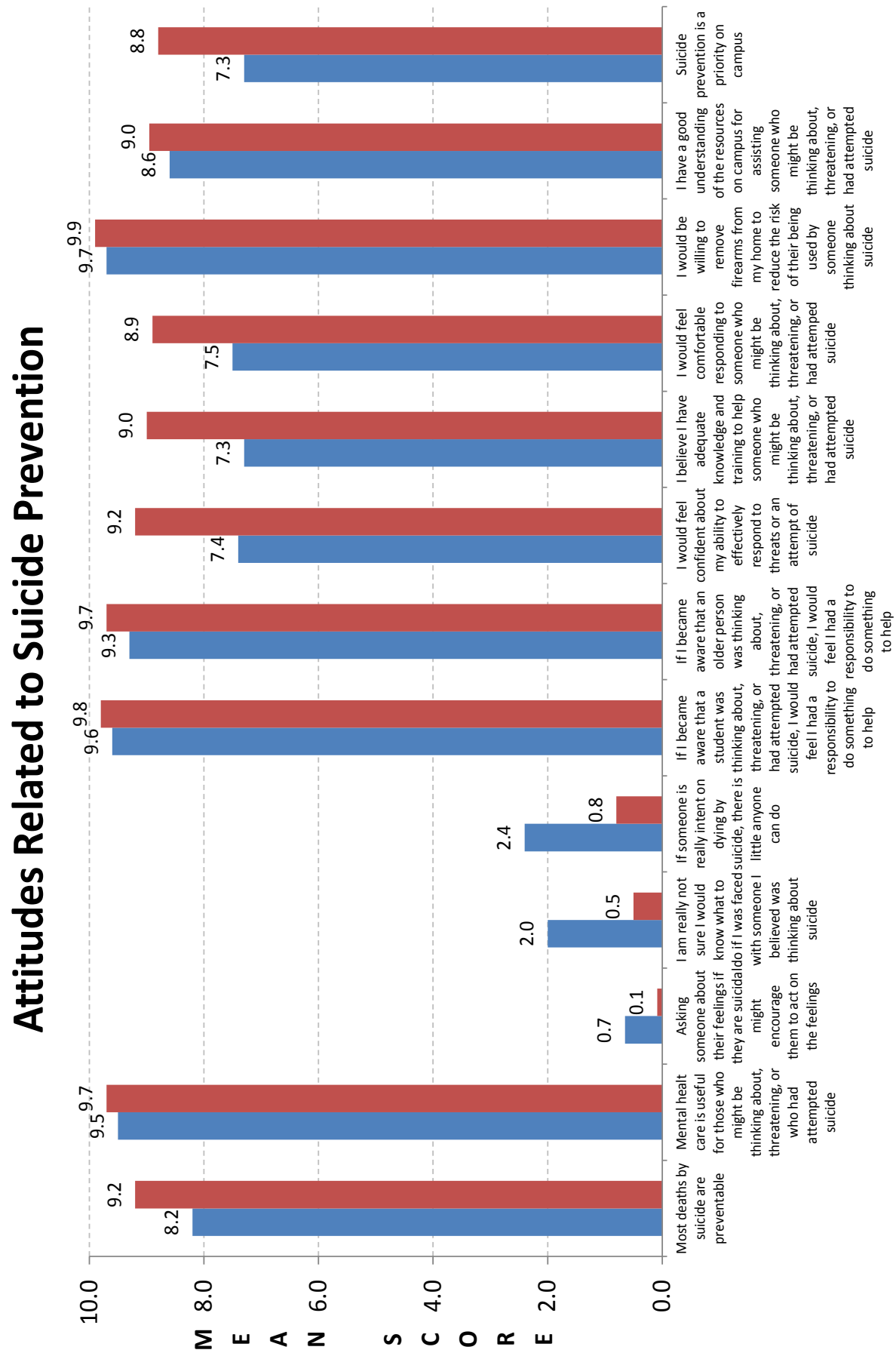
	Pre-Test Percent of Respondents			Post-Test Percent of Respondents		
	True	False	Unsure	True	False	Unsure
In CT, suicide is the second leading cause of death for individuals age 10 to 34. (True)	54	25	21	79	13	8
Males are more likely than females to attempt suicide. (False)	33	63	4	33	67	0
Females are more likely than males to die by suicide. (False)	21	75	4	4	96	0
In CT, hanging/ suffocation is the method most frequently used by those who die by suicide. (True)	54	25	21	88	13	0
Those who attempt suicide frequently communicate their plans in advance. (True)	75	21	4	88	13	0
If a student confides in you about thoughts of suicide, you are bound by confidentiality to keep that information private. (False)	0	100	0	0	96	4
The State of Connecticut does not yet have a suicide prevention plan. (False)	0	83	17	4	96	0
Restricting access to lethal means is an effective suicide prevention practice. (True)	63	33	4	96	4	0

*All percentages have been rounded to the nearest whole number. Due to this, the percentages for some items may not total 100.

Summary of Knowledge Items

	Pre-Test	SD	Post-Test	SD
Mean number of True/False items correct	5.67	1.40	7.00***	1.06
Mean number of True/false items marked as unsure	0.75	1.07	0.13**	0.34

Difference is significant at the * =.05, ** =.01, *** =.001 level


Attitudes Related to Suicide Prevention
MEAN SCORE
10.0
8.0
6.0
4.0
2.0
0.0
Pre-Test
Post-Test
Most deaths by suicide are preventable
Mental healt care is useful for those who might be thinking about, threatening, or who had attempted suicide
Asking someone about their feelings if they are suicidal
I am really not sure I would know what to do if I was faced with someone I believed was thinking about suicide
If someone is really intent on dying by suicide, there is little anyone can do
If I became aware that a student was thinking about, threatening, or had attempted suicide, I would feel I had a responsibility to do something to help
If I became aware that an older person was thinking about, threatening, or had attempted suicide, I would feel I had a responsibility to do something to help
I would feel confident about my ability to effectively respond to threats or an attempt of suicide
I believe I have adequate knowledge and training to help someone who might be thinking about, threatening, or had attempted suicide
I would feel comfortable responding to someone who might be thinking about, threatening, or had attemped suicide
I would be willing to remove firearms from my home to reduce the risk of their being used by someone thinking about suicide
I have a good understanding of the resources on campus for assisting someone who might be thinking about, threatening, or had attempted suicide
Suicide prevention is a priority on campus
9.2
8.2
9.7
9.5
0.7
0.1
2.0
0.5
2.4
0.8
9.8
9.6
9.7
9.3
9.2
7.4
9.0
7.3
8.9
7.5
9.9
9.7
9.0
8.6
8.8
7.3

Attitudes Related to Suicide Prevention

Scale range: 0 =Totally Disagree – 10 =Totally Agree	Mean score: Pre-test	SD	Mean score: Post-test	SD
Most deaths by suicide are preventable.	8.2	1.8	9.2	1.2
Mental health care is useful for those who might be thinking about, threatening, or who had attempted suicide.	9.5	0.8	9.7	0.6
Asking someone about their feelings if they are suicidal might encourage them to act on the feelings.	0.7	1.0	0.1	0.3
I am really not sure I would know what to do if I was faced with someone I believed was thinking about suicide.	2.0	2.7	0.5	0.9
If someone is really intent on dying by suicide, there is little anyone can do.	2.4	2.4	0.8	1.2
If I became aware that a student was thinking about, threatening, or had attempted suicide, I would feel I had a responsibility to do something to help.	9.6	0.7	9.8	0.4
If I became aware that an older person was thinking about threatening or had attempted suicide, I would feel I had a responsibility to do something to help.	9.3	1.5	9.7	0.7
I would feel confident about my ability to effectively respond to threats or an attempt of suicide.	7.4	2.2	9.2	1.1
I believe I have adequate knowledge and training to help someone who might be thinking about, threatening or had attempted suicide.	7.3	2.6	9.0	1.4
I would feel comfortable responding to some who might be thinking about, threatening or had attempted suicide.	7.5	2.4	8.9	1.7
I would be willing to remove firearms from my home to reduce the risk of their being used by someone thinking about suicide.	9.7	1.1	9.9	0.3
I have a good understanding of the resources on campus for assisting someone who might be thinking about, threatening or had attempted suicide.	8.6	2.1	9.0	1.8
Suicide prevention is a priority on campus.	7.3	3.1	8.8	2.0

Difference is significant a the * =.05, ** =.01, *** =.001 level

Stigma Related to Mental Health/Help-Seeking

	Pre-Test	SD	Post-Test	SD
Stigma Scale Rating	4.39	5.75	2.91	3.54

Difference is significant a the * =.05, ** =.01, *** =.001 level

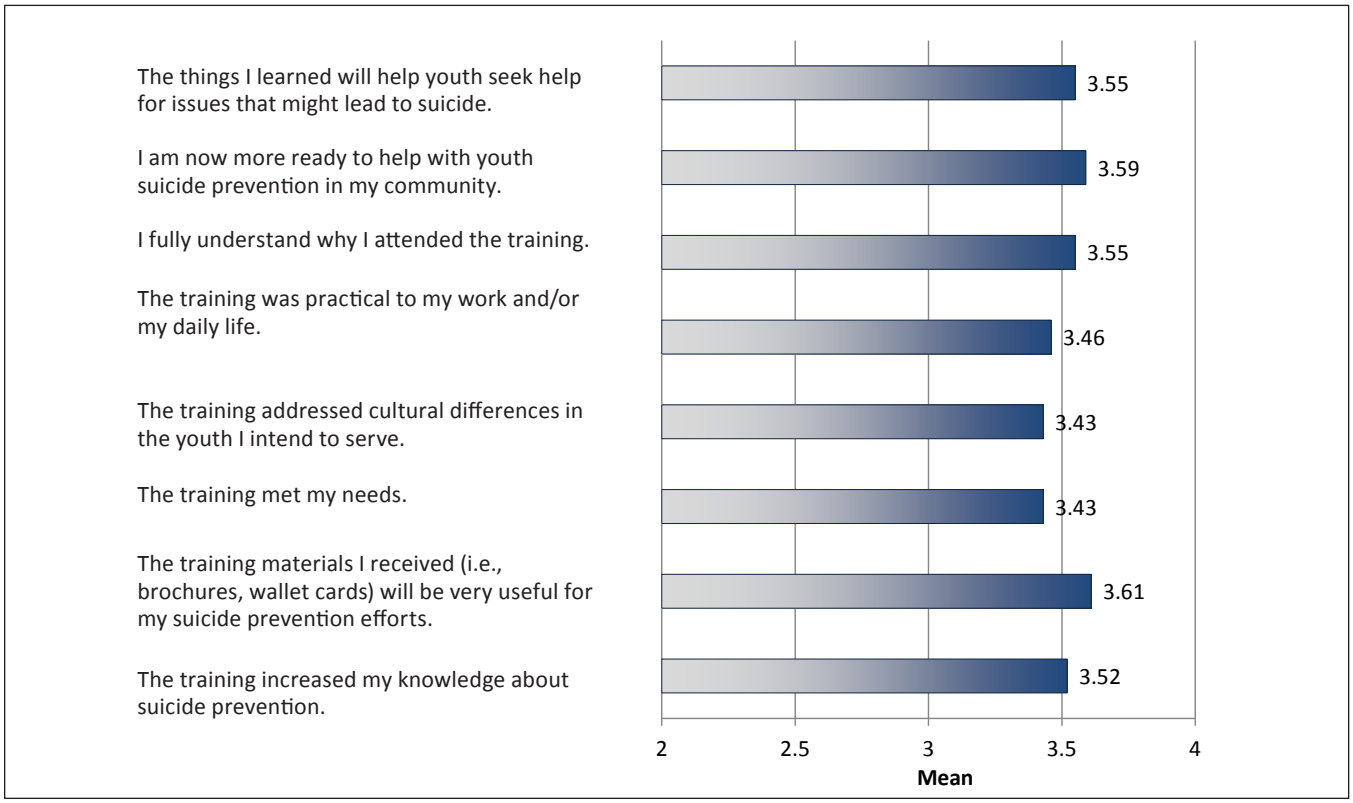
Percentage of Participants Required to Participate in the Training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	9	38	38	38
	No	15	63	63	100
	Don't Know	0	0	0	100
	Total	24	100	100	
Missing	System	0	0		
TOTAL		24	100		

How Participants Intend to Use What They Learned From the Training

	Percent of Participants
Screen youth for suicide behaviors	46
Formally publicize information about suicide prevention and mental health resources	71
Have informal conversations about suicide and suicide prevention with youth and others	71
Identify youth who might be at risk for suicide	71
Provide direct services to youth at risk for suicide and/or their families	46
Train other staff members	83
Make referrals to mental health services for at risk youth	54
Work with adult at-risk populations	33
Other	8
Don't intend to use what I learned	0

Training Content



Training Content – Descriptive Statistics

	N	Minimum	Maximum	Mean	SD
The training increased my knowledge about suicide prevention.	23	1	4	3.52	.790
The training materials I received (i.e., brochures, wallet cards) will be very useful for my suicide prevention efforts.	23	1	4	3.61	.722
The training met my needs.	23	1	4	3.43	.843
The training addressed cultural differences in the youth I intend to serve.	23	1	4	3.43	.788
The training was practical to my work and/or my daily life.	24	1	4	3.46	.884
I fully understand why I attended the training.	22	1	4	3.55	.739
I am now more ready to help with youth suicide prevention in my community.	22	1	4	3.59	.734
The things I learned will help youth seek help for issues that might lead to suicide.	22	1	4	3.55	.739

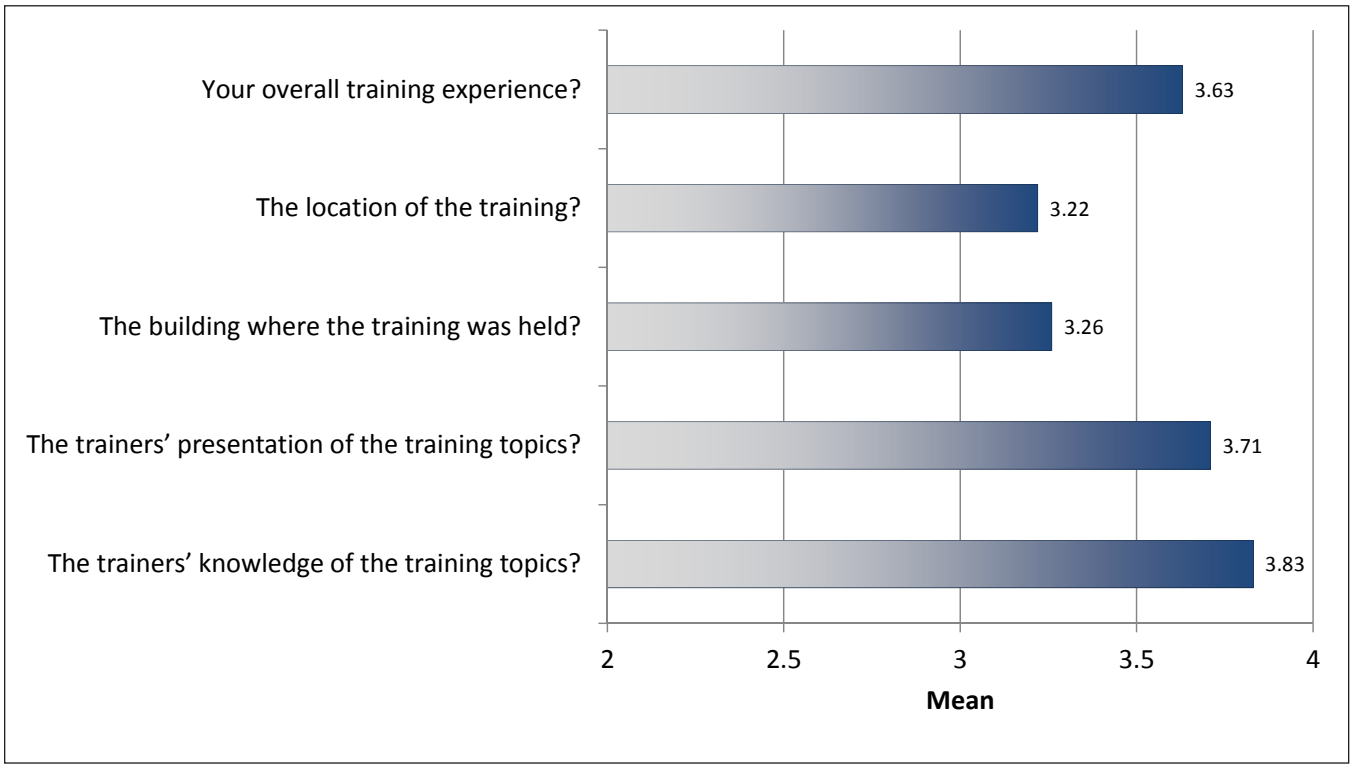
Skill Level of Training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Below my skill level	1	4	4	4
	At my skill level	20	83	83	88
	Above my skill level	3	13	13	100
	Don't know	0	0	0	100
	Total	24	100	100	
Missing	System	0	0		
TOTAL		24	100		

Who Will Benefit from What Was Learned During the Training

	Percent of Participants
Youth	71
Parents/Foster Parents/Caregivers	29
Family	29
Co-Workers	75
Community Members	58
Other	8

Satisfaction With Training



Satisfaction With Training – Descriptive Statistics

	N	Minimum	Maximum	Mean	SD
The trainers' knowledge of the training topics?	24	1	4	3.83	.637
The trainers' presentation of the training topics?	24	1	4	3.71	.751
The building where the training was held?	23	1	4	3.26	.752
The location of the training?	23	1	4	3.22	.795
Your overall training experience?	24	1	4	3.63	.824

Satisfaction With Training Components

	Percent of Participants Who:		
	Liked	Neutral	Disliked
Activities/Case Scenarios	96	4	0
Amount of Material Covered	75	13	13
Atmosphere of Training	83	17	0
Data/Statistics	79	13	8
Discussion/Interaction	96	0	4
Handouts/Materials Provided	92	0	8
Instructor/Trainer	96	4	0
Length of Training	58	25	17
Number of Breaks	79	21	0
Opportunity to Ask Questions	96	0	4
Pace of Training	79	4	17
Resource Information	92	4	4

J2. Connect Prevention – Social Services Training, August 21, 2012.

Prevention – Social Services Training

August 21, 2012

Middletown, CT

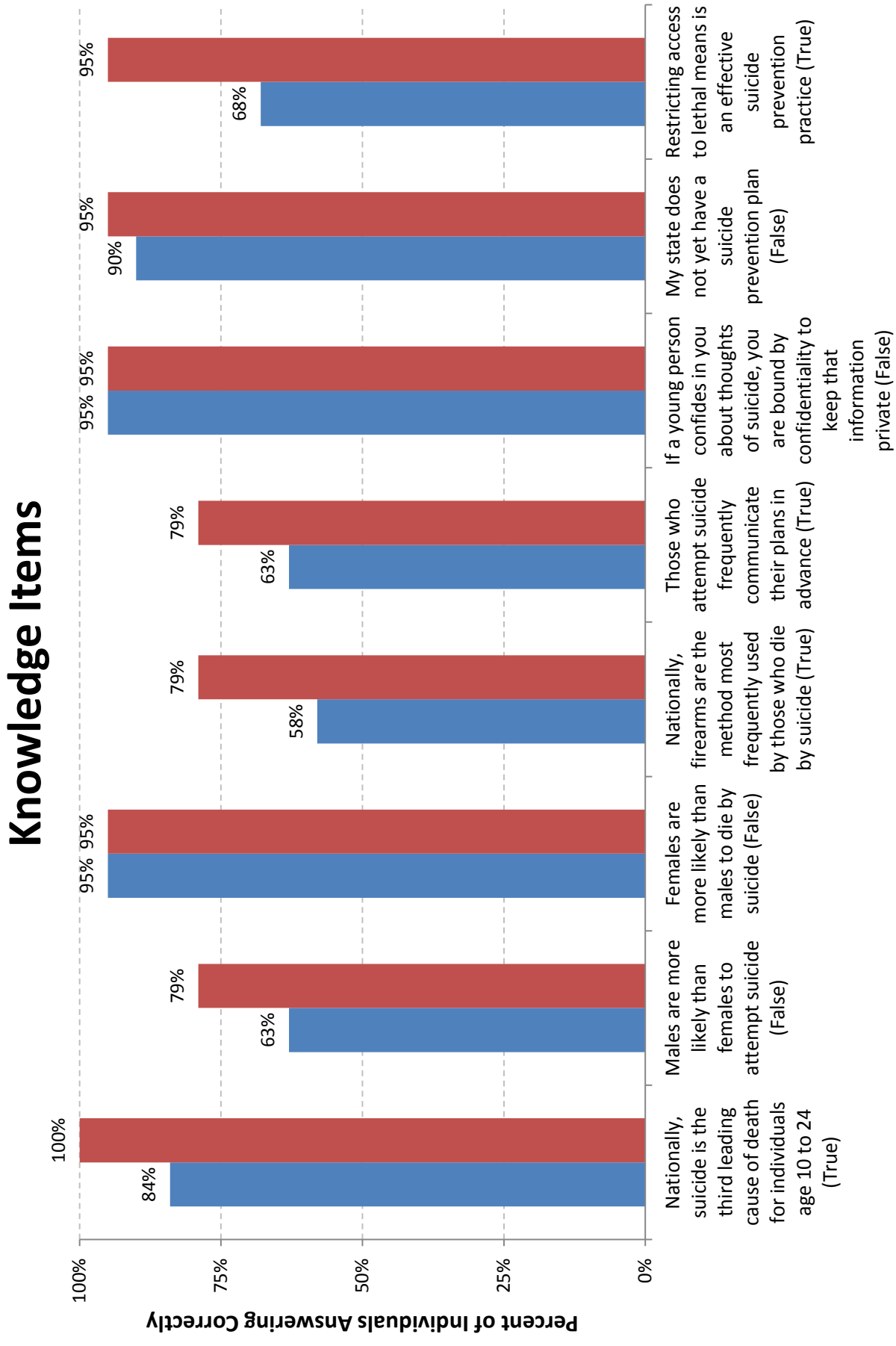
Ann Duckless and Julie Golkowski

Summary:

There were a total of 19 participants in the training who completed an evaluation booklet. From the pre-test to the post-test, training participants demonstrated a change in mean number of knowledge items correct from 6.16 at pre-test to 7.11 at post-test (maximum score possible =8). This change was statistically significant at the 0.01 level.[2] Participants also exhibited the desired changes on items related to attitudes, with seven of the changes being statistically significant. Lastly, participants exhibited a decrease in scores on the stigma scale. This change means that participants reported lower levels of stigma towards Mental Health and Help-Seeking following the training.

The mean scores from the Training Exit Survey ranged from 3.53 to 3.74 on a four point scale (1 to 4). The highest scoring item was "The training was practical to my work and/or my daily life" (3.74) and the lowest score was tied between two items (3.53). The overall rating was 3.63. 87% of participants felt that the training was at their skill level.

[2] Please note: This is a relatively small sample. Any conclusions based on the statistical analyses should be made with caution.


Knowledge Items
Percent of Individuals Answering Correctly
100%
75%
50%
25%
0%
84%
63%
79%
63%
95%
95%
79%
58%
79%
63%
95%
95%
90%
95%
68%
95%
Nationally, suicide is the third leading cause of death for individuals age 10 to 24 (True)
Males are more likely than females to attempt suicide (False)
Females are more likely than males to die by suicide (False)
Nationally, firearms are the method most frequently used by those who die by suicide (True)
Those who attempt suicide frequently communicate their plans in advance (True)
If a young person confides in you about thoughts of suicide, you are bound by confidentiality to keep that information private (False)
My state does not yet have a suicide prevention plan (False)
Restricting access to lethal means is an effective suicide prevention practice (True)
Pre-Test
Post-Test

Knowledge Items

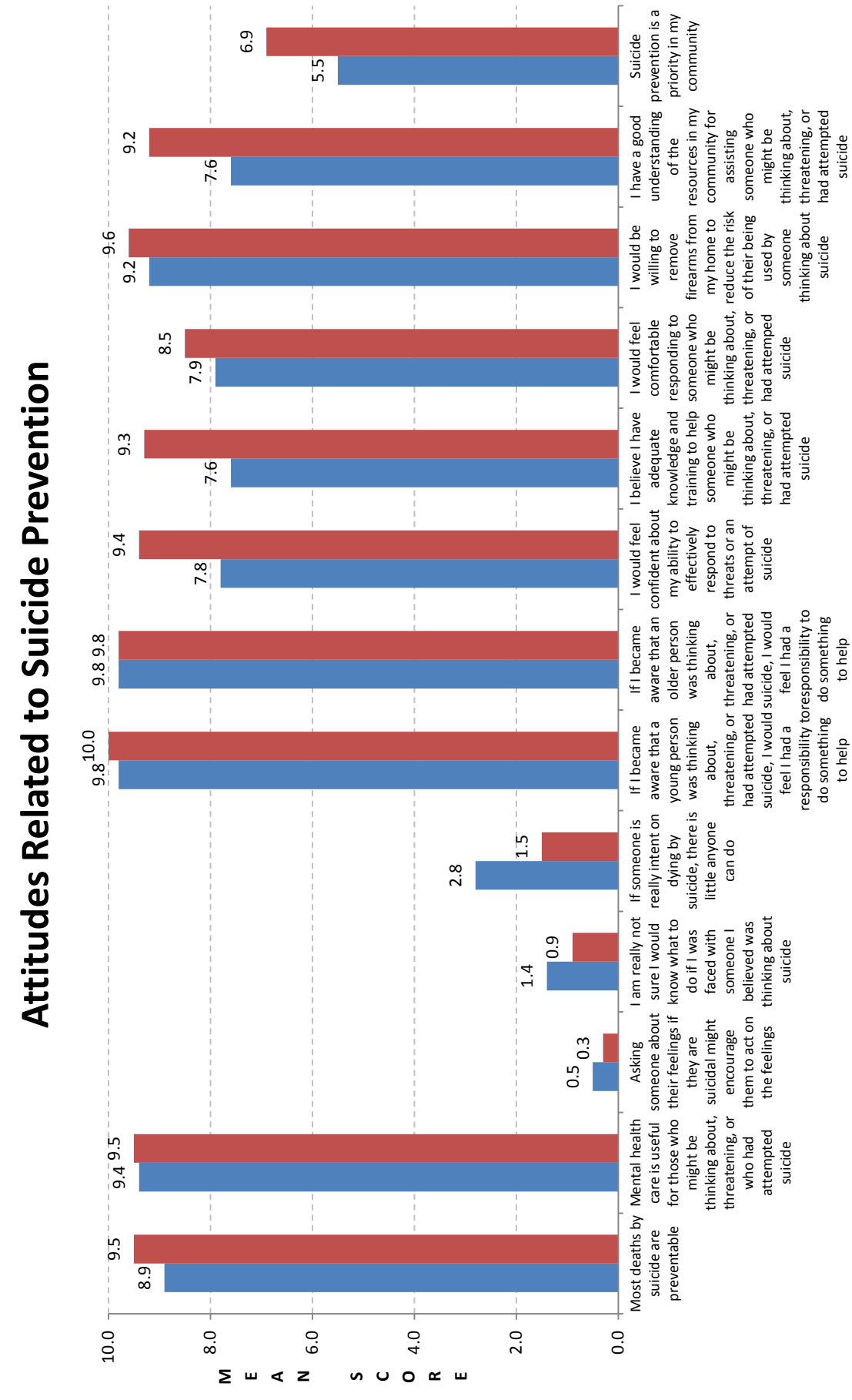
	Pre-Test Percent of Respondents			Post-Test Percent of Respondents		
	True	False	Unsure	True	False	Unsure
Nationally, suicide is the third leading cause of death for individuals age 10 to 24. (True)	84	16	0	100	0	0
Males are more likely than females to attempt suicide. (False)	32	63	5	21	79	0
Females are more likely than males to die by suicide. (False)	0	95	5	5	95	0
Nationally, firearms are the method most frequently used by those who die by suicide. (True)	58	42	0	79	21	0
Those who attempt suicide frequently communicate their plans in advance. (True)	63	37	0	79	21	0
If a young person confides in you about thoughts of suicide, you are bound by confidentiality to keep that information private. (False)	5	95	0	5	95	0
My state does not yet have a suicide prevention plan. (False)	0	90	11	0	95	5
Restricting access to lethal means is an effective suicide prevention practice. (True)	68	21	11	95	5	0

*All percentages have been rounded to the nearest whole number. Due to this, the percentages for some items may not total 100.

Summary of Knowledge Items

	Pre-Test	Post-Test
Mean number of True/False items correct	6.16	7.11**
Mean number of True/false items marked as unsure	0.32	0.05

Difference is significant at the * =.05, ** =.01, *** =.001 level


Attitudes Related to Suicide Prevention
MEAN SCORE
10.0
8.0
6.0
4.0
2.0
0.0
Pre-Test
Post-Test
Most deaths by suicide are preventable
9.5
8.9
Mental health care is useful for those who might be thinking about, threatening, or who had attempted suicide
9.4
9.5
Asking someone about their feelings if they are suicidal might encourage them to act on the feelings
0.5
0.3
I am really not sure I would know what to do if I was faced with someone I believed was thinking about suicide
1.4
0.9
If someone is really intent on dying by suicide, there is little anyone can do
2.8
1.5
If I became aware that a young person was thinking about, threatening, or had attempted suicide, I would feel I had a responsibility to do something to help
9.8
10.0
If I became aware that an older person was thinking about, threatening, or had attempted suicide, I would feel I had a responsibility to do something to help
9.8
9.8
I would feel confident about my ability to effectively respond to threats or an attempt of suicide
7.8
9.4
I believe I have adequate knowledge and training to help someone who might be thinking about, threatening, or had attempted suicide
7.6
9.3
I would feel comfortable responding to someone who might be thinking about, threatening, or had attempted suicide
7.9
8.5
I would be willing to remove firearms from my home to reduce the risk of their being used by someone thinking about suicide
9.2
9.6
I have a good understanding of the resources in my community for assisting someone who might be thinking about, threatening, or had attempted suicide
7.6
9.2
Suicide prevention is a priority in my community
5.5
6.9

Attitudes Related to Suicide Prevention

Scale range: 0 =Totally disagree – 10 =totally agree	Mean score: Pre-test	Mean score: Post-test
Most deaths by suicide are preventable.	8.9	9.5*
Mental health care is useful for those who might be thinking about, threatening, or who had attempted suicide.	9.4	9.5
Asking someone about their feelings if they are suicidal might encourage them to act on the feelings.	0.5	0.3
I am not really sure I would know what to do if I was faced with someone I believed was thinking about suicide.	1.4	0.9
If someone is really intent on dying by suicide, there is little anyone can do	2.8	1.5*
If I became aware that a young person was thinking about, threatening, or had attempted suicide, I would feel I had a responsibility to do something to help.	9.8	10.0*
If I became aware that an older person was thinking about, threatening, or had attempted suicide, I would feel I had a responsibility to do something to help.	9.8	9.8
I would feel confident about my ability to effectively respond to threats or an attempt of suicide.	7.8	9.4***
I believe I have adequate knowledge and training to help someone who might be thinking about, threatening, or who had attempted suicide.	7.6	9.3***
I would feel comfortable responding to some who might be thinking about, threatening, or had attempted suicide.	7.9	8.5
I would be willing to remove firearms from my home to reduce the risk of their being used by someone thinking about suicide.	9.2	9.6
I have a good understanding of the resources in my community for assisting someone who might be thinking about, threatening, or had attempted suicide.	7.6	9.2*
Suicide prevention is a priority in my community.	5.5	6.9*

Difference is significant a the * =.05, ** =.01, *** =.001 level

Stigma Related To Mental Health/Help-Seeking

	Pre-Test	Post-Test
Stigma Scale Rating	3.89	2.37

Difference is significant a the * =.05, ** =.01, *** =.001 level

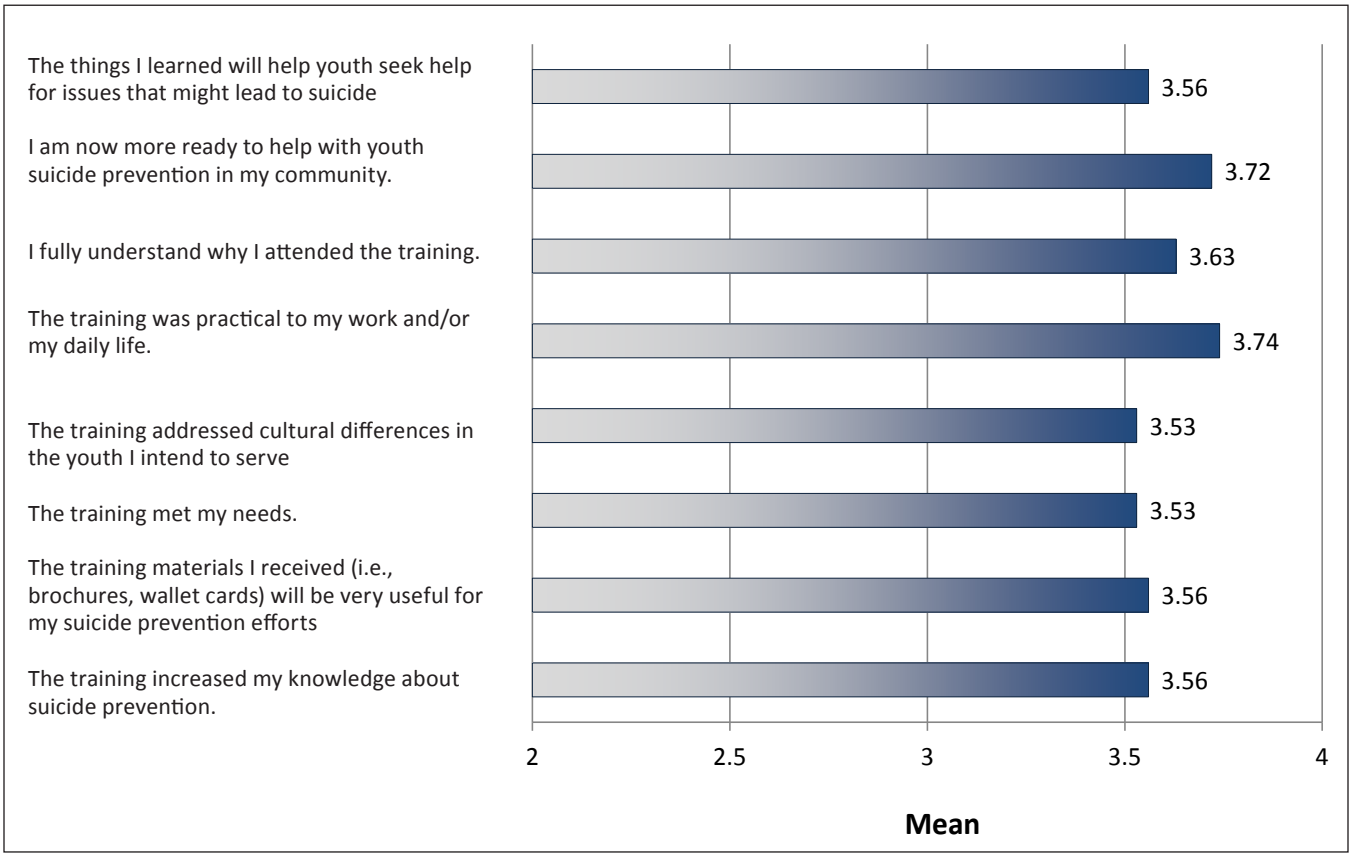
Percentage of Participants Required to Participate in the Training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	6	32	32	32
	No	13	68	68	100
	Don't Know	0	0	0	100
	Total	19	100	100	
Missing	System	0	0		
TOTAL		19	100		

How Participants Intend to Use What They Learned from the Training

	Percent of Participants
Screen youth for suicide behaviors	32
Formally publicize information about suicide prevention and mental health resources	79
Have informal conversations about suicide and suicide prevention with youth and others	63
Identify youth who might be at risk for suicide	26
Provide direct services to youth at risk for suicide and/or their families	32
Train other staff members	84
Make referrals to mental health services for at risk youth	58
Work with adult at-risk populations	32
Other	26
Don't intend to use what I learned	0

Training Content



Training Content – Descriptive Statistics

	N	Minimum	Maximum	Mean	SD
The training increased my knowledge about suicide prevention.	18	1	4	3.56	.784
The training materials I received (i.e., brochures, wallet cards) will be very useful for my suicide prevention efforts.	18	3	4	3.56	.511
The training met my needs.	19	3	4	3.53	.513
The training addressed cultural differences in the youth I intend to serve.	17	3	4	3.53	.514
The training was practical to my work and/or my daily life.	19	3	4	3.74	.452
I fully understand why I attended the training.	19	3	4	3.63	.496
I am now more ready to help with youth suicide prevention in my community.	18	3	4	3.72	.461
The things I learned will help youth seek help for issues that might lead to suicide.	18	3	4	3.56	.511

Skill Level of Training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Below my skill level	1	5	7	7
	At my skill level	13	68	87	93
	Above my skill level	1	5	7	100
	Don't know	0	0	0	100
	Total	15	79	100	
Missing	System	4	21		
TOTAL		19	100		

Who Will Benefit from What Was Learned During the Training

	Percent of Participants
Youth	42
Parents/Foster Parents/Caregivers	47
Family	42
Co-Workers	68
Community Members	79
Other	42

Satisfaction With Training

Satisfaction With Training – Descriptive Statistics

	N	Minimum	Maximum	Mean	SD
The trainers' knowledge of the training topics?	19	3	4	3.84	.375
The trainers' presentation of the training topics?	19	2	4	3.68	.582
The building where the training was held?	19	2	4	3.42	.607
The location of the training?	19	2	4	3.42	.607
Your overall training experience?	19	3	4	3.63	.496

Satisfaction With Training Components

	Percent of Participants Who:		
	Liked	Neutral	Disliked
Activities/Case Scenarios	100	0	0
Amount of Material Covered	89	11	0
Atmosphere of Training	72	28	0
Data/Statistics	89	6	6
Discussion/Interaction	94	6	0
Handouts/Materials Provided	94	6	0
Instructor/Trainer	100	0	0
Length of Training	75	25	0
Number of Breaks	56	44	0
Opportunity to Ask Questions	94	6	0
Pace of Training	72	22	6
Resource Information	89	11	0

J3. Connect Postvention – Social Services Training. January 22, 2013.

Postvention – Social Services Training

January 22, 2013

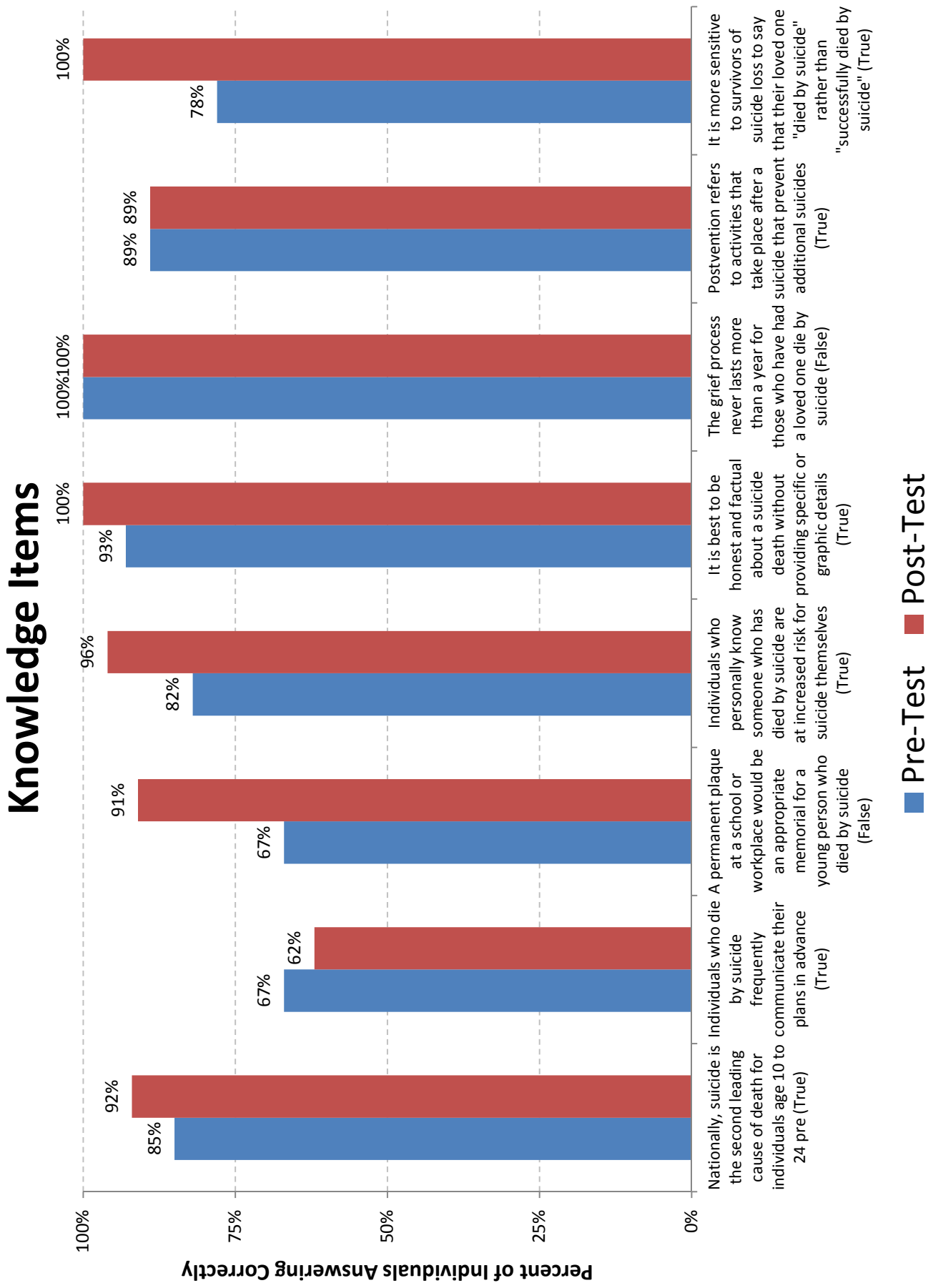
Middletown, CT

Ann Duckless and Elaine de Mello

Summary:

There were a total of 27 participants in the training who completed an evaluation form. From the pre-test to the post-test, training participants demonstrated a change in mean number of knowledge items correct from 6.56 at pre-test to 6.89 at post-test (maximum score possible =8). Participants also exhibited the desired changes on items related to attitudes, with eight of the changes being statistically significant. Lastly, participants exhibited a decrease in scores on the stigma scale. This change means that participants reported lower levels of stigma towards Mental Health and Help-Seeking following the training.

The mean scores from the Training Exit Survey ranged from 3.62 to 3.82 on a four point scale (1 to 4). The highest scoring item was "The training materials I received will be very useful for my suicide prevention efforts" (3.82) and the lowest scoring item was "I am now ore ready to help with youth suicide prevention in my community" (3.62). The overall rating was 3.83. 88% of participants felt that the training was at their skill level.


Knowledge Items
Percent of Individuals Answering Correctly
100%
75%
50%
25%
0%
92%
85%
91%
67%
67%
62%
96%
82%
100%
93%
100%100%
89% 89%
100%
78%
Nationally, suicide is the second leading cause of death for individuals age 10 to 24 pre (True)
Individuals who die by suicide frequently communicate their plans in advance (True)
A permanent plaque at a school or workplace would be an appropriate memorial for a young person who died by suicide (False)
Individuals who personally know someone who has died by suicide are at increased risk for suicide themselves (True)
It is best to be honest and factual about a suicide death without providing specific or graphic details (True)
The grief process never lasts more than a year for those who have had a loved one die by suicide (False)
Postvention refers to activities that take place after a suicide that prevent additional suicides (True)
It is more sensitive to survivors of suicide loss to say that their loved one "died by suicide" rather than "successfully died by suicide" (True)
Pre-Test
Post-Test

Knowledge Items

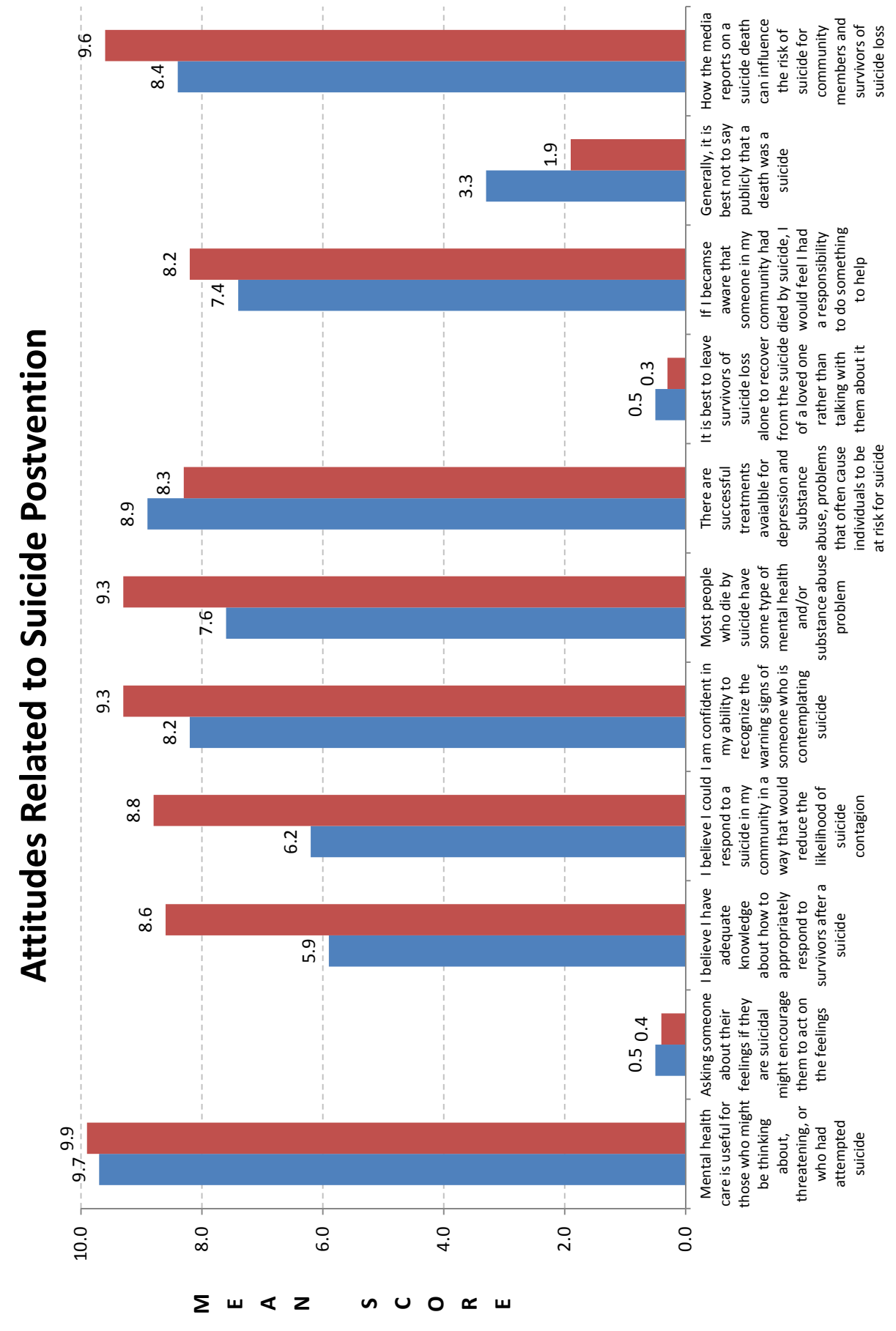
	Pre-test Percent of respondents			Post-test Percent of respondents		
	True	False	Unsure	True	False	Unsure
Nationally, suicide is the second leading cause of death for individuals age 10 to 24 (True)	85	15	0	92	8	0
Individuals who die by suicide frequently communicate their plans in advance (True)	67	30	4	62	35	4
A permanent plaque at a school or workplace would be an appropriate memorial for a young person who died by suicide. (False)	7	67	26	4	91	4
Individuals who personally know someone who has died by suicide are at increased risk for suicide themselves. (True)	81	11	7	96	4	0
It is best to be honest and factual about a suicide death without providing specific or graphic details. (True)	93	0	7	100	0	0
The grief process never lasts more than a year for those who have had a loved one die by suicide. (False)	0	100	0	0	100	0
Postvention refers to activities that take place after a suicide that prevent additional suicides. (True)	89	11	0	89	12	0
It is more sensitive to survivors of suicide loss to say that their loved one "died by suicide" rather than "successfully died by suicide". (True)	78	0	22	100	0	0

*All percentages have been rounded to the nearest whole number. Due to this, the percentages for some items may not total 100.

Summary of Knowledge Items

	Pre-Test	SD	Post-Test	SD
Mean number of true/false items correct	6.56	1.58	6.89	1.63
Mean number of true/false items marked as unsure	0.67	0.88	0.07**	0.27

Difference Is Significant At The * =.05, ** =.01, *** =.001 Level


Attitudes Related to Suicide Postvention
MEAN SCORE
10.0
8.0
6.0
4.0
2.0
0.0
9.7
9.9
0.5
0.4
8.6
5.9
8.8
6.2
9.3
8.2
9.3
7.6
8.9
8.3
0.5
0.3
8.2
7.4
3.3
1.9
9.6
8.4
Mental health care is useful for those who might be thinking about, threatening, or who had attempted suicide
Asking someone about their feelings if they are suicidal might encourage them to act on the feelings
I believe I have adequate knowledge about how to appropriately respond to survivors after a suicide
I believe I could respond to a suicide in my community in a way that would reduce the likelihood of suicide contagion
I am confident in my ability to recognize the warning signs of someone who is contemplating suicide
Most people who die by suicide have some type of mental health and/or substance abuse problem
There are successful treatments availble for depression and substance abuse, problems that often cause individuals to be at risk for suicide
It is best to leave survivors of suicide loss alone to recover from the suicide of a loved one rather than talking with them about it
If I became aware that someone in my community had died by suicide, I would feel I had a responsibility to do something to help
Generally, it is best not to say publicly that a death was a suicide
How the media reports on a suicide death can influence the risk of suicide for community members and survivors of suicide loss
Pre-Test
Post-Test

Attitudes Related to Suicide Postvention

Scale range: 0 =Totally disagree – 10 =totally agree	Mean Score: Pre-Test	SD	Mean Score: Post-Test	SD
Mental health care is useful for those who might be thinking about, threatening, or who had attempted suicide.	9.7	0.53	9.9*	0.43
Asking someone about their feelings if they are suicidal might encourage them to act on the feelings.	0.5	0.95	0.4	0.75
I believe I have adequate knowledge about how to appropriately respond to survivors after a suicide.	5.9	2.33	8.6***	1.42
I believe I could respond to a suicide in my community in a way that would reduce the likelihood of suicide contagion.	6.2	2.32	8.8***	1.45
I am confident in my ability to recognize the warning signs of someone who is contemplating suicide.	8.2	1.61	9.3**	1.28
Most people who die by suicide have some type of mental health and/or substance abuse problem.	7.6	3.09	9.3**	1.01
There are successful treatments available for depression and substance abuse, problems that often cause individuals to be at risk for suicide.	8.9	1.38	8.3	2.97
It is best to leave survivors of suicide loss alone to recover from the suicide of a loved one rather than talking with them about it.	0.5	0.86	0.3	0.53
If I became aware that someone in my community had died by suicide, I would feel I had a responsibility to do something to help.	7.4	2.69	8.2*	2.72
Generally, it is best not to say publicly that a death was a suicide.	3.3	2.88	1.9*	2.84
How the media reports on a suicide death can influence the risk of suicide for community members and survivors of suicide loss.	8.4	1.88	9.6**	0.76

Difference is significant a the * =.05, ** =.01, *** =.001 level

Stigma Related To Mental Health/Help-Seeking

	Pre-Test	SD	Post-Test	SD
Stigma Scale Rating	4.00	4.91	2.89	4.00

Difference is significant a the * =.05, ** =.01, *** =.001 level

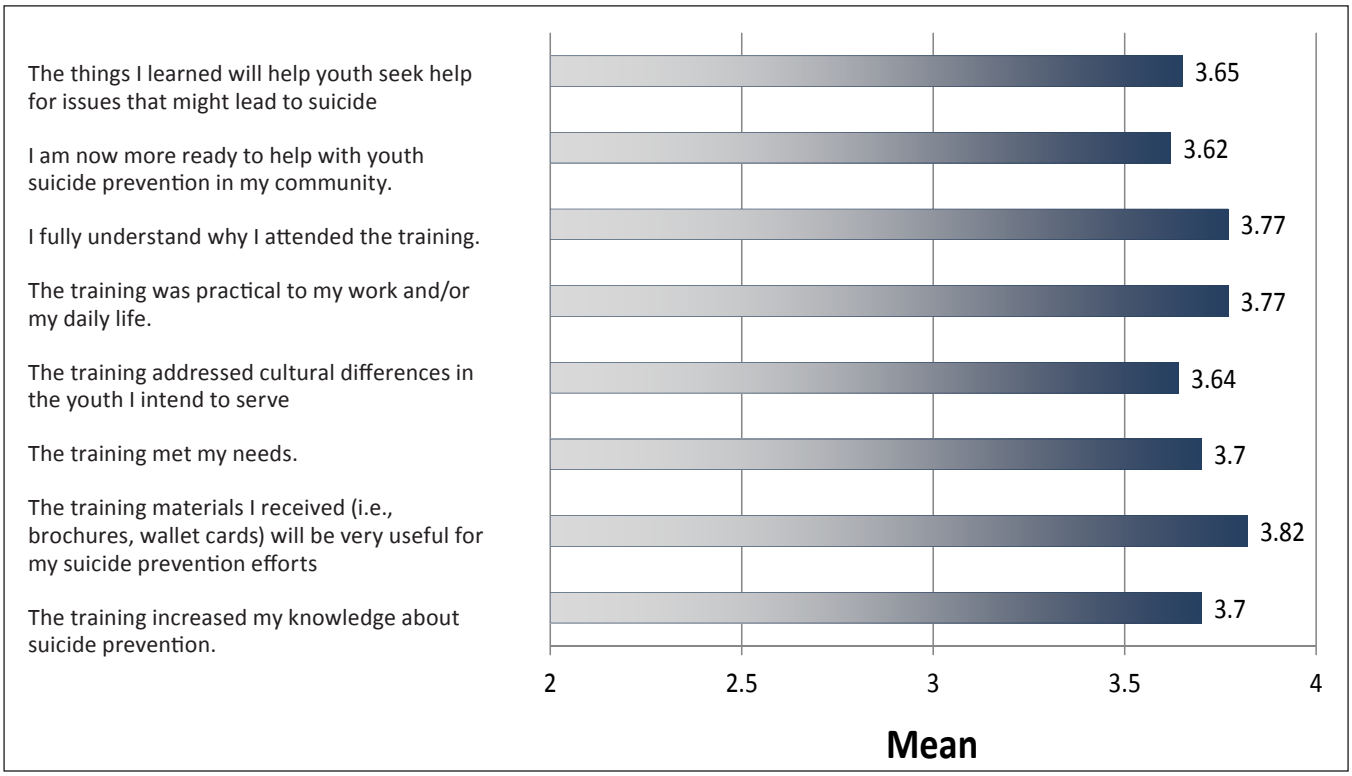
Percentage of Participants Required to Participate in the Training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	2	7	9	9
	No	20	74	87	96
	Don't Know	1	4	4	100
	Total	23	85	100	
Missing	System	4	15		
TOTAL		27	100		

How Participants Intend to Use What They Learned from the Training

	Percent of Participants
Screen youth for suicide behaviors	30
Formally publicize information about suicide prevention and mental health resources	33
Have informal conversations about suicide and suicide prevention with youth and others	70
Identify youth who might be at risk for suicide	41
Provide direct services to youth at risk for suicide and/or their families	37
Train other staff members	59
Make referrals to mental health services for at risk youth	33
Work with adult at-risk populations	30
Other	19
Don't intend to use what I learned	0

Training Content



Training Content – Descriptive Statistics

	N	Minimum	Maximum	Mean	SD
The training increased my knowledge about suicide prevention.	23	3	4	3.70	0.47
The training materials I received (i.e., brochures, wallet cards) will be very useful for my suicide prevention efforts.	22	3	4	3.82	0.39
The training met my needs.	23	3	4	3.70	0.47
The training addressed cultural differences in the youth I intend to serve.	22	3	4	3.64	0.49
The training was practical to my work and/or my daily life.	22	3	4	3.77	0.43
I fully understand why I attended the training.	22	3	4	3.77	0.43
I am now more ready to help with youth suicide prevention in my community.	21	3	4	3.62	0.49
The things I learned will help youth seek help for issues that might lead to suicide	20	3	4	3.65	0.48

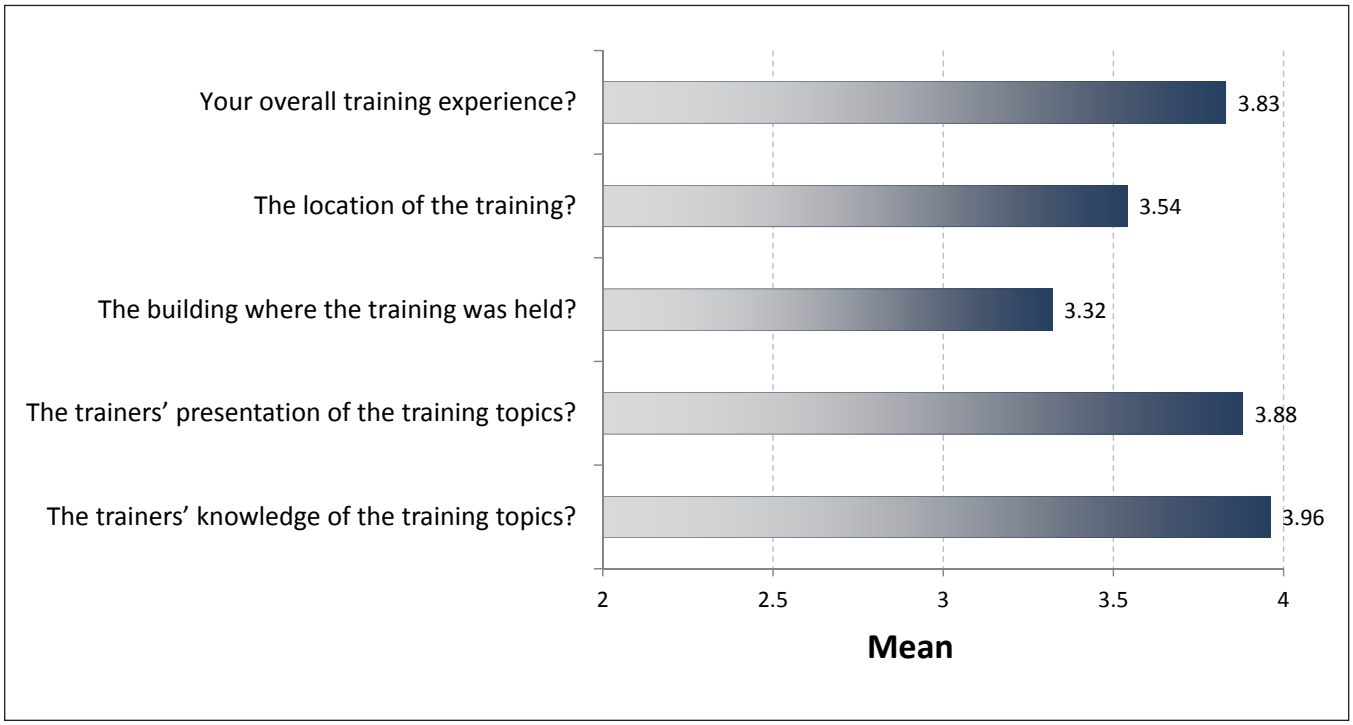
Skill Level of Training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Below my skill level	1	4	4	4
	At my skill level	21	78	88	92
	Above my skill level	2	7	8	100
	Don't know	0	0	0	100
	Total	24	89	100	
Missing	System	3	11		
TOTAL		27	100		

Who Will Benefit from What Was Learned During the Training

	Percent of Participants
Youth	44
Parents/Foster Parents/Caregivers	48
Family	48
Co-Workers	70
Community Members	70
Other	19

Satisfaction With Training



Satisfaction With Training –Descriptive Statistics

	N	Minimum	Maximum	Mean	SD
The trainers' knowledge of the training topics?	25	3	4	3.96	.200
The trainers' presentation of the training topics?	25	3	4	3.88	.332
The building where the training was held?	25	1	4	3.32	.852
The location of the training?	24	3	4	3.54	.509
Your overall training experience?	24	3	4	3.83	.381

Satisfaction With Training Components

	Percent of Participants Who:		
	Liked	Neutral	Disliked
Activities/Case Scenarios	100	0	0
Amount of Material Covered	88	12	0
Atmosphere of Training	68	20	12
Data/Statistics	88	12	0
Discussion/Interaction	92	8	0
Handouts/Materials Provided	100	0	0
Instructor/Trainer	100	0	0
Length of Training	80	20	0
Number of Breaks	88	12	0
Opportunity to Ask Questions	100	0	0
Pace of Training	88	12	0
Resource Information	96	4	0