



YOUTH SUICIDE PREVENTION PROGRAM
ANNUAL EVALUATION REPORT 2002-2003
EVALUATION OF PROGRAM TRAINING WORKSHOPS

Prepared for

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EXECUTIVE SUMMARY

2002-2003 ANNUAL REPORT

EVALUATION OF PROGRAM TRAINING WORKSHOPS

INTRODUCTION

The goal for this evaluation was to assess the impact of the training workshops sponsored by the Youth Suicide Prevention Program (YSPP). YSPP conducts two-day Living Works ASSIST training workshops in various communities throughout the state. A survey, drawn in part from a prior assessment tool created by the University of Washington School of Nursing in an earlier evaluation, was utilized to assess the impact of training on individuals' knowledge about how to identify suicide-warning signs, how to help suicidal persons in need, and how to better assess and intervene in situations where there is a suicidal person in need. In this evaluation, we examined changes in these program outcomes between the beginning and end of the training workshops, and extended out to 3-12 months after the completion of the workshop.

METHODOLOGY

A longitudinal design was used to collect information from participants in the ASIST training sessions. Participants provided a code number in order to track the surveys and to assure confidentiality. Code numbers consisted of the participants' second letter in first name, the two digits of their birth year, the two digits of their birth date and the last letter in their last name. The workshop presenter administered a Baseline survey prior to the first day of the workshop, and then the Post at the conclusion of the second day of the workshop. The Post Survey asked participants for contact information so that a Follow-up survey could be sent to them.

The Follow-up surveys were sent to those participants who included contact information every three months. Many of those who received Follow-up surveys in the 2002-2003 program year actually completed the workshop in the 2001-2002 program year. It was conceivable that a participant could complete a Follow-up survey at four different time points (i.e., three, six, nine and 12 months), though in most instances the participants had only completed one of these Follow-up surveys. Incentives were provided to ensure a high response rate. The response rates for the Follow-up mailings are shown below. Overall, we were fairly successful in gathering response to the Follow-up surveys (39.2 percent response). Examples of each of the survey instruments are presented in *Appendix A*.

Youth Suicide Prevention Program Response Rate – 2002-2003

Number of Months after Pre/Post Survey	Mailed Out	Responded	Response rate
3 months	121	40	33.0%
6 months	45	21	46.6%
9 months	38	18	47.3%
12 months	28	12	42.8%
Overall	232	91	39.2%

METHODS OF ANALYSIS

There were three primary analyses in this study. We first examined the change over time in knowledge and beliefs between the Baseline and Post assessments, i.e., over the course of the two-day workshop. We gathered Baseline and Post data from **142** participants. In the second analysis, we focused on the sample of participants who also provided 3-month Follow-up data. The intent was to examine whether the improvements demonstrated at Post persisted when the participants were three months removed from the workshop. We gathered Baseline, Post, and 3-Month Follow-up data from a total of **73** participants. This sample includes those participants reported on in the 2001-2002 program year analysis. In the third analysis we examined a sample of participants with data at Baseline, Post, and 9-12 months after the workshop. The intent was to explore the persistence of the changes observed from Baseline to Post a number of months

after the workshop. We gathered Baseline, Post, and 9-12-Month Follow-up data from a total of **29** participants.

A combination of analytic approaches was used to compare changes over time. We calculated frequencies and means, and used cross-tabulations and paired t-tests to explore differences in knowledge and beliefs over time.

KEY FINDINGS

The results illustrate the strong positive impact of workshops and training on knowledge of suicide issues, prevention, intervention and assessment.

We observe many instances of significant increases in knowledge over time among participants. This change is most evident in the comparison of the “three C’s” (i.e., comfort, competence and confidence) and the general knowledge of suicide issues between the Baseline and Post assessments.

The analysis of the Baseline/Post/3-Month Follow-up sample indicates that the knowledge gains demonstrated at the Post workshop persist three months later. This finding is consistent for both the self-reported knowledge and belief items, and for the factual multiple-choice questions.

Interestingly, the levels of self-reported knowledge and beliefs remain high even at the 9-12 month Follow-up among those participants with data at three time periods. While there is some drop-off in knowledge between Post and 9-12 months, in most instances this level of knowledge is still significantly greater than observed before participation in the workshops.

Participants in the workshops report enhanced knowledge of suicide prevention, intervention and assessment skills.

The increases in knowledge of suicide prevention and intervention demonstrated on the multiple choice items between Baseline and Post continue at the 3-month assessment point. In some instances, the percent that correctly answer a particular question is highest at the 3-month Follow-up assessment.

There are a couple of examples where the knowledge of suicide prevention and intervention among those with Baseline/Post/9-12 Month Follow-up data reverts back to Baseline levels. In particular, the percent that correctly respond to the question about the “key tasks in the first phase of suicide intervention are..” starts at 29.6 percent, rises to 62.1 percent at Post, but declines back to 31.0 percent at the 9-12 month Follow-up.

Conversely, we also observe instances where knowledge of an item is highest 9-12 months after the workshop. Specifically, the percent that correctly respond to the question “which of the following action plans would likely be most suitable for someone at risk of suicide” increases from 61.5 to 69.0 to 75.9 percent over the three time periods.

In most instances the knowledge of suicide assessment remains consistent between Post and 3-Months, and between Post and 9-12 Months. The notable exception is in knowledge of “what generally determines if behavior is suicidal?” Over time the participants are more likely to answer the *history of prior behavior*, rather than the correct answer, the *intent of the person*.

At the three-month assessment point the participants continued to have contact with suicidal youth.

Almost 40 of those who responded in the Follow-up report contact with one or more suicidal youth, and we find that they are referring youth to a wide range of possible resources, most notably family, mental health agencies, and crisis lines.

In contrast, only 20 percent of the participants with data at 9-12 months reported any contact with suicidal youth, and only 17 percent referred youth to any resources.

RECOMMENDATIONS

Continue with workshop and follow-up assessments of participants. The current program year analysis continues to show that the knowledge and skills attained in the training workshop is sustained 3 months, and in some instances even 9-12 months, after the workshop. The 9-12 Month Follow-up analysis, though, also points to areas where knowledge and skills have declined some as participants move farther away from the training.

Consider ways of follow-up contact with participants after the completion of the workshop. The declines we do observe 9-12 months after the workshop suggest that participants could benefit from some kind of booster training. Perhaps such a booster training could come in the form of a follow-up phone call, a mailing with factual information about suicide issues, or invitations to participate in additional training sessions.

Implement modifications to the existing surveys. The slight changes in the ASIST curriculum, coupled with some of the apparent deficiencies in the survey items, suggest that ORS and YSP should work together in developing a survey that collects more insightful data from participants over time. Some of the particular concerns of the current survey include:

- The validity of asking questions about comfort, competence, and confidence
- The ceiling effects experienced in the responses to the items about beliefs
- The variation in the ease and difficulty of the multiple choice items.

Consider using qualitative methods to gather more insight about long-term impact. The program might think about utilizing a small number of phone interviews with program participants to better understand how individuals are turning knowledge and skills into practice in real world settings.

SECTION 1

BASELINE VS. POST COMPARISON

2002-2003 ANNUAL REPORT

EVALUATION OF PROGRAM TRAINING WORKSHOPS

DEMOGRAPHICS

The demographic characteristics of the 142 individuals in the paired sample are presented in **TABLES 1.1 – 1.4**. We find that this sample is overwhelmingly female (77.5%) and a high percentage of participants are Caucasian (82.7%).

TABLE 1.1: Workshop Location

LOCATION	N	Percent
Highline (2 sessions)	38	26.8%
Colville	17	12.0%
Nespelem	7	4.9%
Port Angeles	20	14.1%
Seattle	26	18.3%
University of Washington (2 sessions)	34	24.0%

TABLE 1.2: Gender

	N	Percent
Female	110	77.5%
Male	32	22.5%

TABLE 1.3: Age

	N	Percent
< 35	61	43.0%
35-49	51	35.9%
50+	30	21.1%

TABLE 1.4: Race/Ethnicity

	N	Percent
Caucasian	115	82.7%
African American	5	3.6%
Latino	3	2.2%
Asian/PI	7	5.0%
Native American	2	1.4%
Other Ethnicity	7	5.0%

EXPERIENCE WITH SUICIDAL YOUTH

At Baseline the workshop participants were asked to report on their level of prior contact with suicidal youth in the previous month.

Over 47 percent (67 individuals) of the participants reported they had at least one contact with a suicidal youth in the last month. Over 27 percent had more than one contact. The average number of contacts in the sample is **1.27**. This average is slightly higher than the number of contacts reported by participants in the 2001-2002 program year. (see **TABLE 1.5**)

Sixty-five of the 67 individuals (97.0 percent) *talked or indirectly talked* with them about concerns for their well-being

Fifty-seven of the 67 individuals (85.0 percent) *asked or indirectly asked* if they were thinking of harming themselves or attempting suicide

Fifty-six of the 67 individuals (83.6 percent) *talked or indirectly talked* with the young person about where they could get help

TABLE 1.5: Number of Contacts With Suicidal Youth in Last Month

	N	Percent
None	75	52.8%
One	28	19.7%
Two or More	39	27.5%

Average = 1.27

LEVELS OF COMFORT, COMPETENCE AND CONFIDENCE

The participants were asked at both Baseline and Post to assess their comfort, competence and confidence in a situation where they may help a suicidal person. These are common questions that have been asked in past assessments of the workshops. For each item, the responses were measured on a scale from one to five where 1=*not at all*, 3=*moderately* and 5=*fully*. In all instances, we observed significant increases over time. (see **TABLE 1.6**)

Increase in level of **comfort** from 3.61 to 4.04

Increase in level of **competence** from 3.20 to 4.08

Increase in level of **confidence** from 4.05 to 4.55

TABLE 1.6: Level of Comfort, Competence and Confidence in Helping Suicidal Youth

Survey Item	N	Baseline	Post	p
How comfortable are you in helping a suicidal person?	142	3.61	4.04	*
How competent would you feel helping a suicidal person?	141	3.20	4.08	*
How confident that you would try to help this suicidal person?	141	4.05	4.55	*

* p < .05 based on paired-samples t-test

SCALE: 1 – Not at all, 3 – Moderately, 5 – Fully

GENERAL KNOWLEDGE OF SUICIDE ISSUES

The survey addressed five questions about the participants' self-reported knowledge of suicide facts, signs and resources. In addition, at both Baseline and Post, the participants were asked to identify three signs a young person might show if they were in danger of attempting suicide. (see **TABLE 1.7**)

There are significant increases over time across each of the general knowledge items. At Post, the majority of respondents report that their knowledge of facts, signs and resources is *very high*.

There is a slight increase in the participants' knowledge of suicide warning signs. This is, in part, because even at Baseline, the participants were already able to identify, on average, 2.51 out of 3 correct warning signs.

TABLE 1.7: Level of Knowledge About General Suicide Facts, Signs and Resources

Knowledge of	N	Baseline Average	Post Average	p
Facts about suicide prevention	142	3.02	4.27	*
Suicide warning signs	142	3.34	4.42	*
How to ask someone about suicide	141	3.16	4.55	*
How to get help for someone who may be suicidal?	142	3.46	4.36	*
Information about local resources	142	3.20	4.31	*
# of suicide warning signs known (3 maximum)	142	2.51	2.61	

* p < .05 based on paired-samples t-test
 SCALE: 1 – very low, 5 – very high

BELIEFS ABOUT SUICIDE

Three survey questions addressed the participants’ beliefs about suicide as an issue or problem in the community. These particular questions are similar to those asked in a community needs assessment completed in the 2000-2001 year evaluation. The questions were measured on a five-point scale where 1 is *strongly disagree* and 5 is *strongly agree*. (see **TABLE 1.8**)

There are significant increases over time on two of the belief items. We observe that the participants are more likely to agree that “suicide among youth people is a major issue in my community” (increase from 3.76 to 4.09), and they are more likely to agree that “the problem of youth suicide should be addressed in my community” (increase from 4.37 to 4.57).

There is no change in sentiment about whether “suicide is preventable in the majority of situations.” We observed a similar pattern of response in the 2001-2002 program year analysis.

TABLE 1.8: Level of Agreement With General Statements About Suicide

	N	Baseline Average	Post Average	p
Suicide among young people is a major issue in my community	140	3.76	4.09	*
The problem of youth suicide should be addressed in my community	141	4.37	4.57	*
Suicide is preventable in the majority of situations	140	4.19	4.25	

* p < .05 based on paired-samples t-test
SCALE: 1 – strongly disagree, 5 – strongly agree

KNOWLEDGE OF SUICIDE PREVENTION AND INTERVENTION

We used a combination of self-reported agreement items and factually based multiple-choice questions to assess changes in the participants’ knowledge of suicide prevention and intervention. Overall, the results suggest dramatic improvements in knowledge across a wide range of dimensions. (see **TABLE 1.9 – 1.10**) The agreement items were asked on a five-point scale where 1 is *strongly disagree* and 5 is *strongly agree*. In particular, we find:

Participants are significantly more likely to agree that “I would want to get more information about their plan.” (4.59 vs. 4.88) We should note that the level of agreement with this statement is very high even at Baseline.

Participants are significantly more likely to agree that they “would raise the question of suicide if someone was showing signs.” (4.32 vs. 4.82)

Participants are significantly more likely to agree that they “would encourage a youth at risk of suicide to talk about their wish to die.” (4.13 vs. 4.65)

TABLE 1.9: Knowledge of Suicide Prevention and Intervention

	N	Baseline Average	Post Average	p
If someone I knew told me they were thinking of suicide, I would want to get more information about their plan	142	4.59	4.88	*
It is harmful for a helper to engage in open communication when dealing with someone at risk of suicide	142	1.52	1.35	
If someone I knew was showing suggesting signs of suicide, I would raise the question of suicide with them	141	4.32	4.82	*
If someone I knew was at risk of suicide, I would encourage them to talk about their wish to die	142	4.13	4.65	*

* p < .05 based on paired-samples t-test
 SCALE: 1 – *strongly disagree*, 5 – *strongly agree*

The multiple-choice items were used to gauge the participants’ understanding of proper responses in different situations where there is a possibility for a suicide intervention. (see **TABLE 1.10**; a full set of frequencies at Baseline and Post is shown in **Appendix B**)

There are significant increases in the percentage of respondents reporting the correct answer across most of the items:

Almost all of the participants provided correct responses to the following questions at Post: “When confronted with the possibility of suicidal behavior in a person, a caregiver should immediately...,” “If a person’s words and/or behavior suggest the possibility of suicide, a helper should...,” and “Low intent attempts or gestures...”.

We find dramatic and significant increases in the percentage that responded correctly to the following items: “Key tasks in the first phase of Suicide Intervention are...” (35.3% vs. 76.8%), and “Which of the following action plans would likely be most suitable for someone at the risk of suicide” (58.2% vs. 83.0%).

In addition, we observe a significant increase in the percent that correctly responded to the following item: “If someone admits to feeling suicidal, a helper should...” (57.0% vs. 82.3%).

TABLE 1.10: Knowledge of Suicide Prevention and Intervention – Multiple Choice Items

Multiple Choice Items	Correct Answer	N	Baseline % Correct	Post % Correct	P
When confronted with the possibility of suicidal behavior in a person, a caregiver should immediately	<i>Discuss it directly with the person</i>	140	72.9%	98.6%	*
Low intent attempts or gesture	<i>Require a suicide intervention</i>	141	95.7%	95.1%	
If a person’s words and/or behavior suggest the possibility of suicide, a helper should	<i>Ask if the person is thinking of suicide</i>	135	73.5%	90.7%	*
If someone admits to feeling suicidal, a helper should	<i>Find out if they’ve thought of how they would do it</i>	135	57.0%	82.3%	*
Key tasks in the first phase of suicide Intervention are	<i>Engagement and identification</i>	136	35.3%	76.8%	*
Which of the following action plans would likely be most suitable for someone at the risk of suicide	<i>No-harm agreement and Follow-up meeting confirmed</i>	133	58.2%	83.0%	*

* p < .05 based on paired-samples t-test

See **Appendix B** for full distributions of responses to each question

KNOWLEDGE OF SUICIDE ASSESSMENT

In the Post survey, the participants were asked a set of multiple-choice questions to evaluate their knowledge of suicide assessment facts and issues. Some of these items were more challenging than others, and they were intended to provide a sense of the participants' ability to assess suicide risk in different scenarios.

The respondents were presented with a scenario describing various characteristics of a youth and asked to estimate the level of suicidal risk involved in the scenario. Over 92 percent correctly estimated the risk as HIGH in this scenario. (see **TABLE 1.11**)

In most instances, the respondents correctly identified the answer to the questions about suicide assessment. There are three items where there is greater uncertainty: (see **TABLES 1.12 – 1.17**)

“What generally determines if behavior is suicidal?” While 59.3 percent correctly reported *the intent of the person*, over 24 percent of the respondents believed that the correct answer was *the history of prior behavior*.

“Which provides the least important information in assessing the risk of suicide?” About 40 percent correctly responded *stress*, yet almost 30 percent reported *mental health* and an additional 23.9 percent reported *symptoms*.

“Suicide plans are assessed on the basis of a person’s...” While almost 70 percent correctly answered the *degree of preparation*, over 24 percent incorrectly reported *stated seriousness*.

TABLE 1.11: Estimation of Level of Suicide Risk

	N	Percent
High	120	92.1%
Moderate	10	7.0%
No-Risk	1	0.7%

TABLE 1.12: Suicide is Most Likely the Result of

	N	Percent
Overwhelming Stress	14	9.9%
Clinical Depression	5	3.5%
Substance Abuse	1	0.7%
No Single Cause (<i>correct</i>)	122	85.9%

TABLE 1.13: Suicide Plans Are Assessed on the Basis of a Person's

	N	Percent
Degree of Preparation (<i>correct</i>)	98	69.5%
Age of Person	1	0.7%
Stated Seriousness	34	24.1%
Apparent Distress	8	5.7%

TABLE 1.14: People Who Express Suicidal Intentions

	N	Percent
Clearly want to die	11	7.7%
Are ambivalent about dying (<i>correct</i>)	130	91.5%
Want to punish others	1	0.7%
Are manipulating	0	0.0%

TABLE 1.15: Which Provides the Most Important Information in Assessing the Risk of Suicide

	N	Percent
Symptoms	27	19.1%
Stress	9	6.4%
Resources (<i>correct</i>)	105	74.5%
Physical Health	0	0.0%

TABLE 1.16: What Generally Determines if Behavior is Suicidal

	N	Percent
The mood of the person	3	2.1%
The intent of the person (<i>correct</i>)	83	59.3%
The lethality of the method used	20	14.3%
The history of prior behavior	34	24.3%

TABLE 1.17: Which Provides the Least Important Information in Assessing the Risk of Suicide

	N	Percent
Symptoms	33	23.9%
Stress (<i>correct</i>)	55	39.9%
Resources	9	6.5%
Mental Health	41	29.7%

SECTION 2

BASELINE/POST/3-MONTH FOLLOW-UP

COMPARISON

2002-2003 ANNUAL REPORT

EVALUATION OF PROGRAM TRAINING WORKSHOPS

DEMOGRAPHICS

The demographic characteristics of the 73 individuals with data at Baseline, Post, and 3-Month Follow-up are presented in **TABLES 2.1-2.3**.

Over 80 percent of respondents are female; over 78 percent are Caucasian.

The majority of respondents at Follow-up are less than 35 years old (45.8 percent). The distribution across age groups is more similar to the distribution among 2002-2003 workshop participants.

TABLE 2.1: Gender – Baseline/Post/3-Month

	N	Percent of cases
Male	14	19.2%
Female	59	80.8%

TABLE 2.2: Ethnicity – Baseline/Post/3-Month

	N	Percent of cases
Caucasian	57	78.1%
Latino/Hispanic	5	6.8%
Mixed ethnicity	2	2.7%
African-American	4	5.5%
Asian/Pacific Islander	3	4.1%
Other	2	2.7%

TABLE 2.3: Age – Baseline/Post/3-Month

	N	Percent of cases
< 35	33	45.8%
35-49	22	30.6%
50+	17	23.6%

LEVELS OF COMFORT, COMPETENCE AND CONFIDENCE

The participants were asked at all three time points to assess their comfort, competence and confidence in a situation where they may help a suicidal person. These are common questions that have been asked in past assessments of the workshops. For each item, the responses were measured on a scale from one to five where 1=*not at all*, 3=*moderately* and 5=*fully*. (see **TABLE 2.4**)

We observe significant increases from Baseline to Follow-up in the participants' level of comfort, competence and confidence. There is a particularly large increase in the level of competence from Baseline to Follow-up, from 3.05 to 4.19.

We observe no significant changes from Post to Follow-up in the participants' level of comfort, competence and confidence. In fact, in some cases the Follow-up average is slightly higher than the Baseline average. These data suggest that the improvement experienced over the course of the workshop persists three months after the intervention.

TABLE 2.4: Level of Comfort, Competence and Confidence in Helping Suicidal Youth – Baseline/Post/3-Months

Survey Item	N	Baseline Average	Post Average	Follow-up Average	P Baseline vs. Follow-up	P Post vs. Follow-up
How comfortable are you in helping a suicidal person?	73	3.60	4.18	4.11	*	
How competent would you feel helping a suicidal person?	73	3.05	4.10	4.19	*	
How confident that you would try to help this suicidal person?	73	4.00	4.56	4.64	*	

*p<.05 based on paired-samples t-test

SCALE: 1 – *Not at all*, 3 – *Moderately*, 5 – *Fully*

GENERAL KNOWLEDGE OF SUICIDE ISSUES

The survey addressed five questions about the participants’ self-reported knowledge of suicide facts, signs and resources. In addition, at all three time points, the participants were asked to identify three signs a young person might show if they were in danger of attempting suicide. (see **TABLE 2.5**)

We observe significant increases from Baseline to Follow-up in participants’ general knowledge of suicide facts, signs and resources.

For the most part, the levels of general knowledge remain high at the three-month Follow-up period. There are a couple instances – “Facts about Suicide Prevention” and “Information about Local Resources” – where the Follow-up average drops off slightly, yet not significantly, from the Post assessment.

TABLE 2.5: Level of Knowledge About General Suicide Facts, Signs and Resources – Baseline/Post/3-Months

Knowledge of	N	Baseline Average	Post Average	Follow-up Average	P Baseline vs. Follow-up	P Post vs. Follow-up
Facts about suicide prevention	73	2.88	4.29	4.16	*	
Suicide warning signs	73	3.23	4.48	4.45	*	
How to ask someone about suicide	73	3.15	4.62	4.57	*	
How to get help for someone who may be suicidal?	73	3.27	4.38	4.36	*	
Information about local resources	73	2.96	4.29	4.14	*	
# of Suicide warning signs known (3 maximum)	73	2.38	2.48	2.46		

*p<.05 based on paired-samples t-test
SCALE: 1 – very low, 5 – very high

BELIEFS ABOUT SUICIDE

Three survey questions addressed the participants’ beliefs about suicide as an issue or problem in the community. The questions were measured on a five-point scale where 1 is *strongly disagree* and 5 is *strongly agree*. (see **TABLE 2.6**)

We find that agreement with the statement “suicide is preventable in the majority of situations” steadily increases from Baseline to the 3-month Follow-up assessment. In fact, the average at 3-months is significantly greater than the average at Baseline (4.47 vs. 4.16).

On the other two questions, there are consistently high levels of agreement at all three time points, yet no differences in the averages across time points.

TABLE 2.6: Level of Agreement With General Statements About Suicide – Baseline/Post/3-Months

	N	Baseline Average	Post Average	Follow-up Average	P Baseline vs. Follow-up	P Post vs. Follow-up
Suicide among young people is a major issue in my community	73	3.83	4.14	4.04		
The problem of youth suicide should be addressed in my community	73	4.38	4.52	4.45		
Suicide is preventable in the majority of situations	73	4.16	4.33	4.47	*	

*p<.05 based on paired-samples t-test
 SCALE: 1 – *strongly disagree*, 5 – *strongly agree*

KNOWLEDGE OF SUICIDE PREVENTION AND INTERVENTION

We used a combination of self-reported agreement items and factually based multiple-choice questions to assess changes in the participants' knowledge of suicide prevention and intervention. The agreement items were asked on a five-point scale where 1 is *strongly disagree* and 5 is *strongly agree*. The multiple-choice items were used to gauge the participants' understanding of proper responses in different situations where there is a possibility of a suicide intervention. (see **TABLES 2.7-2.8**) In particular, we find:

In all instances of the self-reported items we find significant increases over time in the participants' knowledge of suicide prevention and intervention. These increases are more prominent for the following items: "If someone I knew was showing suggesting signs of suicide, I would raise the question of suicide with them" and "If someone I knew was at risk of suicide, I would encourage them to talk about their wish to die."

We observe a U-shaped pattern of response to the statement "it is harmful for a helper to engage in open communication when dealing with someone at risk of suicide." This statement is a reverse item, where answering *strongly disagree* would indicate higher levels of knowledge. We find that the improvement in knowledge evident between baseline and post is tempered some at the 9-12 Month Follow-up period. While the level of knowledge has regressed some at the Follow-up assessment, this average is still significantly different than observed at Baseline.

The responses to the multiple-choice items further indicate knowledge gain over time. In fact, the percentage that correctly responded to an item is significantly greater at 3-Month Follow-up than at Baseline, with no apparent drop-off from the Post assessment on four of the six items. For example, the percentage who responded correctly to the question about "key tasks in the first phase of suicide intervention" increases from 31.4 percent at Baseline to 65.8 percent at Post, and 63.2 percent at Follow-up,

TABLE 2.7: Knowledge of Suicide Prevention and Intervention – Baseline/Post/3-Months

	N	Baseline Average	Post Average	Follow-up Average	P Baseline vs. Follow-up	P Post vs. Follow-up
If someone I knew told me they were thinking of suicide, I would want to get more information about their plan	72	4.51	4.86	4.88	*	
It is harmful for a helper to engage in open communication when dealing with someone at risk of suicide	71	1.66	1.14	1.35	*	*
If someone I knew was showing suggesting signs of suicide, I would raise the question of suicide with them	71	4.18	4.90	4.80	*	
If someone I knew was at risk of suicide, I would encourage them to talk about their wish to die	72	3.86	4.50	4.51	*	

*p<.05 based on paired-samples t-test

SCALE: 1 – strongly disagree, 5 – strongly agree

TABLE 2.8: Knowledge of Suicide Prevention and Intervention – Multiple Choice Items – Baseline/Post/3-Months

	Correct Answer	Baseline % Correct	Post % Correct	Follow-up % Correct	P Baseline vs. Follow-up	P Post vs. Follow-up
When confronted with the possibility of suicidal behavior in a person, a caregiver should immediately...	<i>Discuss it directly with the person</i>	70.4%	97.3%	94.4%	*	
Low intent attempts or gestures...	<i>Require a suicide intervention</i>	97.2%	100.0%	97.2%		
If a person's words and/or behavior suggest the possibility of suicide, a helper should...	<i>Ask if the person is thinking of suicide</i>	73.2%	94.5%	98.6%	*	
If someone admits to feeling suicidal, a helper should...	<i>Find out if they've thought of how they would do it</i>	49.3%	91.8%	87.5%	*	
Key tasks in the first phase of suicide Intervention are	<i>Engagement and identification</i>	31.4%	65.8%	63.2%	*	
Which of the following action plans would likely be most suitable for someone at the risk of suicide	<i>No-harm agreement and Follow-up meeting confirmed</i>	55.2%	67.1%	71.6%		

*p<.05 based on paired-samples t-test

See *Appendix C* for full distributions of responses to each item

KNOWLEDGE OF SUICIDE ASSESSMENT

In the Post survey, the participants were asked a set of multiple-choice questions to evaluate their knowledge of suicide assessment facts and issues. Some of these items were more challenging than others, and they were intended to provide a sense of the participants’ ability to assess suicide risk in different scenarios. These questions were asked again in the three-month Follow-up survey, thus providing the opportunity to determine whether the knowledge gained at the workshop is retained well after the training. A summary in **TABLE 2.9** indicates that:

In general, the knowledge about suicide assessment gained at the workshop persists at the 3-Month Follow-up workshop. In particular, we continue to observe high levels of knowledge on the following questions: “Suicide is most likely a result of...,” “People who express suicidal intentions...,” and “Suicide plans are assessed on the basis of a person’s...”

We do find a significant decline in knowledge about “What generally determines if behavior is suicidal” from 50.7 to 32.4 percent. Of note is that over 53 percent of the respondents at Follow-Up responded that *the history of prior behavior* determines if the current behavior is suicidal rather than the correct answer, the *intent of the person*.

TABLE 2.9: Level of Knowledge About Suicide Assessment – Post/3-Months

	Correct Answer	Post % Correct	Follow-up % Correct	P Post vs. Follow-up
Suicide is most likely a result of...	<i>No single cause</i>	84.9%	88.2%	
Suicide plans are assessed on the basis of a person’s...	<i>Degree of preparation</i>	70.8%	65.7%	
People who express suicidal intentions...	<i>Are ambivalent about dying</i>	90.4%	83.3%	
Which provides the most important information in assessing the risk of suicide...	<i>Resources</i>	65.8%	60.3%	
Generally determines if behavior is suicidal...	<i>The intent of the person</i>	50.7%	32.9%	*
Which provides the least important information in assessing the risk of suicide...	<i>Stress</i>	36.6%	35.2%	

*p<.05 based on paired-samples t-test
See **Appendix D** for full distributions of responses to each item

EXPERIENCE WITH SUICIDAL YOUTH

At both Baseline and Follow-up, the workshop participants were asked to report on their level of contact with suicidal youth in the month prior to the assessment. This serves as a measure of their experience with suicidal youth. In this sample, 41.1 percent of the respondents reported experience with suicidal youth at baseline. At the 3-month Follow-up assessment 39.7 percent reported at least one contact. **TABLE 2.10** compares the levels of experience among those with data at both time points. The full distributions of levels of contact across the three time points are presented in *Appendix E*. We find that:

As expected, those with greater experience at Baseline reported greater contact at Follow-up. For example, almost 93 percent of those with multiple contacts prior to Baseline reported some contact at the Follow-up assessment.

Over 43 percent reported connecting a suicidal youth to a resource. The most common resources include Family (30.1 percent) and Mental Health Agency or Provider (24.7 percent). (see **TABLE 2.11**)

TABLE 2.10: Number of Contacts With Suicidal Youth – Baseline/3-Months

# of Contacts at Baseline	N	% of those with 1+ Contacts at Follow-up
0	43	20.9%
1	16	43.8%
2+	14	92.9%
<i>OVERALL</i>	73	39.7%

See *Appendix E* for full distributions to the experience items

TABLE 2.11: Have Connected Suicidal Youth to the Following Resources (3-Month Follow-up)

	N	Percent of Cases
Crisis Line	13	17.8%
Hospital or Medical Provider	6	8.2%
Mental Health Agency or Provider	18	24.7%
Family	22	30.1%
Friends	12	16.4%
Other	4	5.5%
Had no contact	43	56.2%

* Percentages sum to greater than 100%; respondents could have connected suicidal youth to multiple resources

SECTION 3

BASELINE/POST/9-12-MONTH FOLLOW-UP

COMPARISON

2002-2003 ANNUAL REPORT

EVALUATION OF PROGRAM TRAINING WORKSHOPS

DEMOGRAPHICS

The demographic characteristics of the 29 individuals with data at Baseline, Post, and 9-12 Month Follow-up are presented in **TABLES 3.1-3.2**.

Almost 80 percent of respondents are female.

Over 51 percent of the respondents at Follow-up are less than 35 years old. This age distribution is similar to what we observed among all participants at Baseline.

TABLE 3.1: Gender – Baseline/Post/9-12 Months

	N	Percent of Cases
Male	6	20.7%
Female	23	79.3%

TABLE 3.2: Age – Baseline/Post/9-12 Months

	N	Percent of Cases
< 35	15	51.7%
35-49	8	27.6%
50+	6	20.7%

LEVELS OF COMFORT, COMPETENCE AND CONFIDENCE

The participants were asked at all three time points to assess their comfort, competence and confidence in a situation where they may help a suicidal person. For each item, the responses were measured on a scale from one to five where 1=*not at all*, 3=*moderately* and 5=*fully*. (see **TABLE 3.3**)

We observe significant increases from Baseline to 9-12 Month Follow-up in the participants' level of competence and confidence, and a substantive increase in their level of comfort.

We observe no significant changes from Post to 9-12 Month Follow-up in the participants' level of comfort, competence and confidence. These data suggest that participants demonstrate an improvement over the course of the workshop that continues to persist nine to 12 months after the intervention.

TABLE 3.3: Level of Comfort, Competence and Confidence in Helping Suicidal Youth – Baseline/Post/9-12 Months

Survey Item	N	Baseline Average	Post Average	Follow-up Average	P Baseline vs. Follow-up	P Post vs. Follow-up
How comfortable are you in helping a suicidal person?	29	3.59	4.07	3.93		
How competent would you feel helping a suicidal person?	29	3.10	4.03	3.90	*	
How confident that you would try to help this suicidal person?	29	4.00	4.52	4.55	*	

*p<.05 based on paired-samples t-test

SCALE: 1 – *Not at all*, 3 – *Moderately*, 5 – *Fully*

GENERAL KNOWLEDGE OF SUICIDE ISSUES

The survey addressed five questions about the participants’ self-reported knowledge of suicide facts, signs and resources. In addition, at all three time points, the participants were asked to identify three signs a young person might show if they were in danger of attempting suicide. (see **TABLE 3.4**)

On four of the knowledge items we observe a similar pattern across the three time points. After the initial improvement from Baseline to Post, we find a significant decrease in knowledge between the Post assessment and the 9-12 month follow-up assessment. However, the comparison between Baseline and Follow-up in each instance suggests that while perceived knowledge has declined some, it has not returned to pre-workshop levels. It is common to see such a reverse U-shaped pattern when assessing knowledge retention over a longer follow-up period.

In the case of “how to ask someone about suicide,” there is evidence that this knowledge persists even 9-12 months after the workshop. For this item we do not see a concurrent decrease in the average from Post to Follow-Up. This is important given the emphasis on the issue of “raising the question” in the workshops and the overall program activities.

TABLE 3.4: Level of Knowledge About General Suicide Facts, Signs and Resources – Baseline/Post/9-12 Months

Knowledge of	N	Baseline Average	Post Average	Follow-up Average	P Baseline vs. Follow-up	P Post vs. Follow-up
Facts about suicide prevention	28	2.79	4.18	3.86	*	*
Suicide warning signs	28	3.21	4.54	4.25	*	*
How to ask someone about suicide	28	3.21	4.71	4.50	*	
How to get help for someone who may be suicidal?	28	3.25	4.39	3.93	*	*
Information about local resources	28	2.82	4.25	3.71	*	*
# of suicide warning signs known (3 maximum)	29	2.45	2.52	2.55		

*p<.05 based on paired-samples t-test
 SCALE: 1 – very low, 5 – very high

BELIEFS ABOUT SUICIDE

Three survey questions addressed the participants’ beliefs about suicide as an issue or problem in the community. The questions were measured on a five-point scale where 1 is *strongly disagree* and 5 is *strongly agree*. (see **TABLE 3.5**)

In each of the three statements we observe a similar response pattern where the level of agreement declines back to the Baseline levels at the 9-12 Month assessment point. While in general the averages are quite high at all assessment periods, it is important to note that the beliefs about the problem of youth suicide acquired through the training have tempered some as participants returned to their community settings.

The reverse U-shaped pattern noted above is most evident in the case of beliefs about “suicide is preventable in the majority of situations” where we observe a significant decline in levels of agreement from Post to the 9-12 month Follow-Up assessment (from 4.55 to 4.31).

TABLE 3.5: Level of Agreement With General Statements About Suicide – Baseline/Post/9-12 Months

	N	Baseline Average	Post Average	Follow-up Average	P Baseline vs. Follow-up	P Post vs. Follow-up
Suicide among young people is a major issue in my community	29	3.76	4.28	4.00		
The problem of youth suicide should be addressed in my community	29	4.31	4.66	4.38		
Suicide is preventable in the majority of situations	29	4.21	4.55	4.31		*

*p<.05 based on paired-samples t-test
 SCALE: 1 – *strongly disagree*, 5 – *strongly agree*

KNOWLEDGE OF SUICIDE PREVENTION AND INTERVENTION

We used a combination of self-reported agreement items and factually based multiple-choice questions to assess changes in the participants' knowledge of suicide prevention and intervention. The agreement items were asked on a five-point scale where 1 is *strongly disagree* and 5 is *strongly agree*. The multiple-choice items were used to assess the participants' understanding of proper responses in different situations where there is a possibility for a suicide intervention. (see TABLES 3.6-3.7) In particular, we find:

The data indicate that the significant changes in self-reported knowledge of suicide prevention and intervention from Baseline to Post continue to persist at the 9-12 month Follow-up assessment period. On three of the items the level of agreement with the knowledge statement is still significantly higher at Follow-up than observed at Baseline. For instance, the level of agreement with the statement "if someone I knew was showing signs of suicide, I would raise the question of suicide with them," at Follow-up (average = 4.79) is considerably greater than observed at Baseline (average = 4.07).

An assessment of the multiple choice questions suggests that knowledge on four of the items remains consistently high across the three assessment points. In fact, we find that at the 9-12 Month Follow-up, we observe the highest percentage of respondents who correctly answered the question about the "action plans that would likely be most suitable for someone at the risk of suicide." (75.9 percent)

There are two questions where the levels of knowledge decline significantly between the Post and Follow-up assessment points. For the question about the "key tasks in the first phase of suicide intervention," the percentage that correctly answered *engagement and identification* at Follow-up is almost as low as observed at the Baseline assessment period.

TABLE 3.6: Knowledge of Suicide Prevention and Intervention – Baseline/Post/9-12 Months

	N	Baseline Average	Post Average	Follow-up Average	P Baseline vs. Follow-up	P Post vs. Follow-up
If someone I knew told me they were thinking of suicide, I would want to get more information about their plan	29	4.34	4.90	4.86	*	
It is harmful for a helper to engage in open communication when dealing with someone at risk of suicide	29	1.45	1.10	1.28		
If someone I knew was showing suggesting signs of suicide, I would raise the question of suicide with them	29	4.07	4.90	4.79	*	
If someone I knew was at risk of suicide, I would encourage them to talk about their wish to die	29	3.86	4.31	4.41	*	

*p<.05 based on paired-samples t-test

SCALE: 1 – strongly disagree, 5 – strongly agree

TABLE 3.7: Knowledge of Suicide Prevention and Intervention – Multiple Choice Items – Baseline/Post/9-12 Months

	Correct Answer	Baseline % Correct	Post % Correct	Follow-up % Correct	P Baseline vs. Follow-up	P Post vs. Follow-up
When confronted with the possibility of suicidal behavior in a person, a caregiver should immediately...	<i>Discuss it directly with the person</i>	85.1%	96.4%	93.1%		
Low intent attempts or gestures...	<i>Require a suicide intervention</i>	96.4%	100.0%	89.7%		
If a person’s words and/or behavior suggest the possibility of suicide, a helper should...	<i>Ask if the person is thinking of suicide</i>	71.4%	93.1%	96.5%	*	
If someone admits to feeling suicidal, a helper should...	<i>Find out if they’ve thought of how they would do it</i>	53.9%	96.6%	75.9%		*
Key tasks in the first phase of suicide intervention are	<i>Engagement and identification</i>	29.6%	62.1%	31.0%		*
Which of the following action plans would likely be most suitable for someone at the risk of suicide	<i>No-harm agreement and Follow-up meeting confirmed</i>	61.5%	69.0%	75.9%		

*p<.05 based on paired-samples t-test

See **Appendix F** for full distributions of responses to each item

KNOWLEDGE OF SUICIDE ASSESSMENT

In the Post survey, the participants were asked a set of multiple-choice questions to evaluate their knowledge of suicide assessment facts and issues. Some of these items were more challenging than others, and they were intended to provide a sense of the participants' ability to assess suicide risk in different scenarios. These questions were asked again in the 9-12 Month Follow-up surveys, thus providing the opportunity to determine whether the knowledge gained at the workshop is retained well after the training. A summary in **TABLE 3.8** indicates that:

In general, the knowledge about suicide assessment gained at the workshop persists at the 9-12 Month Follow-up workshop. In particular, we continue to observe high levels of understanding for the following questions: "Suicide is most likely a result of..." "People who express suicidal intentions..." and "Suicide plans are assessed on the basis of a person's..." In the first two questions, over 80 percent still respond correctly 9-12 months after the workshop.

There are two questions where knowledge about suicide assessment appears to decline over time – "What generally determines if behavior is suicidal" (62.1 to 44.4 percent correct), and "Which provides the most important information in assessing the risk of suicide" (62.1 to 46.4 percent correct).

TABLE 3.8: Level of Knowledge About Suicide Assessment – Post/9-12 Months

	Correct Answer	Post % Correct	Follow-up % Correct	P Post vs. Follow-up
Suicide is most likely a result of...	<i>No single cause</i>	75.9%	82.8%	
Suicide plans are assessed on the basis of a person's...	<i>Degree of preparation</i>	72.4%	64.3%	
People who express suicidal intentions...	<i>Are ambivalent about dying</i>	96.6%	89.7%	
Which provides the most important information in assessing the risk of suicide...	<i>Resources</i>	62.1%	46.4%	
Generally determines if behavior is suicidal...	<i>The intent of the person</i>	62.1%	44.4%	
Which provides the least important information in assessing the risk of suicide...	<i>Stress</i>	46.4%	41.4%	

*p<.05 based on paired-samples t-test

See **Appendix G** for full distributions of responses to each item

EXPERIENCE WITH SUICIDAL YOUTH

At both Baseline and the 9-12 Month Follow-up, the workshop participants were asked to report on their level of contact with suicidal youth in the month prior to the assessment. This serves as a measure of experience with suicidal youth.

In the sample of 29 participants, 37.9 percent of the respondents reported experience with suicidal youth at Baseline. At the 9-12 Month Follow-up assessment only 20.7 percent reported at least one contact. The full distributions of levels of contact across the three time points are presented in *Appendix H*.

Only 17.2 percent of the respondents reported connecting a suicidal youth to a resource. The distribution of resources is shown in **TABLE 3.9**.

TABLE 3.9: Have Connected Suicidal Youth to the Following Resources

	N	Percent of cases
Crisis Line	1	3.4%
Hospital or Medical Provider	1	3.4%
Mental Health Agency or Provider	1	3.4%
Family	3	10.3%
Friends	3	10.3%
Other	0	0.0%
Had no contact	24	82.8%

* Percentages sum to greater than 100%; respondents could have connected suicidal youth to multiple resources

APPENDIX A

TRAINING WORKSHOP SURVEYS: PRE, POST AND FOLLOW-UP

**WASHINGTON STATE
YOUTH SUICIDE PREVENTION PROGRAM
Training Workshop Survey – Pre-Workshop**

The Washington State Youth Suicide Prevention Program is interested in collecting information from individuals who participate in different suicide prevention training activities. The intent of this survey is collect information that will assist the program in addressing issues associated with suicide prevention. Your participation is voluntary, and all of your responses will be kept confidential. Thank you for your participation and cooperation!

DATE: ___/___/___

LOCATION: _____

CODE NUMBER: *(The code number is used to track survey and assures the confidentiality of the respondents)*

What is **the second letter of your first name**?

What are the **two digits of the year of your birth date**?

What are the **two digits of the day of your birth date**?

What is the **last letter in your last name**
(if female use maiden name)

My gender: (check one) Male Female

My age: (check one) Less than 18 years old 18 to 24 years old 25 to 34 years old
 35 to 49 years old 50 to 64 years old Over 64 years old

My ethnic or cultural background: (check one) African-American Asian-American Caucasian Latino/Hispanic
 Native American or American Indian Pacific Islander Mixed Ethnicity Other: _____

For questions 1 – 4, we would like to know about your experiences with helping young people.

1. How many young people who showed signs of being suicidal did you have contact with in the last month? _____

2. In any of your interactions with these young people, did you talk to them about your concerns for their well-being? (check one)

Yes No Indirectly Not Sure Had No Contact

3. Did you ask them if they were thinking about harming themselves or attempting suicide?
 (check one)
 Yes No Indirectly Not Sure Had No Contact

4. Did you talk with the young person about where they could get help? (check one)
 Yes No Indirectly Not Sure Had No Contact

5. Imagine yourself in a situation where you might be able to help a suicidal youth. Please answer the questions below by circling the number that best fits you.

	Not at all		Moderately		Fully
	1	2	3	4	5
a) How COMFORTABLE would you feel helping this suicidal person?.....	1	2	3	4	5
b) Considering your current knowledge and skills, how COMPETENT would you feel helping this suicidal person?.....	1	2	3	4	5
c) Overall, how CONFIDENT are you that you would try to help this suicidal person?.....	1	2	3	4	5

6. General Knowledge: Please rate your level of knowledge about the following on a scale from 1 to 5 where 1 is VERY LOW and 5 is VERY HIGH: (circle one number for each)

	Very Low		↔		Very High
	1	2	3	4	5
a) Facts about suicide prevention.....	1	2	3	4	5
b) Suicide warning signs.....	1	2	3	4	5
c) How to ask someone about suicide.....	1	2	3	4	5
d) How to get help for someone who may be suicidal.....	1	2	3	4	5
e) Information about local resources for help with suicide.....	1	2	3	4	5

7. Take a moment and imagine you know a young person who is showing signs of being suicidal. To know if this young person might be in danger of attempting suicide, what 3 signs would you look for?

1. _____
2. _____
3. _____

8. Please rate your level of agreement with the following statements: (check one box for each)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
a) Suicide among young people is a major issue in my community	▼	▼	▼	▼	▼
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) The problem of youth suicide should be addressed in my community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Suicide is preventable in the majority of situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. The following questions are intended to assess your knowledge about suicide prevention and intervention: (check one box for each)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
a) If someone I knew told me that they were thinking of suicide, I would want to get more information about their plan.....	▼	▼	▼	▼	▼
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) It is harmful for a helper to engage in open communication when dealing with someone at risk of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) If someone I knew was showing suggesting signs of suicide, I would raise the question of suicide with them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) If someone I knew was at risk of suicide, I would encourage them to talk about their wish to die.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***Multiple Choice: For questions 10 – 15,
circle only ONE response.***

10. When confronted with the possibility of suicidal behavior in a person, a caregiver should immediately:

- a) Refer the person to experienced suicide resources
- b) Discuss it directly with the person
- c) Call in significant others in the persons life
- d) Encourage the person to talk about the positive aspects of his or her life

11. Low intent attempts or gestures:

- a) Should be ignored
- b) Require a suicide intervention
- c) Should be actively punished
- d) Are not a cause for concern

- 12. If a person's words and/or behavior suggest the possibility of suicide, a helper should:**
- a) Gather more information about what is bothering the person
 - b) Inquire about the support available from family and friends
 - c) Determine if substance abuse is a factor
 - d) Ask if the person is thinking of suicide
- 13. If someone admits to feeling suicidal, a helper should:**
- a) Calmly inquire about what is happening in their life
 - b) Find out if they've thought of how they would do it
 - c) Inform significant others
 - d) Arrange for immediate referral
- 14. Key tasks in the first phase of Suicide Intervention are:**
- a) Inquiry and identification
 - b) Engagement and identification
 - c) Assessment and inquiry
 - d) Contracting and implementation
- 15. Which of the following action plans would likely be most suitable for someone at risk of suicide:**
- a) No-harm agreement and referral for therapy
 - b) No-harm agreement and follow-up meeting confirmed
 - c) Agreement to call a crisis line if troubled again with thoughts of suicide
 - d) Agreement to talk with a significant other the next day

THANK YOU FOR YOUR PARTICIPATION IN THIS QUESTIONNAIRE!

3. Take a moment and imagine you know a young person who is showing signs of being suicidal. To know if this young person might be in danger of attempting suicide, what 3 signs would you look for?

1. _____
2. _____
3. _____

4. Please rate level of agreement with statements: (check one box for each)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
a) Suicide among young people is a major issue in my community	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
b) The problem of youth suicide should be addressed in my community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Suicide is preventable in the majority of situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. The following questions are intended to assess your knowledge about suicide prevention and intervention: (check one box for each)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
a) If someone I knew told me that they were thinking of suicide, I would want to get more information about their plan.....	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
b) It is harmful for a helper to engage in open communication when dealing with someone at risk of suicide.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) If someone I knew was showing suggesting signs of suicide, I would raise the question of suicide with them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) If someone I knew was at risk of suicide, I would encourage them to talk about their wish to die.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Multiple Choice: For questions 6 – 11,
circle only ONE response.**

6. When confronted with the possibility of suicidal behavior in a person, a caregiver should immediately:

- a) Refer the person to experienced suicide resources
- b) Discuss it directly with the person
- c) Call in significant others in the persons life
- d) Encourage the person to talk about the positive aspects of his or her life

- 7. Low intent attempts or gestures:**
- a) Should be ignored
 - b) Require a suicide intervention
 - c) Should be actively punished
 - d) Are not a cause for concern
- 8. If a person's words and/or behavior suggest the possibility of suicide, a helper should:**
- a) Gather more information about what is bothering the person
 - b) Inquire about the support available from family and friends
 - c) Determine if substance abuse is a factor
 - d) Ask if the person is thinking of suicide
- 9. If someone admits to feeling suicidal, a helper should:**
- a) Calmly inquire about what is happening in their life
 - b) Find out if they've thought of how they would do it
 - c) Inform significant others
 - d) Arrange for immediate referral
- 10. Key tasks in the first phase of Suicide Intervention are:**
- a) Inquiry and identification
 - b) Engagement and identification
 - c) Assessment and inquiry
 - d) Contracting and implementation
- 11. Which of the following action plans would likely be most suitable for someone at risk of suicide:**
- a) No-harm agreement and referral for therapy
 - b) No-harm agreement and follow-up meeting confirmed
 - c) Agreement to call a crisis line if troubled again with thoughts of suicide
 - d) Agreement to talk with a significant other the next day

Consider the following scenario:

Physical Health..... No problems
Symptoms..... Somewhat down, hard time getting to sleep, no appetite for the past 2 weeks
Prior Suicidal Behavior..... Drug overdose two years ago
Age..... 17 years
Current Suicide Plan..... Drug overdose
Sex..... Female
Socioeconomic Status..... Middle class background; poor now because of no child support from father
Resources..... Recently moved to city, a few acquaintances, parents divorced, living with mother only
Religion..... Catholic
Stress..... Feeling lonely, blue; failing 2 classes in high school

12. Rate the above case as to your estimation of the level of suicide risk: (check one)

- High Low Moderate No Risk

**Multiple Choice: For questions 13 – 18,
circle only ONE response.**

13. Suicide is most likely a result of:

- a) Overwhelming stress
- b) Clinical depression
- c) Substance abuse
- d) No single cause

14. Suicide plans are assessed on the basis of a person's:

- a) Degree of preparation
- b) Age of person
- c) Stated seriousness
- d) Apparent distress

15. People who express suicidal intentions:

- a) Clearly want to die
- b) Are ambivalent about dying
- c) Want to punish others
- d) Are manipulating

16. Of the following, which provides the most important information in assessing the risk of suicide?

- a) Symptoms
- b) Stress
- c) Resources
- d) Physical health

17. What generally determines if behavior is suicidal?

- a) The mood of the person
- b) The intent of the person
- c) The lethality of the method used
- d) The history of prior behavior

18. Of the following, which provides the least important information in assessing the risk of suicide?

- a) Symptoms
- b) Stress
- c) Resources
- d) Mental health

These are all the questions. Thank you very much for your assistance with this survey. It is likely that we will attempt to follow-up with a mail or phone survey in 3-4 months. We would appreciate it if you could please provide your name and address information for follow-up. Information is strictly confidential and no one outside program will have access to this information.

Name: _____

Address: _____

City/State/Zip _____

Phone: _____

Best Time To Call: _____

THANK YOU FOR YOUR PARTICIPATION IN THIS QUESTIONNAIRE!

WASHINGTON STATE YOUTH SUICIDE PREVENTION PROGRAM

Training Workshop Survey – Follow-Up

The Washington State Youth Suicide Prevention Program is interested in collecting information from individuals who participate in different suicide prevention training activities. If you recall, you participated a suicide prevention-training workshop about 9 months ago. The intent of this survey is collect information that will assist the program in addressing issues associated with suicide prevention. Your participation is voluntary, and all of your responses will be kept confidential. Thank you for your participation and cooperation!

CODE NUMBER: *(The code number is used to track survey and assures the confidentiality of the respondents)*

What is **the second letter of your first name**?....._____

What are the **two digits of the year of your birth date**?_____

What are the **two digits of the day of your birth date**?....._____

What is the **last letter in your last name**
(if female use maiden name)_____

For questions 1 – 4, we would like to know about your experiences helping young people.

- 1. How many young people who showed signs of being suicidal did you have contact with in the last month?** _____
- 2. In any of your interactions with these young people, did you talk to them about your concerns for their well-being?** (check one)
 Yes No Indirectly Not Sure Had No Contact
- 3. Did you ask them if they were thinking about harming themselves or attempting suicide?** (check one)
 Yes No Indirectly Not Sure Had No Contact
- 4. Did you talk with the young person about where they could get help?** (check one)
 Yes No Indirectly Not Sure Had No Contact

5. In the past 3 months, I have connected a suicidal youth to which of the following resources:(please check all that apply)

- Crisis Line
- Hospital or Medical Provider
- Mental Health Agency or Provider
- Family
- Friends
- Other
- I had no contact with a suicidal youth

6. Imagine yourself in a situation where you might be able to help a suicidal youth. Please answer the questions below by circling the number that best fits you.

	Not at all		Moderately		Fully
a) How COMFORTABLE would you feel helping this suicidal person?.....	1	2	3	4	5
b) Considering your current knowledge and skills, how COMPETENT would you feel helping this suicidal person?.....	1	2	3	4	5
c) Overall, how CONFIDENT are you that you would try to help this suicidal person?	1	2	3	4	5

7. General Knowledge: Please rate your level of knowledge about the following on a scale from 1 to 5 where 1 is VERY LOW and 5 is VERY HIGH: (circle one number for each)

	Very Low		↔		Very High
a) Facts about suicide prevention	1	2	3	4	5
b) Suicide warning signs	1	2	3	4	5
c) How to ask someone about suicide	1	2	3	4	5
d) How to get help for someone who may be suicidal	1	2	3	4	5
e) Information about local resources for help with suicide	1	2	3	4	5

8. Take a moment and imagine you know a young person who is showing signs of being suicidal. To know if this young person might be in danger of attempting suicide, what 3 signs would you look for?

1. _____
2. _____
3. _____

9. Please rate level of agreement with statements: (check one box for each)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
a) Suicide among young people is a major issue in my community	▼	▼	▼	▼	▼
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) The problem of youth suicide should be addressed in my community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Suicide is preventable in the majority of situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. The following questions are intended to assess your knowledge about suicide prevention and intervention: (check one box for each)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
a) If someone I knew told me that they were thinking of suicide, I would want to get more information about their plan	▼	▼	▼	▼	▼
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) It is harmful for a helper to engage in open communication when dealing with someone at risk of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) If someone I knew was showing suggesting signs of suicide, I would raise the question of suicide with them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) If someone I knew was at risk of suicide, I would encourage them to talk about their wish to die	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Multiple Choice: For questions 11-16, circle only ONE response.

11. When confronted with the possibility of suicidal behavior in a person, a caregiver should immediately:

- a) Refer the person to experienced suicide resources
- b) Discuss it directly with the person
- c) Call in significant others in the persons life
- d) Encourage the person to talk about the positive aspects of his or her life

12. Low intent attempts or gestures:

- a) Should be ignored
- b) Require a suicide intervention
- c) Should be actively punished
- d) Are not a cause for concern

- 13. If a person's words and/or behavior suggest the possibility of suicide, a helper should:**
- a) Gather more information about what is bothering the person
 - b) Inquire about the support available from family and friends
 - c) Determine if substance abuse is a factor
 - d) Ask if the person is thinking of suicide
- 14. If someone admits to feeling suicidal, a helper should:**
- a) Calmly inquire about what is happening in their life
 - b) Find out if they've thought of how they would do it
 - c) Inform significant others
 - d) Arrange for immediate referral
- 15. Key tasks in the first phase of Suicide Intervention are:**
- a) Inquiry and identification
 - b) Engagement and identification
 - c) Assessment and inquiry
 - d) Contracting and implementation
- 16. Which of the following action plans would likely be most suitable for someone at risk of suicide:**
- a) No-harm agreement and referral for therapy
 - b) No-harm agreement and follow-up meeting confirmed
 - c) Agreement to call a crisis line if troubled again with thoughts of suicide
 - d) Agreement to talk with a significant other the next day

Consider the following scenario:

<i>Physical Health</i>	No problems
<i>Symptoms</i>	Somewhat down, hard time getting to sleep, no appetite for the past 2 weeks
<i>Prior Suicidal Behavior</i>	Drug overdose two years ago
<i>Age</i>	17 years
<i>Current Suicide Plan</i>	Drug overdose
<i>Sex</i>	Female
<i>Socioeconomic Status</i>	Middle class background; poor now because of no child support from father
<i>Resources</i>	Recently moved to city, a few acquaintances, parents divorced, living with mother only
<i>Religion</i>	Catholic
<i>Stress</i>	Feeling lonely, blue; failing 2 classes in high school

- 17. Rate the above case as to your estimation of the level of suicide risk: (check one)**
- High Low Moderate No Risk

Multiple Choice: For questions 18 – 23, circle only ONE response.

- 18. Suicide is most likely a result of:**
- a) Overwhelming stress
 - b) Clinical depression
 - c) Substance abuse
 - d) No single cause
- 19. Suicide plans are assessed on the basis of a person's:**
- a) Degree of preparation
 - b) Age of person
 - c) Stated seriousness
 - d) Apparent distress
- 20. People who express suicidal intentions:**
- a) Clearly want to die
 - b) Are ambivalent about dying
 - c) Want to punish others
 - d) Are manipulating
- 21. Of the following, which provides the most important information in assessing the risk of suicide?**
- a) Symptoms
 - b) Stress
 - c) Resources
 - d) Physical health
- 22. What generally determines if behavior is suicidal?**
- a) The mood of the person
 - b) The intent of the person
 - c) The lethality of the method used
 - d) The history of prior behavior
- 23. Of the following, which provides the least important information in assessing the risk of suicide?**
- a) Symptoms
 - b) Stress
 - c) Resources
 - d) Mental health

THANK YOU FOR YOUR PARTICIPATION IN THIS QUESTIONNAIRE!

APPENDIX B

KNOWLEDGE OF SUICIDE PREVENTION AND INTERVENTION: BASELINE VS. POST

Question	Baseline	Post
When confronted with the possibility of suicidal behavior in a person, a caregiver should immediately		
Refer the person to experienced suicide resources	14.3%	0.0%
Discuss it directly with the person (CORRECT)	72.9%	98.6%
Call in significant others	3.6%	0.0%
Encourage the person to talk about the positive aspects of life	9.3%	1.4%
Low intent attempts or gestures		
Should be ignored	0.7%	0.0%
Require suicide intervention (CORRECT)	95.7%	95.1%
Should be actively punished	2.1%	1.4%
Are not a cause for concern	1.4%	3.5%
If a person's words and/or behavior suggest the possibility of suicide, a helper should		
Gather more information about what is bothering the person	22.8%	9.3%
Inquire about the support available from family and friends	2.9%	0.0%
Determined if substance abuse is a factor	0.7%	0.0%
Ask if the person is thinking of suicide (CORRECT)	73.5%	90.7%
If someone admits to feeling suicidal, a helper should		
Calmly inquire about what is happening their life	31.9%	17.7%
Find out if they've thought of how they would do it (CORRECT)	57.0%	82.3%
Inform significant others	0.7%	0.0%
Arrange for immediate referral	10.4%	0.0%
Key tasks in the first phase of suicide intervention are		
Inquiry and identification	37.5%	19.7%
Engagement and identification (CORRECT)	35.3%	76.8%
Assessment and inquiry	26.5%	2.1%
Contracting and implementation	0.7%	1.4%
Which of the following action plans would likely be most suitable for someone at risk of suicide		
No-harm agreement and referral for therapy	26.1%	12.1%
No-harm agreement and Follow-up meeting confirmed (CORRECT)	58.2%	83.0%
Agreement to call a crisis line if trouble again with suicide thoughts	11.2%	2.8%
Agreement to talk with significant other the next day	4.5%	2.1%

APPENDIX C

KNOWLEDGE OF SUICIDE PREVENTION AND INTERVENTION: BASELINE VS. POST VS. 3M FOLLOW-UP

	Baseline	Post	3M Follow-up
When confronted with possibility of suicidal behavior, a caregiver should...			
Refer the person to experienced suicide resources	18.3%	1.4%	2.8%
Discuss it directly with the person (CORRECT)	70.4%	97.3%	94.4%
Call in significant others in the persons life	4.2%	0.0%	1.4%
Encourage the person to talk about the positive aspects of his or her life	7.0%	1.4%	1.4%
Low intent attempts or gestures...			
Should be ignored	0.0%	0.0%	0.0%
Require a suicide intervention (CORRECT)	97.2%	100.0%	97.2%
Should be actively punished	0.0%	0.0%	0.0%
Are not a cause for concern	2.8%	0.0%	2.8%
If a person's words and/or behavior suggest the possibility of suicide, a helper should...			
Gather more information about what is bothering the person	19.7%	5.5%	0.0%
Inquire about the support available from family and friends	7.0%	0.0%	1.4%
Determine if substance abuse is a factor	0.0%	0.0%	0.0%
Ask if the person is thinking of suicide (CORRECT)	73.2%	94.5%	98.6%
If someone admits to feeling suicidal, a helper should...			
Calmly inquire about what is happening in their life	33.3%	8.2%	9.7%
Find out if they've thought of how they would do it (CORRECT)	49.3%	91.8%	87.5%
Inform significant others	2.9%	0.0%	0.0%
Arrange for immediate referral	14.5%	0.0%	2.8%
Key tasks in the first phase of Suicide Intervention are...			
Inquiry and identification	37.1%	23.3%	26.5%
Engagement and identification (CORRECT)	31.4%	65.8%	63.2%
Assessment and inquiry	30.0%	9.6%	8.8%
Contracting and implementation	1.4%	1.4%	1.5%
Which of the following action plans would likely be most suitable for someone at risk of suicide...			
No-harm agreement and referral for therapy	29.9%	27.4%	22.4%
No-harm agreement and follow-up meeting confirmed (CORRECT)	55.2%	67.1%	71.6%
Agreement to call a crisis line if troubled again with thoughts of suicide	10.4%	5.5%	4.5%
Agreement to talk with a significant other the next day	4.5%	0.0%	1.5%

APPENDIX D

KNOWLEDGE OF SUICIDE ASSESSMENT: POST VS. 3M FOLLOW-UP

	Post	Follow-up
Suicide is most likely a result of...		
Overwhelming stress	9.6%	4.4%
Clinical depression	5.5%	7.4%
Substance abuse	0.0%	0.0%
No single cause (CORRECT)	84.9%	88.2%
Suicide plans are assessed on the basis of a person's...		
Degree of preparation (CORRECT)	70.8%	65.7%
Age of person	0.0%	1.4%
Stated seriousness	25.0%	27.1%
Apparent distress	4.2%	5.7%
People who express suicidal intentions...		
Clearly want to die	8.2%	13.9%
Are ambivalent about dying (CORRECT)	90.4%	83.3%
Want to punish others	1.4%	2.8%
Are manipulating	0.0%	0.0%
Provides the most important information in assessing the risk of suicide...		
Symptoms	31.5%	24.7%
Stress	1.4%	13.7%
Resources (CORRECT)	65.8%	60.3%
Physical health	1.4%	1.4%
Generally determines if behavior is suicidal...		
The mood of the person	4.2%	0.0%
The intent of the person (CORRECT)	50.7%	32.9%
The lethality of the method used	12.7%	13.7%
The history of prior behavior	32.4%	53.4%
Provides the least important information in assessing the risk of suicide		
Symptoms	22.5%	18.3%
Stress (CORRECT)	36.6%	35.2%
Resources	19.7%	23.9%
Mental health	21.1%	22.5%

APPENDIX E

PRIOR EXPERIENCE WITH SUICIDAL YOUTH: BASELINE VS. 3M FOLLOW-UP

	Baseline	3M Follow-up
Number of young people who showed signs of being suicidal that you had contact with		
None	58.9%	60.3%
One or less	21.9%	17.8%
Two-four	16.5%	19.1%
Four or more	2.7%	2.8%
Did you talk to them about your concerns for their well-being?		
Yes	28.8%	35.6%
No	2.7%	0.0%
Indirectly	9.6%	2.7%
Had no contact	57.5%	60.3%
Did you ask them if they were thinking about harming themselves or attempting suicide?		
Yes	28.8%	34.2%
No	9.6%	1.4%
Indirectly	4.1%	4.1%
Had no contact	57.5%	60.3%
Did you talk with them about where they could get help?		
Yes	24.7%	38.4%
No	12.3%	1.4%
Indirectly	2.7%	0.0%
Had no contact	57.5%	60.3%

APPENDIX F

KNOWLEDGE OF SUICIDE PREVENTION AND INTERVENTION: BASELINE VS. POST VS. 9-12M FOLLOW-UP

	Baseline	Post	9-12M Follow-up
When confronted with possibility of suicidal behavior, a caregiver should...			
Refer the person to experienced suicide resources	14.8%	0.0%	6.9%
Discuss it directly with the person (CORRECT)	85.2%	96.6%	93.1%
Call in significant others in the persons life	0.0%	0.0%	0.0%
Encourage the person to talk about the positive aspects of his or her life	0.0%	3.4%	0.0%
Low intent attempts or gestures...			
Should be ignored	0.0%	0.0%	3.4%
Require a suicide intervention (CORRECT)	96.4%	100.0%	89.7%
Should be actively punished	0.0%	0.0%	0.0%
Are not a cause for concern	3.4%	0.0%	6.9%
If a person's words and/or behavior suggest the possibility of suicide, a helper should...			
Gather more information about what is bothering the person	21.4%	6.9%	3.4%
Inquire about the support available from family and friends	7.1%	0.0%	0.0%
Determine if substance abuse is a factor	0.0%	0.0%	0.0%
Ask if the person is thinking of suicide (CORRECT)	71.4%	93.1%	96.6%
If someone admits to feeling suicidal, a helper should...			
Calmly inquire about what is happening in their life	23.1%	3.4%	17.2%
Find out if they've thought of how they would do it (CORRECT)	53.8%	96.6%	75.9%
Inform significant others	3.8%	0.0%	0.0%
Arrange for immediate referral	19.2%	0.0%	6.9%
Key tasks in the first phase of Suicide Intervention are...			
Inquiry and identification	29.6%	20.7%	34.5%
Engagement and identification (CORRECT)	29.6%	62.1%	31.0%
Assessment and inquiry	37.0%	13.8%	27.6%
Contracting and implementation	3.7%	3.4%	6.9%
Which of the following action plans would likely be most suitable for someone at risk of suicide...			
No-harm agreement and referral for therapy	30.8%	27.6%	17.2%
No-harm agreement and follow-up meeting confirmed (CORRECT)	61.5%	69.0%	75.9%
Agreement to call a crisis line if troubled again with thoughts of suicide	7.7%	3.4%	3.4%
Agreement to talk with a significant other the next day	0.0%	0.0%	3.4%

APPENDIX G

KNOWLEDGE OF SUICIDE ASSESSMENT: POST VS. 9-12M FOLLOW-UP

	Post	9-12M Follow-up
Suicide is most likely a result of...		
Overwhelming stress	13.8%	13.8%
Clinical depression	10.3%	3.4%
Substance abuse	0.0%	0.0%
No single cause (CORRECT)	75.9%	82.8%
Suicide plans are assessed on the basis of a person's...		
Degree of preparation (CORRECT)	72.4%	64.3%
Age of person	0.0%	0.0%
Stated seriousness	24.1%	21.4%
Apparent distress	3.4%	14.3%
People who express suicidal intentions...		
Clearly want to die	3.4%	6.9%
Are ambivalent about dying (CORRECT)	96.6%	89.7%
Want to punish others	0.0%	3.4%
Are manipulating	0.0%	0.0%
Provides the most important information in assessing the risk of suicide...		
Symptoms	27.6%	42.9%
Stress	6.9%	10.7%
Resources (CORRECT)	62.1%	46.4%
Physical health	3.4%	0.0%
Generally determines if behavior is suicidal...		
The mood of the person	3.4%	0.0%
The intent of the person (CORRECT)	62.1%	44.4%
The lethality of the method used	10.3%	14.8%
The history of prior behavior	24.1%	40.7%
Provides the least important information in assessing the risk of suicide		
Symptoms	21.4%	20.7%
Stress (CORRECT)	46.4%	41.4%
Resources	10.7%	24.1%
Mental health	21.4%	13.8%

APPENDIX H

PRIOR EXPERIENCE WITH SUICIDAL YOUTH: BASELINE VS. 9-12M FOLLOW-UP

	Baseline	9-12M Follow-up
Number of young people who showed signs of being suicidal that you had contact with		
None	62.1%	79.3%
One or less	17.2%	3.4%
Two-four	17.3%	17.1%
Four or more	3.4%	0.0%
Did you talk to them about your concerns for their well-being?		
Yes	31.0%	17.2%
No	3.4%	0.0%
Indirectly	0.0%	3.4%
Had no contact	62.1%	79.3%
Did you ask them if they were thinking about harming themselves or attempting suicide?		
Yes	34.5%	13.8%
No	6.9%	3.4%
Indirectly	0.0%	3.4%
Had no contact	62.1%	79.3%
Did you talk with them about where they could get help?		
Yes	24.1%	20.7%
No	10.3%	0.0%
Indirectly	3.4%	0.0%
Had no contact	62.1%	79.3%