



---

# YOUTH SUICIDE PREVENTION PROGRAM

---

## *ANNUAL EVALUATION REPORT 2001-2002*

### *EVALUATION OF PROGRAM TRAINING WORKSHOPS*

*Prepared for*

*The Youth Suicide Prevention Program*

*July 2002*

---

*Prepared by*

*Organizational Research Services  
Seattle, Washington*

# TABLE OF CONTENTS

## **Executive Summary**

Introduction.....	1
Methodology.....	2
Methods of Analysis .....	2
Conclusions/Recommendations.....	3

## **Section 1: Baseline vs. Post Comparison**

Demographics .....	5
Experience with Suicidal Youth (gathered at Baseline).....	6
Levels of Comfort, Competence and Confidence.....	7
General Knowledge of Suicide Issues .....	8
Beliefs About Suicide .....	9
Knowledge of Suicide Prevention and Intervention .....	10
Knowledge of Suicide Assessment.....	13

## **Section 2: Baseline /Post/Follow-up Comparison**

Demographics .....	15
Levels of Comfort,, Competence and Confidence.....	16
General Knowledge of Suicide Issues .....	17
Beliefs About Suicide .....	18
Knowledge of Suicide Prevention and Intervention .....	19
Knowledge of Suicide Assessment.....	21
Experience with Suicidal Youth .....	22

## **Appendices**

APPENDIX A: Training Workshop Surveys; Baseline, Post and Follow-up	
APPENDIX B: Knowledge of Suicide Prevention and Intervention: Baseline vs. Post	
APPENDIX C: Knowledge of Suicide Prevention and intervention: Baseline vs. Post vs. Follow-up	
APPENDIX D: Knowledge of Suicide Assessment: Post vs Follow-up	
APPENDIX E: Prior Experience With Suicidal Youth – Baseline vs. Follow-up	

# Table of Tables

TABLE 1.1:	Workshop Location.....	5
TABLE 1.2:	Gender .....	5
TABLE 1.3:	Age.....	5
TABLE 1.4:	Race/Ethnicity.....	5
TABLE 1.5:	Number of Contacts With Suicidal Youth in Last Month .....	6
TABLE 1.6:	Level Of Comfort, Competence and Confidence In Helping Suicidal Youth.....	7
TABLE 1.7:	Level of Knowledge About General Suicide Facts, Signs and Resources .....	8
TABLE 1.8:	Level of Agreement With General Statements About Suicide .....	9
TABLE 1.9:	Knowledge of Suicide Prevention and Intervention .....	11
TABLE 1.10:	Knowledge of Suicide Prevention and Intervention .....	12
TABLE 1.11:	Estimation of Level of Suicide Risk .....	13
TABLE 1.12:	Suicide is Most Likely the Result of.....	13
TABLE 1.13:	Suicide Plans Are Assessed on the Basis of a Person’s.....	14
TABLE 1.14:	People Who Express Suicidal Intentions .....	14
TABLE 1.15:	Which Provides the Most Important Information in Assessing the Risk of Suicide .....	14
TABLE 1.16:	What Generally Determines if Behavior is Suicidal.....	14
TABLE 1.17:	Which Provides the Least Important Information in Assessing the Risk of Suicide .....	14
TABLE 2.1:	Gender.....	15
TABLE 2.2:	Ethnicity .....	15
TABLE 2.3:	Age.....	15
TABLE 2.4:	Level of Comfort, Competence and Confidence in Helping Suicidal Youth – Three Time Points.....	16
TABLE 2.5:	Level of Knowledge About General Suicide Facts, Signs and Resources – Three Time Points.....	17
TABLE 2.6:	Level of Agreement With General Statements About Suicide – Three Time Points .....	18
TABLE 2.7:	Knowledge of Suicide Prevention and Intervention – Three Time Points .....	19
TABLE 2.8:	Knowledge of Suicide Prevention and Intervention – Multiple Choice Items – Three Time Points.....	20
TABLE 2.9:	Level of Knowledge About Suicide Assessment – Multiple Choice Items.....	21
TABLE 2.10:	Number of Contacts With Suicidal youth – Baseline vs. Follow-up.....	22
TABLE 2.11:	Have Connected Suicidal Youth to the Following Resources .....	22

# **EXECUTIVE SUMMARY**

---

***2001-2002 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 and sponsors three different types of suicide prevention training workshops – 2-day Living Works ASIST trainings, 1-hour QPR training sessions, and 1-hour PTA Partnership training sessions. 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. We found that over the project year there were very few QPR and PTA training sessions. Thus, the data in this report only reflect an evaluation of the Living Works ASIST training workshops.

# 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 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. We received Follow-up contact information from 104 participants.

The Follow-up Survey was sent to the 104 participants approximately three months after participation. Incentives were provided to ensure a high response rate. We allowed participants two weeks to return the survey. After that time, up to three phone calls were made to each participant who had not returned their survey. Three weeks after the deadline, the Follow-up phone calls ceased as all means of contact had been exhausted.

A total of 179 surveys were completed; 148 completed Baseline and Post data; 39 completed Baseline-Post-Follow-up data. Examples of each of the survey instruments are presented in *Appendix A*.

## METHODS OF ANALYSIS

There were two primary analyses in this study. We first examined the change over time in knowledge and beliefs between in the Baseline and Post assessments, i.e., over the course of the two-day workshop. We gathered Baseline and Post data from 148 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 39 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.

# CONCLUSIONS/RECOMMENDATIONS

- ◇ **The results demonstrate the strong positive impact of workshops and training on knowledge of suicide issues, prevention, intervention and assessment.** We observe many instances of significant increases over time in knowledge among participants. Moreover, the analysis at three time points indicates that the knowledge gains demonstrated at the Post workshop persist three months later.
- ◇ **There is evidence that the gains over time are more substantial among those participants with less experience with suicide.** A comparison of changes from Baseline to Post suggested that knowledge increased more dramatically among those with zero or one contact with a suicidal youth prior to the workshop. We particularly observe such increases in the measures of competence, confidence, and comfort. This suggests that the workshop is geared more towards informing and supporting those who are less familiar with suicide as an issue and a practice. The program should continue to explore whether other types of outcomes may be more appropriate among those with greater experience prior to the workshop.
- ◇ **Participants in the workshops report enhanced knowledge of suicide prevention, intervention and assessment skills.** The respondents are more likely to have correctly answered a set of multiple-choice questions about prevention, intervention and assessment from Baseline to Post, and these levels of knowledge remain high at Follow-up. We do find, though, there is still fair amount of uncertainty about the factors that provide the “most or least information in assessing the risk of suicide”, and we find that the common response to the question “if someone admits to feeling suicidal, a helper should...” is inconsistent with the expected response of *calmly inquire about what is happening in their life*.
- ◇ **The data indicate that participants continue to have contact with suicidal youth after the workshop.** Over 35 percent 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.
- ◇ **Future questions for examination through continued evaluation:**
  - ◆ Can we start to make any comparisons between the unique impacts of different forms of suicide prevention training?
  - ◆ Is the current survey tool providing enough information for the program about the impacts of training on knowledge, skills and ability?
  - ◆ What are the true long-term effects of the training and how can the program best measure these impacts?
  - ◆ Are the participants turning this knowledge gain into practice, and if so, how can this be measured and documented?

# **SECTION 1**

## **BASELINE vs. POST COMPARISON**

---

*2001-2002 ANNUAL REPORT*

*EVALUATION OF PROGRAM TRAINING WORKSHOP*

# DEMOGRAPHICS

The demographic characteristics of the 148 individuals in the paired sample are presented in **TABLES 1.1 – 1.4**. We find that this sample is overwhelmingly female (81.0%) and a high percentage of participants are Caucasian. About half the individuals participated in one of three Highline workshops.

**TABLE 1.1: Workshop Location**

LOCATION	N	Percent
Highline (3 sessions)	74	50.0%
ESD 112	26	17.6%
Portland	8	5.4%
Jamestown	26	17.6%
Tacoma	14	9.5%

**TABLE 1.2: Gender (n=147)**

	N	Percent
Female	119	81.0%
Male	28	19.0%

**TABLE 1.3: Age**

	N	Percent
< 35	75	51.4%
35-49	45	30.8%
50+	26	17.8%

**TABLE 1.4: Race/Ethnicity**

	N	Percent
Caucasian	114	77.6%
African American	7	4.8%
Latino	6	4.1%
Asian/PI	6	4.1%
Native American	5	3.4%
Other Ethnicity	9	6.0%

# 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. This measure further served as proxy for an individual's experience with suicidal youth, and was used throughout the analysis to compare subgroups of the population.

- ◆ Over 46 percent (67 individuals) of the participants reported they had at least one contact with a suicidal youth in the last month. Almost 21 percent had more than one contact. The average number of contacts in the sample is 0.97. (see **TABLE 1.5**)
  - ◆ Sixty-four of 67 individuals (95.5 percent) *talked or indirectly talked* with them about concerns for their well-being
  - ◆ Fifty-five of the 67 individuals (82.1 percent) *asked or indirectly asked* if they were thinking of harming themselves or attempting suicide
  - ◆ Fifty-five of the 67 individuals (82.1 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**

	<b>N</b>	<b>Percent</b>
None	78	53.8%
One	37	25.5%
Two or More	30	20.7%

# 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 4.14
- ♦ Increase in level of **competence** from 2.97 to 4.10
- ♦ Increase in level of **confidence** from 3.84 to 4.48

We hypothesized that the patterns of change over time might vary with different levels of prior contact with suicidal youth at Baseline. We found that while the increases in the overall sample are consistent for individuals with zero or one contact with a suicidal youth, there is slight variation among those with two or more contacts

- ♦ Specifically, we observe a non-significant change in the level of comfort among those who reported multiple contacts with suicidal youth at Baseline (4.13 to 4.47). We should note that the level of comfort starts high in this subgroup, suggesting that they have less room for improvement over time.

**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?	148	3.61	4.14	*
How competent would you feel helping a suicidal person?	148	2.97	4.10	*
How confident that you would try to help this suicidal person?	147	3.84	4.48	*

\* 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*.
  - ♦ We observe similar patterns of increase over time among those with varying levels of prior contact with suicidal youth.
- ♦ There is a slight increase in the participants' knowledge of suicide warning signs. This is, in part, because even at Baseline, the participants were able to identify, on average, 2.33 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	148	2.58	4.26	*
Suicide warning signs	148	3.09	4.49	*
How to ask someone about suicide	148	2.97	4.68	*
How to get help for someone who may be suicidal?	147	3.17	4.48	*
Information about local resources	148	2.81	4.38	*
# of Suicide warning signs known (3 maximum)	144	2.33	2.43	

\* 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**)

- ♦ The participants strongly agree, even at Baseline, that “the problem of youth suicide should be addressed in my community” and “suicide is preventable in the majority of situations.” We observe little change in these beliefs from Baseline to Post.
- ♦ There is, though, a significant increase in the third item, “suicide among young people is a major issue in my community.” This average increases from 3.65 to 4.03, and suggests that the training is raising the awareness about the issue of youth suicide for participants.
  - ♦ This perception increases among those with varying levels of prior contact with suicidal youth. In other words, we do not observe more dramatic increases among those with less prior experience with suicidal youth.

**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	147	3.65	4.03	*
The problem of youth suicide should be addressed in my community	147	4.35	4.48	
Suicide is preventable in the majority of situations	147	4.13	4.24	

\* 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 less likely to agree that it is “harmful for a helper to engage in open communication when dealing with someone at risk of suicide.” (1.93 vs. 1.37).
- ♦ Participants are significantly more likely to agree that they “would raise the question of suicide if someone was showing signs.” (4.09 vs. 4.78)
- ♦ Participants are significantly more likely to agree that they “would encourage a youth at risk of suicide to talk about their wish to die.” (3.71 vs. 4.46)
- ♦ We also observed some interesting patterns among participants with varying levels of contact with suicidal youth.
  - ♦ Participants with no prior contact with suicidal youth are significantly more likely to agree that “if someone I knew told me they were thinking of suicide, I would want to get more information about their plan.” (4.09 vs. 4.82). In contrast, there is very little change over time on this knowledge item among those with multiple prior contacts.
  - ♦ There is no change in the level of agreement with the statement it is “harmful for a helper to engage in open communication when dealing with someone at risk of suicide” among individuals with multiple prior contacts. As noted earlier, this knowledge item significantly increases in the overall sample.

**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	148	4.41	4.79	
It is harmful for a helper to engage in open communication when dealing with someone at risk of suicide	147	1.93	1.37	*
If someone I knew was showing suggesting signs of suicide, I would raise the question of suicide with them	148	4.09	4.78	*
If someone I knew was at risk of suicide, I would encourage them to talk about their wish to die	147	3.71	4.46	*

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

SCALE: 1 – strongly disagree, 5 – strongly agree

The multiple-choice items were using 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 percent 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”, and “If a person’s words and/or behavior suggest the possibility of suicide, a helper should...”
  - ♦ We find dramatic and significant increases in the percent that responded correctly to the following items: “Key tasks in the first phase of Suicide Intervention are...” (23.6% vs. 64.3%), and “Which of the following action plans would likely be most suitable for someone at the risk of suicide” (43.5% vs. 62.3%).
- ♦ There is a significant decrease in the percentage that respond correctly to the following question “If someone admits to feeling suicidal, a helper should...” (37.0% vs. 4.3%) We, in fact, find that the majority of participants report that the correct response to this item at Post is *find out if they’ve thought of how they would do it*. This finding suggests the possibility that the message conveyed in the training workshops is distinctly different from the message that is perceived by the professional community to be correct (i.e., *calmly inquire about what is happening in their life*). A second possibility is that the wording of the question is inadvertently leading the respondents to a particular answer. In either case, the program should further explore what it is trying to convey in terms of the role of the helper in this situation.

- ◆ There are some variations in patterns of knowledge gain among those with different levels of prior contact with suicidal youth.
  - ◆ Among those with no prior contact, the percent that correctly respond to the following item “Which of the following action plans would likely be most suitable for someone at the risk of suicide” increases from 44.7 to 55.3%. However, this is not a statistically significant improvement from Baseline to Post.
  - ◆ Among those with multiple prior contacts, there is no change in the percent that correctly respond to the following item “if a person’s words and/or behavior suggest the possibility of suicide, a helper should...”. We should note that at Baseline this percentage is already quite high (85.2% correct).

**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>	143	58.7%	95.8%	*
Low intent attempts or gesture	<i>Require a suicide intervention</i>	143	95.8%	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>	138	65.2%	92.8%	*
If someone admits to feeling suicidal, a helper should	<i>Calmly inquire about what is happening in their life</i>	138	37.0%	4.3%	*
Key tasks in the first phase of Suicide Intervention are	<i>Engagement and identification</i>	140	23.6%	64.3%	*
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>	138	43.5%	62.3%	*

\* 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. 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.

- ♦ 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. Almost 86 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?” Only 47.1 percent correctly reported *the intent of the person*. Almost 1/3 of the respondents felt that the correct answer was *the history of prior behavior*.
  - ♦ “Which provides the most important information in assessing the risk of suicide?” Over 56 percent correctly responded *resources*, but an additional 36.3 percent believed the correct answer was *symptoms*.
  - ♦ “Which provides the least important information in assessing the risk of suicide?” Only 28.9 percent correctly responded *stress*. In fact, the distribution of responses across the four possible choices is even, and 27 percent responded *resources*; we know from the previous question that resources are in fact the most important piece of information.

**TABLE 1.11: Estimation of Level of Suicide Risk**

	N	Percent
High	134	85.9%
Moderate	19	12.2%
No-Risk	3	1.9%

**TABLE 1.12: Suicide is Most Likely the Result of**

	N	Percent
Overwhelming Stress	17	10.8%
Clinical Depression	8	5.1%
Substance Abuse	0	0.0%
No Single Cause ( <i>correct</i> )	133	84.2%

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

	N	Percent
Degree of Preparation ( <i>correct</i> )	99	63.9%
Age of Person	1	0.6%
Stated Seriousness	43	27.7%
Apparent Distress	12	7.7%

**TABLE 1.14: People Who Express Suicidal Intentions**

	N	Percent
Clearly want to die	11	7.0%
Are ambivalent about dying ( <i>correct</i> )	147	93.0%
Want to punish others	0	0.0%
Are manipulating	0	0.0%

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

	N	Percent
Symptoms	57	36.3%
Stress	11	7.0%
Resources ( <i>correct</i> )	88	56.1%
Physical Health	1	0.6%

**TABLE 1.16: What Generally Determines if Behavior is Suicidal**

	N	Percent
The mood of the person	14	9.0%
The intent of the person ( <i>correct</i> )	73	47.1%
The lethality of the method used	17	11.0%
The history of prior behavior	51	32.9%

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

	N	Percent
Symptoms	31	20.4%
Stress ( <i>correct</i> )	44	28.9%
Resources	41	27.0%
Mental Health	36	23.7%

## **SECTION 2**

### **BASELINE/POST/FOLLOW-UP COMPARISON**

---

***2001-2002 ANNUAL REPORT***

***EVALUATION OF PROGRAM TRAINING WORKSHOPS***

# DEMOGRAPHICS

The demographic characteristics of the 39 individuals with data at Baseline, Post, and Follow-up are presented in **TABLES 2.1-2.3**.

- ♦ Nearly 80 percent of respondents are female; almost 80 percent are Caucasian.
- ♦ The majority of respondents at Follow-up are less than 35 years old. It appears that the sample with three time points of data is slightly younger than the overall sample. Over 64 percent of these respondents are less than 35 years old. In contrast, only 51 percent of those in the Baseline-Post comparison were less than 35 years old.

**TABLE 2.1: Gender**

	<b>N</b>	<b>Percent of cases</b>
Male	8	20.5%
Female	31	79.5%

**TABLE 2.2: Ethnicity**

	<b>N</b>	<b>Percent of cases</b>
Caucasian	31	79.5%
Latino/Hispanic	3	7.7%
Mixed ethnicity	2	5.1%
African-American	1	2.6%
Pacific Islander	1	2.6%
Other	1	2.6%

**TABLE 2.3: Age**

	<b>N</b>	<b>Percent of cases</b>
< 35	25	64.1%
35-49	8	20.5%
50+	6	15.4%

# 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 3.00 to 4.28.
- ♦ We observe no significant changes from Post to Follow-up in the participants’ level of comfort, competence and confidence. This data suggest that participants demonstrate an improvement of the course of the workshop that persists three months after the intervention.

**TABLE 2.4: Level of Comfort, Competence and Confidence in Helping Suicidal Youth – Three Time Points**

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?	39	3.59	4.18	4.21	*	
How competent would you feel helping a suicidal person?	39	3.00	4.10	4.28	*	
How confident that you would try to help this suicidal person?	39	3.92	4.56	4.67	*	

\*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 participant's general knowledge of suicide preventative measures.
- ◊ For the most part the levels of general knowledge remain high at the three-month Follow-up period. We, in fact, even notice a slight increase from Post to Follow-up in the respondents' perceived knowledge of facts about suicide prevention. (4.28 to 4.56)

**TABLE 2.5: Level of Knowledge About General Suicide Facts, Signs and Resources – Three Time Points**

Knowledge of	N	Baseline Average	Post Average	Follow-up Average	P Baseline vs. Follow-up	P Post vs. Follow-up
Facts about suicide prevention	39	2.69	4.28	4.56	*	
Suicide warning signs	39	3.13	4.49	4.46	*	
How to ask someone about suicide	39	3.03	4.67	4.74	*	
How to get help for someone who may be suicidal?	39	3.08	4.49	4.49	*	
Information about local resources	39	2.64	4.21	4.08	*	

\*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**)

- ♦ The most interesting finding is the pattern of agreement with the belief that suicide is a major issue in the community. While we observe an increase from Baseline to Post in this sample, this level of agreement significantly declines from Post to Follow-up, from 4.21 to 3.83.
- ♦ On the other two questions, there are consistently high levels of agreement at all three time points.

**TABLE 2.6: Level of Agreement With General Statements About Suicide – Three Time Points**

	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	39	3.64	4.21	3.83		*
The problem of youth suicide should be addressed in my community	39	4.31	4.46	4.31		*
Suicide is preventable in the majority of situations	39	4.31	4.44	4.46		

\*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 using to gauge the participants understanding of proper responses in different situations where there is a possibility for a suicide intervention. (see TABLES 2.7-2.8) In particular, we find:

- ♦ In general, the improvements demonstrated from Baseline to Post persist at three-month Follow-up assessment. In particular we find that the dramatic increases in “raising the question of suicide” and “encouraging them to talk about their wish to die”, and the decline in the perceived harm of “engaging in open communication” persist when we examine the data three months after the intervention.
- ♦ Similarly, in most instances the percentage who correctly answer different items about suicide prevention and intervention remains high after three-months. In fact, we observe consistent knowledge gains with respect to knowledge of “action plans most suitable for someone at risk of suicide” from 48.7 percent to 53.8 percent to 64.1 percent at Follow-up.

**TABLE 2.7: Knowledge of Suicide Prevention and Intervention – Three Time Points**

	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	39	4.41	4.87	4.83	*	
It is harmful for a helper to engage in open communication when dealing with someone at risk of suicide	39	1.92	1.13	1.29	*	*
If someone I knew was showing suggesting signs of suicide, I would raise the question of suicide with them	39	4.03	4.87	4.82	*	
If someone I knew was at risk of suicide, I would encourage them to talk about their wish to die	39	3.62	4.38	4.26	*	

\*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 – Three Time Points**

	<b>Correct Answer</b>	<b>Baseline % Correct</b>	<b>Post % Correct</b>	<b>Follow- up % Correct</b>	<b>P Baseline vs. Follow- up</b>	<b>P Post vs. Follow- up</b>
When confronted with the possibility of suicidal behavior in a person, a caregiver should immediately...	<i>Discuss it directly with the person</i>	61.5%	94.9%	94.9%	*	
Low intent attempts or gestures...	<i>Require a suicide intervention</i>	97.4%	100.0%	100.0%		
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>	59.0%	97.4%	100.0%	*	
If someone admits to feeling suicidal, a helper should...	<i>Calmly inquire about what is happening in their life</i>	30.8%	0.0%	10.3	*	
Key tasks in the first phase of Suicide Intervention are	<i>Engagement and identification</i>	25.6%	51.3%	55.3%	*	
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>	48.7%	53.8%	64.1%	*	

\*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 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...”.
- ♦ We do find slight, but not significant declines in knowledge about the “most important information in assessing the risk of suicide”, and “what generally determines if behavior is suicidal.”
- ♦ There is a slight increase from 29.7 to 35.9 percent in correct response to the question about the “least important information in assessing the risk of suicide.” We should note, though, that the percent correct, relative to the other items, continues to remain low.

**TABLE 2.9: Level of Knowledge About Suicide Assessment – Multiple Choice Items**

	<b>Correct Answer</b>	<b>Post % Correct</b>	<b>Follow-up % Correct</b>	<b>P Post vs. Follow-up</b>
Suicide is most likely a result of...	<i>No single cause</i>	84.6%	89.7%	
Suicide plans are assessed on the basis of a person’s...	<i>Degree of preparation</i>	69.2%	64.1%	
People who express suicidal intentions...	<i>Are ambivalent about dying</i>	94.9%	87.2%	
Which provides the most important information in assessing the risk of suicide...	<i>Resources</i>	64.1%	59.0%	
Generally determines if behavior is suicidal...	<i>The intent of the person</i>	46.2%	35.9%	
Which provides the least important information in assessing the risk of suicide...	<i>Stress</i>	29.7%	35.9%	

\*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 experience with suicidal youth. In the full sample at Baseline, we found that 46 percent of the participants reported at least one contact in the prior month. Among those at the Follow-up, 35.1 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:

- ◇ Among those with data at both time points, 43.2 percent reported experience at Baseline, but only 35.1 percent reported any experience at the Follow-up.
- ◇ As expected, those with greater experience at Baseline reported greater contact at Follow-up. For example, 80 percent of those with multiple contacts prior to Baseline reported some contact at the Follow-up assessment.
- ◇ Almost 43 percent reported connecting a suicidal youth to a resource. The most common resources include Family and Mental Health Agency or Provider. (see **TABLE 2.11**)

**TABLE 2.10: Number of Contacts With Suicidal Youth – Baseline vs. Follow-up**

# of contacts at Baseline	N	% of those with 1+ contacts at Follow-up
0	21	23.8%
1	11	36.4%
2+	5	80.0%
<i>OVERALL</i>	37	35.1%

**TABLE 2.11: Have Connected Suicidal Youth to the Following Resources**

	N	Percent of cases
Crisis Line	6	15.0%
Hospital or Medical Provider	3	7.5%
Mental Health Agency or Provider	8	20.0%
Family	11	27.5%
Friends	6	15.0%
Other	3	7.5%
Had no contact	23	57.5%

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

## **APPENDIX A**

---

### ***TRAINING WORKSHOP SURVEYS: BASELINE, POST AND FOLLOW-UP***



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
a) How <b>COMFORTABLE</b> would you feel helping this suicidal person? .....	1	2	3	4	5
b) Considering your current knowledge and skills, how <b>COMPETENT</b> would you feel helping this suicidal person? .....	1	2	3	4	5
c) Overall, how <b>CONFIDENT</b> 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
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 .....	▼	▼	▼	▼	▼
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 .....	▼	▼	▼	▼	▼
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 persons:**

- 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 4 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 x 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 <b>COMFORTABLE</b> would you feel helping this suicidal person? .....	1	2	3	4	5
b) Considering your current knowledge and skills, how <b>COMPETENT</b> would you feel helping this suicidal person? .....	1	2	3	4	5
c) Overall, how <b>CONFIDENT</b> 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 .....	▼	▼	▼	▼	▼
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
<b>Symptoms</b>	Somewhat down, hard time getting to sleep, no appetite for the past 2 weeks
<i>Prior Suicidal Behavior</i> .....	Drug overdose two years ago
<b>Age</b>	17 years
<b>Current Suicide Plan</b>	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***

<b>Question</b>	<b>Baseline</b>	<b>Post</b>
<b>When confronted with the possibility of suicidal behavior in a person, a caregiver should immediately</b>		
Refer the person to experienced suicide resources	25.2%	1.4%
Discuss it directly with the person (CORRECT)	58.7%	95.8%
Call in significant others	3.5%	0.7%
Encourage the person to talk about the positive aspects of life	12.6%	2.1%
<b>Low intent attempts or gestures</b>		
Should be ignored	0.0%	0.0%
Require suicide intervention (CORRECT)	95.8%	97.2%
Should be actively punished	0.0%	0.0%
Are not a cause for concern	4.2%	2.8%
<b>If a person's words and/or behavior suggest the possibility of suicide, a helper should</b>		
Gather more information about what is bothering the person	26.1%	6.5%
Inquire about the support available from family and friends	8.7%	0.7%
Determined if substance abuse is a factor	0.0%	0.0%
Ask if the person is thinking of suicide (CORRECT)	65.2%	92.8%
<b>If someone admits to feeling suicidal, a helper should</b>		
Calmly inquire about what is happening their life (CORRECT)	37.0%	4.3%
Find out if they've thought of how they would do it	43.5%	94.9%
Inform significant others	2.2%	0.0%
Arrange for immediate referral	17.4%	0.7%
<b>Key tasks in the first phase of suicide intervention are</b>		
Inquiry and identification	39.3%	23.6%
Engagement and identification (CORRECT)	23.6%	64.3%
Assessment and inquiry	32.9%	11.4%
Contracting and implementation	4.3%	0.7%
<b>Which of the following action plans would likely be most suitable for someone at risk of suicide</b>		
No-harm agreement and referral for therapy	35.5%	31.2%
No-harm agreement and Follow-up meeting confirmed (CORRECT)	43.5%	62.3%
Agreement to call a crisis line if trouble again with suicide thoughts	18.1%	5.1%
Agreement to talk with significant other the next day	2.9%	1.4%

## **APPENDIX C**

---

### ***KNOWLEDGE OF SUICIDE PREVENTION AND INTERVENTION:BASELINE VS. POST VS. FOLLOW-UP***

	Baseline	Post	Follow-up
<b>When confronted with possibility of suicidal behavior, a caregiver should...</b>			
Refer the person to experienced suicide resources	24.3%	2.6%	2.6%
Discuss it directly with the person (CORRECT)	65.0%	94.9%	94.9%
Call in significant others in the persons life	2.6%	0.0%	2.6%
Encourage the person to talk about the positive aspects of his or her life	7.7%	2.6%	0.0%
<b>Low intent attempts or gestures...</b>			
Should be ignored	0.0%	0.0%	0.0%
Require a suicide intervention (CORRECT)	97.4%	100.0%	100.0%
Should be actively punished	0.0%	0.0%	0.0%
Are not a cause for concern	0.0%	0.0%	0.0%
<b>If a person's words and/or behavior suggest the possibility of suicide, a helper should...</b>			
Gather more information about what is bothering the person	26.3%	2.6%	0.0%
Inquire about the support available from family and friends	13.2%	0.0%	0.0%
Determine if substance abuse is a factor (CORRECT)	0.0%	0.0%	0.0%
Ask if the person is thinking of suicide	59.0%	97.4%	100.0%
<b>If someone admits to feeling suicidal, a helper should...</b>			
Calmly inquire about what is happening in their life (CORRECT)	33.3%	0.0%	10.3%
Find out if they've thought of how they would do it	44.4%	100.0%	87.2%
Inform significant others	5.6%	0.0%	0.0%
Arrange for immediate referral	16.7%	0.0%	2.6%
<b>Key tasks in the first phase of Suicide Intervention are...</b>			
Inquiry and identification	38.9%	33.3%	35.9%
Engagement and identification (CORRECT)	27.8%	51.3%	55.3%
Assessment and inquiry	30.6%	12.8%	5.3%
Contracting and implementation	2.6%	2.6%	2.6%
<b>Which of the following action plans would likely be most suitable for someone at risk of suicide...</b>			
No-harm agreement and referral for therapy	33.3%	41.0%	30.8%
No-harm agreement and follow-up meeting confirmed (CORRECT)	52.8%	53.8%	64.1%
Agreement to call a crisis line if troubled again with thoughts of suicide	8.3%	5.1%	5.1%
Agreement to talk with a significant other the next day	5.6%	0.0%	0.0%

## **APPENDIX D**

---

### ***KNOWLEDGE OF SUICIDE ASSESSMENT: POST VS. FOLLOW-UP***

	Post	Follow-up
<b>Suicide is most likely a result of...</b>		
Overwhelming stress	10.3%	0.0%
Clinical depression	5.1%	10.3%
Substance abuse	0.0%	89.7%
No single cause (CORRECT)	84.6%	0.0%
<b>Suicide plans are assessed on the basis of a person's...</b>		
Degree of preparation (CORRECT)	69.2%	64.1%
Age of person	0.0%	0.0%
Stated seriousness	28.2%	25.6%
Apparent distress	2.6%	10.3%
<b>People who express suicidal intentions...</b>		
Clearly want to die	5.1%	12.8%
Are ambivalent about dying (CORRECT)	94.9%	87.2%
Want to punish others	0.0%	0.0%
Are manipulating	0.0%	0.0%
<b>Provides the most important information in assessing the risk of suicide...</b>		
Symptoms	30.8%	28.2%
Stress	2.6%	12.8%
Resources (CORRECT)	64.1%	59.0%
Physical health	2.6%	0.0%
<b>Generally determines if behavior is suicidal...</b>		
The mood of the person	5.1%	0.0%
The intent of the person (CORRECT)	46.2%	35.9%
The lethality of the method used	12.8%	10.3%
The history of prior behavior	35.9%	53.8%
<b>Provides the least important information in assessing the risk of suicide</b>		
Symptoms	18.9%	12.8%
Stress (CORRECT)	29.7%	35.9%
Resources	21.6%	28.2%
Mental health	29.7%	23.1%

## **APPENDIX E**

---

### ***PRIOR EXPERIENCE WITH SUICIDAL YOUTH: BASELINE VS. FOLLOW-UP***

	<b>Baseline</b>	<b>Follow-up</b>
<b>Number of young people who showed signs of being suicidal that you had contact with</b>		
None	52.4%	65.0%
One or less	26.8%	12.5%
Two-four	18.3%	22.5%
Four or more	2.3%	0.0%
<b>Did you talk to them about your concerns for their well-being?</b>		
Yes	37.8%	30.0%
No	1.2%	0.0%
Indirectly	8.0%	5.0%
Had no contact	52.4%	65.0%
<b>Did you ask them if they were thinking about harming themselves or attempting suicide?</b>		
Yes	32.3%	27.5%
No	8.5%	0.0%
Indirectly	6.7%	7.5%
Had no contact	52.4%	65.0%
<b>Did you talk with them about where they could get help?</b>		
Yes	30.5%	32.5%
No	7.9%	2.5%
Indirectly	8.6%	0.0%
Had no contact	52.4%	65.0%