

Evaluation of the Alaska State Youth Suicide Prevention Project

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Evaluation of the Alaska State Youth Suicide Prevention Project

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CHAPTER 1: STATEMENT OF NEED FROM THE ORIGINAL GRANT PROPOSAL

The population of focus for the Alaska Youth Suicide Prevention Project (AKYSPP) will be Alaska children and youth 10 to 25 years of age. Youth ages 15 to 24 continue to have significantly higher suicide rates than the U.S. population of the same age group and are second only to 25-29 year old age group, which is the highest risk age category in the state. The geographic area to be served will be statewide and will include current prevention and early intervention services grantees and treatment service providers who are currently under grant services agreements with the Department of Health and Social Services. These grantees and providers represent a broad cross section of the state and in particular communities that exhibit high rates of youth suicide and need for effective prevention strategies.

Approximately 130 suicides occur each year in Alaska. That represents one completed suicide every two to three days on average in a population of approximately 700,000 people. According to the 2000 U.S. census, White or Caucasians made up 69.3% of Alaska's population. Alaska Natives and American Indians made up 15.6%. Other minority groups including African American, Hispanic and Latinos and Asian Americans are close to being equally divided at approximately 4%. Alaska has over 216,000 children and youth under age 21. Over 92,000 youth are ages 12 to 20. About 24% of 12 to 24 year olds, almost 22,000 are Alaska Native¹. Alaska anticipates increases in the number of children because the state's largest age group continues to be ages 25-44. Alaska's population is proportionally younger than the rest of the United States. According to 2000 US Census reports, about one third (35%) of the state's population is under 21.

According to recent vital statistics reports, the rate of suicide in 2009 was 20.2 per 100,000, which equated to 140 suicide deaths.² Alaska has been consistently ranked as having the highest suicide rate in the country and is almost double the national average³. Youth suicide in Alaska is also significantly higher than the national average. According to the American Association of Suicidology, *U.S.A. suicide 2007: Official final data*, national suicide rates among 15 to 19 year olds were 9.7 per 100,000. In the Alaska Suicide Follow Back Study 2007 report, the average annual rate for this group, from 2004 – 2006, was 31.6 per 100,000, over three times the US rate. During the period between 2004 and 2006, there were 52 suicide deaths in this age group.

Alaska Natives who comprise 16% of the population account for 39 % of suicides. This ethnic disparity is even greater for Alaskan youth 19 and younger where, over the past 15 years, Alaska Natives accounted for 19% of the youth population and 60% of the suicide deaths in that age group. Alaska Native male teens have suicide rates of up to 72 per 100,000 and much

¹ US Census Bureau, Census 2000 American Indian/Alaska Native Summary, Matrices PCT3 and PCT4.

² Alaska Bureau of Vital Statistics, Suicide Rates, 2009

³ McIntosh, J. L., (2010). *U.S.A. suicide 2007: Official final data*. Washington, DC: American Association of Suicidology, dated May 23, 2010, downloaded from <http://www.suicidology.org>.

higher in Northwest Alaska. According to an unpublished regional health corporation report, suicide is the leading cause of death for 15- to 18-year-olds among Inupiat Eskimos. Young Inupiat in this age group who live in Alaska's northwestern region have a suicide rate of 190.33 per 100,000 (10 yr. average for 1990-2000) ⁴. When comparing Alaska suicide rates and numbers by region, rates are highest in the northwestern part of the state and lowest in the Aleutian Islands and southeast Alaska. Among Alaska Native ethnic groups, Inupiat and Eskimo populations have the highest rates and Aleuts have the lowest rates. Approximately half of all suicides occur in rural Alaska.

Alaska has traditionally targeted suicide prevention efforts in rural Alaska where high rates of suicide have been consistently recognized as a major health priority. Approximately half of suicides occur among the 171 rural villages in Alaska. There are 229 federally recognized tribes and twelve Alaska Native Health Corporations that provide services to Alaska Native and Native Americans who reside in rural and urban service areas. The Native populations in Alaska originate from seven distinct regions in which there are seven very diverse cultures with seven primary languages spoken to include: Inupiat, Yupik, Athabaskan, Cupik, Aleut, Alutiiq, Tlingit, Haida, and Tsimshian. Additionally, there are varying dialects of each primary language spoken.

The devastating effects of suicide along with the high rates of alcohol abuse, domestic violence, sexual abuse, and other problems compounded with lack of resources, access and availability of health related services only exacerbate the problem of suicide in rural Alaska. In addition, solutions that were generated from outside of rural Alaska were not effective due to non-Native itinerant providers who either knew little about the culture, language, subsistence lifestyle, and other customs and traditions of village life nor could immerse themselves long enough in the community to properly assess what is happening and develop strategies with realistic outcomes. Native leaders have long recognized the problem of suicide and have advocated for solutions to be developed at a local level.

Attitudes and beliefs about suicide provide the parameters for action and response within a community. Without this insight, suicide prevention strategies aimed at specific sub-groups are not likely to be effective. In order for meaningful change to occur in Alaskan Native villages, the problems must not be defined by professionals, but rather by the community. This understanding is crucial to developing effective prevention and intervention strategies. In a study of 382 community members in Northwest Alaska measuring adult and youth perceptions of suicide among Inupiat youth, "Respondents answers highlight the need for adults to talk to them about their everyday lives and their futures so that they receive the guidance and support they need to navigate difficulties that arise" ⁵. Whereas adults expressed the need for more formal programs and services, Inupiat youth expressed less desire for services and wanted adults to talk openly with them about their lives.

⁴ Maniilaq Injury Prevention data (1989-2002). Suicide Statistics for Northwest Alaska. Maniilaq Association; Unpublished data, 2003.

⁵ Wexler, L., 2006, Adult and youth community member's belief about youth suicide and its prevention, *International Journal of Circumpolar Health* 65:5.

Perceptions of community members' beliefs about suicide suggest that teens will often not seek out help from formal services. It also supports the notion that stigma associated with suicide and mental health are much stronger in small rural communities. Therefore, a multi-tiered effort is recommended to help bridge the gap between formal and informal suicide prevention strategies that can help support youth and direct services that provide both short term as well as long term treatment solutions that are developmentally appropriate, culturally competent and sustainable.

Other data available to help us understand and explain teen suicide in Alaska is the Youth Risk Behavior Survey⁶. A recently released report indicated that 8.5 % of high school students, grades 9-12, had attempted suicide in the previous 12 months. Most at risk were 10th grade girls who also had higher rates of suicidal ideation and symptoms associated with depression. In addition, only 2.6 % of those who attempted suicide received some form of treatment or emergency care. According to previous YRBS data, suicide attempt rate trends have been fairly stable, with the exception of girls 10-14 and 15-19 years of age which has significantly increased over the past several years and is representative of the national suicide trend among young girls⁷.

Alaska has less reliable data associated with other vulnerable groups that have been identified as having higher risk of suicide such as gay, lesbian and transgender youth. According to the *National Strategy for Suicide Prevention*, special populations include gay and lesbian youth and more attention is needed to provide safe and effective services⁸. Military service members and veterans are also a high-risk group and in 2008 accounted for 27 suicide deaths which represent about a 15% of total suicides for that year. Emerging national data are showing military veterans have suicide rates 7-8 times higher than the general population⁹. Other risk factors identified include youth with mental disorders, substance abuse, prior suicide attempt, sexual abuse, impulsive and aggressive behaviors, and youth having access to firearms. Further research and data collection specifically for these youth populations will help to support the need for suicide prevention in Alaska.

Over the past two to three years, Alaska has begun to build a stronger infrastructure for suicide prevention. Tribal efforts to address the high rates of Alaska Native youth suicide has increased, state prevention services have been expanded, Regional Suicide Prevention Teams have been developed and created, and gatekeeper trainings have been implemented throughout the state. Despite these efforts, suicides continue to occur and is yet to be determined if these efforts are making any impact on the population in any measurable way. Some performance

⁶ Alaska Department of Health and Social Services and the Alaska Department of Education and Early Development (2006). *Alaska Youth Risk Behavior Survey 2007*.

⁷ Center for Disease Control and Prevention, *CDC Shows Largest One Year Increase in Youth Suicide Rates in Past 15 years*. DHHS, Press Release, September 6th, 2007.

⁸ National Strategy for Suicide Prevention: Goals and Objectives for Action. *Special populations*.

⁹ Suicide Mortality Among Individuals Receiving Treatment for Depression in the VA Health System: Associations Patient Treatment Setting Characteristics *Am J Public Health*, Dec 2007; 97: 2193 - 2198.

measures show promise of addressing risk and or protective factors associated with suicide, however, increasing awareness, knowledge, and skills associated with reducing risk of suicide have yet to show a significant reduction rates from previous years with similar rates.

In January, 2010, the Department of Health and Social Services, Statewide Suicide Prevention Council (SSPC), held a suicide prevention summit, “Mending the Net: Suicide Prevention in Alaska”. At this summit, it was evident that the state was implementing efforts at multiple levels to combat suicide but is clearly not enough to reduce Alaska suicide rates. Commitments were made to increase collaboration and partnerships across the state. The Division of Behavioral Health is working in close partnership with the Statewide Suicide Prevention Council and the development of the Alaska Suicide Prevention Plan. The goals identified in the plan were developed in conjunction with the National Strategy for Suicide Prevention; Goals and Objectives.

The Alaska Suicide Prevention Plan is based on the strong belief that *everyone* has a role to play in suicide prevention and individuals and groups that address the physical, psychological, emotional and spiritual needs of individuals and communities must work together if we are to be effective. The main goal is clear: to reduce the incidence of suicide and the non-lethal behavior in Alaska. The heart of the plan is designed to stimulate community level discussions, planning and action. The plan incorporates a comprehensive approach, however, it is noted that there are a number of other critical issues that are necessary to address outside the scope of this plan such as advocacy for mental health parity, cultural competency, overall health and wellness as well as socio-economic development, education and transportation.

There are thirteen goals that are categorized by the three IOM prevention strategy classifications. The universal goals are aimed at educating the public that suicide is preventable, has broad based support, specific treatments may be required as part of Alaska’s health care system, eradication of stigma, a reduction in the means and access to firearms, and for the development of protective factors related to social and emotional growth, development and resiliency. Selective strategies include training and development of individuals and groups who interact with high risk populations to recognize warning signs and learn effective skills to appropriately respond and refer accordingly. Indicated strategies include the promotion of mental health services and behavioral health programs that are available and accessible to all Alaskans, the use of best practices and treatment approaches, support on-going continuum of care from identification to treatment, and for communities to respond appropriately to suicide attempts and suicide completions. The plan also indicates program evaluation and surveillance goals that support research, data collection, community planning, effectiveness of intervention strategies, and to monitor performance of suicide prevention programs and services.

The Alaska Suicide Prevention Plan was developed by the State Suicide Prevention Council. In 2001, the passage of SB 198 established the Alaska Suicide Prevention Council, determined Council membership, and established Council responsibilities as outlined in the Alaska Statutes (AS 44.29.350). The 16-member council (four members of the Legislature and 12 appointed by

governor) is charged with “advising the legislature and the governor with respect to what actions can and should be taken to: (1) improve health and wellness throughout the state by reducing suicide and its effect on individuals, families and communities; (2) broaden the public’s awareness of suicide and the risk factors related to suicide; (3) enhance suicide prevention services and programs throughout the state; (4) develop healthy communities through comprehensive collaborative community-based and faith-based approaches; (5) strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state; and (6) develop and implement a state suicide prevention plan. In 2004, the Alaska Suicide prevention Plan was introduced to the state of Alaska.

Need was based on historical data, interviews with Native elders, existing plans (*Healthy Alaskan’s 2010, In-Step: 2001-2006, the Comprehensive Integrated Mental Health Plan, the National Strategy for Suicide Prevention*)^{10 11}, plans from other states and known best practices in suicide prevention. Draft goals were placed on the Council’s public website for review and comment, priorities developed and the plan was released.

¹⁰ Healthy Alaskans 2010.

¹¹ National Strategy for Suicide Prevention.

CHAPTER 2: OVERVIEW OF THE ALASKA YOUTH SUICIDE PREVENTION PROJECT

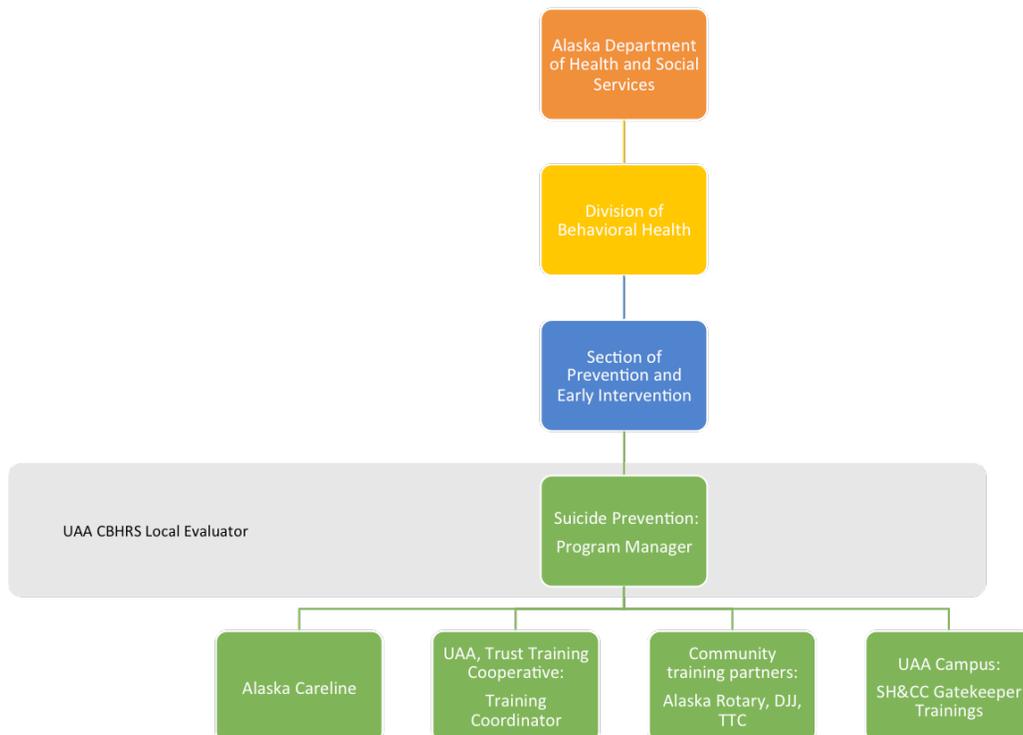
Program Funding

In August of 2012, the Alaska Department of Health and Social Services (DHSS) State Division of Behavioral Health (DBH) was awarded a three year State/Tribal Youth Suicide Prevention Cooperative Agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA). This funding was given to DBH to deliver youth suicide prevention and intervention activities, programs, and trainings throughout Alaska.

Key Program Staff

- James Gallanos, Suicide Prevention Program Coordinator, Alaska Department of Health and Social Services Division of Behavioral Health
- Eric Boyer, Training Coordinator, University of Alaska Anchorage Trust Training Cooperative
- Sarah McConnell, Training Coordinator, University of Alaska Anchorage Trust Training Cooperative

Figure 1: Organizational chart for the Alaska Youth Suicide Prevention Project.



Program Goals and Objectives

The Alaska Youth Suicide Prevention Project (AKYSPP) was carried out in Alaska with the following initial overarching goals in 2012:

1. Increase Alaska's understanding that youth suicide is preventable.
2. Increase promotion of healthy social and emotional growth and youth development.
3. Increased access and availability of youth oriented behavioral health services.
4. Increase use of suicide prevention research and evaluation methods.
5. Decrease suicide and suicide behavior among Alaska's youth.

Over time, as the training model and partners strengthened and community organizations became more involved, AKYSPP goals shifted. While current goals and objectives embody the spirit of the original goals proposed in the grant application, the AKYSPP goals have expanded to reflect a more public health, systems-based, and streamlined approach.

Current goals include:

1. The Alaska Gatekeeper Training model is grounded in research best practices, is culturally responsive to needs of Alaskan communities, and shows evidence of effectiveness;
2. The Alaska Gatekeeper Training curriculum is embedded into current Division of Juvenile Justice (DJJ) organizational system to create a sustainable community training model;
3. DJJ probation services employees are aware of suicide risk factors and know how to respond to those at risk;
4. Residents in Alaska are aware of the Alaska Careline and text services and the Alaska suicide prevention efforts;
5. Agencies, communities, organizations, K-12 schools, and University of Alaska system campuses develop sustainable Gatekeeper Training Model and are engaged in suicide prevention efforts;
6. State of Alaska DBH suicide prevention efforts support building a sustainable training infrastructure that continues after the grant cycle, and;
7. State of Alaska DBH suicide prevention funding and resources are supporting systems, organizations, and strategies currently used in Alaska to adopt the SAMSHA Zero Suicide in Health and Behavioral Healthcare Initiative.

Each of AKYSPP seven goals were paired with goals of the *Alaska State Suicide Prevention Plan: Casting the Net Upstream (2012-2017)* to reflect the cohesive approach the State of Alaska is using to support suicide prevention efforts. Appendix A displays the project logic model and describes goals, objectives, strategies used, and anticipated short, medium, and long term outcomes. The logic model has been considered a living and dynamic document and updated as needed throughout the three years of the project to reflect changes in objectives, strategies, or partnerships. Goals were added as needed to be more reflective of the future of suicide

prevention efforts in Alaska. For example, Goal 7 was added to reflect current best practice and the “next steps” for AKYSPP by incorporating the Zero Suicide Initiative to prevent suicide deaths for individuals receiving care within health and behavioral health systems. The following strategies below have been used to meet Goals 1-6.

Alaska Gatekeeper Training Redevelopment. In 2003, DBH was awarded grant funding from SAMHSA to develop a gatekeeper program targeted to the special circumstances and audience of the state of Alaska. However, the training was criticized for being too long by requiring eight contact hours. Also, the trainers were adapting the training as needed without guidance to make changes that maintained fidelity to the model. In response, DBH redeveloped the Gatekeeper Training model as part of the SAMHSA State/Tribal Youth Suicide Prevention Cooperative Agreement grant funding awarded in 2012.

Provide Alaska Gatekeeper Suicide Prevention Training. In order to reduce the number of suicides and expand the number of individuals in the State of Alaska who recognize the warnings signs of someone at risk for suicide, the AKYSPP has been using a systems-based, public health approach to offer trainings to organizations and community members. Following the work of the Alaska Gatekeeper Team Review, AKYSPP has been using the redeveloped model of the Alaska Gatekeeper Training with a QPR Approach since July of 2013.

Promote the Alaska Careline and “text 4help”. Many communities in Alaska experience service gaps due to the remoteness of the region or having a limited number of behavioral health specialists located in the communities. The Careline is an important resource that all residents of Alaska can access, regardless of the resources available in their community 24 hours a day, seven days a week. Texting services have been provided by the Careline since 2012 and are available 3-11 pm, Tuesday through Saturday. The AKYSPP promoted the Careline and texting services at Alaska Gatekeeper QPR Trainings and through multiple print sources including cards, flyers, pens, zipper pulls, business cards, key chain flashlights, and wristbands.

Purpose of This Report

As part of conditions of AKYSPP funding, SAMHSA required that the program be evaluated by independent evaluators. This evaluation contract was awarded to the Center for Behavioral Health Research and Services (CBHRS) at the University of Alaska Anchorage (UAA). The primary purpose of this document is to provide a description of the AKYSPP, detailing its history, composition, general functioning, and program progress and outcomes. This report represents the evaluation efforts completed during the grant project, using both required national evaluation instruments and locally developed surveys and tools. Emphasis is placed on providing information that will be useful as an organizational analysis of the program and help inform future suicide prevention activities.

CHAPTER 3: SUMMARY OF THE PRODUCTS AND SERVICES INVENTORY (PSI) WITH A FOCUS ON MEDIA AND PROMOTIONAL EFFORTS

Data for the process evaluation were gathered through implementation of required cross-site instruments and locally developed tools to track ongoing AKYSPP progress and efforts. The PSI is a required cross-site evaluation instrument that catalogues prevention products and efforts initiated by the AKYSPP, indicates target populations, and tracks budget expenditures and percent allocations to AKYSPP strategies. Table 1 provides a summary of program activities uploaded to the PSI quarterly. Table 2 summarizes the estimated percentage of funding allocated to each strategy during the grant as captured by the PSI. Other local evaluation tools developed to track project progress and general suicide prevention media efforts are listed below.

Log of project media and estimated reach. Project sponsored activities and staff were featured and interviewed in Alaska and national media and a variety of online and print sources throughout the grant cycle. Media and press and the associated reach are an important indicator of how many residents of Alaska have been exposed to suicide prevention messages.

From 2012- 2015, the AKYSPP project, activities, and training efforts were featured in 11 different print and online newspapers, Alaska Public Radio, five television stations in Anchorage and four in Fairbanks, and featured in an Alaska DHSS Statewide Suicide Prevention Council Press Release (Table 3). As a result, information about Alaska suicide prevention messages, projects, activities, and resources reached thousands of Alaska and US residents.

Three media efforts had particular impact in informing Alaskan and US residents of suicide prevention efforts. The Alaska Business Monthly (ABM) is a business magazine that promotes economic growth in the state and features discussion and analysis of the issues and trends affecting Alaska's business sector. According to sources at ABM, the two articles featured both in print and online on February 12 and 25, 2015 had the potential to be viewed by 80-100,000 individuals in the nation in one month.

The Alaska Dispatch News (an online only news source) and Alaska Daily News (print news source acquired by Alaska Dispatch in 2014), is an award winning news source featuring stories relevant to Alaskans and to the world. According to circulation sources at the Alaska Dispatch, approximately 226,300 readers accessed each article released October 21, 2013, October 25, 2014, and April 17, 2015 for 7 days of print and 30 days online. These articles were related to suicide prevention awareness and decreasing stigma.

As a final example, a suicide prevention public service announcement campaign developed by the advertising firm Spawn Ideas and in collaboration with the Anchorage Rotary Club was featured on five television stations in Anchorage and four in Fairbanks. It is estimated the

campaign was seen by 340,000 individuals (approximately 98% of the 25-54 year old target audience), ten times.

Site visits and direct observation. A site visit was conducted by the cross-site evaluator during the first and second year of the program. The DBH program manager and UAA CBHRS local evaluator attended both visits. The purpose of each site visit was to gather the AKYSPP project team, review program activities, cross-site and local evaluation protocols and procedures, and discuss details of program plans.

Regular meetings and email with program staff. Evaluators and project staff met via telephone to discuss the status of the program and activities that had taken place. Email communication is a standard mode through which key information about program activities and other documents passed. Contact through email was also utilized to address evaluation deadlines and attend to questions.

Table 1: Summary of required cross-site Product and Services Inventory (PSI) data.

Strategy Name	Description	Print Materials	Print Media	Awareness Products	Website Description	Target Entire Community or General Population	Target Youth/ Student
Careline Text 4help to 839863	Increase awareness about texting Careline for help and increase call volume among Alaska youth aged 15-24 years old.	Rack cards, posters, wallet-size cards	Careline "Have you taken the pledge?" campaign printed in the Youth and Elders/Alaskan Federation of Natives tabloid section Fairbanks Daily News-Miner.	Zipper pulls, pens	Developing Careline web-site to host text information and electronic materials.	No	Yes
"You Are Not Alone" school-based campaign	School-based suicide awareness campaign developed and supported by high school students. "You Are Not Alone" wristbands have been distributed and one high school has created a "You Are Not Alone" club and others are considering clubs as well. Presentations have taken place at: Kodiak High School, South High School, Dimond High School, Colony High School, West High School, Eagle River High School, Youth Empowerment of Anchorage, etc.	Careline cards		Wristbands		No	Yes
Awareness Products for Careline	Print materials are being distributed at various events and locations throughout the state to promote the Careline. Events include: *Carry the Cure *Vernon Stickman Run *Irondog Race *AASG promotional film *Winter Bear theater production	Careline Cards				Yes	No
Carry the Cure	People affected by suicide traveled to remote villages via snow machine to raise awareness and deliver suicide prevention messages to community members.					Yes	No
Vernon Stickman Run	Vernon Stickman completed a 140 mile suicide awareness run from Ruby, AK to Kaltag, AK to commemorate the loss of his son to suicide. Careline t-shirts were distributed in villages along run route.	Careline Cards				Yes	No
Iron dog Race	World's longest snowmobile race and Careline posters distributed along race route.	Careline cards and posters				Yes	No

Strategy Name	Description	Print Materials	Print Media	Awareness Products	Website Description	Target Entire Community or General Population	Target Youth/ Student
Railway of Hope	Student led and produced film that will be used to encourage students and Alaska schools to learn suicide prevention risk and warning signs and to promote help seeking among teens. GLS grant supported production and DVD development and distribution.					No	Yes
Winter Bear Play	Theater production Alaska Native culture as protective factor for suicide. Careline posters and cards promoting text services made available after play.	Careline posters and Careline cards				Yes	No
Council on Domestic Violence and Sexual Assault	Ten items of each of the Careline materials including brochures, posters, key chains, and wallet cards were distributed to 151 Alaska State community host contacts for the Council on Domestic Violence and Sexual Assault.	Careline posters and Careline cards				Yes	No
Tanana Chiefs Conference Convention Health Fair	Participation at health fair where suicide prevention products and information was distributed (2014-2015). Attendees were also invited to participate in filling in their ideas for the "Wall of Resistance to Suicide".					Yes	No
2013 First Alaskans Elders and Youth Conference	Workshop engaging community members, and specifically connecting youth to community elders, in a discussion around hope and belonging in for suicide prevention and titled "Cultural & Community Strengths for Suicide Prevention."					Yes	No
2015 Alaska Public Health Conference	Presentation at the local public health conference titled "Community Based Partnerships to Support Evidence Based Community Member Suicide Prevention Training, With an Emphasis on Rural Communities."					Yes	No
Alaska Dept. of Health and Social Services Resource Fair in Fairbanks	The DHSS participated in a resource fair in Fairbanks where community members can learn about the variety of resources and services available by DHSS divisions and programs. Suicide prevention information and resources were offered and discussed with community members.					Yes	No
Railway of Hope	Student led and produced film offered on DVD that will be used to encourage students and Alaska schools to learn suicide prevention risk and warning signs and to promote help seeking among teens.					No	Yes

Strategy Name	Description	Print Materials	Print Media	Awareness Products	Website Description	Target Entire Community or General Population	Target Youth/ Student
Careline magnets	Magnets with Careline contact information			Magnets		Yes	No
Careline flash light key chains	Flashlight key chains to attach to jump drives for Alaska Gatekeeper trainers. Key chain highlights Careline website, telephone number, and test contact information.			Key chains		No	No
Careline Website redesign	State of Alaska supported redevelopment of Careline website to make interface more interactive and visually appealing.					Yes	No
You Are Not Alone wristband	Bright yellow "You Are Not Alone" wristbands distributed to youth at awareness events.			Wristbands		No	Yes
School-based Peer Gatekeeper Training							
Youth QPR Training Development	The 1-hour youth QPR curriculum has been revised slightly to more accurately reflect youth in Alaska and will be presented to approximately.					No	
Alaska Gatekeeper Training with QPR Approach	Developed Alaska based content around QPR core curricula. Local training contractor, Department of Behavioral Health Program Coordinator, and Alaska Child and Family trainer became QPR master trainers to offer TOT to organizations and create a systems-based approach to enable the training model to become sustainable at the conclusion of the grant.					No	
Alaska Careline	A statewide 24/7 anonymous crisis call and texting center for those who are experiencing mental health emergencies including suicide risk. The grant is supporting the new texting service and supporting data collection of service delivery and referrals.						

Strategy Name	Description	Print Materials	Print Media	Awareness Products	Website Description	Target Entire Community or General Population	Target Youth/ Student
Alaska Gatekeeper Suicide Prevention Training Redevelopment Workgroup	Based on QPR methodology, the Alaska Gatekeeper Suicide Prevention Training model was developed in 2003 to teach the background and statistics of suicide in Alaska, things to know about suicide relationship building and assessment, and making and implementing a plan. Although comprehensive, the training model has been criticized for being too long and inflexible, inappropriate for use in all community settings, and not sustainable as a training model. December 10-11, the State Dept of Behavioral Health convened an Alaska Gatekeeper Working group to redevelop the current training model to be more adaptable and community based, while having the capacity to maintain a high level of fidelity when given in a variety of situations. Meeting attendees included original developers of Alaska Gatekeeper Suicide Prevention Training model and master trainers who have been teaching the current model. Pilot testing of newly redeveloped training is planned for February 26. Plans are to use a systems-based approach to make the model more sustainable.						
Training Partnership Development	Seeking to embed the Alaska Gatekeeper Training among existing agencies who are interested to agency support policies and practices that strengthen workforce development among staff with suicide prevention knowledge, awareness and skills. Currently, discussions are underway with the Alaska Native Tribal Health Consortium and Ukpeagvik Inupiat Corporation to provide training and support developing follow-up procedures and protocols into the current training system.						
Alaska Careline Crisis Intervention	A statewide 24/7 anonymous crisis call and texting center for those who are experiencing mental health emergencies including suicide risk. The grant is supporting the new texting service and supporting data collection of service delivery and referrals.						

Strategy Name	Description	Print Materials	Print Media	Awareness Products	Website Description	Target Entire Community or General Population	Target Youth/ Student
Department of Juvenile Justice	Established an MOA to embed the Alaska Gatekeeper Training with QPR approach and EIRF capabilities. Have offered support for suicide prevention policies and practices that strengthen workforce development in knowledge, awareness, and skills.						
Alaska State Rotary	Providing the Alaska Gatekeeper Training with a QPR approach to 1100 Rotary members in FY 2014.						
Youth Alliance for Healthier Alaskans (YAHA)	Advisory group for youth issues in Alaska. Working with YAHA to develop a youth centered and youth led messaging campaign based on SAMSHA criteria.						
North Star Behavioral Health	Developing certified cadre of North Star trainers to provide training opportunities to community organizations and schools. Also, providing groups an introduction to the EIRF and potential methods for integrating tracking systems for youth referrals and follow-ups.						
Alaska Department of Education	Collaborating with the Alaska Department of Education to develop training strategies for teachers and administration.						
Building Your Gatekeeper Training Foundation Webinar Series	Three part webinar series to support the training efforts of current Gatekeeper Trainers. Training titles and descriptions were: 1) "got training?"- This webinar helped our QPR certified trainers who are just getting started. This first webinar will include how to prepare for you first training, how to develop your training outline that suits your audience, allotted training time and aligning with the goals and fidelity of the QPR required content. A brief refresher of Part 1 will also be given as a booster to all trainers. 2) "Gatekeeper Learning Theory: Dr. Paul Quinnett, QPR Institute"- This webinar reviewed Part 2, the essential QPR slides of the Alaska Gatekeeper Training and will help build on the trainers understanding of the theoretical framework of QPR approach. This allows trainers to relate to the underpinning principles which allow the QPR model to be effective in reducing suicidal thoughts and behaviors by connecting those at risk with gatekeepers and others to						

Strategy Name	Description	Print Materials	Print Media	Awareness Products	Website Description	Target Entire Community or General Population	Target Youth/ Student
	<p>promote positive actions towards help and hope. Dr. Paul Quinnett will join us for this relevant in depth discussion.</p> <p>3) "What does help look like? Gatekeeper Asset Mapping and Evaluation"- This webinar reviewed Part 3 of the training which is centered on gatekeeper resources. Gatekeepers need to know what help looks like in their local communities so individuals and families can be connected among a community's safety net or along a continuum of care and services. This requires understanding an agency's or health provider's methods for referral, monitoring and follow up that is clear and direct. Asset mapping can be used as a tool to connect gatekeepers with this information and shared with others in the community. Evaluation not only supports the gatekeeper training, current findings, and our future efforts to evaluate the Alaska Gatekeeper Training model, but also allows us to identify the gaps or missing links in these referral processes or policies and efforts to fill these gaps can also be supported by gatekeepers. Will also help trainers with tips to conduct the evaluation in the smoothest and most efficient way possible. Preservation of the training model is dependent on positive results!</p>						

Table 2: Estimated percent of budget spent on different prevention categories from the required cross-site Product and Services Inventory (PSI).

Prevention Strategy	Percentage of Budget
OUTREACH AND AWARENESS	5
Public Awareness Campaign	5
Outreach and Awareness Activities/Events	0
Outreach and Awareness Products	0
GATEKEEPER TRAINING	40
School-based Peer Gatekeeper Training	0
Community Adult Gatekeeper Training	40
HOTLINES AND HELPLINES	10
COALITIONS AND PARTNERSHIPS	45
Partnerships with agencies and organizations	45
OTHER SUICIDE PREVENTION STRATEGIES	0
Total	100

Table 3: Summary of suicide prevention media coverage, press sources, and estimated reach.

Media source	Publication date	Estimated reach
NEWSPAPER		
<i>Alaska Business Monthly</i>		
Alaska's Rotarians Launch Suicide Prevention Campaign Statewide	2/12/2015	80-100,00 per month combined print and online
Iron Dog racers partner with state to promote suicide prevention	2/25/2015	
<i>Alaska Dispatch/ Alaska Daily News</i>		
Generations connect in heartfelt talk about scourge of suicide in Alaska	10/21/2013	226,300 readers for 7 days of print and 30 days online
Experts say Young's suicide comments triggered much-needed dialogue about 'the S-word'	10/25/2014	
Letter to the editor: Iron Dog team has message	3/2/2015	
Play about redemption and survival speaks to good and bad of Alaska village life	4/17/2015	
<i>The Council Newsletter (Tanana Chiefs Conference)</i>		
CHOP (Community Health and Outreach Program) brings suicide prevention training to rural communities	3/1/2015	Unknown
<i>The Delta Discovery (Yukon-Kuskokwim Delta)</i>		
Letter to the Editor: Iron Dog Team 12 says choose life	3/4/2015	Unknown

<i>Fairbanks Daily News-Miner</i>		
"Have you taken the pledge" ad campaign	10/24/2013	Unknown
Iron Dog team racers support suicide awareness	3/2/2015	
<i>Homer Tribune</i>		
Suicide prevention training provides tools: Local Rotary clubs team up to offer community workshop	4/14/2015	3,000 printed weekly and 1000 online daily
<i>Juneau Empire</i>		
Public invited to attend suicide prevention training	12/3/2014	4,100 paper and 10,000 online daily
Learning to ask 'the' suicide question	12/8/2014	
My Turn: Suicide-an uncomfortable subject	12/11/2014	
<i>Peninsula Clarion</i>		
Learning to ask 'the' suicide question	12/8/2014	4,200 paper and 800 online daily
<i>Redoubt Reporter (Central Kenai Peninsula)</i>		
The Winter Bear' tackles issues of suicide	4/23/2014	3,400-4,000 weekly
<i>Seward City News</i>		
Suicide prevent training for ordinary folks	9/25/2014	2-4,00 online daily
500 suicide gatekeepers trained in Seward	10/3/2014	
<i>UAA College of Health Newsletter</i>		
"Building the Wall of Resistance to Suicide" at the Tanana Chiefs Conference Health Fair	4/2/2015	360 monthly
RADIO		
<i>Alaska Public Radio Network</i>		
Alaska tops Gallup's Index of Well Being	2/19/2015	38,900 daily listeners
TELEVISION		
<i>KTUU Anchorage Channel 2</i>		
Spotlight on youth: "You are not alone"	2/20/2015	26,000 daily viewers / 340,000 monthly online views
<i>KTVA, GCI Cable, KTBY, KYUR (Anchorage); KATN, KFXF, KUAC, KTVF (Fairbanks)</i>		
Anchorage Rotary Club Suicide Prevention PSA Campaign	2/2-4/12/2015	340,000 unique views
OTHER		
<i>Alaska DHSS Statewide Suicide Prevention Council Press Release</i>		
Iron Dog racers partner with state to promote suicide prevention	2/25/2015	1,200 daily viewers

CHAPTER 4: REDEVELOPMENT AND IMPLEMENTATION OF THE ALASKA GATEKEEPER TRAINING WITH A QPR APPROACH

Redevelopment of the Alaska Gatekeeper Training Model

In 2003, the Division of Behavioral Health (DBH) of the State of Alaska was awarded grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a gatekeeper program targeted to the special needs and audiences in Alaska. DBH subsequently awarded a contract to the UAA CBHRS to carry out the development and pilot implementation of targeted Gatekeeper curricula that was tailored to professionals who may have the opportunity to intervene with individuals experiencing suicidal ideation. While developed specifically for mental health professionals, the training was also used in wide range of settings and communities. The training provided skills, facts, and guidelines helpful to a person who works with or is in contact with a suicidal individual. Table 4 details the four parts and learning objectives of the original suicide prevention training.

Table 4: Components and learning objectives of the original Alaska Gatekeeper Training.

Part One: Introduction
<ol style="list-style-type: none"> 1. Identify the prevalence of suicide in Alaska across age, race, regions and high risk populations. 2. Examine and explore common myths and misconceptions versus known facts surrounding suicide based upon current research.
Part Two: Things to Know about Suicide
<ol style="list-style-type: none"> 1. Identify and list the risk factors signs for suicide. 2. Identify and list immediate predictors or warning signs, i.e., clues and triggers for suicide including the key elements of a suicide plan. 3. Evaluate protective factors to assess against suicide risk. 4. Assess interactions between risk factors, warning signs and protective factors to formulate risk profiles.
Part Three: Relationship Building and Assessment
<ol style="list-style-type: none"> 1. Explore and examine negative reactions in order to talk about suicide openly. 2. List ways to prepare gatekeepers in effectively responding to create an environment that engenders trust and confidence. 3. Learn and practice active listening skills to ask directly about suicide. 4. Learn questions to ask once someone acknowledges suicidal thoughts and how to ask them. 5. Learn how to weigh risk factors, and triggers against protective factors to formulate overall assessment of risk and suicidal intent.
Part Four: Making and Implementing the Action Plan
<ol style="list-style-type: none"> 1. Identify action plan principles to engage individuals at risk of suicide in a safety action plan. 2. Learn how to tailor safety action plans to the level of risk utilizing least restrictive care guidelines. 3. Identify the inpatient/outpatient management options are in your area including local resources and how to access them. 4. Learn how to assess and implement follow up care once the immediate crisis is resolved 5. Identify resources to support gatekeeper self-care.

The Alaska Gatekeeper training curriculum was used extensively throughout the state and was considered comprehensive and informative. However, the training was criticized for being too long by requiring eight contact hours and offered little opportunity to adapt to local cultures and environments.

In response, a goal of the SAMSHA State/Tribal Youth Suicide Prevention Cooperative Agreement grant funding awarded in 2012 was to redevelop the Alaska Gatekeeper Training model. DBH convened an Alaska Gatekeeper Team Review with key partners comprising a variety of backgrounds who were actively engaged in suicide prevention work from around the state. The goal of the two-day event was to establish what specific criteria were needed around Alaska's suicide prevention training. A second goal was to establish the building blocks of an Alaska Gatekeeper Training that was more flexible and culturally responsive, supported and sustained trainers and trainings, and engaged all community members in a deeper conversation about suicide prevention. Also discussed were certification criteria for trainers, ongoing support and professional development needed to sustain trainings, the potential role of existing evidence-based models, and maintaining fidelity to a new model of training.

Prior to the official two-day meeting, those participating met to build relationships and provide a place to process any anxiety or concern, if needed, and to ensure a safe and effective working environment for the Gatekeeper Team Review. Day 1 of the meeting agenda included a wider audience (17 participants) and was intended to provide background information and offer a venue for consensus building around a new Alaska model of suicide prevention training. Day 2 of the meeting involved a smaller team of people (10 participants) and structured to be more task-oriented on curriculum development (Tables 5 and 6).

Table 5: Alaska Gatekeeper Review Team agenda.

December 9, 2012	
6 - 8 PM	Pre-meeting gathering
December 10, 2012	
9:00 - 9:30 AM	Welcome, introductions and agenda
9:30 - 10:30 AM	Alaska Gatekeeper Training Model: History and development (James Gallanos and Susan Soule)
10:30 - 11:15 AM	Evaluation report of the current model (Jodi Barnett)
11:15 - 12:00 PM	Current Alaska Gatekeeper adaptations (Eric Boyer and Bridget Hanson)
12:00 - 1:00 PM	Catered lunch
1:00 – 1:45 PM	Rethinking Gatekeeper Training: <i>Lessons learned from a Year of Trial and Error</i> (Lisa Wexler)
1:45 – 2:30 PM	Adaptable intervention model (Kristen Mitchell-Box)
2:30 – 5:00 PM	WORKGROUP I: SWOT Analysis of Alaska Gatekeeper Model (All)
December 10, 2012	
9:15 – 10:00 AM	Review of SWOT Analysis
10:00 – 12:00 AM	WORKGROUP II: Identify learning objectives, core components, and key activities

12:00 - 1:00 PM	Catered lunch
1:00 – 3:00 PM	WORKGROUP III: Identify adaptation paths for target populations and time constraints
3:00 – 4:30 PM	Pulling it all together: Debrief, summarize
4:30 – 5:00 PM	What’s next? Future of the Alaska Gatekeeper Model (James Gallanos, Kristen Mitchell-Box, and Eric Boyer)
5:00 PM	Closing

Table 6: Attendees of the Alaska Gatekeeper Review Team.

Day 1	Affiliation	Day 2
James Gallanos	DBH Prevention Manager	James Gallanos
Eric Boyer	UAA Trust Training Cooperative	Eric Boyer
Kristen Mitchell-Box	UAA CBHRS	Kristen Mitchell-Box
Michael Covone	UAA CBHRS	Michael Covone
Lisa Wexler	University of Massachusetts	Lisa Wexler
Suzanne Womack-Strisik	UAA Department of Psychology, Retired	Suzanne Womack-Strisik
Bridget Hanson	UAA CBHRS	Bridget Hanson
Susan Soule	UAA and State of Alaska, Retired	Susan Soule
Addy Peters	Alaska Child and Family	Addy Peters
Robyn Henry	UA Fairbanks Rural Health Services Program	Robyn Henry
Jodi Barnett	UAA CBHRS	
Barbara Franks	ANTHC, Suicide Prevention	
Wendi Shackelford	Anchorage Police Department	
Wilbur Brown	SEARHC, Program Manager	
Carolyn Greene	DJJ Training Coordinator	
Sharon Fishel	Alaska State Department of Education	
Bridie Trainor	Kawerek	
Diane McEachern	UA Kuskokwim Rural Health Services Program	
Danielle Giroux	ANTHC, Suicide Prevention	

A major focus of Day 1 was completing a SWOT Analysis (strengths, weaknesses, opportunities, and threats) of the original Alaska Gatekeeper Training. The SWOT Analysis is a useful planning method to examine the positive and negative internal strengths and weaknesses and external opportunities and threats and can inform changes to meet an objective. Figure 2 presents results from the SWOT analysis on Day 1.

Figure 2: Results of the Review Team SWOT Analysis of the original Alaska Gatekeeper Training Model.

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Flexibility • Cost • Comprehensive • Activities built in to training (i.e. Myths, worksheet about death and beliefs) • Protective factors as preventative model • Relationship building • Listening • Comfortable with asking other information • Role modeling and other interactive pieces • Trainers allowed to explore own beliefs • Validating for participants with what they are already doing- their stories • Trusting your own experience 	<ul style="list-style-type: none"> • “What is it exactly?” • Too many statistics • Too much information in short time • Length of time needed to cover everything • Little time for participant stories • Not focused- “All things for all people” • Too didactic • Not honoring “the numbers” as real people • No method to check fidelity • How does Gatekeeper fit in with other models and who is it for? • Reliance on referral • Language is clinical • Lack of clarity without active listening • Different levels/abilities of Gatekeeper trainers • Disconnect between what we’re doing and what we hope the outcome will be- difficult to evaluate • Content assumes close relationships • Emphasis on assessment • Keeping attendees energized • Lacks group solidarity • Need self-care for Gatekeeper trainer • Need really good trainers to digest information for participants • Doesn’t reach all adult learners • Doesn’t give practical information • What part can be taken and used? • Lack of interaction and community engagement • Gatekeeper name? • Structure- ppt vs. discussion • Suicide much more than one thing- need other points of view • Need to focus on meaning • Including everyone involved in training

OPPORTUNITIES	THREATS	
<ul style="list-style-type: none"> • Three years of State funding • Department of Education funding • Partnerships • Regional coalitions • Different delivery methods • Mental health providers connecting with community resources • Updating content to reflect technology • Embedding training in existing systems • Determine what is fidelity, core components, goals • Creating ownership of training • Find open back doors • Evaluation opportunities • List serve- tracking trainers and training locations • Packaging and marketing • Performance measures 	<ul style="list-style-type: none"> • Can focus on community strengths • Filling in gaps/gap analysis • Postvention • Stigma reduction • Self-care • Flip all the weaknesses that have been identified • Including bigger picture/vision • Building courage + confidence • Retention of trainers/appreciation/incentive • Define success • Sharing success stories • Conferences/events • Get teens involved • Facebook page of trainers • Digital community of practice • Elevator Speech for Gatekeepers 	<ul style="list-style-type: none"> • Evidence-based grant funding • Need for effectiveness – follow up • Convincing one model is better than another • Possible conflicts of interest with for profits organizations • Doing vs. Thinking • involvement of politics • Suicide prevention assumes control which can lead to pointing of fingers or blame • No ability to measure lives saved • Are we wasting money? • Are we going in the right direction? • Who is the target we are trying to reach? • Different way of looking at things • Not focusing on upstream prevention • Unskilled workers and unsafe talk • Not having good standard of training • Lack of focus • Workforce turnover/issues • Flexibility for trainers to do training

On Day 2, attendees reviewed the SWOT analysis and participated in a brainstorming exercise to explore options for redeveloping the suicide prevention training. During the exercise, the group determined that the new training must have an empowering agenda that included both knowledge and skills (Table 7).

Table 7: Results of a brainstorming exercise with Gatekeeper Review Team.

EMPOWERING AGENDA
<ul style="list-style-type: none"> • Confident, competent (skills), brave and connected... • Self-care (ex. Careline) • Participants know they have a support system • Part of a movement
KNOWLEDGE
<ul style="list-style-type: none"> • Why they need to know about suicide prevention-relevance • Dynamics of suicide • Knowing resilience and protective factors • Role of trauma in suicide • How to create a safe environment • Reduce stigma for help seeking • Acknowledging myths • Culturally-informed • Understanding the importance of listening • Red flags/risks/signs-knowing these
SKILLS
<ul style="list-style-type: none"> • Recognize/when to reach out • Asking the question-knowing when to ask about suicide • Making a connection • Creating rapport • Knowing how to listen/active listening skills • How to respond • What to do, where to go for support • Assessing the situation • How to recognize and respond • Action plan • Creating safe environment • Connect with community members and/or service providers • Policies and procedures-assessment • How to create a safe environment • How to follow up • General: other considerations • Legal responsibilities • Knowing limits of what one can do • Postvention – important to embed...there will be survivors in the audience • Change “gatekeeper” name

Following the Brainstorming Exercise, the group split into two working groups to discuss what they felt was necessary to include for the knowledge content and skill building portions of a new Alaska Gatekeeper Training Model (Table 8).

Table 8: Knowledge and skill-building components identified for the new Gatekeeper Training by Review Team working groups.

KNOWLEDGE CONTENT
<p>For two hours:</p> <ul style="list-style-type: none"> • First: Quick explanation about prevention, intervention, postvention to frame training- explanation will be different based on context of training • Second: Offer what will be trained <ul style="list-style-type: none"> ○ Basic information: <ul style="list-style-type: none"> ▪ Recognize signs/symptoms ▪ Connect with person and ask the question ▪ How to ensure safety at that moment and with some follow-up ▪ Available community/organization resources • Third: Ask “What do you want to get out of training?” <ul style="list-style-type: none"> ○ Create list and maybe check items on list that many people want more information, helps to target training, gives it context and relevance. • For first 45 minutes: <ul style="list-style-type: none"> ○ Emphasize that trying to help will not make it worse ○ It’s ok to talk about suicide ○ Talk about what the person might be feeling: pain, isolation, uselessness, being a burden to others <ul style="list-style-type: none"> ▪ They don’t really want to die but escape pain and suffering and see a different future ○ Describe how changing the social relationship, however brief, can make a change ○ Just talking about it creates immediate change ○ Role of alcohol and drugs leading to impulsive actions- also decreases responsibility for responders ○ Framing basic information around a series of questions for participants (based on Socratic questioning teaching methods suggested by Robin). After participants have answered questions, use follow-up ppt slides to show “real” list to make sure none of the key points were missed: <ul style="list-style-type: none"> ▪ What may be the feelings a person may be having if they are thinking about suicide? (ex. Pain, isolation, loneliness, wanting change) ▪ What does this person need? (ex. Talk, connection, decrease pain) ▪ What would make things worse? (ex. Being afraid to talk, belittling, guns, alcohol) ▪ Why would they not want to talk about their feelings about suicide? ▪ If you suspect suicide, what will it do to that person to ask? ▪ Why would you want to ask about suicide? ▪ What do you see as resources in your community, organization, etc.? (ex. Policies, procedures) ○ Completing knowledge section of training with “Creating a Web” activity- participants have notecards with resources on them. Using a ball of yarn, participants pass the yarn

<p>from one resource to next to show how the community is connected and creates a web of safety.</p> <ul style="list-style-type: none"> • Training longer than two hours would expand each topic and add in more activities, videos, roles plays from a written script, etc.
SKILL BUILDING FOR TRAINING
<ul style="list-style-type: none"> • Did not list actual skill building activities but determined how in-depth to go into the exercises for each time frame • For 2 hours: talk about the skills and have a presenter and participant role play • For 4 hours: use two hours of training sessions to develop skills and some role play exercises • For 6 hours: use four hours of training and then explore more in-depth practice in small groups

Following the Gatekeeper Review Team meeting, DBH and CBHRS reviewed available best practice and evidence-based suicide prevention training programs listed on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) to determine if any fulfilled needs identified by the review committee. Group consensus resulted in the adoption of the QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention as the core component of the new Alaska Gatekeeper Training model. AKYSPP program and training staff have augmented the curriculum by adding Alaska-specific and culturally appropriate information and exercises. The training is approximately 2-hours long and the objectives of the training are to:

1. Learn how suicide impacts Alaska;
2. Learn to differentiate between suicide myths and facts;
3. Recognize the warning signs of suicide;
4. Learn how to instill a sense of hope, and;
5. Learn how to connect people with appropriate supports

A poster presentation describing the Alaska Gatekeeper Training model redevelopment was prepared for the 2014 SAMSHA State/Tribal Youth Suicide Prevention Cooperative Agreement grantee meeting in Washington DC. A copy of the poster can be found in Appendix C.

The redeveloped training is divided into three parts:

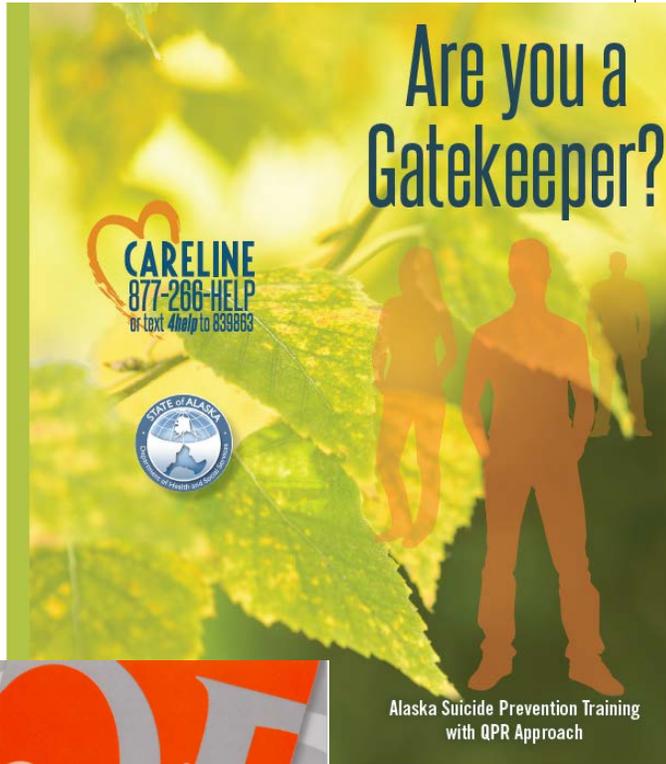
1. Overview: Alaska statistics, protective factors, and Alaskan culture and suicide;
2. QPR Institute Question, Persuade, and Refer slides, and;
3. Accessing Community Resources: Asset mapping exercise

Parts 1 and 3 were developed in collaboration by DBH and CBHRS and were approved by the QPR Institute. While Parts 1 and 3 can be adapted to fit culture and audiences, the fidelity of the training model is maintained by adhering to the core set of 21 QPR slides developed by the QPR Institute. During train the trainer (TOT) events, it is emphasized that these slides cannot be changed, and the set of 21 slides are identified by the QPR logo found at the bottom right of the PowerPoint slide. A version specific to the DJJ probation service section has been developed with plans to create an online training model.

Program and training staff have worked with the QPR Institute to create an Alaska specific QPR suicide prevention information booklet with state resources and contacts that is distributed to all training participants. The DBH also created a brochure describing the training and how to schedule trainings in a community or organization (Figure 3).

Figure 3: Alaska Gatekeeper with a QPR Approach brochure and QPR booklet

A gatekeeper is anyone in a community in a position to recognize the warning signs of someone contemplating suicide. Gatekeepers can be parents, friends, neighbors, teachers and ministers. Many others who are positioned to recognize, reach out and refer someone at risk of suicide including doctors, nurses, behavioral health aides, village public safety officers, office supervisors, elders, foremen, police officers, advisors, caseworkers and firefighters. Gatekeepers do not provide counseling. They are there to listen, encourage those seeking help, and to connect with others who can provide appropriate care. With training, a gatekeeper is you!



Question Persuade Refer

You may be the best person, in the best possible position, to recognize an individual in crisis and to prevent a suicide. By identifying and understanding a person's cries for help and responding appropriately, suicide can be prevented.

Gatekeeper training will help you recognize an individual in crisis.

The Alaska Gatekeeper Training uses the QPR method as its core training. QPR stands for *Question, Persuade and Refer*, an emergency mental health intervention for suicidal persons created by Dr. Paul Quinnett and the QPR Institute. QPR is a simple educational program that teaches community members how to recognize a mental health emergency and how to get a person at risk the help he or she needs. It is also an action plan that can result in saved lives.

Schedule a 2-to-4 hour training for your group or community and learn:

- how suicide affects Alaska regions
- the myths and facts about suicide
- how to recognize the warning signs of suicide
- how to ask someone about suicide
- how to persuade someone to get help
- to identify resources available for help and support

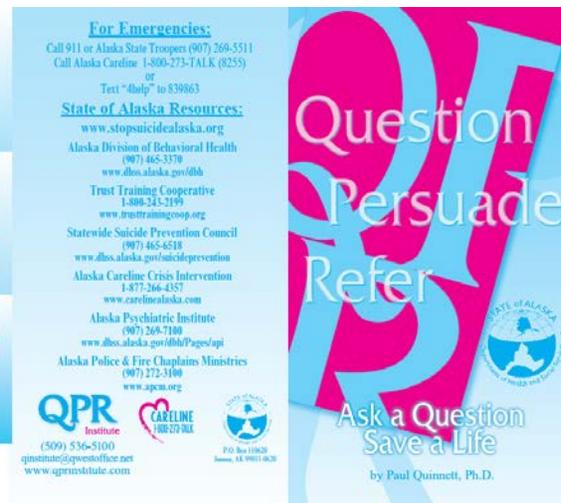
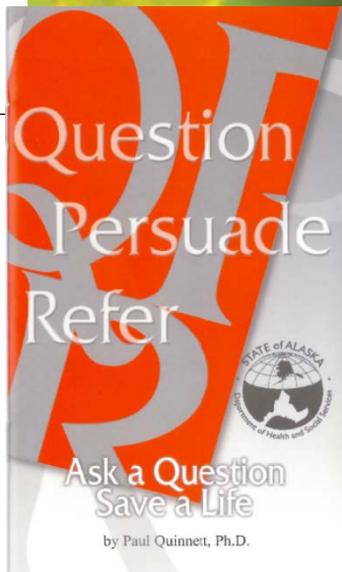
For more information about this training or how to arrange the Alaska Gatekeeper Training to be conducted in your community or agency, please contact:

Eric Boyer UAA's Trust Training Cooperative
eric@alaskachd.org
907-264-6257

or

James Gallanos, MSW, Department of Health and Social Services, Behavioral Health, Office of Prevention and Early Intervention Services
james.gallanos@alaska.gov
907-465-8536

UAA Center for Behavioral Health Research & Services (CBHRS) is approved by the American Psychological Association (APA) to sponsor continuing education for psychologists. CBHRS maintains responsibility for this program and its content. For more information, including target audiences, prerequisites and learning objectives, please visit <http://www.uaa.alaska.edu/cbh/rs/>.



Implementation of the Alaska Gatekeeper Training with a QPR Approach

Twelve trainings to train trainers (TOTs) with representation by 15 organizations have been offered since 2013. The new trainers receive flash drives that have been preloaded with the presentations, evaluation forms, a training needs assessment, background information and literature, and training tips. Future plans for the Alaska Gatekeeper with a QPR Approach include developing a more culturally responsive version in collaboration with the QPR Institute and working with a graphic design firm to package the training to be more user-friendly and visually appealing. By the end of June 2015, there are seven Master Trainers (who have the ability to conduct TOTs), 178 certified trainers, and approximately 3,812 individuals trained.

DHSS SharePoint Site for AKYSPP staff and trainers. Program and evaluation staff used a DHSS Extranet SharePoint Site that provided a means for program staff and Alaska Gatekeeper trainers to coordinate training related activities (Figure 4). The SharePoint site served as a project management tool where project staff and Alaska Gatekeeper trainers could access documents, have discussions, and add training events to a group calendar. Also, accessible only to project staff, was an Excel spreadsheet that collected standardized information about training events (see Appendix G for list of trainings). The spreadsheet gathered the necessary information to track and log quarterly information on the Transformation Accountability System (TRAC) and Common Data Platform (CDP) and the Garrett Lee Smith Suicide Prevention Data Center (SPDC) Prevention Strategy Inventory (PSI), which are required components of the cross-site evaluation and federal data submission requirements.

Figure 4: Screenshot of DHHSS SharePoint Site.

The screenshot shows a SharePoint site titled "Trainers - Home" with the subtitle "Suicide prevention trainers". The page includes a navigation sidebar on the left with links for "Trainers", "Surveys", "Libraries", "Site Pages", "gls team", "Recycle Bin", and "All Site Content". The main content area displays a welcome message: "Welcome to our Alaska Gatekeeper/QPR Trainer site!" followed by a security notice: "This is a secure site. You can only access this site if you are a certified suicide prevention/intervention trainer." Below this is a "Discussion Board for Trainers" with a table of posts:

Subject	Created By	Replies	Last Updated
Alaskans getting trained!	eric@alaskachd.org	0	3/11/2014 11:58 AM
Use the discussion board to blog away your training wisdom, successes, challenges and experiences.	Gallanos, James B	0	10/11/2013 3:30 PM

Below the discussion board is a "Training Document Library" table:

Type	Name	Modified	Modified By
	Alaska Gatekeeper	2/27/2014 11:37 AM	Gallanos, James B

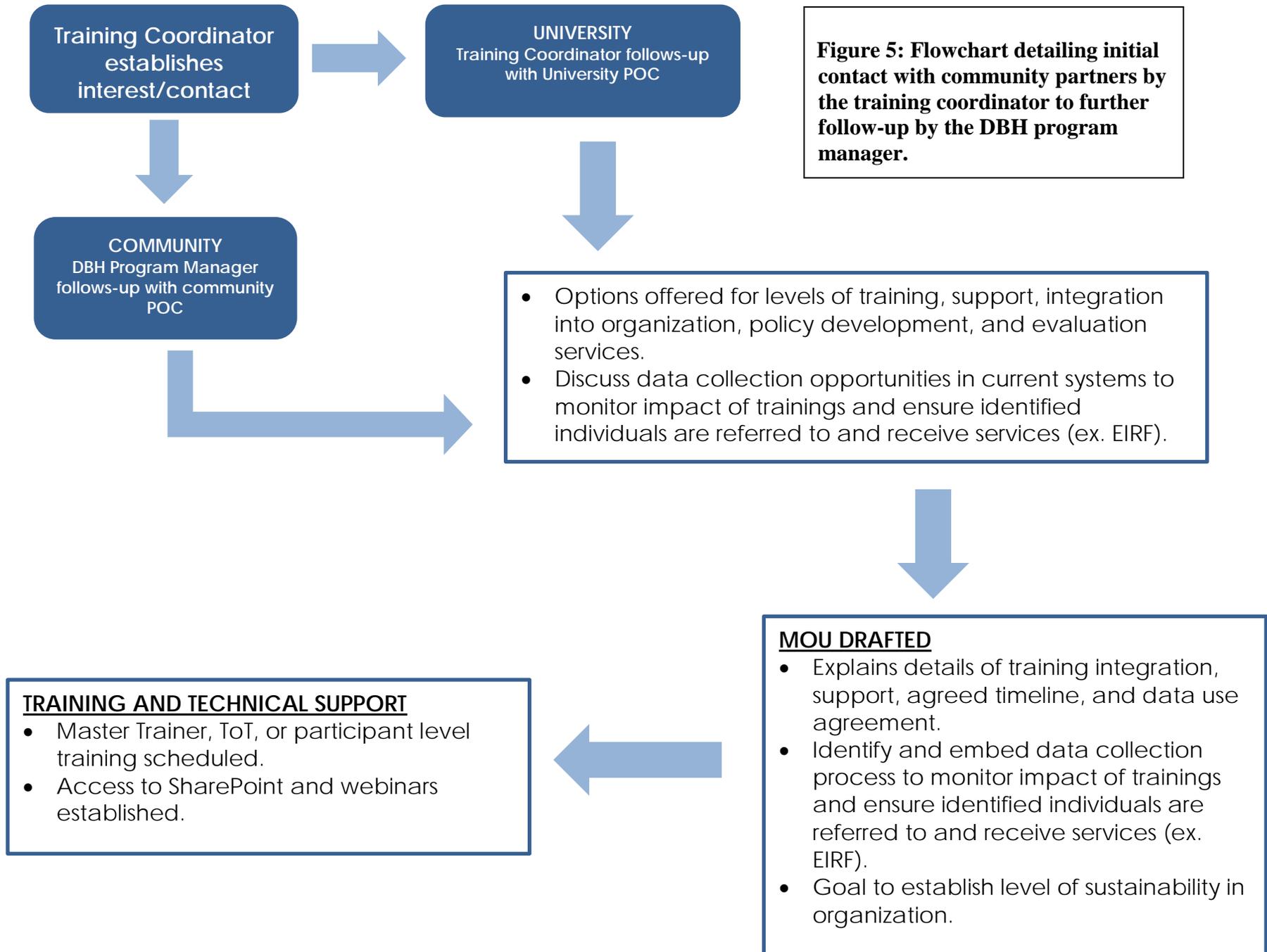
On the right side of the page, there is a "Question Persuade Refer" graphic and contact information for "Alaska Gatekeeper/QPR Master Trainers":

- James Gallanos
907.465.8536
james.gallanos@alaska.gov
- Eric Boyer
907.264.6257
eric@alaskachd.org

Training Sustainability. The AKYSPP logic model (Appendix A) has been updated to reflect anticipated next steps to ensure the Alaska Gatekeeper Training with a QPR Approach continues to be integrated into organizational programs, policies, and procedures to ensure trainings continue beyond the life of the grant. Training sustainability is also reflected in partnerships developed with key community organizations, which were solidified with formal Memorandum of Understandings (MOUs). Figure 5 displays the process from initial contact to further follow-up with potential partners. Please see Appendix B for a template of an MOU and data sharing agreement.

Currently, the DBH has solidified MOUs with two community organizations. Each reflects the specific needs or strengths of that organization. The first, established in 2013, is with the DJJ probation services section. According to MOU, the DBH and the training coordinator provide technical assistance and support in suicide prevention program and policy development. This includes tailoring the Alaska Gatekeeper Training with a QPR Approach to the specific needs of the DJJ probation officers, providing TOTs as needed for probation officers from around the state, revising the curriculum to fit an online training module, and establishing a data sharing agreement to collect EIRF data (described in Chapter 7). As of June 2015, the DJJ has 38 certified Alaska Gatekeeper trainers and 77 probations officers trained from 10 different youth facilities in the 2-hr community level training.

The second was established with North Star Behavioral Health in 2015. North Star is a for-profit residential treatment facility for youth that provides a variety of treatment and services. One of the services provided by North Star is educational outreach to communities and organizations throughout Alaska. Clinical liaisons certified in the Alaska Gatekeeper training model travel statewide and have provided 25 trainings to 882 community members since February 2014.



Alaska Gatekeeper Trainer Registry. Sustainability of the Alaska Suicide Prevention Training with a QPR Approach depends on certified trainers and their availability and willingness to train communities and organizations. DBH wanted to know if trainers would be willing to offer suicide prevention training outside their own organization if requested. In response, DBH created a trainer registry on the DHSS SharePoint site where trainers could indicate if they would be willing to offer their skills to other organizations and communities.

Certified suicide prevention trainers were invited to register on the SharePoint site to access training updates, resources, and information provided by project staff. Examples of resources available on the SharePoint site include the training presentations, evaluation tools, training supply order forms, training needs assessment form, webinar presentations, and background information about QPR.

The trainers were also invited to participate in a registry on the SharePoint site where they could indicate if they would be willing to offer their skills to other organizations and communities. In August 2014, an invitation to participate was sent to approximately 70 individuals who had participated in a TOT. Of those invited, approximately 40 trainers accepted the invitation to join the site and 12 completed the registry survey. Individuals represented several regions in Alaska, nine were willing to travel and had flexible availability, four required training fees, four had not completed any suicide prevention trainings but hoped to schedule trainings soon, 10 stated that their organization had plans to train all employees, and all but two confirmed their agency had established a suicide prevention plan, policy, or procedures.

All trainers were offered a \$10 gift card to Starbucks for taking part in the survey. Methods and survey questions were approved by the UAA Institutional Review Board. Table 9 provides a summary of the trainers and their responses to the request for information on the SharePoint site.

Table 9: Summary of certified trainer responses on SharePoint training registry.

Location/ Region	Can you travel?	What is your availability?	Will you require a nominal fee to help with travel or printed materials not provided by us? If yes, how much per participant or per training will you require?	Have you done any trainings?	Who was your target audience?	If you have not completed any trainings, do you have any planned in the future? Are there any barriers or obstacles that are preventing you from facilitating trainings?	Is there a supervisor or point of contact that we could speak to explore a partnership to strengthen suicide prevention with your agency?	Does your agency have plans to offer the training for all staff as a priority or plans to integrate as part of your required annual or new hire trainings?	Does your agency currently have a suicide prevention plan/policy or procedures that includes training knowledge, skills and or practices?
Northern/ Western AK	Yes	Flexible	No	3	Law enforcement, substance abuse, peer support	N/A	Yes	Yes, working to train staff at our facilities	Unknown
Soldotna	No	Only in facility	N/A	Not yet	N/A	Yes, a facility wide training	No	Yes, we are in the process	We have a policy and a "bundle" to support the direction of care
Prince of Wales Island	No	Summer only	No	No	N/A	Yes, a training for teaching staff	Yes	Yes, teachers/staff in August 2014	Not aware of any
Southeast Alaska	Yes	Sporadic	Not sure	No	N/A	No	Yes	It is part of our training	Yes, the agency does have a plan
Eagle	Sometimes	Limited	Yes	No	N/A	I hope to	Yes	I don't know	Yes, to some extent

Prince of Wales Island	Yes	Call to schedule	Travel, materials, and \$300 a day	1	Mental health paraprofessionals	Several tentative dates	Yes	Yes	Yes
Bethel	Yes	Flexible	Unknown	1	Juvenile probation staff	N/A	Yes	Provided to all probation staff with regular refreshers	Yes
Anchorage	Flexible	Flexible	No	2	1 for clinicians; 1 for parents	N/A	Yes	Yes	Yes
Anchorage	Yes	When schedule	Yes	Yes	Dispatch, clinicians	N/A	No	No	Yes
Southwest AK	Within YK region	Business hours	Yes	2	Behavioral Health professionals	Planning one	Yes	Yes, but not all employees at all facilities	Yes
Anchorage	Yes	Open	Negotiable	Yes	Youth	N/A	Yes	Not a requirement but most chaplains will be trained	Yes
Fairbanks	Possibly	Available after 1-15-15	Unsure, depends on travel	2	High school; medical staff	N/A	Yes	Staff at TCC will attend training	Currently building this as part of trauma informed care

Alaska Gatekeeper Webinar Series. In 2014, DBH developed a set of three online webinars for trainers to refresh training information, discuss new or changing suicide prevention strategies, and review evaluation procedures. The Alaska Gatekeeper with a QPR Approach training model is dependent on the trainers delivering accurate and up to date information to their audiences and aims to create a cohesive cadre of trainers. The webinars also provided a venue for certified trainers to ask questions of project staff and invited speakers. Webinars were recorded so trainers who were not able to attend could benefit from the information.

August 2014, DBH suggested the following list of potential training topics via email to a list serve of certified trainers:

1. Training youth with the QPR youth module and fitting it into the Alaska model;
2. Training teens directly and the appropriate ages for training participants;
3. Implementing the team (lead, co-lead) approach to QPR training;
4. Presentation from the QPR founder Dr. Paul Quinnett;
5. Updates of data and research in Alaska and region;
6. QPR refresher;
7. Review of evaluation procedures;
8. Success stories from the field and what is working well;
9. Explanation of Alaska Gatekeeper website trainer registry; and,
10. Alaska Careline services and resources offered at the community level.

Three webinar topics were selected based on responses to above suggestions. Table 10 describes the three webinars offered to certified trainers in 2014.

Table 10: Dates, speaker, description, and participation in three part webinar series.

Date	Webinar Title	Presenter	Description	Participants
October 14, 2014	Got training?	James Gallanos (DBH) and Eric Boyer (UAA TTC)	This webinar included how to prepare for the first training, how to develop the training outline to suit the audience, allot appropriate training time, and align with the goals and fidelity of the QPR required content. A brief refresher of Part 1 was also given as a booster to all trainers.	13
November 20, 2014	Gatekeeper Learning Theory	Dr. Paul Quinnett (QPR Institute)	This webinar reviewed Part 2, the essential QPR slides of the Alaska Gatekeeper Training and helped to build on the trainers' understanding of the theoretical framework of the QPR approach. It allowed trainers to relate to the underpinning principles of the QPR model and how it can be effective in reducing suicidal	18

			thoughts and behaviors by connecting those at risk with gatekeepers and others to promote “positive actions” towards help and hope.	
December 2, 2014	What does help look like? Gatekeeper Asset Mapping and Evaluation	Kristen Mitchell-Box (UAA CBHRS) and Gretchen Clarke (ICF International)	This webinar is centered on gatekeeper resources. Gatekeepers need to know what help looks like in their local communities so individuals and families can be connected among a community’s safety net or along a continuum of care and services. This requires understanding an agency’s or health provider’s methods for referral, monitoring and follow up that is clear and direct. Asset mapping can be used as a tool to connect gatekeepers with this information and shared with others in the community. Evaluation not only supports the gatekeeper training, current findings, and our future efforts to evaluate the Alaska Gatekeeper Training model, but also allows us to identify the gaps or missing links in these referral processes or policies and efforts to fill these gaps can also be supported by gatekeepers. It also helped trainers with tips to conduct the evaluation in the smoothest and most efficient way possible.	8

Using the “Go to Meeting” platform, trainers could access the presentations remotely and call in to ask questions or participate in discussion. A feature of “Go to Meeting” was the ability to electronically mail an evaluation link to participants at the completion of the webinar. Unfortunately, surveys were not distributed for the second or the third webinars offered in November and December 2014.

Of the nine trainers participating in the webinar in October 2014, four completed the survey. Overall, the trainers highly rated the webinar with each giving a score of 4 (on a scale of 1-5 and 5 being the most positive). Also, the participants felt their interest was held and would recommend the webinar to other trainers. When asked what they like liked most about the webinar, the trainers appreciated the ability to attend during their lunch hour, the ongoing

training and support provided by DBH, the updated slides that could be used for future trainings, and the actual presentation used during the webinar. Two of the four responding to the survey felt the time for the webinar could have been better managed; one had to leave the training early to return to work and the other wanted more time to discuss topics in greater detail. A summary of the results for the first webinar in the series can be found in Table 11.

Table 11: Evaluation results of the first webinar in the training series: “Got Training?”

Participant	1	2	3	4
1. Was your interest held?*	3	4	5	4
2. I now have a much better understanding of...	Preparing training for specific groups, settings, and audiences. Which materials and information I can adapt and which I cannot to maintain fidelity.	Maintain the mood, spirit, and energy of the audience including importance of self-care and emotional climate of the group. How to assess the training needs of a particular group, agency or community.	Preparing training for specific groups, settings, and audiences. Which materials and information I can adapt and which I cannot to maintain fidelity.	Preparing myself as a gatekeeper trainer, Preparing training for specific groups, settings, and audiences. Talk about suicide openly and honestly. Knowing how to prepare materials, notes, handouts, QPR booklets, evaluations and where to locate them.
3. Overall, how would you rate the training?*	4	4	4	4
4. Would you recommend this webinar to other trainers?*	5	4	5	4
4. What did you like most about the webinar?	I was able to use my lunch break to attend and it didn't interfere with my daily tasks at work.	Ongoing training and support.	The updated slides for the slideshows!	I liked the power point presentation during the webinar.
5. What would you recommend changing?	Length of time. Unfortunately, I had to return to work before the webinar was over.	N/A	For some reason, I could not see the first few slides...	Time. Although I think an hour is a good amount of time, wish we could have

				covered all the details.
6. Now that you have completed this webinar, what additional training or topics would be helpful to you?	Unsure at this time. But I know I will think of something during my next training.	How incorporate positive community planning steps.		
7. Other comments, observations, suggestions:	Not at this time.	Thank you!		

*Answers scored on a scale of 1-5 with 5 being the most positive.

CHAPTER 5: EVALUATION OF ALASKA GATEKEEPER QPR TRAININGS

Expanding the number of suicide prevention trainers and training opportunities in the state was a primary goal of the AKYSPP but also to ensure training efforts would remain sustainable at the end of the grant cycle. To achieve this goal, project staff used a systems-based approach and focused on training individuals within organizations or communities, as well as emphasizing integration of suicide prevention efforts into existing policies and procedures. Therefore, the trainers could continue to offer their training knowledge and skills to those within their own system as needed.

The training coordinator with the UAA Trust Training Cooperative completed the requirements to become a Master Trainer in the Question, Persuade, and Refer model of suicide prevention training by the QPR Institute in 2013. As a Master Trainer, the training coordinator for AKYSPP had the ability to provide Train the Trainers (TOT) for communities and organizations. Also, as a Master Trainer, the training coordinator had the ability to support training of other Master Trainers throughout Alaska. As of June 2015, the training coordinator has organized and conducted 12 TOTs with 15 organizations resulting in 178 certified trainers and vetted seven Master Trainers through the QPR Institute (Table 12).

Table 12: Participation in Alaska Gatekeeper QPR TOTs.

Organization	Number Participated and Certified	Date
Division of Juvenile Justice	18	June 2013
Combined training: Alaska Child and Family, Akeela, Inc., Yukon-Kuskokwim Health Corporation, & Division of Juvenile Justice	15	August 2013
Tanana Chiefs Council	16	August 2013
Southeast Alaska Tribal Health Consortium	12	November 2013
Anchorage Police Department & Peninsula Hospital	16	January 2014
Bristol Bay Area Health Consortium	12	February 2014
Ketchikan Police and Schools	24	May 2014
Alaska Department of Education	23	September 2014
Juneau Suicide Prevention Coalition	12	February 2015
Anchorage School District and Matanuska-Susitna Borough School District	12	March 2015
Tanana Chiefs Council	7	April 30/May 1 2015
ASSETS, Incorporated	11	June 2015
Total	178	-

Data Sources for the Evaluation of Alaska Gatekeeper QPR Trainings

To provide useful information on process and outcomes of Alaska Gatekeeper trainings supported by the AKYSPP, the following data sources were utilized. Pre and post training survey methodology was approved by the University of Alaska Institutional Review Board (IRB) for research with human subjects.

Training Activity Summary Page (TASP). The TASP forms were submitted to evaluators or the training coordinator by trainers after trainings were conducted. The TASP forms recorded the total number of participants attending trainings, the location and setting (i.e., school, community, etc.), type of training (general community or training of trainer), and length of training. Participants were counted as a general trainee versus someone working in the mental health field (Appendix H).

Alaska Gatekeeper QPR Pre-Training Survey. Pre-training surveys were administered by trainers and completed by consenting participants immediately before Alaska Gatekeeper trainings. The QPR Pre-training Survey assesses knowledge and beliefs about suicide prior to a training (Appendix I). Completed pre-surveys were delivered to evaluators or the training coordinator by trainers via email, mail, or fax. The pre-training survey was collected from training participants from June 2013 to March 2015.

Alaska Gatekeeper QPR Post-Training Exit Survey (TES). The TES was administered by trainers and completed by consenting participants immediately after attending an Alaska Gatekeeper Training. Items assessed general participant satisfaction with the training, knowledge and beliefs, usefulness of the training, and intended use of the knowledge and skills acquired. Historically, the TES was a required component of the cross-site evaluation, but has been considered an optional component since 2011. The AKYSPP utilized the survey as a posttest because it was considered useful in content and include the QPR Pre-training survey questions to allow for pre to post analyses. Based on feedback by training staff, the instructions and background information section was revised in 2014 to improve readability and understanding among trainees (Appendix J). Completed TES surveys were delivered to evaluators or the training coordinator by trainers via email, mail, or fax. The TES was collected from training participants from June 2013 to March 2015.

Three Month Training Utilization and Promotion Survey (TUP-S). The TUP-S is a quantitative survey administered to individuals who participated in a training activity by the cross-site evaluators over the telephone. The TUP-S consent to follow-up sign-in sheet was collected by trainers and mailed to the cross-site evaluators to follow-up with approximately 10% of all training participants 3 months later. The purpose of the TUP-S is to learn more about trainees' longer-term use and retention of participants' knowledge, skills, and behaviors. Participants receive a \$10 electronic gift card for their participation in both the 3 and 6-month interviews. TUP-S consent to contact form sign-in sheet and 3 and 6-month interview scripts can be found in Appendix E and F.

Alaska Gatekeeper QPR Trainer Interviews. Ten key informant interviews were conducted with individuals who had participated in the newly redeveloped Alaska Suicide Prevention Training with a QPR Approach train the trainer events. The purpose of these interviews was to follow-up with trainers to determine if the suicide prevention training is flexible enough for them to transfer the appropriate knowledge and skills in a culturally effective manner to participating communities and organizations. Another aim was to understand why trainers offer or do not offer trainings once they have been through the training. The interview script can be found in Appendix D.

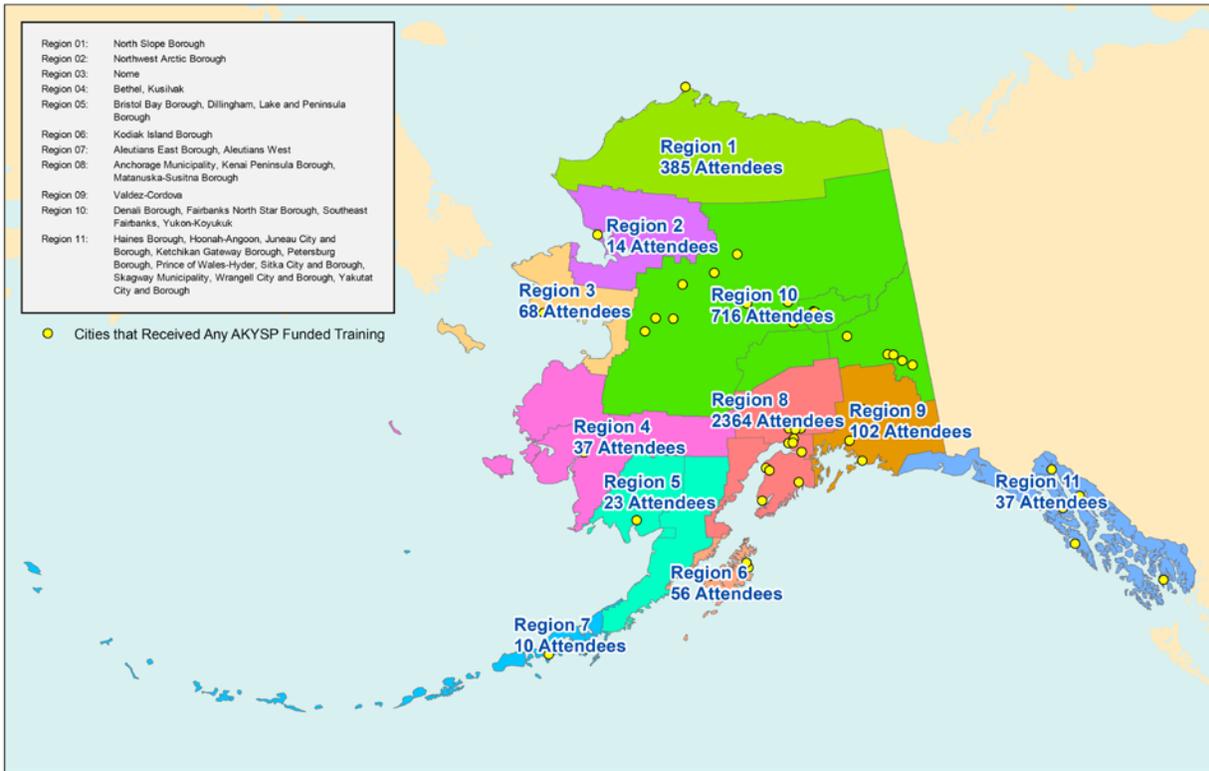
Reach of Gatekeeper Trainings

One hundred ninety-eight Alaska Gatekeeper QPR trainings were conducted by AKYSPP training staff from 2013 through October of 2015 during the no-cost extension. Eleven Campus Gatekeeper Trainings were also conducted. A total of 3,812 individuals were trained in a variety of settings and regions throughout the state through June 2015 (see Figure 6). By the time this report went to print in October of 2015, the number had increased to 6,228. Trainings reached every region of the state with the majority of trainings held in Anchorage. Although participants attended training in Anchorage, some may have resided in other regions of the state. The geographic residence of each training participant is unknown. Of the total number trained, 1,104 of the attendees work in the mental health related field. A summary the trainings provided by the AKYSPP training staff is provided in Appendix G.

Both formal and informal partnerships helped to increase the reach of trainings throughout the state.

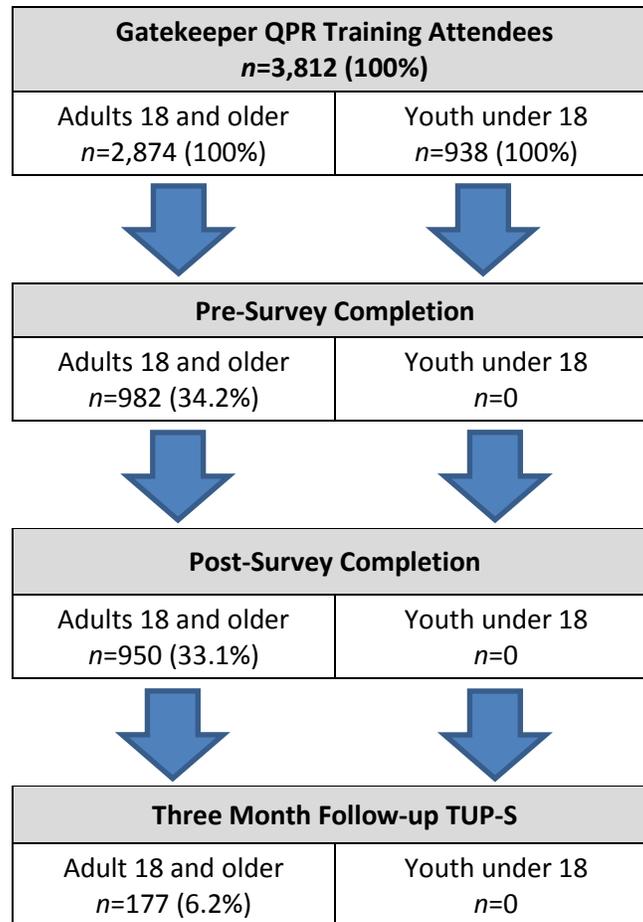
- In Year 3 of the grant, one of the certified gatekeeper trainers and her high school aged daughter developed a youth awareness presentation and presented it to high school students in schools throughout the Anchorage area titled “You Are Not Alone” (YANA).
- Alaska Rotary clubs chose suicide prevention as a focus of their philanthropic work for 2015. As a result of that initiative, the Anchorage Rotary Club worked with Spawn Ideas, Inc. to develop a suicide prevention campaign that ran on television stations in Anchorage and Fairbanks February - April 2015 and 26 Rotary clubs throughout Alaska provided trainings to their members.
- North Star clinical liaisons provided at least 25 trainings in communities around Alaska.
- Fairbanks TTC training coordinator provided 52 suicide prevention trainings to villages and organizations in Fairbanks and the interior of Alaska by partnering with local behavioral health staff or a member of the community to collaboratively deliver the training and meet the needs of local communities.

Figure 6: Map of Alaska Gatekeeper QPR Trainings conducted in Alaska.



Response Rates for Alaska Gatekeeper QPR Training Surveys

Figure 7 describes the survey response rate for all training surveys conducted before, after, and 3 months following Alaska Gatekeeper QPR Trainings through April of 2015. Youth were not eligible to complete training surveys which left a gap in learning about trainings from a youth perspective.

Figure 7: Alaska Gatekeeper QPR Training survey participation rates.

Pre and Post Training Survey Results

Consenting participants 18 years of age and older attending Alaska Gatekeeper QPR trainings were asked to complete a pre- and post-training survey through April of 2015. 982 adults completed a pre-survey and 950 completed a post-survey among the 2,874 adults who attended trainings during this timeframe. Survey items addressed intended learning objectives of the Alaska Gatekeeper Training with a QPR Approach in addition to suicide prevention attitudes and behaviors. Attempts were made to compare results by important demographic groups. Age, gender, and ethnicity did not appear to generate meaningful differences in participant responses. Employment setting, a multiple choice question left blank by approximately 16% of participants, does not take into account the primary nature of their interactions with youth which proved to be the most useful breakout in determining response differences by participants in the 3 month follow-up survey.

Table 13 describes the demographic characteristics of training participants and the settings where they most frequently interact with youth. The majority of participants were White (62.5%) followed by Alaska Native (26.4%) and most were female (62.1%). Many participants interacted with youth in education settings (31.9%) and other community settings (20.8%). The least common employment setting was child welfare (1.9%).

Table 13: Demographic characteristics of Alaska Gatekeeper Training participants.

Demographic Characteristics (n=950)		
Age	n=831	%
18-24	134	16.1
25-34	202	24.3
35-44	160	19.3
45-54	176	21.2
55+	153	19.1
Gender	n=919	%
Male	280	30.5
Female	571	62.1
Transgender	4	0.4
Other	64	7.0
Ethnicity (multiple response)	n=942	%
White	594	62.5
Alaska Native/ American Indian	251	26.4
Asian	27	2.8
Black or African American	32	3.4
Native Hawaiian or Pacific Islander	7	0.7
Other	47	9.5
Employment setting (multiple response)	n=794	%
Education	253	31.9
Higher Education	129	16.2
Mental Health	105	13.2
Juvenile Justice	85	10.7
Substance Abuse	83	10.5
Emergency Response	53	6.7
Tribal Services	54	6.8
Child Welfare	15	1.9
Primary Health	35	4.4
Other Community Settings	165	20.8
Time interacting with youth each week	n=950	%
0-15 minutes	256	26.9
15-30 minutes	96	10.1
30 minutes-1 hour	112	11.8
1-2 hours	89	9.4
More than 2 hours	397	41.8

Pre and post-test scores were analyzed using a repeated measures t-test to explore the differences in skills, knowledge, and attitudes before and immediately after trainings. 885 participants completed both a pre and post training survey and were matched using a unique participant number. Significant self-reported improvements in perceived understanding were reported (Table 14) along with their intentions and confidence to intervene with an identified youth at-risk (Table 15). This indicates that Alaska Gatekeeper QPR trainings have been successful at enhancing perceived knowledge and self-efficacy of training participants. Intentions to intervene were already high at baseline which is not surprising given participant willingness to attend suicide prevention training.

Table 14: Change suicide prevention knowledge, attitudes, and intentions before and after attending Alaska Gatekeeper QPR Trainings.

Indicate how you would rate your knowledge of suicide in the following areas? (1 = Very Low to 5 = Very High)	Pretest n=885	Posttest n=885
	Mean (SD)	Mean (SD)
Facts concerning Suicide Prevention.	3.1 (0.90)	3.9 (0.70)**
Warning signs of suicide.	3.3 (0.87)	4.0 (0.71)**
How to ask someone about suicide.	3.0 (1.10)	4.0 (0.73)**
Persuading someone to get help.	3.1 (0.95)	4.0 (0.74)**
How to get help for someone.	3.2 (0.97)	4.0 (0.73)**
Information about resources for help with suicide.	3.0 (0.97)	4.0 (0.75)**
Please rate what you feel is the appropriateness of asking someone who may be at risk about suicide.	3.6 (1.06)	4.1 (0.77)**
What is the likelihood you will ask someone who appears to be at risk if they are thinking of suicide?	3.6 (1.07)	4.2 (0.78)**
Please rate your level of understanding about suicide and suicide prevention.	3.2 (0.88)	4.0 (0.73)**

**Denotes significant increase from pre to post-test at $p < .001$; Missing responses to items on pre and post surveys were coded as a "3" or "medium".

Table 15: Change in confidence and intentions to intervene with someone at risk before and after attending Alaska Gatekeeper QPR Trainings.

Indicate the degree to which you agree or disagree with each statement. (1=Strongly Disagree to 5=Strongly Agree)	Pre-test n=885	Post-test n=885
	Mean (SD)	Mean (SD)
If someone I knew was showing signs of suicide, I would directly raise the question of suicide with them.	4.0 (0.84)	4.3 (0.74)**
If a person's words and/or behavior suggest the possibility of suicide, I would ask the person directly if he/she is thinking about suicide.	4.0 (0.81)	4.3 (0.74)**

Indicate the degree to which you agree or disagree with each statement. (1=Strongly Disagree to 5=Strongly Agree)	Pre-test n=885	Post-test n=885
	Mean (SD)	Mean (SD)
If someone told me they were thinking of suicide, I would intervene.	4.4 (0.67)	4.5 (0.61)**
I feel confident in my ability to help a suicidal person.	3.6 (0.95)	4.2 (0.74)**
I don't think I can prevent someone from suicide.	2.5 (0.95)	2.2 (1.19)**
I don't feel competent to help a person at risk of suicide.	2.4 (1.01)	2.1 (1.14)**

**Denotes significant increase from pre to post-test at $p < .001$; Missing responses to items on pre and post surveys were coded as a "3" or "neither agree nor disagree".

The TES post-test survey also asked participants to rate the usefulness of the training (Table 16). All responses indicate that the training information would be useful to them in their work or daily lives. Moving forward, it may be useful for AKYSPP program staff to add additional questions to the post-test to ask participants what would make the training even more beneficial to them in order to further increase training satisfaction.

Table 16: Satisfaction and perceived usefulness of the Alaska Gatekeeper Trainings.

Indicate your agreement with the following statements about the training. (1= Strongly Disagree to 4=Strongly Agree)	Post-test n=950	
	Mean (SD)	% Agree/ Strongly Agree
The training increased my knowledge about suicide prevention.	3.5 (0.62)	96.5
The training materials I received will be very useful for my suicide prevention efforts.	3.5 (0.59)	97.5
The training met my suicide prevention needs.	3.4 (0.61)	96.7
The training addressed cultural differences in the youth I intend to serve.	3.3 (0.69)	89.2
The training was practical to my work and/or my daily life.	3.5 (0.62)	96.1
I fully understand why I attended the training.	3.6 (0.58)	97.6
I am now more ready to help with youth suicide prevention in my community.	3.4 (0.60)	96.7
The things I learned will help prevent youth suicide or reduce the problems that might lead to suicide.	3.4 (0.58)	97.4

Half of all training participants (50.1%) were required to attend the Alaska Gatekeeper Training and 79.3% felt the training was delivered at their skill level (Table 17). The post-training survey also addressed the intended use of the information received. Participants felt the information they learned at the training would most often apply to youth (73.0%) and other community members (57.0%), and the majority planned to use the skills learned in their interactions with youth (62.3%). More specifically, attendees planned to use the information they received to have informal conversations about suicide and suicide prevention with youth and others

(54.0%), identify youth who may be at risk for suicide (51.6%), and make referrals to mental health services for at risk youth (43.5%) (Table 17).

Table 17: Perception of Alaska Gatekeeper QPR trainings and expected use of the information learned.

Post-training survey results (n=950)		
Were you required to participate in this training?	n=879	%
Yes	440	50.1
No	439	49.9
How would you rate this training?	n=916	%
Below my skill level	87	9.5
At my skill level	726	79.3
Above my skill level	103	11.2
With whom do you expect to directly apply what you have learned during this training? (Select all that apply)	n=838	%
Youth	612	73.0
Community members	478	57.0
Family	415	49.5
Coworkers	387	46.2
Parents/foster parents/caregivers	340	40.6
With what group do you expect to most often apply what you have learned during this training?	n=881	%
Youth	549	62.3
Community members	170	19.3
Family	69	7.8
Parents/foster parents/caregivers	36	4.1
Coworkers	57	6.0
How do you intend to use what you learned during this training? (Select all that apply)	n=950	%
Have informal conversations about suicide and suicide prevention	513	54.0
Identify youth who may be at risk for suicide	490	51.6
Make referrals to mental health services for at risk youth	413	43.5
Screen youth for suicide behaviors (i.e. using a screening tool)	306	32.2
Work with adult at-risk populations	239	28.5
Provide direct services to youth at risk for suicide and/or their families	257	27.1
Train other staff members	220	23.2
Formally publicize information about suicide prevention resources	208	21.9
Other	131	13.8
I do not intend to use what I learned	24	2.5

Participant and Trainer Experiences and Stories

Personal stories of experiences in using and offering the Alaska Gatekeeper Training with a QPR Approach is a powerful means of illustrating the potential impact suicide prevention training can have for Alaska's residents and communities. Training participants and trainers volunteered to share their experiences in how the newly redeveloped training helped them, or someone they knew, to support someone at risk of suicide. Highlights of these stories are captured in Figure 8 and present a sample of statements from participants and trainers.

Promoting the newly developed Alaska Gatekeeper QPR training also created opportunities to bring about more awareness to suicide locally and the important contributions all communities, no matter the size or available resources, can make to suicide prevention efforts. The Alaska Gatekeeper QPR Training brochure and Alaska Careline promotional products were featured at community and regional health fairs by training and behavioral health staff. The health fairs increased opportunities for community members to have conversations about suicide.

In one example during March of 2014, a certified gatekeeper trainer invited attendees of the Tanana Chiefs Council (TCC) Region Health Fair to participate in a suicide prevention activity. As individuals stopped by the presentation table, they were asked, "Two main things that prevent suicide are 'Hope' and a feeling of 'Belonging.' What in your culture or community gives you a feeling of 'Hope' or of 'Belonging'" (Table 18)?

Figure 8: Quotes from trainers and participants describing impact of training.

I received an email from a woman who said the Gatekeeper training gave her the skills to finally have an honest conversation with her daughter who had been making suicidal comments for several years.

-Gatekeeper trainer in Anchorage

I have found over and over again, that the youth themselves can be involved in suicide prevention. Their voice needs to be heard.

-Gatekeeper trainer with the Anchorage School District

A high school girl spoke with me after the Gatekeeper training and said she now knew how to talk to her close friend who had attempted suicide a few weeks ago.

-Youth Gatekeeper Trainer

I was really interested in this training because I had heard of five suicides since I started school at UAF. The week after I was trained, I was on Skype with a friend from high school. In the middle of our conversation she turned the camera and showed me her arm, which she had just slashed with a knife while we were talking. So I used the information from the gatekeeper training to talk to her. I questioned her, persuaded her to get help, and referred her to resources. So now I am super passionate about this training on campus.

-Participant from the University of Alaska, Fairbanks

I found that the gatekeeper training was very useful. The very day I received training I spoke to a youth who was suicidal. I was able to say the right things and figure out if he had a plan for suicide. The gatekeeper training gave me the confidence to speak with this person and get him help.

-Participant in Tanana

Gatekeeper training was the most relevant mental health training I've ever been to.

- Participant in Juneau

Table 18: Results of the “Hope and Belonging” activity at the TCC Region Health Fair.

Response	Village
Hope	
Spirituality.	Minto
Good role models.	Galena
The ability to Hunt, Fish, Share.	Ft. Yukon
Community Talking Circles.	Kaltag
A sense of self-worth.	Fairbanks
Re-building.	Eagle
Staying active, being outside.	Ft. Yukon
Prevent child abuse.	
Music. Dance. <u>Believe</u> in our future generations.	Galena
Show it! Hugs and encouragement.	Minto
Having something to look forward to.	Beaver
Working together.	Galena and Ft. Yukon
Positive communication between family members.	Venetie
Traditional singing and dancing.	Stevens
Family fellowship. Traditional and cultural activities – patience, hope. Parental involvement.	Ft. Yukon
Hope for healing from addiction through spirituality.	Alatna
Learning to believe in yourself and your dreams.	Hughes
Our kids learning they don’t need alcohol or drugs to have a good time.	Nikolai
Helping each other out – caring.	Anaktuvuk Pass
Our kids.	Huslia
Kids. Elders.	Koyukuk
Music activities.	Galena
Belonging	
Family line – who they belong to, they came from strong, spiritual people.	Alatna
Where you come from.	Koyukuk
Caring for each other.	Galena
Sharing food.	Fairbanks
Subsistence.	Nulato
Support.	North Pole
Family ties. Stick together through thick and thin. Unity!	Northway
Athabascan traditions and activities.	Huslia
Spirituality.	Minto
Love and hugs.	Nulato
Family. Knowledge.	Tok
Family.	Galena
Having good relationships with friends and family.	Galena
Looking out for each other and caring for each other.	Beaver
Being out in nature.	Kaltag
Strong healthy families.	Koyukuk

Three Month Follow-up Training Survey Results

An important indicator of effective suicide prevention training is the retention of knowledge, skills, attitudes, and a change in suicide prevention behaviors. This is assessed three months after participants receive Alaska Gatekeeper QPR trainings using the TUP-S; a quantitative survey administered over the phone to a random selection of consenting individuals by the ICF International cross-site evaluators (Appendix F). The TUP-S consent to contact sign-in sheets (Appendix E) were collected by training staff, provided to evaluators, and mailed to the cross-site evaluators in order to follow-up with approximately 10% of all training participants who provided consent. Interviewers ask the TUP-S participants if they can contact them for a second follow-up call at six months. Participants receive a \$10 electronic gift card for their participation in each of the three and six-month interviews.

TUP-S three month follow-up results are based on surveys from 177 individuals who attended 50 different Alaska Gatekeeper QPR trainings through March of 2015. It is possible to identify the trainings that participants attended but not the ability to link their responses to pre and post survey data for longitudinal analyses. However, the results still provide an in-depth look at the knowledge, attitudes, and behaviors of randomly selected training participants three months after receiving training. Results are compiled by the cross site evaluator quarterly and were imported into SPSS from Excel by CBHRS evaluators for further analyses. Due to the small sample size obtained at six months, results are only reported for the three month follow-up in this report. Demographic characteristics of participants are summarized in Table 19.

Table 19: Demographic characteristics of TUP-S respondents at three months.

Demographic Characteristics	Total (n=177) %
Gender	
Male	31.6
Female	68.4
Ethnicity (multiple responses)	
Hispanic	4.6
African American	3.4
American Indian or Alaska Native	19.2
White	71.2
Other/multiracial	4.7
Nature of work with youth	Version 4 Only (n=158) %
No formal work or generally in the community	36.1
Mental health services	4.4
Counseling or advising	22.8
Teaching	13.9
Case management	12.7
Mentoring	10.1

Table 20 displays the perceived utility of the Alaska Gatekeeper QPR Trainings at three months. Results are broken out by individuals who provide mental health related services to youth, individuals who have other formal interactions with youth (teacher, caseworker, mentor), and individuals who do not have formal interactions with youth. Overall, the vast majority of individuals were satisfied with the training across survey items but scores were somewhat lower for those with no formal interactions with youth. Nearly 98% of all survey participants at three months agreed that the training increased their knowledge about suicide prevention which was the highest scoring item. The lowest score was for the item, “I have used my training to help with youth suicide prevention in my community” (73.6%), particularly among those with no formal interactions with youth (54.9%). Lower levels among this group is likely due to fewer opportunities to intervene with youth as knowledge and skills reported are similar across all groups (see Table 21).

Table 20: Training satisfaction and perceived usefulness among training participants at three months.

Satisfaction and Usefulness (1=strongly disagree to 4=strongly agree)	Total (n=177)	Mental health related work with youth (n=43)	Other formal work with youth (n=58)	No formal work with youth (n=57)
	% Agree to Strongly Agree			
The training materials I received (i.e., brochures, wallet cards, etc.) have been very useful for my suicide prevention efforts	88.4	95.3	85.5	81.8
The training increased my knowledge about suicide prevention	97.7	97.7	100.0	94.7
The training has met my suicide prevention needs	93.0	100.0	91.1	90.7
The training addressed cultural differences in the youth I serve	88.2	95.1	85.7	81.1
The training has proven practical to my work and/or my daily life	93.0	97.7	96.4	83.3
I have used my training) to help with youth suicide prevention in my community	73.6	81.0	80.4	54.9
The things I learned during the have helped me prevent youth suicide or reduce the problems that might lead to suicide (i.e. depression, substance abuse, etc.)	86.1	95.2	88.5	79.2

Table 21 displays suicide prevention knowledge, attitudes and intentions among TUP-S respondents. Perceived knowledge was high with over 90% of participants agreeing that even after three months they still had the knowledge necessary to identify, intervene, and get help

for someone at risk of suicide. Perceived knowledge was high across all groups including those who provide mental health related services to youth and those who interact with youth in other formal and informal roles. Around 90.2% of participants said they are likely to very likely to ask someone who appears to be at risk if they are thinking of suicide. These are positive findings, indicating suicide prevention knowledge, attitudes, and intentions to intervene with someone at risk of suicide is still strong among all types of gatekeepers three months after training has ended.

Table 21: Suicide prevention knowledge, attitudes, and intentions to intervene among training participants at three months.

Perceived Knowledge (1 = very low to 5 = very high)	Total (n=163)	Mental health related work with youth (n=43)	Other formal work with youth (n=58)	No formal work with youth (n=57)
	% High to Very High			
Facts concerning Suicide Prevention.	90.8	95.3	91.4	86.0
Warning signs of suicide.	95.7	100.0	93.1	94.7
How to ask someone about suicide.	93.3	97.7	89.7	93.0
Persuading someone to get help.	93.3	95.3	93.1	91.2
How to get help for someone.	96.9	97.7	98.3	94.7
Information about resources for help with suicide.	91.4	95.3	87.9	91.2
Attitudes (1 =not at all appropriate to 5=very appropriate)	% Appropriate to Very Appropriate			
Appropriateness of asking someone who may be at risk about suicide.	93.3	95.3	93.1	91.2
Intentions (1=not at all likely to 5=very likely)	% Likely to Very Likely			
Likelihood you will ask someone who appears to be at risk if they are thinking of suicide.	90.2	95.3	87.9	87.7

* None of the questions were asked in version 3 of TUP-S

Table 22 displays the ways in which training participants have reported use of suicide prevention information gained at Alaska Gatekeeper QPR trainings within three months. The most common ways are through informal conversations about suicide prevention with others (78.7%), monitoring youth who might be at risk for suicide (60.0%), and providing direct services to youth at risk for suicide or their families (45.7%). The least common ways that training information is used include training adults (18.6%) and youth (16.4%) to intervene with a youth at risk for suicide. Individuals with no formal interactions with youth were least likely to use training information in all ways identified in the TUP-S. It's likely they don't interact with youth on a regular basis but are still using training information in a variety of ways to support

suicide prevention. Individuals who provide formal mental health related services to youth had the highest level of usage overall, particularly in identifying youth who may be at risk, providing direct services to youth at risk for suicide, and making referrals to mental health services for at risk youth. This result likely reflects their increased exposure to youth and their role in providing mental related services. Without knowing the status of these behaviors prior to receiving training, it is difficult to determine if the results represent an increase after receiving training.

Table 22: How training information was used by participants at three months.

Use of suicide prevention training (multiple responses)	Total (n=177)	Mental health related work with youth (n=43)	Other formal work with youth (n=58)	No formal work with youth (n=57)
	% Yes			
Train youth to intervene with a peer at risk for suicide	16.4	18.6	17.2	10.5
Train adults to intervene with a youth at risk for suicide	18.6	32.6	8.6	7.0
Screen youth for suicide behaviors (i.e., using a screening tool)	30.3	51.2	31.6	14.3
Formally publicize information about suicide prevention or mental health resources	32.2	46.5	24.1	31.6
Have informal conversations about suicide and suicide prevention with youth and others	78.7	88.4	78.9	67.9
Identify youth who might be at risk for suicide	60.0	79.1	59.6	37.5
Provide direct services to youth at risk for suicide and/or their families	45.7	62.8	46.4	24.6
Train other staff members	26.4	39.5	12.5	19.6
Make referrals to mental health services for at risk youth	45.7	62.8	40.4	32.1

* Mental health related work includes counseling/advising and mental health services; Other formal work includes teaching, case management, and mentoring.

Table 23 highlights the extent to which training information was used by participants to identify, intervene, and refer youth to services within three months. The table also includes the setting in which the identification was made and the services that youth are referred to. 47.5% of training participants intervened with at least one youth after the training; this percent was greatest for those providing mental health related services to youth (62.8%), followed by those with other formal interactions with youth (55.2%), and lowest for those with no formal interactions with youth (22.8%). Although individuals who do not interact with youth formally may have less contact with youth on a consistent basis or no job related expectation related to

youth, it is positive to see that nearly 23% have seized an opportunity to intervene with at least one youth they felt was at risk.

Among individuals who identified and intervened with at least one youth at risk, the most common settings where identifications took place include school settings (38.9%), followed by juvenile justice settings (22.2%), and digital mediums such as Facebook or texting (18.4%). The least common identification settings include physical health and emergency room settings. For individuals providing mental health related services to youth, schools were the primary location of identifications (55.6%). For those with other formal interactions with youth it was juvenile justice settings (40.6%) and for those with no formal youth interactions, the most common setting for identifications was a digital medium (38.5%).

Among individuals who identified and intervened with at least one youth at risk, referrals were most commonly made to a mental health agency (57.1%), following by a school counselor (29.8%), and a psychiatric hospital/unit (23.8%). Although referrals were common, 21.4% of training participants did not know whether or not the youth actually received any services they were referred to which highlights a gap. Participants who provide mental health related services to youth were the most likely to engage in follow-up activities while those with no formal youth interactions were the least likely. Emphasizing the need and usefulness of conducting follow-ups with youth referred to services at Alaska Gatekeeper QPR trainings, including a discussion of the challenges, may be useful to ensure that youth do not fall through cracks on their way to receiving the help needed. Among youth where follow-ups were done, 57.1% of participants reported that all the youth received services. Reasons why services were not received was not addressed but could include parent refusal of services, youth still waiting for services at the time of the survey, or a more serious reason including the youth didn't get the services needed. Further questions in the TUP-S would be useful to identify the source of any barriers in youth receiving needed services.

In general, 84.6% of individuals who referred youth and the youth received services were satisfied to very satisfied with the Alaska Gatekeeper QPR Training, and the actions they took based on the training were appropriate and effective. Satisfaction levels were consistent, regardless of the type of formal or informal roles training participants had with youth. This indicates the training is helpful in preparing the majority gatekeepers, in a variety of settings, to intervene and refer youth to the appropriate services. About 9.2% of individuals were not at all satisfied which indicates the training left gap for a few individuals. Further exploration into this gap could help to inform and improve the Alaska Gatekeeper QPR Training. Delays in getting services for youth were mentioned by some Gatekeepers which could be a potential source of dissatisfaction. 58.5% of youth received services within a day, 23.1% received services within a week, and 18.5% had to wait longer than a week. It is not clear from the data whether certain types of services resulted in longer wait times. It would be useful to have a discussion with training participants about potential ways to support youth who may have to wait for needed services.

Table 23: Participant interventions with youth at-risk for suicide at three months.

Identifications and interventions after suicide prevention training	Total (n=177)	Mental health related work with youth (n=43)	Other formal work with youth (n=58)	No formal work with youth (n=57)
	% Yes			
Intervened with at least one youth at risk	47.5	62.8	55.2	22.8
Setting where identification took place among individuals who identified youth at-risk (multiple responses)	(n=84)	(n=27)	(n=32)	(n=13)
School	38.9	55.6	31.3	30.8
Child welfare	8.9	3.7	15.6	7.7
Juvenile Justice	22.2	0.0	40.6	23.1
Physical health	3.3	3.7	0.0	7.7
Emergency room	3.3	3.7	6.3	0.0
Mental health agency	10.0	14.8	9.4	0.0
Community recreation/after-school activity	15.6	18.5	9.4	15.4
Home	17.8	11.1	15.6	23.1
Digital medium (i.e. Facebook, email)	18.4	18.5	9.4	38.5
Where youth were referred – by individuals who identified youth at-risk (multiple responses)	(n=84)	(n=27)	(n=32)	(n=13)
Mental health agency	57.1	77.8	56.3	53.8
Psychiatric hospital/unit	23.8	33.3	25.0	0.0
Emergency room	15.5	22.2	12.5	7.7
Substance abuse treatment center	19.0	25.9	21.9	7.7
School counselor	29.8	33.3	37.5	30.8
Private mental health practice	19.0	11.1	12.5	15.4
Mobile crisis unit	2.4	0.0	0.0	15.4
Some other place (police, hotline, elder, etc.)	17.9	22.2	18.8	15.4
Whether youth received services - among individuals who referred youth at risk	(n=84)	(n=27)	(n=32)	(n=13)
No knowledge of whether youth received services	21.4	11.1	25.0	38.5
All received services (100%)	57.1	63.0	59.4	46.2
A few to most received services (51-99%)	21.5	25.9	15.6	15.4

* Mental health related work includes counseling/advising and mental health services; Other formal work includes teaching, case management, and mentoring.

Other benefits experienced by Alaska Gatekeeper QPR training participants at three months included developing stronger social and familial relationships (51.6%), connecting to members

of the community (55.9%), placing greater awareness on the importance of communication (61.7%), and having a greater sense of competence (66.5%) and well-being (54.4%). There are no apparent differences in results between the primary setting of interactions with youth or by the nature of their interactions with youth.

The three greatest perceived barriers to implementing youth suicide prevention in the community or workplace were a lack of awareness about the problem of suicide, lack of funding, and lack of access to appropriate services. The greatest facilitators include increased community awareness and both training and professional development opportunities. Barriers and facilitators did not appear to differ greatly by the primary setting of interactions with youth or the nature of their interactions with youth. The Division of Behavioral Health's efforts to increase suicide prevention training and both outreach and awareness efforts through AKYSPP grant funding is in line with the key facilitators and barriers identified by training participants. Working with organizations to prioritize suicide prevention is another way. Lack of funding and lack of access to appropriate services for youth are much tougher barriers to address through short-term grant funding. However, the Division of Behavioral Health is in an overall position to advocate for funding and mental health services for suicide prevention at the state level as opportunities present themselves.

Table 24: Barriers and facilitators to implementing youth suicide prevention in the community or workplace at three months.

Barriers	Total (n=177) % Yes
Lack of awareness of the problem of suicide	27.5
Lack of funding	19.9
Access to appropriate services	18.7
Something else	17.0
Time constraints	13.5
Workplace characteristics	3.5
Facilitators	% Yes
Increased community awareness	26.2
Training and professional development opportunities	25.6
Community resources	15.1
Community collaboration	14.5
State, tribe, or agency prioritization of suicide prevention	14.0
Other reason	4.7

Trainer Interview Results

Ten key informant interviews were conducted with individuals who participated in the redeveloped Alaska Gatekeeper QPR train the trainer events. The purpose of these interviews was to follow-up with the new trainers to determine if the redeveloped training is flexible enough for them to transfer the appropriate knowledge and skills in a culturally effective manner to participating communities and organizations. Also, DBH wanted to understand why trainers offer or do not offer trainings once they have been through the training.

A major goal of the AKYSPP was to create a sustainable training model that would continue to be actively offered to communities and organizations after the grant cycle. To meet this goal, AKYSPP staff focused on integrating the new Alaska Gatekeeper curriculum into existing systems, institutions, and organizations by training individuals who work closely within those systems. This systems-based approach enables the curriculum to be used, updated, and adapted in-house to respond to changes in suicide risk and population demographics. It also helps to inform development or revision of suicide prevention policies and procedures appropriate for that organization. The sustainability of the training, however, depends on the ability of newly trained trainers to offer the Alaska Gatekeeper QPR Training to their community or organization as needed. Although the TOTs were planned strategically to targeted groups or individuals who were most likely to continue to offer trainings in their workplace or community, many have not.

Ten trainers were chosen as key informants from a list of 134 certified Alaska Gatekeeper trainers supplied by the AKYSPP training coordinator. Approximately half were chosen because they were expected to offer trainings for their organizations, but had not since attending the TOT. The other half has been very actively training in their community or organization.

Participants were invited to be interviewed by email or phone, and all but one was conducted over the phone. Key informants received consent information and were offered an opportunity to opt out of the interview. Discussions were not audio recorded, but transcribed by a member of the evaluation staff and lasted approximately 15-20 minutes. All participants were given a \$10 gift card to Starbucks for their time. Key informants were asked a series of open-ended questions, with follow-up prompts as needed. The interview script can be found in Appendix D. Key informant interview script and methods were approved by UAA Institutional Review Board.

Trainers selected for an interview work in a variety of settings and serve remote, rural, and urban communities with populations ranging from less than 100 to greater than 5000. The participants attended the TOT to supplement their current workplace duties. All but one key informant felt the TOT they attended adequately prepared them to present the Alaska Gatekeeper QPR Training. However, one mentioned that he did not start training immediately after the TOT and would have appreciated a refresher. The individual who did not feel prepared attended a second TOT, where she retained the skills and knowledge better because the group was much smaller and more interactive.

Two trainers had not provided any training since attending the TOT. One mentioned they participated in the training for information only, because they were working on a suicide prevention project for their organization. Because of the information given at the TOT, she was able to tailor the project to better educate the staff and increase awareness of suicide. The other trainer mentioned that neither his workplace, nor any other organization in his community, had requested training since his certification.

The Alaska Gatekeeper QPR Training was developed so attendees could increase skills in identifying and supporting individuals at risk for suicide. Four trainers mentioned they use the evaluations at the end of training to gauge if the participants felt they increased their skill level. The rest had a variety of strategies to gauge whether the audience was retaining the information. For example, one asks many questions of her participants to determine what the group is learning and one described how she asked participants to practice asking “the question” with their neighbor and then discussing how it made them feel. Another made sure that participants received a QPR booklet and wristbands printed with the Alaska Careline contact information. Two also mentioned they provided follow-up support.

Key informants were asked if they had experienced any difficult training situations. Overall, trainers felt audiences had been very receptive. However one mentioned he felt the content could be somewhat “triggering” for attendees and another was inundated with what she felt were too many youth attending a training at one time. In both instances, the trainers said they responded to the situations by making themselves available after the training for as long as needed. As one trainer said, he made sure to “talk it out” and another stated she “tried to avoid repetition and ... get them involved by asking their opinions on topics.”

All participants felt it was very useful to be a certified trainer in their community. Two mentioned they were trusted sources of information and support for their community. Two others appreciated having the skills and knowledge to use outside of training sessions. In one example, the certified trainer is also an adjunct college professor and has been able to apply the skills learned during interactions with students if need extra support is needed or if they are experiencing depression or grief. One trainer felt that offering resources and trainings to communities across the state with a common theme and with consistent information was very valuable; presenting the local resources and Alaska information increases its value as a local and statewide initiative. Also mentioned as very important by one key informant, was how the training has engaged youth and emphasized how they “can play a role in suicide prevention.” One particularly enthusiastic trainer stated, “I’ve always been passionate about any suicide prevention trainings. I’m excited to give this [training] to our staff and students.” None of the trainers could think of a reason not to be a trainer or offer trainings. As one said, “No, it’s like first aid, you never know when you might need it.” Only one trainer mentioned a type of person who should not be a suicide prevention trainer; one that is not patient, doesn’t care, or is unwilling to listen.

Seven of the key informants felt their trainings had influenced suicide prevention policies, procedures, and practices in their organization or community. For example, one trainer described conducting training at a school and then providing the principal with a model suicide prevention policy the principal could adapt for the school. Two other trainers described how offering trainings had increased community discussions and engagement leading to initiatives like establishing suicide prevention clubs in schools. Four other trainers mentioned that their organizations now review policies regularly and that the suicide prevention training has been integrated into their annual mandatory trainings. In a last example, one trainer mentioned that their organization did not have a policy in place, but the TOT raised his awareness of the importance of establishing a suicide prevention policy and reviewing other procedures to determine where updates could be made.

All key informants felt supported by DBH and the Trust Training Cooperative with training updates, list serve emails, and supplies like QPR booklets, brochures, and Alaska Careline cards and pamphlets. Four mentioned by name the valuable support they received from the DBH program manager and the project training coordinator. They felt project staff was very accessible for questions or any other needs, except two mentioned needing a larger supply of QPR booklets and Alaska Careline cards.

Participants were also asked what they needed to feel more supported in their work. Two trainers wanted QPR refreshers more frequently, and another idea offered was to convene in-person to brainstorm training ideas and “learn different ways people conduct trainings.” Three trainers mentioned wanting more cultural information and more in depth discussion for the training slide regarding Alaskan culture.

An important consideration when developing the Alaska Gatekeeper Training with a QPR Approach was to ensure that the training model would be flexible and adaptable to a variety of audiences, while maintaining the fidelity of the evidence-based intervention. Trainers were asked if they had made any adaptations to the training to better fit their audiences, and five trainers had modified the trainings. For example, of the two that added expanded discussion sessions, one made it more youth friendly by talking “about what ‘giving hope’ looks like in a practical sense.” Another added clips of a student led and produced documentary titled “Railway to Hope,” and one more added in their personal story of being a survivor of suicide.

The majority of the trainers felt the training to be useful and broad enough in scope to meet the needs of their community, and as one trainer said, “I can’t think of how it could be more useful. I love it.” Another commented how much they liked the QPR booklets “because [the booklets] have got it all and they’re pretty small and easy to hand out.” Two trainers suggested adding more discussion around cultural relevance. Of those two, one mentioned they were trying to tailor it to be more representative of the Tlingit culture. Another suggestion was to add “more space for people’s own thoughts.” Three other suggestions included making the training more interactive, including self-care information for a gatekeeper who may have just

helped someone at risk for suicide or in crisis, and include “elders and the role that they can play in community suicide prevention.”

The trainers were also invited to comment on the three separate sections of the Alaska Gatekeeper Training with a QPR Approach: 1) Introduction and overview; 2) QPR core training, and; 3) Accessing community resources. None of the trainers suggested changes for Part 1, but two mentioned the QPR slides in Part 2 seemed awkward and contained “too many words.” Two trainers felt challenged with Part 3 because of the limited resources they were able to suggest or that were available in their communities and other rural locations in Alaska. As one of these two stated, “We have limited resources, but we always give out the Careline number.”

In general, the trainers believed being an Alaska Gatekeeper Training with a QPR Approach trainer was valuable to both themselves and their community. They enjoyed being a trusted member of their community and being seen as a source of important information. They felt the training was broad enough to meet their needs, and several had made adaptations to better suit their audiences. They felt supported by the AKYSPP staff, but would like greater quantities of QPR and Alaska Careline supplies and would like more opportunities for refresher trainings. Also, trainers would like more explanation and discussion about the role and importance of Alaskan culture in suicide prevention. Of those not delivering trainings, the training they attended was used as a source of information only, they were not contacted by their organization to deliver trainings, or they had not reached out and offered their services.

Recommendations include:

1. Offering in-person refresher and/or booster trainings for certified trainers at regular intervals. Ideally these could be offered concurrently at other events where trainers are likely to be in attendance. Examples include the School Health and Wellness Institute, the Annual School on Addictions and Behavioral Health, the Alaska Public Health Association Conference, etc.
2. Create a more formalized application process to attend a TOT with an assurance of offering future trainings for their community or organization. Also, ensure the individuals who are enrolled in the TOT have related suicide prevention duties integrated into their job description.
3. Provide more detailed information about Alaskan culture and its importance in suicide prevention. Information could be disseminated via a webinar, additional PowerPoint slides, or at the refresher/booster trainings.
4. Integrate more open space and/or discussion into the training to allow participants time to process their own lived experience or the acquired skills and knowledge offered in the training.
5. Integrate a test call to the Alaska Careline into the training and offer more resources for help and support for those communities that may not have adequate mental or behavioral health support. Suggestions could include web-based sources like supportive Facebook pages and the National Suicide Prevention Lifeline chat function.

CHAPTER 6: EVALUATION OF MEDIA CAMPAIGN FOR THE ALASKA CARELINE

The Alaska Careline is a valuable resource available to all Alaska residents 24 hours a day, 7 days a week. Texting services are available 3-11 pm Tuesday-Saturday. A key focus of the grant was to promote the Careline and increase awareness of its availability and use, and especially the new texting service. The Careline is staffed with trained mental health specialists who can provide confidential counseling, support, suggestions for resources, and follow-up contact during a time of crisis.

Alaska Careline Promotional Products

The Careline was featured as a key resource in all public communication of state suicide prevention activities and as a source of support for individuals at-risk of suicide, as well as their family, friends, and other community members. Examples include the print and media sources listed in Chapter Two of this report. AKYSPP also promoted the Careline and texting services through multiple print sources including cards, flyers, pens, zipper pulls, business cards, key chain flashlights, magnets, and wristbands (Figure 9). The promotional materials were distributed at a variety of community events like the annual Iron Dog Races, Alaska Gatekeeper QPR trainings, health fairs, schools, health centers, and crisis centers.

Change in Careline Activity over Time

Figure 10 displays total Careline contacts (both incoming and outgoing calls and texts) by quarter, including calls that were forwarded to other call centers due to over-capacity. Total contacts have doubled to reach 3,277 during Q4 of 2015. Overflow calls forwarded to call centers outside of Alaska at times when the Careline is at peak capacity. These were virtually non-existent prior 2014 but increased to 261 by Q4 of 2015. Figures 11-13 display Careline contacts per quarter by age, gender, and ethnicity from 2012 through 2015. Demographic questions are never asked directly of callers but are estimated based on information provided during the conversation. Age is the toughest category to estimate while gender is the easiest. Total Careline contacts remained the highest for individuals 45-64 years of age, peaking at 1860 calls during Q4 of 2015. Total contacts are lowest for youth 10-24 years of age but volume has tripled since 2012 to reach 669 calls during Q4 of 2015. Little to no change in Careline activity has occurred among individuals 25-44 years of age. Contacts are higher for females than males, but both genders have experienced similar increases. Contacts by ethnicity are broken out by Alaska Native versus Non-Alaska Native/Unknown. Total contacts serving Alaska Native individuals comprise roughly 20% of the total Careline contacts, but volume has doubled for both groups since 2012. It is unclear how many contacts are made for individuals with unknown ethnicities as they are combined with non-Alaska Native ethnicities.

Figure 9: AKYSPP Alaska Careline dissemination products.



CARELINE
CRISIS INTERVENTION

Careline is Alaska's 24/7 someone-to-talk-to suicide prevention line.

Text 4HELP to 839863 Tuesday-Saturday, 3 PM to 11 PM.

National Suicide Prevention Lifeline or call 1-877-266-4357 anytime. From phones with a non-907 area code, Lifeline, the national hotline: 1-800-273-8355.

Careline and Lifeline's help is free and confidential.



Be safe w/ur phone. Don't text and drive.

This card was developed for part of a grant number 5M480371 from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

R U Suffering?

UR Not Alone

If you or someone close is suffering...
Text 4HELP to 839863

Careline Text is available Tuesday through Saturday, from 3 PM to 11 PM.

Or call Careline at 1-877-266-4357 anytime. Careline is Alaska's 24/7 someone-to-talk-to suicide prevention line. From phones with a non-907 area code, call Lifeline, the national hotline: 1-800-273-8355. Careline's and Lifeline's help is free and confidential.

Take us home, and text us later.

*Standard msg&data rates apply.






iron dog

Team 12



Robert Strick **Steffen Strick Jr.**

LIFE IS A TEAM EFFORT!

Team 12

Robert Strick	Steffen Strick Jr.
Machine: 2014 Polaris Switchback Pro R 600	Machine: 2014 Polaris Switchback Pro R 600
Age: 29	Age: 28
Hometown: McGrath	Hometown: McGrath
Racer status: Veteran	Racer status: Veteran
Years raced: 2013, 12th place	Years raced: 2013, 12th place

LIFE IS A TEAM EFFORT! Need to talk? Call CARELINE, 24/7 Alaska's suicide prevention & someone-to-talk-to line.

877-266-HELP (4357)
Text 4help to 839863 (limited hours)

CARELINE
877-266-HELP
or text 4help to 839863



UR Not Alone

If you or a loved one is suffering...

- Depression/grief/loss
- Domestic violence
- Sexual assault
- Substance abuse
- Thoughts of self-harm

Text 4HELP to 839863

We can help. Careline now has a text message program just for you. Take us home, and text us later.

*Standard msg&data rates apply. Text STOP to opt out.




Have you taken the pledge?

We can help you keep it.

I pledge to live, honor and protect myself from any harm, to love my family, my friends and my village, today we stand together to stop suicide in Alaska
Tanona 4-h kids



CARELINE
877-266-HELP
or text 4help to 839863

www.carelinealaska.com *Text hours are Tues Sat, 3:00pm-11:00pm (standard rates may apply)

Suicide Warning Signs

Verbal: I'm thinking of ending it all I might as well shoot myself I can't go on, it's hopeless Life is not worth living Nothing matters anymore	Behavioral: Withdrawal, isolation Impulsiveness; recklessness Putting affairs in order Increased use of drugs or alcohol Expressed hopelessness
--	---

Worried about a friend? Worried about yourself?
Talk to someone or call us.
With Help Comes Hope.

LINDA MICHOBA
Patrick Folger SemaKen
Christian Sommer
Natawnee Wiehl
Teionna Wiehl
Genova Wright



"I was too scared to tell my friends"

"My parents would never understand"

"It seemed too horrible for words... then I texted about it and got help"

We are good listeners.
Text 4HELP to 839863

Careline Text is available Tuesday through Saturday, from 3 PM to 11 PM.

Or call Careline at 1-877-266-4357 anytime. Careline is Alaska's 24/7 someone-to-talk-to suicide prevention line. From phones with a non-907 area code, call Lifeline, the national hotline: 1-800-273-8355. Careline's and Lifeline's help is free and confidential.

Take us home, and text us later.

*Standard msg&data rates apply.

UR Not Alone
If you or a loved one is suffering...
• Depression/grief/loss
• Domestic violence
• Sexual assault
• Substance abuse
• Thoughts of self-harm

Text 4HELP to 839863
Text 4help to 839863 (limited hours) or call 1-877-266-4357 anytime. Careline is Alaska's 24/7 someone-to-talk-to suicide prevention line. From phones with a non-907 area code, call Lifeline, the national hotline: 1-800-273-8355. Careline's and Lifeline's help is free and confidential.






Figure 10: Careline incoming and outgoing contacts by quarter.

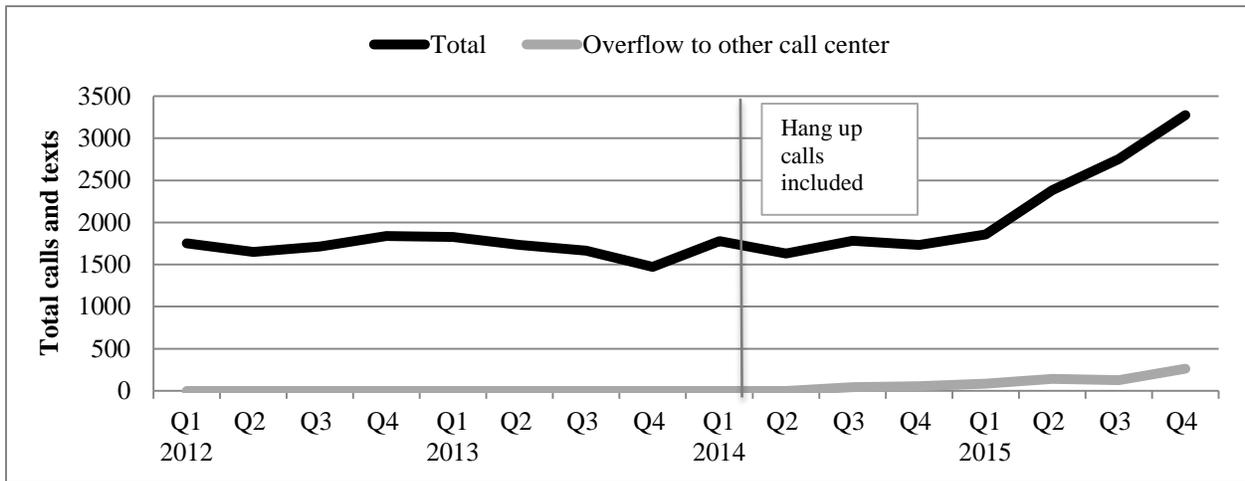


Figure 11: Careline incoming and outgoing contacts by quarter and age.

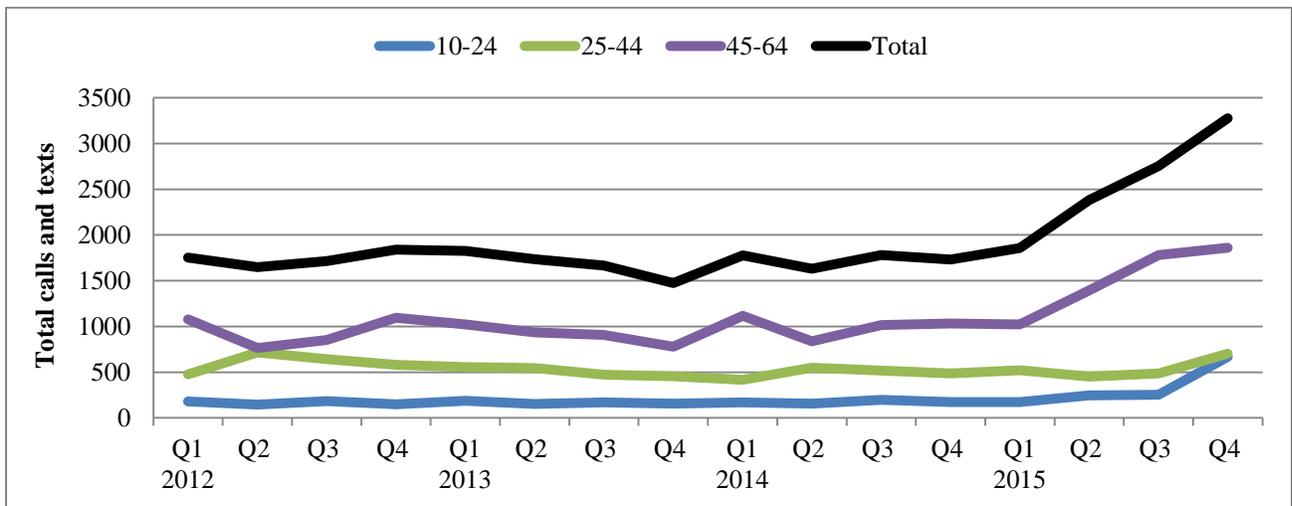


Figure 12: Careline incoming and outgoing contacts by quarter and gender.

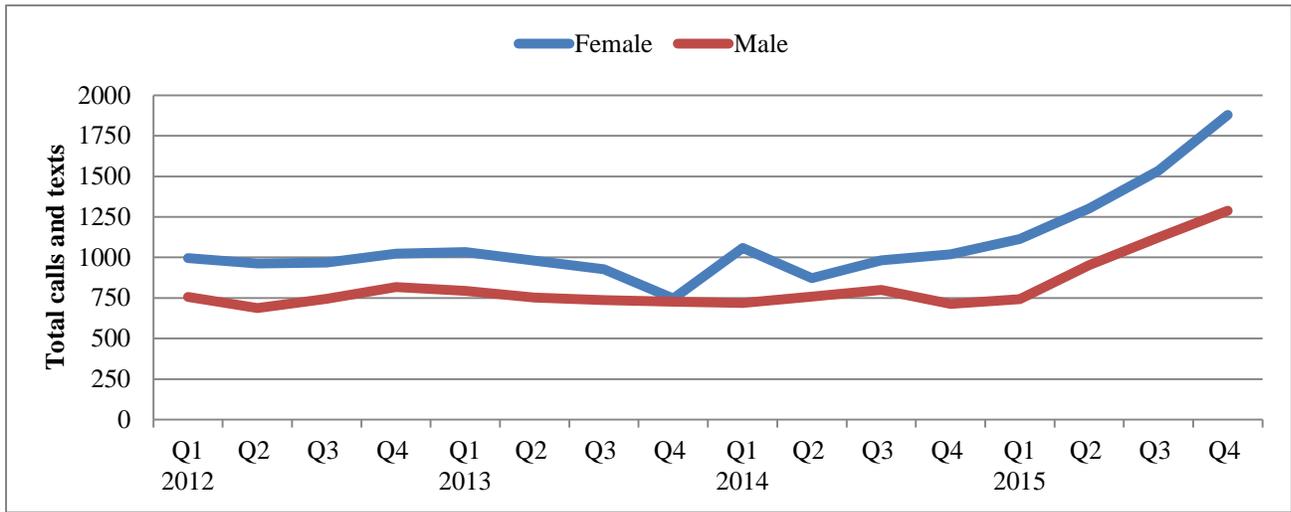
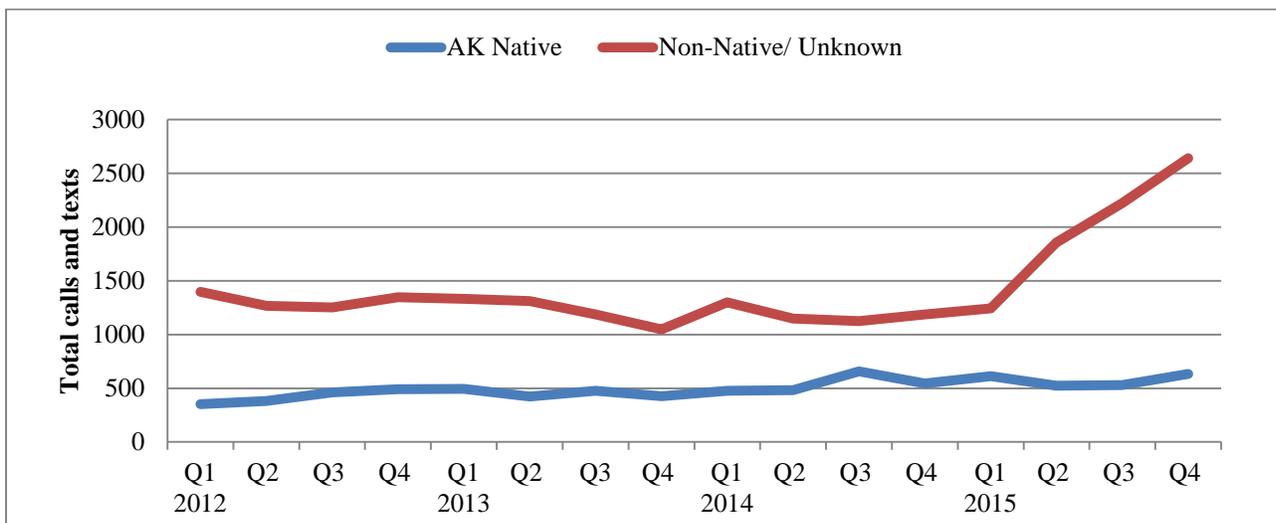
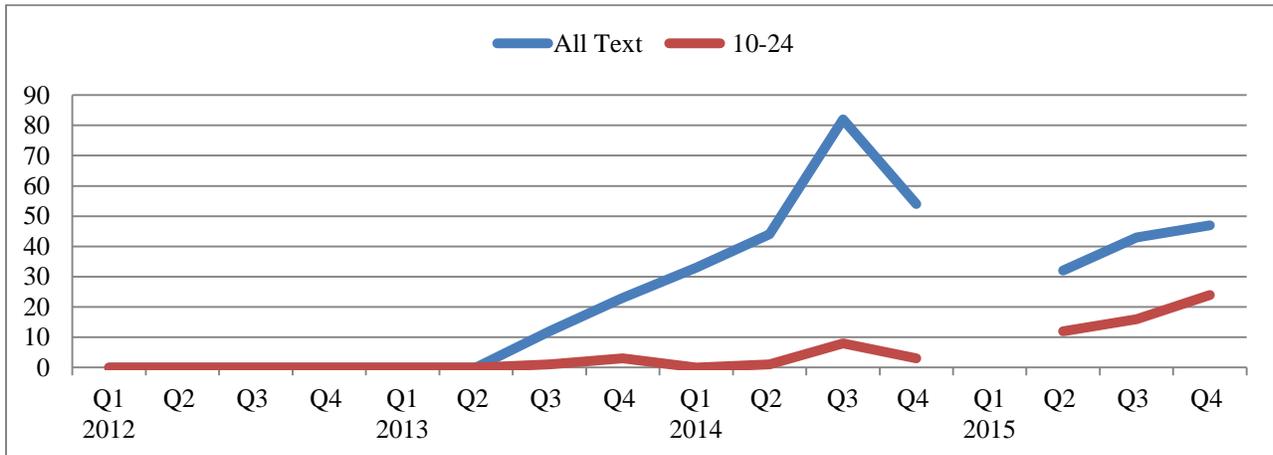


Figure 13: Careline incoming and outgoing texts by quarter and ethnicity.



All media and promotional items for the Careline feature the “*text 4help,*” with a special focus on marketing the texting service to youth. The Careline texting service began in Q1 of 2013 with texting contacts collected quarterly (Figure 14). The highest number of total texts was in Q3 of 2014 at 82 texts. Usage of the text service by Careline among 10-24 years olds has slowly increased over time to account for 50% of all texts during Q4 of 2015. There is a gap in data availability during Q1 of 2015. Use of the texting service is significantly lower than the calling service possibly because it is somewhat newer, less well-known, not available 24 hours a day, or it’s a help seeking format that individuals are not as comfortable with.

Figure 14: Careline text contacts among youth 10-24 years of age by quarter.

Total Careline contacts, including incoming and outgoing calls and texts, were relatively stable from Q1 of 2012 through Q2 of 2014 but have doubled since that time. This indicates more Alaskans are reaching out to utilize this service. While Careline contacts vary by demographic characteristics, the increase appears to include all demographic groups with the exception of 25-44 year olds. Alaska Native youth continue to have the highest rates of suicide but appear to utilize the services less than other age and demographic groups. However, without the ability to look at call rates per 100,000 among different demographic groups, it is hard to know how utilization truly differs by demographic groups.

Careline has also not been able to keep up with local demand and continues to forward more and more callers to an external calling center outside of Alaska which demonstrates the continued need for funding of the Careline to meet the increasing needs of Alaska residents. No information can be collected from calls that are forwarded to another call center leading to an increasing gap in knowledge about who is utilizing the service.

Overall, the data is positive and indicates that media efforts by AKYSPP may have increased Alaskan residents' awareness and use of the Careline for support. Another reason for the increase may be due to the re-marketing of the Careline in Q2 of 2014 to be more inclusive of anyone in need of support. While formerly considered a crisis line or suicide prevention line, data collection efforts indicated that this labelling deterred some individuals from using the service because they did not feel their need met crisis levels. The new tagline for the Careline reads "*suicide prevention and someone to talk to line*".

There are numerous limitations and suggestions for further data collection efforts. Attempts have also been made to collect more specific information on unique callers (i.e. new caller, return caller) but numbers change and some numbers show up as unknown or blocked numbers making tracking this information less than perfect. The nature of the call (domestic violence, parenting, suicide, loneliness, etc.) is now being monitored more closely which could

provide more information on how Careline services are being used and if any increases are related specifically to suicide. Finally the outcome of the calls is being monitored (dispatch, reduced risk, received services, and accepted follow-up) to better understand the effectiveness of calls.

The following are suggestions for ongoing quarterly data collection efforts by AKYSPP staff and evaluators to better understand Careline usage and by whom, including usage directly related to suicide. If possible, a data sharing agreement could be established to allow future evaluators to analyze de-identified data for project specific purposes alleviating the need to make special data requests of Careline staff each time new data is desired.

1. Current data does not distinguish between incoming and outgoing calls. It would be helpful to obtain data for each category separately below.
 - a. Total incoming calls (minus pranks/wrong number/hang-ups) by age, gender, ethnicity
 - b. Total incoming texts (minus pranks/wrong number) by age, gender, ethnicity
 - c. Total rollover calls
 - d. Total outgoing follow-up calls by age, gender, and ethnicity
 - e. Total outgoing follow-up texts by age, gender, and ethnicity
 - f. Calls and texts specific to suicide
 - i. Incoming calls (minus pranks/wrong number/hang-ups) by age, gender, ethnicity
 - ii. Incoming texts (minus pranks/wrong number/hang-ups) by age, gender, ethnicity
 - iii. Follow-up calls and texts by age, gender, and ethnicity
2. The outcome of incoming calls by category (TBD)
3. Currently Non-Native and Unknown ethnicities are combined into one category. It would be possible to request ethnicity data for Alaska Native, Non-Native, and Unknown separately.

CHAPTER 7: EARLY IDENTIFICATION, REFERRAL, AND FOLLOW-UP (EIRF) WITH YOUTH AT RISK OF SUICIDE

SAMHSA recognizes that youth at-risk for suicide can sometimes fall through multiple cracks in a fragmented and sometimes distracted health care system. A goal of SAMHSA, through the AKYSPP grant, is to ensure that any youth who are potentially at-risk for suicide are identified, referred to supportive services, and receive care. It is considered best practice for those who identify and refer youth to ensure they receive the services they are referred to. The Early Identification, Referral and Follow-Up (EIRF) Form is designed to be used by an agency to track youth throughout the identification, referral, to follow-up process. It is a national evaluation requirement of the AKYSPP grant (see Appendix K). Collecting EIRF data allows agencies to develop mechanisms to track the necessary information, determine potential system gaps, and eventually take steps to fill the gaps identified.

Results of the DJJ Pilot Project to Collect EIRF Data

The DJJ probation services has made great strides as a partner in AKYSPP grant efforts by formalizing an MOU with the AKYSPP, developing policies to ensure youth are systematically screened for suicide risk upon intake, establishing a DJJ specific Alaska Gatekeeper QPR Training curriculum to be provided to probation officers annually, certifying 17 probations officers as Alaska gatekeeper trainers, and training 80 staff members. Because of these successes, taking steps to understand and improve the identification, referral and treatment network for youth identified at risk seemed like an appropriate opportunity for DJJ probation services. They agreed to pilot EIRF data collection efforts for the AKYSPP for one year.

During the one year pilot period, DJJ probation services staff identified 32 youth at-risk of suicide across the state and reported them using the EIRF form from July 2014 to June 2015. This is a huge success as it is possible that some of these youth would not have been identified without establishing the policies that they did. Demographic characteristics of at-risk youth identified are summarized in Figures 15-17.

Figure 15: Gender of youth identified as at-risk for suicide through DJJ.

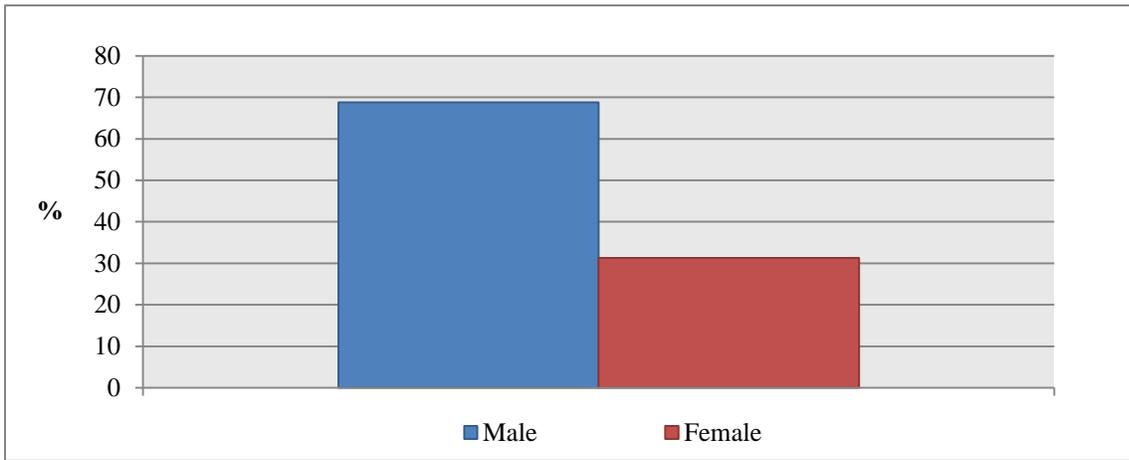


Figure 16: Age of youth identified as at-risk for suicide through DJJ.

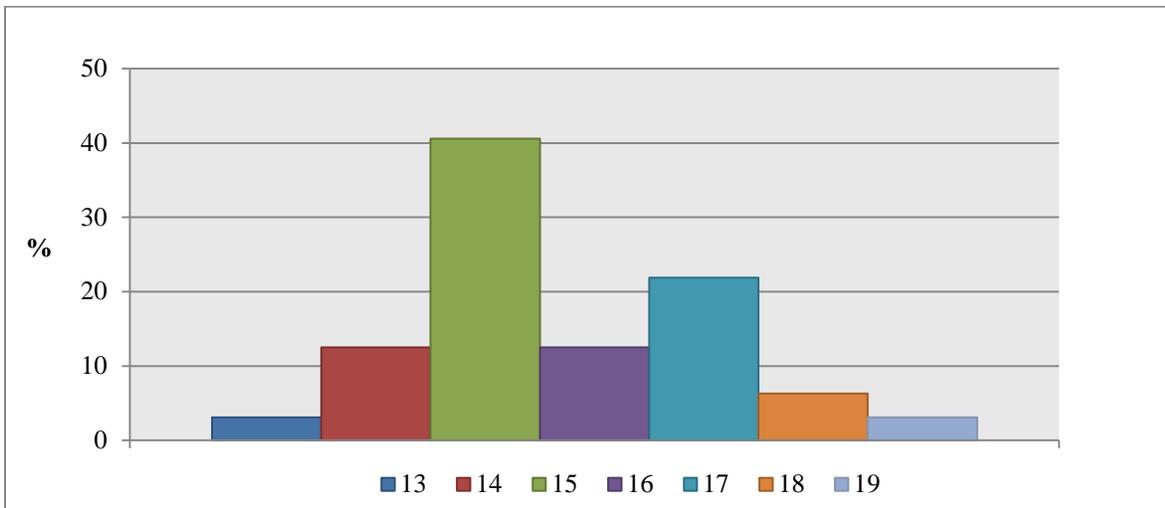


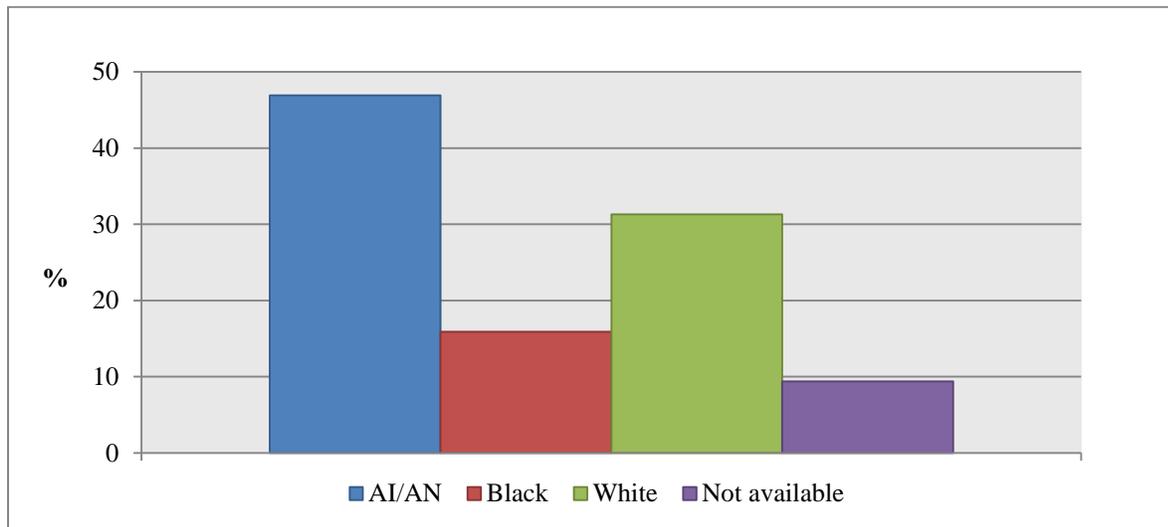
Figure 17: Ethnicity of youth identified as at-risk for suicide through DJJ.

Figure 18 shows the identification source of youth at-risk for suicide. The majority of the youth were identified by a probation officer or other juvenile justice staff (34%). This is not surprising since DJJ was the only organization collecting the EIRF data for AKYSPP. Other sources of identification were the intake screening interview or through other members of the ongoing youth care team. Figure 19 displays the setting that youth were identified in; the majority in a juvenile justice setting (35%). Overall, 75% of the 32 youth were referred for mental health services, 6% were referred for non-mental health services, and 10% were referred for both. Only 3% of youth were not referred for any services because youth were already receiving supports. Of the 27 youth referred for mental health services, the most common services include psychiatric hospital (52%), private mental health agency (33%), emergency room (26%), and DJJ mental health clinic (19%).

Figure 18: Sources of early identification of at-risk youth.

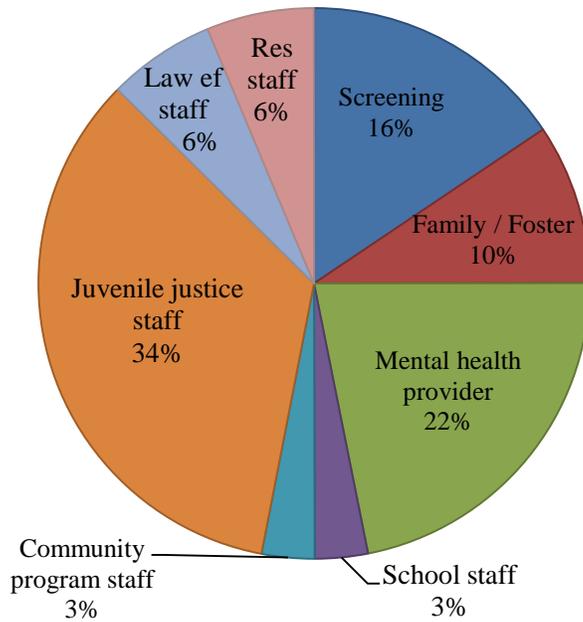
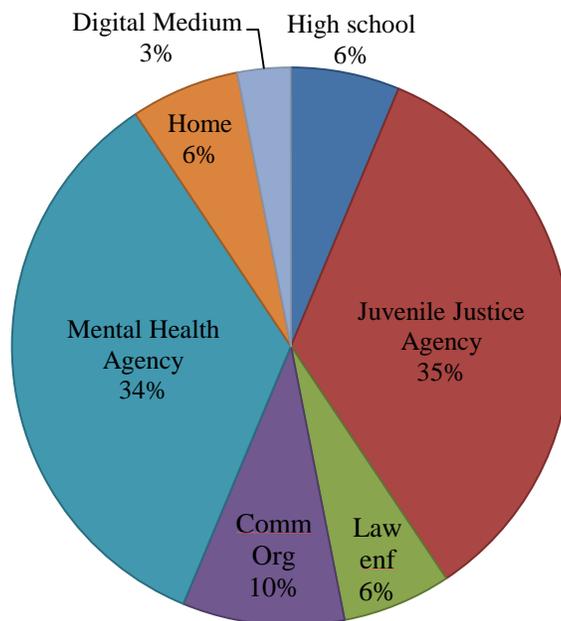


Figure 19: Setting that at-risk youth were identified.



Of the 27 youth that were referred for mental health services, Figures 20 and 21 display the identification, referral, and follow-up path of these youth using the EIRF form. A total of 13 youth that were referred for services attended their first appointment within 3 months of the referral which indicates that there were no gaps in the system. However, 11 youth were referred for services but there is no documentation about whether or not they received services within three months of being referred. This highlights a gap. During follow-up discussions with DJJ after the pilot phase of data collection, reasons for these gaps are twofold and plans were discussed to fill the gaps.

One gap identified is strictly in the timing of documentation and submittal of EIRF data to AKYSPP evaluators on a quarterly basis. If a youth is identified and referred within a given quarter, data is submitted to evaluators, but the youth may still be in the process of receiving services which would not be reflected in the data if services were received during the next quarter. Based on this discovery, it was determined that data should be sent to evaluators quarterly, but only for youth that received services or the 3 month window to receive services has ended.

The second gap identified is not having knowledge of whether youth received services if they were referred to an outside agency. DJJ fully understands the importance of this information acknowledges concerns over the time and resources it would take to collect. This gap is still being discussed internally within DJJ in terms of logical next steps given the limited time and resources that are available. It would require a mechanism be put in place and/or phone calls to an outside agency to determine if services were received. Ensuring that youth receive services is considered best practice and in the spirit of the EIRF data collection effort to reduce gaps in systems of care for youth at-risk of suicide. It may have the added benefit of reducing liability for DJJ by documenting that they have taken steps to ensure youth they identify as being at risk for suicide aren't falling through the cracks during the referral process. If a youth does not receive services, it's still useful to document the reasons why (parental refusal, wait list, youth did not show up, another clinician did not make the promised contact).

Figure 20: Youth that received mental health services within 3 months after referral.

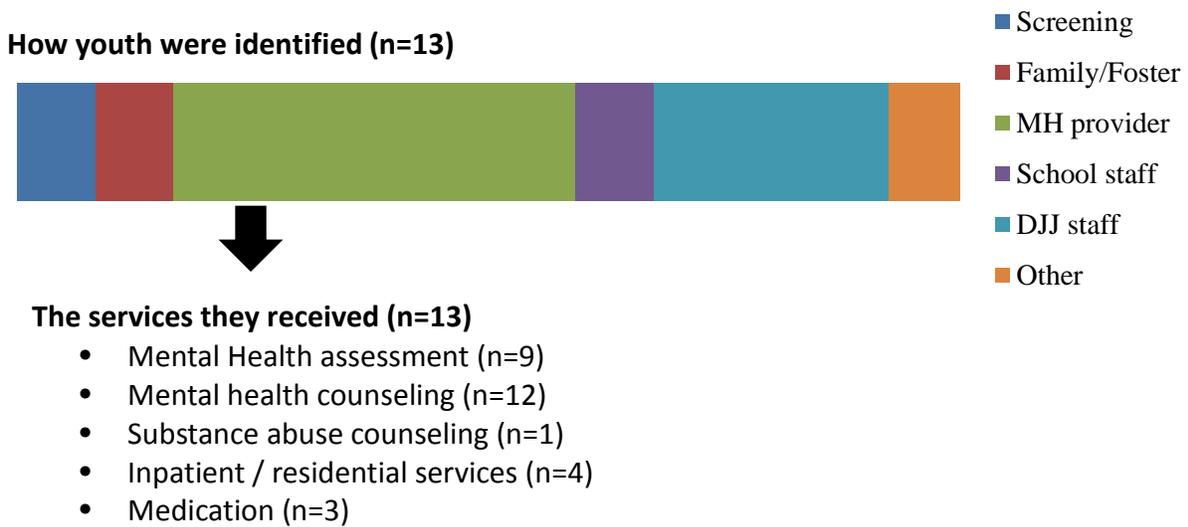
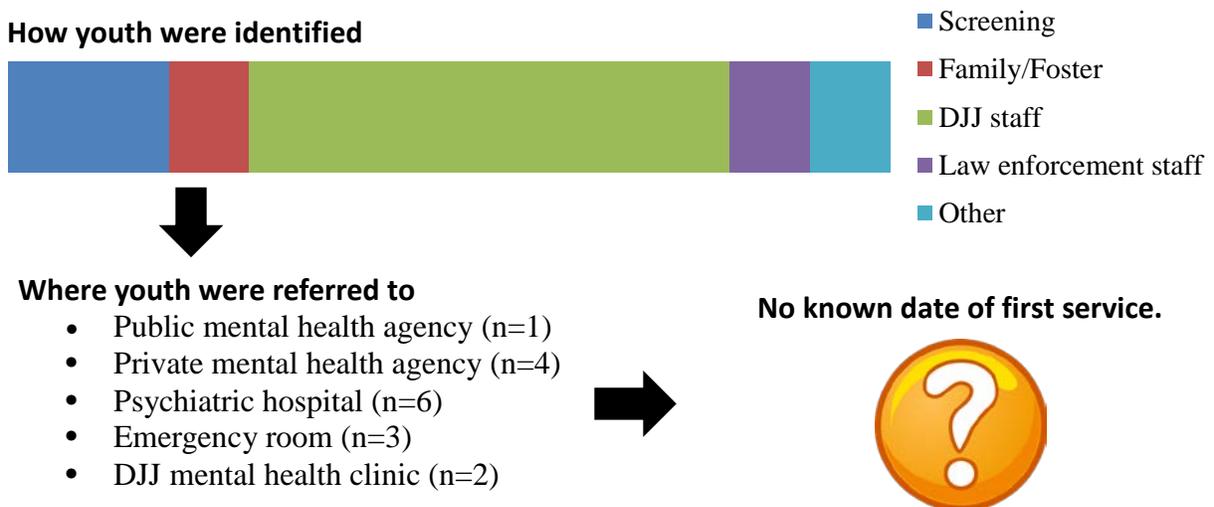


Figure 21: Youth with no documented date of first mental health service within 3 months after a referral.



CHAPTER 8: AKYSPP PROJECT SUMMARY AND FUTURE CONSIDERATIONS

This chapter provides a summary of evaluation findings for the AKYSPP from August 2012 through June of 2015. Below is a list of project strengths, challenges, and considerations for future suicide prevention efforts. CBHRS evaluators implemented standardized data collection procedures in accordance with the requirements of the federal cross-site evaluation and developed data collection tools and instruments for project evaluation purposes.

Key Strengths and Successes

The Alaska Gatekeeper Training has been redeveloped as a training that is shorter in duration, maintains fidelity to the evidence-based QPR model, and meets the needs of diverse audiences. DBH successfully redeveloped a suicide prevention training using a collaborative approach to gather insight and ideas from individuals involved in suicide prevention work throughout Alaska. The new Alaska Gatekeeper QPR Training is shorter in duration, maintains fidelity to the QPR model, and is adaptable and flexible for a broad array of communities and organizations in Alaska. Qualitative feedback from both trainers and participants indicate that the training has been well received and the skills and knowledge obtained in the training has been helpful in starting conversations about suicide and identifying and supporting individuals at-risk of suicide.

There has been broad dissemination of Alaska Gatekeeper QPR Trainings and expansion through new partnerships. AKYSPP program staff offered the Alaska Gatekeeper QPR Training throughout Alaska to over 6,000 residents and in keeping with fidelity to the newly adopted training model. They have identified many opportunities to reach different facets of the population through training partnerships that have grown organically over the life of the grant. Examples of these partnerships include the development of the “You Are Not Alone” youth awareness campaign, youth trainings, and high school club formations to reach hundreds of youth in addition to the collaboration with Alaska Rotary clubs where the goal was to provide training to every club in the state.

The sustainability of the Alaska Gatekeeper QPR Trainings has been enhanced through systems-based integration methods. AKYSPP program staff created strong partnerships with organizations to ensure the sustainability of the state’s suicide prevention training model. Highlights include a partnership with TCC to deliver collaborative trainings to empower local trainers and embedding the training into the DJJ’s programs, policies, and procedures where all probation officers and juvenile justice officers receive annual Alaska Gatekeeper QPR Training and all youth are screened for suicide risk upon intake and during ongoing check-ins. North Star Behavioral Health clinical liaisons that have been trained are offering trainings to community members throughout Alaska. Leadership is exploring policies to ensure Alaska Gatekeeper QPR Trainings are offered to all new employees with annual refreshers.

Alaska Gatekeeper QPR Trainings improve suicide prevention knowledge, attitudes, and intentions to use information immediately following the training. Results from 885 individuals completing both pre and post training surveys demonstrated significant increases in perceived suicide prevention knowledge such as identifying suicide warning signs and how to ask someone about suicide. Confidence in skills to intervene and intentions to intervene with someone who may be at risk for suicide also increased. Nearly 97% of participants felt the training met their suicide prevention needs indicating high satisfaction with the training and 73% expected to directly apply what they learned with youth, the primary target of the AKYSPP.

Three months after receiving training, the majority of trainees use suicide prevention information from Alaska Gatekeeper QPR Trainings with youth. Suicide prevention knowledge, attitudes, and confidence remained high among all training participants who were contacted after three months. Over 61% of trainees used training information to monitor youth who may be at risk of suicide while 47.5% actively intervened with at least one youth they felt was at-risk. Trainees providing mental health related services to youth were most likely to use training information in a variety of ways followed by those with other formal roles with youth. Participants who interact with youth informally or more generally in the community used training information but less often, probably due to less available opportunities or job-related expectations. The majority felt the training prepared them during their last intervention with a youth they identified as at-risk and the youth received services, regardless of the role they had with youth.

The Alaska Careline has doubled in activity. Total incoming and outgoing Careline calls and texts (i.e. contacts) doubled from early 2014 through June of 2015. While youth 10-24 years of age make up the smallest proportion of total Careline contacts, contacts have tripled for this age group to reach 20% of all Careline contacts in 2015. DBH and the AKYSPP sponsored the creation of many promotional items that were distributed at community events, schools, health centers, and training events. Careline contact information was included on all promotional items and in all communication about suicide prevention and was featured in the redeveloped Alaska Gatekeeper QPR Training as an important resource for all Alaskan residents. These promotional efforts likely contributed to the increases in Careline activity seen. The Careline was also re-marketed in late 2013, an effort outside of the AKYSPP grant, which also may have contributed to increased Careline activity.

Key Challenges and Limitations

Participation in Alaska Gatekeeper QPR data collection for evaluation purposes was inconsistent. Collecting training information and pre and post participant surveys from all training staff through email reminders and follow-up phone calls was challenging without incentives. It is assumed that final training numbers do not account for all trainings that took place and the pre and post-surveys received, while extensive in number, represent a portion of all individuals trained and all trainers that delivered trainings.

No evaluation data from youth under 18 left a gap in understanding impacts of the Alaska Gatekeeper QPR Training. Youth under 18 years of age comprised a third of the known individuals reached through Alaska Gatekeeper QPR Trainings. Unfortunately the pre and post training surveys were designed for adults 18 and older so youth feedback was not obtained. Obtaining UAA IRB approval for youth surveys around suicide prevention is often a huge challenge and parent consent is needed. However, lack of understanding the impact of the training on youth is a huge gap, as youth are often more likely to talk to a fellow student or friend than an adult.

Limitations of the pre, post, and three month follow-up survey in content and methodology. Zip code was only tracked at the training level, not at the participant level. Lack of zip code information about participants and trainers regarding where they resided and planned to use the information obtained made it difficult to determine the reach of training efforts and identify gaps in the state. Having further demographic questions in the pre and post survey such as primary nature of trainee interactions with youth and primary employment setting as separate questions would also be useful to understand the results by different audiences in the state (rural/urban) and in combination with other demographic variables. Existing demographic questions were confusing with multiple responses pervasive making analysis by demographic variables difficult.

Lack of longitudinal evaluation design at three months limits understanding of behavior change after trainings. Obtaining 177 three month follow-up surveys from cross-site evaluators was a huge strength of the AKYSPP evaluation efforts as data is not released by ICF cross-site evaluators unless a sample size threshold is reached. Many of the same questions were asked about knowledge and attitudes on both the AKYSPP pre and post training surveys and the 3 month follow-up surveys conducted by ICF cross-site evaluators. However, there was no ability link the individuals who took part in three month follow-up surveys to their responses on AKYSPP pre and post surveys. A lack of unique identifier limited the use of more sophisticated and useful longitudinal analyses to determine the true impact of trainings and for whom over time. The three month evaluation surveys were helpful to determine suicide prevention behavior three months after participants received training but it is difficult to determine which behaviors would have occurred, even without the training without a longitudinal design.

Maintaining training momentum with certified Gatekeeper trainers is challenging. Maintaining a cohesive cadre of active Alaska Gatekeeper QPR trainers and ensuring they have the support and supplies needed requires ongoing time and resources. 178 individuals were trained as certified trainers but half did not use their acquired skills and knowledge to offer trainings in their organization or community. A lack of clarity about how to maintain trainer certification led to difficulty in tracking ongoing efforts of trainers after becoming certified.

A great deal of time and dedicated staffing is necessary to cultivate partnerships. Creating formal partnerships with community organizations was a success in AKYSPP efforts but working closely with organizations to review suicide prevention policies, engage leadership, and

integrate Alaska Gatekeeper QPR Trainings takes time and ongoing support. The program manager was unable to dedicate more than 20% of his time to the oversight of the project and the training coordinator's primary role was to deliver trainings and certify trainers and other master trainers. Neither had time to follow-up with all the potential contacts, strengthen existing partnerships through ongoing systems-level changes, or develop further partnerships due to limited grant time and resources.

Careline data collection systems changed and some gaps in data availability exist. Tracking total Careline contacts (incoming and outgoing calls and texts) was inconsistent throughout the grant cycle due to small changes in tracking systems and methods of collection. However, these inconsistencies did not lead to the large increase in Careline contacts reported. It would be useful to break out the number of incoming calls and texts separately from outgoing calls and texts to get a sense of how many people reach out to the Careline each quarter. Grouping these by reason for the call would help to determine how many were specific to suicide by demographic variables and how many were related to other needs for support. Because the Careline is functioning at full capacity, more and more calls are forwarded to other call centers outside of Alaska. We do not have information about these callers leaving a gap in knowing who exactly is using the Careline service.

Resistance to data collection efforts in order to track youth at risk for suicide through the identification, referral to services, and follow-up pathways. While considered best practice to reduce youth falling through the cracks, and a cross-site evaluation requirement of the AKYSPP, working with agencies to track youth at risk of suicide through early identification, referral, and follow-up pathways was challenging. Several entities were approached regarding this data collection efforts but ultimately refused the collaboration because it was seen as redundant in some cases or burdensome. DJJ was the only partner who embraced the opportunity to pilot this data collection effort to learn about and improve their system.

Future Suggestions and Considerations

Continue to offer Gatekeeper QPR trainings in Alaska as a public health approach because of positive evaluation findings and national research supporting Gatekeeper Trainings as one potential way to reduce youth suicide rates. One study has shown that counties implementing gatekeeper trainings had significantly lower suicide rates among the 10 to 24 year old population the year after trainings than similar counties that did not implement trainings (1.33 fewer deaths per 100 000; $P=.02$). Training implementation made more of a difference in smaller and more rural counties of which Alaska has many. However, no evidence of an effect was found beyond one year indicating the need for ongoing training or booster trainings among those already trained.¹²

¹² Warpath, C., et. al (2015). Impact of the Garret Lee Smith Youth Suicide Prevention Program on Suicide Mortality, *American Journal of Public Health*, 105, 896-993.

Continue to focus on organizations, schools, and agencies to integrate Alaska Gatekeeper QPR Training with special consideration of areas of high need and other existing gaps.

Because trainers are less likely to offer trainings when it is not part of their employment role and it is not aligned with the organizational, school, or community priorities and policies, continuing to focus primary training efforts on partnerships with agencies and organizations to embed the training as a component of their mission and ensure it is part of the job description of key staff will help to sustain Alaska Gatekeeper QPR training efforts despite variability in funding streams. Focusing on areas and populations with the highest rates such as western and northwestern Alaska can help to increase impact.

Consider creating greater expectations to maintain certified Alaska Gatekeeper QPR trainer status and create tailored support and booster trainings to certified trainers.

Creating clear expectations of trainers would allow DBH to better track who is an active trainer, help to ensure ongoing quality of trainings delivered, tailor ongoing communication to certified trainers, recruit new trainers, and remind individuals of upcoming booster training opportunities if their trainer status is about to expire. Certified trainer expectations are at the discretion of DBH staff, and may need to consider time and resources available, but may include the expectation of delivering a minimum of two trainings per year with the submittal of attendance logs and basic training summary form to DBH with booster trainings required annually or bi-annually. Refresher or booster training could be offered through webinars or at conferences where certified trainers may be likely to attend such as the School Health and Wellness Institute, the Annual School on Addictions and Behavioral Health, Alaska Public Health Association Conference, and the Division of Behavioral Health Annual Grantee Conference. These booster trainings could allow for rich discussions among current trainers including unique adaptations and approaches used by trainers who work in a similar fields or settings.

Consider creating an online version of the Alaska Gatekeeper QPR Training. Because delivering in-person trainings or booster trainings requires time and resources that are more difficult to provide when grant funds go away, developing an online training for both individual and group viewing could prove useful for sustainability in times of limited funding.

Focus future evaluation efforts on youth who receive the Alaska Gatekeeper QPR training.

Many trainings have been delivered to youth under 18 years of age but no evaluation efforts have occurred to understand youth satisfaction with the training and impact among this target population. Youth are often likely to seek out friends or other peers to talk about important issues. Obtaining IRB approval for youth data collection efforts and receiving both parental consent and youth assent for participation can be challenging and time intensive. Using focus group methods may be most useful with a youth population to understand how youth are helping their friends and other students before and after the training. It may help to inform training content for this population and aid in understanding help seeking behavior among youth, including the low rates of Careline usage among youth.

Expand suicide prevention trainings for targeted audiences as part of a multi-tiered training approach. The Alaska Gatekeeper QPR training is a short training designed to build essential suicide prevention knowledge and skills for variety of general audiences throughout Alaska. The QPR institute has developed trainings for more targeted populations to develop the skills they need in their professional roles such as first responders (QPR Triage) and for mental health clinicians and counselors (QPRT Assessment). Continuing to offer trainings for all types of individuals who may be in contact with youth at risk, both through informal and formal roles, will expand the safety net in Alaska for all youth at risk.

Promote and integrate SAMHSA’s goal of “Zero Suicide”. Providing targeted training is important as a component of a comprehensive suicide prevention plan but ensuring health care and other systems adopt and promote SAMSHA’s goal of “Zero Suicide” is another effort that DBH could build upon. This would require a great deal of commitment from organizational leadership, delivery of technical assistance by DBH and other experts as funding allows, and a thorough examination of policy, systems, and environments along the continuum of care that can influence those at risk for suicide. For health care and other systems to reach the “Zero Suicide” goal, it will be necessary to make suicide prevention a core priority. Providing public recognition by DBH to systems that establish a goal of “Zero Suicide” and the steps they have taken in their organization can help create momentum.

Reinforce the usefulness of EIRF tracking mechanisms and consider creating financial incentives to build and evaluate systems-based suicide prevention approaches. Ensuring any youth identified as being at risk for suicide receives the support or services they need is considered a best practice in suicide prevention. This can be tracked through the required SAMSHA cross-site evaluation survey called the EIRF which help to identify gaps in the referral and follow-up care pathway. By focusing on organizations to embed Alaska Gatekeeper Trainings, EIRF data collection can allow for an evaluation of whether gaps in the pathway to care are being filled and if suicide prevention trainings and changes in policies and procedures are leading to a reduction in suicide within these systems. Postvention follow-ups once youth leave services may be a useful addition as it can be a vulnerable time for youth. Financial incentives and adequate support may be needed to build strong data collection plans, systems, and mechanisms to support evaluation efforts.

Continue social media and outreach and awareness efforts to encourage help-seeking among youth 10-24 years of age. Alaska Gatekeeper QPR Trainings teach individuals to recognize the warning signs of others and intervene if there is concern that someone is at risk of suicide. However, reducing the stigma around suicide and encouraging help seeking behavior through outreach and social marketing efforts is another approach which may be useful to complement gatekeeper training efforts.

APPENDICES

Appendix A. Alaska State Youth Suicide Prevention Project Logic Model

FY2015 Alaska Youth Suicide Prevention Project Goal: Alaskans communicate, cooperate, and coordinate suicide prevention efforts. (Alaska State Suicide Prevention Plan (ASSPP) FY2012-2017, Goal 3)					
Goals & Objectives	Strategies	Inputs/Outputs	Short-Term Strategy Outcomes (1-2 years)	Long-Term Strategy Outcomes (3-5 years)	Impact (6-10 years)
<p>Goal 1: The Alaska Gatekeeper Training model is grounded in research best practices, is culturally responsive to needs of Alaskan communities, and shows evidence of effectiveness. (ASSPP Goal 3, Strategies 3.2, 3.7 & 3.8)</p> <ul style="list-style-type: none"> ✓ <i>Objective 1: Identify core-components of effective Gatekeeper Trainings through current research and key-informant input to inform training refinement.</i> ✓ <i>Objective 2: Develop guidance on making local adaptations to Alaska Gatekeeper Training while maintaining fidelity to core model.</i> ✓ <i>Objective 3: Training graphically and visually modernized and re-packaged.</i> ✓ <i>Objective 4: Train a minimum of 7 individuals from DBH, TTC, APD ACS, and tribal health organizations to be Master trainers in Gatekeeper Training Model.</i> ✓ <i>Objective 5: Process and outcome evaluation methods developed to build evidence of effectiveness and fidelity during implementation.</i> 	<ul style="list-style-type: none"> • Convene Gatekeeper Advisory Group to identify core elements and adaptable activities of current Alaska Gatekeeper Training Model and to gain feedback on local needs and best practices of Gatekeeper Training in Alaska. • Contract with curriculum development team to revise and update curriculum. • Contract with evaluators to develop evaluation processes and tools for revised training. 	<p>Inputs</p> <ul style="list-style-type: none"> • Alaska gatekeeper training revision and curriculum development contractor (CBHRS). • Alaska Suicide Prevention Statewide Communications Group led by DBH program coordinator. • CBHRS evaluators. • Gatekeeper Advisory Group <p>Funding: \$30,000 for curriculum development; \$72,000 for evaluation services (managed across Goals 1-5)</p> <p>Outputs</p> <ul style="list-style-type: none"> • Training and presentation materials developed and consolidated for new trainers on Training flash drive. • Training needs checklist to provide structure for trainers in preparing for training opportunities. • Process and outcome evaluation tools for tracking training data. 	<p>Evaluation Methods Employed</p> <ul style="list-style-type: none"> • Trainers have access to evaluation materials. • Trainers utilize relevant evaluation materials. • Participants and trainers take part in evaluation surveys and interviews. <p>Satisfaction with Training Model</p> <ul style="list-style-type: none"> • Trainers are satisfied with training manuals and materials • Participants are satisfied with the training, manuals, and materials <p>Trainings Implemented with Fidelity</p> <ul style="list-style-type: none"> • Trainers deliver trainings with fidelity to the training model. • Trainers deliver trainings with appropriate cultural adaptations. <p>Evaluation</p> <ul style="list-style-type: none"> • TASP cover page • Pre-Post-Follow up Evaluation Surveys(QPR pretest and TES) • Pilot Testing • Training fidelity measures. 	<p>Gatekeeper Training Model has Evidence of Effectiveness</p> <ul style="list-style-type: none"> • Participants demonstrate increases in Gatekeeper knowledge, attitudes, and confidence to intervene. • Participants report an increase in the number of youth they have identified at risk and intervened with. • Gatekeeper Training shows evidence of effectiveness across different settings, target audiences, and cultures. <p>Evaluation</p> <ul style="list-style-type: none"> • TASP cover page, developed evaluation measures • Pre-Post-Follow up Evaluation Surveys(QPR pretest and TES) 	<p>Decrease in Suicidal Attempts and Completions</p> <ul style="list-style-type: none"> • Decrease in # of suicide attempts. • Decrease in # of suicide completions. <p>Evaluation</p> <ul style="list-style-type: none"> • Alaska Bureau of Vital Statistics • Alaska Trauma Registry • AKVDRS • Careline usage

<p>Goal 2: The Alaska Gatekeeper Training curriculum is embedded into current Department of Juvenile Justice (DJJ) organizational system to create a sustainable community training model. (ASSPP Goal 2, Strategy 2.1; Goal 3, Strategies 3.2, 3.3, & 3.6)</p> <ul style="list-style-type: none"> ✓ <i>Objective 1: Assist in revising/developing DJJ policies and procedures to include Alaska Gatekeeper Training model into current organizational training system.</i> ✓ <i>Objective 2: Develop culturally appropriate DJJ training presentation referencing specific DJJ policies and procedures.</i> ✓ <i>Objective 3: Train a minimum of 15 probation officers to be trainers in Gatekeeper Training Model.</i> ✓ <i>Objective 4: Build capacity and sustainability in DJJ suicide prevention program with qualified Gatekeeper trainers.</i> ✓ <i>Objective 5 (in process): Develop online version of Alaska Gatekeeper Training appropriate for DJJ employees and community.</i> 	<ul style="list-style-type: none"> • Organization Policies and Procedures Revised/Developed to embed Alaska Gatekeeper Training Model into existing DJJ training systems. • DJJ Employees Trained as Trainers in Alaska Gatekeeper Model to build sustainability in suicide prevention training and current organizational staff training system. • Alaska Gatekeeper Trainings Delivered to increase knowledge and skills to identify warning signs of those at risk for suicide, determine the level of risk, and how to respond appropriately given community resources. In addition, trainings developed to improve negative attitudes and decrease stigma associated with suicide. 	<p>Inputs</p> <ul style="list-style-type: none"> • Center for Human Development Trust Training Cooperative (TTC) for community coordination, assessment, planning, technical assistance, training implementation, organizational policy/procedure development, and support. • DBH program coordinator provides technical assistance and/or training as needed. • DJJ staff trainers and TTC trainers will deliver trainings to their organizations and at annual training events. • CBHRS evaluators. <p>Funding: \$225,000 (Split with Goal 5); \$72,500 for evaluation services (managed across Goals 1-5)</p> <p>Outputs</p> <ul style="list-style-type: none"> • DJJ Gatekeeper trainers located statewide. • Directory of qualified DJJ trainers. • DJJ policies and procedures include 	<p>Increase DJJ Employee Knowledge, Skills, and Improve Attitudes</p> <ul style="list-style-type: none"> • Increase number of employees who receive training. • Increase knowledge of risk factors and warning signs among training attendees. • Improve negative attitudes and decrease stigma associated with suicide. • Increase in confidence to intervene among training attendees. • Increase awareness of suicide prevention resources available. <p>Evaluation</p> <ul style="list-style-type: none"> • TASP cover page • Pre-Post-Follow up Evaluation Surveys(QPR pretest and TES) • Pilot Testing 	<p>DJJ Sustainable Gatekeeper Training Model</p> <ul style="list-style-type: none"> • Gatekeeper training integrated into ongoing organizational training schedule. <p>Evaluation</p> <p>Increase in DJJ Youth Identified at Risk for Suicide & Supported</p> <ul style="list-style-type: none"> • Increase in the number of youth 12-20 who are identified at risk for suicide • Increase in number of youth 12-20 yrs referred for services. • Increase in number of youth 12-20 yrs who receive help from DJJ employees when having thoughts of suicide. <p>Evaluation</p> <ul style="list-style-type: none"> • EIRF • Careline usage • TASP cover page, developed evaluation measures • Pre-Post-Follow up Evaluation Surveys (QPR pretest and TES) 	
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<p>Goal 3: DJJ employees are aware of suicide risk factors and know how to respond to those at risk. (ASSPP Goal 2, Strategy 2.1; Goal 3, Strategies 3.2, 3.3, & 3.6)</p> <ul style="list-style-type: none"> ✓ <i>Objective 1: Train a minimum of 80 probation officers, 5 mental health staff, 15 clerical staff, and 15 social services associates to have the knowledge and skills to intervene if somebody is at risk for suicide.</i> ✓ <i>Objective 2: Establish procedures in DJJ reporting system for EIRF data collection/tracking.</i> 		<p>standardized and consistent suicide prevention training</p> <ul style="list-style-type: none"> • DJJ policies and procedures establish methods of measuring the impact of training and ensuring youth are referred to and receive services (EIRF). 			
<p>Goal 4: Residents in Alaska are aware of the Alaska Careline and text services and the Alaska suicide prevention efforts. (ASSPP Goal 2, Strategy 2.2; Goal 3, Strategies 3.2, & 3.3; Goal 4, Strategy 4.1)</p> <ul style="list-style-type: none"> ✓ <i>Objective 1: Increase community member's awareness of Careline text service by 25%.</i> ✓ <i>Objective 2: Increase education system (primary, secondary, and university) awareness of Careline and text service by 25%.</i> ✓ <i>Objective 3: Create 20 of MOAs with community organizations and schools that include the TEXT service/Careline as referral source.</i> 	<ul style="list-style-type: none"> • Promotion of Careline Text Service targeting youth through media campaign and established MOAs. • Promotion of Careline Text Service on campuses in University of Alaska system and primary and secondary school system with support from the Alaska Department of Education. • Text Service supported at Careline 24/7. • DBH participation in variety statewide suicide prevention activities to promote Alaska Careline and texting services and Alaska suicide 	<p>Inputs</p> <ul style="list-style-type: none"> • Alaska Careline staff and DBH Injury Prevention coordinator. • CBHRS evaluators. • Media campaign contractors (Clouburst). • Promotional materials including magnets, bracelets, Careline business cards, etc. • Website updates to create more user-friendly and informative platform • Mobile app development. • Relationships with Comprehensive Grantees <p>Funding: \$50,000 contract with Alaska Careline; \$10,000 contract for media campaign (Clouburst); \$_____ for mobile</p>	<p>Increase in use of Careline as a referral source.</p> <ul style="list-style-type: none"> • Increase in number of youth 10-24 contacting Careline via telephone. <p>Increase in use of TEXT service "4help" to 839863</p> <ul style="list-style-type: none"> • Increase in number of youth 10-24 contacting Careline through text option. <p style="text-align: center;">Evaluation</p> <ul style="list-style-type: none"> • Careline usage 	<p>Increase in Youth at Risk for Suicide Being Identified & Supported</p> <ul style="list-style-type: none"> • Increase number of youth being referred and accessing services. <p style="text-align: center;">Evaluation</p> <ul style="list-style-type: none"> • EIRF • Careline usage 	

<ul style="list-style-type: none"> ✓ Objective 4: Increase usage of Careline text service by 25% over the next 3 years. ✓ Objective 5: Develop media campaign (including participation in activities and events, online resources, and print materials) to increase visibility of Alaska Careline and texting services and Alaska suicide prevention efforts. 	<p>prevention efforts.</p>	<p>app development</p> <p>Outputs</p> <ul style="list-style-type: none"> • Established Careline texting service. • Useful and interactive website. • Flexible mobile app for Careline services. • Increased visibility of Alaska Careline and texting services and Alaska suicide prevention efforts. • Increase in use of telephone and texting Careline services. 			
<p>Goal 5: Agencies, communities, organizations, K-12 schools, and University of Alaska system campuses develop sustainable Gatekeeper Training Model and are engaged in suicide prevention efforts (ASSPP Goal 1, Strategies 1.8 & 1.9; Goal 3, Strategy 3.1).</p> <ul style="list-style-type: none"> ✓ Objective 1: Create MOU/MOAs with agencies, communities, organizations, and schools to establish systems based approaches and to increase involvement in suicide prevention efforts. ✓ Objective 2: Include EIRF or other referral/follow-up data collection/tracking procedures into MOU/MOAs. ✓ Objective 3: Identify and select agencies, communities, organizations, K-12 schools, 	<ul style="list-style-type: none"> • Partner with agencies, communities, organizations, K-12 schools, and University of Alaska system campuses to raise awareness of suicide prevention efforts and available resources. • Expand Training Resources in school settings and create opportunities for more youth involvement. • Develop Semester 1-hr Course Offering at UAA. • Develop System of Coordination from Initial Contact with Alaska state agencies, communities, 	<p>Inputs</p> <ul style="list-style-type: none"> • TTC and DBH Injury Prevention program coordinator will deliver trainings to groups expressing interest in systems based approaches to suicide prevention efforts and resources. • TTC will coordinate TOT events to train individuals to be Gatekeeper trainers within organizations. • TTC and DBH will offer technical assistance/support for trainings (Sharepoint, webinars, etc.) and policy/procedure. development as necessary. • Deb and Kathryn Casello promoting the youth version of QPR training and the "You 	<p>Increase in Suicide Prevention and Promotion Among Communities</p> <ul style="list-style-type: none"> • Increased number of groups interested in incorporating the Alaska Gatekeeper Training Model into current training programs. • Developed suicide prevention policies and procedures for groups. • Established MOAs with groups. • Embedded trainers into groups. • Increased numbers of individuals trained with all partner organizations. • Increase referral network capacity to respond. <p style="text-align: center;">Evaluation</p> <ul style="list-style-type: none"> • Number of signed MOAs • TASP cover page data 	<p>Expanded network of community suicide prevention resources</p> <ul style="list-style-type: none"> • Increase in number of individuals trained in and more confident in their skills, ability and knowledge about suicide prevention and engaging with someone exhibiting suicidal ideation. • Increase in number of suicide prevention resources that include both early intervention and strength based approaches. • Increase network of resources that exists to support youth at risk for suicide. <p>Gatekeeper Training model sustained in community organizations</p> <p>Communities increase use of suicide prevention resources</p>	

<p>and University of Alaska system campuses to receive training.</p> <p>✓ Objective 4: Identify and select agencies, communities, organizations, and schools establish trainers within their current training system.</p>	<p>organizations, K-12 schools, and University of Alaska system campuses to establishing an MOA.</p> <ul style="list-style-type: none"> • MOAs Established with Alaska state agencies, communities, organizations, K-12 schools, and University of Alaska system campuses to develop systems-based collaborations for the Gatekeeper Training Model. • EIRF or Similar Referral/Follow-up Data Collection/Tracking Procedures established with communities, organizations, K-12 schools, and University of Alaska system campuses. • Introduce and Provide Resources for Suicide Prevention Policies and Procedures to communities, organizations, K-12 schools, and University of Alaska system campuses. 	<p>Are Not Alone" campaign.</p> <ul style="list-style-type: none"> • UAA Student Health and Counseling Center and Care Team providing on campus training and support. • CBHRS evaluators. <p>Funding: \$225,000 (split with Goal 2/3); \$72,000 for evaluation services (managed across Goals 1-7); \$40,000 supporting the "You Are Not Alone" campaign in ASD schools</p> <p>Outputs</p> <ul style="list-style-type: none"> • Community organizations integrate Gatekeeper Training Model into training schedules. • Community organizations and individuals aware of state suicide prevention efforts and opportunities to support efforts. • MOA process established and flow chart created describing partnership development. • High school students participating in "You are Not Alone" clubs and trainings 	<ul style="list-style-type: none"> • <i>Pre-Post-Follow up Evaluation Surveys (QPR pretest and TES) data</i> • <i>TUP-S</i> • <i>Key Informant interviews with trainers</i> 	<p>Evaluation</p> <ul style="list-style-type: none"> • <i>RNS</i> • <i>EIRF</i> • <i>Careline usage</i> 	
<p>Goal 6: State of Alaska DBH suicide prevention efforts support building a sustainable training infrastructure that continues after the grant cycle. (ASSPP Goal 1, Strategy 1.5; Goal 2, Strategies 2.1-2.2; Goal 3, Strategies 3.2 & 3.8).</p>	<ul style="list-style-type: none"> • Develop Management System within the State of Alaska DBH to manage statewide training efforts of the Alaska Gatekeeper Training Model. 	<p>Inputs</p> <ul style="list-style-type: none"> • DBH Injury Prevention program coordinator • TTC • Alaska State Division of Public Health and Bureau of Vital 	<p>Increased Discussions About Suicide among Community Members.</p> <ul style="list-style-type: none"> • Alaska residents more confident in knowledge, skills and ability in their interactions with someone 	<p>Gatekeeper Training Model has Evidence of Effectiveness</p> <ul style="list-style-type: none"> • Increase in number of youth identified at risk and referred to appropriate care. • Gatekeeper Training shows 	

<ul style="list-style-type: none"> ✓ Objective 1: Establish Gatekeeper Trainers within organizations and ensure training is included in job duties (ex: Department of Education). ✓ Objective 2: Embed Gatekeeper Training Model into current organizational training schedules. ✓ Objective 3: State of Alaska DBH establishes training infrastructure including management and technical assistance to support Gatekeeper Trainers. ✓ Objective 4: Develop culturally appropriate Alaska Gatekeeper Model additions and versions to increase flexibility of training model. ✓ Objective 4: State of Alaska DBH maintains current training evaluation system. ✓ Objective 5: Evaluate training data annually to determine impact on suicide prevention efforts. 	<ul style="list-style-type: none"> • Develop Support and Technical Assistance framework to respond to Gatekeeper needs and questions. • Maintain Evaluation Database to track training efforts. • Maintain SharePoint site to communicate with Gatekeeper Trainers. • Maintain Registry of Trainers. • Offer Periodic Training Updates. • Create Cohesive Alaska Gatekeeper Model Training Package that that demonstrates flexibility in training approaches, while maintaining fidelity to the training model, and appeals to a variety of learning styles. • Create Online Version of Alaska Gatekeeper Training Model to give organizations flexibility in training delivery. • Develop Culturally Responsive version of Alaska Gatekeeper Model. 	<p>Statistics</p> <ul style="list-style-type: none"> • Data sources (ABVS, BRFSS, NSDUH, YRBS, etc.) • Alaska Native Epidemiology Center • Alaska Suicide Prevention Council • Graphic design firm to revise/repackage Alaska Gatekeeper Model training package. <p>Funding:</p> <p>Outputs</p> <ul style="list-style-type: none"> • Gatekeeper Training Model in circulation and maintained in organizations throughout State of Alaska after the end of the grant cycle. • Training evaluation data representative of Gatekeeper Training efforts and accurately tracked. 	<p>experiencing suicidal ideation.</p> <p>Alaska Residents Aware of Resources (including Careline and texting services) for Referral and Follow-up.</p> <p>Evaluation</p> <ul style="list-style-type: none"> • <i>Alaskan residents trained in Alaska Gatekeeper Model willing to share their stories.</i> • <i>Pre-Post-Follow up Evaluation Surveys(QPR pretest and TES)</i> • <i>TUP-S</i> 	<p>evidence of effectiveness across different settings, target audiences, and cultures.</p> <p>Reduced Stigma Associated with Suicide.</p> <p>Alaska Residents Aware of Resources (including Careline and texting services).</p> <p>Evaluation</p> <ul style="list-style-type: none"> • <i>TASP cover page, developed evaluation measures</i> • <i>Pre-Post-Follow up Evaluation Surveys (QPR pretest and TES)</i> • <i>TUP-S</i> 	
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<p>Goal 7: State of Alaska DBH suicide prevention funding and resources are supporting systems, organizations, and strategies currently used in Alaska to adopt the SAMSHA Zero Suicide in Health and Behavioral Healthcare Initiative (ASSPP Goal 1, Strategies 1.1-1.9; Goal 3, Strategy 3.6-3.8; Goal 4, Strategy 4.1 & 4.2; Goal 6, Strategies 6.1-6.3).</p> <ul style="list-style-type: none"> ✓ <i>Objective 1: State of Alaska DBH Strategic Plan prioritizes suicide prevention and providing access to care and resources for all residents.</i> ✓ <i>Objective 2: State of Alaska DBH provides a framework to organizations that wish to pursue the Zero Suicide Initiative.</i> ✓ <i>Objective 3: State of Alaska DBH funding priorities reflects needs of communities by identifying gaps in resources and care and bridging those gaps to strengthen a suicide prevention infrastructure.</i> ✓ <i>Objective 4: State of Alaska DBH can communicate suicide prevention efforts to community stakeholders.</i> ✓ <i>Objective 5: Expand training opportunities to offer QPRT Training to first responders and health care providers and systems.</i> 	<ul style="list-style-type: none"> • Develop Standards and Give Recognition to organizations working to achieve a Zero Suicide practice model. Examples of organizations include: <ol style="list-style-type: none"> 1. Primary care centers and rural health clinics 2. Public health nursing clinics 3. EMT and emergency care centers 4. Public safety and law enforcement 5. K-12 schools and college campuses 6. Vocational tech and job centers 7. Public assistance centers 8. Residential treatment facilities • Standards will include integrating the AK Suicide Prevention plan into the organization, implementing policies and protocols, providing Gatekeeper Trainings to members, including best practices in suicide prevention, intervention and postvention, developing community safety net, abides by safe messaging guidelines in all media outlets, and promoting the Alaska Careline and text services. • Develop a Data Collaboration to identify a comprehensive list of statewide suicide related 	<p>Inputs</p> <ul style="list-style-type: none"> • DBH Injury Prevention program coordinator • TTC Training Coordinator • Alaska State Division of Public Health and Bureau of Vital Statistics • Alaska Native Epidemiology Center • Data sources (ABVS, BRFS, NSDUH, YRBS, etc.) • Alaska Suicide Prevention Council • CBHRS evaluator • Contractor to develop dissemination products (The Cloudburst Group) <p>Funding: No cost extension</p> <p>Outputs</p> <ul style="list-style-type: none"> • Strategic plan aligns with key efforts and current systems to decrease gaps in services and resources. • Dissemination products for a variety of state and community stakeholders that are visually pleasing and easily translate the State of Alaska DBH's suicide prevention efforts. • OPRT Training coordination. 	<p>Increased awareness of gaps, opportunities, resources, etc. in suicide prevention efforts.</p> <p>Highlight successful suicide prevention efforts currently in use in communities or organizations around Alaska.</p> <p>Recognized areas where further research and data collection is needed.</p> <p>Increased numbers of first responders and health care providers training in suicide prevention triage methods.</p>	<p>Use data to plan strategic and systematic approach to continue appropriate suicide prevention efforts and use resources effectively and efficiently.</p> <p>Alaskan systems/people/providers are aware of and linked to appropriate resources to ensure individuals are referred and receive appropriate services.</p>	
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	<p>data (i.e., ABVS, BRFSS, NSDUH, YRBS, AK Trauma Registry, AVDRS, Alaska Native Epi data (ANTHC), program/project level data, GLS, Careline, gatekeeper training evaluations, outreach, awareness and stigma reduction campaigns (AMHT/SSPC. etc.) to guide future work and plans for sustainability.</p> <ul style="list-style-type: none"> • Partner with State of Alaska and ANTHC to clarify youth (ages 12-24) suicide attempt data. • Develop Visualization of suicide prevention efforts for a variety of target audiences to disseminate to state and community stakeholders. • QPRT Training Offered to first responders, health care providers and health care systems in Alaska. 				
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Appendix B. AKYSPP Memorandum of Understanding Template**MEMORANDUM OF UNDERSTANDING AND DATA SHARING AGREEMENT**

Between Alaska State Division of Behavioral Health and <Organization Title>

**FOR COOPERATION IN CHILD AND YOUTH SUICIDE PREVENTION ACTIVITIES,
GATEKEEPER TRAINING AND DATA-SHARING**

This Memorandum of Understanding (MOU) and Data Sharing Agreement (DSA) is entered into between the Alaska State Division of Behavioral Health (DBH) and _____, collectively referred to herein as the “Parties.”

WHEREAS, the parties to this MOU recognize that many Alaska State children and youth may be at risk for suicide. Alaska has been consistently ranked as having the highest suicide rate in the country and is almost double the national average¹³. Youth suicide in Alaska is also significantly higher than the national average. According to the American Association of Suicidology, *U.S.A. suicide 2007: Official final data*, national suicide rates among 15 to 19 year olds were 9.7 per 100,000. In the Alaska Suicide Follow Back Study 2007 report, the average annual rate for this group, from 2004 – 2006, was 31.6 per 100,000, over three times the US rate. During the period between 2004 and 2006, there were 52 suicide deaths in this age group.

Alaska Natives who comprise 16% of the population account for 39 % of suicides. This ethnic disparity is even greater for Alaskan youth 19 and younger where, over the past 15 years, Alaska Natives accounted for 19% of the youth population and 60% of the suicide deaths in that age group. Alaska Native male teens have suicide rates of up to 72 per 100,000 and much higher in Northwest Alaska. According to an unpublished regional health corporation report, suicide is the leading cause of death for 15- to 18-year-olds among Inupiat Eskimos. Young Inupiat in this age group who live in Alaska’s northwestern region have a suicide rate of 190.33 per 100,000 (10 yr average for 1990-2000)¹⁴. When comparing Alaska suicide rates and numbers by region, rates are highest in the northwestern part of the state and lowest in the Aleutian Islands and southeast Alaska. Among Alaska Native ethnic groups, Inupiat and Eskimo populations have the highest rates and Aleuts have the lowest rates. Approximately half of all suicides occur in rural Alaska.

WHEREAS, the parties to this MOU are committed to supporting and assisting in efforts to reduce suicides and suicidal behaviors as set forth in this MOU;

WHEREAS, the DBH is the recipient of the three-year youth suicide prevention grant (AKYSPP) from the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA); and

¹³ McIntosh, J. L., (2010). *U.S.A. suicide 2007: Official final data*. Washington, DC: American Association of Suicidology, dated May 23, 2010, downloaded from <http://www.suicidology.org>.

¹⁴ Manila Injury Prevention data (1989-2002). Suicide Statistics for Northwest Alaska. Manila Association; Unpublished data, 2003.

WHEREAS, under the AKYSPP, the DBH is to develop and implement state-wide youth suicide prevention and early intervention strategies, which must involve collaboration among youth-serving institutions and agencies and should include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting agencies and organizations; and

WHEREAS, DBH has determined to provide suicide prevention services for Alaska State children and youth ages 10 to 24 use an approach including social marketing and “gatekeeper training” to identify and assist those at risk; and

WHEREAS, “gatekeeper training” refers to a program to train persons who regularly come into contact with children and youth, including teachers, counselors, recreation workers, health care professionals, case workers, police, front-line government employees, ministers and others in being able to identify signs of children and youth who are at risk for suicide or other self-destructive behaviors and refers to the Alaska-based QPR (Question, Persuade, Refer) method of recognizing and accessing treatment for these children and youth at risk; and

WHEREAS, DBH wishes to offer gatekeeper trainer training to selected staff employed by (the Partner Agencies), to ensure the availability of QPR Trainers among employees at each agency and to provide a mechanism for ongoing gatekeeper training and follow-up with respect to children and youth who are identified as being at risk for suicide or suicidal behaviors;

NOW, THEREFORE, the parties to this MOU agree as follows:

I. PROGRAM GOALS AND OBJECTIVES

This MOU is intended to provide an appropriate framework for DBH to arrange for training of staff persons, who work at _____ which are parties to this Agreement, and who regularly come in contact with children and youth ages 10 to 24, so that they may be trained as “gatekeepers” who are equipped to appropriately respond to children and youth whom they encounter in their jobs and to identify, assist and refer those at risk of suicide to enable them to receive mental health services. Ultimately, the purpose of this MOU, the gatekeeper training and referral of at risk children and youth, is to reduce suicides, attempted suicides and suicidal behaviors among Alaska State children and youth.

This MOU is also intended to enable the sharing of data, in compliance with Alaska and federal law, necessary for coordination of care and treatment purposes, for the limited purpose of ensuring that children and youth, who are referred for and wish to receive mental health services, actually receive services, and for the purpose of enabling collection of data and tracking of mental health services to ascertain the number of children and youth, who express risk for suicide, who receive follow-up care. This will also enable DBH to meet SAMHSA grant performance requirements for data collection and to provide de-identified data to SAMHSA regarding the number of [persons referred for treatment who receive treatment] as well as associated demographic information. This will also benefit partnering agency by:

- 1) Improving suicide prevention efforts.
- 2) Determine if suicide prevention efforts identify and support youth at risk for suicide.
- 3) Document the need for suicide prevention efforts where communities may have fewer resources.
- 4) Reinforce the importance of staff roles, responsibilities and practices in responding to individuals at risk of suicide.

II. SCOPE OF SERVICES

Pursuant to the applicable authorities and in the furtherance of the shared goals of the Parties to carry out the purposes of this MOU expeditiously and economically, the Parties do hereby agree:

A. RESPONSIBILITIES OF DIVISION OF BEHAVIORAL HEALTH

1. DBH will assign the AKYSPP Program Manager to serve as DBH liaison persons for implementation of this MOU.
2. DBH will offer Alaska Suicide Prevention Training with QPR (Question, Persuade, Refer) Approach Train-the-Trainer training at no cost to staff persons at Partner Agency/ies, an evidence-based training program that teaches Trainers how to recognize a mental health emergency, respond appropriately to a suicidal person, link identified suicidal persons to help and ultimately how to train others in the QPR method.
3. DBH will offer this training utilizing QPR-certified Master Trainers employed by DBH. DBH will also purchase all necessary training materials from QPR, and will provide this at no cost to trainees or Partner Agency/ies.
4. Staff persons who successfully complete the training will themselves become QPR Trainers and will be capable of providing training to other staff at their Partner Agency.
5. DBH and the University of Alaska Trust Training Cooperative (TTC) will provide ongoing technical assistance and consultation to all trainers.
6. DBH or TTC will offer to co-lead at least the initial QPR training provided by each Trainer of a Partner Agency, and will assist or co-lead additional trainings upon request, using DBH or TTC staff.
7. DBH will provide training to Points of Contact (“POCs”) in Partner Agencies in how to make a referral, how to talk to families about mental health issues, and how to ask families for follow-up information.
8. DBH will provide on-site training with respect to completion of forms, including the Training Activity Summary Page (TASP), the QPR pretest, Training Exit Survey (TES),

Training Utilization and Preservation Survey sign-in sheet attached as Exhibit A and the Early Identification and Referral Form (EIRF) attached as Exhibit B.

9. DBH will provide guidance on protocol development and policies for referring youth who may be at risk for suicide.
10. DBH and TTC will provide technical assistance in developing a data collection process to monitor impact of trainings and ensure identified individuals are referred to and receive services (ex. EIRF).
11. DBH will arrange for QPR Train-the-Trainer training to be offered at least once during this grant period, and will offer training a second time if deemed necessary by DBH or Partner Agency/ies.
12. If a Partner Agency loses a QPR-trained Trainer, DBH will use its best efforts to arrange training for one or more additional agency staff persons to attend QPR Train-the-Trainer training.

B. RESPONSIBILITIES OF DISTRICT PARTNER AGENCIES

1. Partner Agency agrees to designate a single liaison person within the agency to communicate with DBH AKYSPP Program Manager regarding implementation of this MOU.
2. Partner Agency agrees to send a minimum of one (1) to five (5) staff persons to an all-day QPR-sponsored Train-the-Trainer training during the grant period, in the event that an adequate number of qualified agency staff persons have not already received Train-the-Trainer training and been certified as QPR Trainers.
3. Partner Agency agrees to recognize those agency staff persons who have successfully completed the 1-day QPR-sponsored Train-the-Trainer training (“QPR Trainers”) and enable them to provide in-house training to agency staff on a continuing basis.
4. When new staff are being selected to become QPR Trainers, Partner Agency will use its best efforts to select capable staff persons to attend training who: interact with children and youth in their positions (or supervise staff who interact with children or youth); have an interest in suicide prevention efforts; are interested and willing to commit to provide ongoing training to other agency staff; appear likely to stay at their organizations for several years; are capable of meeting the data collection requirements by completing required forms; and who are able to connect youth to mental health services.
5. Partner Agency agrees to support the training of additional agency staff in the Question, Persuade, Refer (QPR) Gatekeeper Training by the agency’s QPR Trainers. Training of staff will consist of 2-hour gatekeeper training sessions in groups of five to 50 persons, with the goal that by July 31, 2015 (the end of the SAMHSA grant period) all agency staff persons, who directly interact with children and youth will have received QPR gatekeeper training at

least once, and will be able to effectively question, persuade and refer children and youth who are at risk for suicide to mental health services.

6. Partner Agency agrees to support, encourage and enable the work of QPR Trainers as follows:
 - (a) Integrate QPR training into the agency's regular in-staff training program, so that trainings are scheduled several times per year to accommodate all staff and at least once per year to refresh staff's knowledge on this issue.
 - (b) Inform QPR Trainers that they will be expected to meet the obligations described in this section.
 - (c) Authorize and enable QPR Trainers to conduct ongoing QPR training of gatekeeper staff within their agency during business hours to enable staff to recognize signs and symptoms of suicide and how to talk to suicidal youth.
 - (d) Have QPR Trainers provide trainings for their agency staff.
 - (e) Require staff to attend scheduled 2-hour QPR gatekeeper training session as necessary to ensure that all agency staff who interact with children and youth receive the training.
 - (f) Authorize QPR Trainers to collect the appropriate data as needed to meet SAMHSA grant cross-site evaluation requirements (including Training Activity Survey Page (TASP), QPR pretest, Training Exit Surveys (TES), and Training Utilization and Prevention Survey (TUP-S) Sign-In Sheets each time trainer conducts a training session, to submit all forms and Sign-In Sheet to AKYSPP Evaluator, and to complete and submit to AKYSPP Evaluator.
 - (g) Designate QPR Trainers as the points of contact (POCs) within their agency for all youth who are identified as at risk for suicide and authorize trainers to make the appropriate referrals to mental health services. All staff will refer youth, deemed at risk, to the point of contact (POC) and/or will keep POC informed of any referrals made by other qualified staff.
 - (h) Identify and embed data collection process to monitor impact of trainings and ensure identified individuals are referred to and receive services (ex. EIRF). The POC will complete the Early Identification and Referral Form (EIRF) each time a staff person reports an intervention or an encounter with a youth. The POC will also follow-up with the youth and submit EIRF forms to DBH at least quarterly, without any identifying data except an ID number for statistical tracking purposes. The POC will help to provide information to the AKYSPP Evaluator to assist in completion of the 3-month follow-up section, describing the type of services the at-risk youth received.

- (i) Develop (or update as needed) agency policies and protocols for recognizing and referring youth who are at risk for suicide and other mental health needs, with the assistance of gatekeeper trainers and, if desired, DBH AKYSPP grant staff.
- (j) Advise DBH if trainer leaves the agency and consult with DBH with respect to designation of a replacement and arrangements for data collection and ongoing service provision for youth who are at risk.

III. EFFECTIVE DATE AND DURATION OF MOU

A. This MOU shall be effective between DBH and each respective Partner Agency as of the date that both the DBH Director and the Director of the particular Partner Agency has signed this MOU.

B. The period of this MOU shall be from the date that this agreement is executed by DBH and each of the other parties as provided above, through July 31, 2015, unless terminated in writing by the Parties prior to the expiration.

C. In the event that the period of the Grant from SAMHSA to DBH is extended, the Parties may extend the term of this MOU until the end of the extended period of the Grant, by entering a written modification.

IV. DATA SHARING AND CONFIDENTIAL INFORMATION

A. The Parties to this MOU will use, restrict, safeguard and dispose of all information related to services provided by this MOU, in accordance with all relevant federal and local statutes and regulations.

B. DBH will safeguard the confidentiality of the de-identified Early Identification and Referral Form (EIRF), as well as any other personal health information (“PHI”) or mental health information (“MHI”), which DBH may come into possession of, in compliance with the D.C. Mental Health Information Act, HIPAA, any other applicable District laws and regulations, and the Capitol CARE Grant award conditions. DBH will not further disclose this information.

C. Partner Agencies will provide information to DBH as provided in Section II of this MOU, in conformity with the laws and regulations applicable to their respective agencies including, as applicable, Alaska State Official Code § _____. Partner Agencies will obtain child and/or parent authorization, if required by law.

V. AUTHORITY FOR MOU

All parties to this MOU are agencies within Alaska State (the State) and are authorized to enter into this MOA pursuant to Alaska State Official Code §_____, as well as, pursuant to their respective enabling statutes.

VI. FUNDING PROVISIONS

There are no costs associated with this MOU and no money will be exchanged between the Parties for performance of their responsibilities under this MOU.

VII. TERMINATION

Either Party may terminate this MOU in whole or in part by giving thirty (30) calendar days advance written notice to the other Party.

VIII. AGENCY LIAISONS AND NOTICE

The following individuals are the agency liaisons for each Party under this MOU for the purposes of implementing the MOU, sending and receiving any notices pertaining to this MOU, and communicating with the Project Director for the Capital CARES Grant regarding implementation:

1. Alaska State Division of Behavioral Health:
Name: James Gallanos
Address: P.O. Box 110620, Juneau, AK 99801
Phone number: 907-465-8536
Email: james.gallanos@alaska.gov

2. University of Alaska Anchorage Trust Training Cooperative:
Name: Eric Boyer
Address: 2702 Gambell St, ste 103, Anchorage, AK 99503
Phone number: 907-264-6257
Email: eric@alaskachd.org

3. University of Alaska Anchorage Center for Behavioral Health Research and Services Program Evaluator:
Name: Kristen Mitchell
Address: 3150 Alumni Loop, NSB #207, Anchorage, AK, 99508
Phone number: 907-786-6381
Email: kmmitchell6@uaa.alaska.edu

4. Partner Agency:

6. Partner Agency:
- 7.

IX. MODIFICATIONS

The terms and conditions of this MOU may be modified only upon prior written agreement by the Parties.

X. MISCELLANEOUS

The Parties shall comply with all applicable laws, rules and regulations whether now in force or hereafter enacted or promulgated.

IN WITNESS WHEREOF, the Parties hereto have signed this Agreement as of the date written below:

James Gallanos
Program Manager
Department of Behavioral Health (DBH)

Date

Appendix D. Certified Trainer Key Informant Interview Script

Hello, my name is [INSERT INTERVIEWER NAME], and I'm calling to talk to you about the Alaska Gatekeeper Training with a QPR Approach suicide prevention train the trainer event that you attended on [INSERT TRAINING DATE]. Have you participated in an interview about this training before?

IF NO: Great! Is now a good time for me to give you more information?

IF NO: Is there a better time to call back?

IF YES: As I said, my name is [INSERT INTERVIEWER NAME], and I work for UAA. We were contracted by State of Alaska the State of Alaska Division of Behavioral Health to conduct an evaluation of suicide prevention programs in Alaska. We are interviewing a random sample of people who have attended suicide prevention trainings. We hope to learn more about the trainings, how you have used what you learned, and the impact of the training on you and your interactions with your peers.

In the last year, you participated in a training called **Gatekeeper Suicide Prevention Training**, as part of the **Garrett Lee Smith Memorial (GLS) Youth Suicide Prevention and Early Intervention Program**. This survey asks questions about the training, what you plan to do with what you learned during the training, and your satisfaction with the training. Findings from this survey will help inform the State of Alaska about suicide prevention activities.

The survey will take approximately 15 minutes to complete and you will receive \$10 for your participation. If you are interested, I will give you some more information and get your verbal consent.

Before I ask you whether you agree to be interviewed, there are a few more things that you should know.

Rights Regarding Participation: Your input is important; however, your participation in this survey is completely voluntary. There are no penalties or consequences for not participating. You can choose to stop the interview at any time, or not answer a question, for whatever reason. If you stop the interview, at your request, we will destroy the survey. You may ask any questions that you have before, during, or after you complete the survey. May I continue?

Privacy: Your answers are private and will not be linked to your name. Your name will never appear in any report that summarizes the findings of the evaluation. All findings will be reported in aggregate; this is, they will be combined with responses from other individuals.

Risks: Completing this interview poses few, if any, risks to you. Some questions may make you feel uncomfortable. You can choose not to answer any question for any reason. You may choose to stop the survey at any time, or not answer a question, for whatever reason. You will not be penalized for stopping. You can contact the evaluation team lead in charge of this survey at any time. If you stop the interview, at your request, we will destroy your survey.

Benefits: Your participation will not result in any direct benefits to you. However, your input will contribute to the statewide effort to prevent suicide.

I am not an expert in the subject matter, so you can't hurt my feelings and there aren't any wrong answers. We're just interested in your thoughts and opinions.

Compensation: You will receive a \$10 Starbucks card for participating in this survey.

Contact information: If you have any concerns about completing this survey or have any questions about the study, please contact Kristen Mitchell-Box, principal investigator, at (907) 786-6381 or kmmitchell6@uaa.alaska.edu.

Do you have any questions?

Do you agree to participate in this interview?

IF NO, Thank you for your time and have a good day.

IF YES, continue.

Thank you in advance for your willingness to participate. The interview will be audio taped by the evaluation team unless you request not to be audiotaped. The tape will be in the sole possession of the evaluation team and will be destroyed at the end of the project. At the end of the study, we will erase the tapes and throw them away. Your name and answers to these questions will be kept private. To begin, I'm going to ask you some questions about your job and the organization you serve.

1. What is your job title?
2. How many people does your community or organization serve?
 - <100
 - 100-250
 - 250-500
 - 500 and 1,000
 - 1,000-5,000
 - >5,000
3. Do you work in urban, rural, or remote community?

Next, I'm going to ask you about your experiences with presenting the Alaska Gatekeeper training, any extra support you may need in giving the trainings, and if you have any suggestions to improve the trainings.

4. Did the train the trainer event adequately prepare you to give trainings for your community/work/organization, etc.?
5. Since attending your train the trainer event, have you provided any training to your community/work/organization, etc.?
 - a. **IF NO:**

- i. What has been the reason you have not been able to offer a Gatekeeper Training? [**Skip to question 6**].
 - b. **IF YES:**
 - i. Tell me about a recent Gatekeeper Training program.
 1. Prior to the training, how did you identify employee training needs in the community/work/organization, etc.?
 2. During the training, how did you ensure the gatekeeper skills were successfully transferred?
6. What has been the most difficult training situation that you have had to deal with?

Prompt:

 - a. Please describe.
 - b. How did you respond and what did you do?
7. What has been the most useful aspect of being a trainer for your community?

Follow-up with:

 - a. Any reason NOT to be a trainer?
8. Has your training influenced any suicide prevention policies, procedures, or practices in your community/work/organization, etc.?
9. Please comment on the support for your training efforts provided to you by Alaska State DBH.

Prompt:

 - a. For example, continuing education like the webinar series, SharePoint site, training jump drive given to you at the Train the Trainer, etc.
 - b. What suggestions do you have on ways we can better support you as a trainer?
 - c. Do you need anything to make you feel more prepared or confident in your ability to offer Gatekeeper training?
10. Have you made any adaptations to the standard training?

If **YES:** What changes have you made?
11. How could the Alaska Gatekeeper with a QPR Approach training be more useful for you in your community?

Prompt:

 - a. How could it be more culturally relevant or community specific?
12. Do you have any specific feedback for the different training sections:
 - a. **Part 1:** Introduction and Overview including Alaska statistics, protective factors, and Alaskan culture and suicide

- b. **Part 2:** QPR (Question, Persuade, and Refer) Institute slides
 - c. **Part 3:** Accessing Community Resources including the asset mapping exercise
13. What further materials or information would be helpful for your participants during training?

Thank you very much for your time today. Your information will be very valuable to the State of Alaska in its efforts to reduce suicide among youth. If you have any questions or concerns about this survey, please contact Kristen Mitchell, University of Alaska Anchorage, (907)-786-6381.

Appendix E. Three Month Utilization and Preservation Survey (TUP-S) Consent Form

Training ID: **Training Date:** **Location of Training:** **Training Facilitator:**

Participant Name	Best Phone Number (direct number with area code)	Phone Number Type	Job title, Agency, Mailing Address	Primary Email	Best time to call? (AM/PM)	Willing to participate in Survey? (Yes/No)
		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell				<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell				<input type="checkbox"/> Yes <input type="checkbox"/> No

Appendix F. Three Month Training Utilization and Preservation Survey (TUP-S)

OMB No. 0930-0286

Expiration Date January 31, 2017

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0286. Public reporting burden for this collection of information is estimated to average 10 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 2-1057, Rockville, Maryland, 20857.

Cross-site Evaluation of the Garrett Lee Smith Memorial (GLS) State/Tribal Youth Suicide Prevention and Early Intervention Program

**Training Utilization and Preservation Survey S/T Version
and Verbal Consent Script**

Hello, my name is [INSERT INTERVIEWER NAME], and I'm calling to talk to you about the training that you attended on [INSERT TRAINING DATE]. Is now a good time for me to give you more information?

IF NO: Is there a better time to call back?

IF YES: Great! As I said, my name is [INSERT INTERVIEWER NAME], and I work for ICF, a company that has been contracted to conduct a cross-site evaluation of suicide prevention programs funded by SAMHSA (which stands for the Substance Abuse and Mental Health Services Administration). As part of this evaluation, we are interviewing a random sample of people who have attended campus suicide prevention training. We hope to learn more about the trainings, how you have used what you learned, and the impact of the training on you and your interactions with your peers.

On [DATE OF TRAINING] you participated in a training called [INSERT TRAINING NAME], as part of the **Garrett Lee Smith Memorial (GLS) Campus State/Tribal Youth Suicide Prevention and Early Intervention Program**. At the end of the training, you consented to be contacted for a follow-up survey. We are contacting you now to administer the survey. This survey asks questions about the training, what you plan to do with what you learned during the training, and your satisfaction with the training. Findings from this survey will help inform SAMHSA about suicide prevention activities.

The survey will take approximately 10 minutes to complete and you will receive \$10 for your participation. If you are interested, I will give you some more information and get your verbal consent.

Before I ask you whether you agree to be interviewed, there are a few more things that you should know:

Rights Regarding Participation: Your input is important; however, your participation in this survey is completely voluntary. There are no penalties or consequences for not participating. You can choose to stop the interview at any time, or not answer a question, for whatever reason. If you stop the interview, at your request, we will destroy the survey. You may ask any questions that you have before, during, or after you complete the survey. May I continue?

Privacy: Your answers are private and will not be linked to your name. Your name will never appear in any report that summarizes the findings of the cross-site evaluation. All findings will be reported in aggregate; this is, they will be combined with responses from other individuals.

Additional Protection: In addition, to protect the information that you give us, we have obtained a Certificate of Confidentiality from the United States Department of Health and Human Services (DHHS). The Certificate of Confidentiality will protect the members of the research staff from being forced, even under a subpoena, to release any information in which you are identified. Exceptions to the Certificate of Confidentiality are information on child abuse and neglect, or information regarding imminent danger to yourself or others, which we will report to the appropriate local and state agency. Additionally, DHHS may see your information if we are audited. Finally, the certificate of confidentiality does not imply the endorsement or the disapproval of the DHHS.

Risks: Completing this interview poses few, if any, risks to you. Some questions may make you feel uncomfortable. You can choose not to answer any question for any reason. You may choose to stop the survey at any time, or not answer a question, for whatever reason. You will not be penalized for stopping. You can contact the evaluation team lead in charge of this survey at any time. If you stop the interview, at your request, we will destroy your survey.

Benefits: Your participation will not result in any direct benefits to you. However, your input will contribute to a national effort to prevent suicide.

I am not an expert in the subject matter, and I do not work for the people who provided the training, so you can't hurt my feelings and there aren't any wrong answers. We're just interested in your thoughts and opinions.

Compensation: You will receive \$10 for participating in this survey.

Contact information: If you have any concerns about completing this survey or have any questions about the study, please contact Christine Walrath, principal investigator, at (646) 695-8154 or christine.walrath@icfi.com.

Do you have any questions?

Do you agree to participate in this interview?

IF YES, continue.

Thank you in advance for your willingness to participate. This call may be recorded and/or monitored for quality assurance purposes.

Part I. Great, thanks. To begin, I’m going to ask you some questions about the knowledge you gained at the training. (Training Knowledge)

About 3 months ago, you participated in a training regarding suicide prevention, correct?

Three months ago was [today’s date –3 months].

- Yes
- No

Now that it has been about 3 months since your training, we want to know how well you think the [INSERT TRAINING NAME] has helped in your work, home, or community.

[Interviewer Instructions: If asked, the setting of interest is the one where they are most likely to use their training]

For each of the following statements, please tell me if you Strongly agree, Agree, Disagree, or Strongly disagree.

Please rate the following statements about [INSERT TRAINING NAME].

	1 Strongly disagree	2 Disagree	3 Agree	4 Strongly agree	5 N/A/No opinion
a. The training increased my knowledge about suicide prevention.					
b. The training materials I received (i.e., brochures, wallet cards) have been very useful for my suicide prevention efforts.					
c. The training has met my suicide prevention needs.					
d. The training addressed cultural differences in the youth I serve.					
e. The training has proven practical to my work and/or my daily life.					
f. I have used my training to help with youth suicide prevention in my community.					
g. The things I learned during the training have helped me prevent youth suicide or reduce the problems that might lead to suicide (i.e., depression, substance use).					

Have you used your training to: (Select all that apply.)

- Screen youth for suicidal behaviors (i.e., using a screening tool)
- Formally publicize information about suicide prevention or mental health resources
- Have informal conversations about suicide and suicide prevention with youth and others
- Identify youth who might be at risk for suicide
- Provide direct services to youth at risk for suicide and/or their families

- Train other staff members
- Make referrals to mental health services for at-risk youth
- Work with adult at-risk populations
- Other (please describe: _____)
- Don't intend to use what I learned

Do you intend to use what you learned?

- Yes
- No
- Don't know
- Refused to answer

Many suicide prevention trainings also focus on developing life skills and identifying positive aspects of life that reduce the likelihood of suicide. We would like to know how well you think **[INSERT TRAINING NAME]** enhanced your ability to identify strengths for yourself and others in your work, home, or community.

[Interviewer Instructions: If asked, the setting of interest is the one where they are most likely to use their training]

For each of the following statements, please tell me if you Strongly agree, Agree, Disagree, or Strongly disagree.

Please rate the following statements about **[INSERT TRAINING NAME]**.

	1 Strongly disagree	2 Disagree	3 Agree	4 Strongly agree	5 N/A/No opinion
a. The training has helped me develop stronger social and familial relationships.					
b. The training has helped me connect to members of the community.					
c. As a result of the training, I place greater value on connections to friends and family.					
d. The training showed me the importance of high self-esteem and self-confidence.					
e. As a result of the training, I am more aware of the importance of communication.					
f. As a result of the training, I have a greater sense of competence.					
g. As a result of the training, I have a stronger sense of well-being.					

Please indicate how you would rate your knowledge of suicide in the following areas.
 For each of the following statements, please tell me how you would rate your knowledge: Very high, High, Low, or Very low.

	1 Very low	2 Low	3 High	4 Very high	5 N/A/No opinion
a. Facts concerning suicide prevention.					
b. Warning signs of suicide.					
c. How to ask someone about suicide.					
d. Persuading someone to get help.					
e. How to get help for someone.					
f. Information about resources for help with suicide.					
g. Please rate what you feel is the appropriateness of asking someone who may be at risk about suicide.					
h. What is the likelihood you will ask someone who appears to be at risk if they are thinking of suicide?					
i. Please rate your level of understanding about suicide and suicide prevention.					

How appropriate do you think it is to ask someone who may be at risk for suicide about suicide?

- Very high
- High
- Low
- Very low
- Don't know
- Refused

What is the likelihood you will ask someone who appears to be at risk if they are thinking of suicide?

- Very likely
- Likely
- Somewhat likely
- Not at likely
- Don't know
- Refused

Part II. This set of questions asks about your post training behaviors.

In the 3 months since your training, have you used your training to train adults to intervene with a youth aged 10–24 who were at risk for suicide?

Three months ago was [today's date–3 months].

- Yes
- No

[If No, skip to #5b]

a. **[If Yes]** About how many?

- 1–5
- 6–10
- 11–20
- >20

b. Have you used your training to train youth to intervene with a peer at risk for suicide?

- Yes
- No

•

[Interviewer instructions: If asked, youth are aged 10–24]

•

• **[If No, skip to #6]**

c. **[If Yes]** About how many?

- 1–5
- 6–10
- 11–20
- >20

In the 3 months since your training, have you used **[INSERT TRAINING NAME]** to identify youth you thought might be at risk for suicide?

Three months ago was [today's date –3 months].

- Yes
- No

[Interviewer instructions: If asked, this should be based on what they learned during their training; if asked, youth are aged 10–24]

[If No, skip to question 13]

a. **[If Yes]** About how many youth have you identified?

- 1–5
- 6–10
- 11–20
- >20

b. In which of the following settings were they identified? (Select all that apply.)

- School
- Child welfare agency
- Juvenile justice agency
- Law enforcement agency
- Physical health agency (e.g., primary care, pediatrician's office)
- Emergency response unit or emergency room

- Mental health agency
- Community-based organization, recreation, or after school activity
- Home
- Digital medium (e.g., Facebook or text message)
- Other (please describe: _____)

c. What was the setting where most of these identifications were made? (Select all that apply.)

- School
- Child welfare agency
- Juvenile justice agency
- Law enforcement agency
- Physical health agency (e.g., primary care, pediatrician's office)
- Emergency response unit or emergency room
- Physical health agency
- Mental health agency
- Community-based organization, recreation, or after school activity
- Home
- Digital medium (e.g., Facebook or text message)
- Other (please describe: _____)

Okay, to what services, resources, or individuals did you refer the youth you identified?
(Select all that apply.)

- Mental health agency
- Psychiatric hospital/unit
- Emergency room
- Substance abuse treatment center
- School counselor
- Private mental health practice
- Mobile crisis unit
- Other (please describe: _____)

Do you know whether the youth received the services to which they were referred?

- Yes
- No

a. **[If No]** Why don't you know if the youth received services? **[Then skip to item #9]**

b. **[If Yes]** Think about the youth referred. About how many of the youths whom you referred to services actually received those services?

- All (100%)
- Almost all (75–99%)
- Most (50–75%)
- Some (25–50%)
- A few (1–25%)
- None (0)

Now, think back to the most recent youth you identified who actually received services.

	1 Very satisfied	2 Satisfied	3 Neutra l	4 Somewha t satisfied	5 Not at all satisfied
13. How satisfied are you that your training and the actions you took on the basis of your training were appropriate and effective?					

14. Thinking about this same youth, about how many days did it take from the time you made the referral to when they received their first service?

[Interviewer instructions: If asked, services could include: mental health assessment/treatment; substance use assessment/treatment; psychiatric hospitalization; emergency room or mobile crisis]

- Less than 1 day
- Less than 1 week
- Between 1 and 2 weeks
- Between 3 and 4 weeks
- More than 1 month

- Again, thinking about this same youth, what was the first service he or she received?
 - Mental health assessment
 - Substance use assessment
 - Mental health counseling
 - Substance abuse counseling
 - Psychiatric services or medication management without therapy
 - Inpatient or residential psychological services
 - Other service (Please describe: _____)

- Did he or she receive any additional mental health services since that first appointment?
 - Yes
 - No

[If No, skip to #13]

- a. **[If yes]** What were they?
 - Mental health assessment
 - Substance use assessment
 - Mental health counseling
 - Substance abuse counseling
 - Inpatient services
 - Family therapy
 - Group therapy
 - Medication
 - Other service (Please describe: _____)
 - Don't know

Part III. Great, thanks! The following questions are about how easy or difficult it has been to implement what you learned in your training in your community, home, or workplace.

	1 Not supportive at all	2 Somewhat supportive	3 Very supportive	4 No opinion
15. How supportive has your community or workplace been of implementing what you learned through the [INSERT TRAINING NAME]?				

16. Of the following issues, what is the greatest facilitator of implementing youth suicide prevention in your community or workplace?

- Training/professional development opportunities
- Increased community awareness
- Community resources
- Community collaboration
- State, tribe, or agency prioritization of suicide prevention

17. Of the following issues, what is the greatest barrier to implementing youth suicide prevention in your community or workplace?

- Access to appropriate services
- Lack of awareness about the problem of suicide
- Time constraints
- Workplace characteristics
- Lack of funding

18. Our final set of questions is about your personal background. We would like you to identify the primary settings in which you might interact with youth. Within each setting, we will ask you about the professional or volunteer role that BEST describes you. (You can select one setting /one role.)

Please indicate the **primary** setting in which you interact with youth:

- Education (K-12)
- Substance abuse
- Juvenile justice/probation
- Emergency response
- Higher education (college/university)
- Tribal services/tribal government
- Child welfare
- Mental health
- Primary health care (other than mental health)
- Other community settings
- Don't know
- REFUSED

19. What is your job title?

20. On a typical day, about how much time do you spend interacting or talking directly with youth?
(Select one.)

[Interviewer instructions: If asked, youth are aged 10–24]

- 0–15 minutes
- 15–30 minutes
- 30 minutes–1 hour
- 1–2 hours
- More than 2 hours

21. What is the nature of the work that you do with youth?

- Teaching
- Counseling/advising
- Providing mental health services
- Case management (e.g., child welfare, juvenile justice)
- Mentoring
- No formal work; interactions with youth are intermittent within the community setting

22. Have you received any booster training in suicide prevention in the last 3 months?

- Yes
- No

a. If yes, which training(s) have you received?

We would like to ask a few additional questions about your background:

23. What is your gender?

- Female
- Male
- Transgender
- Other

24. What is your age? _____ years

25. Are you Hispanic or Latino? (Select one.)

- Yes
- No

26a. If yes, which group represents you? (Select one or more.)

- Mexican, Mexican American, or Chicano
- Puerto Rican
- Cuban
- Dominican
- Central American
- South American

27. What is your race? (Select one or more.)

- American Indian or Alaska Native

- Asian
 - Black or African American
 - Native Hawaiian or other Pacific Islander
 - White
2. Are you willing to be contacted again in 3 months to answer questions about how you've used the information and skills you learned in the training?
- Yes
 - No

Thank you very much for your time today. Your information will be very valuable to SAMHSA in its efforts to reduce suicide among youth. If you have any questions or concerns about this survey, please contact Gingi Pica, ICF International, at (646) 6951-8130.

Appendix G. Summary of Trainings Provided by the AKYSPP June 2013-June 2015

6/30/2013	18	7	McLaughlin Youth Center	Eric Boyer	99508
8/8/2013	18	4	Alaska Children's Services	Eric Boyer	99508
8/13/2013	35	35	Boys and Girl's Home	Eric Boyer	99701
8/13/2013	35	30	Fairbanks Youth Advocates	Eric Boyer	99710
8/29/2013	17	3	Tanana Chiefs Council	Eric Boyer	99701
9/25/2013	10	10	Yuut Center (Bethel)	Eric Boyer	99559
10/10/2013	13	13	National Association of Social Workers' Conference	Eric Boyer	99501
11/2/2013	9	0	School Health and Wellness Conference	James Gallanos, Trish Smith	99501
12/16/2013	10	10	Volunteers of America	Trish Smith	99501
1/23/2014	20	20	Anchorage Police Training Academy	Jill Ramsey & Eric Boyer	99508
2/4/2014	41	41	Alaska's Vocational Technical Center	Eric Boyer	99664
2/10/2014	20	2	Allakaket	Valerie Bergman & Sarah McConnell	99720
2/10/2014	20	0	Northway	Sarah McConnell	99764
2/10/2014	25	0	Tok	Sarah McConnell	99780
2/10/2014	25	0	Ruby	Sarah McConnell	99768
2/13/2014	9	1	Kaltag	Sarah McConnell & Jessica Goff	99748
2/14/2014	4	4	Alaska Statewide Special Education Conference	Eric Boyer	99502
2/18/2014	7	7	Alaska Child and Family	Alaska Child and Family Staff	99507
2/20/2014	15	0	Ruby	Shawna Hildebrand & Sarah McConnell	99779
2/24/2014	11	11	Bristol Bay Health Corporation	Eric Boyer	99756
2/27/2014	15	15	Wasilla Behavioral Health Services	Eric Boyer	99654
3/3/2014	27	27	Bethel Village Public Safety Officers	Eric Boyer	99559
3/6/2014	25	0	Huslia	Sarah McConnell	99746
3/6/2014	20	0	Huslia	Doreen David & Sarah McConnell	99746
3/6/2014	15		Cook Inlet Tribal Conference	Becky Bitzer & Sarah McConnell	99508
3/27/2014	10	1	University of Alaska, Fairbanks	Eric Boyer	99775
3/31/2014	15	2	Minto Community Hall	Sarah McConnell	99758
4/1/2014	16	0	Fairbanks Westmark Hotel	Valerie Bergman	99701
4/4/2014	10	9	Soteria	Eric Boyer	99503
4/15/2014	15	0	Interior Regional Housing Authority	Sarah McConnell	99701
4/18/2014	23	23	Full Lives Conference	Eric Boyer & Wendi Shackelford	99503

4/22/2014	3	0	Alaska Center for Resource Families	Sarah McConnell	99701
4/23/2014	2	2	Alaska Child and Family	Alaska Child and Family Staff	99507
4/25/2014	25	25	National Education Association		99503
4/25/2014		25	National Education Association Teachers' Conference	Jill Ramsey & Eric Boyer	99503
4/25/2014	26	26	Community Connections	Eric Boyer & Wendi Shackelford	99901
4/30/2014	14	14	British Petroleum Energy Center	Becky Bitzer	99507
5/7/2014	57	57	Alaska Child and Family	Alaska Child and Family Staff	99507
5/24/2014	9	1	Rural Alaska Honors Institute	Sarah McConnell	99775
5/29/2014	3	0	LINKS Parent Resource Center	Sarah Twaddle	99654
5/30/2014	19	0	University of Alaska Anchorage Class	Eric Boyer	999508
6/3/2014	13	13	North Star Residential Treatment Center	Wayne Jackson and Eric Boyer	99503
6/4/2014	25	25	North Star Residential Treatment Center	Eric Boyer	99503
6/11/2014	7	0	Bethel Youth Facility	Department of Juvenile Justice Staff	99559
6/17/2014	13	6	Chief Peter John Tribal Building	Sarah McConnell & Valerie Bergman	99701
6/17/2014	7	7	Alaska Child and Family	Alaska Child and Family Staff	99507
6/19/2014	7	2	Mat-Su Youth Facility	Department of Juvenile Justice Staff	99645
6/23/2014	8	0	Johnson Youth Center	Department of Juvenile Justice Staff	99827
6/24/2014	2	2	Nome Youth Probation	Department of Juvenile Justice Staff	99762
6/24/2014	2	0	Nome Youth Probation	Department of Juvenile Justice Staff	99762
6/25/2014	26	0	McLaughlin Youth Center	Department of Juvenile Justice Staff	99508
6/26/2014	7	2	Kenai	Department of Juvenile Justice Staff	99611
6/26/2014	10	10	Fairbanks Youth Facility	Department of Juvenile Justice Staff	99701
6/27/2014	2	2	Valdez Probation	Department of Juvenile Justice Staff	99686
7/1/2014	3	3	Kodiak Probation	Department of Juvenile Justice Staff	99615
7/16/2014	14	14	North Star Palmer Residential Treatment Center	Wayne Jackson and Eric Boyer	99645
7/22/2014	8	8	Alaska Child and Family	Alaska Child and Family Staff	99507
7/31/2014	5	5	Alaska Vocational and Technical Center	Eric Boyer	99664
8/11/2014	32	32	Seward School District	Sarah Twaddle	99664
8/12/2014	14	14	Northwest Artic Borough School District	Becky Bitzer	99752
8/19/2014	4	4	Alaska Child and Family	Alaska Child and Family Staff	99507

8/21/2014	17	16	Eastern Aleutian Tribe	Sarah McConnell	99503
8/22/2014	7	7	Hoonah Police Department	Wendi Shackelford & Jill Ramsey	99829
8/27/2014	15	2	Winter Bear	Sarah McConnell	99709
8/28/2014	20	14	Eastern Aleutian Tribe	Sarah McConnell	99503
8/28/2014	13	13	AK Child & Family	Eric Boyer	99503
9/10/2014	22	1	Nome Rotary	Becky Bitzer	99762
9/10/2014	5	0	University of Alaska Anchorage Student Union	Lizzy Donovan & Elizabeth Williams	99508
9/12/2014	2	0	University of Alaska Anchorage Student Union	Lizzy Donovan & Elizabeth Williams	99508
9/19/2014	3	1	Aleutians East Borough School District	Sarah McConnell	99612
9/19/2014	7	7	Aleutians East Borough School District	Sarah McConnell	99661
9/24/2014	22	22	Alaska Department of Education and Early Development	Eric Boyer	99503
9/25/2014	23	0	Eagle River High School	Deb Casello	99577
9/29/2014	80	0	Alaska Vocational and Technical Center	Eric Boyer	99664
9/29/2014	70	0	Alaska Vocational and Technical Center	Eric Boyer	99664
9/30/2014	300	15	Seward Jr/High School	Sarah Twaddle & Eric Boyer	99664
9/30/2014	18	18	Seward community	Sarah Twaddle & Eric Boyer	99664
10/8/2014	23	23	Valdez Providence Clinic	Sarah Twaddle	99573
10/14/2014	14	0	Kenai Peninsula Distance Learning	Sarah Twaddle	99669
10/15/2014	6	0	Avail High School	Deb Casello	99501
10/16/2014	12	0	School health and Wellness Conference	Becky Bitzer	99501
10/16/2014	12	12	Anchorage School Wellness Conference	Becky Bitzer & Wendi Shackelford	99503
10/16/2014	65	0	South Anchorage Rotary Club	Eric Boyer	99507
10/17/2014	44	0	Haines High School	Lindsey Moore	99827
10/21/2014	11	11	Department of Labor	Eric Boyer	99503
10/21/2014	10	10	Department of Labor	Eric Boyer	99503
10/21/2014	4	4	Alaska Child and Family	Alaska Child and Family Staff	99507
10/28/2014	40	0	West Anchorage High School	Deb Casello	99517
10/30/2014	6	0	Youth Empowerment of Anchorage	Deb Casello	99501
11/3/2014	12	0	Tanana Chiefs Conference	Sarah McConnell	99701
11/4/2014	9	1	Dillingham High School	Becky Bitzer	99576
11/4/2014	22	1	Cordova Elementary School	Sarah McConnell	99574
11/5/2014	8	2	Cordova Community Medical Center	Sarah McConnell	99574
11/5/2014	9	0	Sound Alternatives	Sarah Twaddle & Sarah McConnell	99574
11/10/2014	35	0	Eagle River High School	Deb Casello	99577

11/10/2014	10	0	Kenai Rotary Club	Eric Boyer	99611
11/12/2014	7	0	University of Alaska Fairbanks Psychology Practicum	Sarah McConnell	99775
11/11/2014	22	22	Wasilla Sunrise Rotary Club	Eric Boyer	99629
11/12/2014	28	28	AK State School Counselors Conference	Deb Casello	99501
11/12/2014	12	3	Prospector Hotel (Juneau)	Eric Boyer	99801
11/13/2014	61	6	Fairbanks North Star Borough School District	Sarah McConell	99701
11/13/2014	3	1	Dillingham hospital	Becky Bitzer	99765
11/14/2014	12	0	University of Alaska Anchorage Student Union	Lizzy Donovan & Elizabeth Williams	99508
11/15/2014	17	0	West Anchorage High School	Deb Casello	99517
11/18/2014	9	0	University of Alaska Fairbanks Psychology Class	Sarah McConnell	99508
11/19/2014	11	0	Kodiak High School	Deb Casello	99615
11/21/2014	21	21	State of AK	Sarah McConnell	99507
11/21/2014	14	13	Fairbanks Community Mental Health Services	Sarah McConnell	99701
11/22/2014	17	1	Tuzzy Consortium Library	Becky Bitzer	99723
11/22/2014	16	0	Denali Family Services	Wayne Jackson & Elke Villegas	99504
11/23/2014	20	0	Wasilla Rotary	Eric Boyer	99629
11/24/2014	48	0	South Anchorage High School	Deb Casello	99516
11/25/2014	4	4	Alaska Child and Family	Alaska Child and Family Staff	99507
12/3/2014	7	2	Nome-Beltz High School	Becky Bitzer	99762
12/4/2014	90	5	Juneau Douglas High School	James Gallanos	99801
12/5/2014	14	13	Division of Vocational Rehabilitation	Sarah McConnell	99701
12/9/2014	80	0	Colony High School Junior Reserve Officers' Training Corps	Deb Casello	99645
12/16/2014	4	4	Alaska Child and Family	Alaska Child and Family	99507
1/5/2015	38	0	Valdez High School	Sarah Twaddle	99686
1/13/2015	125	0	Rotary Club	Eric Boyer	99503
1/16/2015	35	0	AK Division of Vocational Rehabilitation	Eric Boyer	99501
1/16/2015	10	0	International Rotary Club	Eric Boyer	99507
1/20/2015	7	7	Alaska Child and Family	Alaska Child and Family Staff	99507
1/21/2015	15	0	Loussac Library	Eric Boyer	99503
1/21/2015	12	0	Loussac Library	Eric Boyer	99503
1/28/2015	15	0	Service High School	Deb Casello	99507
1/30/2015	25	0	Loussac Library	Eric Boyer	99503
1/30/2015	9	0	University of Alaska Southeast	Becky Porter & Elizabeth Williams	99801
1/30/2015	9	0	University of Alaska Southeast	Becky Porter & Elizabeth Williams	99801

1/30/2015	7	0	University of Alaska Southeast	Becky Porter & Elizabeth Williams	99801
2/2/2015	5	2	Tok	Sarah McConnell	99780
2/3/2015	4	0	Tanacross	Sarah McConnell	99776
2/3/2015	13	1	Northway	Sarah McConnell	99764
2/3/2015	28	0	Nome High School	Deb Casello	99762
2/3/2015	28	2	Soldotna City Library	Eric Boyer	99669
2/4/2015	3	1	Tetlin	Sarah McConnell	99779
2/5/2015	13	0	Mentasta	Sarah McConnell	99780
2/6/2015	4	0	Dot Lake	Sarah McConnell	99737
2/10/2015	32	0	Houston High School	Deb Casello	99694
2/12/2015	15	14	University of Alaska Center for Human Development	Eric Boyer	99503
2/12/2015	15	0	Aleyeska Hotel	Eric Boyer	99587
2/12/2015	11	0	University of Alaska Fairbanks	Sarah McConnell	99775
2/12/2015	6	0	University of Alaska Fairbanks	Sarah McConnell	99775
2/13/2015	2	0	University of Alaska Anchorage Student Union	Lizzy Donovan & Elizabeth Williams	99508
2/16/2015	12	12	Alzheimer's Resources of Alaska	Eric Boyer	99645
2/16/2015	25	0	Vocational Training and Resource Center	James Gallanos	99801
2/17/2015	3	3	Alaska Child and Family	Alaska Child and Family Staff	99507
2/18/2015	20	0	University of Alaska Fairbanks Senior Seminar	Sarah McConnell	99775
2/20/2015	24	24	Alzheimer's Resources of Alaska	Eric Boyer	99645
2/24/2015	66	0	Haines High School	Deb Casello	99827
2/27/2015	45	0	Anchorage Safety and Security Conference	Eric Boyer	99502
3/1/2015	10	0	Alaska National Guard Child and Youth Program	Deb Casello	99503
3/1/2015	16	0	University of Alaska Fairbanks Psychology Club	Sarah McConnell	99775
3/6/2015	50	0	Coast Inn Hotel Anchorage	Eric Boyer	99502
3/10/2015	6	1	Nenana Native Council Tribal Hall	Sarah McConnell	99760
3/10/2015	15	0	Westmark Hotel Anchorage	Eric Boyer	99503
3/12/2015	9	0	Minto Lakeview Lodge	Sarah McConnell	99758
3/19/2015	14	14	University of Alaska Anchorage Center for Human Development	Eric Boyer	99503
3/19/2015	8	0	University of Alaska Fairbanks Rural Student Services	Sarah McConnell	99775
3/24/2015	13	0	University of Alaska Fairbanks	Sarah McConnell	99775
3/30/2015	55	0	Wasilla High School	Deb Casello	99654
3/31/2015	25	0	Thunder Mountain High School	Deb Casello	99801
3/31/2015	10	0	Yaakoosge Daakahidi High School	Deb Casello	99801
3/31/2015	48	0	Juneau Douglas High School	Deb Casello	99801

4/6/2015	10	0	Koyukuk School	Sarah McConnell	99754
4/7/2015	10	1	Galena Community Hall	Sarah McConnell	99741
4/8/2015	8	0	Karluk School	Sarah McConnell	99608
4/9/2015	7	1	Alaska Pacific University	Elizabeth Williams	99508
4/10/2015	8	0	University of Alaska Anchorage Student Union	Lizzy Donovan & Elizabeth Williams	99508
4/13/2015	22	22	Department of Interior, Aviation Division	Eric Boyer	99507
4/13/2015	14	0	University of Alaska Fairbanks Rural Social Work Class	Sarah McConnell	99775
4/14/2015	15	0	Kodiak Middle School	Sarah McConnell	99615
4/16/2015	24	0	Alaska Career College	Emilie Cattrell	99508
4/17/2015	45	45	Full Lives Conference	Eric Boyer	99503
4/17/2015	5	0	University of Alaska Anchorage Student Union	Elizabeth Williams	99508
4/21/2015	18	1	Tanana Community Hall	Sarah McConnell	99777
4/21/2015	6	0	Mary J. Sommers School	Sarah McConnell	99777
4/22/2015	62	10	Faith Lutheran Church	Sarah McConnell	99603
4/23/2015	6	34	Kachemak Bay Rotary Club	Sarah McConnell	99603
4/24/2015	8	4	Turning Point Counseling Services	Sarah McConnell	99701
4/24/2015	8	3	Turning Point Counseling Services	Sarah McConnell	99701
4/24/2015	9	0	University of Alaska Fairbanks Eileen Panigeo MacLean House	Sarah McConnell	99775
4/28/2015	12	2	Fairbanks Westmark Hotel	Sarah McConnell	99701
5/7/2015	15	1	Quzinkie Community Center	Joe McGee	99644
5/7/2015	4	0	Quzinkie School	Joe McGee	99644
5/8/2015	11	0	Satterberg Law Firm	Sarah McConnell	99701
5/28/2015	7	0	Alaska Career College	Emilie Cattrell	99508
6/05/2015	5	0	University of Alaska Anchorage Eagle River Campus	Emilie Cattrell	99577
6/16/2015	12	0	University of Alaska Anchorage Student Union	Elizabeth Williams	99508

Appendix H. AKYSPP Training Activity Summary Page (TASP)

OMB No. 0930-0286

Expiration Date: January 31, 2017

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0286. Public reporting burden for this collection of information is estimated to average 80 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 2-1057, Rockville, Maryland, 20857.

Cross-site Evaluation of the Garrett Lee Smith Memorial (GLS) State/Tribal Youth Suicide Prevention and Early Intervention Program

Short Version Training Activity Summary Page

Training date: / / Training ID:

Mental health professionals: + Others: = Total trainees:

Number of trainees under 18 years of age who attended the training:

Number of trainees with primary role in each setting (*participants should only be counted in one category*):

Education (K-12)	<input type="text"/>
Higher education (college/university)	<input type="text"/>
Substance abuse	<input type="text"/>
Juvenile justice/probation	<input type="text"/>
Emergency Response	<input type="text"/>
Tribal services/tribal government	<input type="text"/>
Child welfare	<input type="text"/>
Mental health	<input type="text"/>
Primary health care	<input type="text"/>
Other community settings Please describe:	<input type="text"/>

Name of facility: ZIP code:

Type of training (select one): QPR: Gatekeeper training:

Total duration of training: Total number of hours: minutes:

OMB No. 0930-0286

Expiration Date: January 31, 2017

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0286. Public reporting burden for this collection of information is estimated to average 80 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 2-1057, Rockville, Maryland, 20857.

Cross-site Evaluation of the Garrett Lee Smith Memorial (GLS) State/Tribal Youth Suicide Prevention and Early Intervention Program

Original Training Activity Summary Page

Training date: / /

Training ID
(First 3 digits represent Site ID):
} Site ID

The following information on the number of trainees in the TR1 and WD2 categories is required for posting TRAC data to the Suicide Prevention Data Center. Please note that TR1 and WD2 are mutually exclusive categories. For further details, please see additional guidance provided in your TRAC Users Guide.

How many trainees fall under the WD2 category (the number of people in the mental health and related workforce trained in mental health-related practices/activities that are consistent with the goals of the grant)?

How many trainees fall under the TR1 category (the number of individuals who have received training in prevention or mental health promotion)?

Total number of trainees who attended the training:

____ + _____ = _____

(Do not leave this question blank. If none of the trainees belong to the category, enter “0.”)

Number of trainees under 18 years of age who attended the training:

Number of trainees with primary role in each setting (*participants should only be counted in one category*):

- Education (K-12) □□□
- Higher education (college/university) □□□
- Substance abuse □□□
- Juvenile justice/probation □□□
- Emergency Response □□□
- Tribal services/tribal government □□□
- Child welfare □□□
- Mental health □□□
- Primary health care □□□
- Other community settings □□□
- Other please describe: _____

Name of training: _____

Name and ZIP code of facility where training was held (*leave blank for online trainings*):

Name: _____

ZIP code: □□□□□

Type of training (select one):

- QPR (Question, Persuade, Refer)
- Yellow Ribbon
- ASIST (Applied Suicide Intervention Skills Training)
- Signs of Suicide (SOS)
- Sources of Strength
- Youth Depression Suicide: Let's Talk
- SafeTALK
- Connect (formerly Frameworks)
- Lifelines
- AMSR (Assessing and Managing Suicide Risk)
- RRSR (Recognizing and Responding to Suicide Risk)
- Campus Connect
- American Indian Life Skills Development
- Kognito
- Response (A Comprehensive High School-based Suicide Awareness Program)
- CALM (Counseling on Access to Lethal Means)
- Other: Please specify: _____
-

If you have selected "Other" as type of training, please select one of the following:

- Gatekeeper training
- Screener training

- Clinical intervention/treatment training
- Postvention training
- General awareness training

What is the primary intended outcome for participants in this training? (select one)

- To screen youth for suicide behaviors (i.e., using a screening tool)
- To have conversations about suicide and suicide prevention with youth and others
- To identify youth who might be at risk for suicide
- To provide direct services to youth at risk for suicide and/or their families
- To train other staff or community members
- To make referrals to mental health services for at risk youth
- To work with adult at-risk populations
- To enhance life skills and coping mechanisms

Total duration of training:

Total number of hours minutes

Is this a train-the-trainer event?

- Yes
- No

Is this an online training?

- Yes
- No

Is this a booster or follow-up training?

- Yes
- No

If no, are there any plans to conduct follow-up or booster trainings in the future?

- Yes
- No

Appendix I. Alaska Gatekeeper QPR Pre-Training Survey

	1 Very Low	2 Low	3 Medium	4 High	5 Very High
1. Facts concerning Suicide Prevention					
2. Warning signs of suicide					
3. How to ask someone about suicide					
4. Persuading someone to get help					
5. How to get help for someone					
6. Information about resources for help with suicide					
7. Please rate what you feel is the appropriateness of asking someone who may be at risk about suicide					
8. What is the likelihood you will ask someone who appears to be at risk if they are thinking of suicide?					
9. Please rate your level of understanding about suicide and suicide prevention.					

	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree
10. If someone I knew was showing signs of suicide, I would directly raise the question of suicide with them.					
11. If a person's words and/or behavior suggest the possibility of suicide, I would ask the person directly if he/she is thinking about suicide					
12. If someone told me they were thinking of suicide, I would intervene					
13. I feel confident in my ability to help a suicidal person					
14. I don't think I can prevent someone from suicide					
15. I don't feel competent to help a person at risk of suicide					

Appendix J. Alaska Gatekeeper QPR Post Training Exit Survey (TES)

Training Exit Survey: Gatekeeper Training

Thank you for answering our questions. Your answers are very important.

The questions are about what you are learning in this class. We want to know how you will use the information you are learning, and if you were happy with what you learned. The answers to the questions will help the State of Alaska make the class better.

Please read everything before you answer the questions. You will need 10 minutes to answer the questions. If you do not want to answer the questions, give the papers back to the teacher. There are no right or wrong answers. You can ask the teacher questions at any time.

Privacy: Your name and your answers to the questions are private. Your answers will not be shared with other students or teachers.

Procedures: Everyone in the class will be asked to answer the questions.

Risks: Nothing bad will happen if you complete the survey. Nothing bad will happen if you do not answer the questions. You can stop answering the questions or skip a question. If you stop answering the questions, we will throw away the papers.

Contact information: Call Kristen Mitchell-Box at 907-786-6381 (or email kmmitchell6@uaa.alaska.edu) if you have questions.

Your answers will help the State of Alaska learn how this class can help prevent suicide.

The main categories on the following page represent different settings in which you might interact with youth. Within each setting, different professional and volunteer roles are presented. Please **FIRST** select the primary setting in which you interact with youth. **SECOND**, within that setting, please select the **ONE ROLE** that you feel best describes you.

For example, if you work as a counselor with a school-based health center, then you would select “education (K–12)” as the setting, and within that setting you would select “mental health clinician/counselor/psychologist”. If you work as a counselor with a community-based mental health services agency, then you would select “mental health” as the setting, and within that setting, you would select “mental health clinician/counselor/psychologist”.

- Education (K–12)**
- Teacher
 - School administrator
 - Mental health clinician/counselor/psychologist
 - Social worker/case worker/care coordinator
 - Emergency/crisis care worker
 - Program evaluator
 - Administrative assistant/clerical support personnel
 - Academic advisor
 - Tutor
 - Other: _____
- Substance abuse**
- Program/system administrator
 - Mental health clinician/counselor/psychologist
 - Social worker/case worker/care coordinator
 - Emergency/crisis care worker
 - Program evaluator
 - Administrative assistant/clerical support personnel
 - Other: _____
- Juvenile justice/probation**
- Program/system administrator
 - Probation officer
 - Social worker/case worker/care coordinator
 - Detention facility guard
 - Program evaluator
 - Administrative assistant/clerical support personnel
 - Other: _____
- Emergency response**
- Police officer or other law enforcement staff
 - Program/system administrator
 - Emergency medical technician
 - Fire fighter
 - Program evaluator
 - Administrative assistant/clerical support personnel
 - Other: _____
- Higher education (college/university)**
- Faculty/professor/researcher
 - Administrator (e.g., dean's office, vice president, provost)
 - Residential life staff
 - Mental health clinician/counselor/psychologist
 - Social worker/case worker/care coordinator
 - Emergency/crisis care worker
 - Program evaluator
 - Administrative assistant/clerical support personnel
 - Student
- Tribal services/tribal government**
- Traditional tribal healer
 - Tribal elder
 - Elected tribal official
 - Program/system administrator
 - Mental health clinician/counselor/psychologist
 - Social worker/case worker/care coordinator
 - Community outreach worker
 - Emergency/crisis care worker
 - Program evaluator
 - Administrative assistant/clerical support personnel
 - Other: _____
- Child welfare**
- Program/system administrator
 - Mental health clinician/counselor/psychologist
 - Social worker/case worker/care coordinator
 - Emergency/crisis care worker
 - Program evaluator
 - Administrative assistant/clerical support personnel
 - Other: _____
- Mental health**
- Program/system administrator
 - Mental health clinician/counselor/psychologist
 - Social worker/case worker/care coordinator
 - Emergency/crisis care worker
 - Program evaluator
 - Administrative assistant/clerical support personnel
 - Other: _____
- Primary health care (other than mental health)**
- Program/system administrator
 - Physician
 - Nurse
 - Nursing assistant/health technician
 - Program evaluator
 - Administrative assistant/clerical support personnel
 - Other: _____
- Other community settings**
- Parent or foster/resource parent
 - Other caregiver
 - Relative
 - Youth mentor
 - Volunteer (i.e., Big Brother Big Sister, CASA)
 - Youth advocate
 - Clergy/religious educator
 - Other: _____

2. On a typical day, about how much time do you spend interacting or talking directly with youth? (Select one.)
 - 0–15 minutes
 - 15–30 minutes
 - 30 minutes–1 hour
 - 1–2 hours
 - More than 2 hours

3. Were you required to participate in this training?
 - Yes
 - No
 - Don't know

4. How do you intend to use what you learned during this training? (Select all that apply.)
 - Screen youth for suicide behaviors (i.e., using a screening tool)
 - Formally publicize information about suicide prevention and mental health resources
 - Have informal conversations about suicide and suicide prevention with youth and others
 - Identify youth who might be at risk for suicide
 - Provide direct services to youth at risk for suicide and/or their families
 - Train other staff members
 - Make referrals to mental health services for at risk youth
 - Work with adult at-risk populations
 - Other (please describe: _____)
 - Don't intend to use what I learned

Please indicate your agreement with the following statements about the training.

	1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree	5 N/A or No Opinion
5. The training increased my knowledge about suicide prevention.					
6. The training materials I received (i.e., brochures, wallet cards) will be very useful for my suicide prevention efforts.					
7. The training met my suicide prevention needs.					
8. The training addressed cultural differences in the youth I intend to serve (i.e., provided different cultural examples, identified					

different cultures).					
9. The training was practical to my work and/or my daily life.					
10. I fully understand why I attended the training.					
11. I am now more ready to help with youth suicide prevention in my community.					
12. The things I learned will help prevent youth suicide or reduce the problems that might lead to suicide (i.e., depression, substance use).					

13. How would you rate the training? (Select one.)

- Below my skill level
- At my skill level
- Above my skill level
- Don't know

5. With whom do you expect to directly apply what you have learned during this training? (Select all that apply.)

- Youth
- Parents/foster parents/caregivers
- Family
- Coworkers
- Community members
- Other (please describe: _____)

6. With what group do you expect to **most often** apply what you have learned during this training? (Select one.)

- Youth
- Parents/foster parents/caregivers
- Family
- Coworkers
- Community members
- Other (please describe: _____)

Now that you have received this training, please indicate how you would rate your knowledge of suicide in the following areas:

	1 Very Low	2 Low	3 Medium	4 High	5 Very High
16. Facts concerning Suicide Prevention					
17. Warning signs of suicide					
18. How to ask someone about suicide					
19. Persuading someone to get help					
20. How to get help for someone					
21. Information about resources for help with suicide					
22. Please rate what you feel is the appropriateness of asking someone who may be at risk about suicide					
23. What is the likelihood you will ask someone who appears to be at risk if they are thinking of suicide?					
24. Please rate your level of understanding about suicide and suicide prevention.					

Please read each statement and use the rating scale to indicate the degree to which you agree or disagree with it. It is important that you answer all statements according to your beliefs and not what you think others may want you to believe.

	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree
25. If someone I knew was showing signs of suicide, I would directly raise the question of suicide with them.					
26. If a person's words and/or behavior suggest the possibility of suicide, I would ask the person directly if he/she is thinking about suicide					
27. If someone told me they were thinking of suicide, I would intervene					
28. I feel confident in my ability to help a suicidal person					

29. I don't think I can prevent someone from suicide					
30. I don't feel competent to help a person at risk of suicide					

*Questions 16-30 were developed by the QPR institute; www.qprinstitute.com

Background information

31. What is your gender?

- Female
- Male
- Transgender
- Other

What is your age? _____ years

Are you Hispanic or Latino? (Select one.)

- Yes
- No

33a. If yes, which group represents you? (Select one or more.)

- Mexican, Mexican American, or Chicano
- Puerto Rican
- Cuban
- Dominican
- Central American
- South American

What is your race? (Select one or more.)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White

Thank you for answering the questions. Your answers are very important to the State of Alaska.

Appendix K. Early Identification, Referral, and Follow-up (EIRF) Individual Form

OMB No. 0930-0286 Expiration Date: January 31, 2017

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0286. Public reporting burden for this collection of information is estimated to average 20 hours per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 2-1057, Rockville, Maryland, 20857.

**Early Identification, Referral and Follow-up
(EIRF) Individual Form**

Date: (Date of identification):

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Month Day Year

Participant ID (Site-assigned):

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Sources of information used to complete this form. (Select all that apply.)

- Case record review or existing data system
- Directly from a provider (i.e., case manager, clinician, mental health professional)
- Directly from a gatekeeper (i.e., not a mental health professional)
- Other (**Please describe – e.g. “self”:** _____)

Early Identification Activity Setting (Select one.)

- High school
- College or University
- Child Welfare Agency
- Juvenile Justice Agency
- Law Enforcement Agency
- Physical Health Agency (e.g., primary care, pediatrician’s office, etc.)
- Mental Health Agency
- Community-based organization, recreation or after school activity
- Home
- Emergency Response Unit or Emergency Room
- Digital medium (e.g. Facebook or text message)
- Other (**Please describe:** _____)

Zipcode where the youth was identified

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Source of Early Identification of Youth (Select one)

- Screening (Select this option for all youth identified at-risk through a group screening activity corresponding to an EIRF Screening Form no matter who conducted the screening. This response option should be selected for each youth determined to be at risk at the conclusion of the entire screening process—for example, following the post-screening interview or debriefing process.)
- Family member/ Foster family member / Caregiver
- Mental health service provider (e.g., clinician, school counselor, etc.)
- Teacher or other school staff except school counselor (including college or university staff)
- Community based organization, recreation, religious, or after school program staff
- Child welfare staff
- Probation officer or other juvenile justice staff
- Primary care provider (i.e., pediatrician)
- Emergency responder or emergency room staff
- Police officer, security guard, or other law enforcement staff
- Peer
- Other (Please describe – e.g., “self”: _____)

Section I. Early Identification

1. Youth Age:

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 (years)

2. Youth Gender:

- Male
- Female
- Trans male/Trans man
- Trans female/Trans woman
- Gender non-conforming
- Other (Please specify) _____

3. Youth Sexual Orientation

- Heterosexual (that is straight)
- Gay or Lesbian
- Bisexual
- Not sure

4. Is the youth of Hispanic or Latino cultural/ethnic background?

- Yes
- No [Skip to item 5]
- Don't know [Skip to item 5]

4a. [IF YES] Which group describes his/her Hispanic or Latino cultural/ethnic background? Is he/she (Select all that apply)?

- Mexican, Mexican-American, or Chicano
- Puerto Rican
- Cuban

- Dominican
- Central American
- South American
- Other Hispanic origin (**Please specify:** _____)

5. Which group(s) describes the youth? Is he/she (select all that apply)?

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- No race available (**Please describe:** _____)

Section II. Referral Information

6. Was the youth referred for either mental health or nonmental health related services?

- Yes, the youth was referred to mental health and non-mental health related services [Skip to item 7].
- Yes, the youth was referred to non-mental health related services only [Skip to item 7].
- Yes, the youth was referred to mental health related services only [Skip to item 8].
- No

6a. [IF NO] Why was the youth not referred for any type of services? (Select the ONE primary reason).

- Youth was already receiving services or supports.
- No capacity at provider agencies to receive a referral.
- Youth determined not to be at risk during referral process (for example, if a youth is identified by his or her teacher at school but upon discussion with the school's care coordinator, they determine that the youth is not at risk for suicide and does not need a referral for further mental health services).
- Unable to contact youth
- Other (**Please describe:** _____)

If the youth was NOT referred to any type of services (i.e. you answered item 6a), please end the survey. Otherwise, please continue.

7. [IF THE YOUTH WAS REFERRED TO NON MENTAL HEALTH RELATED SERVICES] Where was the youth recommended for non-mental health support? (Select all that apply.)

- School or other academic organization
- Family or extended family
- Community based organization, recreation, religious, or afterschool program
- Physical health provider (e.g., medical, vision, hearing, dental)
- Law enforcement or juvenile justice agency

- Child welfare agency or shelter
- Other (**Please describe:** _____)

If the youth was referred to mental health related services: Continue to Question 8
If the youth was NOT referred to mental health related services: Quit the Survey

8. [IF YES] Date of referral for mental health related services:

Month		Year			

8a. [IF YES] Where was the youth referred for mental health related services? (Select all that apply.)

- Public Mental Health Agency or Provider
- Private Mental Health Agency or provider
- Psychiatric Hospital/Unit
- Emergency Room
- Substance Abuse Treatment Center
- School Counselor
- Mobile Crisis Unit
- Crisis hotline
- Other (**Please describe:** _____)

Section III. Follow-up to Mental Health Referral

9. In the 3 months following the date of referral, did the youth receive mental health services as a result of the mental health referral?

- Yes [Skip to item 10]
- No
- Don't know

9a. [IF NO] What was the primary reason why the youth did not receive a mental health service?

- Made an appointment for youth but youth did not attend.
- Youth was wait-listed for at least 3 months.
- Parent or youth refused service for personal reasons (i.e., not financial reasons).
- Youth did not have insurance or could not afford services.
- Youth did not have transport to the appointment.
- Other (**Please describe:** _____)

9b. [IF Unknown] What was the primary reason why you do not know if the youth received a mental health service?

- Parent permission for tracking required but not granted.
- No tracking system in place.

- Tracking system requires an agreement to share data but the agreement is not in place.
- Tracking system prohibits data sharing.
- Parent or youth could not be contacted.
- Other (**Please describe:**_____)

If youth did not receive mental health services or if that is unknown [i.e., you answered question 9a or 9b]: End survey. Otherwise, please continue.

10. [IF YES] What service did the youth receive at the initial appointment? (Select all that apply.)

- Mental health assessment
- Substance use assessment
- Mental health counseling
- Substance abuse counseling
- Inpatient or residential psychological services
- Medication
- Other service (**Please describe:** _____)

11. [IF YES] Date of initial appointment:

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Month Day Year

12. Zip code of initial appointment location

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13. Did the youth attend a second visit for a mental health service within 3 months after the first appointment?

- Yes [Skip to item 14]
- No
- Don't know

13a. [IF NO] What was the primary reason why the youth did not receive a second mental health service?

- Made an appointment for youth but youth did not attend.
- Youth was wait-listed for at least 3 months.
- Parent or youth refused service for personal reasons (i.e., not financial reasons).
- Youth did not have insurance or could not afford services.
- Youth did not have transport to the appointment.
- Other (**Please describe:**_____)

13b. [IF unknown] What was the primary reason why the youth did not receive a second mental health service

