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Research Report

Evaluation of the California Mental Health Services Authority's Prevention and Early Intervention Initiatives

Progress and Preliminary Findings

Edited by M. Audrey Burnam, Sandra H. Berry, Jennifer L. Cerully, and Nicole K. Eberhart

Sponsored by the California Mental Health Services Authority (CalMHSA)

The research described in this report was sponsored by the California Mental Health Services Authority (CalMHSA), and was produced within RAND Health, a division of the RAND Corporation.

CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families and communities. Prevention and Early Intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

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RAND, SRI, Field, and UCLA were all involved with the initial stages of project formation and planning. Staff at RAND and SRI International carried out subsequent activities and writing tasks. Where the team is referenced in this document as "RAND" it should be understood to include the entire multi-organizational team collaborating on this project.

Preface

This report provides preliminary findings from the RAND Corporation's evaluation of the California Mental Health Services Authority (CalMHSA) Prevention and Early Intervention (PEI) programs. Where early results are not available, a progress update is provided instead.

CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. PEI programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

CalMHSA aims to reduce adverse outcomes for people who experience mental illness in the state of California. The PEI program is composed of three strategic initiatives that are developing statewide capacities and interventions focused on (1) stigma and discrimination reduction (SDR), (2) suicide prevention (SP), and (3) student mental health (SMH). Under each initiative, community agencies serve as PEI Program Partners, performing activities intended to meet the initiative's goals.

RAND has been tasked with evaluating the PEI initiative at three levels – the level of each Program Partner involved in implementing activities, the level of the strategic initiative (i.e., SDR, SP, and SMH), and the statewide level. The statewide evaluation focuses on large-scale surveys and the analysis of suicide vital statistics. At the program and initiative levels, our evaluation takes a unified approach to very diverse programs by focusing on six core program activities: (1) the development of policies, protocols, and procedures; (2) networking and collaboration; (3) informational resources; (4) training and education programs; (5) social marketing/media campaigns and interventions to influence media production; and (6) hotline and "warmline" operations providing crisis support and basic social support, respectively.

This document was prepared with the input of stakeholders across the state of California and was funded by counties through the voter approved Mental Health Services Act (Prop. 63). In particular, members of the Statewide Evaluation Experts (SEE) Team provided input to guide the document's development and provided feedback on a draft of the report. The SEE is a diverse group of CalMHSA partners and community members, including CalMHSA board members, representatives of counties of varied sizes, representatives of the California Mental Health Directors Association, a representative from the California Institute for Mental Health, members of the Mental Health Services Oversight and Accountability Commission, representatives from the California Department of Health Care Services and the California Mental Health Planning Council, individuals with expertise in cultural/diversity issues, behavioral scientists with evaluation expertise, and consumers and family members who have received mental health services.

The research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health. Questions about this document can be directed to Nicole Eberhart at eberhart@rand.org.

Abstract

Background: The California Mental Health Services Authority (CalMHSA) Prevention and Early Intervention (PEI) program aims to reduce adverse outcomes for California residents who experience mental illness. This program comprises three strategic initiatives that are developing statewide capacities and interventions intended to (1) reduce stigma and discrimination towards those with mental illness, (2) prevent suicide, and (3) improve student mental health. Under each initiative, community agencies serve as PEI Program Partners, performing activities intended to meet the goals of the initiatives.

Aims: This evaluation aims to evaluate the progress of the CalMHSA PEI program in achieving its goals at the program and initiative levels and to establish baseline population tracking of key risk factors and long-term outcomes targeted by the initiatives.

Methods and Approach: The evaluation approach was based on a conceptual model that focuses on assessing the capacities and resources developed by programs, the processes by which these capacities and resources are implemented and disseminated, short-term outcomes, and long-term outcomes resulting from the PEI program. Program-level data were collected using tools and methods developed for the evaluation, as well as reviews of Program Partner materials. Population tracking to date included analyses of suicide rates across California, results from a recent survey of the California adult population, and preliminary findings from school-based surveys.

Results: Our evaluation to date shows that Program Partners have been highly productive in developing new program capacities and resources. Program Partners have greatly expanded their capacities to deliver numerous new PEI program activities and many new programs have been launched. The reach of new programs is rapidly expanding. At this phase of the evaluation, short-term impacts of PEI program activities are not yet known.

Conclusions: Results of capacity building and development of infrastructure and resources are promising, but many program activities are still being implemented. Short-term outcomes related to key program activities will be evaluated over the next two years of the evaluation. While long-term outcomes will be tracked at the population level, it may not be possible to observe impacts within the evaluation time frame.

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Summary

In 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA), which includes a mandate that the state provide prevention and early intervention (PEI) services and education for people who experience mental illness in the state of California. The California Mental Health Services Authority (CalMHSA), a coalition of California counties formed to provide economic and administrative support to mental health service delivery, formed the Statewide PEI Implementation Program based on extensive recommendations from a large number of stakeholders statewide. The CalMHSA Statewide PEI program is composed of three strategic initiatives focusing on: (1) reduction of stigma and discrimination toward those with mental illness, (2) prevention of suicide, and (3) improvement in student mental health. Each initiative is implemented with the assistance of community agencies serving as PEI Program Partners (see Table S.1 for the Program Partners under each initiative).

Table S.1
CalMHSA Statewide PEI Program Partners by Initiative

Stigma and Discrimination Reduction (SDR)	Suicide Prevention (SP)	Student Mental Health (SMH)
• Disability Rights California • Entertainment Industries Council, Inc. • Integrated Behavioral Health Project/Center for Care Innovations • Mental Health America of California • Mental Health Association of San Francisco • National Alliance on Mental Illness • Runyon, Saltzman & Einhorn • United Advocates for Children and Families • SDR Consortium	• AdEase • Didi Hirsch Psychiatric Services • Family Service Agency of the Central Coast • Family Service Agency of Marin • Institute on Aging Center • Kings View • LivingWorks • San Francisco Suicide Prevention • Transitions Mental Health Association	• California County Superintendents Educational Services Association • California Department of Education • California Community Colleges • California State University • University of California

In 2011, the RAND Corporation was contracted by CalMHSA to design and implement a three-year statewide evaluation of the statewide PEI initiative. The evaluation involves assessing PEI Program Partner activities, the three major initiatives (i.e., stigma and discrimination reduction [SDR], suicide prevention [SP], and student mental health [SMH] initiatives), and the overall CalMHSA statewide PEI initiative. Specifically, the RAND evaluation team is collaborating with the PEI Program Partners to achieve the following evaluation aims:

- Evaluate PEI Program Partners' progress toward meeting statewide objectives
- Assess the activities implemented and resources created by PEI Program Partners
- Evaluate program outcomes, including:
  - Targeted program capacities and their reach (i.e., the number of people exposed to program materials, services, social marketing messages, and training)
  - Short-term outcomes (e.g., attitudes and knowledge about mental illness, behavior toward people with mental illness)
  - Longer-term outcomes (e.g., reduced suicide, reduced discrimination, improved student performance).

To meet these aims, the evaluation focuses on evaluating Program Partner resources and capacity-building efforts. We have organized these into six types of core activities that occur across initiatives:

(1) the development of policies, protocols, and procedures
(2) networking and collaboration
(3) informational resources
(4) training and educational programs
(5) media/social marketing campaigns and interventions to influence how media productions depict mental health
(6) hotline and "warmline" operations, that is, providing crisis support and basic social support, respectively.

Because Program Partners are required to conduct evaluations of their activities, RAND is evaluating a strategically selected subset of activities identified through conversations with CalMHSA and the Program Partners.

In addition to evaluating these activities, the RAND evaluation is also developing baseline assessments of population risk factors and outcomes for the initiatives. These baseline assessments provide a platform for longer-term monitoring of population risk factors and outcomes over time. The evaluations' baseline population tracking includes an analysis of county- and region-wide suicide rates, an in-progress student and faculty survey of the school mental health climate across California, and a statewide survey of California adults' beliefs about suicide, mental health stigma and discrimination, and the mental health climate in schools.

The evaluation aims are derived from the priorities set forth in the CalMHSA Statewide PEI Implementation Work Plan[1] and are set forth in detail in an evaluation plan developed by RAND and approved by CalMHSA. In addition, the RAND evaluation team has been providing technical assistance to Program Partners to enhance their ability to assist in the evaluation of the initiatives and promote continuous quality improvement efforts.

This report presents early findings on the capacities and resources developed by the Stigma and Discrimination Reduction, Suicide Prevention, and Student Mental Health initiatives. In addition, results of a baseline statewide survey of the general population of California's knowledge, attitudes, and beliefs toward mental health are presented. While Program Partners implemented many activities within the past year, other activities are still in development and will be implemented over the coming year. Thus, results presented at this time are necessarily preliminary.

Stigma and Discrimination Reduction

Within the categories of core activities identified above, the RAND evaluation strategically focused on the central and well-defined activities that represent major program efforts. In the Stigma and Discrimination Reduction (SDR) Initiative, the RAND evaluation identified and focused on key activities that fell under four of the six core activity areas (see Table S.2).

Table S.2
Key Activities Being Evaluated Under the Stigma and Discrimination Reduction Initiative

Type of Core Activity	
Development of policies, protocols, and procedures	X
Networking and collaboration	
Development of informational/online resources	X
Training and educational programs	X
Media/social marketing campaigns and interventions to influence media production	X
Hotline and "warmline" operations	

SDR Initiative Program Partners have developed many capacities and resources, including improving policies, procedures, and protocols, as well as informational resources related to stigma and discrimination reduction. These capacities and resources include fact sheets, tool kits, and reviews that identify and assess promising practices in SDR in community organizations. Many online resources have also been developed. For online resources, we present early results from website analytics to track how users are finding and interacting with Program Partner sites,

[1] This document is available online at http://calmhsa.org/programs/pei-statewide-projects/

what resources they are downloading, and where in California site visitors are located. These results show that there have been over 45,000 visits to online resources sponsored by CalMHSA, and site visitors have come from many areas across California. We continue to track the Program Partners' online dissemination of tools and materials in order to assess program reach. We are also implementing tools for understanding resource effectiveness.

SDR Program Partners are also hosting trainings and educational programs. These offerings target a wide variety of audiences, such as people with mental health challenges, family members of people with mental health challenges, landlords, health providers, county mental/behavioral health service managers, teachers, and students. Many of these trainings utilize contact with consumers of mental health services to help reduce stigma and discrimination (an evidence-based practice). Because tools for tracking the reach and impact of these trainings and presentations have been in place only for a short time, we are as yet unable to report results on these.

In addition to providing informational resources and trainings, SDR Program Partners are implementing two media-related stigma and discrimination reduction strategies: providing media training to journalism and entertainment professionals and conducting a social marketing campaign targeting populations across the lifespan, with an emphasis on youth. Evaluations of these activities are in progress; no results are available at this time.

Suicide Prevention

The RAND evaluation of the Suicide Prevention (SP) Initiative determined that SP Initiative Program Partners' central, well-defined activities fall into four of the six core activity areas, which represent the major program efforts (see Table S.3).

Table S.3
Key Activities Being Evaluated Under the Suicide Prevention Initiative

Type of Core Activity	
Development of policies, protocols, and procedures	
Networking and collaboration	X
Development of informational/online resources	
Training and educational programs	X
Media/social marketing campaigns and interventions to influence media production	X
Hotline and "warmline" operations	X

The SP Initiative Program Partners are focused on building hotline and "warmline"[2] capacities across the state, promoting networking and collaboration among hotlines and

[2] A warmline is a non-crisis telephone service that provides encouragement and support to persons in need.

"warmlines," and using social marketing efforts to promote suicide and mental health awareness. Our evaluation includes an assessment of the networking and collaboration resulting from the efforts of Program Partner Didi Hirsch (a mental health service agency with a dozen locations in and around Los Angeles), which is facilitating the California Suicide Prevention Network (CSPN). Reviews of related documents (e.g., Memoranda of Understanding [MOUs] with partners and emergency/crisis intervention protocols, policy recommendations, and meeting rosters and agendas) are in progress, and RAND will conduct key informant interviews and a survey regarding collaboration at a later stage of the evaluation.

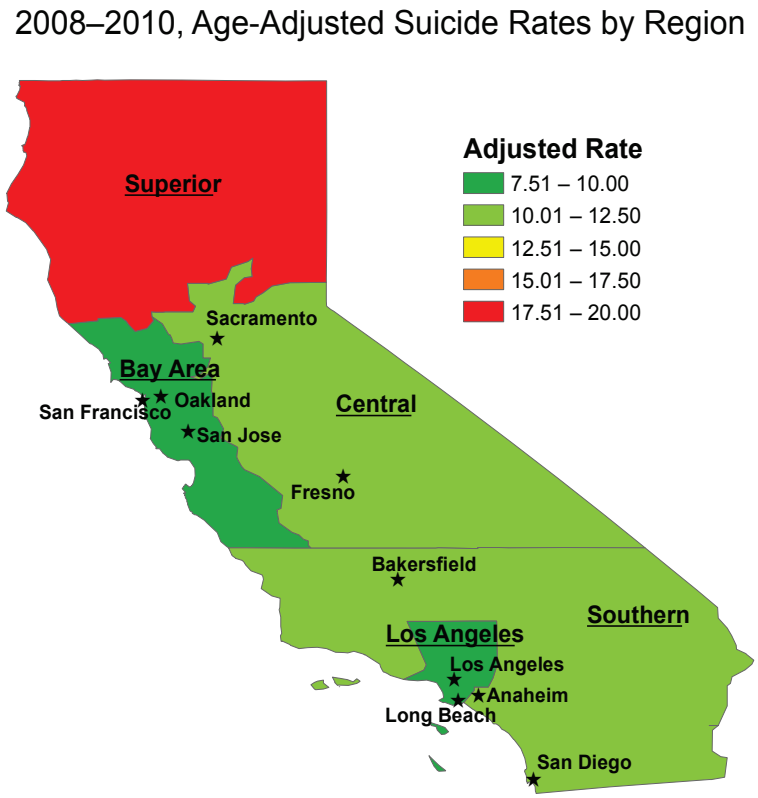
Program Partners created or expanded four new crisis response services, and several existing hotlines are seeking accreditation or have been accredited since the beginning of the contract period. To understand the reach of hotline and warmline operations, we are tracking call volume. We have developed a protocol for systematically monitoring hotline call quality.

Evaluations of several suicide intervention trainings (LivingWorks' SafeTalk and ASIST trainings) are ongoing. Data on the demographics of training participants reached to date are available, and post-training surveys indicate high satisfaction with the trainings and increases in perceptions of self-efficacy and intentions to help people at risk. Monitoring of fidelity to the ASIST training protocol is in progress.

One Program Partner, AdEase, is conducting a social marketing campaign related to suicide prevention. The evaluation of SP social marketing activities is still in progress. Campaign components are described in the report; we will evaluate campaign messages and their efficacy during years two and three of the evaluation. Preliminary data on the reach of the Know the Signs website (www.suicideispreventable.org) are presented in this report and show that over 470,000 visits were made to the site between November 2012 and February 2013. More data on campaign reach will be provided at a later point.

In addition to the evaluation of the key Program Partner activities above, we have analyzed suicide fatalities in California to establish baselines against which later suicide rates may be compared. Age-adjusted suicide rates by region are presented in Figure S.1. Two major findings emerge from this analysis. First, the suicide rate is highest in California's most-rural areas (e.g., Humboldt, Mendocino, Siskiyou, Butte, and Amador counties), indicating that those who live in these areas are at higher risk for suicide. Second, suicides in these areas actually account for a very small proportion of California's overall number of suicides (approximately 6%), indicating that resources must still be allocated to the areas of the state with the highest numbers of suicides.

Figure S.1. Map of Age-Adjusted Suicide Rates by Region (2008–2010)



Student Mental Health

The RAND evaluation of the Student Mental Health (SMH) Initiative strategically assesses Program Partners' most central efforts, which fall into the three core activity areas highlighted in Table S.4. The SMH Initiative Program Partners are focusing on improving the mental health of both K–12 and higher education students throughout California. These Program Partners are developing resources for improving student mental health, conducting trainings for educational professionals, and promoting networking and collaboration among school campuses and neighboring community organizations.

Table S.4
Key Activities Being Evaluated Under the Student Mental Health Initiative

Type of Core Activity	
Development of policies, protocols, and procedures	
Networking and collaboration	X
Development of informational/online resources	X
Training and educational programs	X
Media/social marketing campaigns and interventions to influence media production	
Hotline and "warmline" operations	

The evaluation of SMH activities related to networking and collaboration will focus on the California County Superintendents Educational Services Association county consortia, the State SMH Policy Workgroup, University of California and California State University SMH Initiative Advisory Groups, California Community Colleges Regional Strategizing Forums, and inter- and intra-campus collaborations among the higher-education Program Partners. Reviews of related documents (e.g., meeting rosters, agendas, policy recommendations) are in progress. Key informant interviews and a collaboration survey will be conducted later.

SMH Program Partners are making many informational resources available online. These include resources about mental health issues for students and information for faculty and staff regarding approaches to supporting students with mental health needs. Thus far, RAND evaluators have reviewed websites hosting informational resources, for content and target audience. Website analytics and feedback survey data are currently available for online resources developed by California County Superintendents Educational Services Association (for K–12 schools). Early results are presented in this report and indicate that initial interest in the website has come primarily from school administrators and mental health professionals who are interested in students of all ages. Site visitors reported coming to the site to seek materials on a wide variety of topics, with mental health/wellness, bullying, and behavior management among the most prevalent. We are currently developing a follow-back survey to assess the usefulness of the materials.

SMH Program Partners implemented a variety of training programs to promote the early identification and appropriate referral of students experiencing mental health issues. Thus far, we have provided technical assistance to SMH Program Partners to implement tools to evaluate SMH trainings, as well as tools for tracking the reach of trainings. In the future, several trainings will be selected for detailed content analysis. We present available data on training presentations and their reach in this report. Preliminary analyses of training survey data indicate that participants reported being satisfied with the training and experienced increased self-efficacy and behavioral intentions after undergoing training.

In addition to the evaluation of the key Program Partner activities above, we have designed baseline surveys of student, faculty, and staff perceptions of school climate and student attitudes and behavior related to mental health, and we are in the process of collecting these data. The K–12 survey has not yet been fielded, but preliminary data based on 6,309 higher education students and 3,025 faculty and staff are available. Their responses suggest that about 20 percent of higher education students are likely experiencing a mental health problem, and 25 percent of student respondents reported either having used or having been referred to campus mental health services. Some 25 to 35 percent of students reported that their academic performance was negatively affected by anxiety or depression. However, 67 percent of students indicated that they know where to go for help with a personal problem. Students generally believed that the campus climate with respect to mental health issues is positive (e.g., more friendly than hostile). Faculty and staff agreed that their campuses provide adequate mental health counseling and support to students. Twenty-four percent of faculty and staff reported having talked with a student about mental health once or twice, 30 and 46 percent did so a few or many times, but almost half (46%) did not discuss mental health with students in the past six months. Twenty percent of faculty/staff reported having attended some form of training on student mental health during the past six months. Over 50 percent of faculty/staff stated that they knew where to refer students who need mental health resources.

In summary, SMH Program Partners are engaging in a wide variety of activities, including collaborating with other organizations, providing informational resources, and offering training on student mental health issues. RAND evaluation activities designed to assess reach of these expanded capacities and resources are in progress. The ongoing administration of surveys of SMH climate provides a useful baseline against which to compare future school climate data.

General Population Survey: Baseline Preliminary Results

We used random digit dialing to conduct a general population statewide survey of California adults. The survey includes questions about such topics as mental health literacy, stigmatizing attitudes, and exposure to CalMHSA PEI efforts. The main purpose of the survey is to serve as a baseline against which later data on these topics can be compared. It also serves as a measure of early exposure of the general population to CalMHSA activities. A similar survey will be fielded in approximately one year so that changes from baseline can be determined. We caution that one year is a short time frame in which to observe widespread population-level change and suggest continued tracking to observe population-level change over time.

Results presented here are preliminary, and we are continuing to analyze the survey data. We reached a diverse group of 2,001 California adults (age 18 and over). The sample closely matches known California population characteristics in terms of sex, age, race, ethnicity, education, income, and employment.

Two-thirds of respondents were aware of stigma and discrimination toward people with mental health challenges. Some respondents indicated stigmatizing attitudes and beliefs (e.g., about one-quarter of respondents thought that people with mental health challenges are dangerous), but many also reported some positive beliefs about potential for recovery and contributing positively to society (e.g., 70 percent of respondents thought that a person with mental illness can recover). Some 92 percent of respondents expressed a willingness to support people with mental health challenges. About 20 percent of respondents reported that they would hesitate to disclose having experienced a mental health challenge to their friends or family, and 17 percent indicated that they would hesitate to seek treatment for such a challenge out of fear of what others would think.

Respondents varied in their opinions about suicide. About two-thirds of respondents believed that suicide is preventable, and just over half thought that suicide is always preceded by warning signs. About half also believed, incorrectly, that talking about suicide can cause suicide. Nearly half of respondents did not know that men are at greater risk of completing suicide than women. Respondents indicated that if they were having suicidal thoughts they would be more likely to seek face-to-face help from a counselor or other mental health professional than to use other possible resources.

Respondents with a child in a K–12 school or in an institution of higher education and respondents who were themselves students in an institution of higher education were asked about school climate for handling issues related to mental health. Parents of K–12 students and students in higher educational institutions indicated that they "somewhat agree" with the idea that their school helped students and provided quality counseling and other resources to help students with social, emotional, and behavioral problems. Students typically agreed that their institution helps students and provides quality counseling.

Exposure to CalMHSA activities at the population level has been difficult to detect early in the project period. Eleven percent of respondents reported having seen or heard of the slogan "Each Mind Matters," 8 percent had heard of "ReachOut," and 9 percent had seen or heard of "Suicide Is Preventable." However, 2 percent or less of respondents visited the Each Mind Matters, ReachOut, or Suicide Is Preventable websites. We note, however, that the Each Mind Matters website did not exist until partway through the data collection period. Also, some social marketing activities were targeted toward 14- to 24-year-olds, and the survey was only administered to Californians 18 and older. Thirty-nine percent of respondents reported seeing or hearing ads with specific AdEase taglines (e.g., "Know the Signs"). Furthermore, 16 percent reported having attended some sort of training about mental illness, but we cannot determine if these trainings were among those implemented through CalMHSA's PEI initiatives.

Commentary

This report presents early evaluation findings for many newly developed program activities that together represent the implementation of interdependent statewide strategies designed to

reduce mental health stigma and discrimination, prevent suicide, and improve student mental health. Many program activities are not yet fully implemented and the evaluation is ongoing. Nonetheless, the question of whether these programs are producing their intended effects is a pressing one for California decisionmakers and other stakeholders. This commentary offers our perspective on how well it is progressing so far.

There is a logical, science-informed path from the statewide strategic plan to achieving actual reduction in mental health stigma and discrimination, reduction in suicide, and improvement in student mental health. This path involves: (1) the strategic planning of comprehensive, inter-related program components, (2) development of new PEI program capacities, (3) delivery of new program activities to achieve broad reach to California's diverse population and result in significant exposure to program materials, (4) impact of program activities on targeted short-term outcomes such as knowledge and attitudes, and (5) impact on longer-term outcomes for California's population.

These PEI initiatives are bold and ambitious efforts for the state of California – both because of the uniqueness of a new strategic "statewide" approach to prevention and early intervention programs and because they are managed by a relatively new and innovative organizational body that involves joint decisionmaking across California's many and diverse counties. The components of the statewide PEI strategic plan were carefully and broadly informed through a strategic planning process that involved diverse stakeholders.

To date, it is clear that Program Partners have been highly productive in developing new program capacities that relate to the components of the strategic plan. Furthermore, the launching of many program activities is well under way. This is impressive given the relatively short time Program Partners have had to develop and implement new program activities. So far, reach of program activities is relatively limited (a result of being in the early stages of implementation) or cannot yet be determined, and many program activities are in a phase of rapid expansion of their reach. We do not know yet whether programs are having their intended short-term impacts on participants/audiences, but we expect to be able to answer those questions for key program activities over the next one to two years, within the time frame of this evaluation. We caution that it may be unrealistic to expect observable population changes in the long-term outcomes of interest during this period, given the start-up time required to build and launch new programs, the relatively brief period over which program effects will be observed, and the importance of broad population reach and exposure for prevention to have an impact.

Acknowledgments

We would like to thank Program Partner staff for their cooperation, and we are grateful to the Statewide Evaluation Experts (SEE) Team, a diverse group of California stakeholders, for their input into this evaluation. We also thank Brett Ewing, Diana Lavery, Beth Roth, Daniel Sommerhauser, and Christopher Young at RAND for assistance in managing and analyzing data for this project, and Mark DiCamillo and other staff at Field Research Corporation for their work on the statewide general population survey. We are grateful to Bernie Beltran, Christopher Dirks, Fatima Ford, and Kerry Newsome at RAND for administrative support in assembling this report. The RAND Health Quality Assurance process employs peer reviewers. This document benefited from Donna Farley and Joshua Breslau, whose rigorous technical reviews of this report served to improve its quality. Finally, we thank the CalMHSA staff for their ongoing guidance and assistance.

Abbreviations

AAS	American Association for Suicidology
ACA	Affordable Care Act
ACHA-NCHA	American College Health Association–National College Health Assessment
ADHD	Attention Deficit Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
AP	Associated Press
ASIST	Applied Suicide Intervention Skills Training
CalMHSA	California Mental Health Services Authority
CalSCHLS	California School Climate, Health, and Learning Survey
CAPS	Counseling and Psychological Services
CARS	Center for Applied Research and Solutions
CBG	Campus Based Grant
CBITS	Cognitive Behavioral Intervention for Trauma in Schools
CCC	California Community Colleges
CCSESA	California County Superintendents Educational Services Association
CDC	Centers for Disease Control and Prevention
CDE	California Department of Education
CEU	Continuing Education Unit
CHKS	California Healthy Kids Survey
CiMH	California Institute for Mental Health
COE	County Office of Education
CPT	California Public Television
CQI-FAIR	Quality Improvement, Fidelity, Assessment, and Implementation Ratings
CRM	Continuing Relationship Maintenance
CSCS	California School Climate Staff Survey
CSPN	California Suicide Prevention Network
CSS	California Student Survey
CSU	California State University
DC	District of Columbia
DIS	Designated Instruction and Services
DK	Don't Know
DRC	Disability Rights California
EBL	Eliminating Barriers to Learning
EIC	Entertainment Industries Council, Inc.
ERMHS	Educationally Related Mental Health Services

ETS	Ending the Silence
FSA Marin	Family Service Agency of Marin
FSACC	Family Service Agency of the Central Coast
GSS	General Social Survey
IBHP/CCI	Integrated Behavioral Health Project/Center for Care Innovations
IDEA	Individuals with Disabilities Education Improvement Act
IOOV	In Our Own Voice
IRB	Institutional Review Board
ISP	Internet Service Provider
IVST	Interactive Video Simulation Training
K6	Kessler Psychological Distress Scale
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning
LPS	Lanterman-Petris-Short Act
M	Mean
MERLOT	Multimedia Educational Resource for Learning and Online Teaching
MHAC	Mental Health America of California
MHAS	Mental Health Advocacy Services
MHASF	Mental Health Association of San Francisco
MHCC	Mental Health Consumer Concerns, Inc.
MHFA	Mental Health First Aid
MHSA	Mental Health Services Act
MOU	Memorandum of Understanding
NA	Not Applicable
NAMI	National Alliance on Mental Illness
NCHA	National College Health Assessment
NCS	National Comorbidity Study
NCS-R	National Comorbidity Study Replication
NHIS	U.S. National Health Interview Survey
NIMBY	"Not in my backyard"
NIMH	National Institute of Mental Health
NSPL	National Suicide Prevention Lifeline
P&TA	Parents and Teachers as Allies
PCOE	Placer County Office of Education
PDF	Portable Document Format
PEI	Prevention and Early Intervention
PEP	Provider Education Program
PIRE	Pacific Institute for Research & Evaluation
PR	Public Relations
PTSD	Post-Traumatic Stress Disorder
QI	Quality Improvement
QPR	Question, Persuade, Refer

RS&E	Runyon Saltzman & Einhorn
SAMHSA	Substance Abuse and Mental Health Services Administration
SCOE	Sacramento County Office of Education
SD	Standard Deviation
SDR	Stigma and Discrimination Reduction
SE	Standard Error
SEE	Statewide Evaluation Experts
SELPA	Special Education Local Plan Area
SHC	School Health Center
SIM	Suicide Intervention Model
SLO	San Luis Obispo
SMH	Student Mental Health
SMHP	Student Mental Health Program
SMHPW	Student Mental Health Policy Workgroup
SP	Suicide Prevention
T4T	Training for Trainers
TETRIS	Training Educators Through Recognition and Identification Strategies
TMHA	Transitions Mental Health Association
TOT	Training of Trainers
TW	Telephone Worker
UACF	United Advocates for Children and Families
UC	University of California
UCUES	University of California Undergraduate Experience Survey
URL	Uniform Resource Locator
VA	Department of Veterans Affairs
VPN	Virtual Private Network

1. Introduction

This report presents early findings from an ongoing evaluation of the California Mental Health Services Authority (CalMHSA) statewide Prevention and Early Intervention (PEI) program, a set of new program activities that together represent the implementation of interdependent statewide strategies designed to reduce mental health stigma and discrimination, prevent suicide, and reduce negative consequences associated with mental health problems among California's students.

The CalMHSA Statewide Prevention and Early Intervention (PEI) Program

The CalMHSA statewide PEI program aims to reduce adverse outcomes for people who experience mental illness in the state of California. The PEI program is composed of three strategic initiatives that are developing statewide capacities and interventions intended to (1) reduce stigma and discrimination toward those with mental illness, (2) prevent suicide, and (3) improve student mental health. Under each initiative, community agencies serve as PEI Program Partners, performing activities intended to meet the goals of the initiative (Table 1.1 lists Program Partners and initiatives and Appendix A provides brief descriptions of each Program Partner and its activities).

Evaluation Approach

In 2011, RAND was commissioned to evaluate the statewide PEI initiative. The evaluation involves assessing PEI Program Partner activities, the three major initiatives (i.e., stigma and discrimination reduction (SDR), suicide prevention (SP), and student mental health (SMH) initiatives), and the overall CalMHSA statewide PEI initiative. Specifically, the RAND evaluation team is collaborating with the PEI Program Partners to achieve the following evaluation aims:

- Evaluate PEI Program Partners' progress toward meeting statewide objectives
- Assess the activities implemented and resources created by PEI Program Partners
- Evaluate program outcomes, including:
  - Targeted program capacities and their reach (i.e., the number of people exposed to program materials, services, social marketing messages, and training)
  - Short-term outcomes (e.g., attitudes and knowledge about mental illness, behavior toward people with mental illness)
  - Longer-term outcomes (e.g., reduced suicide, reduced discrimination, improved student performance).

Table 1.1
CalMHSA Statewide PEI Program Partners by Initiative

Stigma and Discrimination Reduction (SDR)	Suicide Prevention (SP)	Student Mental Health (SMH)
• Disability Rights California • Entertainment Industries Council, Inc. • Integrated Behavioral Health Project/ Center for Care Innovations • Mental Health America of California • Mental Health Association of San Francisco[a] • National Alliance on Mental Illness • Runyon, Saltzman & Einhorn • United Advocates for Children and Families • SDR Consortium	• AdEase • Didi Hirsch Psychiatric Services[b] • Family Service Agency of the Central Coast • Family Service Agency of Marin • Institute on Aging Center • Kings View • LivingWorks • San Francisco Suicide Prevention • Transitions Mental Health Association	• California County Superintendents Educational Services Association • California Department of Education • California Community Colleges • California State University • University of California

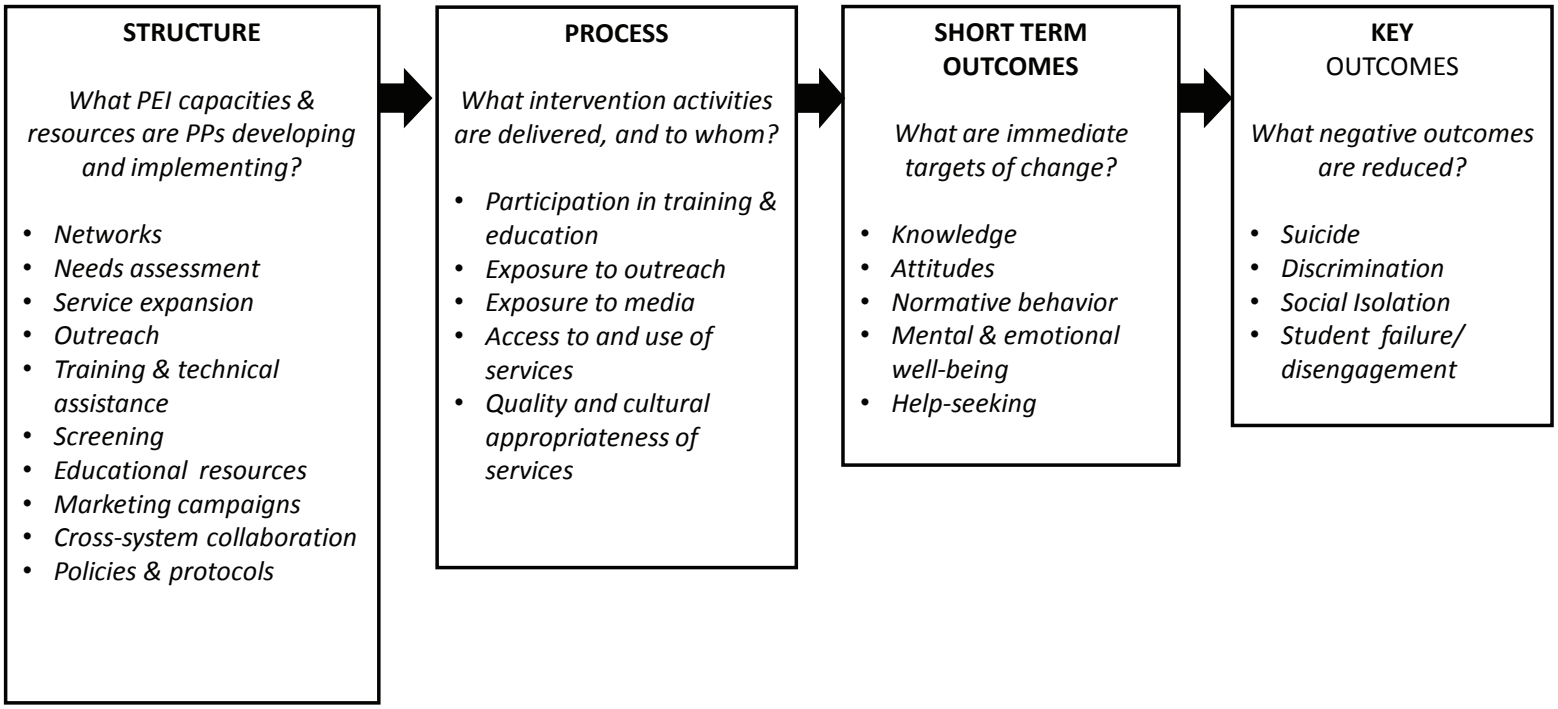
[a]Mental Health Association of San Francisco has two different CalMHSA contracts to implement Resource Development and Promising Practices activities, respectively.
[b]Didi Hirsch has two different CalMHSA contracts to implement Suicide Prevention Network and Regional and Local Suicide Prevention Capacity Building activities, respectively.

The evaluation focuses on several levels – the level of individual Program Partners, the level of the CalMHSA initiative (i.e., SDR, SP, SMH), and at the cross-initiative, statewide level. At the level of the Program Partner, our evaluation focuses on describing the program components/capacities that were developed, and collaborating with each Program Partner to collect data on the reach of key program components to intended audiences/participants. At the initiative level, key program activities were selected for focused studies of short-term outcomes. At the cross-initiative, statewide level, the evaluation is designed to track and analyze population change in risk factors and suicide rates.

The RAND evaluation does not attempt to provide a comprehensive assessment of the performance of any single Program Partner. However, Program Partners were required to develop their own evaluation plans to inform the development and/or improvement of their programmatic efforts. These Program Partner evaluation activities will, in many cases, complement RAND's evaluation and provide a more complete picture of Program Partner performance.

We are using a Structure-Process-Outcome conceptual model (see Figure 1.1) to guide our evaluation approach. Structures refer to the PEI capacities and resources that Program Partners are developing. Examples include development of networks, trainings, educational resources, marketing campaigns, policies, and protocols. Processes refer to the intervention activities that are delivered, and to whom. They are the mechanism through which structures lead to outcomes. Outcomes refer to the impact of the capacities and interventions and include both short-term outcomes (i.e., immediate targets of change) and key outcomes (i.e., the long-term negative outcomes the programs aim to reduce). Examples of short-term outcomes are attitudes and knowledge, while some key outcomes are suicide, discrimination, and student failure/disengagement. Note that while we expect that many of the programs will ultimately impact longer-term, key outcomes, it is difficult to attribute changes in the key outcomes to any particular program. As such, we are predominately examining key outcomes at the statewide rather than program level.

Figure 1.1.
Evaluation Conceptual Model



To assess the structures developed by Program Partners, RAND evaluators have reviewed and described key Program Partner materials and capacities. To assess processes, Program Partners have implemented or are implementing tools to track reach to various targeted populations. Assessment of short-term outcomes has not yet occurred but will involve different methods depending on the type of activity being evaluated. Finally, to address long-term outcomes, we are tracking data over time using population-level tools (e.g., the general population survey described in Chapter 5, calculations of population risk factors and suicide described in Chapter 2). As part of the evaluation, we have developed a large number of evaluation tools (e.g., sign-in sheets, pop-up web surveys, follow-back surveys). In addition, we have provided technical assistance to help integrate these tools into Program Partners' workflows. We describe these evaluation tools throughout the report. More details on the evaluation tools for each initiative, including their content, are available in Appendixes B, C, D, and F.

Key Activities

Because the PEI Program Partners are implementing a large number of diverse activities, our evaluation identifies the core ones and sorts them into six categories. The core activities and examples of key evaluation questions for each activity include the following:

- **The development of policies, protocols, and procedures** – What types of policies, protocols, and procedures have been developed and who do they target? What influences do the policies, protocols, and procedures have on short-term and key outcomes?
- **Networking and collaboration** – What types of networks and collaborations have been developed and for what purposes?
- **The development of informational/online resources** – What informational resources have been developed and who is the target audience? How do the informational resources influence short-term and key outcomes?
- **Training and educational programs** – What training and education programs are being executed and who are the trainees? Do these programs improve short-term and key outcomes?
- **Media/social marketing campaigns and interventions to influence media production** – What messages are being delivered as part of media campaigns? Who do these messages reach? Do media campaigns affect short-term and key outcomes?
- **Hotline and "warmline" operations** – Are crisis hotlines and warmlines following best practices? Are they reaching those in need?

Within these categories of key activities, the RAND evaluation strategically focuses on the central and well-defined activities that represent major program efforts. The activities being evaluated under each initiative are presented in Table 1.2.

Table 1.2
Key Activities Being Evaluated Under Each PEI Initiative

	SDR	SP	SMH
Development of policies, protocols, and procedures	X		
Networking and collaboration		X	X
Development of informational/online resources	X		X
Training and educational programs	X	X	X
Media/social marketing campaigns and interventions to influence media production	X	X	
Hotline and warmline operations		X	

In addition to our program-level evaluation, we are evaluating the impact of the various programs at the initiative and statewide levels. First, the SP evaluation team obtained California county and regional suicide rates to better understand which areas have the greatest suicide rates and thus may be appropriate targets for the most intensive intervention and the closest monitoring of results for suicide prevention efforts. Second, the SMH evaluation team is also administering a survey to students, faculty, and staff at K–12 and higher education institutions across the state to better understand school climate as it relates to mental health. Finally, we have conducted a baseline statewide survey of the general population of California adults to understand levels of stigma and discrimination, beliefs about suicide, and beliefs about the mental health climate in schools and to determine early exposure to PEI program activities. We plan to conduct a follow-up general population survey one year after the baseline in order to assess change over time, as well as another statewide survey that focuses on individuals with mental health concerns.

What's in This Report

This report presents evidence of Program Partners' productivity in building capacities and resources. We note, however, that this report is not intended to provide a comprehensive description of all Program Partner activities; rather, it focuses on the activities that are being evaluated independently by RAND and does not include the results of Program Partners' evaluations of their own activities. Where possible, we demonstrate the reach of these capacities

and resources. To date, we can say little about short- or long-term effectiveness, as the data necessary to draw conclusions about effectiveness have not yet been fully collected. Thus, we caution that results presented here are necessarily preliminary as many program activities are not yet fully implemented, and the evaluation is ongoing.

Organization of This Report

The remainder of this report summarizes our findings thus far. Section I (Chapters 2 through 4) presents results at both the initiative and program levels. Chapter 2 presents the current status and results of SDR Program Partner activities, Chapter 3 presents the current status and results of SP Program Partner activities and presents data on suicide rates throughout the state of California, and Chapter 4 describes the evaluation of SMH Program Partners, as well as the survey of students, faculty, and staff at K–12 and higher education institutions across the state.

Section II (Chapter 5) provides the results of the first administration of the statewide survey of the general population of California.

Section III (Chapter 6) provides a commentary on the evaluation thus far.

SECTION I. INITIATIVE- AND PROGRAM-LEVEL ACTIVITIES

2. Stigma and Discrimination Reduction

In this chapter, we review findings to date in regard to each of the Stigma and Discrimination Reduction (SDR) Initiative Program Partners. These partners include Disability Rights California, Entertainment Industries Council, Inc., Integrated Behavioral Health Project/Center for Care Innovations, Mental Health Association of San Francisco, National Alliance on Mental Illness, Runyon Saltzman & Einhorn, United Advocates for Children and Families, and the SDR Consortium. These Program Partners have been developing and implementing materials and outreach activities that aim to reduce stigma and discrimination through changing policies, protocols, and procedures, or guidelines; developing and implementing educational materials, trainings, and presentations that are targeted toward reducing stigma; and conducting media and social marketing campaigns to reduce stigma and discrimination.

Our evaluation aims to review the new program capacities and materials, to assess the reach of materials and activities (e.g., the number and characteristics of people exposed to materials or who participate in trainings), and investigate the effectiveness of Program Partner activities in positively shifting knowledge, attitudes, and behaviors. This chapter summarizes the development of program capacities and materials and, when available, the early "reach" of these activities. Key materials were reviewed, described, and compared to the evidence base where relevant. To assess reach of activities, we developed a variety of tools (see Appendix B). Because many of these tools are currently being implemented, the data on reach presented here are largely limited to web analytic tracking. Later phases of the evaluation will assess the effectiveness of selected programs in achieving their targeted short-term outcomes by using surveys to determine the extent of knowledge, attitude, and behavior changes and studies of the efficacy of social marketing campaign messages.

Activities related to the development of policies, protocols, and procedures for reducing stigma vary and range from the development of tool kits for different audiences (e.g., journalists, communities wanting to hold mental health roundtables) to stakeholder trainings, meetings, and educational presentations. At this point in the evaluation, information on the reach and outcomes of the documents and activities that aim to change policies, protocols, and procedures and that are not hosted online is limited.

Most SDR Program Partners are creating informational resources for a variety of audiences and distributing these resources online. These resources are diverse and include items such as informational website content, fact sheets about various SDR-related topics, and a documentary film. This chapter contains information obtained through website analytic tools regarding the dissemination of online resources. Additional information on reach and the effects of informational and online resources on short-term outcomes is not yet available.

All SDR Program Partners are conducting training and/or educational presentations targeting a variety of audiences (e.g., health providers, entertainment writers, journalists, people with mental health challenges and their families). The content of trainings and educational presentations currently in place is briefly reviewed here, but information about the reach and short-term impact of the training is not yet available.

Two SDR Program Partners – Entertainment Industries Council, Inc. and Runyon Saltzman & Einhorn, – are conducting media and social marketing activities. We have begun tracking the reach of activities occurring online through the use of web analytic tools. Complete data on reach and on the impact of these activities are not yet available.

In sum, SDR Program Partners have expanded and built new capacities and developed materials for reducing mental health stigma and discrimination in California. Although preliminary evidence of reach of these capacities is available, many evaluation tools were in the implementation phase at the time of writing. In addition, Program Partners continue developing new tools, materials, and trainings. Thus, we will not fully understand the nature or the reach of the programs' activities until the end of year three of the contract period. Similarly, we do not yet have information about the effects of activities on short-term outcomes of interest, such as knowledge, attitudes, and behavior toward people with mental health challenges. This information will be available at the end of year three of the contract period.

Table 2.1 provides an overview of the status of SDR Program Partner activities, summarizing the information contained in this report and forthcoming information.

Evaluation Methods

To evaluate policies, protocols, and procedures, we are reviewing Program Partner materials for their content, purpose, and structure; target population; implementation; and evidence base.

To evaluate informational and online resources, we are assessing the intended audience of the resource, and the content and whether it is consistent with the research literature. To evaluate online resources, we are examining website "reach" (i.e., utilization) using Google Analytics. We are also collecting data from website user surveys and six-month follow-up surveys, but the current report focuses on website content and analytics.

To evaluate training and educational programs, we are assessing the content and structure of the trainings and associated materials, including consistency with the evidence base; we are using a sign-in sheet and training tracking tool to assess "reach"; and we are using a pre-post survey and follow-up survey to assess short-term outcomes of trainings. At the time of the current report, only information on the structure and content of trainings was available; results for reach and short-term outcomes will be presented in a future report.

Table 2.1
Status of SDR Evaluation Activities

	Describe Capacities	Monitor Reach to Target Audiences	Evaluate Short-Term Outcomes
Policies, Protocols, and Procedures			
Program Partners: Disability Rights California; Entertainment Industries Council; Integrated Behavioral Health Project/ Center for Care Innovations; Mental Health Association of San Francisco; Runyon Saltzman & Einhorn; United Advocates for Children and Families	**This Report:** Summary of content of resources developed to inform implementation of new policies, protocols, and/or procedures to support stigma and discrimination reduction in the environment. These resources vary across Program Partners and include items such as policy papers and organizational/community tool kits. **Future:** Summary of content of future resources in development or to be developed.	**This Report:** Web analytic data provided for online resources **Future:** Data on audiences who received resources	**Future:** Data on how recipients of the resources used the information
Informational/Online Resources			
Program Partners: Disability Rights California; Entertainment Industries Council; Integrated Behavioral Health Project/Center for Care Innovations; Mental Health Association of California; Mental Health Association of San Francisco; Runyon Saltzman & Einhorn; United Advocates for Children and Families	**This Report:** Summary of content of websites and other informational resources developed to support stigma and discrimination reduction in the environment **Future:** Summary of content of future resources in development or to be developed	**This Report:** Web analytic data provided for online resources **Future:** Data on audiences who received resources	**Future:** Data on how recipients of the resources used the information

	Describe Capacities	Monitor Reach to Target Audiences	Evaluate Short-Term Outcomes
Training and Educational Programs			
Program Partners: Disability Rights California; Entertainment Industries Council; Integrated Behavioral Health Project/ Center for Care Innovations; Mental Health Association of California; Mental Health Association of San Francisco; National Alliance on Mental Illness; Runyon Saltzman & Einhorn; United Advocates for Children and Families	**This Report:** Topics covered by training programs; consistency of training approach with evidence base **Future**: Similar review of future trainings	**Future:** Data on the audiences who were exposed to trainings	**Future:** Data on how training participants' attitudes change from pre- to post-training
Media/Social Marketing Campaigns and Interventions			
Entertainment Industries Council; Runyon Saltzman & Einhorn	**This Report:** Brief mention of target audiences for social marketing campaigns and interventions **Future:** Detailed information on social marketing campaign messages being evaluated	**This Report:** Web analytic data provided for websites associated with campaigns and interventions **Future:** Data on audiences exposed to campaigns and interventions	**Future:** Results of testing specific campaign messages

Note: The evaluation plan for an additional Program Partner, the Stigma and Discrimination Reduction Consortium, is in development.

Policies, Protocols, and Procedures

We reviewed materials that Program Partners submitted to RAND or CalMHSA in order to describe the key policies, protocols, and procedures developed so far by the SDR initiative–funded programs (see Table 2.2). Our review assessed their content, purpose, and structure; target population for the policy/procedure/best practice; implementation through May 2013; and the degree to which the policy/procedure/best practice is evidence based and adapted for the target population. This is important in establishing the likelihood that a given activity will have an influence on stigma as well as the probability that the intended audience will engage with the materials. In some cases, review of materials is still in progress.

Table 2.2
Policy, Protocol, and Procedure Activities of SDR Programs

SDR Program	Policy, Protocol, Procedure
DRC	Policy papers[a]
EIC	Resources for journalist and entertainment media creators: depiction suggestion and informational sheets for journalists and media creators, style guide for journalists; newsletters/email blasts; website additions*; Muestra Esto/Picture This* publication; content analyses of primetime television programming and news media
IBHP/CCI	Development of policy recommendations and strategies to advance recommendations for integrated care through a report to local and state policy makers; development and dissemination of resource materials/tool kit; establishment of Integrated Behavioral Health Project/Center for Care Innovations as a clearinghouse for technical assistance
MHASF Promising Practices	Literature review on promising SDR practices; identification of promising practices/community-led SDR programs; co-learning experiences with community development partners using promising SDR practices; database/clearinghouse website of promising SDR practices
MHASF Resource Development	Create a framework, instruments, and assessment tools for evaluating existing evidence-based SDR training programs; work with community development partners to assess SDR programs; create online database/clearinghouse for evidence-based SDR programs
RS&E	Speakers' bureau website; arts stigma reduction manual[a]
UACF	Community roundtable tool kit

[a]These activities and products are planned or not yet complete.

Note: DRC = Disability Rights California. EIC = Entertainment Industries Council, Inc. IBHP/CCI = Integrated Behavioral Health Project/Center for Care Innovations. MHASF = Mental Health Association of San Francisco. RS&E = Runyon Saltzman & Einhorn. UACF = United Advocates for Children and Families.

Disability Rights California

Disability Rights California is in the process of creating policy papers on a variety of topics, including first responders, hostile education environment, recovery-focused hospital diversion and aftercare, people in jails who are incompetent to stand trial, NIMBYism (based on the acronym for "not in my backyard," that is, opposition to mental health services being offered in one's own area), and supportive housing. Its subcontractor, Mental Health Advocacy Services (MHAS), is developing policy papers on youth with mental disabilities as they transition to post-secondary school youth with mental health challenges in the juvenile justice system. In addition, subcontractor Mental Health Consumer Concerns, Inc. (MHCC) is drafting a policy paper on services provided by faith-based communities.

Entertainment Industries Council, Inc.

Entertainment Industries Council, Inc. has developed a number of key materials to reduce the negative portrayal and stigmatization of mental illness in both entertainment and news media, and ultimately to reduce mental illness stigma and discrimination among the general public through this shift. We briefly review these resources below.

TEAM Up Tools for Entertainment & Media is a set of online resources for journalists and entertainment media creators. Launched June 3, 2013, the resources cover mental health concerns and comprise the following:

- English- and Spanish-language resources created by Entertainment Industries Council, Inc. under CalMHSA (further described immediately below)
- an email link for media creators to obtain First Draft technical assistance from Entertainment Industries Council, Inc. (a service offered free of charge to media creators – primarily television and film writers – that connects them with a mental health expert who can review a script, answer questions, or provide story ideas or details)
- video of some Entertainment Industries Council, Inc. events (see Trainings and Presentations)
- three podcasts discussing mental illness stigma
- links to mental health–related publications from Entertainment Industries Council, Inc. that were sponsored by other (non-CalMHSA) funders
- a calendar of CalMHSA events relevant to media professionals and journalists.

The resources cover the full range of materials that might motivate change (e.g., the content analyses and story ideas), inform change (e.g., the fact sheets and style guide), and facilitate change (e.g., the technical assistance). They are generally well-written and designed to easily find and digest information quickly. The **"Reporting Mental Health Style Guide"** applies key principles of mental illness stigma reduction through recommendations to include stories of recovery, avoid labeling, and avoid portraying people with mental health problems as dangerous. Other recommendations vary in the likelihood that they will influence stigma (e.g., it is not clear that describing the variety of professionals who play a role in treatment and recovery will decrease stigma, or that describing the toll mental illness takes on family members might actually increase stigma). A few of the resources are described as research-based but do not provide a citation or link to research evidence. Adding this information would enhance credibility and clarity and might increase impact. In other cases, adding links to additional resources would be helpful. For example, linking the **Reporting on Mental Health Toolkit** to the **Reporting on Mental Health Style Guide** and the **Associated Press Style Guide** would be useful, as would links to the National Institute of Mental Health website for factual assertions (e.g., rates of mental illness in the U.S.) and websites of CalMHSA partners with relevant expertise (e.g., United Advocates for Children and Families for family stories, Disability Rights California for policy contributions, and Mental Health America of California for workplace

wellness). Materials appropriately specify cultural considerations. The resources are available at eiconline.org/teamup.

Integrated Behavioral Health Project/Center for Care Innovations

Integrated Behavioral Health Project/Center for Care Innovations has created a tool kit and policy papers. The "Partners in Health: Mental Health, Primary Care and Substance Use Interagency Collaboration Tool Kit, 2nd Edition, 2013" is intended to support collaborations across primary care, behavioral health, and substance abuse treatment sectors. The 2009 edition of the tool kit has been updated to incorporate content specific to the implementation of integrated care within the state of California and to add key resources related to the integration of care for substance use–related problems. The 353-page tool kit was posted for download at Integrated Behavioral Health Project/Center for Care Innovation's website beginning April 26, 2013. The tool kit contains many different types of information, including scientific research on integrated behavioral health, quotes from medical and behavioral health providers on the positive benefits of integrated care, illustrative examples from case studies, and practical information on the logistics of establishing interagency collaborations. The tool kit incorporates materials and resources developed by national experts on integrated care and from existing research studies conducted on collaborative care programs (e.g., AIMS Center Integrated Team Building Tool). The tool kit contains sections specific to California, including a section on Finances (e.g., Funding Streams for Mental Health and Substance Use Services in California; Billing Codes for Federally Qualified Health Centers in California) and California Contacts (e.g., Some Key California Organizations, California County Mental Health Contacts).

A policy paper focused on a response to the Berkeley Forum's report, "A New Vision for California's Healthcare System," is currently under development. Integrated Behavioral Health Project/Center for Care Innovations plans to address the report's omission of mental health and substance use services.

Mental Health Association of San Francisco Promising Practices

The MHASF Promising Practices program has conducted several activities aimed at creating culturally competent best practices in stigma and discrimination reduction. These activities include working with Columbia University researchers from October 2012 to March 2013 to write a first draft of a literature review on promising SDR practices. MHASF has also identified and posted promising practices in community-led SDR programs to an online SDR practices database/clearinghouse, and MHASF has been engaged in a co-learning process with three California community development partners that have been implementing culturally targeted promising SDR practices since July 2012. MHASF reports that dialogues with these community development partners allow them to simultaneously learn from each other. Through the co-learning process, MHASF is identifying its community development partners' strengths, learning how community development partners can address SDR (or enhance existing culturally specific

ways to address SDR), and highlighting the important cultural/racial/ethnic work already taking place in the community. MHASF also reports it is engaging in programs in Alameda, Humboldt, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, Stanislaus, and Sutter/Yuba counties.

Mental Health Association of San Francisco Resource Development

The MHASF Resource Development program has taken a number of steps toward developing resources for enhancing SDR programs. It reported creating and updating an online database/clearinghouse of 105 SDR programs and developing a framework for evaluating SDR programs, along with accompanying tools. MHASF is also working with community development partners to use the framework and tools to evaluate their own SDR programs.

The evaluation tool kit contains several tools, including the California Quality Improvement–Fidelity, Assessment, and Implementation Ratings (CQI-FAIR) instrument. The CQI-FAIR can be used to determine the evidence-based elements in an SDR program, and it is accompanied by a "Ten Steps for CQI-FAIR On Site Visits" guide to conducting an evaluation using the CQI-FAIR. Other elements of the tool kit include a pre- and post-SDR program audience evaluation and a "Platform Skills Fidelity Measure" to assess program fidelity.

Runyon Saltzman & Einhorn

Runyon Saltzman & Einhorn has produced one resource that fits within the category of policies, protocols, and procedures: a speakers' bureau website, SpeakOurMinds.org. The website is evaluated and described in the Online Resources section of this chapter.

Runyon Saltzman & Einhorn also plans to create an Arts Stigma Reduction manual. Progress on this goal was slowed by a loss of personnel. The firm is currently working in partnership with the National Alliance on Mental Illness to identify appropriate staffing and expertise to complete the manual and distribute it in the coming year.

United Advocates for Children and Families

United Advocates for Children and Families created a Community Network Roundtable tool kit to aid counties seeking to hold their own Community Network Roundtables. These are designed to bring together many parties interested in reducing stigma and discrimination within a region to create a community plan toward this end. The tool kit contains information on tools and advice on how to develop a Community Network Roundtable; how to write a community plan for reducing mental health stigma and discrimination; how to start an advocacy campaign; a PowerPoint slideshow with information about mental health stigma and discrimination and basic information about mental health; logistics for holding a Community Network Roundtable event (e.g., how to talk about activities with the press, making sure the meeting is accessible for people with disabilities); and sample materials (e.g., agendas, evaluation forms, community plan). The slideshow content appears to be evidence-based, using definitions of stigma and discrimination

that are consistent with the research literature and citing appropriate publications on the prevalence and consequences of stigma and discrimination. The slideshow also lists contact strategies such as United Advocates for Children and Families' primary approach to SDR, which is consistent with prevailing theory when certain criteria are met for the contact experience.

Assessing Dissemination of Policies, Protocols, and Procedures

To address the issues of how often policies, protocols, and procedures were accessed or disseminated, we use several evaluation tools, including a Document Tracking Tool and, for websites only, Google Analytics and a Website User Survey (see Appendix B for evaluation tools). Currently, only Google Analytics is fully in place to track dissemination of policies, protocols, and procedures materials being distributed online. Measures include the number of visitors; the amount of time spent on the website; the frequency with which CalMHSA materials are downloaded; and if videos are available, how many times they are viewed. This activity is reviewed in more detail below in the Online Resources section.

Informational Resources

Three CalMHSA SDR initiative–funded programs are making a range of informational resources available to general audiences. Table 2.3 highlights these programs and their planned resources.

Table 2.3
Select Informational Resource Activities of SDR Programs

SDR Program	Informational Resource
DRC	Fact sheets
MHASF-RD	Stigma reading list
RS&E	Special reports for LA Youth; Each Mind Matters website
UACF	Expand and enhance current website (publications, calendars, services, forums)

Note: DRC = Disability Rights California. MHASF = Mental Health Association of San Francisco. RS&E = Runyon Saltzman & Einhorn. UACF = United Advocates for Children and Families.

RAND is selectively reviewing the key informational resources developed and supported by the CalMHSA SDR initiative–funded programs to assess the topics covered; whether the topics, policies, and laws addressed are consistent with the empirical and theoretical literature on SDR; the breadth of the stigma and discrimination issues addressed (e.g., Do they address the needs of the general population as well as the needs of specific populations?), and the intended audience.

Disability Rights California

Disability Rights California and its subcontractor, MHAS, have both posted 31 fact sheets on their websites and are developing additional fact sheets. The completed fact sheets were reviewed for topics and target audience:

- Nine were on housing-related topics, with five targeting tenants with a mental health disability (or their advocates) and four targeting landlords.
- Three were targeted toward a general audience and addressed stigma and discrimination definitions and common myths (e.g., that people with mental health disabilities are violent).
- Seven were on topics related to the provision of mental health services. Most of these targeted people with mental health disabilities or a general audience, but one specifically targeted mental health service providers.
- One, created for the general population, addressed discrimination against people with mental health disabilities in the workplace.
- One addressed the topic of writing plainly for a wide variety of audiences.

MHAS also developed ten fact sheets on mental health in schools, all targeted toward parents of children with mental health disabilities.

The fact sheets all provide information in plain language about laws and rights related to the topic at hand. Many of the fact sheets designed for people with mental health disabilities provide information about how to exercise their rights (e.g., how to seek reasonable accommodations from a landlord or employer) and how to seek an advocate to help them exercise their rights or respond to discrimination. Fact sheets designed for gatekeepers (e.g., landlords, employers) contain information on their legal responsibilities and how to meet them.

Educational approaches to SDR such as these have proven effective in reducing stigmatization of people with mental health challenges (Corrigan et al., 2012). Several of the fact sheets either draw upon or directly cite research literature supporting their claims. For example, the fact sheet on definitions of stigma and discrimination contains definitions commonly found in the research literature on SDR.

Mental Health Association of San Francisco Resource Development

In addition to the specific stakeholder materials developed (described in the Policies, Protocols, and Procedures section), MHASF has created a few materials appropriate for a broader audience. They include a stigma reading list that currently contains links to four items: a website, research report, academic journal article, and academic book chapter about different types of stigma.

Runyon Saltzman & Einhorn

The articles in LA Youth, which present information about mental health and mental illness from the perspective of teens talking to other teens, include a few facts about specific disorders

(e.g., bipolar disorder, eating disorders) and information dispelling some myths about mental illness (e.g., dangerousness or violence). They emphasize how to talk and think about mental illness, e.g., the avoidance of labeling and use of negative terms, and ways to be supportive to friends. A question and answer session with the director of services from Los Angeles Unified School District focuses on appropriate responses to disclosures of potential mental health problems from friends. Personal stories of recovery are included, indirectly, through the use of case descriptions by individuals who discuss acquaintances with mental health challenges. Because the articles target a number of the beliefs thought to underlie mental health stigma, they fit with the evidence base.

The "Each Mind Matters" website is described in the Online Resources section of this report.

United Advocates for Children and Families

United Advocates for Children and Families is making informational resources available through the expansion of its current website, which it is rebranding as a "Gateway to Hope." The Online Resources section provides more information about the website content and its use.

Online Resources

Seven of the nine Program Partners funded under the CalMHSA Stigma and Discrimination Reduction initiative have made resources available online, and an additional program (Mental Health America of California) is poised to do so in the near future (see Table 2.4). These materials include the items previously described in the Policies, Protocols, and Procedures and Information Resources sections (e.g., tool kits, an online speakers' bureau, a documentary film, reports, and fact sheets) that are intended to be made accessible online. In this section, we evaluate the websites themselves as well as their reach. In Table 2.4 we briefly describe the website content and when they became available online. Appendix E provides a detailed review of website content and functionality, including the URL for each Program Partner site, a description of the user interface and the site contents, information on the site's target audience, a description of available web links and search functionality, and whether registration is required to access Online Resources. Immediately below, we focus on reach of these websites and their content. Although we focus on CalMHSA-funded pages and resources, it is important to keep in mind that for some Program Partners, these resources are integrated with areas of their websites that are funded through other means, and it is not always possible to distinguish reach of CalMHSA online resources from reach of other aspects of a program's website.

Table 2.4
Websites Related to CalMHSA-Funded SDR Initiative Programs

SDR Program Partner and URL	Website Description	Status
DRC http://www.disabilityrightsca.org	The DRC site contains a section featuring all SDR fact sheets created with CalMHSA funds	CalMHSA-funded materials were added to website in October 2011. DRC and RAND are collaborating to produce Google Analytics reports that will be equivalent to RAND's own.
DRC (subcontractor MHAS) http://www.mhas-la.org	The MHAS site contains a section featuring fact sheets about education-related mental health services created with CalMHSA funds	Fact sheets posted beginning in September 2012. Tracking traffic metrics since April 24, 2013.
EIC http://www.eiconline.org/teamup	Two sets of online resources, one for journalists and one for entertainment media creators, contain a style guide, depiction suggestions, content analyses, links to fact sheets, video of relevant events, podcasts, and a link to request technical assistance for stories	Tool kits officially launched online June 3, 2013. Tracking traffic metrics since April 4, 2013.
IBHP/CCI http://www.ibhp.org/	"Virtual library" stocked with resources to support integrated care among primary care, mental health, and substance abuse treatment sectors. Houses the updated *2013 Edition of the Partners In Health Tool Kit*.	Launched in September 2012
MHAC http://www.mhac.org/programs/wellness-works.cfm	Videos and PowerPoint presentations of Wellness Works! training models	Website is under development
MHASF (Promising Practices and Resource Development) http://dignityandrecoverycenter.org	The website for the Center for Dignity, Recovery, & Stigma Elimination was created with CalMHSA funds and hosts materials created	Launched in March 2013 Tracking traffic metrics since May

SDR Program Partner and URL	Website Description	Status
	entirely through the MHASF Promising Practices and Resource Development programs	7, 2013
RS&E http://www.speakourminds.org	An online tool for organizations to find local mental health speakers bureaus (by aggregating and promoting existing bureaus in California), and an online tool kit to help mental health speakers increase their skills	Launched in April 2013
RS&E http://www.eachmindmatters.org	Hub for distributing CalMHSA-funded CPT documentary "A New State of Mind" and other CalMHSA messages and materials	Launched in May 2013
RS&E http://www.reachouthere.com	Online resources for teens and young adults 14–24 years old including forums	Launched in May 2012
UACF http://www.uacf4hope.org/	The retooling and rebranding of the UACF website into the Gateway to Hope site is supported by CalMHSA funds, and it contains a variety of resources for children with mental health challenges and their families	Launched in November 2011. Tracking traffic metrics since November 8, 2011.

Note: CPT = California Public Television. DRC = Disability Rights California. EIC = Entertainment Industries Council, Inc. IBHP/CCI = Integrated Behavioral Health Project/Center for Care Innovations. MHAC = Mental Health America of California. MHASF = Mental Health Association of San Francisco. RS&E = Runyon Saltzman & Einhorn. UACF = United Advocates for Children and Families.

Assessing Reach of Online Resources

We assessed reach through the use of website analytics, working with each Program Partner to gain access using Google Analytics. Google Analytics, the industry standard application for web analytics, captures a wide range of metrics on the use of and interaction with web properties, as well as traffic sources and additional information. For this report, we gathered and summarized traffic metric findings for most Program Partners from April through June 2013. Websites are grouped by Program Partner and appear in alphabetical order by program name. A glossary of terms used when presenting website analytics is presented in Appendix F. Google Analytics is a useful tool for understanding the number of times a website is accessed and the

duration of a "visit." It can also provide information about the visitor's location, other characteristics, and how the visitor came to visit the site (e.g., through a specific search term). A few limitations of the data should be kept in mind. Google Analytics does not distinguish multiple visits from the same visitor versus single visits from multiple people, nor can it tell us key demographic characteristics (e.g., gender, race, or age). Length of visit is generally considered an indicator of user engagement with the site. Google Analytics calculates length of visit without including the final page visited because many web users leave their browsers open on a page after they finish using it, which would result in visit lengths being vastly overestimated. Thus, visit length is always underestimated, though relative amounts of time spent at different sites is still informative. Another standard indicator is the percentage of visitors who enter the site and leave rather than continue viewing other pages within the site. A high "bounce rate" may suggest that many users did not find what they were looking for or did not need the information offered by the website. But it could also mean that users immediately found what they wanted and then left.

Disability Rights California

Because Disability Rights California had concerns about providing RAND access to Google Analytics directly, we are working with the organization to obtain data equivalent to those provided by our own Google Analytics reports. These data were unavailable for this report.

MHAS (subcontractor to Disability Rights California)

Traffic Metrics and User Engagement

In total, MHAS received 1,507 visits to its website between April 24 and June 7, 2013, resulting in 2,412 page views and 2,447 downloads. The majority of users (56%) accessed the website through keyword searches using search engines such as Google. Of those who accessed the site by searching, about 16 percent appeared to be searching specifically for MHAS. Thirty-four percent of users accessed the website directly, by typing the URL into their browser, clicking on a bookmark, or following a link in an email or other electronic document (e.g., PDF). The remaining users accessed the website via referral links from other sites (10%). Of these referral links, 14 percent of visits originated from the Department of Housing and Urban Development page. No referrals came from the CalMHSA Each Mind Matters site.

The average visit duration across all users was 1 minute, 23 seconds, with users visiting an average of 1.60 pages each time. About 65 percent of visits to the homepage resulted in users leaving the website from the same page.

User Characteristics

Within California, most site visits originate from the Los Angeles metro area, where MHAS is located (see Table 2.5 and Figure 2.1).

Table 2.5
MHAS Website –- Rank Order of California Traffic Metrics by Metro Area

Metro	Visits	Pages / Visit	Avg. Visit Duration
Los Angeles CA	852	1.72	0:01:49
San Francisco–Oakland–San Jose CA	107	1.4	0:00:47
Sacramento-Stockton-Modesto CA	50	1.4	0:01:09
San Diego CA	49	1.39	0:00:47
Fresno-Visalia CA	13	1.54	0:00:42
Santa Barbara–Santa Maria–San Luis Obispo CA	9	1.11	0:00:07
Bakersfield CA	4	1.5	0:00:13
Chico-Redding CA	4	2.5	0:04:17
Not available from Google Analytics	3	1	0:00:00
Palm Springs CA	3	1	0:00:00
Eureka CA	2	1.5	0:03:04
Monterey-Salinas CA	2	1	0:00:00
Yuma AZ–El Centro CA	1	1	0:00:00

Resources Downloaded

The top five resources downloaded from the MHAS site (see Table 2.6) are fact sheets on education-related mental health services. MHAS indicates that fact sheets such as these are the most important resources available for download on the MHAS site, and that the third item in Table 2.6 (i.e., the fact sheet entitled "What Are Educationally Related Mental Health Services and When Should I Ask for Them?") is the most central to its goals.

Figure 2.1. Geographic Distribution of Traffic to MHAS Website Across California Metro Areas

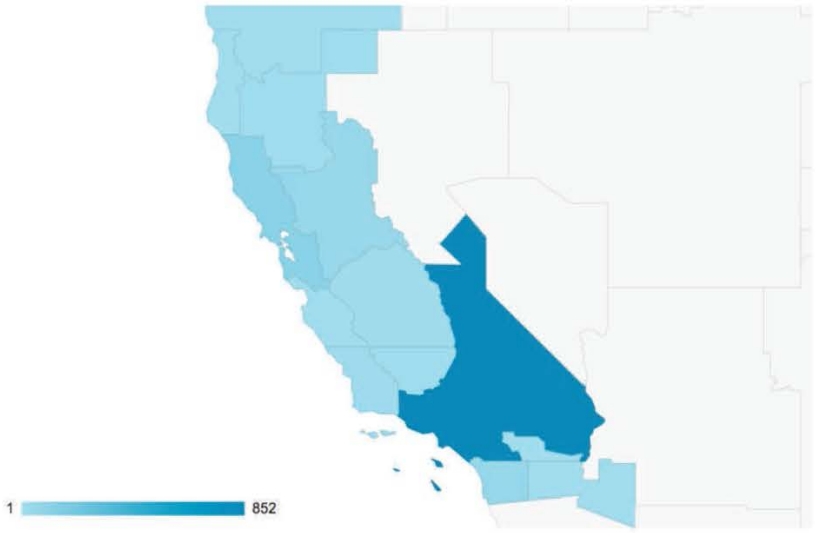


Table 2.6

Top Five Resources Downloaded from the MHAS Website

Resource Title	Resource URL	Downloads
Fact sheet entitled "How do I request an Educationally Related Mental Health Services (ERMHS) assessment for my child?"	http://www.mhas-la.org/SpecialEducation/ERMHSAssessments-Handout2of3V312.13.12.pdf	261
Fact sheet entitled "Parent and Mental Health Service Provider Have Requested Special Education Assessment by the School But Nothing Has Happened"	http://www.mhas-la.org/SpecialEducation/ParentFactSheetAssessmentReqNoResponseV312.13.12.pdf	261
Fact sheet entitled "What Are Educationally Related Mental Health Services and When Should I Ask for Them?"	http://www.mhas-la.org/SpecialEducation/TypesOfServicesAvailable-Handout3of3V312.13.12.pdf	261
Fact sheet entitled "Charter Schools Are Public Schools That Are Required to Comply with the Individuals with Disabilities Education Improvement Act (IDEA)"	http://www.mhas-la.org/SpecialEducation/CharterSchoolsFactSheetV312.13.12.pdf	259
Fact sheet entitled "My Child Has Received 'Designated Instruction and Services' (DIS) Counseling for Some Time, but He Is Still Getting in Trouble in Class"	http://www.mhas-la.org/SpecialEducation/ParentFactSheetFailedMHServicesV312.13.12.pdf	259

Entertainment Industries Council, Inc.

Traffic Metrics and User Engagement

Entertainment Industries Council, Inc. received 1,088 visits to its website during the April 4 through June 7, 2013 reporting period, resulting in 3,849 page views and 72 downloads. The majority of users (51%) accessed the website directly, by typing the URL into their browser, clicking on a bookmark, or following a link in an email or other electronic document (e.g., PDF). Another large group (35%) made their way to the site through referral (that is, by clicking on a link on another website). Of these site users, about 43 percent came from reingolddev.com and 29 percent came from prweb.com. The remaining site visitors entered as a result of keyword searches (15%) using a search engine such as Google. About 5 percent of these visitors used search terms indicating that they were looking specifically for the TEAM Up Style Guide. Additionally, four visits (1%) came from the Each Mind Matters site.

The average visit duration on Entertainment Industries Council, Inc.'s site was nearly 7 minutes, and users typically visited 3 to 4 pages while there. This suggests a very high level of engagement with Entertainment Industries Council, Inc. materials. About half of users left the Entertainment Industries Council, Inc. site without moving to a second page.

User Characteristics

Somewhat surprisingly, given that Entertainment Industries Council, Inc. is based in California and many of the entertainment creators and some of the journalists it targets are also in California, most U.S. visitors came from the District of Columbia (DC) or Virginia. This may be a result of the National Conference on Mental Health, which took place in DC on June 3, 2013 (during the reporting period) and cited Entertainment Industries Council, Inc. and its work. Indeed, as Table 2.7 illustrates, the longer visits to the Entertainment Industries Council, Inc. site originate primarily from the DC area. Within California, as would be expected, the majority of visits come from the Los Angeles area, a center for the entertainment industry (see Table 2.8 and Figure 2.2).

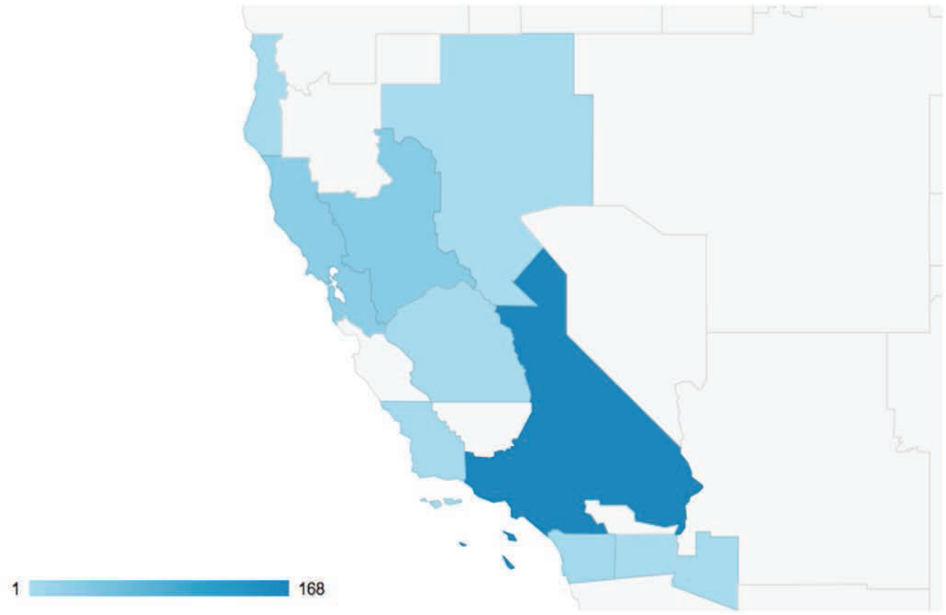
Table 2.7
Number of Visits by State to Entertainment Industries Council, Inc. Website
(April 4through June 7, 2013)

State	Visits	Pages / Visit	Avg. Visit Duration
District of Columbia	351	4.38	0:10:13
Virginia	336	4.42	0:08:42
California	245	2.17	0:01:46
Maryland	20	2.7	0:02:05
New York	19	2.63	0:04:03

Table 2.8
Entertainment Industries Council, Inc. Website – Rank Order of California Traffic Metrics by Metro Area

Metro	Visits	Pages / Visit	Avg. Visit Duration
Los Angeles CA	168	2.3	0:01:43
Sacramento-Stockton-Modesto CA	32	1.81	0:00:39
San Francisco–Oakland–San Jose CA	27	2.19	0:04:05
San Diego CA	6	1.83	0:00:19
Eureka CA	4	1.25	0:01:24
Santa Barbara–Santa Maria–San Luis Obispo CA	3	1.67	0:00:30
Fresno-Visalia CA	3	1	0:00:00
Yuma AZ–El Centro CA	1	3	0:02:08

Figure 2.2. Geographic Distribution of Traffic to Entertainment Industries Council, Inc. Website Across California Metro Areas



Resource Downloads

Table 2.9 lists the CalMHSA resources on Entertainment Industries Council, Inc.'s website that are most often downloaded by visitors. The Style Guide for reporters is by far the most

downloaded. The list suggests, in general, that Entertainment Industries Council, Inc. may be reaching journalists more than entertainment media creators at this point in its CalMHSA program implementation. This may change as more presentations for entertainment content creators (First Draft briefings) take place in the coming year.

Table 2.9
Top Five Resources Downloaded from Entertainment Industries Council, Inc. Website

Resource Title	Downloads
Style Guide: Reporting on Mental Health	26
Mental Health Story Ideas	8
Spotlight on Depiction of Health and Social Issues: Mental Illness, Wellness and Recovery (English)	8
Interview Tips for Stories Related to Mental Health or Suicide	7
Sample News and Feature Stories Style Guide	5

Integrated Behavioral Health Project/Center for Care Innovations

Traffic Metrics and User Engagement

The Integrated Behavioral Health Project/Center for Care Innovations website received 5,444 visits, 10,331 page views, and 476 downloads during the period from April 11through June 7, 2013. Over half of users (65%) accessed the website by keyword searches using a search engine such as Google. Many of the search terms that these users typed to get to the site are not obtainable through Google Analytics, making it difficult to determine what brought users to the site. Another 26 percent of users accessed the website directly, by typing the URL into their browser, clicking on a bookmark, or following a link in an email or other electronic document (e.g., PDF). The remaining 9 percent were referred into the site via an external link. Of these 9 percent, 44 percent were directed to the Integrated Behavioral Health Project/Center for Care Innovations site from integration.samhsa.gov. No users were directed from the Each Mind Matters site.

Among all users of the Integrated Behavioral Health Project/Center for Care Innovations website, the average duration of visits was just short of two minutes, with an average of about 2 pages viewed per visit. The bounce rate was 65 percent, indicating that more than half of users entered the website's homepage and departed the site without accessing other parts or features of the website.

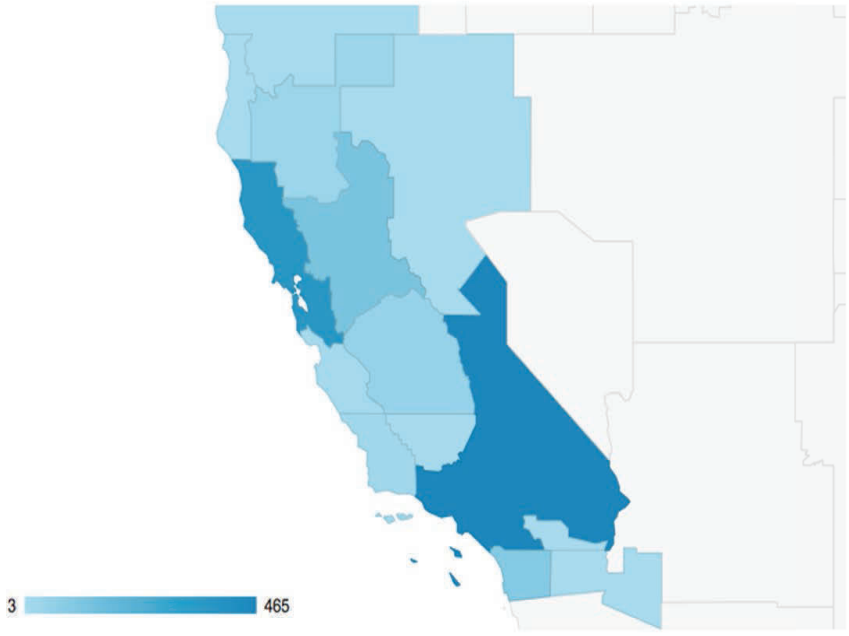
User Characteristics

The highest number of visitors to the Integrated Behavioral Health Project/Center for Care Innovations website came from California. Not surprisingly, within California, most website visits were from the state's largest metro areas: Los Angeles, San Francisco–San Jose, and Sacramento-Stockton-Modesto (see Table 2.10 and Figure 2.3).

Table 2.10
Integrated Behavioral Health Project/Center for Care Innovations Website – Rank Order of California Traffic Metrics by Metro Area

Metro	Visits	Pages / Visit	Avg. Visit Duration
Los Angeles CA	465	2.43	0:02:48
San Francisco–Oakland–San Jose CA	371	2.1	0:02:07
Sacramento-Stockton-Modesto CA	125	1.71	0:01:43
San Diego CA	99	1.74	0:01:17
Fresno-Visalia CA	49	2.55	0:05:18
Chico-Redding CA	39	2.44	0:02:48
Santa Barbara–Santa Maria–San Luis Obispo CA	19	1.63	0:09:01
Monterey-Salinas CA	11	4.27	0:07:06
Bakersfield CA	9	1.33	0:01:27
Palm Springs CA	6	2.5	0:07:27
Yuma AZ–El Centro CA	3	3.33	0:03:20
Eureka CA	3	1	0:00:00

Figure 2.3. Geographic Distribution of Traffic to Integrated Behavioral Health Project/Center for Care Innovations Website Across California Metro Areas



Resource Downloads

Integrated Behavioral Health Project/Center for Care Innovations' most downloaded document is its collaboration tool kit; the top five downloaded resources are shown in Table 2.11.

Table 2.11
Top Five Resources Downloaded from Integrated Behavioral Health Project/Center for Care Innovations

Resource Title	Resource URL	Downloads
Partners in Health: Mental Health, Primary Care and Substance Use Interagency Collaboration Tool Kit, 2nd Edition, 2013	http://www.ibhp.org/uploads/file/IBHPInteragency%20Collaboration%20Tool%20Kit%202013%20.pdf	88
Treating the Whole Person While Reducing Costs: Practical Lessons from the California Integrated Behavioral Health Project PowerPoint Presentation	http://www.ibhp.org/uploads/file/IBHP_Altarum_Presentation-FINAL[1]_mr[1].ppt	23
Sample Behavioral Health Assessment Form	BHAssessment.pdf	22
MINI Patient Health Survey	MINI health survey used by Sierra.doc	15
The Functional Assessment Form	FunctionalAssessmentform, Buncombe Co NC.pdf	12

Mental Health Association of San Francisco (Promising Practices and Resource Development)

Traffic Metrics and User Engagement

Mental Health Association of San Francisco received 562 visits to its website from May 7 through June 7, 2013, resulting in 2,392 page views. RAND is working with MHASF to track downloads; we expect to include data on the most downloaded resources in our next report. The majority of users (76%) accessed the website directly, by typing the URL into their browser, clicking on a bookmark, or following a link in an email or other electronic documents (e.g., PDFs). A smaller number of users accessed the site through referral links from other sites (17%). About 60 percent of referrals came from mentalhealthsf.org, and about 12 percent came from either calmhsa.org or the Each Mind Matters site. The other 7 percent of users appear to be people looking specifically for the website.

The average visit duration across all users was 4:13 minutes, with users visiting an average of 4.26 pages each time. About 35 percent of visits to the website resulted in users leaving from the entry page.

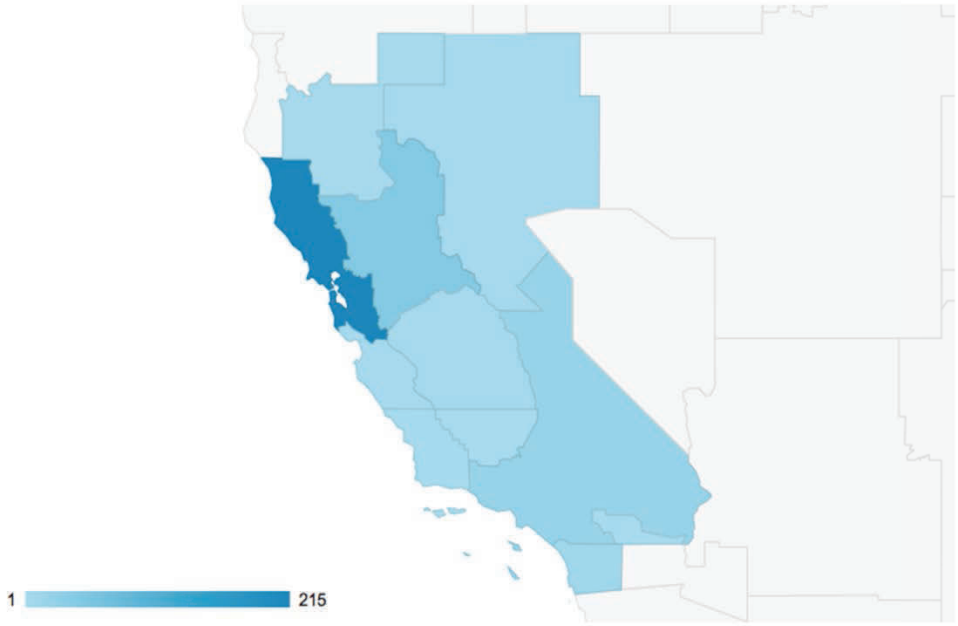
User Characteristics

The majority of site visits originating from the U.S. came from California, particularly the San Francisco Bay Area, where Mental Health Association of San Francisco is located (see Table 2.12 and Figure 2.4).

Table 2.12
Mental Health Association of San Francisco Website – Rank Order of California Traffic Metrics by Metro Area

Metro	Visits	Pages / Visit	Avg. Visit Duration
San Francisco–Oakland–San Jose CA	215	4.82	0:05:48
Sacramento-Stockton-Modesto CA	46	3.67	0:03:46
Los Angeles CA	20	3.7	0:04:28
San Diego CA	11	4.27	0:05:03
Reno NV	5	4.4	0:03:44
Fresno-Visalia CA	5	6.4	0:03:17
Chico-Redding CA	4	6.25	0:04:25
Monterey-Salinas CA	3	3.67	0:00:56
Santa Barbara–Santa Maria–San Luis Obispo CA	2	6	0:05:49
Bakersfield CA	1	2	0:00:39
Palm Springs CA	1	1	0:00:00

Figure 2.4. Geographic Distribution of Traffic to Mental Health Association of San Francisco Website Across California Metro Areas



Runyon Saltzman & Einhorn (Speak Our Minds)

Traffic Metrics and User Engagement

Speak Our Minds had 429 visits between April 22 and June 7, 2013, resulting in 4,859 page views and 264 downloads. Sixty-eight percent of these visits were a result of direct access (typing the URL into a browser, clicking on a bookmark, or following a link in an email or other electronic document such as a PDF). Twenty-six percent of visits were through referral (clicking a link on another website). Of these, 85 percent were from the Each Mind Matters site. Six percent of visits came as a result of an online search engine such as Google.

The average visitor to Speak Our Minds is highly engaged, staying for 5 minutes and viewing more than 11 pages. About a third of visitors viewed only the homepage before leaving the site.

User Characteristics

Within the U.S., most visits come from California, consistent with the focus of the tool on finding speakers in the California area (see Table 2.13). Within California, visitors are fairly well dispersed though focused within the Bay Area and Los Angeles/San Diego regions, as shown in Table 2.14 and the map in Figure 2.5.

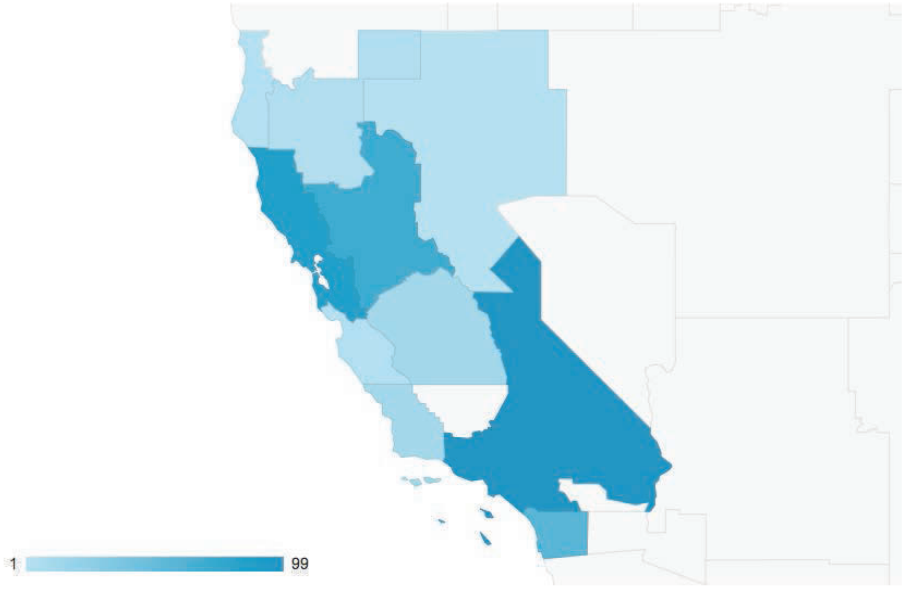
Table 2.13
Speak Our Minds Website – Traffic Metrics of Top Five States

State	Visits	Pages / Visit	Avg. Visit Duration
California	348	13.15	0:05:26
District of Columbia	27	3.56	0:04:50
Massachusetts	11	3.45	0:02:43
Maryland	8	6.88	0:03:01
Washington	7	2.86	0:01:13

Table 2.14
Rank Order of California Traffic to Speak Our Minds Website by Metro Area

Metro	Visits	Pages / Visit	Avg. Visit Duration
Los Angeles CA	99	33.65	0:07:49
San Francisco–Oakland–San Jose CA	86	3.95	0:03:20
Sacramento-Stockton-Modesto CA	70	3.54	0:03:53
San Diego CA	58	6.78	0:06:59
Santa Barbara–Santa Maria–San Luis Obispo CA	13	4.69	0:02:29
Fresno-Visalia CA	13	11.23	0:06:36
Chico-Redding CA	4	6.5	0:05:21
Eureka CA	2	13	0:04:18
Monterey-Salinas CA	2	1.5	0:01:01

Figure 2.5. Geographic Distribution of Traffic to Speak Our Minds Website Across California Metro Areas



Resources Downloaded

The CalMHSA resources most often downloaded from the Speak Our Minds site are most directly focused on stigma reduction, though the flyer template for promoting events is also popular with users (see Table 2.15).

Table 2.15
Top Five Resources Downloaded from Speak Our Minds Website

Resource Title	Resource URL	Downloads
Discussion Starters: Stigma and Mental Illness	http://www.speakourminds.org/wp-content/uploads/2013/04/Stigma-Discussion-Starters.pdf	37
Presentation/Event Flyer Template	http://www.speakourminds.org/wp-content/uploads/2013/04/Presentation-Event-Flyer-Template-1.doc	32
Mental Health Matters…But Why Focus on Stigma?	http://www.speakourminds.org/wp-content/uploads/2013/04/Why-Stigma.pdf	23
Myths & Facts: The Stigma of Mental Illness and Resulting Discrimination	http://www.speakourminds.org/wp-content/uploads/2013/04/Stigma-Myths-Facts.pdf	22
Stigma and Discrimination Reduction Messages. Key Audience: Decision Makers	http://www.speakourminds.org/wp-content/uploads/2013/04/Stigma-Reduction-Messages-Decision-Makers.pdf	22

Runyon Saltzman & Einhorn (Each Mind Matters)

Traffic Metrics and User Engagement

The Each Mind Matters site had 11,000 visits between May 1 and June 7, 2013, suggesting strong reach. These visits resulted in 24,818 page views and 95 downloads. Fifty-five percent of all visitors come directly to the site, and 35 percent come via referral from another site. A large number of these referrals were from social media sites, with 62 percent coming from Facebook and 9 percent from Twitter. Ten percent came through a search, using terms that suggest users were seeking the Each Mind Matters site directly. This suggests effective use of social media and online resources to drive users to the online version of the documentary hosted on the site.

The average visit to Each Mind Matters is about 2.5 minutes in length, and most visitors view only 2 pages. It should be noted that these short visits do not preclude viewing of the documentary, which is substantially longer than 2 minutes. As noted earlier, Google Analytics

calculates length of visit without including the final page visited. We provide more data on documentary viewing further below.

User Characteristics

Within the U.S., most visits are from California (Table 2.16), and within California, visits are well-distributed across the state, though most come from the population-dense areas of Northern and Southern California (Table 2.17 and Figure 2.6).

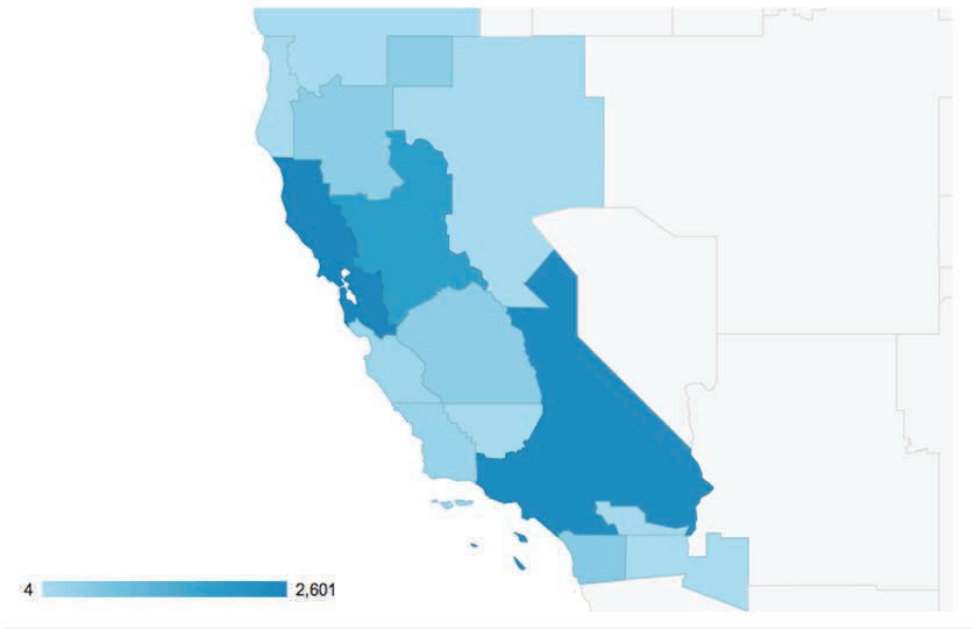
Table 2.16
Each Mind Matters Website – Traffic Metrics of Top Five States

State	Visits	Pages / Visit	Avg. Visit Duration
California	8,818	2.32	0:02:46
New York	155	1.74	0:01:26
Florida	131	2.08	0:01:42
Texas	126	1.9	0:01:48
District of Columbia	120	2.48	0:03:09

Table 2.17
Rank Order of California Traffic to Each Mind Matters Website by Metro Area

Metro	Visits	Pages / Visit	Avg. Visit Duration
San Francisco–Oakland–San Jose CA	2,601	2.11	0:02:37
Los Angeles CA	2,441	2.49	0:03:23
Sacramento-Stockton-Modesto CA	1,815	2.35	0:02:34
San Diego CA	524	2.41	0:02:23
Chico-Redding CA	410	2.42	0:02:33
Fresno-Visalia CA	404	2.45	0:02:36
Santa Barbara–Santa Maria–San Luis Obispo CA	245	2.17	0:01:57
Monterey-Salinas CA	179	2.33	0:01:57
Palm Springs CA	59	1.61	0:01:20
Bakersfield CA	50	2.74	0:04:25
Eureka CA	38	2.92	0:02:37
Medford–Klamath Falls OR	12	2.17	0:00:55
Yuma AZ–El Centro CA	4	1.5	0:05:24

Figure 2.6. Geographic Distribution of Traffic to Each Mind Matters Website Across California Metro Areas



Resource Downloads and Video Views

We identified the top video views on Each Mind Matters and the number of views, plays, and finishes associated with each (see Table 2.18). These represent the number of times the video loaded (either on Vimeo, the site hosting the videos, or another site in which the video is embedded), the number of times the play button was pushed, and the number of times the video was played in its entirety, respectively.

Table 2.18
Number of Views of "A New State of Mind" Documentary[a]

Video Title	Date Posted	Number of Plays	Number of Views	Number of Finishes
A New State of Mind documentary (SD and HD versions)	May 31, 2013	3,357	8,967	399
A New State of Mind exclusive trailer	April 29, 2013	3,008	17,271	1,888

[a]Number of plays, views, and finishes are reported between date posted and June 29, 2013. Numbers are based on Vimeo data, to which Runyon Saltzman & Einhorn granted RAND access for this report.

Runyon Saltzman & Einhorn (ReachOut)

Traffic Metrics and User Engagement

ReachOut had more than 2 million visits to its website in the period between May 8, 2012, when the ReachOut Forums portion of its website, sponsored by CalMHSA, became active, and June 7, 2013. Three percent of these visits, or a total of 60,434 visits, involved a Forum page view. There were a total of 336,029 page views across these visits. Twenty-five percent of visitors come directly to the ReachOut site. The majority (49%) of visitors come via referral, typically through Yahoo, and about 23 percent of users find the site using a search engine such as Google. Although most keyword search terms driving visits to the site are unavailable through Google Analytics, among the known search terms, two of the most used are the two-word name of the site. Thus, users who enter this way appear to already be aware of ReachOut. Searches that feature some combination of the words "reach," "out," and "here," which take users to the forums and are featured in Runyon Saltzman & Einhorn ads for the forum sites, account for 1,558 visits. The search "buscaapoyo.org" (BuscaApoyo is the Spanish-language forum) accounted for 20 visits and "buscaapoyo.com" accounted for 8 visits. These data suggest that at least a small segment of visitors came to the site as a result of Runyon Saltzman & Einhorn advertising.

The average visit to ReachOut is about 1 minute, 37 seconds in length, and most visitors view about 3 pages. The bounce rate is 53 percent. Those who entered the ReachOut site on a forum page initially (i.e., the "landing" page was a forum page) had much longer visits that lasted, on average, 2 minutes, 47 seconds. It should be noted that these short visits do not preclude taking part in an online discussion. As noted earlier, Google Analytics calculates length of visit without including the final page visited. Like other ReachOut visitors, those who landed on a forum page viewed about 3 pages on average. The bounce rate for forum landing visitors was higher than the bounce rate overall, at 69 percent. As we have noted elsewhere, this may indicate people were less interested in the site when they landed on the forum pages, or quite the opposite, that they were more likely to find what they needed on the initial page and subsequently left.

User Characteristics

Within the U.S., most visits to ReachOut are from California (Table 2.19), and there were 31,267 visits from California that involved viewing a forum page (Table 2.20). These visits are well-distributed across the state, though most come from the Los Angeles and San Francisco Bay Area (Table 2.20).

Table 2.19
ReachOut Website – Traffic Metrics of Top Five States

State	Visits	Pages / Visit	Avg. Visit Duration
California	149,802	3.39	0:02:33
Texas	64,154	2.66	0:01:22
Florida	47,864	2.84	0:01:50
New York	47,304	2.53	0:01:41
Michigan	37,663	2.80	0:01:34

Table 2.20
ReachOut Website Visits That Involved Forum Views –- Rank Order of California Traffic Metrics by Metro Area

Metro	Visits
Los Angeles CA	12,052
San Francisco–Oakland–San Jose CA	8,752
San Diego CA	3,832
Sacramento-Stockton-Modesto CA	3,726
Monterey-Salinas CA	1,055
Fresno-Visalia CA	962
Bakersfield CA	231
Palm Springs CA	215
Santa Barbara–Santa Maria–San Luis Obispo CA	203
Chico-Redding CA	199
Eureka CA	24
Yuma AZ–El Centro CA	16

United Advocates for Children and Families

Traffic Metrics and User Engagement

United Advocates for Children and Families received 3,664 visits to its website between November 8, 2012, and June 7, 2013. There were 11,371 page views and 410 downloads. A large proportion of users (41%) access the site using search engines such as Google. About 37 percent accessed the website directly, and a smaller number of users (22%) accessed the site through

referral links from a variety of other nonprofit sites, including Placer County (placer.networkofcare.org; placer.ca.gov), a listing of nonprofits (nonprofitlist.org), the Alameda County Sheriff's Office Youth & Family Services Bureau (acsoyfsb.org), and the California Department of Education (cde.ca.gov). Four referrals (< 1%) came from CalMHSA's Each Mind Matters site.

Users spent about 3.5 minutes on the site, visiting about 10 pages, on average. About 40 percent of visits to the homepage resulted in users leaving the website from the same page.

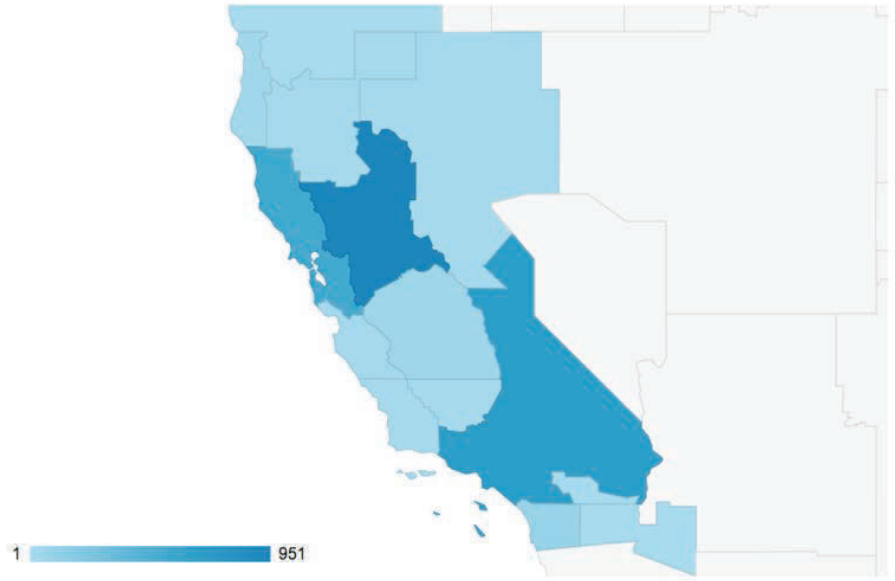
User Characteristics

The majority of site visits originate from sources in the state of California (N = 2,421), particularly the Sacramento-Stockton-Modesto, Los Angeles, and San Francisco–Oakland–San Jose CA metro areas (see Table 2.21 and Figure 2.7).

Table 2.21
United Advocates for Children and Families Website –- Rank Order of California Traffic Metrics by Metro Area

Metro	Visits	Pages / Visit	Avg. Visit Duration
Sacramento-Stockton-Modesto CA	951	4.44	0:05:19
Los Angeles CA	666	3.01	0:03:30
San Francisco–Oakland–San Jose CA	539	2.89	0:02:51
San Diego CA	86	2.6	0:01:58
Fresno-Visalia CA	56	3.89	0:03:14
Eureka CA	34	4.88	0:07:02
Monterey-Salinas CA	19	2.11	0:01:50
Chico-Redding CA	17	2.47	0:02:12
Bakersfield CA	15	3.07	0:02:40
Santa Barbara–Santa Maria–San Luis Obispo CA	10	2.3	0:02:51
Palm Springs CA	4	4.5	0:02:04
Yuma AZ–El Centro CA	1	2	0:00:20

Figure 2.7. Geographic Distribution of Website Traffic Across California Metro Areas



Resources Downloaded

We identified the top five resources downloaded from the United Advocates for Children and Families site (see Table 2.22). They include a fact sheet about mental health disorders, a newsletter (no longer available online), and an annual report. United Advocates for Children and Families indicates that two of its most important items available for download with respect to its stigma and discrimination reduction goals are "2012 Stigma and Discrimination Reduction Focus Group Report" and "Improving Mental Health Outcomes: A Stigma and Discrimination Survey." These items are not among the top five downloaded resources.

Table 2.22
Top Five Resources Downloaded from the United Advocates for Children and Families Website

Resource Title	Resource URL	Downloads
The Institute for Parent Leadership Training Chapter Guide 2012	http://www.uacf4hope.org/sites/default/files/documents/Chapters/UACF%20Chapter%20Toolkit_V2.pdf	32
UACF Multi-Annual Report, 2007–2009	http://www.uacf4hope.org/sites/default/files/documents/Multi_Annual%202007-2009.pdf	32
Fact sheet about mental health disorders	http://www.uacf4hope.org/sites/default/files/documents/RESOURCES/About%20Mental%20Disorders.doc	29
Winter 2012 Newsletter	No longer available online	21
Community Chapter Application	http://www.uacf4hope.org/sites/default/files/Chapter%20Application%20Form_online.pdf	20

Table 2.23
Rank Order of California Traffic Metrics Across All SDR Websites by Metro Area

Metro	Total Number of Visits to CalMHSA-Funded Websites
Los Angeles CA	16,763
San Francisco–Oakland–San Jose CA	12,698
Sacramento-Stockton-Modesto CA	6,815
San Diego CA	4,665
Fresno-Visalia CA	1,505
Monterey-Salinas CA	1,271
Chico-Redding CA	677
Santa Barbara–Santa Maria–San Luis Obispo CA	504
Bakersfield CA	310
Palm Springs CA	288
Eureka CA	107
Yuma AZ–El Centro CA	26
Total	45,629

Note: Numbers of visits are tracked for longer time periods for some websites. Thus, these websites contribute more to regional traffic totals than others.

Reach of CalMHSA Websites to California Residents

A total of 45,629 visits were made to CalMHSA SDR websites from within California as tracked in this report (see Table 2.23). Because not all websites were tracked as soon as they became active, this is a minimum estimate of the reach of CalMHSA's web-based resources to California residents (and does not include other online reach such as social media posts). The California population is just over 37 million (U.S. Census Bureau, 2013). We should not assume each visit represents a unique individual, but if it did, this would indicate that 0.1 percent of the California population were exposed to a CalMHSA SDR website.

We cannot compare SDR sites to equivalent, recently created sites promoting mental health because public data are only available describing major, very heavily trafficked websites. These data are collected by services such as Compete (www.compete.com) that enroll large panels and

track their web use over time. Web analytics based on panel behavior are derived for individual sites and can be purchased to use as a comparison to web analytics derived from one's own website.

If we compute average monthly California traffic across the SDR sites we can compare their visit rate to the reach of the U.S. Substance Use and Mental Health Services Administration's (SAMHSA) website, and to the national website for National Alliance on Mental Illness, which are the two websites for which data are available that contain content most similar to that of the CalMHSA sites. These websites should be considered gold standards for reach, rather than equivalent comparisons. According to web metrics obtained through Compete, SAMHSA's website experienced an average of 342,976 visits per month in the period covering January through June 2013 – a number of visits equivalent to 0.1 percent of the U.S. population. National Alliance on Mental Illness national visits averaged 273,970 per month, or 0.088 percent of the U.S. population. In comparison, CalMHSA SDR websites had an average of 11,226 monthly visitors from California, equivalent to 0.03 percent of the state's population. Thus, SDR initiative reach to its target population is about one-third the reach of SAMHSA or National Alliance on Mental Illness. The data we used for this calculation are probably unstable. Websites are mostly new, and data were based on only a month or two of visits; patterns of use might well fluctuate seasonally and increase with time. Nonetheless, the numbers suggest moderately good reach at this point in time. Web visitors came from all across the state, though as would be expected, 65 percent of SDR web traffic came from the densely populated metropolitan areas of the San Francisco Bay and Los Angeles.

Trainings/Education

All of the SDR programs except the SDR consortium are conducting trainings or educational programs aimed at enhancing mental health knowledge and reducing stigma and discrimination (summarized in Table 2.24 below).

Table 2.24
Training/Education Activities of SDR Programs

SDR Program	Training/Education
DRC	In-person training; training on understanding anti-discrimination laws/policies; training modules (audiences to be determined)
EIC	First Draft briefings on top mental health media issues to entertainment writers and journalists; Picture This forums for mental health stakeholders to assist them in working with the media
IBHP/CCI	Provider trainings via local and regional meetings, learning collaboratives, and monthly webinars, targeting primary care physicians, case managers, and administrators and mental health clinicians and administrators; stakeholder trainings for health plan administration, colleges/universities/professional schools, other school settings, and public officials
MHAC	Wellness Works!, a workplace mental health program aimed at reducing mental health stigma and discrimination and supporting mental wellness in the workplace
MHASF Promising Practices	Statewide training conferences; additional trainings for county mental/behavioral health service managers and ethnic service managers
MHASF Resource Development	Statewide training conferences, training tool kit
NAMI	Training for NAMI programs In Our Own Voice (community groups); Ending the Silence (high school); Parents and Teachers as Allies (teachers and school administrators); Provider Education Program (e.g., gatekeepers – criminal justice, health care providers)
RS&E	California Public Television (CPT) documentary screenings
UACF	Keynote speeches, Caring Communities training, Tell Your Story training

Note: DRC = Disability Rights California. EIC = Entertainment Industries Council, Inc. IBHP/CCI = Integrated Behavioral Health Project/Center for Care Innovations. MHAC = Mental Health America of California. MHASF = Mental Health Association of San Francisco. NAMI = National Alliance on Mental Illness. RS&E = Runyon Saltzman & Einhorn. UACF = United Advocates for Children and Families.

RAND will be conducting intensive evaluations of the programs' major and well-defined training activities and conducting less intensive evaluations of the activities that involve a lower level of effort and/or are less well-defined. To do so, we developed four tools that we use as appropriate to a training's content, audience, and the setting in which the training takes place. Details on these tools, which include a sign-in sheet, a pre-post survey, a follow-up survey, and a training tracking tool, are provided in Appendix B. None of the programs had fully implemented the tools at the time of this report.

Here, we focus our evaluation on the content of the trainings and associated materials, attending to description (e.g., types of information provided, stereotypes countered), structure (e.g., formal instruction, interactive discussions), length, and resources developed. We draw conclusions about whether trainings' and presentations' content and structure are consistent with the evidence base wherever possible. We discuss what we have learned so far in this regard below. Though relevant information is typically limited, we also explore issues of sustainability, i.e., whether a training is likely to have continued dissemination and impact beyond CalMHSA funding. Many Program Partners are continuing to develop the content of these trainings, so our analysis is incomplete at this time.

Disability Rights California

We reviewed two Disability Rights California trainings for information on content and structure. "Intensive Home-Based Mental Health Services as Educationally Related Mental Health Services*"* described the legal precedent for intensive home-based services, types of services, and reasons for why these services should be included in educationally related mental health services. This training does not appear to counter a specific stereotype about mental illness or any of the factors thought to underlie stigma or discrimination, and it is unlikely that it might influence them, though it may promote better services for people with mental health challenges. "Lanterman-Petris-Short Act Conservatorship: Understanding the LPS Procedures" included an overview of different Lanterman-Petris-Short Act (LPS) holds and procedures; the meaning of being "willing and able" to receive voluntary mental health services; the array of available mental health services; third-party assistance; tips for communicating with a public defender; duties of public guardians; and temporary conservator specific issues. The training also contained information about the stigma associated with being institutionalized for a mental health disability. The primary goal of the training appears to be to combat discrimination through the provision of information about the legal rights of people with mental health challenges. However, the target audience for each training is unclear based on the materials provided, and the length of the trainings is unknown. Both of these factors are likely to play a role in presentation effectiveness. Indeed, it is unclear to what extent this approach will be effective, based on the literature. Emphasizing the stigma and discrimination experienced by those with mental health challenges has backfired in some cases, enhancing perceived stigma (Corrigan et al., 2001). On the other hand, those seeking out Disability Rights California's information and services may in many cases already feel highly stigmatized and are considering combating the problem through legal means. Thus, they may be less vulnerable to the "boomerang" effect than populations whose preexisting levels of mental illness stigma awareness were low. Providing information about laws and rights protecting those with mental health problems may also have a positive influence on prescriptive norms. That is, knowing that society protects people with mental health problems indicates that most people consider discrimination against them inappropriate. Norms play an important role in prejudice and discrimination, so educating people

about relevant laws, while largely untested by stigma research, may be effective in reducing stigmatizing attitudes (Devine and Sharp, 2009).The presentation also includes information on how people with mental health challenges can contact Disability Rights California to speak with an attorney or advocate if they need assistance with the issues discussed in the presentation, providing a resource for those experiencing discrimination to seek help. If an individual does so, and is successful, this action might directly reduce discriminatory practices.

PowerPoint slides are available for both trainings at Disability Rights California's website, making their continued distribution more likely.

Entertainment Industries Council, Inc.

RAND reviewed the online report for the "Muestra Esto/Picture This" forum. The *Muestra Esto/Picture This* report describes the action strategy that was generated by participants in the Los Angeles Muestra Esto forum. Targeted at journalists, and included in the online TEAM Up resources, it identifies priority topics to address in news stories about mental health and mental illness as well as suggestions regarding messaging techniques — ways to frame stories about mental health. The goal is to influence story writing so that news stories will foster understanding and acceptance of persons with mental health challenges and increase help-seeking by such individuals, particularly within the Latino community. The report includes letters of support from prominent public figures (e.g., the mayor of Los Angeles, the Director of the County Department of Mental Health), many of whom are Hispanic or Latino, enhancing its credibility with the targeted audience. It contains myriad short statements by participants in, and supporters of, the forum, accompanied by photos of some of them and their titles or backgrounds. The two-page section identifying priorities for coverage is located near the center of the report; it can be found easily by referencing the table of contents. Another two-page section presents a personal story of mental health challenges and recovery. A "Did You Know" section presents key facts about mental health and illness in a concise narrative understandable to a lay reader (e.g., defines integration of care; and describes available treatments, prevalence of mental health problems, some facts specific to Latinos, and information about different types of care providers). A glossary provides brief descriptions of more than a dozen disorders and conditions. A list of organizations working in the area of mental health is provided as a resource for journalists, and the report concludes with the Entertainment Industries Council, Inc. Style Guide for Reporting on Mental Health. Spanish- language versions of the *Muestra Esto* report and video are available on the TEAM Up website.

Muestra Esto/Picture This appears to be a useful reference for people looking for a variety of information and is presented in a manner likely to be appealing and informative to the audience. References are included, bolstering the report's credibility and likely impact. However, suggestions about priority areas for media coverage are not directly relevant to stigma reduction in most cases. There are two exceptions, one being the recommendation to use careful language in describing mental illness. This is consistent with evidence and theory suggesting that labels

(of "mental illness" or specific diagnoses) are a contributor to stigma, and adoption of this guideline might indeed reduce mental illness stigma among the writers' audience (Link et al., 2004). The other is the recommendation to portray the ways in which stigma and discrimination can adversely impact lives by affecting housing and employment, etc. This recommendation is more problematic in that as noted above in the analysis of Disability Rights California's trainings, focusing on discrimination has the potential to backfire by increasing fear of stigmatization and perceptions of its prevalence among those facing mental health challenges (Corrigan et al., 2001).

Integrated Behavioral Health Project/Center for Care Innovations

Integrated Behavioral Health Project/Center for Care Innovations is providing a variety of training opportunities aimed at increasing the uptake of integrated care across the primary care, substance abuse, and mental health treatment sectors. These include Learning Collaboratives, Webinars, Health Plan Presentations, Health Plan Trainings, and Provider Trainings. We describe each of these in the following section and then consider them in light of the evidence base supporting the provision of integrated care and the reduction of mental illness stigma.

Learning Collaboratives

Integrated Behavioral Health Project/Center for Care Innovations is organizing and convening Learning Collaboratives that involve representatives from the county mental health, primary care, substance abuse, and health plans sectors. The Learning Collaboratives are a continuation of IBHP/CCI's previous and ongoing work to support and strengthen integrated behavioral health efforts among health care clinics and consortia throughout California. In January, February, and March 2013, IBHP/CCI held in-person sessions with each of the three California Institute for Mental Health (CiMH) Quality Improvement learning communities to "harvest" and document their insights in order to create resources and curricula to disseminate findings to other counties. These meetings were followed up by a "harvest of the harvests" in March to examine lessons learned across the collaboratives and counties that have been part of IBHP/CCI's ongoing work, and to identify promising practices to disseminate to other counties. During this time, IBHP/CCI also collaborated with CiMH to implement strategies for strengthening and sustaining the current Learning Collaboratives, which are working with 25 counties that are engaged in activities to build capacity for integrating care across County Mental Health, substance use, primary care, other safety-net providers, and health plans. The collaborative topics (established during the preceding quarter) are: (1) Advancing Recovery Practices; (2) Small County Care Integration Collaborative; (3) Care Integration Collaborative; and (4) Strategies for Integrating Health, Prevention, and Community.

IBHP/CCI considers the launch of Learning Collaboratives for CalMHSA-funded activities to have begun May 2013. The goal of the Learning Collaboratives is to facilitate the cross-pollination of ideas and to work toward the reduction of barriers that hinder interagency

collaborations. They currently consist of monthly telephone calls conducted in collaboration with the CiMH and may include in-person meetings on a twice-a-year basis. The content and format of the Learning Collaboratives are still evolving.

Webinars

Beginning in March 2013, Integrated Behavioral Health Project/Center for Care Innovations launched a 15-month webinar series focusing on a range of clinical and operational topics related to the delivery of integrated care. This effort is being conducted in collaboration with the federal Agency for Healthcare Research and Quality (AHRQ) and its subcontractor, University of Colorado. IBHP/CCI is part of the leadership group that decides on the topics, content, and faculty of the webinars. The IBHP/CCI is driving content based on technical assistance needs identified through its work with the California Primary Care Association and CiMH, as well as direct work with counties. The webinars are being disseminated through the California Primary Care Association. These trainings target primary care clinics but also will be relevant to counties interested in working with primary care sectors to promote access to behavioral health care. Many of the webinar topics are still under development. As of this report, three webinars have been delivered. Information pertaining to the title of the webinars, presentation date, and the number of registrants and attendees for webinars already delivered is provided in Table 2.25 below.

Table 2.25
Integrated Behavioral Health Project/Center for Care Innovations Webinar Topics, Registrants, and Attendees

Month/Year	Title or Planned Topic	Registration/ Attendance
March 2013	Integrating Your Practice: Key Building Blocks	Registered: 144 Attended: 27
April 2013	A Workforce for Integration	Registered: 103 Attended: 54
May 2013	The State of Healthcare Policy	Registered: 101 Attended: 45
June 2013	Measuring Integration: The Integration Quality Atlas	Registered: 102

Health Plan Presentations

Integrated Behavioral Health Project/Center for Care Innovations will be holding a series of conversational, targeted meetings with health plan administrators to disseminate information that builds the case for the provision of integrated care. Up to three presentations are planned with small groups of five to ten health plan administrators. The health plan presentations are expected to start in October 2013.

Health Plan Trainings

Educational trainings targeted at personnel from health plans who deal directly with health plan members are under development.

Other Provider Trainings/Presentations

Between January and March 2013, Integrated Behavioral Health Project/Center for Care Innovations gave presentations on the Affordable Care Act (ACA) and behavioral health integration at various clinics in Los Angeles, including Eisner Pediatric and Family Medicine clinic. IBHP/CCI is continuing to develop trainings for other clinics and is working with partners, including CalMHSA programs, to incorporate their materials and expertise in integrated care into others' trainings and to enhance its own trainings (e.g., working to incorporate the resources Mental Health Association of San Francisco has identified on mental illness stigma into its integrated care training resources).

Fit of Integrated Care with the SDR Evidence Base

No studies to date have examined whether integrated care reduces the stigma associated with mental illness or treatment seeking. Although such evidence is lacking, it has been suggested that the provision of integrated care, particularly with respect to facilitating access to behavioral health care in primary care settings, is an effective means to reducing stigma. Proponents argue that the integration of brief mental health screening and behavioral health care within primary care may enable individuals who do not normally disclose mental health problems to do so in a less stigmatizing context than specialty mental health care (Shim and Rust, 2013).

Another argument in favor of integrating behavioral health care within primary care settings to reduce stigma and discrimination is that considering mental health on par with, and in conjunction with, physical health is more respectful of those with mental health problems (California Department of Mental Health, n.d.).

RAND will be assessing the degree to which Integrated Behavioral Health Project/Center for Care Innovations trainings resulted in attendees making policy and practice changes within its organizational settings. This will inform whether IBHP/CCI's efforts under CalMHSA may be improving care. However, the linkage between integrated care, stigma, and discrimination, if it exists, is not direct, and we will be unable to observe whether the care that is provided shifts toward more supportive practices or results in more supportive attitudes among care providers, consistent with the long-term goals of the SDR initiative.

Mental Health America of California

Mental Health America of California's Wellness Works! workplace mental health program is based on the *Mental Health Works* curriculum developed by the Canadian Mental Health Association. As described by Mental Health America of California, Wellness Works! targets and trains key individuals in the workplace environment to provide effective support to employees

living with mental health challenges. Wellness Works! consists of multiple workshops, ranging from hour-long to a full day of training. Target audiences include supervisors, managers, senior executives, small business owners, human resources professionals, occupational health, and union leadership. Wellness Works! materials were not available for evaluation at the time this report was written.

Mental Health Association of San Francisco Promising Practices

Mental Health Association of San Francisco organized the first of two annual statewide SDR training conferences in March 2013. The conference was entitled "Tools for Change: Freeing Our Communities from the Stigma of Mental Illness." The organization also indicates that additional training programs will be conducted for community behavioral/mental health managers and ethnic service managers in the future. RAND will not be evaluating the content of Mental Health Association of San Francisco Promising Practices trainings.

Mental Health Association of San Francisco Resource Development

MHASF has also developed a training tool kit that incorporates 16 training tools and resources for SDR programs. RAND will not be evaluating the content developed and disseminated by MHASF Resource Development.

National Alliance on Mental Illness

National Alliance on Mental Illness is providing four previously developed educational programs as part of its CalMHSA scope of work. Below, we provide information about the four different curricula, and the types and numbers of presenters for each. At the conclusion of this section, we discuss how these programs fit with the evidence base regarding how to reduce stigma and discrimination around mental illness and whether current activities are sustainable beyond CalMHSA funding.

In Our Own Voice (IOOV)

IOOV is a public education program developed by National Alliance on Mental Illness that consists of a 60 to 90 minute presentation delivered by two presenters who share their personal stories of recovery. The IOOV presentation begins with an Introduction; moves on to Dark Days, Acceptance, Treatment, and Coping Skills; and concludes with Successes, Hopes, and Dreams to convey that recovery from mental illness is possible. The structure of IOOV facilitates direct interaction and experiences with individuals who have successfully recovered from mental illness.

IOOV has a Presenter's Manual, which provides step-by-step instructions with respect to the content to be delivered, communication and facilitation skills, and tailoring for various audiences. There is an IOOV Coordinator's Manual that provides support and guidance to IOOV Coordinators at the state or local affiliate level. The Coordinator's Manual covers issues such as

budgeting, staffing, program policies and best practices, and program evaluation. National Alliance on Mental Illness has previously developed tools to track the delivery of presentations and pre-post surveys to assess program outcomes. The manuals and evaluation tools provide the kind of infrastructure needed to support replication and dissemination and tracking of immediate outcomes.

Parents and Teachers as Allies (P&TA)

P&TA is a previously developed two-hour in-service program for teachers, administrators, school health professionals, parents, and other school community members. The focus of P&TA is on assisting school professionals to recognize the early signs of mental illness in children and adolescents and to know how to intervene to connect families to needed mental health services. P&TA is presented in six segments: Welcome and Introductions, Early Warning Signs of Mental Illnesses, Family Response (Stages of Emotional Reactions among Family Members Dealing with the Trauma of Mental Illness), Living with Mental Illness, Group Discussion, and Closing Remarks and Evaluation. In addition to providing educational information about mental illness, P&TA has built into its presentation a variety of opportunities for contact with individuals who have had different levels and types of experiences with mental illness. A presenter manual for P&TA has also previously been developed, which was adapted from National Alliance on Mental Illness's Family to Family Education program.

Provider Education Program (PEP)

PEP is a five-week course that targets providers or line staff at public agencies who work directly with individuals with persistent and serious mental illness. In addition to the dissemination of educational information, PEP aims to convey the emotional and practical ramifications for individuals coping with a mental illness or caring for someone with a mental illness. PEP is delivered by a five-member teaching team consisting of two family members of individuals with a mental illness who have been trained as Family-to-Family Education program teachers, two individuals with "lived experience" who have supportive family relationships and are committed to the recovery process, and a mental health professional who has experienced a mental illness or has a family member with "lived experience." PEP is comprised of five three-hour classes, each covering one of the following topics: Orientation, Clinical Bases, Responding Effectively to Consumers and Families, Inside Mental Illness, and Working Toward Recovery. A core component of PEP is the incorporation of direct contact with individuals who have experienced a mental illness as well as with the family members of individuals with a mental illness. A presenter manual for PEP also has been developed.

Ending the Silence (ETS)

ETS is a 50-minute presentation that is typically given during a high school freshman or sophomore health class. ETS is delivered by two presenters who share their experiences of recovering from a diagnosable mental health condition. The purpose of ETS is to help students

learn about the symptoms of various mental health conditions and how to intervene to obtain help for themselves, friends, or family members. At the conclusion of ETS, students are provided an informational resource card with phone numbers and websites for mental health agencies as well as a list of symptoms and warning signs of mental illness. Parents are also sent a postcard to inform them about the program and available services provided by their local National Alliance on Mental Illness affiliate. Similar to the other National Alliance on Mental Illness programs, a presenter manual has been developed to support the delivery of ETS.

Fit of National Alliance on Mental Illness Programs with the SDR Evidence Base

As noted above, all of the National Alliance on Mental Illness programs include interaction with a person who has experienced a mental health challenge. Interpersonal contact strategies have been associated with attitudinal and behavioral changes toward individuals with mental illness (Corrigan et al., 2003a; 2003b). This is in line with "intergroup contact theory" which posits that prejudices may be reduced when facilitated interactions between groups occur under the following conditions: equal group status within the situation, shared common goals, intergroup cooperation, and support for the interaction from an authority figure (Allport, 1979). Few evaluations have examined the nature of contact strategies in educational presentations, and it is possible they do not meet these conditions. However, a recent meta-analytic test of intergroup contact theory suggests that these optimal conditions may not be as essential as previously conceived for prejudice reduction (Pettigrew and Tropp, 2006).

In addition, a number of studies have directly evaluated IOOV. These studies have been mostly restricted to student populations. Wood and Wahl randomly assigned 114 college undergraduates to an IOOV presentation or a control presentation condition (Wood and Wahl, 2006). Students who received the IOOV presentation exhibited increases in mental health knowledge and more positive attitudes toward people with mental illness compared to the control condition immediately after the presentation. In a cross-over design involving 43 undergraduates who were exposed to both IOOV and psychoeducation, IOOV was associated with decreased stigma for bipolar disorder and unipolar depression, but not for general mental illness or schizophrenia compared to psychoeducation (Rusch et al., 2008). Pitman, Noh, and Coleman examined the effects of IOOV with 30 social work students and found pre/post differences with respect to an increase in knowledge and more positive attitudes toward mental illness (Pitman, Noh, and Coleman, 2010). Among adolescents, one study conducted a school-based cluster-randomized trial with 156 teenage girls aged 13–17 years that examined the effects of IOOV (Pinto-Foltz, Logsdon, and Myers, 2011). Findings were mixed with no evidence of reduction of mental illness stigma at one-, four-, or eight-week follow up; however, gains in mental health literacy were found at four- and eight-week follow up.

Sustainability and Fidelity of National Alliance on Mental Illness Programs Post-CalMHSA Funding

National Alliance on Mental Illness is a well-developed organization with affiliates and presenters throughout much of California. These provide a sound basis for sustaining activities following CalMHSA funding. Indeed, funds from CalMHSA are largely being used to increase numbers of presentations given, increase coordination between local affiliates and National Alliance on Mental Illness California (the prime recipient of funds under CalMHSA), and obtain evaluation data beyond those collected previously. Thus, there is clear sustainability, though it is uncertain whether coordination among affiliates and enhanced evaluation capacity will remain after the additional funding from CalMHSA ends. Nor is it clear whether the numbers of presentations will revert to prior levels.

An additional, related issue regarding sustainability is that of fidelity. Even the most effective programs with strong infrastructure for delivery must ensure that the key components that make a program effective are present each time a presentation is made, and that nothing is added that might render the program less effective or cause unintended negative outcomes. National Alliance on Mental Illness recognizes this in the manuals for IOOV, PT&A, PEP, and ETS. For example, the manuals provide guidance on how presenters can share their personal experiences with mental illness and the recovery process. Presenters are advised to "Stay Away from Hot Potatoes" such as graphic violence or descriptions, religion, or abuse so that these issues do not dominate the presentation. Rather, the presentations should focus on mental health and recovery. Moreover, National Alliance on Mental Illness has outlined best practices for the delivery of IOOV, which address sustaining program quality (e.g., refresher for presenters after three years of initial training), program format (e.g., IOOV conducted within an hour and half), training (e.g., at least eight people for IOOV training), building community/refreshing best practice (e.g., convene presenter gathering at least once a year in every state). These are issues that RAND will be exploring with National Alliance on Mental Illness in the next year.

Runyon Saltzman & Einhorn

Runyon Saltzman & Einhorn has not yet conducted community screenings of the CPT documentary; they are planned for the coming months (June–September).

United Advocates for Children and Families

With CalMHSA funds, United Advocates for Children and Families has developed a train-the-trainer curriculum entitled "Caring Communities" and enhanced an existing train-the-trainer curriculum entitled "Tell Your Story." Training leader guides for both curricula were reviewed to document program goals, target audiences, and materials.

Caring Communities' target audience is broad and includes family members, consumers of mental health services, youth, and mental health gatekeepers throughout the state. Participants are trained to train others to give presentations that aim to combat mental health stigma and

discrimination. The one day training session covers basic information about mental, emotional, and behavioral health disorders and challenges and their impacts on individuals and families; understanding mental health stigma and discrimination; treatments for mental, emotional, and behavioral health disorders and challenges; and building the skills and capacity to respond to individuals with mental, emotional, and behavioral health disorders and challenges. The training involves brief lectures, videos, group discussions, and small group and individual activities. Resources developed as part of this curriculum include a trainer's manual, which contains PowerPoint slides, as well as a pre- and post-training survey. The training materials contain appropriate information on basic mental health literacy (i.e., mental health symptoms, disorders, treatments, and appropriate crisis response). The section of the materials focusing on stigma and discrimination provides definitions of these concepts that are consistent with the literature. Discussion of stigma and discrimination is framed largely in terms of bullying and its effects, but no strategies for SDR or addressing bullying are included. There is some evidence to suggest that educational efforts such as these are sufficient to reduce stigma, though not as effective as other strategies, such as contact between a person with mental illness and the audience (Yamaguchi, Mino, and Uddin, 2011). United Advocates for Children and Families' train-the-trainer approach to training could be sustainable without continued CalMHSA funding, but this would depend on trainees' commitment to holding trainings over the long term and abilities to find suitable audiences for the trainings.

The goal of the Tell Your Story train-the-trainer curriculum is to teach "consumers, families, and youth to tell their stories in a manner that impacts system change, community response, and neutralizes the stigma and discrimination often associated with mental health challenges." The one-day training provides information appropriate to the goal of teaching people to tell their stories. Topics include how to use stories to promote change and involve writing a personal story about participants' own experiences with mental health challenges. Other topics include public speaking techniques and how to handle difficult situations when presenting. Information on how to hold a successful training is also presented. The training involves brief lectures, videos, group discussions, and individual activities. Resources developed as part of this curriculum include a trainer's manual, which contains PowerPoint slides, as well as a participant workbook. The Tell Your Story approach to reducing stigma is not strongly grounded in the SDR evidence base. When presenters are those who have personally experienced mental health problems, "contact" is involved, and thus there is some theoretical basis for predicting stigma reduction (Yamaguchi, Mino, and Uddin, 2011). But the scientific literature does not predict shifts in stigma as a result of hearing the stories of family members and others affected indirectly by mental illness. United Advocates for Children and Families conducted three Tell Your Story trainings in Los Angeles with five local leaders selected by Magnolia Place (a community-based partner) on March 15, 2013. Additional Tell Your Story trainings were also conducted in San Diego on April 15, 2013 and attended by 11 local leaders selected by Mental Health Association of San Diego and Family Youth Roundtable; and trainings were conducted in San Bernardino on April 22, 2013 and

attended by eight local leaders selected by Victor Community Support Services. As with Caring Communities, the sustainability of Tell Your Story training depends on trainees' commitments to holding presentations and abilities to find suitable audiences for them.

Media/Social Marketing Campaigns and Interventions

Two Stigma and Discrimination initiative–funded programs are developing and conducting social marketing campaigns or media interventions as a central part of their activities. The programs and their activities are highlighted in Table 2.26 below. Information evaluating these will be covered in future reports.

Table 2.26
Media/Social Marketing Activities of SDR Programs

SDR	Media/Social Marketing Activities
EIC	Intervention for media to increase positive/decrease negative portrayals of mental illness
RS&E	Three-pronged social marketing campaign directed at youth 9–13 years, transitional age youth 14–24 years, and adults with influence over those with mental health challenges, including ads, CPT documentary, ReachOut Forums, and (to be conducted beginning Fall 2013) in-school theater presentations

Note: EIC = Entertainment Industries Council, Inc. RS&E = Runyon Saltzman & Einhorn.

Summary

SDR Program Partners have developed many capacities and resources related to policies, procedures, and protocols, as well as informational resources. These capacities and resources include fact sheets, tool kits, and the identification and assessment of promising practices in SDR in community organizations. For online resources, we have made substantial progress in using website analytics to track how users are finding and interacting with Program Partner sites, what resources they are downloading, and where in California they are located. We are currently working with Program Partners to implement tools for tracking the reach of resources that are not disseminated online. Tools for understanding the effectiveness of these resources and capacities and the helpfulness of informational resources are also in the process of being implemented by Program Partners.

SDR Program Partners are also making available a host of trainings and educational programs. These include trainings for a wide variety of audiences, including people with mental health challenges, family members of people with mental health challenges, landlords, health providers, county mental/behavioral health service managers, teachers, students, and more. Many of these trainings utilize contact with people with mental health challenges (an evidence-based

practice) to help reduce stigma and discrimination. Because tools for tracking reach of trainings and educational presentations and changes in attitudes, beliefs, and behaviors in response to these presentations have only been in place for a short time, we are unable to provide results on these topics at this time.

SDR Program Partners are also addressing SDR through media: providing media training to journalism and entertainment professionals and conducting a multi-audience social marketing campaign. A selective review of the social marketing messages and materials developed is in progress. We have not yet collected data on message dissemination or tested message efficacy.

In sum, SDR Program Partners have made great progress in developing resources and capacities to reduce the stigmatization and discrimination of people with mental health challenges. Ongoing and future evaluation activities will provide more detail on the reach of these resources and capacities, as well as their effectiveness in reducing stigma and discrimination.

3. Suicide Prevention

In this chapter, we review findings to-date regarding key Suicide Prevention (SP) Program Partner activities and products. There are 15 Program Partners – seven of which are funded directly by CalMHSA and eight via subcontracts – that have been working to expand or enhance crisis counseling via hotlines, warmlines, Internet-based "chat," or text messaging. In addition, one of the crisis centers has been funded to strengthen the network of crisis centers in the state and enhance best practices for suicide prevention, one Program Partner has been focusing on social marketing related to suicide prevention, and another has been conducting trainings to improve efforts to identify and intervene with people at risk of suicide in California.

RAND's evaluation of suicide prevention activities targets four specific areas around which the rest of this chapter is organized: whether (1) networking and collaboration activities are enhancing the capacity of crisis response in the community and increasing access to and the provision of high-quality care; (2) trainings or educational programs are increasing awareness and improving identification of individuals at risk; (3) social marketing is improving knowledge about suicide and crisis intervention skills; and (4) hotlines and warmlines are improving identification of individuals at risk, enhancing crisis response, and increasing access to and the provision of high-quality care. Though virtually all Program Partners have activities across all of these areas, as described below and in our original evaluation plan, RAND selected to evaluate specific partner activities in each domain, generally representing where significant funds were being allocated. Table 3.1 below provides an overview of the status of SP Program Partner activities in a variety of different categories, summarizing what information is contained in this report and what information will be forthcoming.

This chapter summarizes the development of program capacities across these activities. When available, we describe new program capacities built (e.g., the creation of a new crisis hotline or of social marketing materials), milestones achieved (e.g., obtaining hotline accreditation), and the "reach" of various activities (e.g., the number of people trained or volume of contacts with each crisis service) as of the time of writing. We based our assessment of capacities on a review of key materials produced by Program Partners and updates provided to either CalMHSA or members of the evaluation team. We developed a variety of tools (see Appendix B) to assess the reach of activities, and present data here on the reach of social marketing materials, trainings, and call volume. We also present preliminary data on the effectiveness of LivingWorks' trainings, though later phases of the evaluation will assess the effectiveness both of social marketing materials using online experiments and of hotlines and warmlines.

Table 3.1.
Status of Suicide Prevention Evaluation Activities

	Describe Capacities	Monitor Reach to Target Audiences	Evaluate Short-term Outcomes
Networks and Collaborations			
Program Partners: Didi Hirsch (program 1)	**This Report:** Summary of key activities of the California Statewide Suicide Prevention Network (CSPN). **Future:** Summary of the number and nature of collaboratively developed materials, resources, and practices.	**Future:** Data on the level of collaboration.	**Future:** Analysis of the degree to which networks and collaborations meet objectives (e.g., coordinating services, sharing resources, enhancing cultural competence).
Training and Educational Programs			
Program Partners: LivingWorks	**This Report:** Description of training activities (i.e., Applied Suicide Intervention Skills Training [ASIST] and SafeTALK). **Future**: Descriptive analysis of data from live observations of ASIST workshops to determine how ASIST trainings are delivered in community settings.	**This Report:** Data on number of ASIST and SafeTALK trainings administered and number of participants, by region of California. Demographic data on ASIST training participants, based on post-training surveys. **Future:** Additional data on the number of trainings administered, number of participants, and their demographics, for both ASIST and SafeTALK trainings.	**This Report:** Preliminary data on satisfaction with ASIST trainings, change in intervention self-efficacy, and change in behavioral intentions. **Future:** Additional data on post-training changes in self-efficacy and behavioral intentions.
Media/Social Marketing Campaigns and Interventions			

	Describe Capacities	Monitor Reach to Target Audiences	Evaluate Short-term Outcomes
Program Partners: AdEase	**This Report:** Status of select facets of AdEase's social marketing campaign, including description of activities and materials. **Future:** Detailed review of social marketing materials. Sustainability analysis.	**This Report:** Web analytic data provided by website associated with campaign. **Future:** Additional web analytic data; data on the reach and frequency of message exposure.	**Future:** Results of testing the efficacy of specific campaign messages. Evaluation of changes in media messages about suicide that may be attributed to the creation and dissemination of the Media Advocacy tool kit. Data on whether Californians exposed to the messages have improved knowledge about suicide and confidence in the ability to intervene with a person in suicidal crisis.
Hotline/Warmline Operations			
Program Partners: Didi Hirsch (program 2); FSACC; FSA Marin; Institute on Aging; King's View; SF Suicide Prevention; TMHA. Subcontracts: Kern County, WellSpace Health, Contra Costa County, Santa Clara County, San Mateo County	**This Report:** Description of activities, including summary of new crisis and mental health support services developed and accreditation activities/status. **Future:** Updated description of new and expanded services and accreditation activities/status.	**This Report:** Data on volume of hotline and warmline calls received . **Future:** Additional data on call/chat volume.	**Future:** Data from live monitoring of hotline calls (i.e., call content, call response quality).

Note: FSA Marin = Family Service Agency of Marin. FSACC = Family Service Agency of the Central Coast. TMHA=Transitions Mental Health Association.

Evaluation Methods

With respect to the first evaluation area – networking and collaborations – RAND's evaluation focuses primarily on the California Statewide Suicide Prevention Network (CSPN), funded through one of two CalMHSA grants to Didi Hirsch, a community mental health center in Los Angeles County. At this point in the evaluation, the evaluation team has been compiling and reviewing documents related to collaboration across CSPN members. In the near term, the

evaluation team will use various approaches to describe the nature of existing networks and collaborations, the role of CalMHSA funds in enhancing collaborations, the degree to which networks and collaborations meet objectives (e.g., coordinating services, sharing resources, enhancing cultural competence), and the sustainability of networks and collaborative partnerships.

The second evaluation area, trainings and educational programs, focuses on LivingWorks' delivery of two types of training, ASIST and SafeTALK. We developed a protocol for monitoring fidelity to LivingWorks ASIST training protocol, as well as a survey for administration at the end of each ASIST training that assesses participant demographics, demographic characteristics of the clients the participant works with or wants to work with, training content, training satisfaction, and gatekeeper efficacy. These post-training surveys were administered beginning in January 2013, and we present these data for seven trainings.

In area three, social marketing, RAND is evaluating AdEase's contract to promote awareness of the warning signs and risk factors for suicide in the general population so that they can help others. In this report, we primarily discuss the program capacities built as part of the campaign.

Finally, area four focuses on hotline and warmline services. We summarize capacities built (services that were developed), milestones achieved (accreditation), and reach (volume of contacts for each agency and outreach activities). We conclude with a discussion of the live monitoring component of our evaluation that we plan to conduct with crisis centers in the near term.

In summary, SP Program Partners have been focused on increasing the number of Californians equipped to recognize and intervene with persons at risk for suicide, and have expanded or enhanced the ability to intervene with individuals reaching out for help. The first year of this evaluation has been spent better understanding the services Production Partners offer and creating tools that can be used to evaluate these services. As the evaluation moves forward, Production Partners will continue to develop new products and capacities as well as expand the reach of their activities. Though we present preliminary information here about these capacities and reach, we are poised to fully understand the nature of these activities – and to assess how these activities may be preventing suicide in California – at the end of year three of the contract period.

Networking and Collaborations

Didi Hirsch has created the California Statewide Suicide Prevention Network (CSPN), which has been developing crisis line data metrics that all participating crisis lines will collect. In addition to the statewide network, it established regional task forces that will serve as best practice advisory boards. These regional task forces will convene topic-specific workgroups on high-risk populations and identify a best practice for each region. Didi Hirsch will publicize

these best practices by promoting their publication on the national suicide Best Practices Registry website.

Program Partner Collaboration Activities

Eleven partnering crisis lines agreed on six metrics to be the "Common Metrics for Crisis Centers" to be collected during calls. These metrics were call volume; demographics; reason for call; risk; follow-up; and caller satisfaction. In addition, the crisis lines developed a training manual for training crisis call workers and provided a data capture template for reporting the metrics and a common metrics report. The CSPN also formed regional task forces and conducted informal needs assessments in each of six California regions. Also, in preparation for the establishment of a Best Practices Workgroup, CSPN pulled together six Regional Planning Committees and convened meetings in all regions. In these committee meetings, members discussed suicide-related data pertinent to their regions using a CSPN-created handbook containing data on suicide from the California Department of Public Health, results of the informal needs assessment, and local suicide prevention practices. Didi Hirsch planned to schedule County Liaison calls in quarter 4 2012–2013 to select a final priority area for each region, and then begin forming Best Practices Workgroups to ultimately develop components and apply them to the Best Practices Registry.

Next Steps for Evaluating Networking and Collaborations

RAND, in partnership with SRI International, will lead the evaluation of networking and collaborations. Through multiple methods, including document reviews, key informant interviews, and participant surveys, the SRI research staff will collect data that inform the nature of existing networks and collaborations, the role of CalMHSA funds in enhancing collaborations, the degree to which networks and collaborations meet objectives (e.g., coordinating services, sharing resources, enhancing cultural competence), and the sustainability of networks and collaborative partnerships. We are currently compiling and reviewing documents related to collaboration activities (e.g., Memoranda of Understanding [MOUs] with partners and emergency/crisis intervention protocols, policy recommendations, and meeting rosters and agendas). A protocol for key informant interviews is in development, and these interviews will provide detailed descriptive data about the CalMHSA-supported collaborative organizations and activities that have emerged over the last contract year. Finally, the SRI research team will conduct a collaboration survey in Spring 2014 to collect information from a wider population of participants in CalMHSA-supported collaborative organizations and activities. The survey will focus on how closely programs are collaborating within networks and communities, and outcomes related to collaboration, such as enhanced access to and coordination of services. In designing the collaboration survey, we will draw on existing surveys that Program Partners have developed and implemented to reduce duplication and respondent burden.

Trainings and Educational Presentations

RAND's evaluation on training for suicide prevention is focused on LivingWorks' delivery of two trainings – ASIST and SafeTALK.[3] Here, we discuss our progress to date working with LivingWorks to evaluate the reach and implementation of these trainings.

Evaluation Tools

Several tools will be used to evaluate LivingWorks' trainings. First, we developed a protocol for monitoring fidelity to LivingWorks' ASIST training. We also developed an ASIST post-training survey that assessed participant demographics; demographic characteristics of the clients the participant works with or wants to work with; and training content, training satisfaction, and gatekeeper efficacy. These instruments are described in Appendix C. We will also be evaluating the reach of SafeTALK trainings (e.g., how many are conducted a month, in what geographical areas, and to how many training participants).

LivingWorks Training Activities

LivingWorks is a suicide intervention training company with international offices in Calgary, Canada, and U.S. offices in Fayetteville, North Carolina. LivingWorks' training programs with CalMHSA are coordinated through subcontracts: Didi Hirsch, Contra Costa County, and WellSpace (formerly known as the Effort). The trainings to be administered include SafeTALK, ASIST, ASIST T4T, and eSuicide Talk. SafeTALK is a three-hour suicide alertness workshop. ASIST is an intensive two-day suicide intervention workshop. SafeTALK and ASIST are also taught as a training-for-trainers (T4T) certification program. SafeTALK T4T is a two-day training that teaches skills to deliver the SafeTALK workshop, and ASIST T4T is a five-day course. Finally, eSuicide Talk is a 60-minute, online version of its "Suicide Talk" training that provides more general knowledge training for community audiences. The LivingWorks program targets a broad, statewide population.

Reach of LivingWorks Training

Table 3.2 details the number of CalMHSA-sponsored trainings administered and the number of participants that have been trained by region for quarters 2 and 3 (October 1, 2012–March 31, 2013). LivingWorks planned to train 240 candidates in a total of ten trainings in ASIST T4T and 100 candidates in a total of ten trainings in its SafeTALK T4T across all the three years of its contract period. In quarter 3, eSuicideTalk was released to select trainer coordinators, staff, and county liaisons for their review. LivingWorks also increased the total number of paid individual user licenses from 2,900 to 16,100 to help outreach, especially in rural communities, and to

[3] It is important to note that many of the Program Partners, as part of their contracts, are conducting community outreach and education that may focus on suicide awareness generally as well as the skills necessary to identify persons at risk and how to intervene with them.

introduce the concept of suicide awareness in areas that do not have a fully developed training plan.

Table 3.2
CalMHSA-Sponsored Trainings by Region for Q2 and Q3, 2012–2013

Training Program	Number of Trainings					Number of Participants				
	Southern CA	Central CA	Northern CA	Total	3-Year Goal	Southern CA	Central CA	Northern CA	Total	3-Year Goal
ASIST T4T	2	0	0	2	10	25	0	0	50	240
SafeTALK T4T	1	0	0	1	10	10	0	0	10	100
ASIST Workshops	12	1	16	29 [a]	N/A	217	7	309	533 [b]	N/A
SafeTALK Workshops	4	3	7	14	N/A	62	46	89	197	N/A

[a] Two workshops were located outside California.
[b] One workshop is missing the number of participants.

LivingWorks has been working with ASIST trainers to implement the CalMHSA-post-training form as of January 2013. Post-training surveys were administered at seven out of 29 CalMHSA-sponsored ASIST workshops (N=117 participants out of 533 total participants; see Table 3.3). The training participants who completed the survey were mostly between the ages of 26 and 59, White, and female. Just over 20 percent were of Hispanic, Latino, or Spanish origin. About 38.5 percent reported serving English and Spanish clients. In addition, the most common occupations of the participants included military service (13.7%), counselors (12.8%), law enforcement (11.1%), administrators (6.8%), and social workers (6.8%).

Training Implementation

We have also been evaluating the implementation of ASIST workshops through fidelity monitoring observations and post-training participant evaluation surveys.

Fidelity Monitoring

The RAND research team worked closely with senior staff at LivingWorks and the three CalMHSA subcontract coordinators to establish a safe and feasible fidelity monitoring observational protocol that would be respectful of trainers and participants in the ASIST workshops.

To measure fidelity, we counted the number of sections the trainer covered in the ASIST training. To measure adherence, we assessed how the trainers engaged participants according to ASIST-identified trainer competencies (i.e., positive feedback) and other communication methods. As part of measuring adherence, we also measured how trainers adapted the training for their specific target populations (e.g., whether trainers gave examples of how suicide affects

the target population). Two RAND observers were trained on the fidelity workflow and protocol, and then attended an ASIST training workshop to become familiar with the training material. They subsequently coded sample trainings from the ASIST T4T DVD series to increase inter-rater reliability. After the first observation, the trainers met to discuss and review their codes with a third RAND research staff member who had attended an ASIST T4T.

Table 3.3
Demographics of ASIST Training Participants (N=117)

Demographics	%
Age	
16–18	0.9
19–21	6.0
22–25	14.5
26–59	73.5
60–84	5.1
Male	38.5
Hispanic, Latino, or Spanish origin	21.4
Race[a]	
White	54.7
Black/African American	8.5
Asian	3.4
American Indian/Native	4.3
Native Hawaiian/Pacific Islander	0.9
Other	6.8
Job/work setting	
Military	13.7
Counselor in school/university/mental health	12.8
Law enforcement in school/university/mental health	11.1
Administrator in school/university/mental health	6.8
Social work in mental health/other mental health/other setting	6.8
Educator in school/university/mental health	5.1
Psychologist in school/university/mental health	5.1
Nurse in mental health/other mental health/other setting	3.4
Volunteer in mental health/other mental health/other setting	2.6
Other (unknown, youth worker)worker, chaplain)	29.1

[a] Race categories not mutually exclusive.

Ultimately, the RAND research team decided, based on the allocated budget and resources, to observe a convenience sample of five CalMHSA-sponsored ASIST trainings hosted by community organizations. Working directly with the three CalMHSA subcontract coordinators who identified potential trainings to observe, the RAND research team introduced the fidelity monitoring evaluation to trainers to assess their interest, and scheduled trainings accordingly. We have conducted two observations (Didi Hirsch and Department of Mental Health in Los Angeles) and as of the time of this writing have three additional observations scheduled for summer 2013 (U.S. Border Patrol in San Diego, La Familia Counseling Service in Alameda County, and Naval Station in Kings County). Results of the fidelity monitoring will be presented in the next report.

Post-Training Satisfaction

Table 3.4 describes the average participant ratings of satisfaction. On a scale from 1 to 10, where 1 indicated "definitely no" and 10 indicated "definitely yes," participants attending the seven ASIST workshops for which the survey was administered reported average scores between 8.8 and 9.4 on items related to whether their training was helpful, met the needs of diverse students, and was important to attend.

Table 3.4
Average Rating of Satisfaction with ASIST Training

	M(SD)
Helpfulness	9.4 (1.2)
Meets the needs of people I work with	8.8 (1.8)
Importance of attending trainings	9.4 (1.4)

Note: Higher scores indicate greater satisfaction.

Preliminary Data on Changes in Short-Term Outcomes Resulting from Training

Intervention Self-Efficacy. Table 3.5 describes average participant ratings of self-efficacy and how participants' skills changed before and immediately after the training. Participants attending the seven ASIST workshops reported significant changes in overall self-efficacy from pre- to post-training ($p < .0001$). On a 5-point Likert scale, participants rated their self-efficacy before the training [1 (Strongly Disagree), 2 (Disagree), 3 (Neither Disagree nor Agree), 4 (Agree)], and after the training with a rating between 4 (Agree) and 5 (Strongly Agree).

Table 3.5
Average Ratings of ASIST Training Participant Intervention Self-Efficacy

	Pre M(SD)	Post M(SD)
Prepared to help a person at risk	3.2 (1.2)	4.5 (0.6)
Confidence to help a person at risk	3.2 (1.2)	4.5 (0.6)
Identify places or people where I should refer	3.5 (1.1)	4.5 (0.6)
Easy access to education and resources to learn	3.5 (1.1)	4.5 (0.6)
Comfort discussing suicide with others	3.4 (1.3)	4.4 (0.7)
Overall Self-Efficacy Score	3.4 (1.0)	4.4 (0.5)*

* $p < .001$ for paired t-test comparing "pre" and "post" overall self-efficacy scores.
Note: Higher scores indicate greater level of self-efficacy (on a scale from 1 to 5).

Intervention Behaviors. Table 3.6 describes the average participant ratings of behavioral intentions for the seven trainings measured. Participants reported significant changes in their overall behavioral intentions from pre- to post-training ($p < .0001$). Participants reported increased behavioral intentions after completion of the training.

Table 3.6
Average Ratings of ASIST Training Participant Intervention Behaviors

	Pre M(SD)	Post M(SD)
Would ask directly if thinking about suicide	3.4 (1.1)	4.7 (0.6)
Would do a suicide intervention	3.6 (1.1)	4.8 (0.5)
Overall Behavior Score	3.5 (1.0)	4.7 (0.4)*

* $p < .001$ for paired t-test comparing "pre" and "post" overall self-efficacy scores.
Note: Higher scores indicate greater level of self-efficacy (on a scale from 1 to 5).

Summary

To date, the RAND team has made significant progress working collaboratively with LivingWorks to evaluate ASIST workshops using post-training surveys and creating a fidelity protocol for live observation. Thus far, LivingWorks has provided data on seven ASIST workshops and these preliminary data indicate that trainings are helpful and important. More data will be forthcoming as data from only seven trainings are limited in terms of generalizability. We also plan to conduct descriptive analyses summarizing the reach of SafeTALK trainings to determine how often and in what settings these trainings are being administered. We will also descriptively analyze our fidelity data from the live observations of

ASIST workshops to determine how ASIST trainings are being delivered in these select community settings.

Media/Social Marketing Campaigns and Interventions

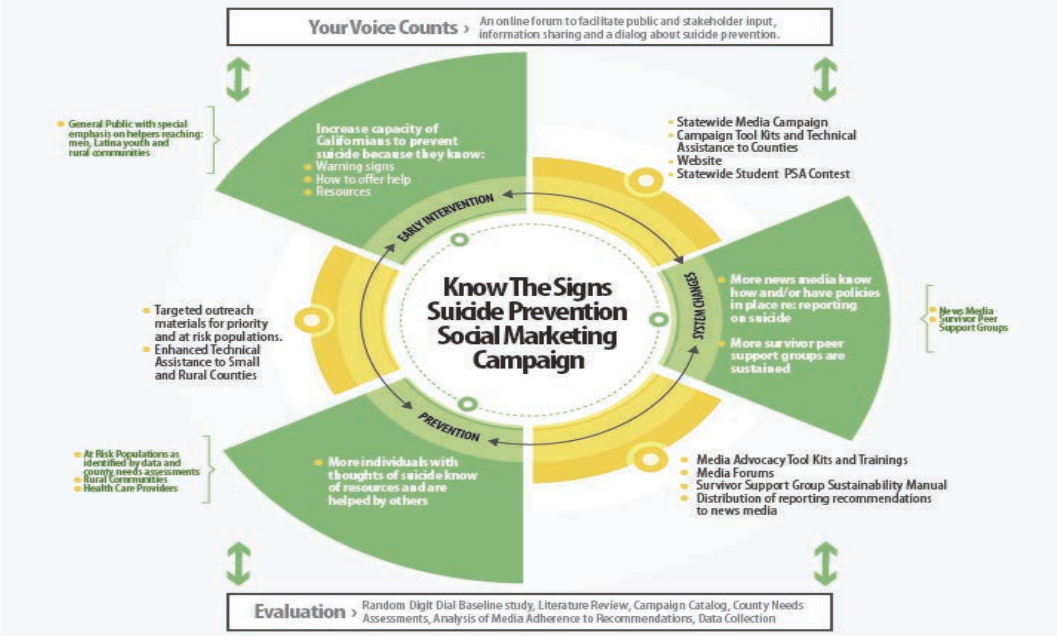
RAND's evaluation on social marketing focuses on AdEase's contract, the Know the Signs social marketing campaign. This statewide mass media campaign prepares more Californians to prevent suicide by encouraging them to know the warnings signs, offer support to persons at risk, and reach out to local resources. Campaign materials are aimed at helpers (not those at risk) with an emphasis on helpers of higher-risk groups including middle-aged white men and young Latinas. In conjunction with the media campaign, AdEase is providing technical assistance tool kits to implement the campaign locally (with a specific emphasis on rural counties). This assistance includes one-on-one support, webinars, and a variety of tool kits such as how to use social media for suicide prevention. A second goal of the campaign is to educate the news media and others about how to more safely report suicide, and safe and effective messaging for suicide, which is in part achieved through a media outreach tool kit; media forums; and safe messaging trainings as part of the Directing Change video contest, a statewide high school student video contest. The third goal is to ensure that those at risk of suicide are aware of resources and helped by others through the Directing Change contest, the development of materials promoting local suicide prevention crisis lines, the development of a tool kit about how to sustain survivor support group organizations, and a safety planning mobile app. As of October 2013, the Directing Change video contest was ongoing and the safety planning mobile app was still in development. Here we discuss the status of select facets of AdEase's social marketing campaign. This overview is not meant to be comprehensive, but rather to highlight many of the social marketing capacities built.

Materials

Social Marketing Campaign Materials. AdEase has created television spots, radio spots, print ads, digital ads, billboards, suicide prevention posters, brochures and other outreach materials, a media outreach tool kit, a manual on how to use social media for suicide prevention, and the www.suicideispreventable.org website, which includes a local resource page for each county. To ensure counties benefit from the resources, all campaign materials can be used and customized by counties and the campaign team provides technical support to counties to implement the campaign materials locally to enhance the reach of the campaign throughout the state.

To inform the development of the marketing campaign, AdEase, in partnership with the Education Development Center and Your Social Marketer, Inc. completed a range of research activities that resulted in the campaign framework and messaging logic model (Figure 3.1).

Figure 3.1. AdEase Messaging Logic Model



AdEase conducted a literature review to identify unique considerations and recommendations for developing suicide prevention messaging campaigns. Based on this review, AdEase recommended that all campaign messaging adhere to the *Safe and Effective Messaging for Suicide Prevention.* AdEase also recommend that campaign developers "have resources and counseling services available to assist audience members involved in focus groups and testing who may be experiencing suicidal thoughts or other mental health issues" and consider how messages may affect vulnerable populations, not just the general population. Additional resources informed this campaign, including notes from meetings with 52 of the 58 counties to learn about existing activities and needed resources, a catalog of existing suicide prevention campaigns, and a Random Digit Dial (RDD) phone survey to measure knowledge, attitude, and beliefs with 2,003 respondents representative of the state and every county. The RDD study found that confidence in the ability to discuss suicide was positively correlated with knowledge about resources (e.g., crisis line) and of warning signs for suicide and that "those reporting knowledge of at least one warning sign were significantly more likely to agree that they felt confident that they could discuss suicide with someone they care about and less likely to agree that it was none of their business." Data from Nielsen Prizm segments were also used to determine media consumption for each target audience. From this information, the partners focused the social marketing campaign on "Know the Signs" and created the messaging logic model. From July 2012 to March 2013, AdEase conducted two rounds of focus groups with urban and rural residents (three in Spanish) to test the statewide campaign materials.

Your Voice Counts Web Forum

The *Your Voice Counts* forum facilitates information sharing among suicide prevention stakeholders across the state. The forum was used to get input on the development of the campaign, and now the "Resource Center" houses all campaign materials as a central place for counties and partners to download and access all campaign materials. It is maintained with ongoing post and site enhancements and as of December 2012 had 453 members representing 50 counties in California and 74 different resources. Through a partnership with Didi Hirsch, AdEase established regional suicide prevention network workgroups on the *Your Voice Counts* forum in addition to other workgroups to facilitate information sharing.

Directing Change Contest

The Directing Change video contest was launched in August 2012 as a collaborative activity between the three statewide initiatives: suicide prevention, stigma and discrimination reduction, and student mental health. It is a contest for high school students, asking them to create 60-second videos focused on either preventing suicide or eliminating mental health stigma. Winning teams were selected on a regional and statewide level and received cash prizes with a match to their school. To promote the contest, and in partnership with the California Department of Education, approximately 5,000 copies of promotional materials (including information about best practice school-based programs and information about how to have suicide prevention policies in place on campus) were mailed to every school district and every high school. The AdEase team also worked with over 300 after-school and community-based programs to promote the contest. Program Partners (e.g., Inspire USA, Entertainment Industries Council, Inc., National Alliance on Mental Illness, University of California, California Department of Education, California County Superintendents Educational Services Association, Transitions Mental Health Association [TMHA]) also helped to promote the contest by reaching out to high school students, teachers, and counselors around the state. The contest received 371 submissions, representing 922 students from 142 schools. Winners were announced in an awards ceremony in May 2013. Winning videos can be viewed on www.directingchange.org. Each of the 142 participating schools also received materials for a suicide prevention or mental health program on campus (e.g., Signs of Suicide® Prevention Program [SOS], Suicide Awareness Voices of Education [SAVE], National Alliance on Mental Illness's Ending the Silence).

www.suicideispreventable.org

AdEase issued a press release to promote the website, which was launched in September 2012 and has been working to optimize the site for mobile devices. AdEase has been discussing with LivingWorks opportunities to adapt the ASIST video on the website. AdEase is also compiling metrics tracking engagement on the site that will be released as a separate AdEase document.

Media Advocacy Tool Kit

The media advocacy tool kit ("Making Headlines: Guide to Working with the Media") contains campaign talking points, recommendations for reporting on suicide, a tip sheet for prepping people with personal stories about suicide for a media interview, and three topical template articles (in rural communities, among older adults, and lethal means restriction). It is available on the Your Voice Counts online forum and was also disseminated at a media forum held in Los Angeles. To inform the development of the media advocacy tool kit, AdEase conducted an analysis of media coverage of suicides during the last six months of 2011 to determine the extent to which the coverage consistently adhered to the Recommendations for Reporting on Suicide. This analysis revealed that newspaper and television coverage of suicide did not consistently adhere to these recommendations. Few media outlets provided helpful resources or interviewed suicide prevention or mental health professionals for reliable information. Specifically, the report revealed that "although sensational reporting was not the usual practice, it was determined that much more could be done to promote the concepts of preventability, inform the public about available resources and reduce graphic coverage." To disseminate the media advocacy tool kit, eight media forums were conducted with media representatives, county government agencies, and schools, and local organizations in Butte, Los Angeles, Sacramento, San Diego, and Stockton between September 2012 and April 2013.

Spanish Campaign Materials

Campaign materials were developed in Spanish in partnership with a bilingual communications consultant from Adinfinitum and reviewed by focus groups and a Spanish-language workgroup on Your Voice Counts. Spanish-language materials include a TV spot, a Spanish-language website, radio spot, billboard, digital ads, outreach materials such as posters and brochures, and a print ad; the campaign was posted to *Your Voice Counts* for dissemination. The campaign team is now also working on the development of a low literacy suicide prevention outreach tool in Spanish for distribution by health "promotores" throughout the state.

Dissemination

In addition to the dissemination efforts for each component of the social marketing campaign described above, AdEase also conducted outreach and technical assistance to counties and tracked website traffic, user engagement, and media impressions.

Outreach to Counties

All materials (television spots, radio spots, print ads, billboards, a media outreach tool kit, and suicide prevention posters and brochures) were delivered to California counties and partners via the *Your Voice Counts* forums and a series of presentations, webinars, and one-on-one technical assistance. Between January and March 2013, *Your Voice Counts* hosted 13 forums (7

public, 3 private, 3 closed), posted 13 announcements (5 contained new content), and housed 43 distinct resources (e.g., webinars).

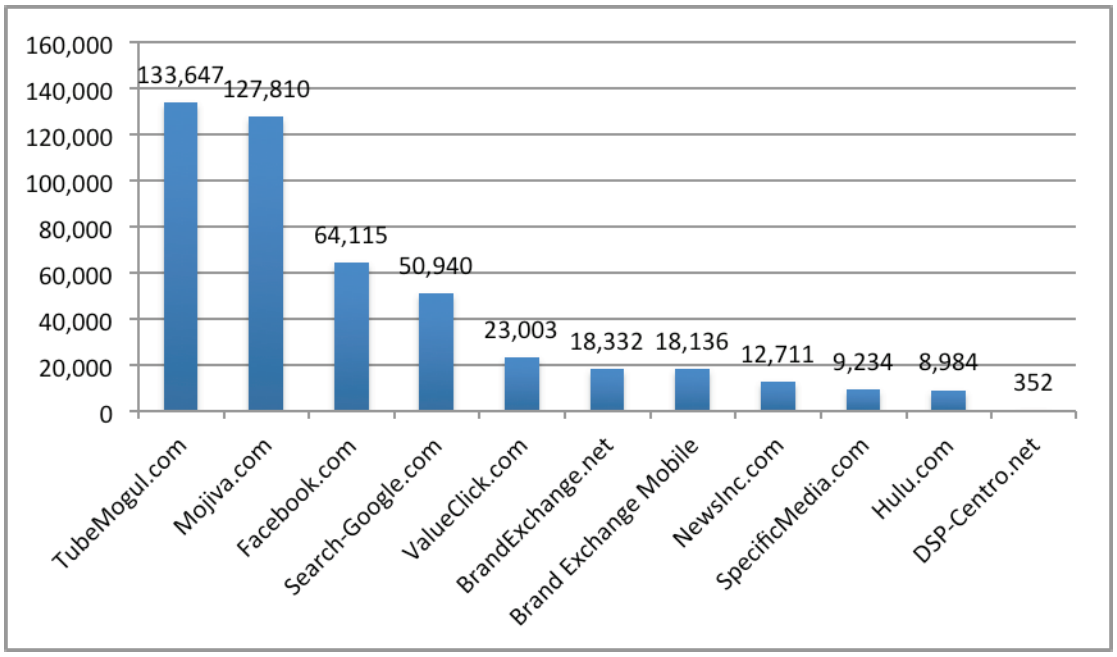
Campaign staff provided webinars, monthly campaign updates, and support to all 58 counties to implement the campaign locally. In addition, campaign staff were working closely with interested rural/small counties to assist them in promoting suicide prevention locally and implementing "mini marketing campaigns" in their counties. During the past year, the campaign staff shared with these counties eight webinars, covering topics such as creating task forces, finding and using local data, outreach to men, restricting access to lethal means, advocating with the media, and making better use of the Know the Signs campaign and the various stigma reduction programs funded by CalMHSA.

AdEase also made multiple presentations at numerous regional task force meetings, at the statewide coordinating meeting, the CalMHSA Statewide Evaluation Experts (SEE) Team meeting, meetings of the mental health board of directors, and meetings with child-serving organizations such as California County Superintendents Educational Services Association and United Advocates for Children and Families.

Website Traffic Metrics and User Engagement

The Know the Signs website (www.suicideispreventable.org) had 471,925 visits between November 2012 and February 2013. The visits came from the mobile website (25%), TubeMogul.com and Mojiva.com digital advertisements (55%), advertisements on the Facebook.com social networking website (14%), and an online Google search (11%) (see Figure 3.2).

Figure 3.2.
Click-Throughs to the Know the Signs Website



Most website visits (86.5%) were first-time visits, as measured by a unique IP address, and 13.5 percent were return visits. Users primarily stayed on the homepage (average of 1.20–1.23 pages per visit), and the average visit duration ranged between 29 and 38 seconds (see Table 3.7). Around 85 percent of visitors viewed only the homepage before leaving the site. Within California, visitors were dispersed, though mostly focused within the San Francisco and Los Angeles metropolitan areas, as shown in Table 3.8.

Table 3.7
Know the Signs Website –- Traffic Metrics (November 2012–February 2013)

Website	Visits	First-Time Visits (Unique IP Address)	Pages / Visit	Avg. Visit Duration	Bounce Rate[a]
English Desktop	290,547	254,428	1.21	0:00:29	86.34%
English Mobile	107,921	88,977	1.20	0:00:30	86.27%
Spanish Desktop	51,618	45,988	1.23	0:00:34	85.84%
Spanish Mobile	21,839	18,963	1.23	0:00:38	84.56%

[a]Bounce rate is the percentage of visitors who enter the site and "bounce" (leave the site) rather than continue viewing other pages within the site.

Table 3.8
Rank Order of California Traffic to Know the Signs Website by Metro Area

Metro	First-Time Visits
Los Angeles	162,233
San Francisco	75,997
Sacramento-Stockton-Modesto	35,707
San Diego	29,643
Fresno	24,481
Bakersfield	5,055
Santa Barbara	4,521
Monterey-Salinas	3,913
Chico-Redding	3,083

Other Media

The Know the Signs social marketing campaign was also disseminated through television advertisements on both public and cable stations, billboards, magazine advertisements (e.g., Newsweek, Sports Illustrated), and advertisements using digital media (see Table 3.9).

Table 3.9
Media Impressions[a]

Metro	Television Impressions	Billboard Impressions	Magazine Impressions	Digital Media Impressions
Los Angeles	21,010,875	132,467,400	5,101,001	191,023,969
San Francisco	7,100,000	42,625,856	4,127,373	78,135,746
Sacramento-Stockton-Modesto	2,231,820	42,735,056	1,028,550	45,899,502
San Diego	2,085,000	24,207,456	1,264,577	33,641,729
Fresno	2,132,500	13,306,472	190,490	21,112,422
Bakersfield	954,200	0	190,488	8,392,514
Santa Barbara	0	0	380,976	8,739,132
Monterey-Salinas	467,572	0	19,488	9,461,713
Chico-Redding	209,739	0	95,244	5,842,027
Palm Springs	312,000	0	95,244	5,580,985
Eureka	252,116	0	4,762	1,906,723
Yuma	270,420	0	11,429	4,375,541
Other	103,246	0	3,678	1,281,790

[a] *Impressions* represent the total number of people that may have been exposed to the campaign. The numbers are based on average television viewership, traffic in areas where billboards were placed, magazine subscriptions, and website traffic on the websites where digital media advertisements were placed.

Next Steps in Evaluating AdEase Social Marketing Efforts

RAND is planning to review the social marketing materials created by AdEase and conduct an independent analysis of selected products in addition to experiments to evaluate the efficacy of selected materials. We also plan to evaluate changes in media messages about suicide that may be attributed to the creation and dissemination of the Media Advocacy tool kit. Using both survey and audience metrics compiled by AdEase, we will measure the reach and frequency of message exposure and whether Californians exposed to the messages have improved knowledge about suicide and confidence in their ability to intervene with a person in suicidal crisis. Finally, we will evaluate the sustainability of social marketing interventions. AdEase also conducted its own baseline media analysis. Findings from this analysis are available in a summary report prepared by AdEase (available online at http://calmhsa.org/wp-content/uploads/2011/11/Media-Analysis-Final-Approved-09-2012.pdf) and will be used to inform our final evaluation report.

Hotline and Warmline Operations of Suicide Prevention Programs

In this section we highlight the activities of crisis services funded through the SP initiative. We summarize the crisis services that were developed and those that were accredited and present data on the volume of calls or chats received by each agency based on the information available through CalMHSA quarterly reports. It is important to note that many of the Program Partners,

as part of their contracts, are also conducting community outreach and education that may focus on suicide awareness generally as well as the skills necessary to identify people at risk and how to intervene with them. We conclude with a discussion of our live monitoring of crisis centers.

Hotlines, Chat, and Text Services Created or Expanded

In the project period, CalMHSA-funded activities have led to the following new or expanded crisis response services:

1. New Central Valley Suicide Prevention Hotline (operated by Kings View)
2. New North Bay Suicide Prevention Hotline (coordinated and operated by FSA Marin)
3. New warmline services for both Northern and Southern Santa Barbara Counties (operated by TMHA and by the Mental Wellness Center of Santa Barbara via the TMHA Contract)
4. LA Warmline expansion of hours (operated by Didi Hirsch)
5. New chat and chat/text counseling (operated by Wellspace Health, formerly The Effort; San Francisco Suicide Prevention; and Optum Health for Didi Hirsch)

As part of their contracts, different agencies either created or purchased electronic call management software. Institute of Aging created an in-house electronic management system for tracking all inbound and outbound calls that has been used since April 2012. Family Service Agency of Marin, Kings View, and TMHA use the iCarol helpline software platform.

Accreditation

While many crisis lines funded by CalMHSA were already accredited by the American Association for Suicidology (AAS) (i.e., Didi Hirsch, San Francisco Suicide Prevention, Contra Costa, San Mateo, Family Service Agency of Marin), other crisis lines planned to obtain accreditation during the contract period. For example, Santa Clara was accredited in November 2012 and AAS applications and review are under way for the Institute on Aging; TMHA's crisis services in San Luis Obispo and Kern Counties; Family Services Agency of the Central Coast; and Kings View, which operates the new Central Valley Suicide Prevention Hotline. In addition to AAS accreditation, Contra Costa was accredited for crisis chat by ContactUSA and San Francisco Suicide Prevention is planning to apply for ContactUSA accreditation. Finally, though many crisis lines were already part of the National Suicide Prevention Lifeline (NSPL), during the contract period San Francisco Suicide Prevention joined Lifeline's National Chat Network, and Kings View gained provisional membership status with full membership status awaiting accreditation.

Call Volume

We extracted call volume from the Q1–Q3 quarterly reports, when such information was readily available, and from Program Partners. Call volume totals per quarter are presented in

Table 3.10. This information shows how varied call centers are with respect to call volume, from centers that respond to around or slightly under 1,000 calls per quarter (Family Service Agency of Marin, TMHA's Hotline and Warmlines, Family Service Agency of the Central Coast, and Kings View) to larger centers like Didi Hirsch, Institute on Aging, and the consortium of four centers funded under the San Francisco Suicide Prevention umbrella that may have phone contacts in the magnitude of 10,000 per quarter. It is also noticeable that call volume increased at Family Service Agency of the Central Coast, Family Service Agency of Marin, Institute on Aging, TMHA's hotline, and San Francisco Suicide Prevention's crisis chat program.

Table 3.10
Estimated Call Volume for SP Program Partner Hotlines and Warmlines, 2012–2013

	2012–2013		
	Q1	**Q2**	**Q3**
Didi Hirsch[a]	9,035	8,504	7,148
FSACC	1,117	761	1,170
FSA Marin[b]	715	766	889
Institute on Aging	14,902 (6,233 call-ins & 8,669 call-outs)	16,486 (6,957 call-ins & 9,529 call-outs)	18,042 (7,901 call-ins & 10,141 call-outs)
Kings View[c]			921
SFSP – Hotline[d]	28,230	30,053	29,989
SFSP – Chat	643	782	1,015
TMHA – Hotline	683	861	1,116
TMHA – North and South Santa Barbara County Warmline	44	78	169
Kern County – Hotline	5,512	5,028	5,669
WellSpace Health	N/A	6,555	6,863

[a]Includes crisis line calls from six counties; LA Warmline not included.
[b]Includes calls made to the regional line and Lifeline for the expanded counties; does not include all calls to FSA Marin's existing Hotline and Grief Counseling numbers.
[c]Operation of the Central Valley Suicide Prevention Hotline commenced in January 2013.
[d]Call volume presented in aggregate for all four agencies funded under the SFSP contract; call volume for each agency is not available in quarterly reports for Q1 and Q2 of 2012.
Note: FSA Marin = Family Service Agency of Marin. FSACC = Family Service Agency of the Central Coast. SFSP = San Francisco Suicide Prevention. TMHA = Transitions Mental Health Association.

Next Steps for the RAND Evaluation

The RAND study team conducted a comprehensive literature review to identify how crisis hotlines have been evaluated in the past. Our review revealed 17 such research studies from as early as 1969 (these studies are presented in Appendix C). The most recent, rigorous, and informative of these evaluation designs were studies in which independent, trained observers rated call content. The RAND evaluation strategic plan includes a replication of this evaluation design with all CalMHSA Program Partners contracted to initiate, expand, or enhance their crisis call services.

RAND study staff held in-person meetings with researchers and other stakeholders who have previously conducted or been involved in live monitoring for "lessons learned" from previous evaluations, as well as suggestions for contributing to the field more broadly. Using these "lessons," we drafted a call monitoring protocol for Program Partner review. Two RAND staff then used the draft protocol to rate a sample of calls made to a call center outside of California that records calls. This experience resulted in further modifications to the draft protocol.

In June, we shared with each of the seven crisis centers our draft call monitoring assessment protocol, as well as our rationale for including each section and a sample description of how we would use the information in our evaluation. We scheduled conference calls with each of these centers to obtain their feedback and suggestions for the draft protocol and to learn how we might best conduct live monitoring with minimal disruption to the operating procedures of each call center. As of this writing, we had conducted three such calls (TMHA, Institute on Aging, Didi Hirsch) and had three additional calls scheduled and one remaining to schedule. We will conduct a second round of calls to outreach to subcontractors. We will also submit this protocol to the RAND Institutional Review Board, develop a sampling plan, recruit and train observers, and further tailor the protocol to the operations of the crisis call centers. Fieldwork is expected to get under way in early 2014.

Suicide Rates Across California

In this section, we present the results from our analysis of suicide fatalities in California. We performed age-adjustment and estimated the variability associated with each county and region's suicide rate to establish a baseline from which we could compare counties' and regions' suicide rates to each other, as well as to measure changes in each area's suicide rates over time.

Data

All data are for calendar years 2008 – 2010 and were extracted from California Department of Public Health's online injury database, EpiCenter (http://epicenter.cdph.ca.gov/). We collected suicide counts using the Overall Injury Surveillance tool, which includes fatality data based on registered death certificates. Specifically, we selected all cases resulting in death (outcome) from

a self-inflicted injury (cause). We generated data across five-year age groups, county of residence (note this is not necessarily the county in which the death occurred), sex, and year.

We also used EpiCenter's Population Data tool to collect the corresponding population values. These data are derived from data sets reported by the California Department of Finance's Demographic Research Unit and incorporate adjustments based on the 2010 U.S. Census. We were able to extract population data that mirrored the categorization of the suicide count data.

CalMHSA and the California Mental Health Director's Association organize counties into designated mental health regions, shown in Table 3.11. We conducted all analyses at both the county and regional levels. Note that because Los Angeles is the only county in the Los Angeles Region, the sample calculations at the county and regional levels for Los Angeles were equivalent.

Table 3.11
California Mental Health Regions

Region	Counties
Bay Area	Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma
Central	Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo, Yuba
Los Angeles	Los Angeles
Southern	Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Ventura
Superior	Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity

Methods

Crude Rates. Given our desire to compare suicide rates across counties, and the relative infrequency of suicide occurrences, especially in small counties, we chose to aggregate the data across sex, age, and year to provide a single suicide rate per county. We calculated this crude rate (provided in Table 3.12) by simply dividing the three-year count by the three-year population for each county and multiplying by 100,000 to arrive at a rate per 100,000 people.

Age-Adjusted Rates. To ensure that any observed differences in suicide rates across counties were not simply the reflection of differences in age distributions of county populations we calculated the age-adjusted suicide rates for each county using the direct age-adjustment technique. To do this, we re-categorized the suicide counts and population totals into four age groups (0–24, 25–49, 50–74, 75+) and recalculated crude rates for each age group and county (our calculations for Los Angeles County are provided as an example in Table 3.12). We summed the population values over all of the counties to determine the three-year California population for each age group. Next, we multiplied these crude rates by the California population (divided by 100,000) to estimate the expected number of suicides in each county/region for each

age group, if the county/regional population were to match the state population. By summing these expected values and dividing by the sum of the populations (and again multiplying by 100,000), as shown in Table 3.12, we derive an age-adjusted rate (per 100,000) for each county/region. These values, listed in Table 3.12, allow us to compare suicide rates as though each county had the same age distribution, mirroring that of California.

Table 3.12
Example Age-Adjustment Calculations of Suicide Rates for Los Angeles

Age Groups	LA Suicides (2008–2010)	LA Population (2008–2010)	Crude Rate per 100,000	California Population	Expected No. of Suicides
0–24	263	10,451,010	2.52	**39,725,392**	999.69
25–49	1,013	10,937,624	9.26	**39,793,061**	3,685.48
50–74	873	6,563,679	13.30	**25,892,289**	3,443.80
75+	209	1,476,785	14.15	**5,840,015**	826.50
Total	2,358	29,429,098	8.01	**111,250,757**	8,955.46

$$\text{Age-Adjusted Rate} = \frac{8955.46 \times 100{,}000}{111{,}250{,}757} = 8.05$$

Standard Deviations. We calculated the standard deviation for each of these age-adjusted rates. This allowed us to quantify the uncertainty surrounding the calculated rates and determine a range within which we could expect the rate to fall. This is useful for making both geographic comparisons as well as comparisons over time. For example, if the age-adjusted suicide rate in 2011 was above or below the range (the age-adjusted rate +/- the standard deviation), then we would have evidence of a statistically significant increase or decrease in a county or region's suicide rate. An example calculation is provided in Table 3.13, and the resulting values for other counties are given in Table 3.14. As expected, the counties with the smallest populations tend to have the largest standard deviations.

Table 3.13
Example Standard Deviation Calculations for Suicide Rates in Los Angeles

L.A. population (2008–2010)	29,429,098
Age-adjusted rate per 100,000	8.05
Standard deviation	0.17 per 100,000
Range	(7.88, 8.22)

$$\text{Standard Deviation} = \sqrt{\frac{\text{rate} \times (1 - \text{rate})}{\text{population}}}$$

$$= \sqrt{\frac{\frac{8.05}{100{,}000} \times \left(1 - \frac{8.05}{100{,}000}\right)}{29{,}429{,}098}} = \sqrt{2.735 \times 10^{-12}} = 1.654 \times 10^{-6}$$

$$= 0.17 \; per \; 100{,}000$$

Mapping. To better visualize California's suicide rates, we used ArcGIS mapping software to generate a map of California counties/regions color-coded by suicide rate. We used the County shapefile provided by California's Surface Water Ambient Monitoring Program.[4] The counties were grouped and color-coded in suicide rate increments of five deaths per 100,000 people (Figure 3.3); the corresponding regional map is provided in Figure 3.4, although here we used a smaller increment (2.5 deaths per 100,000) to form the scale. Rates based on very low suicide counts (i.e., in counties with small populations) were not reliable, since a small change in the number of deaths can have a seemingly drastic change in the rate, making meaningful change difficult to discern over time. Therefore we used stripes to indicate that a county had a suicide count of fewer than 20 over the three-year range. In this way we can still visualize a rate for the county but know to be cautious when making comparisons.

Results

By County. The crude and age-adjusted rates are listed alphabetically in Table 3.14. Excluding rates that are based on fewer than 20 suicides and are thus unstable, age-adjusted rates ranged from a low of 5.37 in Imperial County to a high of 28.53 in Lake County. Figure 3.3 presents these estimates geographically (the numbers for each county are the same as those presented in the table). The counties with the most populated cities (Los Angeles, San Francisco) have the lowest suicide rates in the state; the highest rates (red) are in the least populated counties. These rely on fewer than 20 suicides and are thus unstable (indicated by the diagonal lines), but counties in the north (Humboldt, Mendocino, Siskiyou) have high and stable suicide rates, as do some north-central counties (Butte, Amador).

[4] Shapefile available at http://swamp.mpsl.mlml.calstate.edu/resources-and-downloads/database-management-systems/swamp-25-database/templates-25/gis-shapefile-layers

Table 3.14
California Suicide Data by County (2008–2010)

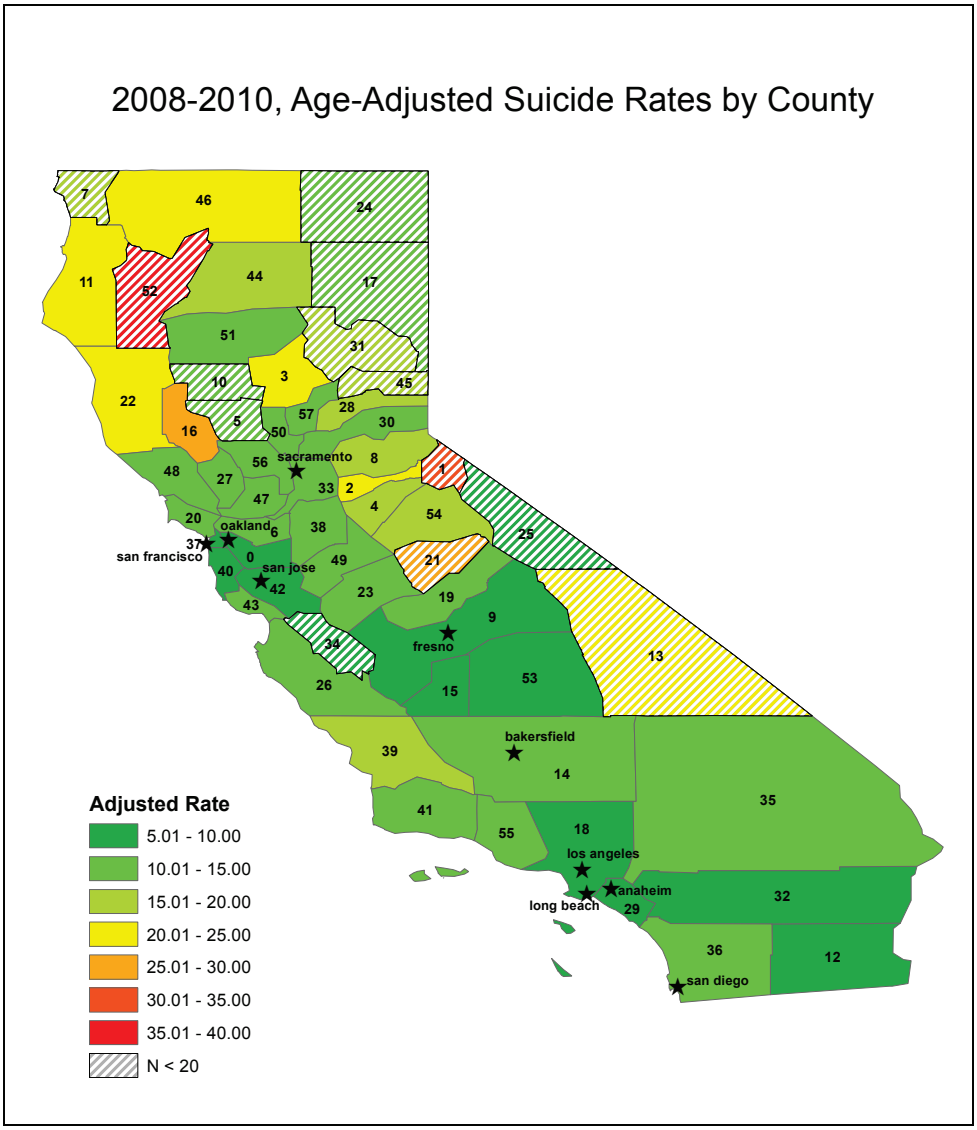
ID #	County	Total Suicides (2008–2010)	Total Population (2008–2010)	Crude Rate per 100,000	Age-Adjusted Rate per 100,000	Standard Deviation
0	Alameda	417	4,509,078	9.25	9.04	0.45
1	Alpine	1	3,524	28.38[a]	32.21[a]	30.23
2	Amador	30	113,659	26.39	22.87	4.49
3	Butte	132	657,778	20.07	20.20	1.75
4	Calaveras	27	136,502	19.78	17.71	3.60
5	Colusa	8	63,873	12.52[a]	13.06[a]	4.52
6	Contra Costa	354	3,128,969	11.31	11.01	0.59
7	Del Norte	17	85,689	19.84[a]	19.28[a]	4.74
8	El Dorado	94	539,462	17.42	16.17	1.73
9	Fresno	195	2,770,192	7.04	7.53	0.52
10	Glenn	9	84,346	10.67[a]	10.84[a]	3.58
11	Humboldt	103	401,527	25.65	24.52	2.47
12	Imperial	26	518,922	5.01	5.37	1.02
13	Inyo	12	55,444	21.64[a]	20.67[a]	6.10
14	Kern	247	2,492,752	9.91	10.76	0.66
15	Kings	32	456,621	7.01	7.31	1.27
16	Lake	58	193,206	30.02	28.53	3.84
17	Lassen	13	104,607	12.43[a]	11.70[a]	3.34
18	Los Angeles	2,358	29,429,098	8.01	8.05	0.17
19	Madera	45	450,407	9.99	10.36	1.52
20	Marin	116	754,267	15.38	13.58	1.34
21	Mariposa	18	54,768	32.87[a]	29.26[a]	7.31
22	Mendocino	70	263,270	26.59	24.78	3.07
23	Merced	73	762,420	9.57	10.71	1.19
24	Modoc	5	28,910	17.30[a]	13.48[a]	6.83
25	Mono	3	42,244	7.10[a]	6.36[a]	3.88

ID #	County	Total Suicides (2008–2010)	Total Population (2008–2010)	Crude Rate per 100,000	Age-Adjusted Rate per 100,000	Standard Deviation
26	Monterey	122	1,240,272	9.84	10.07	0.90
27	Napa	47	407,110	11.54	10.83	1.63
28	Nevada	49	295,578	16.58	15.61	2.30
29	Orange	809	8,998,669	8.99	8.92	0.31
30	Placer	156	1,032,587	15.11	14.19	1.17
31	Plumas	12	60,401	19.87[a]	17.14[a]	5.33
32	Riverside	611	6,473,097	9.44	9.74	0.39
33	Sacramento	534	4,232,765	12.62	12.63	0.55
34	San Benito	12	165,474	7.25[a]	8.10[a]	2.21
35	San Bernardino	649	6,077,592	10.68	11.39	0.43
36	San Diego	1,072	9,233,456	11.61	11.60	0.35
37	San Francisco	269	2,407,628	11.17	9.93	0.64
38	San Joaquin	196	2,042,401	9.60	10.04	0.70
39	San Luis Obispo	132	804,797	16.40	15.35	1.38
40	San Mateo	203	2,147,197	9.45	8.85	0.64
41	Santa Barbara	138	1,266,656	10.89	11.23	0.94
42	Santa Clara	450	5,321,958	8.46	8.32	0.40
43	Santa Cruz	105	784,937	13.38	13.12	1.29
44	Shasta	111	530,968	20.91	19.73	1.93
45	Sierra	1	9,752	10.25[a]	16.35[a]	12.95
46	Siskiyou	28	134,925	20.75	20.30	3.88
47	Solano	139	1,238,862	11.22	11.12	0.95
48	Sonoma	215	1,441,486	14.92	13.97	0.98
49	Stanislaus	164	1,537,737	10.67	11.09	0.85
50	Sutter	41	282,618	14.51	14.62	2.27
51	Tehama	30	189,457	15.83	14.75	2.79
52	Trinity	14	41,370	33.84[a]	35.24[a]	9.23

ID #	County	Total Suicides (2008–2010)	Total Population (2008–2010)	Crude Rate per 100,000	Age-Adjusted Rate per 100,000	Standard Deviation
53	Tulare	116	1,313,493	8.83	9.64	0.86
54	Tuolumne	35	166,258	21.05	19.45	3.42
55	Ventura	268	2,455,930	10.91	10.86	0.66
56	Yolo	62	598,257	10.36	11.30	1.37
57	Yuba	30	215,534	13.92	14.42	2.59

[a] Fewer than 20 suicides in the county indicate that the rate estimate is unstable.

Figure 3.3. Map of California Suicide Rates by County (2008–2010)

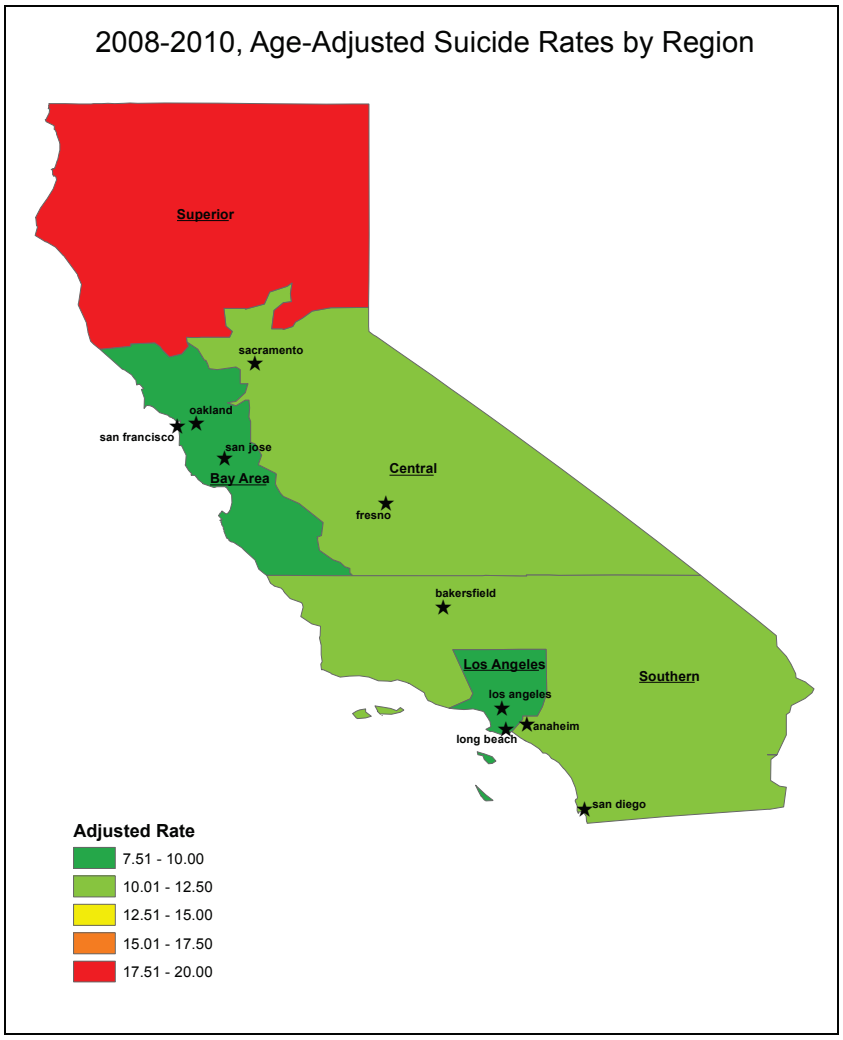


By Region. The trends we observed by county are even more pronounced in the regional analysis, presented in Table 3.15 and Figure 3.4. The age-adjusted suicide rate in the Superior region is 20 per 100,000, which is almost double the next highest suicide rate of 11.4 per 100,000 in the Central Region. However, the Superior Region is also California's least populated region, and the rate is based on 660 suicides over the three-year period. On the other hand, Los Angeles had the lowest rate of 8.05 suicides per 100,000, though in this more populated region this estimate is based on 2,358 suicides over three years. The greatest number of suicides was in the Southern region, where, over three years, 3,952 Californians died by suicide.

Table 3.15
California Suicide Data by Region (2008–2010)

Region	Total Suicides (2008–2010)	Total Population (2008–2010)	Crude Rate per 100,000	Age-Adjusted Rate per 100,000	Standard Deviation
Bay Area	2,449	23,547,238	10.40	10.00	0.21
Central	1,864	16,806,893	11.09	11.40	0.26
Los Angeles	2,358	29,429,098	8.01	8.05	0.17
Southern	3,952	38,321,871	10.31	10.50	0.17
Superior	660	3,145,657	20.98	19.98	0.80

Figure 3.4. Map of California Suicide Rates by Region (2008–2010)



Implications

Review of suicide prevention efforts across California must be considered in light of where in the state these efforts exist relative to where residents are dying by suicide. As described, the story is complicated. The suicide rate is highest in California's least densely populated areas; thus, reducing the *per-individual* risk of suicide is important in these areas. However, suicides in this region account for only 6 percent of California's suicides; thus, it is critical that suicide prevention programs be focused in the more densely populated regions to ultimately reduce the burden that suicide poses to the state.

Summary

The SP initiative evaluation focuses on core Program Partner activities including training, social marketing, networking and collaboration, and hotline and warmline services.

Evaluations of training focus on LivingWorks' SafeTalk and ASIST trainings that are ongoing. Data on the demographics of these training participants are available, and post-training surveys indicate high satisfaction with the trainings and increases in perceptions of self-efficacy and intentions to help people at risk. Monitoring of fidelity to the ASIST training protocol is in progress.

The evaluation of SP social marketing activities is also in progress. One Program Partner, AdEase, is conducting a social marketing campaign. The evaluation of campaign messages and their efficacy, as well as campaign reach, will be assessed at a later point.

Networking and collaboration evaluation is focusing on the efforts of Program Partner Didi Hirsch, which is facilitating the CSPN. Reviews of related documents are in progress. Key informant interviews and a collaboration survey will be conducted later.

Much of the SP Program Partner activities relate to increasing capacity and quality of hotline and warmline operations. New crisis hotlines have been created; warmline and chat services have been added, and outreach to expand services to underserved populations is under way by several Program Partners. In addition, several existing hotlines are seeking accreditation or have been accredited since the beginning of the contract period and several have increased their capacity for electronic call management and statistical reporting on call volume. To understand the reach of hotline and warmline operations, we are tracking call volume. We have developed a protocol for systematically monitoring hotline call quality that we will be implementing shortly. This evaluation component will make a significant contribution to the field of research on suicide prevention services; provide CalMHSA with an independent, rigorous assessment of suicide prevention services provided by the crisis centers; and provide useful information to individual call centers for their own use in training, quality assurance, and reporting to consumers, funders, and other stakeholders.

In addition to evaluating the key Program Partner activities, we have analyzed suicide fatalities in California to establish baselines against which later suicide rates may be compared. Two major findings emerged from this analysis. First, the suicide rate is highest in California's least densely populated areas, indicating that an individual's risk is highest in these areas. Second, suicides in these areas account for a very small proportion of California's overall number of suicides, indicating that resources must still be allocated to high density areas of the state.

In sum, SP Program Partners have engaged in a wide variety of efforts to enhance services and expand capacity, including creating the CSPN, conducting trainings, initiating social marketing campaigns, and increasing hotline and warmline capacity and quality. Many of the evaluation activities are currently in progress. The RAND SP evaluation team also conducted an analysis of California suicide rates, providing a useful baseline for comparing future suicide fatality data.

4. Student Mental Health

In this chapter, we review findings to date in regard to the SMH Program Partners. These partners include the California County Superintendents Educational Services Association, the California Department of Education, the University of California, the California State University, and the California Community Colleges. These Program Partners have been developing and implementing a range of activities designed to prevent and intervene early with student mental health issues, focused primarily on K–12 schools and higher education campuses across California. These activities include conducting a broad range of trainings, developing materials for online website use, and establishing collaborations within and across educational institutions and/or other institutions in a community to address student mental health issues.

Our evaluation aims to assess the (1) nature and influence of Program Partner networking and collaborative activities, (2) content and use of the Program Partner websites, (3) reach and effectiveness of Program Partner training activities in modifying trainee knowledge and attitudes, and (4) campus-wide surveys, described in greater detail below (see Table 4.1).

Table 4.1 provides an overview of the status of SMH Program Partner activities in a variety of different categories, summarizing the information contained in this report, and information that will be forthcoming.

Evaluation Methods

To evaluate the influence of networking and collaboration activities, RAND will also be conducting (1) a quantitative analysis of community and Program Partner data to track whether collaborative activities are associated with increases in referral and utilization rates, (2) semi-structured interviews with key informants from networks and collaborations, and (3) a survey of participants in the networks and collaborations to assess the influence of these relationships. At this point in the evaluation, the team has identified five strategically planned networks and collaborations within the SMH Initiative to focus our efforts, and we have described these networks in this report. We are also compiling and reviewing documents and materials developed from Program Partners' collaborative activities, including standard policy protocols, policy recommendations, and meeting rosters and agendas.

To evaluate informational and online resources, RAND will collect (1) descriptive information about website content, (2) analytics regarding website utilization, (3) a website user feedback form, (4) and a website user follow-up survey. We will focus on websites developed and supported by the CalMHSA SMH PEI–funded programs. At this point in the evaluation, we have collected data about the content of each website (including when it was launched and who

the target audience is) and website analytics (e.g., total visits, most viewed content) and present these preliminary data in the report.

To evaluate trainings, we have developed two measures (the Training Activities Worksheet and the Statewide Training Evaluation Survey) to help us understand the nature of the training content and approach, who the training reached, and the changes in student mental health that resulted from training activities. Both of these measures are currently in the field, and we report the available preliminary data from two Program Partners.

Finally, we have developed four surveys for K–12 and higher education students and staff and present these preliminary data in the report as well. These surveys assess school climate, mental health, and the availability and use of mental health services.

Table 4.1
Status of SMH Evaluation Activities

	Describe Capacities	Monitor Reach to Target Audiences	Evaluate Short-term Outcomes
Networks and Collaborations			
Program Partners: California County Superintendents Educational Services Association; California Department of Education; University of California; California State University; California Community Colleges	**This Report:** Summary of the strategically planned networks and collaborations that we identified for all five SMH PPs. **Future:** Summary of the number and nature of collaboratively developed materials, resources, and practices.	**Future:** Data on the level of collaboration, and where applicable, the degree to which the materials, resources, and policies generated by the collaborative partnerships standardized practices across campuses or districts.	**Future:** Quantitative analysis of data from community health/mental health departments and SMH Program Partners where those data are available, in order to track whether collaborative activities are associated with increases in referral and utilization rates. Analysis of the level of availability/ accessibility, use, and quality of collaboratively developed materials, resources, and practices.
Informational/Online Resources			
Program Partners: California County Superintendents Educational Services Association; California Department of Education; University of California; California State University; California Community Colleges	**This Report:** Summary of content and target audience of websites developed by SMH PPs, including the number and nature of materials made available. **Future:** Summary of content of websites that are not yet launched.	**This Report:** Web analytic data and website feedback survey data provided for California County Superintendents Educational Services Association only. **Future:** Additional web analytic data will be provided for all PP websites.	**Future:** Follow-back survey data on the helpfulness of the informational/online resources, from a survey assessing user perceptions of utility, quality, and impact of online materials.
Training and Educational Programs			
Program Partners: California County Superintendents Educational Services Association; California Department of Education; University of California; California State University; California Community Colleges	**This Report:** Summary of topics covered by training programs. **Future**: Detailed content analysis of select trainings.	**This Report:** Data on number of trainings conducted by all SMH PPs. **Future:** Data on the audiences who were exposed to trainings.	**This Report:** Data from the training evaluation surveys were analyzed to assess immediate post-training changes in knowledge, attitudes, and behavior among training participants. **Future:** Additional data on post-training changes in knowledge, attitudes, and behavior.

–This chapter summarizes information about available website content and preliminary information about the utilization of the California County Superintendents Educational Services Association website, as well as preliminary information regarding the reach of trainings. The chapter also provides information from students, staff, and faculty on a select number of higher education campuses that completed the campus-wide survey during Spring 2013. Later phases of the evaluation will assess the effectiveness of Program Partner training activities in shifting trainee knowledge and attitudes, as well as additional information regarding website utilization and collaborative activities. We will also be conducting surveys on higher education campuses and K–12 schools to obtain a better understanding of the campus environment with respect to supporting students with mental health issues.

The Program Partner websites that have already launched contain a substantial amount of information and resources for individuals seeking information about student mental health. Users of California County Superintendents Educational Services Association's website (the only website for which such information was available at the time of this writing) are primarily school administrators and mental health professionals who work with students across the K–12 age spectrum. The sections of the California County Superintendents Educational Services Association website that have received the most traffic include anger management, mental health wellness, and bullying.

All Program Partners have begun training activities. California Department of Education has sponsored three TETRIS (Training Educators Through Recognition and Identification Strategies) train-the trainer trainings, and each California Department of Education participant is committed to conducting three local trainings in his/her school or district following participation in a train-the-trainer event by April 30, 2014. California County Superintendents Educational Services Association has sponsored 168 trainings across a range of topics and venues. California Community Colleges has conducted approximately 425 presentations and trainings that reached approximately 16,000 faculty, staff, and student participants between September 2012 and April 2013. California State University has conducted 200 trainings, presentations, and outreach events between September 2012 and March 2013. University of California has conducted approximately 1,100 trainings and informational events for faculty, staff, graduate teachers, research assistants, and students between October 2012 and March 2013.

The higher education campus-wide student surveys, described in greater detail below, involved 6,309 participating students on select campuses during Spring 2013. Key findings from the preliminary data, based on validated screeners, indicate that 20 percent of students completing the survey met or exceeded the cutoff for probable mental health problems during the 30 days prior to completing the survey. Twenty-five percent of students completing the survey reported they had been referred by or sought mental health services or counseling from their current college/university campus's counseling or Health Service Center, and 75 percent of students who reported receiving services said they received them on campus. The majority of

students also reported having received information from their campuses on mental health and substance use.

In sum, SMH Program Partners have been developing capacities and conducting trainings and programs to enhance the capacity of faculty, teachers, and staff to meet the mental health needs of students, and to increase higher education students' knowledge and awareness of mental health issues. Although preliminary evidence of the reach of these trainings and websites is available, many aspects of the evaluation were still being developed and implemented at the time of this report, and thus were not available for evaluation. Additional information about the reach and impact of this broader range of activities will be available toward the end of year three of the contract period.

Networking and Collaboration

We provide a brief summary of the key collaborative activities that we will be evaluating and a brief description of our plans to evaluate them through document reviews, interviews, and a survey.

Program Partners' Collaboration Entities and Activities

We have identified five strategically planned networks and collaborations within the SMH Initiative on which to focus evaluation efforts with respect to SMH Program Partner networking and collaboration activities.

1. The California County Superintendents Educational Services Association county consortia, which consist of representatives from organizations including county mental health, probation, school districts, foster care, and youth agencies, who work together locally and regionally to build cross-system collaboration, education and training, technical assistance to schools, and school-based demonstration projects
2. The State SMH Policy Workgroup convened by the California Department of Education, which includes members representing multiple sectors and consumers of the mental health community (such as Department of Mental Health, California Department of Education, Mental Health Directors Association, Special Education Local Plan Areas [SELPAs], community-based organizations, consumer and advocacy groups, and researchers), who work together to develop a framework for student mental health, identify best practices, and recommend policies at the state, regional, and district levels
3. University of California and California State University SMH Initiative advisory workgroups, which consist of the directors of counseling services from selected campuses CalMHSA campus coordinators, campus administrators, and other stakeholders, who work together to provide oversight and guidance on management of system-wide activities
4. California Community Colleges Regional Strategizing Forums, events hosted by California Community Colleges Campus-Based Grantees, to foster dialogue with local collaborators (e.g., county mental health, community agencies, advocacy organizations, other higher education campuses) about best practices related to student mental health resources and services

5. Various California Community Colleges, California State University, and University of California SMH inter- and intra-campus collaboration activities, such as collaborative conferences, education and training events, and online resource clearinghouses

Next Steps for Evaluating Networking and Collaboration

We are currently compiling and reviewing documents and materials developed from Program Partners' collaborative activities, including standard policy protocols, policy recommendations, and meeting rosters and agendas.

In addition to the analysis described in the SP section above, in order to track whether collaborative activities are associated with increases in referral and utilization rates, we will conduct a quantitative analysis of data from community health and mental health departments and SMH Program Partners where those data are available (e.g., University of California Counseling and Psychological Services [CAPs], California State University counseling centers). We will also conduct semi-structured interviews with five to ten key informants for each of the five networks and collaborations listed above, and conduct a survey of participants in the networks and collaborations.

Informational/Online Resources

Under the CalMHSA SMH Initiative, funded Program Partners have made a range of resources available online (Table 4.2). These materials include information for students on mental health issues as well as information for faculty and staff regarding approaches to supporting students with mental health needs.

We aim to evaluate whether the online informational resources being developed by the CalMHSA SMH Initiative–funded programs improve student mental health. To accomplish this aim, we are collecting data using many strategies: descriptive information about website content, website analytics, a website user feedback form, and a website user follow-up survey. Below we list a brief description of the measures and methods used to collect data. In addition, we outline the structure, process, and outcomes gathered from the online resources evaluation.

Table 4.2
Online Informational Resources Developed by SMH Initiative–Funded Programs

SMH Program Partner	Online Resource Description	Status
CCSESA	Online clearinghouse of best, promising, and community-defined practices (with a focus on grades K–8)	Website live; tracking traffic metrics since September 2012
CDE/PCOE	(1) Web-based clearinghouse of information for educators (with a focus on grades 9–12)	Clearinghouse under development
	(2) Web-based repository for trainer materials, resources, videos, and links.	Web-based repository live; tracking traffic metrics began April, 2013
CCC	Online dissemination of resources, materials, and policies relevant for the CCC system and community	Website live
CSU	Web-based repository of information for faculty, staff, and students across institutions of higher education (i.e., CCC, CSU, UC)	Under development
UC	Online clearinghouse with information for mental health stakeholders consisting of resources, and best and promising practices	Under development

Note: CCSESA = California County Superintendents Educational Services Association. CCC = California Community Colleges. CDE = California Department of Education. CSU = California State University. PCOE = Placer County Office of Education. UC = University of California.

Website content. To evaluate website content, we have been (or will be when websites are launched) reviewing the materials made available on websites developed and supported by the CalMHSA SMH PEI–funded programs (California County Superintendents Educational Services Association, California Department of Education, California Community Colleges, California State University, and University of California). This review will assess the general content of the information provided, the breadth of student mental health issues addressed (e.g., Do materials address the needs of the general student population as well as the needs of specific populations, such as LGBTQ [lesbian, gay, bisexual, transgender, queer or questioning students], student veterans, or students with mental health problems?), and the extent to which available materials address universal prevention and/or targeted prevention and early intervention issues.

Website analytics. We are working with each Program Partner to evaluate its website utilization using website analytics, such as Google Analytics. Google Analytics are described in greater detail in Appendix F.

Website user feedback form and follow-back survey. To gather basic information about the characteristics of people visiting the CalMHSA SMH Initiative–funded websites, we are working with each Program Partner to develop a voluntary and confidential website feedback form tailored to each website that assesses basic demographics and reasons for visiting the website, as well as follow-up surveys about users' website experiences and perceived utility, quality, and

impact of online materials (see Appendix D). Together, the surveys are designed to complement information we will obtain from the website analytics on basic traffic metrics for each website. Below we review the materials made available on websites developed and supported by the CalMHSA SMH Initiative–funded programs (California County Superintendents Educational Services Association, California Department of Education, California Community Colleges, California State University, and University of California). For each, we present the website URL, a general description of the website, the target audience for the site, topic areas for which resources are presented, the depth of the website content, and the degree of interaction the user can have with the site. We also describe our evaluation activities related to the site.

California County Superintendents Educational Services Association

- **Website URL:** http://www.regionalk12smhi.org/
- **General description of the website**: The interactive website, collaboratively developed by partners that include California County Superintendents Educational Services Association, Sacramento County Office of Education (SCOE), and Regional Lead County Offices of Education, serves as a clearinghouse of resources and information. The resources are rated using clearly defined criteria (e.g., evidence-based practice, promising practice, emerging practice), which are articulated to users (see http://www.regionalk12smhi.org/ratingLevels.cfm). This dense website is packed with links, downloadable files, and descriptions of regional activities.
- **Target audience**: Primary target of Pre K–12th grade teachers, school staff, or administrators; secondary target of mental health providers, parents, caregivers, and community members who work with schools
- **Resource topic areas**: Anger Management; Behavior Management; Bullying; Drugs/Alcohol/Tobacco; Gangs; Mental Health/Wellness; Parent/Family/Community Collaboration; Pregnancy; Professional Development; School Climate and Culture; Stigma and Discrimination Reduction; Suicide; Violence; Youth Development
- **Depth of the website**: There are multiple external links and downloadable materials available for each of the resource topic areas listed above. Each mental topic area's access page offers links to Publications & Tools, Programs & Practices, and Implementation sections, wherein users can find materials to access. The Publications & Tools link under "Anger Management," for example, offers 13 external links and downloadable documents. Its Programs & Practices section offers more than 30 links to available programs, and the Implementation area offers four links to external programs. Considering the 14 targeted resource topic areas with which the site concerns itself, the available resources easily number into the hundreds. The site provides a search function by which the user can search by keyword, resource type, topic, target audience, program rating level, grade level, format, and response to intervention level.
- **General level of interaction**: The materials on the site are accessible without registration, but a registration/log-in option exists. Registration requires listing areas of interest and grade levels, along with first and last name, email address, zip code, primary role, and a password. Registered users receive email updates according to their areas of interest once per month.

- **Overview of evaluation activities**: Development of the California County Superintendents Educational Services Association website began in Spring 2012. California County Superintendents Educational Services Association's Regional K–12 Student Mental Health Initiative Clearinghouse was the first SMHI site to launch. The evaluation team from RAND and SRI worked closely with California County Superintendents Educational Services Association with respect to using Google Analytics to evaluate website activity (results provided below) since its launch in Fall 2012. The evaluation team also worked closely with California County Superintendents Educational Services Association to develop a brief voluntary registration form to obtain additional data from website users. Emails provided by consenting registrants will be used in future evaluation activities to obtain additional information about website usage and satisfaction.

California Department of Education/PCOE

- **Website URL:** http://sites.placercoe.k12.ca.us/ebl/
- **General description of the website**: The PCOE Eliminating Barriers to Learning (EBL) site is designed to serve the Training Educators Through Recognition and Identification Strategies (TETRIS) program. The site offers links to the four main partners: The California Department of Education, the Placer County Office of Education, CalMHSA, and the California Department of Mental Health. This is a portal through which people can access specific training courses and materials, rather than general mental health information. The site focuses on the EBL curriculum, a training course that promotes the early identification of student mental health issues and provides information regarding training on the promotion of student mental wellness for administrators and all school staff. The EBL was originally developed by SAMHSA and consists of five modules (foundation; social-emotional development, mental health, and learning; making help accessible to students and families; strategies to promote a positive classroom climate; and cultural competence). The site includes trainer materials, resources, videos, links, and information from Kognito, a developer of online role-playing simulations and games where users build interpersonal skills to effectively manage challenging conversations in the areas of health and behavioral health.
- **Target audience**: Administrators and school staff for K–12 who want to use the EBL program in their schools.
- **Resource topic areas**: Depression and Other Mood Disorders; Anxiety Disorders; Disruptive Behavior Disorders; Eating Disorders; Attention-Deficit/Hyperactivity Disorder
- **Depth of the website**: The site is extensive with relatively few external links. Those consist of a resources section pointing users to approximately ten state and national mental health resources, links to ten YouTube videos, and a link to learn more about a recommended role-playing intervention training via Kognito. The training materials on the site include dozens of downloadable Microsoft Office documents and PDF files. The site also provides contact information for the coordinator and director of PCOE, as well as an application (to print and complete) for participation in TETRIS training programs.
- **General level of interaction**: The materials on the site are accessible without registration, but a registration/log-in option exists. Registration requires a user name, password, and email address.

Overview of Evaluation Activities: Due to technological constraints at the Program Partner level, we could not conduct Google Analytics. Instead, we will use AWStats and Qualtrics (software comparable to Google Analytics) to track site traffic. RAND and SRI are working with PCOE to develop a feedback survey to voluntarily obtain information from site visitors.

California Community Colleges (Student Mental Health)

- Website URL: http://www.cccstudentmentalhealth.org/main.php
- **General description of the website**: This website, managed by California Community Colleges' training and technical assistance contractor, CARS (Center for Applied Research and Solutions) functions as the main portal for training and technical assistance for California Community Colleges' Student Mental Health Program (SMHP). The front page offers contact information, registration forms, links for training and regional events and webinars (with video access to archived webinars), and downloadable brochures and slideshows. The homepage also provides access to program resources, information on funding, and information on program evaluation.
- **Target audience**: California Community Colleges mental health providers, professionals, and partners.
- **Resource topic areas**: Overall Mental Health; Suicide Prevention
- **Depth of the website**: Resources available include downloadable web banners, radio spots (mp3s) for promoting programs, program guides, campus profiles, PowerPoint presentations, brochures, and detailed program evaluation information. Each page offers internal and external links to sites and materials, and gives users the ability to click to download individual resources or to click a large button to download all resources (a file size is given). Headings and designations make navigating clear, but there is currently no search function.
- **General level of interaction**: This site requires no user registration—all information is accessible to anyone. However, if users are interested in receiving technical assistance or participating in a webinar or training event, the link navigates them to registration pages where they must document their California Community Colleges campus affiliation.
- **Overview of evaluation activities**: Currently, the RAND and SRI team is working with California Community Colleges to establish access to the website for Google Analytics. Additionally, RAND is working with California Community Colleges to develop a feedback form that will be hosted on the website that will collect voluntary information from users about their interests in student mental health issues and basic demographic information.

California Community Colleges (Chancellor's Office)

- **Website URL:** http://extranet.cccco.edu/Divisions/StudentServices/MentalHealthServices.aspx
- **General description of the website**: This page includes general information on student mental health resources available through the Chancellor's Office of the California Community Colleges. There are links to suicide prevention information, student mental health services, training and technical assistance, and the Chancellor's Office Advisory Group on Student Mental Health.

- **Target audience**: Staff and professionals in the California Community Colleges and student mental health community of providers.
- **Resource topic areas**: Overall Mental Health
- **Depth of the website**: There is a search option and a site map. There are links to registration for training, and to videos and slides, as well as a large variety of mental health services links: (MHSA Information/Resources; California Community Colleges SMHP: Training & Technical Assistance, Suicide Prevention Training, Campus Based Grants, Program Evaluation; Chancellor's Office Advisory Group on Student Mental Health: Docs & Forms, Partners, Resources, Mental Health Listservs, Suicide Prevention Info, Contacts)
- **General level of interaction**: There is very little beyond the general portal aspects. No registration is required for general navigation unless users are interested in registering for technical assistance and training. This link navigates them to the CARS website pages (see above).
- **Overview of evaluation activities**: Currently, RAND/SRI is working with California Community Colleges to establish access to the website for Google Analytics. The primary focus is to determine how many users access the page and then proceed on to additional information housed on the CARS website (see above).

California State University

- **Website URL:** http://www.merlot.org/merlot/index.htm
- **General description of the website:** MERLOT (Multimedia Educational Resource for Learning and Online Teaching) is a free and open online community of resources designed primarily for faculty, staff, and students of higher education from around the world to share their learning materials and pedagogy. MERLOT is a cutting-edge, user-centered collection of peer reviewed online learning materials, catalogued by registered members. MERLOT's strategic goal is to improve the effectiveness of teaching and learning by increasing the quantity and quality of peer-reviewed online learning materials that can be easily incorporated into faculty-designed courses. California State University's Student Mental Health Clearinghouse, which is currently under development, will be hosted on MERLOT as one of its two dozen different discipline communities (from Agriculture and Environmental Sciences to World Languages).
- **Timeline of launch**: The SMH section of MERLOT is scheduled to launch in summer 2013.
- **Target audience:** Faculty, staff, and students of higher education with interests in student mental health
- **Overview of evaluation activities**: Currently, RAND/SRI is working with California State University to establish access to the website for Google Analytics. Additionally, RAND is working with California State University to develop a feedback form that will be hosted on the website that will collect voluntary information from users about their interests in student mental health issues and basic demographic information.

University of California

- **Website URL**: Not yet available, under development.
- **General description of the website**: In year two of the SMH Initiative, University of

California will develop a comprehensive web-based resource repository ("clearinghouse") for system-wide sharing of data and information on student mental health issues.

- **Timeline of launch**: The project initially "kicked off" in June of 2012, but due to systematic constraints and staffing changes, the project had to be postponed. It was subsequently assigned a new web development team in March 2013. The second official project "kick-off" with the new development team in place occurred March 13, 2013 as the design team began redesigning the site's infrastructure. The redesigned website is scheduled to launch in Fall 2013.
- **Target audience**: The site is hosted by the University of California Office of the President and serves as a space to showcase University of California's collective efforts in meeting the mental health needs of its students. The website will be designed to reach a broad audience, inviting mental health providers from the various college/university, county, and community agencies to browse through UC's resources and utilize them as appropriate for their population.
- **Overview of evaluation activities**: Currently, RAND/SRI is working with University of California to establish access to the website for Google Analytics. Additionally, RAND is working with University of California to develop a feedback form that will be hosted on the website that will collect voluntary information from users about their interests in student mental health issues and basic demographic information.

Assessing Reach of Informational/Online Resources

For this report, we gathered and summarized user information and traffic metric findings for California County Superintendents Educational Services Association's Regional K–12 Student Mental Health Initiative Clearinghouse from September 1, 2012 through March 31, 2013. Because websites for California Community Colleges, California State University, University of California, and California Department of Education/PCOE are under development or in early stages of tracking, traffic metric findings for these funded programs will be presented in later reports. We first present findings from the website feedback form that describes the types of people visiting the website. Second, we present findings from the website traffic metrics (Google Analytics) that assess the number of visits, type of user engagement, and sources of visits.

California County Superintendents Educational Services Association's Regional K–12 Student Mental Health Initiative Clearinghouse Process Outcomes

Website Feedback Form

Embedded within California County Superintendents Educational Services Association's website registration form are several voluntary questions that gather basic demographic information and reasons users visit the website. Starting in September 2012, 175 people registered with the California County Superintendents Educational Services Association clearinghouse website (Table 4.3); the heaviest period of registration was during March 2013 following dissemination of information about the website by California County Superintendents

Educational Services Association. Registered users came from 126 zip codes across California. The majority of registered users self-identified as school administrators (36%) and mental health staff (35%) (Table 4.4). Registered users were also asked to indicate all grade levels of interest (Table 4.5) and topics of interest (Table 4.6). As indicated by the high endorsements across all grades and all 14 topic areas, registered users are interested in seeking information across a wide range of ages and topics related to student mental health.

Table 4.3
Number of Registrations by Month

Year – Month	N	Percentage
2012 – Sept	18	10
2012 – Oct	5	<1
2012 – Nov	6	3
2012 – Dec	16	9
2013 – Jan	13	7
2013 – Feb	15	9
2013 – Mar	102	58
Total	175	

Table 4.4
Number of Registered Users by Role

Role	Counts	Percentage
Administrators	63	36
Mental health staff	62	35
Other	34	19
Parents/caregivers/community	1	1
Students	1	1
Teachers/school staff	14	8
Total	175	

Table 4.5
Number of Grade Levels Chosen

Grade Level	Counts	Percentage
Pre K	78	45
K–3	119	68
4–6	129	74
7–8	131	75
9–12	137	78

Note: Percentages are calculated based on n = 207 respondents. Respondents could select multiple grades.

Table 4.6
Rank Order of Student Mental Health Topic Areas of Interest

Topics	Counts	Percentage of Users
Mental Health/Wellness	161	92
Bullying	143	82
Behavior Management	140	80
Anger Management	135	77
School Climate and Culture	135	77
Suicide	132	75
Parent/Family/Community Collaboration	125	71
Violence	120	69
Professional Development	117	67
Youth Development	117	67
Stigma and Discrimination Reduction	111	63
Drugs/Alcohol/Tobacco	110	63
Gangs	93	53
Pregnancy	69	39

Note: Percentages are calculated based on n= 207 respondents. Respondents could select multiple topics.

Summary of Website Feedback Data to Date

The available website registrant data suggest that initial interest in the website has come primarily from school administrators and mental health professionals, with fewer teachers completing the voluntary demographic questions on the registration form. It is unclear, however, if this is a reflection of those individuals who initially accessed the website and/or are completing the registration form, or if the site will continue to reflect the level of interest among

different stakeholder groups. Site visitors completing the demographic questions on the registration form are expressing interest in students from preschool through high school, potentially reflecting the broad range of information available on the website. Finally, we note that three of the top five topics of interest address student externalizing and/or behavior problems, consistent with more frequent identification of such problems among students, and highlight the importance of continued efforts to support educators in prevention and early intervention efforts addressing such challenges in their classrooms.

Traffic Metrics

We are collecting basic web metrics, primarily using Google Analytics, that include traffic metrics, file downloads, navigation metrics, indicators of user engagement, search and referral data, and basic user data such as domain, ISP, and geographic location. RAND has also discussed with California County Superintendents Educational Services Association and other Program Partners the ability to make limited modifications to planned reports to assist Program Partners in answering additional questions about their website and user base.

In total, California County Superintendents Educational Services Association received 2,667 unique visits to its website clearinghouse (see Table 4.7). As indicated by the growth in site visits and page views from the September–December 2012 reporting period to the January–March 2013 reporting period, the website has seen an increase in traffic.

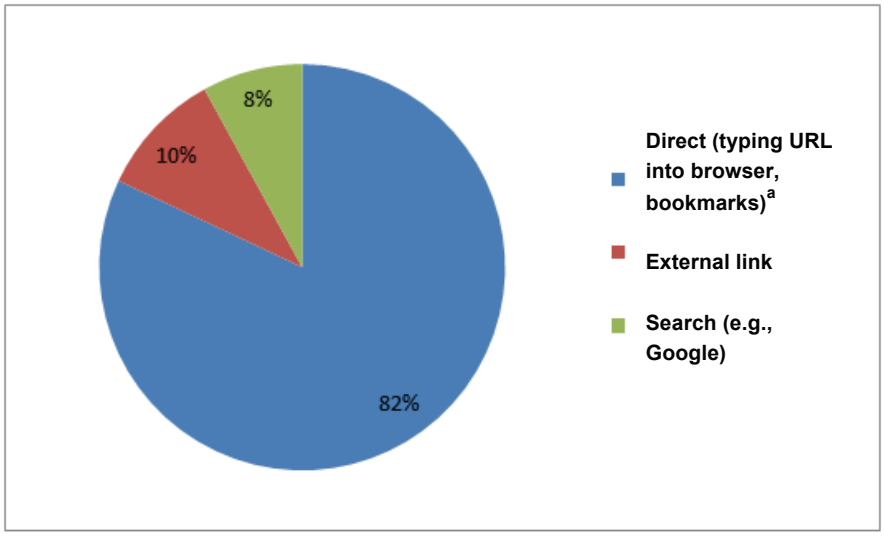
Table 4.7
Total Site Visits and Page Views

	September–December 2012	January–March 2013	Total
Site visits	679	1,988	2,667
Page views	3,793	7,686	11,479

Traffic Sources

Figure 4.1 illustrates the different ways people accessed the website. The majority of users (82%) accessed the website directly, by typing the URL into their browser, clicking on a bookmark, or following a link in an email or other electronic documents (e.g., PDFs). Some of this traffic may account for visits from browsers/networks that do not share traffic source information. The remaining means of accessing the website were via external link on another website (10%) and through a keyword search (8%) using a search engine such as Google or Yahoo!

Figure 4.1. Ways Users Accessed Website



[a]Also includes visits from (untagged) links in email messages and links in some electronic documents (e.g., PDFs).

Table 4.8
Top Five Website Referrals

Source	Visits[a]	Pages / Visit	Avg. Visit Duration (min)
venturacountyselpa.com	43	4.84	02:20
sites.placercoe.k12.ca.us	38	3.82	03:36
calmhsa.org	36	6.53	03:22
facebook.com	8	3.75	00:39
vcoe.org	7	3	00:47

[a]Total visits were 241 across 55 sources.

Table 4.8 expands upon the category of users who accessed the website via an external link on another website (i.e., referrals). The largest number of referrals originated from California Office of Education affiliates (e.g., SELPA), PCOE, or via CalMHSA's website. As described below, this may to some extent be attributed to the fact that each County of Education web page has a link to the clearinghouse.

User Engagement and Navigation

The average visit duration across all users was 2:44 minutes, with users visiting an average of 4.3 pages each time. However as indicated by the bounce rate, 48 percent of visits to the homepage resulted in users leaving the website without navigating further into the site's other feature (e.g., other links, pages, etc.). There may be multiple reasons explaining the 48 percent

bounce rate. These can include a user obtaining needed information from the first page visited, or realizing the site is not the one the user was searching for, or the user did not need the information offered. Additionally, because the California County Superintendents Educational Services Association homepage houses the portal for its data collection system, these users may be simply linking on the portal to complete quarterly reports and enter program data. Unfortunately, we do not have the ability to obtain this type of information via Google Analytics.

As indicated in Table 4.9, Anger Management was the resource topic most visited by website users with 820 page views (26% of users). However, the large number of page views may also be due to the fact that Anger Management was the first topic listed.

Table 4.9
Rank Order of Most Visited Resource Topics on California County Superintendents Educational Services Association Website

	Page Views	Percentage	Avg. Time on Page (min)
Anger Management	820	26	1:01
Mental Health/Wellness	416	13	0:43
Bullying	344	11	0:48
Behavior Management	331	11	0:46
Suicide	321	10	1:09
Drugs/Alcohol/Tobacco	206	7	0:55
School Climate and Culture	161	5	1:23
Youth Development	130	4	0:52
Violence	103	3	1:26
Gangs	98	3	0:20
Stigma and Discrimination Reduction	67	2	0:39
Parent/Family/Community Collaboration	65	2	0:37
Professional Development	51	2	0:54
Pregnancy	20	1	0:21
Total	3,133	100	--

Based on Google Analytics data, Programs and Practices was the most viewed content type (353 views, 62%) for the Anger Management resource topic, with an average time of 1:35 minutes on the page (Table 4.10).

Table 4.10
California County Superintendents Educational Services Association Website – Anger Management Visits by Content Type

	Page Views	Percentage	Avg. Time on Page (min)
Publications & Tools	166	29	1:17
Programs & Practices	353	62	1:35
Implementation	46	8	0:50
Total	565	100	--

User Characteristics

The overwhelming majority of the visits were restricted to the United States (>99%; n = 2,634), with a small number of visits coming internationally (>1%; n = 6). Within the United States, the majority of site visits originated from sources in California (n = 2,463, 93%). As would be expected, the majority (77%) of visits in California originate from the state's three largest metro areas: Sacramento-Stockton-Modesto, Los Angeles, and San Francisco–Oakland–San Jose (see Table 4.11 and Figure 4.2).

Table 4.11
California County Superintendents Educational Services Association Website – Top Five Sources of Website Traffic by California Metro Area

Metro	Visits
Sacramento-Stockton-Modesto, CA	922
Los Angeles, CA	579
San Francisco–Oakland–San Jose, CA	389
San Diego, CA	107
Chico-Redding, CA	102

Figure 4.2. Geographic Distribution of Traffic to California County Superintendents Educational Services Association Website Across California Metro Areas

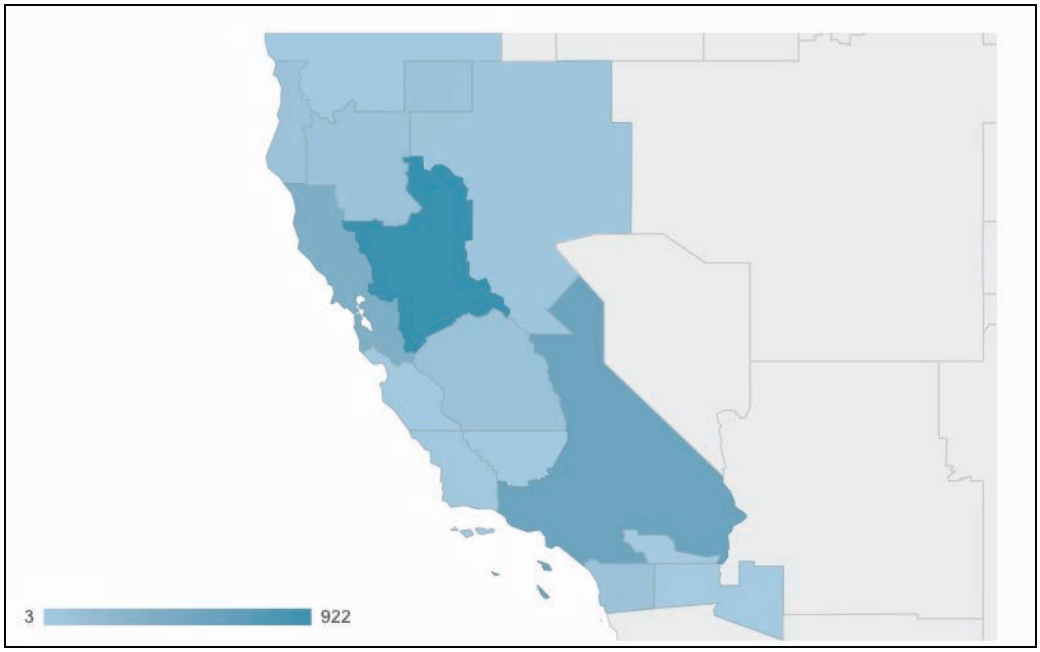


Table 4.12 reports the top five Internet Service Provider (ISP) referrals from county or state organizations. ISP referrals provide information about the origins of website visits based on the Internet provider. For example, the top number of visits (n = 292) originated from the SCOE ISP, indicating that a large percentage of use of the site during this period came from individuals logged into the SCOE system. As part of California County Superintendents Educational Services Association's roll out of the Regional K–12 Student Mental Health Initiative website, SCOE included a link to California County Superintendents Educational Services Association's website. The 292 page visits from SCOE ISPs suggest that this may have been effective in increasing website visits. Additionally, the large number of visits from County Offices of Education (COE) ISPs may be attributed to the fact that each COE web page has a link to the clearinghouse and some other county sites.

Table 4.12
Top ISP Referrals from County or State Organizations to California County Superintendents Educational Services Association Website

Service Provider	Visits
Sacramento County Office of Education	292
California State University Network	82
San Bernardino County Superintendent of Schools	75
Los Angeles County Office of Education	64
Ventura County Office of Education	63

Next Steps for Evaluating Online Resources

The helpfulness of the informational/online resources will be assessed using a survey that assesses user perceptions of utility, quality, and impact of online materials. This survey is currently under development.

Trainings and Educational Presentations

Our CalMHSA statewide training evaluation of the Student Mental Health Initiative aims to evaluate whether mental health trainings conducted by CalMHSA-funded programs are leading to changes that will improve student mental health. To accomplish this aim, we collected data in two ways: a training evaluation survey completed by training participants and a training activities worksheet completed by trainers. Below we describe these data collection tools and our efforts to understand the nature of training content and approach, who the training reached, and the changes in student mental health that resulted from training activities.

Data Collection Tools

Training Activities Worksheet. The RAND team developed Training Activities Worksheets to document all CalMHSA-supported training and education events across campus- and school-affiliated locations. For each training, trainers completed a training activities worksheet to document training date, region/district campus for which the training was held, training topic, number of participants, and training length. Trainers could either complete the worksheet online or with an Excel sheet. For higher education Program Partners, the RAND team extracted information from campus quarterly reports to complete the worksheet.

Statewide Training Evaluation Survey. The RAND team developed CalMHSA statewide training surveys to assess characteristics of training participants and their training satisfaction and changes in efficacy and behaviors as a result of their participation in CalMHSA-supported

SMH trainings (see Appendix D). SMH Program Partners delivered a variety of trainings on wide-ranging topics. Through data from this survey, we aim to demonstrate the effects of these trainings on specific learning objectives focused on identifying, supporting, and referring to services (as necessary) students with mental health challenges. The SMH K–12 and higher education partners share these training objectives in a majority of their training events.

The retrospective survey is delivered in one sitting and asks participants to report their perceptions of their attitudes, knowledge, and behaviors both *before* the training and *after* the training on one rating scale. These procedures have been documented to show that respondents can accurately assess their own progress over time (Pratt, McGuigan, and Katzev, 2000; Rohs, 1999). Indeed, the "retrospective pretest" approach is advantageous when a participant's frame of reference is likely to change over time (e.g., when they are likely to overestimate or underestimate their understanding before they have seen educational materials), and it is a practical approach when there is not sufficient time for two assessments (Pratt, McGuigan, and Katzev, 2000). We worked with our survey design expert to craft language to explain to trainers and participants how to complete the "before" and "after" questions.

Program Partner Training Activities

California County Superintendents Educational Services Association. School-based demonstration programs and related trainings that encourage positive school climate, best practices, and that build the capacity of schools and communities to implement PEI strategies that promote SMH began in the Fall of 2012. Trainings span (1) awareness trainings; (2) training of trainers; (3) standard sets of learning goals and objectives; (4) teaching skills and interventions to prevent problems or change behavior; and (5) training on curriculum for classroom implementation. Trainings are geared toward district and site administrators, counselors, teachers, paraprofessionals, students, parents, and/or community members.

Examples of training opportunities include: *Positive Behavioral Intervention and Supports (PBIS); Coping and Support Training (CAST); SafeTALK; Second Step; and Triple P–Positive Parenting Program.*

- PBIS focuses on promoting a positive school climate, exemplified by defining, teaching, and supporting appropriate student behaviors
- PBIS encourages school staff to balance setting rules and expectations for students while also acknowledging them for appropriate behavior. A key feature of PBIS is to support school staff in their decisionmaking, thereby allowing them to focus on the academic needs of students.
- CAST teaches life skills—building self-esteem, monitoring and setting goals, decision-making, and personal control—to build resiliency against risk factors and to control early signs of substance abuse and emotional distress. The program's goals are to increase mood management, school achievement, and drug use control.

- SafeTALK trains high school staff to identify persons with thoughts of suicide and connect them to suicide first aid resources. LivingWorks also provides Training for Trainers.
- Second Step provides developmentally appropriate lessons for students in Pre-K through middle school for prevention of substance abuse, bullying, and violence and for the development of social-emotional skills.
- Triple P's five-level system teaches parents skills to support their children and access community resources for behavior and developmental concerns. Triple P has also been expanded to provide teachers, paraeducators, counselors, secretaries, and administrative assistants with tips and strategies for handling bullying and aggressive behavior.

California Department of Education. California Department of Education administers two types of Training Educators Through Recognition and Identification Strategies (TETRIS) Eliminating Barriers to Learning (EBL) trainings. Level 1 trainings are described as professional development for trainers, whereas Level 2 trainings are second-generation trainings that Level 1 trained trainers provide in their school, district, or region. The Level 1 trainings are classified as TETRIS EBL "Training of Trainers" (TOT) events. The TETRIS EBL TOT focuses on professional development for trainers, and in turn, the California Department of Education is seeking continual improvement and relies on feedback from TETRIS EBL participants on how to improve the workshops. A key component of TETRIS EBL TOT is instructing participants to deliver professional development to help educators and school staff identify support and refer students in emotional distress. TETRIS EBL TOT participants are encouraged to conduct three local (Level 2) trainings by April 30, 2014.

Participants in the Level 1 TETRIS TOT included local training teams of two or more participants with representation from: (1) at least one mental health professional (California Department of Education encouraged local districts to build collaborations with county and community mental health partners); (2) counselors, school social workers, or psychologists as well as teachers and counselors (ideally one staff with experience in classroom instruction); and (3) other recommended staff including administrators, school nurses, directors, pupil personnel services, child welfare and attendance supervisors, special educations staff, and 504 administrators. California Department of Education encouraged districts to invite frontline staff such as school secretaries, attendance workers, registrars, and campus monitors to attend the TETRIS EBL TOT, given these individuals' critical roles in observing and supporting students.

California Community Colleges. Using CalMHSA funds, the California Community Colleges Chancellor's Office and the Foundation for California Community Colleges awarded 23 campus-based grants (CBGs) to community college groups on 30 California Community Colleges campuses to enhance their student mental health supports and services. Both CBGs (i.e., 30 campuses) and non-CBG campuses (i.e., the remaining 82 campuses of the California Community Colleges system) could deliver local SMH-specific training opportunities such as

Kognito, a California Community Colleges system-wide contractor that provides access to online SMH trainings at no cost to all California Community Colleges campuses, and other in-person or online training topics that meet the needs of the local campus community (e.g., supporting student veterans, peer-to-peer groups, the LGBTQ population, transition-aged youth in foster care). Some training events may also be provided in collaboration with the California State University system (which facilitates train-the-trainer events for Mental Health First Aid and ASIST trainer certifications) or the University of California system (which hosts an "Ethics in Media" training event accessible to all SMH Program Partners).

California State University. Using CalMHSA funding in FY 2012–13, the California State University Chancellor's Office distributed sub-awards to all California State University campuses to support campus contributions to curriculum development and training, peer-to-peer support programs, and suicide prevention. In addition, the California State University Chancellor's Office annually provides funding and infrastructure support for system-wide suicide prevention trainings at no cost to all campuses, including Mental Health First Aid (MHFA) and ASIST programs. The trainings consist of a train-the-trainer model to certify individuals across the California State University system in ASIST and in MHFA; training opportunities were also provided to the California Community Colleges and University of California systems. To complement the MHFA and ASIST trainings, the California State University campuses provide other SMH trainings (e.g., Kognito; Question, Persuade, Refer [QPR]; Active Minds; Bystander trainings) to meet assessed needs at the local campus community level.

University of California. All ten University of California campuses are working together to implement a system-wide student mental health initiative under the direction of the University of California Office of the President. This initiative includes an investment in student and staff/faculty trainings to recognize and respond to the signs and symptoms of distress. University of California SMH trainings include topics such as student distress recognition, mental health referrals, crisis intervention, and Red Folder protocols (i.e., reference guides to access available resources). These topics are all relevant for administration of the CalMHSA statewide training survey. However, University of California campuses also may conduct trainings and targeted outreach that are not appropriately evaluated via the statewide training survey, such as student health and wellness presentations targeted for particular groups (e.g., eating disorders in sororities and fraternities).

Next Steps for Evaluating Capacities Built Through Training and Educational Programs

The RAND team will conduct a content analysis of select trainings toward the end of the data collection period. We will select one to three of the most frequent trainings and request facilitator and participant training materials. We have adapted a content analysis protocol from previous

RAND research (Acosta et al., 2012a), and will descriptively summarize the training (e.g., structure/length, medium, content), target population (e.g., Who is the training addressed to?), training goals (e.g., What are the training objects of the training? If relevant, what are the learning outcomes of the training? How do trainings align with CalMHSA PEI goals?), purpose of training materials (e.g., What is the purpose of material distributed to participants at the training?), and breadth of materials (e.g., whether the material included additional links to mental health resources [e.g., local vs. national], other services or care, or additional information or education).

Assessing the Reach of Training

The RAND team focuses this portion of the evaluation on preliminary data on the number of individuals trained and the characteristics of trainings. These data have already been submitted by our K–12 Program Partners (i.e., California County Superintendents Educational Services Association and California Department of Education) but not yet from our higher education Program Partners. We briefly describe preliminary data below.

California County Superintendents Educational Services Association. California County Superintendents Educational Services Association trainers started administering training surveys in early February 2013. As detailed in Table 4.13, as of March 2013, this organization sponsored 168 trainings with training topics including crisis or behavioral intervention, suicide prevention (e.g., ASIST, MHFA), general mental health promotion, and bullying prevention. Teachers and superintendents attended the majority of these trainings. The most commonly delivered training category was general mental health promotion (n = 94 trainings), which focused on understanding stressors, mental health issues, eliminating barriers to learning, and cultural competency. Some additional training topic examples included understanding attention deficit hyperactivity disorder (ADHD), the effects of trauma on behavior and learning, the adolescent brain, and the resilient mindful learner project. On average, the duration of general mental health promotion trainings was three hours and the average attendance was 42 participants.

Characteristics of California County Superintendents Educational Services Association training participants who completed training surveys are presented in Table 4.14. Participants were mostly between the ages of 26 and 59, White, and female. About 35 percent of participants identified as being of Hispanic, Latino, or Spanish origin.

California Department of Education. ,Participants in the Level 1 TETRIS TOT included local training teams of two or more participants with representation from: (1) at least one mental health professional (California Department of Education encouraged local districts to build collaborations with county and community mental health partners); (2) counselors, school social workers, or psychologists as well as teachers and counselors (ideally one staff with experience in classroom instruction); and (3) other recommended staff including administrators, school nurses,

directors, pupil personnel services, child welfare and attendance supervisors, special educations staff, and 504 administrators. California Department of Education also encouraged districts to invite frontline staff such as school secretaries, attendance workers, registrars, and campus monitors to attend with their teams, given these individuals' critical roles in observing and supporting students.

Table 4.13 shows California Department of Education's trainings from January through March 2013. California Department of Education trainers conducted three Level 1 TETRIS TOT trainings with an average duration of 7 hours and average attendance of 35 participants. Participants in two of these trainings received a version of the survey with pre-post questions, while those in the third training received the qualitative version without the pre-post questions. California Department of Education will submit data from Level 2 trainings in Summer or Fall 2013 after online surveys are installed.

Characteristics of California Department of Education training participants who completed training surveys are presented in Table 4.14. Participants were mostly between the ages of 26 and 59, White, and female. About 34 percent of participants identified as Black or African American.

Table 4.13
Summary of Training Events Across SMH Program Partners

Program Partner	Training Category	Number of Trainings	Attendees M(SD) (min, max)	Length Hours M(SD) (min, max)	Median Attendees	Median Length
CCSESA	Crisis or behavioral intervention	35	49.2 (44.7) (8, 166)	5.6 (3.5) (1, 18)	33	6
	Suicide prevention	13	38.5 (37) (8, 136)	2.7 (0.6) (1, 3)	29	3
	General mental health promotion	94	37.6 (55.6) (2, 385)	2.8 (3.3) (1, 24)	20	2
	Other (e.g., bullying prevention)	26	60.7 (106.4) (4, 400)	4.4 (3.3) (2, 16)	19.5	2
CDE	TETRIS TOT Level 1 training	3	34.7 (4.5) (30, 39)	7 (0) (N/A)	35	7

Note: Data are valid as of March 1, 2013 (CDE) and March 31, 2013 (CCSESA). CCSESA = California County Superintendents Educational Services Association. CDE = California Department of Education.

Table 4.14
Demographics of Training Participants Attending California County Superintendents Educational Services Association and California Department of Education Trainings

Demographics	CCSESA (n = 2,287) (%)	CDE (n = 91) (%)
Age		
16–25	12.8	0
26–59	80.4	90.0
60–84	6.7	10.1
85+	0	0
Male	23.8	12.4
Hispanic, Latino, or Spanish origin	35.2	8.0
Race[a]		
White	62.7	82.8
Black/African American	5.2	34.4
Asian	6.4	4.6
American Indian/Native American/Alaska Native	3.3	1.1
Native Hawaiian/Pacific Islander	1.7	1.1
Other	20.7	3.4

[a] Multiple responses allowed.

California Community Colleges. The California Community Colleges conducted approximately 425 presentations and trainings reaching approximately 16,000 faculty, staff, and student participants between September 2012 and April 2013. The presentations and trainings covered a range of topics that included early recognition of students in distress, crisis or behavioral interventions, suicide prevention general mental health promotion, peer-to-peer counseling sessions, and veterans issues. In addition, California Community Colleges is supporting the use of online training programs developed by Kognito geared primarily toward suicide prevention.

Additionally, the California Community Colleges campuses conducted up to 60 training- of-trainers sessions from January 2013 to April 2013 that trained almost 1,500 participants, predominantly faculty and staff. The majority of trainings were on early recognition of distress, suicide prevention, and general health promotion.

California State University. The California State University campuses reported about 200 trainings, presentations, and outreach events between September 2012 and March 2013. These

activities included QPR training, MHFA training, Kognito training, Healthy Minds events, student services counseling, in-class presentations on stress management, anxiety and well-being, workshops on prevention and early intervention of crises and violence, and Step Up! bystander presentations.

The events and activities ranged in audience size from three (e.g., Fitness Center staff training at California State University Chico) to 5,700 (e.g., Blues project presentations at California State University Northridge). In total, the events and activities reached almost 17,000 faculty, staff, and students.

University of California. The University of California campuses conducted approximately 1,100 trainings and informational events for faculty, staff, graduate teachers, research assistants, and students between October 2012 and March 2013. Specifically, they offered a total of 174 faculty and staff trainings, 112 graduate teacher/research assistant trainings, and 744 student trainings, as well as 73 student bystander informational events during the time period. These training activities and events reached over 3,600 faculty and staff, 2,200 graduate teachers/research assistants, and 30,000 students.

Trainings for faculty and staff focused on topics such as Campus Violence Prevention, How to Assist Emotionally Distressed Students, Stigma Reduction, Suicide Assessment and Treatment, Question, Persuade, Refer (QPR) training sessions, as well as an introduction to and services provided by the campus CAPS. Trainings educated the graduate teachers/research assistants on self-care with an emphasis on relationship issues, conflict resolution, and responding to students in distress.

Student training and informational events included presentations on Mental Health Wellness and Coping, Time Management, surviving oral exams and other topics during Celebrate Your Body week, debriefing sessions after student death, and CAPS online Bystander trainings through its websites.

Preliminary Data on Changes in Short-Term Outcomes Resulting from Training

The RAND team analyzed data from the training evaluation surveys to assess immediate post-training changes in knowledge and attitudes among training participants. We aggregated and summarized results across all Program Partners that provided training data. Higher scores indicate greater satisfaction, self-efficacy, and behavioral intentions.

Statistical Analyses. The RAND team conducted basic descriptive analyses of California County Superintendents Educational Services Association (n = 168 trainings) and California Department of Education (n = 3 trainings) survey data (higher education data forthcoming) to provide a preliminary analysis of how training participants rated the value of their trainings. RAND also conducted paired t-tests on participants' overall ratings of self-efficacy and behavioral intentions that were averaged across individual items (see Tables 4.17 – 4.21) to

assess changes in skills and behaviors associated with the training. Please note that these data are preliminary with additional data forthcoming. Similar analyses will be conducted with data from higher education Program Partners upon receipt of survey data.

Training Satisfaction. Tables 4.15 and 4.16 describe the average participant ratings of satisfaction. On average, participants who attended California County Superintendents Educational Services Association's trainings offered ratings between 4.2 and 4.4 (on a scale where 4 indicated "agreed" and 5 indicated "strongly agreed"), suggesting that they believed their training was helpful, met the needs of diverse students, and important to attend. Participants who attended two of three of California Department of Education's TETRIS TOT trainings also felt the training was helpful, but disagreed or strongly disagreed that the training met the needs of diverse students. This finding may be related to the nature of TETRIS TOT trainings being professional development on how to train others versus direct education on how to intervene with students with mental health challenges.

Table 4.15
Average Ratings of Training Satisfaction Across California County Superintendents Educational Services Association

Training Satisfaction Subscale	CCSESA [a] M(SD)
Helpfulness	4.4 (0.8)
Meets the needs of diverse students	4.2 (0.9)
Importance of attending trainings	4.4 (0.9)

[a] Higher scores indicate greater satisfaction.

Table 4.16
Average Ratings of Training Satisfaction Across California Department of Education

Training Satisfaction Subscale	CDE [a] M(SD)
Helpfulness	4.7 (0.6)
Meets the needs of diverse students	2.4 (1.7)
Importance of attending trainings	N/A [b]

[a] Higher scores indicate greater satisfaction.

[b] A previous version of the survey did not include this question.

Self-efficacy. Tables 4.17 and 4.18 describe the average participant ratings of self-efficacy and how participant skills changed before and immediately after the training. Participants attending California County Superintendents Educational Services Association and two of the

three California Department of Education's TETRIS TOT trainings reported significant changes in overall self-efficacy from pre- to post-training ($p < .0001$). Specifically, they reported that they felt significantly greater confidence in knowing where to refer students, greater comfort discussing mental health, greater confidence helping students, and increased awareness of warning signs. Participants who attended California County Superintendents Educational Services Association trainings also reported greater self-efficacy in their ability to access education and resources to further learn about mental health distress.

Table 4.17
Average Ratings of Participant Self-Efficacy for California County Superintendents Educational Services Association Trainings[a]

Participant Self-Efficacy Subscale	CCSESA Pre M(SD)	CCSESA Post M(SD)
Confidence to identify where to refer students	3.5 (0.9)	4.2 (0.7)*
Easy access to education and resources to learn	3.4 (0.9)	4.2 (0.7)*
Comfort discussing mental health with students	3.6 (1.0)	4.2 (0.8)*
Confidence to help students	3.5 (0.9)	4.2 (0.7)*
Awareness of warning signs	3.5 (0.9)	4.2 (0.7)*
Overall Self-Efficacy Score	3.4 (0.8)	4.1 (0.7)*

* p<.001 for paired t-test comparing "pre" and "post" self-efficacy scores.
[a] Higher scores indicate greater level of self-efficacy (on a scale of 1 to 5).

Table 4.18
Average Ratings of Participant Self-Efficacy for California Department of Education Trainings[a]

Participant Self-Efficacy Subscale	CDE Pre M(SD)	CDE Post M(SD)
Confidence to identify where to refer students	4.0 (0.8)	4.5 (0.6)*
Easy access to education and resources to learn	4.4 (0.7)	3.8 (0.9)*
Comfort discussing mental health with students	4.0 (1.1)	4.3 (0.7)*
Confidence to help students	3.8 (0.9)	4.3 (0.6)*
Awareness of warning signs	4.2 (0.8)	4.4 (0.7)*
Overall Self-Efficacy Score	4.0 (0.7)	4.4 (0.5)*

*p<.001 for paired t-test comparing "pre" and "post" self-efficacy scores.
[a] Higher scores indicate greater level of self-efficacy (on a scale of 1 to 5).

Training Behaviors. Tables 4.19 and 4.20 describe the average participant ratings of behavioral intentions. Participants attending California County Superintendents Educational Services Association trainings and two of the three California Department of Education's TETRIS TOT trainings reported significant changes in how their overall behavioral intentions changed from pre- to post-training ($p < .0001$). Specifically, they reported significant increases in their likelihood to encourage students to seek help from professionals, parents, or friends; provide advice and guidance; give students a phone number to call; ask students questions to assess the problem; and call a security or administrator to support the student. Participants from both California County Superintendents Educational Services Association and California Department of Education trainings also reported a slight decrease in their likelihood of getting involved in a student's personal life after the training.

Table 4.19
Average Ratings of Participant Behaviors for California County Superintendents Educational Services Association Trainings[a]

Participant Behavior Subscale	CCSESA Pre M(SD)	CCSESA Post M(SD)
Encourage help from professional	2.9 (0.9)	3.5 (0.7)*
Encourage help from parents or friends	3.3 (0.7)	3.7 (0.5)*
Provide advice and guidance	2.9 (0.8)	3.5 (0.7)*
Give student a specific number or person to call	2.8 (0.7)	3.3 (0.8)*
Ask student questions to assess problem	2.7 (0.9)	3.4 (0.7)*
Call security/administrator/ counselor	3.2 (0.9)	3.6 (0.6)*
Get involved	3.3 (0.9)	3.2 (1.2)
Overall Behavior Score	2.9 (0.6)	3.4 (0.5)*

* p<.001 for paired t-test comparing "pre" and "post" behavior scores.
[a] Higher scores indicate greater likelihood to act (on a scale of 1 to 4).

Table 4.20
Average Ratings of Participant Behaviors for California Department of Education Trainings[a]

Participant Behavior Subscale	CDE Pre M(SD)	CDE Post M(SD)
Encourage help from professional	3.5 (0.7)	3.8 (0.5)*
Encourage help from parents or friends	3.4 (0.7)	3.7 (0.4)*
Provide advice and guidance	3.2 (0.8)	3.6 (0.7)*
Give student a specific number or person to call	3.1 (0.9)	3.4 (0.8)*
Ask student questions to assess problem	3.3 (0.8)	3.8 (0.4)*
Call security/administrator/counselor	3.1 (1.1)	3.4 (0.8)*
Get involved	3.6 (0.8)	3.4 (1.1)*
Overall Behavior Score	3.3 (0.8)	3.6 (0.6) *

* p<.001 for paired t-test comparing "pre" and "post" behavior scores.
[a] Higher scores indicate greater likelihood to act (on a scale of 1 to 4).

Student Mental Health Baseline Student and Faculty/Staff Campus-Wide Surveys

The student mental health campus-wide survey evaluations aim to evaluate whether the trainings and PEI activities resulted in changes consistent with (1) improved student mental health, (2) changes in the school/campus environment, and (3) changes in student behavior and attitudes. To accomplish this aim, four surveys were developed: (1) a student higher education survey, (2) a faculty/staff higher education survey, (3) a student K–12 education survey, and (4) a staff K–12 education survey. Below, we describe the development, dissemination, and evaluation of the surveys, first for the higher education surveys and then for the K–12 surveys. Only a subset of schools has administered the surveys, and the surveys have not yet formally closed. As a result, the survey results presented are preliminary results.

Survey Development

Higher Education Survey. RAND developed voluntary and confidential higher education surveys to be administered to students and faculty/staff at participating higher education campuses from the higher education Program Partners (University of California, California State University, and California Community Colleges). Items were selected in collaboration with Program Partners. RAND derived the items from standardized and valid measures of student mental health (e.g., U.S. National Health Interview Survey [NHIS], Kessler Psychological

Distress Scale [K6] [Pratt, 2009]), as well as from measures currently used in the California higher education systems (e.g., National College Health Assessment) where possible.

K–12 Education Survey. In addition to the higher education survey, RAND is currently developing two voluntary and confidential surveys to be administered to California K–12 students and staff that will address the question: Did the trainings and PEI activities result in changes consistent with improved (1) student mental health, (2) school/campus environment, and (3) student behavior and attitudes?

As with the higher education survey, items were selected in collaboration with the Program Partners. RAND derived the items from several statewide surveys, including standardized and valid measures of student mental health (e.g., the California School Climate, Health, and Learning Survey [CalSCHLS], the California Healthy Kids Survey [CHKS], and the California School Climate staff survey [CSCS]). RAND will work with CalMHSA-funded programs and WestED to identify the most appropriate sample of schools for participation and then obtain their participation. RAND will work with WestED to field the survey. RAND will also work with California Department of Education and California County Superintendents Educational Services Association to identify comparison schools or districts that have *not* substantially participated in training activities but are comparable in certain dimensions (such as student enrollment, racial/ethnic distribution, region, and percentage of students on free or reduced-price lunch) and that, optimally, have completed the survey as part their participation in the California Tobacco Use Prevention Education program or other programs that support completion of the survey. Because the surveys are commonly completed by 5th, 7th, 9th, and 11th grade students, we will work with the Program Partners to ensure that we have appropriate coverage of efforts at different school levels.

Higher Education Campus-Wide Measures

The student and faculty/staff surveys were designed to assess experiences and attitudes related to student mental health, perceptions of how campuses are serving students' mental health needs, and perceptions of overall campus climate with respect to student mental health and well-being (see Appendix D for the measure). As described above, we adapted items from standardized and valid measures of student mental health (e.g., NHIS K6 [Pratt, 2009]), as well as measures currently used in the California K–12 and higher education systems (e.g., CSCS, CHKS, National College Health Assessment, University of California Undergraduate Experiences Survey) that assessed student mental health issues. However, in some cases, items were reworded to be appropriate for general student and faculty/staff populations across the various Program Partners. The full set of items is included in Appendix D. Below we provide a summary of each of the constructs included in the student survey and the faculty/staff survey.

Higher Education Student Survey

Demographics. Demographic information included 14 items that assessed age, gender, ethnicity (Hispanic, Latino, or Spanish origin), race, English as primary language, identification with special student population (LGBTQ/foster care youth/ethnic minorities/student veterans/homeless youth/students with disabilities/other), deployment history, student status and years at campus, and primary academic goal.

Level of Distress and Functioning. Three items were adapted from the National College Health Assessment (NCHA) II ("American College Health Association (ACHA) National College Health Assessment (NCHA)," 2013) and the validated K6 self-administered mental health survey (Kessler et al., 2003) that assessed feelings, psychological state, and occurrence of any symptoms of distress in the past 30 days and past 12 months. Respondents rate these items on 5-point Likert scales.

Student Coping and Resilience. Three scales were adapted from the NCHA II and California Healthy Kids Survey Resilience Module B. RAND developed one item to assess student coping and resilience. Items broadly assessed impairment of academic success due to psychological distress, coping with a personal problem or stress, and ability to access supportive services on campus. Respondents also rate these items on Likert scales.

Use of Student Counseling Services. Ten items were used to assess student experiences with counseling or mental health services. Seven items were adapted from the University of California Undergraduate Experience Survey (The Regents of the University of California, 2008), and three items were developed by RAND. Items asked about referral for services, referral sources, quality of services received, reasons why students may not have engaged in services, and receipt of information on specific mental health issues. Respondents rate items using a combination of Yes/No response options and Likert scales.

Campus Climate. Perceived campus climate was assessed using two items from the University of California Undergraduate Experience Survey (UCUES) (The Regents of the University of California, 2008) and the CSCS (WestED, 2013e). One item assessed perceived general climate for students on campus along a variety of dimensions (e.g., hostile versus friendly, impersonal versus caring), and the other item assessed the degree to which campuses provided support for students in need of mental health or counseling services and students with distress.

Higher Education Faculty/Staff Survey

Demographics. Demographic information included eight items that assessed age, gender (male, female, other), ethnicity (Hispanic, Latino, or Spanish origin), and race, as well as additional questions about respondents' role at their organization and the types of students they work with.

Campus Climate. Campus climate items covered three broad categories: (1) campus services for student mental health needs (four items), (2) programs and resources for staff, faculty, and

students regarding student mental health issues (nine items), and (3) campus support for student mental health needs (11 items). All items were adapted from the CSCS (WestED, 2013e) and the Health-Promoting School Survey (Rogers et al., 1998). Respondents rated items on a 5-point Likert scale.

Faculty/Staff Activities to Support Student Mental Health. We assessed faculty and staff activities to support student mental health using one item adapted from the MHFA Survey (Kitchener and Jorm, 2002) that asked how often respondents talked with students about their mental health problems, as well as four items developed by RAND that asked about respondents' experience with attending online and in-person trainings on student mental health issues. Specifically, we asked respondents whether they had attended any training, and to give us reasons why they did or did not attend. In addition, two items developed by RAND assessed the number of students that respondents have been concerned about due to psychological distress, and the number of students they have referred for services.

K–12 Education Student Measures

We adapted items from the CalSCHLS, which includes the CHKS and CSCS to assess demographics, level of distress and functioning, student coping and resilience, and use of and access to student counseling services.

Demographics. Demographic items were adapted from the WestED CHKS Core Module (WestED, 2013a). It includes six items that will assess age, gender (male, female, other), ethnicity (Hispanic, Latino, or Spanish origin), race, and living arrangement.

Level of Distress and Functioning. Three items were adapted from the CHKS Core Module (WestED, 2013a) that ask about frequency of use of alcohol or drugs and feelings of sadness or hopelessness.

Student Coping and Resilience. Five items were adapted from the CHKS Resilience Module B (WestED, 2013c), and one item was developed by RAND to assess student coping and resilience. The items assess impairment of academic success due to psychological distress, coping with a personal problem or stress, and ability to access supportive services on campus. Items were assessed using 4-point Likert scales.

Use of and Access to Student Counseling Services. Five items were used to assess student experiences with counseling or mental health services. One item was used from the CHKS California Student Survey (CSS) Module (WestED, 2013b) and four items from CHKS School Health Center (SHC) Module (WestED, 2013d).

K–12 Education Staff Measures

We also adapted items from the CSCS for the staff version of the survey. The CSCS is a survey of educators that also includes questions related to student mental health, school climate, and the availability of appropriate and culturally relevant support services, including whether the school provides counseling and support to students who need it, and the extent to which the

school collaborates well with organizations for youth who have substance use or other types of problems.

Demographics. Demographic items were adapted from the WestED CHKS Core Module (WestED, 2013a). They include seven items that will assess race/ethnicity, role at the school, types of services provided to students, and years worked at the school.

Mental Health Outcomes. We adapted one item from the CSCS that assessed staff opinions about problems they may have observed in doing their job at school. Staff are instructed to rate the severity of the following problems: student alcohol and drug use, student tobacco use, harassment or bullying among students, physical fighting between students, disruptive student behavior, and student depression or other mental health problems.

Mental Health Services. We used three items from the CSCS to assess perceptions of availability of student mental health services. Using a 4-point Likert scale, items assessed to what extent their school provides health or prevention services and activities. .Finally, one item assessed whether staff felt they needed more professional development, training, mentorship, or other support to provide positive behavioral support and meet the social, emotional, and developmental needs of youth.

Overview of Survey Dissemination Procedures and Progress

Higher Education Surveys. In collaboration with the campus Program Partners, RAND is disseminating a student mental health campus-wide survey to both faculty/staff and students. Some campuses have chosen to send an email with a link to the survey to all faculty/staff and students, while others will be distributing the survey to a randomly selected sample of faculty/staff and students, with the goal of achieving a minimum of 3 percent of students and faculty/staff from each campus, or 150 to 200 respondents, whichever is greater. To help facilitate recruitment of respondents, campuses' Institutional Research Offices or other recognized entities will distribute a letter of invitation (drafted by RAND/SRI with feedback from the Program Partners) by email with a customized website link to students and faculty/staff. The website link is hosted and managed by the RAND data team. From the email, potential respondents can follow the link to an introductory and consent page where they can agree to participate in the survey. At the end of the survey, respondents will have the opportunity to submit their email address to be entered into a $1,000 prize drawing for each higher education system (University of California, California State University, and California Community Colleges). These email addresses will be stored separately from the survey data and will not be connected to individual surveys in any way. At no time will RAND reach out to the potential participants directly.

Four California Community Colleges campuses and four University of California campuses participated in a soft-launch of the web-based surveys in Spring 2013. All remaining campuses that elect to participate across California Community Colleges, California State University, and University of California are scheduled to field the surveys during Fall 2013 and Spring 2014.

K–12 Education Surveys. In collaboration with the K–12 Program Partners (California Department of Education and California County Superintendents Educational Services Association) and WestED, the evaluation will include a K–12 mental health campus-wide survey distributed to both staff and students during the 2013–14 academic year. RAND is working closely with California County Superintendents Educational Services Association and California Department of Education to develop a sampling plan for schools.

Survey Preliminary Results

As indicated, the higher education surveys were designed to evaluate whether the trainings and prevention and early intervention (PEI) activities resulted in changes consistent with (1) improved student mental health, (2) changes in the school/campus environment, and (3) changes in student behavior and attitudes. To address this aim, we are evaluating the data collected from the higher education campus-wide survey for students and faculty/staff. We first present findings from the student survey and then from the faculty/staff survey.

Student Survey Preliminary Results

A total of 6,309 students participated in the higher education survey, with 5,491 from the University of California system and 794 from the California Community Colleges system. A handful of respondents chose not to identify themselves with a system of higher education (n = 24). As the surveys were currently in the field at the time this report was written, response rates are not yet available.

Demographics. Demographic information is presented in Table 4.21. The majority of respondents for the student survey were between 17 and 25 years of age (n = 5,190, 82%), followed by ages 26–59 (n = 1,074, 17%), ages 60–84 (n = 10, < 1%), and ages 85+ (n = 6, <1%). Sixty-three percent (n = 3,987) of respondents identified themselves as male, 36 percent (n = 2,254) as female, and less than 1 percent (n = 38) as other (e.g., transgender). Twenty percent (n = 1,223) of respondents identified themselves as being Hispanic, Latino, or of Spanish origin, and 90 percent of those respondents (n = 712) reported English as their primary language. The majority of respondents were undergraduate students (n = 5,226, 84%).

Table 4.21
SMH Student Survey Respondent Demographics

	N	Percentage
Age		
17–25	5,190	83
26–59	1,074	17
60–84	10	0
85+	6	0
Gender		
Male	3,987	63
Female	2,254	36
Other (e.g., transgender)	38	<1
Hispanic, Latino, or Spanish origin		
Yes	1,223	20
No	5,037	80
English as primary language		
Yes	712	90
No	83	10
Student status		
Undergraduate student	5,226	84
Graduate student	1,024	16
Full time	5,823	93
Part time	433	7
Years at this campus:		
1	1,978	32
2	1,711	27
3	1,191	19
4	941	15
5	225	4
≥6	177	3

Level of Distress and Functioning. Students were asked about their general level of distress and functioning over the past 30 days, using a 5-point Likert scale ranging from 1 = all of the

time to 5 = none of the time (see Table 4.22 for a list of items). The average aggregate score ranged between 3 (some of the time) to 4 (a little bit of the time). In the preliminary analysis, approximately 20 percent of students (n = 1,257) met or exceeded the recommended threshold of 13 for having a probable mental health problem (Kessler et al., 2003). This rate is comparable to other higher education surveys (Hunt and Eisenberg, 2010), but higher than the general population (Ward, Schiller, and Freeman, 2013). We will assess if this level of distress is seen among future respondents from other campuses. Future analyses will also examine the percentage of the student population meeting different thresholds and will explore the variation in rates of distress and functioning among several subgroups of interest.

Table 4.22
SMH Student Survey –- Level of Distress and Functioning

The next questions are about how you have been feeling during the past 30 days.	**N**	**M**	**SD**
a. How often did you feel nervous?	6,280	3.15	0.89
b. How often did you feel hopeless?	6,273	3.77	1.06
c. How often did you feel restless or fidgety?	6,271	3.22	1.01
d. How often did you feel so depressed that nothing could cheer you up?	6,276	4.02	1.04
e. How often did you feel that everything was an effort?	6,263	3.21	1.13
f. How often did you feel worthless?	6,278	4.05	1.11

Note: 1 = all of the time, 2 = most of the time, 3 = some of the time, 4 = a little bit of the time, 5 = none of the time.

Student Coping and Resilience. Students were asked to report whether various behaviors or stressful situations had impacted their academic performance over the last 12 months, using a Likert scale ranging from 1 = this did not happen to 6 = significant disruption/took a leave of absence. For each behavior or situation, the average respondent indicated that he/she did not experience impairment related to academic performance (see Table 4.23). However, 6 percent reported some level of impairment in the past year due to alcohol use, 35 percent reported impairment due to anxiety, 9 percent due to the death of a friend or family member, 25 percent due to depression, 5 percent due to an eating disorder/problem, and 45 percent due to stress.

Table 4.23
SMH Student Survey –- Impact of Distress on Academic Performance

Within the last 12 months, have any of the following affected your academic performance?	N	Percentage Impaired[a]
Stress?	2,837	45
Anxiety?	2,185	35
Depression?	1,564	25
Death of a friend or family member?	567	9
Alcohol use?	400	6
Eating disorder/problem?	294	5

[a]Impairment is defined as endorsing any of the following: received lower grade on an exam, received lower grade in a course, received incomplete/dropped course, significant disruption/took a leave of absence.

Students also reported on their survey whether they knew where to go for help if they were experiencing stress or a personal problem, and about their skills or approaches to cope with the problem. On average, 57 percent to 79 percent of respondents endorsed "very true" or "pretty much true" that they knew where to go for help and had a variety of ways to cope with the problem (Table 4.24).

Use of Student Counseling Services. Twenty-five percent (n = 1,540) of students indicated that they had either used counseling or mental health services through their current college/university campus's Counseling or Health Service Center, or had been referred to such services. Table 4.25 indicates that in the majority of cases (71.8%) the student him/herself initiated the process of seeking services.

Table 4.24
SMH Student Survey –- Coping Skills

How true do you feel these statements are about you personally?	N	Percentage pretty much or very true
I accept mistakes as part of the learning process.	4,933	79
I seek alternative solutions to a problem.	4,741	76
I can work out my problems.	4,628	74
I know where to go for help with a personal problem.	4,203	67
I am aware of where to go on campus if I need mental health or other similar supportive services.	4,044	64
When I need help, I find someone to talk with.	3,806	61
I try to work out problems by talking or writing about them.	3,593	57

Note: 1 = not at all true, 2 = a little true, 3 = pretty much true, 4 = very much true.

Table 4.25
SMH Student Survey – Initiator of Service Seeking for Student Receiving or Referred for Counseling Services

Initiator	N	Percentage
Student	1,095	71.8
Parent	340	22.3
Resident Assistant (RA)	282	18.5
Student Health	154	10.1
Peer (Health) Educator	131	8.6
Professor/Teaching Assistant	107	7.0
Other	92	6.0
Friend	83	5.4
Academic Advisor	62	4.1
Medical Provider	45	2.9

Note: Multiple responses allowed. Denominator based on 1,526 students who responded to this question.

Seventy-five percent of students who sought or were referred for mental health services or counseling ended up receiving such services on campus (n = 1,199), and 77 percent (n = 922) received services in the last 12 months. Among students who reported receiving services, the quality of the services received was rated as good (mean [M] = 3.06, standard deviation [SD] = 0.90). Students who did not receive services (75%, n = 4,742) either felt they did not need

services (75.4%), did not have enough time (32.4%), or did not think it would help (26.5%). Almost one-quarter (22.5%) responded that they were embarrassed to use student counseling services, and almost 20 percent of respondents did not know which services were offered, how to access them, and/or were worried about costs. About 17 percent of students did not know they were eligible for student counseling services. Finally, when students were asked if they would consider seeking help from a mental health professional if they were having a personal problem that was really bothering them, 75 percent (n = 4,714) reported "yes."

Table 4.26
SMH Student Survey –- Reasons Students Did Not Receive Student Counseling Services

Reason	N	Percentage
I didn't feel I needed services.	3,741	75.4
I didn't have enough time.	1,608	32.4
I didn't think it would help.	1,313	26.5
I was embarrassed to use it.	1,115	22.5
I didn't know what it offered.	1,080	21.8
I didn't know how to access it.	1,013	20.4
I had concerns about possible costs.	1,003	20.2
I didn't know if I was eligible.	846	17.0
I had concerns about possible lack of confidentiality.	497	10.0
I had never heard of it.	472	9.5
The wait for an appointment was too long.	261	5.3
The hours are inconvenient.	253	5.1
The location is inconvenient.	189	3.8
I got help from another university service or staff person instead.	139	2.8
It has a poor reputation.	133	2.7

Note: Multiple responses allowed. Denominator based on 4,962 students who responded to this question.

Students were also asked a series of questions to assess the reach of information about student counseling and mental health services on campus. Generally the reach of information on depression/anxiety, alcohol and other drug use, and stress reduction was moderately high, ranging from 45 to 69 percent of students receiving information from their college or university (see Table 4.27). However, information on grief and loss, how to help others in distress, problem use of the Internet or computer games, relationship difficulties, suicide prevention, and tobacco use was less frequently received, ranging from 35 to 5 percent reach.

Table 4.27
SMH Student Survey –- Percentage Who Received Information on Student Mental Health Topics from Their College/University

Depression/anxiety	**45**
Information provided through online resources (e.g., Facebook, email, campus website, Student Health 101)	64
Information provided through in-person training at your campus	53
Information provided through online training at your campus	25
Alcohol and other drug use	**69**
Information provided through online resources (e.g., Facebook, email, campus website, Student Health 101)	81
Information provided through in-person training at your campus	57
Information provided through online training at your campus	61
Grief and loss	**12**
Information provided through online resources (e.g., Facebook, email, campus website, Student Health 101)	65
Information provided through in-person training at your campus	59
Information provided through online training at your campus	30
How to help others in distress	**35**
Information provided through online resources (e.g., Facebook, email, campus website, Student Health 101)	66
Information provided through in-person training at your campus	66
Information provided through online training at your campus	38
Problem use of Internet/computer games	**5**
Information provided through online resources (e.g., Facebook, email, campus website, Student Health 101)	78
Information provided through in-person training at your campus	45
Information provided through online training at your campus	38
Relationship difficulties	**23**
Information provided through online resources (e.g., Facebook, email, campus website, Student Health 101)	60
Information provided through in-person training at your campus	67
Information provided through online training at your campus	25
Stress reduction	**59**

Information provided through online resources (e.g., Facebook, email, campus website, Student Health 101)	72
Information provided through in-person training at your campus	66
Information provided through online training at your campus	30
Suicide prevention	**29**
Information provided through online resources (e.g., Facebook, email, campus website, Student Health 101)	73
Information was provided through in-person training at your campus	53
Information provided through online training at your campus	41

Note: These categories allow for multiple responses. Denominator is based on total population that received information for the corresponding topic.

For students who answered "yes" to receiving information on the topics related to student mental health (Table 4.28), we asked how useful the information received was. Students reported an average rating ranging from 3 to 4 on a scale of 1 = not useful to 5 = very useful.

Campus Climate. Students reported on the overall climate of their campus with respect to mental health issues. Data indicated that students felt their campuses were more friendly than hostile (M = 4.78, SD = 1.06 on a scale of 1 = hostile to 6 = friendly), more caring than impersonal (M = 4.13, SD = 1.32 on a scale of 1 = impersonal to 6 = caring), more tolerant of diversity than intolerant (M = 4.67, SD = 1.30 on a scale of 1 = intolerant to 6 = tolerant), and more safe than dangerous (M = 4.54, SD = 1.25 on a scale of 1 = dangerous to 6 = safe). Finally, students reported on a variety of statements about their campus and themselves in regard to student mental health issues (Table 4.29).

Table 4.28
SMH Student Survey –- Usefulness of Information on Student Mental Health Issues

Was the information useful?	N	M	SD
Depression/anxiety	2,797	3.35	0.98
Alcohol and other drug use	4,332	3.42	1.14
Grief and loss	746	3.45	1.08
How to help others in distress	2,201	3.62	0.95
Problem use of Internet/computer games	321	3.21	1.10
Relationship difficulties	1,430	3.34	1.07
Stress reduction	3,685	3.45	1.07
Suicide prevention	1,804	3.55	1.05
Tobacco use	1,166	3.27	1.24

Note: 1 = not useful to 5 = very useful.

Table 4.29
SMH Student Survey –- Campus Climate and Individual Behavior

How much do you agree with the following statements about your campus and yourself?	N	M	SD
a. My school provides adequate counseling and support services for students.	6,257	3.72	0.91
b. My school provides effective confidential support and referral services for students needing help because of substance use, violence, or other problems (e.g., a Student Assistance Program).	6,240	3.74	0.86
c. My school emphasizes helping students with their social, emotional, and behavioral problems.	6,236	3.59	0.96
d. People with mental health problems experience high levels of prejudice and discrimination at my school.	6,240	2.60	1.03
e. Faculty members on my campus are concerned about students' emotional well-being.	6,241	3.34	1.00
f. My school does a good job of getting the word out to students about the available mental health services on campus for students.	6,250	3.39	1.05
g. There is an emotionally supportive climate on this campus for students with mental health needs.	6,245	3.42	0.91
h. There is an emotionally supportive climate on this campus for students with substance abuse problems.	6,240	3.33	0.92
i. There is an emotionally supportive climate on this campus for students who have been victims of abuse or other violence.	6,241	3.59	0.92

Note: 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree.

Faculty/Staff Survey Preliminary Results

In total, 3,025 faculty and staff participated in the survey, 2,754 from the University of California system and 233 from the California Community Colleges system. Note that some respondents chose not to identify with a particular higher education system (n = 38). As the survey was in the field at the time of this report, response rates had not yet been determined.

Demographics. The majority of respondents for the faculty/staff survey were between 26 and 59 years of age (n = 2,323, 78%). Sixty-eight percent of respondents identified themselves as female, 32 percent as male, and less than 1 percent as other (e.g., transgender). Fifteen percent were of Hispanic, Latino, or Spanish origin. Respondents reported an array of roles at their campus and educational backgrounds. See Table 4.30 for further detail.

Table 4.30
Faculty/Staff Survey Respondent Demographics

	N	Percentage
Age		
17–25	358	12
26–59	2,323	78
60–84	293	10
85+	4	<1
Gender		
Male	952	32
Female	2,016	68
Other (e.g., transgender)	6	<1
Hispanic, Latino, or Spanish origin		
Yes	442	15
No	2,506	85
Current role at your campus		
Other	1,292	44
Administrator	833	29
Full-time faculty	555	19
Part-time faculty/adjunct faculty	224	8
Education level		
Graduate or professional degree (MA, PhD, JD, MD)	1,463	49
Bachelor's degree	1,001	34
Some college or technical school	294	10

	N	Percentage
Associate or technical degree	152	5
High school diploma/GED	69	2

Campus Climate. Faculty/staff responded to two sets of questions. First, on a Likert scale from 1 = strongly disagree to 5 = strongly agree, faculty/staff answered questions about the overall climate of their campus as it relates to student mental health (Table 4.31). Faculty/staff felt that their campus provides adequate counseling and support services for all students as well as for students with unique needs. Faculty/staff also felt that their campus provides effective confidential support and referral services for students needing help because of depression, stress, substance use, violence, or other emotional issues and that their campus emphasizes helping students with social, emotional, and behavioral needs.

Table 4.31
Faculty/Staff Report of Student Mental Health Services on Campus

How much do you agree with the following statements about this campus?	N	M	SD
This campus provides adequate counseling and support services for students.	2,985	3.66	0.93
This campus provides adequate counseling and support services for students with unique needs (e.g., diverse ethnic/language groups, LGBTQ, low income).	2,978	3.72	0.94
This campus provides effective confidential support and referral services for students needing help because of depression, stress, substance use, violence, or other emotional issues.	2,977	3.68	0.92
This campus emphasizes helping students with their social, emotional, and behavioral needs.	2,983	3.64	0.96

Note: 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree.

Second, faculty/staff answered questions on a Likert scale from 1 = not at all to 5 = a great deal, regarding the extent to which their campus actively put into place programs and policies to address student mental health needs (Table 4.32). Faculty/staff varied in the extent to which they believed different programs were in place, but most faculty and staff believed that there were support, resources, or programs for students with mental health needs. They were least likely to believe that training programs to help staff/faculty recognize and respond to students at risk for suicide were in place or that there were social media campaigns to reduce stigma and improve awareness of student mental health for the whole campus.

Table 4.32
Faculty/Staff Report of Student Mental Health Programs on Campus

To what extent is your campus actively putting into place the following policies or programs?	N	M	SD
Programs and resources for students that promote the responsible use of, or abstinence from, alcohol.	2,895	3.42	1.00
Programs and resources for staff and faculty to refer students for help with drug or alcohol problems.	2,931	3.18	1.09
Support, resources, or programs for students with mental health needs.	2,897	3.66	0.96
Support, resources, or programs for staff and faculty to refer students with mental health needs.	2,938	3.40	1.07
Training programs to help students recognize and respond to other students with mental health needs.	2,855	3.10	1.06
Training programs to help staff and faculty recognize and respond to students with mental health needs.	2,932	3.10	1.15
Training programs to help students recognize and respond to students at risk for suicide.	2,847	3.06	1.08
Training programs to help staff and faculty recognize and respond to students at risk for suicide.	2,918	2.99	1.17
A social media campaign to reduce stigma and improve awareness of student mental health for the whole campus.	2,881	2.80	1.16

Note: 1 = not at all, 2 = very little, 3 = somewhat, 4 = a moderate amount, 5 = a great deal.

Faculty/Staff Activities to Support Student Mental Health. In addition to faculty/staff perceptions about campus climate and campus services/programs for students, we assessed faculty and staff activities to support student mental health. In the past six months, 24 percent of faculty/staff reported talking to a student about the student's mental health problems at least once or twice, 17 percent did so a few times, and 13 percent did so many times. However, a large percentage (46%) of faculty/staff did not talk with students about their mental health at all in the last six months (Table 4.33). Given the stigma around mental health and Program Partner efforts to enhance the campus climate with respect to mental health despite its stigma, as well as staff and faculty knowledge, awareness, and skills in identifying and intervening with students experiencing mental health problems, the rates of faculty who report talking with a student about the student's mental health problems are encouraging.

Table 4.33
Faculty/Staff Report of Student Mental Health Programs on Campus

In the past 6 months, how often have you talked with students about their mental health problems?		
Never	1,369	46%
Once or twice	712	24%
A few times	523	17%
Many times	388	13%

With respect to trainings relevant to student mental health issues, 20 percent (n = 581) of faculty/staff reported attending any trainings online or in-person to help better support students with mental health problems over the past six months, whereas 80 percent did not attend any trainings (n = 2,388). The majority of faculty/staff who attended the trainings (n = 581) indicated that they did so because the trainings provide helpful information (72%), they want to improve their ability to help students with mental health problems (60%), and they think the trainings are a way to affect student mental health at their campuses (53%) (Table 4.34).

Table 4.34
Reasons Faculty/Staff Attended Student Mental Health Trainings

	N	**Percentage**
The trainings provide helpful information.	418	72
I am not required to participate, but I wanted to improve my ability to help students with mental health problems.	350	60
I think the trainings are a way to affect student mental health at my campus.	309	53
Training is part of my job to work with students with mental health problems.	253	44
My campus encouraged and supported me to go.	220	38
The trainings could accommodate my schedule.	137	24
The campus or my job required me to participate.	129	22
I receive an incentive (e.g., continuing education unit [CEUs], bonuses) from my campus to participate in training.	23	4

Note: Multiple responses allowed. Denominator based on 581 faculty/staff who responded to this question.

The majority of faculty/staff who did not attend trainings in the last six months (n = 2,388) indicated that they did not know trainings were offered (60%). See Table 4.35 for the full list of reasons faculty/staff did not attend student mental health trainings in the last six months.

Table 4.35
Reasons Faculty/Staff Did Not Attend Student Mental Health Trainings

	N	Percentage
I didn't know what trainings were offered.	1,424	60
The training is not required.	747	31
My campus does not encourage me to go.	651	27
I have been too busy to participate.	639	27
Student mental health does not affect my daily work.	527	22
I didn't feel I needed to participate.	493	21
I didn't know how to access online trainings.	464	19
I don't receive an incentive (e.g., CEUs, bonuses) from my campus to participate in training.	323	14
Trainings don't accommodate my schedule.	292	12
The information provided about the training was not sufficient.	243	10
I don't have a personal or professional interest in student mental health.	181	8
Available trainings aren't very helpful.	122	5
I don't think the trainings would affect student mental health at my campus.	86	4

Note: Multiple responses allowed. Denominator based on 2,388 faculty/staff who responded to this question.

Faculty/staff were also asked whether they accessed information about student mental health online through their university's or campus's website. Twenty percent (n = 612) reported that they accessed information online in the past six months.

Faculty/staff were asked to indicate the extent to which they agreed with various issues about student mental health needs on campus and things they may have done to help address the issue on their campus. The majority of faculty/staff (63% to 56%) agreed that they can identify places or people where they should refer students with mental health needs/distress (63%), that programs on campus send the message to students that help is available for mental health problems (58%), that they are able to help students in distress get connected to the services they need (58%), and that they are aware of the warning signs of mental health distress (56%). In contrast, fewer faculty/staff felt confident in their ability to help students address mental health issues (34%) or felt that they can only help a student with mental health distress if the student seeks assistance (33%). See Table 4.36 for specific questions and the percentage that agreed.

Table 4.36
Faculty/Staff Opinions on Student Mental Health Issues

	N	Percentage Agreed
I can identify the places or people where I should refer students with mental health needs/distress.	1,854	63
The programs on campus send the message to students that help is available for mental health problems.	1,701	58
I am able to help students in distress get connected to the services they need.	1,724	58
I am aware of the warning signs of mental health distress.	1,663	56
This campus has an adequate number of resources or people to whom I could refer students with mental health needs/distress.	1,434	49
I feel comfortable discussing mental health issues with all types of students.	1,362	46
Our college/university has online resources that I can utilize for addressing student mental health.	1,298	44
I have easy access to the educational or resource materials I need to learn about student mental health.	1,176	40
I don't have the necessary skills to discuss mental health issues with a student.	1,080	37
I am confident in my ability to help students address mental health issues.	1,000	34
I can only help a student with mental health distress if they seek assistance.	984	33

Within the past six months, 50 percent (n = 1,501) of faculty/staff reported being concerned about one or more students due to the student's psychological distress and 34 percent (n = 1,014) of faculty/staff referred at least one student for support services.

Summary

The SMH Networking and Collaboration evaluation will focus on the California County Superintendents Educational Services Association country consortia, the State SMH Policy Workgroup, University of California and California State University SMH Initiative Advisory Groups, California Community Colleges Regional Strategizing Forums, and inter- and intra-campus collaborations among the higher education Program Partners. We are currently reviewing related documents and will conduct key informant interviews and a collaboration survey later.

SMH Program Partners are making many informational resources available online. These include resources about mental health issues for students and information for faculty and staff regarding approaches to supporting students with mental health needs. Thus far, we reviewed these websites for content and target audience. Website analytic and feedback survey data are not yet available for SMH Program Partners, with the exception of California County

Superintendents Educational Services Association. We are designing a follow-back survey to capture users' opinions about the website and the quality and utility of the content shortly after they have visited the site.

SMH Program Partners implemented a variety of training programs, including TETRIS TOT and community college training programs. We have provided technical assistance to SMH Program Partners to implement training surveys, as well as tools for tracking the reach of trainings. In the future, we will be selecting several trainings for detailed content analysis. Preliminary analyses of training survey data indicate that participants reported being satisfied with the training and experiencing increased self-efficacy and behavioral intentions after undergoing training.

In addition to the evaluation of the key Program Partner activities, we have begun collecting data for and have designed baseline surveys of student, faculty, and staff perceptions of school climate and student attitudes and behavior related to mental health. The K–12 survey has not yet been fielded, but preliminary data based on higher education students, faculty, and staff are available. Responses to date suggest that about 20 percent of higher education students are likely to be experiencing a mental health problem, and 25 percent reported having been referred to campus mental health services. About 25 to 35 percent of students reported that their academic performance was negatively affected by anxiety or depression. However, most students indicated that they know where to go for help when they need it. Students generally believed there was a positive campus climate vis a vis mental health issues. Faculty and staff reported that their campuses provided adequate mental health counseling and support to students. About a quarter (24%) of faculty and staff reported having talked with a student about mental health once or twice, and 30 percent did so a few or many times, but a large proportion (46%) did not discuss mental health with students in the past six months. Twenty percent of faculty/staff reported having attended some form of training on student mental health in the past six months. Over half of faculty/staff felt that they knew where to refer students who need mental health resources.

In sum, SMH Program Partners are engaging in a wide variety of activities, including collaborating with other organizations, providing informational resources, and offering training on student mental health issues. Many evaluation activities designed to assess reach of these expanded capacities and resources are in progress. Ongoing surveys of school mental health climate provide a useful baseline against which to compare future school climate data.

SECTION II: GENERAL POPULATION STATEWIDE SURVEY

5. RAND General Population Survey Baseline Results

In this chapter, we present the results of a general population statewide survey of California adults. The survey is intended to provide a measure of the population-level knowledge, beliefs, attitudes, and behavioral intentions that are targets for change across the three PEI initiatives and Program Partners' activities (see list of survey topics in Table 5.1). The survey will be administered again in approximately one year to help determine population-level changes across the items listed in Table 5.1 and provide some insight into the degree to which these changes might be attributable to CalMHSA statewide PEI activities. A full listing of survey questions can be found in Appendix G. Results presented below are preliminary; in-depth analysis of the survey data is ongoing.

Table 5.1
General Population Survey Topics for Each PEI Initiative

SDR
• Awareness of mental health stigma and discrimination • Social distance from people with mental health challenges • Perceived dangerousness of people with mental health challenges • Beliefs about mental health recovery • Social inclusion of people with mental health challenges • Provision of support to people with mental health challenges • Self-labeling as a person with a mental health challenge • Mental health treatment seeking behavior and intentions • Willingness to disclose a mental health challenge • Potential exposure to CalMHSA SDR activities
SP
• Knowledge about suicide • Self-efficacy for serving in a gatekeeper role • Potential exposure to CalMHSA SP activities • Attention to SP social marketing messages • Liking of SP social marketing messages • Resource preference
SMH
• K–12 mental health school climate • Higher education mental health school climate

Overview of Respondents and Procedures

The general population survey randomly sampled 2,001 adults (Wave 1) across California who are 18 and older and who were reachable by telephone (landline or cell phone); it excludes

the approximately 2 percent of California adults without a telephone. We will follow up with a subset of participants from the first wave in approximately one year. RAND developed the survey content. Field Research Corporation collected data between May 10 and June 22, 2013, using its computer-assisted telephone interview (CATI) system. The survey was administered in English or Spanish, depending on the preferred language of the respondent.

Sampling and Recruitment Procedures

The sample was drawn from random digit dial lists of both household landline and cell phone numbers. Adults reached by cell phone or at households with only one adult were invited to participate. In households where more than one adult resided, the adult with the most recent birthday was invited to participate. Adults were eligible to participate if they confirmed that they were at least 18 years of age and resided in California. Adults who were willing to participate in a follow-up survey in one year and consented to participate in the current survey wave were enrolled. A $10 cash incentive upon completion of the follow-up survey would be provided to all respondents. There were 74,987 phone numbers opened and dialed, and 2,001 adults who completed the survey. We estimate that about 50 percent of the known *eligible* households cooperated with this survey, although there may have been more eligible households among those we were unable to contact and screen. There were 1,693 participants who completed the survey in English, and 308 who completed it in Spanish.

Weighting the Sample

We applied a two-stage weighting procedure to the data so that the results of the survey approximate those of the adult population of California. First, a weighting adjustment was made to account for the possibility that some individuals in the sample would have a greater likelihood of selection because they have both household landline phones and cell phones. This adjustment was made based on respondents' answers to survey questions about the proportion of personal calls they receive on their home and cell phones. Second, post-stratification weights were applied to align the characteristics of the survey sample with the broader California adult population (according to the 2010 U.S. Census). Post-stratification weights were developed based on respondents' geographic location, race and ethnicity, age, and gender.

Sample Characteristics

Respondent characteristics for both the unweighted and weighted samples are presented in Table 5.2. The sample was evenly split between male and female respondents, with participants spread fairly evenly between ages 18 and 64. Respondents were racially and ethnically diverse with 60 percent of the sample identifying as White/Caucasian; 5 percent as Asian; and 7 percent as Black/African American. The remainder of the sample identified as being another race or multiracial. About 21 percent of respondents identified as being Latino or Hispanic. Respondents' educational attainment also varied, with about 14 percent of respondents not

having completed a high school degree and about 19 percent each obtaining high school diplomas and college degrees, respectively. More than half of respondents were employed (42 percent for wages and 13 percent self-employed). Marital status was 26 percent never married and 42 percent married. Approximately half of respondents reported a pre-tax annual household income of $40,000 or less, and 17 percent reported household income greater than $100,000. The demographic characteristics of the sample are similar to the general population of California, and all expected age, racial, and ethnic groups are included in the sample.

Table 5.2
Sociodemographic Characteristics of General Population Survey Respondents

	Unweighted Frequency	Weighted Frequency	Unweighted Percentage	Weighted Percentage
Gender (n = 2,001)				
Male	963	984.06	48.13	49.20
Female	1,038	1,016.00	51.87	50.80
Age (n = 1,575)				
18–29	361	476.06	22.92	27.96
30–39	288	368.06	18.29	21.62
40–49	345	380.03	21.90	22.32
50–64	572	471.99	36.32	27.73
65 or older	9	6.22	0.57	0.37
Hispanic/Latino ethnicity (n = 1,966)				
Latino/Hispanic	617	670.89	31.38	34.12
Not Latino/Hispanic	1,349	1,295.00	68.62	65.88
Race (n = 1,947)				
Alaskan Native	1	0.30	0.05	0.02
American Indian	29	27.81	1.49	1.43
Asian	96	173.26	4.93	8.90
Black/African American	131	120.95	6.73	6.21
Hispanic/Latino (volunteered)	406	446.26	20.85	22.93
Multiracial	110	94.92	5.65	4.88
Native Hawaiian	3	5.75	0.15	0.30
Other Pacific Islander	12	23.13	0.62	1.19
White/Caucasian	1,159	1,054.00	59.53	54.15
Education (n = 1,994)				
8th grade or less	143	140.95	7.17	7.07

	Unweighted Frequency	Weighted Frequency	Unweighted Percentage	Weighted Percentage
Some high school/did not graduate	139	152.00	6.97	7.62
High school graduate	377	390.98	18.91	19.61
Trade/vocational school	67	68.95	3.36	3.46
1–2 years of college	419	415.20	21.01	20.83
3–4 years of college/did not graduate	138	143.39	6.92	7.19
College graduate (B.A./B.S.)	380	379.56	19.06	19.04
5–6 years of college	51	47.39	2.56	2.38
Master's degree	159	148.26	7.97	7.44
Graduate work past Master's/Ph.D.	121	107.03	6.07	5.37
Employment (n = 1,986)				
Employed for wages	843	917.96	42.45	46.29
Self-employed	258	258.30	12.99	13.03
Looking for work	169	184.76	8.51	9.32
Retired	451	332.27	22.71	16.76
Homemaker/keeping house	168	173.33	8.46	8.74
Disabled	159	151.73	8.01	7.65
Student	168	209.40	8.46	10.56
Marital status (n = 1,979)				
Married	839	769.69	42.40	38.89
Not married but live with partner	165	190.71	8.34	9.64
Separated	91	93.21	4.60	4.71
Divorced	235	213.57	11.87	10.79%
Widowed	142	104.01	7.18	5.26%
Never married	507	608.02	25.62	30.72
Annual household income (pre-tax) (n = 1,738)				
Under $20,000	462	491.07	26.58	28.32
$20,000–$40,000	375	387.65	21.58	22.36
$40,000–$60,000	257	259.18	14.79	14.95
$60,000–$80,000	201	189.51	11.57	10.93
$80,000–$100,000	141	131.01	8.11	7.55
$100,000 or more	302	275.65	17.38	15.90

Preliminary Results

Several caveats should be kept in mind while interpreting these results. First, they are preliminary; analyses are ongoing. Second, as part of our introduction and informed consent we indicated the topic of the survey and its length (about 25 minutes to complete). While we have no specific indication that these factors introduced bias, it is possible that people with more interest in mental health participated at a higher rate. However, demographic data indicate that a full range of the California population age 18 and over is represented and among those who listened to the introduction the response rate was about 50 percent, which is relatively high. Third, this survey is not designed to assess the reach of efforts targeted at particular subsets of the population, such as children and adolescents (who are excluded from the sample), or particular groups, such as opinion leaders (who are included in the sample, but not in large enough numbers to make accurate estimates).

Stigma and Discrimination Reduction (SDR)

Many of the general population survey questions were relevant to the SDR initiative and assessed attitudes and beliefs about people with mental health challenges. These data will provide a useful point of comparison for similar items that are in the pre-post survey, so that changes in attitudes and beliefs after training and educational presentations can be contextualized in terms of the attitudes and beliefs of the broader California adult population. We note at the outset that there are many different ways of measuring mental illness stigma. Our survey incorporated a variety of such measures in an attempt to capture the full range of constructs that have been examined previously and that are relevant to CalMHSA's SDR approach (Link et al., 2004). We summarize the baseline results for several key areas and discuss them in the context of other California, national, and international surveys where possible. Responses to each SDR-relevant survey question have also been analyzed by respondents' demographic characteristics, and results are presented in Appendix H.

Awareness of Stigma and Discrimination

We found that 73 percent of those surveyed strongly or moderately agree that people with mental illness experience high levels of prejudice and discrimination (see Table 5.3). Only 41 percent moderately or strongly agree that people are generally caring and sympathetic toward people with mental illness. This could be interpreted as recognition among the majority of Californians that mental illness is a stigmatized condition that creates challenges and barriers for those experiencing it. If people are correct in their assessments of societal attitudes, stigmatization of mental illness is high in California. In contrast, the Centers for Disease Control (CDC) and Prevention find that 67 percent of California adults believe that people are generally caring and sympathetic toward those with mental illness – an estimate that is considerably higher than ours. However, the items were part of a broad CDC survey on health behaviors such as

smoking and exercise, and this may play a role in our differing results. In a sample of Australian adults, Reavley and Jorm (2011) looked at perceptions of discrimination for specific types of mental illness. They found that 59 percent of respondents think that a person with depression would be discriminated against, 74 percent for early schizophrenia, 84 percent for chronic schizophrenia, and 40 percent for PTSD. These percentages are more in line with our sample's assessment of levels of prejudice and discrimination.

Table 5.3
Awareness of Stigma and Discrimination (%)

Survey Item	CalMHSA General Population Survey Respondents Agreeing	Australian Adults Agreeing (Reavley and Jorm, 2011)	California Adults Agreeing (CDC, 2010)	U.S. Adults Agreeing (CDC, 2010)
People with mental illness experience high levels of prejudice and discrimination.	73			
A person with [disorder] would be discriminated against.				
Depression		59		
Early schizophrenia		74		
Chronic schizophrenia		84		
PTSD		40		
People are generally caring and sympathetic toward people with mental illness.	41		67	57

Social Distance

Social distance is a measure of people's unwillingness to interact or have contact with other people with specified characteristics. It is generally considered an indicator of stigma. We asked about social distance in regard to "someone with a serious mental illness." We learned that 34 percent of Californians would definitely or probably be unwilling to move next door to such a person, 23 percent would definitely or probably be unwilling to spend an evening socializing with him or her, and 29 percent would definitely or probably be unwilling to work closely on a job with him or her (see Table 5.4).

People may vary in what they think of when asked about "someone with a serious mental illness," and prior research suggests that the specific symptoms described (e.g., psychosis) and labels applied (e.g., "depression") can affect the measurement of social distance and other indicators of stigma. For this and other reasons, researchers often employ vignettes describing a specific scenario so that all participants have the same set of circumstances in mind when responding (Link et al., 2004). We adapted this strategy later in the survey. Respondents were

read a vignette depicting a person with one of three specific mental health problems – depression, schizophrenia, or PTSD. The three social distance questions we asked about "someone with mental illness" were repeated in reference to the person depicted in the vignette. When we combine results for these three conditions, we find that 19 percent of those surveyed would definitely or probably be unwilling to move next door to someone with one of these problems, 18 percent would definitely or probably be unwilling to spend an evening socializing with him or her, and 22 percent would definitely or probably be unwilling to work closely on a job with him or her.

However, responses were quite different for each of the three mental health conditions. Responses to PTSD and depression were very similar, with 11 percent of individuals definitely or probably unwilling to move next door to someone with symptoms of PTSD and 12 percent unwilling to do so for someone with symptoms of depression. Thirteen percent were probably or definitely unwilling to socialize with someone with either diagnosis; 13 percent were also probably or definitely unwilling to work closely on a job with someone with depression symptoms and 17 percent with someone with PTSD symptoms. In contrast, for schizophrenia, around one in three California adults was definitely or probably unwilling to move next door to (34%), socialize with (28%) ,or work closely with (37%) someone with that diagnosis.

Table 5.4
Social Distance (%)

Survey Item	CalMHSA General Population Survey Respondents	GSS 2006 Respondents (Pescosolido et al., 2010)	Australian Adults (Reavley and Jorm, 2011)
Unwilling to move next door to			
Someone with a serious mental illness	34		
A person with depression	12	20	
A person with PTSD	11		8
A person with schizophrenia	34	45	
Unwilling to spend an evening socializing with			
Someone with a serious mental illness	23		
A person with depression	13	30	
A person with PTSD	13		7
A person with schizophrenia	28	52	
Unwilling to work closely on			

Survey Item	CalMHSA General Population Survey Respondents	GSS 2006 Respondents (Pescosolido et al., 2010)	Australian Adults (Reavley and Jorm, 2011)
a job with			
Someone with a serious mental illness	29		
A person with depression	13	47	
A person with PTSD	17		10
A person with schizophrenia	37	62	

Nonetheless, these numbers compare favorably to recent national estimates. Pescosolido et al. (2010) found that most respondents to the General Social Survey in 2006 said that they were unwilling to socialize (52%) or work closely with (62%) someone with schizophrenia, and 45 percent were unwilling to live next door to someone with schizophrenia (Pescosolido et al., 2010). Acceptance of those experiencing depression was substantially better, but 47 percent of adults rejected the idea of working with a person with depression, 30 percent were unwilling to socialize with such a person, and 20 percent were unwilling to live next door to such a person. Attitudes toward PTSD were not assessed.

Comparable data are available on this topic for a representative sample of Australian adults. Reavley and Jorm (2011) found that 10 percent of respondents would be unwilling to work closely with someone with PTSD; 7 percent would be unwilling to socialize, and 8 percent would be unwilling to live next door to someone with PTSD.

Perceived Dangerousness

In response to a question about whether a person with mental illness is a danger to others, 23 percent of those surveyed by RAND moderately or strongly agreed (see Table 5.5). This is consistent with the findings of a study that found that 23 percent of a nationally representative sample of 5,251 adults moderately or strongly agreed that a person with mental illness is a danger to others (Kobau et al., 2010). In an earlier 1989 survey of public attitudes, 24 percent of respondents agreed that people with chronic mental illness are more dangerous than the general population (Borinstein, 1992).

RAND also asked about perceived dangerousness by inquiring whether survey participants thought the person we described as experiencing symptoms of depression, schizophrenia, or PTSD might act violently toward others. Thirty-one percent thought this was very or somewhat likely. But again, this varied substantially across diagnosis. In the case of depression and PTSD, 21–23 percent felt violence toward others was somewhat or very likely, while about twice as many, 45 percent, thought so in the case of schizophrenia. Previous research in the United States used a similar approach. In 2006, 60 percent endorsed these views about schizophrenia, and 32

percent did so for depression (Pescosolido et al., 2010). These surveys did not examine attitudes toward PTSD. But in a 2011 national survey of Australian adults, Reavley and Jorm (2011) found that 18 percent agreed or strongly agreed that a person with PTSD was dangerous.

We also included a question about gun policies and mental illness because of the prevalent coverage of this issue in response to the shooting at Sandy Hook Elementary School and other recent events. Much of this media coverage seems to assume or imply that people with mental health problems are dangerous, although some of the coverage directly refutes this notion. Seventy-nine percent of those we surveyed believed that "People who have a mental illness should not be allowed to buy a gun." This reflects a much higher level of perceived dangerousness than our other items. This might be because the other questions we asked specifically refer to violence against others, and guns may also be used to injure oneself, or it might reflect a greater willingness to reveal one's beliefs about mental illness and dangerousness when the issue of potential gun violence is raised.

Table 5.5
Perceived Dangerousness (%)

Survey Item	CalMHSA General Population Survey Respondents Agreeing	CDC HealthStyles Respondents Agreeing (Kobau et al., 2010)	GSS 2006 Respondents Agreeing (Pescosolido et al., 2010)	Australian Adults Agreeing (Reavley and Jorm, 2011)
[Person below] is a danger to others.				
A person with a mental illness	23	23		
A person with depression	21		32	
A person with PTSD	23			18
A person with schizophrenia	45		60	

Recovery Beliefs

Seventy percent of those surveyed moderately or strongly agreed that people with mental illness can recover (see Table 5.6). In contrast, Kobau et al. (2010) found that 29 percent of respondents moderately or strongly agreed with this item. In response to our items describing symptoms of depression, schizophrenia, or PTSD, 91 percent thought recovery was somewhat or very likely. For each condition, recovery was believed likely by 94 percent who heard about a person with symptoms of depression, 95 percent who heard about someone with PTSD, and 81 percent who heard about schizophrenia symptoms.

Table 5.6
Recovery Beliefs (%)

Survey Item	CalMHSA General Population Survey Respondents Agreeing	CDC HealthStyles Respondents Agreeing (Kobau et al., 2010)
[Person below] can recover.		
A person with a mental illness	70	29
A person with depression	94	
A person with PTSD	95	
A person with schizophrenia	81	

Social Inclusion

Only 13 percent of those we spoke to moderately or strongly agreed that people who have a mental illness are "never going to contribute much to society" (see Table 5.7). This suggests recognition that people with mental health challenges have much to offer and perhaps also recognition that recovery is possible. In contrast, 33 percent of a New Zealand sample (Vaughan and Hansen, 2004) agreed with this item.

Table 5.7
Social Inclusion Beliefs (%)

Survey Item	CalMHSA General Population Survey Respondents Agreeing	New Zealand Respondents Agreeing (Vaughan and Hansen, 2004)
People who have mental illness are never going to contribute much to society.	13	33

Provision of Support

Ninety-two percent of those surveyed strongly or moderately agreed that they want to be as supportive as possible to people experiencing a mental illness (see Table 5.8). There is ample opportunity for providing such support in our sample. About half of those surveyed (51%) said they have a family member who has had a mental health problem, and nearly two-thirds (62%) had personal contact with someone with a mental health problem in the 12 months prior to the survey. Ninety-two percent of those who had contact with someone with a mental health problem in the past year said that they *had* provided emotional support to this person. But somewhat fewer (71%) had helped him or her connect to community resources, friends, or family for additional support, and only 66 percent had helped the person find professional help.

Consistent with this, only 77 percent said they know how they could be supportive of people with mental illness. This suggests a potential gap for CalMHSA efforts to fill—informing people of ways they can help—and indeed, this is the focus of some of the programs' efforts. A second gap, one that many of the programs, particularly AdEase, aim to address, is recognition of symptoms and signs of a mental health problem. Sixty-eight percent of those surveyed moderately or strongly agreed that they can do so, indicating room for education in this area. Finally, 69 percent moderately or strongly agreed that they plan to take action to prevent discrimination against people with mental illness, a percentage CalMHSA programs might also aim to improve.

Table 5.8
Provision of Support (%)

Survey Item	CalMHSA General Population Survey Respondents Agreeing
I want to be as supportive as possible to people experiencing a mental illness.	92
I know how I can be supportive of people with mental illness.	77
I can recognize symptoms and signs of a mental health problem.	68
I plan to take action to prevent discrimination against people with mental illness.	69

Self-Labeling and Treatment Seeking

In addition to societal attitudes and behavior, self-stigma can be a significant impediment to those living with mental health challenges. That is, people who hold negative attitudes toward mental illness may be reluctant to label themselves as having a mental health problem. This, in turn, might act as a barrier to social inclusion and to seeking or adhering to treatment. In our sample, 23 percent of those surveyed reported that they had ever had a mental health problem. This is well below the estimated lifetime prevalence of mental disorder, which is 46 percent based on structured clinical interviews with a sample of the U.S. population (Kessler et al., 2005). If the true prevalence (that is, the actual rate of mental health problems whether or not people are willing or able to report them in response to our survey) is the same in our sample as it is nationally, this suggests that only about half of people who have had such problems (a) recognize them and (b) are willing to report them. This would be a very low rate of "self-labeling." Our phrasing is not specific – we did not ask about a diagnosable mental disorder but a "mental health problem," so some difference in percentages would be likely, but we might expect that our phrasing would elicit over- rather than under-reporting (i.e., that a minor problem not meeting clinical criteria might be included). If our sample is biased in some way that the national estimate is not, this might also affect the accuracy of the reported percentage of self-labeling. Some research suggests that those with mental health problems are less likely to

participate in surveys (Eaton et al., 1992), though this effect is far too small to account for a difference in prevalence of 23 versus 46 percent. And other studies indicate that people who have a stake in a topic are *more* likely to participate in a survey about it, so people with experience with mental illness, directly or indirectly, might be more likely to respond to our survey. Ultimately, we cannot be certain of the reason for the apparently low rates of reporting a lifetime experience of mental health problems, but our findings are consistent with the idea that mental illness stigma interferes with recognition and reporting of mental illness.

If self-labeling is an indicator of recognition and acceptance of personal mental health challenges, we might expect that those who reported a problem also reported that they had sought treatment. Indeed, 90 percent of them did so (see Table 5.9). And 91 percent of survey participants reported that they would "definitely" or "probably" seek treatment if they had a "serious emotional problem" in the future, although 17 percent thought they would put off seeking treatment for fear of letting others know about their problem. Altogether, these data suggest that self-stigma is present in California adults, and even if mental illness were recognized by an individual experiencing symptoms, self-stigma would interfere with treatment-seeking in 9–17 percent of such people. There is certainly room for improvement in these numbers.

Table 5.9
Treatment-Seeking (%)

Survey Item	CalMHSA General Population Survey Respondents
Sought treatment for a mental health problem.[a]	90
Would definitely or probably seek treatment if they had a serious emotional problem in the future.	91
Would put off seeking treatment for fear of letting others know about their problem.	17

[a] *This item was asked only if respondents indicated that they had personally experienced a mental health problem.*

Disclosure of a Mental Health Problem

Nineteen percent of those we spoke with said they would probably or definitely conceal a mental health problem from their family or friends (see Table 5.10). And of those who have coworkers or are students, 42 percent said they would probably or definitely conceal a mental health problem from coworkers or classmates. Thus, there is substantial fear of being stigmatized by casual acquaintances.

Table 5.10
Disclosure of a Mental Health Problem (%)

Survey Item	CalMHSA General Population Survey Respondents
Would definitely or probably hide mental health problem from family or friends.	19
Would definitely or probably hide mental health problem from coworkers or classmates.	42

Potential Exposure to CalMHSA SDR Activities

We asked about exposure during the past 12 months to the various venues CalMHSA is directing its SDR activities to (see Table 5.11). We caution that this baseline assessment of exposure occurred early in the implementation of many of the activities of SDR programs but later for others. Thus, responses do not reflect an absolute "pre-exposure" baseline.

A good example is provided by the question about television documentary exposure. Thirty-three percent of respondents reported they had watched a documentary on television about mental illness, and 36 percent said they had seen an ad or promotion for such a documentary. It is unlikely that these were exposures to "A New State of Mind," the documentary created under Runyon Saltzman & Einhorn's scope of work for CalMHSA. The survey was conducted between May 10 and June 22, 2013. About half of all respondents to the survey answered the question about seeing a television documentary after "A New State of Mind" had aired, and about half answered it before. In these groups, respectively, 33 percent and 35 percent said they had seen a television documentary about mental illness in the past 12 months. These are not entirely unexpected results for our baseline survey. Runyon Saltzman & Einhorn took a social marketing approach to reducing stigma, but not one strongly grounded in mass media. The documentary aired on television and in primetime, but it aired on CPT, where viewership is relatively low. The small percentage of viewers within the California population as a whole may simply have been too low to pick up in a survey of 2,001 individuals. As Runyon Saltzman & Einhorn continues to distribute the documentary with additional airings, through the Each Mind Matters website and at planned community events through September, we may observe a shift in reported exposure.

Table 5.11
Potential Exposure to CalMHSA SDR Activities (%)

Survey Item	CalMHSA General Population Survey Respondents
Watched a documentary on television about mental illness	33
Seen an advertisement or promotion for a television documentary about mental illness	36
Watched some other movie or television show in which a character had a mental illness	68
Seen or heard a news story about mental illness	74
Attended an educational presentation or training either in person or online about mental illness	16
Received documents or other informational resources related to mental illness through the mail, email, online, or in person	25
As part of your profession, received professional advice about how to discuss mental illness or interact with people who have mental illness	23
Visited the website "ReachOut dot com"	2
Seen or heard an advertisement for "ReachOut dot com"	8
Seen or heard the slogan or catch phrase "Each Mind Matters"	11
Visited the website "Each Mind Matters dot org"	<1
Visited another website to get information about mental illness	15

Another CalMHSA Program Partner, Entertainment Industries Council, Inc., is attempting to affect portrayals of mental illness and mental health in entertainment media and news stories. Our baseline survey indicates that 68 percent remembered seeing a movie or television show in the past year in which a character had a mental illness, and 74 percent had seen or heard a news story about mental illness. Not all these portrayals will have been affected by Entertainment Industries Council, Inc.; indeed, it may be the case that none were at baseline, since Entertainment Industries Council, Inc.'s efforts to reach content creators through briefings is just beginning. But it suggests very fertile ground for reaching people with positive portrayals of mental illness.

Eleven percent of respondents said they had seen or heard the catch phrase "Each Mind Matters," the new slogan for CalMHSA efforts. However, less than 1 percent reported visiting the 'eachmindmatters.org' website, the hub for CalMHSA dissemination and the host of the "A New State of Mind" documentary. Fifteen percent said they had visited another website to get information about mental illness, but we cannot know whether this was a CalMHSA site.

Eight percent of respondents had seen or heard an ad for ReachOut.com, and about 2 percent of respondents said they had visited the Reachout.com website. ReachOut.com hosts the ReachOut forums for youth to discuss mental health issues that CalMHSA funds and promotes through Runyon Saltzman & Einhorn. Nonetheless, our survey sample was limited to adults 18 years or older, and the target ages for this CalMHSA effort are 14 to 24; thus, high rates of exposure and use would not be expected. Only 14 percent of our weighted survey sample (213 individuals) is in the targeted age range. Within this group, a higher percentage, 12 percent, report exposure to a ReachOut.com advertisement. When compared to the rest of the survey sample (7.5% of whom report exposure), this is a statistically significant difference, chi-square = 4.98, $p < .05$). Similarly, 2.5 percent of 18–24-year-olds reported visiting the ReachOut website, while only 1.5 percent of the rest of the sample did so. (This difference was not tested because the small numbers of individuals involved would render such a test unreliable.) Differences in exposure across these age ranges suggest that the ReachOut campaign is effectively targeting its messages and bolster our confidence that reports of exposure and website use are valid. Among the individuals who remembered seeing or hearing a Reachout.com ad, the average number of times they recalled seeing it in the past month was 2.5. These individuals recalled paying the ads a moderate amount of attention (an average rating of 4.5 on a 7-point scale) and somewhat liking the ads (average rating of 5 on a 7-point scale). In summary, it appears that about one in eight youths in the targeted age range recalls having been exposed to ReachOut ads, and many of these youth were exposed multiple times. Although only a very small percentage of targeted youth actually visited the ReachOut site in the time frame studied, this constitutes about one in five of those who were reached. With continued outreach to cover more of the targeted age range, the strategy shows potential to bring youth to the ReachOut forum hosted by CalMHSA on this site.

A fairly substantial percentage of individuals, 16 percent, reported that they had attended an educational presentation or training about mental illness. This percentage is impressive given the likely reach of such efforts, which involve much smaller audiences for any given effort than a mass media outlet might afford. Because these presentations tend to be of greater length and sometimes involve personal contact and interaction, they might also be expected to have a greater impact on the small numbers they do reach. The 15 percent exposure estimate, which translates into one in seven California adults, should be interpreted in that light. Similarly, 25 percent of survey respondents reported receiving some kind of informational resources on mental illness—a very large percentage for such efforts—and 23 percent said they did so as part of their profession, suggesting good reach to stakeholders. Of course, not all these presentations, trainings, and resources were likely to have been a result of CalMHSA activities.

Suicide Prevention (SP)

Several general population survey questions were relevant to the SP initiative. We summarize the baseline results for survey questions designed to inform the evaluation of

training/education activities, social marketing campaigns, and hotlines and warmlines. These questions largely assess beliefs about suicide, exposure to CalMHSA SP-related activities, and intentions to contact a hotline or warmline if needed.

Training/Education

RAND's SP training evaluation is focused on LivingWorks' contract that trains Californians on how to deliver two of its standardized trainings (i.e., ASIST and SafeTALK).[5] As part of the general population survey, we asked all respondents questions about knowledge on suicide and perceived efficacy in their ability to intervene with those at risk. This provides a baseline measure to which we can compare the responses to the LivingWorks' Post-Training Evaluation Form. Since the first wave of data collection for this survey is complete, we can assess Californians' responses to the questions in these domains. Once post-training surveys are complete, we will be able to compare responses from trainees to those in the general population.

Knowledge About Suicide

The survey asks five questions about suicide knowledge using questions adapted from the Knowledge and Attitudes About Suicide scale (see Appendix G). These items assess individuals' declarative knowledge and attitudes about suicide and suicide risk factors (Shaffer et al., 1991). Three questions tap respondents' general thoughts about whether suicide is preventable; one asks a factual question, and two ask questions that have implications for intervention behavior. In addition to the traditional "true" and "false" response values used with this scale, we added a "don't know" option to reduce guessing and more accurately assess knowledge (Pennington, Pachana, and Coyle, 2001). The results for each of the knowledge items are presented in Figure 5.1; responses across demographic groups are presented in Table 5.12.

Beginning with the items tapping respondents' general thoughts about suicide prevention, two-thirds of Californians think that suicide is usually preventable, and 24 percent do not know whether it is or is not. This is promising news: It suggests that most residents do not need to be convinced that suicide is preventable, and that this specific message only needs to reach a quarter of residents. If we look across demographic categories presented in Table 5.12, lack of knowledge seems greater in two groups. Twenty-nine percent of Californians between 50 and 64 did not know if suicide is usually preventable. This group is important, because those 50 or older accounted for 1,868 suicides in California (exactly half of all California suicides) in 2010. The suicide rate in this group is also double that of California's overall rate, with the highest rates among those 85 or older. Black/African Americans are the other group with a higher proportion (32%) that "did not know" whether suicide was usually preventable. This group also had a

[5] It is important to note that many of the Program Partners, as part of their contracts, are conducting community outreach and education that may focus on suicide awareness generally as well as the skills necessary to identify persons at risk and how to intervene with them.

greater proportion (13% versus 9%) who believed that the statement was false. A similar pattern was seen with respect to the statement, "You can't stop people who really want to commit suicide": One-third of Californians agreed with this statement, although 41 percent of those between 50 and 64 and 44 percent of Black/African Americans agreed.

It is well established that while women are more likely to attempt suicide, the risk of suicide death is three to four times higher for men than for women at all ages. The statement, "[W]omen are more at risk of suicide than men" is false, and one-third of Californians endorsed this option. The largest category was "don't know," endorsed by almost half of all Californians. There are no dramatic differences across demographic categories, except that among American Indians more than half responded correctly. However, it should be noted that the concept of "risk" may confuse some survey respondents, and thus may have inherent limitations in accurately assessing knowledge.

Finally, with respect to intervention behaviors, 54 percent of Californians agreed with the statement, "There are always warning signs before a suicide," and an equal proportion disagreed with the statement, "Talking about suicide can cause suicide." With respect to the former statement, many awareness campaigns (including those funded by CalMHSA) seek to promote suicide warning signs, and responses provide a benchmark of understanding. Just over one-quarter of Californians did not believe that there were always warning signs before a suicide, a proportion that was higher among White Californians, of whom 35 percent did not believe that there were always warning signs. Use of the term *always* in this statement may not accurately tap knowledge about suicide, however, and we are considering revising the way this question is worded in the follow-up survey. Seventeen percent of respondents falsely agreed with the statement, "Talking about suicide can cause suicide," a proportion that was somewhat higher among those over 65, Hispanic/Latino Californians, and American Indians. Indeed, extant research suggests that talking about suicide does not cause suicide (Gould et al., 2005).

Figure 5.1. Knowledge About Suicide, All Respondents

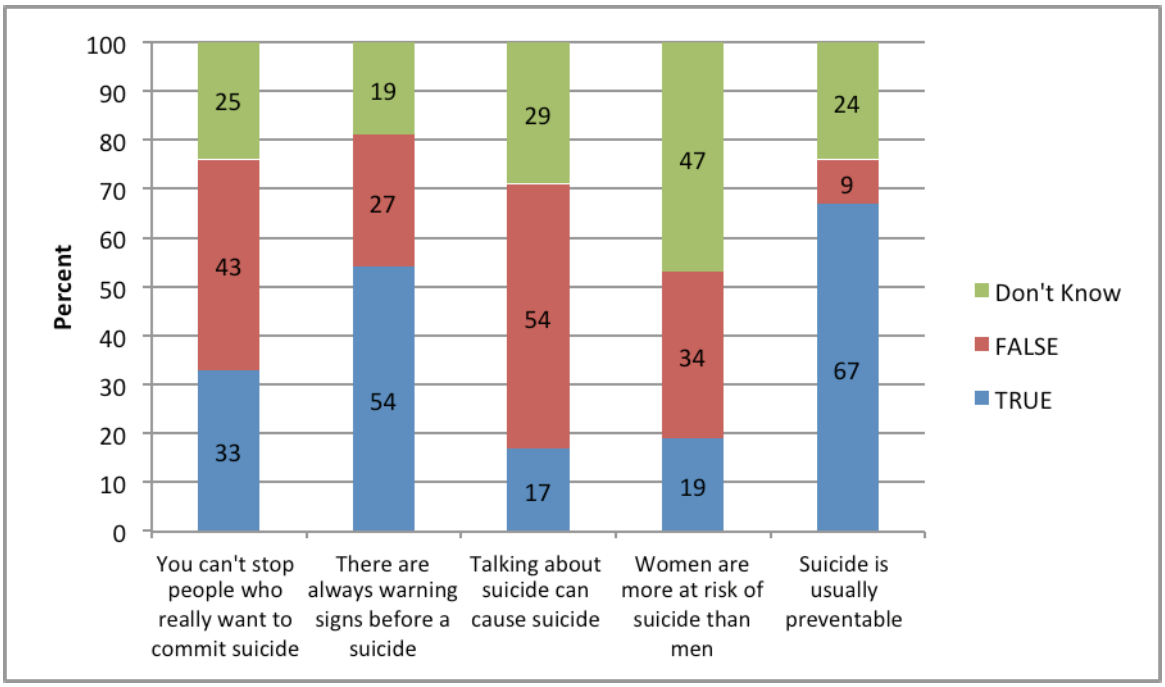


Table 5.12
Knowledge About Suicide by Sex, Age, Ethnicity, and Race (%)

		You can't stop people who really want to commit suicide.			There are always warning signs before a suicide.			Talking about suicide can cause suicide.			Women are more at risk of suicide than men.			Suicide is usually preventable.		
		T	F	DK	T	F	DK	T	F	DK	T	F	DK	T	F	DK
	TOTAL	32.6	42.9	24.5	54.1	27.1	18.8	17.1	54.2	28.7	19.2	34.2	46.6	66.6	9.3	24.1
Sex	Male	35.2	42.0	22.8	50.3	29.1	20.6	19.0	51.8	29.2	16.9	33.9	49.1	68.6	9.0	22.4
	Female	30.1	43.7	26.1	57.7	25.2	17.1	15.3	56.5	28.2	21.3	34.4	44.3	64.6	9.6	25.8
Age	18–29	20.5	60.1	19.4	58.8	25.4	15.7	20.1	57.5	22.4	23.6	37.5	38.9	79.3	6.1	14.5
	30–39	29.8	43.3	26.9	54.2	27.8	18.0	15.6	57.8	26.7	18.2	35.8	46.0	68.3	8.2	23.5
	40–49	29.7	43.5	26.8	60.4	22.0	17.6	17.0	54.2	28.7	17.4	33.5	49.1	66.7	10.4	22.9
	50–64	41.2	35.4	23.4	50.3	31.2	18.5	15.0	54.5	30.5	18.1	32.1	49.9	59.4	12.1	28.5
	65 or older	21.2	44.0	34.8	52.1	35.0	12.9	24.3	35.5	40.2	12.7	32.1	55.2	54.5	21.2	24.3
Latino/ Hispanic Origin	Yes	28.3	42.0	29.7	67.0	15.1	17.9	23.1	45.8	31.1	23.3	32.3	44.4	73.3	6.1	20.6
	No	34.3	43.4	22.3	47.6	33.3	19.2	14.1	58.4	27.6	17.1	35.2	47.7	63.2	10.9	25.9
Race	Multiracial	36.9	44.4	18.7	60.9	26.6	12.4	19.6	62.2	18.2	24.2	36.2	39.6	74.3	8.9	16.8
	White	33.1	44.0	22.9	46.5	35.0	18.6	14.3	57.9	27.9	16.8	36.6	46.7	65.6	9.8	24.7
	Black/African American	43.5	31.2	25.4	60.1	22.2	17.7	16.8	49.2	34.0	16.6	35.4	47.9	55.7	12.6	31.7
	Asian	27.7	49.8	22.5	53.3	20.7	26.0	16.8	53.5	29.7	18.1	28.3	53.6	61.5	12.1	26.4
	Native Hawaiian		67.4	32.6		66.9	33.1		100			34.3	65.7	67.4		32.6
	Other Pacific Islander	39.8	34.8	25.4	71.4	25.0	3.6	22.3	57.5	20.2	44.8	16.1	39.1	63.9	20.2	15.8
	American Indian	20.4	57.3	22.3	70.4	25.6	4.0	31.7	50.3	18.0	26.2	51.7	22.1	84.7	6.8	8.5
	Alaskan Native		100		100			100					100	100		
	Hispanic/Latino	29.3	38.4	32.2	69.8	11.4	18.8	23.4	43.0	33.6	24.1	29.5	46.4	71.2	5.9	22.9

Intervention Efficacy

Intervention efficacy refers to feelings of competence and capability in serving as gatekeepers to identify, intervene, and refer people at risk of suicide to help. We adapted seven questions from a scale used in a randomized control trial of a gatekeeper training administered to adults in secondary schools (Wyman et al., 2008). Care was taken to "match" items from the survey to items on the LivingWorks Post-Training Evaluation Form. The average level of gatekeeper efficacy is presented in Table 5.13. On a scale from 1 ("high efficacy") to 7 ("low efficacy"), respondents scored almost directly in the middle (M = 3.7, SD = 0.0). There were no dramatic differences across most demographic groups, although those over 65 may view themselves as slightly more efficacious.

Table 5.13
Intervention Efficacy by Sex, Age, Ethnicity, and Race

		Intervention Efficacy[a]
		Mean (SD)
	Total	3.7 (0.0)
Sex	Male	3.8 (0.0)
	Female	3.7 (0.0)
Age	18–29	3.5 (0.1)
	30–39	3.7 (0.1)
	40–49	3.8 (0.1)
	50–64	3.8 (0.1)
	65 or older	3.4 (0.6)
Latino/Hispanic Origin	Yes	3.8 (0.1)
	No	3.7 (0.0)
Race	Multiracial	3.8 (0.1)
	White	3.6 (0.0)
	Black/African American	4.0 (0.1)
	Asian	3.8 (0.1)
	Native Hawaiian	3.3 (0.7)
	Other Pacific Islander	3.6 (0.5)
	American Indian	3.4 (0.3)
	Alaskan Native	4.3 (0.0)
	Hispanic/Latino	3.9 (0.1)

[a]Range: 1 = high efficacy, 7 = low efficacy.

Exposure

Data on exposure to social marketing products is presented in Table 5.14. Almost half of all Californians reported seeing an advertisement for a suicide hotline or crisis line in the past 12 months, with 38 percent reporting seeing the advertisement in the past 6 months and seeing the message around four times in the past month, or once per week. A smaller, but still substantial, proportion (39%) reported seeing or hearing advertisements with the specific AdEase taglines: "Know the Signs," "Pain Isn't Always Obvious," or "Suicide Is Preventable"—again, most (31% of the total) saw the message in the past 6 months and reported having seen the message just over three times in the past month. Fewer Californians reported seeing or hearing an advertisement about recognizing the warning signs of suicide (31%) or for the website suicideispreventable.org (9%). Fewer than 2 percent of respondents reported having visited the website suicideispreventable.org.

Table 5.14
Exposure to Suicide Prevention Messages, All Respondents

	Past 12 Months (%)	Past 6 Months (%)	Frequency in Past Month M (SD)
Advertisement for a suicide hotline/crisis line	48.7	38.3	3.9 (0.4)
Advertisement about recognizing the warning signs of suicide	31.1	N/A	N/A
Advertisement with slogans "Know the Signs," "Pain Isn't Always Obvious," or "Suicide Is Preventable"	38.9	31.1	3.2 (0.3)
Advertisement for suicide prevention with website "Suicide Is Preventable dot org"	8.9	6.9	3.2 (0.8)
Exposure to website "Suicide Is Preventable dot org"	1.6	1.0	N/A

Attention, Liking, and Helpfulness

Those who reported exposure to each of three advertisements in the past month were asked how much attention they paid to the advertisement and how much they liked these advertisements. Results to these questions are presented in Table 5.15. On a scale from 1 to 7 with 7 indicating paying "very close attention," Californians exposed to messages about the website suicideispreventable.org paid most attention to the message (M = 4.8, SD = 0.2), followed by the messages specific to AdEase (M = 4.6, SD = 0.1), and finally by the more generic question about advertisements for a suicide hotline or crisis line (M = 4.4, SD = 0.1). Individuals who reported visiting the website suicideispreventable.org in the past 6 months were asked how helpful the website was in providing the information the person was looking for on a

scale from 1 (not helpful) to 7 (very helpful). Although (as described above) fewer than 2 percent of Californians had visited the website, those who did found it very helpful (M = 6.2, SD = 0.3).

Table 5.15
Thoughts About Suicide Prevention Messages, All Respondents

	Attention[a] Mean (SD)	Liking[b] Mean (SD)	Helpfulness[c] Mean (SD)
Advertisement for a suicide hotline/crisis line	4.4 (0.1)	5.0 (0.1)	N/A
Advertisement with slogan "Know the Signs," "Pain Isn't Always Obvious," or "Suicide Is Preventable"	4.6 (0.1)	5.0 (0.1)	N/A
Advertisement for suicide prevention with website "Suicide Is Preventable dot org"	4.8 (0.2)	4.9 (0.2)	N/A
Exposure to website "Suicide Is Preventable dot org"	N/A	N/A	6.2 (0.3)

[a] Range: 1 = no attention, 7 = very close attention.
[b] Range: 1 = not at all, 7 = a lot.
[c] Range: 1 = not helpful, 7 = very helpful.

Using the knowledge and efficacy questions from the statewide survey described above, we examined how those exposed to the various messages and resources varied in responses. It is important to note that we cannot attribute these differences to the exposure itself; while the advertisement may have changed knowledge or intervention efficacy, it is equally likely that those with high knowledge or high intervention efficacy were more likely to recall seeing the various messages or visiting suicideispreventable.org.

Effects of Exposure to Social Marketing Efforts on Knowledge About Suicide

Results pertaining to associations between message exposure and knowledge about suicide are presented in Table 5.16. With respect to respondents' general thoughts about suicide prevention, respondents who reported exposure to the generic advertisement for a suicide hotline or crisis line, AdEase's Know the Signs campaign messages, or advertisements about suicide warning signs were more likely to agree that suicide is usually preventable. There was a particularly large difference between those who had and had not visited suicideispreventable.org—87 percent thought that suicide is usually preventable versus 66 percent. Similarly, those exposed to either generic messages about suicide hotlines or crisis lines, the AdEase Know the Signs campaign, or ads for suicide prevention with the website suicideispreventable.org were more likely to mark as false the statement, "You can't stop people who really want to commit suicide."

Although the differences are not as great, those respondents who reported exposure to each of the messages were more likely to report correctly as false the statement, "Women are more at risk of suicide than men." Similarly, those exposed to each of the marketing efforts were also more likely to report correctly as false the statement, "Talking about suicide can cause suicide." Close to 80 percent of those who visited suicideispreventable.org (relative to 54 percent of those

who had not visited the website) indicated as “true” the statement, “There are always warning signs before a suicide.” Although the difference was not as great for the other exposures, those reporting exposure to each of the messages were more likely to indicate this statement as true than those reporting no exposure.

Additionally, for every type of exposure and for every statement, those exposed to a marketing effort were less likely to respond “don’t know” to a given statement than those reporting no exposure. This shift can account for a substantial amount of the differences observed above. For example, for the statement, “Talking about suicide can cause suicide,” exposure to marketing efforts corresponded to an increase in responding “false” while the percentage of those responding “true” remained similar between the groups with and without exposure. In fact in a majority of the cases in which those reporting exposure were more likely to mark a statement as “false,” they were also (slightly) more likely to mark a statement as “true,” reflecting the tendency for fewer “don’t know” responses in general.

Table 5.16
Knowledge About Suicide by Exposure to Social Marketing Efforts (%)

		You can't stop people who really want to commit suicide			There are always warning signs before a suicide			Talking about suicide can cause suicide			Women are more at risk of suicide than men			Suicide is usually preventable		
		True	**False**	**DK**	**True**	**False**	**DK**	**True**	**False**	**DK**	**True**	**False**	**DK**	**True**	**False**	**DK**
Total		32.6	42.9	24.5	54.1	27.1	18.8	17.1	54.2	28.7	19.2	34.2	46.6	66.6	9.3	24.1
Exposed to…																
ads for suicide/crisis hotline	Yes	32.7	48.6	18.8	56.8	28.9	14.3	16.6	59.3	24.1	20.4	38.1	41.5	70.9	10.0	19.2
	No	32.2	37.7	30.1	51.9	24.9	23.2	18.0	49.3	32.6	18.3	30.7	51.0	62.2	8.6	29.2
ads about recognizing suicide warning signs	Yes	35.2	45.3	19.5	61.2	26.0	12.8	18.2	58.6	23.3	21.8	38.7	39.6	72.8	8.6	18.6
	No	30.9	42.2	26.9	51.7	26.9	21.4	17.1	51.9	31.0	18.4	32.0	49.7	63.8	9.8	26.4
ads with slogan "Know the Signs," "Pain Isn't Always Obvious," or "Suicide Is Preventable"	Yes	32.9	49.4	17.7	58.1	29.5	12.4	18.0	59.0	23.1	21.3	38.8	39.9	74.0	7.2	18.8
	No	32.6	39.0	28.4	52.1	25.1	22.7	17.3	50.7	31.9	18.5	31.3	50.3	62.1	10.6	27.3
"Suicide Is Preventable dot org" website	Yes	33.7	43.5	22.8	78.7	12.8	8.6	18.6	64.3	17.2	9.0	58.9	32.1	87.0	0.0.	13.0
	No	32.6	42.9	24.5	53.7	27.4	19.0	17.2	53.9	28.9	19.3	33.7	47.0	66.3	9.4	24.3
ads for suicide prevention with the "Suicide Is Preventable dot org" website	Yes	30.2	50.7	19.0	60.2	27.5	12.3	17.6	60.4	22.0	19.9	40.8	39.2	71.8	13.9	14.3
	No	33.0	42.1	24.9	53.9	26.6	19.4	17.4	53.4	29.2	19.1	33.4	47.5	66.0	9.0	25.0

Effect of Exposure to Social Marketing Efforts on Intervention Efficacy

As shown in Table 5.17, across all respondents, the mean level of efficacy was 3.9, essentially directly between high efficacy (= 1) and low efficacy (= 7). Those exposed to each of the social marketing efforts scored 0.2 to 0.3 points lower than those unexposed, indicating greater efficacy. The only greater difference was among those who visited suicideispreventable.org, whose mean score was 3.2. Again, we cannot attribute this difference to the exposure itself and are currently unable to discern whether those with high intervention efficacy were more likely to visit suicideispreventable.org.

Table 5.17
Intervention Efficacy by Exposure to Social Marketing Efforts

		Intervention Efficacy[a]
Total		**3.9 (0.0)**
Exposed to…		**Mean (SD)**
ads for suicide/crisis hotline	Yes	3.5 (0.0)
	No	4.0 (0.0)
ads about recognizing suicide warning signs	Yes	3.4 (0.1)
	No	3.9 (0.0)
ads with slogan 'Know the Signs," "Pain Isn't Always Obvious," or "Suicide Is Preventable"	Yes	3.5 (0.0)
	No	3.9 (0.0)
"Suicide Is Preventable dot org" website	Yes	3.2 (0.2)
	No	3.8 (0.0)
ads for suicide prevention with the "Suicide Is Preventable dot org" website	Yes	3.4 (0.1)
	No	3.8 (0.0)

[a]Range: 1 = high efficacy, 7 = low efficacy.

Hotline and Warmline Operations

Many of the CalMHSA SP activities involve the operation of hotlines, which provide support in a crisis. Other CalMHSA SP activities involve warmlines. These differ from hotlines in that they typically provide social support outside of a crisis.

Resource Preference

Respondents were asked, "If you were seeking help for suicidal thoughts and knew where to find resources to help, how likely would you be to use each of the following resources…" The resources we asked about were:

- Visit a website for information about suicide risk and resources
- Call a crisis line or hotline for advice about suicide risk and resources
- Text a crisis text line for advice about suicide risk and resources
- Go to a web-based crisis chat service for advice about suicide risk and resources
- Seek help face-to-face from family members or friends
- Seek help face-to-face from a counselor or other mental health professional.

Respondents were asked to rate each resource on a 4-point scale, with 1 = very likely and 4 = very unlikely.

Responses to these questions are presented in Table 5.18. Across the entire sample, respondents were most likely to report that they would seek help face-to-face from a counselor or other mental health professional (M = 1.8, SD = 0.0) and least likely to text a crisis text line for advice about suicide risk and resources (M = 2.7, SD = 0.0). These patterns generally held across age-by-gender categorizations; however, it is important to note that our survey was conducted among adults in California. (The minimum age of respondents in our survey was 18.) It is possible that those younger than 18 would report that they would be more likely than adults to use newer forms of communication, like text messaging or web-based chat.

Table 5.18
Resource Accessibility by Age by Sex

Sex: (Q49)	TOTAL	Male					Female				
Age: (Q48a/b)		18–29	30–39	40–49	50–64	65+	18–29	30–39	40–49	50–64	65+
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
If you were seeking help for suicidal thoughts and knew where to find resources to help, how likely would you be to… *											
visit a website for information about suicide risk or resources: (Q38a)	2.0 (0.0)	2.0 (0.1)	1.9 (0.1)	2.1 (0.1)	2.2 (0.1)	1 (.)	1.8 (0.1)	1.8 (0.1)	1.7 (0.1)	2.0 (0.1)	2.8 (0.5)
call a crisis line or hotline for advice about suicide risk and resources: (Q38b)	2.2 (0.0)	2.4 (0.1)	2.3 (0.1)	2.1 (0.1)	2.3 (0.1)	1 (.)	2.4 (0.1)	2.1 (0.1)	2.1 (0.1)	2.0 (0.1)	2.0 (0.5)
text a crisis text line for advice about suicide risk and resources: (Q38c)	2.7 (0.0)	2.5 (0.1)	2.5 (0.1)	2.7 (0.1)	2.8 (0.1)	1 (.)	2.8 (0.1)	2.3 (0.1)	2.4 (0.1)	2.9 (0.1)	3.3 (0.5)
go to a web-based crisis chat service for advice about suicide risk and resources: (Q38d)	2.6 (0.0)	2.5 (0.1)	2.4 (0.1)	2.5 (0.1)	2.8 (0.1)	4 (.)	2.6 (0.1)	2.3 (0.1)	2.4 (0.1)	2.7 (0.1)	4 (.)
seek help face-to-face from family members or friends: (Q38e)	1.9 (0.0)	1.9 (0.1)	1.9 (0.1)	2.0 (0.1)	2.0 (0.1)	1 (.)	2.1 (0.1)	1.9 (0.1)	1.8 (0.1)	1.8 (0.1)	1.6 (0.4)
seek help face-to-face from a counselor or other mental health professional: (Q38f)	1.8 (0.0)	1.9 (0.1)	1.9 (0.1)	1.8 (0.1)	1.9 (0.1)	1 (.)	1.8 (0.1)	1.6 (0.1)	1.7 (0.1)	1.6 (0.1)	1.7 (0.4)

* 1 = very likely, 4 = very unlikely.

Student Mental Health (SMH)

A portion of the general population survey asks about three subsamples of interest to the SMH Initiative: (1) parents or legal guardians of a child who attends a K–12 school in California; (2) a current student attending a college or university in California (either full or part-time); and (3) parents or legal guardians of a child who attends a college or university in California. If participants endorsed membership to one of the three subsamples, they were asked two questions about school climate in relation to student mental health: the degree to which the school (a) helps students with social, emotional, and behavioral problems (CHKS, WestED, 2013a) and (b) provides quality counseling or other ways to help students with social, emotional, or behavioral needs (CHKS, 2012b). Each item was rated on a 1 to 5 scale (1 = strongly disagree, 3 = neither disagree nor agree, 5 = strongly agree). Preliminary results for the K–12 and higher education subsamples are described below (see Table 5.19).

K–12

A total of 396 (19.8%) participants reported being parents of a child attending a K–12 school in California. These participants reported an average score of 3.8 (SE = 0.1) out of 5, indicating that they agreed somewhat that their school helped students, and an average score of 3.8 (SE = 0.1), also indicating that they agreed somewhat that their school provided quality counseling and other ways to help students with social, emotional, and behavioral problems. About 5 percent of parents reported they did not know the answers to these questions.

Higher Education

A total of 226 (11.3%) participants were currently attending a college or university in California. These participants reported an average score of 3.9 (SE = 0.1), indicating that their school helped students, and an average score of 4.1 (SE = 0.1), indicating that their school provided quality counseling and other ways to help students. Less than 4 percent of students reported they did not know the answers to these questions.

A total of 191 (9.5%) participants reported being parents of a child in college or university. These parents reported an average score of 3.6 (SE = 0.1), indicating that their child's school helped students, and agreed somewhat that their school provided quality counseling and support to students (M = 3.8, SE = 0.1). Between 13 and 16 percent of parents reported not knowing how their child's college or university fared on these items.

Summary of School Mental Health Survey Results

Overall, most participants reported that they agreed somewhat that their school emphasized helping and providing quality counseling/help to students with social, emotional, and behavioral problems. There were minimal missing data for these items, except for parents of students in college or university. These findings are intuitive, because parents may be more aware of how schools support

student mental health when their children are younger and in the K–12 system than when children are older and enrolled in higher education. Still, missing data were quite low overall.

These data provide preliminary information about the school climate of California K–12 and higher education schools and will be useful to monitor over time. Note that these data are only preliminary, cannot necessarily be attributed to CalMHSA programming, and are based on self-report. These results do not represent first-hand experience for students with mental health issues and thus cannot be generalized to the effectiveness of student mental health services. Instead, they represent views about the school's climate from a random sample of currently enrolled higher education students and parents of K–12 and higher education students. Overall, data are promising and provide preliminary insight about the school climate of California K–12, colleges, and universities.

Table 5.19
Participant Reports of School Climate (%)

	Disagree Strongly	Disagree Somewhat	Neither Agree Nor Disagree	Agree Somewhat	Agree Strongly	Don't Know
K–12						
Parents of students						
Emphasizes helping students	9.4	8.7	13.1	22.4	41.8	4.6
Provides counseling/help	10.2	8.4	14.1	23.9	38.6	4.7
Higher Education						
Current students						
Emphasizes helping students	4.7	8.3	18.9	23.0	41.3	3.9
Provides counseling/help	4.6	5.2	15.0	25.0	46.9	3.4
Parents of students						
Emphasizes helping students	11.2	5.7	22.1	18.1	29.1	13.7
Provides counseling/help	8.3	2.6	20.5	17.9	34.6	16.1

Summary

In conducting the general population survey, we aimed to establish baseline levels of knowledge, attitudes, and beliefs about SP, SDR, and SMH among the California population and learn about early exposure to CalMHSA activities. Results presented here are preliminary, and we are continuing to analyze the survey data.

Two-thirds of respondents were aware of stigma and discrimination toward people with mental health challenges. They personally held some stigmatizing attitudes and beliefs (e.g., that people with mental health challenges are dangerous), but many also reported some positive beliefs about the potential for recovery and contributing positively to society. Nearly all respondents expressed a willingness to support people with mental health challenges. Some

respondents reported that they would be hesitant to disclose experiencing a mental health challenge or to seek treatment for it for fear of what others would think.

Respondents varied in their opinions about suicide. About two-thirds of respondents recognized that suicide is preventable, and just over half thought that there are always warning signs before suicide. About half also disagreed that talking about suicide can cause suicide. Many respondents did not know that men are at greater risk of committing suicide than women. Respondents indicated that if they were having suicidal thoughts, they would most likely seek help face-to-face from a counselor or other mental health professional compared to using other possible resources.

Respondents with a child in a K–12 school or in an institution of higher education and students in an institution of higher education were asked about school climate for handling mental health-related issues. Parents of K–12 students and students in higher education agreed somewhat that their school helped students and provided quality counseling and other ways to help students with social, emotional, and behavioral problems. Respondents who were themselves students agreed that their institution helped students and providing quality counseling.

Exposure to CalMHSA activities at the population level is difficult to detect early in the project period. We highlight here that 11 percent of respondents reported having seen or heard of the slogan "Each Mind Matters," 8 percent had heard of "ReachOut," and 9 percent knew of the "Suicide Is Preventable" site. However, 2 percent or less of respondents visited the Each Mind Matters, ReachOut, and Suicide Is Preventable websites. Thirty-nine percent of respondents reported seeing or hearing ads with specific AdEase taglines (e.g., "Know the Signs"). Sixteen percent reported having attended some sort of training about mental illness, although we cannot determine whether these were CalMHSA-funded trainings.

SECTION III: COMMENTARY

6. Commentary

In this section, we step back from the detailed findings to date to offer our commentary on "how it's going so far." Stakeholders are intensely interested in knowing, as soon as possible, whether these investments in prevention and early intervention have been worthwhile, and what, if any, further investments are justified. The statewide PEI program investments were intended as one-time infusions of Proposition 63 tax dollars to develop prevention and early intervention program capacities that did not previously exist, and to launch a broad, multicomponent, prevention and early intervention campaign. The program activities included in this campaign are generally consistent with current behavioral science theory, empirical evidence, and best-practice guidelines (Collins et al., 2012; Stein et al., 2012; Acosta, 2012b). Nonetheless, the question of whether these particular prevention and early intervention programs are producing their intended effects is a pressing one for California decisionmakers and other stakeholders.

Capacity Development

The development of new prevention and early intervention capacities were key activities for all Program Partners and necessarily preceded the actual delivery of the prevention and early intervention programs to targeted audiences. These capacities generally included the following:

- Creation of organizational structures required to implement programmatic components of the PEI initiatives (e.g., the embedding of new program goals within existing organizations, creation of collaborative and community relationships, development of organizational systems for managing PEI programs and contract requirements, making organizational changes that enabled program accreditation)
- Development of knowledge relevant to the PEI programs being implemented (e.g., literature reviews, information gathering, planning processes, staff training)
- Development of specific material resources required for PEI interventions (e.g., staff, equipment, materials, tools, websites).

While Program Partner organizations had existing capacities upon which they could build, the prevention and early intervention activities that these organizations were contracted to implement were new efforts, and in most cases represented an entirely new focus of program development and dissemination.

Our evaluation to date shows that the Program Partners have been highly productive in developing new program capacities. Program Partners have developed the capacities to deliver numerous new prevention and early intervention program activities. Program Partner efforts have resulted in the development of new organizational systems, staff expertise, informational resources, collaborative relationships, training protocols, materials developed and tailored for diverse target audiences, and internal evaluation capacity. This has all been accomplished in a relatively short time – only two years from the initial selection of Program Partner organizations.

Given the many challenges inherent in developing entirely new program activities, this is an impressive accomplishment.

There are also many unique and innovative aspects of this capacity development that derive from the broader policy and organization context of the implementation of these statewide PEI initiatives. To our knowledge, these initiatives are the first mental health prevention and early intervention programs to be implemented at the state level; most prevention and early intervention programs have been, and continue to be, implemented at the county level, under the direction of each county's mental health authority. It is also important to appreciate that these many and diverse Program Partner–developed capacities are components of an interrelated and complementary strategic plan, one that was carefully and broadly informed through a strategic planning process that involved diverse stakeholders (Clark et al., 2013). These PEI initiatives are arguably bold and ambitious efforts for the state of California – both in the uniqueness of a new strategic "statewide" approach to PEI programs and because they are managed by a relatively new and innovative organizational body that requires joint decisionmaking across California's many and diverse counties. It is remarkable that so much has been accomplished so quickly given such an innovative statewide strategic plan to implement and a new organizational entity to manage the implementation of the strategic plan, .

Another important and innovative aspect of the statewide PEI initiatives is the emphasis on evaluation. In addition to the independent evaluation being conducted by RAND, each of the Program Partners was required to plan its own evaluation activities, with a focus on developing capacities for performance assessment and quality improvement. Program Partners were provided technical assistance, as needed, to carry out their own evaluation activities, as well as assistance to develop the data required for the RAND evaluation. This investment in developing evaluation capacity, at both the program and broader initiative and population levels, is ground-breaking. These evaluation efforts not only will help inform decisions about further investment in statewide PEI activities but also have resulted in the development of evaluation approaches and tools that can be useful models for other county-directed PEI activities. The development of capacity to monitor population-level outcomes, risk factors, and exposure to PEI activities provides a platform for statewide assessment of the longer-term impacts of investments in PEI activities.

The statewide PEI initiatives, as originally designed, were intended to be a three-year investment in statewide PEI capacity development. Capacity development represents a large up-front investment in creating new program resources. Once new capacities are developed, it is logical to expect that program activities will be less costly to maintain and continue to deliver. However, a loss of ongoing funding could in some cases result in a loss of capacities (e.g., loss of staff expertise and disassembling of organizational systems and tools) that will not be recoverable without duplicative up-front investment.

The key policy questions that are becoming urgent for CalMHSA and other stakeholders are the following: (1) What among these statewide PEI activities should be sustained? (2) Is there any near-term fine-tuning of the initiatives that is likely to be beneficial? In spite of the impressive development of program capacities that indicate an ambitious statewide strategic PEI

plan can indeed be implemented, and quickly, it is difficult to answer these questions at this time. Below, we summarize the ways that the RAND evaluation will inform stakeholders about the reach, short-term impacts, and long-term impacts of the PEI initiatives.

Reach

In order to have impact, it is important that PEI programs result in a broad reach to their relevant populations. The reason that broad reach is generally a critical aspect of any health prevention and early intervention strategy is that there is almost always an imperfect relationship between the risk factors and the adverse health state (e.g., illness) that is the object of the preventive intervention. If a preventive intervention is targeted only to a small number of high-risk individuals, it will fail to prevent the many more cases of illness that occur among the much larger proportion of individuals who are not identified as high-risk. In order for preventive interventions to have the potential to reduce the prevalence of an illness or other adverse health consequence, they must be broadly targeted, with the aim of reducing the entire distribution of risk in the population. Geoffrey Rose's classic text, *The Strategy of Preventive Medicine*, calls this "the prevention paradox," and his insights into strategies for improving health at the population level have become key principles of preventive medicine (Rose, 1992).

Many health prevention strategies are educational in nature and attempt to increase knowledge or change attitudes in ways that can lower risks of adverse health outcomes – for example, strategies for reducing tobacco use and improving nutrition include educational components. As suggested by the Rose "prevention paradox," these prevention strategies are usually targeted to a broad population rather than just high-risk individuals (e.g., heavy smokers or those who are obese). In addition, educational approaches generally require repeated exposure and diverse sources of consistent messages to begin to see shifts in population risk factors.

In this evaluation of the statewide PEI initiatives, then, it is important to monitor the "reach" of the various prevention activities that are being implemented, that is, how many people participated in various prevention activities such as trainings and presentations or accessed informational materials. In addition, the number of individuals who are "exposed" to various prevention education messages is important to track. A television documentary, for example, may reach a large population of potential viewers in the media market when the movie is aired, but unless viewers are tuning into and closely attending to the documentary, they are not "exposed" to those preventive messages. In another example, an individual may access website materials (this individual was "reached") but may not read and understand the materials (no "exposure" to the educational information). Finally, some of the PEI prevention activities focus on a selected group of individuals who in turn are expected to educate or influence others. These include train-the-trainer activities, the development of trained speakers, interventions directed to media entertainment writers, and those that focus on gatekeepers such as faculty, peer leaders, health providers, and police. For these kinds of interventions, it is important to track the "secondary" reach beyond the targeted audience – that is, how do these individuals who

participate in the PEI program activities in turn engage in behavior that has the potential to influence others.

While it is conceptually straightforward to measure the reach of program activities and exposure to program educational information, it is often practically difficult or infeasible to obtain this information. We have worked very closely with each Program Partner to develop practical approaches and tools to track the reach of and exposure to their key program activities, in areas where it is feasible to do so.

The statewide PEI strategic plan emphasizes targeting and reach to historically underserved and vulnerable populations and reaches across the age span. This emphasis has scientific and social equity justification, but it also creates many programmatic challenges. Many Program Partners have worked to develop culturally appropriate and age-appropriate approaches to the diverse audiences that they target, with very little information available from the empirical literature to guide this tailoring. In some cases, Program Partners are also developing unique delivery approaches to find and reach vulnerable or historically underserved populations. To the extent it is feasible, Program Partners have put into place methods for documenting the reach of their program activities to specific vulnerable and underserved populations, but this sort of demographic information is sometimes particularly sensitive and difficult to obtain, and in these cases is limited.

From the information that Program Partners have been able to provide us to date, it is clear that the launch of many program activities is well under way, particularly for the short time that the programs have had to develop and implement their PEI activities. It is also clear that reach is so far relatively limited, given the potential of most of these programs to much more broadly penetrate their target populations.

Even another year of activity is a relatively brief time to achieve extensive reach of, and population exposure to, PEI educational efforts. It is likely, however, that implementation of program activities will be sufficiently far along to evaluate future potential for reach. In other words, we expect that within the next year, all program activities will be fully implemented and have had at least a few months of delivery to their target audiences, which will provide a period for observing reach.

Short-Term Outcomes

Prevention and early intervention activities "work" by modifying risk factors. The PEI program activities implemented in these statewide mental health initiatives are intended to reduce longer-term risk and therefore adverse mental health consequences by creating short-term impacts that include changing attitudes, increasing knowledge, promoting positive behavior (such as support-giving and help-seeking), and promoting well-being. In some cases the statewide PEI activities target broad community or school populations; in some cases they target those who are in key positions to influence others; and sometimes activities more directly target those at risk for or currently experiencing mental health problems. Logically, people must be exposed to the interventions, and then the interventions must have short-term intended effects on

those who are exposed to them in order to have the potential to contribute to longer-term prevention of adverse consequences associated with mental health problems.

Our evaluation is designed to examine short-term effectiveness of many but not all program activities. The studies we have designed vary depending on the type of activity; they include studies of fidelity to evidence-based training protocols, hotline call adherence to best practice standards, pre-post evaluations of participants exposed to presentations and trainings, media message experiments, and collaboration network surveys.

To date, we can say little about short-term outcomes because none of these studies is complete and some have not yet begun data collection. Generally, these studies are on track as planned, though in some cases they are somewhat delayed because of some delays in implementation of program activities.

Each of the short-term outcome studies in the evaluation plan is critically important for deciding whether key program components are performing adequately or whether they need improvement. We note, however, that the short-term outcome evaluations tend to be the parts of the RAND evaluation that have generated the most sensitivity on the part of Program Partners and have required extensive negotiation and mutual accommodation between our evaluation team and the Program Partners. Many issues have arisen, including concerns about the data collection burden on staff and participants, concerns about disruption of program operations, issues regarding protection of human subjects' privacy and confidentiality, and questions about how data will be used and reported. While many issues have been resolved, some Program Partners continue to bring new issues to our attention, and we continue to work with them to alleviate concerns so that all of the planned outcome studies can be conducted. Because the study of hotline call adherence to best practice standards was just recently approved as an added component of our evaluation contract, we are still in the initial phases of working with Program Partners to implement this study. This is a state-of-the-art evaluation approach and the only way in which the performance of the PEI program investment in hotlines will be assessed.

The RAND evaluation was designed as a comprehensive one-time evaluation of the overall CalMHSA statewide prevention and early intervention initiatives. Short-term outcome studies focus on a few key program components but do not encompass all the PEI activities in which Program Partners are engaged, nor is it the goal of the RAND evaluation to fully evaluate the performance of specific Program Partner organizations. Separate from the RAND evaluation, all Program Partners were mandated to conduct specific evaluation studies to inform their planning and implementation of PEI activities or to test the effectiveness of their interventions. These studies should contribute to evaluation of Program Partner performance and in many cases to a broader knowledge of the short-term effects of specific program activities.

Longer-Term Outcomes

Many of the risk factors of interest, as well as the adverse mental health–related consequences that are the ultimate targets of the statewide PEI initiatives, are observable only at the population level. The reason for this is that program effects on these outcomes are likely to

be distant in time from short-term program effects and are also likely to be removed from the original program participants. For example, an individual who is exposed to suicide prevention education today might, in a few years, encourage a friend to seek treatment for emotional distress, which in turn will increase the likelihood that the friend will get treatment and will reduce the risk of adverse mental health consequences, including suicide, for the friend. It would obviously be difficult to link a particular program activity to that longer-term outcome. In addition, multiple prevention and early intervention program activities can have additive effects toward reducing the risk for adverse mental health consequences over the longer term. A broad social marketing campaign, for example, might reinforce the messages of a targeted school-based educational program, and together these programs would increase the likelihood of improved mental health knowledge.

Prevention strategies that have been successful in reducing population risk factors, such as tobacco use and high blood pressure, are often composed of many diverse program activities that are all aimed toward changing health behavior. Ultimately, these multipronged prevention programs can be observed to shift the distribution of the behavioral risk factor toward a lower mean in the general population, which in turn is associated with reduced incidence of the adverse health consequence of interest (e.g., lung cancer and heart disease [Lightwood and Glantz, 2013]).

It follows that long-term population tracking is essential to evaluating the impact of the statewide PEI initiatives on longer-term outcomes. As part of the RAND evaluation, we are putting into place population surveys and expanding existing population surveys, in order to establish baseline tracking of the longer-term risk factors and outcomes of interest and to establish methods for tracking changes over time. Initial findings from partially launched higher-education surveys, and from a statewide adult population survey, were presented in this report. Other population surveys are yet to be launched. Together, they form a strong and fairly comprehensive evaluative infrastructure for longer-term tracking of prevention and early intervention outcomes of interest.

Longer-term tracking of population indicators in itself does not readily answer the question of whether particular prevention and early intervention strategies produced any changes that might be observed. A number of methodological and statistical approaches can be used to try to disentangle other potential influences (for example, socioeconomic effects) from program effects on outcomes. The rigor of this sort of analysis is greatly improved if comparison population data are available from populations that have not been exposed to the programs (for example, from other states or from time periods prior to the program implementation). We have looked into opportunities to develop these comparisons, and when possible, we have drawn on existing survey measures to maximize comparability to existing data from other populations.

We caution that the period of active PEI efforts and evaluation for these initiatives is very short for seeing impacts on most of the longer-term outcomes of interest. However, it is possible that we will be able to observe some one-year changes in population attitudes and knowledge, and both our school and adult population surveys are designed to capture these. These surveys

are also designed to track exposure to some program activities that are more difficult to track directly through Program Partner monitoring.

Ongoing Performance Assessment and Improvement

It was not a goal of the RAND evaluation to develop a system of ongoing performance assessment for PEI program activities. However, many of the approaches and tools used to collect information about the reach and short-term impacts of program activities can be utilized by Program Partner organizations to develop an ongoing monitoring and reporting capacity. Ideally, prevention and early intervention programs should incorporate ongoing evaluation of reach and short-term outcomes as part of their own management and performance improvement activities. Ongoing evaluation can help programs in their efforts to refine and improve their prevention and early intervention activities. Some Program Partners are developing a monitoring and evaluation infrastructure to do this; others see the evaluation mandates associated with their CalMHSA contract as a one-time burden and do not envision developing a longer-term evaluation capability.

Stakeholder questions about how to improve the quality and value of PEI strategies and program efforts could be addressed by the development and maintenance of ongoing performance assessment and improvement systems for PEI programs.

Conclusions

There is a logical, science-informed path from the statewide strategic plan to reduction in mental health stigma and discrimination, reduction in suicide, and improvement in student mental health. This path involves (1) the strategic planning of comprehensive, interrelated program components, (2) development of new prevention and early intervention program capacities, (3) delivery of new program activities to achieve broad reach to California's diverse population and result in significant exposure to program materials, (4) impact of program activities on targeted short-term outcomes such as knowledge and attitudes, and (5) impact on longer-term outcomes for California's population. It is important to evaluate these efforts so that other prevention and early intervention efforts (e.g., in counties, other states) can make use of the knowledge that the evaluations generate and focus investment on effective strategies.

Are the statewide PEI programs on track toward reaching the goals of the strategic plan? At this time, it is clear to us that statewide PEI program capacities have been greatly expanded, that delivery has been launched for many program components, and that reach is in a rapidly expanding phase. We do not know yet whether programs are having their intended short-term impacts on participants/audiences, but we expect to be able to answer those questions for key program activities within the time frame of this evaluation. We caution that it may be unrealistic to expect observable population changes in the long-term outcomes of interest, given the start-up time required to build and launch new programs, the relatively brief time that program effects will be observed, and the importance of broad population reach and exposure necessary for prevention to have an impact.

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Appendix A. Program Partner Descriptions

This appendix contains brief descriptions of each Program Partner's CalMHSA activities. SDR Program Partners are described first, followed by SP and SMH Program Partners.

Stigma and Discrimination Reduction

Disability Rights California

Disability Rights California is a nonprofit advocacy organization mandated to advance the human and legal rights of people with disabilities. It provides advocacy, legal services, training, and information on a range of disability-related issues. It has regional offices in Sacramento, Oakland, Fresno, Los Angeles, and San Diego, and small satellite offices in many other locations throughout California. Its CalMHSA SDR Project is statewide, and key activities include interactive training on understanding antidiscrimination laws/policies and the role that individuals can play in eliminating stigma and discrimination. The training modules will be directed at specific populations, including schools, courts, law enforcement, health providers, employers, human resources staff, landlords, and consumers. Disability Rights California staff have created fact sheets on stigma and discrimination–related topics and plan to write policy papers on similar issues. The project plan includes creation of an advisory group and coordination of activities with other SDR Program Partners.

Entertainment Industries Council, Inc.

Entertainment Industries Council, Inc. is a nonprofit organization that works with the entertainment industry and news media to bring awareness about health and social issues. It is located in Los Angeles County, and its target populations include media writers, producers, directors, performers, journalists, and media executives. Entertainment Industries Council, Inc. is developing resources (i.e., a style guide, tool kits, fact sheets, and newsletters) for journalists and entertainment media professionals to increase positive portrayals and decrease inaccurate portrayals of people with mental health challenges in the media. These resources are promoted through educational presentations, individualized technical assistance, a website, and partnerships with media and broadcasting associations (e.g., Associated Press). Entertainment Industries Council, Inc. is also working with journalism and TV schools to incorporate these resources into their curriculum and to encourage students to apply them through competitions. Entertainment Industries Council, Inc. also educates stakeholders who represent various cultural and language groups on how to become more effective media sources regarding mental health issues in their communities by bringing them together with media representatives at forums.

Integrated Behavioral Health Project/Center for Care Innovations

The Integrated Behavioral Health Project (IBHP), a team of consultants supported administratively by the Tides Center/Center for Care Innovations based in San Francisco, provides resources, technical assistance, education and training, and evaluation in order to build capacity across the state of California to advance primary care and behavioral health integration. IBHP plans to leverage existing infrastructure across the state by working in collaboration with associations such as the California Primary Care Association and California Institute for Mental Health (to develop and disseminate relevant training materials and tool kits on integrated behavioral health care models, programs, and services via conferences, learning communities, and regional forums. Training and capacity-building activities will target a range of stockholders, including general and behavioral health care providers; consumers/peer providers; county, clinic, and health plan administrators; and the workforce pipeline. IBHP also intends to develop and distribute policy recommendations and reports to local and state policymakers to further the case for the provision of integrated behavioral health care. Other collaborative activities include coordinating activities with other Program Partners, establishing an Integration Policy and Practice Initiative advisory group, and engaging upper-educational institutions in curriculum development and training.

Mental Health America of California

Mental Health America of California is an organization that focuses on mental health advocacy, public policy, and education. It seeks to ensure that all Californians in need of mental health services have access to the appropriate services at the appropriate time. Mental Health America of California is a statewide organization located in Sacramento with nine affiliates that work at the local level. Its Wellness Works! program seeks to reduce mental health stigma and discrimination and promote mental wellness in the workplace through corporate training. Wellness Works! offers multiple workshops, ranging from 30-minute lunch-and-learns to a full day, aimed at various audiences including supervisors, managers, senior executives, small business owners, human resources professionals, occupational health, union leadership, law enforcement, and employees. Through custom workshops and training products with blended online learning, Wellness Works! aims to improve working lives by helping individuals with various roles in the workplace to provide effective support to employees struggling with mental health problems. Wellness Works! also addresses the organizational factors that affect overall workplace mental health with an emphasis on creating psychologically safe and healthy work environments benefiting all workers.

Mental Health Association of San Francisco Resource Development

Mental Health Association of San Francisco (MHASF) is a mental health education, advocacy, research, and service organization. Located in San Francisco, its CalMHSA programs have statewide targets. It has two funded CalMHSA programs, one of which is the Resource Development program, which focuses on continual quality improvement of Stigma and

Discrimination Reduction (SDR) programs (e.g., speaker bureaus). It has also developed resources such as a research-based model and manual on best practices for delivery of SDR programs and an efficacy measure tool kit to facilitate self-evaluation of fidelity to best practices of SDR programs and outcomes. These resources are distributed and supported through trainings and a website. The website (www.dignityandrecoverycenter.org) will house a registry of SDR programs that is searchable by program characteristics (e.g., program type, geographical location). MHASF disseminates its education through journal articles and other publications. Training has been offered and will continue to be offered to community development partners, other community organizations, and consumers through an annual statewide conference and smaller training venues. More targeted technical assistance will be offered to community development partners via intensive on-site visits focused on program evaluation and grassroots training/technical assistance. In addition to coordinating with other Program Partners, the planned networking activities include establishing a Research Leadership Workgroup and conducting annual SDR conferences.

Mental Health Association of San Francisco Promising Practices

MHASF's Promising Practices program aims to encourage promising practices in SDR among community-based organizations. MHASF has conducted (and continues to conduct) a statewide scan of community-based SDR programs and collected information on communities served and existing levels of efficacy through the assistance of Program Partners, community organizations, ethnic services managers ,and county liaisons. Results of this scan are being used, in collaboration with the above-mentioned partners and organizations, to identify promising practices and activities within cultural, ethnic, and racial communities, as well as any existing gaps. Six to nine community development partners will engage in a co-learning process about culturally specific SDR promising practices and concepts of mental health and wellness that will result in reports capturing lessons learned. In addition, MHASF is working with university researchers and several youth investigators to develop best practices for working with historically underserved communities. Once models and materials are developed from the co-learning and academic research activities, they will be shared with ethnic service managers, county liaisons, SDR advocates, and the community through statewide conferences, regional workshops, train-the-trainer sessions, webinars, and a website. Its website, dignityandrecoverycenter.org, also houses a registry of SDR speakers and programs serving specific cultural, ethnic, and racial community organizations that can be searched by program characteristics. In addition to coordinating with other Program Partners, MHASF plans to establish an interdisciplinary network of state, regional, and local SDR programs and to create academic-community partnerships.

National Alliance on Mental Illness

National Alliance on Mental Illness California is a grassroots organization of families and individuals whose lives have been affected by mental illness. National Alliance on Mental Illness California is located in Sacramento, but its activities target populations statewide. Key

CalMHSA-funded activities include educational presentations about mental illness and recovery that incorporate speakers who share about their own or family member's "lived experience" of overcoming challenges related to mental illness. Specifically, National Alliance on Mental Illness's *In Our Own Voice* program targets general and specific audiences, *Ending the Silence* is designed for high school students, "Parents and Teachers as Allies" is an in-service presentation for K–12 faculty and staff on early warning signs of mental illness, and the Provider Education Program is designed to help providers to increase their empathy and understanding.

Runyon Saltzman & Einhorn

Runyon Saltzman & Einhorn, located in Sacramento, is a communications firm providing advertising, public relations, and social marketing expertise. It has developed and is implementing a statewide, multipronged social marketing campaign directed at caregivers of children birth to age 8, tweens ages 9–13, transitional age youth ages 14–24, and adults 25+ who identify as decisionmakers (e.g., teachers, doctors, employers, etc.). The caregiver campaign promotes information about mental health challenges and services through a cadre of popular parent bloggers. The tween campaign consists of school assemblies and a website with related materials. Cable television, digital, and radio ads will be created to drive the tween audience to the website. For the transitional-age youth campaign, Runyon Saltzman & Einhorn developed and launched online ReachOut forums with radio, online, and print advertisements that drive youth to the ReachOut website where they can obtain information and join the conversation in online forums. For the decisionmaker adults, Runyon Saltzman & Einhorn and KVIE produced a California Public Television (CPT) documentary about mental health challenges and stigma, along with a public relations outreach campaign for the documentary, a website with a speakers bureau and resources, and mini-grants to support community documentary screenings and dialogues. Runyon Saltzman & Einhorn's efforts to serve specific ethnic and cultural communities include workshops for congregational leaders in the African American community; forums for Latino families; and outreach efforts, community events, and collateral materials targeting Hmong, Laotian, and Cambodian decisionmakers. Finally, Runyon Saltzman & Einhorn developed a website, EachMindMatters.org, to create awareness of the many statewide efforts to end the stigma of mental illness and to showcase the activities, programs, and projects that are a part of this movement. The CPT documentary and related promotional materials will be housed on this site.

SDR Consortium

The SDR Consortium aims to inform and collaborate with CalMHSA and CalMHSA Program Partners to reduce stigma and discrimination. The Consortium is composed of approximately 25 members who represent a diverse group of mental health advocates, agencies, and consumers. The Consortium meets quarterly to discuss CalMHSA SDR efforts and have discussed and provided feedback to CalMHSA on topics such as reaching diverse communities, implementation of the Each Mind Matters campaign, and sustainability of CalMHSA statewide PEI efforts.

United Advocates for Children and Families

United Advocates for Children and Families (UACF) is a nonprofit organization with a mission to improve the quality of life for those with mental, emotional, and behavioral challenges and to eliminate institutional discrimination and social stigma through advocacy, training, and networking. UACF's key activities include train-the-trainer programs for Caring Communities and Tell Your Own Story curricula, Community Network Roundtables, keynote speeches, and activities targeting veterans,-children, youth, consumers, and families. Through expansion of its current website, UACF will provide access to publications, event calendars, courses, services, discussion forums, and surveys. The website will highlight the projects, trainings, and educational materials of UACF, and provide a one-stop shop of access for materials and resources as provided by local community-based organizations as well as other CalMHSA partners. This new website will be rebranded as a "Gateway to Hope" and absorb the current UACF website. It aims to offer not only multilingual options, but opportunities for peer engagement, support, and information across the targeted populations.

Suicide Prevention Program Partners

AdEase

AdEase is an ad, marketing, and public relations agency. It has locations in San Diego, San Francisco, and San Jose, but its CalMHSA program targets California statewide. One of AdEase's major CalMHSA activities is a statewide social marketing effort with the tagline "Know the Signs," which is focused on communicating warning signs and risk factors for suicide to the general population so that they can help others. AdEase also intends to help counties reach out to high-risk groups. Training/education activities include media advocacy training, training for media, and a targeted campaign for primary care physicians. Another key CalMHSA activity is implementation of *Your Voice Counts*, a web-based tool to provide Program Partners and others with a voice in the development of materials for statewide suicide prevention, stigma reduction, and student wellness activities. Target populations include the general public, physicians, youth/students, non-English speakers, rural/urban residents, suicide survivors, and local media advocates.

Didi Hirsch Program 1: Suicide Prevention Network Program

Didi Hirsch is a community mental health center located in Los Angeles County. Its crisis line is over 50 years old, the oldest in the United States. The organization has two funded CalMHSA programs, the Suicide Prevention Network Program of which targets ten crisis centers across the state. The program aims to bring together these crisis lines to develop standardized crisis line data metrics that all participating crisis lines will collect. In addition to the statewide network, it is also establishing regional task forces that will serve as best practice advisory boards. These regional task forces convene topic-specific workgroups on high-risk populations

and identify a best practice for each region. Didi Hirsch will publicize these best practices by helping get them get accepted onto the national suicide Best Practices Registry website.

Didi Hirsch Program 2: Regional & Local Suicide Prevention Capacity Building Program

Didi Hirsch's Program 2 targets Los Angeles, Orange, Riverside, San Bernardino, San Diego, Imperial, and Ventura Counties in Southern California. Its major goals relate to hotline and warmline service enhancement and expansion. The program is expanding its bilingual crisis line to include services in Korean and Vietnamese, expanding the hours of its Los Angeles County warmline and its National Alliance on Mental Illness–Orange County warmline, and establishing a new ACCESS warmline in collaboration with the Los Angeles County Department of Mental Health. Didi Hirsch is becoming the dedicated crisis line for Southern California counties and plans to do outreach to counties to let them know that Didi Hirsch is their dedicated crisis line and to describe the services Didi Hirsch provides. Didi Hirsch also plans to identify and compile a list of local resources for its referral database so that it can better able serve neighboring counties. In addition, it plans to provide hotline and warmline data back to the counties it is serving. While this program focuses largely on suicide prevention capacity building rather than networks, there is still a key network component. Specifically, the program is establishing the Southern California Warmline Network to generate standard best practices for warmlines. Didi Hirsch will then disseminate the network's findings. This program particularly targets Vietnamese and Korean Southern Californians, as well as individuals in the Southern California counties listed above.

Family Service Agency of the Central Coast

Family Service Agency of the Central Coast, a community mental health center located in Santa Cruz, serves the Central Coast counties of Santa Cruz, San Benito, and Monterey. Its program targets the Central Coast sub-region of the Bay Area. Its key CalMHSA activities revolve around its crisis hotline, educational outreach, and web-based outreach. The program plans to implement enhanced screening, training, and supervision of its volunteer hotline operators; purchase and implement an electronic call management system (e.g., iCarol) for the hotline; network with other crisis responding agencies, hotlines, and local mental health service providers to coordinate services and share ideas; and attain American Association of Suicidology (AAS) accreditation for the hotline. The program also plans to conduct training activities, including trainings with support groups run by other organizations (e.g., Hospice) to improve referrals for crisis or bereavement services, which the program plans to enhance. Finally, the program has plans to develop informational materials including web-based outreach (workshops, community events, and website) and culturally competent educational materials. Family Service Agency of the Central Coast's target populations include crisis responders; community gatekeepers; at-risk groups such as youth, elderly adults, incarcerated adults, youth involved in the juvenile justice system, youth at risk of gang involvement; veterans; LGBTQ youth and adults; and survivors of suicide loss.

Family Service Agency of Marin

Family Service Agency of Marin is a community mental health center that operates a hotline. Located in Marin County, it targets the counties of Marin, Sonoma, Solano, Napa, Lake, and Mendocino. The program plans to expand its hotline service from one to six counties, and to conduct outreach to targeted groups in each county. It is using needs assessment to identify specific communities to target (e.g., rural, veterans, etc.) in the five new North Bay counties it serves. It has implemented an electronic call management system, iCarol, and hopes to improve the quality and capacity of its hotline services. With respect to training/education activities, it plans to provide suicide prevention outreach to the larger community and more targeted training and outreach to emergency responders. With respect to networking activities, it is forming the North Bay Suicide Prevention Regional Council, a collaboration of liaisons from each of the six counties listed above. The Council plans to create individual county suicide prevention committees and action plans based on local needs. More broadly, Family Service Agency of Marin also plans to network with other crisis responding agencies, hotlines, and local mental health service providers to coordinate services and share ideas. In the past year, Family Service Agency of Marin merged with Buckelew Programs, serving Marin, Sonoma, and Napa Counties. The goal of this merger was to increase the Agency's capacity to engage the counties in the North Bay Suicide prevention project.

Institute on Aging

The Institute on Aging is a senior care organization located in San Francisco. Its CalMHSA program targets the elderly in Sacramento, El Dorado, Placer, Amador, Sutter, Yuba, Yolo, Butte, Colusa, Glenn, Trinity, Humboldt, Lassen, Calaveras, Tuolumne, Siskiyou, and Modoc counties, with a special emphasis on elderly individuals living in rural areas. The Institute maintains a 24-hour toll-free hotline for older and disabled adults, and its CalMHSA activities include development and implementation of an electronic call management system for the hotline; attaining AAS accreditation; and networking with other crisis responding agencies, hotlines, and local mental health service providers to coordinate services and share ideas. The program also includes training activities, including developing and offering online training to health professionals and gatekeepers in elderly suicide prevention; providing educational sessions on elderly suicide to "The Effort," a medical/behavioral health center in Sacramento; and conducting community education and outreach. Since funding, "The Effort" has been renamed "WellSpace Health" and, under the Institute on Aging contract, received funds from CalMHSA to expand its capacity to include online (i.e., chat) and text crisis communication.

Kings View

Kings View is a community mental health center with a corporate office in Fresno County and locations in 14 counties. The CalMHSA program aims to establish and publicize a new Central Valley Suicide Prevention Hotline that is now available 24/7. It will be training new volunteers as part of this process and will seek to develop curriculum modules and training

programs focused on developmental, adjustment, and diversity issues. The program targets Fresno, Madera, Mariposa, Merced, and Stanislaus counties in Central California, and target populations include consumers and family members, public and private health providers, rural communities, business community and employers, multicultural residents and organizations, spiritual and faith-based organizations, youth and older adults, LGBTQ community members and leaders, and educational staff and representatives.

LivingWorks

LivingWorks is a suicide intervention training company with an international office in Calgary, Canada, and U.S. offices in Fayetteville, North Carolina. LivingWorks' training programs with CalMHSA are coordinated through three California subcontracts: Didi Hirsch, Contra Costa County, and WellSpace (formerly known as the Effort). The trainings to be administered include SafeTALK, ASIST, and eSuicideTALK. SafeTALK is a 3-hour suicide alertness workshop. ASIST is an intensive 2-day suicide intervention workshop. LivingWorks uses a training-for-trainers (T4T) program to credential trainers. SafeTALK T4T is a 2-day training that teaches skills to deliver the SafeTALK workshop, and ASIST T4T is a 5-day course. eSuicideTALK is a 60-minute, online version of its SuicideTALK training that provides more general-knowledge training for community audiences. The LivingWorks' program targets a broad, statewide population.

San Francisco (SF) Suicide Prevention

The SF Suicide Prevention contract is an umbrella contract for four crisis centers (SF Suicide Prevention, Contra Costa County, San Mateo/Star Vista, and Santa Clara County) that are all independent of each other. The four programs intend to meet regularly and support all four programs funded under the same contract. SF Suicide Prevention, Contra Costa, and San Mateo/Star Vista all plan to develop and/or expand their chat and/or text capabilities. In addition, SF Suicide Prevention intends to join the Contact USA network, supporting crisis chat responders. Santa Clara intends to gain AAS accreditation for its hotline. All four programs intend to implement community education and outreach to target populations, with San Mateo/Star Vista and Santa Clara focusing on rural communities. More broadly, the group of programs may also target LGBTQ individuals, adolescents, African Americans, seniors, Latinos, transition-age young adults, Asians/Pacific Islanders, and middle age adults in the Bay Area of California.

Transitions Mental Health Association

Transitions, a community mental health center located in San Luis Obispo, is using CalMHSA funds to attain AAS accreditation for its hotline, as well as to establish warmlines in Santa Barbara County. It also plans to establish a regional provider network in Kern, San Luis Obispo, and Santa Barbara counties. It plans to conduct outreach through its website. With respect to policies, protocols, and best practices, it intends to expand the role of its Peer Advisory and Advocacy Team and to develop protocols to identify and disseminate best practices. While

Transitions primarily targets consumers in Kern, San Luis Obispo, and Santa Barbara counties, it plans to disseminate best practices to crisis centers both regionally and statewide.

Student Mental Health Program Partners

California Community Colleges

California Community Colleges' Student Mental Health Program (California Community Colleges SMHP) activities focus on prevention strategies that address the mental health needs of students at California's community colleges, and advance the collaboration between educational settings and county behavioral health services, which form the foundation for future MHSA programs. The California Community Colleges SMHP is a collaborative partnership between the California Community Colleges Chancellor's Office and the Foundation for California Community Colleges. The main components of the California Community Colleges SMHP are the development and implementation of campus-based grants (CBGs) to community colleges and a statewide training and technical assistance system to support the contracts, regional training efforts, and resource development and dissemination. The California Community Colleges SMHP is also supporting various modules of the At-Risk suicide prevention training for faculty, staff, and students across the system. Embedded in the above components are plans to continue work with stakeholder groups and the California State University and University of California systems on select projects and in regional strategizing forums. Maintaining a focus on student veterans remains an important element of program implementation, as is a recent effort to address the mental health needs of transition-aged foster youth.

California County Superintendents Educational Services Association

California County Superintendents Educational Services Association's (CCSESA's) Regional K–12 Student Mental Health Initiative is based on a statewide framework of prevention and early intervention strategies for student mental health that preserves regional flexibility. CCSESA has identified four major goals: (1) cross-system collaboration; (2) school-based demonstration programs; (3) education and training of education and mental health personnel, parents/caregivers, and community partners; and (4) technical assistance for school-based program development. These efforts are achieved and sustained by building the capacity of existing systems and personnel. CCSESA, through regional lead counties, develops regional plans for each region; builds capacity for providing technical assistance for school-based mental health program development and implementation; facilitates policy and protocol changes across systems for prevention and early identification; builds capacity for providing education and training of school, district, and mental health personnel, parents/caregivers, and community partners; implements school-based demonstration programs; creates an online statewide clearinghouse of resources and best practices; and has four representatives on the Student Mental Health Policy Workgroup (SMHPW) chaired by California Department of Education.

California Department of Education

The California Department of Education convenes and chairs SMHPW with quarterly meetings that began in 2012. The SMHPW proposes critical student mental health policy recommendations to the State Superintendent of Public Instruction and the California legislature. These policy recommendations will help build capacity among K–12 schools, mental health providers, mental health organizations, youth development agencies, and others to appropriately refer and treat students with mental health needs. The California Department of Education CalMHSA SMHI PEI efforts have also increased the number of training educators through Recognition and Identification Strategies (TETRIS) Eliminating Barriers to Learning workshops. TETRIS workshops focus on high-quality professional development for school and district-level staff to recognize, support, and appropriately refer and respond to students who experience mental health issues.

California State University

The California State University SMH initiative entails the implementation of system-wide initiatives directed by the Chancellor's Office (including social marketing campaigns, suicide prevention trainings, and the development of a resource clearinghouse) as well as the implementation of campus-based prevention programs, funded through sub-awards to all 23 campuses (including curriculum development and training, peer-to-peer support programs, and suicide prevention programs). All components focus on preventative measures, such as health and wellness events, that address the mental health needs of California State University students in collaboration with state and county behavioral health services.

University of California

The University of California is using a system-wide, two-phase initiative to address student mental health issues. Phase I includes developing and enhancing campus programs and services for peer-to-peer support, faculty/staff/student training, and suicide prevention. New or enhanced programs/services implemented on University of California campuses include training programs to recognize and respond to students with mental health disorder–related behaviors, implementing American Foundation for Suicide Prevention's Interactive Screening Program to each University of California campus; creating a system-wide social marketing campaign to disseminate information to students, and developing a comprehensive web-based "clearinghouse" for program material, training manuals, and other outreach material. Phase II includes strengthening the University of California's relationship with the California State University and California Community Colleges systems by collaborating on projects that increase access to services to all students within the systems, and by providing outreach and resources statewide.

Appendix B.1. SDR Evaluation Tools – Key Document Tracking Tool

The Key Document Tracking Tool tracks the dissemination of the following types of documents: policy papers/reports, protocols/procedures, newsletters, informational materials, resource materials/tool kits, media messages, and evaluation reports. The Tool collects information about start/end dates of distribution, method of distribution (e.g., email, in-person, mail), number of copies distributed, and the location where documents were distributed (e.g., statewide, specific counties). The Tool also records the number of people for whom email addresses were collected for the follow-up survey. Similar to the Trainings and Educational Presentations Worksheet (Appendix B.2.), the Key Document Tracking Tool is completed by Program Partner staff and provides a more accurate estimate of the distribution of materials than would relying on other instruments such as the follow-up survey. Not all individuals will provide email addresses for the follow-up survey, and not all of those who do provide emails will complete the follow-up survey.

The Key Document Tracking Tool also tracks whether the documents were disseminated to specific targeted audiences such as people living with mental health challenges, family members of people living with mental challenges, LGBTQ individuals, racial/ethnic minority groups, particular age groups, and veterans. In addition, the Tool assesses whether target audiences included individuals serving in gatekeeper roles, such as educators, health providers, etc.

Data collected via Google Analytics will provide metrics on the distribution of key documents through downloads on SDR program websites.

Table B.1. Key Document Tracking Tool

Item #	Item Wording	Response scale	Construct measured	Source (e.g., GSS, See Change)
1	Program Partner name	Select from list of Program Partner and subcontractor organization names	Program Partner name	Original
2	Title of document	Open-ended	Title of key document being submitted	Original

Item #	Item Wording	Response scale	Construct measured	Source (e.g., GSS, See Change)
3	Type of document	Select one: policy paper or report; protocol or procedure (includes self-assessment tools); newsletter; informational materials (fact sheets); resource materials/tool kit; evaluation report (if selected, survey ends here)	Type of document	Original
4	Targeted audience (select all that apply)	General audience; People living with mental health challenges; Family of people living with mental health challenges; Specific demographic groups (You will have an opportunity to indicate which specific groups later on in this survey) [takes respondents to item 5]; Gatekeepers (You will have an opportunity to indicate specific jobs/roles later on in this survey)[takes respondents to item 6]	Targeted audience	Original

Item #	Item Wording	Response scale	Construct measured	Source (e.g., GSS, See Change)
5	Targeted demographic groups (select all that apply)	Males; Lesbian, Gay, Bisexual, Transgender, Queer, or Questioning (LGBTQ); Veterans; Specific Age Groups [If selected, following response options appear: Youth (0–15 years); Transition age youth (16–25 years); Adults (26–59 years); Older adults (60+ years)]; Specific Racial/Ethnic Groups [If selected, following response options appear: Hispanic/Latino; African-American/Black; Asian; Native Hawaiian/Other Pacific Islander; Native American/American Indian/Alaska Native; Other (specify)]; Other (specify	Targeted demographic groups	Original

Item #	Item Wording	Response scale	Construct measured	Source (e.g., GSS, See Change)
6	Targeted gatekeeper jobs/roles (select all that apply)	Educators or other staff at an educational institution; Employers or human resource staff; Healthcare providers or staff; Mental health service providers or staff; Other health or mental health providers or staff; Justice/Corrections/Law Enforcement professionals; Journalism/Entertainment media professionals; Landlords or property managers; Policymakers/Legislators; Representatives of a faith-based organization; Representatives of a community organization; Lawyers/Attorneys; Individuals who identify as Lesbian, Gay, Bisexual, Transgender, Queer, or Questioning; Veterans; Other (specify)	Targeted gatekeepers	Original
7	Number of people for whom emails for follow-up survey were collected	Open-ended	Number of email addresses collected	Original
8	Start date for distribution of document (For websites, indicate initial date document was uploaded to website)	mm/dd/yy or still ongoing	Start date for distribution	Original
9	End date for distribution of document or indicate distribution is still ongoing	mm/dd/yy or still ongoing	End date for distribution	Original

Item #	Item Wording	Response scale	Construct measured	Source (e.g., GSS, See Change)
10	Ways document was distributed (select all that apply)	Email; In-person meetings (other than educational presentations or trainings); Mail; Leave with agencies or organizations (including schools); Presentation or Training; Website [go to items 10a and 10b]		Original
10a	Enter your website URL corresponding to this document	Open-ended	Website URL	Original
10b	Has download tracking for this document been added to your Google Analytics specifications?	No [Message appears telling them to contact technical assistance provider, then proceed to item 11]; Yes [If no other method of distribution identified in item 10, then complete tool. If other methods of distribution identified, proceed to item 11).	Download tracking	Original
11	Total quantity distributed. Does not pertain to website downloads	Open-ended	Quantity distributed	Original
12	Is this quantity the actual number of an estimate?	Actual/Estimate	Quantity actual or estimated	Original
13	Locations distributed (select one)	Statewide/Specific counties (select all that apply from list of counties)/Other (specify)		Original
14	Notes	Open-ended	Comments from Program Partner	Original

Appendix B.2. SDR Evaluation Tools – Training and Educational Presentations Worksheet

The Trainings and Educational Presentations Worksheet tracks the reach and dissemination of SDR trainings and educational presentations. While other SDR surveys are designed to be completed by the targets of CalMHSA efforts (individuals receiving information or training), this worksheet is completed by Program Partner staff. It is designed to capture missing information when survey data cannot be collected or when survey data are incomplete. For example, even though 50 people might attend a particular presentation, only 40 may turn in sign-in sheets or pre-post surveys. The Worksheet provides program staff with the ability to record the actual number of attendees, whereas relying on a count based upon the number of completed sign-in sheets or surveys could result in an undercount. In addition to number of attendees, the Worksheet tracks the geographical locations in which trainings/presentations are delivered, the method of delivery (i.e., in person, webinar, other), whether a video of a person discussing his/her personal experiences with a mental health challenge was shown, the number of presenters as well as the number of presenters who shared about their personal experiences with a mental health challenge, and the number of attendees for whom email addresses were obtained for follow-up surveys. The Worksheet also tracks whether sign-in sheets and pre-post surveys were administered. If neither the sign-in sheet nor the pre-post survey is administered, then an additional set of questions are asked about the demographic and gatekeeper composition of the audience. Altogether, the Worksheet can connect multiple sources of data from a single training or presentation. The Worksheet is administered via a web-based platform.

Table B.2. Training and Educational Presentations Worksheet

Item #	Item Wording	Response scale	Construct measured	Source (e.g., GSS, See Change)
1	Program Partner name	Select from list of Program Partner and subcontractor organization names	Program Partner name	Original
2	First two letters of trainer's last name	Open-ended	To help correctly identify programs	Original
3	Title of training, presentation, curriculum, event, workshop, or conference	Open-ended	Title of presentation	Original

Item #	Item Wording	Response scale	Construct measured	Source (e.g., GSS, See Change)
4	Topic if different from title	Open-ended	Topic if different from title	Original
5	Have materials/curriculum from training, presentation, event, workshop, or conference been submitted?	Yes/No/Don't know	Materials uploaded to TeamSpace site	Original
6	Date of presentation	mm/dd/yy	Date of presentation	Original
8	Location delivered (select one)	Statewide/Specific counties (select all that apply from list of counties)/Other (specify)	Location of presentation	Original
9	Method of delivery	In person/Webinar/Other (specify)	Method of presentation delivery	Original
10	Number of people in audience	Open-ended	Number of people in audience	Original
11	As part of the presentation/training, was a video shown of a person sharing his/her personal experiences with a mental health challenge?	Yes/No	Contact strategy used?	Original
12	Number of presenters	Open-ended	Number of presenters	Original
13	Number of presenters who disclosed to the audience that they have personally experienced a mental health challenge	Open-ended	Contact strategy used?	Original
14	Was a pre-post survey administered regarding this training/presentation?	Yes/No	Pre-post survey administered	Original
15	Number of attendees for whom emails for follow-up survey were collected	NA/Open-ended	Number of email addresses collected	Original

Item #	Item Wording	Response scale	Construct measured	Source (e.g., GSS, See Change)
16	Was a sign-in sheet collected for training/presentation?	Yes(Tool ends here)/No	Availability of detailed attendance data	Original
17	Was this audience of the general public?	Yes/No	Audience composition	Original
18	Was the audience made up of (more than half were) people who have had mental health challenges?	Yes/No/Don't know	Audience composition	Original
19	Was the audience made up of (more than half were) family members of person who have/had mental health challenges?	Yes/No/Don't know	Audience composition	Original
20	Specific subgroups you knew were in the audience (select all that apply)	Educators or other staff at an educational institution; Employers or human resource staff; Healthcare providers or staff; Mental health service providers or staff; Other health or mental health providers or staff; Justice/Corrections/Law Enforcement professionals; Journalism/Entertainment media professionals; Landlords or property managers; Policymakers/Legislators; Representatives of a faith-based organization; Representatives of a community organization; Lawyers/Attorneys; Individuals who identify as Lesbian, Gay, Bisexual, Transgender, Queer, or Questioning; Veterans; Other (specify)	Audience composition	Original

Item #	Item Wording	Response scale	Construct measured	Source (e.g., GSS, See Change)
21	Was the audience mostly made up of (more than half were)…? (select one)	Youth (0–15 years)/Transition age youth (16–25 years)/Adults (26–59 years)/Older adults (60+ years)/None of the above – No one age group made up more than half of the audience/Don't know	Audience composition	Original
22	Was the audience mostly made up of (more than half were)…? (select one)	Male/Female/None of the above – there were approximately equal numbers of males and females/Don't know	Audience composition	Original
23	Was the audience mostly made up of (more than half were) people of Hispanic/Latino ethnicity?	Yes/No/Don't know	Audience composition	Original
24	Was the audience mostly made up of (more than half were)…? (select one)	Whites; Blacks/African-Americans; Asian-Americans; Native Hawaiians/Other Pacific Islanders; Native Americans/American Indians/Alaska Natives; Another Racial/Ethnical group; None of the above – no one racial/ethnic group made up more than half of the audience/Don't know	Audience composition	Original
25	Notes	Open-ended	Comments from Program Partner	Original

Appendix B.3. SDR Evaluation Tools – Sign-In Sheet

The purpose of the sign-in sheet is to collect basic information describing participants in SDR trainings or educational presentations. Before the start of a training or presentation, participants are asked to complete the sheet, which requests information about their demographics (e.g., gender, age, race/ethnicity), gatekeeper status (i.e., whether they serve in a job or role where they can significantly influence the lives of individuals affected by mental health problems), and whether in their role or job they are especially likely to reach targeted audiences of interest to CalMHSA (e.g., racial/ethnic minorities; veterans; lesbian, gay, bisexual, transgendered, queer or questioning individuals). Participants are also asked to provide their email address to be possibly contacted in the future for the follow-up survey (described in Appendixes B.5 – B.7).

The sign-in sheets allow for the measurement of program reach/participation, collection of email addresses for use in recruiting participants to subsequent surveys, response rates to those surveys (i.e., of the participants in a training, how many complete the pre-post or follow-up survey – described in Appendixes B.4 – B.7 below), and differential response rates across important subgroups to these subsequent surveys. For example, if 100 individuals complete sign-ins for a presentation, but only 50 complete a pre-post survey, this will provide an indication of how complete our data are regarding the response of the entire audience to that presentation. Similarly, if 50 males and 50 females complete a sign-in sheet, but only 50 females complete the pre-post survey, this will provide an index of how representative the data from the completed surveys are with respect to men's versus women's reaction to the presentation. Collecting demographic and other participant characteristics on both the sign-in sheets and subsequent surveys (e.g., pre-post, follow-up) enables the tracking of differential response rates across various groups and a more accurate interpretation of the data from subsequent surveys. Further, the sign-in sheets are likely to provide more precise estimates of the number of individuals attending trainings and presentations than would relying on counts based on completed pre-post or follow-up surveys, which are subject to a lower than 100 percent response rate.

SDR programs administer the sign-in as participants are assembling for a presentation or waiting for it to begin. It is a self-administered paper and pencil form. A few programs collect this information in advance of presentations as people register for trainings and confirm attendance the day of the event, and do so electronically or with an alternate form that is part of their own evaluations.

Table B.3. Sign-In Sheet

			Original source			
Scale item (item wording)	**Response scale**	**Construct measured**	**Title of Scale**	**Source (e.g., GSS, See Change)**	**Citation**	**Rationale/comments**
Name	open-ended	Participant name		Original		For program purposes (will not be submitted to RAND)
Email address	open-ended	Participant email address		Original		For program purposes and to administer follow-up survey (will not be submitted to RAND)
What is your gender?	Male, Female, Other	Participant gender		Original		
How old are you?	18–25 yrs; 25–59 yrs; 60 or more yrs	Participant age		Original		
How would you describe yourself? (Mark all that apply)	White; Black or African-American; Asian-American; Native Hawaiian/other Pacific Islander; American Indian/Native American/Alaska Native; Other (specify)	Participant race		Original		
Are you Latino or Hispanic?	Yes, No	Participant Latino ethnicity		Original		

			Original source			
Scale item (item wording)	**Response scale**	**Construct measured**	**Title of Scale**	**Source (e.g., GSS, See Change)**	**Citation**	**Rationale/comments**
Do any of these jobs/roles apply to you? (Mark all that apply)	Educator or staff at educational institution; Employer or human resources staff; Health or mental health provider staff or related profession; Justice/Corrections/Law Enforcement; Journalism/Entertainment media; Landlord or property owner; Policymaker/Legislator; Representative of a faith-based or community organization; Lawyer/attorney	Participant CalMHSA-targeted gatekeeper role		Original		Identify gatekeepers in audience
IF YOU CHECKED ONE OR MORE JOBS/ROLES IN THE LAST COLUMN: Is your work in the role especially likely to reach or involve any of these groups? (mark all that apply)	Racial/ethnic minorities; LGBTQ (Lesbian, Gay, Bisexual, Transgendered, Queer or Questioning); Youth (0–15 years old); Transition age youth (16–25 years old); Older adults (60+ years old); Veterans; People personally experiencing mental health challenges; Family of people who are experiencing mental health challenges	Reach of gatekeeper role		Original		This item is used to assess all CalMHSA groups of interest in a single item. Other instruments assess these using separate items.

Appendix B.4. SDR Evaluation Tools – Pre-Post Training Survey

The pre-post survey was developed for the purpose of tracking changes related to the delivery of educational presentations and trainings under the Stigma and Discrimination Reduction Initiative. The pre-post survey contains several attitudinal measures including attitudes toward people with mental health problems (e.g., social distance; perceived dangerousness); attitudes toward mental health treatment (e.g., effectiveness); and recovery beliefs. In addition, the pre-post survey includes measures of mental health knowledge; confidence/self-efficacy in providing support to individuals with mental health problems; perceptions of societal discrimination against individuals with mental health problems; likelihood of openness/concealment toward mental health problems; behavioral intentions toward supporting individuals with mental health problems; and level of prior experience with mental health problems. Within it, a set of post-test-only items assesses whether the educational presentation or training included a speaker who revealed that he or she has personally experienced mental health challenges and, if so, the nature of the "contact" with the speaker (e.g., did the participant enjoy the speaker's presentation, or feel he or she really got to know the speaker?). Many of the pre-post survey items were drawn from population-based stigma surveillance studies or other mental health stigma reduction campaigns conducted in the U.S. or other countries. Selection of measures was partly based on whether measures had demonstrated change over time or in apparent response to stigma reduction efforts. In addition, drawing from measures administered in U.S. population–based studies allows for the use of comparative norms in interpreting results.

Demographics (e.g., age, race/ethnicity) and gatekeeper status (e.g., job in law enforcement, employer) that are of key interest to CalMHSA are also tracked by the pre-post survey. Most SDR programs administer the pre-post survey immediately before and after the delivery of the educational presentation or training. The pre-post survey is a self-administered pen-and-paper survey. To assess longer-term changes, the post survey section can be administered at a later time after the delivery of the educational presentation or training (e.g., 1-month, 6-month, or 1-year follow-up), but would require the tracking and re-contacting of participants.

The pre-post survey broadly targets constructs related to mental illness stigma and discrimination. Stigma and discrimination reduction programs that focus on constructs other than those included in the pre-post survey or on only a subset of constructs can make adaptations to suit their purposes. In addition, the pre-post survey was developed for use with adult audiences of stigma and discrimination reduction educational and training programs. Use with younger audiences would require substantial revisions with respect to language and wording.

Table B.4. Pre-Post Training Survey

				Original source		
Item #	**Scale item (item wording)**	**Response scale**	**Construct measured**	**Title of Scale**	**Source (e.g., GSS, See Change)**	**Citation**
1a	How willing would you be to move next door to a person who has a serious mental illness?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely unwilling	Social distance		General Social Survey (GSS) 1996, 2006	(Pescosolido et al., 2010)
1b	How willing would you be to: spend an evening socializing with someone who has a serious mental illness?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely unwilling	Social distance		GSS 1996, 2006	(Pescosolido et al., 2010)
1c	How willing would you be to start working closely on a job with someone who has a serious mental illness?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely unwilling	Social distance		GSS 1996, 2006	(Pescosolido et al., 2010)
2	If someone in your family had a mental illness, would you feel ashamed if people knew about it?	4 point scale; Definitely/Probably/Probably not/Definitely not	Social distance		World Psychiatric Association's Global Campaign to Fight Stigma and Discrimination Because of Schizophrenia – Open the Doors (items used in Canada and Germany)	(Gaebel et al., 2008; Stuart and Arboleda-Florez, 2001)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
3a	Please tell us how much you agree or disagree with these statements. I believe a person with mental illness is a danger to others.	5-point scale; Strongly agree/Moderately agree/Neither agree or disagree/Moderately disagree/Strongly disagree	Dangerousness		Centers for Disease Control and Prevention (CDC) 2006 HealthStyles Survey	(Kobau et al., 2010)
3b	I believe a person with mental illness can eventually recover.	5-point scale; Strongly agree/Moderately agree/Neither agree or disagree/Moderately disagree/Strongly disagree	Recovery		CDC 2006 HealthStyles Survey	(Kobau et al., 2010)
3c	I know how I could be supportive of people with mental illness if I wanted to be	5-point scale; Strongly agree/Moderately agree/Neither agree or disagree/Moderately disagree/Strongly disagree	Support provision; Self-Efficacy		Like Minds, Like Mine	(Brown and Wyllie, 2010)
3d	People who have had a mental illness are never going to be able to contribute to society much	5-point scale; Strongly agree/Moderately agree/Neither agree or disagree/Moderately disagree/Strongly disagree	Social inclusion; Recovery		Like Minds, Like Mine	(Brown and Wyllie, 2010)
3e	I plan to take action to prevent discrimination against people with mental illness	5-point scale; Strongly agree/Moderately agree/Neither agree or disagree/Moderately disagree/Strongly disagree	SDR behavioral intentions		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
3f	People with mental problems experience high levels of prejudice and discrimination	5-point scale; Strongly agree/Moderately agree/Neither agree or disagree/Moderately disagree/Strongly disagree	Perceived discrimination; Societal beliefs		See Change	(Brown, 2012)
4	How many people in the United States, out of 100, will have a mental health problem at some point in their lives?	Open ended response ranging from 0–100	Mental health knowledge; Normative beliefs		See Me, Scotland (2008)	(Mehta et al., 2009)
5	If you had a serious emotional problem, would you definitely go for professional help, probably go, probably not go, or definitely not go for professional help?	4-point scale; Definitely go/Probably go/Probably not go/Definitely not go	Treatment seeking		National Comorbidity Study(NCS)/ National Comorbidity Study Replication (NCS-R)	(Mojtabai, 2007)
6	Of the people who see a professional for serious emotional problems, what percent do you think are helped?	Open ended response ranging from 0–100%	Treatment efficacy		NCS/NCS-R	(Mojtabai, 2007)
7a	Imagine that you had a problem that needed to be treated by a mental health professional. Which of the following would you do?	4 point scale; Definitely/Probably/Probably not/ Definitely not	Concealment		See Change	(Brown, 2012)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	Would you deliberately conceal your mental health problem from co-workers or classmates?					
7b	Would you deliberately conceal your mental health problem from your friends or family?	4 point scale; Definitely/Probably/Probably not/ Definitely not	Concealment		See Change	(Brown, 2012)
7c	Would you delay seeking treatment for fear of letting others know about your mental health problem?	4 point scale; Definitely/Probably/Probably not/ Definitely not	Concealment; Treatment delay		See Change	(Brown, 2012)
8	We are interested in whether people who attended today hold certain jobs or roles. Please indicate whether any of these describes you. (MARK ALL THAT APPLY)	Educator or other staff at an educational institution; Employer or human resources staff; Healthcare provider or staff; Mental health service provider or staff; Other health or mental health profession; Lawyer/Attorney; Justice system/Corrections/Law enforcement; Journalist or Entertainment Media professional; Landlord or Property Manager; Policymaker/Legislator; Representative of a	Participant CalMHSA-targeted gatekeeper role		Original	

Item #				Original source		
	Scale item (item wording)	**Response scale**	**Construct measured**	**Title of Scale**	**Source (e.g., GSS, See Change)**	**Citation**
		community or faith-based organization				
9	Are you Latino or Hispanic?	Yes/No	Participant Latino ethnicity		Original	
10	Please tell us which one or more of the following you would use to describe yourself. (MARK ALL THAT APPLY)	White; Black or African-American; Asian-American; Native Hawaiian/other Pacific Islander; American Indian/Native American/Alaska Native; Other (specify)	Participant race		Original	
11	What is your age?	Open ended	Participant age		Original	
12	What is your gender?	Male; Female; Other	Participant gender		Original	
13	Have you ever had a mental health problem?	Yes/No	Participant personal history of mental illness		MHFA	(Kitchener and Jorm, 2004)
14	Do you have a family member who has or has had a mental health problem?	Yes/No	Participant – family member with mental illness		See Change	(Brown, 2012)
15	Did you ever serve on active duty in the Armed Forces of the United States?	Yes/No	Participant veteran status		Original	
16	How would you describe yourself?	Heterosexual or straight; Gay or lesbian; Bisexual; Other	Participant sexual orientation		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
17	We want to know what parts of California our work reaches. What zip code do you live in?	Open ended	Participant zip code		Original	
1	Did today's presentation include a speaker (either in-person or on video) who has personally experienced mental health challenges?	Yes/No	Contact		Original	
2a	If you checked "yes" above, please tell us how much you agree or disagree with these statements about the speaker who has experienced mental health challenges. If there was more than one, tell us about the one who spoke the most. a. I enjoyed the speaker's presentation.	Strongly Agree to Strongly Disagree	Contact theory: Positive contact		Original	
2b	b. I was able to choose whether to listen to the speaker--no one made me come here or pay attention to him/her.	Strongly Agree to Strongly Disagree	Contact theory: Voluntary contact		Original	
2c	c. The speaker was my equal or peer.	Strongly Agree to Strongly Disagree	Contact theory: Equal status		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
			between speaker and participant			
2d	d. The speaker and I had some similar goals in coming here today.	Strongly Agree to Strongly Disagree	Contact theory: Common goals		Original	
2e	e. I really got to know the speaker during today's presentation.	Strongly Agree to Strongly Disagree	Contact theory: Intimate contact		Original	
3a	How willing would you be to move next door to a person who has a serious mental illness?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely unwilling	Social distance		GSS 1996, 2006	(Pescosolido et al., 2010)
3b	How willing would you be to: spend an evening socializing with someone who has a serious mental illness?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely unwilling	Social distance		GSS 1996, 2006	(Pescosolido et al., 2010)
3c	How willing would you be to start working closely on a job with someone who has a serious mental illness?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely unwilling	Social Distance		GSS 1996, 2006	(Pescosolido et al., 2010)
4	If someone in your family had a mental illness, would you feel ashamed if people knew about it?	4 point scale; Definitely/Probably/Probably not/Definitely not	Social distance		World Psychiatric Association's Global Campaign to Fight Stigma	(Gaebel et al., 2008; Stuart and Arboleda-Florez, 2001)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
					and Discrimination Because of Schizophrenia – Open the Doors (items used in Canada and Germany)	
5a	Please tell us how much you agree or disagree with these statements. I believe a person with mental illness is a danger to others.	5-point scale; Strongly agree/Moderately agree/Neither agree or disagree/Moderately disagree/Strongly disagree	Dangerousness		CDC 2006 HealthStyles Survey	(Kobau et al., 2010)
5b	I believe a person with mental illness can eventually recover.	5-point scale; Strongly agree/Moderately agree/Neither agree or disagree/Moderately disagree/Strongly disagree	Recovery		CDC 2006 HealthStyles Survey	(Kobau et al., 2010)
5c	I know how I could be supportive of people with mental illness if I wanted to be	5-point scale; Strongly agree/Moderately agree/Neither agree or disagree/Moderately disagree/Strongly disagree	Support provision; Self-Efficacy		Like Minds, Like Mine	(Brown and Wyllie, 2010)
5d	People who have had a mental illness are never going to be able to contribute to society	5-point scale; Strongly agree/Moderately agree/Neither agree or	Social inclusion; Recovery		Like Minds, Like Mine	(Brown and Wyllie, 2010)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	much	disagree/Moderately disagree/Strongly disagree				
5e	I plan to take action to prevent discrimination against people with mental illness	5-point scale; Strongly agree/Moderately agree/Neither agree or disagree/Moderately disagree/Strongly disagree	SDR behavioral intentions		Original	
5f	People with mental problems experience high levels of prejudice and discrimination	5-point scale; Strongly agree/Moderately agree/Neither agree or disagree/Moderately disagree/Strongly disagree	Perceived discrimination; Societal beliefs		See Change	(Brown, 2012)
6	How many people in the United States, out of 100, will have a mental health problem at some point in their lives?	Open ended response ranging from 0–100	Mental health knowledge; Normative beliefs		See Me, Scotland (2008)	(Brown, 2012)
7	If you had a serious emotional problem, would you definitely go for professional help, probably go, probably not go, or definitely not go for professional help?	4-point scale; Definitely go/Probably go/Probably not go/Definitely not go	Treatment seeking		NCS/NCS-R	(Mojtabai, 2007)
8	Of the people who see a professional for serious emotional problems, what percent do you think are	Open ended response ranging from 0–100%	Treatment efficacy		NCS/NCS-R	(Mojtabai, 2007)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	helped?					
9a	Imagine that you had a problem that needed to be treated by a mental health professional. Which of the following would you do? Would you deliberately conceal your mental health problem from co-workers or classmates?	4 point scale; Definitely/Probably/Probably not/ Definitely not	Concealment		Original	
9b	Would you deliberately conceal your mental health problem from your friends or family?	4 point scale; Definitely/Probably/Probably not/ Definitely not	Concealment		Original	
9c	Would you delay seeking treatment for fear of letting others know about your mental health problem?	4 point scale; Definitely/Probably/Probably not/ Definitely not	Concealment; Treatment delay		Original	

Appendix B.5. SDR Evaluation Tools – Follow Up Survey

The follow-up survey is designed to track the use of materials and information imparted by SDR programs among gatekeepers. The follow-up survey is typically used when the target audience of an SDR program is predominantly composed of individuals in gatekeeper roles. However, the follow-up survey can be used with more general and broader audiences as well. For instance, all individuals who access materials and resources via SDR program websites, trainings, or other venues will be asked to complete a follow-up survey, on the assumption that many but not all of them will serve in gatekeeper roles, or may hold an unspecified role in which they have substantial influence over the lives of one or more persons with a mental health challenge (e.g., as a family member or a personal consumer of mental health services). The follow-up survey is a self-administered web-based survey administered at least a month (and on average 6 months) after participation in an SDR program to ensure that sufficient time has passed for individuals to have an opportunity to use the materials or information.

The follow-up survey assesses whether participants serve in any of the following gatekeeper roles: educator/educational staff, employer/human resources, health care provider, mental health provider/professional, law enforcement/justice system, journalist/entertainment media, landlord/property manager, or policymaker/legislator. The follow-up survey then assesses whether participants have used SDR materials or information in a variety of ways in support of people with mental health problems. The follow-up survey largely focuses on gatekeepers' use of SDR program materials and information to initiate changes at the organizational or policy level. For example, the follow-up survey asks gatekeepers whether SDR program information or materials were used to advocate for a policy or practice change; implement a stigma/discrimination reduction program at their organization; introduce new legislation; adopt more culturally competent SDR approaches; or start a new collaborative relationship with another organization. The follow-up survey also assesses gatekeepers' intention to use SDR program information and materials in the future. In addition, the survey evaluates whether gatekeepers serve in a role that reaches particular demographic groups of interest to CalMHSA. The survey asks gatekeepers if their role or work is especially likely to reach particular age groups, racial/ethnic minority groups, veterans, lesbian, gay, bisexual, transgendered, queer or questioning individuals, or people with mental health challenges or their family members.

The follow-up survey can be used alone if the primary interest is in tracking gatekeepers' use of SDR materials and information or in conjunction with the pre-post survey if the goal is also to track gatekeepers' shifts in attitudinal and behavioral changes related to mental health stigma, or if it is expected that follow-up response rates will be low (given the follow-up requires time to elapse and recontact of participants is likely to garner fewer responses than the pre-post survey). The follow-up survey is a self-administered web-based survey. SDR programs collect the email addresses of participants and sends an email containing a web link to the follow-up survey and a request to complete it at a time 1–9 months after the SDR educational presentation or training.

As previously noted, the follow-up survey targets gatekeepers' use of SDR program materials and information to implement changes within both their own and other organizations. SDR programs that involve gatekeepers' use of information, materials, or skills in specific targeted ways other than those covered by the follow-up survey can make needed modifications. For example, follow-up surveys for Entertainment Industries Council, Inc. (see Appendixes B.6 and B.7) were tailored to tap into the specific uses of information provided during their trainings for journalists and media professionals. The Entertainment Industries Council, Inc. Journalist follow-up survey (Appendix B.6) asks if the information obtained from the Entertainment Industries Council, Inc. training resulted in journalists changing the way they portrayed mental illness in an article or story and, if so, to provide information on where and when the story appeared.

Table B.5. Follow-Up Survey

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
1	Please indicate whether any of these jobs or roles describes you. (CHECK ALL THAT APPLY)	Lawyer/Attorney, Educator or other staff at an educational institution, Employer or human resources staff, Healthcare provider or staff, Mental health service provider or staff, Other health or mental health profession, Justice system/Corrections/Law enforcement, Journalist or Entertainment Media professional, Landlord or Property Manager, Policymaker/Legislator, Representative of a Faith-Based or Community Organization, Other (specify):	CalMHSA-targeted gatekeeper role		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
2	What types of information or services did you receive from [Program Partner name]? (CHECK ALL THAT APPLY)	Attended an event, training, or educational presentation (in-person); Attended an online event, training, or educational presentation; Received one on one technical assistance; Received materials or information (online, in person or by mail/email); Visited the website; None of the above	Services received		Original	
3	When did you receive information or services from [Program Partner]? (CHECK ALL THAT APPLY)	Within the past 30 days; More than 30 days ago but less than 6 months ago; 6 months to one year ago; More than 1 year ago	When services were received		Original	
4a	How did you use the information or services that you obtained from [Program Partner] in your role or job? (CHECK ALL THAT APPLY) I acted in ways that are more supportive of people with mental illness.	Check if statement applies	Use of information/services received		Like Minds, Like Mine	(Brown and Wyllie, 2010)
4b	I behaved in a way that ensured that someone with mental illness was not discriminated against	Check if statement applies	Use of information/services received		Original	
4c	I introduced new policy or legislation to a legislative body	Check if statement applies	Use of information/services received		Original	
4d	I made an actual policy or practice change	Check if statement applies	Use of information/services received		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
4e	I shared the information with colleagues at my organization	Check if statement applies	Use of information/services received		Original	
4f	I shared the information with another organization	Check if statement applies	Use of information/services received		Original	
4g	I shared the information with people with mental illness or their family members	Check if statement applies	Use of information/services received		Original	
4h	I/My organization adopted more culturally competent approaches to reducing stigma and discrimination against people with mental illness	Check if statement applies	Use of information/services received		Original	
4i	I/My organization started a new collaborative relationship with another organization	Check if statement applies	Use of information/services received		Original	
4j	I/My organization implemented a stigma/discrimination reduction program	Check if statement applies	Use of information/services received		Original	
4k	I/My organization evaluated a stigma/discrimination reduction program	Check if statement applies	Use of information/services received		Original	
4l	I used the information in another way	Check if statement applies	Use of information/services received		Original	
4 (no letter)	CHECK HERE IF YOU HAVE NOT USED THE INFORMATION	Check if statement applies	Use of information/services received		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
5	How likely is it that you will use the information or services that you obtained from [Program Partner] in the future? (CHECK ONE)	Very likely, somewhat likely, somewhat unlikely, very unlikely	Intention to use information/services in future		Original	
6	Which age groups do you reach or are you involved with in this (these) role(s) or job(s)? (CHECK ALL THAT APPLY)	Youth 0–15; Youth 16–25; Adults 26–59; Adults 60 or older	Reach of gatekeeper role		Original	
7	Is your work especially likely to reach or involve racial or ethnic minorities? (CHECK ONE)	Yes/No (If no skip to 8)	Reach of gatekeeper role		Original	
7a	Which racial/ethnic groups? (CHECK ALL THAT APPLY)	Hispanics/Latinos; Blacks or African-Americans; Asian-Americans; Native Hawaiians/other Pacific Islanders; American Indians/Native Americans/Alaska Natives; Other (specify)	Reach of gatekeeper role		Original	
8	Think about the past 30 days. On how many days did you have contact AS PART OF YOUR JOB OR ROLE with someone who has a mental illness? (CHECK ONE)	Every day, Most days, Some days, A few days, None	Reach of gatekeeper role		Original	
9	Is your work especially likely to reach or involve veterans? (CHECK ONE)	Yes/No	Reach of gatekeeper role		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
10	Is your work especially likely to reach or involve sexual minorities (LGBTQ; lesbian, gay, bisexual, transgendered, queer or questioning)? (CHECK ONE)	Yes/No	Reach of gatekeeper role		Original	
11	It would help us to understand what locations [PROGRAM PARTNER] is reaching. What is the primary zip code in which you perform the role or job you indicated?	Open-ended	Reach of gatekeeper role		Original	
12	What is your gender?	Male, Female, Other	Gatekeeper gender		Original	
13	What is your age?	Open-ended	Gatekeeper age		Original	
14	Are you Latino or Hispanic?	Yes/No	Gatekeeper Latino ethnicity		Original	
15	Please tell us which one or more of the following you would use to describe yourself.	White, Black or African-American, Asian-American, Native Hawaiian/other Pacific Islander, American Indian/Native American/Alaska Native, Other (specify)	Gatekeeper race		Original	
16	Are you a consumer of mental health services or a family member of a consumer of these services?	Yes/No	Gatekeeper self or family member is a consumer of mental health services		Original	

Appendix B.6. SDR Evaluation Tools – Entertainment Industries Council, Inc. Journalist Follow-Up Survey

Table B.6. Entertainment Industries Council, Inc. Journalist Follow-Up Survey

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
1	What is your role or job? (CHECK ALL THAT APPLY)	Reporter; News editor/producer; Publisher/station management; Journalism faculty; Journalism student; Other (please specify)	CalMHSA-targeted gatekeeper role		Original	
2	What types of information or services did you receive from Entertainment Industries Council, Inc.? (CHECK ALL THAT APPLY)	Attended an event, briefing, or educational presentation (in-person); Attended an event, briefing, or educational presentation (online); Received one on one technical assistance; Received materials or information about best practices for journalists covering mental illness/mental health; Visited the website; None of the above	Services received		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
3	When did you receive information or services from [Program Partner]? (CHECK ALL THAT APPLY)	Within the past 30 days; More than 30 days ago but less than 6 months ago; 6 months to one year ago; More than 1 year ago	When services were received		Original	
4a	How did you use the information or services that you obtained from Entertainment Industries Council, Inc.? (CHECK ALL THAT APPLY) I wrote an article or story about mental illness that I hadn't previously planned to write.	Check if statement applies	Use of information/services received		Original	
4b	I changed the way mental illness was portrayed in an article or story	Check if statement applies	Use of information/services received		Original	
4c	I used the information to change policy at my organization on portraying mental illness	Check if statement applies	Use of information/services received		Original	
4d	I passed the information on to a colleague who also works in media	Check if statement applies	Use of information/services received		Original	
4e	Other (specify)	Check if statement applies (with open-ended field)	Use of information/services received		Original	
4 (no letter)	CHECK HERE IF YOU HAVE NOT USED THE INFORMATION	Check if statement applies	Use of information/services received		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
5	[If a or b checked above] Please tell us where and when the story appeared (or where and when it is likely to appear if it hasn't yet).	For Print or Online Stories (If don't have exact information, provide as much as you can): Name of newspaper, magazine, website, etc.; Title of article; Date it appeared; Check here if article was written but did not appear or mental illness depiction was edited out; For Broadcast Stores (If don't have exact information, provide as much as you can): Name of program/station; Original air date(s); Check here if the portrayal has not aired			Original	
6	How likely is it that you will use the information or services about mental health you obtained from Entertainment Industries Council, Inc. in the future? (CHECK ONE)	Very likely, somewhat likely, somewhat unlikely, very unlikely	Intention to use information/services in future		Original	
7	Which audience age groups do you reach in this role? *(CHECK ALL THAT APPLY)*	Youth 0–15; Youth 16–25; Adults 26–59; Adults 60 or older	Reach of gatekeeper role		Original	
8	Is your audience especially likely to include racial or ethnic minorities?	Yes/No (If no skip to 9)	Reach of gatekeeper role		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
8a	Which racial/ethnic groups? CHECK ALL THAT APPLY	Hispanics/Latinos; Black or African-Americans; Asian-Americans; Native Hawaiians/other Pacific Islanders; American Indians/Native Americans/Alaska Natives	Reach of gatekeeper role		Original	
9	Is your audience more likely to include people with mental illness or their family members than the typical audience?	Yes/No	Reach of gatekeeper role		Original	
10	Is your audience especially likely to include veterans?	Yes/No	Reach of gatekeeper role		Original	
11	Is your audience especially likely to include sexual minorities (gay, lesbian, bisexual, transgendered, queer or questioning)?	Yes/No	Reach of gatekeeper role		Original	
12	It would help us to understand what locations Entertainment Industries Council, Inc. is reaching. What is the primary zip code in which you perform the role or job you indicated?	Open-ended	Reach of gatekeeper role		Original	
13	What is your gender?	Male, Female, Other	Gatekeeper gender		Original	
14	What is your age?	Open-ended	Gatekeeper age		Original	
15	Are you Latino or Hispanic?	Yes/No	Gatekeeper Latino ethnicity		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
16	Please tell us which one or more of the following you would use to describe yourself.	White, Black or African-American, Asian-American, Native Hawaiian/other Pacific Islander, American Indian/Native American/Alaska Native, Other (specify)	Gatekeeper race		Original	

Appendix B.7. SDR Evaluation Tools – Entertainment Industries Council, Inc. Media Follow-Up Survey

Table B.7. Entertainment Industries Council, Inc. Media Follow-Up Survey

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
1	What is your role or job? (CHECK ALL THAT APPLY)	Television Writer/Researcher; Television Producer/Director; Network or Studio Executive; Television and film student; Other (please specify):	CalMHSA-targeted gatekeeper role		Original	
2	What types of information or services did you receive from Entertainment Industries Council, Inc.? (CHECK ALL THAT APPLY)	Attended an event, briefing, or educational presentation (in-person); Received one on one technical assistance; Received materials or information about mental illness (online, in person, or by mail/email); Visited the website; None of the above	Services received		Original	
3	When did you receive information or services from [Program Partner]? (CHECK ALL THAT APPLY)	Within the past 30 days; More than 30 days ago but less than 6 months ago; 6 months to one year ago; More than 1 year ago	When services were received		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
4a	How did you use the information or services that you obtained from Entertainment Industries Council, Inc.? (CHECK ALL THAT APPLY) I wrote a story that included mental illness that I hadn't previously planned to write.	Check if statement applies	Use of information/services received		Original	
4b	I changed the way mental illness was portrayed in a story	Check if statement applies	Use of information/services received		Original	
4c	I introduced a major new character with mental illness or added mental illness to an existing major character	Check if statement applies	Use of information/services received		Original	
4d	I introduced a minor new character with mental illness or added mental illness to an existing minor character	Check if statement applies	Use of information/services received		Original	
4e	I introduced a mental illness plotline or story arc to an existing story	Check if statement applies	Use of information/services received		Original	
4f	I used the information to change policy on portraying mental illness	Check if statement applies	Use of information/services received		Original	
4g	I passed the information on to a colleague who also works in media	Check if statement applies	Use of information/services received		Original	
4h	I used the information in another way	Check if statement applies	Use of information/services received		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
4 (no letter)	CHECK HERE IF YOU HAVE NOT USED THE INFORMATION	Check if statement applies	Use of information/services received		Original	
5	If you checked any of a-e above, please tell us where and when the story appeared (or where and when it is likely to appear if it hasn't yet).	For Television Stories (If don't have exact information, provide as much as you can): Name of series, program or movie; Original air date(s); Title of episode(s); If ongoing, provide date and title of first relevant episode; Check here if the portrayal has not aired; For Film/Other Media (If don't have exact information, provide as much as you can): Type of Media; Title; Date(s) appearing; Check here if the portrayal has not been released or otherwise used/distributed			Original	
6	How likely is it that you will use the information or services about mental health you obtained from Entertainment Industries Council, Inc. in the future? (CHECK ONE)	Very likely, somewhat likely, somewhat unlikely, very unlikely	Intention to use information/services in future		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
7	Which audience age groups do you reach in this role? *(CHECK ALL THAT APPLY)*	Youth 0–15; Youth 16–25; Adults 26–59; Adults 60 or older	Reach of gatekeeper role		Original	
8	Is your audience especially likely to include racial or ethnic minorities?	Yes/No (If no skip to 9)	Reach of gatekeeper role		Original	
8a	Which racial/ethnic groups? CHECK ALL THAT APPLY	Hispanics/Latinos; African-Americans; Asian-Americans; Native Hawaiians/other Pacific Islanders; American Indians/Native Americans/Alaska Natives	Reach of gatekeeper role		Original	
9	Is your audience more likely to include people with mental illness or their family members than the typical audience?	Yes/No	Reach of gatekeeper role		Original	
10	Is your audience especially likely to include veterans?	Yes/No	Reach of gatekeeper role		Original	
11	Is your audience especially likely to include sexual minorities (gay, lesbian, bisexual, transgendered, queer or questioning)?	Yes/No	Reach of gatekeeper role		Original	
12	It would help us to understand what locations Entertainment Industries Council, Inc. is reaching. What is the primary zip code in which you perform the role or job you indicated?	Open-ended	Reach of gatekeeper role		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
13	What is your gender?	Male, Female, Other	Gatekeeper gender		Original	
14	What is your age?	Open-ended	Gatekeeper age		Original	
15	Are you Latino or Hispanic?	Yes/No	Gatekeeper Latino ethnicity		Original	
16	Please tell us which one or more of the following you would use to describe yourself.	White, Black or African-American, Asian-American, Native Hawaiian/other Pacific Islander, American Indian/Native American/Alaska Native, Other (specify)	Gatekeeper race		Original	

Appendix B.8. SDR Evaluation Tools – Website Survey

The Website Survey is designed to collect information about visitors or users of information and resources made available via SDR program websites. The Website Survey tracks demographic information, gatekeeper roles, geographical location in which a gatekeeper's role or job is performed, experience with mental health problems directly or in a family member, intention to use information from the website in the future, and perceived helpfulness of the information obtained from the website. The survey also queries for open-ended comments or feedback on how users of the website can be better served, and email addresses for the purposes of being contacted in the future to complete the follow-up survey. It is a self-administered web survey; an invitation and link to the Website Survey is placed on SDR program websites.

In addition to the Website Survey, we are using Google Analytics to obtain information about the use of SDR websites and materials. While the survey provides information on users of and perceptions regarding the website, Google Analytics provides information on website use (i.e., "reach"). Key metrics include traffic (e.g., total site visits, page views), downloads (e.g., PDF documents, PowerPoint presentations), navigation metrics (e.g., entry, exit pages), user engagement (e.g., duration of sites visit), search/referral (e.g., referred by link from external site, search engine), and user data (e.g., geographic location, ISP information).

Table B.8. Website Survey

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
1	Please indicate whether any of these jobs or roles describes you. (CHECK ALL THAT APPLY)	Lawyer/Attorney; Educator or other staff at an educational institution; Employer or human resources staff; Healthcare provider or staff; Mental health service provider or staff; Other health or mental health profession; Justice system/Corrections/Law enforcement; Journalist or Entertainment Media professional; Landlord or Property Manager; Policymaker/Legislator; Representative of a Faith-Based or Community Organization; Other (specify):	CalMHSA-targeted gatekeeper role		Original	
2	In what zip code do you perform this role or job?	Open-ended	Gatekeeper zip code		Original	
3	Is your work in the role especially likely to reach or involve any of these groups? (mark all that apply)	Racial/ethnic minorities; LGBTQ (Lesbian, Gay, Bisexual, Transgendered, Queer or Questioning); Youth (0–15 years old); Transition age youth (16–25 years old); Older adults (60+ years old); Veterans; People living with mental health challenges; Family of person living with mental health challenges, None of these apply	Reach of gatekeeper role		Original	
4	What is your gender?	Male; Female; Other	Gatekeeper gender		Original	
5	What is your age?	Open-ended	Gatekeeper age		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
6	Are you Latino or Hispanic?	Yes/No	Gatekeeper Latino ethnicity		Original	
7	Please tell us which one or more of the following you would use to describe yourself.	White, Black or African-American, Asian-American, Native Hawaiian/other Pacific Islander, American Indian/Native American/Alaska Native, Other (specify)	Gatekeeper race		Original	
8	Are you a consumer of mental health services or a family member of a consumer of these services?	Yes/No	Gatekeeper personal history of mental illness		Original	
9	How likely is it that you will use the information or services that you obtained from this website in the future? (CHECK ONE)	Very likely, Somewhat likely, Somewhat unlikely, Very unlikely	Intention to use information/services in future		Original	
10	How helpful are the information, resources or services that you obtained on this website? (CHECK ONE)	Very helpful, Somewhat helpful, A little bit helpful, Not at all helpful	Helpfulness of information/services provided		Original	
11	Please tell us how we can better serve you using the comment box below.	Open-ended	Comment		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
12	We would like to contact you later to find out whether or how you used the information, resources or services you obtained from our website. If you are willing to participant, please enter your email address here.	Open-ended	Email address		Original	

Appendix C.1. Suicide Prevention-Related Material – Suicide Prevention Fidelity Monitoring (ASIST)

The fidelity monitoring protocol was developed by including key stakeholder input from LivingWorks and Dr. Wendi Cross at the University of Rochester. Dr. Cross led the Applied Suicide Intervention Skills Training (ASIST) fidelity monitoring for Dr. Gould's research study, and we had a phone conversation with her about the domains she measured in her previous research (Cross and West, 2011). We also developed fidelity questions based on a thorough review of the ASIST curriculum, which entailed a RAND staff member attending the five-day ASIST train-the-trainer training and two RAND observers attending a two-day ASIST training. Finally, questions were also adapted based on a high-level review of the cultural competency literature. The protocol is currently being used in select ASIST two-day training observations to measure fidelity to the ASIST training protocol and adherence to trainer competencies. Two observers observe the training and complete the protocol by comparing the protocol items to the material presented. Domains are listed below.

Fidelity Checklist

- There are 39 items corresponding to training activities on Day 1, and 18 items on Day 2 of the training. Observers check off "yes," "only in part," or "no" based on whether the activity was presented. For each activity, there are columns for "diversity" and "comments" for observers to mark when activities are discussed in the context of diversity (e.g., examples of suicide statistics for a particular group; adapting scenarios to a certain demographic) and a column for additional comments the observers may have.

Adherence Checklist

- *ASIST Trainer Competencies*: Observers rate trainers based on the ASIST trainer guidelines. Four items rate trainers on whether they talked about suicide directly, provided positive feedback to the participants (and not negative feedback), and presented using the Suicide Intervention Model (SIM) framework. Most items were rated on a 0–3 scale (0=Not at all to 3=Throughout the training).
- *General Facilitator Proficiencies*: Observers rate trainers on seven items. These items assess whether the trainer was collaborative, engaging, organized, and able to manage the group (Cross and West, 2011). Items also query whether the trainer conveyed empathy (Stein et al., 2003) and rate the overall participation level of the group.

Diversity and Inclusiveness: Observers rate trainers on ten items, including whether the training is conducted in Spanish, whether the participants are being trained to work with a particular group (e.g., LGBTQ, veteran, foster care youth, other), whether the trainer tailors concepts to the target population, whether participants comment on the curriculum and its applicability to particular groups, whether the training is sensitive to the needs of a specific group, whether the trainer is accepting of diverse cultural differences and values among trainees

(Kumaş-Tan et al., 2007), and whether the trainer is knowledgeable about suicide-related cultural beliefs (Fernandez et al., 2004). Most items were rated on a 0–3 scale (0=Not at all to 3=A lot).

The fidelity monitoring protocol is relevant to the following research question: Are training protocols implemented with fidelity?

Table C.1. Suicide Prevention Fidelity Monitoring Protocol

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
F2.1	Review Group Rules	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		Developed by RAND based on ASIST Curriculum Review and collaboration with LivingWorks	
F2.2	Discuss feelings and experiences from 'Cause of Death' video: Discuss reactions to video	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F2.3	Introduce self and have participants introduce themselves (remember these target populations for adherence items/may occur in large group or break out setting)	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F2.4	Emphasize how experiences have made participants more optimistic or pessimistic about helping.	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
F2.5	Introduce River of Suicide (pg. 4 of workbook)	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F2.6a	Review attitudes from workbook page 3: Ask participants to record their attitudes on poster	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F2.6b	Review reactions to at least two attitudes	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F2.6c	Ask the advantages/disadvantages of the attitude if the person at risk discovered their beliefs (e.g., if they wore it on their nametag)	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.1a	Introduce Suicide Intervention Model: Review river of suicide (slide 12.1. pg. 5 of workbook)	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.1b	Review order and pairing of “connecting-understanding-assisting” triangles (slides	Yes/Only in Part/No;	Trainer's inclusion of		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	12.2–12.5)	Diversity discussed? (Check if applies); Comments (Open-ended)	curriculum component			
F3.2a	Review the first phase (connecting to explore invitations of person at risk; ask directly about suicide): Conduct exercise (participants write on three charts labeled groups, events, and reactions corresponding to people at risk)	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.2b	Conclude from exercise that anyone can be at risk, not just those listed from exercise	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.2c	Review slide 13 (workbook page 7) reviewing invitations a person at risk might provide to a caregiver to help	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.2d	Role-play Jack and ask participants to explore invitations with Jack	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.3a	Asking about thoughts of suicide: Review page 5 of the workbook: Understanding phase	Yes/Only in Part/No; Diversity discussed?	Trainer's inclusion of curriculum component		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		(Check if applies); Comments (Open-ended)				
F3.3b	Role-play Jack and ask participants to ask about suicide thoughts	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.4a	Review the understanding phase (to listen for reasons for dying and living; and review risk)	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.4b	Explore why it is important to know reasons for dying/living	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.4c	Role-play Jack and brainstorm reasons for dying and living	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.5a	Review Risk Review (slide 14–15.6): State that current suicide plan is an alert	Yes/Only in Part/No; Diversity discussed? (Check if applies);	Trainer's inclusion of curriculum component		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		Comments (Open-ended)				
F3.5b	State that being in unbearable pain is an alert	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.5c	State that being alone or without resources is an alert	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.5d	State that prior suicidal behavior is an alert	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.5e	State that current or past mental health history is an alert	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.5f	Role-play Jack either after each alert or altogether at end and ask participants to practice CPR++	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
F3.6a	Review the assisting phase (to contract a safeplan and follow-up on commitments; slides 16.1–16.14): Keep safe	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.6b	Safety contact	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.6c	Safe/no use of alcohol/drugs	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.6d	Link resources	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.6e	Disable the suicide plan	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.5f	Ease the pain	Yes/Only in Part/No;	Trainer's inclusion of		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		Diversity discussed? (Check if applies); Comments (Open-ended)	curriculum component			
F3.6g	Link to resources	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.6h	Protect against the danger/support survival skills	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.6i	Link to healthcare worker	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.6j	Role-play Jack using safeplan	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.7	Describe that follow-up covers the safety steps immediately following the intervention	Yes/Only in Part/No; Diversity discussed?	Trainer's inclusion of curriculum component		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		(Check if applies); Comments (Open-ended)				
F3.8	Summarize the Suicide Intervention Model on page 5	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F3.9	Introduction of Checkpoints	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.1a	Aunt/Nephew Audio and Video segment:	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.1b	Discuss reactions to both	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.2a	Structure of the Suicide Intervention Model: Describe that journey of person at risk is longer than the caregiver (slide 18–19)	Yes/Only in Part/No; Diversity discussed? (Check if applies);	Trainer's inclusion of curriculum component		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		Comments (Open-ended)				
F4.2b	Describe how flags go up and down and signal to next step in the intervention (slides 20.1–20.6)	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.3a	Process of an intervention (slides 21.1–21.3): Themes are connected and unpredictable; process is fluid or moving depending on two parties	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.3b	Themes represent different points in the intervention (slides 23.1–4)	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.3c	State that by listening to reasons for dying, reasons for living often emerge (slides 24.1–24.2)	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.3d	State that a perfect intervention is not possible and may go in-sync and out-of-sync (use examples from *Cause of Death* video)	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
F4.3e	State that checkpoints (slide 26) determine if parties are in-sync	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.4	Hand out wallet card	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.5	Conduct Shotgun role-play (say scene, ask "what would you say")	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.6	Conduct Ambivalence role-play – one trainer plays patient, the other facilitates role-play, participants reflect the death part of the statement, then the life, and then both parts together.	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.7	Conduct Bridge role-play (ask participants to close eyes, one trainer on chair, ask "what would you say", invite participants to intervene, trainers help participants work through suicide intervention model)	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F4.8	Conduct Nick exercise (trainer says "but Nick says…", conclude that intervention	Yes/Only in Part/No;	Trainer's inclusion of		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	doesn't always work and authorities need to be involved)	Diversity discussed? (Check if applies); Comments (Open-ended)	curriculum component			
F4.9	Conduct workgroup simulations (in pairs, one person at risk, another is caregiver); debrief after each simulation and provide positive feedback.	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F5.1	Review self-care ideas	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F5.2	Instruct participants to review their hopes on pg. 3 and to network with participants with the same hope, discuss their hope in small groups	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F5.3	Brainstorm lists of resources	Yes/Only in Part/No; Diversity discussed? (Check if applies); Comments (Open-ended)	Trainer's inclusion of curriculum component		RAND	
F5.4	Conclude the workshop: New community (describe slide 28)	Yes/Only in Part/No; Diversity discussed?	Trainer's inclusion of curriculum component		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		(Check if applies); Comments (Open-ended)				
A1	Did the trainer talk about suicide directly?	4-point scale: (0: Not at all. 1: Trainer references suicide very occasionally. 2: Trainer makes direct reference to suicide most of the time. 3: Trainer specifically talks about suicide.)	ASIST Trainer Competencies		RAND	
A2	Did the trainer provide positive feedback to participants (e.g., telling the participant about the good things they did on the role-play)?	4-point scale: (0: Trainer does not provide positive feedback to participants. 1: Trainer provides feedback very occasionally. 2: Trainer provides positive feedback most of the time. 3: Trainer provides positive feedback throughout the training.)	ASIST Trainer Competencies		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
A3	Did the trainer provide negative feedback to participants (e.g., tells participants what they did wrong during simulations)?	3-point scale: (0: Trainer does not provide negative feedback to participants. 1: Trainer provides some negative feedback. 2: Trainer provides a lot of negative feedback.)	ASIST Trainer Competencies		RAND	
A4	Did the trainer work within the Suicide Intervention Model (SIM) framework?	4-point scale: (0: Session consists entirely of other suicide prevention models that are not SIM. 1: Some SIM concepts or techniques are included in the training, but out of the context of the SIM model. 2: The trainer stays within a SIM framework consistently. 3: The trainer stays within a SIM model, conveys an understanding of that	ASIST Trainer Competencies		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		model to participants and uses the model to deal with the participants' concerns)				
A5	Was the trainer collaborative with the training participants (e.g., encourages them to share the talking)?	4-point scale (0: Not at all. 1: Trainer responds to opportunities to collaborate very occasionally. 2: Trainer fosters collaboration and power sharing most of the time. 3: Trainer actively fosters and encourages sharing throughout the training.)	General Facilitator Proficiencies		RAND	
A6	Did the trainer engage in open-ended questioning to help participants explore their learning?	4-point scale (0: Not at all, no questions asked. 1: Very occasionally. 2: Most of the time, about half of the time. 3: Almost all of	General Facilitator Proficiencies		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		the time)				
A7	How well organized did participants run simulations (e.g., separating trainer and role-player, managing time; encourage participation)?	5-point scale (0: Not at all. 1: Sometimes. 2: About half of the time. 3: Most of the time. 4: Almost all of the time)	General Facilitator Proficiencies		RAND	
A8	Did the trainer convey empathy to the participants?	4-point scale (0: Major and consistent lack of empathy. 1: Although there may be moments of emphatic connection, session as a whole is marked by absence of empathy; 2: Trainer makes consistent effort to understand participants and responds with empathy to the emotions of the participants most of the time 3: Trainer meets	General Facilitator Proficiencies		(Stein et al., 2003b).	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		criteria for 2 almost all of the time)				
A9	Was the trainer able to manage the group?	4-point scale (0: Not at all: 1: Some control over the group. 2: Moderate control over the group, despite some difficulties. 3: Trainer is able to control the group in order to convey the material.)	General Facilitator Proficiencies		(Cross and West, 2011b)	
A10	What was the overall group participation level (e.g., role-plays and workgroup discussions)?	4-point scale (0: Low, most group members reticent. 1: Low for some participants, moderate to high for others. 2: Moderate to high for most participants. 3: All students	General Facilitator Proficiencies		(Cross and West, 2011b)	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		participating actively (e.g., strong willingness to participate in role-plays))				
A11	How well did the trainer manage the time?	4-point scale (0: Not well – was consistently late or ran over time, or ended significantly early. 1: A little – Was on time for some sections, but not the majority of the other sections. 2: Moderately – Was on time for most sections. 3: Very good – Was on time for all sections)	General Facilitator Proficiencies		RAND	
A12	Was the training conducted in Spanish?	Yes/No	Diversity and Inclusiveness		RAND	
A13	How many individuals participated in the training?	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A14a	To your knowledge, please mark if the individuals being trained worked with one or more target populations:	LGBTQ/ Veteran/ Foster Care Youth/ Other (specify)/	Diversity and Inclusiveness		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		Other (specify)/ Other (specify)				
A14b	Provide a brief description of the group (Who were they? Who did they serve?):	Open-ended	Diversity and Inclusiveness		RAND	
A15a	Of the individuals at the training, please indicate the number that you think fell in the following categories (all rows must add to Total specified above): Age 0–15	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15b	Age 16–25	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15c	Age 26–59	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15d	Age 80–84	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15e	Age 85+	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15f	Age Unknown	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15g	Male	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15h	Female	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15i	Gender Unknown	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15j	Hispanic or Latino	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15k	Non-Hispanic/non-Latino	Open-ended (Integer	Diversity and Inclusiveness		RAND	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		expected)				
A15l	Unknown	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15m	White	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15n	Black or African American	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15o	Asian	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15p	American Indian/ Native American	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15q	Native Hawaiian/ Pacific Islander	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A15r	Other Race	Open-ended (Integer expected)	Diversity and Inclusiveness		RAND	
A16a	Did the trainer tailor concepts to the target population so that they were meaningful to participants?	4-point scale (0: Not at all. 1: Trainer provides some examples of tailoring, but done very rarely. 2: Trainer tailors concepts most of the time. 3: Trainer tailors concepts by providing examples and	Diversity and Inclusiveness		(Cross and West, 2011b)	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		referring back to the population throughout the training.)				
A16b	Provide examples (what do they say, how do they introduce the discussion and open it up):	Open-ended	Diversity and Inclusiveness		RAND	
A17a	Did any participant comment on how the curriculum was, or was not, applicable to any groups (e.g., during breaks)?	Yes/No	Diversity and Inclusiveness		RAND	
A17b	Provide examples:	Open-ended	Diversity and Inclusiveness		RAND	
A18a	Did participants comment on how the trainer(s) was, or was not, sensitive to the needs of a specific group?	Yes/No	Diversity and Inclusiveness		RAND	
A18b	Provide examples:	Open-ended	Diversity and Inclusiveness		RAND	
A19a	Was the trainer accepting of diverse cultural differences and values among trainees?	4-point scale (0: Not at all. 1: A little. 2: Some. 3: A lot)	Diversity and Inclusiveness		(Kumaş-Tan et al., 2007).	
A19b	Provide examples:	Open-ended	Diversity and Inclusiveness		RAND	
A20	Was the trainer knowledgeable about suicide-related cultural beliefs?	4-point scale (0: Not at all. 1: A little. 2: Some. 3: A lot)	Diversity and Inclusiveness		(Fernandez et al., 2004b)	
A21a	Did the trainer acknowledge and reflect on the importance of the participants' suicide-related experience and/or cultural beliefs?	4-point scale (0: Not at all. 1: A little. 2: Some. 3: A lot)	Diversity and Inclusiveness		RAND	
A21b	Provide examples:	Open-ended	Diversity and Inclusiveness		RAND	

Coordinators tell trainers script: We have a great opportunity to offer you a chance to show how you're helping people in the community learn how to deal with the very important issue of suicide. Your support can make this process possible and help gather information about the value of ASIST.

CalMHSA has asked the RAND Corporation, a nonprofit research organization, to evaluate the outcomes of programs and trainings funded by Prop 36. As part of the evaluation, RAND would like to observe five 2-day ASIST trainings being offered by CalMHSA trained ASIST Trainers. At least one of the two workshop trainers needs to have been trained through CalMHSA. Their goal is to see how the training is being delivered as well as how the participants learn ASIST.

We wanted to see if you would let two RAND staff members sit in on a training you will be providing in the near future. We know a sense of safety in the workshop environment is a priority. During your ASIST workshop, the two RAND observers would sit off to the side so they wouldn't disrupt the group. We can talk later about how to introduce them at the beginning of the training so your participants know why they're there.

We want to make you as comfortable as possible with this activity. Any notes taken by the observers are confidential so they won't be shared with your coworkers or boss. I want to stress that they are not "grading" you on your performance, and they are not sharing the notes they take with me or LivingWorks. They are strictly for research purposes.

Your participation is voluntary, but we really encourage you to be open to this opportunity. It will help CalMHSA better understand how well ASIST is delivered in various communities.

Trainers tell participants script: Today our ASIST workshop is going to look slightly different from standard workshops. Our workshop has been selected to be a part of the CalMHSA (formerly known as Prop 63) research project. We have two observers, Marylou and Dionne, here from the RAND Corporation, the research organization selected by CalMHSA. They will sit off to the side and observe me and (co-trainer's name) – **the trainers** – not to grade us but to watch the process of an ASIST workshop. On our first day, they will not be taking any notes. On the second day, they will be taking notes – not of what you say or share, but notes documenting of how [co-trainer's name] and I are delivering the training. This morning, in just a little bit, we will be dividing into two workgroups. Both Marylou and Dionne will be observing together in only one group.

Safety is of the utmost importance to us, LivingWorks, CalMHSA and RAND. Your willingness to allow this opportunity for further evidence of the great work done through ASIST is greatly appreciated. If you would prefer to be in a group not being observed, please let me or my co-trainer know.

1. RAND coders observe Day 1 with no note-taking during sessions; coders are able to take notes on fidelity protocol on Day 2. Two coders attend one session and will not split up, even if group does, to ensure consistency in how things are coded.

Appendix C.2. Suicide Prevention–Related Material — Suicide Prevention Hotline Monitoring

Great care was taken in developing the live monitoring hotline protocol. This included a site visit to and interviews with the staff of the National Suicide Prevention Lifeline (NSPL), a thorough review of past research that has used live monitoring, a review of crisis call standards currently required by the NSPL, interviews with Dr. Madelyn Gould, who has published papers on live monitoring and is currently evaluating the NSPL using live monitoring, review of Dr. Gould's live monitoring protocols, and a site visit to a local crisis line where RAND staff reviewed recordings of crisis calls. The draft protocol currently measures the following domains:

- *Basic descriptive caller information.*
- *Call characteristics.* Describes the calls that get monitored, including length, type, reasons for premature end, reasons that a call cannot be rated
- *Content of calls*. In addition to content around suicidality, much of the time on calls is spent talking about real-life problems and the precipitating crises. In this section, we gather information about the types of calls. This information could be useful in gathering appropriate referrals and resources and in counselor training.
- *Questions to determine possible suicide risk.* The NSPL 2006 Suicide Risk Assessment Standards (Joiner et al., 2007) requires that on each call, the counselor asks a minimum of three questions related to current suicidal desire, recent suicidal desire, and lifetime suicide attempts.
- *Possible imminent risk.* NSPL describes four areas that should be addressed in a complete suicide assessment (suicidal desire**,** suicidal capability, suicidal intent, buffers/connectedness). All these are used to determine imminent risk, which determines what steps are expected on the call to ensure safety. The monitor can also rate imminent risk independently, as in the Gould protocols. <u>If the caller is determined to be at imminent risk for suicide, NSPL's 2011 Imminent Risk Policy states that the following steps should occur and that we will measure:</u>
    - The use of *Active Engagement*, which requires that hotline staff make reasonable efforts to collaborate with callers at imminent risk to better secure their safety.
    - The use of *Active Rescue*, which requires that staff take all action necessary to secure the safety of a caller and initiate emergency response with or without the caller's consent if they are unwilling or unable to take action on their own behalf.
- *Telephone worker characteristics*. As stipulated by NSPL, these include asking questions about suicide in a direct, honest, and open manner, enabling caller to admit to current suicidal ideation, building rapport and trust, collaborating with call (listening, understanding what is happening for this caller now), and reaching an agreement on what the issues are.
- *Changes in caller.* Changes in perceived caller's attitude during the call.
- *Overall call rating.*

The hotline monitoring protocol is relevant to the following research questions:

- Are those who call receiving quality care during the call?

- Are those who call benefiting from the call?
-

Table C.2. Suicide Prevention Hotline Monitoring Protocol

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
Monitor's Name	Open Ended	Name of monitor		***Gould's ASIST protocol***	In press
Center Code #	Open Ended	Center Code		***Gould's ASIST protocol***	In press
Line (caller called)	Open Ended	Line used		***Gould's ASIST protocol***	In press
Date of Call	Open Ended	Call date		***Gould's ASIST protocol***	In press
Call Start Time	Open Ended	Call time		***Gould's ASIST protocol***	In press
Call End Time	Open Ended	Call time		***Gould's ASIST protocol***	In press
Call Duration	Open Ended	Call length		***Gould's ASIST protocol***	In press
Technical/Other Problems resulted in abrupt termination of call?	Yes/No (If Yes, answer next 3 questions)	Call disruptions		***Gould's ASIST protocol***	In press
Counselor/caller unable to hear each other (i.e. static, noise)	Check if statement applies	Call disruptions		***Gould's ASIST protocol***	In press
Caller had to hang up (i.e. someone walked in, told to get off telephone)	Check if statement applies	Call disruptions		***Gould's ASIST protocol***	In press
Cell or portable telephone problems (no battery charge left/losing service)	Check if statement applies	Call disruptions		***Gould's ASIST protocol***	In press
Caller put on hold?	Yes/No (If Yes,	Call disruptions		***Gould's***	In press

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
	answer next question)			***ASIST protocol***	
How many times?	Open Ended	Call disruptions		***Gould's ASIST protocol***	In press
Counselor's phone name (if available)	Open Ended	Counselor's name		***Gould's ASIST protocol***	In press
Caller's gender	Male/Female/Don't Know	Caller's gender		***Gould's ASIST protocol***	In press
Caller's eligibility status?	Eligible/Ineligible (if 'ineligible', answer next 10 questions)	Monitoring eligibility		***Gould's ASIST protocol***	In press
Not suicidal or was not in a crisis (e.g. information or referral request)	Check if statement applies	Monitoring eligibility		***Gould's ASIST protocol***	In press
Chronic caller on a particular plan such as time limit or standard message for them	Check if statement applies	Monitoring eligibility		***Gould's ASIST protocol***	In press
Lacked the capacity to give consent (e.g. in midst of psychotic episode or exhibiting dementia or so intoxicated/high that it interfered with communication)	Check if statement applies	Monitoring eligibility		***Gould's ASIST protocol***	In press
Minor (less than 18 years of age)	Check if statement applies	Monitoring eligibility		***Gould's ASIST protocol***	In press
Non-English speaking caller	Check if statement applies	Monitoring eligibility		***Gould's ASIST protocol***	In press
Obscene caller	Check if statement applies	Monitoring eligibility		***Gould's ASIST***	In press

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
				protocol	
Prank caller	Check if statement applies	Monitoring eligibility		***Gould's ASIST protocol***	In press
Third party caller (not in crisis and not suicidal)	Check if statement applies	Monitoring eligibility		***Gould's ASIST protocol***	In press
Continuation of a previous call with SAME COUNSELOR, but SM did not hear first call	Check if statement applies	Monitoring eligibility		***Gould's ASIST protocol***	In press
Counselor not eligible to be silent monitored	Check if statement applies	Monitoring eligibility		***Gould's ASIST protocol***	In press
Brief Summary of Call	Open Ended	Call summary		***Gould's ASIST protocol***	In press
Which of the following topics were discussed during the call? (check all that apply)—Relationship problems	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Family problems	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Work problems	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Concern about a family member	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
Financial problems	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Suicidal thoughts/intent	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Traumatic event	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Loss of family/friend	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Homelessness	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Drug/ETOH problems	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Sexual orientation problems	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Illness/injury/disability problems	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Chronic pain	Check if statement applies	Call contents		***Developed by RAND based on***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
				Gould protocols	
Depression	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Exposure to violence	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Veteran/military issues	Check if statement applies	Call contents		***Developed by RAND based on Gould protocols***	
Is caller currently thinking about suicide? (Four-part question)	Status (Yes/No/DK [Don't Know]), telephone worker (TW) asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Risk Assessment		***Gould ASIST protocol modified to match NSPL wording***	(Joiner et al., 2007)
Has caller thought about suicide in the past? (Four-part question) (If yes, answer next question)	Status (Yes/No/DK), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Risk Assessment		***Gould ASIST protocol modified to match NSPL wording***	(Joiner et al., 2007)
When last had thoughts? (Four-part question)	Status (Within 2 months/ more than 2 months/ DK), TW asked? (Yes/No), Caller offered? (Yes/No), TW explored? (Yes/No)	Risk Assessment		***Gould ASIST protocol modified to match NSPL wording***	(Joiner et al., 2007)
Has caller attempted suicide in past? (Four-part question)	Status (Yes/No/DK), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Risk Assessment		***Gould ASIST protocol modified to match***	(Joiner et al., 2007)

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
				NSPL wording	
Suicide ideation	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Desire		***Adapted from NSPL guidelines and the Lifeline Quality Improvement (QI) Monitoring Form***	
Psychological pain	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Desire		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Hopelessness	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Desire		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Perceived burden on others	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Desire		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Feeling trapped	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Desire		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Feeling lonely	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No),	Suicide Desire		***Adapted from NSPL guidelines and the***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
	TW explored? (Yes/No)			***Lifeline QI Monitoring Form***	
Reasons for dying	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Desire		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Attempt in progress	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Capability		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Plan with known method	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Capability		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Preparatory behaviors	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Capability		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Expressed intent to die	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Capability		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
History of suicide attempts	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Intent		***Adapted from NSPL guidelines and the Lifeline QI Monitoring***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
				Form	
Available means	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Intent		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Exposure to death by suicide	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Intent		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
History of violence	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Intent		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Recent acts/threats of aggression	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Intent		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Current intoxication/substance use	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Intent		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
History of substance abuse	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Intent		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Recent dramatic	Discussed? (Check if	Suicide Intent		***Adapted***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
mood changes	applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)			***from NSPL guidelines and the Lifeline QI Monitoring Form***	
Decreased sleep	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Intent		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Increased anxiety	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Intent		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Out of touch with reality	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Intent		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Extreme agitation or rage	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Suicide Intent		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Immediate supports	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Buffers/Connectedness		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Social supports	Discussed? (Check if applies), TW asked? (Yes/No), Caller	Buffers/Connectedness		***Adapted from NSPL guidelines***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
	Offered? (Yes/No), TW explored? (Yes/No)			***and the Lifeline QI Monitoring Form***	
Planning for future	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Buffers/Connectedness		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Engagement with helper	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Buffers/Connectedness		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Ambivalence for living/dying	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Buffers/Connectedness		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Core values/beliefs	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Buffers/Connectedness		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Sense of purpose	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored? (Yes/No)	Buffers/Connectedness		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Reasons for living	Discussed? (Check if applies), TW asked? (Yes/No), Caller Offered? (Yes/No), TW explored?	Buffers/Connectedness		***Adapted from NSPL guidelines and the Lifeline QI***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
	(Yes/No)			***Monitoring Form***	
Was imminent risk present at any point during call?	Yes/No/Don't Know (If Yes, answer following 2 questions)	Imminent Risk		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Imminent risk was reduced during call	Check if statement applies	Imminent Risk		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Imminent risk still present at end of call	Check if statement applies	Imminent Risk		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Was an action or safety plan developed or discussed with the caller?	Yes/No (If Yes, answer next 16 questions)	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Get rid of potential means to suicide/make caller's environment safe	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Safe/no use of alcohol/drugs	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
Make sure caller has people to be with/is not alone	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Use past survival skills during current crisis	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Identify personal resources/coping strategies	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Talk about informal/social safety resources	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Talk about formal/professional resources	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Referral to professional help	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Talk about crisis services caller	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
could use (ER/911)				***guidelines and the Lifeline QI Monitoring Form***	
Talk about calling hotline(s)	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Develop plan collaboratively	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Discuss order of steps in plan and put them in order	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Ask how likely the caller will use plan when in distress	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Discuss potential barriers to plan	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Ask if plan will keep caller safe	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
				Lifeline QI Monitoring Form	
Ask if caller agrees to plan	Yes/No/NA	Action or Safety Plan		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Was Rescue initiated/facilitated by crisis center?	Yes/No/Don't Know/NA	Rescue utilization		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Was rescue with caller's consent/cooperation?	Yes/No/Don't Know/NA (If No or Don't Know, ask following question)	Rescue utilization		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Was imminent risk reduced enough during the call so that rescue was not needed?	Yes/No/Don't Know/NA	Rescue utilization		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
SM initiated contact with Center's Representative for Required Intervention	Yes/No (If Yes, answer next 5 questions)	Rescue utilization		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Rescue already being initiated by center	Check if statement applies	Rescue utilization		***Adapted from NSPL guidelines and the Lifeline QI Monitoring***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
				Form	
SM's all prompted rescue	Check if statement applies	Rescue utilization		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Center unable to rescue, reason:	Check if statement applies	Rescue utilization		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Center said they do not rescue without caller's consent	Check if statement applies	Rescue utilization		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
Center chose not to rescue for other reason	Check if statement applies	Rescue utilization		***Adapted from NSPL guidelines and the Lifeline QI Monitoring Form***	
During the call, the TW: Allowed caller to talk about his/her feelings/situation?	4 point scale (Not at all/A little/Moderately/A lot), NA (Not applicable)	Counselor Behavior		***Gould ASIST protocol***	In press
Reflected back caller's feelings?	4 point scale (Not at all/A little/Moderately/A lot), NA	Counselor Behavior		***Gould ASIST protocol***	In press
Reflected back caller's situation?	4 point scale (Not at all/A little/Moderately/A lot), NA	Counselor Behavior		***Gould ASIST protocol***	In press
Challenged caller	4 point scale (Not at	Counselor Behavior		***Gould***	In press

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
(in negative way)	all/A little/Moderately/A lot), NA			***ASIST protocol***	
Condescending	4 point scale (Not at all/A little/Moderately/A lot), NA	Counselor Behavior		***Gould ASIST protocol***	In press
Connected/Established rapport with caller	4 point scale (Not at all/A little/Moderately/A lot), NA	Counselor Behavior		***Gould ASIST protocol***	In press
Disempowered caller (made caller feel less confident & in control)	4 point scale (Not at all/A little/Moderately/A lot), NA	Counselor Behavior		***Gould ASIST protocol***	In press
Empowered caller (made caller feel more confident & in control)	4 point scale (Not at all/A little/Moderately/A lot), NA	Counselor Behavior		***Gould ASIST protocol***	In press
Displayed inappropriate behavior (i.e. fell asleep, laughed at caller)	4 point scale (Not at all/A little/Moderately/A lot), NA	Counselor Behavior		***Gould ASIST protocol***	In press
Was judgmental	4 point scale (Not at all/A little/Moderately/A lot), NA	Counselor Behavior		***Gould ASIST protocol***	In press
Overall, was sensitive/receptive to caller's problems	4 point scale (Not at all/A little/Moderately/A lot), NA	Counselor Behavior		***Gould ASIST protocol***	In press
Preached/ or forced his/her opinions on caller	4 point scale (Not at all/A little/Moderately/A lot), NA	Counselor Behavior		***Gould ASIST protocol***	In press
Was respectful	4 point scale (Not at all/A little/Moderately/A lot), NA	Counselor Behavior		***Gould ASIST protocol***	In press
Showed Empathy/Validated	4 point scale (Not at all/A	Counselor Behavior		***Gould ASIST***	In press

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
caller (i.e. 'it must be hard for you')	little/Moderately/A lot), NA			***protocol***	
At the end of the call, the CALLER FELT:… Less AGITATED	4 point scale (Not at all/A little/Moderately/A lot), NA	Changes in Caller Behavior		***Gould ASIST protocol***	In press
Less ALONE	4 point scale (Not at all/A little/Moderately/A lot), NA	Changes in Caller Behavior		***Gould ASIST protocol***	In press
Less CONFIDENT & in control (DISEMPOWERED)	4 point scale (Not at all/A little/Moderately/A lot), NA	Changes in Caller Behavior		***Gould ASIST protocol***	In press
Less OVERWHELMED	4 point scale (Not at all/A little/Moderately/A lot), NA	Changes in Caller Behavior		***Gould ASIST protocol***	In press
Less SUICIDAL	4 point scale (Not at all/A little/Moderately/A lot), NA	Changes in Caller Behavior		***Gould ASIST protocol***	In press
More CONFIDENT & IN CONTROL (EMPOWERED)	4 point scale (Not at all/A little/Moderately/A lot), NA	Changes in Caller Behavior		***Gould ASIST protocol***	In press
More HOPEFUL	4 point scale (Not at all/A little/Moderately/A lot), NA	Changes in Caller Behavior		***Gould ASIST protocol***	In press
Was good contact established?	Established good contact/Established good contact with some weaknesses/ Did not establish good contact, or important weaknesses/NA	Overall Call Ratings		***NSPL QI Monitoring Tool***	
Was collaborative problem-solving approach used?	Collaborative problem-solving approach used/ Collaborative problem-solving approach used with	Overall Call Ratings		***NSPL QI Monitoring Tool***	

Scale item (item wording)	Response scale	Construct measured	Original source		
			Title of Scale	Source (e.g., GSS, See Change)	Citation
	some weaknesses/Did not use collaborative problem-solving approach, or important weaknesses/NA				
Were referrals/resources provided collaboratively?	Referrals or resources provided collaboratively/ Referrals or resources provided collaboratively with some weaknesses or incomplete/ No referrals or resources provided, not collaborative, or important weaknesses/NA	Overall Call Ratings		***NSPL QI Monitoring Tool***	
On a scale from 1 to 5, please rate how you think the counselor handled the call (circle one):	5 point scale (1= very ineffective intervention, 5= very effective intervention)	Overall Call Ratings		***NSPL QI Monitoring Tool***	

Appendix C.3. Suicide Prevention–Related Material—Crisis Line Evaluation Studies

Table C.3. Crisis Line Evaluation Studies

Citation (listed chronologically)	Evaluation Design	Evaluation Findings
(Weiner, 1969)	A comparison of suicide rates in Los Angeles County before and after the introduction of a crisis hotline. Also, comparisons were made with the suicide rates in other California counties (1 of the other 3 counties had a prevention program, 2 did not).	Researchers did not find a decrease in the suicide rate of Los Angeles Country after implementation of the program, but rather an increase. The suicide rate seemed to increase slightly with the rise in number of calls.
(Bidwell, Bidwell, and Tsai, 1971)	An evaluation of the demographic data records from a three year period from September 1, 1966 to August 31, 1969 of crisis hotline calls were compared with data from those who had died by suicide. Names were compared to see whether the reported names of those who had committed suicide were found within the call logs of the help line.	The findings support the hypothesis that suicidal attempters and suicides constitute two epidemiological populations, albeit overlapping, and that the crisis intervention method of the suicide prevention programs can reach the first group but not the second. In other words, the demographics of the callers more closely resembled the attempters group versus the suicide completion group.
(Lester, 1971)	The census track of 214 callers (of 626 possible) was identified and correlated with census tracks of local suicides for 1966–68.	Census tracts in Buffalo with one or more suicide in 1966–68 accounted for 86% of callers and 81.6% of the population.
(Litman, 1976)	Among a group of persons in contact with a crisis center, this study compared an experimental group that received outbound calls Continuing Relationship Maintenance, or CRM) once per week for an average of 18 months per person (and a control group.	No differences in completed suicides, suicide risk, willingness to accept help. CRM group was less likely to live alone, had more improved personal relationships, better use of professional help, less depression.
(Leenaars and Lester, 1995)	Pearson correlation between provincial suicide rates and (a) absolute number of crisis centers, (b) density of crisis centers per capita, and (c) density of crisis centers per area.	All correlations negative, though no tests of statistical significance were performed
(Mishara and Daigle, 1997)	Trained observers listened to and coded calls in real time in order to ascertain the relative effectiveness of the volunteers' various intervention styles on the reduction of psychological distress of the callers. The volunteers' ability to encourage the caller to make a “no suicide contract” was also assessed.	An overall decrease in depressed mood was found from the beginning to the end of calls, but depression only decreased in 14% of calls and remained the same in 85% of calls. There was also a significant decrease in suicide urgency from the beginning to the end of the call (urgency decreased in 27% of calls), especially for non-chronic callers. Contracts were made in 68% of calls, more frequently with chronic callers. Calls were classified as "Rogerian style" or "directive style". Those volunteers using Rogerian style had significantly more decreases in caller depression and more contracts.

Citation (listed chronologically)	Evaluation Design	Evaluation Findings
(Fiske and Arbore, 2000)	The study measured depressive symptoms, hopelessness, and life satisfaction before and after clients received 1 year of services (including warmline with both inbound and outbound calls) from the agency.	A paired t-test revealed a significant reduction in hopelessness among the clients. There were no significant changes in depressive symptoms or life satisfaction. There were no changes in hopelessness, depressive symptoms, or life satisfaction in the comparison group.
(King et al., 2003)	Independent raters quantify changes in suicidality over the course of a call or counseling session by reviewing the first 5 minutes when suicidality first became evident and last 5 minutes of the call.	Decreases in callers' mental state and suicide ideation occurred from the beginning to the end of the call; a decrease in calls rated to be at "imminent risk" and an increase in those rated as "no suicide urgency" was also observed.
(Mishara, Houle, and Lavoie, 2005)	Pre-test, post-test, and follow-up questionnaires were administered to participants who received each of five different support styles, including telephone counseling, though participants were not randomly assigned. Questionnaires contained questions about themselves as well as about the suicidal man. Questionnaires to the family/friends addressed issues such as coping mechanisms and utilization of resources, whereas the questionnaires related to the suicidal man included topics such as suicidal behaviors and alcoholism. Some topic areas overlapped. No control group.	There were no differences across the five support styles. Participants reported that suicidal men were less likely to have suicide attempts or ideation and depressive symptoms post-training, and these effects were maintained at the 6 month follow-up. The programs did not increase knowledge/use of resources for the participants or suicidal man. Participants reported that treatment did not reduce the suicidal man's use of alcohol/drugs. On the pre-test questionnaire, participants also reported some reasons for not discussing the man's suicidal intentions with him: 32% cited not wanting to upset the suicidal person and 21% reported feeling embarrassed or ashamed to discuss the issue of suicide.
(Mishara, 2007a)	Trained observers listened to and coded calls in real time. The professional helpers were rated on different categories: their ability to conduct a suicide risk assessment in accordance with AAS accreditation, their ability to send emergency rescue if needed, and their ability to intervene according to existing theories related to active listening and collaborative problem-solving models.	81% of calls had a good initial rapport between helpers and callers. Only half of helpers asked about suicidal ideation. Of the callers who were reporting ideation, 46% were not asked about a plan; most were not asked about prior attempts.
(Mishara, 2007b)	Trained observers listened to and coded calls in real time. This evaluation is related to Mishara, 2007. It looks to analyze whether there is a correlation between the behavior of the helpers and any short-term outcomes seen in the callers.	Empathy, respect, supportive approach, good contact, and collaborative problem solving were significantly related to positive outcomes. Active listening was not related to outcomes.
(Meehan and Broom, 2007)	Call logs were completed by volunteers, and 535 callers between March and September 2004 were mailed a questionnaire on their perceptions of the service (only 41 mailed form back). The form included satisfaction for call, reasons for call, and time it took after learning about hotline to call.	Demographic data on callers presented; those who completed the questionnaire were generally happy with how their call was handled.
(Gould et al., 2007)	Counselors at 8 crisis centers conducted standardized assessments at the beginning and end of calls, and also asked if they could follow-up in 1–2 weeks with the caller. Follow-up calls were made by independent research	Seriously suicidal individuals reached out to telephone crisis services. Significant decreases in suicidality were found during the course of the telephone session, with continuing decreases in hopelessness and

Citation (listed chronologically)	Evaluation Design	Evaluation Findings
	interviewers.	psychological pain in the following weeks. A caller's intent to die at the end of the call was the most potent predictor of subsequent suicidality.
(Kalafat et al., 2007)	Counselors at 8 crisis centers conducted standardized assessments at the beginning and end of calls, and also asked if they could follow-up in 1–2 weeks with the caller. Follow-up calls were made by independent research interviewers.	Significant decreases in callers' crisis states and hopelessness were found during the course of the telephone session, with continuing decreases in crisis states and hopelessness in the following weeks. A majority of callers were provided with referrals and/or plans of actions for their concerns and approximately one third of those provided with mental health referrals had followed up with the referral by the time of the follow-up assessment. While crisis service staff coded these callers as nonsuicidal, at follow-up nearly 12% of them reported having suicidal thoughts either during or since their call to the center.
(Ho et al., 2011)	The evaluation uses a pretest/post-test design to evaluate the effectiveness of a center's programs using monthly Bureau of Health data to track suicide rate changes since the center's opening in 2006.	From 2005 to 2008, suicide rates decreased, Kaohsiung Suicide Prevention Center crisis-line calls increased, the number of telephone counseling sessions increased, and suicide attempt reporting increased.
(Gould et al., 2012)	Lifeline callers who had received a mental or behavioral health care referral were interviewed two weeks after their call to assess depression, referral follow-through, and barriers to utilization both in suicidal callers and non-suicidal crisis callers.	Decreases in callers' mental state and suicide ideation occurred from the beginning to the end of the call; a decrease in calls rated to be at "imminent risk" and an increase in those rated as "no suicide urgency" were also observed.
(Knox et al., 2012)	Administrative data on calls to the Veteran's Crisis line, which was established in July 2007, are reviewed.	Since the inception of the Department of Veterans Affairs' (VA) suicide hotline, the percentage of veterans self-identifying as veterans has increased from 30% to just over 60% as of September 30, 2010; the volume of calls as of this time was 171 000. Seventy percent of callers were male veterans, and those who disclosed their age were between 40 and 69 years old. Approximately 4000 referrals were made to the VA's suicide prevention coordinators as of 2008; there were 16 000 referrals at the end of September 2010.

Appendix D. Student Mental Health Tools

Training

Training Procedures

Four versions of the training evaluation survey were administered for K–12 and higher education Program Partners. Two versions were customized to students and two versions were tailored to administrators and staff. Within each of these versions were pre-post and post-only surveys. Pre-post surveys were administered using paper-pencil forms for Program Partners. Post-only surveys were administered for Program Partners that did not have procedures in place to collect pre-training data. Post-only or retrospective surveys have been supported with high validity in previous studies (Pratt, McGuigan, and Katzev, 2000; Rohs, 1999). The post-only version of the survey was administered using paper-pencil or Internet. If Internet, participants could either complete the survey on their mobile phones by texting a four-digit number and receiving a mobile-compatible URL or they could complete the survey on their computer going directly to a training URL.

Training Measures

We adapted items from the Survey of Knowledge, Attitudes, & Gatekeeper Behaviors for Suicide Prevention in Schools (Wyman et al., 2008) to measure training participant efficacy and behaviors. This measure was designed for evaluations of the QPR gatekeeper program in high schools and colleges (Tompkins and Witt, 2009; Wyman et al., 2008). Therefore, in some cases, items were reworded to be appropriate for training participants across the various Program Partners.

Demographics. Demographic information included age, gender (male, female, other), and ethnicity (Are you of Hispanic, Latino, or Spanish origin?), and race (White, Black or African American, Asian, American Indian/Native American/Alaska Native, Native Hawaiian or Pacific Islander, Other). Additional questions asked about their role at their organization and the types of students they work with.

Training satisfaction. Four items were created to assess training usefulness and quality. Each item was on a 5-point scale (1=Strongly Disagree to 5=Strongly Agree; 1=Not at all Helpful to 5=Very Helpful; or 1=Very Poor to 5=Excellent). Questions were "Was the training that you received helpful?" "Please rate the quality of training that you received," "The training I received meets the unique needs of the students I work with (e.g., diverse ethnic/language groups, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning [LGBTQ], low income)," and "It is important for staff and faculty to attend trainings like this one to support students with mental health issues."

Efficacy. Five items were adapted from suicide gatekeeper training surveys, which measured individuals' feelings of competence and capability serving as gatekeepers (Tompkins and Witt,

2009; Wyman et al., 2008). These items were converted from a 7-point scale to a 5-point scale (1=Strongly Disagree to 5=Strongly Agree). Questions included "I can identify the places or people where I should refer students with mental health needs/distress," "I have easy access to the educational or resource materials I need to learn about student mental health," "I feel comfortable discussing mental health issues with students," "I am confident in my ability to help students address mental health issues," and "I am aware of the warning signs of mental health distress."

Behaviors. Nine items were adapted that assessed participant behaviors (Tompkins and Witt, 2009; Shaffer et al., 1991). These items were rated on a 4-point scale (1=Not at all likely to 4=Very likely). Each item began with, "If a student showed signs that s/he might be experiencing mental health distress, I would..." and was followed by questions such as, "Encourage him/her to get professional help (e.g., hospital, mental health center, counselor, etc.)," "Call a crisis line with him/her present (e.g., 911, city/campus crisis hotline) to get help," "Provide him/her with advice and guidance about how to help himself/herself," and "Feel it wasn't really my business to get involved in his/her personal life."

Website Survey

Website Survey Evaluation Procedure

As part of the CalMHSA student mental health initiative, several higher education and K–12 CalMHSA-funded Program Partners will be developing websites that broadly provide access to information and resources related to student mental health. To gather basic information about the types of people visiting the websites, RAND developed a voluntary and confidential website feedback form, as well as follow-up surveys about users' website experiences and perceived utility, quality, and impact of online materials. Together, the surveys are designed to complement information RAND will obtain from the website analytics on basic traffic metrics for each website.

Following approval by RAND's IRB, the feedback forms and follow-up surveys will be disseminated on a rolling basis, dependent on the active status of each Program Partner's website. To help facilitate recruitment, a link to the feedback form will be hosted on each funded program website. Website users may choose to follow the link to the brief and voluntary feedback form. Also, respondents may choose to provide their email address for the follow-up survey, which will be disseminated by RAND two to four weeks following the completion of the feedback form. RAND will evaluate data from the feedback forms and follow-up surveys to assist in the assessment of the frequency of access, return-use among website users, and potential reach of CalMHSA-funded websites.

Website Survey Measure

During development of the website feedback form and follow-up survey, RAND reviewed existing measures of website usage and perceived utility (e.g., the *Cognitive Behavioral Intervention for Trauma in Schools [*CBITS] website experience survey) to compile a

recommended list of items that assess website user characteristics and user experience. The recommended items were vetted through a systematic review process within the RAND/SRI student mental health team, during which research team members advised on the inclusion or exclusion of identified items, revised the set of items, and provided recommendations for additional items. The core set of items is currently being reviewed by CalMHSA-funded program stakeholders to provide final recommendations on wording and the inclusion of items tailored to each website.

Higher Education and K–12 Website Feedback Form

Relevant Aim: Did the materials reach key diverse subgroups?

The website feedback form included items that assessed basic demographics (role in school, zip code or system of higher education), reason for visiting the website, how they heard about the website, and interest in special student groups (LGBTQ, Foster Care Youth, Ethnic Minorities, Student Veterans, other)

Higher Education and K–12 Website Follow-Up Survey

Relevant Aims: How much were the online materials accessed and by whom? Did the materials reach key diverse subgroups? Were the online materials helpful?

The follow-up survey adapted items from the CBITS website user engagement survey that assessed the following domains: usability of the website, quality of the site and materials, perceived value of the site and materials, repeat visits, likelihood of future engagement.

Table D. Student Mental Health Tools

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
These items ask you to think about how your actions may have changed as a result of this training. Please read each statement and rate how likely it would have been for you to act in the following way BEFORE participating in this training. Then, rate how likely it is now AFTER participating in this training. We understand that not all of the topics may have been covered in the training. If this is the case, your ratings may be the same for "Before" and "After." *If a student showed signs that s/he might be experiencing mental health distress, I would...*	4-point scale; Not at all likely to Very likely	Behaviors		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS				
a) Encourage him/her to get professional help (e.g., hospital, mental health center, counselor, etc.).	4-point scale; Not at all likely to Very likely	Behaviors		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
b) Call a crisis line with him/her present (e.g., 911, city/campus crisis hotline) to get help.	4-point scale; Not at all likely to Very likely	Behaviors		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CARS				
c) Encourage him/her to talk with parents or friends about problems.	4-point scale; Not at all likely to Very likely	Behaviors		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS				
d) Provide him/her with advice and guidance about how to help himself/herself.	4-point scale; Not at all likely to Very likely	Behaviors		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
e) Take him/her to get help (e.g., hospital, mental health center, counselor, etc.).	4-point scale; Not at all likely to Very likely	Behaviors		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS				
f) Give him/her a specific number or person to call.	4-point scale; Not at all likely to Very likely	Behaviors		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS				
g) Ask him/her specific questions to assess their level of distress or seriousness of problem.	4-point scale; Not at all likely to Very likely	Behaviors		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
h) Call security/ administrator/ counselor to support the student.	4-point scale; Not at all likely to Very likely	Behaviors		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Shaffer et al., 1991)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS				
i) Feel it wasn't really my business to get involved in his/her personal life.	4-point scale; Not at all likely to Very likely	Behaviors		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Shaffer et al., 1991)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
How much do you agree with the following statements about this campus? a. This campus provides adequate counseling and support services for students. b. This campus provides adequate counseling and support services for students with unique needs (e.g., diverse ethnic/language groups, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning [LGBTQ]; low income). c. This campus provides effective confidential support and referral services for students needing help because of depression, stress, substance use, violence, or other emotional issues. d. This campus emphasizes helping students with their social, emotional, and behavioral needs.	5-point scale: Strongly disagree to Strongly agree	Campus support services		CSCS adaptation	Adapted from (WestED, 2013e)				HigherEd Staff	
To what extent is your campus actively putting into place the following policies or programs? a. Programs and resources for students that promote the responsible use of, or abstinence from, alcohol. b. Programs and resources for staff and faculty to refer students for help with drug or alcohol problems.	5-point scale plus don't know: Not at all/ Very little/ Somewhat/ A moderate amount/ A great deal	Campus support services		Core item – Campus Support Services					HigherEd Staff	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
c. Support, resources, or programs for students with mental health needs. d. Support, resources, or programs for staff and faculty to refer students with mental health needs. e. Training programs to help students recognize and respond to other students with mental health needs. f. Training programs to help staff and faculty recognize and respond to students with mental health needs. g. Training programs to help students recognize and respond to students at risk for suicide. h. Training programs to help staff and faculty recognize and respond to students at risk for suicide. i. A social media campaign to reduce stigma and improve awareness of student mental health for the whole campus.										
Any additional comments would be appreciated.	Open-ended	Comments		developed by and incorporated at the request of the relevant Program Partner		CARS				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
In the future, I would be interested in attending a training on the following topic(s):	Open-ended	Comments		developed by and incorporated at the request of the relevant Program Partner		CARS				
In the future, I would be interested in on-site consultation regarding:	Open-ended	Comments		developed by and incorporated at the request of the relevant Program Partner		CARS				
In the future, I would be interested in resource materials regarding:	Open-ended	Comments		developed by and incorporated at the request of the relevant Program Partner		CARS				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
Please write any additional comments you have about the ASIST workshop or clarify any of your responses.	Open-ended	Comments		developed by and incorporated at the request of the relevant Program Partner		ASIST				
Over the last two weeks, how many times have you had five or more drinks of alcohol at a sitting? By one drink, we mean one regular size can/bottle of beer or wine cooler, one glass of wine (5 ounces), one mixed drink, or one shot glass (1.5 ounces) of liquor.	N/A, I don't drink/ None/ 1 time/ 2–3 times/ 4–5 times/ 6 or more times	Coping and resilience		NCHA-II	("American College Health Association (Acha) National College Health Assessment (Ncha)," 2013)				HigherEd Student	
Within the last 12 months, have any of the following affected your academic performance? a. Alcohol use? b. Anxiety? c. Death of a friend or family member? d. Depression? e. Eating disorder/ problem? f. Stress?	This did not happen to me/ Experienced this, but my academic performance was not affected/ Received lower grade in an exam/ Received lower grade in a course/ Received incomplete or dropped course/ Significant disruption or took a leave of	Coping and resilience		NCHA-II	("American College Health Association (Acha) National College Health Assessment (Ncha)," 2013)				HigherEd Student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
	absence									
How true do you feel these statements are about you personally? a. I know where to go for help with a personal problem. b. I try to work out problems by talking or writing about them. c. I can work out my problems. d. I accept mistakes as part of the learning process. e. I seek alternative solutions to a problem. f. When I need help, I find someone to talk with. g. I am aware of where to go on campus if I need mental health or other similar supportive services.	4-point scale: Not at all true/ A little true/ Pretty much true/ Very much true	Coping and resilience		CHKS Resilience Module B	(WestED, 2013c)				HigherEd Student	
How much do you agree with the following statements? a. I lead a purposeful and meaningful life. b. My social relationships are supportive and rewarding. c. I am engaged and interested in my daily activities. d. I am optimistic about my future.	5-point scale: Strongly disagree to Strongly agree	Coping and resilience		Core item					HigherEd Student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
How strongly do you agree or disagree with the following statements about your school? a) I feel close to people at this school b) I am happy to be at this school c) I feel like I am part of this school d) The teachers at this school treat students fairly e) I feel safe in my school (at my school)	5-point scale; Strongly disagree to Strongly agree	Coping and Resilience		CHKS	(WestED, 2013a)				K–12 student	
How strongly do you agree or disagree with the following statements about your school? There is a teacher or some other adult who… a) really cares about me b) tells me when I do a good job c) notices when I'm not there d) always wants me to do my best e) listens to me when I have something to say f) believes that I will be a success	5-point scale; Strongly disagree to Strongly agree	Coping and Resilience		CHKS	(WestED, 2013a)				K–12 student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
How strongly do you agree or disagree with the following statements about your school? Outside of my home and school, there is an adult who… a) really cares about me b) tells me when I do a good job c) notices when I am upset about something d) believes that I will be a success e) always wants me to do my best f) whom I trust	5-point scale; Strongly disagree to Strongly agree	Coping and Resilience		CHKS	(WestED, 2013a)				K–12 student	
How true do you feel these statements are about you personally? a) I know where to go for help with a problem. b) I try to work out problems by talking or writing about them. c) I can work out my problems. d) I can do most things if I try. e) When I need help, I find someone to talk with. f) I try to understand how other people feel and think. g) I understand my moods and feelings. h) I understand why I do what I do.	4 point scale: Not at all true/ a little true/ pretty much true/ very much true	Coping and Resilience		CHKS Resilience Module	(WestED, 2013c)				K–12 student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
How true do you feel these statements are about you personally? I have a friend about my own age ... a) who really cares about me. b) who talks with me about my problems. c) who helps me when I'm having a hard time. d) who talks with me about my problems. e) who listens to me when I have something to say.	4 point scale: Not at all true/ a little true/ pretty much true/ very much true	Coping and Resilience		CHKS Resilience Module	(WestED, 2013c)				K–12 student	
Please rate the extent to which you agree with the following statements: a. The programs on campus send the message to students that help is available for mental health problems. b. I can only help a student with mental health distress if they seek assistance. c. I have easy access to the educational or resource materials I need to learn about student mental health. d. Our college/university has online resources that I can utilize for addressing student mental health. e. This campus has an adequate number of resources or people to whom I could refer students with	5-point scale: Strongly disagree to Strongly agree	Staff activities to support mental health		Core item					HigherEd Staff	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
mental health needs/distress. f. I can identify the places or people where I should refer students with mental health needs/distress. g. I feel comfortable discussing mental health issues with all types of students. h. I am aware of the warning signs of mental health distress. i. I don't have the necessary skills to discuss mental health issues with a student. j. I am confident in my ability to help students address mental health issues. k. I am able to help students in distress get connected to the services they need.										
The next series of items asks you to think about how your skills may have changed as a result of this training. Please read each statement and rate the extent to which you would have agreed with the statement BEFORE participating in this training. Then, rate the extent to which you agree with the statement now AFTER participating in this training. We understand that not all of the topics may have been covered in the training. If this is the case, your ratings may be the same	5-point scale; Strongly disagree to Strongly agree	Efficacy		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Wyman et al., 2008) and (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
for "Before" and "After."										
a) I can identify the places or people where I should refer students with mental health needs/distress.	5-point scale; Strongly disagree to Strongly agree	Efficacy		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Wyman et al., 2008) and (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS/ ASIST				
b) I have easy access to the educational or resource materials I need to learn about student mental health.	5-point scale; Strongly disagree to Strongly agree	Efficacy		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Wyman et al., 2008) and (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS/ ASIST				
c) I feel comfortable discussing mental health issues with students.	5-point scale; Strongly disagree to Strongly agree	Efficacy		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Wyman et al., 2008) and (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS/ ASIST				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
d) I am confident in my ability to help students address mental health issues.	5-point scale; Strongly disagree to Strongly agree	Efficacy		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Wyman et al., 2008) and (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS/ ASIST				
e) I am aware of the warning signs of mental health distress.	5-point scale; Strongly disagree to Strongly agree	Efficacy		Core item – Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools	Adapted from (Wyman et al., 2008) and (Tompkins and Witt, 2009)	HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS				
The next series of items asks you to think about how your knowledge and skills may have changed as a result of this training. Please read each statement and rate the extent to which you would have agreed with the statement BEFORE participating in this training. Then, rate the extent to which you agree with the statement now, AFTER participating in this training. We understand that not all of the topics may have been covered in the	6-point scale; Strongly disagree to Strongly agree plus NA	Efficacy		developed by and incorporated at the request of the relevant Program Partner		CCSESA				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
training. If this is the case, your ratings may be the same for "Before" and "After." a) I have high level of usable knowledge about the topic. b) I feel confident in my ability to apply the skills presented in today's training. c) I understand the relationship between this training and early intervention and prevention.										
If a person's words and /or behaviors suggest the possibility of suicide, I would ask directly if he/she is thinking about suicide. Before taking the ASIST training, may answer would have been.	5-point scale; Strongly disagree to Strongly agree plus NA	Efficacy		developed by and incorporated at the request of the relevant Program Partner		ASIST				
If someone told me he or she was thinking of suicide, I would do a suicide intervention. Before taking the ASIST training, my answer would have been.	5-point scale; Strongly disagree to Strongly agree plus NA	Efficacy		developed by and incorporated at the request of the relevant Program Partner		ASIST				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
I feel prepared to help a person at risk of suicide. Before taking the ASIST training, my answer would have been.	5-point scale; Strongly disagree to Strongly agree plus NA	Efficacy		developed by and incorporated at the request of the relevant Program Partner		ASIST				
Over the past 6 months, have you accessed information about student mental health online through your university or campus' website?	Yes/ No	Information		Core item					HigherEd Staff	
Have you received information on the following topics from your college or university? Depression/anxiety Alcohol and other drug use Grief and loss How to help others in distress Problem use of internet/computer games Relationship difficulties Stress reduction Suicide prevention Tobacco use	Yes/ No	Information		NCHA-II	("American College Health Association (Acha) National College Health Assessment (Ncha)," 2013)				HigherEd Student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
If yes… Was the information useful?	5-point scale: Not useful to Very useful	Information		NCHA-II	("American College Health Association (Acha) National College Health Assessment (Ncha)," 2013)				HigherEd Student	
Was any of the information provided through online resources (e.g., Facebook, email, campus website, Student Health 101)?	Yes/ No	Information		Core item					HigherEd Student	
Was any of the information provided through in-person training at your campus?	Yes/ No	Information		Core item					HigherEd Student	
Was any of the information provided through online- training at your campus?	Yes/ No	Information		Core item					HigherEd Student	
Are you currently involved in or have you participated in any of the Mental Health Services Act (MHSA) planning in your county? If so, please tell us your involvement.	Open-ended	Involvement		developed by and incorporated at the request of the relevant Program Partner		CDE Level 2 Training				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
What is your knowledge about the Mental Health Services Act (MHSA) Proposition 63?	5-point; None/Very little/ Some knowledge/ Competent/ Expert	Knowledge		developed by and incorporated at the request of the relevant Program Partner		CDE Level 2 Training				
In the past 6 months, approximately how many students have you been concerned about due to their psychological distress?	Numerical write-in	Level of distress and functioning		Core item					HigherEd Staff	
Within the last 12 months, how would you rate the overall level of stress you have experienced?	5-point scale: No stress/ Less than average stress/ Average stress/ More than average stress/ Tremendous stress	Level of distress and functioning		NCHA-II	("American College Health Association (Acha) National College Health Assessment (Ncha)," 2013)				HigherEd Student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
The next questions are about how you have been feeling during the past 30 days. a. How often did you feel nervous? b. How often did you feel hopeless? c. How often did you feel restless or fidgety? d. How often did you feel so depressed that nothing could cheer you up? e. How often did you feel that everything was an effort? f. How often did you feel worthless?	5-point scale: All of the time/ Most of the time/ Some of the time/ A little bit of the time/ None of the time	Level of distress and functioning		NCHA-II	"American College Health Association (ACHA) National College Health Assessment (NCHA)," 2013)				HigherEd Student	
Now think back about how you have been feeling over the last 12 months. a. How often did you feel nervous? b. How often did you feel hopeless? c. How often did you feel restless or fidgety? d. How often did you feel so depressed that nothing could cheer you up? e. How often did you feel that everything was an effort? f. How often did you feel worthless?	5-point scale: All of the time/ Most of the time/ Some of the time/ A little bit of the time/ None of the time	Level of distress and functioning		NCHA-II	"American College Health Association (ACHA) National College Health Assessment (NCHA)," 2013)				HigherEd Student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
The next questions ask for your opinions about problems you may have experienced in doing your job at this school. How much of a problem AT THIS SCHOOL is ... a) student alcohol and drug use? b) student tobacco use? c) harassment or bullying among students? d) physical fighting between students? e) disruptive student behavior? f) student depression or other mental health problems?	insignificant problem, mild problem, moderate problem, severe problem	Mental Health Outcomes		CSCS	(WestED, 2013e)				K–12 staff	
During your life, how many times have you been … a) very drunk or sick after drinking alcohol? b) “high” (loaded, stoned, or wasted) from drugs?	0 times/ 1 time/ 2 times/ 3 times/ 4–6 times/ 7 or more times	Mental Health Outcomes		CHKS	(WestED, 2013a)				K–12 student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
During the past 30 days, on how many days did you use … a) cigarettes b) smokeless tobacco (dip, chew or snuff)? c) at least one drink of alcohol? (BRFSS: One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor.) d) five or more drinks of alcohol in a row, that is, within a couple of hours? e) marijuana (pot, weed, grass, hash, bud)? f) any other illegal drug or pill to get "high"?	0 days/ 1 day/ 2 days/ 3–9 days/ 10–19 days/ 20–30 days	Mental Health Outcomes		CHKS	(WestED, 2013a)				K–12 student	
During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more that you stopped doing some usual activities?	No/Yes	Mental Health Outcomes		CHKS	WestED, 2013a)				K–12 student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
The next questions ask about this school's health or prevention services and activities. To what extent does this school … a) provide alcohol or drug use prevention instruction? b) provide tobacco use prevention instruction? c) provide conflict resolution or behavior management instruction? d) provide harassment or bullying prevention? e) provide services for students with disabilities or other special needs	4 point scale: A lot, some, not much, not at all	Mental health Services		CSCS	(WestED, 2013e)				K–12 staff	
Do you feel that you need more professional development, training, mentorship or other support to do your job in any of the following areas? a) positive behavioral support and classroom management. b) meeting the social, emotional, and developmental needs of youth (e.g., resilience promotion) c) creating a positive school climate	Yes/ No/ not applicable	Mental health Services		CSCS	WestED, 2013c)				K–12 staff	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
We would like to learn more about your experiences with the website. a) The website is easy to use. b) The website is of high overall quality. c) The website includes tools or resources that are helpful. d) The website is a time-efficient way for me to get information about student mental health issues. e) The website had the information I was looking for. f) The website is a valuable resource. g) The information on the website increases my knowledge about how to address student mental health needs.	5-point scale; Strongly disagree to Strongly agree	Satisfaction		Core item				HigherEd/ K–12 CDE/K–12 CCSESA		
If Yes, please answer the following questions: a) The downloadable materials were useful. b) The downloadable materials are a valuable feature of the website.	5-point scale; Strongly disagree to Strongly agree	Satisfaction		Core item				HigherEd/ K–12 CDE/K–12 CCSESA		
Please let us know about other important student, faculty, or staff mental health issues on your campus that weren't addressed in the survey.	Write -in	Campus climate		Core item					HigherEd Staff	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
Based on your experience and observation, rate the general climate for students at your campus along the following dimensions: Hostile to Friendly Impersonal to Caring Intolerant of diversity to tolerant of diversity Dangerous to Safe	6-point scale: 1 to 6	Campus climate		UCUES	(The Regents of the University of California, 2008)				HigherEd Student	
How much do you agree with the following statements about your campus and yourself? a. My school provides adequate counseling and support services for students. b. My school provides effective confidential support and referral services for students needing help because of substance use, violence, or other problems (e.g., a Student Assistance Program). c. My school emphasizes helping students with their social, emotional, and behavioral problems. d. People with mental health problems experience high levels of prejudice and discrimination at my school. e. Faculty members on my campus are concerned about students' emotional well-being	5-point scale: Strongly disagree to Strongly agree	Campus climate		CSCS	(WestED, 2013e)				HigherEd Student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
f. My school does a good job of getting the word out to students about the available mental health services on campus for students. g. There is an emotionally supportive climate on this campus for students with mental health needs. h. There is an emotionally supportive climate on this campus for students with substance abuse problems. i. There is an emotionally supportive climate on this campus for students who have been victims of abuse or other violence.										
Please indicate how much you agree or disagree with the following statements about this school. This school... a) is a supportive and inviting place for students to learn. b) sets high standards for academic performance for all students. c) provides adequate counseling and support services for students. d) promotes trust and collegiality among staff. e) fosters an appreciation of student diversity and respect for each other. f) effectively handles student discipline and behavioral problems.	4 point scale plus N/A: Strongly agree to strongly disagree. If the question is not applicable to your job, and you could not know enough to answer it, mark "Not Applicable."	School climate		CSCS	(WestED, 2013e)				K–12 staff	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
g) is a safe place for students. h) is a safe place for staff. i) motivates students to learn j) encourages parents to be active partners in educating their child.										
How much do you agree with the following statements about this school? This school... a) collaborates well with community organizations to help address substance use or other problems among youth. b) provides effective confidential support and referral services for students needing help because of substance abuse, violence, or other problems (e.g., a Student Assistance Program) c) considers substance abuse prevention an important goal. d) emphasizes helping students with their social, emotional, and behavioral problems. e) foster youth development, resilience, or asset promotion?	5 point scale: Strongly agree to strongly disagree	School climate		CSCS	(WestED, 2013e)				K–12 staff	
In the past 6 months, how often have you talked with students about their mental health problems?	Never/ Once or twice/ A few times/ Many times	Staff activities to support mental health		Core item					HigherEd Staff	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
Over the past 6 months, have you attended any trainings online or in-person to help you better support students with mental health problems?	Yes/ No	Staff activities to support mental health		Core item					HigherEd Staff	
If no… Faculty and staff have many reasons why they do not participate in student mental health trainings. Which of these reasons are the most true for you? (Check all that apply)	I didn't feel I needed to participate./ The training is not required./ I don't have a personal or professional interest in student mental health./ Student mental health does not affect my daily work./ I don't receive an incentive (e.g., CEU's, bonuses) from my campus to participate in training./ My campus does not encourage me to go./ Available trainings aren't very helpful./ I don't think the trainings would affect student mental health at my campus./ I didn't know what trainings were offered./ The information provided about the training was	Staff activities to support mental health		Core item					HigherEd Staff	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
	not sufficient./ I didn't know how to access online trainings./ I have been too busy to participate./ Trainings don't accommodate my schedule./ Other (Please specify):									
If yes… Faculty and staff have many reasons why they participate in student mental health trainings. Which of these reasons are the most true for you? (Check all that apply)	Training is part of my job to work with students with mental health problems./ The campus or my job required me to participate./ I am not required to participate, but I wanted to improve my ability to help students with mental health problems./ I receive an incentive (e.g., CEU's, bonuses) from my campus to participate in training./ My campus encouraged and supported me to go./ The trainings provide helpful information./ I think the trainings are a way to affect student	Staff activities to support mental health		Core item					HigherEd Staff	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
	mental health at my campus./ The trainings could accommodate my schedule./ Other (Please specify):									
In the past 6 months, approximately how many students that you have been concerned about due to their psychological distress have you referred for support services?	Numerical write-in	Staff activities to support mental health		Core item					HigherEd Staff	
Please rate the trainer on the following: a) Enthusiasm and interest in the topic and participants. b) Preparation for the training. c) Understanding of community college needs. d) Knowledge/competence in the area of assistance. e) Responsiveness to questions. f) Training topics clearly communicated. g) Awareness of relevant cultural and linguistic issues.	5-point scale; Excellent/ Good/ Average/ Fair/ Poor	Trainer quality		developed by and incorporated at the request of the relevant Program Partner		CARS				
I attended two consecutive 8-hours days of training (including lunch hour).	Yes/No	Training		developed by and incorporated at the request of the relevant Program		ASIST				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
				Partner						
All trainers were present at the workshop for the full 2 days.	Yes/No	Training		developed by and incorporated at the request of the relevant Program Partner		ASIST				
The "Jack" exercise was done on the afternoon of day 1.	Yes/No	Training		developed by and incorporated at the request of the relevant Program Partner		ASIST				
Please comment on the physical aspects of this training (e.g., facility seating arrangements, room, lighting, etc., food).	Open-ended	Training		developed by and incorporated at the request of the relevant Program Partner		CARS				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
If the content was useful, please indicate how the content was useful in the box below.	Open-ended	Training content		developed by and incorporated at the request of the relevant Program Partner		CARS				
If the content was not useful, please indicate why.	Multi-choice; Objectives not clear/ Too complex/ Too much content/ Too simplistic/ Not well organized/ Other	Training content		developed by and incorporated at the request of the relevant Program Partner		CARS				
Please rate the content of the training on the following: a) The content of this training was useful in addressing student mental health on my campus. b) The content of this training met my expectations. c) The content was comprehensive. d) The content was current and relevant to my campus' emerging needs. e) The content of the training addressed cultural and linguistic factors.	5-point scale; Strongly agree to Strongly disagree	Training content		developed by and incorporated at the request of the relevant Program Partner		CARS				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
How likely is it that you will do the following as a result of the training? a) Share acquired information, skills or knowledge with others. b) Use materials presented in the training to guide implementation of mental health related strategies on campus. c) Apply the concepts and practices presented to the operations of my campus/department.	5-point scale; Very likely to Not likely	Training content		developed by and incorporated at the request of the relevant Program Partner		CARS				
Please rate the extent to which you agree with the following statements: a) The training I received meets the unique needs of the students I work with (e.g., diverse ethnic/language groups, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ), low income).	5-point scale; Strongly disagree to Strongly agree	Training satisfaction		Core item		HigherEd Staff/ HigherEd Student/ CARS/ CDE Level 2/ CCSESA/ ASIST				
Please rate the extent to which you agree with the following statements: b) It is important for staff and faculty to attend trainings like this one to support students with mental health issues.	5-point scale; Strongly disagree to Strongly agree	Training satisfaction		Core item		HigherEd Staff/ HigherEd Student/ CARS/ CDE Level 2/ CCSESA/ ASIST				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
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Please rate the quality of training that you received.	5-point scale; Very poor to Excellent	Training satisfaction		Core item		HigherEd Staff/ HigherEd Student/ CARS				
Was the training that you received helpful?	5-point scale; Not at all helpful to Very helpful	Training satisfaction		Core item		HigherEd Staff/ HigherEd Student/ CARS/ CDE Level 2/ CCSESA/ ASIST				
Please rate the extent to which you agree with the following statements: a) Overall, the training was helpful. d) The activities in this training gave me sufficient examples and practice.	5-point scale; Strongly disagree to Strongly agree	Training satisfaction		developed by and incorporated at the request of the relevant Program Partner		CDE Level 2				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
On a scale of 1 to 10, please write the rating number that best describes your response to the questions. a) How would you rate the quality of the ASIST workshop? b) Would you recommend ASIST to others? c) This workshop has practical use in my personal life. d) This workshop has practical use in my work life. e) This workshop was helpful.	10-point scale; definitely no to definitely yes	Training satisfaction		Program Partner specific and includes the two core training usefulness items used across all forms and training quality item, however all on 10-point scale		ASIST				

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			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
Please rate the extent to which you agree with the following statements: a) The training addressed prevention and early intervention topics relevant to student mental health. b) The training objectives were clearly communicated and followed. c) The content was well organized. d) The resources/materials distributed were pertinent and useful. e) The trainer was knowledgeable. f) The information was presented in a clear and engaging manner. g) The trainer facilitated activities and discussion effectively. h) Overall, the training was helpful.	6-point scale; Strongly disagree to Strongly agree plus NA	Training satisfaction		developed by and incorporated at the request of the relevant Program Partner		CCSESA				
Please indicate how useful the training materials were and will be in the future. a) How useful were the training materials? b) How useful will these materials be to you in the future?	5-point scale; Very useful/ Mostly useful/ Somewhat useful/ A little useful/ Not at all useful	Training satisfaction		developed by and incorporated at the request of the relevant Program Partner		CARS				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
Please rate your overall satisfaction with this training.	5-point scale; Very satisfied to Not at all satisfied	Training satisfaction		developed by and incorporated at the request of the relevant Program Partner		CARS				
Have you ever been referred for or used counseling or mental health services on campus from your current college/university's Counseling or Health Service?	Yes/ No	Use of services		UCUES	(The Regents of the University of California, 2008)				HigherEd Student	
If yes… Who referred you?	Self/Student Health /Resident Assistant (RA) /Medical Provider/ Academic Advisor /Parent/ Peer (Health) Educator/ Friend/ Professor or Teaching Assistant / Other	Use of services		UCUES	(The Regents of the University of California, 2008)				HigherEd Student	
If self… how did you hear about the services?	Advertisement (such as a brochure or flyer)/ University website /Student Health website /A Mental Health Screening Program /Other	Use of services		UCUES	(The Regents of the University of California, 2008)				HigherEd Student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
If yes, but not self … Did you end up receiving psychological or mental health services on campus?	Yes/ No	Use of services		UCUES	(The Regents of the University of California, 2008)				HigherEd Student	
If yes… Was the service that you received effective?	4-point scale: Not effective/ Somewhat effective/ Mostly effective/ Very effective	Use of services		UCUES	(The Regents of the University of California, 2008)				HigherEd Student	
Please rate the quality of service that you received.	Poor/ Fair/ Good/ Excellent	Use of services		UCUES	(The Regents of the University of California, 2008)				HigherEd Student	
Have you received services in the last 12 months?	Yes/ No	Use of services		Core item					HigherEd Student	
Students have many reasons why they don't end up using psychological or mental health services. Which of these reasons were true for you? (check all that apply)	I didn't feel I needed services./ I had never heard of it./ I didn't know what it offered./ I didn't know if I was eligible./ I didn't know how to access it. I didn't think it would help./ I had concerns about possible costs./I had concerns about possible lack of confidentiality./I was	Use of services		UCUES	(The Regents of the University of California, 2008)				HigherEd Student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
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	embarrassed to use it./ I didn't have enough time./ It has a poor reputation./ The hours are inconvenient./ The location is inconvenient./ The wait for an appointment was too long./ I got help from another university service or staff person instead.									
If in the future you were having a personal problem that was really bothering you, would you consider seeking help from a mental health professional?	Yes/ No	Use of services		Core item					HigherEd Student	
If yes… Would you consider seeking help on campus from your current college or university's Counseling or Health Services?	Yes/ No	Use of services		Core item					HigherEd Student	
Have you ever felt that you needed help (such as counseling or treatment) for your alcohol or other drug use?	No, I never used alcohol or other drugs /No, but I do use alcohol or other drugs /Yes, I have felt that I needed help	Use of services		CHKS CSS Module	(WestED, 2013b)				K–12 student	
Have you ever used the Health Center at your current school for	No /Yes /Does not apply; My school does	Use of services		CHKS SHC Module	(WestED, 2013d)				K–12 student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
information or services?	not have a School Health Center									
Are any of the following reasons why you have NOT used the School Health Center? a) I didn't need any services. b) I didn't know there was a School Health Center. c) I was afraid my parent/guardian(s) or other students would find out.	Yes, this is a reason/ No, this is not a reason	Use of services		CHKS SHC Module	(WestED, 2013d)				K–12 student	
If you HAVE used the School Health Center, did you receive services for counseling to help you deal with issues like stress, depression, family problems or alcohol or drug use?	Yes/ No/ I don't know/remember	Use of services		CHKS SHC Module	(WestED, 2013d)				K–12 student	
The School Health Center has helped me to … a) Get help I did not get before. b) Get help sooner than I got before. c) Get information and resources I need. d) Use tobacco, alcohol or drugs less. e) Deal with personal and/or family issues. f) Do better in school. g) Feel more connected to people at my school.	4 point scale plus N/A: Strongly agree to strongly disagree, plus don't know/doesn't apply	Use of services		CHKS SHC Module	(WestED, 2013d)				K–12 student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
What is the primary information you're seeking for yourself or to help someone else?	Higher Ed Options: Bullying prevention; Development of Behavior Intervention Teams; Mental health training programs (please specify below); Applied Suicide Intervention Skills Training (ASIST); Kognito; Mental Health First Aid; Question, Persuade, Refer (QPR); Step Up!; Other: Methods to identify, support, and refer students with social, emotional, and/or behavioral problems; Prevention of eating disorders; Prevention of sexual violence; Prevention of pregnancy/sexually transmitted disease (STD); Prevention of gangs; Reduction of behavioral problems; Promotion of supportive school climate and culture;	Use of services		Core item			HigherEd/ K–12 CDE/K–12 CCSESA			

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
	Stigma and discrimination reduction; Substance abuse prevention; Suicide prevention; Support for student veterans; Support for Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ) students; Other K–12 Options: Anger management; Positive behavior intervention and support (PBIS); Bullying prevention; Development of Behavior Intervention Teams; Prevention and Early Intervention Planning; Prevention of the use of drugs/alcohol/tobacco; Prevention of gangs Mental health/wellness; Mental health programs; Applied Suicide Intervention Skills Training									

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			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
	(ASIST); Kognito Suicide Prevention; Mental Health First Aid; Question, Persuade, Refer (QPR); Step Up!; Methods to identify, support, and refer students with social, emotional, and/or behavioral problems; Parent/family/community collaboration; Pregnancy/Sexually Transmitted Disease (STD) prevention; Promotion of supportive school climate and culture; Reduction of behavioral problems; Stigma and discrimination reduction; Suicide prevention; Violence prevention; Other									
When you visited the site, did you download any resources?	Yes / No / There were no materials available to download.	Use of services		Core item				HigherEd/ K–12 CDE/K–12 CCSESA		

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
Since first accessing the website, have you visited it again?	Yes/No	Use of services		Core item				HigherEd/ K–12 CDE/K–12 CCSESA		
If yes, about how many times have you accessed the website since your first visit?	1 or 2 times / 3 – 5 times / 6 or more times	Use of services		Core item				HigherEd/ K–12 CDE/K–12 CCSESA		
If no, why didn't you access the website again?	I did not find the information useful / I did not have time to access and navigate the site again / The website was confusing or hard to navigate / One visit was enough to give me the information I needed / I found information from another source / Other (please specify):	Use of services		Core item				HigherEd/ K–12 CDE/K–12 CCSESA		
I will likely access the website again in the near future	Higher Ed: Strongly disagree to Strongly agree K–12: Very much / Somewhat / Not at all	Use of services		Core item				HigherEd/ K–12 CDE/K–12 CCSESA		

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
What is your education level?	Less than high school diploma or GED/ High school diploma or GED/ Some college or technical school/ Associate or technical degree/ Bachelor's degree/ Graduate or professional degree (MA, PhD, JD, MD)	Demographics		Core item			K–12 CCSESA/ K–12 CDE		HigherEd Staff	
Do you currently work with or have interest in working with any of the following special populations?	HigherEd: LGBTQ/ Student Veterans/ Foster Care Youth/ Ethnic Minorities/ Other PK–12: LGBTQ/ Foster care youth/ Ethnic minorities/ Homeless youth/ Students with disabilities/ Students in alternative schools for at-risk youth/ Other ASIST: LGBTQ/ Student veterans/ Foster care youth/ Students in alternative schools for at-risk youth/ Ethnic minorities/ Seniors/ Homeless youth/	Demographics		Core item		HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS/ ASIST	HigherEd/ K–12 CDE/K–12 CCSESA		HigherEd Staff/ HigherEd Student	

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
	Students with disabilities/ Other									
Which student population do you currently work with?	HigherEd: All undergraduates/Undergraduates in residence halls/Graduate students/Other PK–12 training: Pre-K/K–5th grade/ 6–8th grade/9–12th grade K–12 system wide: Pre-K / K–3 (early elementary) / 4–6 (late elementary) / 7–8 (middle school/junior high) / 9–12 (high school) / Other (Please specify)	Demographics		Core item		HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS	HigherEd/ K–12 CDE/K–12 CCSESA		HigherEd Staff/ HigherEd Student	
What is your age?	16–25/26–59/60–84/85+ HigherEd: 16–18/19–21/22–25/26–59/60–84/85+ HigherEd student system wide: 17/18/19/20/21/22/23/ 24/25/26–59/ 60–84/ 85+	Demographics		Core item		HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS/ ASIST	HigherEd/ K–12 CDE/K–12 CCSESA		HigherEd Staff/ HigherEd Student/ K–12 Staff	

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What is your gender?	Male/ Female/ Other (e.g. Transgender)	Demographics		Core item		HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS/ ASIST	HigherEd/ K–12 CDE/K–12 CCSESA		HigherEd Staff/ HigherEd Student/ K–12 Staff/ K–12 Student	
What is your race?	White/Black or African American/Asian/American Indian or Native American or Alaska Native/Native Hawaiian or Pacific Islander/Other	Demographics		Core item		HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS/ ASIST	HigherEd/ K–12 CDE/K–12 CCSESA		HigherEd Staff/ HigherEd Student/ K–12 Staff/ K–12 Student	
Are you of Hispanic, Latino, or Spanish origin?	Yes/No	Demographics		Core item		HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS/ ASIST	HigherEd/ K–12 CDE/K–12 CCSESA		HigherEd Staff/ HigherEd Student/ K–12 Staff/ K–12 Student	

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			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
What is your current role at your school or campus?	HigherEd Staff: Full-time faculty/Part-time faculty or Adjunct faculty/Administrator/ Other HigherEd Student: Undergraduate student/Residence hall advisor/Student veteran/Graduate student/Peer educator, leader or counselor/Student activities or club leader(e.g., ActiveMinds, LGBTQ group, Fraternity or Sorority)/Other PK–12 training: Full-time faculty or teacher or assistant teacher/ Part-time faculty or adjunct faculty/ Administrator/Other School Staff/ Other Non-school Staff Website: Administrator / Teacher / Other School Staff (Please specify) / Mental Health Staff / Parent,	Demographics		Core item		HigherEd Staff/ HigherEd Student/ CDE Level 2/ CCSESA/ CARS	HigherEd		HigherEd Staff/ HigherEd Student/ K–12 staff	

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	Caregiver and Community Member / Student / Other (Please specify)									
If yes, which group do you identify with?	Mexican, Mexican American or Chicano/ Puerto Rican/ Cuban/ Dominican/ Central American/ South American/ Other	Demographics		Core item					HigherEd Student	
Is English your primary language?	Yes/ No	Demographics		Core item					HigherEd Student	
Do you identify with any of the following populations?	HigherEd: LGBTQ/Foster Care Youth/Ethnic Minorities/ Student Veterans/ Homeless youth/ Students with disabilities/ Other	Demographics		Core item					HigherEd Student	
If Student Veterans is checked, how many times were you deployed?	0/1/2/3	Demographics		Core item					HigherEd Student	
Check if you are …	Undergraduate student full time/ Undergraduate student part time/ Graduate student full time/ Graduate student part time	Demographics		Core item					HigherEd Student	

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And fill in years at this campus.	Write in	Demographics		Core item					HigherEd Student	
What is your primary academic goal at your current campus?	Certificate/ Associate's degree/ Transfer to four-year/ Bachelor's degree/ Graduate or professional degree/ Acquire job skills/ Educational development/ Other	Demographics		Core item					HigherEd Student	
Do you provide services to the following types of students?	Migrant education students /Special education /English language learners /None of the above	Demographics		Core item					K–12 staff	
How many years have you worked: (a) at any school in your current position (e.g., teacher, counselor, administrator, food service)? (b) in any position, at this school?	Less than one year /1 to 2 years /3 to 5 years /6 to 10 years /Over 10 years	Demographics		Core item					K–12 staff	
If you are Asian or Pacific Islander, which groups best describe you?	Does not apply, I am not Asian or Pacific Islander /Asian Indian /Cambodian /Chinese /Filipino /Hmong / Japanese /Korean /Laotian /Vietnamese /Native Hawaiian, Guamanian, Samoan,	Demographics		Core item					K–12 student	

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	Tahitian or other Pacific Islander /Other Asian									
How old are you?	10 years old or younger /11 years old /12 years old /13 years old /14 years old /15 years old /16 years old /17 years old /18 years old or older	Demographics		Core item					K–12 student	
What grade are you in?	6th grade /7th grade /8th grade /9th grade /10th grade /11th grade /12th grade /Other grade /Ungraded	Demographics		Core item					K–12 student	

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What best describes where you live?	A home includes a house, apartment, trailer, or mobile home. A home with both parents /A home with only one parent /Other relative's home /A home with more than one family /Friend's home /Foster home, group care, or waiting placement /Hotel or motel /Migrant housing /Shelter /On the street (no fixed housing), car or van, park campground or abandoned building /Other transitional or temporary housing /Other living arrangement	Demographics		Core item					K–12 student	
Choose the option below that best describes your agency or organization:	County Mental Health/ Community-based Mental health/ Probation or Law enforcement/ Children's services/ Youth services/ School district/ County office of	Demographics		developed by and incorporated at the request of the relevant Program Partner		CCSESA				

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	education/ Family advocate/ Alcohol or drug prevention/ Foster care/ Family or caregiver/ Other									
What are the ages of the people you serve?	0–17/ 18–25/ 26–59/ 60+	Demographics		developed by and incorporated at the request of the relevant Program Partner		ASIST				
What are the race/ethnicity of the people you serve?	White/ Black or African American/ Asian/ American Indian or Native American or Alaska Native/ Native Hawaiian or Pacific Islander/ Hispanic/ Other	Demographics		developed by and incorporated at the request of the relevant Program Partner		ASIST				
What is the primary language of the people you serve?	English/ Spanish/ Arabic/ Cambodian/ Cantonese/ Farsi/ Japanese/ Hmong/ Mandarin/ Russian/ Tagalog/ Vietnamese/ Other	Demographics		developed by and incorporated at the request of the relevant Program Partner		ASIST				

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Please indicate how long you served in your current position?	1–2 years/ 3–4 years/ 5–6 years/ 6 or more years	Demographics		developed by and incorporated at the request of the relevant Program Partner		CARS				
Please circle the letter next to your primary role or job.	Administrator/ Firefighter/ Volunteer/ Law Enforcement/ Student/ Clergy or Pastoral/ Youth Worker/ Psychologist/ Military Branch/ Counselor/ Nurse/ Social Worker/ Chaplain or Assistant Military Branch/ Educator/ Physician/ Transit Worker/ Other	Demographics		developed by and incorporated at the request of the relevant Program Partner		ASIST				
What type of setting do you work in usually or most of the time?	School or University/ Mental health care setting/ Medical care setting/ Religious organization/ Other	Demographics		developed by and incorporated at the request of the relevant Program Partner		ASIST				

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
What zip code do you work in?	Write-in	Demographics		developed by and incorporated at the request of the relevant Program Partner		ASIST				
With which system of higher education, if any, are you primarily affiliated with?	Higher Ed Website: University of California/ California State University/ Community Colleges of California/ California private university or college, out-of-state university or college/ None of the above K–12 Website: Write in zip code	Demographics		Core item			HigherEd/ K–12 CDE/K–12 CCSESA			

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
How did you hear about the website?	Paper Advertisements (such as a brochure, flyer or newsletter ad)/ Online Advertisement (such as an email, website ad)/ University website/ Student Health website or magazine (e.g., Student Health 101)/ UC Interactive Screening Program (ISP)/ University faculty, staff, administrator/ Mental health training program (e.g., Kognito, Mental Health First Aid)/ Other (Please specify)	Demographics		Core item			HigherEd			
What are the training objects of the training? If relevant, what are the learning outcomes of the training? How do trainings align with CalMHSA PEI goals (e.g., 1–5 scale; diversity)?	Open-ended	Training goals		Content analysis methods and findings	Adapted from (Acosta et. al, 2012a)					x
Who is the training addressed to (e.g., general, faculty/students, advisors that work with student veterans, Spanish-speaking participants)?	Open-ended	Target population		Content analysis methods and findings	Adapted from (Acosta et al., 2012a)					x

Scale item (item wording)	Response scale	Construct measured	Original source			Instruments in which item is used				
			Title of Scale	Source (e.g., GSS, See Change)	Citation	Training survey	Website Feedback Form	Website Follow Up	SMH Campus-Wide Survey	SMH training material qualitative analysis
What is the purpose of material distributed to participants at the training (e.g., providing education or information, providing resources to promote help-seeking, or promoting a specific organization (e.g., counseling center or a specific website)).	Open-ended	Purpose of training materials		Content analysis methods and findings	Adapted from (Acosta et al., 2012a)					x
Whether the material included additional links to hotlines (e.g., local vs. national), other services or care, or additional information or education.	Open-ended	Breadth		Content analysis methods and findings	Adapted from (Acosta et al., 2012a)					x

Note: CCSESA = California County Superintendents Educational Services Association. CDE = California Department of Education. UC = University of California.

Appendix E. Review of SDR Program Partner Websites and Their Contents

Disability Rights California

Disability Rights California has responsibility for two CalMHSA-funded sites, their own and one hosted by its subcontractor, MHAS.

- **Website URL:** www.disabilityrightsca.org
- **General description of the website**: The website hosts the fact sheets that Disability Rights California has created with CalMHSA funds (at http://www.disabilityrightsca.org/CalMHSA/CalMHSAfactsheets.html; see Informational Resources section), as well as all other Disability Rights California information. The CalMHSA fact sheets page features a listing of all stigma and discrimination–related fact sheets, organized by topic and publication date. These fact sheets are downloadable PDF files available in English and Spanish. Many are available in other languages, including Korean, Chinese, Tagalog, Hmong, Vietnamese, Cambodian, Russian, Armenian, and Arabic. Fact sheets are organized into sections under the headings "Fact Sheets on Definitions & Myths," "Fact Sheets on Employment," "Fact Sheets on the Mental Health System," "Fact Sheets on Housing." At the bottom of the page, users are provided a link to the fact sheets created by Disability Rights California subcontractor MHAS and a link to a survey about the fact sheet. While on the fact sheets page, users also see a sidebar allowing them to easily navigate the Disability Rights California site.
- **Target audience**: The target audience matches those for the fact sheets (see the Informational Resources section), which includes people with mental health disabilities, their advocates, landlords, employers, and mental health providers.
- **Links and search**: At the very bottom of the fact sheets page, users see links to other CalMHSA-related sections of the site, including the advisory group, other resources, news and press, and trainings and materials. Most links are to internal pages, but the other resources and news and press pages link to external partner sites and to online news articles, respectively. The site provides a search function at the top of each page.
- **Registration**: The materials on the site are accessible without registration.

MHAS (subcontractor to Disability Rights California)

- **Website URL:** http://www.mhas-la.org/
- **General description of the website**: The website hosts the fact sheets that MHAS created through its subcontract with Disability Rights California (see Informational Resources section). The fact sheets page features a listing of fact sheets, organized into two columns. The first column is titled "Information for Parents and Caregivers," and the second, "Information for Educators and Service Providers." These fact sheets are downloadable PDF files available in English. While on the fact sheets page, users also see a sidebar allowing them to easily navigate the remainder of the MHAS site.

- **Target audience**: The target audience matches those for the fact sheets (see the Informational Resources section), which includes parents of children with mental health disabilities, educators, and mental health providers.
- **Links and search**: As part of the sidebar, users are presented with links to several external sites, including Facebook and Twitter. There is no search function on the page.
- **Registration**: The materials on the site are accessible without registration. Users are able to sign up for an email newsletter, although it is unclear what information is presented in the newsletter and how frequently it is sent.

Entertainment Industries Council, Inc.

- **Website URL:** http://www.eiconline.org/teamup
- **General description of the website**: This section of the broader eiconline.org website houses the CalMHSA TEAM Up tool kits for journalists and entertainment media creators (see Policies, Protocols, and Procedures and Informational Resources sections). The broader website provides information on a variety of other issues addressed by Entertainment Industries Council, Inc. and contains resources funded outside of CalMHSA. Some of these resources are also related to mental health and mental illness stigma. The link to the TEAM Up tools on the homepage can only be seen if the user scrolls down from the opening screen or views the page in very small font. There is a "topic areas" section at the top of the homepage that includes mental health, but the TEAM Up tool kit is not among the materials to which this links. In the section of the page where the TEAM Up link appears, the accompanying text and labeling do not highlight that materials and tools for portraying mental health are provided as part of TEAM Up – one must read the text carefully to learn that this is the case. This is unlikely to be a barrier for visitors who know the TEAM Up name, but more casual visitors to Entertainment Industries Council, Inc.'s site would be more likely to find and use the tool kits if the label "Tools for Writing About Mental Health" or something similar was displayed in large type. Once the user gets to the TEAM Up page, the user interface is highly appealing and it is easy to find relevant information.
- **Target audience**: entertainment media creators and journalists/other news professionals
- **Links and search**: Most links on the TEAM Up main page and the main pages for each of the two tool kits take the user to components of the tool kit; a few are to other Entertainment Industries Council, Inc. materials not funded by CalMHSA (e.g., fact sheets on various mental health problems available on other parts of the Entertainment Industries Council, Inc. site). There are only a few external links; one is to EachMindMatters.org, another allows one to follow TEAM Up on Twitter. The site provides a search function.
- **Registration**: The materials on the site are accessible without registration. Users can provide an email to join an Entertainment Industries Council, Inc. email list. It is not clear on the website what kinds of materials would be sent or how often, if one chose to do so.

Integrated Behavioral Health Project/Center for Care Innovations

- **Website URL:** http://www.ibhp.org
- **General description of the website**: The website serves as a clearinghouse of resources on strategies, tools, research, and policy issues related to advancing the integration of behavioral health and primary care. The website contains a "News" section which posts

announcements of upcoming workshops and conferences, funding opportunities, and resources supporting integrated care. There is also a section on "Training Opportunities and Archives" with links to the following: On-Demand Integrated Care-Related Webcasts and Videos, Integrated Behavioral Health Project/Center for Care Innovations-sponsored training PowerPoint presentations (i.e., "Treating the Whole Person While Reducing Costs" and "The Business Case for Bidirectional Integrated Care"), and More Training Archives. The "On-Demand Integrated Care-Related Webcasts and Videos" section of the Integrated Behavioral Health Project/Center for Care Innovations website provides links to PowerPoint presentations with audio or videos that are sponsored by another organization.

- **Target audience**: Health care organizations, administrators, and providers
- **Links and search**: Most of the links are to external websites or to downloadable materials created by other organizations or individuals outside of Integrated Behavioral Health Project/Center for Care Innovations. Approximately 30 links are provided that connects users either to a single presentation on a particular topic or to a library of webcasts sponsored by another organization. There were a number of links to webinars which were unavailable and one link which led to a different webinar topic than described. The site provides a search function.
- **Registration**: The majority of materials on the website can be accessed without registration except for links to webinars created by the Center for Integrated Healthcare Solutions. Most of the links for these webinars require an email address registration and a subset of these webinars require additional contact information (e.g., name, city, state, zip code, organization).

Mental Health Association of San Francisco (Promising Practices and Resource Development Programs)

- **Website URL:** http://dignityandrecoverycenter.org/
- **General description of the website**: The homepage of the website features large photos of people with mental health challenges or advocates for this community and a quote about their experience. At the top of this page, users see menu options labeled "who we are," "what we do," "center registry," "tools for change," "collaborate," and "news & events." The "who we are" link describes the people involved in the CalMHSA efforts. The "what we do" link describes both the resource development and promising practices initiatives. The "center registry" allows users to search SDR programs in a number of ways – by keyword, program focus (i.e., transition-aged youth), program method (e.g., speakers bureau, performing arts), languages, and counties. The "tools for change" section provides materials developed through the resource development program (e.g., the CQI-FAIR instrument; see Policies, Protocols, and Procedures section). The "collaborate" section provides information about community development partners, and the "news & events" section provides text about several mental health related news items.
- **Target audience**: The target audience is individuals and organizations interested in implementing and evaluating SDR programs.
- **Links and search**: Links to external partner sites are provided in the "who we are" section, under the "our partners" section. There is a search function at the top of the page.
- **Registration**: The materials on the site are accessible without registration. Individuals or organizations wanting to get more involved in Center efforts can review the information in the "collaborate" section.

Runyon Saltzman & Einhorn

Runyon Saltzman & Einhorn has three websites it operates under CalMHSA: Speak Our Minds, Each Mind Matters, and ReachOut Forums.

Speak Our Minds (Runyon Saltzman & Einhorn)

- **Website URL:** http://www.speakourminds.org
- **General description of the website**: The interface is a very straightforward one. The site is divided into four sections. The section at the top is labeled "Find a Speaker" and links to a search tool that can be used find speakers on mental health topics using one's zip code. There is also an option to specify "Specialty Areas" for speakers that encompasses target audiences and topics. It includes some key CalMHSA SDR categories (e.g., Lesbian, Gay, Bisexual, Transgender, Questioning [LGBTQ] individuals) and some categories central to Runyon Saltzman & Einhorn's campaign targets (e.g., youth 13 and under, young adults 14–24). A second search option is to specify language of the presentation, with 13 different languages listed. The result of searching is a printable list of speakers bureaus with location (city), contact information, specialty areas, and languages spoken. The list also links through further, to short descriptions of each organization listed. It is easy to use, but would be improved by more descriptive messages when searches produce a null result. Entering a zip code outside of California or asking for a language unavailable in one's area produce identical results – a message inviting the user to contact Speak Our Minds or to search again without feedback as to why the search failed.

  The second section is labeled "Tools for Speakers" and consists of such. Its goal is to help speakers incorporate stigma-reducing messages in their mental health presentations and consists of four subsections. The "To Say" subsection of the speaker tools consists of 12 PDF files from various sources (some in Spanish) providing guidelines and talking points. The "To Share" section provides two flyer templates and a pre-post presentation evaluation survey that assesses beliefs about mental illness and treatment seeking. The "To Show" subsection contains video and graphics including links to the "A New State of Mind" documentary and the trailer promoting it, a tool kit for disseminating documentary messages, and links to video segments of the award winning Los Angeles County Department of Mental Health series "Profiles of Hope." The final subsection of the speaker resource portion of the site, "To Grow," provides two PDF files about use of language (avoiding negative labels and use of jargon) and tools for following up with organizations after giving a presentation to learn if it met their needs. The organization and labels within the Tools for Speakers section are not intuitive and it might be easier for speakers to find resources if a short descriptive menu were provided on the opening page of this subsection.

  The remaining two overarching sections of Speak Our Minds are a "contact" section allowing users to submit a question about a speakers bureau or apply to be included on the site, and an "about" section that contains information identifying the purpose of the site as fighting the stigma of mental illness, describing the funding source as CalMHSA and Prop 63, and linking to EachMindMatters.org.
- **Target audience**: community and other organizations seeking mental health speakers, mental health speakers

- **Links and search**: The site does not provide a separate search function, but the speakers bureau interface is itself a search through the website materials relevant for finding a speaker.
- **Registration**: The materials on the site are accessible without registration.

Each Mind Matters (Runyon Saltzman & Einhorn)

- **Website URL:** http://www.eachmindmatters.org
- **General description of the website**: Each Mind Matters was originally intended as a venue for distributing the Runyon Saltzman & Einhorn documentary "A New State of Mind: Ending the Stigma of Mental Illness" beyond its original air date (see Informational Resources section for more on the documentary), and for providing associated materials and messages as part of Runyon Saltzman & Einhorn's social marketing campaign. The website's role has recently been expanded so that it now serves as the central hub for disseminating CalMHSA's efforts to stakeholders and the general public. The top half of the homepage features a graphic illustrating the message that each mind matters with figures of a dozen or so people, and invites visitors to view the documentary. This alternates with a photo of a crowd of people and an invitation for visitors to "join California's mental health movement." The bottom half of the page (and the menu at the top) provides news and information, links to the Each Mind Matters blog, a place to pledge support to the Each Mind Matters movement, a page that links to ReachOut.com, SuicideIsPreventable.org, and Speak Our Minds, and a tool kit of materials (digital banners and buttons) users can access if they want to help promote the documentary and its messages. Links are also provided at the bottom of the page for those in crisis and those seeking care. There also is a draw-down index at the top of the page, which includes the "Great Minds Gallery." This section currently contains the documentary, documentary trailer, and promotional items, but is intended to later house additional personal stories of mental health challenges and recovery. The lime green theme of the Each Mind Matters campaign is incorporated throughout.
- **Target audience**: General public
- **Links and Search**: The site does not include a search function.
- **Registration**: The materials on the site are accessible without registration.

ReachOut (Runyon Saltzman & Einhorn)

- **Website URL:** http://www.reachout.com/forums
- **General description of the website**: ReachOut is a well-established website that existed prior to the CalMHSA SDR initiative, operated by Inspire, USA. Through Runyon Saltzman & Einhorn, CalMHSA funded the addition of the ReachOut Forum, a venue for youth and young adults ages 14 to 24 to discuss personal issues and mental health challenges and provide one another support. The Forum is moderated by trained peer supporters who also post to the website. Visitor comments are also moderated prior to posting to ensure unsafe content is not included. The top half of the main page for the Forum provides links for visitors to register, introduce themselves on the Forum, and view a video describing community guidelines. Scrolling down reveals four subsections: a Welcome section, a Regular Forum Features section, a Discuss Specific Mental Health Issues and Topics section (broken into a set of 15 forums for discussing topics including anxiety, substance use, relationships, and school pressures), and a Lounge for discussing lighter topics, playing games, and posting art work. The Forum page display is available

in English and Spanish. There is a Spanish language forum that includes subforums on the 15 mental health topics included in the English language forum. There is a brief menu across the top of the Forum homepage. The top of the Forum page also prominently includes the telephone number for the Boys Town National Hotline under the banner "Need Help Now?" and clicking on this banner links the visitor to a list of phone numbers and websites for dealing with issues from suicide to child abuse. A wide variety of informational and other resources is also available on the ReachOut homepage.

- **Target audience**: General public ages 14 to 24 years
- **Links and search**: The site includes a search function.
- **Registration**: Visitors can view discussions and materials without registration, but registration is required to reply or post to the site.

United Advocates for Children and Families

- **Website URL:** http://www.uacf4hope.org/
- **General description of the website**: The United Advocates for Children and Families homepage features a large graphic featuring "Gateway to Hope" branding and information about United Advocates for Children and Families' services, followed by several links to events and educational opportunities, newsletter subscription, and membership information, as well as links to several surveys. At the top of each page on the site, users are presented with several menu options, including "Home," "Meet UACF," "UACF Institute," "Programs & Partners," "Resources," "News," and "Support UACF." "Meet UACF" features information on United Advocates for Children and Families' mission, history, and staffing. "UACF Institute" provides more information on a number of United Advocates for Children and Families services, such as Parent Leadership Training and the United Advocates for Children and Families Hope Line. "Programs & Partners" lists partnerships with other organizations, including CalMHSA. "Resources" provides lists of resources on a large number of topics (e.g., crisis lines, mental health advocates). "News" features newsletters and press releases. "Support UACF" provides opportunities to donate to United Advocates for Children and Families. The entire website is available in a large number of languages ranging from Afrikaans to Yiddish.
- **Target audience**: The target audience is broad, and resources are available for families of children with mental health challenges, as well as the general public.
- **Links and search**: Many links on the site are internal and take users to other sections of the United Advocates for Children and Families site. Several links to external sites appear, most notably under the "Programs & Partners" and "Resources" sections. There is a search function at the top of the page.
- **Registration**: The materials on the site are accessible without registration.

Appendix F. Definition of Website Analytics Terms

Table F. Website Analytics Definition of Terms

Term	Definition
Site Visits	A session on or group of interactions with a particular domain (website) within a given time period. This could include multiple page views or file downloads. For Google Analytics, this time period resets after 30 minutes of user inactivity or at midnight.
Page Views	The successful loading of a webpage by a web browser. Manually refreshing a page after loading it would log two page views. Site visits often contain multiple page views.
Traffic Sources	The origin of traffic to a website, i.e., how a user or users arrived at a particular website.
Direct	Accounts for traffic from users who typed the URL directly into their browsers, clicked bookmarked links, (untagged) links from email messages, or links from document files such as PDFs or Microsoft Word files that do not track clicks. (May also account for users whose networks or browsers do not share their traffic source information.
Referral	Accounts for traffic originating from other websites.
Keyword Search	Accounts for traffic originating from search engine results pages, such as a Google result page. (does not count "paid" search, which displays websites on search engine results pages when users type specific keywords—for a fee.)
Pages/Visit	Also called "page depth," this metric counts the number of pages viewed during a site visit.
Bounce Rate	The percentage of visits in which the "entry" and "exit" pages are one and the same. (i.e., the user leaves the site after landing on a page, without navigating further into the site)
Metro Area	Google Analytics derives users' geographic location from mapping IP addresses. Mobile devices and virtual private networks (VPNs) can compromise accuracy and many users' network and/or browser configurations will result in no data of this sort transferred to Google Analytics (i.e., "(not set)"). However, geographic data still provides inferential data on where users reside. Google Analytics "metro" areas are essentially designated marketing areas, providing a practical level of detail between the "region" (i.e., states) and "city" levels.

Appendix G. General Population Survey Items

Table G. General Population Survey Items

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
1a	A person with mental illness is a danger to others.	5-point scale; Strongly agree/Moderately agree/Neither agree nor disagree/Moderately disagree/Strongly disagree	Dangerousness		CDC 2006 HealthStyles Survey	(Kobau et al., 2010)
1b	A person with mental illness can eventually recover.	5-point scale; Strongly agree/Moderately agree/Neither agree nor disagree/Moderately disagree/Strongly disagree	Recovery		CDC 2006 HealthStyles Survey	(Kobau et al., 2010)
1c	People who have had a mental illness are never going to be able to contribute much to society	5-point scale; Strongly agree/Moderately agree/Neither agree nor disagree/Moderately disagree/Strongly disagree	Social Inclusion; Recovery		Like Minds, Like Mine	(Brown and Wyllie, 2010)
1d	People with mental illness experience high levels of prejudice and discrimination	5-point scale; Strongly agree/Moderately agree/Neither agree nor disagree/Moderately disagree/Stron	Beliefs about experienced stigma and discrimination		See Change	(Brown, 2012)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		gly disagree				
2	Do you agree or disagree with the following statement: "People who have a mental illness should not be allowed to buy a gun"?	2-point scale; Agree/Disagree	Attitudes toward gun ownership		Original	
3	How many people in the United States, out of 100, will have a mental health problem at some point in their lives?	Open ended response ranging from 0–100	Mental Health Knowledge; Normative Beliefs		See Me, Scotland (2008)	(Mehta et al., 2009)
4	Of the people who see a professional for serious emotional problems, what percent do you think are helped? You may choose any number between 0 and 100 for your answer.	Open ended response ranging from 0–100	Beliefs about treatment efficacy		NCS/NCS-R	(Mojtabai, 2007)
5a	Would you be willing or unwilling to move next door to a person who has a serious mental illness?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely unwilling	Social Distance		GSS 1996, 2006	(Pescosolido et al., 2010)
5b	Would you be willing or unwilling to spend an evening socializing with a person with someone who has a serious mental illness?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely	Social Distance		GSS 1996, 2006	(Pescosolido et al., 2010)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		unwilling				
5c	Would you be willing or unwilling to start working closely on a job with someone who has a serious mental illness?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely unwilling	Social Distance		GSS 1996, 2006	(Pescosolido et al., 2010)
5x	Do you have a family member who has had a mental health problem?	Yes/No	Participant has a family member with mental illness		See Change	(Brown, 2012)
6	If someone in your family had a mental illness, would you feel ashamed if people know about it?	4 point scale; Yes, ashamed – Definitely/Yes, ashamed – Probably/No, not ashamed – Probably/No, not ashamed – Definitely	Social Distance		World Psychiatric Association's Global Campaign to Fight Stigma and Discrimination Because of Schizophrenia – Open the Doors (items used in Canada and Germany)	(Gaebel et al., 2008; Stuart and Arboleda-Florez, 2001)
7	In the past 12 months did you interact with or have personal contacts with anyone with a mental health problem?	Yes/No (if yes, ask questions 8, 9, 10)	Contact with people with mental illness		MHFA	(Jorm et al., 2010; Kitchener and Jorm, 2004; Morawska et al., 2013)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
8	Thinking about the last time this happened...To what extent did you provide emotional support, like listening to or helping to calm him or her – not at all, a little, some or a lot?	4 point scale; Not at all, a little, some, a lot	Support provision		MHFA	(Jorm et al., 2010)
9	To what extent did you help that person seek professional help – not at all, a little, some or a lot?	4 point scale; Not at all, a little, some, a lot	Support provision		MHFA	(Jorm et al., 2010)
10	To what extent did you help that person to connect with community resources, others with mental health problems, or friends or family to obtain support – not at all, a little, some or a lot?	4 point scale; Not at all, a little, some, a lot	Support provision		MHFA	(Jorm et al., 2010)
11a	In the past 12 months, would you say that you made sure someone with a mental illness was treated with respect	Yes/No	SDR Behavior		Like Minds, Like Mine	(Brown and Wyllie, 2010)
11b	In the past 12 months, would you say that you acted in ways that were supportive of people with mental illness	Yes/No	SDR Behavior		Like Minds, Like Mine	(Brown and Wyllie, 2010)
11x	Have you (yourself) ever had a mental health problem?	Yes/No (if yes, ask question 11y)	Participant personal history of mental illness		MHFA	(Kitchener and Jorm, 2004)
11y	Have you ever sought treatment for a mental health problem?	Yes/No	Treatment seeking		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
12	If you had a serious emotional problem, would you go for professional help?	4-point scale; Yes, Definitely go/Yes, Probably go/No, Probably not go/No, Definitely not go	Treatment seeking		NCS/NCS-R	(Mojtabai, 2007)
12x	Imagine that you had a problem that needed to be treated by a mental health professional. Would you delay seeking treatment for fear of letting others know about your mental health problem?	4 point scale; Yes, Definitely go/Yes, Probably go/No, Probably not/No, Definitely not	Concealment		See Change	(Brown, 2012)
13	Would you try to hide your mental health problem from family or friends?	4 point scale; Yes, Definitely go/Yes, Probably go/No, Probably not/No, Definitely not	Concealment		See Change	(Brown, 2012)
14	Would you try to hide your mental health problem from co-workers or classmates?	4 point scale; Yes, Definitely go/Yes, Probably go/No, Probably not/No, Definitely not	Concealment; Treatment delay		See Change	(Brown, 2012)
15	Now I'm going to describe a person – let's call (him John) (her Mary). After I read a description of (him/her) I'll ask you some questions about how you think and feel about (him/her). Again, there are no	No response required	Introduction to vignettes		GSS 1996, 2006	(Pescosolido et al., 2010)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	right or wrong answers. I'm only interested in what you think of (John/Mary).					
15a	(John/Mary) is an adult (man/woman). For the past two weeks (he/she) has been feeling really down. (He/She) wakes up in the morning with a flat heavy feeling that sticks with (him/her) all day long. (He/She) isn't enjoying things the way (he/she) normally would. In fact nothing gives (him/her) pleasure. Even when good things happen, they don't seem to make (John/Mary) happy. (He/She) pushes on through (his/her) days, but it is really hard. The smallest tasks are difficult to accomplish. (He/She) finds it hard to concentrate on anything. (He/She) feels out of energy and out of steam. And even though (John/Mary/) feels tired, when night comes (he/she) can't go to sleep. (John/Mary) feels pretty worthless, and very discouraged. (John's/Mary's/) family has noticed	No response required	Depression vignette		GSS 1996, 2006	(Pescosolido et al., 2010)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	that (he/she) hasn't been (himself/herself) for about the last month and that (he/she) has pulled away from them. (John/Mary/) just doesn't feel like talking.					
15b	(John/Mary) is an adult (man/woman). Up until a year ago, life was pretty okay for (John/Mary). But then, things started to change. (He/She) thought that people around (him/her) were making disapproving comments, and talking behind (his/her) back. (John/Mary) was convinced that people were spying on (him/her) and that they could hear what (he/she) was thinking. (John/Mary) lost (his/her) drive to participate in (his/her) usual work and family activities and retreated to (his/her) home, eventually spending most of (his/her) day in (his/her) room. (John/Mary) was hearing voices even though no one else was around. These voices told (him/her) what do and what to think. (He/She) has been living this way for six months.	No response required	Schizophrenia vignette		GSS 1996, 2006	(Pescosolido et al., 2010)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
15c	(John/Mary) is a 30-year old who lives with (his wife/her husband). Recently (his/her) sleep has been disturbed and (he/she) has been having vivid nightmares. (He/She) has been increasingly irritable, and can't understand why. (He/She) has also been jumpy, on edge and tending to avoid going out, even to see friends. Previously (he/she) had been highly sociable. These things started happening around two months ago. (John/Mary) owns a shop with (his wife/her husband) and has found work difficult since a man armed with a knife attempted to rob the cash register while (he/she) was working four months ago. (He/She) sees the intruder's face clearly in (his/her) nightmares. (He/She) refuses to talk about what happened and (his wife/her husband) says (she/he) feels that (he/she) is shutting (her/him) out.	No response required	PTSD vignette		MHFA	(Reavley and Jorm, 2011)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
16a	Would you be willing or unwilling to move next door to [NAME]?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely unwilling	Social distance		GSS 1996, 2006	(Pescosolido et al., 2010)
16b	Would you be willing or unwilling to spend an evening socializing with [NAME]?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely unwilling	Social distance		GSS 1996, 2006	(Pescosolido et al., 2010)
16c	Would you be willing or unwilling to start working closely on a job with [NAME]?	4 point scale; Definitely willing/Probably willing/Probably unwilling/ Definitely unwilling	Social distance		GSS 1996, 2006	(Pescosolido et al., 2010)
17a	In your opinion, is it likely that [NAME] will eventually recover?	4 point scale; Very likely/Somewhat likely/Not very likely/Not at all likely	Recovery		CDC 2006 HealthStyles Survey	(Kobau et al., 2010)
17b	Is it likely that [NAME] would do something violent to other people?	4 point scale; Very likely/Somewhat likely/Not very likely/Not at all likely	Violence		GSS 1996, 2006	(Pescosolido et al., 2010)
18a	I know how I could be supportive of people with mental illness if I wanted to be	5-point scale; Strongly agree/Moderately agree/Neither agree nor disagree/Moderately disagree/Stron	Support Provision; Self-Efficacy		Like Minds, Like Mine	(Brown and Wyllie, 2010)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		gly disagree				
18b	I want to be as supportive as possible to people experiencing a mental illness	5-point scale; Strongly agree/Moderately agree/Neither agree nor disagree/Moderately disagree/Strongly disagree	Support provision		Like Minds, Like Mine	Brown and Wyllie, 2010)
18c	I can recognize the signs that someone may be dealing with a mental health problem or crisis	5-point scale; Strongly agree/Moderately agree/Neither agree nor disagree/Moderately disagree/Strongly disagree	Knowledge of symptoms		Original	
18d	People are generally caring and sympathetic to people with mental illness	5-point scale; Strongly agree/Moderately agree/Neither agree nor disagree/Moderately disagree/Strongly disagree	Societal beliefs		CDC 2006 HealthStyles Survey; BRFSS 2007	(Kobau et al., 2010)
18e	I plan to take action to prevent discrimination against people with mental illness	5-point scale; Strongly agree/Moderately agree/Neither agree nor disagree/Moderately	SDR Behavioral intentions		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
		disagree/Strongly disagree				
19(1)a	You can't stop people who really want to commit suicide	True/False/DK	Knowledge and beliefs about suicide	Knowledge and attitudes about suicide		Adapted from (Shaffer et al., 1991)
19(1)b	There are always warning signs before a suicide	True/False/DK	Knowledge and beliefs about suicide	Knowledge and attitudes about suicide		Adapted from (Shaffer et al., 1991)
19(1)c	Talking about suicide can cause suicide	True/False/DK	Knowledge and beliefs about suicide	Knowledge and attitudes about suicide		Adapted from (Shaffer et al., 1991)
19(1)d	Women are more at risk of suicide than men	True/False/DK	Knowledge and beliefs about suicide	Knowledge and attitudes about suicide		Adapted from (Shaffer et al., 1991)
19(1)e	Suicide is usually preventable	True/False/DK	Knowledge and beliefs about suicide	Knowledge and attitudes about suicide		Adapted from (Shaffer et al., 1991)
19(2)a	I feel comfortable discussing suicide with my friends, colleagues and family members	7 point scale (1=strongly agree; 7=strongly disagree), DK	Efficacy	Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in		Adapted from (Wyman et al., 2008) (Tompkins and Witt, 2009)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
				schools		
19(2)b	I am aware of the warning signs of suicide	7 point scale (1=strongly agree; 7=strongly disagree), DK	Efficacy	Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools		Adapted from (Wyman et al., 2008) (Tompkins and Witt, 2009)
19(2)c	I can recognize friends, colleagues, and family members contemplating suicide by the way they behave	7 point scale (1=strongly agree; 7=strongly disagree), DK	Efficacy	Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools		Adapted from (Wyman et al., 2008) (Tompkins and Witt, 2009)
19(2)d	I don't have the necessary skills to talk about suicide with a friend, colleague, or family member	7 point scale (1=strongly agree; 7=strongly disagree), DK	Efficacy	Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in		Adapted from (Wyman et al., 2008) (Tompkins and Witt, 2009)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
				schools		
19(2)e	If a person's words and/or behaviors suggest the possibility of suicide, I would ask directly if he or she is thinking about suicide	7 point scale (1=strongly agree; 7=strongly disagree), DK	Efficacy	Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools		Adapted from (Wyman et al., 2008) (Tompkins and Witt, 2009)
19(2)f	I have easy access to the educational or resource materials I need to learn about helping a person at risk of suicide	7 point scale (1=strongly agree; 7=strongly disagree), DK	Efficacy	Survey of knowledge, attitudes, & gatekeeper behaviors for suicide prevention in schools		Adapted from (Wyman et al., 2008) (Tompkins and Witt, 2009)
19(2)g	I can identify the places or people where I should refer somebody thinking about suicide	7 point scale (1=strongly agree; 7=strongly disagree); DK	Efficacy	Survey of knowledge, attitudes, & gatekeeper behaviors for suicide		Adapted from (Wyman et al., 2008) (Tompkins and Witt, 2009)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
				prevention in schools		
19(3)	Have you personally known anyone who has died by suicide?	Yes/No/DK	Exposure to suicide			
20	During the past 12 months, have you...					
20a	watched a documentary on television about mental illness	Yes/No	Exposure to CalMHSA-funded activities or services		Original	
20b	seen an advertisement or promotion for a television documentary about mental illness	Yes/No	Exposure to CalMHSA-funded activities or services		Original	
20c	watched some other movie or television show in which a character had a mental illness	Yes/No	Exposure to CalMHSA-funded activities or services		Original	
20d	seen or heard a news story about mental illness	Yes/No	Exposure to CalMHSA-funded activities or services		Original	
20e	seen or heard a news story about someone who committed suicide	Yes/No	Exposure to CalMHSA-funded activities or services		Original	
20f	seen or heard a news story about suicide rates or how many	Yes/No	Exposure to CalMHSA-		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	suicides there are		funded activities or services			
20g	attended an educational presentation or training either in person or online about mental illness	Yes/No	Exposure to CalMHSA-funded activities or services		Original	
20h	received documents or other informational resources related to mental illness through the mail, email, online or in person	Yes/No	Exposure to CalMHSA-funded activities or services		Original	
20i	as part of your profession, received professional advice about how to discuss mental illness or interact with people who have mental illness	Yes/No	Exposure to CalMHSA-funded activities or services		Original	
20j	visited the website "ReachOut dot com"	Yes/No	Exposure to CalMHSA-funded activities or services		Original	
20k	seen or heard an advertisement for "ReachOut dot com"	Yes/No (If yes, go to 21)	Exposure to CalMHSA-funded activities or services		Original	
20l	During the past 12 months, have you… seen or heard an advertisement for a suicide hotline or crisis line	Yes/No/DK (If Yes, immediately ask 24)	Exposure to CalMHSA-funded activities or services			Adapted from (Farrelly et al., 2002)
20m	seen or heard an advertisement about recognizing the warning signs of	Yes/No/DK	Exposure to CalMHSA-funded			Adapted from (Farrelly et al., 2002)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	suicide		activities or services			
20n	seen or heard an advertisement that has the slogan "Know the Signs" or "Pain isn't Always Obvious" or "Suicide is Preventable"	Yes/No/DK (If Yes, immediately ask 28)	Exposure to CalMHSA-funded activities or services			Adapted from (Farrelly et al., 2002)
20o	visited the website "Suicide is Preventable dot org"	Yes/No/DK (If Yes, immediately ask 36)	Exposure to CalMHSA-funded website			Adapted from (Farrelly et al., 2002)
20p	seen or heard an advertisement for suicide prevention with the website "Suicide is Preventable dot org"	Yes/No/DK (If Yes, immediately ask 32)	Exposure to CalMHSA-funded activities or services			Adapted from (Farrelly et al., 2002)
20q	seen or heard the slogan or catch phrase "Each Mind Matters"	Yes/No	Exposure to CalMHSA-funded website		Original	
20r	visited the website "Each Mind Matters dot org"	Yes/No	Exposure to CalMHSA-funded website		Original	
20s	visited another website to get information about mental illness	Yes/No	Exposure to CalMHSA-funded activities or services		Original	
21	In the past 30 days, about how many times did you see or hear an advertisement for "ReachOut dot com"? Just use your best estimate	Open-ended (if > 0, go to 22 and 23)	Frequency of exposure to CalMHSA-funded activities or services		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
22	How much attention did you pay to these advertisements on a scale of 1–7, where 1 means no attention and 7 means very close attention?	7 point numeric scale with 1 = no attention and 7 = very close attention	Attention to advertisements for CalMHSA-funded activities or services		Original	
23	How much did you like these advertisements on a scale of 1–7, where 1 means not at all and 7 means a lot?	7 point numeric scale with 1 = not at all and 7 = a lot	Liking of advertisements for to CalMHSA-funded activities or services		Original	
24	Was this within the past 6 months	Yes/No/DK (If Yes, ask 25)	Exposure to CalMHSA-funded activities or services			Adapted from (Farrelly et al., 2002)
25	In the past month, about how many times have you seen or heard an advertisement for a suicide hotline or crisis line?	Open ended (if >0 ask 26 and 27)	Frequency of exposure to CalMHSA-funded activities or services			Adapted from (Farrelly et al., 2002)
26	How much attention did you pay to these advertisements on a scale of 1–7, where 1 means no attention and 7 means very close attention?	7 point numeric scale with 1 = no attention and 7 = very close attention	Attention to advertisements for CalMHSA-funded activities or services			Adapted from (Beaudoin, 2009)
27	How much did you like these advertisements on a scale of 1–7, where 1 means not at all and 7 means a lot?	7 point numeric scale with 1 = not at all and 7 = a lot	Attention to advertisements for CalMHSA-funded activities or services			

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
28	Was this within the past 6 months?	Yes/No/DK (If Yes, ask 29)	Exposure to CalMHSA-funded activities or services			
29	In the past month, about how many times have you seen or heard an advertisement with any of these slogans?	Open ended (if >0 ask 30 and 31)	Frequency of exposure to CalMHSA-funded activities or services			Adapted from (Farrelly et al., 2002).
30	How much attention did you pay to these advertisements on a scale of 1–7, where 1 means no attention and 7 means very close attention?	7 point numeric scale with 1 = no attention and 7 = very close attention	Attention to advertisements for CalMHSA-funded activities or services			Adapted from (Beaudoin, 2009)
31	How much did you like these advertisements on a scale of 1–7, where 1 means not at all and 7 means a lot?	7 point numeric scale with 1 = not at all and 7 = a lot	Attention to advertisements for CalMHSA-funded activities or services			
32	Was this within the past 6 months?	Yes/No/DK (If Yes, ask 33)	Exposure to CalMHSA-funded activities or services			Adapted from (Farrelly et al., 2002).
33	In the past month, about how many times have you seen or heard an advertisement for suicide prevention with the website "Suicide is Preventable dot org"?	Open ended (if >0 ask 34 and 35)	Frequency of exposure to CalMHSA-funded activities or services			Adapted from (Farrelly et al., 2002).

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
34	How much attention did you pay to these advertisements on a scale of 1–7, where 1 means no attention and 7 means very close attention?	7 point numeric scale with 1 = no attention and 7 = very close attention	Attention to advertisements for CalMHSA-funded activities or services			Adapted from (Beaudoin, 2009)
35	How much did you like these advertisements on a scale of 1–7, where 1 means not at all and 7 means a lot?	7 point numeric scale with 1 = not at all and 7 = a lot	Attention to advertisements for CalMHSA-funded activities or services			
36	Was this within the past 6 months?	Yes/No/DK (If Yes, ask 37)	Exposure to CalMHSA-funded activities or services			Adapted from (Farrelly et al., 2002)
37	How helpful was the "Suicide is Preventable dot org" website in providing you the information you were looking for on a scale of 1–7, where 1 means not helpful and 7 means very helpful?	7 point numeric scale with 1 = not helpful and 7 = very helpful	Helpfulness of CalMHSA-funded activities or services			
38a	If you were seeking help for suicidal thoughts and knew where to find resources to help, how likely would you be to… visit a website for information about suicide risk or resources	4 point numeric scale with 1 = very likely and 4 = very unlikely	Likelihood of resource utilization			Based on (Tompkins and Witt, 2009)
38b	call a crisis line or hotline for advice about suicide risk and	4 point numeric scale with 1 = very	Likelihood of resource utilization			Based on (Tompkins and Witt, 2009)

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	resources	likely and 4 = very unlikely				
38c	text a crisis text line for advice about suicide risk and resources	4 point numeric scale with 1 = very likely and 4 = very unlikely	Likelihood of resource utilization			Based on (Tompkins and Witt, 2009)
38d	go to a web-based crisis chat service for advice about suicide risk and resources	4 point numeric scale with 1 = very likely and 4 = very unlikely	Likelihood of resource utilization			Based on (Tompkins and Witt, 2009)
38e	seek help face-to-face from family members or friends	4 point numeric scale with 1 = very likely and 4 = very unlikely	Likelihood of resource utilization			Based on (Tompkins and Witt, 2009)
38f	seek help face-to-face from a counselor or other mental health professional	4 point numeric scale with 1 = very likely and 4 = very unlikely	Likelihood of resource utilization			Based on (Tompkins and Witt, 2009)
39	Do you currently attend a college or university in California, either full or part-time?	Yes, No, Refuse	Eligibility			
40a	My school emphasizes helping students with their social, emotional, and mental health problems.	5-point scale, Strongly Disagree to Strongly Agree	School Climate; short-term outcome		CSCS	(WestED, 2013e)
40b	My school provides quality counseling or other ways to help students with social, emotional, or mental health needs.	5-point scale, Strongly Disagree to Strongly Agree	School Climate; short-term outcome		CSCS	(WestED, 2013e)
41	Are you the parent or legal guardian of anyone who attends a K–12 school, or a college or university in California? (IF	Yes child in K–12 school, Yes child in a CA college/university, Yes child	Eligibility			

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	YES, ASK:) Is that a K–12 school, a college or university, or both?	in both, No neither, Refused				
42	How many of your children attend a K–12 school in California?	Write in Number	Eligibility			
43	We would like to ask a few questions about only one of your children who attend a K–12 school in California. As a way to select which child to discuss, please tell me the first name of the child who has had the most recent birthday. (IF REFUSED, ASK:) What are his or her initials?	Write in	Eligibility			
43a	How many children have the same birthday?	Write in Number	Eligibility			
43b	What are the names of each child? (If refused, ask:) What are the initials of each child?	Write in	Eligibility			
44a	The school emphasizes helping students with their social, emotional, and mental health problems.	5-point scale, Strongly Disagree to Strongly Agree	School Climate; short-term outcome		CSCS	(WestED, 2013e)
44b	The school provides quality counseling or other ways to help students with social, emotional, or mental health needs.	5-point scale, Strongly Disagree to Strongly Agree	School Climate; short-term outcome		CSCS	(WestED, 2013e)
45	How many of your children attend a	Write in Number	Eligibility			

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	college or university in California?					
46	We would like to ask a few questions about only one of your children who attend a college or university in California. As a way to select which child to discuss, please tell me the first name of the child who has had the most recent birthday. (IF REFUSED, ASK:) What are his or her initials?	Write in	Eligibility			
46a	How many children have the same birthday?	Write in Number	Eligibility			
46b	What are the names of each child? (If refused, ask:) What are the initials of each child?	Write in	Eligibility			
47a	The school emphasizes helping students with their social, emotional, and behavioral problems.	5-point scale, Strongly Disagree to Strongly Agree	School Climate; short-term outcome		CSCS	(WestED, 2013e)
47b	The school provides quality counseling or other ways to help students with social, emotional, or behavioral needs.	5-point scale, Strongly Disagree to Strongly Agree	School Climate; short-term outcome		CSCS	(WestED, 2013e)
48a	What is your age, please?	Open-ended	Respondent age		Original	
49	Because it is sometimes difficult to determine over the phone, am I speaking to a man or woman?	Male; Female	Respondent gender		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
50	What is the highest year of school that you have finished and gotten credit for?	8th grade or less; Some high school/did not graduate; High school graduate; Trade/vocational school; 1–2 years of college; 3–4 years of college/(did not graduate); College graduate (B.A./B.S.); 5–6 years of college; Master's degree; Graduate work past Master's/MD/Ph.D.	Respondent educational attainment		Original	
51	What is your current employment status? That is, are you currently employed for wages, self-employed, looking for work, retired, a homemaker or keeping house, disabled or a student in school?	Employed for wages; Self-employed; Looking for work; Retired; Homemaker/keeping house; Disabled; Student (If employed for wages, ask items 52a-g)	Respondent employment status		Original	
52a	Do you work as a teacher at any level?	Yes/No	CalMHSA-targeted gatekeeper role		Original	
52b	Do you make hiring or firing decisions as part of your job?	Yes/No	CalMHSA-targeted gatekeeper role		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
52c	Do you work for a mental health service provider or in the mental health field?	Yes/No	CalMHSA-targeted gatekeeper role		Original	
52d	Do you work for a health provider, hospital or in some other health-related field?	Yes/No	CalMHSA-targeted gatekeeper role		Original	
52e	Do you work in any part of the criminal justice system, such as in law enforcement or corrections?	Yes/No	CalMHSA-targeted gatekeeper role		Original	
52f	Do you work as a journalist, a reporter, in media or in the entertainment field?	Yes/No	CalMHSA-targeted gatekeeper role		Original	
52g	Are you an elected official or a policymaker in government?	Yes/No	CalMHSA-targeted gatekeeper role		Original	
53	Are you a landlord or property manager?	Yes/No	CalMHSA-targeted gatekeeper role		Original	
54	Do you currently have a leadership role in a community or civic organization, such as the Chamber of Commerce, United Way or PTA?	Yes/No	CalMHSA-targeted gatekeeper role		Original	
55	Did you ever serve on active duty in the Armed Forces of the United States?	Yes/No	Respondent veteran status			
56	Do you happen to have any guns, rifles, pistols or other firearms in your home?	Yes/No/DK	Gun ownership		Original	(Pew Research Center, 2012)
57	Which of the following best describes your present	Married; Not married but live with	Respondent marital status		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
	marital status – married, not married but live with a partner, separated, divorced, widowed, or never married?	partner; Separated; Divorced; Widowed; Never married				
58	Are there any children under age 18 living in your household, including babies?	Yes/No	Respondent – minors in the home		Original	
59	For classification purposes, would you describe yourself as homosexual (if male, say: or gay) (if female, say: gay or lesbian), heterosexual or straight, bisexual, or something else?	Homosexual/Gay; Heterosexual/Straight; Bisexual; Something else	Respondent sexual orientation		Original	
60	Are you a Latino or of Hispanic origin, such as Mexican-American, Latin American, South American, or Spanish-American?	Yes/No	Respondent Latino ethnicity		Original	
61	We'd like to know what your racial background is. Are you White or Caucasian, Black or African-American, Asian, Native Hawaiian, other Pacific Islander, American Indian, Alaskan native, or a member of another race? (answer can be a multiple)	White/Caucasian; Black/African-American; Asian; Native Hawaiian; Other Pacific Islander; American Indian; Alaskan Native; Other (specify)	Respondent race		Original	
62	Do you speak any languages other than (English) (Spanish) at home with your family and friends?	Yes/No (if yes, go to 63)	Respondent languages spoken		Original	

Item #	Scale item (item wording)	Response scale	Construct measured	Original source		
				Title of Scale	Source (e.g., GSS, See Change)	Citation
63	What other languages do you speak at home other than (English) (Spanish)? (answer can be a multiple)	English; Spanish; Mandarin; Cantonese; Korean; Vietnamese; Tagalog; Hindi; Russian; Armenian; Japanese; Hmong; Other (specify)	Respondent languages spoken		Original	
64	What is your ZIP code?	Open-ended	Respondent zip code		Original	
65	We don't want to know your exact income, but just roughly, could you tell me if your annual household income before taxes is under $20,000, $20,000 to $40,000, $40,000 to $60,000, $60,000 to $80,000, $80,000 to $100,000 or $100,000 or more?	Under $20,000; $20,000-$40,000; $40,000-$60,000; $60,000-$80,000; $80,000-$100,000; $100,000 or more	Respondent income		Original	