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Training Outcomes from the Samaritans of New York Suicide Awareness and Prevention Programme Among Community- and School-based Staff

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Abstract

The Samaritans of New York public education suicide awareness and prevention programme is designed to train lay and professional staff on effective suicide prevention practices and how to “befriend” a person in crisis. However, little is known about the individual level characteristics of staff who attend these trainings. Community- and school-based staff (N=365) completed pre and post training measures of self-efficacy regarding their knowledge about suicide and suicide prevention and their ability to intervene with individuals at risk for suicide. Results indicate increased self-efficacy after suicide prevention training ($M=3.7$, $SD=0.6$) than before ($M=3.3$, $SD=0.7$) ($t=-13.24$, $p<.05$). Trainees with higher levels of education and previous contact with suicidal individuals were significantly more likely to indicate gains in self-efficacy after training.

Keywords

suicide; suicide prevention; training; evaluation; Samaritans

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Suicide is a prevalent public health issue worldwide (Mann *et al.*, 2005). Over the last 45 years, worldwide suicide rates have increased by 60% with an estimated 1,000,000 lives lost to suicide each year (Goldsmith *et al.*, 2002; WHO, 2008). In response to this problem, preventing suicide has become a global initiative at both the societal and individual levels. One such global approach to suicide prevention is the collective effort of the 193 member countries of the World Health Organisation (WHO). In 1999, the WHO developed the Suicide Prevention (SUPRE) initiative that focuses on global suicide awareness, surveillance, education, and support. Central elements within these programmes is the development of awareness that suicide is a public health problem and providing support and referrals to an individual in distress prior to a suicidal act. While organisations such as the WHO focus on suicide prevention at the broader societal levels, it is the staff of human service organisations and schools within local communities that focus on providing immediate suicide prevention services at the individual and family level.

Suicide prevention consists of several domains, of which public awareness and education are two key aspects (Goldsmith *et al.*, 2002; Mann *et al.*, 2005). Two forms of public awareness and education that focus on training include programmes that seek to educate the public and those that train other informal (e.g. lay staff) and formal helpers (e.g. social workers) called gatekeepers. Public education focuses training on the citizenry of a population and is aimed at improving recognition of suicide and promoting help-seeking through improved understanding of the causes and risk factors for suicidal behaviour. Gatekeeper education focuses on training in the community and within formal organisations to staff that have actual or perceived “frontline” contact and a help-giving role with potentially vulnerable populations. Given this role, many social workers act as gatekeepers in community agencies and schools working to identify at-risk individuals and direct them to appropriate clinical services for further assessment, intervention, and treatment.

Two recent international reviews focus on these forms of public awareness and education for preventing suicide (Dumesnil and Verger, 2009; Isaac *et al.*, 2009). Among studies focusing on public awareness campaigns regarding suicide or depression, 15 programmes in eight countries produced modest gains in the citizenry having knowledge of and improved attitudes about these mental health conditions (Dumesnil and Verger, 2009). In the review of gatekeeper training studies, 13 studies in seven countries reported positive improvements in the trainees' knowledge of, and attitudes about, suicide and suicide prevention, intervention skills, and service access, with six of the studies finding significant decreases in the suicide rates and in the number of suicide attempts and deaths by suicide (Isaac *et al.*, 2009). Conceptually, these types of studies are similar in that the focus is on the individuals who are exposed to suicide prevention information and how after being educated, the focus is on individual level changes in their knowledge, attitudes, skills, and behaviours. However, little is known about the individual level characteristics of the citizens or trainees before exposure to suicide prevention information.

In the few studies that have included analysis on the characteristics of the individuals trained in suicide prevention, the training outcomes have generally been positive. In the international suicide prevention literature, one study has focused on a novel form of suicide prevention and intervention abilities training for adults (Tierney, 1994), while others focus

on gatekeeper training to increase effectiveness of health care interventions (Botega *et al.*, 2007), and to facilitate increased access to care for diverse populations (Capp *et al.*, 2001). A recent randomised trial found significant increases in post training queries about suicide among primarily school personnel with natural gatekeeper roles rather than control participants (Wyman *et al.*, 2008). Other uncontrolled suicide prevention training studies with staff from a department of psychiatry (Cross *et al.*, 2007), community based veteran counselling centres (Matthieu *et al.*, 2008), medical centres for veterans (Matthieu *et al.*, 2009), and human resource staff (Matthieu *et al.*, 2006), found significant increases in perceived knowledge and perceived abilities of trainees immediately after training.

However, to our knowledge, few suicide prevention training studies focus specifically on the pre training characteristics and the relationship of these individual level characteristics with immediate training outcomes. To examine this, we focus on one particular agency and program, the Samaritans of New York's public education suicide awareness and prevention programme. The Samaritans is a suicide prevention organisation that focuses primarily on providing crisis hotline services in its 400 centres throughout the world (Holding, 1975; Barraclough and Jennings, 1977; Jennings *et al.*, 1978; Greer and Anderson, 1979; Hall and Schlosar, 1995; King and Frost, 2005), with many of the branches also offering additional programmes and services in their communities (e.g., suicide survivor support groups and workshops on suicide). The present study aims to examine baseline and post training differences among participants who attended this training programme regarding their knowledge about suicide and suicide prevention and their ability to intervene with individuals at risk for suicide. In addition, this study will also explore the influence of previous exposure to suicidal individuals as well as other predictors on gains subsequent to training.

Methods

Sampling Strategy

The Samaritans of New York's Public Education Suicide Awareness and Prevention training programmes were offered at no cost to clinical and non-clinical employees. Agencies contract directly with the Samaritans of New York for delivery of the programme. Once contracted, agency staff are required to attend the training. In selecting participants, supervisors considered the staff member's job description, population served, interest, and availability to attend the training. For this study, the contracting agencies consisted of a large metropolitan public school systems' division of student support personnel and a cross-section of health and human service community-based organisations serving at-risk populations of every age, background, and culture who believed their frontline staff could benefit from training. Two training sessions were conducted in 2005 for 558 individuals; 365 individuals completed the pre and post training surveys for a response rate of 65% for this study.

Curriculum and Training Procedures

The Samaritans of New York has created and refined a professional public education curriculum in New York City based on its 25-year history of training hotline volunteers in

the befriending model (which has been described previously in Matthieu *et al.* (2006); however a brief overview is provided. Based on the suicide prevention hotline curriculum, the Samaritans of New York developed a 3-hour public education suicide awareness and prevention programme to train lay and professional staff on effective suicide prevention practices and how to “befriend” a person in crisis. This training programme is based on teaching the skills, tools, and techniques associated with *active listening*, an approach to communication that puts the focus on the person being “helped,” what he/she thinks, feels and is going through (Rogers, 1961). A second component of the training curricula is *sensitivity training* which addresses the fears, beliefs, assumptions, presumptions, biases, judgments and personal values that impact and, often, impede, how lay and professional caregivers approach and respond to those at risk (Ross, 2005), and applies it to conditions such as depression, alcohol and substance abuse, eating disorders, as well as community violence and sexual identity issues. Next participants are introduced to the *Samaritans Communications Model*. The combination of non-judgmental behaviour, active listening and adherence to the communications model is abbreviated in the phrase “befriending” (Ross, 2005).

The 3 hour training included an overview of the Samaritans befriending model, current research knowledge and statistics about suicide, myths and stigma surrounding suicide, warning signs, intervention and risk assessment techniques as well as the keys to effective active listening, the sensitivity component, and developing a site specific suicide prevention plan. The training took place in a large training room, the set-up of the seating designed for easy access, good sight lines, and close proximity between presenter and participants. The training was delivered by one of the authors according to well-established training procedures that have been used to train over 30,000 community mental health care providers in the New York City metropolitan area.

Surveys

All information collected for this study was secondary data having been collected by the Samaritans of New York staff as a part of their routine practice of training evaluations using self-administered pre and post training feedback surveys. Use of the anonymised survey data analysed for this study was approved by the Institutional Review Board at Washington University in St. Louis. The survey data included four major sections.

Demographics—Participants were asked about their age, gender, and race/ethnicity. Education was assessed with participants reporting their “Highest degree attained” with response options that included: 1 (junior high), 2 (high school), 3 (trade/vocational school), 4 (1-2 years college), 5 (3-4 years college), 6 (5+ years of college), 7 (graduate school). Experience was assessed by participants reporting their “Total years of experience in education, mental or public health, and/or social service field?” with response options that included: 1 (0 years), 2 (1-5), 3 (6-10), 4 (11-15), 5 (16-20), 6 (21-25), 7 (more than 25 years). Clinical interviewing experience was assessed as a yes or no question. A final question assessed the “Quality of previous training received in suicide and suicide prevention?” with the response options of very low, low, medium, high, and very high.

Satisfaction—Participants were asked to respond to nine items about their level of satisfaction with the Samaritans of New York public education suicide awareness and prevention training using a 5-point scale (not at all, 2, 3, 4, definitely). For example, participants rated the likelihood that they would recommend the training to others. An exploratory factor analysis indicated that the nine items loaded onto a single factor. The 9 item scale had good reliability (Cronbach's $\alpha=0.81$)

Exposure—Participants were asked the questions: “Have you had contact with someone you thought was suicidal? If yes, did you talk to them about your concerns? If yes, did you ask if they were thinking about killing themselves?” Response options were collapsed into yes and no. Participants were also asked, “Do you know someone who has died by suicide?” (yes/no) and “If yes, how do you know this person? (check all that apply)” with the response options: family, friend, co-worker, patient, neighbour, acquaintance, and other.

Self-Efficacy—Participants were asked to respond to ten items about their perceived knowledge of suicide and suicide prevention (five items) and their ability to intervene with someone at risk for suicide (five items) using a 5-point scale (very low, low, medium, high, very high). This 10-item measure of self-efficacy was slightly modified from a measure previously used and tested in a number of suicide prevention training studies (Matthieu *et al.*, 2006; Cross *et al.*, 2007; Matthieu *et al.*, 2008; Wyman *et al.*, 2008). Items included knowledge about local resources for help with suicide and participants' ability to ask someone if they were thinking about suicide. In this study, an exploratory factor analysis indicated that the 10 items loaded onto a single factor. The 10-item scale had good reliability (Cronbach's $\alpha=0.94$).

Data Analysis

Data were entered into SPSS for analysis. Pre training surveys attained information on baseline self-efficacy, whereas post-training surveys assessed the participants' self-efficacy and satisfaction with the training. Differences in sample mean pre and post training scores were analysed using paired t-tests to determine the amount of change from pre to post on appropriate survey items. Bivariate correlation analyses were performed in order to assess the association of the dependent variable (self-efficacy) with age, gender, race, education, total years experience, contact with someone thought to be suicidal, and knowing someone who has died by suicide. Bivariate correlations were also computed for two exposure variables (“Do you know someone who has died by suicide?” and “Have you had contact with someone you thought was suicidal?”) with demographic factors. The associated tests of significance were computed using Pearson's r for continuous variables and Spearman's for ordinal/ranked variables. The Bonferroni corrected alpha levels required for significance were .007 (.05/7) and .008 (.05/6). Finally, two linear regressions were estimated to identify factors predictive of pre and post training self-efficacy scores. Missing data on some survey items led to sample size differences for some variables.

Demographic Characteristics

As noted in Table 1, the sample was predominately middle-aged females with over 70% of the sample coming from diverse racial and ethnic backgrounds. In addition, the sample was

highly educated and experienced; over half of the sample reported their highest education level was graduate school and nearly half of the sample had over 11 years of experience in education, mental or public health, or a social service field. Finally, participants were asked about the quality of previous suicide prevention training, with less than a quarter of participants reported having received training that was rated at high or very high quality.

Results

Associations with Exposure to Suicide and Self-efficacy

In order to examine associations of exposure to suicidal individuals with the demographic characteristics of the sample, bivariate correlations were computed for the exposure items: “Have you ever had contact with someone you thought was suicidal?” and “Do you know someone who has died by suicide?” Results indicate that having contact with suicidal individuals was significantly correlated with education, years of experience, clinical interviewing, and the quality of previous suicide prevention training, whereas knowing someone who died by suicide was significantly correlated with age, gender, and years of experience (see Table 1).

Bivariate correlations were also computed for the dependent variable self-efficacy (data not shown) at pre and post training with demographic and exposure to suicide items. Pre training self-efficacy was significantly correlated with contact with someone thought to be suicidal ($r=.513$), education ($r=.383$), total years of experience ($r=.232$), and knowing someone who has died by suicide ($r=.159$). Post training self-efficacy was also significantly correlated with contact with someone thought to be suicidal ($r=.380$), education ($r=.313$), total years of experience ($r=.217$), and knowing someone who has died by suicide ($r=.178$).

In terms of exposure to suicidal individuals, 85% of the sample had previous contact with someone thought to be suicidal (see Table 2) while fewer respondents reported knowing someone who had died by suicide (52.1%). Among the participants who did know someone who died by suicide, nearly three quarters knew the person in a personal capacity (e.g. family, friend, acquaintance, or neighbour) versus fewer than 20% with whom the participant had a professional relationship (e.g., patient or co-worker).

Pre and Post Training Self-efficacy

The differences between pre-training and post-training scores of self-efficacy were examined using a paired t-test. Table 3 provides descriptive data on the item level results. Across all items, participants' scores increased from pre to post, with the overall results indicating that at post training, participants' mean score on self-efficacy ($M=3.7$, $SD=0.6$) was significantly higher than at pre-training ($M=3.3$, $SD=0.7$) ($t = -13.24$; $p<.05$). The magnitude of this change from pre to post is of a medium effect size (.6) using Cohen's d (Cohen, 1988).

Satisfaction

As noted in Table 4, while slightly more than half of the sample reported that the Samaritans' training related to issues they deal with frequently in their work setting, a significant majority of the sample reported that after the training they perceived an increased ability to

assess for suicide risk (78.5%), and increased comfort in talking about suicide (78.0%). In addition, over 90% of the sample believed that the information presented in the training was important, and would recommend the training to others.

Predictors of Self-Efficacy

In Table 5, we present results of two linear regressions conducted to determine the predictive value of the following variables on pre and post training self-efficacy scores: age, gender, race, education, total years of experience, contact with someone thought to be suicidal, and knowing someone who has died by suicide. Model 1 indicated that age, gender, race, education, total years experience, contact with someone thought to be suicidal, and knowing someone who has died by suicide were significantly related to pre training mean self-efficacy scores $F(7,319)=20.8, p<.001$, with these variables accounting for 30% of the variance in the model. Model 2 indicated that the predictor variables were also significantly related to post training mean self-efficacy scores $F(7, 284)= 9.7, p<.001$, with these variables accounting for 17% of the variance.

Discussion

This study examined pre training characteristics and satisfaction among community and school based staff who attended The Samaritans of New York Suicide Awareness and Prevention training programme. Findings reveal that the Samaritans of New York's programme had a significant impact on increasing participants' self-efficacy specifically regarding their knowledge about suicide and suicide prevention and their ability to intervene with individuals at risk for suicide. In a review of the training research literature, self-efficacy is related to the transfer of training to actual behaviour change (Salas and Cannon-Bowers, 2001). This is important given that the overall programme impact, measured at a medium effect size (.6) indicates that trainees had significant gains in suicide related knowledge and enhanced abilities to intervene from attending this brief training. However, research is needed on the translation of training effectiveness into actual practice behaviours that are sustained over time.

Study findings also reveal that the strongest significant relationship at the bivariate level, having contact with someone thought to be suicidal ($r=.513$), was related to pre-training self-efficacy. The regression model also indicated that higher levels of education and previous contact with someone thought to be suicidal influenced pre training self-efficacy, and both variables significantly influenced self-efficacy at post training. These consistent findings could be due to higher levels of knowledge and abilities at baseline and modest, but statistically significant gains in terms of self-efficacy after participating in suicide awareness and prevention training. Previous studies have focused on overall gains in suicide prevention knowledge and efficacy from Samaritans training (Matthieu *et al.*, 2006), yet results from this study suggest that suicide prevention training programmes might want to consider individual level factors such as education and suicide exposure among the characteristics that may also significantly influence trainees' abilities to recognise and to assist individuals in distress.

Finally, high levels of exposure to suicidal individuals and satisfaction with the training suggest that the programme is well received and beneficial to lay and frontline professional staff who work in community and school based settings. In comparison to previous literature and given their job role in these settings, the percentage of trainees exposed to suicidal individuals (85%) and trainees who know someone who died by suicide (52%), are slightly higher than a previous Samaritan study conducted with front line customer service providers for an urban city's department of human resources, at 65% and 48%, respectively (Matthieu *et al.*, 2006). In terms of satisfaction, nearly 80% of the trainees prior to the training felt that their previous suicide prevention training had been of very low to medium quality. However, after attending the Samaritans training, over 90% of the trainees would recommend the training to others noting that the information presented was important.

Limitations

It is important to keep in mind that this study has several limitations, including possible selection bias of participants. This sample is comprised of trainees in New York with data only obtained from those who self-selected to participate. Nonetheless, the large sample size and the diversity of the sample are noteworthy. It should be mentioned that Cohen's d is often considered a crude estimate of the effect size and should be interpreted with caution (McGrath and Meyer, 2006). However, in this study it provided a useful benchmark for detecting differences from pre to post training. Additionally, results of the bivariate analysis should be interpreted cautiously, as the strength of the relationships ranged from very small (e.g., $r=.159$) to only moderate ($r=.513$) in this study. Another limitation is that due to the lack of a control group, results cannot be definitively attributed to the training programme. Finally, these data are based on a three-hour, education training delivered with a live trainer to employees from diverse community- and school-based settings. The generalisability of these findings to other populations, service settings, and to other training methods is limited.

Implications

The Samaritans, as an international suicide prevention organisation, provides local community based services such as crisis hotlines via its 400 centres throughout the world. Given the worldwide crisis in deaths by suicide and the recent findings from the WHO World Mental Health Surveys that again confirm the link between mental disorders and suicidal behaviour, there continues to be a need for community based suicide prevention services in both developed and developing countries (Nock *et al.*, 2009). However, additional findings from this WHO study also suggest that some suicidal individuals do not have symptoms of a mental disorder; therefore focusing efforts only on training health professionals to screen and to treat mental illnesses is not enough.

Public awareness campaigns and gatekeeper training programmes can both utilise a public health approach to broaden the reach of suicide prevention education to the general public and to all frontline formal and informal helpers. As formally trained mental health professionals, social workers in community and school based settings have a foundational skill set, that with enhanced specialised training in suicide prevention, can aid them in identifying and referring suicidal individuals to appropriate clinical services for further assessment, intervention, and treatment. In addition, enhanced specialised training would

provide an additional opportunity to expose social workers to new and cutting edge empirical research on suicide and suicide prevention research. New research findings, particularly those regarding risk and protective factors among at-risk groups (e.g., minority youth, elders with comorbid conditions), can greatly enhance best practices in assessment and treatment. Social workers can also improve access to suicide prevention education by participating in public awareness initiatives, state or regional planning efforts, or delivering evidence based trainings on suicide prevention in their local communities and in work settings. Finally, policy initiatives are needed to support and to sustain routine and mandatory workplace suicide awareness and prevention educational programmes and empirically supported best practices.

However, research is limited on the long term impact of individuals exposed to either form of suicide prevention information (Dumesnil *et al.*, 2009; Isaac *et al.*, 2009). While gatekeeper training has been studied in one RCT in school settings (Wyman *et al.*, 2008), more rigorous studies are needed to determine the immediate and longitudinal impact of training on gatekeepers' referral patterns in diverse community settings. Increased attention on the methodology of referral making to include the access to, and coordination of, care, and tracking of referred individuals by trained gatekeepers needs to be fully elucidated. Finally, rigorous research is needed to demonstrate whether public awareness and gatekeeper training programmes increase help seeking behaviours of at risk individuals and ultimately have an impact on decreasing the rates of suicide ideation, attempts, and deaths by suicide.

Conclusions

The Samaritans of New York's suicide awareness and prevention programme can improve the ability of lay and professional staff's use of effective suicide prevention practices. As higher education and previous contact with someone who participants thought to be suicidal remained significant indicators of self-efficacy following training, it is important to focus suicide prevention training efforts on participants with front line responsibilities who are in a position to identify and to refer individuals in distress or a suicidal crisis to appropriate clinical services. Social workers, once trained, are distinctly poised in community and school based settings to provide timely and effective suicide prevention services.

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Table 1

Sample characteristics of suicide awareness and prevention trainees (N=365).

Demographics	Total (N=365)	
Age²	Range 19-66 (M=41.5, SD=11.0)	
Gender²	N	%
Males	94	26.5
Females	261	73.5
Race/Ethnicity		
African American	94	26.9
Asian American	18	5.2
Caucasian	99	28.4
Hispanic/Latino	99	28.4
Other	39	11.2
Highest Education¹		
High School	18	5.1
Trade/Vocational School	1	0.3
1-2 years of college	50	14.1
3-4 years of college	51	14.4
5+ years of college	39	11.0
Graduate School	196	55.2
Years of Experience^{* 1,2}		
0	6	1.6
1-5	77	21.1
6-10	88	24.1
11-15	59	16.2
16-20	52	14.2
21-25	32	8.8
More than 25	39	10.7
Clinical Interviewing¹		
Yes	128	38.4
Quality of previous suicide prevention training^{1**}		
Very Low	40	11.3
Low	82	23.1
Medium	154	43.4
High	66	18.6
Very High	13	3.6

* Total Years experience in education, mental or public health, or social service field.

** Quality of training in suicide prevention prior to Samaritans of New York Public Education Training.

¹ Significantly correlated with contact with someone thought to be suicidal at the .008 Bonferroni corrected alpha level.

² Significantly correlated with know someone who has died by suicide at the .008 Bonferroni corrected alpha level.

Table 2

Previous exposure of trainees to individuals at risk for suicide (N=365).

<u>Item</u>	<u>Total</u>		
	N	Freq.	%
<u>Contact with someone you thought was suicidal?</u>			
Yes	354	301	85.0
<u>If yes, did you talk to them about your concerns?</u>			
Yes	312	288	92.3
<u>If yes, did you ask if they were thinking about killing themselves?</u>			
Yes	304	272	89.5
<u>Do you know anyone who has died by suicide?</u>			
Yes	355	185	52.1
<u>How do you know this person? *</u>			
Family	229	62	27.1
Friend	229	55	24.0
Co-worker	229	17	7.4
Patient	229	25	10.9
Neighbour	229	19	8.3
Acquaintance	229	34	14.8
Other	229	66	28.8

* Participants were asked to check all that apply.

Table 3

Pre and post training scores on self-efficacy (N=365).

Item	Pre-Test M (SD)	Post-Test M (SD)	t	df	Sig.
Knowledge of facts concerning suicide prevention	3.0 (.9)	3.7 (.7)	-13.0	329	0.0
Knowledge of warning signs of suicide	3.1 (.9)	3.7 (.7)	-11.7	329	0.0
Knowledge of how to ask someone about suicide	3.1 (.9)	3.7 (.8)	-12.9	329	0.0
Knowledge of how to get help for someone	3.4 (.9)	3.7 (.8)	-6.2	331	0.0
Knowledge of information on local resources for help with suicide	3.0 (1.0)	3.6 (.8)	-11.1	330	0.0
Ability to ask someone if they are thinking about suicide	3.3 (1.0)	3.7 (.8)	-7.9	331	0.0
Ability to persuade someone to get help	3.3 (.8)	3.7 (.8)	-8.4	331	0.0
Appropriateness of asking someone who may be at risk about suicide.	3.6 (1.1)	3.9 (.8)	-6.2	318	0.0
Likelihood you will ask someone who appears to be at risk if they are thinking about suicide	3.7 (1.0)	4.0 (.9)	-5.9	317	0.0
Level of understanding about suicide and suicide prevention	3.2 (.8)	3.7 (.8)	-10.8	320	0.0

Note: Scale ranged from very low, low, medium, high, to very high.

Table 4

Satisfaction assessed after the suicide awareness and prevention training (N=365).

Item	Total (N=365)	
	Score of 4 or higher	
	%	Mean (SD)
Important information was presented	94.8	4.6 (0.6)
Would recommend to others	93.9	4.6 (0.7)
Written materials were helpful and supportive	87.6	4.4 (0.7)
Encouraged re-examination of my preconceptions	79.1	4.2 (1.0)
Increased ability to assess suicide risk	78.5	4.1 (1.0)
Increased comfort in talking about suicide	78.0	4.1 (1.0)
Devoted sufficient time to expand my awareness	73.5	4.0 (1.0)
Dealt with issues I deal with frequently	59.2	3.7 (1.1)
Explored issues that made me uncomfortable *	49.2	3.3 (1.6)

* Reverse coded to reflect the percentage of participants that were comfortable in the training.

Note. Scale ranged from *not at all* to *definitely* on a five-point Likert scale.

Table 5

Linear Regression: Predictors of Pre and Post Training Self-Efficacy (N=365).

Dependent Variables	Beta (β)	SE	95% CI		T-Test	Sig.
			Lower	Upper		
Pre-Training						
Model 1						
Constant	1.6	0.2	1.2	2.1	6.7	0.0
Age	-0.0	0.0	-0.1	0.1	-0.4	0.7
Gender	0.1	0.1	-0.1	0.3	1.2	0.2
Race/Ethnicity	-0.0	0.1	-0.2	0.1	-0.4	0.7
Education	0.1	0.0	0.1	0.2	4.1	0.0
Total years experience	0.1	0.0	-0.0	0.1	1.9	0.1
Contact with someone they thought was suicidal	0.3	0.0	0.2	0.4	8.0	0.0
Know someone who has died by suicide	0.1	0.1	-0.1	0.2	1.0	0.3
Post-Training						
Model 2						
Constant	2.7	0.2	2.2	3.1	11.5	0.0
Age	0.0	0.0	-0.1	0.1	0.2	0.8
Gender	0.1	0.1	-0.1	0.2	0.4	0.7
Race/Ethnicity	-0.1	0.1	-0.2	0.1	-1.1	0.3
Education	0.1	0.0	0.0	0.1	3.2	0.0
Total years experience	0.0	0.0	-0.0	0.1	1.6	0.1
Contact with someone they thought was suicidal	0.1	0.0	0.1	0.2	4.2	0.0
Know someone who has died by suicide	0.1	0.1	-0.0	0.2	1.4	0.2

Notes: Variables in linear regressions were scaled as follows: Age (continuous scale), Gender (Female=1, Male=0), Race/Ethnicity (Caucasian=0, All other=1), Highest Education (ordinal scale of highest education attained 1=junior high, 2= high school, 3=trade vocational school, 4= 1-2 years of college, 5= 3-4 years of college, 6= 5+ years of college, 7= graduate school), Total Years Experience (ordinal scale of total years of experience 1= 0, 2= 1-5, 3=6-10, 4=11-15, 5=16-20, 6= 21-25, 7=more than 25). Contact with someone they thought was suicidal and know someone who has died by suicide (dichotomous scales 1= yes, 0=no).