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Evaluating the California Mental Health Services Authority's Suicide Prevention Initiative

Year 1 Findings

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Sponsored by the California Mental Health Services Authority (CalMHSA)



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Introduction

When California voters passed Proposition 63—the Mental Health Services Act (MHSA)—in 2004, the state and counties were mandated to develop an approach to provide prevention and early intervention (PEI) services and education for Californians who experience mental illness and who access services in the state. In turn, the California Mental Health Services Authority (CalMHSA)—a coalition of California counties designed to provide economic and administrative support to mental health service delivery—formed the PEI Implementation Program, based on extensive recommendations from a large number of stakeholders statewide. The program aims to reduce adverse outcomes for Californians who experience mental illness, through three strategic initiatives that develop statewide capacities and interventions 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 to meet the initiative’s goals.

In 2011, the RAND Corporation was asked to design and implement a three-year statewide evaluation of the three major CalMHSA PEI initiatives—stigma and discrimination reduction (SDR), suicide prevention (SP), and student mental health (SMH)—at three levels: the level of each program partner implementing activities, the level of the strategic initiative (i.e., SDR, SP, and SMH), and the statewide level. 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/online resources
4. training and education programs
5. social marketing/media campaigns and interventions to influence media production
6. hotline and “warmline” operations providing crisis support and basic social support, respectively.

The evaluation aims to

- assess the activities implemented and the resources created by PEI program partners
- evaluate program partners’ progress toward meeting statewide goals and objectives
- evaluate program outcomes, including
 - targeted program capacities and their reach (e.g., provision of services)
 - short-term outcomes (e.g., attitudes and knowledge about mental illness)
 - long-term outcomes (e.g., reduced suicide, reduced discrimination, and improved student performance).

Key objectives are to establish baselines and community indicators, conduct thorough program evaluations, identify innovative programs for replication, and promote continuous quality improvement efforts. Also, the evaluation team has been providing technical assistance to program partners to help them develop their capability to help evaluate the initiatives.

This report summarizes Year 1 findings from the ongoing evaluation of many newly developed programmatic activities focused on the SP Initiative. While many efforts have been implemented in the past year, others are still in development with plans for implementation over the coming year. Thus, the evaluation is ongoing, and the results are preliminary.

What Is the Suicide Prevention Initiative Doing?

There are nine Program Partners involved in the SP Initiative:

- AdEase
- Didi Hirsch Psychiatric Services (Didi Hirsch)
- Family Service Agency of the Central Coast (FSACC)
- Family Services Agency of Marin (FSA Marin)
- Institute on Aging (IoA)
- Kings View
- LivingWorks
- San Francisco Suicide Prevention (SFSP)
- Transitions Mental Health Association (TMHA).

In addition, there are a number of subcontracts, including:

- AdEase subcontracts with Education Development Center and Your Social Marketer, Inc.
- Didi Hirsch Psychiatric Services subcontract with Optum Health; Helpline, Inc.; SFSP; Wellspace Health; Kern County Mental Health; and Community Health Improvement Partners
- IoA subcontracts with Wellspace Health
- SFSP subcontracts with Contra Costa Crisis Center, Star Vista, and Santa Clara County
- TMHA subcontract with Kern County and Mental Wellness Center of Santa Barbara
- LivingWorks subcontracts with Didi Hirsch, Wellspace Health, and Contra Costa Crisis Center
- FSA Marin subcontracts with the Sonoma County Indian Health Project.

Didi Hirsch serves as a program partner for both California Suicide Prevention Network (CSPN) activities and Regional and Local Suicide Prevention Capacity Building activities.

The SP program partners are focusing on four of the six core activities listed above: (1) networking and collaboration; (2) trainings or educational programs for a broad range of audiences; (3) social marketing; and (4) hotlines (to include web- and text-based crisis response services) and warmlines (a warmline is a noncrisis telephone service that provides encouragement and support to persons in need). In particular, many program partners are working to expand or enhance crisis counseling through hotlines, warmlines, Internet-based “chat,” or text messaging. Also, one of the crisis centers is funded to strengthen the network of crisis centers in the state and enhance best practices for suicide prevention; one program partner is focusing on social marketing related to suicide prevention; and another program partner is conducting trainings to increase the cadre of Californians taught how to identify and intervene

with people at risk of suicide. This document summarizes the development of program capacities across these activities in Year 1 of the evaluation. In addition to evaluating progress across the key activities, we also analyzed suicide fatalities in California to establish baselines against which later suicide rates may be compared, and those results are presented here.

What Is the Status of the Evaluation of Suicide Prevention Program Partner Activities?

Table 1 provides an overview of the status of SP Program Partner activities in a variety of different categories, summarizing the information contained in this report, and noting information that will be forthcoming in the future.

Table 1. Status of Suicide Prevention Evaluation Activities

Program Partners	Describe Program Partner Capacities	Monitor Reach to Target Audiences	Evaluate Short-Term Outcomes
Networks and Collaborations			
Didi Hirsch (program 1)	<p>This Report: Summary of key activities of the California Statewide Suicide Prevention Network (CSPN).</p> <p>Future: Summary of the number and nature of collaboratively developed materials, resources, and practices.</p>	<p>Future: Data on the level of collaboration.</p>	<p>Future: Analysis of the degree to which networks and collaborations meet objectives (e.g., coordinating services, sharing resources, enhancing cultural competence).</p>
Training and Educational Programs			
LivingWorks	<p>This Report: Description of training activities (i.e., Applied Suicide Intervention Skills Training [ASIST] and safeTALK).</p> <p>Future: Descriptive analysis of data from live observations of ASIST workshops to determine how ASIST trainings are delivered in community settings.</p>	<p>This Report: Data on number of ASIST and safeTALK trainings administered and number of participants, by region of California.</p> <p>Demographic data on ASIST training participants, based on post-training surveys.</p> <p>Future: Additional data on the number of trainings administered, number of participants, and their demographics, for both ASIST and safeTALK trainings.</p>	<p>This Report: Preliminary data on satisfaction with ASIST trainings, change in intervention self-efficacy, and change in behavioral intentions.</p> <p>Future: Additional data on post-training changes in self-efficacy and behavioral intentions.</p>
Media/Social Marketing Campaigns and Interventions			
AdEase	<p>This Report: Status of select facets of AdEase’s social marketing campaign, including description of activities and materials.</p> <p>Future: Detailed review of social marketing materials. Sustainability analysis.</p>	<p>This Report: Web analytic data provided for website associated with campaign.</p> <p>Future: Additional web analytic data; data on the reach and frequency of message exposure.</p>	<p>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 a media advocacy toolkit. 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.</p>
Hotline/Warmline Operations			
Didi Hirsch (program 2); FSACC; FSA Marin; Institute on Aging; Kings View; SF Suicide Prevention; TMHA; Kern County; WellSpace Health	<p>This Report: Description of activities, including summary of new crisis and mental health support services (i.e., warmlines) developed and accreditation activities/status.</p> <p>Future: Updated description of new and expanded services and accreditation activities/status.</p>	<p>This Report: Data on volume of calls or chats received is reported for hotlines and warmlines.</p> <p>Future: Additional data on call/chat volume.</p>	<p>Future: Data from live monitoring of hotline calls (i.e., call content, quality).</p>

What Have Suicide Prevention Initiative Program Partners Accomplished So Far?

Networking and Collaboration

In terms of networking and collaboration activities, the evaluation is *assessing whether such activities are enhancing the capacity of crisis response in the community and increasing access to such capacity and the provision of high-quality care*. Within this core activity, the focus of the evaluation itself is 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. A principal CSPN activity is developing crisis line data metrics that all participating crisis lines will collect in the future. CSPN 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 best practices for each region. Didi Hirsch will publicize these best practices by promoting their publication and aim to have it included on the Suicide Prevention Resource Center's national suicide Best Practices Registry website.

In Year 1, CSPN made progress on developing common crisis line data metrics, selecting the six metrics agreed to by each of the 10 partnering crisis lines: (1) call volume, (2) demographics (e.g., gender, age of caller), (3) reason for call (e.g., suicidal content, abuse and violence), (4) risk (e.g., suicidal intent), (5) follow-up (is the caller willing to receive a follow-up call), and (6) caller satisfaction (perceived helpfulness of call). CSPN also developed a training manual for all participants to use in training their crisis call workers, providing a data capture template for collecting the metrics, and reporting the metrics in a common format. The common metric project is currently developing and testing a caller satisfaction survey for use by all partnering crisis lines. CSPN has 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 formed six regional planning committees and convened meetings in all regions. In these meetings, committee members discussed suicide-related data pertinent to their regions using a CSPN-created data 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 (i.e., behavioral health representatives in each county) calls in the fourth quarter (Q4) of 2012–2013 to select a final priority area for each region and then begin forming best practices workgroups to ultimately develop components and apply to the Best Practices Registry.

Trainings and Educational Programs

RAND's evaluation focus is on *assessing whether the trainings or educational programs are increasing awareness and improving identification of individuals at risk*. The evaluation focuses on LivingWorks—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, with Didi Hirsch, Contra Costa Crisis Center, and WellSpace Health, and target a broad statewide population. The trainings to be administered include:

- **safeTALK**—a three-hour suicide alertness workshop for “anyone over the age of 15 to identify persons with thoughts of suicide and connect them to suicide first aid resources”
- **Applied Suicide Intervention Skills Training (ASIST)**—an intensive two-day suicide intervention workshop for people “who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide”
- **eSuicide Talk**—a 60-minute, online version of LivingWorks’ “Suicide Talk” training that provides more general knowledge training for community audiences.

LivingWorks also uses two training-for-trainers (T4T) programs to credential trainers who conduct safeTALK and ASIST workshops:

- **safeTALK T4T**—a two-day training that teaches skills to deliver the safeTALK workshop
- **ASIST T4T**—a 5-day course that does the same for the ASIST workshop.

Our focus in this evaluation year is on evaluating seven of 29 LivingWorks ASIST trainings in terms of their reach, the fidelity of their implementation, and some of their short-term outcomes. To assess implementation procedures, we 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. Ultimately, based on the allocated budget and resources, we opted to observe a convenience sample of five CalMHSA-sponsored trainings hosted by community organizations. All five observations were not completed at the time of this report, so results of the fidelity monitoring will be presented in the next report.

To assess other implementation issues and short-term outcomes, we administered post-training surveys beginning in January 2013, and we present these data for the seven ASIST trainings. The survey measures participant demographics, demographic characteristics of the clients the participant works with or wants to work with, training content, training satisfaction, and gatekeeper efficacy (feelings of competence and capability in serving as gatekeepers to identify, intervene, and refer people at risk of suicide to help), as well as training behaviors.

Reach of LivingWorks Training

Table 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 safeTALK T4T across all three years of its contract period.

Table 2. CalMHSA-Sponsored LivingWorks Trainings, by California Region, Q2 and Q3 of Year 1

Training Program	Number of Trainings (by Region)				3-Year Goal	Number of Participants (by Region)				3-Year Goal
	South	Central	North	Total		South	Central	North	Total	
ASIST T4T	1	1	2	4	10	20	24	47	91	240
safeTALK T4T	1	0	0	1	10	10	0	0	10	100
ASIST workshops	12	1	16	29*	NA	217	7	309	533**	NA
safeTALK workshops	4	3	7	14	NA	62	46	89	197	NA

* Two workshops were located outside of California that are not included in this total.

** One workshop is missing the number of participants.

In Quarter 3, LivingWorks released esuicideTALK to select trainer coordinators, staff, and county liaisons for their review. LivingWorks also increased the total number of paid individual user licenses of esuicideTALK from 2,900 to 16,100 to help outreach, especially in rural communities, and to introduce the concept of suicide awareness in areas that do not have a fully developed training plan.

Training Implementation and Preliminary Data on Changes in Short-Term Outcomes

One of the key training implementation issues addressed was how satisfied trainees were with their training. Participants attending the seven ASIST workshops for which the survey was administered reported that their training was helpful, met the needs of diverse students, and was important to attend.

Two short-term outcomes assessed preliminarily through the surveys for those attending the seven ASIST workshops were intervention self-efficacy and intervention behavioral intentions. In both cases, the survey sought to understand how participant skills changed before and immediately after the training. Participants attending the seven ASIST workshops reported significant changes in overall self-efficacy (e.g., feeling prepared to help and having confidence in helping a person at-risk, comfort discussing suicide with others) after training. Participants reported significant changes in their overall behavioral intentions after completion of the training; such changes included the willingness of participants to ask clients directly about whether they were thinking about suicide and whether participants would be willing to intervene with someone they thought was at risk for suicide.

Media/Social Marketing Campaigns and Interventions to Influence Media Production

The first-year evaluation focused on AdEase’s contract for “Know the Signs,” a statewide social marketing campaign. Table 3 highlights the three goals of the Know the Signs campaign and what is being done to achieve the goals.

Table 3. “Know the Signs” Campaign Goals and Efforts to Accomplish Them

Goal	How the Goal Is Being Supported
Prepare more Californians to prevent suicide by encouraging them to know the warning signs for suicide, offer support to persons at risk, and reach out to local resources	<ul style="list-style-type: none"> • Providing materials aimed at helpers (not those at risk)—emphasis on helpers of middle-aged white men and young Latinas. • Providing technical assistance—including one-on-one support, webinars, and toolkits, such as how to use social media for suicide prevention—to all counties (with a specific emphasis on rural counties) to implement the campaign locally
Educate the news media and others about how to more safely report on suicide and safe and effective messaging for suicide	<ul style="list-style-type: none"> • Providing media outreach toolkit, media forums, and safe messaging trainings
Ensure that those at risk of suicide are aware of resources and helped by others	<ul style="list-style-type: none"> • Creating statewide “Directing Change” high school student video contest • Developing materials promoting local suicide prevention crisis lines • Developing toolkit 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 select facets of AdEase’s social marketing campaign—in particular, the materials being developed and the dissemination (reach) of those materials. Our assessment highlights some, but not all, of the social marketing capacities built.

AdEase 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 toolkit, a manual on how to use social media for suicide prevention, and the Know the Signs campaign website www.suicideispreventable.org (the Spanish language version is www.elsuicidiodoesprevenible.org), which includes a local resource page for each county. To ensure that counties benefit from the resources and to enhance the reach of the campaign throughout the state, 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 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. A literature review identified unique considerations and recommendations for developing suicide prevention

messaging campaigns. It recommended that all campaign messaging adhere to the “Safe and Effective Messaging for Suicide Prevention” recommendations provided by the Suicide Prevention Resource Center and suggested that campaign developers should “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.” It also recommended that the campaign consider how messages may affect vulnerable populations, in addition to the general population. The campaign was further informed by 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 that asked about knowledge, attitudes, and beliefs among over 2,000 respondents representative of the state and every county. The RDD survey 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 Prizim 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. Between July 2012 and March 2013, AdEase conducted two rounds of focus groups with urban and rural residents (three in Spanish) to test the statewide campaign materials.

Table 4 highlights key campaign materials and activities that occurred within the evaluation period.

Table 4. Key “Know the Signs” Materials and Activities That Have Occurred in Each

Material	Activities That Have Taken Place
<p>“Your Voice Counts” web forum—facilitates information sharing among suicide prevention stakeholders across the state</p>	<ul style="list-style-type: none"> • Used to get input on the development of the campaign • Provides central place (under “Resource Center”) for counties and partners to download and access all campaign materials and maintained with ongoing post and site enhancements • Has (as of December 2012) 453 members representing 50 counties in California and 74 different resources • Established regional suicide prevention network workgroups and other workgroups through partnership with Didi Hirsch
<p>“Directing Change” contest—contest for high school students, asking them to create 60-second videos focused on either preventing suicide or eliminating mental health stigma</p>	<ul style="list-style-type: none"> • Launched in August 2012 as collaborative activity between the three initiatives • Promoted contest and, in partnership with California Department of Education, mailed approximately 5,000 copies of promotional materials to every school district and high school • Worked with more than 300 after school and community-based programs to promote the contest <ul style="list-style-type: none"> ◦ Promoted through program partners to high school students, teachers, and counselors across the state • Received 371 submissions, representing 922 students from 142 schools • Announced winners in May 2013

Material	Activities That Have Taken Place
The Know the Signs website, www.suicideispreventable.org	<ul style="list-style-type: none"> • Issued press release to promote website—launched in September 2012 • Working to optimize the site for mobile devices • Currently in conversations with LivingWorks to adapt ASIST video for posting on website • Compiling metrics that track engagement on site to be released as separate, AdEase document
Media advocacy toolkit (“Making Headlines: Guide to Working with the Media”) —contains campaign talking points, recommendations for reporting on suicide, tip sheet for prepping people with personal stories about suicide for a media interview, and three topical template articles	<ul style="list-style-type: none"> • Informed by analysis of media coverage of suicides during the last six months of 2011 to determine how much coverage consistently adhered to the “Recommendations for Reporting on Suicide.” • Made available on the “Your Voice Counts” forum • Disseminated at eight media forums with media representatives, county government agencies, schools, and local organizations in Los Angeles, San Diego, Stockton, Butte, and Sacramento between September 2012 and April 2013
Spanish Campaign Materials	<ul style="list-style-type: none"> • Developed in Spanish in partnership with a bilingual communications consultant from Adindefinitum and reviewed by focus groups and a Spanish language workgroup on “Your Voice Counts” • Include TV spot, a Spanish-language website, radio spot, billboard, digital ads, outreach materials such as posters and brochures, and print ad • Posted to “Your Voice Counts” for dissemination • Now developing low-literacy suicide prevention outreach tool in Spanish for distribution by health “promotores” throughout state

Dissemination

Beyond 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.

All materials (television spots, radio spots, print ads, billboards, a media outreach toolkit, and suicide prevention posters and brochures) were delivered to California counties and partners through “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 (seven public, three private, three closed), posted 13 announcements (five contained new content), and housed 43 distinct resources (e.g., webinars).

Campaign staff (1) provide webinars, monthly campaign updates, and support to all 58 counties to implement the campaign locally and (2) work closely with those rural/small counties that expressed an interest to help them promote suicide prevention locally and implement “mini marketing campaigns.” During the past year, staff shared eight webinars with these counties, 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 CalMHSA-funded stigma-reduction programs.

AdEase also presented multiple times 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 (CCSESA) and United Advocates for Children and Families (UACF).

Table 5 summarizes the Know the Signs website’s key metrics.

Table 5. Key Metrics for Know the Signs Website (www.suicideispreventable.org), November 2012–February 2013

Category	Key Metrics
Traffic	<ul style="list-style-type: none"> • Number of visits: 471,925 • 27% of visits were accessed through mobile website • Of the total visits: <ul style="list-style-type: none"> ○ 55% came through TubeMogal.com and Mojiva.com digital advertisements ○ 14% came through advertisements on Facebook ○ 11% came through an online Google search ○ 20% came through other sources (e.g., ValueClick.com, BrandExchange.net)
User engagement	<ul style="list-style-type: none"> • 86% were first-time visits • Average time on site: 29–38 seconds • Average number of pages visited: 1.20–1.23 pages per visit • Percent leaving from the homepage: 85%
User Characteristics	<ul style="list-style-type: none"> • Top sources of traffic to site in California: Los Angeles: 162,233 visits; San Francisco: 75,997 visits; Sacramento-Stockton-Modesto: 35,707 visits; San Diego: 29,643 visits; Fresno: 24,481 visits

In addition to the website, 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. The primary dissemination metric was media impressions, which capture the total number of people that may have been exposed to the campaign. In Los Angeles, for example, which has the highest number of media impressions, there were more than 21 million television impressions, 132 million billboard impressions, 5 million magazine impressions, and 191 million digital media impressions. After Los Angeles, the order is the same as for the website: San Francisco, Sacramento-Stockton-Modesto, San Diego, and Fresno.

Hotline and Warmline Operations

In this section, we highlight the activities of crisis and mental health support (i.e., warmline) services funded through the SP Initiative. We summarize the crisis services developed and accredited and present data on the volume of calls or chats received by each agency, when such information was available in the quarterly reports they submit to CalMHSA. Many of the program partners, as part of their contracts, are also conducting community outreach and education that may focus on promotion of their crisis line, suicide awareness generally, or the skills necessary to identify those at risk and methods for intervening.

Hotlines, Chat, and Text Services Created or Expanded

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

Hotlines, Warmlines, Chat, and Text Services Created or Expanded

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

- New Central Valley Suicide Prevention Hotline (operated by Kings View)
- Newly named North Bay Suicide Prevention Hotline (coordinated and operated by FSA Marin)
- 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)
- New LA Warmline service, which expands hours of coverage for local warmlines (operated by Didi Hirsch)
- New or expanded chat and/or text counseling (WellSpace Health, San Francisco Suicide Prevention, and Didi Hirsch)

As part of their contracts, different agencies either created or purchased electronic call management software. The Institute on Aging created an in-house electronic management system for tracking all inbound and outbound calls that has been “actively used since April 2012.” FSA Marin, Kings View, and TMHA are among the centers that use the iCarol helpline software platform.

Accreditation

While many crisis lines funded by CalMHSA were already accredited by the American Association for Suicidology (AAS) (Didi Hirsch, San Francisco Suicide Prevention, Contra Costa Crisis Center, Star Vista, FSA Marin), others planned to obtain accreditation during the period of contract. For example, Santa Clara and the Institute on Aging were accredited in 2012 and AAS applications and review are underway for TMHA’s crisis services in San Luis Obispo, Kern County, FSACC, 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 Year 2 Q1–Q3 (July 1, 2012–March 31, 2013) quarterly reports, *when such information was readily available*, and from program partners. Call volume totals per quarter are presented in Table 6. This information shows how varied call centers are with respect to call volume. It is also notable that call volume increased at FSACC, FSA Marin, Institute on Aging, TMHA, and San Francisco Suicide Prevention’s crisis chat program.

Table 6. Estimated Call Volume for Suicide Prevention Program Partner Hotlines and Warmlines, 2012–2013

Hotline or Warmline	2012–2013		
	Q1	Q2	Q3
Didi Hirsch*	9,035	8,504	7,148
FSACC	1,117	761	1,170
FSA Marin	715	766	889
Institute on Aging	14,902 (6,233 call-ins and 8,669 call-outs)	16,486 (6,957 call-ins and 9,529 call-outs)	18,042 (7,901 call-ins and 10,141 call-outs)
Kings View**			921
San Francisco Suicide Prevention: Hotline***	28,230	30,053	29,989
San Francisco Suicide Prevention: Chat	643	782	1,015
TMHA	683	861	1116
TMHA: N. and S. SB County Warmline	44	78	169
Kern County: Hotline	5,512	5,028	5,669
WellSpace Health	Not available	6,555	6,863

* LA warmline calls not included.

** Operation of the Central Valley Suicide Prevention Hotline commenced in January 2013.

*** 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.

What Do We Find in Evaluating California Suicide Rates?

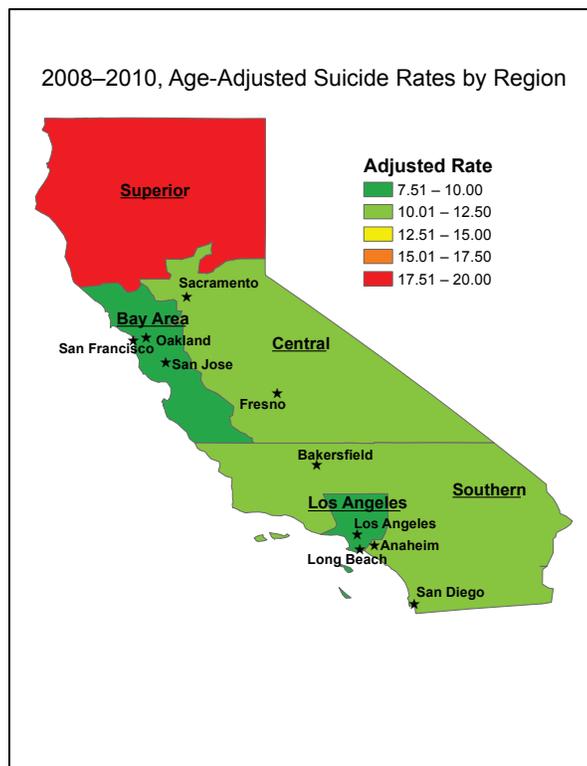
In addition to evaluating key program partner activities, we analyzed suicide fatalities in California to establish baselines against which later suicide rates may be compared. Key findings from that analysis include the following:

- Over the past decade, the suicide rate in California has been consistently lower than the national suicide rate.

- Nearly three-quarters of California suicides are among adults, which is generally consistent with the nation as a whole.
- In 2009, males accounted for three-quarters of California suicides, also generally consistent with national patterns.
- Suicide rates in California are consistently higher among whites, as is true more broadly for the United States.
- Suicide surveillance in California could be improved (for example, surveillance data could be more timely).
- Suicide rates vary dramatically by region in California.

The last finding is illustrated by Figure 1, which shows age-adjusted suicide rates by region. Suicide rates are highest in California’s most rural areas (e.g., Humboldt, Mendocino, Siskiyou, Butte, and Amador counties). However, because of the sparse population in these areas, suicides in rural areas account for a very small proportion of California’s overall number of suicides (approximately 6 percent), indicating that resources must still be allocated to the areas of the state with the highest numbers of suicides. The highest number of suicides over the three-year period was in the Southern region—nearly 4,000—while the lowest was in the Superior region (660).

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



What Are the Plans for Future Evaluation of the Suicide Prevention Initiative?

Continuing evaluation efforts are planned in all four core areas. SRI International, RAND's partner in the CalMHSA Statewide Evaluation, will lead the evaluation of networking and collaboration. SRI research staff will collect data on the nature of existing networks and collaborations, the role of CalMHSA funds in enhancing collaborations, the extent 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 collaborative activities (e.g., memoranda of understanding [MOUs] with partners and emergency/crisis intervention protocols, policy recommendations, and meeting rosters and agendas). We are also developing a protocol for key informant interviews, and these interviews will provide detailed descriptive data about the CalMHSA-supported collaborative organizations and activities that have emerged over the past contract year. Finally, the SRI research team will conduct a collaboration survey in the spring of 2014 to collect information from a wider population of participants in CalMHSA-supported collaborative organizations and activities. The survey questions will focus on how closely programs are collaborating within networks and communities, as well as outcomes related to collaboration, such as enhanced access to and coordination of services.

In terms of trainings or educational programs, thus far, LivingWorks has provided data on seven ASIST workshops, and these preliminary data indicate that trainings are helpful and important. Data on more trainings are forthcoming to provide greater generalizability. We also plan to conduct descriptive analyses of the reach of ASIST and safeTALK trainings to determine how often and in what settings these trainings are being administered. We will also descriptively analyze our data from the live observations of ASIST workshops to determine how ASIST trainings are delivered in community settings.

As for the social marketing area, 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 attributable to dissemination of the media advocacy toolkit. 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.

In the hotline and warmline area, our comprehensive literature review identified a rigorous evaluation design in which independent, trained observers rated call content. RAND's evaluation strategic plan includes replicating this design with all CalMHSA program partners contracted to initiate, expand, or enhance their crisis call services.

In this evaluation year, 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 members 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 2013, we shared with each of the seven crisis centers our draft hotline 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 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, the Institute on Aging, Didi Hirsch) and have three additional calls scheduled and one remaining to schedule.

A second round of outreach will be conducted with the five subcontractors. Next steps include applying to the RAND Institutional Review Board, developing a sampling plan, recruiting and training observers, and further tailoring the protocol to the operations of the crisis call centers. Fieldwork is expected to get under way in early 2014.