

Garrett Lee Smith State/Tribal Youth Suicide Prevention Grant
Florida Adolescent Suicide Awareness and Prevention Project (A.S.A.P.)
Update for 06-30-09

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Major Goals of the Grant Program

1) QPR Gatekeeper Training

2) Case Management

3) SOS

4) Parent Involvement

5) Social Marketing

Accomplishments:

Updates on what we have done on our 5 main grant programmatic activities.

Aim 1: Staff Gatekeeper Trainings

QPR training continues to roll along nicely; so far 13 trainings with 204 participants have taken place. 130 of these participants were foster care parents. Virginia and Kristy from Mental Health America have also conducted trainings with various sectors in the community. They have conducted trainings with employees from the Department of Child and Family Services, with Northwest Behavioral Health, which is a behavioral practice out by the beach, Youth Crisis Center, a multi-faith-based organization (known as Fresh Ministries), and with some pediatric practices. One of our trainers, who is from Elder Source, an aging resource center in DC, also conducted their first training with grandparents. On the logistic side, MHA continues to provide ongoing guidance and support to the other QPR trainers. Recently, they added slides to the typical QPR slides to help trainers with the research protocol and to give local statistics on suicide and to note groups that are particularly at risk. **On the *evaluation side***, pre and post test data has been entered and analyzed on a total of 107 participants so far from these trainings. So far, we are seeing a gain in knowledge based on the training and an overall satisfaction with the trainings. However, only 21 participants agreed to be contacted for a 3 month follow-up.

Aim 2: Case Management/Crisis Services

Ray, our County Case Manager, is documenting crisis calls received by the Rapid Response Team. They have a chart system in place to continue documentation. Unfortunately, Ray still hasn't received any calls due to QPR suicide prevention efforts, but is prepared and ready to provide case management services. Terri, the supervisor from United Way 211 crisis services, who has also been trying to collect crisis data, informed us they have changed their protocol so that they now will be better able to capture and gather demographic information and the source of calls – self or other referrals. 211 services have recently been reaccredited by AAS. **On the *evaluation side***, Ray and Terri have given us crisis response baseline data. Terry recently reported to us that in the past month, they received 130 calls, of which 34 were active crisis calls and 8 calls were from youth between the ages of 14-19. Of the 34

crisis calls, 5 resulted in 911 dispatch calls. The research aim to collect data from youth at baseline and 6 months later has been approved by the USF IRB. Ray is being added to the evaluation team to help conduct these evaluation interviews face to face.

Aim 3: School Based Prevention

Kathy Bowles, our liaison with the Duval County school system, has worked to develop several master point plans that will allow school personnel (teachers and staff) to participate in QPR training as part of their continuing education requirements. We are happy to report that the school district approved these master point plans. Virginia from MHA has created an initial draft of a school suicide prevention strategic action plan, and is planning to collaboratively work with Kathy and her staff. **On the evaluation side**, we have been busy working on finishing up the evaluation component of the student gatekeeper program which will be first implemented in high schools and then possibly in middle schools. We are in the final stages of creating the evaluation materials, including a pre, post and follow up survey for youth who participate in the training, as well as an evaluation manual similar to what we have made for QPR. Additional good news to report: the Duval Public schools administered the YRBS survey to students throughout the school district and we learned that 100% of Duval schools completed the survey which really impressed the CDC. The schools have received the baseline data from the spring and it is being analyzed. It looks like data will be available county wide and also by individual schools.

Aim 4: Parent Involvement

First, there have been a large number of QPR trainings targeted to foster care parents. In addition, Susan has spent a lot of time researching parent involvement activities in the literature and around the country. Susan has continued to collaborate with the school board to coordinate and implement components of the Family Guide in a school, targeting SED students. The idea is to teach parents how to advocate for

their kids relative to mental health services. Kristy, MHA's mental health educator, has been communicating with people from the "STEPS" program of family support services about also implementing components of the Family Guide. Susan talked to an advocate from Voices and Choices program which does one on one in home education with parents on how to be more involved in their child's mental health care, and has volunteered MHA to be a partner with them in Duval county. She has also been getting ideas from the Broward county MHA in Florida on parent involvement since they are part of the Voices and Choices program. **On the *evaluation side***, we have continued analyzing parent targeted QPR data and we continue to document all parent involvement activities as they occur.

Aim 5 Social Marketing

One accomplishment that we do have is the creation of what we call "the Debbie plan". One of the members of the USF team named Debbie took Marc Karver's notes from the Phoenix conference and various other social marketing notes and used this to create a step by step guide for the development of a social marketing strategic plan. We plan to share this guide with our new social marketing agency when they come on board. We are happy to state that 6 firms have contacted USF and shown interest in working on our grant. We are in the process of screening and interviewing these potential social marketing firms.

Macro update: We have spent the last couple of weeks recoding the TES data to be entered in the SPDC on 7.11.09. Data for the Existing Database Inventory (EDI) was collected and submitted to Macro. We also were able to identify various systems within DC that are involved with mental health and suicide prevention efforts for the Referral Network Survey. We submitted this information to Macro as well.

Plans:

Aim 1: Staff Gatekeeper trainings – MHA and the other trained QPR trainers plan to continue to do training and outreach. Sectors targeted for QPR trainings are health, public health, faith based and mental health, higher education, the children’s home society, and the health department. Susan will be doing QPR at pediatric practices. MHA is also offering to conduct regularly trainings, on a quarterly basis, with some of these agencies. Virginia and Kristy will be hosting a trainer get together to discuss lessons learned and barriers encountered in July. This will be an opportunity to provide additional training and support, to answer questions, and review evaluation materials. **On the evaluation side**, we will be collecting the 3 month follow-up information soon and then we should be able to share interesting information on how the training has affected the actual behavior of our participants. As for the pre, post data, an aesthetically pleasing report is being generated for feedback to the trainers and to assess the evaluation measure on an ongoing basis. As QPR trainer schedules become more set, MHA will conduct several observations of training to evaluate implementation with each QPR trainer.

Aim 2: Case Management services –Ray plans to collaborate with MHA and attend QPR trainings so that trained persons might better understand what his role is and be more persuaded to call him when they identify a youth at risk. Virginia is also planning to follow-up with the supervisors from trained agencies to emphasize Ray’s role. **On the evaluation side**, we are ready to start tracking and interviewing identified and referred youths. However, we came up with an interesting idea. Child Guidance’s Rapid Response team receives a good number of calls for case management separate from the suicide prevention program and Ray’s job. We have decided that this provides the perfect opportunity for a comparison group of referred suicidal youths. We plan to try following 50 rapid response youths vs. 50 youths identified by the suicide prevention program to determine differences

in client characteristics at baseline, and later differences in service utilization and in outcomes. And as mentioned earlier, Ray will be planning to do some of our case management baseline and follow-up interviews in person rather than by phone which will increase our final number of youths tracked as this has been documented in the research literature as typically very difficult to do. Terri and Ray will also continue to collect crisis line data.

Aim 3: School based prevention –Kathy will be meeting with the school board in early July. By then, principal appointments will be finalized per school and hopefully all cuts and transfers of health educators will be finalized. Choosing of targeted schools will happen probably mid-July once Kathy knows which schools will have receptive principals and qualified and receptive health educators. Virginia from MHA will be working on modifications of the initial draft of a school suicide prevention strategic action plan. There is a plan to train all health educators and PE teachers in QPR. Kathy will be meeting with Veronica, Theresa, and Ray from the Child Guidance Center as they have an agreement with CGC relative to the rapid response team responding to at risk youths, they will look at amending their agreement. There will be a push to train school coaches, guidance counselors, school psychologists, and social workers in QPR. **On the evaluation side**, our high school evaluation measure should be done soon and we are continuing on developing a middle school evaluation version. We plan to submit an IRB to USF and the Duval County School Board. Virginia and Kristy are planning to help school health educators when they deliver the training program by specifically helping with coordination of evaluation measures. We also look forward to eventually having YRBS data by school and the schools will be collecting YRBS data every year of the grant.

Aim 4: Parent Involvement – At our last quarterly meeting of Duval County stakeholders, we had a fascinating discussion about parent involvement. The plan is to have a subcommittee meeting in

which we would work on defining what exactly parent involvement could mean relative to suicide prevention. Clearly defining this would also aid the evaluation team in evaluating parent involvement suicide prevention activities. Meanwhile, MHA will continue to review the literature and other resources as well as consult with experts about parent involvement. In a more clearly defined area, many additional parent targeted QPR trainings are planned. Kathy from Duval schools also suggested that school parent involvement centers may be useful for grant related parent involvement.

Aim 5 Social Marketing- USF has started and will continue to prescreen potential applicants and they are working on setting up interviews. They expect that interviews will occur in July and our new social marketing firm will probably start in August. We will insist on the new social marketing firm first creating a strategic plan for social marketing as outlined out in the grant and consistent with SAMHSA/SPRC suggestions that were presented in Phoenix. Susan has suggested that the social marketing program should take on parent involvement as part of their mission. We do plan to work with the new social marketing firm so that evaluation activities will be weaved into programmatic activities. And we hope to incorporate Theory of Planned Behavior materials into this evaluation. We want to evaluate how the social marketing campaign affects key aspects of behavior change – changing attitudes, changing perceived social norms and stigma, and changing perceived capability to engage in certain desired behaviors.