EXAMINING TRAINER-TRAINEE ALLIANCE AS A MODERATOR OF ATTITUDES AND ENGAGEMENT IN SUICIDE PREVENTION BEHAVIORS ACROSS YOUTH-SERVING SECTORS

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Examining Trainer-Trainee Alliance as a Moderator of Attitudes and Engagement in Suicide Prevention Behaviors Across Youth-Serving Sectors

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Abstract

This study explores the impact of the trainer-trainee alliance on the effectiveness of gatekeeper training across youth-serving sectors. It examines whether alliance moderates the relationship between attitudes toward suicide prevention and actual engagement in prevention behaviors among youth-serving professionals. Participants (N = 858) from the sectors of education, healthcare, child welfare, and first responders were included in the study. Analyses included multiple regression models for the total sample and individually by sector to explore moderation effects. Findings indicated that while a stronger trainer-trainee alliance correlates with more favorable attitudes toward suicide prevention post-training, this alliance did not significantly moderate the relationship between attitudes and suicide prevention behavior. Additionally, the study finds that positive attitudes toward suicide prevention do not consistently translate into increased engagement in prevention behaviors, highlighting the complexity of achieving long-term behavioral change in this context.

Keywords: suicide prevention, gatekeeper training, trainer-trainee alliance, suicide prevention attitudes, suicide prevention behaviors

Introduction

The prevalence of suicide in adolescents is a critical public health concern that has escalated significantly in recent decades. As the second leading cause of death among individuals aged 10 to 24, the rising suicide rates in this demographic highlight an urgent need for effective prevention strategies (CDC, 2023). The period of adolescence is characterized by rapid physical, emotional, and social changes, which can increase susceptibility to mental health issues (Curtin et al., 2016). This developmental phase underscores the necessity of addressing the factors contributing to suicidal behaviors and implementing comprehensive prevention measures.

The increase in suicide rates among adolescents is both alarming and indicative of broader societal and psychological issues. According to data from the CDC (2023), the suicide rate increased by 36% from 2001 to 2021. In 2021 alone, the suicide rate was 14.1 per 100,000 people, with young people, particularly those aged 5-24, experiencing a notable increase during the pandemic. This trend highlights the need for immediate and sustained attention from healthcare providers, educators, first responders, policymakers, and communities. Factors contributing to this rise include academic pressures, social media influences, bullying, family dynamics, and more (CDC, 2023). Adolescents are navigating a complex social environment while forming their self-concept, which can lead to feelings of isolation, self-doubt, and inadequacy. These pressures, compounded by the ever-present stigma surrounding mental health, often deter young people from seeking necessary help, increasing their risk of suicidal behavior (Shain et al., 2016).

Given the escalating rates of adolescent suicide, prioritizing prevention efforts is crucial. Effective prevention strategies can significantly reduce not only the incidence of suicide but also the broader mental health challenges faced by adolescents. Research indicates that many

adolescents who attempt or die by suicide have shown warning signs in the months leading up to the event, including behavioral changes, social withdrawal, and expressions of hopelessness (Curtin et al., 2016). Recognizing these signs and providing timely support can prevent suicidal thoughts from escalating into actions. School personnel, healthcare providers, first responders, and community organizations are crucial in early intervention efforts. These institutions frequently serve as the first line of contact for adolescents with mental health issues in identifying the warning signs of suicidality as well as having the opportunity to connect them with appropriate resources (Shain et al., 2016). Research shows that gatekeeper training enhances the ability to recognize signs like isolation and hopelessness, increases intervention confidence, and improves referral practices (Isaac et al., 2009; Burnette et al., 2015), which are crucial steps in preventing suicide among youth.

Effective engagement of individuals in suicide prevention within youth-serving organizations is paramount in the success of gatekeeper training efforts. The Theory of Planned Behavior, which provides a framework for conceptualizing individual behavior change, serves as the foundation for understanding participant attitudes towards suicide prevention and their motivations to use the prevention skills they learned (Shain et al. 2016). Further, recent prevention work has found that the creation of a supportive prevention training climate, namely optimizing the relationship or alliance between trainer and trainee, is significant in predicting the effectiveness of gatekeeper training across various training contexts (Shain et al. 2016). Therefore, this study seeks to evaluate the implementation context of gatekeeper training among multiple youth-serving organizations in determining how alliance mitigates attitudes of participants toward suicide prevention in predicting their engagement in suicide prevention behaviors.

Suicide Prevention Gatekeeper Training

Suicide prevention gatekeeper training is a crucial public health intervention designed to equip individuals with the skills and knowledge necessary to recognize, respond to, and refer individuals at-risk of suicide to appropriate services. These programs aim to create a network of "gatekeepers" within communities, individuals who are able to identify warning signs of suicidal ideation and take action before it escalates into a crisis (Hawgood et al., 2022). Gatekeeper training focuses on several key components, including the identification of verbal, behavioral, and situational cues associated with suicide risk, learning how to engage with at-risk individuals compassionately and non-judgmentally, and developing confidence in referring these individuals to appropriate mental health services (Burnette et al., 2015). The widely used Question, Persuade, and Refer (QPR) program teaches gatekeepers how to ask direct questions about suicidal thoughts, persuade individuals to seek help, and refer them to mental health professionals (Aldrich et al., 2018; Gryglewicz et al., 2024). Studies show that QPR training increases participants' knowledge, intervention skills, and willingness to engage with individuals at-risk, making it an effective tool in suicide prevention (Aldrich et al., 2018).

One critical aspect of gatekeeper training is determining who gets trained. The primary target groups include individuals in youth-serving organizations, schools, healthcare settings, and community organizations, where early identification of suicide risk is particularly important. School personnel, such as teachers, counselors, and administrators, are often on the frontline in recognizing students experiencing distress, especially during adolescence when mental health issues commonly arise (Yonemoto et al., 2019). Similarly, staff in community organizations, such as sports teams and clubs, can be instrumental in identifying at-risk youth outside of clinical settings (Quinnett, 2023). Healthcare providers are another key demographic for gatekeeper

training, as they frequently encounter individuals with suicidal ideation in both emergency and primary care settings (Hawgood et al., 2022). In addition to professionals, training programs often extend to broader community members, including clergy, police officers, and the general public, which enhances the potential for widespread suicide intervention in diverse environments (Burnette et al., 2015).

The effectiveness of gatekeeper training has been supported by numerous studies. For example, Aldrich et al. (2018) demonstrated that QPR training significantly improves participants' confidence and capacity to intervene with individuals at-risk for suicide. However, it is important to ensure that such programs are delivered with consistent quality and competency standards. According to Hawgood et al. (2022), clear standards of competency should be established for all gatekeeper training programs to ensure that participants are adequately prepared to handle suicidal crises. The presence of standardized training protocols can help prevent variability in the quality of training across different settings, enhancing the overall effectiveness of suicide prevention efforts (Gryglewicz et al., 2024).

Gatekeeper training is a vital strategy for suicide prevention, particularly in youth-serving environments and community organizations. By teaching individuals to recognize signs of suicide risk, engage with at-risk individuals, and refer them to appropriate resources, these programs have the potential to save lives. With evidence supporting the effectiveness of models like QPR and growing recognition of the need for standardized competency in training, gatekeeper programs remain a cornerstone of public health approaches to mitigating suicide risk (Quinnett, 2023; Yonemoto et al., 2019).

Factors contributing to engagement in suicide prevention behaviors

The Theory of Planned Behavior (TPB) provides a strong framework for understanding and enhancing the efficacy of suicide prevention gatekeeper training. The TPB emphasizes three key psychological constructs: attitudes, perceived behavioral control, and subjective norms, that influence an individual's intention to engage in a behavior, such as suicide prevention, as well as their actual engagement in behaviors (Ajzen, 2020). Understanding these constructs allows for the optimization of gatekeeper training programs, ensuring they are more effective in encouraging individuals to apply their training in real-world situations (Burnette et al., 2015).

Attitudes toward suicide prevention significantly influence whether individuals engage in and apply the knowledge gained from gatekeeper training. Research by Ramberg et al. (2021) suggests that positive attitudes toward suicide prevention are directly related to higher engagement levels in training and subsequent prevention behaviors. When individuals perceive suicide prevention as valuable and believe they can make a difference, they are more likely to participate in gatekeeper programs and act on the warning signs they identify. This is particularly important for individuals working in youth-serving organizations where timely intervention can be critical in preventing suicide (Yonemoto et al., 2019; Quinnett, 2023).

The effective evaluations of gatekeeper training programs reinforce the importance of addressing all three TPB constructs, attitudes, perceived behavioral control, and subjective norms, when designing and implementing these programs (Steinmetz et al., 2016). For example, the QPR model has been widely studied and shown to increase participants' confidence in recognizing and responding to suicide risk, while also fostering a sense of social responsibility to intervene (Aldrich et al., 2018). For the present study, attitudes and suicide prevention behaviors will be the primary TPB constructs evaluated. Applying the Theory of Planned Behavior to

suicide prevention gatekeeper training highlights the importance of addressing psychological factors that influence an individual's decision to engage in preventative behaviors. Specific to this study, positive attitudes toward suicide prevention are vital in ensuring that individuals not only complete gatekeeper training but also use the skills they have learned in real-world situations (Burnette et al., 2015; Gryglewicz et al., 2024).

Alliance's role in gatekeeper training

The trainer-trainee alliance plays an important role in shaping the outcomes of gatekeeper training. Alliance refers to the collaborative, trusting, and goal-oriented relationship between trainers and trainees that allows for effective delivery, reception, and implementation of suicide prevention training (DiClemente & Velasquez, 2015; Kaufman & Raiz, 2014). Alliance is operationalized in this context by indicators such as perceived trainer empathy, clear and responsive communication, trainee engagement, and mutual belief in the value of training (Gordon & Gertner, 2021; Hughes & Cummings, 2019). A positive relationship between trainers and trainees is fundamental to enhancing the effectiveness of the training. According to Totura et al. (2019), a supportive and collaborative trainer-trainee relationship fosters greater involvement in the training process and improves the likelihood that trainees will utilize the skills learned in real-world scenarios. This is corroborated by Kaufman and Raiz (2014), who argue that a strong alliance between trainers and trainees boosts the effectiveness of suicide prevention training programs by enhancing trainees' confidence and commitment to applying their skills. Furthermore, Cross et al. (2010) provide evidence that effective trainer-trainee rapport is crucial for translating training into practical, observable skills. Their research shows that a positive alliance facilitates better communication and learning outcomes, which are essential for the successful implementation of gatekeeper training.

The impact of the trainer-trainee alliance on behavior change is well-supported by research. Steinmetz et al. (2016) demonstrate that interventions based on the Theory of Planned Behavior are more effective when participants feel a strong support system from trainers. Their meta-analysis reveals that a positive trainer-trainee relationship enhances the likelihood of behavior change by increasing trainees' perceived behavioral control the engage in prevention behaviors and motivation to act. This finding is consistent with Ramberg et al. (2021), who report that a favorable attitude towards suicide prevention, fostered by effective trainer relationships, significantly influences the preventive behaviors of staff exposed to suicidal individuals. Their study underscores the importance of a supportive training environment in promoting proactive behaviors. Additionally, Matthieu et al. (2008) observe that a strong alliance between trainers and trainees is crucial for specialized settings, such as training for veterans. They find that this relationship enhances the application of learned behaviors, leading to improved outcomes in suicide prevention efforts.

The long-term effects of the trainer-trainee alliance on behavior change are significant and enduring. Wyman et al. (2008) provide evidence that a robust alliance results in sustained behavioral changes among school staff, enhancing their ability to identify and intervene with at-risk students over time. Their randomized trial highlights the importance of ongoing support and positive relationships in maintaining effective suicide prevention practices. Similarly, Isaac et al. (2009) confirmed that a positive trainer-trainee relationship enhances engagement and confidence, which leads to better application of suicide prevention strategies in various settings. Their systematic review emphasizes the critical role of supportive relationships in ensuring the long- term success of gatekeeper training programs. Condron and Bonner (2017) further support this view, finding that while knowledge of suicide risk factors is important, it is the strong

alliance with trainers that ensures effective application of this knowledge in counseling settings.

According to Totura et al. (2019), in their study of youth suicide prevention programs, the quality of the relationship between trainers and trainees significantly affected the trainees' willingness to act on their training. They found that a stronger alliance led to more pronounced changes in attitudes and behaviors, with participants demonstrating greater commitment to engaging in suicide prevention activities. Similarly, Kaufman and Raiz (2014) found that a supportive trainer-trainee relationship enhanced the effectiveness of training, as trainees who felt supported were more likely to transfer their positive attitudes into behavior changes, such as recognizing at-risk individuals and making appropriate referrals. The importance of alliance as a moderator was further reinforced by Wyman et al. (2008), whose study showed that strong trainer-trainee relationships improved school staff's ability to detect and respond to suicidal behavior among students.

Each of these studies indicate the trainer-trainee alliance can serve as a key moderator in gatekeeper training programs, enhancing the relationship between attitudes towards suicide prevention and engagement in suicide prevention. Of remaining interest is how alliance may function differentially in conjunction with suicide prevention attitudes and behaviors across various youth-serving organizational contexts.

The context across youth-serving organizations

Strong social connections and supportive relationships with family, peers, and mentors are protective factors against suicide (Shain et al., 2016). Comprehensive, community-wide approaches to suicide prevention, involving collaboration among schools, healthcare providers, parents, first responders, and community organizations, are essential in creating a supportive network for adolescents in need (Shain et al., 2016).

Gatekeeper training for suicide prevention is widely implemented across various youth-serving sectors, including educators, healthcare workers, and first responders. However, the outcomes of such training, particularly regarding attitudes, engagement in suicide prevention behaviors, and the potential moderating role of alliance between gatekeeper trainer and trainee, can vary significantly across these sectors.

Teachers and school personnel play a pivotal role in identifying and responding to students at risk of suicide. Graham and Little (2019) found that gatekeeper training positively influenced educators' attitudes toward suicide prevention, leading to increased confidence in identifying and supporting at-risk students. However, the degree to which these attitudes are translated into behaviors (such as making referrals or initiating conversations with students) was often contingent on the strength of the trainer-trainee alliance. Pence and Johnson (2018) further explored the role of alliance, suggesting that educators who felt a strong connection with their trainers were more likely to implement their training in real-world scenarios, demonstrating a stronger attitude-behavior link (Moon et al., 2017; Pence & Johnson, 2018; Tompkins et al., 2009).

Healthcare workers, particularly those on the front lines, face unique challenges in suicide prevention. DiClemente and Velasquez (2015) argue that professional relationships within healthcare settings, including the trainer-trainee alliance, play an important role in determining how well healthcare professionals incorporate suicide prevention strategies into their practice. For this group of individuals, where mental health knowledge may already be relatively high, gatekeeper training aims to reinforce positive attitudes and improve behavioral responses, such as intervention in crisis situations.

Previous research has noted that when healthcare professionals experienced a positive

alliance with their trainers, their willingness to engage in suicide prevention behaviors increased significantly, highlighting the moderating role of trainer-trainee relationships in transforming attitudes into concrete actions (Hughes & Cummings, 2019; Trainor & VanBuren, 2013). Further, McCormick and Poole (2016) emphasized that healthcare workers who perceived a strong trainer-trainee bond showed greater confidence in using their newly acquired skills, particularly in high-pressure scenarios.

First responders, including law enforcement officers and juvenile justice staff, often face intense situations involving individuals at-risk for suicide, making gatekeeper training critical for their roles. Kauffman (2018) found that first responders' attitudes toward suicide prevention improved significantly after gatekeeper training, with a marked increase in their willingness to engage in behaviors such as crisis intervention. However, the strength of the trainer-trainee alliance was a crucial determinant of how likely these attitudes were translated into behaviors. Osteen et al. (2021) also highlighted the importance of alliance, showing that first responders with a strong bond with their trainers were more likely to apply their training in real-life scenarios, such as deescalating suicidal crises. Kubiak et al. (2019) observed that when law enforcement officers had strong alliances with their trainers, their confidence in dealing with adolescent mental health crises improved significantly. This not only enhanced their attitudes but also increased their engagement in behaviors that aligned with the goals of gatekeeper training, such as making appropriate referrals to mental health services.

While attitudes toward suicide prevention generally improve across sectors after gatekeeper training, the translation of these attitudes into behaviors is significantly influenced by the strength of the trainer-trainee alliance. This alliance moderates the relationship between attitudes and behaviors, making it a critical factor in the success of suicide prevention efforts

across educators, healthcare workers, and first responders. Each sector presents with unique challenges, missions, and exposure to youth. While the existing literature has shown that strong professional alliances enhance the impact of gatekeeper training, it is likely that the unique contexts of each service sector would have an effect on alliance and the relationship between attitudes and actions toward suicide prevention.

The Present Study

This study aimed to explore how the alliance between trainers and trainees in QPR gatekeeper suicide prevention training moderates the relationship between trainees' attitudes toward suicide prevention and their engagement in prevention behaviors (see Figure 1). The need for this investigation was grounded in the rising prevalence of adolescent suicide, which had underscored the urgency of effective prevention strategies. Gatekeeper training had been shown to improve participants' confidence in recognizing and addressing suicide risk, but the quality of the trainer-trainee relationship was thought to play a crucial role in how effectively trainees apply their skills. Additionally, the study examined how this moderating effect differed across various youth service sectors, including educators, healthcare workers, and first responders. These sectors were critical in identifying and intervening in adolescent suicide risk, and gatekeeper training equipped them with the skills to recognize and respond to warning signs of at-risk behavior.

Two hypotheses guided this study. The first was that the trainer-trainee alliance would moderate the relationship between attitudes toward suicide prevention and engagement in prevention behaviors, with stronger reported alliance by training participants amplifying this relationship. The second hypothesis posited that the moderating effect of alliance would be most pronounced among first responders, given the high-stakes situations they frequently encounter

and that first responders may not have believed suicide prevention to be a key mission of their profession. This study built on existing research by examining the role of alliance in different sectors, contributing to a more nuanced understanding of how suicide prevention training can be optimized to improve outcomes across diverse professional environments.

Method

Procedure

QPR gatekeeper training was implemented in rural and urban communities in a Southeastern state with significant concerns about youth at-risk for suicide. The program involved a two-hour in-person group training session delivered by certified QPR instructors (N=17) who were experienced trainers with prior mental health and/or suicide prevention experience. Paper surveys were collected immediately prior to (pre-training) and after (post-training) sessions, and then again at 3-months following the program using an online format. Each survey took approximately 15 minutes to complete. All study procedures were approved by a university Institutional Review Board.

Participants

A total of 5,226 adult gatekeepers participated in the QPR program. The final sample for the present study included 858 participants who completed a survey at pre-test, post-test, and follow-up. The mean age of participants was 41.7 (SD = 13.1; 71% female). Approximately 56% of the sample identified as White, 22% Black, and 17% Latinx. Participants had varying levels of education: 29% earned less than a bachelor's degree, 29% earned a bachelor's degree, and 42% earned a master's degree or higher. Several youth-serving sectors were represented: education (28%), law enforcement (13%), behavioral health (14%), juvenile justice and child welfare (11%), and community support services (e.g., homeless shelters, victim services, after

school programs, LGBTQ centers, faith-based organizations; 34%).

Measures

Demographic Measure

Participants were asked to complete questions on their demographic information (gender, race/ethnicity, age, and education level), as well as the youth-serving organizational sector they primarily affiliate with: education, first responders, mental health/substance use, faith-based, medical, non-profit/social service, grassroot, Department of Juvenile Justice, and Department of Children and Families/child welfare.

The Planned Behavior and Implementation Questionnaire (PBIQ)

The Planned Behavior and Implementation Questionnaire (PBIQ; Totura et al., 2019) included the primary outcomes of interest (i.e., attitudes, alliance, and suicide prevention behaviors). The design of the measure was guided by the TPB (Ajzen, 2019), implementation science (Fixsen et al., 2005), and prior youth suicide prevention studies examining training effectiveness (Brown Hangartner et al., 2019; Gryglewicz et al., 2017, 2018, 2020; Totura et al., 2019). All items utilized a Likert scale which ranged from “strongly disagree” (=1) to “strongly agree” (=5). Items were summed and standardized to obtain composite scores for each TPB outcome of interest. Attitudes were measured at all three time points and included three items that reflected perceptions about mental illness and suicide prevention; higher scores represented more positive attitudes (“when a youth is talking about suicide, it should be taken seriously”). Alliance was measured using 4 items at post-training only (i.e., “I like the person who taught the QPR training”). Alliance was operationalized in this context by indicators such as perceived trainer competency, clear and responsive communication, trainee engagement, and mutual belief in the value of training (Gordon & Gertner, 2021; Hughes & Cummings, 2019). Suicide prevention behaviors

assessed the frequency of questioning about suicide, persuading an at-risk individual to seek help, and referring an at-risk individual to community resources. After answering "yes" to a filter question assessing "any interaction with youth in the past 3 months," participants were asked to report the number of youth with whom they utilized QPR strategies in the prior three months (1 = none to 4 = 4 or more). Higher scores reflected frequent use of suicide prevention behaviors. Behaviors were measured at pre-training and 3- month follow-up (see Appendix for measures). Internal consistency was assessed using Cronbach's alpha. The attitudes scale demonstrated low internal consistency at both pre-test ($\alpha = .53$) and post-test ($\alpha = .50$). The trainer-trainee alliance showed excellent internal consistency at post-test ($\alpha = .91$).

Analysis Plan

Preliminary Analyses

Means and standard deviations were run for each of the study variables. In addition, correlations were run between each of the study variables to present simple patterns in expected associations. Predictor and moderator variables were grand mean centered prior to analyses.

Moderator Regression Analyses

Interactions between Attitudes at post-training toward suicide prevention and participant-reported Alliance were computed (e.g., Attitudes X Alliance). A regression model was then run, using simultaneous entry with each of the study variables and the interaction entered together, in predicting actual Engagement in suicide prevention behaviors from Attitudes toward suicide prevention. This process identified whether Alliance moderates the Attitudes to Engagement in prevention behaviors relationship. This regression model was then run separately for each sector in order to evaluate the relative strength of identified moderator effects across different professionals.

Results

Descriptive Statistics

Table 1 presents the means and standard deviations for each composite variable for the total sample and by sector.

Pre-training behavior scores were generally low across all sectors, with the total sample reporting a mean of 1.41 (*SD* = 1.13) at-risk youth intervened with, indicating minimal engagement in behaviors prior to training. The first responders sector reported a significantly higher pre-training behavior mean ($\bar{X}$ = 1.96, *SD* = 1.29), suggesting greater initial engagement in prevention behaviors compared to other sectors. Post-training behavior scores showed a slight decrease for the overall sample ($\bar{X}$ = 1.12, *SD* = 1.12), but some variability was observed across sectors. Specifically, the mental health/substance abuse ($\bar{X}$ = 1.33, *SD* = 1.26) and DJJ & DCF/CW ($\bar{X}$ = 1.38, *SD* = 1.30) sectors reported higher behavior mean scores post-training, indicating more substantial engagement in the targeted behaviors following the training. However, a paired sample t-test indicated that suicide prevention behaviors significantly decreased from pre-training ($\bar{X}$ = 1.41, *SD* = 1.13) to follow-up for the total sample ($\bar{X}$ = 1.12, *SD* = 1.12), $t(673) = -7.62$, $p < .001$, along with all sectors with the exception of the DJJ & DCF/CW sector, $t(75) = -1.48$, $p = .07$.

Pre-training attitudes were consistently high across all sectors, with the means close to the upper end of the 5-point survey response scale, reflecting generally favorable attitudes toward suicide prevention. This pattern was consistent across individual sectors, with pre-training means ranging from 4.44 to 4.69. Post-training attitudes showed the same trend for the total sample and across all sectors, suggesting a potential ceiling effect. Despite a decline at

follow-up assessment, attitudes toward suicide prevention remained high across all sectors. Notably, a paired samples t-test revealed a statistically significant increase in attitudes toward suicide prevention from pre-training ($\bar{X}$ = 4.62, *SD* = 0.45) to post-training ($\bar{X}$ = 4.70, *SD* = 0.50), $t(655) = -3.56$, $p < .001$) for the total sample. This increase was also observed in all sectors, with the first responder, DJJ & DCF/CW, and Other sectors yielding statistically significant results. However, the education, $t(207) = 1.45$, $p = .07$, and mental health/substance abuse, $t(77) = .78$, $p = .22$, sectors were non-significant.

Post-training alliance scores were also high, with the total sample reporting a mean of 4.66 (*SD* = 0.58) on a 5-point response scale, suggesting that participants generally felt a strong alliance with the intervention providers. The DJJ & DCF/CW sector reported the highest post-training alliance score ($\bar{X}$ = 4.78, *SD* = 0.45), while the first responders sector reported the lowest ($\bar{X}$ = 4.46, *SD* = 0.66). Despite these variations, all sectors had relatively high mean scores, indicating that participants across all sectors felt positively about the alliance with the intervention providers.

The analysis of variance (ANOVA) conducted to examine the differences in post-training attitudes across professional sectors revealed no significant effect of sector membership on attitudes. The F-statistic was 0.775 ($p = 0.54$), indicating that sector did not account for a meaningful difference in post-training attitudes. Effect sizes were minimal, suggesting that the variance explained by sector membership was negligible. Specifically, eta-squared (η^2) was 0.005, indicating that only 0.5% of the variance in post-training attitudes was explained by sector. Additionally, epsilon-squared and omega-squared (both fixed and random) were near zero, further supporting the lack of a significant effect.

The analysis of variance conducted to examine the differences in pre-training and follow-up behavior across professional sectors revealed significant effects of sector membership on both pre-training and follow-up behaviors. For pre-training behavior, the F-statistic was 12.030 ($p < 0.001$), indicating that sector membership accounted for a meaningful difference in engagement with suicide prevention behaviors prior to the training. Effect sizes were medium, with eta-squared (η^2) equal to 0.074, suggesting that 7.4% of the variance in pre-training behavior was explained by sector. Epsilon-squared and omega-squared were also consistent with this, indicating a medium effect size. For follow-up behavior, the F-statistic was 7.849 ($p < 0.001$), indicating that sector membership again accounted for a meaningful difference in behavior scores at the 3-month follow-up. Effect sizes were small, with eta-squared (η^2) equal to 0.049, indicating that 4.9% of the variance in follow-up behavior was explained by sector. Epsilon-squared and omega-squared were also small, supporting the interpretation that the magnitude of the sector differences was small.

Additionally, the analysis of post-training alliance scores revealed significant differences across sectors, with the F-statistic being 5.286 ($p < 0.001$). This indicates that the trainer-trainee alliance was perceived differently across sectors.

Table 1

Descriptive Statistics for Study Constructs

Variables	Total Sample		Education		First Responders		Mental Health/ Substance Abuse		DJJ&DCF/CW		Other	
	$\bar{X}$	*SD*	$\bar{X}$	*SD*	$\bar{X}$	*SD*	$\bar{X}$	*SD*	$\bar{X}$	*SD*	$\bar{X}$	*SD*
Behavior Mean (Pre)	1.41	1.13	1.19	1.01	1.96	1.29	1.58	1.19	1.44	1.10	1.32	1.10
Behavior Mean (Follow-Up)	1.12	1.12	.91	.94	1.33	1.26	1.38	1.30	1.25	1.20	1.08	1.09
Attitudes (Pre)	4.62	.44	4.64	.41	4.51	.43	4.69	.40	4.63	.45	4.63	.49
Attitudes (Post)	4.69	.50	4.69	.57	4.62	.49	4.73	.45	4.73	.37	4.70	.48
Attitudes (Follow-Up)	4.57	.41	4.57	.42	4.44	.36	4.62	.41	4.58	.45	4.60	.40
Alliance (Post)	4.66	.58	4.58	.68	4.46	.66	4.71	.48	4.78	.45	4.76	.47

Note. N = 674 for the total sample, 211 for Education, 93 for First Responders, 79 for Mental Health/Substance Abuse, 75 for DJJ&DCF/CW, and 216 for Other (Faith-based, medical, non-profit, social service, grassroot, community)

Bivariate Correlation Analyses

Bivariate correlations conducted for the total sample and by each sector are presented in Tables 2-7.

For the total sample, pre-training engagement in prevention behaviors was strongly correlated with follow-up engagement ($r = .60$, $p < .001$), indicating individuals who engaged in prevention behaviors before training were likely to continue engaging in prevention behaviors. Pre-training attitudes toward suicide prevention were positively correlated with attitudes at post-training ($r = .34$, $p < .001$) and follow-up attitudes ($r = .36$, $p < .001$). Post-training and follow-up attitudes were also correlated ($r = .30$, $p < .001$), suggesting some maintenance over the 3-month follow-up period. Alliance was positively associated with post-training ($r = .23$, $p < .001$) and follow-up attitudes ($r = .19$, $p < .001$), but not with follow-up engagement in behaviors ($r = .05$), indicating alliance is associated with attitudes, but not suicide prevention behaviors.

Across all service sectors, pre-training suicide prevention behavior was significantly and positively correlated with follow-up behavior, indicating that participants who were already engaging with at-risk youth prior to training were likely to continue those behaviors post-training. These associations were statistically significant in each sector: education ($r = .58$, $p < .001$), first responders ($r = .52$, $p < .001$), mental health/substance abuse ($r = .67$, $p < .001$), DJJ & DCF/CW ($r = .58$, $p < .001$), and the other professionals sector ($r = .63$, $p < .001$).

Pre-training attitudes toward suicide prevention, however, showed weak or non-significant associations with both pre-training and follow-up behaviors across sectors. In the education and mental health/substance abuse sectors, pre-training attitudes were positively associated with pre-training behavior ($r = .15$, $p < .05$; $r = .08$, $p < .05$, respectively), but not with

behavior at follow-up. In other sectors, these associations were non-significant (e.g., first responders: r = -.02 and .08; DJJ & DCF/CW: r = .11 and .01).

Post-training attitudes were significantly associated with both pre-training and follow-up attitudes across all sectors, suggesting that participants' attitudes were maintained over time. Correlations between post-training and follow-up attitudes ranged from r = .26 to r = .41 (all p < .05), with stronger associations observed in the DJJ & DCF/CW (r = .41, p < .001) and first responder sectors (r = .39, p < .001).

Alliance measured at post-training was significantly correlated with post-training attitudes in four of the five sectors: education (r = .21, p < .001), first responders (r = .33, p < .001), mental health/substance abuse (r = .10, not statistically significant), and other sector (r = .25, p < .001). In the mental health/substance abuse sector specifically, while the correlation between alliance and post-training attitudes was not significant, alliance was significantly correlated with both pre-training (r = .24, p < .05) and follow-up attitudes (r = .29, p < .05), suggesting that stronger trainer-trainee alliance was generally associated with more favorable attitudes toward suicide prevention immediately following training and, in some sectors, at 3-month follow-up. However, alliance was not significantly associated with follow-up behavior in any sector, indicating that while alliance is associated with attitudes, it does not appear to directly relate to engagement in suicide prevention behaviors.

Table 2

Bivariate Correlations Between Variables for Total Sample

Variable	1.	2.	3.	4.	5.	6.
1. Behavior Mean (Pre)	1.0	-	-	-	-	-
2. Behavior Mean (Follow-Up)	.60**	1.0	-	-	-	-
3. Attitudes (Pre)	.06	-.002	1.0	-	-	-
4. Attitudes (Post)	-.02	-.05	.34**	1.0	-	-
5. Attitudes (Follow-Up)	-.01	.03	.36**	.30**	1.0	-
6. Alliance (Post)	-.01	.05	.11**	.23**	.19**	1.0

** $p < .001$, * $p < .05$, two-tailed.

Table 3

Bivariate Correlations Between Variables for Education Sector

Variable	1.	2.	3.	4.	5.	6.
1. Behavior Mean (Pre)	1.0	-	-	-	-	-
2. Behavior Mean (Follow-Up)	.58**	1.0	-	-	-	-
3. Attitudes (Pre)	.15*	.07	1.0	-	-	-
4. Attitudes (Post)	-.02	-.02	.27**	1.0	-	-
5. Attitudes (Follow-Up)	.01	-.06	.35**	.28**	1.0	-
6. Alliance (Post)	.03	.07	.06	.21**	.20**	1.0

** $p < .001$, * $p < .05$, two-tailed.

Table 4

Bivariate Correlations Between Variables for First Responders Sector

Variable	1.	2.	3.	4.	5.	6.
1. Behavior Mean (Pre)	1.0	-	-	-	-	-
2. Behavior Mean (Follow-Up)	.52**	1.0	-	-	-	-
3. Attitudes (Pre)	-.02	.08	1.0	-	-	-
4. Attitudes (Post)	-.13	-.15	.52**	1.0	-	-
5. Attitudes (Follow-Up)	-.10	.10	.44**	.39**	1.0	-
6. Alliance (Post)	-.14	-.05	.17	.33**	.19	1.0

** $p < .001$, * $p < .05$, two-tailed.

Table 5

Bivariate Correlations Between Variables for Mental Health/Substance Abuse Sector

Variable	1.	2.	3.	4.	5.	6.
1. Behavior Mean (Pre)	1.0	-	-	-	-	-
2. Behavior Mean (Follow-Up)	.67**	1.0	-	-	-	-
3. Attitudes (Pre)	.08*	.06	1.0	-	-	-
4. Attitudes (Post)	-.06	-.18	.50**	1.0	-	-
5. Attitudes (Follow-Up)	.12	.11	.26**	.26*	1.0	-
6. Alliance (Post)	.17	.15	.24*	.10	.29*	1.0

** $p < .001$, * $p < .05$, two-tailed.

Table 6

Bivariate Correlations Between Variables for DJJ & DCF/CW Sector

Variable	1.	2.	3.	4.	5.	6.
1. Behavior Mean (Pre)	1.0	-	-	-	-	-
2. Behavior Mean (Follow-Up)	.58**	1.0	-	-	-	-
3. Attitudes (Pre)	.11	-.09	1.0	-	-	-
4. Attitudes (Post)	.13	.05	.47**	1.0	-	-
5. Attitudes (Follow-Up)	.01	-.07	.60**	.41**	1.0	-
6. Alliance (Post)	.06	.15	.05	.08	.17	1.0

** $p < .001$, * $p < .05$, two-tailed.

Table 7

Bivariate Correlations Between Variables for Other Sector

Variable	1.	2.	3.	4.	5.	6.
1. Behavior Mean (Pre)	1.0	-	-	-	-	-
2. Behavior Mean (Follow-Up)	.63**	1.0	-	-	-	-
3. Attitudes (Pre)	.06	-.07	1.0	-	-	-
4. Attitudes (Post)	.03	-.02	.27**	1.0	-	-
5. Attitudes (Follow-Up)	.03	.11	.27**	.26**	1.0	-
6. Alliance (Post)	-.02	.01	.09	.25**	.08	1.0

** $p < .001$, * $p < .05$, two-tailed.

Moderator Regression Analyses

Multiple regression analyses were conducted to examine whether trainer-trainee alliance moderated the relationship between post-training attitudes toward suicide prevention and engagement in suicide prevention behaviors. Six regression models were tested across the total sample and for each individual professional sector (see Tables 8-13).

The regression model for the total sample predicting engagement in suicide prevention behaviors from post-training attitudes was significant [$F(6, 643) = 65.38$, $p < .001$]. Although post-training attitudes were statistically significant in the regression model ($\beta = –.08$, $t(5) = -2.08$, $p = .04$), the negative direction of the association indicates that higher post-training attitudes were unexpectedly associated with *lower* engagement in suicide prevention behaviors at follow-up. Trainer-trainee alliance was not a significant predictor of follow-up behavior ($\beta = .05$, $t(5) = 1.34$, $p = .18$). Additionally, the interaction between post-training attitudes and alliance was not significant, ($\beta = -.07$, $t(5) = -1.94$, $p = .05$), indicating that alliance did not moderate this relationship.

In all sectors, the regression models predicting behavioral engagement were significant. Pre-training ($\beta = -.12$, $t(5) = -2.11$, $p = .04$) and follow-up ($\beta = .14$, $t(5) = 2.36$, $p = .02$) attitudes in the other sector were significant predictors. Only the first responders sector demonstrated post-training attitudes negatively predicting follow-up behaviors ($\beta = -.27$, $t(5) = -2.33$, $p = .02$). Alliance did not serve as a predictor for any sector. Notably The interaction effect of post-training attitudes and alliance also was not statistically significant in any sector, demonstrating that the trainer-trainee alliance did not moderate the relationship between attitudes and engagement across the different groups studied.

Table 8

Moderator Regression Analysis Predicting Follow-up Suicide Prevention Behaviors for the Total Sample

Variables	*β*	*B*	*SE*	*t*	*p*
	Behaviors (Follow-Up)				
(Constant)	--	1.09	.04	30.63	<.001
Behavior Mean (Pre)	.61	.60	.03	19.54	<.001
Attitudes (Pre)	-.03	-.09	.09	-.98	.33
Attitudes (Post)	-.08	-.17	.08	-2.08	.04
Attitudes (Follow-Up)	.06	.16	.10	1.64	.10
Alliance (Post)	.05	.09	.07	1.34	.18
Attitudes (Post) X Alliance	-.07	-.12	.06	-1.94	.05

Table 9

Moderator Regression Analysis Predicting Follow-up Suicide Prevention Behaviors for Education Sector

Variables	*β*	*B*	*SE*	*t*	*p*
	Behaviors (Follow-Up)				
(Constant)	--	1.00	.06	18.05	<.001
Behavior Mean (Pre)	.60	.56	.06	10.15	<.001
Attitudes (Pre)	.01	.01	.15	.07	.94
Attitudes (Post)	-.01	-.01	.11	-.10	.92
Attitudes (Follow-Up)	-.08	-.18	.14	-1.25	.21
Alliance (Post)	.04	.05	.09	.58	.56
Attitudes (Post) X Alliance	-.08	-.09	.07	-1.23	.22

Table 10

Moderator Regression Analysis Predicting Follow-up Suicide Prevention Behaviors for First Responders Sector

Variables	*β*	*B*	*SE*	*t*	*p*
	Behaviors (Follow-Up)				
(Constant)	--	1.13	.13	8.45	<.001
Behavior Mean (Pre)	.52	.51	.09	5.70	<.001
Attitudes (Pre)	.15	.43	.32	1.33	.19
Attitudes (Post)	-.27	-.70	.30	-2.33	.02
Attitudes (Follow-Up)	.17	.60	.36	1.68	.10
Alliance (Post)	-.01	-.03	.22	-.11	.91
Attitudes (Post) X Alliance	-.12	-.35	.35	-1.00	.32

Table 11

Moderator Regression Analysis Predicting Follow-up Suicide Prevention Behaviors for Mental Health/Substance Abuse Sector

Variables	*β*	*B*	*SE*	*t*	*p*
	Behaviors (Follow-Up)				
(Constant)	--	1.19	.11	10.51	<.001
Behavior Mean (Pre)	.66	.72	.09	7.63	<.001
Attitudes (Pre)	.08	.25	.34	.74	.46
Attitudes (Post)	-.19	-.53	.29	-1.79	.08
Attitudes (Follow-Up)	.05	.15	.29	.50	.62
Alliance (Post)	.003	.01	.24	.04	.97
Attitudes (Post) X Alliance	-.08	-.44	.51	-.88	.38

Table 12

Moderator Regression Analysis Predicting Follow-up Suicide Prevention Behaviors for DJJ & DCF/CW Sector

Variables	*β*	*B*	*SE*	*t*	*p*
	Behavior (Follow-Up)				
(Constant)	--	1.19	.12	9.94	<.001
Behavior Mean (Pre)	.59	.65	.11	6.00	<.001
Attitudes (Pre)	-.17	-.45	.34	-1.31	.20
Attitudes (Post)	.05	.17	.36	.46	.65
Attitudes (Follow-Up)	-.02	-.04	.33	-.13	.90
Alliance (Post)	.15	.39	.26	1.48	.14
Attitudes (Post) X Alliance	-.14	-.91	.63	-1.45	.15

Table 13

Moderator Regression Analysis Predicting Follow-up Suicide Prevention Behaviors for Other Sector

Variables	*β*	*B*	*SE*	*t*	*p*
	Behavior (Follow-Up)				
(Constant)	--	1.09	.06	17.79	<.001
Behavior Mean (Pre)	.62	.62	.05	11.43	<.001
Attitudes (Pre)	-.12	-.28	.13	-2.11	.04
Attitudes (Post)	-.06	-.15	.15	-1.01	.32
Attitudes (FU)	.14	.38	.16	2.36	.02
Alliance (Post)	.03	.08	.14	.55	.59
Attitudes (Post) X Alliance	-.02	-.03	.12	-.27	.79

Discussion

This study explored the implementation of suicide prevention gatekeeper training across multiple youth serving professional sectors, examining the relationships among attitudes toward suicide prevention, engagement in suicide prevention behaviors, and the alliance between trainer and trainee. The results highlighted both the strengths and limitations of existing gatekeeper training programs, underscoring the complexity of translating knowledge and attitudinal changes into actual behavioral engagement to identify and intervene with at-risk youth. While attitudes toward suicide prevention improved slightly post-training, mean levels of engagement in suicide prevention behaviors, or the average number of youth intervened with, was relatively low at pre-training, and in some cases, even declined at 3- month follow-up. This pattern reinforces the ongoing challenge in intervention science—achieving long-term behavioral change in high-stakes contexts like suicide prevention (Ajzen, 1991; Wyman et al., 2008). This discussion aims to contextualize the findings within the broader literature, explore the role of the trainer-trainee alliance, and identify implications for future training strategies.

The Trainer-Trainee Alliance as a Moderator of Behavior and Attitude Changes

The significant area of exploration in this study was the role of the trainer-trainee alliance in influencing both attitudes toward suicide prevention and prevention behaviors following training. Previous research has underscored the importance of the trainer-trainee relationship in facilitating successful learning outcomes (Kaufman & Raiz, 2014; Wyman et al., 2008). The present study found that, for the total sample, a stronger alliance between trainers and trainees was associated with more favorable attitudes toward suicide prevention after training, although the correlation was modest (r = .23). While the trainer-trainee alliance may have contributed to a

supportive context facilitating positive attitudes, it was not significantly correlated with engagement in suicide prevention behaviors (r = .05).

The Theory of Planned Behavior (Ajzen, 2020), which posits that attitudes, perceived behavioral control, and subjective norms significantly influence behavioral intentions and subsequent actions toward health-related behavior change, served as the theoretical framework for this study. However, the findings did not strongly support this theory in understanding behavior change within the context of suicide prevention training. Although a strong trainer-trainee alliance, operationalized as mutual trust, open communication, and shared goals, was associated with more positive attitudes, it did not moderate the process of engaging in prevention behaviors. Participants reported relatively high levels of alliance, which suggests that they felt a strong connection with their respective trainers. Contributing factors to these high ratings may include perceived trainer competence, personalized support, and the creation of a comfortable learning environment (Doyle et al., 2017). Despite these positive elements, the alliance did not translate into significantly increased engagement in prevention behaviors, which suggests that opportunities on the part of the trainer, such as ongoing support through supervision, feedback, or booster sessions, could have helped maintain and strengthen the skills and attitudes gained during initial training (Graham & Little, 2019). The gatekeeper training utilized in this study was a two-hour session that did not include continued support or reinforcement of skills, which may have contributed to the limited behavioral engagement observed during the follow-up period. Other factors on the part of the individual participant, such as confidence, perceived behavioral control, or practical opportunities to intervene, may also be more central to behavior change in this context.

Moreover, while past research suggests that the trainer-trainee alliance is important, the present results indicate that it may not be sufficient on its own to ensure lasting behavior change, particularly following shorter training sessions. Attitudes toward suicide prevention were overwhelmingly positive across all sectors both before and after training, with a modest increase post-training ($\bar{X}$ = 4.62 to 4.69). This slight change in attitudes, coupled with generally weak or non-significant correlations between attitudes and behaviors (*r* typically < .10, with some sector-level correlations up to *r* = .15), highlights the well-documented challenge of translating attitude shifts into meaningful behavioral change. In line with Ajzen's (1991) Theory of Planned Behavior, these findings suggest that while positive attitudes are necessary for intervention, they are not sufficient to motivate actual behavior change. Attitude-behavior consistency is influenced by external factors such as situational constraints, social norms, and the opportunity to engage in prevention behaviors (Ajzen, 2020; Brown Hangartner et al., 2019). The lack of significant behavioral engagement during the follow-up period may be partly due to limited opportunities for participants to engage with at-risk youth in their service sectors, an area that warrants further study.

According to the Theory of Planned Behavior, perceived behavioral control often predicts behavior more strongly than attitudes alone, particularly in high-pressure or unpredictable situations. Prior research on youth-focused gatekeeper training has emphasized the importance of fostering confidence and perceived competence in suicide prevention behaviors (Burnette et al., 2015; Totura et al., 2019). Future training programs may benefit from incorporating more interactive components, such as sector-specific role-plays, simulations, and applied practice, to enhance participants' perceived preparedness and ability to respond confidently in real-world scenarios where timely intervention is critical (Doyle et al., 2017).

Sector-Specific Variations in Training Outcomes

The study revealed sector-specific variations in training outcomes, offering insights into how different professional roles may benefit from tailored interventions. First responders had the highest pre-training behavior scores, suggesting they were already highly engaged in suicide prevention efforts. Although engagement significantly declined from pre-training to the 3-month follow-up across the full sample ($t(673) = -7.62$, $p < .001$), this trend among first responders may reflect the short follow-up window, which may not have allowed sufficient opportunity to encounter at-risk individuals. Their focus on immediate physical stabilization during crises could also limit the application of suicide prevention strategies in the short term.

Education and Mental Health/Substance Abuse professionals showed modest post-training gains, but behavior change was less sustained at follow-up. In both sectors, higher pre-training engagement predicted more consistent follow-up behavior, indicating that ongoing reinforcement may be needed to maintain improvements. DJJ and DCF/Child Welfare professionals demonstrated improved attitudes post-training but no significant changes in behavior at follow-up, possibly due to structural barriers within their work environments. The other sector showed slight declines in attitudes and mixed behavior outcomes, suggesting that suicide prevention may be perceived as less central to their roles.

Each of the regression models showed that, for most sectors, post-training variables, including attitudes, alliance, and their interaction, were not significant predictors of suicide prevention behaviors at the 3-month follow-up. However, in the total sample and first responders, post-training attitudes negatively predicted follow-up behaviors, suggesting that participants who reported more favorable attitudes immediately after training were less likely to report engaging in suicide prevention behaviors at follow-up. This counterintuitive finding may

reflect a temporary boost in perceived competence or optimism that did not translate into sustained behavioral change, or a social desirability effect in attitude ratings that did not align with actual behavior. Additionally, in the other sector, follow-up attitudes were positively associated with behavior, indicating that enduring favorable views of suicide prevention may be more influential in sustaining engagement. These patterns suggest that timing of attitude measurement matters and highlight the importance of exploring how attitudinal shifts evolve and interact with real-world practice over time.

Nonetheless, these findings align with theoretical perspectives that suggest individuals with lower baseline engagement are more likely to benefit from programs focused on building foundational knowledge, confidence, and practical skills (Burnette et al., 2015). For such groups, training that emphasizes core prevention skills and addresses gaps in confidence and competence in suicide prevention may prove more effective in fostering lasting behavior change.

Implications for Suicide Prevention Training Programs

The findings from this study highlight the need for a reevaluation of suicide prevention training strategies for professionals who serve youth across various service sectors. The weak correlation between attitude changes and behavioral engagement suggests that training programs should not solely focus on attitudinal shifts but also emphasize skill development and competency in applying learned skills. To bridge the gap between knowledge acquisition and behavioral application, especially in specific youth-serving sectors, future training implementations should incorporate active learning techniques, such as role-playing, simulation exercises, and real-time feedback aligned with each sector’s roles and responsibilities. These techniques help trainees gain hands-on experience, allowing them to practice and refine the skills

needed to intervene effectively with at-risk youth in their professional contexts (Doyle et al., 2017).

Incorporating scenario-based learning is particularly important for sectors like first responders, who may already engage in high-level crisis intervention but may not view suicide prevention as a central responsibility (Kubiak et al., 2019). For these professionals, advanced training that focuses on complex, high-stakes scenarios may enhance the effectiveness of suicide prevention interventions. On the other hand, professionals in sectors with lower initial engagement, such as mental health and substance use providers, may benefit from foundational skill-building, confidence-building, and knowledge reinforcement (Burnette et al., 2015). These providers may engage with fewer acutely at-risk youth compared to first responders, particularly if they are working with an established client list rather than encountering individuals in crisis situations on a regular basis. In both cases, the trainer-trainee alliance remains essential but should be supplemented with ongoing support and context-specific strategies to promote the application of skills and ensure lasting behavior change.

Strengths and Limitation

The study's multi-sector approach is one of its greatest strengths, providing a comprehensive view of the effectiveness of suicide prevention training across different professional contexts. By examining participants from diverse sectors, including first responders, mental health professionals, and juvenile justice staff, the study sheds light on the variability of training outcomes and the factors influencing them. Additionally, the longitudinal data examining the context of program implementation, including the perceived supportiveness of the training environment, allowed for an exploration of both immediate and sustained impacts of the

training, offering valuable insights into the long-term effectiveness of suicide prevention programs.

However, several limitations must be considered. First, the reliance on self-reported measures introduces potential bias, including social desirability bias, which could lead to inflated or underreported attitudes, alliance, and behavioral engagement levels (Gryglewicz et al., 2020). To mitigate this, future studies should incorporate multi-rater reports of alliance and objective behavioral assessments, such as administrative records or direct observation, to provide a more accurate picture of trainer-trainee relationships and behavioral engagement. Additionally, participants reported on the number of youth they intervened with as a measure of behavioral engagement. It is possible a more robust measure of behavior would consist of asking participants the frequency with which they engaged in specific prevention behaviors consistent with the QPR training, such as asking youth about their risk, persuading seeking help, and/or referring for mental health services. Furthermore, the lack of an experimental design limits the ability to draw causal conclusions. While randomized controlled trials (RCTs) are often considered the gold standard for evaluating intervention outcomes, ethical concerns, particularly in youth-serving contexts, make it inappropriate to withhold potentially beneficial training or services. However, ethically sound alternatives such as waitlist control designs or stepped-wedge trials could offer more rigorous evaluation while ensuring all participants eventually receive the intervention (Fixsen et al., 2005).

In addition, the attitudes measures in the study had Cronbach's alphas below .60, suggesting limited internal consistency. Low reliability weakens the precision of these scales and may have attenuated observed relationships between key constructs, particularly alliance and

behavioral outcomes. Future research should refine these measures to improve psychometric properties and ensure greater confidence in the associations tested.

Another limitation of this study is the absence of consideration for external factors such as workplace policies, organizational support, and systemic barriers that may affect the application of suicide prevention skills. Future research should explore these contextual factors to provide a more holistic understanding of the facilitators and barriers to effective implementation of suicide prevention training. Additionally, the 3-month follow-up period may not have allowed ample time for all participants, especially those working in less crisis-intensive settings, to encounter and engage with at-risk youth, potentially limiting their opportunity to demonstrate behavior change. Finally, the relatively small standard deviations observed for several key variables (e.g., attitudes and alliance) suggest restricted variability in responses, which could have limited the ability to detect stronger associations between predictors and behavioral outcomes.

Future Directions

Future research should explore strategies to enhance long-term behavioral engagement following suicide prevention training. Approaches such as follow-up booster sessions, digital reinforcement tools, and ongoing supervision have shown promise in maintaining the effectiveness of gatekeeper training (Beidas & Kendall, 2010; Gagne et al., 2005). Future studies should also investigate sector-specific barriers to behavioral change, including organizational constraints, stigma surrounding suicide prevention, and time limitations in professional settings. Understanding these barriers can inform the development of more tailored, context-specific training interventions that maximize the impact of suicide prevention efforts.

Integrating suicide prevention training into broader mental health competency frameworks may help reinforce these skills as part of ongoing professional development. This approach could ensure that suicide prevention skills remain a central component of professionals' knowledge base, even beyond the initial training period.

Conclusion

This study highlights the need for sector-specific adaptations to suicide prevention training programs. While improvements in attitudes were observed across sectors, translating these into sustained behavioral engagement remains a challenge. The findings suggest that trainer-trainee alliance, while important for training delivery, may not play a central role in predicting behavior change. To address gaps in behavioral engagement, training programs should prioritize the development of practical skills through methods such as scenario-based learning, role-play, and ongoing support. By emphasizing real-world application and perceived behavioral control, suicide prevention efforts can be more effective in preparing professionals to identify and intervene with at-risk individuals. Future research should continue to investigate mechanisms that enhance long-term behavior change, particularly in under-resourced or high-need sectors, to ensure that training has a lasting and meaningful impact.

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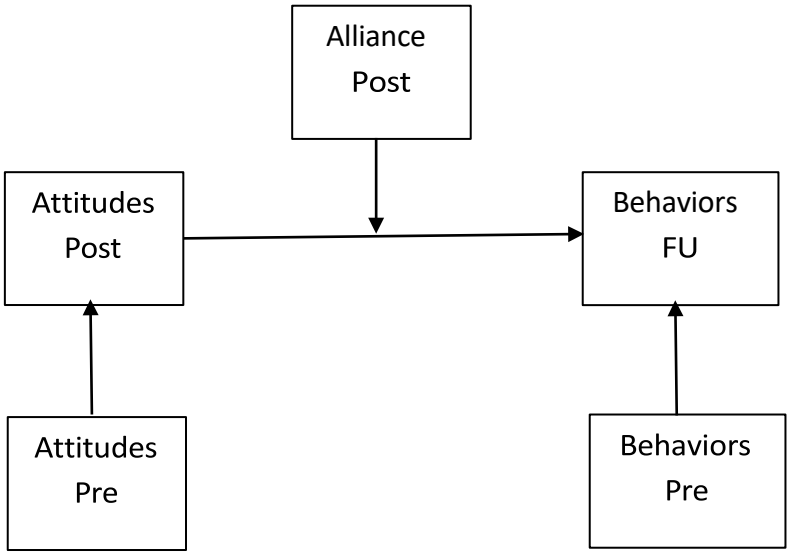
Figure 1. Conceptual model of alliance moderating the relationship between attitudes and suicide prevention behaviors.



Appendix

Today's Date: ___ ___/_____/_____
Month Day Year

Evaluation of QPR Training for Staff

Your answers are confidential and will only be seen by evaluation staff at the University of South Florida.

1. What are the initials of your first and last name?

____ ____
First Last

2. What year were you born?

1 9 ___ ___

3. What county do you *live* in?

_____

4. What county do you *work* in?

_____

5. What is your gender?

- ○ Male
- ○ Female
- ○ Other

6. Are you Hispanic or Latina/o?

- ○ Yes – Specify _____ (e.g. Mexican, Cuban)
- ○ No
- ○ Don't know / Not applicable

7. Which Racial/Ethnic group best describes you? Please circle all that apply.

- ○ American Indian or Alaskan Native – Specify _____
- ○ Asian – Specify _____ (e.g., Chinese, Korean)
- ○ Black or African American
- ○ Native Hawaiian or Pacific Islander
- ○ White (or Caucasian)

8. What is the highest grade in school that you completed?

- ○ Some high school
- ○ Completed high school or GED
- ○ Vocational, technical, trade, or business school beyond the high school level
- ○ Some college, but no degree
- ○ Associate degree
- ○ Bachelor's degree
- ○ Some graduate school
- ○ Master's degree
- ○ Doctoral degree

9. Select <u>one</u> category that <u>best</u> describes your work role:

○ Teacher	○ Case Manager
○ Advocate	○ Support Staff
○ Administrator	○ Emergency/Crisis care worker
○ Program Supervisor	○ Consultant
○ Therapist	○ Caregiver of youth
○ Case Manager	○ Other-- Specify _____

10. How would you classify your sexual orientation?

- ○ Heterosexual or straight
- ○ Gay or lesbian
- ○ Bisexual

11. Please circle the number from the scale below that best describes your sexual orientation.

Exclusively heterosexual with no homosexual (Straight)	Predominantly heterosexual, only incidentally homosexual	Predominantly heterosexual, but more than incidentally homosexual	Equally heterosexual and homosexual	Predominantly homosexual, but more than incidentally heterosexual	Predominantly homosexual, only incidentally heterosexual	Exclusively homosexual (Gay/Lesbian)
1	2	3	4	5	6	7

12. Do you identify as being a member of any of the following groups?
Please choose all that apply.

- ⬭ Foster Parent
- ⬭ Military Family
- ⬭ Veteran
- ⬭ Survivor/Lost someone to suicide
- ⬭ Close to someone who has attempted suicide
- ⬭ Survivor of personal suicide attempt
- ⬭ Religious or Faith-based Groups
- ⬭ Other– Specify _____

13. On the following scale, how frequently do you interact with youth from the following groups?

	Rarely (Monthly or Less)		Sometimes (Weekly)		Very Often (Daily)
a. LGBTQ Status	⬭	⬭	⬭	⬭	⬭
b. Foster Care Children	⬭	⬭	⬭	⬭	⬭
c. American Indian/ Alaskan Native	⬭	⬭	⬭	⬭	⬭
d. Hispanic/Latino/a	⬭	⬭	⬭	⬭	⬭
e. African American	⬭	⬭	⬭	⬭	⬭
f. Veterans	⬭	⬭	⬭	⬭	⬭
g. Military Families	⬭	⬭	⬭	⬭	⬭
h. Survivors/Those who have lost someone to suicide	⬭	⬭	⬭	⬭	⬭
i. Those close to someone who has attempted suicide	⬭	⬭	⬭	⬭	⬭
j. Survivors of personal suicide attempt	⬭	⬭	⬭	⬭	⬭
k. Substance Users	⬭	⬭	⬭	⬭	⬭
l. Victims of Bullying and Victimization	⬭	⬭	⬭	⬭	⬭
m. College Students	⬭	⬭	⬭	⬭	⬭
n. Youth involved in the Juvenile Justice system	⬭	⬭	⬭	⬭	⬭
o. Young adults, not in college	⬭	⬭	⬭	⬭	⬭

You may notice that many questions seem very similar and it may appear that we are repeating questions, but we are not. Due to the nature of our work, it is recommended that we ask very similar questions. We appreciate your attention to the slight differences in wording in our questions.

Please consider the last 3 months you had contact with *youth* for the following questions.

	None	1	2	3	4 or more	N/A---do not see youth
14. How many youth seemed upset or depressed?	○	○	○	○	○	○
15. How many youth did you notice withdrawing from friends or family?	○	○	○	○	○	○
16. In how many youth did you see a drastic change in behavior or mood?	○	○	○	○	○	○
17. How many youth did you tell to seek help ?	○	○	○	○	○	○
18. With how many youth from culturally and linguistically diverse groups (e.g. LGBTQ, African American, Hispanic/Latino/a, etc.) did you tell to seek help?	○	○	○	○	○	○
19. How many youth did you ask whether she or he was considering suicide?	○	○	○	○	○	○
20. How many youth from culturally and linguistically diverse groups (e.g. LGBTQ, African American, Hispanic/Latino/a, etc.) did you ask whether she or he was considering suicide?	○	○	○	○	○	○
21. How many youth at risk for suicide did you hear talk about dying by suicide?	○	○	○	○	○	○
22. How many youth at risk for suicide did you take to a counselor or other mental health resource?	○	○	○	○	○	○
23. How many at risk for suicide from culturally and linguistically diverse groups (e.g. LGBTQ, African American, Hispanic/Latino/a, etc.) did you take to a counselor or other mental heath resource?	○	○	○	○	○	○
24. For how many youth at risk for suicide did you call the National Suicide Prevention Lifeline (NSPL)?	○	○	○	○	○	○
25. For how many youth at risk for suicide did you call a non-NSPL crisis line?	○	○	○	○	○	○
26. For how many youth at risk for suicide did you call 911?	○	○	○	○	○	○

27. Think of your interactions with youth and pick the best answer which describes how prepared you feel to do the following:

	Not at all	Slightly	Moderately	Well	Quite Well
a. Identify suicide warning signs.	⬭	⬭	⬭	⬭	⬭
b. Ask questions about suicide.	⬭	⬭	⬭	⬭	⬭
c. Respond to youths telling you about suicidal thoughts.	⬭	⬭	⬭	⬭	⬭
d. Get youths to say they will not attempt suicide.	⬭	⬭	⬭	⬭	⬭
e. Talk/persuade a youth into seeking help.	⬭	⬭	⬭	⬭	⬭
f. Make any needed referrals.	⬭	⬭	⬭	⬭	⬭
g. Report suicidal thoughts or suicide attempts.	⬭	⬭	⬭	⬭	⬭

28. Rate the extent to which you "Agree" or "Disagree" with the following statements:

	Strongly Agree				Strongly Disagree
a. Other staff will expect me to use the QPR skills that I am taught.	⬭	⬭	⬭	⬭	⬭
b. Other staff like me are expected to refer youth at risk for suicide.	⬭	⬭	⬭	⬭	⬭
c. In my family we do not discuss the topic of suicide.	⬭	⬭	⬭	⬭	⬭
d. In my group of friends I would be expected to ask about someone's risk for suicide.	⬭	⬭	⬭	⬭	⬭
e. My workplace encourages me to ask youth about thoughts of suicide.	⬭	⬭	⬭	⬭	⬭
f. My supervisor encourages me to ask youth about thoughts of suicide.	⬭	⬭	⬭	⬭	⬭
g. My organization is pretty open to my learning new things.	⬭	⬭	⬭	⬭	⬭
h. Implementing the QPR program will address an important unmet need of our organization.	⬭	⬭	⬭	⬭	⬭
i. Implementing the QPR program will have more benefits than drawbacks for my organization.	⬭	⬭	⬭	⬭	⬭
j. The QPR program is similar to the values and policies of my organization.	⬭	⬭	⬭	⬭	⬭
k. My organization's decision to offer the QPR program is a good idea.	⬭	⬭	⬭	⬭	⬭

29. Rate the extent to which you "Agree" or "Disagree" with the following statements:

	Strongly Disagree				Strongly Agree
a. Depression is a treatable condition.	⬭	⬭	⬭	⬭	⬭
b. Mental illness is just as serious as physical illness.	⬭	⬭	⬭	⬭	⬭
c. When a youth is talking about suicide, it should be taken seriously.	⬭	⬭	⬭	⬭	⬭
d. It's not my place to refer a suicidal youth.	⬭	⬭	⬭	⬭	⬭
e. If someone wants to commit suicide, I can't change his or her mind.	⬭	⬭	⬭	⬭	⬭

30. What does being culturally sensitive mean to you?

_____

_____

_____

_____

_____

For the following questions, please use the following definition of cultural sensitivity.

Cultural sensitivity involves using approaches which acknowledge a given person's values, beliefs, and expectations. For example, being culturally sensitive may involve acknowledging a person's family customs or spiritual beliefs.

31. Rate the extent to which you "Agree" or "Disagree" with the following statements:

		Strongly Disagree				Strongly Agree
a.	Cultural sensitivity is important to suicide prevention efforts.	○	○	○	○	○
b.	I feel confident in my ability to engage suicidal youth in different backgrounds.	○	○	○	○	○
c.	Learning about culture-specific information is important for suicide prevention.	○	○	○	○	○
d.	Most people I know think that culture-specific information is unnecessary for speaking with suicidal youth.	○	○	○	○	○
e.	Who were you considering as "most people" for the question above?	_____				
f.	I have necessary skills to engage suicidal youth from diverse cultural backgrounds.	○	○	○	○	○
g.	Most people I know think that cultural sensitivity is important to suicide prevention efforts.	○	○	○	○	○
h.	Who were you considering as "most people" for the question above?	_____				

Version 4--- 8.15.13

To be filled out AFTER the training

You may notice that many questions seem very similar and it may appear that we are repeating questions, but we are not. Due to the nature of our work, it is recommended that we ask very similar questions. We appreciate your attention to the slight differences in wording in our questions.

1. Rate the extent to which you "Agree" or "Disagree" with the following statements:

		Strongly Disagree				Strongly Agree
a.	I like the person who taught the QPR training.	○	○	○	○	○
b.	I was comfortable participating in this training.	○	○	○	○	○
c.	I felt that the QPR trainer was able to listen to and understand questions and/or concerns about the presentation.	○	○	○	○	○
d.	I felt that the QPR trainer welcomed my comments and questions.	○	○	○	○	○

2. Rate the extent to which you "Agree" or "Disagree" with the following statements:

		Strongly Disagree				Strongly Agree
a.	I felt that the trainer delivered a convincing presentation.	○	○	○	○	○
b.	The trainers seemed to know what they are talking about.	○	○	○	○	○
c.	I felt that the trainer increased my interest in learning about suicide prevention.	○	○	○	○	○
d.	I actively participated in the suicide prevention training discussions.	○	○	○	○	○
e.	The training made me think about suicide prevention.	○	○	○	○	○
f.	I asked questions during the suicide prevention presentation.	○	○	○	○	○

3. Please circle Yes or No based on the training you just attended.

a.	We were given QPR informational booklets.	YES	NO
b.	We discussed suicide statistics.	YES	NO
c.	We discussed ways to persuade someone to stay alive.	YES	NO
d.	We learned what the letters in the acronym STAY stand for.	YES	NO
e.	We learned the warning signs of suicide (i.e. direct verbal, indirect verbal, behavioral, situational).	YES	NO
f.	We watched the QPR video.	YES	NO
g.	We learned tips for asking the suicide question.	YES	NO
h.	We watched a CNN video clip about suicide.	YES	NO
i.	We learned the common myths and misconceptions about suicide.	YES	NO
j.	We were shown slides about suicide prevention.	YES	NO
k.	We discussed facts regarding risk groups of suicide.	YES	NO
l.	We learned multiple ways to ask a person if they are suicidal.	YES	NO
m.	We discussed tips for referring a suicidal person for treatment.	YES	NO

4. Do you feel you can direct a suicidal youth to resources in the community?

- ○ Yes
- ○ No – Resources are not available
- ○ No – Resources are not receptive to referrals
- ○ Unsure
- ○ NA – I do not work with youth

5. Rate the extent to which you "Agree" or "Disagree" with the following statements:

		Strongly Disagree				Strongly Agree
a.	Depression is a treatable condition.	○	○	○	○	○
b.	Mental illness is just as serious as physical illness.	○	○	○	○	○
c.	When a youth is talking about suicide, it should be taken seriously.	○	○	○	○	○
d.	It's not my place to refer a suicidal youth.	○	○	○	○	○
e.	If someone wants to commit suicide, I can't change their mind.	○	○	○	○	○

6. Think of your interactions with youths and pick the best answer which describes how prepared you feel to do the following:

		Not at all	Slightly	Moderately	Well	Quite Well
a.	Identify suicide warning signs	○	○	○	○	○
b.	Ask questions about suicide.	○	○	○	○	○
c.	Respond to youths telling you about suicidal thoughts.	○	○	○	○	○
d.	Get youths to say they will not attempt suicide.	○	○	○	○	○
e.	Talk/persuade a youth into seeking help.	○	○	○	○	○
f.	Make any needed referrals.	○	○	○	○	○
g.	Report suicidal thoughts or suicide attempts.	○	○	○	○	○

7. Please mark how much you agree or disagree with each of the following statements:

		Strongly Disagree				Strongly Agree
a.	The trainer was knowledgeable about my culture.	○	○	○	○	○
b.	The training did not address cultural issues that were important to me.	○	○	○	○	○
c.	The QPR training materials included sufficient information about my culture.	○	○	○	○	○
d.	Learning about culture-specific information is important for suicide prevention.	○	○	○	○	○
e.	Most people I know think that culture-specific information is unnecessary for speaking with suicidal youth.	○	○	○	○	○
f.	Who were you considering as "most people" for the question above?	_____				

	Strongly Disagree				Strongly Agree
g. The training improved my understanding of cultural issues in suicide prevention.	⬭	⬭	⬭	⬭	⬭
h. Most people I know think that cultural sensitivity is important to suicide prevention efforts.	⬭	⬭	⬭	⬭	⬭
i. Who were you considering as "most people" in the question above?	________________				
j. Cultural sensitivity is important to suicide prevention efforts.	⬭	⬭	⬭	⬭	⬭
k. I feel confident in my ability to engage suicidal youth of culturally and linguistically diverse backgrounds.	⬭	⬭	⬭	⬭	⬭
l. I have the necessary skills to engage suicidal youth of culturally and linguistically diverse backgrounds.	⬭	⬭	⬭	⬭	⬭
m. The trainer did not address cultural issues that were important to me.	⬭	⬭	⬭	⬭	⬭
n. The QPR training materials contained sufficient information about youth from other cultures.	⬭	⬭	⬭	⬭	⬭

8. What aspects of the training did you feel were culturally sensitive?

BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB

____

____

____

9. What did you feel was missing?

____

____

____

10. How well did the trainer provide culturally sensitive training?

____

____

____

____

11. What could be improved about the trainer in regards to cultural sensitivity?

____

____

____

____

Todays' Date: _____

1. What are the initials of your first and last name?

____ ____
First Last

2. What year were you born?

1 9 ___ ___

3. What county do you *live* in?

_____

4.What county do you *work* in?

_____

5. Have you moved in the last 3 months?

- ○ Yes
- ○ No

6. Have you changed jobs in the last 3 months?

- ○ Yes
- ○ No

7. Please refer to your interactions with youths. Bubble in the circle which best describes how **prepared** you feel to perform the following:

	Not at all	Slightly	Moderately	Well	Quite Well
a. Identify suicide warning signs	○	○	○	○	○
b. Ask questions about suicide.	○	○	○	○	○
c. Respond to youths telling you about suicidal thoughts.	○	○	○	○	○
d. Get youths to say they will not attempt suicide.	○	○	○	○	○
e. Talk/persuade a youth into seeking help.	○	○	○	○	○
f. Make any needed referrals.	○	○	○	○	○
g. Report suicidal thoughts or suicide attempts.	○	○	○	○	○

8. Do you feel you can direct a suicidal youth to resources in the community?

- ○ Yes
- ○ No – Resources are not available
- ○ No – Resources are not receptive to referrals
- ○ Unsure
- ○ NA – I do not work with youth

Todays' Date: _____

9. Rate the extent to which you "Agree" or "Disagree" with the following statements:	Strongly Disagree 1	2	3	4	Strongly Agree 5
a. My workplace encourages me to ask youths about thoughts of suicide.	○	○	○	○	○
b. My supervisor encourages me to ask youth about thoughts of suicide.	○	○	○	○	○
c. My organization is pretty open to my learning new things.	○	○	○	○	○
d. Implementing the QPR program will address an important unmet need of our organization.	○	○	○	○	○
e. Implementing the QPR program will have more benefits than drawbacks for my organization.	○	○	○	○	○
f. The QPR program is similar to the values and policies of my organization.	○	○	○	○	○
g. My organization's decision to offer the QPR program is a good idea.	○	○	○	○	○
h. Other staff will expect me to use the QPR skills that I am taught.	○	○	○	○	○
i. Other staff like me are expected to refer youth at risk for suicide.	○	○	○	○	○
j. In my family we do not discuss the topic of suicide.	○	○	○	○	○
k. In my group of friends I would be expected to ask about someone's risk for suicide.	○	○	○	○	○
l. I feel confident in my ability to engage suicidal youth of different backgrounds.	○	○	○	○	○
m. I have the necessary skills to engage suicidal youth of diverse cultural backgrounds.	○	○	○	○	○
n. The training helped me engage youth from diverse cultural backgrounds.	○	○	○	○	○
o. Culture-specific information from the training was helpful for interacting with suicidal youth.	○	○	○	○	○

Todays' Date: _____

10. Rate the extent to which you "Agree" or "Disagree" with the following statements:

	Strongly Disagree				Strongly Agree
a. Depression is a treatable condition.	○	○	○	○	○
b. Mental illness is just as serious as physical illness.	○	○	○	○	○
c. If someone wants to commit suicide, I can't change their mind.	○	○	○	○	○
d. When a youth is talking about suicide, it should be taken seriously.	○	○	○	○	○
e. It's not my place to refer a suicidal youth.	○	○	○	○	○

11. The following questions refer to the "It's Time to Talk about It" Family Guide that you received during the QPR training you attended:

a. Did you receive a copy of the guide? ○ *Yes* ○ *No*
If yes, how many copies? _____

b. Did you read the guide? ○ *Yes* ○ *No*

c. Do you still have a copy of the guide? ○ *Yes* ○ *No*

d. Have you shared the guide with others? ○ *Yes* ○ *No*
If yes, please mark all that apply and specify how many people:

- ○ Your spouse/significant other – How many?
- ○ Your child (daughter/son) – How many? _____
- ○ Your child's friend – How many? _____
- ○ Family member who is a youth – How many? _____
- ○ Adult family member – How many?
- ○ Friend – How many? _____
- ○ Co-worker – How many? _____
- ○ Other, please specify_____- How many? _____

e. Have you used the guide to help someone at risk? ○ *Yes* ○ *No* *If yes, how many people?*_____

f. Has the guide influenced you to participate in suicide prevention activities/events?
○ *Yes* ○ *No* *If yes, please describe:*_____

g. How helpful has the guide been for you?
○ *Not at all helpful* ○ *A little helpful* ○ *Somewhat helpful* ○ *Very helpful*

Todays' Date: _____

Since participating in the QPR training 3 months ago, please refer to your contact with youth for the following questions.	*None*	*1*	*2*	*3*	*4 or more*	*N/A*
12. How many youth seemed upset or depressed?	⬭	⬭	⬭	⬭	⬭	⬭
13. How many youth did you notice withdrawing from friends or family?	⬭	⬭	⬭	⬭	⬭	⬭
14. In how many youth did you see a drastic change in behavior or mood?	⬭	⬭	⬭	⬭	⬭	⬭
15. How many youth did you hear talk about dying by suicide?	⬭	⬭	⬭	⬭	⬭	⬭
16. For how many youth at risk for suicide did you call the National Suicide Prevention Lifeline?	⬭	⬭	⬭	⬭	⬭	⬭
17. For how many youth at risk for suicide did you call a non-National Suicide Prevention Lifeline crisis line?	⬭	⬭	⬭	⬭	⬭	⬭
18. For how many youth at risk for suicide did you call 911?	⬭	⬭	⬭	⬭	⬭	⬭

Please proceed to questions 18-20 for each youth referred.	*None*	*1*	*2*	*3*	*4 or more*	*N/A*
19. How many youth did you ask whether she or he was considering suicide?	⬭	⬭	⬭	⬭	⬭	⬭
20. How many youth from different cultural groups (e.g. LGBTQ, African American, Hispanic/Latino/a, etc.) did you ask whether she or he was considering suicide?	⬭	⬭	⬭	⬭	⬭	⬭
21. How many youth at risk for suicide did you tell to seek help?	⬭	⬭	⬭	⬭	⬭	⬭
22. How many youth from different cultural groups (e.g. LGBTQ, African American, Hispanic/Latino/a, etc.) at risk for suicide did you tell to seek help?	⬭	⬭	⬭	⬭	⬭	⬭
23. How many youth at risk for suicide did you take to a counselor or other mental health resource?	⬭	⬭	⬭	⬭	⬭	⬭
24. How many youth at risk for suicide from different cultural groups (e.g. LGBTQ, African American, Hispanic/ Latino/a, etc.) did you take to a counselor or other mental health resource?	⬭	⬭	⬭	⬭	⬭	⬭

25. If you referred a youth from a different culture, what information from the training did you find useful?

_____

_____

_____

Todays' Date: _____

26. What other sources did you consult?

_____
_____
_____
_____

27. What information would you have liked to have known before approaching the youth?

_____
_____
_____

****If *no referrals were made*, skip questions 28-39.****

Youth 1 Initials:_____

28. What was your relationship with this youth?

- ○ Teacher
- ○ School Counselor
- ○ Mental Health Counselor
- ○ Medical Doctor
- ○ Parent/Guardian
- ○ Community Center
- ○ Social Service Capacity
- ○ Law Capacity
- ○ Faith Leader
- ○ Employer
- ○ Other, please specify_____

29. Why did you refer this youth?

- ○ Seemed upset/depressed
- ○ Withdrawing from friends or family
- ○ Doing poorly in school
- ○ A peer recently died by suicide
- ○ Youth expressed wanting to die or giving up
- ○ Saw/heard evidence of self-harm
- ○ Youth had made a suicide attempt before
- ○ Other, please specify_____

30. Where did you refer this youth?

- ○ School Counselor
- ○ Mental Health Counselor
- ○ Medical Doctor
- ○ Parent/Guardian
- ○ Community Center
- ○ Faith Leader
- ○ Other, please specify_____

Todays' Date: _____

Youth 2 Initials:_____

31. What was your relationship with this youth?

- ○ Teacher
- ○ School Counselor
- ○ Mental Health Counselor
- ○ Medical Doctor
- ○ Parent/Guardian
- ○ Community Center
- ○ Social Service Capacity
- ○ Law Capacity
- ○ Faith Leader
- ○ Employer
- ○ Other, please specify_____

32. Why did you refer this youth?

- ○ Seemed upset/depressed
- ○ Withdrawing from friends or family
- ○ Doing poorly in school
- ○ A peer recently died by suicide
- ○ Youth expressed wanting to die or giving up
- ○ Saw/heard evidence of self-harm
- ○ Youth had made a suicide attempt before
- ○ Other, please specify_____

33. Where did you refer this youth?

- ○ School Counselor
- ○ Mental Health Counselor
- ○ Medical Doctor
- ○ Parent/Guardian
- ○ Community Center
- ○ Faith Leader
- ○ Other, please specify_____

Todays' Date: _____

Youth 3 Initials:_____

34. What was your relationship with this youth?

- o Teacher
- o School Counselor
- ○ Mental Health Counselor
- o Medical Doctor
- ○ Parent/Guardian
- o Community Center
- ○ Social Service Capacity
- o Law Capacity
- ○ Faith Leader
- ○ Employer
- ○ Other, please specify_____

35. Why did you refer this youth?

- ○ Seemed upset/depressed
- ○ Withdrawing from friends or family
- ○ Doing poorly in school
- ○ A peer recently died by suicide
- ○ Youth expressed wanting to die or giving up
- ○ Saw/heard evidence of self-harm
- ○ Youth had made a suicide attempt before
- ○ Other, please specify_____

36. Where did you refer this youth?

- ○ School Counselor
- ○ Mental Health Counselor
- ○ Medical Doctor
- o Parent/Guardian
- ○ Community Center
- o Faith Leader
- ○ Other, please specify_____

Todays' Date: _____

Youth 4 Initials:_____

37. What was your relationship with this youth?

- ○ Teacher
- ○ School Counselor
- ○ Mental Health Counselor
- ○ Medical Doctor
- ○ Parent/Guardian
- ○ Community Center
- ○ Social Service Capacity
- ○ Law Capacity
- ○ Faith Leader
- ○ Employer
- ○ Other, please specify_____

38. Why did you refer this youth?

- ○ Seemed upset/depressed
- ○ Withdrawing from friends or family
- ○ Doing poorly in school
- ○ A peer recently died by suicide
- ○ Youth expressed wanting to die or giving up
- ○ Saw/heard evidence of self-harm
- ○ Youth had made a suicide attempt before
- ○ Other, please specify_____

39. Where did you refer this youth?

- ○ School Counselor
- ○ Mental Health Counselor
- ○ Medical Doctor
- ○ Parent/Guardian
- ○ Community Center
- ○ Faith Leader
- ○ Other, please specify_____