Arizona Department of Education
FFY2018 Award Year
Arizona Project AWARE
Advancing Wellness and Resiliency in Education

Annual Progress Report
Year 1, 9/30/18 – 9/29/2019

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Introduction

In Year One, Arizona Project AWARE planned and implemented strategies and activities to build a robust platform for accomplishing the project's three key goals:

(1) Build and maintain infrastructure for mental health services in Arizona schools for school-age children.

(2) Conduct outreach and engagement with school-aged youth and their families to increase awareness and identification of mental health issues and to promote positive mental health.

(3) Provide professional development and training to school personnel, SEA staff, community partners and other adults who interact with school-aged youth, to detect and respond to mental health issues.

These three AWARE goals frame our work to address Arizona's challenges to individual, family, and community mental health and wellness. Arizona has a high prevalence of mental illness paralleled with low access to mental health services (access ranking 32nd for adults and 47th for young people[1]), and lacks behavioral health and support staff at local education agencies to provide consistent and quality mental health outreach, detection, intervention, and referral services. While addressing these challenges, we also aim to draw from and build on considerable strengths and resources available at the state and local levels.

The Arizona Department of Education's (ADE) is the State Education Authority (SEA) responsible for Project AWARE. Our lead state partner is the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency and mental health authority. Our three selected local education agencies (LEAs) are within zip codes identified as high or very high risk for health disparities based on social determinants of health, including lack access to care, insufficient education, and prevalent poverty: Baboquivari Unified School District (Sells)[2], Glendale Elementary School District (Glendale), and Sunnyside Unified School District (Tucson). Arizona AWARE also partners and collaborates with other state agencies, school districts, and community agencies to achieve the AWARE goals and, has engaged LeCroy & Milligan Associates, Inc. (Tucson) as the state's AWARE evaluator. LeCroy & Milligan Associates provided SPARS and other supporting data integrated into this Progress Report.

We have organized our AWARE Annual Year One Progress Report as follows:

1. Key Accomplishments and Difficulties by Goal Area
2. Project Changes
3. Data Summary
4. Disparity Impact Statement (Revised)
5. Appendices
    I. Logic Model
    II. Cross-LEA Needs Assessment/Resource Mapping Summary
    III. Evidence-Based Suicide Prevention Training Summary
    IV. Training Evaluation Report: Youth Mental Health First Aid
    V. Training Evaluation Report: School Threat Assessment

[1] Mental Health America's Annual State of Mental Health Report (2016)

[2] Baboquivari Unified School District replaced Pinon Unified District; this change is discussed in more detail later in this report.

Year One Progress

In ADE's capacity as the SEA, state staff initiated preparation of a project logic model to summarize the inputs, activities, outputs, and outcomes of Arizona AWARE at the SEA, LEA, and student levels (Appendix I). We recognize that Project AWARE requires complex systems change at the state and local levels; hence, this model will evolve. The main pathways for change at the SEA and LEA levels in Year One were:

1) Infrastructure build: Staffing, policy change, assessing access to tiered mental health services, and partnerships/collaborations with community organizations, school districts, and other state agencies.
2) Awareness: Building awareness of mental health as a component of overall health and wellness, and reducing stigma to acknowledging mental health concerns and accessing care.
3) Training and professional development: Systems transformation supporting school community mental health and wellness, and school threat assessment, mental health awareness, and suicide prevention.

I. Key Accomplishments and Difficulties by Goal Area

Goal 1: Build and maintain infrastructure for mental health services in Arizona schools for school-age children.

Accomplishments

1. In our capacity as the **SEA**, we developed our infrastructure as follows:
   - Created the Arizona AWARE logo representative of the agency partnership between the SEA/SMHA and the SEA/AHCCCS, using the sun rays from the AHCCCS logo, the outline of the state of Arizona, and themes from the Department of Education logo. This allows for a common branding across our communications with school districts and their communities.
   - Supported passage of Arizona's Mitch Warnock Act (Senate Bill 1468, 2019, or ARS 15-120, 2019) requiring school districts, charter schools, and Arizona teacher training programs to include suicide awareness and prevention training and mandating that all school staff who interact with students in 6th-12th grade be trained in an evidence-based, best practice suicide prevention curriculum once every three years. This law was signed by Governor Ducey on May 8,2019 (Also see Section III, Table 1, **IPP-PD1**)
   - Secured agreements (contracts, MOUs, MOAs) with 33 partners to improve mental health-related practices/activities that align with Arizona AWARE goals. (Also see Section III, Table 1, **IPP- PC1**)

     In alphabetical order, partners include:
     - AHCCCS: To designate a Co-Project Coordinator working directly with the SEA Arizona AWARE Team to communicate and coordinate activities and serve as technical expert and/or coordinator within their agency to support all goals, objectives, and activities of Project AWARE. (Quarter 2)

- Blue Ridge Mountain Unified School District (Lakeside): to promote mental health literacy and suicide prevention programs and to provide the community opportunities to participate In Youth Mental Health First Aid Trainings, including access to manuals, at no cost. (Quarter 3)
- Community Counts Suicide Prevention Coalition (Yavapai County): to partner in the goal of lowering suicide rates in Arizona, specifically among youth, through education, training, and advocacy. Community Counts, the parent agency for the Suicide Prevention Coalition of Yavapai County (SPCYC), will promote suicide prevention and provide the community with opportunities to view the film, "The Ripple Effect" purchased by the Project AWARE Team. (Quarter 4)
- JED Foundation: to foster a mental health awareness campaign in statewide K-12 settings through student created posters with age appropriate messages to elementary, middle school, and high school students. (Quarter 3)
- La Frontera EMPACT Suicide Prevention Center (Tempe), a SAMHSA MHAT grantee: to strengthen the relationship between ADE and this behavioral health provider, and help to achieve the grant goals of both entities, through co-facilitation of Youth Mental Health First Aid (YMHFA) trainings. ADE and La Frontera alternately report training data to SAMHSA for quarterly measures. (Quarter 4)
- LeCroy & Milligan Associates, Inc.: To provide evaluation services to Arizona AWARE. (Quarter 2). Arizona AWARE also entered into an inter-agency service agreement with Southwest Institute for Research on Women, University of Arizona to assist in writing the original Arizona AWARE grant application and to provide consultation for Year One evaluation planning in partnership with LeCroy and Milligan Associates, Inc.; SPARS will be updated to include the University of Arizona agreement.
- Trainer agreements:
  - Comprehensive School Threat Assessment Guidelines (CSTAG): ADE entered into MOAs with 27 professionals to form a cadre of regional CSTAG trainers. Each attended a 2.5-day workshop and train-the-trainer in CSTAG with Dr. Dewey Cornell of the University of Virginia, with the goal of preventing youth violence through a systematic approach that aims to provide support to students and staff through a comprehensive and equitable process. (Quarter 4)

- Established an internal agency Social Wellness Committee, with two working subgroups: (1) Agency Asset-Mapping, which prepared a draft agency survey to document the various social wellness activities within the SEA and how their connection/integration can be enhanced; and (2) Social Emotional Learning, SEL Workgroup, which began writing an application to join the Collaborative for Academic, Social, Emotional Learning (CASEL) Collaborating States Initiative (CSI) to initiate creating state guidelines and/or competencies in K-12 SEL and to learn from national experts and from other state agencies in various stages of the process.
- Established a combined Arizona AWARE and Mental Health Collaborative Improvement and Innovation Network (CoIIN) Advisory Committee comprising representatives from AHCCCS, Arizona Department of Health Services, Maternal and Child Health Program, Arizona State University's Counseling Department, First

Things First (the Arizona Early Childhood Health and Development Board), and the Governor's Office of Youth, Faith, and Families. The Advisory Committee met in July 2019, as well as by webinar in August and September, prior to attending a Leadership Launch Development Training (September 23-24, Columbia, Maryland) with Arizona AWARE staff facilitated by the National Center for School Mental Health, University of Maryland.

- Began creation of a Behavioral Health Resource Document containing a wide variety of behavioral health resources available in Arizona for school district personnel. This document will be shared in an electronic format through the ADE Communications Team and on the Arizona AWARE website.
- Engaged in professional development for Arizona AWARE staff: three staff members attended the 2.5-day Professional Development for Healthy Schools in partnership with CDC Healthy Schools, Professional Development for Healthy Schools Institute (May 1-3, 2019, Chattanooga, TN.) The Institute's goal was to provide state teams with training on Mental Health; Social Emotional Learning; Engagement; and Health Equity, within the framework of the Whole School, Whole Community, Whole Child (WSCC) model, to enhance and expand work that states are currently engaged in with their districts statewide. This professional development bridged two grants: Center for Disease Control (CDC1801) Health Students Ready to Learn, attended by a grant specialist; and Project AWARE, attended by Arizona AWARE's Grant Manager and AHCCCS Co-Coordinator. The opportunity fostered collaboration on the integration of WSCC as model framework and comprehensive approach to student, staff, and community wellness.
- Increased access to mental health services for Medicaid eligible students. AHCCCS noted a 200% increase in Medicaid eligible students receiving behavioral health services in schools from FY18 to FY19, with over 80 providers statewide. (Although a Year 2 statistic, more than 14,600 students received at least one behavioral health service in a school setting in November 2019.

2. In the capacity as selected **LEAs**, developed their infrastructure as follows:
   - Began local planning to align AWARE with other behavioral health/social emotional learning initiatives within their districts.
   - Identified AWARE Community Project Managers and hired mental health professionals.
   - Participated in the SEA's training on Comprehensive School Threat Assessment Guidelines (CSTAG).
   - Participated in SEA site visits.
   - Participated in a district needs assessment and resource mapping facilitated by Arizona AWARE's evaluator, LeCroy and Milligan Associates, Inc. (See Appendix II for a cross-district summary.)
3. The **SEA and LEAs** together:
   - Joined and began participating in the School Mental Health CoIIN facilitated by the National Center for School Mental Health, University of Maryland. This CoIIN supports Arizona AWARE in systems transformation through focused and purposeful

small changes that can be measured and adjusted to forward larger systems change.

- The LEAs completed quality assessments through the School Health Assessment and Performance Evaluation System (SHAPE) to assess their school mental health services and supports.

Difficulties encountered and actions taken

Difficulties we have encountered in infrastructure build at the SEA and LEA levels include:

- Recruiting, hiring, and orienting new staff within systems with varying human resource policies, procedures, and timelines.
  Action: To be aware of differences in human resource recruitment and hiring processes and provide support and encouragement to LEAs.
- Experiencing staff turnover, resulting in loss of knowledge and continuity, and decreased capacity; and the time needed to replace staff and orient new hires to Project AWARE and their roles.
  Action: Team members contributed to the degree possible to minimize loss in project momentum.
- Negotiating information sharing between a school district located on and serving a tribal nation, while respecting historical negative experiences and trauma experienced by Indigenous communities associated with data collection, and data use and dissemination without informed consent of sovereign nation leaders and the tribal community.
  Action: We are very mindful of Baboquivari Unified School District's concerns about sharing data that are generally required for participation in Project AWARE, and informed SAMHSA that Arizona AWARE may have limited data availability from this LEA. Moving forward, we aim to negotiate a data sharing agreement between the Department of Education and Baboquivari Unified School District that is acceptable to this district and the Tohono O'odham Nation leadership.
- Aligning FERPA, HIPAA, and state legislation with Project AWARE GPRA required measures for students screened for mental health concerns, and the number/percent of students receiving services.
  Action: We participate in state and national conversations regarding privacy concerns associated with mental health screening in schools and documenting services received.
- Completing our Behavioral Health Resource Document that took into consideration resources from and opinions of multiple stakeholders and agency representatives.
  Action: The substantial content of the document will be condensed and tailored to the target audience prior to formatting for ease of use.
- Integrating the goals and initiatives of Project AWARE and the School Mental Health CoIIN and defining the roles of the Advisory Committee formed late in Year One.
  Action: We recognize the considerable value of integrating Project AWARE and CoIIN, and aim to do so with maximum added value and least burden for Arizona AWARE LEAs. We are working on role definition for the Advisory Committee and to establish regular communication and a meeting schedule in Year Two.

Goal 2: Conduct outreach and engagement with school-aged youth and their families to increase awareness and identification of mental health issues and to promote positive mental health.

Accomplishments

1. Arizona AWARE web pages:
   - The Arizona AWARE webpages on the ADE/SEA website added the topics of behavioral health and suicide prevention. The webpages include links to community resources, crisis response, training opportunities, and latest news and information. https://www.azed.gov/shs/projectaware/
   - The AHCCS website includes a link to Arizona AWARE and information about accessing behavioral health services in schools for students with Medicaid benefits. https://www.azahcccs.gov/AHCCCS/Initiatives/BehavioralHealthServices/
2. Arizona AWARE video: ADE/SEA contracted with Whiteboard Geeks to create a compelling and creative mental health awareness video and to emphasize the training and resources available to school districts and their communities. In Year One, the Arizona AWARE team accomplished the creation of a draft script and draft voiceover and will continue to work on completion of this video in Quarter 1 of Year 2.
3. Arizona AWARE mental health awareness campaign: As also mentioned under Goal 1, MOUs, we entered into an agreement with the JED Foundation – a nonprofit that protects emotional health and prevents suicide for the nation's teens and young adults – to foster a mental health awareness campaign in statewide K-12 settings through student created posters with age appropriate messages to elementary, middle school, and high school students.
4. Parent and youth attendance at the School Mental Health CoIIN Launch Development Training (September 23-24, Columbia, Maryland): ADE/SEA sponsored parent and youth representatives to attend the Launch, and both students and parents prepared a PowerPoint presentation to share messages with state teams on how to effectively engage youth and family voice in all decision making.

Difficulties encountered and actions taken

- Production of the Arizona AWARE video did not complete in Year One as intended.
  Action: We recognized the value of submitting the draft script and audio for feedback from individual stakeholders and focus groups, resulting in multiple script revisions and improvements. The video will be ready for release in Quarter 2 of Year Two.
- Although a formal agreement was signed with the JED Foundation for the statewide awareness campaign, the Arizona AWARE team's capacity was impacted by staffing changes/new hires and work on the campaign has not been initiated.
  Action: We recognize the necessity to bring together multiple state agencies in support of the campaign for a united voice and consistent messaging and with full Arizona AWARE team staffing in Quarter 2 of Year Two, we will begin campaign planning.

Goal 3: Provide professional development and training to school personnel, SEA staff, community partners and other adults who interact with school-aged youth, to detect and respond to mental health issues.

Accomplishments

1. Identification of evidence-based suicide prevention trainings: In collaboration with AHCCCS and LeCroy & Milligan Associates, Inc., Arizona AWARE researched, identified, and described eight evidence-based suicide prevention trainings, including one with an online training option, that meet school staff, community partners, and other adults' needs to detect and respond to mental health concerns of school-aged youth. In addition to supporting AWARE Goal 3, this resource also assists school districts in responding to Arizona's Mitch Warnock Act (Senate Bill 1468, 2019, or ARS 15-120) requiring school districts, charter schools, and Arizona teacher training programs to include suicide awareness and prevention training. In Year Two, Arizona AWARE will widely distribute this resource to school districts and communities to aid their decision on selecting a training program for their district. (See Appendix III)
2. Hire of an Arizona AWARE Training Specialist: ADE/SEA recruited for and hired a dedicated Arizona AWARE Training Specialist to coordinate mental health awareness and suicide prevention trainings for school districts and their communities and to assist school districts in mental health awareness and suicide prevention training and professional development decision-making.
3. Completion of training/professional development in school threat assessment, mental health literacy, and suicide prevention:
    - Individuals not in the mental health or related work forces: **2,274 individuals in total** were trained through use of Arizona AWARE grant resources. (Also see Section III, Table 1, **IPP-TR1)**
        - Quarter 1: 25 individuals participated in the Role of Positive School Culture and Climate at ADE's School Health & Safety Conference co-sponsored by Arizona AWARE.
        - Quarter 2: 140 individuals in total; 10 health plan medical directors, 30 Prescott-area community members, and 15 community stakeholders attended three separate presentations on Arizona's suicide prevention efforts; 50 individuals attended the state suicide prevention plan meeting to review suicide prevention activities and goals; and 35 individuals from the Arizona Foster Care Board attended a suicide prevention session that focused on foster children.
        - Quarter 3: 117 individuals in total; 15 Arizona Local Health Officers Association attended a suicide prevention presentation; 100 community members, school board members, and school staff who do not have regular contact with students attended the Suicide Prevention Panel, State Security in Schools Conference; and 2 individuals trained in Kagan Dynamic Trainer, a preparatory for increasing the number of presentations, using best methods, in support of the goals of the Project AWARE grant.
        - Quarter 4: 1,992 individuals in total participated in 14 different events, most of which occurred during the September 2019 Suicide Prevention Month.

- People in the mental health or related work force to enhance their capacity to address mental health concerns consistent with the Project AWARE grant, including: school social workers, psychologists, nurses, doctors, law enforcement personnel, and providers who do not offer mental health services but do provide other supports and services to individuals with mental health needs. **1,740 individuals in total** attended workshops, trainings, and other professional development opportunities through use of Arizona AWARE grant resources. (Also see Section III, Table 1, **IPP-WD2)**
    - Quarter 1: 349 individuals in total attended ADE's School Health & Safety Conference, which was co-sponsored by AWARE; 41 participated in the U.S. Department of Education (REMS), School Behavioral Threat Assessments training; 28 were trained in YMHFA; 34 completed the School Nurse Continuing Education Track, New Perspectives on Cyberbullying and New Resources from the State of Arizona; 190 attended training on the Role of Positive School Culture and Climate; and 56 participated in Arizona State University's Authentic Relationships Discussion Activity.
    - Quarter 2: 45 individuals in total; 6 district staff from AWARE LEAs completed a train-the-trainer event in Dr. Bruce Perry's Neuro-sequential Model Network/Trauma Training to assist schools in dealing with trauma and its effects on students; 35 individuals attended an East Valley Training on Suicide Prevention Strategies; and 4 social workers from Chandler Unified School District received technical assistance and training on suicide prevention strategies and resources.
    - Quarter 3: 853 individuals participated in 17 workforce development opportunities focused on mental health-related topics, including trauma-informed practices, suicide prevention, behavioral health, staff wellness, and YMHFA.
    - Quarter 4: 493 individuals participated in 16 workforce development training events in support of the goals of the grant.
- Training evaluation reports specific to Youth Mental Health First Aid and School Threat Assessment training are shared in Appendix IV.

4. The Helios Education Foundation and AHCCCS hosted three community forums on behavioral health in schools in September 2019; 350 individuals from around the state attended and most were educators.

Difficulties Encountered and Actions Taken

- Planning and launching training/professional development was challenged by Arizona AWARE staff capacity to implement a wide array of infrastructure, school and community awareness, and training in Year One.
  Action: ADE/SEA recruited for and hired a Training Specialist dedicated to Arizona AWARE.

II. Project Changes

1. ADE/SEA

During the majority of Year One, the 0.5 FTE Suicide Prevention Specialist from AHCCCS, who served as Co-Coordinator for Arizona AWARE, was a staff person with considerable additional duties and responsibilities at AHCCCS. Both AHCCCS and the Department of Education agreed on the need to hire a half-time person entirely dedicated to Arizona AWARE. This position was posted, and interviewing occurred at the end of Year One, although the hire was made at the beginning of Year Two.

Towards the end of Year One, the ADE AWARE Co-Coordinator accepted a promotion within School Health and Safety at ADE. ADE/SEA initiated the process to hire a replacement Co-Coordinator, but an offer was not made until the beginning of Year Two.

As previously mentioned under Goal 3, Arizona AWARE hired a full-time Training Specialist during Year One to coordinate mental health related professional development training for school districts across the state and to provide support to trainers to be successful in their role.

Associated challenges: Arizona AWARE staff changes at the state level have presented some difficulties to progressing with our goals because responsibilities have been stretched and our capacity challenged. Nevertheless, the team stepped forward to ensure that we kept pace with implementing strategies and activities to achieve our goals.

2. LEA

Arizona AWARE is committed to the inclusion of a school district serving a tribal nation. Arizona has 22 federally recognized tribes and these indigenous communities are often disproportionately impacted by poverty and health disparities, including mental health and wellness. Initially, Arizona AWARE selected the Pinon Unified School District serving Navajo Nation as one of our state's LEAs. Following considerable outreach to the Pinon district without accomplishing engagement, we determined our course would be to select an alternative school district serving a tribal community. We selected Baboquivari Unified School District serving the Tohono O'odham Nation in southern Arizona and have successfully engaged this district in participation in Arizona AWARE.

3. Evaluator

During Year One, Arizona AWARE evaluation services were provided by the Southwest Institute for Research on Women, University of Arizona, and LeCroy and Milligan Associates (Tucson). For Years Two-Five, ADE/SEA issued a competitive bid and selected LeCroy & Milligan Associates (Tucson) as the evaluator.

III. Data Summary

Table 1 summarizes Arizona Project AWARE's Year One SPARS data; narrative is provided in Section I, Accomplishments and Difficulties by Goal Area.

Table 1: Arizona Project AWARE SPARS data, Year One

Measure		Results				
		Q1	Q2	Q3	Q4	Total
IPP-TR1	Individuals who have received training in prevention or mental health promotion. (N)	25	140	117	1,992	2,274
IPP-WD2	People in the mental health and related workforce trained in mental health related practices/activities that are consistent with the goals of the grant. (N)	349	45	853	493	1,740
IPP-PD1	State and local policy changes completed as a result of the grant. (N)			1 (State)		1 (State)
IPP-PC1	Organizations that entered into a formal written inter/intra-organizational agreement (e.g., MOUs/MOAs) to improve mental health-related practices/activities that are consistent with the goals of the grant. (N)	0	2	1	30	33

Notes:
N=Number
IPP-PD1: SPARS correction will be made; currently inadvertently captures PC1 data.
IPP-PC1: SPARS correction will be made; currently omits the Year One interagency service agreement with the University of Arizona, Southwest Institute for Research on Women for evaluation planning services.
GPRA-Screening and GPRA-Service data were not collected in Year One.

Table 2 summarizes LEA CoIIN data that Arizona AWARE LEAs uploaded to the School Based Health Alliance's School Mental Health CoIIN Basecamp project in September 2019, the first month quantitative data were reported to CoIIN. The National Center for School Mental Health provides an Excel data template to the LEAs for tracking and reporting purposes. The LEA Community Project Manager, or designee, updates the requested data at the end of each month and uploads the file to Basecamp by the fifth of the following month.

All of the data elements tracked and reported for CoIIN are relevant to Project AWARE; three of the data elements—number of students screened and numbers of students eligible for and enrolled in Tier 2/3 services—are required Government Performance and Results Act (GPRA) measures or part of required Project AWARE GPRA measures. The CoIIN data elements are:

- Number of **enrolled** students,
- Number of **chronically absent** students—chronic absence refers to missing 10% or more school days[3],

[3] For more information on chronic absence definitions, see: https://www.attendanceworks.org/policy/federal-policy/

- Number of students **screened**—screening is the assessment of students to determine whether they may be at risk for a mental health concern,
- Number of students **eligible** for Tier 2 or Tier 3 services,
- Number of students **enrolled** in Tier 2/3 services, and
- Number of students with **functional improvements**—the type of functioning tracked can be individual to the student or to the type of service received, and the measure of functioning is up to the LEA.

Two of the Project AWARE LEAs reported partial data for September 2019: Glendale Elementary School District and Sunnyside Unified School District, whereas Baboquivari Unified School District, did not, in part because of their relatively recent addition to Project AWARE and the CoIIN.

Table 2: Arizona AWARE LEA CoIIN Data, September 2019

Data Element	Glendale ESD	Sunnyside USD
Enrolled students	11,627	16,041
Chronically absent	2,995 (25.8%)	3,921 (24.4%)
Students screened	42	Not tracked Yr. 1
Students eligible for Tier 2 or Tier 3 services	Not tracked Yr. 1	Not tracked Yr. 1
Number of students enrolled in Tier 2/3 services	Not tracked Yr. 1	Not tracked Yr. 1
Number of students with functional improvements	Not tracked Yr. 1	Not tracked Yr. 1

IV. Disparity Impact Statement - Revised

The following provides an updated Arizona Project AWARE Disparity Impact Statement replacing Pinon Unified School District with Baboquivari Unified School District.

School Health and Safety Programs
Arizona Project AWARE 2018 Award Year
Disparity Impact Statement

1. **Proposed Number of Individuals to be Served and Identification of Disparate Population -** Total Number of Students to be Served: Approximately 29,955 targeted students and 1,112,146 statewide.

The LEAs selected for the Arizona Project AWARE program are **Baboquivari Unified School District**, **Glendale Elementary District** and **Sunnyside Unified District**. The 3 LEAs selected are identified as being underserved and have high to very high percentages of determinants of health according to the Arizona Healthy Communities Index (2016) indicating zip codes throughout the state that lack access to care, with insufficient education and prevalent poverty rates. These three LEAs will be served over the entire 5-year grant period.

LEA/ Catchment Area/Region	Demographic Characteristic Race and Ethnicity	English Language Learners	Gender F/M	Socio-Economic Status	Sexual Identity
Baboquivari UD/85634/ Southern AZ **Tohono O'odham Nation** 966 Students	918 American Indian/Alaskan Native, 30 Hispanic/Latino, 11 Multi-Race Non-Hispanic	Data Not Available	495 F 471 M	51% Poverty Rate 91% Free and Reduced Lunch	Data Not Available
Glendale ED/85301/ Central AZ 12,489 Students	355 Asian, 237 American Indian/Alaskan Native, 1328 Black/African American, 9522 Hispanic Latino, 1587 White, 27 Native Hawaiian or other Pacific Islander, 297 Multi-Race Non-Hispanic	2838	6430 F 6923 M	36% Poverty Rate 95.17% Free and Reduced Lunch	Data Not Available
Sunnyside UD/85706 Southern AZ 16,500 Students	68 Asian, 511 American Indian/Alaskan Native, 360 Black/African American, 14602 Hispanic Latino, 642 White, 14 Native Hawaiian or other Pacific Islander, 99 Multi-Race Non-Hispanic	2738	7906 F 8390 M	37% Poverty Rate 82% Free and Reduced Lunch	Data Not Available

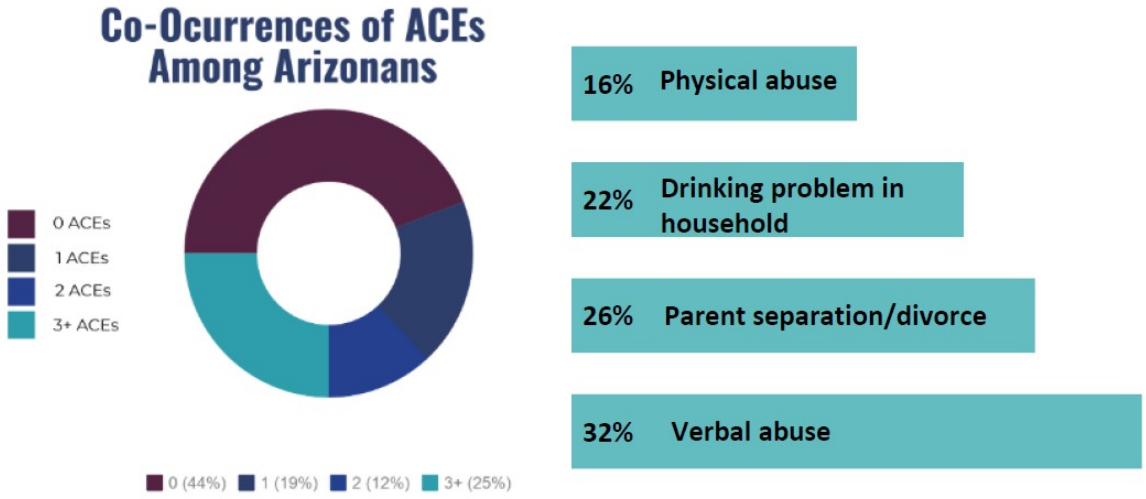
Baboquivari Unified School District #40 is in the community of Sells on the Tohono O'odham Nation in southern Arizona and serves approximately 966 students at six schools: one primary elementary, one intermediate elementary, two middle, and two high schools. More than half (51.3%) of the families in the district communities are below the federal poverty level. The district has a dropout rate of 7.9% and a four-year graduation rate of 60.8%, both well below the state averages. According to results from 2018 ADE-required assessments, 66% of students were minimally proficient in English Language Arts, and 65% were minimally proficient in Math. Additionally, 9.6% of students have disabilities.

Glendale Elementary School District presents with a community that serves approximately 12,489 students at 17 schools. It is a Title I district with approximately 95.17% free and reduced lunch and a student population made up of approximately 1600 students in special education, 480 refugee students and 2,500 English Language Learners.

Sunnyside Unified School District is in the community of Tucson, Arizona in Pima County and serves approximately 16,500 students. The Sunnyside District is the second largest school district in Tucson and covers 93.6 square miles, including the southern part of the City of Tucson and areas adjacent in Pima County, including the San Xavier Reservation. Approximately 82% of SUSD students qualify to receive free and reduced-price meals. Approximately 83% of SUSD students are Hispanic, 8.8% are White, 5.3% are Native American, 2.6% are African American, and less than 0.6% are Asian American. About 20% of the students are classified as English Language Learners (ELL), and approximately 4% of the students are identified as homeless.

Mental Health America's Annual State of Mental Health Report (2016) ranked Arizona last in the nation for the state's high prevalence of mental illness and low access to mental healthcare. Arizona's low ranking included high poverty, high toxic chemical release, low graduation rates, poor access to mental healthcare and lack of resources. Arizona ranked 32nd for mental healthcare for adults, while the state ranks 47th for mental healthcare for young people. According to the 2011-2012 National Survey of Children's Health, Adverse Childhood Experiences (ACEs) are common in Arizona's children as well. Over one-quarter (26.4%) of children ages 0 to 17 have already experienced one adverse family experience and nearly one-third (31.1%) have experienced two or more. This is significantly higher than the national average of children experiencing two or more ACEs (22.6%). Even worse, in Arizona children ages 12 to 17, 44.4% have experienced two or more ACEs, compared to the national average of 30.5%.

56% of Arizonans reported experiencing at least one adverse childhood experience (ACE).
The most common ACE reported is verbal abuse from a parent or adult in the home.



2014 and 2016 BRFSS

Arizona is lacking in services at the LEA level with a decrease in behavioral health specialists and supportive staff such as school nurses due to lack of state mandates and budget limitations. Arizona does not collect consistent data on the number of school nurses and school counselors and currently relies on self-reported data through technical assistance programs.

Additional need is evident in the Arizona Child Fatality Review Program Twenty Third Annual Report, November 15, 2016:

- Child suicides increased from the year prior and accounted for 6% of child deaths.
- Ninety-eight percent of suicides were determined to be preventable.
- Drug use, family discord, and parental divorce were identified as preventable factors.
- The majority of suicide deaths occurred in children 15 through 17 years old (n=35).
- White, non-Hispanic and American Indian deaths were disproportionately higher.

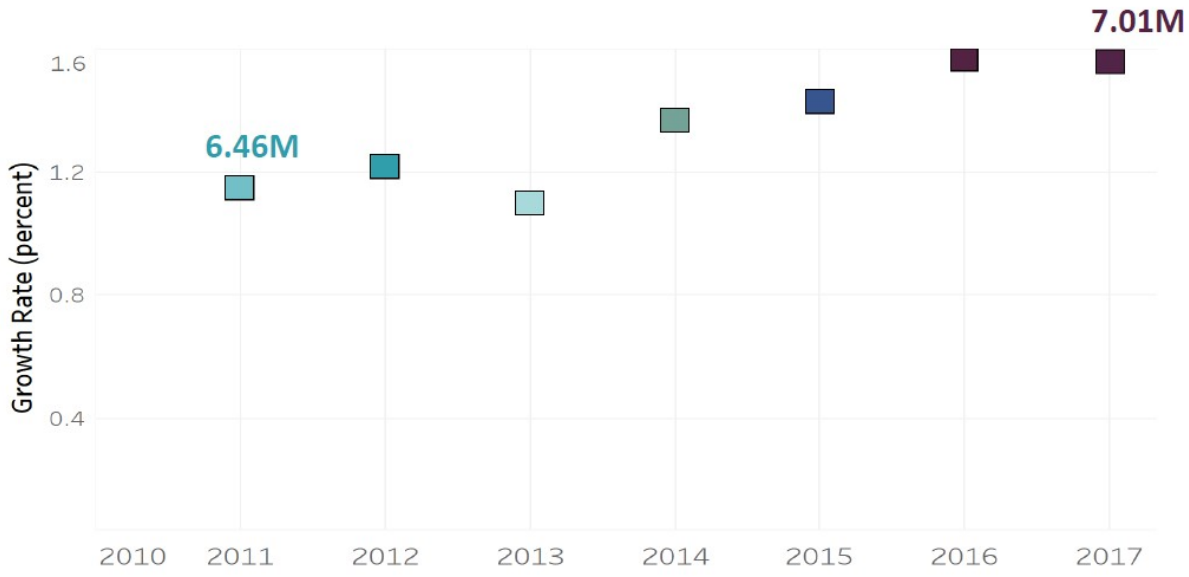
The combined statewide data indicates the need to build infrastructure and increase awareness of mental health issues and connect youth and their families to school and community-based mental health services. The need for mental health interventions, outreach and early detection is clearly great. ADE and partners, recognize the need to provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues.

Number of proposed unduplicated individuals to serve annually and over the entire project period with grant funds.	**YR1**	**YR2**	**YR3**	**YR4**	**YR5**	**TOTAL**
Unduplicated school aged youth # of students in all 3 LEAs	**1000**	**3000**	**3000**	**3000**	**1000**	**11,000**
School staff	**500**	**500**	**500**	**500**	**500**	**2500**
Community partners	**50**	**20**	**20**	**10**	**10**	**110**

Arizona has a diverse population that resides in a wide range of urban, suburban, and rural communities. Arizona ranked 6th among the nation's fastest growing states in 2017. Between 2010 – 2017, the largest population growth has been among Asian, multiracial and Black Arizonans. The U.S. Census Bureau American Community Survey reports 25.3% of Arizona's children under 18 are living below the poverty level with highest poverty seen in Apache County (45%) and Navajo County (39.3%). Services and activities in Arizona need to be designed and implemented with cultural responsiveness in response to the low socio-economic status and lack of resources throughout the state.

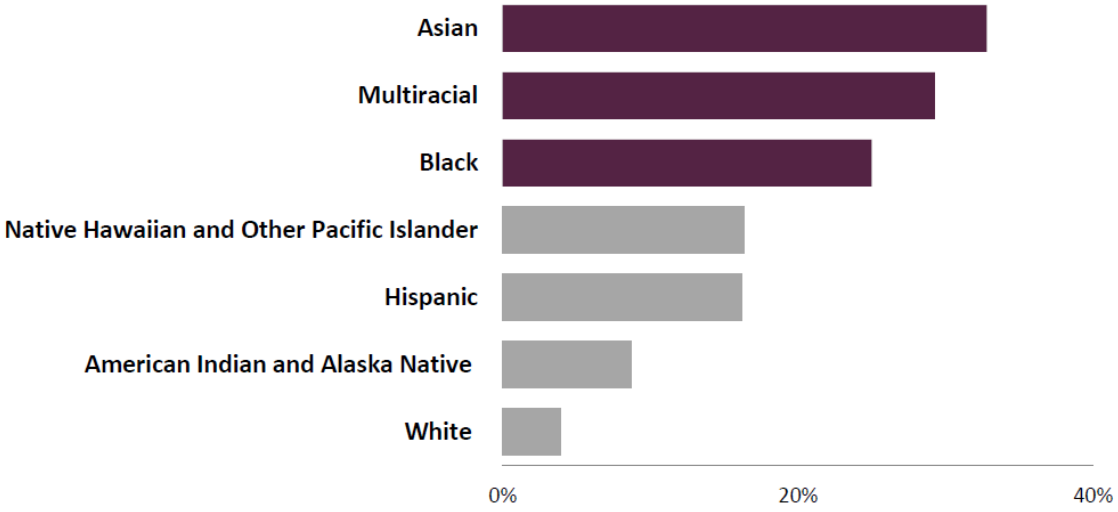
Arizona's population is the 6th fastest growing in the United States.

Since 2010, the average population growth rate is **1.4%**.



U.S. Census Bureau, National Population by Characteristics: 2010-2017

Between 2010 – 2017, the largest population growth has been among Asian, multiracial and Black Arizonans.



U.S. Census Bureau, National Population by Characteristics: 2010-2017

In Arizona, about 72,000 adolescents aged 12–17 (13.2% of all adolescents) per year in 2013–2014 had at least one major depressive episode (MDE) within the year prior to being surveyed. The percentage increased from 2010– 2011 to 2013–2014. *(Behavioral Health Barometer, Arizona 2015-SAMHSA).* In 2016, there were 1310 deaths. Maricopa County had the highest rate of suicide with 683 deaths. State wide, there were 292 suicides by women, and 1018 by men. The youngest suicide was age 9; the oldest suicide was age 96.

2. **ADE's quality improvement plan**: Through a comprehensive assessment, ADE AWARE Team, will identify gaps in resources to increase/improve access to culturally competent and developmentally appropriate school and community-based mental health services. The ADE AWARE Team will connect the 3 selected LEAs with evidenced-based practices that are culturally competent and developmentally appropriate for school-aged youth. The ADE AWARE Team will develop a plan to implement evidence-based, culturally competent, and developmentally appropriate community-based mental health services for school aged youth, supported by mental health specialists, to foster screening, early intervention and immediate response to mental health issues targeting high needs sub-populations in an effort to reduce disparities.

3. **ADE's quality improvement plan methods for development and implementation:** The ADE AWARE Team will work with the targeted LEAs and districts across the state to provide technical assistance on the ADE behavioral health resource document. This document will include resources identifying supportive services targeting all regions of Arizona. This document will assist districts with the development of policies and procedures to ensure adherence to the Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards

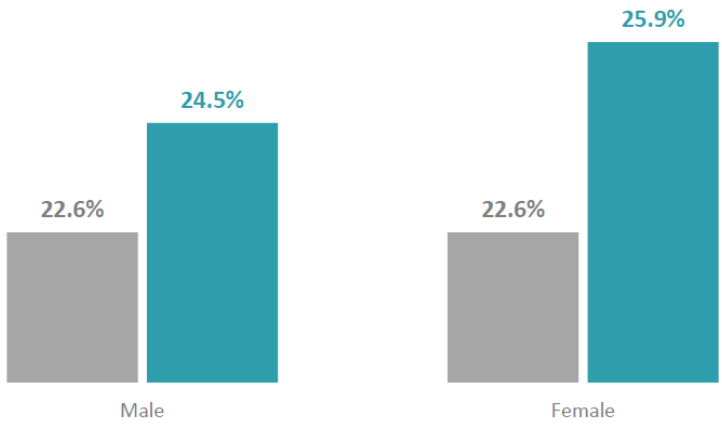
and the provision of effective care and services supporting identified high needs sub-populations in their geographic regions. Adherence to the CLAS standards will include attention to:

a. Diverse cultural health beliefs and practices: Training materials, resources, and technical assistance will support the culture and language of selected subpopulations

b. Preferred languages: Interpreters and translated materials will be used for non-English speaking clients as well as those who speak English but prefer materials in their primary language. Key documents will be translated into Spanish.

Reported on StopBullying.gov, Lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth and those perceived as LGBTQ are at an increased risk of being bullied. Results from the 2017 Youth Risk Behavior Survey show that, nationwide, more U.S. high school students who self-identify as lesbian, gay, or bisexual (LGB) report having been bullied on school property (33%) and cyberbullied (27.1%) in the past year, than their heterosexual peers (17.1% and 13.3%, respectively). The study also showed that more LGB students (10%) than heterosexual students (6.1%) reported not going to school because of safety concerns. Among students who identified as "not sure" of their sexual orientation, they also reported being bullied on school property (24.3%), being cyberbullied (22%), and not going to school because of safety concerns (10.7%). The ADE AWARE Team will work to develop statewide date

In 2016, 25% of Arizona's children between 6 and 17 years of age indicate they were bullied, picked on or excluded by other children compared to 22% nationally. (Arizona vs. U.S.)



2017 YRBSS

Program Sustainability: ADE AWARE Team will work with internal and external stakeholders to promote the statewide adoption of the Center for Disease Control's Whole School, Whole Community, Whole Child behavioral health inclusive framework through workshops and technical assistance to establish a culture with the inclusion of mental health awareness and a social emotional approach to increase healthful behaviors and diminish the stigma of silence related to mental health issues.

Appendices

I. Logic Model
II. Cross-LEA Needs Assessment/Resource Mapping Summary
III. Evidence-Based Suicide Prevention Training Summary
IV. Training Evaluation Report: Youth Mental Health First Aid
V. Training Evaluation Report: School Threat Assessment

Arizona Project AWARE Logic Model

	Inputs	Activities/Outputs	Short-term Outcomes (Changes in Knowledge, Attitudes, and Awareness)	Intermediate Outcomes (Changes in Behaviors, Practices, and Policies)	Long-term Outcomes (Changes in Environment)
SEA/State Level	○ ADE AWARE project team ○ AWARE resources ○ State partners ○ Project evaluators ○ Other grant funding and state resources ○ Whole School, Whole Community, Whole Child (WSCC) model	○ Trainings ○ Technical Assistance ○ Evidence-Based Practices/Research ○ COIIN Meetings ○ Facilitate Collaboration and Integration (with AHCCCS, other state agencies, other grants/teams in ADE)	○ Increased mental health awareness and literacy ○ Increased knowledge of those working with youth to be able to detect and respond to mental health issues ○ Reduced mental health stigma ○ Increased training of adults ○ Increased awareness among school staff of MH training opportunities ○ Increased awareness of existing state programs, policies, and procedures related to behavioral health	○ State policy changes that promote mental health ○ Increased collaboration between state and local entities to address mental health needs ○ Increased collaboration between private and public entities to address mental health	○ Infrastructure in place for improved access to services ○ Increased availability of resources ○ Reduced system barriers to access care
LEA/District Level	○ LEA AWARE project team ○ Community partners/ service providers ○ Faculty/staff ○ Families ○ Other grant funding and state resources	○ Local management team/partner meetings ○ Collaboration and integration with community partners, project managers, school mental health staff, school resource officers ○ Student and family involvement in district planning ○ Identification and linkage of direct, school- and community-based supports ○ Implementation of EBPs with fidelity and using trauma-informed care ○ Communication and information sharing across systems ○ Integration of service delivery ○ LEA-specific activities/outputs TBD ○ Activities/outputs from non-AWARE grants	○ Increased mental health awareness and literacy ○ Increased knowledge of those working with youth to be able to detect and respond to mental health issues ○ Reduced mental health stigma ○ Increased training of adults ○ Increased school staff awareness of MH training opportunities ○ Increased school staff knowledge of MH resources	○ Increased ability of school staff to connect to resources ○ Local policy changes that promote mental health for both staff and students ○ Increased participation in MH trainings	○ Infrastructure in place for improved access to services ○ District-wide alignment to trauma-informed and restorative practices
← **EVALUATION, FEEDBACK, AND CONTINUOUS QUALITY IMPROVEMENT** ↻					

	Inputs	Activities/Outputs	Short-term Outcomes (Changes in Knowledge, Attitudes, and Awareness)	Intermediate Outcomes (Changes in Behaviors, Practices, and Policies)	Long-term Outcomes (Changes in Environment)
Student Level	○ Students	○ Student and family involvement in mental health marketing and awareness campaigns ○ Student and family involvement in efforts to promote resiliency and emotional wellness ○ Parent forums ○ Parent participation in mental health activities and events ○ LEA-specific activities/outputs TBD	○ Increased mental health awareness and literacy ○ Increased early identification of at-risk youth ○ Reduced mental health stigma	○ Increased mental health referrals ○ Increased access to and utilization of mental health services ○ Improved academic performance ○ Increased graduation rates ○ Decreased behavioral incidents ○ Decreased absenteeism ○ Decreased suicide attempts	○ Increased willingness of students to seek help ○ Students feel safer at school ○ Students feel more supported at school ○ Students feel connected to school ○ Students have adult on campus they trust and can talk to ○ Improved general wellbeing of students and teachers
← EVALUATION, FEEDBACK, AND CONTINUOUS QUALITY IMPROVEMENT ↻					

Cross-LEA Needs Assessment/Resource Mapping Summary Conducted in Year One

Introduction

Arizona Project AWARE's evaluator, LeCroy & Milligan Associates, Inc., conducted needs assessments and resource mapping for the three selected local education agencies (LEAs):

- Baboquivari Unified School District (BUSD), Sells, Pima County (serving students residing within the Tohono O'odham Nation)
- Glendale Elementary School District (GESD), Glendale, Maricopa County
- Sunnyside Unified School District (SUSD), Tucson, Pima County

Primary and secondary information for the needs assessment/resource mapping reports was collected in Year One, although the reports were not finalized until November 2019. Members of the state level Arizona AWARE team have, however, elected to summarize information contained in these reports in Arizona AWARE's Year One progress report as the findings inform Year Two planning.

The full LEA needs assessment/resource mapping reports contain a wide array of data abstracted from a variety of sources in the public domain. Arizona AWARE state level team members have extracted a selection of secondary data for the Year One progress report that closely tie to demonstrated need for inclusion as an Arizona AWARE LEA. These are presented for all three LEAs (**see Tables 1 - 6**).

LeCroy & Milligan Associates, Inc. also included in the needs and assets/resource mapping reports primary qualitative data. This primary source was collected through focus groups and interviews, primarily with school staff and some parents. Arizona AWARE team members at the state level have summarized key findings from the primary qualitative data for the Year One Progress Report (**see Table 7**). Of note, at the request of Baboquivari Unified School District primary data were not made available to ADE/SEA and are therefore not included in this summary. In Year Two, ADE/SEA will ensure that data agreements are in place with LEAs before additional primary data are collected for the Arizona AWARE evaluation to ensure agreement between the SEA and LEAs on data collection and use. Whereas Baboquivari Unified School District is located on tribal lands and serves the Tohono O'odham Nation, the SEA will be observant of needs specific to collecting and distributing data associated with a sovereign nation.

Table Abbreviations: Number=# and Percent=%

Table 1: Community Indicators

	BUSD	GESD	SUSD	Arizona
Total Population (#)	7,088	103,621	90,840	6,728,577
Total Households (#)	1,803	33,818	25,953	Not Available
Socio-Demographic/Economic Indicators				
Median Household Income	$23,005	$34,928	$34,221	$51,340
Race/Ethnicity				
American Indian/Alaskan Native	92%	1%	3%	4.4%
Asian	1%	3%	1%	3.1%
Black	1%	8%	3%	4.3%
Hawaiian and Other Pacific Islander	0%	0%	0%	0.2%
Hispanic or Latino (of any race)	2%	54%	76%	30.5%
White	3%	32%	15%	77.8%
Some other race alone	0%	0%	0%	7.0%
Two or more races	1%	2%	1%	3.3%
Language Spoken at Home				
Speak English only	83%	49%	40%	Not Available
Speaks English very well	17%	45%	50%	Not Available
Speaks English less than very well	0%	6%	9%	Not Available
Poverty Indicators				
Family income below poverty level	51.3%	40.3%	35.8%	12.9%
Families with Food Stamps/SNAP benefits	58.7%	47.3%	47.7%	13.2%
Female householder or no husband present	52.0%	39.0%	37.0%	12.4%
Population Ages 5-17 years[2]				
Of total population	Not available	14.9%	21.3%	12.9%
In poverty	Not available	31.8%	29.8%	19.3%

[1] National Center for Education Statistics, District Demographic Dashboard, derived from the U.S. Census Bureau American Community Survey, 2012-2016 https://nces.ed.gov/Programs/Edge/ACSDashboard/0403950

[2] ADE, Census Data 2017 www.azed.gov/titlei/census/

Table 2: School Data

	BUSD	GESD	SUSD	Arizona
Grades served	K-12	K-8	K-12	K-12
School district enrollment[1] (#)	966	12,513	15,584	1,092,599
Total teachers, principals, other school leaders[2] (#)	91	683	829	62,242
Considered inexperienced[2]	21%	43%	16%	22%
Total teachers[2] (#)	91	683	796	60,401
In first three years (experience indicator) [3]	25%	35%	19%	19%
Average teacher salary[3]	$48,105	$40,049	$46,511	$48,951
Health support staff (FTE)[4]	9	42	126.4	Not Available
Enrolled in free/reduced lunch program[5]	91%	87%	82%	56%
Students with chronic absenteeism[6] (#)	19	3,008	6,443	212,332
Incidents of violence[6] (#)	None reported	2,234	None reported	25,851
Dropout rate (grades 7-12)[7] (formula calculated)	7.9	0.6	3.3	4.97
Four-year graduation rate (from high school) [7]	61%	Not applicable	76.5%	78.0%

[1]ADE, Accountability Research Data, 2017-2018 www.azed.gov/accountability-research/data/

[2]ADE Arizona School Report Cards, 2018 https://azreportcards.azed.gov/districts and https://azreportcards.azed.gov/state-reports

[3]Arizona Auditor General, Arizona School District Spending, Fiscal Year 2018 www.azauditor.gov/sites/default/files/19-203_Report_With_Pages.pdf

[4]ADE Public Reports, 2018-2019; health support staff includes counselors, psychologists, social workers, support or intervention specialists, health office aides and nurses www.ade.az.gov/sder/publicreports.asp

[5]ADE, Health and Nutrition Services, Free/Reduced Lunch Program, 2018-2019 http://www.azed.gov/hns/frp/

[6]ADE Arizona School Report Cards, 2015-2016 https://azreportcards.azed.gov/districts and https://azreportcards.azed.gov/state-reports

[7]ADE Accountability Research Data, 2018 www.azed.gov/accountability-research/data/

Arizona Youth Survey

The Arizona Criminal Justice Commission's Statistical Analysis Center, in partnership with the Arizona State University's School of Criminology and Criminal Justice, conducted the Arizona Youth Survey (AYS) in the spring of 2018. The 2018 AYS was administered to a statewide sample of 8th, 10th, and 12th grade youth and assessed the prevalence and frequency of risk behaviors and protective factors. References for the AYS are:
http://azcjc.gov/sites/default/files/pubs/AYSReports/2018/2018_Arizona_Youth_Survey_State_Report.pdf and http://azcjc.gov/content/arizona-youth-survey for county data.

Table 3 contains **a selection** of the behaviors reported in the LEA needs assessment/resource mapping reports to provide a snapshot of risk behaviors and protective factors associated with mental health and wellness. Glendale Elementary School District is located in Maricopa County; Baboquivari Unified School District and Sunnyside Unified School District are located in Pima County.

Table 3: Arizona Youth Survey

	Maricopa County			**Pima County**			**State of Arizona**		
Students participating across grades 8, 10, 12	34,263 (70%)			1,803 (4%)			49,009		
	G8	G10	G12	G8	G10	G12	G8	G10	G12
Risk Factors (%)									
Family conflict	51.8	39.4	38.3	50.5	36.7	38.2	51.4	39.6	38.6
Academic failure	45.8	49.4	44.4	49.00	47.4	40.0	46.2	49.6	44.0
Perceived risk of drug use	54.6	53.9	61.5	53.6	59.4	64.4	54.2	54.2	61.1
Protective Factors (%)									
Family attachment	52.9	48.4	55.6	55.2	47.1	51.7	52.3	47.5	55.4
Opportunities for prosocial involvement at school	67.7	70.6	68.6	41.7	74.2	75.7	67.5	69.5	68.5
Prosocial involvement peers/individual	34.5	36.9	29.3	39.6	36.6	32.5	35.4	36.7	29.6
Substance Use (% for one or more occasions in lifetime)									
Alcohol	29.4	45.5	59.3	26.9	50.7	59.2	30.6	47.2	59.2
Marijuana	14.8	30.7	44.0	12.2	36.4	46.1	15.7	31.8	44.1
Marijuana concentrates	13.9	25.1	33.6	8.4	29.7	34.3	14.1	25.1	32.7
Prescription opioids (without doctor telling them to)	7.7	8.5	9.7	5.2	12.4	11.4	7.8	9.4	10.1
School (%)									
Feel safe at school – indicated “no”	21.1	22.1	19.1	32.6	19.3	14.3	22.0	22.3	19.4
During the past 12 months…									
Picked on or bullied at school	36.5	22.8	16.7	35.1	27.9	18.9	37.0	24.1	17.4
In a physical fight on school property	12.0	5.7	3.1	6.8	7.6	4.2	12.6	6.2	3.4
Handguns: Sort of or very easy to get a handgun (%)	14.2	18.3	26.8	14.0	20.7	28.8	15.7	19.8	27.7
Witnessed or experienced violence									
Seen someone punched, kicked, choked, or beaten up	56.2	49.5	39.0	46.0	54.4	35.5	56.8	50.0	38.5
Been punched, kicked, choked, or beaten up	26.2	16.4	12.0	21.3	17.7	11.8	26.9	17.4	12.4
Been harassed or made fun of by another person online or through text	33.3	28.6	22.9	38.6	29.2	24.5	33.2	28.9	23.3

Table 4: Suicide Rates by County of Residence

Glendale Elementary School District is located in Maricopa County; Baboquivari Unified School District and Sunnyside Unified School District are located in Pima County.

	Maricopa County	Pima County	State of Arizona
Suicide Rate[1]			
Aged adjusted per 100,000 (2017)	15.2	19.4	18.0

[1]Arizona Department of Health Services, Suicide and Self Inflicted Injury, December 2018 https://pub.azdhs.gov/health-stats/report/suicide/2018/suicide-report-12-2018.pdf

Table 5: Resource Mapping – School District

Information is from LeCroy & Milligan Associates, Inc. search of the three school districts' websites; Table 5 focuses on behavioral health and wellness related policies, procedures, and resources.

At least one policy/procedure in place	BUSD	GESD[4]	SUSD
Guidelines for contacting law enforcement	Not referenced	Yes	Yes
Emergency response plan/threat assessment	Not referenced	Yes	Yes
Student wellness – promotion, including nutrition and physical activity	Yes[1]	Yes	Yes
Student mental health specific	None found[3]	None found	None found
Student behavior/discipline	Not referenced	Yes	Yes
Availability of psychological services	Not referenced	Yes	Yes
Employee wellness	Not referenced	Yes	Yes[6]
Parent engagement	Yes	Yes[5]	Yes

[1]Healthy meals at schools

[2]There is a link on the BUSD website to the Tohono O'Odham Resource Directory, Health and Human Services Section

[3] There is a link to the Tohono O'Odham Resource Directory, Behavioral Health Section

[4] GUSD has a Behavioral Health and School Safety Department

[5] Glendale-area has family resource centers

[6] Monthly tips in Sunnyside of Health

Table 6: Resource Mapping – Community

Information is from LeCroy & Milligan Associates, Inc. search of various data sources providing information on community resources and reflects service types available with a 5 mile radius of the school district. Table 6 focuses on behavioral health resources and, because of BUSD rural location, this district is further annotated if distance is greater than a 5 mile radius.

Number of services	BUSD	GESD	SUSD
Child abuse prevention and reporting	None found	1	1
Substance abuse counselor – licensed	Not reported	8	None found
Substance use disorders	6**	17	13
Substance abuse treatment	1	20	8
Mental health and support groups	8**	41	50
Mental health treatment	1*	24	9
Suicide prevention and counseling	1**	None found	None found

* 6-16 mile radius

** 31-50 mile radius

Primary Data

LeCroy & Milligan Associates, Inc. conducted focus groups and interviews with school staff, and some parents of current students, at all three school districts using focus group and interview guides. As noted in the Introduction to this summary, primary data collected from BUSD is not available for distribution. Table 7 shares findings extracted from the LeCroy & Milligan Associates, Inc. reports by the state level Arizona AWARE team to illustrate the range of themes that emerged from this qualitative data collection.

Table 7: Primary Data from Focus Groups and Interviews

	GESD	SUSD
Number and type of participants	28 individuals, mostly school staff and some parents of current students	25 school staff
Most common concerns students are facing	• Lack of coping, conflict resolution/anger management, and social skills • Family issues and inconsistency outside of school • Stress and anxiety	• Anxiety • Family issues
Examples of other common concerns students are facing	• Trauma • Bullying • Low self-esteem • Depression • Social media/internet use	• Depression • Suicidal ideation • Gender identity and sex • Attention/behavior
Emotional/behavioral needs-student and families	Student and family needs are high in all area; for behavioral health needs are: • Mental health promotion • Social-emotional learning • Individual counseling • Family counseling/parent-child relationship building • Parenting programs • Services and supports for parent mental health concerns and substance use disorders • Increased mental health literacy/efforts to reduce mental health stigma	Needs of a student can cut across categories: • Family or individual counseling • Parent-child relationship building • Lack of awareness of mental health needs • Parental depression • Substance abuse • Transition supports from middle to high school, consistent groups (e.g., coping skills)
Services and supports - available	• School-based staff: social emotional learning specialists (SELS), psychologists, nurses • School-based groups/programs: e.g., specialized classrooms, bullying prevention, social emotional skills, grief and loss, and others based on need • Community: behavioral health providers, crisis team including for self-harm or suicidal ideation, Teen Lifeline	• School-based staff: The AWARE team, school counselors, educational psychologists, nurses, health aides, social workers • School-based groups/programs: e.g., social and emotional skills (self-regulation, tolerance for others, grief, family support, impulse control), grief groups, drug use (e.g., marijuana), girl empowerment, DACA and undocumented student support • A number of community programs; e.g., behavioral health providers/programs; Strengthening Families, University of Arizona College Academy for Parents, Higher Ground, mobile health van, grief/loss support

	GESD	SUSD
Services and supports - barriers	• School: no single source of information, varying services and supports at each school • Parents: denial of their child's needs, low mental health literacy, and stigma • Limited access to behavioral health providers (a pressing issue impacting many students), including lack of insurance (including Medicaid), affordability, and transportation	• School: Not enough staff to support student needs • Parents: Not agreeing to services/denial of their child's needs, difficulty transporting student to services, mental health related stigma • Providers: lack of follow-through from community partners, lack of community partner understanding of how the school system or special education works, and a limited number of bilingual providers.
Staff wellness	• Student needs and lack of parental response leads to high stress among school staff • District is investing in employee physical and mental health to help address problems with staff retention; district has a Health and Wellness Department	• District staff do not have sufficient time or resources available to counsel and support all the youth they serve to the degree needed • (District has a staff wellness newsletter – identified in resource mapping)
Mental health screening in schools	• No universal screening • Variability across schools in how students are being screened	• No universal screening • Limited screening methods may have been utilized on an ad-hoc basis at some schools • Challenges include: question wording to make it clear not diagnosing students, staff who implement screenings leave the district, and the current approach is more reactive than proactive, responding to students where clear issues have been identified
Other	• Enhance communication and dissemination of information about resources among school staff both within and across schools • Consistently implement policies and procedures related to behavioral health across schools	• Services and supports vary by school.

Suicide Awareness and Prevention Trainings: Overview

Earlier this year, the Mitch Warnock Act (SB 1468) was passed which "requires school districts, charter schools, and Arizona teacher training programs to include suicide awareness and prevention training and directs AHCCCS to make suicide awareness and prevention training available."

To meet these requirements, the Arizona Health Care Cost Containment System (AHCCCS) consulted with LeCroy & Milligan Associates to create a list of eight to ten suicide prevention evidence-based trainings. This final list, presented to AHCCCS and the Arizona Department of Education, contained eight, evidence-based/evidence-selected trainings including an online training option for communities with limited access and mobility.

LeCroy and Milligan Associates used a comprehensive and rigorous approach to identifying training programs included in this resource list. For more information on the methodology, please see pages 9-10.

Suicide Awareness and Prevention Trainings: Review

Training	Question, Persuade, Refer (QPR) Gatekeeper Training for Suicide Prevention
Offered by	QPR Institute
Summary	QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention is a one to two hour educational program designed to teach lay and professional "gatekeepers" the warning signs of a suicide crisis and how to respond. Gatekeepers can include anyone who is strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers). The process follows three steps: (1) Question the individual's desire or intent regarding suicide, (2) Persuade the person to seek and accept help, and (3) Refer the person to appropriate resources. Trainees receive a QPR booklet and wallet card as a review and resource tool that includes local referral resources.
Structure	The training is delivered in person by certified QPR gatekeeper instructors or online. Although the foundation for the QPR Gatekeeper Training for Suicide Prevention is the same for all audiences, the training can be customized for use with specific audiences in collaboration with the QPR Institute. Extended learning modules on specific topics are available to complement the basic one to two hour course (including a module specifically for school health professionals).
Additional Information	https://www.sprc.org/resources-programs/qpr-gatekeeper-training-suicide-prevention

Suicide Awareness and Prevention Trainings: Review

Training	Applied Suicide Intervention Skills Training (ASIST)
Offered by	Living Works
Summary	ASIST is a two-day, two-trainer, workshop designed for members of all caregiving groups. Family, friends, and other community members may be the first to talk with a person at risk but have little or no training. ASIST can also provide those in formal helping roles with professional development to ensure that they are prepared to provide suicide first aid help as part of the care they provide. The emphasis is on teaching suicide first-aid to help a person at risk stay safe and seek further help as needed. Participants learn to: (1) use a suicide intervention model to identify persons with thoughts of suicide; (2) seek a shared understanding of reasons for dying and living; (3) develop a safe plan based upon a review of risk; (4) be prepared to do follow-up; and (5) become involved in suicide-safer community networks. The learning process is based on adult learning principles and is highly participatory. Graduated skills development occurs through mini-lectures, facilitated discussions, group simulations, and role plays.
Structure	Two-day training session by certified ASIST trainers.
Additional Information	https://www.sprc.org/resources-programs/applied-suicide-intervention-skills-training-asist

Suicide Awareness and Prevention Trainings: Review

Training	At-Risk for High School Educators (Kognito)
Offered by	Kognito Interactive
Summary	Kognito At-Risk for High School Educators is a one-hour, online, interactive gatekeeper training program that teaches high school teachers and other educators how to: (1) identify students exhibiting signs of psychological distress, including depression, anxiety, substance abuse, and thoughts of suicide; (2) approach students to discuss their concern; and (3) make a referral to school support services. Through role-plays with animated and responsive avatars, participants engage in simulated conversations with three students of concern with the help of a virtual coach. In these virtual conversations, users learn effective conversation strategies for broaching the topic of psychological distress, motivating the student to seek help, and avoiding pitfalls, such as attempting to diagnose the problem or giving unwarranted advice. This online course is available from Kognito Interactive for a fee.
Structure	One-hour online. Organizations can purchase yearly subscriptions to the simulation that include hosting, technical assistance, program evaluation, and usage reports.
Additional Information	https://www.sprc.org/resources-programs/kognito-risk-high-school-educators

Suicide Awareness and Prevention Trainings: Review

Training	Youth Mental Health First Aid
Offered by	Mental Health First Aid
Summary	Youth Mental Health First Aid is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. Youth Mental Health First Aid is primarily designed for adults who regularly interact with young people. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders.
Structure	The Mental Health First Aid program is an interactive session delivered by certified trainers. The program is 12 hours and can be conducted as one 1-day seminar, two 1-day events spaced over a short period of time, or as four 3-hour sessions.
Evidence	BPR, SPRC, Meta-analyses, Cultural adaptability
Additional Information	http://www.sprc.org/resources-programs/mental-health-first-aid-usa

Suicide Awareness and Prevention Trainings: Review

Training	Suicide Alertness for Everyone (safeTALK)
Offered by	Living Works
Summary	SafeTALK is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. SafeTALK stresses safety while challenging taboos that inhibit open talk about suicide. The 'TALK' letters stand for the practice actions that one does to help those with thoughts of suicide: Tell, Ask, Listen, and KeepSafe. The safeTALK learning process is highly structured, providing graduated exposure to practice actions. The program is designed to help participants monitor the effect of false societal beliefs that can cause otherwise caring and helpful people to miss, dismiss, or avoid suicide alerts and to practice the TALK step actions to move past these barriers. Six 60-90 second video scenarios, each with non-alert and alert clips, are selected from a library of scenarios and strategically used through the training to provide experiential referents for the participants. Note that there is another training called Start that may be a good fit for some districts as well and can be reviewed at the LivingWorks website.
Structure	4-hour training by a certified safeTALK trainer.
Additional Information	https://www.sprc.org/resources-programs/suicide-alertness-everyone-safetalk

Suicide Awareness and Prevention Trainings: Review

Training	More than Sad- Suicide Prevention Education for Teachers and Other School Personnel
Offered by	American Foundation for Suicide Prevention
Summary	Developed by the American Foundation for Suicide Prevention, More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel is designed to help educators better understand suicidal behavior in adolescents, including its causes, treatment and prevention. participants, and other resources. An expert advisory panel guided the development of the program. The program answers the following questions: How big a problem is youth suicide? How can teachers help prevent youth suicide? What puts teens at risk for suicide? What treatments are available? How can teachers identify at-risk students? How else can schools decrease risk?
Structure	The program is built around two 25-minute DVDs: More Than Sad: Preventing Teen Suicide and More Than Sad: Teen Depression. The facilitator materials are downloadable from the AFSP website and include a Facilitator's Guide, slides for teacher trainers, instructional manual for program.
Additional Information	https://www.sprc.org/resources-programs/more-sad-suicide-prevention-education-teachers-and-other-school-personnel

Suicide Awareness and Prevention Trainings: Review

Training	Be a Link! Suicide Prevention Gatekeeper Training
Offered by	Yellow Ribbon
Summary	Developed by Yellow Ribbon, *Be A Link!* is a two-hour adult gatekeeper training program. The program can be implemented in a variety of settings, including schools, workplaces, and community groups. The training provides participants with knowledge to help them identify youth at risk for suicide and refer them to appropriate help resources. Training includes information on risk and warning signs of suicide, community referral points for those who may need help, and crisis protocols for those who may be at risk.
Structure	Program toolkit with manual and PowerPoint (on CD). Specialized in-person training also available for school staff (2-1/2 hours).
Additional Information	https://www.sprc.org/resources-programs/be-link-suicide-prevention-gatekeeper-training

Suicide Awareness and Prevention Trainings: Review

Training	ACT on FACTS (updated version of Making Educators Partners in Youth Suicide Prevention)
Offered by	Society for the Prevention of Teen Suicide
Summary	ACT on FACTS is an updated version of the school-based suicide awareness program "Making Educators Partners in Suicide Prevention." Like its predecessor, ACT on FACTS is a two-hour online interactive training program, designed in a series of modules. It addresses the critical but limited responsibilities of educators in the process of identification and referral of potentially suicidal youth. It focuses on the practical realities and challenges inherent in the school setting through a variety of training formats that include lecture, question and answer with content experts, interactive exercises and role plays. In addition to its other content, the program highlights four categories of youth who may be at elevated risk for suicide: youth involved in bullying, LGBTQ youth, gifted youth, and students being reintegrated back into school after a suicide attempt. The training includes optional content that addresses suicide in elementary and middle schools. There is also an additional module that includes the stories of individual survivors of suicide loss as well as a high school that experienced an episode of contagion. The focus in telling these stories is to highlight the importance of emphasizing resilience and protective factors after a loss event.
Structure	Two hours online in a series of modules. In-person training also available.
Additional Information	https://www.sprc.org/resources-programs/making-educators-partners-youth-suicide-prevention-act-facts

Suicide Awareness and Prevention Trainings: Methodology

The following summarizes LeCroy & Milligan Associates methodology to develop a list of evidence-based or evidence-supported suicide prevention trainings.

Literature and website review:

- *Preventing Suicide: A Toolkit for High Schools,* Substance Abuse and Mental Health Services Administration (SAMHSA), 2012. We identified evidence-based training programs for staff education and training and/or gatekeepers. Per SAMHSA, programs were only included if in the National Registry of Evidence-Based Programs and Practices (NREPP) for any additional suicide prevention trainings in a school setting (specifying "gateway" trainings).
- Suicide Prevention Resource Center (SPRC) website We identified additional suicide prevention trainings for school settings (specifying "gateway" trainings).
- Articles addressing cultural considerations in suicide prevention and implications for trainings, including specific trainings to consider for Native American populations. These met a basic standard of evidence and were appropriate for the target specific audience.
    - To *Live To See the Great Day that Dawns,* U.S. Department of Health and Human Services, 2010.
    - *Suicide Prevention: Resources for American Indian/Alaskan Native Communities,* National Congress of American Indians Policy research Center, 2010.
    - *The Need for Culturally Tailored Gatekeeper Training Intervention Program in Preventing Suicide Among Indigenous Peoples: A Systematic Review* (Nasir, et. al 2016).

Selecting training programs:

- With reference to the literature and web-based review, we developed a master spreadsheet that included key information about each training: its purpose; population of focus; mode and setting; frequency and duration; features and core components; adaptations; and source/developer.
- We removed any trainings from the list that were not a good fit for this intended purpose based on the following exclusion criteria:
    - Not focused on training adults who interact with youth; e.g., peer training programs.
    - Difficult to implement in schools statewide because of duration or other characteristics; e.g., multi-week accreditation programs.
    - Not Tier 1 gatekeeper trainings; i.e., Tier 2 or Tier 3 programs targeting at-risk or identified youth.
    - Little or no evidence available; e.g., not listed in NREPP or BPR and no mention of supporting research on training website.

- To make the final determination of what trainings were included in the list, we searched the Academic Search Ultimate Database for meta-analyses of suicide prevention trainings, using terms including “suicide prevention,” “school-based,” “evidence-based,” and “gatekeeper trainings.” We used these to look for additional evidence in support of specific trainings on our list.
    - We only included those meta-analyses that identified specific training curricula, as opposed to those that analyzed results across studies of gatekeeper training programs without identifying the specific trainings.
    - The following meta-analyses were reviewed: *A Systematic Review of School-Based Suicide Prevention Programs* (Katz, et. al., 2013); *School-based Gatekeeper Training Programmes in Enhancing Gatekeepers’ Cognitions and Behaviors for Adolescent Suicide Prevention: A Systematic Review* (Mo, Ko, & Xin, 2018); *What Works in Youth Suicide Prevention? A Systematic Review and Meta-Analysis* (Robinson, et al., 2018); and *Gatekeeper Training for Suicide Behaviors: A Systematic Review* (Yonemoto, et al., 2019).
- We used this information to create a summative score of evidence for all remaining trainings on the list, with a point awarded for each of the following:
    - Included in the SAMHSA Suicide Prevention Toolkit for High Schools;
    - Included in NREPP and/or BPR;
    - Listed on the SPRC website;
    - Supporting evidence referenced in one or more meta-analyses OR specifically listed as culturally adaptable, including for tribal communities.
- All trainings with a score of 3 or 4 were included in the final list.

Project AWARE—
Training Assessment Results: Year 1, Quarter 4

December 2019

LeCroy & Milligan
ASSOCIATES, INC.

Submitted to:
State of Arizona
Department of Education
1535 W. Jefferson Street
Phoenix, AZ 85007

Submitted by:
LeCroy & Milligan Associates, Inc.
2002 N. Forbes Blvd. Suite 108
Tucson, AZ 85745
Ph: (520) 326-5154
Fax: (520) 326-5155
www.lecroymilligan.com

About LeCroy & Milligan Associates, Inc.:

Founded in 1991, LeCroy & Milligan Associates, Inc. is a consulting firm specializing in social services and education program evaluation and training that is comprehensive, research-driven and useful. Our goal is to provide effective program evaluation and training that enables stakeholders to document outcomes, provide accountability, and engage in continuous program improvement. With central offices located in Tucson, Arizona, LMA has worked at the local, state and national level with a broad spectrum of social services, criminal justice, education and behavioral health programs.

Suggested Citation:

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Table of Contents

Introduction

The Arizona Department of Education (ADE) began offering mental health literacy and suicide prevention trainings during July 2019 as part of Project AWARE (Advancing Wellness and Resiliency in Education). Project AWARE is a 5-year federal grant initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), part of the Department of Health and Human Services (DHHS). As part of the evaluation of Project AWARE, ADE is collecting training assessment data at all Project AWARE mental health literacy and suicide prevention trainings. The purpose of the data collection is four-fold: (1) to collect additional information about the training participants; (2) to assess participants' perceptions of the trainings and the trainers; (3) to assess changes in participants' knowledge and attitudes about mental health; and (4) to solicit feedback from participants for training improvement. This report provides results of training assessments from seven trainings conducted during Fiscal Year 1 (FY1) Quarter 4 (Q4) of Project AWARE. All seven trainings for this report were Youth Mental Health First Aid (YMHFA) trainings, the purpose of which is to teach participants how to recognize and assist a youth who is experiencing a mental health or substance use problem or is in crisis. The YMHFA curriculum covers anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including ADHD), and eating disorders. The trainings also teach participants a 5-step action plan for how to help youth in both crisis and non-crisis situations.

Methodology

This section describes the training assessment instrument and the procedures for collecting and reporting the Project AWARE training assessment data. It also presents the response rates for the seven trainings held between August 19, 2019, and September 24, 2019, the training period covered in this report.

Data Collection and Reporting

Data Collection Instrument

ADE created a brief training assessment form (see Appendix) by modifying the standard Youth Mental Health First Aid (YMHFA) assessment, which is administered both before and after a YMHFA training (i.e., a pre/post assessment). In contrast, the Project AWARE training assessment form is only administered after a training, while still capturing information about participants' pre-training and post-training knowledge and attitudes (i.e., a retrospective-pre/post assessment). The assessment captures all four types of information described above, including information about the participants themselves, participants' ratings of the trainings and instructors, changes in participants' knowledge and attitudes, and participant feedback for improvement.

Data Collection and Reporting Procedures

ADE began using the assessment form for all Project AWARE mental health literacy and suicide prevention trainings on August 19, 2019. Training instructors distribute hard copy assessment forms to all participants at the end of each training. Participants complete the assessment forms (responses are anonymous), and place the forms directly into an envelope, which is sealed and sent to the Project AWARE Training Coordinator at ADE. The Training Coordinator then scans the forms and sends them electronically to the Project AWARE Evaluator, who enters, cleans, analyzes and summarizes the data and results for ADE on a quarterly basis.

Response Rates

A total of 102 individuals participated in the seven YMHFA trainings during Q4 of FY1 of Project AWARE, with attendance ranging from 8 to 28 participants. The median number of participants was 11. Of the 102 training participants, 93 (91%) completed training assessments. Exhibit 1 shows the number of training participants, the number of completed assessments, and the response rate for each training. Response rates ranged from a low of 55% at one training to a high of 100% at three trainings. Response rates were 88% or higher for six of the seven trainings.

Exhibit 1. Number of training participants and response rate, by training

Training	# Participants	# Assessments	Response Rate
1	28	26	**93%**
2	15	14	**93%**
3	23	23	**100%**
4	8	7	**88%**
5	11	6	**55%**
6	8	8	**100%**
7	9	9	**100%**
TOTAL	102	93	**91%**

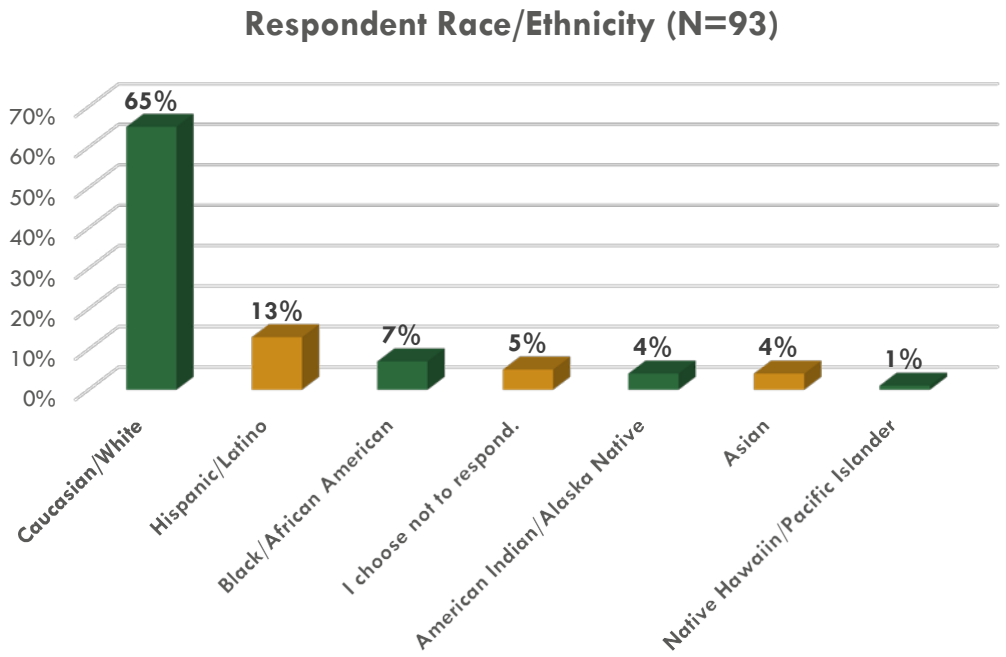
Results

This section presents the results of the training assessment data including a description of training participants, instructor ratings, changes in participant knowledge and attitudes about mental health, and feedback for training improvement.

Participant Information

Of the 93 training participants who completed training assessment forms, almost two-thirds (65%) of respondents identified as Caucasian/White, and 13% identified as Hispanic or Latino (Exhibit 2). Seven percent of respondents identified as Black, and equal percentages identified as American Indian/Alaska Native and Asian. Additionally, 5% of respondents selected "I choose not to respond."

Exhibit 2. Respondent Race/Ethnicity (N=93)



Most respondents (92 percent) were 45 years of age or older, with 60 percent of respondents between 45 and 60 years of age, and 29 percent of respondents between 61 and 80 years of age (Exhibit 3). Of the eight percent of respondents who were younger than 45 years of age, only one respondent (1 percent) was younger than 25.

Most (86 percent) of respondents were female, as shown in Exhibit 4. A majority of respondents reported that their current role or occupation was in the field of education, and, perhaps not surprisingly, 90% (n=90) reported that they worked directly with students. On average, respondents had been working in their current role for eight years.

Exhibit 3. Respondent Age (N=91)

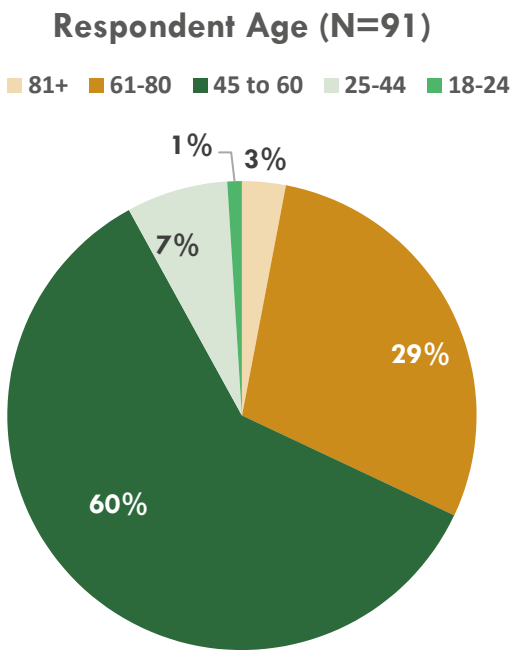
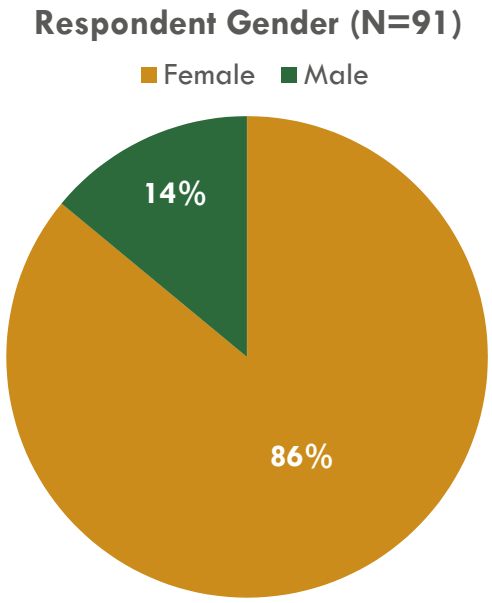


Exhibit 4. Respondent Gender (N=91)



Participants were asked three yes/no questions about their past experiences with mental health training and mental illness. More than half (56%; n=91) of respondents reported that they had previously participated in at least one mental health training. Almost one-third (31%; n=87) of respondents replied affirmatively to the question, "Do you identify as a person with lived experience or a person in long-term recovery?" Additionally, 37% (n=90) of respondents reported that they support a family member with serious mental illness.

Instructor Ratings

Across the seven trainings, respondents rated the training instructors very positively. Most respondents (93%) agreed or strongly agreed that instructors demonstrated knowledge of the material presented. In addition, 92% of respondents agreed or strongly agreed that instructors' presentation skills were engaging and approachable, and 91% agreed or strongly agreed that instructors facilitated activities and discussion in a clear and effective manner.

Exhibit 4. Respondents' Ratings of Training Instructors (N=92)

Statement	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
The instructor's presentation skills were engaging and approachable.	57%	35%	4%	2%	2%
The instructor demonstrated knowledge of the material presented.	60%	33%	3%	1%	3%
The instructor facilitated activities and discussion in a clear and effective manner.	61%	30%	5%	0%	3%

Respondents could also provide additional feedback for the training instructors. Nineteen of the 93 respondents (20%) provided additional feedback. While some of the respondents provided general, positive comments about the instructors (e.g., "Great job!"), many respondents commented on how informative, engaging, or clear the instructors were. All participant comments are listed verbatim below and are grouped according to the specific instructor quality that is addressed in the comment.

Instructors were informative

Positive:

- *Great job very informative*
- *Very informative engaging*
- *The presentation demonstrated knowledge was very engaging and friendly*
- *With so many people coming from all different walks of life, I appreciated that you started us at the beginning.*

Instructors were/were not engaging

Positive:

- *Super engaging and relatable*
- *Kept me engaged for the majority of presentation by providing relevant info scenarios and solutions*

Feedback/recommendations:

- *Presentation was not always engaging or approachable.*
- *Instructor was not approachable and at times seemed agitated by the group discussion should have prevented the discussion before it got so far off topic to avoid annoyance & stay on schedule*

Instructors were/were not clear

Positive:

- *Good job, very clear*

Feedback/recommendations:

- *Instructions for activities were consistently unclear*
- *Some instructions hard to hear unclear*
- *Some of the activities/exercises were confusing when explained. Maybe ask for questions first before dispersing.*
- *Audience seemed to need further discussion clarification and at times was prevented/dismissed due to what seemed like instructors focus on getting through notes/content.*

General assessment of instructors

Positive:

- *Outstanding!*
- *You guys are awesome*
- *You guys are great!*
- *They were great*
- *Great Job!*
- *Great job it's a long presentation*

Feedback/recommendations:

- *When it was [instructor A's] turn [instructor B] "interjected" and added comments. How is [instructor A] going to learn that way, if [instructor B] is always jumping in? "I will help you get in the car there."*

Changes in Knowledge and Attitudes

Participants were asked to indicate their level of agreement, from strongly agree to strongly disagree, with a series of statements about feeling confident that they could recognize and/or respond to a young person who might be experiencing a mental health or substance use problem or crisis. Participants were asked about their level of agreement with a statement about feeling confident in a particular ability retrospectively after the training. For example, did they feel they were confident asking a young person if they're thinking of committing suicide BEFORE the training, and how would they rate this confidence after the training. For each statement, participants selected one of five response options: strongly disagree, disagree, uncertain, agree, or strongly agree, which were coded from 1 to 5, respectively, with higher numbers representing greater agreement. There were six sets of before/after statements:

BEFORE the training, I felt confident I could…/AFTER the training, I feel confident I can…

1. …recognize signs a young person may be dealing with a mental health or substance use problem or crisis.
2. …reach out to a young person who may be dealing with mental health or substance use problem or crisis.
3. …ask a young person if they're considering committing suicide.
4. …actively, compassionately listen to a young person in distress.
5. …assist a young person who may be dealing with mental health or substance use problem or crisis in seeking help.
6. …recognize and correct misconceptions about mental health, mental illness, and substance use.

Each set of before/after statements had two responses, one for the level of agreement with the pre-training statement and one for the level of agreement with the post-training statement. Both responses ranged from 1 to 5, with higher numbers representing greater agreement with the statement. To examine individual-level change, we calculated the difference between the numeric response values for the "before" and "after" statements in each set by subtracting the response value of the "before" statement from the response value of the "after" statement. Thus, a positive difference indicates that the individual's level of agreement with the statement increased as a result of the training—i.e., moved toward the strongly agree end of the continuum. Similarly, a negative difference would indicate level of agreement decreased as a result of the training, and the absolute value of the difference would indicate the number of categories the respondent moved toward strongly disagree. It is worth noting, however, that none of the calculated differences were negative. Finally, a difference of zero indicates no change in level of agreement as a result of the training.

Recognizing Signs of a Problem or Crisis

Before the training, only twelve percent of respondents strongly agreed that they felt confident they could recognize the signs a young person may be dealing with a mental health or substance use problem or crisis (Exhibit 5a). After the training, about two-thirds (67%) of respondents strongly agreed that they felt confident they could recognize such signs. The percentages of respondents who *disagreed* or were *uncertain* that they felt confident they could recognize signs in a young person decreased from 41% *before* the training, to 1% *after* the training. Additionally, after the training, 99% of respondents agreed or strongly agreed that they felt confident they could recognize signs a young person may be dealing with a mental health or substance use problem or crisis, and no respondents disagreed or strongly disagreed with that statement.

Exhibit 5a. Pre- and Post-Training Confidence in Ability to Recognize Signs of Mental Health or Substance Use Problem or Crisis (N=93)

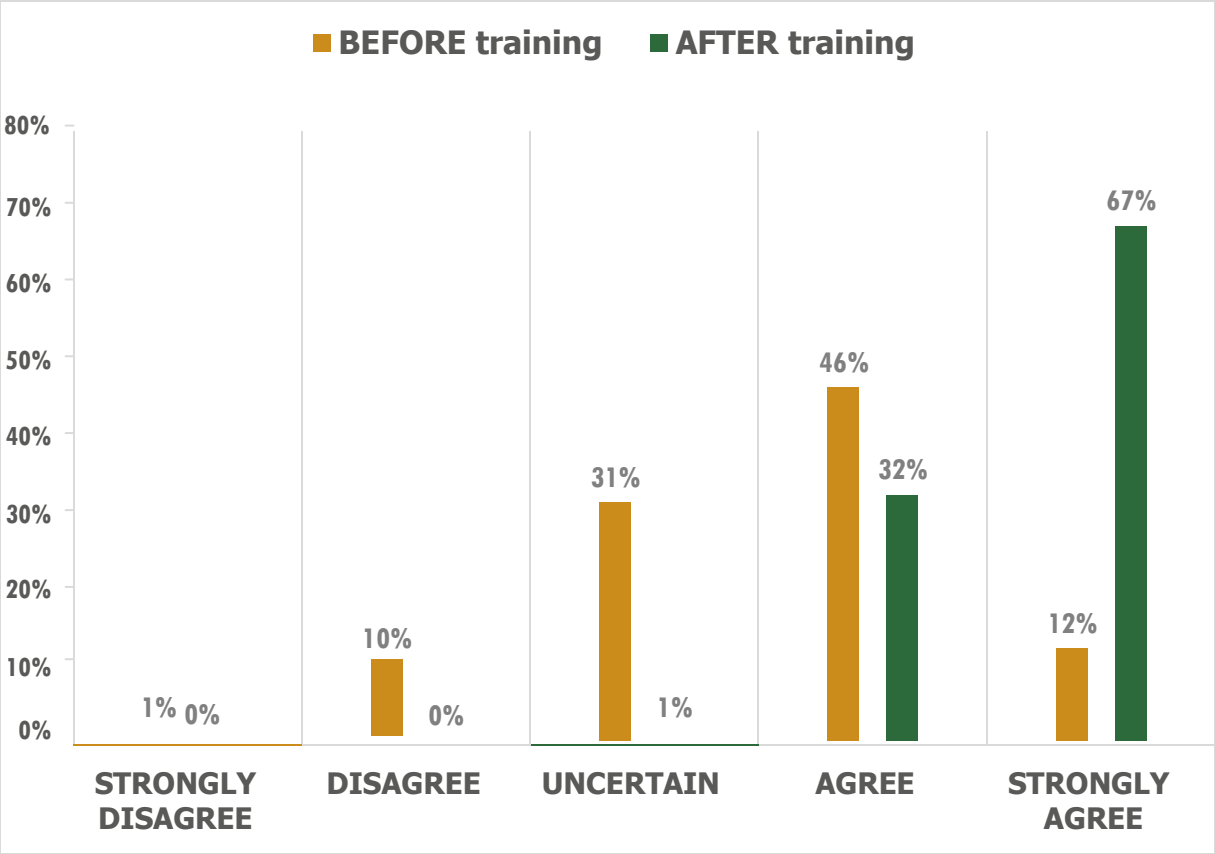


Exhibit 5b. Change in Confidence in Ability to Recognize Signs of Mental Health or Substance Use Problem or Crisis (N=93)

Pre-/Post-Training Change	%
No Change	26%
One Category	43%
Two Categories	24%
Three Categories	6%
Four Categories	1%

Although roughly one-quarter (26%) of respondents reported no change in confidence related to recognizing signs a young person may be experiencing a mental health or substance use problem or crisis, about three-quarters (74%) of respondents did report a change in confidence as a result of the training (Exhibit 5b). Forty-three percent of respondents increased by one category—e.g., from "uncertain" to "agree" or from "agree" to "strongly agree"—and almost one-fourth (24%) of respondents moved two categories as a result of the training—e.g., from "disagree" to "agree" or from "uncertain" to "strongly agree."

Reaching Out to a Person with a Problem or Crisis

Before the training, only 10% of respondents strongly agreed that they felt confident they could reach out to a young person who may be dealing with a mental health or substance use problem or crisis (Exhibit 6a). After the training, 58% of respondents strongly agreed that they felt confident they could reach out to a young person in that situation. The percentages of respondents who said they strongly disagreed, disagreed or were uncertain that they felt confident they could reach out to a young person in crisis decreased from 44% *before* the training, to 2% *after* the training. After the training, 98% of respondents agreed or strongly agreed that they felt confident they could reach out to a young person who may be dealing with a mental health or substance use problem or crisis, and no respondents strongly disagreed with that statement.

Exhibit 6a. Pre- and Post-Training Confidence in Reaching Out to Someone with Mental Health or Substance Use Problem or Crisis (N=93)

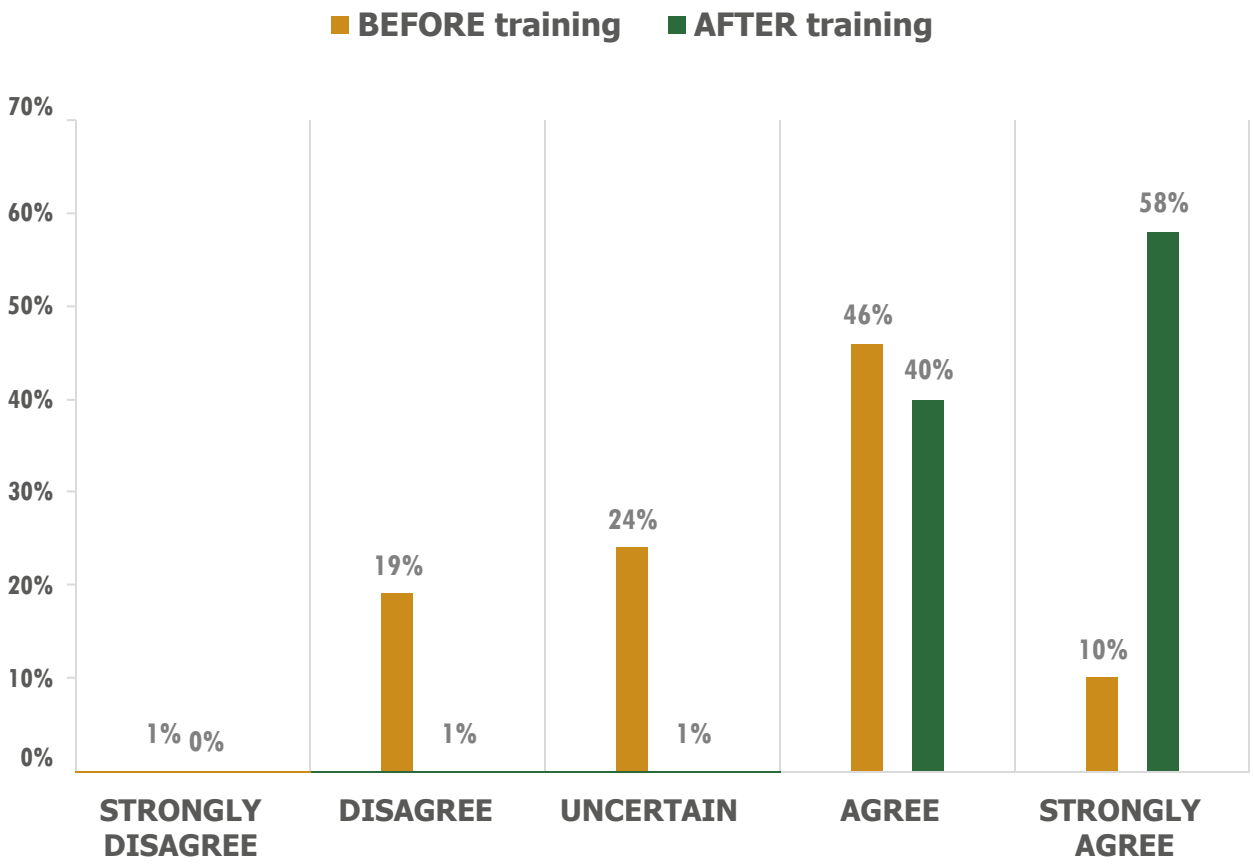


Exhibit 6b. Change in Confidence in Ability to Reach Out to Someone with Mental Health or Substance Use Problem or Crisis (N=93)

Pre-/Post-Training Change	%
No Change	23%
One Category	43%
Two Categories	24%
Three Categories	10%
Four Categories	1%

The pre-/post-training changes in confidence related to reaching out to a young person who may be experiencing a mental health or substance use problem or crisis (Exhibit 6b) were similar to those shown in Exhibit 5b in the previous section. Although just under one-quarter (23%) of respondents reported no change in confidence, just over three-quarters (77%) of respondents did report a change in confidence as a result of the training. Forty-three percent of respondents increased by one category—e.g., from "uncertain" to "agree" or from "agree" to "strongly agree"—and almost

one-fourth (24%) of respondents moved two categories as a result of the training—e.g., from "disagree" to "agree" or from "uncertain" to "strongly agree."

Asking Someone if They're Considering Committing Suicide

Before the training, 17% of respondents strongly agreed that they felt confident they could ask a young person if they're considering committing suicide (Exhibit 7a). After the training, 52% of respondents strongly agreed that they felt confident they could ask a young person if they're considering committing suicide. Additionally, the percentages of respondents who said they strongly disagreed, disagreed or were uncertain that they felt confident they could ask a young person if they're considering committing suicide decreased from 52% *before* the training, to 3% *after* the training. After the training, 97% of respondents agreed or strongly agreed that they felt confident they could ask a young person if they're considering committing suicide.

Exhibit 7a. Pre- and Post-Training Confidence in Asking a Young Person If They're Considering Committing Suicide (N=93)

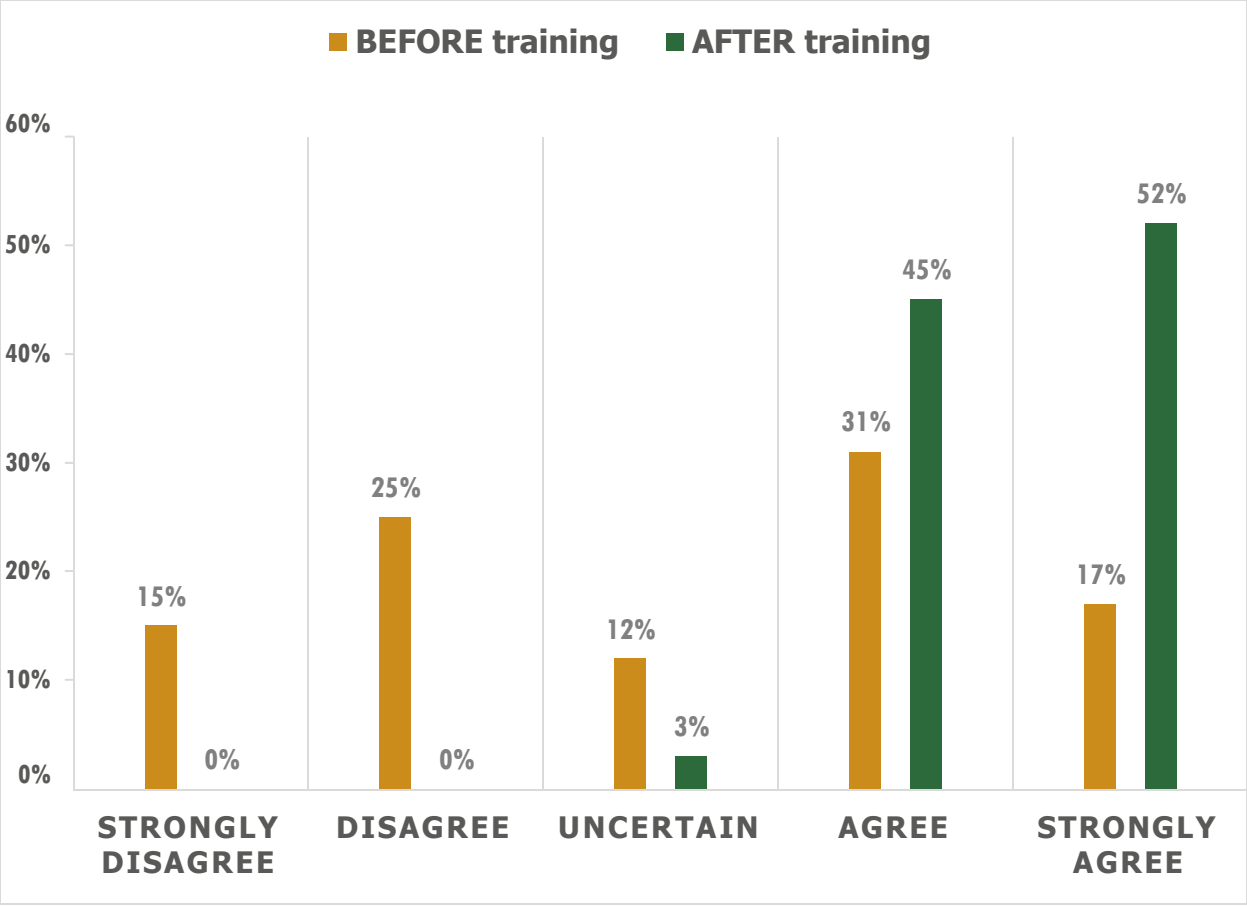


Exhibit 7b. Change Confidence in Ability to Ask a Young Person If They're Considering Committing Suicide (N=93)

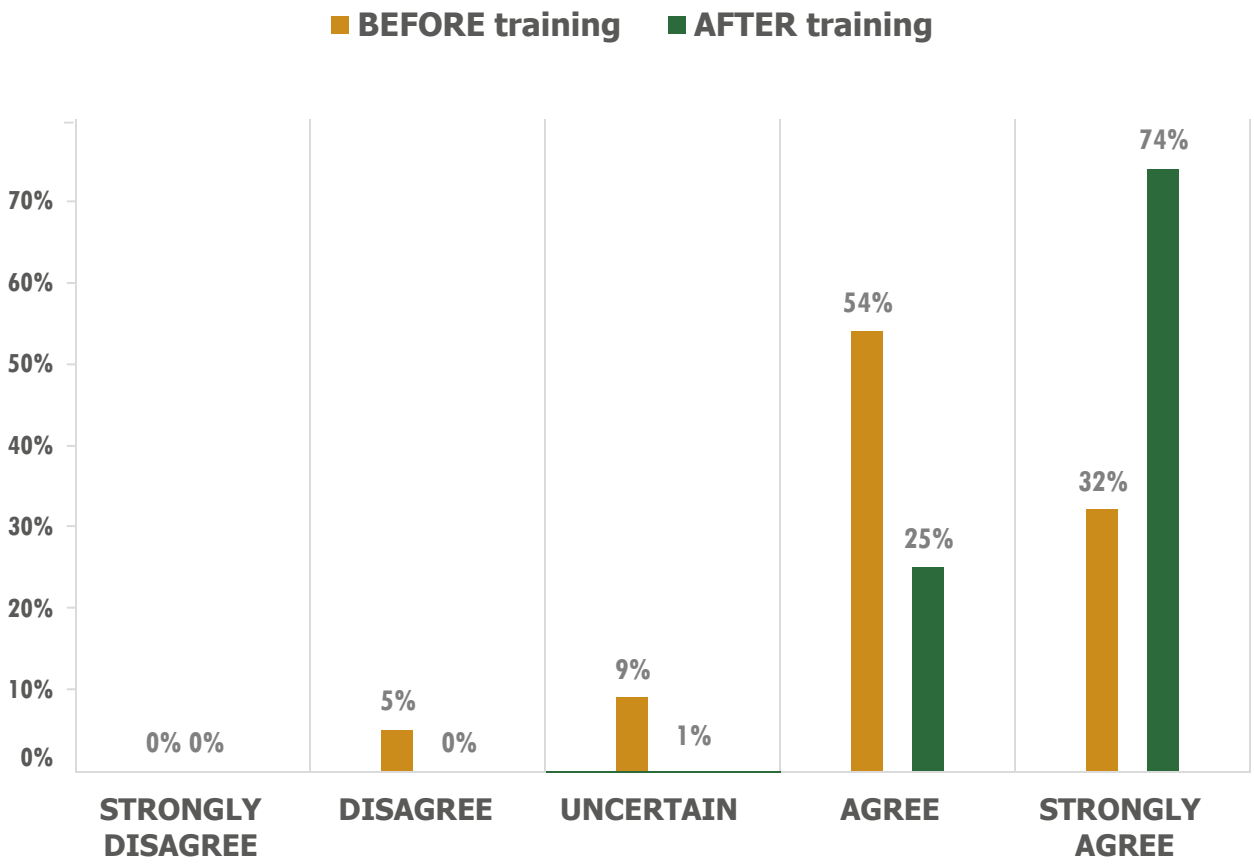
Pre-/Post-Training Change	%
No Change	26%
One Category	30%
Two Categories	19%
Three Categories	22%
Four Categories	3%

The pre-/post-training changes in confidence related to asking a young person if they're considering committing suicide (Exhibit 7b) were very similar to those shown in Exhibits 5b and 6b with roughly one-quarter (26%) of respondents reporting no change in confidence, and roughly three-quarters (74%) of respondents reporting a change in confidence as a result of the training. What is notable about the changes in confidence related to asking a young person if they're considering committing suicide is that of the 74% who experienced change, 44% increased by two or more categories. More than one-fifth (22%) of respondents moved three categories as a result of the training, either from "strongly disagree" to "agree," or from "disagree" to "strongly agree." Thus, the increases in individuals' confidence related to asking a young person if they're considering committing suicide were greater than increases in confidence related to recognizing signs or reaching out to a young person who may be experiencing a mental health or substance use problem or crisis (Exhibits 5b and 6b, respectively).

Actively, Compassionately Listening to a Person in Distress

Before the training, roughly one-third (32%) of respondents strongly agreed that they felt confident they could actively, compassionately listen to a young person in distress (Exhibit 8a). After the training, roughly three-quarters (74%) of respondents strongly agreed that they felt confident they could actively, compassionately listen. After the training, no respondents (0%) strongly disagreed or disagreed that they felt confident they could actively, compassionately listen to a young person in crisis, and only 1% of respondents said they were uncertain. It is worth noting that before the training, 86% of respondents agreed or strongly agreed that they felt confident they could actively, compassionately listen to a young person in crisis, so participants' confidence in their ability in this area was already relatively high.

Exhibit 8a. Pre- and Post-Training Confidence in Actively, Compassionately Listening to a Young Person in Distress (N=93)



Given the high level of confidence participants had in their ability to actively, compassionately listen to a young person in crisis, it is not surprising that 43% of respondents reported no change in confidence as a result of the training (Exhibit 8b). Additionally, 47% of respondents only moved one category (e.g., "agree" to "strongly agree," "uncertain" to "agree," etc.)

Exhibit 8b. Change in Confidence in Ability to Actively, Compassionately Listen to a Young Person in Distress (N=93)

Pre-/Post-Training Change	%
No Change	43%
One Category	47%
Two Categories	5%
Three Categories	4%

Assisting a Person in Seeking Help

Before the training, only 10% of respondents strongly agreed that they felt confident they could assist a young person with a mental health or substance use problem or crisis in seeking help (Exhibit 9a). After the training, half (50%) of respondents strongly agreed that they felt confident they could assist a young person who may be dealing with mental health or substance use problem or crisis in seeking help. The percentages of respondents who said they strongly disagreed, disagreed or were uncertain that they felt confident they could assist a young person in seeking help decreased from 49% *before* the training, to 2% *after* the training. After the training, 98% of respondents agreed or strongly agreed that they felt confident they could assist a young person with a mental health or substance use problem in seeking help, and no respondents strongly disagreed with that statement.

Exhibit 9a. Pre- and Post-Training Confidence in Assisting Person with Mental Health or Substance Use Problem or Crisis in Seeking Help (N=93)

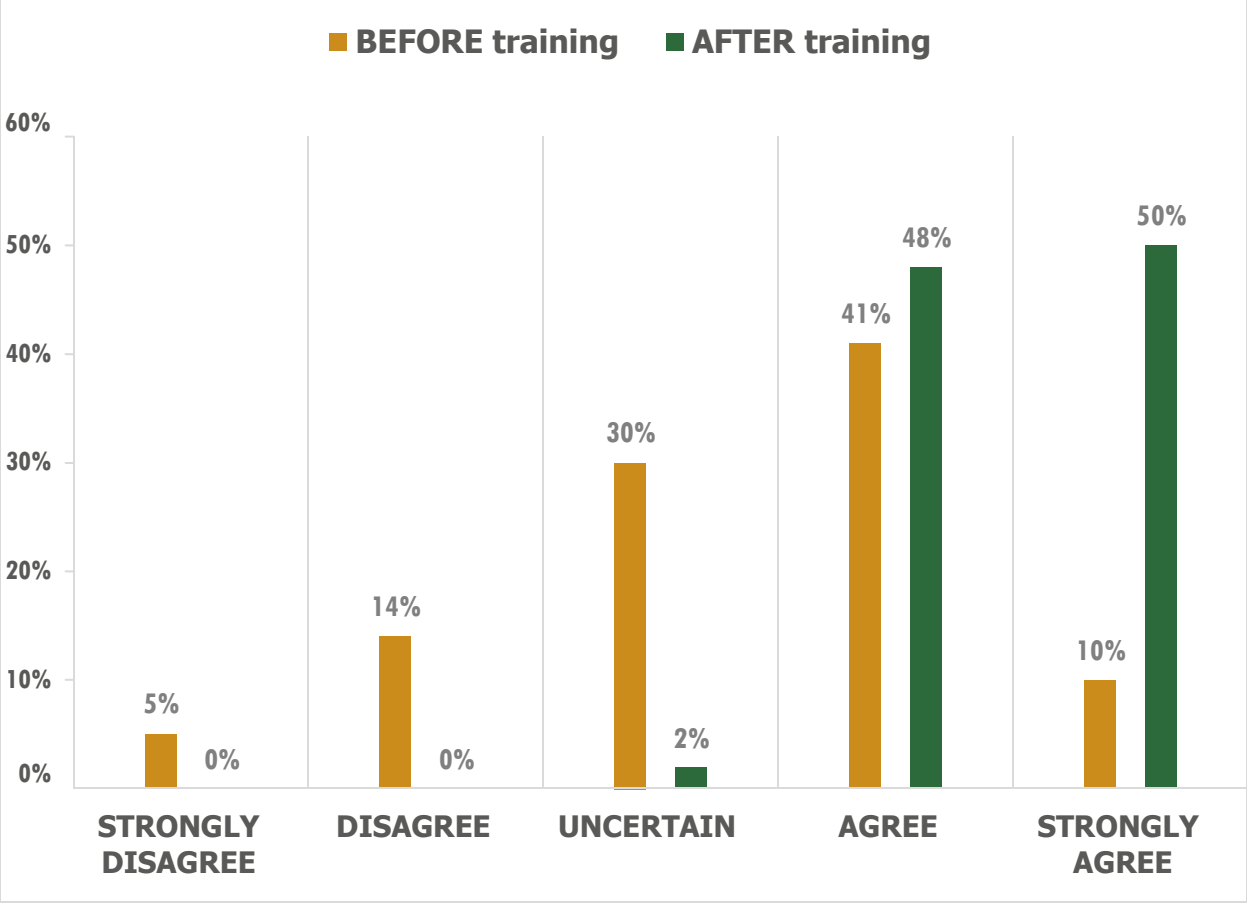


Exhibit 9b. Change in Confidence in Ability to Assist Person with Mental Health or Substance Use Problem or Crisis in Seeking Help (N=93)

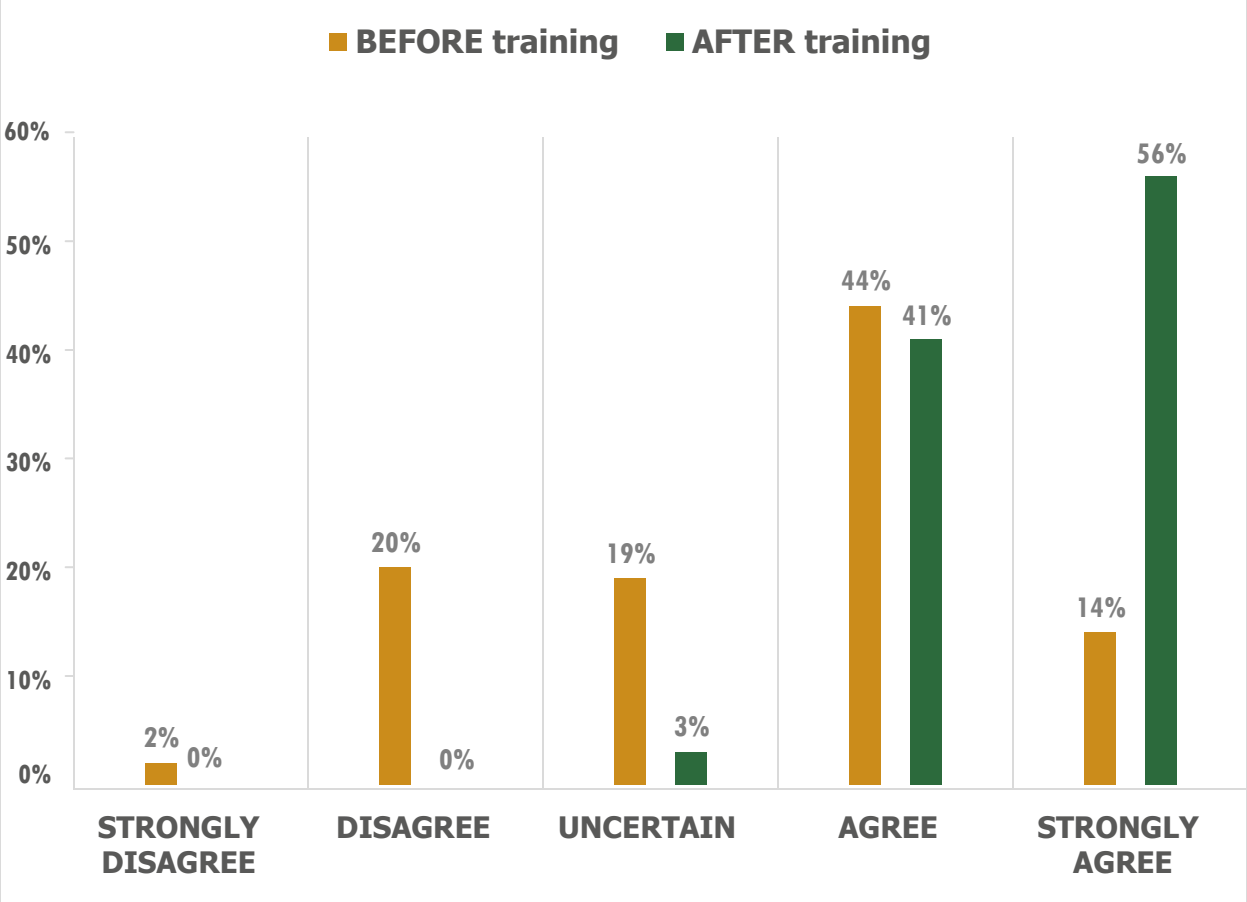
Pre-/Post-Training Change	%
No Change	23%
One Category	46%
Two Categories	24%
Three Categories	5%
Four Categories	2%

Although just under one-quarter (23%) of respondents reported no change in confidence related to assisting a young person with a mental health or substance use problem or crisis in seeking help, over three-quarters (77 %) of respondents did report a change in confidence as a result of the training (Exhibit 9b). Forty-six percent of respondents increased by one category—e.g., from "uncertain" to "agree" or from "agree" to "strongly agree"—and almost one-fourth (24%) of respondents moved two categories as a result of the training (e.g., from "disagree" to "agree" or from "uncertain" to "strongly agree"). Seven percent of respondents moved three or four categories as a result of the training—for example, from "strongly disagree" or "disagree" to "strongly agree."

Recognizing and Correcting Misconceptions

Before the training, 14% of respondents strongly agreed that they felt confident they could recognize and correct misconceptions about mental health, mental illness, and substance use (Exhibit 10a). After the training, 56% of respondents strongly agreed that they felt confident they could recognize and correct misconceptions about mental health, mental illness, and substance use. The percentages of respondents who said they strongly disagreed, disagreed or were uncertain that they felt confident they could recognize and correct misconceptions decreased from 41% *before* the training, to 3% *after* the training. After the training, 97% of respondents agreed or strongly agreed that they felt confident they could recognize and correct misconceptions about mental health, mental illness, and substance use.

Exhibit 10a. Pre- and Post-Training Confidence in Recognizing and Correcting Misconceptions about Mental Health, Mental Illness, and Substance Use (N=93)



Seventy-two percent of respondents reported a change in confidence related to recognizing and correcting misconceptions about mental health, mental illness, and substance use as a result of the training (Exhibit 10b). Thirty-nine percent of respondents increased by one category (e.g., from "uncertain" to "agree" or from "agree" to "strongly agree"), and almost one-fourth (24%) of respondents moved two categories as a result of the training (e.g., from "disagree" to "agree" or from "uncertain" to "strongly agree"). Additionally, 10% of respondents moved three or four categories as a result of the training—for example, from "strongly disagree" or "disagree" to "strongly agree." Twenty-eight percent of respondents reported no change in confidence as a result of the training.

Exhibit 10b. Change Confidence in Ability to Recognize and Correct Misconceptions about Mental Health, Mental Illness, and Substance Use (N=93)

Pre-/Post-Training Change	%
No Change	28%
One Category	39%
Two Categories	24%
Three Categories	9%
Four Categories	1%

Participant Feedback

Respondents were asked about their overall feedback regarding the training course, as well as any topics or issues they expected the training to cover but were not addressed. The results for each of these are described below.

Overall Response to Training

To capture respondents' overall response to the training, they were presented with six statements and instructed to select all that applied, in other words, all that they agreed with. One percent of respondents selected, "I choose not to respond." The percentage of respondents who selected each statement is presented in Exhibit 11.

Exhibit 11. Overall Response to Training (N=93)

Statement	%
This course was helpful and informative	87%
This course has better prepared me for the work I do professionally.	74%
This course did not have enough information and/or activities to prepare me to assist someone dealing with a mental health or substance use problem or crisis.	5%
I do not feel that I benefited from this course.	5%
I choose not to respond.	1%
Other	10%

The nine respondents who selected "other" provided the following comments and feedback:

General comments:

- *Great course we all need to take this. All employees in district.*
- *Very important topic in today's classroom!*
- *Excellent presentation. Very interactive!*
- *I am already trained in mental health, so I already know a lot of the content. However, this was a good refresher specific to crisis events.*
- *As a psychologist, I feel well trained in this area already. This was more of a refresher than learning anything new.*

Feedback/recommendations:

- *Clarify what might be the misconceptions about scenarios.*
- *There was a tremendous amount of great information. Condensing it in 6 hours felt rushed. I would prefer to split info into 2 days so that it would allow for further training.*
- *Some more hands-on activities would help.*
- *Trainer A interjected 26 times while Trainer B was talking! Caused unnecessary waste of time.*

Additional Topics or Issues

Respondents were asked to share any topics or issues that they expected the training to cover but were not addressed. This was an open-ended question—i.e., no response options were provided—and space was provided for participants to write their responses. Only eight participants (9% of respondents) provided feedback:

- *What are safe things to say to a student in crisis*
- *Ways to assist students in class with mental illness*
- *How can I apply directly to my role if I'm not a teacher, role specifics that apply*
- *How mental health is handled in different cultures wish there was more discussion*
- *What are legal rights when alone? How do I assist with minimal legal liability & ramifications?*
- *A more comprehensive list of resources available in our community. We received emergency #'s but various organizations that can be used/to give to families would be nice.*
- *Why focus so much on suicide? What about the other mental disorders/ substance abuse/ anxiety?*
- *I think it might be helpful to practice doing the suicide risk questions with partners as an activity.*

Participants provided helpful feedback about topics that, in their opinion, were not covered enough, such as things to say to a student in crisis and mental health issues other than or not involving suicide. Other participants suggested additional topics that would have been useful to cover, such as how the knowledge and skills could be applied in various occupational roles

or translated across different cultures. Participants also mentioned a desire for more information about legal issues and community resources. This type of information could be included in supplemental handouts and distributed to participants at the end of the training.

Summary of Results

Respondents rated the trainings positively, with 87% of respondents reporting that the training was helpful and informative, and 74% of respondents reporting that the training better prepared them for the work they do professionally. Respondents rated the training instructors very positively as well, with over 90% agreeing or strongly agreeing with all three statements about the instructors: their presentation skills were engaging and approachable; they demonstrated knowledge of the material; and they clearly and effectively facilitated activities and discussion.

Overall, training participants who completed assessments reported increases in their confidence, as a result of the training, in all six areas of focus: recognizing signs a young person may be dealing with a mental health or substance use problem or crisis; reaching out to the person; asking the person if they're considering committing suicide; actively, compassionately listening to the person; assisting the person in seeking help; and recognizing and correcting misconceptions about mental illness and substance use. In fact, in five of the six areas, the training increased confidence for more than 70% of respondents.

Finally, some of the feedback and recommendations provided by training participants could be incorporated in future trainings without extensive effort or cost. For example, additional information about legal rights and liability could be distributed to participants as a handout. Similarly, providing a comprehensive list of resources could be as simple as giving participants a list of websites that provide information about available resources.

Appendix: Training Assessment

Training Evaluation

Instructor(s): Location: Date:

Presenter Evaluation	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
The instructor's presentation skills were engaging and approachable.	O	O	O	O	O
The instructor demonstrated knowledge of the material presented.	O	O	O	O	O
The instructor facilitated activities and discussion in a clear and effective manner.	O	O	O	O	O
Feedback for instructor:					

Key Learning Objectives	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
BEFORE this training I felt confident that I could…Recognize the signs a young person may be dealing with a mental health problem, substance use problem, or crisis.	O	O	O	O	O
AFTER this training I feel more confident that I can… Recognize the signs a young person may be dealing with a mental health problem, substance use problem, or crisis.	O	O	O	O	O
BEFORE this training I felt confident that I could… Reach out to a young person who may be dealing with a mental health problem, substance use problem, or crisis.	O	O	O	O	O
AFTER this training I feel more confident that I can… Reach out to a young person who may be dealing with a mental health problem, substance use problem, or crisis.	O	O	O	O	O
BEFORE this training I felt confident that I could… Ask a young person if they're considering committing suicide.	O	O	O	O	O
AFTER this training I feel more confident that I can… Ask a young person if they're considering committing suicide.	O	O	O	O	O
BEFORE this training I felt confident that I could…Actively, compassionately listen to a young person in distress.	O	O	O	O	O
AFTER this training I feel more confident that I can… Actively, compassionately listen to a young person in distress.	O	O	O	O	O
BEFORE this training I felt confident that I could…Assist a young person who may be dealing with a mental health problem, substance use problem, or crisis in seeking help.	O	O	O	O	O
AFTER this training I feel more confident that I can…Assist a young person who may be dealing with a mental health problem, substance use problem, or crisis in seeking help.	O	O	O	O	O
BEFORE this training I felt confident that I could…Recognize and correct misconceptions about mental health, mental illness, and substance use as I encounter them.	O	O	O	O	O
AFTER this training I feel more confident that I can…Recognize and correct misconceptions about mental health, mental illness, and substance use as I encounter them.	O	O	O	O	O

What is your overall response to this course? (check all that apply)

O This course was helpful and informative.
O This course has better prepared me for the work that I do professionally.
O This course did not have enough information and/or activities to prepare me to assist someone dealing with a mental health or substance use problem or crisis.
O I do not feel that I benefited from this course.
O I choose not to respond.
O Other
If other, please explain:

Please share any topics or issues you expected this course to cover that were not addressed:

_____

_____

Participant Information

How do you describe your race/ethnicity (check all that apply)			
O	American Indian or Alaskan Native	O	Native Hawaiian or other Pacific Islander
O	Asian	O	Caucasian/White
O	Black or African American	O	I choose not to respond
O	Hispanic or Latino origin	O	Other:

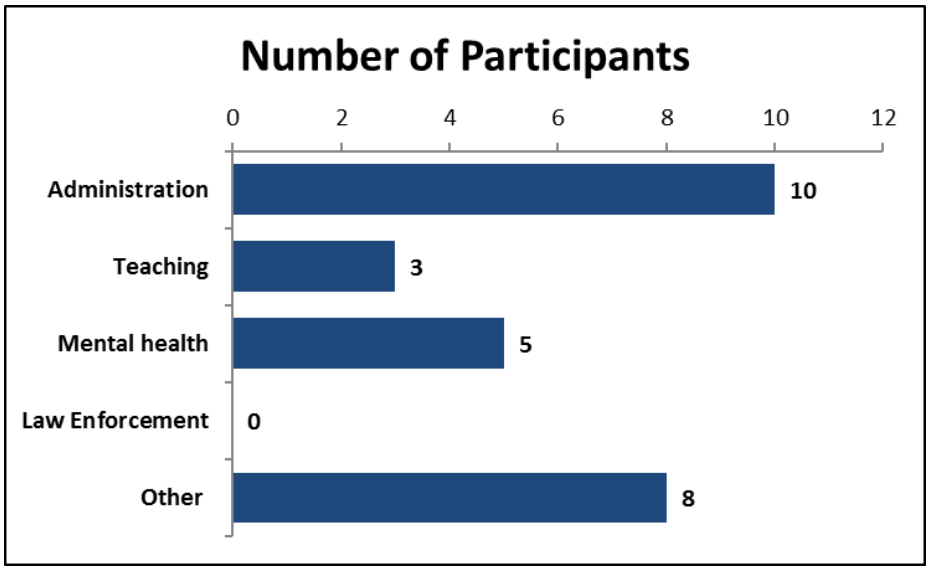
What is your age range?

O 18-24 years O 25-44 years O 45-60 years O 61-80 years O 81 years or older

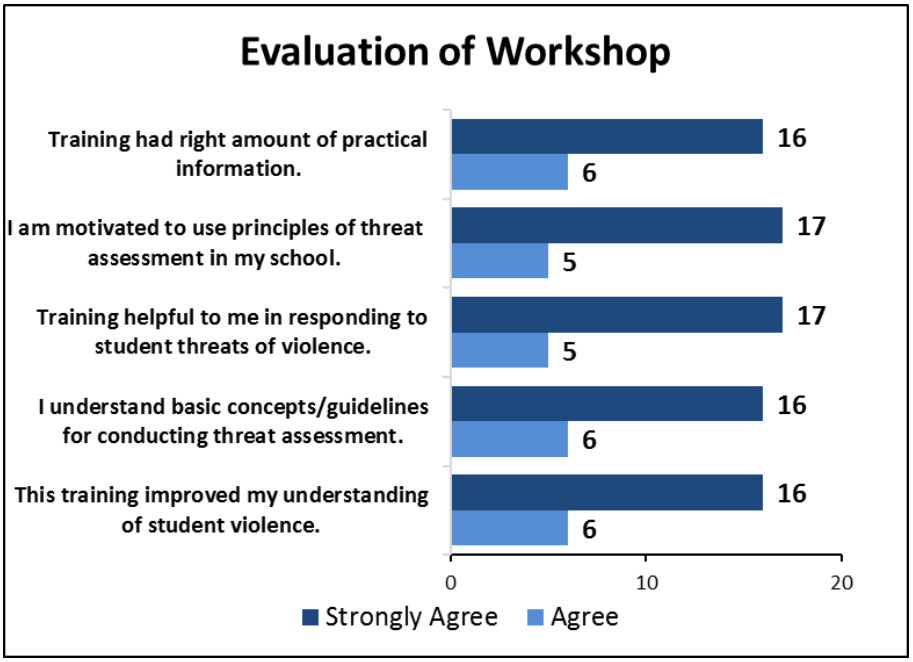
What is your gender?
What is your current role/position/occupation?
How many years have you worked in this role?
Do you regularly interact with students as part of your current position? O Yes Ω No
Have you participated in any previous mental health training? O Yes Ω No
Do you identify as a person with lived experience or a person in long-term recovery? O Yes Ω No
Do you support a family member with serious mental illness? O Yes Ω No

Evaluation of Threat Assessment Training
Apache Junction, Arizona
September 12, 2019

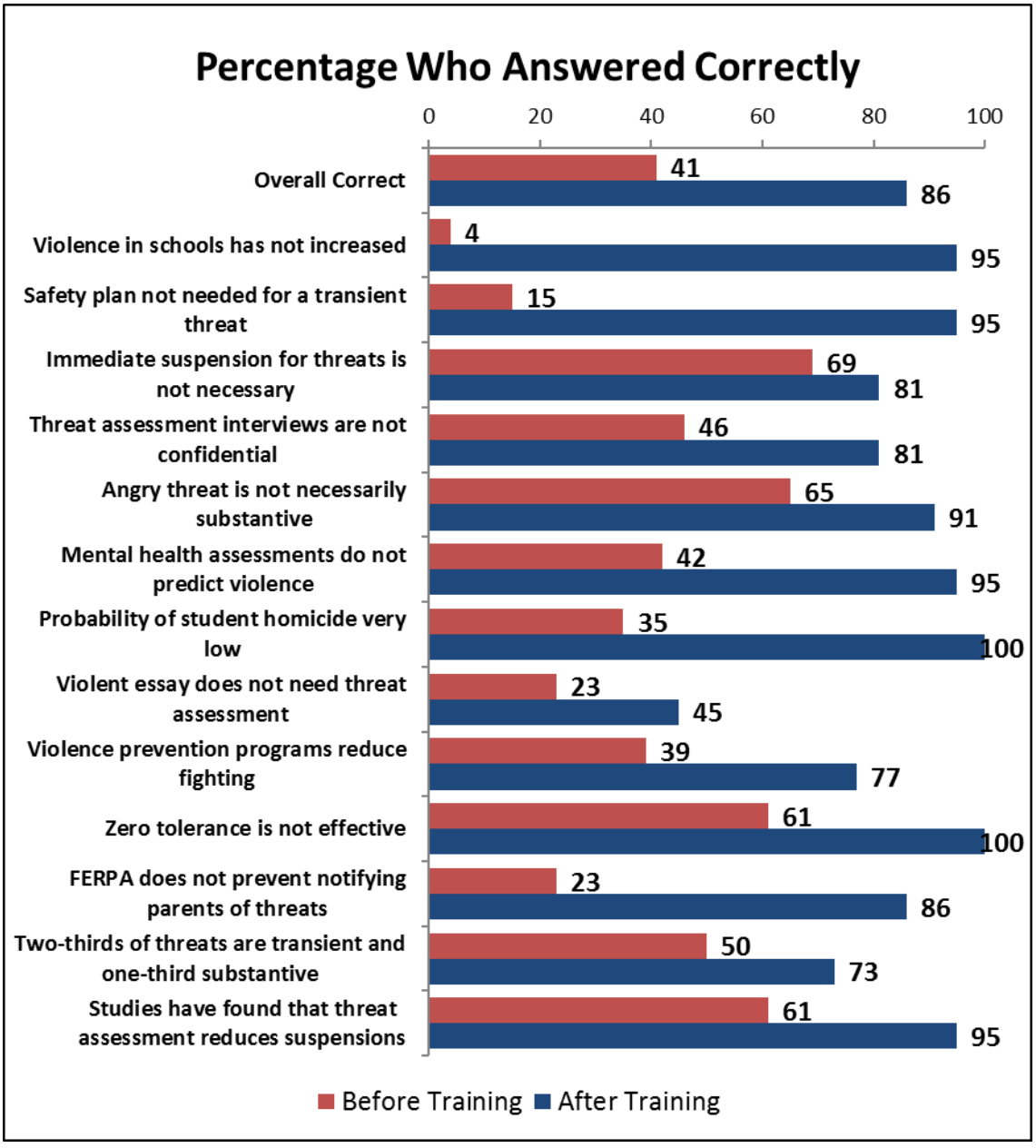
If we can provide any additional assistance or answer any questions, please let us know. We received completed surveys from a total of 26 participants in the following categories: Administration, Teaching, Mental Health, or Other.



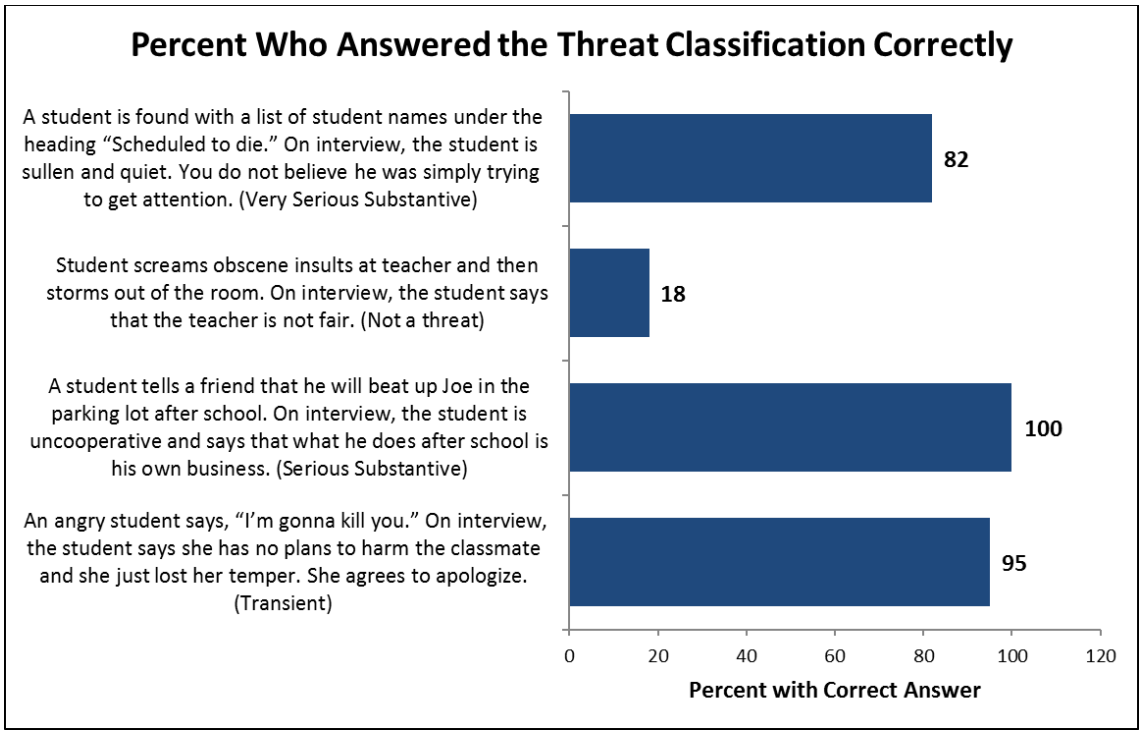
Evaluation statements could be answered Strongly Disagree, Disagree, Agree, or Strongly Agree, or left blank. All of the participants gave positive evaluations.



Participants were asked a series of questions before and after training. The percentage of participants who answered each question correctly increased substantially after training. The overall increase was from 41% to 86 %. Questions are reworded as correct statements in the chart.



Participants were asked to classify four threat situations as *No Threat, Transient Threat, Serious Substantive Threat,* or *Very Serious Substantive Threat.* The chart shows the percentage of participants who answered correctly for each threat.



Comments:

- You both did a great job and I appreciate the discussions among the group along the way.
- Very informative
- Useful data and lots of information
- Lots of interesting information
- Just a bit warmer would be great!
- Well done.
- Good presentation and logically presented.
- Presenters were great