Program Evaluation of the Samaritans of New York’s Public Education Suicide Awareness and Prevention Training Program

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The Samaritans of New York provide a public education suicide awareness and prevention training program focusing on suicide awareness and training in the skills and philosophy to befriend a person in crisis. Fifty-nine participants from a city department of human resources “helpline” to participated in a 3-hr employee training for information line service providers. Participants completed a pre/postmeasure of knowledge and efficacy to manage a caller in distress or in a suicidal crisis. The participants were predominately female ($n = 52; 88\%$), 90% from diverse cultural groups, with ages ranging from 20 to 65 ($M = 44; SD = 10.3$). Results showed that participants scored significantly higher on measures of perceived knowledge about suicide and self-efficacy to intervene with a person thought to be at risk for suicide after training ($M = 25.7$, $SD = 5.9$) than before ($M = 15.0$, $SD = 6.1$) ($t = -10.71$, $p < .0001$). The training program increased the abilities, awareness, and confidence levels of people whose jobs it is on a daily basis to provide care, comfort, and support for those who are in crisis and at risk for suicide. [Brief Treatment and Crisis Intervention 6:295–307 (2006)]

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Within the field of suicide prevention, programs are organized according to the program audience or population of focus for prevention efforts: universal, selective, or indicated (Goldsmith, Pellmar, Klienman, & Bunney, 2002). A subset of each of these prevention programs focuses more narrowly on increasing knowledge and changing attitudes about suicide, including such programs as suicide awareness, gatekeeper training, and case management for youth and elders at heightened risk for suicide (Goldsmith et al., 2002).

Recently, an international expert consensus report called for increased empirical investigation to further develop the evidence base for suicide prevention research (Mann et al., 2005). In addition, a number of suicide prevention programs have been rated via an empirical review by the American Foundation for Suicide

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Prevention in collaboration with the Suicide Prevention Resource Center (2005). This review found that only four programs are rated as having enough scientific evidence to deem them effective, and eight programs were rated as promising with further evidence warranted. However, prior to submitting a program for this type of external scientific review, much work is involved in developing, refining, and testing a suicide prevention program.

This paper describes the initial evaluation of one developing program, that of the Samaritans of New York’s Public Education Suicide Awareness and Prevention Training Program, which focuses on educating frontline caregivers and service providers in the key behaviors and skills they have found to be effective in “befriending” a person in crisis. To our knowledge, no other empirical evaluation of this program exists. We will first define and describe a framework for program evaluation, then review the historical development of the Samaritans of New York and its training programs, and conclude with the results from the evaluation of the public education suicide awareness and prevention training program.

Framework for Evaluation

Program evaluation, broadly defined, can have two foci: that of the agency and that of the program the agency delivers to community members. According to a recent Government Accountability Office report (GAO, 2005), which is based on over a decade of work reviewing federally supported programs, there are fundamental differences between the assessment of an agency via its performance measures and the program evaluation of one of its service components.

According to this GAO (2005) report, performance measurement is the systematic analysis, often undertaken by management or other agency leaders, to assess the development, progress toward, and attainment of the agency’s broadly based strategic plan or goals. Conversely, program evaluation is the in-depth study of one particular aspect of an agency’s operations or activities, usually conducted by internal or external evaluators with expertise in the area, to assess the programs’ achievement of its particular goals and objectives, to identify areas of success or needed improvement, and to determine the program’s efficacy and effectiveness (GAO, 2005).

Although both performance measurement and program evaluation aid in top-level decision making and fiscal accountability, program evaluation focuses on the iterative process of development and testing the program elements (GAO, 2005). The purpose of the testing phase is to ensure that the program delivers meaningful outcomes to the community or to the program recipients and can involve a variety of approaches to evaluating the program. The GAO (2005) report further defines these analytic approaches to program evaluation into four main types.

1. Process (or Implementation) Evaluation: This form of evaluation assesses the extent to which a program is operating as it was intended. It typically assesses program activities’ conformance to statutory and regulatory requirements, program design, and professional standards or customer expectations.

2. Outcome Evaluation: This form of evaluation assesses the extent to which a program achieves its outcome-oriented objectives. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness but may also assess program process to understand how outcomes are produced.

3. Impact Evaluation: Impact evaluation is a form of outcome evaluation that assesses the net effect of a program by comparing
program outcomes with an estimate of what would have happened in the absence of the program. This form of evaluation is employed when external factors are known to influence the program’s outcomes, in order to isolate the program’s contribution to achievement of its objectives.

4. Cost-Benefit and Cost-Effectiveness Analyses: These analyses compare a program’s outputs or outcomes with the costs (resources expended) to produce them. When applied to existing programs, they are also considered a form of program evaluation. Cost-effectiveness analysis assesses the cost of meeting a single goal or objective and can be used to identify the least costly alternative for meeting that goal. Cost-benefit analysis aims to identify all relevant costs and benefits, usually expressed in dollar terms. (GAO report, 2005, p. 5)

These four evaluation methodologies are critical aspects to developing a research strategy or an evaluation plan that ultimately provides outcomes and feedback to federal funding sources, legislators/policy makers, board members, or local decision makers. Since the early 1990s, programs receiving federal funding have been tasked with the requirements of the Government Performance and Results Act of 1993, which, over the years, has increased the need for collaboration between community-based agencies and independent program evaluators or research teams from academic institutions to demonstrate outcomes that the program is working.

With differing organizational capacity and limited resources for evaluation (Mulroy & Lauber, 2004), agencies have often created programs without benefit of ongoing research or evaluation partnerships. A move toward coproduction of the evaluation (Quinn Patton, 1997) has risen from the need of practitioners to work with researchers (and vice versa) to develop the internal capacity of the agency to evaluate the efficacy and effectiveness of their programs throughout each step in the development phase. Assessing a program, especially impact evaluation, has been deemed as critically needed in the area of suicide prevention (Kaleveld & English, 2005). The Samaritans of New York’s partnership with an academic research team is offered as one example of a suicide prevention program that is being developed and evaluated over time in a collaborative process.

**Samaritans’ Program Evaluation: Agency and Training Program Goals**

For over 2 years, two of the authors (A. Ross and K. L. Knox) interacted as members of a state suicide prevention council, building a professional relationship founded on the mutual interests of promoting best practices within their home state. Over this time period, a spirit of cooperativeness, respect for research evidence, and openness to share sensitive agency data grew until a challenge was posed between them—work together to improve the state of science for emerging suicide prevention programs.

Their secondary focus being the question they frequently discussed following research conferences they had attended; namely, can humanistic, empathetic behavior increase the effectiveness of lay and professional community health workers who initially engage and provide care for individuals in distress and perhaps at risk for suicide. Their conversations also focused on the need for awareness and sensitivity in these “frontline” caregivers to impact the identification, care, and treatment of those at risk; one from the perspective of population-based research with the U.S. Air Force’s (USAF) suicide prevention program (K. L. Knox) and the other from community-based efforts in...
developing volunteer and gatekeeper-training programs (A. Ross).

In developing this focus and considering its influence upon their individual areas of work, both authors have continually referred to the scientific literature impacting the field of suicide prevention. Recent evidence from the National Comorbidity Study Replication (NCS-R) demonstrates the ongoing need for depression identification and treatment, an important risk factor for suicide prevention efforts (Kessler et al., 2003). The NCS-R reveals that of those suffering with major depression in the last year, only about half (51.6%) are in treatment, whereas treatment is adequate in 41.9% of these treatment seekers. Another study by an international consensus panel of selected experts in suicide research (Mann et al., 2005) reviewed the evidence and found that as many as 80% of those who died from suicide had untreated mental illness before they died. These results married with the findings from the USAF (Knox, Litts, Talcott, Feig, & Caine, 2003) pointed to the need for increased efforts within the field for community-based approaches to suicide prevention. As one model, the Air Force Suicide Prevention Program (AFSPP) provided evidence on the need to increase the health of the overall community in a multifaceted way—with one AFSPP intervention being to train leaders on the various "points of access" for preventive mental health care and another intervention to increase awareness and sensitivity of peers and the frontline caregivers in the community by training them to identify and intervene with individuals in distress (For a description of all 11 AFSPP initiatives, see AFDAM 44-160 at the following http://sp.datausa.com/index.html.).

Based on this history, the research team and the leadership of the Samaritans of New York formulated two goals for their initial joint venture, one focused on the agency and one focused on a particular training program. Initially, the agency defined as its performance measures: (a) partnership with an external research team from a federally funded suicide prevention center and (b) coproduction of a program evaluation of one particular training program, the Public Education Suicide Awareness and Prevention Training Program.

The coproduction of the program evaluation was undertaken to assist the agency in its goal to determine the feasibility and utility of incorporating standardized training practices and evaluation into their ongoing community-based educational programs. As a result of training over 25,000 guidance counselors, social workers, crisis response staff, and other lay and professional caregivers and service providers, the Samaritans were interested in finding a scientific way to prove what they had experienced over the previous 18 years. Based on agency-designed surveys as well as the feedback of those who had participated in their training programs, the staff noticed that the personal concerns, fears, and insecurities that frontline providers had with regard to suicide and responding to people in crisis was just as important as their perceived gaps in knowledge of key information, assessment models, and the availability of resources. In addition, the agency was also interested in assessing whether adding a research component on a small scale is useful before they decide to undertake a large-scale research endeavor.

At the first planning meeting for the program evaluation, the agency leadership and the research team discussed the selection of the suicide awareness and prevention education training program for the formal program evaluation as the partnerships’ primary goal. This program was selected because it was an established brief training program (3 hr), was deemed successful by agency leadership based on ongoing public response and demand, and had the capacity to be standardized and replicated. The agency was also interested in learning how to improve upon
the survey methodology it had previously been utilizing to gauge participant feedback and program effectiveness, which also tied into the broader goal to build internal capacity of the agency staff to undertake increasingly more rigorous evaluations.

Another identified goal at the planning meeting was to work collaboratively to design and incorporate a staged approach to the outcome evaluation of this program. Thus, the plan was to have the agency, using its own internal resources, begin to unfold an evaluation plan in small increments so as to not be overwhelmed at any one time with the necessary research elements and tasks (i.e., research ethics review, analysis plan, outcome measures, etc.). The research team also agreed to commit internal resources (e.g., hiring of a summer research assistant each year, addition of a postdoctoral fellow to the research team) and to devote salary-supported time to the project for the two research team members.

Once the staged plan was agreed upon, the research team began consulting with the agency staff via conference calls and in-person visits to discuss the constructs of interest to be measured and to discuss the process of integrating the selected outcome measures into the training protocol. In addition, the research team, on each of the calls, would review the overall evaluation plan and how the individual task at hand was one step closer to building an evidence base for the program.

The agency leadership began by reviewing its internal resources (e.g., mission statement, strategic plan, budget, staffing, etc.) to determine its own existing capacity for engaging in research over the next 3–5 years. With replication discussed as one of the most critical components for transferring the training presentation from the developer to other instructors, the agency leadership also agreed that a short-term goal must be to hire additional staff. This new staff member was to, ultimately, become an additional training instructor for the training, with devoted time allocated to manual development, creation of the training protocols, and supervised performance of the transferred training content with the developer.

Once the existing content and materials from the training were reviewed, the next task was to develop the assessment instrument that would collect data on the training program as well as any additional data that would be helpful for the agency’s promotion or reporting practices.

The curriculum for the training program was defined by its focus on suicide awareness and training in the skills and philosophy to identify and befriend a person in crisis. Therefore, the selected research design was to determine whether training participants exhibited gains in knowledge and self-efficacy from attending the suicide awareness and prevention public education training. An analytic strategy using pre- and posttraining assessments linked to each individual training participant was decided upon as the initial step in assessing gains from the training presentation. The ability to incorporate the distribution and collection of the surveys was deemed by the agency staff to be feasible and acceptable to the training participants when described as a quality improvement measure for the instructor and the agency.

The agency initiated the evaluation of the suicide awareness and prevention education training in spring of 2005. The long-term evaluation plan is to collect data at each training and send it to the research team for data entry and preparation of the data for scientific meetings, publications, and agency-reporting requirements. The data collection phase will continue for approximately 3 years after this preliminary reporting period. Once the program is standardized and initial testing with the manualized approach is completed, alternative evaluation designs will be explored.
Having described a framework for program evaluation and the emergence of the research partnership, we will now present a brief description of the origins of the training program’s content followed by the results of the initial program evaluation.

**Historical Overview of the Samaritans of New York**

The Samaritans of New York, Inc., is a member of the world’s oldest and largest suicide prevention network (Ross, 1997). Founded over 50 years ago, the Samaritans have become known worldwide as a model of humanistic helping practice, an approach they refer to as befriending. Samaritan centers throughout the world offer suicide prevention public education curriculums that provide awareness about suicide as well as training in the skills and philosophy to befriend a person in crisis (Befrienders International, 1997). The design of these programs is culturally dependent, population sensitive, and tied to the prevailing attitudes, mores, and social behaviors of the communities being served. Examples of this cultural adaptation include but are not limited to the following: Samaritans volunteers in Sri Lanka being trained to go into hospitals and respond to people who have already attempted suicide, befriending taking place through the performance of “street theatre” in Madras, and Lifeline and other programs designed to train peer support counselors in jails and prisons in England and other countries around the world (Befrienders International, 1995).

In the United States, the Samaritans of New York are the representatives of Samaritans USA (the umbrella organization of the 10 American Samaritans branches) and in this role hold one of the 12 seats on the National Council for Suicide Prevention (NCSNP). The NCSNP grew out of the initial Reno Conference in 1998 that was instrumental in U.S. Surgeon General David Satcher, M.D., developing the National Strategy for Suicide Prevention under the Department of Health and Human Services (Public Health Service, 2001). In addition to this national leadership position, the Samaritans of New York are invested in expanding community awareness of the risk of suicide and the keys to prevention as well as developing evidence-based tools and programs that lead to reductions in the mortality and morbidity associated with suicide. Since 1983, the Samaritans of New York has trained volunteers as crisis response workers on their 24-hr suicide prevention hotline, the development of which has provided the basis for their suicide awareness and prevention public education training program curriculum, which is the object of this evaluation.

**Crisis Hotline Volunteer Training Program**

Crisis hotlines using the Samaritans-befriending model worldwide have been the subject of limited research a number of years ago (Barraclough & Jennings, 1977; Fox, 1978; Greer & Anderson, 1979; Jennings, Barraclough, & Moss, 1978). More recently, a retrospective cohort study in the United Kingdom reported significant decreases in the number of suicides after an environmental intervention using the Samaritans crisis hotline signage was displayed in a public area renowned for individuals taking their life by suicide (King & Frost, 2005).

In an effort to standardize training for the crisis line volunteers who have various levels of education and experience, a 36-hr training program was created by the Samaritans of New York with befriending and interpersonal communications at its core (Ross, 1991). The primary tenets of befriending are based on Samaritans “Seven Practices and Principles’
which are practiced throughout almost 400 Samaritans centers worldwide (Samaritans,
2006):

- To be available to anyone at any time who is in crisis
- To listen to someone without making judgments or expressing personal values
- To maintain a confidential and safe environment when providing support
- To explore the person’s thoughts and feelings and steer toward the pain he/she is experiencing
- To recognize that every person has the right to make his/her own decisions about their lives including ending a contact or communication and his/her right to take their own life
- To explore each person’s own situation and not to focus on solving problems or directing him/her to a certain course of action, which the helper thinks would be beneficial
- To recognize that Samaritans is only one element of the mental health support community and to work together with people in every field to address the issues that lead to suicide (Samaritans, 2000a).

In the process of concretizing their volunteer-training and hotline practice, the Samaritans of New York also created a model that outlines a step-by-step process for responding to any individual who may be in distress or experiencing suicide ideation and may be calling the hotline in an active crisis state. The Samaritans Crisis Communications Model is a time based procedure consisting of the following stages: (a) make first contact; (b) establish rapport; (c) explore the present situation; (d) look for warning signs; (e) assess the “degree of risk”; and (f) explore options (Ross, 2006). Trainees are instructed to follow this model whenever they provide assistance to any caller to the hotline, no matter what their stated purpose or point of departure in the conversation.

The model’s rationale is based upon observation, practice and literature that shows that if an individual chooses to call a crisis line service that clearly states its purpose is “suicide prevention,” it is both cautionary and necessary to address their current emotional state and assess their degree of suicide risk. This assessment practice is empirically supported in a crisis hotline study that noted a lack of consistency in hotline workers assessing caller’s degree of risk and the benefit of using a supportive directive approach in dealing with callers in distress (Daigle & Mishara, 1995). Additionally, this study found that service consistency, following formal procedures and assessing every call completely was extremely important to outcomes. Accordingly, the Samaritans 3-hr suicide awareness public education curricula, derived from the 36-hr volunteer hotline training, utilizes the same Crisis Communication Model though it is adapted for “direct contact” as opposed to the anonymous and confidential relationship Samaritans volunteers have with the people utilizing their emotional support hotline service.

**Suicide Awareness and Prevention Training**

The goals of the public education suicide awareness and prevention training program are the following: to provide suicide awareness and prevention training to frontline lay and professional caregivers and service providers; to acquire additional communication skills, prevention tools, and approaches to helping people that will enable them to become more comfortable and confident in responding to those who are at risk and/or in crisis; and to better recognize those who are “at risk” for suicide and to educate on the most effective ways to respond to those in a suicide crisis.
(Samaritans, 2000b). The 3-hr awareness, skills development, and prevention tools-training curriculum included didactic and highly interactive skills-based presentations on the following topics (Ross, 2005):

1. Current trends, research knowledge, and statistics about suicide and effective prevention
2. Stigmas, myths, and misconceptions surrounding suicide
3. Acknowledging caregiver’s concerns and fears
4. Understanding the crisis experience
5. Keys to effective active listening practice
6. Warning signs, risk, and protective factors
7. Intervention and risk assessment techniques
8. Developing a site-specific suicide prevention plan and protocols.

The 3-hr awareness, skills development, and prevention tools-training curriculum focuses on risk assessment techniques and interventions for managing an individual in a suicidal crisis based on the Samaritans Crisis Communication Model. It was this training that was selected for evaluation. In the Methods section, we will present the process undertaken to collect the data and the evaluation results of the public education suicide awareness and prevention training program.

**Methods**

**Sampling Strategy**

The Samaritans of New York’s Public Education Suicide Awareness and Prevention Training Programs are offered at no cost to clinical and nonclinical employees of the contracting agencies. Once contracted, the agency staff was required to attend the training by their supervisors. Therefore, employees were identified by job description, interest, availability, and supervisor support to attend the training.

For this evaluation, the contracting agency was a large urban city department of human resources in the northeast who were interested in training for their frontline customer service providers. Sixty-four participants enrolled in the training with 59 individuals participating in the evaluation. Therefore, the response rate was 92% for this study.

**Curriculum and Training Procedures**

The training program was 3 hr in duration. The training took place in the local agency’s training room, the setup of the seating designed for easy access, good sight lines, and close proximity between presenter and participants. The training was conducted by one of the authors who designed the program (A. Ross), according to well-established training procedures that have been used to train over 25,000 community mental health care providers in the New York City Metropolitan area.

As noted previously, the curriculum includes didactic and highly interactive skill-based presentations on the following topics: the Samaritans-befriending model, current research knowledge and statistics about suicide, myths and stigma surrounding suicide, warning signs, intervention and risk assessment techniques, as well as the keys to effective active listening and developing a site-specific suicide prevention plan.

**Surveys**

All information collected for this study was secondary data having been collected by the Samaritans staff as a part of their routine practice of training evaluations using self-administered pre- and posttraining surveys. The survey data included the following: sociodemographic (e.g., age, gender, education), previous experience variables (e.g., professional role, clinical
interviewing experience, quality of participant’s previous training, on-the-job support when responding to crisis situations, previous knowledge of someone who has died by suicide), results of the pre- and posttraining assessments regarding knowledge and efficacy to manage a caller in distress or a caller in need of assistance due to a suicidal crisis, and the degree of satisfaction and comfort with the completed educational program.

**Data Analysis**

Data were initially entered into Excel and imported into SAS version 10.1 for analysis. Pretraining surveys attained information on baseline knowledge and attitudes about suicide prevention, whereas posttraining surveys tested the participants’ acquired knowledge, attitudes, and satisfaction with the training. Differences in group means were analyzed to determine the amount of change from pre to post on appropriate survey items. Missing data on some survey items led to sample size differences for some variables.

**Results**

**Sample**

Of the eligible employees participating in the pilot study, 59 provided evaluation data. As noted in Table 1, the majority of the sample was African-American (62.1%) women (88.1%) with an average age of 44 years, 66.2% of whom had at least 1–2 years of college education.

Almost 95% of the sample reported having no previous clinical interviewing experience. Yet, experiences with suicidal individuals were common among the sampled participants: almost 65% had previous contact with someone thought to be suicidal. Slightly less than three-quarters of the participants’ report they had spoken to the person they were concerned about, with 33% asking directly and 25.6% asking indirectly about thoughts of wanting to kill themselves.

In terms of death by suicide, 47.5% \( (n = 28) \) knew someone who died by suicide. Of the

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relationships to the decedents noted, 32.1% of those who died by suicide were friends while family, acquaintances, and others were each reported at 25% of those who lost someone to suicide.

At pretraining, an assessment of previous workplace training regarding suicide and suicide prevention as well as on-the-job support for handling crisis situations was assessed. In terms of the participant’s previous training, 68.4% (n = 39) rated the quality very low to low on a five-point scale. The quality of personal support received on the job when responding to crisis situations was rated by 52.6% (n = 30) of participants to be of medium quality.

To assess changes in knowledge and attitudes (feelings of self-efficacy), we compared participants’ pre- and posttraining scores. Participants scored significantly higher on measures of perceived knowledge about suicide and suicide prevention and self-efficacy to intervene with a person thought to be at risk for suicide after training (M = 25.7, SD = 5.9) than before (M = 15.0, SD = 6.1) (t = −10.71, p < 0.0001).

The feedback questions focused on the importance of the training, comfort, as well as other satisfaction items assessed at posttraining (see Table 2). The evaluation of the suicide prevention curriculum revealed that 91.1% of participants felt that the training presented important information, with 91.3% of participants stating they would recommend the training to others. In terms of the length of the training, 72.8% of participants stated the training devoted sufficient time to expand their awareness regarding suicide and suicide prevention and 71.9% of participants reported feeling more comfortable in talking about suicide.

### Discussion

Based on this initial program evaluation, there was an impact demonstrated in the training outcomes from the 3-hr training as noted by changes in participants' knowledge and attitudes. However, it is unknown at this time whether the changes are sustainable for the individual participants or if there are any long-term impacts of the training on the workplace interactions these trainees have with the consumers of their services.

In regards to the previous literature, this study is the first step in a program of research for the Samaritans of New York to evaluate its public education suicide awareness and prevention training program. Using a different
suicide prevention program in a workplace (Cross, Matthieu, Cerel, & Knox, 2006) and in a college setting (Matthieu et al., 2006), researchers found that on average, approximately two thirds of these samples had previous contact with someone thought to be suicidal, similar to findings in this study. Given the diversity of these samples, it appears that suicide may affect more community members than perhaps previously thought. If so, then increased community-based prevention efforts, such as the suicide awareness and prevention public education trainings, are of paramount importance.

Increasingly more is being published about lessons learned in the development of an empirically based program. However, little is written on the early stages of the collaborative partnership, specifically the rapport and trust-building phases, which are the foundation upon which any research alliance is built. It is our hope that this discussion of the historical development of this partnership encourages others to share critical stages and decisions that occur much earlier in the collaboration process.

In addition, agencies and researchers alike are responding to the increasing pressure from federal funding sources to utilize increasingly more complex evaluation methodologies, to build integrated community partnerships, and demonstrate the efficacy of the program, all with limited or slashed budgets. In lean fiscal times, finding mutually beneficial partnerships between nonprofit agencies and research or evaluation teams is growing more and more complex. The competing demands for time other than that devoted to the project must be acknowledged as part of the collaboration and measures to maximize efficiency for both the agency and the research team must be negotiated early in the process. In sum, finding the right collaborators who respect the contributions of each team member is critical to facilitate the multiyear development of a suicide prevention program.

**Limitations**

It is important to keep in mind that this program evaluation has several limitations, including possible selection bias of participants. In addition, these data are based on a 3-hr, multimedia, public education training delivered with a live trainer to employees at a large urban city department of human resources. The generalizability of these findings to other populations, service settings, and to other training methods (e.g., online) is limited at this time.

**Conclusions**

These findings indicate that this suicide awareness training program, based on the crisis communications model, shows promise in enhancing participants sensitivity, knowledge, and abilities to assess individuals who may be in distress or contemplating suicide. The Samaritans public education suicide awareness and prevention training program increased the awareness, abilities, and confidence levels of people whose jobs it is on a daily basis to provide care, comfort, and support for those who are in crisis and at risk for suicide. Future research is needed to determine the efficacy of this curriculum and its impact on frontline service providers who do not have professional clinical training.

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