Implementation of an Online Suicide Prevention Training Program with Undergraduate and Graduate Students at a California State University

Cheryll May P. Villamor

California State University, Northern California Consortium Doctor of Nursing Practice

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DOI: https://doi.org/10.31979/etd.39mv-znmg
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Implementation of an Online Suicide Prevention Training Program
with Undergraduate and Graduate Students at a California State University

Cheryll May P. Villamor

A doctoral project completed in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice in the Valley Foundation School of Nursing, San José State University

May 2023
# Doctoral Project Team Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Affiliation</th>
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<tbody>
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<td>Assistant Professor San José State University</td>
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<td>Lecturer, San José State University</td>
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<td>Practice Mentor</td>
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Dedication
This work is dedicated to all of us — we can make a difference in someone’s life, we truly can.

If you need help, reach out — we are here for you.

Acknowledgements
Reverie: For our dance breaks, hugs and constant reminders to take a break. I am truly blessed to have you as my daughter. You inspire me every day with your curiosity and love for life.

Nuri: For our walks in the morning and evenings it helped me destress and appreciate nature.

Josefina, Rudy, Cleofe, and Charmaine: My family, with your endless encouragement and never give up attitude. You are my source of strength.

Fe and Laverne: For loving unconditionally, our sisterhood is a treasure beyond value.

Vincent Lam: Senior Mental Health Education Coordinator for sharing this training within our SFSU community as part of his mission of fostering a culture of care that destigmatizes mental health, normalize seeking support and cultivates self/community care.

SJSU DNP Team and Classmates: My time with you all was a time well spent and cherish this time in my life. I wish all of you to be happy, healthy and filled with love.
IMPLEMENTATION OF AN ONLINE PREVENTION TRAINING PROGRAM
WITH UNDERGRADUATE AND GRADUATE STUDENTS AT A
CALIFORNIA STATE UNIVERSITY

Cheryll May P. Villamor, PMHNP-BC
Doctor of Nursing Practice Program
The Valley Foundation School of Nursing
San José State University
May 5, 2023
Abstract

**Background:** One of the leading causes of death in the college age population is suicide. While colleges provide opportunities in the acquisition of knowledge and skills for future careers; those same opportunities can also bring about challenges that put students at risk for suicide such as: dealing with their mental health issues, finding and maintaining support system, financial costs, and the pressure from ensuring academic success. One of the ways to help student at risk for suicide is by early intervention by connecting them with mental health support system such as crisis counselors. Question, Persuade, and Refer (QPR) is a suicide prevention training that raises awareness of suicide and teach participants fundamental suicide intervention skills. **Purpose:** This quality improvement project aimed to determine the impact of an online QPR training program intended to increase prevention on campus. **Method:** This project implemented a 90 minute training using powerpoint, handouts and question and answer period with undergraduate and graduate students. **Result:** A total of 70 students completed the pre-questionnaire, training and post questionnaire. The paired t-tests on four QPR scales (self-knowledge, attitude, self-efficacy, and skills) and the number of students who had the number 988 saved on their phones were all highly significant. **Conclusion:** QPR demonstrates that it is effective in the short term in making students more open to asking someone if they were suicidal, more confident in their abilities to prevent suicide, and more likely to offer assistance.
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Introduction

Healthcare Challenge

Suicide is one of the leading causes of death among college age and university students. (Centers for Disease Control and Prevention [CDC] 2021; Suicide Prevention Resource Center [SPRC], 2020). It is the third highest cause of death for those aged 18 to 24, the second highest for those aged 24 to 35 (CDC, 2021; SPRC, 2020). The American College Health Association (ACHA, 2021) reports that one in five undergraduate students have screened positive for suicidal ideation (SI), and 2% have actually attempted suicide (SA).

According to the Education Data Initiative (2022), college students span many suicide-risk age categories: while 66.6% of undergraduate college students are 24 years old or younger, graduate school programs have a much broader range of ages—42.1% of American graduate students are 18- to 24-year-olds, 4.19% of such students are 30- to 34-year-olds, and 2.83% are 35- to 39-year-olds. The average age of full-time undergraduate students is 21.8 years old, while part-time undergraduate students are 27.2 years old. The Council of Graduate Schools (2022) reports the average age of a full-time master's student today is 33 years old, and the average age of a full-time doctorate student is 27-37 years old.

Associated Risk Factors Among College Students

Transitioning from high school to college is stressful for many people, as students must learn to navigate various psychological and social aspects of college life, such as adjusting to a new environment, finding and maintaining a support system, and keeping up with academic demands. Recent data shows that two common mental health conditions of university students—depression and anxiety—come with an increased risk of suicide; 39% of recent undergraduates
and graduates screened positive for generalized anxiety disorder (GAD) and that 35% of undergraduates and 32% of graduates students have major depressive disorder (Chirikov et al., 2020; Francis & Horn, 2017; Vlasova, 2020). Furthermore, a 2018 ACHA survey reports that 84% of students “felt exhausted and it was not caused by physical activity,” 63% “felt lonely,” and 69% “felt very sad, “75% of students have occasionally experienced “overwhelming anxiety,” 53% “felt hopeless,” and 42% “felt so depressed that it was difficult to function” (ACHA, 2018). Overall, college and university students are experiencing symptoms that impact the quality of their lives, and these symptoms are associated with an increased risk for suicide.

The use of drugs and alcohol is one factor that can raise the risk of suicide, which can be a particular concern in a college setting. According to the ACHA (2018) survey, 62% of surveyed college students had consumed alcohol within the previous 30 days, with 49% doing so within the previous 1 to 9 days, 11.6% within the prior 10 to 29 days, and 0.8% using all 30 days. Substance abuse increases the likelihood of both fatal and nonfatal overdoses, suicide attempts, and suicide death. Individuals with drug use and alcohol dependence are 10 to 14 times more likely to die by suicide than the general population, and an estimated 22% of suicide deaths have been accompanied by alcohol intoxication (Ehsang & Ahmed, 2018).

Suicide Prevention

Suicide prevention comprises a collection of efforts that are used to reduce the risk of suicide. The SPRC (2020) lists nine strategies that, together, form a comprehensive suicide prevention and mental health promotion approach. The organization writes that:
1. **Identifying and aiding a person at risk** can assist in reaching those in greatest need and connecting them to care and support, such as gatekeeper training, suicide screening, and education on the warning signs of suicide.

2. **Increasing help-seeking behavior** by helping people recognize when they need help. Self-help tools and outreach campaigns can reduce barriers to getting help, such as not knowing what services are available. Other interventions may promote peer norms that encourage help-seeking or make services more accessible and culturally sensitive.

3. **Ensuring access to effective mental health and suicide care treatment**, such as safety planning, evidence-based treatments and therapies, and trained providers, can help prevent suicide. Reducing financial, cultural, and logistical barriers to care are additional ways to improve mental health and suicide care access.

4. **Supporting safe care transitions and creating organizational linkages** by ensuring a smooth transition for individuals’ care and facilitating information sharing among caregivers. Ideally, both those at risk of suicide and their support networks (e.g., family, friends, etc.) should be involved. Formal referral protocols, interagency agreements, cross-training, follow-up contact, and rapid referrals support continuity of care.

5. **Responding effectively to individuals in crisis** in a community, accomplished by having hotlines, helplines, mobile crisis teams, walk-in crisis clinics, and peer-support programs, can help evaluate, stabilize, and refer ongoing care for suicidal patients.

6. **Providing for immediate and post-term “postvention”**— A postvention is a set of rules that helps an organization or community respond to a suicide death in an effective and
caring way. Immediate and long-term care is given to those who have lost a loved one and to lowering the risk to others.

7. Reducing access to the means of suicide educating family and friends about carefully storing pharmaceuticals and firearms, distribute gun safety locks, and change medication packaging.

8. Enhancing life skills and resilience by using mobile apps, self-help materials, and skills training to learn about stress management and coping techniques. Using such methods can help individuals better handle economic stress, divorce, illness, aging, and other major life challenges.

9. Promoting social connectedness and support can help prevent suicide despite risk factors. Social programs for specific populations can increase connectedness by reducing isolation, promoting belonging, and fostering emotionally supportive relationships.

In 2021, the Surgeon General issued six calls to action for the implementation of a National Suicide Prevention Program (U.S. Department of Health & Human Services, 2021, January 19). These strategies entail:

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1. Activating a brand-based public health response to suicide</td>
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<tr>
<td>2. Addressing upstream factors that impact suicide</td>
<td></td>
</tr>
<tr>
<td>3. Ensuring lethal means safety</td>
<td></td>
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<tr>
<td>4. Supporting the adoption of evidence-based care for suicide risk</td>
<td></td>
</tr>
<tr>
<td>5. Enhancing crisis care and care transitions</td>
<td></td>
</tr>
<tr>
<td>6. Improving the quality, timeliness, and use of suicide-related data</td>
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</table>
The approaches and strategies of the SPRC and the Surgeon General share the vision of reducing the likelihood of death by suicide by providing evidence-based research interventions to the community. One such method is gatekeeper training (GKT). GKT involves training people to become “gatekeepers”—individuals who can identify people experiencing suicide thoughts, feelings and/or plans and refer them to appropriate services (Hawgood et al., 2021). The rationale for gatekeeper training is that at-risk individuals are often unlikely to seek formal sources of support, but they may communicate their concerns to informal support persons. Those trained as gatekeepers are in the position to connect at-risk individuals to formal support systems if they recognize suicide risk factors and warning signs (Zinzow et al., 2020). In the past, individuals who undertook GKT were shown to have increased self-efficacy in terms of the intention to act, as well as improved suicide knowledge, including an understanding of common myths and facts about suicide, skills like recognizing suicide signs and symptoms, and what to ask and how to ask questions when speaking with a suicidal person (Hawgood et al., 2021). The National Center for Injury Prevention and Control (NCIPC) supports GKT as a strategy to disseminate suicide prevention information (Samuolis et al., 2020).

*Question, Persuade, and Refer (QPR)*

Research establishing evidence-based suicide prevention programs is a significant public health priority (Samuolis, 2020). Question, persuade, and refer (QPR) training from QPR Institute is one kind of GKT which has trained over 5 million individuals and was listed in the National Registry of Evidence-based Practices and Policies (NREPP) (Substance abuse and mental health services administration [SAMHSA], 2019). QPR was created to save lives by teaching individuals to recognize the warning signs of suicide and to provide guidelines on how
to question a person about suicidal thoughts, persuade them to get help, and refer the person to professional help.

QPR training consists discussing common myths and facts about suicide; conversations about what kinds of questions to ask troubled individuals, including what to say and how to ask questions; and actionable steps to take when a person is at risk for suicide. Typical QPR training time is flexible, it can be 60 minutes to 2 hours, involving an hour long PowerPoint presentation, and a question and answer period. A longer QPR training allows the option of role play integrated into the training session. A maximum group size of 25 is recommended for each training (QPR, 2022) so that participants can connect more closely with their peers and become more confident and at ease when expressing their ideas and perspectives.

**Literature Review**

A systematic search for relevant peer-reviewed articles published between 2017 and 2022 using the online search tool OneSearch with appropriate combinations of the following keywords: “college campus,” “evaluation,” “QPR gatekeeper training,” “QPR gatekeeper,” “suicide intervention,” “suicide prevention,” “United States,” “college students,” and “university students.”

**QPR Training on College Campuses**

Samuolis (2020) evaluated 161 college students attending QPR training that involved peer-led implementation. The study showed a significant increase in all items assessing knowledge of suicide, self-efficacy, and the likelihood of intervention. Over the course of the study, the average summary score for knowledge of suicide items increased significantly from
21.71 at pretest to 30.38 at posttest, $t(161) = -24.743, p < .01$; the total summary score for self-efficacy to intervene increased considerably from 10.74 at pretest to 12.51 at posttest, $t(161) = -10.371, p < .01$; and the summary score for intervention likelihood increased from 11.43 at pretest to 13.56 at posttest, $t(161) = -15.255, p < .01$ (Samuolis, 2020). Another study of QPR training conducted by Aldrich et al. (2018) with undergraduate students, faculty, and staff ($N = 108$) showed that, compared to the participants’ understanding prior to the training, there was a demonstrated increase in knowledge about suicide prevention ($n = 57, 73\%$), recognition of suicide warning signs ($n = 57, 73\%$), awareness of local resources to aid in suicide prevention ($n = 52, 67.5\%$), and feeling more prepared to intervene with a suicidal person ($n = 66, 72.7\%$). Both of these studies addressed opportunities for growth by recommending increasing sample size, ethnic diversity, and participation by the male sex.

Litteken and Sale (2017) investigated the long-term effectiveness of QPR training in adults working with youth. The researchers’ primary data collection started in 2010 with a pretest and ended in 2011 with a posttest, but also included a two-year follow-up survey, with all data collection completed by January 2014. The study results showed the effectiveness of the QPR training the participants undertook, as the participants’ level of suicide knowledge and their ability to identify warning signs of suicide increased. The respondents also demonstrated that they retained the training knowledge over the large gap in time between the training and the two-year follow-up survey. Overall, the participants reported feeling comfortable speaking directly with individuals about suicide intentions and stated they had increased confidence in helping those who indicated that they were suicidal.
In another QPR study, Adams et al. (2018) found that among their research participants, all first-year student leaders demonstrated comparable gains in all areas in the variously timed posttest surveys they gave compared to a pretest survey: 68% completed the pre-training survey, 56% completed the immediate post-training survey, 32% completed the 6-month follow-up survey, and 18% completed the 9-month follow-up survey. In all, 113 respondents (42.0%) completed the pre-training questionnaire and at least one post-training questionnaire. Although there was knowledge improvement between the pre- and post-training questionnaires, the investigators also found that the learned QPR knowledge deteriorated over time, both at the 6-month and 9-month follow-ups. The greatest increase in knowledge, competency, and self-efficacy item scores occurred between the pre-training and the immediate post-training surveys: using the Friedman test, the researchers found statistically significant differences in the ranking of the composite knowledge scores at three and four data collection points \( n = 41, \) Friedman’s Q = 54.205, \( p = .000; \) \( n = 15; \) Friedman’s Q = 28.543, \( p = .000; \) \( n = 15, \) Friedman’s Q = 28.543, \( p = .000). \) The immediate post-training survey yielded lower mean scores than the 6-month and 9-month follow-up questionnaires. At the conclusion of their study, Adams et al. suggested that requiring a refresher session for returning student leaders would likely be helpful in having the leaders remember the initial training information.

**Theoretical Framework**

Ajzen’s (2019) theory of planned behavior (TPB) was used here as the foundational theoretical framework to guide and evaluate QPR GKT effectiveness. According to TPB, intentions shape human behavior, and there are three constructs that influence intentions:
1. **Attitude** is a person’s beliefs toward a particular act or behavior, which includes assessing whether they believe that the act or behavior will positively or negatively impact their lives.

2. **Subjective norm** is the beliefs about the normative expectations of other people (Arafat & Ibrahim, 2018), including cultural norms, people’s opinions, and the beliefs of a social group.

3. **Perceived behavioral control** (PBC) is a person’s belief concerning how easy or hard it would be to act in a certain way or to display a specific behavior.

The best predictor for forming a behavioral intention, which results in a displayed behavior or act, is when a person exhibits a positive attitude toward the action or behavior, coupled with favorable social norms and a high PBC level (Ajzen, 2019). QPR interactive training provides a safe space to discuss and learn about suicide. According to Ranahan and Keef (2021), having an environment conducive to group conversations about suicide breaks the cultural taboo of not discussing suicide because people can discuss it openly and directly without guilt and stigma.

In providing a safe space for learning about suicide, QPR training imparts vital suicide prevention tools and the critical role of the person who is intervening. A person is encouraged to self-assess their personal beliefs and general knowledge of suicide while simultaneously learning about suicide myths and facts and recognizing the signs and symptoms of suicidal behavior. This training methodology is intended to steer a person’s attitude toward the belief that their actions can have a positive impact by saving a person’s life. Lastly, the training provides
recommendations with optimal ways to intervene, how to verbalize concern and provides materials on local crisis support meant to connect someone in need in their community.

Gaps in Practice

It is essential to teach college students how to prevent suicide. The key to effective intervention and prevention is early detection and treatment of those at risk. Consequently, it is crucial to address the dearth of educational resources for college students in the areas of suicide prevention and means reduction.

Purpose

This current research addresses the first and second actions of the Surgeon General’s National Strategy for Suicide Prevention (2021) (i.e., “Activating a brand-based public health response to suicide” and “Addressing upstream factors that impact suicide”) by implementing and evaluating an online suicide prevention program via the QPR GKT with college students in order to increase suicide prevention on campus.

Process Outcomes

Outcome 1: By the end of the training increase students’ self rated knowledge, attitude, self-efficacy and skills score.

Outcome 2: By the end of the training, increase the % of students who have the National Suicide Prevention number saved on their phones.

Methods

Design
A single group, quasi-experimental design to evaluate the effectiveness of QPR training in four areas: suicide knowledge, attitude, self-efficacy, and skills.

**Setting and Participants**

The QPR GKT was presented via Zoom—a video and web conferencing service—with San Francisco State University (SFSU) students. SFSU is a public, urban university located in San Francisco, California, comprising six college departments: College of Liberal and Creative Arts, College of Business, College of Education, College of Ethnic Studies, College of Health and Social Sciences, and College of Science and Engineering. In 2021, SFSU had an enrollment of 21,687 undergraduate students and 1,921 graduate students (San Francisco State University, 2021).

A non-probability convenience sample of SFSU undergraduate and graduate students were invited to participate in the QPR training. The eligibility requirements for participation were as follows: (1) full- or part-time SFSU undergraduate or graduate students; (2) 18 years of age; and (3) English literacy. The exclusion criterion for participation is a valid mental health license (e.g., licensed marriage and family therapists, licensed social workers, psychologists, psychiatrists, mental health nurses, or psychiatric technicians). In addition, the following demographic information was collected: gender, and recent suicide training in the last two years.

**Measurement**

As summarized in Figure 1 the data collected the participants’ demographic information, as well as data from the QPR pre- and post-questionnaires, which were used for assessing the participants’ self-knowledge of suicide, likelihood of intervening, and self-efficacy to intervene. Although the QPR survey used in this study is not an empirically validated instrument, Wyman
et al. (2008) assessed the study’s Cronbach’s $\alpha$ value in a randomized controlled study of secondary school staff, finding that the survey had a Cronbach’s $\alpha = .97$.

To assess perceived knowledge, study participants were asked to answer six items on a 5-point scale: 1 (low) to 5 (high). To assess their willing attitude to undertake suicide prevention measures, participants were asked to answer two items on a 5-point scale: 1 (never) to 5 (always). Lastly, to measure self-efficacy and skills knowledge, participants were asked to answer five items on a 5-point scale: 1 (strongly disagree) to 5 (strongly agree).

**Figure 1**

Instrumentation

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Operational Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>Age (any age &gt;18)</td>
</tr>
<tr>
<td></td>
<td>Sex</td>
</tr>
<tr>
<td></td>
<td>Level of education (undergraduate or graduate)</td>
</tr>
<tr>
<td></td>
<td>Full time or part time</td>
</tr>
<tr>
<td></td>
<td>Literate in the English language</td>
</tr>
<tr>
<td></td>
<td>Suicide training within 2 years</td>
</tr>
<tr>
<td></td>
<td>Exclusion criteria: holding a current mental health license</td>
</tr>
<tr>
<td>Measure Design</td>
<td>Pre- and post-training questionnaires</td>
</tr>
</tbody>
</table>
| Self-knowledge                      | Please rate your level of knowledge about suicide and suicide prevention on a scale of 1 (low) to 5 (high)
|-----------------------------------|------------------------------------------------------------------------------------------------------------------|
| 1. Facts concerning suicide prevention | 2. Warning signs of suicide
| 3. How to ask someone about suicide | 4. Persuading someone to get help
| 5. How to get help for someone     | 6. Information about local resources for help with suicide |
| Attitude                          | Attitude was measured using two items on the pre- and post-training questionnaires on a scale from 1 (Never) to 5 (Always)
| 1. Do you feel that asking someone about suicide is appropriate? | 2. Do you feel likely to ask someone if they are thinking of suicide? |
| Self-efficacy                     | Self-efficacy was measured using three items on the pre- and post-training questionnaires on a scale from 1 (strongly disagree) to 5 (strongly agree)
| 1. I don’t feel competent to help a person at risk for suicide. | 2. I don’t think I can prevent someone from suicide.
| 3. I feel confident in my ability to help a suicidal person. | |
| Skills                            | Skills were measured using three items on the pre- and post-training questionnaires on a scale from 1 (strongly disagree) to 5 (strongly agree)
| 1. If someone told me they were thinking of suicide, I would intervene. | 2. If a person’s words and/or behavior suggest the possibility of suicide, I would ask the person directly if they are thinking about suicide. |
Do you have #988 saved in your phone? | One question was posed on the pre- and post-training questionnaires about having the suicide and crisis lifeline phone number (#988) saved on their phone, with the answers being either “Yes” or “No.”

### Procedure

From September to November of 2022, SFSU students were invited to take part in this study. Email flyers (Appendix A) were distributed to student organizations and promoted via the SFSU Health Promotion and Wellness and Counseling and Psychological Services (CAPS) departments. The flier instructed students to visit a Wix website and select their preferred training date. Each training session accommodated no more than 25 participants. The website (Appendix B) and flyers contained information about QPR, training dates and times, training duration, a QR code, and contact details for the trainer.

Each participant received a link to the pre-questionnaire containing demographic survey (Appendix C) one week before each training session. Then, after the training concluded, participants were given the post-questionnaire (Appendix C) and encouraged to complete it as soon as possible. In addition, they were given a QPR link with a code to retrieve their QPR training certificate.

The training consisted of a PowerPoint presentation, community resource handout (Appendix D), and a question-and-answer session. During training, participants learned about the common causes of suicidal behavior, the warning signs of suicide, the implementation of QPR methods for a person who may be suicidal, and how to obtain assistance for a person in crisis. In addition, participants were provided with local and national suicide intervention resources.
Trainers are required to be the last person in the training in order to address any final questions from participants.

**Data Analysis**

Data gathered from the pre- and posttest questionnaires were analyzed using SPSS. The assessment of all variables used descriptive statistics, and paired t-tests determined any significant changes regarding the four main items of knowledge of suicide, attitude, self-efficacy, and skills. Statistical significance was determined using alpha = 0.05.

**Risks**

This study was examined and approved by the SFSU Institutional Review Board (IRB) as standard educational practice and was exempted from full committee review. Participants were informed that they can withdraw from the study at any moment without consequence.

**Benefits**

Participants in the study learned how to spot a potential suicide crisis, including the warning indications that someone with whom they were communicating may be suicidal. In addition, they learned how to refer a person in distress to the next level of treatment, such as the SFSU College Counseling Center and The National Suicide Prevention Hotline, #988.

**Payment**

The QPR training was offered to participants for free.

**Chapter 3: Results**

During the Fall 2022 semester at SFSU, the QPR training was offered eleven times. On average, there were ten people in each training session. A total of 114 students attended the training with 97 students completed the pre-training questionnaire, and 87 completed the post-
training questionnaire. In total, 70 students completed both questionnaires and were included in the final sample. These students’ demographic characteristics are summarized in Table 1.

**Demographic characteristics of the sample**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
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<tbody>
<tr>
<td>18 - 24</td>
<td>33</td>
<td>47.1</td>
</tr>
<tr>
<td>25 - 31</td>
<td>19</td>
<td>27.1</td>
</tr>
<tr>
<td>32 - 38</td>
<td>10</td>
<td>14.3</td>
</tr>
<tr>
<td>39 - 45</td>
<td>3</td>
<td>4.3</td>
</tr>
<tr>
<td>45+</td>
<td>5</td>
<td>7.1</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>56</td>
<td>80.0</td>
</tr>
<tr>
<td>Man</td>
<td>12</td>
<td>17.1</td>
</tr>
<tr>
<td>Non-binary/Non-conforming</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>Enrollment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>56</td>
<td>80.0</td>
</tr>
<tr>
<td>Part-time</td>
<td>14</td>
<td>20.0</td>
</tr>
<tr>
<td>Current level of education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergraduate</td>
<td>46</td>
<td>65.7</td>
</tr>
<tr>
<td>Graduate</td>
<td>24</td>
<td>34.3</td>
</tr>
<tr>
<td>Have you had suicide training in the past two years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>63</td>
<td>90.0</td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>10.0</td>
</tr>
<tr>
<td>Do you have an active mental health license?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>70</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The pre- and post-training questionnaires included 14 questions: 13 items belonged to the four subscales designed to assess the students’ knowledge, attitudes, skill, and self-efficacy regarding suicide prevention. Paired $t$-tests were conducted to assess the students’ improvement in these four areas as a result of the QPR training. As shown in Table 2, the improvements made in all four areas were highly significant ($p < .001$). These results are further illustrated in Figure 1.

![Figure 1. Pre-to-Post QPR Training Improvements](image)

<table>
<thead>
<tr>
<th>QPR Scales</th>
<th>Pre-Training Mean</th>
<th>SD</th>
<th>Post-Training Mean</th>
<th>SD</th>
<th>Paired Differences Mean</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>2.56</td>
<td>0.82</td>
<td>4.26</td>
<td>0.59</td>
<td>1.69</td>
<td>0.76</td>
<td>18.64</td>
<td>69</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Attitude</td>
<td>2.97</td>
<td>0.92</td>
<td>4.20</td>
<td>0.69</td>
<td>1.23</td>
<td>0.90</td>
<td>11.43</td>
<td>69</td>
<td>&lt; .001</td>
</tr>
</tbody>
</table>
An additional question was included in the pre- and post-training questionnaires to determine if the students had the suicide and crisis lifeline (#988) stored on their phones. A McNemar’s test of symmetry was conducted to determine if there had been a significant increase in the number of students reporting that they had #988 stored on their phones after the QPR training. As shown in Table 3, only 15.7% of the students had #988 stored on their phones before the training, whereas 95.7% had the number stored after the training, which was a highly significant increase ($p < .001$).

**Table 3**

<table>
<thead>
<tr>
<th>McNemar test of symmetry comparing pre- to post-training number who had #988 saved in their phones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Training</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

*McNemar test of symmetry

Improvement scores were computed for the four QPR scales by subtracting the pre-training scores from the post-training scores. Independent samples $t$-tests were computed between younger respondents 18 – 24 years of age and those who were 25 years of age and older. As shown in Table 4, the younger respondents improved significantly more with regard to skills ($t (68) = 2.60$, $p = .011$). This result can also be interpreted to mean that the older participants
improved significantly less with regard to skills. The results of these comparisons are further illustrated in Figure 2.

Table 4
Independent samples t-tests by age group on the four QPR improvement scores

<table>
<thead>
<tr>
<th>QPR Improvement</th>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>1.75</td>
<td>0.72</td>
<td>1.64</td>
<td>0.80</td>
<td>0.60</td>
<td>68</td>
<td>.553</td>
</tr>
<tr>
<td>Attitude</td>
<td>1.36</td>
<td>0.79</td>
<td>1.11</td>
<td>0.98</td>
<td>1.19</td>
<td>68</td>
<td>.238</td>
</tr>
<tr>
<td>Skills</td>
<td>0.77</td>
<td>0.69</td>
<td>0.34</td>
<td>0.71</td>
<td>2.60</td>
<td>68</td>
<td>.011</td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>0.95</td>
<td>0.73</td>
<td>1.03</td>
<td>0.67</td>
<td>-0.46</td>
<td>68</td>
<td>.645</td>
</tr>
</tbody>
</table>

Figure 2. Age comparison of Pre-to-Post QPR Training Improvements

Discussion

The purpose of this project was to implement and evaluate a 1.5 hour online suicide prevention program via the QPR GKT with undergraduate and graduate students in order to
increase suicide prevention on a college campus. The project's two process outcomes were 1) to increase students' self-ratings of self-knowledge, attitude, self-efficacy, and skills following the training, and 2) an increase in the proportion of students with the National Suicide Prevention Hotline number saved in their phones. Following the training, the paired t-tests on four QPR scales (self-knowledge, attitude, self-efficacy, and skills) and the number of students with the #988 saved on their phones were all highly significant (p < .001) (Tables 2 and 3). In addition, the alpha significance levels for age comparisons between the 18-24 and 25+ age groups were significantly different with p = .011 for skills. The alpha level considered significant self-knowledge, attitude and self-efficacy was p < .05.

The findings of this training indicate that QPR shifts students' knowledge about suicide toward being more open and willing to ask a person in crisis if they need support and believing that they have the skills and resources to help, adding to the body of evidence demonstrating its short-term effectiveness in a college setting (Aldrich et al., 2018). Regardless of who (staff, campus police, advisors, faculty, students, etc.) received QPR training, the post-questionnaire results indicate that a participant's role did not correlate significantly with the outcomes (Aldrich et al., 2018, Mitchell et al., 2013), meaning that no particular group scored higher or lower than others. This demonstrates that any audience, regardless of educational background, can learn from QPR training due to the concise and structured training presentation process and the content's customization for everyday individuals.

In contrast to the conventional in-person method used in earlier research, this training was delivered online and contributes to a previous study demonstrating online suicide prevention training as useful and effective for teaching an emotionally sensitive topic (Scott et al., 2016).
Students who may not have participated as much in an in-person training were able to comment and ask questions privately without fear of judgment or shame by turning off videos and entering private questions to the chat box. What is missed is the presenter not being able to fully read the classroom, for example, if the presenter notice a change in a student's affect or body language during the training and wants to check in with the student after the training, there is a greater likelihood of doing so due to physical proximity. As a result of the technological nature of being able to log off, it is not possible to follow up on students who dropout of online training, despite the fact that they are permitted to do so at any time.

**Sustainability**

The online training modality makes it easy for students to attend training at their preferred setting given the sensitivity of the subject and utilizing Zoom through SFSU account, there is no additional cost. The ability for students to choose their learning location is enabled by technology that supports the thought that learning will occur when learning spaces match or support individual preferences and needs (Wang and Han, 2021). The danger is that their location may not be conducive to learning due to poor wifi or external distractions such as environmental noise. To mitigate this risk, students were advised on the best learning environment for this training, which was a quiet area with little foot traffic and a strong wi-fi connection.

Additionally, in-person training could be offered, however, an extra step is needed to coordinate a room reservation versus creating a Zoom invite. For example, consider a last minute change where a room may not be available due to maintenance, and another room that can hold a number of audience members might not be available for the exact day of training. With Zoom
training, it might not take place if the trainer is not feeling well to train or if the trainer is having technical issues.

With the college students expressing interest, a strategy to incorporate students’ vision for a suicide prevention via social media campaign (Thorn et al., 2020). According to Pew Research Center, 71% of 18-to-29-year-olds use Instagram, 65% use Snapchat, and 50% use TikTok (Auxier & Anderson, 2021). Collaboration with student organizations that support mental health, such as Active Minds, a non-profit organization that promotes mental health awareness and education for young adults on numerous college campuses, has the potential to influence university-wide attitudes, social norms, and behaviors. Using social media to promote suicide prevention and trainings has the potential to reduce environmental impact. Promotion for training can be freely shared on social media and reposted multiple times after being viewed.

**Limitations**

Timing, self-selection bias, demographic constraints, and a relatively small sample size constituted the limitations of this study. The number of participants who attended the training might have been affected by scheduling difficulties. For instance, students interested in attending the training but did not due to prior obligations such as attending another class, working, or caring for family members. Additionally, timing of questionnaire delivery may have impacted post-questionnaire results; as students were provided and encouraged to complete the post-questionnaire after the training, factors that may have hindered the response rate include emotional impact after discussing a sensitive topic, leaving one emotionally drained, and the fact that perhaps the post-questionnaire was not required to be completed, resulting in participants opting out.
Due to self-selection bias, individuals who signed up for and attended the training likely had a strong interest in the subject matter; hence, the transfer of training and knowledge was more readily absorbed for comprehension and application. Since this experiment lacked a random control group, it was not possible to compare the knowledge, attitude, self-efficacy, and skills ratings of participants who attended with little to no interest in the subject vs those who were eager to learn more.

The student's race/ethnicity and major/area of study were not obtained. This was a limiting feature because it was unable to display the demographics of the students enrolled in the course; this would have been advantageous, as certain groups are more at risk for suicide than others. Regarding school majors, it would reveal which departments in the various SFSU colleges received training and whether training expansion should be extended to those with lower attendance. In addition, focusing on professions with a higher suicide rate, such as illustration, animation, and criminal investigation for women, and professional sports and engineering for men, to prepare students for interpersonal relationships in the workplace.

Lastly, there were 70 male participants, a smaller sample size of male students, than the proportion of male students at SFSU (43% of full-time undergraduates and 42% of graduates) (San Francisco State University Office of Institutional Research, 2022). Collaboration with fraternities, specifically their advisory boards and chapter leaders, is one strategy for increasing training for the male population.
Conclusion

This study discovered highly significant changes in self-rating scores immediately after QPR training, indicating that students were more open to asking someone if they were suicidal, more confident in their ability to prevent suicide, and more willing to help. QPR training can be incorporated into existing curriculum or used for staff/faculty professional development because training durations can range from 60 to 120 minutes. Moreover, colleges have a responsibility not only to educate students academically, but also to ensure the safety and support of individuals in the academic community; as such, the findings of this project indicate that suicide prevention training is extremely beneficial. The goal is to incorporate QPR into a new policy requiring mandatory training for new, incoming students, similar to the Sexual Violence Prevention Education Online Training mandated by CSU Executive Order 1095, to further the college's commitment to providing a safe and healthy learning environment (San Francisco State University, 2022).
References


campaign=TrendMD_APA3month_Dec2018%26utm_source=TrendMD&utm_medium=


Free Suicide Prevention Training
Question, Persuade, Refer

What is QPR?
Question, Persuade, Refer (QPR) teaches college students to recognize and respond to mental health crises.

- QUESTION
  - The person’s desire or intent regarding suicide.
- PERSUADE
  - The person to seek and accept help.
- REFER
  - The person to appropriate resources

PRESENTER:
Cheryl Villamor is a mental health nursing clinical professor at San Francisco State in the School of Nursing Department. She is a yoga teacher and a social emotional learning facilitator.

Everyone has a role in preventing suicide:
- Virtual Training via Zoom
- 90 minutes
- You must be 18 years of age or older

REGISTER TODAY!

Fri. Sep 9 6pm - 7:30pm
Fri. Sep 16 6pm - 7:30pm
Fri. Sep 23 6pm - 7:30pm
Fri. Sep 30 6pm - 7:30pm
Fri. Oct 7 6pm - 7:30pm

*Registration spots are limited, so please only register if you can attend the event. No recording of this training will be available.

If you are interested in a group training, please email: cherylm@nfsu.edu
Appendix B

Note. Website for QPR training: https://cheryllmayvillamor.wixsite.com/youcan

### Question, Persuade, Refer

Question, Persuade, Refer, or QPR is a 90 minute online suicide prevention training designed to increase your ability to recognize suicidal thoughts and behaviors, and to refer the person at risk to a professional resource.

- Complete a 11 item survey assessing suicide and suicide prevention self knowledge, attitudes, and skills and a 6 item demographic survey (2-3 minutes to complete)
- Powerpoint Presentation with 14 Breaks
- Complete a 11 item survey (5-2 minutes to complete)
- Receive a QPR training certificate (3 year expiration date)

### Save Your Spot

No upcoming events at the moment

### 988 Suicide & Crisis Lifeline

The 988 Suicide & Crisis Lifeline offers 24/7 call, text and chat access to trained crisis counselors who can help people experiencing suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress.

### Get in Touch

If you have any questions or would like to book a training session, please fill out the form.

---

Appendix C
Q1. Please make up your own ID number using the first letter of your first name (in capital letter) and the last 5 digits of your cell phone number. [Example: Jane + last five digit of cell phone = J64660]

Q2. Please rate your level of understanding about suicide and suicide prevention.

Low ☐ Somewhat Low ☐ Medium ☐ Somewhat High ☐ High ☐

Q3. How would you rate your knowledge in the following area?

Facts concerning suicide prevention

Low ☐ Somewhat Low ☐ Medium ☐ Somewhat High ☐ High ☐

Q4. How would you rate your knowledge in the following area?

Warnings signs of suicide

Low ☐ Somewhat Low ☐ Medium ☐ Somewhat High ☐ High ☐
### Q6. How would you rate your knowledge of suicide prevention in the following area?

<table>
<thead>
<tr>
<th>How to ask someone about suicide</th>
<th>Low</th>
<th>Somewhat Low</th>
<th>Medium</th>
<th>Somewhat High</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Persuading someone to get help</th>
<th>Low</th>
<th>Somewhat Low</th>
<th>Medium</th>
<th>Somewhat High</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

### Q7. How would you rate your knowledge of suicide prevention in the following area?

<table>
<thead>
<tr>
<th>How to get help for someone</th>
<th>Low</th>
<th>Somewhat Low</th>
<th>Medium</th>
<th>Somewhat High</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

### Q8. How would you rate your knowledge of suicide prevention in the following area?

<table>
<thead>
<tr>
<th>Information about local resources for help with suicide</th>
<th>Low</th>
<th>Somewhat Low</th>
<th>Medium</th>
<th>Somewhat High</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

### Q9. Do you feel likely to ask someone if they are thinking of suicide?

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Mostly</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

### Q10. Do you feel that asking someone about suicide is appropriate?

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Mostly</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
Q11. If someone told me they were thinking of suicide, I would intervene.

Q12. If someone’s words and/or behavior suggest the possibility of suicide, I would ask them directly if they are thinking about suicide.

Q13. I don’t feel competent to help a person at risk for suicide.

Q14. I don’t think I can prevent someone from suicide.

Q15. I feel confident in my ability to help a person who is suicidal.

Q16. Do you have #988 saved in your phone?

Yes ☐ No ☐

Q17. Choose your age group:
Q18. Gender
- Woman
- Man
- Transgender
- Non-binary/Con-conforming
- Prefer not to respond

Q19. Enrollment status
- Full-time
- Part-time

Q20. Current level of education
- Undergraduate
- Graduate

Q21. Have you had suicide training in the past two years?
- No
- Yes

Q22. Do you have an active mental health license? [Example: PsyD, PhD, LCSW, LMFT, Psych RN, Counselor]
Q1. Please make up your own ID number using the first letter of your first name (in capital letter) and the last 5 digits of your cell phone number. [Example: Jane + last five digit of cell phone = J64660]

Q2. How would you rate your knowledge in the following area?

- Facts concerning suicide prevention
  - Low
  - Somewhat Low
  - Medium
  - Somewhat High
  - High

Q3. How would you rate your knowledge in the following area?

- Warnings signs of suicide
  - Low
  - Somewhat Low
  - Medium
  - Somewhat High
  - High

Q4. How would you rate your knowledge in the following area?

- How to ask someone about suicide
  - Low
  - Somewhat Low
  - Medium
  - Somewhat High
  - High
Q5. How would you rate your knowledge of suicide prevention in the following area?

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Somewhat Low</th>
<th>Medium</th>
<th>Somewhat High</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persuading someone to get help</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q6. How would you rate your knowledge of suicide prevention in the following area?

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Somewhat Low</th>
<th>Medium</th>
<th>Somewhat High</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to get help for someone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q7. How would you rate your knowledge of suicide prevention in the following area?

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Somewhat Low</th>
<th>Medium</th>
<th>Somewhat High</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information about local resources for help with suicide</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q8. Do you feel likely to ask someone if they are thinking of suicide?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Mostly</th>
<th>Always</th>
</tr>
</thead>
</table>

Q9. Do you feel that asking someone about suicide is appropriate?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Mostly</th>
<th>Always</th>
</tr>
</thead>
</table>
Q10. If someone told me they were thinking of suicide, I would intervene.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Q11. If someone’s words and/or behavior suggest the possibility of suicide, I would ask them directly if they are thinking about suicide.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Q12. I don’t feel competent to help a person at risk for suicide.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Q13. I don’t think I can prevent someone from suicide.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Q14. I feel confident in my ability to help a person who is suicidal.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Q15. Do you have #988 saved in your phone?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Appendix D
SFSU CAMPUS RESOURCES:

Counseling and Psychological Services (CAPS):
Student Services Building
Room 205
1600 Holloway Avenue
San Francisco, CA 94132
(415) 338-2208
Monday through Friday:
8 a.m. - 4:45 p.m.

You may consult with Counseling and Psychological Services (CAPS) counselor faculty at (415) 338-2208 during hours of operations. If CAPS is open, you can walk the student to the CAPS for an emergency consultation or appointment. If the mental health emergency occurs after the CAPS is closed, call UPD (University Police) at 911 on your campus land line. If you can call from your cell phone, dial (415) 338-2222.

SFSU LIST OF MENTAL HEALTH RESOURCES:

Counseling, Psychological, and Mental Health Resources (Click Here)

Campus Academic and Student Life Resources
- Academic Advising Center
- Campus Recreation
- Career Services & Leadership Development
- Career Center
- CHOC Student Center
- Center for Student Affairs
- Institute for Civic and Community Engagement
- Learning Assistant Center
- Legal Resource Center
- Pride at SF State
- Project Connect
- Project Rebound
- Student Activities & Events
- Student Resource & Empowerment Center

Campus Health Resources
- Access Medical Student Group
- Basic Skills
- Disability Programs and Resources Center
- Health Promotion & Wellness
- Legacy H. Smith Counseling Clinic
- Psychology Clinic
- The SAFE Place
- Student Health Services
- University Police Department

Mental Health & Wellness Resources and Guides
- Guide to Mental Health Resources
- LGBTQ+ Mind-Body Guide

Coping Resources for Students
- FAQ for Students
- Mindful, Mindful Resources
- Tips for Dealing with Stress
- Searching for Therapy

SLIDING SCALE Fee Counseling and Psychotherapy
Access Line: Lifeline (800) 273-8255
Alma Institute
Alumni Family
California Institute of Integral Studies
Health Authority Psychological Services
Hispanic American Foundation for Social Services
HCVN, Inc.
Jewish Family and Children's Service
Mental Health Research Group
National Recovery Center/Recovery Center
Substance Abuse Treatment & Recovery
Substance Abuse Treatment and Referrals
Addiction Resources
Stigma
Alcohol Use and Mental Health
Addiction Recovery
VHA Resources and Helpline
National Mental Health Association
Pride at SF State
Mindfulness Meditation
Alcoholics Anonymous
Antigender, Antigender Transgender

Resources for Women and LGBTQ+ Persons
- Community United Against Violence (CUAV)
- Gateways to Change
- Queer LifeSpace
- Gender Health Clinic
- LGBTQ+ Mental Health Services for Women
- NCOM, Inc.

Domestic Violence Support Services
- Community Health
- HMO Health Project San Francisco
- American College of Traditional Chinese Medicine City Clinic
- Project Access Counseling Center at Peace Street
- National Alliance on Mental Illness (NAMI) San Francisco
- Native American Health

Well Clinic
- LGBT

ADDITIONAL RESOURCES:

Call/Txt the National Suicide Prevention Lifeline at 988

Call San Francisco Suicide Prevention at 415-781-0500

Text the Crisis Text Line:
Text HOME to 741-741
If in California text “HOME” to 686868

Text “TalkWithUs” to 66746

24/7 Crisis Line for Youth 12-24 & families in crisis: (800) 843-5200

The Trevor Project (LGBTQ+):
(866) 488-7386 (text, chat or call)