



The Efficacy of Mental Health PEI Trainings Across California's Higher Education Systems

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The California Mental Health Services Authority (CaMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families and communities. Prevention and Early Intervention programs implemented by CaMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities



California's Statewide Prevention and Early Intervention (PEI) activities implemented by the California Mental Health Services Authority (CaMHSA) and funded under Proposition 63 included PEI training for **college and university** faculty, staff, and students. Many of you may have been part of that effort. My goal today is to describe some preliminary findings **from the statewide evaluation conducted by the RAND Corporation** that examines PEI trainings across CA's higher education system.

Agenda

- Overview of CalMHSA SMH PEI training initiative
- Description of RAND's statewide training evaluation
 - Description of evaluation sample
- Review of preliminary results:
 - Reach and penetration of training events
 - Characteristics of training participants
 - Self-efficacy and behavioral intentions of training participants
- Discussion about sustainability of training events and evaluation

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I'll first describe a subset of trainings focused on PEI that the higher ed system was delivering, discuss RAND's training evaluation, and then preliminary results. **Since this presentation is officially a Round Table format, I will end by facilitating a discussion with you—to learn about your views and experiences in sustaining training events and training evaluation.**

PEI Training and Resources Across Higher Ed

- **Training** events for faculty, staff, and students:
 - Suicide prevention (e.g., ASIST, QPR)
 - Mental Health First Aid (MHFA)
 - Recognizing and responding to signs of distress
 - Support for vulnerable populations (e.g., LGBTQ, veterans, first-year and graduate students)
 - Other general mental health and wellness topics (e.g., combating stress, eating disorders)
- **Resources** for faculty, staff, and students:
 - CCC: Systemwide training and TA for campus-based grantees; Kognito offered to all campuses at no cost
 - CSU: Centrally-supported (CSUCO) cross-system train-the-trainer events and list of certified trainers in MHFA/ASIST
 - UC's Red Folder initiative: Quick reference guide (and brief training) of mental health resources customized for each campus

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As many of you already know, CA's higher ed system focused on the following PEI trainings. **Many campuses supported** Mental Health First Aid and other suicide prevention **training**. Other training **topics** also included early recognition of **student** distress, support for vulnerable **student** populations known to have higher rates of mental health issues, and other general mh and wellness topics.

The higher ed **partners** also used CalMHSA funding to provide **cross-campus, systemwide** resources. For example, the CCC provided; CSU; UC...

Red Folder: The customized folders identify common signs of student distress and direct faculty/staff and graduate teaching/research assistants through campus protocol to clarify who they should contact in the event of an emergency. The folders also provide tips for how to approach a student who may be in distress and connect that student with the appropriate resource.

Online Resources: Examples

The image displays three examples of online resources for student mental health:

- University of California Student Mental Health Resources & Promising Practices:** A website with a navigation menu (HOME, SUICIDE PREVENTION, TRAINING AND PROGRAMS, RESOURCES, ABOUT, CONTACT) and a search bar. The main content area features a "Red Folder Initiative" section, which includes a description of the initiative, a list of "Student Promising Practices" (Peer Programs, Student Training, Special Populations, Videos / PSAs, Student Video Content, Social Media, Faculty/Staff Promising Practices), and a "Red Folder Initiative" button. A sidebar on the right contains a "Subscribe to updates" button.
- CSU The California State University:** A list of websites for various CSU campuses, including Bakersfield, Channel Islands, Chico, Dominguez Hills, East Bay, Fresno, Fullerton, Humboldt, Long Beach, Los Angeles, Maritime Academy, Monterey Bay, Northridge, Pomona, Sacramento, San Bernardino, San Diego, San Francisco, San Jose, San Luis Obispo, San Marcos, Sonoma, and Stanislaus. Each campus name is followed by a URL.
- Student Mental Health Program Training and Technical Assistance for California Community Colleges:** A website with a navigation menu (Home, About CCC SMHP, Training & Technical Assistance, Resources, Campus Based Grants, Evaluation) and a search bar. The main content area features a "Training & Technical Assistance" section, which includes a description of the program, a "Request Training & Technical Assistance Now" button, and contact information for CCC SMHP (ph (855) 304-1647). A sidebar on the right contains a "Request TA / Training" button and a "Register for an Event" button.

UC's SMHI website (with Red Folder and other training information); CSU's list of campuses' SMH websites; and CCC's SMHP website (with training and TA sign-up).

Training Evaluation Focus Across Higher Ed

- **Training reach and penetration:**
 - **Who did the training reach, including members of diverse targeted populations?**
- **Training participant ratings:**
 - **Did participants view the training as high quality and helpful?**
 - **Did participants benefit?**
 - **Self-efficacy: Knowledge and attitudes about intervening**
 - **Behaviors: Intent to intervene**

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What was the focus of our training evaluation efforts? We wanted to understand two main things – first, who did the training reach, and did it reach the intended population(s)-- including those who were of diverse backgrounds? Second, we wanted to understand what training participants thought about these trainings, and so we measured quality (Did participants view the training as high quality and helpful?), and whether they benefitted as measured by two outcomes (self-efficacy and behavioral intentions). I'll show you examples of the things we measured in just a bit.

Evaluation Included a Sample of PEI Trainings

- **UC:** Sampling plan per campus, including approximately **6 student** (2 per quarter/3 per semester) and **2-3 staff/faculty** trainings (1 per quarter/semester)
 - Standardized trainings (i.e., MHFA, QPR, ASIST, Red Folder) prioritized for evaluation
- **CSU:** **All standardized** trainings (i.e., MHFA, QPR, ASIST)
- **CCC:** **All Campus-based Grant** training events (i.e., from 30 campuses)

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RAND was charged to evaluate a **subset** of PEI trainings across the higher education system—so the statewide evaluation did not measure the efficacy of a specific type of training, **and we did not evaluate all trainings that were conducted.**

How did we determine the subset of trainings to evaluate? Basically we worked with each system to determine feasible, representative samples to use in the statewide evaluation. Our goal was to maintain consistent criteria while also reducing data collection burden and barriers where feasible. So, for example, we focused much of our efforts on evaluating standardized, manualized trainings across the systems, such as MHFA, ASIST, and QPR.

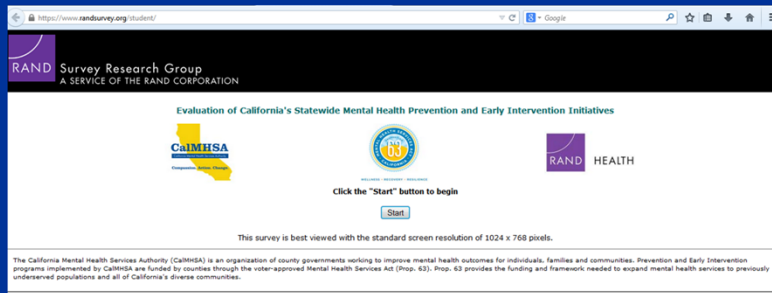
UC: Each UC campus selected approximately 6 student trainings and 2–3 staff/faculty trainings to be evaluated with the statewide training survey per year per campus (although campuses could opt to include more than 8 trainings if they wanted to).

CSU: CSU campuses administered the statewide training survey after MHFA, ASIST, and QPR trainings. In addition, RAND accessed the evaluation data from the online-administered Kognito training survey data.

CCC: Using CalMHSA funds, CCC awarded campus-based grants (CBGs) to 30 CCC campuses to enhance their student mental health supports and services. These campuses administered the statewide training surveys at all training events, where feasible.

Data Collection Procedures Promoted Consistency

- Training reach and penetration:
 - Campus, date, topic, and total attendance
- Training participant ratings:
 - Student and staff surveys
 - Anonymous paper, internet, mobile surveys



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To ensure consistency in survey administration and data collection, the RAND TA team distributed a number of tools to support the evaluation, such as detailed instructions, flow charts, and pre-written scripts for trainers to use to invite participants to complete the surveys.

To measure training reach and participation, we asked trainers to submit information about their training topic, date, campus location, and attendance.

To measure training quality and outcomes, we used participant self-report surveys. We had slightly different surveys for student and staff, with only minor wording changes in some questions where necessary.

Response rate was a big concern, so we developed three different survey modalities: a paper version, an internet survey (accessible via a URL), and a process to text a phone number to receive the survey URL directly on participants' cell phones. Here's an example of the cover page participants saw when they logged onto the survey – note the various logos and how RAND is highlighted to pre-empt confidentiality concerns.

Participant Ratings: Pre and Post

- Traditional pre-post (administered twice; before and after) and retrospective pretest versions (administered once; after)

(ON EACH LINE MARK ONE FOR "BEFORE" AND ONE FOR "AFTER")	BEFORE I attended this training					AFTER I attended this training				
	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
	1	2	3	4	5	1	2	3	4	5
a) I can identify the places or people where I should refer other students with mental health needs/distress.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I have easy access to the educational or resource materials I need to learn about student mental health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Trainers provided with materials to assist in consistent administration
- Procedures approved by RAND IRB; campus review as necessary

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We wanted to assess how helpful the training was by comparing ratings before and after the training. To do so, we created a traditional version of a pre-post survey where participants complete the survey before and then again after. We also created a “retrospective version” of the survey that required only one administration of the survey, and instructed participants to think about their ratings of each statement BEFORE participating in the trainings and then AFTER the training. Research shows that these retrospective procedures are valid and sometimes even more accurate (Pratt et al., 2000; Rohs, 1999), because people sometimes have a more accurate gauge of their baseline level after they have had the experience of training.

Trainers were provided a script and handout describing the evaluation and data collection. The script encouraged participants to complete the survey as soon as possible, affirmed that it was confidential, that it would only take about 5 minutes, and that it would help us to improve and sustain future trainings.

RAND received IRB approval for the training evaluation and facilitated the review and approval by campus IRBs where needed.

Assessing Confidence to Intervene or Refer

- Self-efficacy (5-point scale from ***Strongly Disagree*** to ***Strongly Agree***)
 - Internal
 - *I feel comfortable discussing mental health issues with students.*
 - *I am confident in my ability to help students address mental health issues.*
 - *I am aware of the warning signs of mental health distress.*
 - External
 - *I can identify the places or people where I should refer students with mental health needs/distress.*
 - *I have easy access to the educational or resource materials I need to learn about student mental health.*

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Adapted from suicide gatekeeper surveys, factor analysis done on these items from our campus-wide survey that assessed internal and external locus of self-efficacy.

Staff version of the survey

Assessing Likelihood to Intervene or Refer

- Behaviors (4-point scale from ***Very Unlikely*** to ***Very Likely***)
 - Internal
 - Ask him/her specific questions to assess their level of distress or seriousness of problem.
 - Encourage him/her to get professional help (e.g., hospital, mental health center, counselor, etc.).
 - External
 - Encourage him/her to talk with parents or friends about problems.
 - Give him/her a specific number or person to call.
 - Call security/administrator/counselor to support the student.

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Adapted from suicide gatekeeper surveys

Reach of Trainings: Students and Females

	UC	CSU	CCC
# trainings evaluated	99	234	93
# students	398	2903	728
# staff	434	803	480
% female	73%	68%	73%

Reach of Trainings: Diverse Participants

Category	%
Female	69.6
Ethnicity	
White, not Latino	37.1
Latino	36.4
Asian American	13.1
Black/African American	5.5
Other	7.9

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Total observations – 5769. Table describes percent of respondents we have data for.

Reach of Trainings: Diverse Participants

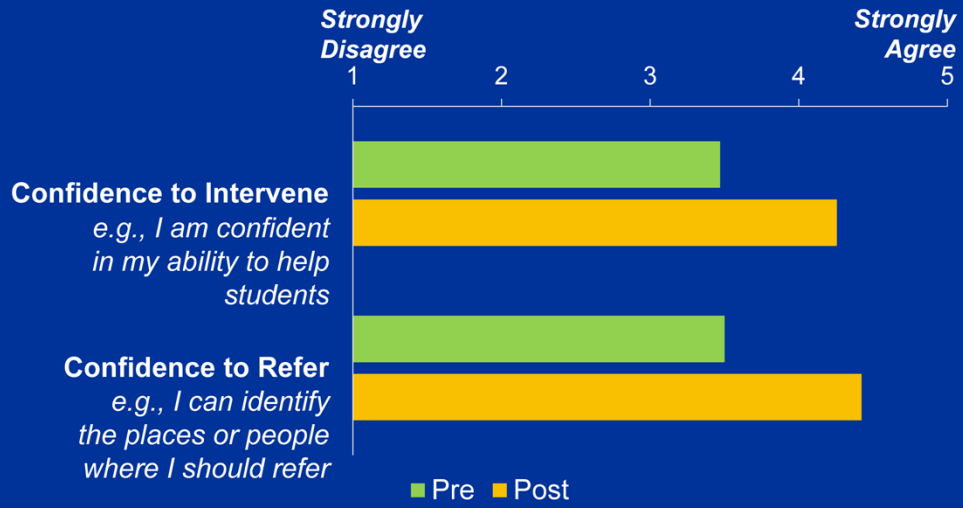
Category	%
Female	69.6
Ethnicity	
White, not Latino	37.1
Latino	36.4
Asian American	13.1
Black/African American	5.5
Other	7.9
Role	
Student	73.0
Other staff	8.5
Full/Part-time Faculty	8.2
Administrator	5.6
Other (e.g., volunteer)	3.2
Health/Mental Health	1.6

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Total observations – 5769. Table describes percent of respondents we have data for.

Participants' Perceptions of Self-Efficacy



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Average Changes in Self-Efficacy by Group

Group	CONFIDENCE	
	Intervene	Refer
Ethnicity^a		
Latino	0.06*	0.12**
Asian American	-0.03	-0.05
Black/African American	0.09	0
Other	-0.02	0.02
Role^b		
Student	0.04	0.15*
Full/Part-time Faculty	0.04	0.19*
Health/Mental Health	-0.23**	-0.3**
Other staff	0.03	0.02
Other (e.g., volunteer)	0.08	0.16

^a Whites are the reference group

^b Administrators are the reference group

* $p < .05$; ** $p < .01$

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Overall, there were improvements after the training, but we also wanted to examine whether there were particular groups that benefitted more so we looked at differences in outcomes by system, race/ethnicity, and role. First, we found no significant differences by system. CCC, CSU, UC had similar improvements in self-efficacy. This table represents the average number of points on the scale that each group increased or decreased by after the training compared to the reference group. If there was a positive value, that means they had a greater improvement. So, let's look at the bars I highlighted in yellow.

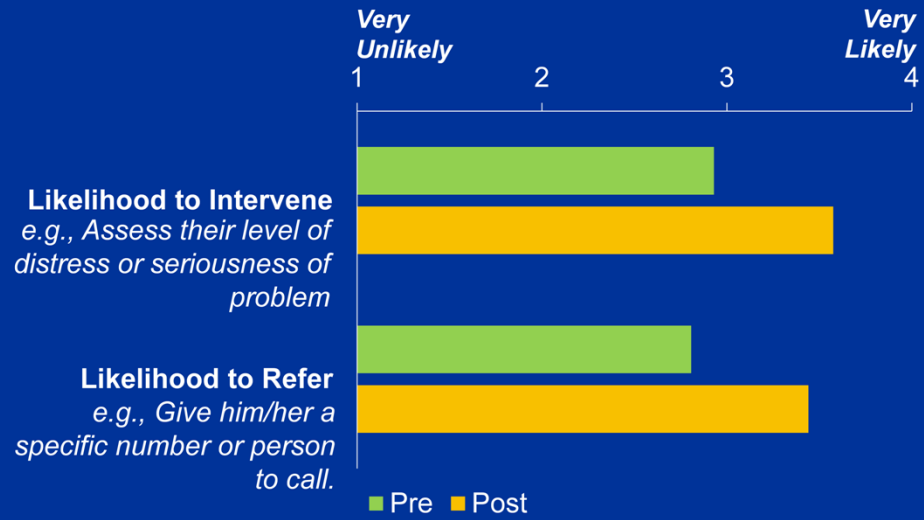
When we examined race/ethnicity, our statistics program used Whites as the reference group. So, this column shows whether these groups improved more or less compared to Whites. The only statistically significant finding we found was that compared to White participants, Latino participants had a significantly larger change by 0.06 points in their confidence to intervene and 0.12 points in their confidence to refer.

We also examined the role of the training participant. We only found statistically significant differences in participants' confidence to refer. On average, compared to administrators, students and faculty had significantly larger changes in their confidence to refer, while health/mental health professionals had smaller changes in their external self-efficacy scores

(which was expected because health/mental health professionals likely already had the confidence to refer because of their training background and clinical experience).

I'm curious what your thoughts are about these findings. For example, why might Latinos have had greater improvements compared to Whites. How about why these roles had greater improvements in their confidence to refer vs. intervening?

Participants' Perceptions of Behavioral Intentions



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BDS= SAME ISSUE- I THINK LANGUAGE IS TOO JARGONY. MAYBE
"LIKELIHOOD OF DOING SOMETHING..." OR SOMETHING LIKE THAT

Average Changes in Intentions by Group

Group	LIKELIHOOD	
	Intervene	Refer
Ethnicity^a		
Latino	-0.01	-0.02
Asian American	-0.07⁺	-0.11[*]
Black/African American	-0.02	-0.04
Other	-0.05	-0.09[*]
Role^b		
Student	-0.02	0.11
Full/Part-time Faculty	0.10⁺	0.16^{**}
Health/Mental Health	-0.15	-0.11
Other staff	0.05	0.07
Other (e.g., volunteer)	0.11	0.17 [*]

^a Whites are the reference group

^b Administrators are the reference group

* $p < .05$; ** $p < .01$, + $p < .1$

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Again, overall there were improvements in likelihood to intervene and refer after the training, but we also examined differences in outcomes by system, race/ethnicity, and role. Again, we found no significant differences by system. CCC, CSU, UC had similar improvements in their likelihood to intervene and refer. This table represents the average number of points on the scale that each group increased or decreased by after the training compared to the reference group. If there was a positive value, that means they had a greater improvement. So, let's look at the bars I highlighted in yellow.

When we examined race/ethnicity, our statistics program used Whites as the reference group. So, this column shows whether these groups improved more or less compared to Whites. The only statistically significant finding we found was that compared to White participants, Asian and Other participants were significantly less likely to refer. Other participants consisted of biracial, American Indian, Arabic, and any other self-written responses.

We also examined the role of the training participant. We only found statistically significant differences in participants' likelihood to intervene and refer. On average, compared to administrators, faculty had significantly larger changes. We see a statistical trend in their likelihood to intervene, while statistically significant improvements in their likelihood to refer when compared to administrators.

I'm curious what your thoughts are about these findings. We're not sure what to make of them. For example, why might Asians have had smaller improvements compared to Whites? How about why faculty would have greater improvements in their likelihood to refer and intervene?

