

TURNING YOUR DATA INTO KNOWLEDGE AND ACTION

PART 2 OF 3

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Interpreting what you have

GLS NOE Data

Now that you have a goal of what you want to share and who you want to share it with, let's review your GLS-related data and other sources of information. You have collected vast amounts of data as part of the National Outcomes Evaluation (NOE). This data can help you communicate to your audience the things you have accomplished in your suicide prevention program. Sources of GLS data include:

- ✓ Instrument Datasets
- ✓ Grantee Summary Reports
- ✓ Previous Infographics

A full list of evaluation questions addressed by GLS data can be found in Appendix A.

A closer look at your GLS NOE data

The worksheet below walks you through where to locate data elements from the GLS NOE data that you have already collected.

Directions: Fill-in the number below by locating the data from your Grantee Summary Report (GSR).

Number of people trained through Gatekeeper training program (TASP)

Number of youth screened through suicide screening program (EIRF-S)

Percent of trainees who used training to identify youth at risk for suicide (TUP-S)

Number of youth identified as at-risk through a screening activity or by a gatekeeper (EIRF-S)

Percent of youth who receive mental health services following referral out of youth referred to mental health services (EIRF-I)

Percent reduction in suicide/suicide attempts among youth reached by your program (SBHF)

Secondary Data

In addition to the data collected for the NOE, there are numerous sources for secondary data (See Appendix B). Before jumping into all the secondary data think about the following questions and make some notes.

- 1.) What do you want to share with your audience?

- 2.) Do you want to share national/state/local data?

- 3.) Now, restate your data communication goal and audience:

- 4.) Which data sources (NOE or Secondary data) will be useful in supporting your message?

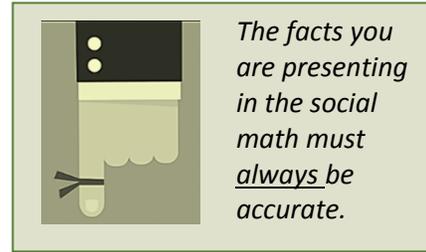
As a reminder, here are some examples of things you can find from secondary data:

- ✓ Suicide death rate (per 100,000) by county
- ✓ Comparison of state suicide death rate to national average
- ✓ Number of self-reported suicide attempts
- ✓ Mental health service use

Social Math

To help put some of these statistics into everyday context, we can use social math. The comparison you make should be easy to understand.

- ✓ Break a number by time/place
- ✓ Compare an abstract number to something familiar



Ex: If one less suicide occurred each day, society would recover about \$300 million in total lifetime costs, enough to cover 4 years of college tuition, room and board for 17,000 students.

Below is an example to help you work through a social math problem.

DO YOUR MATH HOMEWORK!

What is your BIG number?
(I.e. number of suicides, number of people trained)

What can you compare this to that will make it meaningful to your audience?

This is your social math result!

Appendix A – GLS NOE Evaluation Questions

Evaluation Questions and Sub questions	Primary Data Sources									Secondary Data Sources				
	PSI	TES/TASP	TUP-S	TUP-S Enhanced	EIRF-I	EIRF-S	YESI	SBHF/MIS	BHPS	Medicaid	HCUP	NSDUH	NCHA/CSMH	CDC Mortality Files
EQ 1: Are certain training approaches effective in building capacity to increase youth identification (when compared with more basic trainings)?														
1.1: What type of training curricula are grantees implementing?	X	X												
1.2: Which population(s) are being trained?	X	X	X											
1.3: What are the expected outcomes associated with training participation?		X												
1.4: What factors related to the training (e.g., use of active learning strategies), the trainee (e.g., 'natural gatekeepers'), and the setting (e.g. 'threshold effects') predict differences in gatekeeper behavior following participation?		X	X											
EQ 2: Are GLS prevention activities effective in developing continuity of care from identification, to referral of youth at risk for suicide, to the provision of needed services?														
2.1: What proportion of youth identified by GLS grantees receive follow-up support?					X									
2.2: Do youth characteristics predict follow-up support and adherence to follow-up care (e.g., gender, race-ethnicity) or setting of identification?					X									
2.3: Does the proportion of youth receiving follow-up care increase over the duration of GLS program activities?					X									
2.4: What are the practices and supports used by the grantees to ensure that identified youth receive referral and follow-up?	X				X				X					
2.5: What are the gaps in support for youth identified as at risk for suicide?					X									
2.6: What are the patterns of identification, referral, and follow-up for youth identified as at risk for suicide?					X	X		X						
2.7: What are the follow-up services received by at-risk youth?					X			X						

2.8: How does the identification, referral, and service experience impact follow-up adherence after an early identification for youth/students who remain in care compared to those who drop out of care or do not seek follow-up care?								X											
2.9: What factors are associated with continuity of care/adherence from the youth' perspective?								X											
2.10: What early identification and referral practices are effective from youth perspectives in ensuring follow-up care adherence for youth who stay in follow-up care compared to youth who do not seek follow-up care or drop out of care?								X											
2.11: What are the service experiences for youth/students identified as at risk through the GLS Suicide Prevention Program who remain in follow-up after referral compared to youth/students who do not remain in follow-up care?								X											
2.12: What are the barriers and facilitators to service access and utilization for youth/students after identification and referral?								X											

EQ 3: Does the provision of services by GLS behavioral health provider networks implementing a Zero Suicide framework reduce suicide attempts, hospitalization, and associated costs (return on investment) compared to non-GLS behavioral health providers?

3.2: What suicide safer environment care activities are being implemented by campus health services?	X								X										
3.3: Are access and utilization of campus behavioral health services higher for students on campuses that integrate clinical screenings or suicide assessments into campus primary and behavioral health care?	X								X										
3.4: Are suicide ideation, attempts, and completions lower for students on campuses that are more fully implementing the suicide safer environment framework activities?	X								X									X	
3.5: Are suicide attempts reduced for youth receiving services by GLS behavioral health providers compared to non-GLS providers?											X	X							
3.6: Are hospital readmissions and in-hospital deaths by suicide lower for youth (at risk for suicide) who use services from providers that have implemented NSSP Goals 8 and 9 activities?											X	X							

EQ 4: Was there a reduction in suicide behavior in the areas exposed to GLS interventions compared with similar areas that were not exposed to those interventions?

4.1: Was there a reduction in suicide mortality in youth aged 10–18 following implementation of school-based suicide prevention strategies during 2006–2011?	X	X	X									X		X
4.1a: Was the difference associated with the level of ‘saturation’ of teachers and school staff with trainings?	X	X	X									X		X
4.2: Was there a reduction in suicide mortality and attempts in youth aged 19–24 following the implementation of higher-education–based prevention strategies during 2006–2011?	X	X	X									X	X	X
4.3: Was there a reduction in self-inflicted injury requiring hospitalization in youth aged 10–24 following GLS training implementation in 20 States?*		X	X									X		X
4.4: Was there a reduction in suicide mortality and attempts in youth aged 19–24 following the implementation of GLS trainings in community settings?*		X	X									X		X
EQ 5: What is the anticipated impact (in terms of averted suicide attempts and suicide deaths) of specific GLS interventions (e.g., increased use of role-play in gatekeeper trainings, implementation of follow-up contact after identification at school)?														
5.1: What is the anticipated impact of using longer gatekeeper trainings instead of brief gatekeeper trainings?	X	X	X	X								X		X
5.2: What is the anticipated impact of incorporating role-playing in every brief gatekeeper training and/or booster intervention following gatekeeper training?	X	X	X	X								X		X
5.3: What is the anticipated impact of incorporating follow-up contact after identification at school?	X				X	X	X					X		X
5.4: What is the anticipated impact of implementing Zero Suicide in a number of mental health organizations?	X							X	X	X	X	X		X
EQ 6: What are the positive and negative unintended consequences of suicide prevention activities (e.g., identification and referral of at-risk adults into care)?														
6.1: What are the potential unintended consequences documented in the literature? Is there any indication of the magnitude of these consequences within GLS based on extant instruments?	X	X	X	X		X			X			X		X
6.2: How many adults are served by behavioral health providers partnering with GLS grantees? How frequently did GLS trainees use the training to work with adults at risk? How frequently did GLS trainees disseminate information from the training among their personal/professional network?	X	X	X	X		X			X			X		X

Appendix B – Secondary Data Resources

Data Source	Items Available	Years
Centers for Disease Control and Prevention - WONDER Online Databases (CDC WONDER)	<ul style="list-style-type: none"> • Compressed mortality • Multiple cause of death • Population totals • Demographic breakdowns 	1999-2017
Centers for Disease Control and Prevention - Web-based Injury Statistics Query and Reporting System (WISQARS)	<ul style="list-style-type: none"> • Fatal and nonfatal injury • Violent death • Cost of injury • National level data 	2000-2017
National Survey on Drug Use and Health (NSDUH)	<ul style="list-style-type: none"> • Substance use • Mental health • Health behaviors • State level data 	1971-2016
United States Census Bureau – Small Area Health Insurance Estimates (SAHIE)	<ul style="list-style-type: none"> • Uninsured rates 	2005-2017
United States Census Bureau – Small Area Income and Poverty Estimates - SAIPE	<ul style="list-style-type: none"> • Poverty rates 	2005-2017
Bureau of Labor Statistics – Local Area Unemployment Statistics (BLS)	<ul style="list-style-type: none"> • Unemployment rates 	1999-2017
Area Health Resources Files (AHRF)	<ul style="list-style-type: none"> • Health care providers • Health care facilities 	1999-2016
National Center for Education Statistics (NCES)	<ul style="list-style-type: none"> • Enrollment • Faculty • Institutional offerings 	
American College Health Association – National College Health Assessment (ACHA-NCHA)	<ul style="list-style-type: none"> • Substance use and mental health • Health behaviors • Membership/participation required 	
Healthy Minds Network Healthy Minds Study (Healthy Minds)	<ul style="list-style-type: none"> • Mental health and use of services • Health behaviors • Membership/participation required 	