BREAKING DOWN BARRIERS

Using Youth Suicide-Related Surveillance Data from State Systems

» TECHNICAL REPORT

SPRC | Suicide Prevention Resource Center

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Introduction

The Suicide Prevention Resource Center (SPRC), funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), is tasked with providing training and technical assistance to suicide prevention practitioners at the state, local, and provider levels. State Garrett Lee Smith Memorial Act (GLS) grantees are tasked with planning, coordinating, implementing, and evaluating suicide prevention efforts for youth aged 10–24. In order to have the broadest impact possible during the grant, SAMHSA encourages State GLS grantees to focus prevention efforts on systems that serve youth at high risk.

Research suggests that youth who are involved with juvenile justice (JJ), child welfare (CW), and public behavioral health (PBH) systems often have multiple risk factors for suicide, including a history of mental illness (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002), substance use disorders (OJJDP, 2014), physical or sexual abuse (US Department of Justice, 2009), and/or poverty (Knitzer & Lefkowitz, 2006). Despite a clear need for suicide surveillance data from these systems for prevention purposes, little is known about how or whether these systems collect suicide-related data, and the potential for data sharing between these systems and GLS grantees. For this reason, SPRC is seeking to help GLS grantees connect with JJ, CW, and PBH systems, with the goal of using data from these systems to improve suicide prevention decision making and help assess the impact of suicide prevention services (where appropriate).

To learn more about barriers, successes, and resources available for strengthening this information sharing, SPRC conducted key informant interviews with State administrators and a survey with GLS State grantees. This technical report details that research. It accompanies a paper, *Breaking Down Barriers: Using Youth Suicide-Related Surveillance Data from State Systems*[1], which was developed for SAMHSA and GLS State grantees to highlight challenges and opportunities for data sharing between youth-serving state systems and state suicide prevention efforts.

[1] Available at http://www.sprc.org/resources-programs/breaking-down-barriers-using-youth-suicide-related-surveillance-data-state

Key Informant Interviews Report

Background

Using information gathered during key informant interviews, this report explores suicide-related data collected within the juvenile justice and child welfare systems, the barriers to this collection, and data-sharing opportunities and challenges between juvenile justice and child welfare systems and state suicide prevention systems.

Methods

SPRC Prevention Specialists, working in collaboration with Garrett Lee Smith State grant directors, sought juvenile justice and child welfare administrators with an established relationship with state-level suicide prevention efforts to participate in an hour-long, semi-structured interview on suicide-related data. SPRC staff also contacted national agencies representing juvenile justice and child welfare (the Council of Juvenile Corrections Administrators and the National Association of Public Child Welfare Administrators, respectively) to gather additional tools and resources on suicide data collection and to seek additional informants.

Interviews were conducted from October through December 2015 with a total of nine administrators from five states and two national agencies. Of the nine administrators interviewed, four represented juvenile justice, four represented child welfare, and one represented a combined system of juvenile justice and child welfare.[2]

A semi-structured interview template was developed to ensure exploration of core concepts and comparability across interviews, facilitating thematic analysis. The interview template was modified slightly to accommodate each audience (i.e., state-level administrators or national-level representatives; see Appendices A and B, respectively). The format also offered flexibility for in-depth exploration of system nuances, as time allowed. The interview was recorded and was designed to cover the following topics:

1. **Data collection within juvenile justice or child welfare systems**, including how suicide-related attempt and death data are collected, stored, and managed. Informants were also asked about barriers to collecting information on suicide-related data, and how this information has been/might be used.
2. **Data sharing between the juvenile justice or child welfare systems and the suicide prevention system**, including barriers and facilitators to establishing and maintaining data-sharing system(s), potential utility of such systems, and technical assistance needs.

Although incentives were not used for participation in these interviews, participants were reminded that their participation could help other system administrators better understand data-sharing opportunities across state systems. A Ph.D.-level researcher used thematic analysis to extract common themes from interview

[2] This count does not include exploratory interviews (those conducted for the purpose of determining appropriate points-of-contact). When two or more representatives from the same agency participated on the same call, they are counted as a single administrator.

notes and transcripts. Each theme identified in this report is accompanied by the number of informants who endorsed the theme to provide supportive evidence of theme emergence.

Part I: Data Collection within Juvenile Justice and Child Welfare Systems

Description of how juvenile justice and child welfare systems collect, store, and manage information on suicide deaths.

- In the juvenile justice system, states that participate in the Performance-Based Standards system (PbS; a national, non-profit organization focused on collection of data in juvenile justice systems for continuous quality improvement purposes), collect data on death by suicide and report it in an online, national database. Definitions of "suicide" for participating state systems are uniform, based on a very inclusive definition developed by mental health experts for the PbS glossary. Within any given state, some facilities may participate in PbS while others do not, which can leave gaps in the representativeness of the data. Data are confidential, although some states share with the legislature or governor's office. In South Carolina, for example, PbS data are publicly available online (https://doc.sd.gov/documents/about/publications/PbSPublicReport2014-2015.pdf). A state's Child Death Review Board (if present) may have information on the death of justice system-involved youth.
- Child welfare informants reported that data on deaths by suicide for system-involved youth may come from the Child Death Review Board. In these cases, definitions of suicide are determined by the Medical Examiner or Coroner. In fact, the Child Death Review Board may have information on the deaths of system-involved youth, even if this information is not known to that state's CW department. For example, some states have policies where youth who have transitioned out of the CW system and subsequently die (generally within three years of receiving services) are tracked through the Child Death Review Board. However, the CW system might not know about this death unless it is well-connected with its Child Death Review Board, the death is reported through its hotline, and/or there is suspicion that it was abuse-related.

Description of how juvenile justice and child welfare systems collect, store, and manage information on suicide attempts.

- Juvenile justice informants reported that data on suicide attempts may be collected through incident reports, narratives, or "text box fields," and that this data is not collected in a systematic, required way. Systems that participate in PbS do collect information on attempts (both with and without injury), although not all states participate in PbS. PbS-participating states may also experience gaps in data, as only some facilities within a state may participate.
- All states have a State Automated Child Welfare Information System (SACWIS) with mandated reporting requirements, but these requirements do not include suicide-related reporting. CW informants reported that data on suicide attempts are generally collected though incident reports, narratives, or text box fields. As with juvenile justice, this data may not be collected in a formalized or standardized way.

Barriers to collecting suicide-related data

1. **Low occurrence of in-system deaths resulting in:**
   A. Lack of political will for prioritizing resources for suicide tracking (n = 6)
   For example, one informant stated, *"We've had a lot of big technology projects and our information tech support hasn't always been as good as it is now. It's been a resource issue. I don't know if it's been on our radar to look at suicide data in this way. I don't know that any of us have been thinking about it."* Another informant observed that incidents are *"rare,"* so *"other interests prevail."*

   B. Inconsistent use of standard data collection systems, use of informal data collection systems, or use of data collection systems that are not well developed (n = 4). Lack of prioritization has led some administrators to collect data outside of the national PbS system for cost-saving reasons, which may hinder their ability to define and systematically collect information on suicide-related attempts and deaths in the juvenile justice system. Low occurrence of in-system deaths also results in unfamiliarity with reporting protocols.

How juvenile justice and child welfare systems use suicide-related data

1. **Data are used for case management purposes (n = 2)**
   Informants described a *"very clear, immediate procedure"* for responding to attempts, reviewing data on attempts as they occur and applying system protocols, as appropriate.

Part II: Sharing Data Between Juvenile Justice, Child Welfare, and Suicide Prevention Systems

Barriers to sharing data between juvenile justice or child welfare and suicide prevention systems

1. **Need for a clear, consistent definition of suicidality (n = 7)**
   Informants agreed that a clear and consistent definition of suicidality is needed. For example, one informant stated, *"One of the challenges of collecting that kind of data is a clear definition of suicide ideation. Even suicide attempts versus cutting… you just have to be real clear on the definitions…"* Another informant observed that the collection of suicide-related information may rely on *"an individual's determination that it was an attempt at suicide,"* which limits the utility of the data. When suicide attempts are collected via incident reports, defining an incident may be *"a judgement call."* Agencies that are better equipped to deal on-site with a mental health crisis may be less apt to call in a crisis team. Because crisis team engagement typically generates an incident report, inconsistent reporting results from this variance in on-site expertise. As one informant noted, *"Operationalizing suicide attempts would be another thing because a mental health clinician might not consider cutting a suicide attempt, but you might have another staff person who codes it that way or remarks it that way in the narrative."* Consistency is also needed regarding screening. One informant reported collecting information about previous suicide attempts/thoughts in a single, compound question (e.g., a drop-down box indicating "attempts/thoughts"), making it difficult to separate attempts versus ideation.

2. **Privacy concerns (n = 6)**

Informants were concerned with violating HIPAA regulations, speaking of the need to "heavily redact" some of the data so that individuals could not be identified. Informants also spoke about a need to run reports in-system before sharing more broadly. Other informants spoke about how small numbers could contribute to the unintended release of identifiers. For example, one informant stated, *"We've got some rural counties… they might send one kid to our facilities once a year. If somebody really dug into it, they could identify who that youth was."* Some informants also spoke of a reluctance to share information that could reflect poorly on the department—what was termed as a *"head in the sand"* approach.

3. **Use of narrative systems (n = 4)**
   Informants reported that data on suicide attempts while a youth was actively in-system were not collected *"in a formalized manner"* (n = 2). Others described *"A textbox in lieu of a hard drop down or hard edit,"* meaning that pulling suicide-related data would involve qualitative analysis of case records (n = 4). Informants agreed that the use of narrative systems inhibits easy cross-system sharing.

4. **Use of home-grown data systems that might not easily connect with other state data systems (n = 2)**
   One informant described a data collection system that could not connect with other state systems because it was *"a home-built system"* that was not built in the language of the other computer programs. Another informant described a system where data were stored in manual-entry tables and documents on a protected drive within the overall behavioral health system.

5. **Need for leadership to prioritize the collection and use of the data by providing necessary resources (n = 3)**
   Informants described concerns about system capacity (complicated queries), staff time, and other resources. As one informant observed, *"We have a lot of data but no one to look at it."* Another informant, from the CW system, stated, *"We have data, but we don't know what to do with it."* Another stated that it "*takes time to build these complicated queries."* Prioritization of the project by leadership would be required to mobilize needed resources.

Utility of data if cross-sharing between juvenile justice, child welfare, and suicide prevention systems were possible

1. **Use the data to increase youth safety and management (n = 4)**
   Informants described using aggregate data to improve youth safety. One informant stated, *"It could be helpful to determine if there are any spots that are not safe, or maybe better ways of managing youth."* Another informant observed that the data might be useful for making the case for trauma-informed care, especially if the data demonstrate that this approach results in reduced injuries for staff and youth, fewer restraints, and fewer dollars needed for hospital visits.

TA needs

1. Need for strong partnerships (with mental health services, academics, and managed care). Reduced *"silos,"* and a stronger understanding of *"sister agencies"* (n = 2)

2. Help determining enhancements that could/should be made to the current system to improve collection and reporting (n = 2)

3. Resource assistance on common terms and definitions used nationally (n = 1)
4. TA that is politically sensitive, designed to meet the needs of partners where they are (n = 1)

Part III: Conclusion and Recommendations

The current report sought to use information gathered during key informant interviews with juvenile justice and child welfare administrators to explore suicide-related data collected within the juvenile justice and child welfare systems, the barriers to this collection, and data sharing opportunities and challenges between juvenile justice and child welfare systems and state suicide prevention systems.

According to informants, systematic data on in-system deaths by suicide for juvenile justice and child welfare systems may be gathered by the state Child Death Review Boards. For the juvenile justice system, data collection on attempts/ideation varies, from the easily aggregated online PbS system to less formalized, narrative-based systems relying on incident-report data. In the child welfare system, data on suicide attempts and ideation is mainly narrative-based. Juvenile justice and child welfare administrators spoke of the low priority of collecting suicide-related information as a major barrier, particularly considering the low occurrence of in-system deaths. At present, suicide-related information is mainly used for case management purposes.

Several significant barriers to data sharing between juvenile justice and child welfare and suicide prevention systems were noted by informants. Many spoke of the need for a consistent definition of suicidality and consistent protocols for collection of suicide-related information. Others spoke of privacy concerns, particularly for very rural or non-diverse communities where demographics could become unintended identifiers. Data sharing was limited by the use of narrative or home-grown data systems that do not easily connect cross-system. Data sharing also requires resources, including staff time and system capacity. Informants expressed hope that should cross-system data sharing occur, it could be useful for increasing youth safety and making the case for evidence-based responses.

This report indicates a strong need for TA to help juvenile justice and child welfare systems develop clear definitions of suicide and clear protocols for recording suicide-related data. Juvenile justice and child welfare systems need strong partners in the mental health, academic, and managed care sectors to increase available resources and help them “make the case” for collecting and using suicide-related information to inform decision making and explore outcomes. Juvenile justice and child welfare systems may benefit from the leadership of national-level stakeholders who can lead the charge for prioritization and encourage reporting consistencies.

Garrett Lee Smith State Grantee Survey Report

Background

This report describes results from a GLS State grantee survey distributed in March–May of 2016.

Methods

Participants were GLS state grantees from Cohorts 8 (n = 5), 9 (n = 16), and 10 (n = 5). These 26 sites initiated their current funding cycles in 2013, 2014, and 2015, respectively. An individual, web-based survey link was sent to the Project Director of each GLS grant, who was instructed to consult with relevant staff before submitting a single survey on behalf of his or her organization. SPRC implemented a pilot test of the online instrument in December, 2015 with two GLS sites. Corrections and clarifications were made based on the pilot test, and the full survey was released on March 15, 2016 for Cohort 8 and 9 grantees, and on April 19, 2016 for Cohort 10 grantees. Grantees were given approximately one month to complete the survey (until April 15, 2016 for Cohorts 8 and 9; until May 5, 2016 for Cohort 10).

The 42-item instrument (see Appendix C for full instrument) asked grantees to reflect on:

a. Formal and informal partnerships with JJ, CW, or PBH
b. Current implementation of suicide prevention programming in JJ, CW or PBH
c. Current level of availability and access to JJ, CW, and PBH data
d. Ease of access to JJ, CW, and PBH data (if available)
e. Current use of JJ, CW, and PBH data (if available)
f. Importance of access to data from JJ, CW, and PBH systems
g. Importance of various stakeholder partners in creating buy-in data for a state data-sharing system (i.e., a system that shares data between juvenile justice, child welfare, or public behavioral health and a GLS grant)
h. The impact of various potential barriers, including availability, funding, analytic capacity, data quality, access, political support/stakeholder buy-in, and collaboration/partnership formation on accessing and using data from JJ, CW, and PBH systems
i. Technical assistance needs (including importance and timing)
j. Utility of the SPRC Surveillance Success Stories as a resource for improving project capacity to access and use partner data
k. Other resource suggestions

Although incentives were not used for participation in these interviews, participants were reminded that their participation could help other system administrators better understand data-sharing opportunities across state systems. Social Science Research and Evaluation, Inc. (SSRE), SPRC's subcontracting agency, managed the

collection of the data for the pilot, full survey administration, and data analysis. Participants were notified that their participation was voluntary and not a requirement of their GLS grant.

Results

All five grantees in Cohort 8 responded (100%), fourteen grantees in Cohort 9 responded (88%), and three grantees in Cohort 10 responded (60%). The overall response rate across cohorts was 85% (22 of 26). Twenty-one respondents completed the entire survey and one respondent provided a partial response. This latter respondent was included in all analyses. In most cases (68%), the respondent was the GLS Project Director.

Most respondents indicated that they had an established formal or informal partnership with JJ (86%), CW (76%), and PBH (91%). Most respondents also reported implementation of suicide prevention programming in PBH systems (85%), although fewer were actually implementing suicide prevention programming in JJ systems (62%) and less than half were implementing suicide prevention programming in CW systems (48%).

Data Availability

Approximately half (50-55%) of all GLS respondents reported JJ or CW system collection of data on deaths by suicide. Less than a third of respondents (32%) knew whether their state JJ or CW systems were collecting data on suicide attempts, and very few (14%) knew whether their state JJ or CW systems were collecting data on ideation. GLS grantees generally knew more about data collection systems in public behavioral health. Nearly two-thirds (64%) indicated knowledge of system collection of data on suicide deaths, over one-third (36%) indicated knowledge of system collection of data on suicide attempts, and nearly a quarter (23%) affirmed knowledge of system collection of data on suicide ideation (see Table 1).

Table 1: Percentage of respondents indicating that their state systems collect suicide-related data (n = 22)

Does your state system collect the following data?		Unsure	No	Yes
JUVENILE JUSTICE	Data on suicidal ideation?	64%	23%	14%
	Data on suicide attempts?	50%	18%	32%
	Data on deaths by suicide?	46%	5%	50%
CHILD WELFARE	Data on suicidal ideation?	64%	23%	14%
	Data on suicide attempts?	50%	18%	32%
	Data on deaths by suicide?	36%	9%	55%
PUBLIC BEHAVIORAL HEALTH	Data on suicidal ideation?	41%	36%	23%
	Data on suicide attempts?	36%	27%	36%
	Data on deaths by suicide?	31.8%	5%	64%

Respondents did not always have access to state system data. Of those GLS respondents who reported that suicide-related data were being collected in JJ, 6 of 11 respondents had access to death data, 4 of 7 respondents had access to attempt data, and 2 of 3 respondents had access to data on suicide ideation. Of those GLS respondents who reported that suicide-related data were being collected in CW, 8 of 12

respondents had access to death data, 5 of 7 respondents had access to attempt data, and 2 of 3 respondents had access to data on suicide ideation. In contrast, all respondents who indicated that their PBH systems collect suicide-related data were able to access it. Fourteen respondents could access PBH data on deaths, 8 respondents could access data on suicide attempts, and 5 respondents could access data on ideation (see Table 2).

Table 2: Percentage (and number) of respondents whose state systems collect suicide-related data who have access to this data

As a GLS grantee, do you have access to the following data from your state's system?*		Unsure	No	Yes
JUVENILE JUSTICE	Data on suicidal ideation?	0% (n = 0)	33% (n = 1)	67% (n =2)
	Data on suicide attempts?	29% (n = 2)	14% (n = 1)	57% (n = 4)
	Data on deaths by suicide?	18% (n = 2)	27% (n = 3)	55% (n = 6)
CHILD WELFARE	Data on suicidal ideation?	33% (n = 1)	0% (n = 0)	67% (n = 2)
	Data on suicide attempts?	14% (n = 1)	14% (n = 1)	71% (n = 5)
	Data on deaths by suicide?	25% (n = 3)	8% (n = 1)	67% (n = 8)
PUBLIC BEHAVIORAL HEALTH	Data on suicidal ideation?	0% (n = 0)	0% (n = 0)	100% (n = 5)
	Data on suicide attempts?	0% (n = 0)	0% (n = 0)	100% (n = 8)
	Data on deaths by suicide?	0% (n = 0)	0% (n = 0)	100% (n = 14)

*Note: This analysis includes only those respondents who said their state systems collected this data (see Table 1).

Respondents who were able to access JJ, CW, and PBH data were asked to reflect on two to three aids that helped them access and utilize the data. Emerging themes demonstrate the importance of relationship-building for developing data infrastructure and accessing existing data. See Table 3 for a thematic analysis of qualitative responses.

Table 3: Qualitative feedback on aids that helped grantees to access and utilize suicide-related data from state JJ, CW, and PBH systems*

Please list 2-3 aids that helped you access and utilize suicide-related data from state's [JJ, CW, or PBH] system.		
System	**Theme**	**Sample Comments**
JUVENILE JUSTICE	Same Department; Collaborative Relationships; Partnerships (n = 6)	• Collaborative relationships. • Informally it was through a friend of a friend. Formally, it will be somewhat difficult. • Personal relationships with key administrators is very important. They need to put a name with a face, they also need to be assured of what you are going to use the data for. Data use for prevention and training purposes, goes much further if they don't feel like you are investigating them.
	Available through another shared data source (n = 1)	• State public health client records include client reports of contact with justice system.

CHILD WELFARE	Same Department; Collaborative Relationships; Having a "champion" (n = 7)	• The state's Family Advocate is VERY interested and invested in the issue of suicide prevention, particularly for kids in the foster care system. • Are in same department. • Current relationships with leadership teams in DCF -ongoing persistence/follow-up, making connecting with DCF to collect this information.
	Available through another shared data source (n = 1)	• This is based on public community behavioral health client database, data field "DCBS involvement".
	None (n = 1)	• There were no aids that helped in getting the data from the child welfare system.
PUBLIC BEHAVIORAL HEALTH	Relationships; Shared Division/Department (n = 9)	• Prior relationships -MOUs -leadership commitment to share the information based on shared goals. • Part of same division. • Relationship with staff in the DOH that maintains the data base, and a working relationship with the Secretary of the DOH. • The Division of Behavioral Health administers the GLS grant. The only challenging aspect was matching data on completed suicides from Vital Records to the public behavioral health database. This data merger was possible because of the positive relationships between the Division of Behavioral Health and Division of Public Health
	Available through another shared data source (n = 2)	• Client data records and ICD codes give make it possible to get more info about suicidal ideation or behavior. Agreement with Vital Statistics allow us to crosswalk client records and death data. • Regular reports at monthly meetings. Annual reports. Suicide Fatality Review Committee meetings.
	Other (n = 2)	• I have not requested the suicide data from our public behavioral health system yet.

*Qualitative information on aids was collected only from those who reported having access to JJ, CW, or PBH data. Respondents were told that by "aids," we were referring to relationships, infrastructure, agreements, system characteristics—anything that made it easier to access and/or utilize data.

Data Importance

GLS grantees were asked how important it is/would be to have access to data on suicidal ideation, attempts, and deaths in the JJ, CW, and inpatient and outpatient PBH systems. Grantees were also asked about the importance of having death records from vital statistics to allow for cross-referencing. Mean scores indicate that access to vital records is particularly important to GLS grantees (mean = 4.81), and that access to attempt and death data in the inpatient and outpatient public behavioral health system was similarly important (mean = 4.62 for deaths and attempts in the inpatient system; mean = 4.75 and 4.76 for attempts and deaths, respectively, in the outpatient system). Data on ideation generally received the lowest mean scores (4.29 for JJ, 4.33 for CW, 4.55 for PBH). In general, grantees put less importance on securing data from the JJ and CW systems. As seen in Table 4, grantees thought it was more important to get data on suicidal ideation in the PBH system than getting any data (even attempts and deaths) from JJ (mean score of 4.55 for PBH ideation, 4.52 for JJ attempts, 4.50 for JJ deaths).

Table 4: Grantee perceptions of the importance of having access to suicide-related data (ideation, attempts, and death) in JJ, CW, and PBH Systems (organized in descending mean order)

As a GLS grantee, how important is it/would it be to have access to the following data…	Not at all important	Not very important	Somewhat important	Fairly important	Very important	Mean (1 = not at all important-5 = very important)
Access to vital statistics (death) records (to allow for cross-referencing with systems records)	0.0% (0)	0.0% (0)	4.8% (1)	9.5%(2)	85.7%(18)	4.81
Data on suicide attempts in the *outpatient* PBH system?	0.0% (0)	0.0% (0)	0.0% (0)	23.8% (5)	76.2% (16)	4.76
Data on deaths by suicide in the *outpatient* PBH system?	0.0% (0)	0.0% (0)	0.0% (0)	25.0% (5)	75.0% (15)	4.75
Data on suicide attempts in the *inpatient* PBH system?	0.0% (0)	0.0% (0)	4.8% (1)	28.6% (6)	66.7% (14)	4.62
Data on deaths by suicide in the *inpatient* PBH system?	0.0% (0)	0.0% (0)	4.8% (1)	28.6% (6)	66.7% (14)	4.62
Data on suicide attempts in the CW system?	0.0% (0)	0.0% (0)	4.8% (1)	33.3% (7)	61.9% (13)	4.57
Data on deaths by suicide in the CW system?	0.0% (0)	0.0% (0)	4.8% (1)	33.3% (7)	61.9% (13)	4.57
Data on suicidal ideation in the PBH System	0.0% (0)	0.0% (0)	10.0% (2)	25.0% (5)	65.0% (13)	4.55
Data on suicide attempts in the JJ system?	0.0% (0)	0.0% (0)	4.8% (1)	38.1% (8)	57.1% (12)	4.52
Data on deaths by suicide in the JJ system?	0.0% (0)	0.0% (0)	5.0% (1)	40.0% (8)	55.0% (11)	4.50
Data on suicidal ideation in the CW system?	0.0% (0)	0.0% (0)	14.3% (3)	38.1% (8)	47.6% (10)	4.33
Data on suicidal ideation in the JJ system?	0.0% (0)	0.0% (0)	14.3% (3)	42.9% (9)	42.9% (9)	4.29

Barriers

GLS grantees were asked to reflect on the impact of several potential barriers on their ability to access and use data from JJ, CW, and PBH systems. The eight listed barriers included: (a) availability, (b) funding, (c) analytic capacity, (d) data quality, (e) access, (f) political support from suicide prevention, (g) political support from system administration, and (h) collaboration/partnership formation. As seen in Table 5, availability and data quality received the highest mean score, indicating the greatest impact.

Table 5: Grantee perceptions of the impact of eight common barriers in access and utilizing data from JJ, CW, and PBH Systems

How much of an impact do the following barriers have on your ability to access and use data from your state's [JJ, CW, PBH] system?	Mean Score 1 = "No impact"; 5 = "A great deal of impact" *		
	Juvenile Justice	Child Welfare	Public Behavioral Health
Availability	4.13	4.13	3.33
Funding	3.79	3.43	3.06
Analytic Capacity	3.31	3.33	2.94
Data Quality	4.33	4.13	3.67
Access	3.81	3.17	3.06
Political Support/Stakeholder Buy-In from suicide prevention administration	3.50	3.36	2.88
Political Support/Stakeholder Buy-In from [JJ, CW, PBH]	3.77	3.40	3.00
Collaboration/Partnership Formation	3.75	3.36	3.00

* Options also included "unknown." These were calculated to "missing" for the calculation of the mean.

Qualitative Additions: "Staff time to pull the data requested" (n = 1, JJ, CW, and PBH); Restrictions on data sharing in the state's mental health code (n = 1, PBH)

Technical Assistance Needs and Existing Resources

GLS grantees were asked whether their site has (or anticipates having over the period of the grant) TA needs related to accessing or using data from JJ, CW, or PBH systems. As indicated in Figure 1, most grantees reported not needing TA in this area over the period of their grant. Of those who did report needing TA (n = 6), most (n = 5) identified TA in JJ and CW as a "medium" need. Half of those who reported needing TA (n = 3) had a "high need" for TA in accessing and utilizing data from the PBH system (see Table 5). As indicated in Table 6, those with TA needs generally do not anticipate having immediate needs. (Only one respondent identified TA in each of these systems as an "immediate need.") Among those who need TA, the biggest need is for helping partners improve the quality of the data that they collect related to suicide (see Table 7).

Figure 1: Number and percent of GLS Grantees who report needing TA on accessing or utilizing data from JJ, CW, or PBH over the grant period

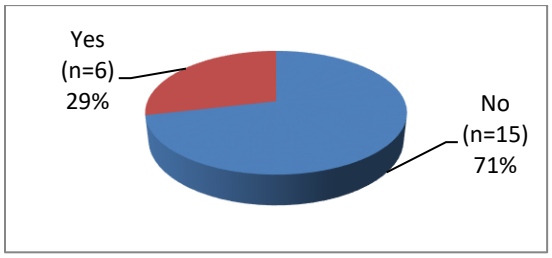

Table 5: Degree of perceived need among grantees who reported needing TA in JJ, CW, or PBH (n = 6)

Please rate your site's overall level of TA need in accessing and utilizing data from the following systems…	Not a need	Low	Medium	High
Juvenile Justice System	0.0% (0)	0.0% (0)	83.3% (5)	16.7% (1)
Child Welfare System	0.0% (0)	0.0% (0)	83.3% (5)	16.7% (1)
Public Behavioral Healthcare System	16.7% (1)	16.7% (1)	16.7% (1)	50.0% (3)

Table 6: Timing of perceived need among grantees who reported needing TA in JJ, CW, or PBH (n = 6)

Please specify the timing of your site's need for technical assistance in the following systems…	Immediate need	Need in the next 6 - 12 months	Need in the next 12+ months
Juvenile Justice System	16.7% (1)	50.0% (3)	33.3% (2)
Child Welfare System	16.7% (1)	50.0% (3)	33.3% (2)
Public Behavioral Healthcare System	25.0% (1)	75.0% (3)	0.0% (0)

Table 7: Type of perceived need among grantees who reported needing TA in JJ, CW, or PBH

Please rate your site's overall anticipated level of need for TA in each of the following areas:	Priority of Need				
	Not a need	Low	Medium	High	Mean (1= not a need; 4 = high need)
Increasing funding for accessing and utilizing data from partners	0.0% (0)	0.0% (0)	66.7% (4)	33.3% (2)	3.33
Increasing staff capacity to manage and analyze data from partners	0.0% (0)	0.0% (0)	50.0% (3)	50.0% (3)	3.50
Helping partners improve the quality of the data that they collect related to suicide	0.0% (0)	0.0% (0)	16.7% (1)	83.3% (5)	3.83
Gaining access to partner data	0.0% (0)	0.0% (0)	66.7% (4)	33.3% (2)	3.33
Building political support and stakeholder buy-in for cross-system data sharing	0.0% (0)	0.0% (0)	66.7% (4)	33.3% (2)	3.33
Increasing staff knowledge on how to use data from partners for planning and impact measurement purposes	0.0% (0)	33.3% (2)	33.3% (2)	33.3% (2)	3.00
Assistance in collaboration/partnership formation	0.0% (0)	40.0% (2)	60.0% (3)	0.0% (0)	2.60

GLS grantees were also asked about the utility of SPRC's Surveillance Success Stories, which highlight successes in accessing data from government agencies, community mental health centers, Medicaid, vital statistics, and other partners. Most respondents found these resources to be at least "somewhat useful" (see Table 8).

Table 8: Grantee perception of the utility of SPRC's Surveillance Success Stories

SPRC has released a series of "Surveillance Success Stories", highlighting GLS grantee successes in accessing data from government agencies, community mental health centers, Medicaid, vital statistics, and other partners. How useful have these success stories been in improving the capacity of your project to access and use partner data?	Total %
I do not recall the "Surveillance Stories" (n=2)	10.5%
Not At All Useful (n=0)	0.0%
Not Very Useful (n=2)	10.5%
Somewhat Useful (n=8)	42.1%
Mostly Useful (n=4)	21.1%
Very Useful (n=3)	15.8%

Part III: Conclusions and Recommendations

The current report describes the results of a GLS State grantee survey that explored states' availability and access to JJ, CW, and PBH data; barriers to access; and technical assistance needs. It is part of a broader effort to help connect GLS grantees with JJ, CW, and PBH data systems to improve suicide prevention decision making and help assess the impact of suicide prevention services.

Although GLS State grantees were somewhat familiar with data collection systems in state public health systems (64% knew whether this system collected information on death by suicide), respondents did not generally know whether their state JJ or CW systems collected information on suicide attempts or deaths. *This indicates that a "first step" for connecting GLS grantees with state-system data may be simply to help them make connections with their JJ or CW system, to determine which data are being collected, how data are being*

collected, and who is collecting it. In public behavioral health, GLS grantees were universally able to gain access to existing data, but this was not true in JJ and CW, where availability of data did not always guarantee access.

Grantees indicated that access to vital records and suicide-related attempt and death data from PBH systems is particularly important to their initiatives, but placed less importance on accessing data from CW and JJ. In fact, the data suggest that grantees thought it was more important to get data on suicidal ideation in the PBH system than getting any data (even attempts and deaths) from JJ. This speaks to a need for increasing grantee motivation to work with JJ in particular. Data quality and availability were some of the largest barriers in accessing data from youth-serving systems.

Few GLS State grantees reported needing TA in accessing and utilizing suicide-related data from youth-serving systems over the period of the grant, although SAMHSA has identified this as a priority for State GLS-funded initiatives. Of those GLS grantees who reported needing TA in this area, helping partners improve the quality of suicide-related data collected was of particular importance. This indicates that *an important "next step" for connecting GLS grantees with state-system data may be to help them strengthen the infrastructure of these systems to collect data in a way that can be shared and is of high quality. Infrastructure-building is a focus of many of the resources included in "Breaking Down Barriers: Using Youth Suicide-Related Surveillance Data from State Systems," the broader SPRC report.*

References

Knitzer, J., & Lefkowitz, J. (2006). Helping the most vulnerable infants, toddlers, and their families. *Pathways to Early School Success Issue Brief No. 1.* New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

Office of Juvenile Justice and Delinquency Prevention. (2014, December). *Juvenile offenders and victims: 2014 national report.* Washington, DC: National Center for Juvenile Justice. Retrieved from: http://www.ojjdp.gov/ojstatbb/nr2014/downloads/NR2014.pdf

Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 59*(12), 1133-1143.

U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. (2009, October). *Children's exposure to violence: A comprehensive national survey.* Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/227744.pdf.

Appendix A: Key Informant Instrument for State-Level Administrators

Interview Guide: Understanding Connections between Juvenile Justice, Child Welfare or Public Behavioral Health Systems and Suicide Prevention

This interview template was developed to collect information on suicide-related data collection, use and sharing between state suicide prevention systems and SAMHSA's identified priority systems of juvenile justice, child welfare, and public behavioral health. The semi-structured format of this interview template ensures that core concepts are explored and that there is comparability across interviews, facilitating thematic analysis. The format also offers flexibility for in-depth exploration of system nuances, as time allows.

Interviewer(s): _____
Time: _____
Date: _____
Respondent (name, title, state): _____

Section 1: Introduction of Project and Project Purpose

The Suicide Prevention Resource Center (SPRC) is a national resource center supported by the Substance Abuse and Mental Health Services Administration, or SAMHSA. We provide training and technical assistance to suicide prevention practitioners and help organizations make connections to inform suicide prevention efforts. Because youth involved in [juvenile justice/child welfare/ public behavioral health systems] are at higher risk for suicide attempts and death, we are interested in helping state suicide prevention systems link with [juvenile justice/child welfare/public behavioral health] systems to share data to improve suicide prevention decision making and to help assess the impact of suicide prevention efforts. The purpose of this interview is to find out about the suicide-related data collected within [State's] [juvenile justice/child welfare/public behavioral health] system, the barriers to collecting it, and also to learn about data sharing between your system and the state suicide prevention system. Information you provide during this interview will be combined with interviews from informants in other states and analyzed to generate themes and case examples. These themes and case examples will be used to develop a report for SAMHSA and our state clients to highlight challenges and opportunities for data sharing with suicide prevention systems. The interview should take about an hour of your time.
(Pause for Questions)

We're hoping to record this interview in case we don't get everything into our notes. We would not share the interview recording outside of SPRC, and would destroy the recordings within a year after the end of the project.

(Pause for Questions)

(Start recording). Could you just confirm, now that I've started the recording, that you agree to have this interview be recorded?

Section 2: Data Collection within System

1a. Let's start by talking about data collection within your system. Have you previously or do you currently collect data within your system on suicide attempts?

1b. Have you previously or do you currently collect data within your system on deaths from suicide?

IF YES to 1a OR 1b:

Content *Ask separately for attempts and deaths, if applicable. Use past-tense if collected in the past, but not currently collecting.*)

- Tell me about that data. How do you define suicide attempts? How do you define death by suicide? Do you include preparatory self-directed violence? What other information do you collect on attempts – e.g., Demographics? Event

information like resultant injury, concurrent substance use, mechanism? What information do you collect on death by suicide?

Format/Collection (*Ask separately for attempts and deaths, if applicable. Use past-tense if collected in the past, but not currently collecting.*)

- Who collects the data?
- From whom is the data collected?
- In what format (e.g., electronic, paper)?
- How is it stored and managed (e.g., In what platform? Who controls it? Who collects it? How? Who enters it?)?
- How long have you been collecting suicide-related data in this way?

Utility

- How have you analyzed the data that you've collected (e.g., by demographics)? Have you produced products illustrating your findings? Who have you communicated your findings to?
- How have you used/How do you plan to use the data (e.g., for planning? To show impact?)?
- How useful has the data been?

Assistance

- Did you receive any technical assistance/peer sharing/other help when setting up your system for collecting suicide-related data? From whom? How was it helpful?
- Is there additional technical assistance that would be helpful as you seek to optimize your data collection system (Content? Format? Analysis needs?)?

IF NO to 1a OR 1b (or if collected in the past, but not currently collecting):

Barriers

- What are the barriers to collecting suicide-related information?

Utility

- If you were to collect this data, who do you think would use it and how (e.g., planning, impact)?
- Why would it be important to you to collect this data?

Assistance

- If you are interested in setting up a system for collecting suicide-related data, what assistance might be helpful to you (Content? Format?)?

Section 3: Data Sharing and Data Sharing Opportunities

2a. Next, let's talk about your connections with the suicide prevention system in your state. Are you connected with your state's suicide prevention system (or your state's Garrett Lee Smith grantee) in any way, even if it doesn't relate to data? If so, could you describe that connection?

2b. Does that connection extend to data sharing?

IF YES to 2b:

Set-up

- When you decided to start sharing suicide-related data, who did you need to consult to decide to do this or get approval, and what systems did you need to have in-place (e.g., formalized agreements)?

- Who helped facilitate this? What partners were involved in the project? What was the involvement of state leadership?
- What funds, if any, were used to share the data? Where did these come from?
- Were there technical challenges in sharing this data? (e.g., Did you have difficulties trying to match identifiers across systems?)

Utility

- How has the data benefited your suicide prevention activities?

Barriers and technical assistance

- What were some of the barriers to sharing suicide-related data that you had to overcome? How did you overcome these barriers?
- Did you receive any technical assistance/peer sharing/other help when setting up your data sharing system? From whom? How was it helpful? Are there resources you can share/direct us to?
- Is there additional technical assistance that would be helpful as you seek to optimize your system for sharing data (Content? Format?)?

IF NO to 2b:

Set-up

- What barriers would you anticipate to sharing suicide-related data across systems? How could you overcome these barriers?
- If you decided to start sharing suicide-related data, who would you need to consult and what systems would you need to have in-place (e.g., formalized agreements)?
- Who could help facilitate this? What partners would be most beneficial? How might state leadership be involved?
- Would additional funds be required to facilitate data sharing?
- What would be some of the technical challenges in sharing this data?

Utility

- If you were to cross-share across systems, how might you use the data (e.g., for planning? To show impact?)? How could data sharing benefit your suicide prevention activities? Are there any other benefits you see?

Technical Assistance

- If you opted to share data across systems, what technical assistance would you need (Content? Format?)?

Section 4: Additional Comments and Conclusion

3. Is there any additional information that you'd like to add to help us better understand how to foster data sharing between state suicide prevention systems and your system?

4. Are you comfortable with SPRC using your program as a case study for this work? [Please share the following with interviewee: We will send you drafts of any materials we produce using your story so you have time to review and feel comfortable with the content. If interviewee is reluctant to be used as a case study, offer a de-identified case study presentation. That is, we can use the learnings from their story without identifying their program.]

Appendix B: Key Informant Instrument for System-Level Administrators

Interview Guide: Understanding Connections between Juvenile Justice, Child Welfare or Public Behavioral Health Systems and Suicide Prevention Developed for use with National Agency Representatives

This interview template was developed to collect information on suicide-related data collection, use and sharing between state suicide prevention systems and SAMHSA's identified priority systems of juvenile justice, child welfare, and public behavioral health. The semi-structured format of this interview template ensures that core concepts are explored and that there is comparability across interviews, facilitating thematic analysis. The format also offers flexibility for in-depth exploration of system nuances, as time allows.

Interviewer(s): _____
Time: _____
Date: _____
Respondent (name, title, state): _____

Section 1: Introduction of Project and Project Purpose

The Suicide Prevention Resource Center (SPRC) is a national resource center supported by the Substance Abuse and Mental Health Services Administration, or SAMHSA. We provide training and technical assistance to suicide prevention practitioners and help organizations make connections to inform suicide prevention efforts. Because youth involved in [juvenile justice/child welfare] systems are at higher risk for suicide attempts and death, we are interested in helping state suicide prevention systems link with [juvenile justice/child welfare] systems to share data to improve suicide prevention decision making and to help assess the impact of suicide prevention efforts. The purpose of this interview is to explore, from a the viewpoint of a national agency representative, the challenges, benefits, and TA needs associated with collecting suicide-related data within [juvenile justice/child welfare] systems and the challenges, benefits, and TA needs related to sharing that data across state systems. Information you provide during this interview will be combined with interviews from informants in other states and analyzed to generate themes and case examples. These themes and case examples will be used to develop a report for SAMHSA and our state clients to highlight challenges and opportunities for data sharing with suicide prevention systems. The interview should take about an hour of your time.
(Pause for Questions)

We're hoping to record this interview in case we don't get everything into our notes. We would not share the interview recording outside of SPRC, and would destroy the recordings within a year after the end of the project.

(Pause for Questions)

(Start recording). Could you just confirm, now that I've started the recording, that you agree to have this interview be recorded?

Section 2: Data Collection within System

1a. Let's start by talking about data collection within the [juvenile justice/child welfare] field. From your perspective as a national agency representative, do most [juvenile justice/child welfare] systems collect data on suicide attempts?

1b. From your perspective as a national agency representative, do most [juvenile justice/child welfare] systems collect data on deaths by suicide?

- *If YES to 1a OR 1b:*

  Content, format, and collection *Ask separately for attempts and deaths, if applicable.*

- Are there any common themes in…
    - How most systems collect that data?
    - How most systems store and manage that data (e.g., the systems and format they use)?
    - How most systems analyze and use that data?
    - How most systems define "suicide attempt" or "death by suicide"?

If yes (to any), please describe.

2. Barriers

- For state systems that are not currently collecting suicide-related data, what are some of the barriers to collecting that information that might be common across state [juvenile justice/child welfare] systems?

3. Utility

- How might the collection of suicide-related data be useful/How IS the collection of suicide-related data useful for the [juvenile justice/child welfare] system? Who would/does use this data? Why would it be/is it important for state systems to collect this data?

4. Assistance

- If a [juvenile justice/child welfare] state system were interested in setting up a system for collecting suicide-related data, what assistance do you think would be most helpful to them?
- As a national agency, do you (or a related agency) provide guidance to [juvenile justice/child welfare] systems on data collection (e.g., recommended data fields, common definitions)? If yes, please describe. As a national agency, do you (or a related agency) provide guidance to [juvenile justice/child welfare] systems on data collection as it relates to suicide (e.g., recommended data fields, common definitions)? What additional assistance might be useful to you?

Section 4: Data Sharing and Data Sharing Opportunities

5. Next, let's talk about connections with the suicide prevention system. From your perspective as a national agency representative, have most [juvenile justice/child welfare] systems formed connections with their state's suicide prevention system, even if it doesn't relate to data? If so, could you describe some of the more notable connections that have been made?*

6. Based on your knowledge, are there any [juvenile justice/child welfare] systems that have formed strong data-sharing connections with their state's suicide prevention system?*

7. What would be (or what have you seen to be) the benefits to forming data-sharing connections with the suicide prevention system? Who would use/has used this data and how?

8. What would be the barriers to forming data-sharing connections with a state suicide prevention system?

9. What technical assistance would [juvenile justice/child welfare] systems need to set up and put into effect data sharing with the BH system?

*Ask for referral to that state's [juvenile justice/child welfare] representative

Section 5: Additional Comments and Conclusion

10. Is there any additional information that you'd like to add to help us better understand how to foster data sharing between state suicide prevention systems and [juvenile justice/child welfare] systems?

11. Are you comfortable with SPRC quoting you, as a national agency representative, in our final report? [Please share the following with interviewee: We will send you drafts of any materials we produce using your story so you have time to review and feel comfortable with the content. If interviewee is reluctant to be quoted, offer de-identified quotations. That is, we can use the learnings from their interview without identifying information.]

Appendix C: Accessing and Utilizing Suicide Data from Juvenile Justice, Child Welfare, and Public Behavioral Healthcare Systems: A State GLS Grantee Survey

Section 1: Grantee Information

1. Please provide the following information for the individual completing this survey.
   a. First and Last Name: [text]
   b. Email Address: [text]
   c. Please select your GLS grant site from the drop-down list below: [menu]
   d. What is your role in the GLS project? [choose one]
      a. GLS Project Director
      b. GLS Project Evaluator or Epidemiologist
      c. I prefer not to answer
      d. Other GLS Staff (specify) [text]

Section 2: Existing Partnerships

Our first few questions will ask about partnerships with your state's juvenile justice, child welfare, and public behavioral health system. By "partnership", we mean a formal or informal arrangement where you exchange information and/or resources with another state system to meet mutual goals. This "partnership" could include arrangements with either the whole system or with just part of that system. The "partnership" does not have to be data-related. By "public behavioral health system" we are referring to your state's publicly-funded system for providing treatment for substance use disorders and mental illness, both inpatient and outpatient.

2. As a GLS grantee, do you have an established formal or informal partnership with… [choose one per row]

a. Your state's juvenile justice system?	**No**	**Yes**
b. If yes, please describe the nature of the partnership: [text]		
c. Your state's child welfare system:	**No**	**Yes**
d. If yes, please describe the nature of the partnership: [text]		
e. Your state's public behavioral health system:	**No**	**Yes**
f. If yes, please describe the nature of the partnership: [text]		

3. As a GLS grantee, are you implementing suicide prevention programming in… [choose one per row]

a. Your state's juvenile justice system?	**No**	**Yes**
b. If yes, please describe the suicide prevention programming that you are implementing in this system: [text]		
c. Your state's child welfare system?	**No**	**Yes**
d. If yes, please describe the suicide prevention programming that you are implementing in this system: [text]		
e. Your state's public behavioral health system?	**No**	**Yes**
f. If yes, please describe the suicide prevention programming that you are implementing in this system: [text]		

Section 3: Data in the Juvenile Justice System

The next few questions ask about availability of and access to data in your state's juvenile justice system.

4. Does your state's **juvenile justice** system collect the following data? [choose one per row]

	Unsure	No	Yes
a. Data on suicidal ideation?			
b. Data on suicide attempts?			
c. Data on death by suicide?			
d. Any other suicide-related data?			

If NO or UNSURE to 4a through 4d, SKIP to Question 10; If YES to any go to Q6.

5. Please describe what other suicide-related data your state's **juvenile justice** system collects. [**ONLY IF Q4d is "Yes"**] [text]

6. As a GLS grantee, do you have **access** to the following data from your state's **juvenile justice system**? [choose one per row]

	Unsure	No	Yes
a. Data on suicidal ideation?			
b. Data on suicide attempts?			
c. Data on death by suicide?			
d. Any other suicide-related data?			
If yes (to any), please describe: [text]			

If NO to 6a through 6d, SKIP to Question 10; If YES to any go to Q7.

7. As a GLS grantee, how easy was it for you to access your state's **juvenile justice system** data? [choose one]
   a. Very difficult b. Somewhat difficult c. Neither easy nor difficult d. Somewhat easy e. Very easy

8. Please list 2-3 aids that helped you access and utilize suicide-related data from state's **juvenile justice system**. By "aids" we are referring to relationships, infrastructure, agreements, system characteristics – anything that made it easier for you to access and/or utilize data. [text]

9. As a GLS grantee, how have you used data from your state's **juvenile justice system** to inform your suicide prevention efforts? [select all that apply]
   a. For planning prevention, intervention and/or postvention activities.
   b. To assess impact of suicide prevention services.
   c. For case management purposes.
   d. We have not used these data to inform our suicide prevention efforts.
   e. Unsure/Don't know
   f. Other (please describe): [text]

Section 4: Data in the Child Welfare System

The next few questions are about availability of and access to data in your state's child welfare system.

10. Does your state **child welfare** system collect the following data? [choose one per row]

	Unsure	No	Yes
a. Data on suicidal ideation?			
b. Data on suicide attempts?			

c. Data on death by suicide?			
d. Any other suicide-related data?			

If NO to 10a through 10d, SKIP to Question 16; If YES to any go to Q12.

11. Please describe what other suicide-related data your state's **child welfare** system collects. [**ONLY IF Q10d is "Yes"**] [text]

12. As a GLS grantee, do you have **access** to the following data from your state's **child welfare system**? [choose one per row]

	Unsure	No	Yes
a. Data on suicidal ideation?			
b. Data on suicide attempts?			
c. Data on death by suicide?			
d. Any other suicide-related data?			
If yes (to any), please describe: [text]			

If NO to 12a through 12d, SKIP to Question 16; If YES to any go to Q13.

13. As a GLS grantee, how easy was it for you to access your state's **child welfare system** data? [choose one]
    b. Very difficult b. Somewhat difficult c. Neither easy nor difficult d. Somewhat easy e. Very easy

14. Please list 2-3 aids that helped you access and utilize suicide-related data from state's **child welfare system**. By "aids" we are referring to relationships, infrastructure, agreements, system characteristics – anything that made it easier for you to access and/or utilize data. [text]

15. As a GLS grantee, how have you used data from your state's **child welfare system** to inform your suicide prevention efforts? [select all that apply]

a. For planning prevention, intervention and/or postvention activities.
b. To assess impact of suicide prevention services.
c. For case management purposes.
d. We have not used these data to inform our suicide prevention efforts.
e. Unsure/Don't know
f. Other (please describe): [text]

Section 5: Data in the Public Behavioral Health System

The next few questions are about availability of and access to data in your state's public behavioral health system.

16. Does your state **public behavioral health** system collect the following data? [choose one per row]

	Unsure	No	Yes
a. Data on suicidal ideation?			
b. Data on suicide attempts?			
c. Data on death by suicide?			
d. Any other suicide-related data?			

If NO to 16a through 16d, SKIP to Question 22; If YES to any go to Q18.

17. Please describe what other suicide-related data your state's **public behavioral health** system collects.
[**ONLY IF Q16d is "Yes"**] [text]

18. As a GLS grantee, do you have **access** to the following data from your state's **public behavioral health system**? [choose one per row]

	Unsure	No	Yes
a. Data on suicidal ideation?			
b. Data on suicide attempts?			
c. Data on death by suicide?			
d. Any other suicide-related data?			
If yes (to any), please describe: [text]			

If NO to 18a through 18d, SKIP to question 22.

19. As a GLS grantee, how easy was it for you to access your state's **public behavioral health system** data? [choose one]

a. Very difficult b. Somewhat difficult c. Neither easy nor difficult d. Somewhat easy e. Very easy

20. Please list 2-3 aids that helped you access and utilize suicide-related data from state's **public behavioral health system**. By "aids" we are referring to relationships, infrastructure, agreements, system characteristics – anything that made it easier for you to access and/or utilize data. [text]

21. As a GLS grantee, how have you used data from your state's **public behavioral health system** to inform your suicide prevention efforts? [select all that apply]

a. For planning prevention, intervention and/or postvention activities.
b. To assess impact of suicide prevention services.
c. For case management purposes.
d. We have not used these data to inform our suicide prevention efforts.
e. Unsure/Don't know
f. Other (please describe): [text]

Section 6: Importance of Data Access

22. As a GLS grantee, how important is it/would it be to have access to the following data… [choose one per row]

	Not at all important	Not very important	Somewhat important	Fairly important	Very important
a. Data on suicidal ideation in the juvenile justice system?					
b. Data on suicide attempts in the juvenile justice system?					
c. Data on deaths by suicide in the juvenile justice system?					
d. Data on suicidal ideation in the child welfare system?					
e. Data on suicide attempts in the child welfare system?					
f. Data on deaths by suicide in the child welfare system?					
g. Data on suicidal ideation in the public behavioral health system?					
h. Data on suicide attempts in the *outpatient* public behavioral health system?					

i.	Data on deaths by suicide in the *outpatient* public behavioral health system?					
j.	Data on suicide attempts in the *inpatient* public behavioral health system?					
k.	Data on deaths by suicide in the *inpatient* public behavioral health system?					
l.	Comments: [text]					

23. As a GLS grantee, how important is it/would it be to have access to vital statistics (death) records (to allow for cross-referencing with the systems records listed above)? [choose one]

a. Not at all important
b. Not very important
c. Somewhat important
d. Fairly important
e. Very important

Section 7: Barriers and Facilitators to Cross-System Data Sharing

In this section, we will be asking about barriers and facilitators for sharing data between GLS grantees and state systems.

24. How important would each of the following **stakeholders** be for **creating buy-in** for a data-sharing system in your state (e.g., a system that shares data between juvenile justice, child welfare, or public behavioral health and your GLS grant)? (NOTE: *If you already have data-sharing systems in-place, how important ARE each of the following stakeholders?*) [choose one per row]

	Not at all important	Not very important	Somewhat important	Fairly important	Very important
a. Administrators (from the juvenile justice, child welfare, and/or public behavioral health systems)					
Comments: [text]					
b. Health Department Epidemiologist					
Comments: [text]					
c. State Epidemiological Workgroups/State Data and Surveillance Teams					
Comments: [text]					
d. Government officials (e.g., Governor, local mayors)					
Comments: [text]					
e. Support staff for data collection, management, and analysis					
Comments: [text]					
f. System Consumers/Consumer advocates (e.g., child welfare advocates, system-involved youth)					
Comments: [text]					
g. Other (please list and rate): [text]					
Comments: [text]					

The next series of questions ask about barriers on your ability to access and use data from your state's *Juvenile Justice System*.

25. How much of an impact do the following barriers have on your ability to access and use data from your **state's juvenile justice system**? (*Note: If you already access and use data from juvenile justice, please think back on the barriers you needed to overcome to access and use this data*.) [choose one per row]

	Unknown impact	No impact	Not very much impact	Some impact	A fair amount of impact	A great deal of impact
a. **Availability** (e.g., the system does not collect the data, or collects the data in a format that is difficult to use – like in narrative format)						
b. **Funding** (e.g., funding for data analysis; funding for data collection)						
c. **Analytic Capacity** (e.g., existing staff capacity for data collection and analysis and/or establishing a partnership with a local university or data analyst)						
d. **Data Quality** (e.g., inconsistent definitions of "suicide"; underreporting; missing data; low incidence/prevalence)						
e. **Access** (e.g., lack of MOUs or other avenues to support cross-system sharing; confidentiality/HIPAA concerns)						
f. **Political Support/Stakeholder Buy-In from suicide prevention administration** (e.g., Lack of political will/administrative support for cross-system data sharing with Juvenile Justice; questions about the utility of data sharing; competing priorities)						
g. **Political Support/Stakeholder Buy-In from Juvenile Justice** (e.g., Lack of political will/administrative support for cross-system data sharing; questions about the utility of data sharing; competing priorities)						
h. **Collaboration/Partnership Formation** (e.g., administration turn-over; difficulty "getting the appropriate people to the table")						
i. **Other (please rate and specify):** [text]						

The next series of questions ask about barriers on your ability to access and use data from your state's *Child Welfare System*.

26. How much of an impact do the following barriers have on your ability to access and use data from your **state's child welfare system**? (*Note: If you already access and use data from the child welfare system, please think back on the barriers you needed to overcome to access and use this data*.) [choose one per row]

	Unknown impact	No impact	Not very much impact	Some impact	A fair amount of impact	A great deal of impact
a. **Availability** (e.g., the system does not collect the data, or collects the data in a format that is difficult to use – like in narrative format)						
b. **Funding** (e.g., funding for data analysis; funding for data collection)						
c. **Analytic Capacity** (e.g., existing staff capacity for data collection and analysis and/or establishing a partnership with a local university or data analyst)						
d. **Data Quality** (e.g., inconsistent definitions of "suicide"; underreporting; missing data; low incidence/prevalence)						
e. **Access** (e.g., lack of MOUs or other avenues to support cross-system sharing; confidentiality/HIPAA concerns)						
f. **Political Support/Stakeholder Buy-In from suicide prevention administration** (e.g., Lack of political will/administrative support for cross-system data sharing with Child Welfare; questions about the utility of data sharing; competing priorities)						
g. **Political Support/Stakeholder Buy-In from Child Welfare** (e.g., Lack of political will/administrative support for cross-system data sharing; questions about the utility of data sharing; competing priorities)						
h. **Collaboration/Partnership Formation** (e.g., administration turn-over; difficulty "getting the appropriate people to the table")						
i. **Other (please rate and specify):** [text]						

The next series of questions ask about barriers on your ability to access and use data from your state's *Public Behavioral Health System*.

27. How much of an impact do the following barriers have on your ability to access and use data from your **state's public behavioral healthcare system**? (*Note: If you already access and use data from the public behavioral healthcare system, please think back on the barriers you needed to overcome to access and use this data*.)

	Unknown impact	No impact	Not very much impact	Some impact	A fair amount of impact	A great deal of impact
a. **Availability** (e.g., the system does not collect the data, or collects the data in a format that is difficult to use – like in narrative format)						
b. **Funding** (e.g., funding for data analysis; funding for data collection)						
c. **Analytic Capacity** (e.g., existing staff capacity for data collection and analysis and/or establishing a partnership with a local university or data analyst)						
d. **Data Quality** (e.g., inconsistent definitions of "suicide"; underreporting; missing data; low incidence/prevalence)						
e. **Access** (e.g., lack of MOUs or other avenues to support cross-system sharing; confidentiality/HIPAA concerns)						
f. **Political Support/Stakeholder Buy-In from suicide prevention administration** (e.g., Lack of political will/administrative support for cross-system data sharing with Public Behavioral Health; questions about the utility of data sharing; competing priorities)						
g. **Political Support/Stakeholder Buy-In from Public Behavioral Health** (e.g., Lack of political will/administrative support for cross-system data sharing; questions about the utility of data sharing; competing priorities)						
h. **Collaboration/Partnership Formation** (e.g., administration turn-over; difficulty "getting the appropriate people to the table")						
i. **Other (please rate and specify):** [text]						

Section 8: Technical Assistance Needs

	No	Yes
28. Does your site have (or anticipate having over the period of the GLS grant) TA needs related to accessing or utilizing data from Juvenile Justice, Child Welfare, or the Public Behavioral Healthcare Systems? [choose one]		

If NO, SKIP to Question 35.

29. Please rate your site's overall level of TA need in accessing and utilizing data from the following systems… [choose one per row]	Not a need	Low	Medium	High
Juvenile Justice System				
Child Welfare System				
Public Behavioral Healthcare System				

If all are "Not A Need", SKIP to Question 34. Questions 30 – 32 appear, as needed, based on Q29.

30. Please describe your TA needs on accessing and utilizing data from the **Juvenile Justice** system. [text]

31. Please describe your TA needs on accessing and utilizing data from the **Child Welfare** system. [text]

32. Please describe your TA needs on accessing and utilizing data from the **Public Behavioral Healthcare** system. [text]

Rows in Question 33 appear for all rows in Q29 where the answer is "Low," "Medium," or "High".

33. Please specify the timing of your site's need for technical assistance in the following systems… [choose one per row]	Immediate Need	Need in 6-12 months	Need in 12+ months
Juvenile Justice System			
Child Welfare System			
Public Behavioral Healthcare System			

34. Please rate your site's overall anticipated level of need for TA in each of the following areas: [choose one per row]

	Priority of Need			
	Not a need	Low	Medium	High
a. Increasing funding for accessing and utilizing data from partners				
b. Increasing staff capacity to manage and analyze data from partners				
c. Helping partners improve the quality of the data that they collect related to suicide				
d. Gaining access to partner data				
e. Building political support and stakeholder buy-in for cross-system data sharing				
f. Increasing staff knowledge on how to use data from partners for planning and impact measurement purposes				
g. Assistance in collaboration/partnership formation				
h. Other (please rate and specify): [text]				

Section 9: Conclusion

35. SPRC has released a series of "Surveillance Success Stories", highlighting GLS grantee successes in accessing data from government agencies, community mental health centers, Medicaid, vital statistics, and other partners. How useful have these success stories been in improving the capacity of your project to access and use partner data? [choose one]

a. I do not recall the "Surveillance Success Stories"
b. Not at all useful
c. Not very useful
d. Somewhat useful
e. Mostly useful
f. Very useful

36. Think about your grant site's experience on data sharing with the following systems. Do you have any experience, lessons learned, or materials that you would be willing to share with other grantees that could benefit their work? [choose one per row]

	No	Yes
Juvenile Justice System		
Child Welfare System		
Public Behavioral Healthcare System		

Questions 37-39 appear only for items in Question #35 where the response was "Yes."

37. Please describe the experience, lessons learned, or materials that you would be willing to share with other grantees that could benefit their work related to your experience sharing data with the **juvenile justice system**? [text]

38. Please describe the experience, lessons learned, or materials that you would be willing to share with other grantees that could benefit their work related to your experience sharing data with the **child welfare system**? [text]

39. Please describe the experience, lessons learned, or materials that you would be willing to share with other grantees that could benefit their work related to your experience sharing data with the **public behavioral health system**? [text]

40. Would you be willing to be contacted by SPRC Staff to answer any additional questions or for a more in-depth interview on your cross-system data sharing? [choose one]

No	Yes

41. Who else provided input in completing this survey [choose all that apply]

a. I did not receive additional staff assistance in completing this survey
b. GLS Project Director
c. GLS Project Evaluator or Epidemiologist
d. Other GLS Staff (specify) [text]
e. Other (specify) [text]

42. Additional thoughts/comments (anything we didn't ask you about that you think would be helpful for us to know): [text]

Please see the link below for further resources on using surveillance data to measure impact, including SPRC's Surveillance Success Stories and a link to our September webinar on Suicide Surveillance within the public behavioral healthcare system.
Suicide Surveillance within Health Care Systems and Beyond[3]

We would also encourage you to access the materials available as part of the GLS Cohort 10 State Training Series - *Using Surveillance Data to Measure Grant Impact.*

[3] The audience for the survey above was GLS grantees. This link is only accessible to GLS grantees.