

# Evidence-Based & Evidence-Informed Practices in Suicide Prevention

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Nebraska State Suicide Prevention Summit

Lincoln, Nebraska

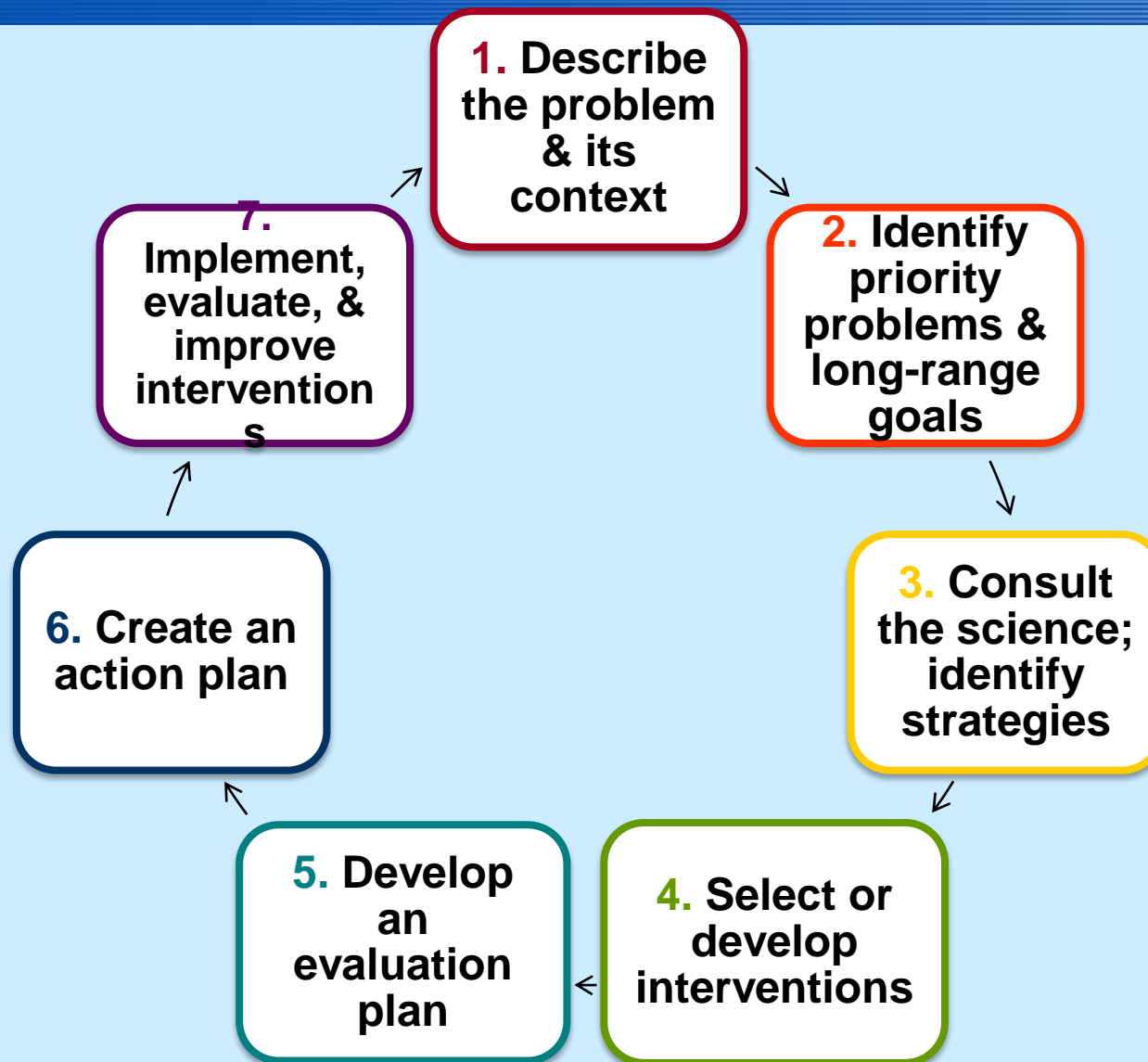
January 29, 2010

# What does “Evidence-Based” mean?

- **Evidence-based =**
  - Has demonstrated a **causal link** between program and **outcome** through **rigorous evaluation methodology**
  - Achieves desired outcome
  - Accurate to say “effective”
- **Current research and expertise →**
  - Help create an “evidence-base” for our work

1. Address multiple levels of influence and design efforts to work in sync
2. Increase protective factors and reduce risk factors
3. No one strategy or “one-size-fits all solution” will solve it - suicide is a complex and multi-determined problem

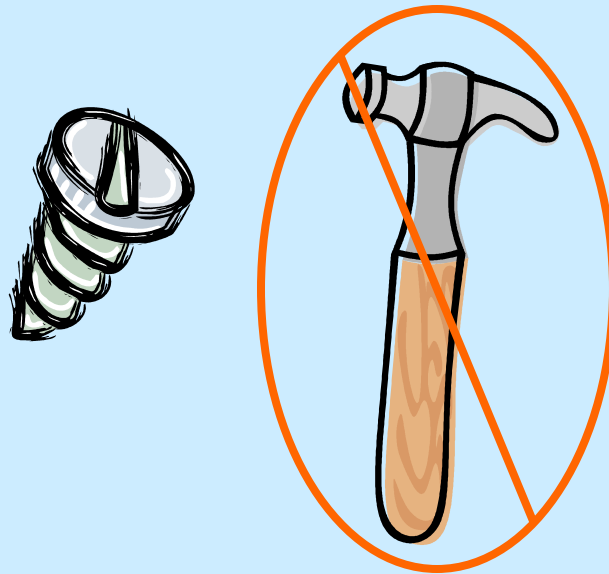
# Strategic Planning Process



# Many Steps Required *Before* Choosing Programs

- Assess the problem
  - Incidence/Prevalence
  - Demographics
  - Risk/Protective Factors
- Assess community readiness, resources
  - What's in place already?
- Set priorities
  - Populations, risk/protective factors
- Articulate:
  - What specific results or *changes* do we hope to achieve, and how will those help reduce suicide?

The best hammer in the world is not helpful if you really need a screwdriver.



## Best Practices Registry (BPR) for Suicide Prevention

**Section I** → Is there an evidence-based program that matches our needs?

**Section II** → Are there guidelines or standards for programs of this type?

**Section III** → Are there programs or materials that match our needs whose content meets current standards in the field?

- **Not** levels of effectiveness (“best to worst”)
  - BPR sections are “apples and oranges”



- Each section lists different types of programs and uses different review criteria





**SPRC SUICIDE PREVENTION RESOURCE CENTER**

If you are in crisis, call the National Suicide Prevention Lifeline at 1-800-273-TALK

**This Month Don't Miss...**

**NEW! Youth Suicide Fact Sheets Based on NVDRS Data**  
The Harvard Injury Control Research Center, in partnership with SPRC, analyzed the CDC's National Violent Death Reporting System (NVDRS) data to create two fact sheets on youth suicide. These new resources, Youth Suicide and Adolescent Status, offer information on youth at the time of death, methods of suicide among young adult students

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**suicide Trend Data**  
Harvard Injury Control Research Center analyzes trends in suicide over a twenty-year period. Data is presented in graph form by years, age group, sex, and race/ethnicity for 1985 - 2004. For each year, a color presentation and a black and white presentation is available.

## **From two sources:**

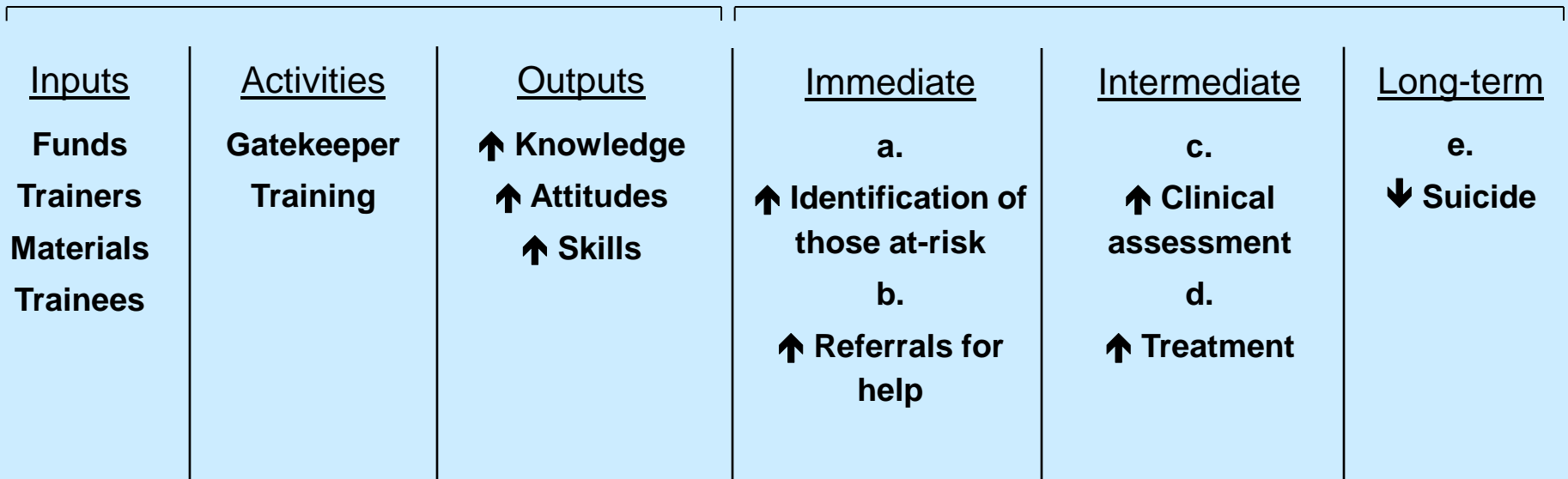
1. Section Ia: SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP)
2. Section Ib: SPRC/AFSP Evidence-Based Practices Project (stopped conducting reviews in 2005)

Generally requires outcomes to be “proximal” to suicide rates/risk

## Generic Gatekeeper Training Logic Model

### Process

### Outcomes



## Eligibility for NREPP review:

- One or more positive outcomes ( $p \leq .05$ )
- Results documented in
  - published peer-reviewed publication; or
  - comprehensive evaluation report
- Publicly available documentation describing the intervention and its proper implementation

## Section Ia:

- **Prevention Programs**

- o [American Indian Life Skills Development/Zuni Life Skills Development](#)
- o [CARE \(Care, Assess, Respond, Empower\)](#)
- o [CAST \(Coping and Support Training\)](#)
- o [Columbia University TeenScreen](#)
- o [Emergency Room Intervention for Adolescent Females](#)
- o [Lifelines Curriculum](#)
- o [PROSPECT \(Prevention of Suicide in Primary Care Elderly: Collaborative Trial\)](#)
- o [SOS Signs of Suicide](#)
- o [United States Air Force Suicide Prevention Program](#)

## Section Ia (continued)

- **Treatment Programs**

- [Cognitive Behavioral Therapy for Adolescent Depression](#)
- [Dialectical Behavior Therapy](#)
- [Multisystemic Therapy With Psychiatric Supports \(MST-Psychiatric\)](#)

## Section Ib (programs that are not in NREPP)

- **Community-Based Programs**

- [Reduced Analgesic Packaging](#)

- **Emergency-Room Programs**

- [ER Means Restriction Education for Parents](#)

- **School-Based Programs**

- [Reconnecting Youth](#)

- **Service Delivery**

- [Psychotherapy in the Home](#)

## Why don't we stop at evidence-based programs?

- Development of a research base takes time
- Not realistic to expect small program components (e.g., a poster) to reduce suicide rates
- Meanwhile, though, we know some things about developing program *content*
  - These “standards” can be disseminated; and
  - We can review materials for their adherence to these standards
- Reviewing **content** is not a substitute for examining **outcomes**



- **Section II listings**
  - Summarize current knowledge in the field
  - Provide “best practice” guidance and recommendations that practitioners can use *during* development for own settings
- Connection with “best practices”
  - They *rely* on available research, e.g.
    - Consensus meetings / multiple stakeholders
    - Literature reviews / experts
  - BUT, unlike NREPP programs, they are not based on evaluations of individual programs or practices



- Lists suicide prevention programs and practices
  - Awareness materials
  - Educational and training programs
  - Protocols and policies
- Implemented in **specific settings**
- Address specific objectives of the **NSSP**
- **Content** has been reviewed for adherence to designated standards
- Materials must be publicly available (may cost \$)

## How does the BPR help?

- It's a useful information source
  - Evidence-based programs
  - Expert and consensus statements
  - Practices whose content meets standards
- It **does NOT**, however, provide a simple answer about what to implement in your community

1. Use best practices in the context of a strategic, data-driven planning process
  
2. Be a thoughtful consumer
  - a. Existing programs
  - b. Research evidence
  
3. Use registry criteria

## Be a thoughtful consumer

- Programs/practices (listed on the BPR)
  - Do they fit our needs?
  - Are adjustments needed?
    - Be sure to retain key elements
- Look at the specifics
  - Program strengths and weaknesses
  - Even evidence-based programs aren't universally effective

# A “Decision Support Tool”

Quotes from the *National Registry of Evidence-Based Programs and Practices (NREPP)* web site (also apply to the BPR)

- “NREPP users are encouraged to carefully weigh all information provided.”
- “Being included in the registry does not mean an intervention is ‘recommended’ or that it has been demonstrated to achieve good results in all circumstances.”
- “....NREPP users are strongly encouraged to read the whole intervention summary, particularly the ‘Key Findings’ sections that summarize the research results for each outcome.”

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- A joint project of
  - SPRC (Suicide Prevention Resource Center)
  - AFSP (American Foundation for Suicide Prevention)



Home » Best Practices Registry

**Best Practices Registry (BPR) For Suicide Prevention**

The BPR consists of three sections, each with different types of best practice listings. In essence, the BPR is three registries in one. [Read More...](#)

**BPR Overview**    **Advice on Using the BPR**    **Search All Listings**

**Best Practices Registry**

**Section I: Evidence-Based Programs**    **Section II: Expert/Consensus Statements**    **Section III: Adherence to Standards**

**FAQ**    **How to Apply**    **Help**    **Marketing Materials**

The BPR is a collaboration between the Suicide Prevention Resource Center (SPRC) and the American Foundation for Suicide Prevention (AFSP).

Funding is provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

If you or someone you know is in suicidal crisis, call **1-800-273-TALK (8255)**. National Suicide Prevention Lifeline

- About SPRC
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  - Section III: Adherence to Standards
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