The Garrett Lee Smith (GLS) Suicide Prevention National Outcomes Evaluation is supported through contract no. HHSS2832012000071/HHSS28342002T (reference no. 283-12-0702) awarded to ICF International by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS).

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SAMHSA
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UTILIZING NATIONAL EVALUATION DATA TO BENEFIT YOUR PROGRAM

State/Tribal Breakout 3C

Tuesday 2:30 – 3:45



DISCLAIMER

The views, opinions, and content expressed in this publication do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

SESSION OVERVIEW

- **Review of GLS National Outcomes Evaluation (NOE) Impact Findings**
- **GLS NOE Data Highlights**
- **Examples of Grantee use of data in their communities**
  - **Nebraska:** Mark DeKraai & Denise Bulling
  - **Choctaw Nation:** Barbara Plested
- **Questions/Closing**

REVIEW OF GLS NOE IMPACT FINDINGS

GLS NOE IMPACT QUESTIONS

As a result of GLS implementation, is there a reduction in…

- **Youth suicide attempts?**
- **Youth suicide mortality?**

Do the **benefits (cost savings) outweigh the cost** of implementing the program?

SHORT TERM IMPACTS

2007-2010

79,379 averted suicide attempts through 2010 (at most 4 years of follow up)

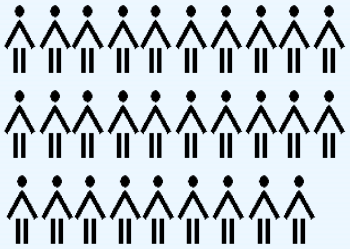
$222.1M in total medical savings over 4 years of programming

$4.50 in medical cost savings for each dollar invested

427 lives saved through 2010 (at most 4 years of follow up)

LONG TERM IMPACTS

2007-2015



882 lives saved through 2015 (at least 6 years of follow up)

Extended years of impact seen after consecutive years of GLS programming in a county

20% greater impact in rural communities

USING NATIONAL PROGRAM FINDINGS LOCALLY

QUESTIONS TO CONSIDER

- What stakeholders would benefit from knowing these national levels impacts?
- Where can you disseminate these findings?
- How can you incorporate this national-level evidence into your local evaluations efforts?
- How can you use these NOE impacts to inform your program?

GLS NOE DATA HIGHLIGHTS

WHAT IS THE LONG TERM IMPACT (2007-2015) OF GLS ON YOUTH SUICIDE RATES?

The impact of GLS implementation on youth suicide mortality, starting one year after implementation, was estimated for counties originally exposed to GLS activities between 2006 and 2009 and includes data from State and Tribal grantees originally funded in cohorts 1 through 5

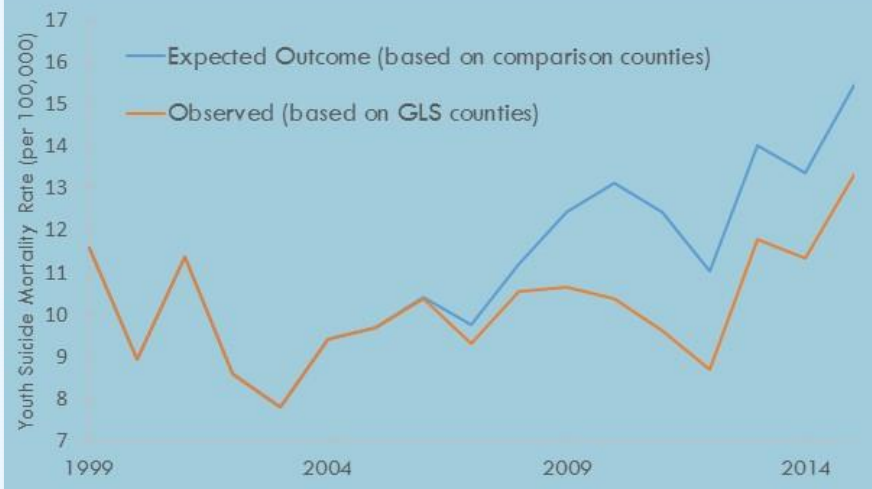
IN THE PRESENCE OF GLS ACTIVITIES, **THE YOUTH SUICIDE RATE WAS LOWER** THAN IF GLS HAD NOT BEEN IMPLEMENTED, RESULTING IN

882 LIVES SAVED

THIS EFFECT WAS SEEN FOR UP TO **TWO YEARS** FOLLOWING GLS IMPLEMENTATION IN A COUNTY.

THE POSITIVE IMPACT IS EVEN GREATER IN RURAL COUNTIES [POPULATIONS LESS THAN 50,000]

DIFFERENCE BETWEEN YOUTH SUICIDE RATE IN RURAL GLS COUNTIES AND MATCHED CONTROL RURAL COUNTIES



THE GLS EFFECT ON YOUTH SUICIDE RATES IS

20% STONGER

IN RURAL COUNTIES THAN IN NON-RURAL COUNTIES, RESULTING IN

2.4 FEWER DEATHS PER 100,000 YOUTH

2 YEARS AFTER GLS IMPLEMENTATION.

SHORT TERM IMPACT OF GLS PROGRAMS (2006-2009) ON YOUTH SUICIDE ATTEMPTS AND YOUTH SUICIDE MORTALITY

The impact of GLS on youth suicide attempts and youth suicide mortality, starting one year after implementation, was determined for youth in counties with GLS activities between 2006 and 2009. This includes activities for State and Tribal grantees in cohorts 1-5.

Is GLS impacting youth suicide attempts?

4.9 FEWER ATTEMPTS PER 1,000 YOUTH ONE YEAR FOLLOWING IMPLEMENTATOIN OF GLS ($p<0.05$)

79,379
averted suicide attempts

Suicide attempts determined for youth aged 16-23

Is GLS impacting youth suicide deaths?

Suicide mortality determined for youth aged 10-24

427
lives saved

1.3 FEWER DEATHS PER 100,000 YOUTH ONE YEAR FOLLOWING IMPLEMENTATOIN OF GLS ($p<0.05$)

The modelled impact on youth suicide attempts and youth suicide mortality was seen for 1 year following GLS implementation

The cost savings of GLS programs utilized the short term impact (2007-2010) of GLS implementation on youth suicide attempts in counties exposed to GLS activities between 2006 and 2009. This includes activities for State (n=46 grantees) and Tribal (n=12 grantees) grantees in cohorts 1-5.

DO THE **COST SAVINGS** OF GLS **OUTWEIGH THE COST** OF IMPLEMENTING THE PROGRAM?

GLS programs implemented from 2006-2009 **AVERTED 79,379** suicide attempts, which avoids...

11,424 ED visits

$34.1M cost savings

19,448 Hospital stays

$187.8M cost savings

$222.1M total cost savings

$49.4M spent in GLS Program Costs over 4 years, returns...

SAVINGS of $4.50 in healthcare costs for **EACH DOLLAR** invested

NOE INSTRUMENT-SPECIFIC FINDINGS AND USES

TRAINING ACTIVITY SUMMARY PAGE (TASP)

1.3 MILLION

TRAINED GATEKEEPERS AS A RESULT OF GLS GRANT PROGRAMS

Gatekeepers are "natural helpers" or adults who interact with youth as part of their regular day. These individuals are trained to recognize warning signs for suicide and know how to respond appropriately.

STATE AND TRIBAL GRANTEES

963,368

GATEKEEPERS WERE **TRAINED** IN YOUTH SUICIDE PREVENTION AND EARLY INTERVENTION DURING **24,456** TRAININGS

33,446

YOUTH WERE **IDENTIFIED** FOR SUICIDE RISK BY A TRAINED GATEKEEPER

ONLINE TRAININGS

4.4% of State and Tribal trainings were online

10.5% of campus trainings were online

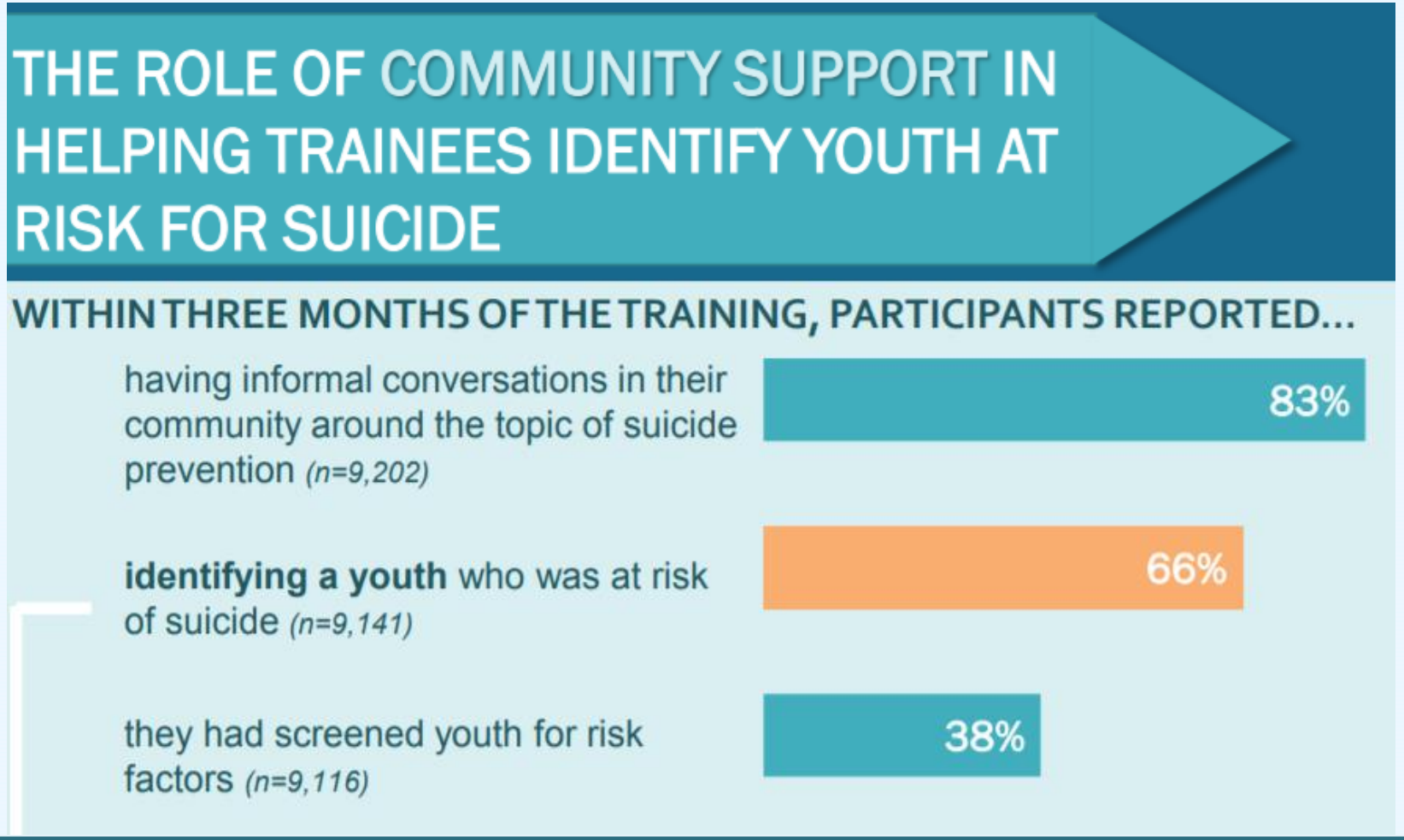
CAMPUS GRANTEES

341,232

GATEKEEPERS WERE TRAINED IN YOUTH SUICIDE PREVENTION DURING **11,478** TRAININGS

Data Source: Training Activity Summary Page (TASP), June 2017, State Tribal Cohorts 1-11; Campus Cohorts 1-10

TRAINING UTILIZATION AND PRESERVATION SURVEY (TUP-S)



PREVENTION STRATEGIES INVENTORY (PSI)

CARE TRANSITIONS AFTER HOSPITAL DISCHARGE

Care transitions are high-risk times for patients. Caregivers and clinicians must bridge patient transitions from inpatient hospitalization, emergency departments, or primary care to outpatient behavioral health care.

http://zerosuicide.sprc.org/toolkit/transition

15 of the 42 State/Tribal grantees (cohorts 9-11) report providing **care transitions after an Emergency Room discharge**

- **CARING CONTACTS** are brief communications with patients during care transitions.
- These contacts can promote a patient's feeling of connection to treatment and increase participation in collaborative treatment.
- Examples of these caring contacts include: postcards, letters, email messages, text messages, phone calls, or home visits

Of grantees doing care transitions (n=21)…

Seven grantees are following up via letter after inpatient hospitalization, but this strategy is less common after emergency department discharge

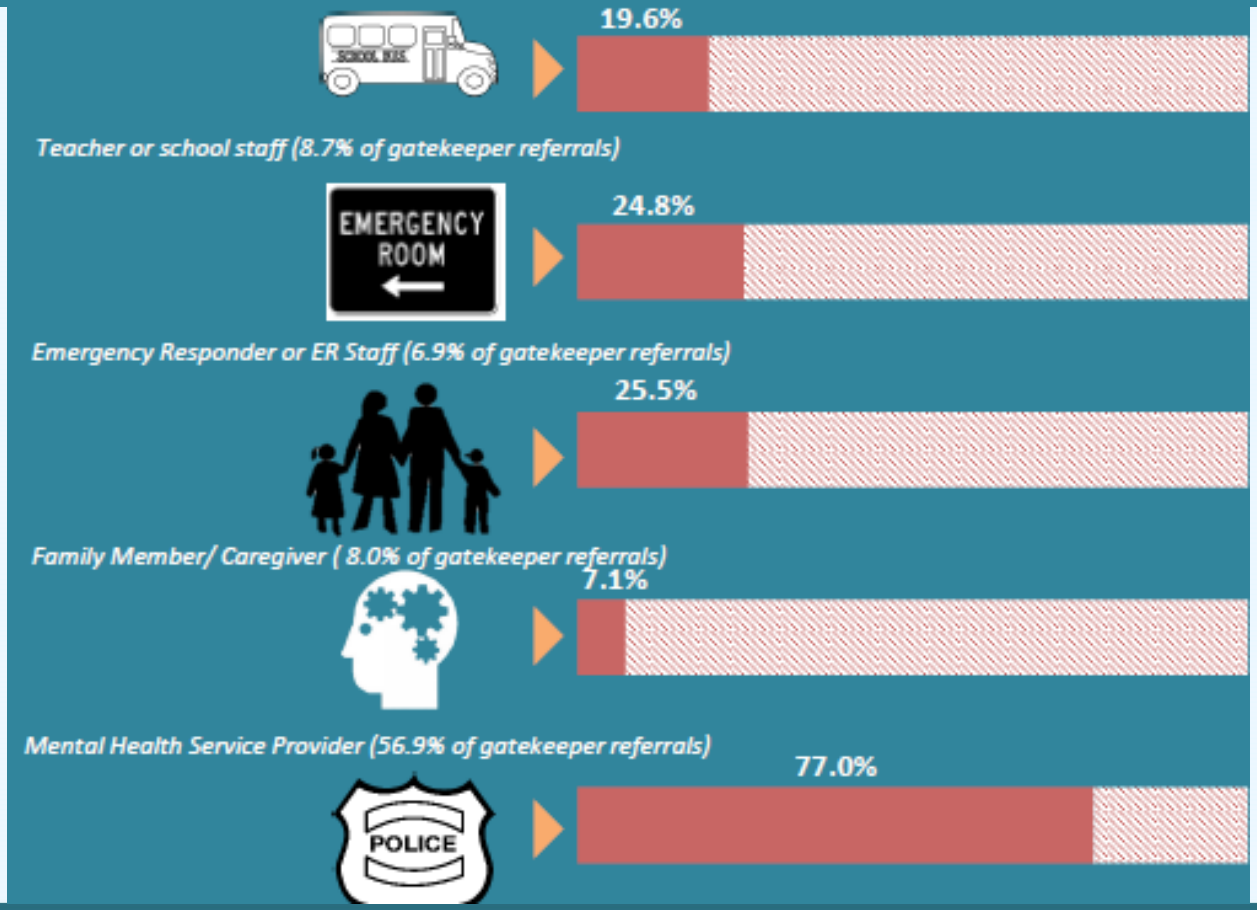
Eight grantees reported using home visits following an emergency department discharge, including 3 out of the 4 tribal grantees reporting care transitions

Twenty grantees are following up via phone call after emergency department or inpatient hospitalization discharge

Five grantees are following up via text message reminders of appointments after emergency department discharge and inpatient hospitalization

EARLY IDENTIFICATION REFERRAL AND FOLLOW-UP (EIRF)

REFERRALS TO CRISIS AND NON-CRISIS SERVICES BY GATEKEEPER TYPE



EXAMPLES OF GRANTEE USE OF DATA IN THEIR COMMUNITIES

NEBRASKA YOUTH SUICIDE PREVENTION PROJECT

- Mark DeKraai, Project Evaluator
- Denise Bulling, Project Coordinator

NEBRASKA GLS YOUTH SUICIDE PREVENTION PROJECT

DENISE BULLING, PH.D.
MARK DEKRAAI, PH.D.

2018 GLS SUICIDE PREVENTION GRANTEE MEETING

MARCH 20, 2018

University of Nebraska | Public Policy Center

NEBRASKA SUICIDE PREVENTION GRANT - OVERVIEW

- Coalition Building through 6 BH Regions
- State Planning & Policy Change
- Outreach – 220,034 Nebraskans Reached
- LOSS Teams available to 1,259,609 Nebraskans
- 1,030 Youth Screened for Suicide

NEBRASKA SUICIDE PREVENTION GRANT - OVERVIEW

- Community Gatekeeper Training (3,037 trained)
- School Gatekeeper Training
  - 82,519 Kognito
  - 10,991 QPR
  - 6,910 MEP
- Clinician Training
  - 456 CAMS
  - 128 AMSR

NEBRASKA YOUTH SUICIDE PREVENTION GRANT – EXAMPLES OF USING NATIONAL AND STATE EVALUATION DATA

- Tracking Screening & Referrals by BH Region

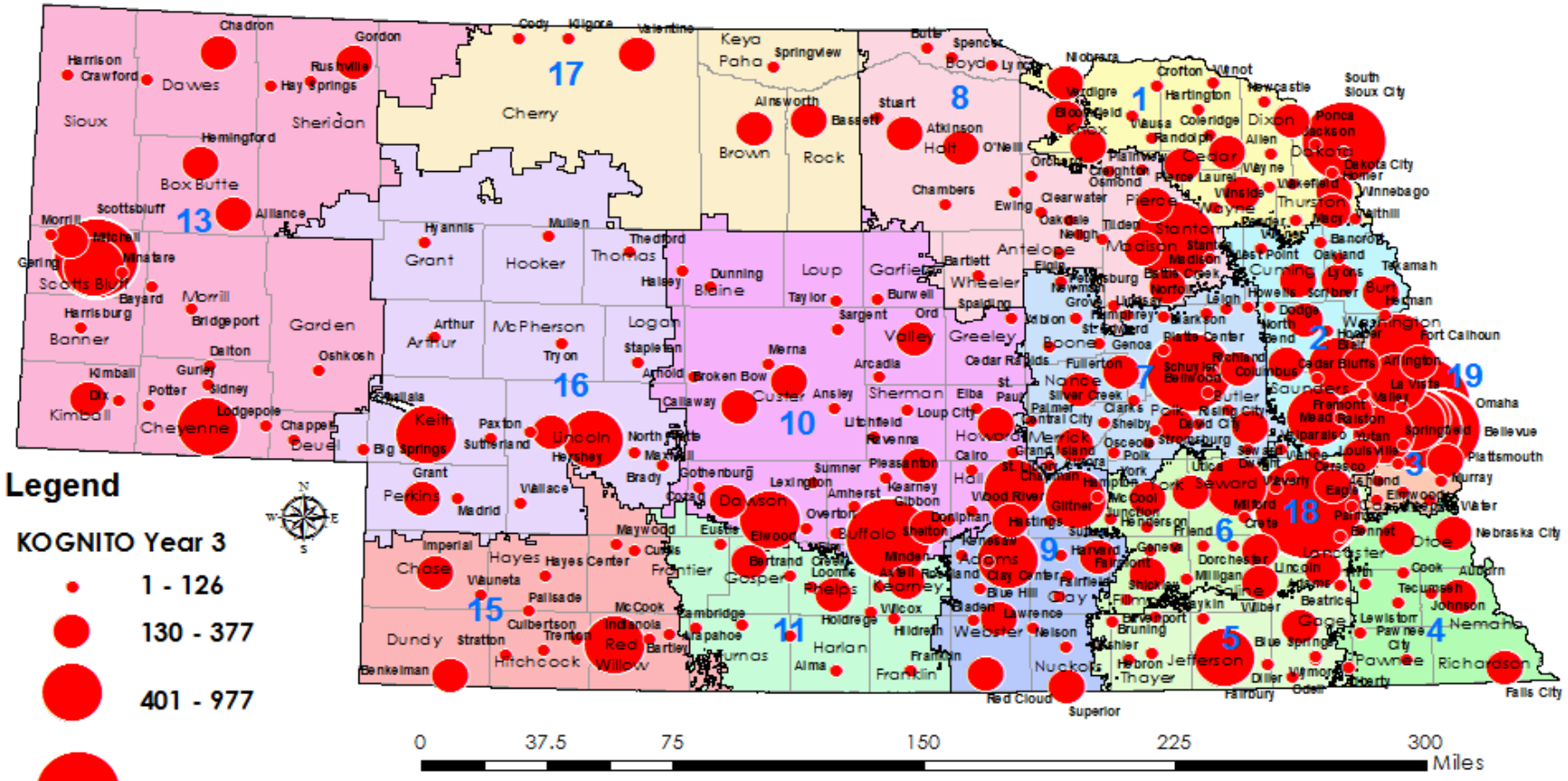
- Geomapping Project Interventions

NEBRASKA GLS
SCREENING, IDENTIFICATION, REFERRAL, AND ACCESS BY BEHAVIORAL HEALTH REGION

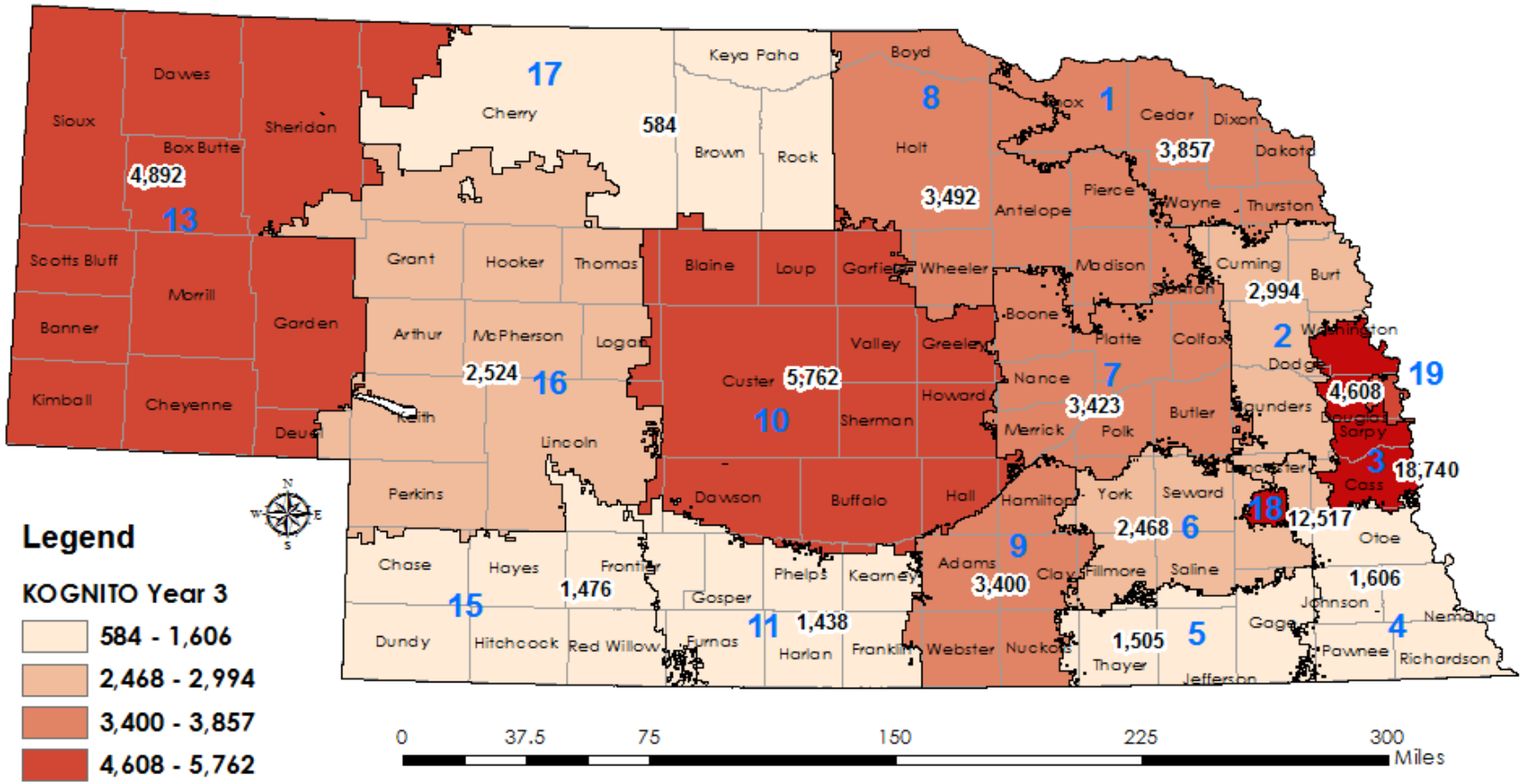
Behavioral Health Region (BHR)	# Screened by BHR	# Identified at risk for suicide	# Referred to services or supports*	# Received MH services within 3 months
1	135	106 (78.5%)	14 (13.2%)	4 (28.6%)
2	87	34 (39.1%)	3 (8.8%)	2 (66.7%)
3	209	100 (47.8%)	16 (16.0%)	5 (31.3%)
4	98	51 (52.0%)	12 (23.5%)	8 (66.7%)
5	162	67 (41.4%)	9 (13.4%)	1 (11.1%)
6	339	179 (52.8%)	53 (29.6%)	23 (43.4%)
Total	1,030	537 (52.1%)	107 (19.9%)	43 (40.2%)

EXAMPLE GEO-MAPPING EVALUATION QUESTIONS

- What is the distribution of school gatekeeper training by Educational Service Unit?
- What is the distribution of mental health professional training by Behavioral Health Region?
- How are interventions related to risk areas?
- How are risk areas related to Lifeline call volume?

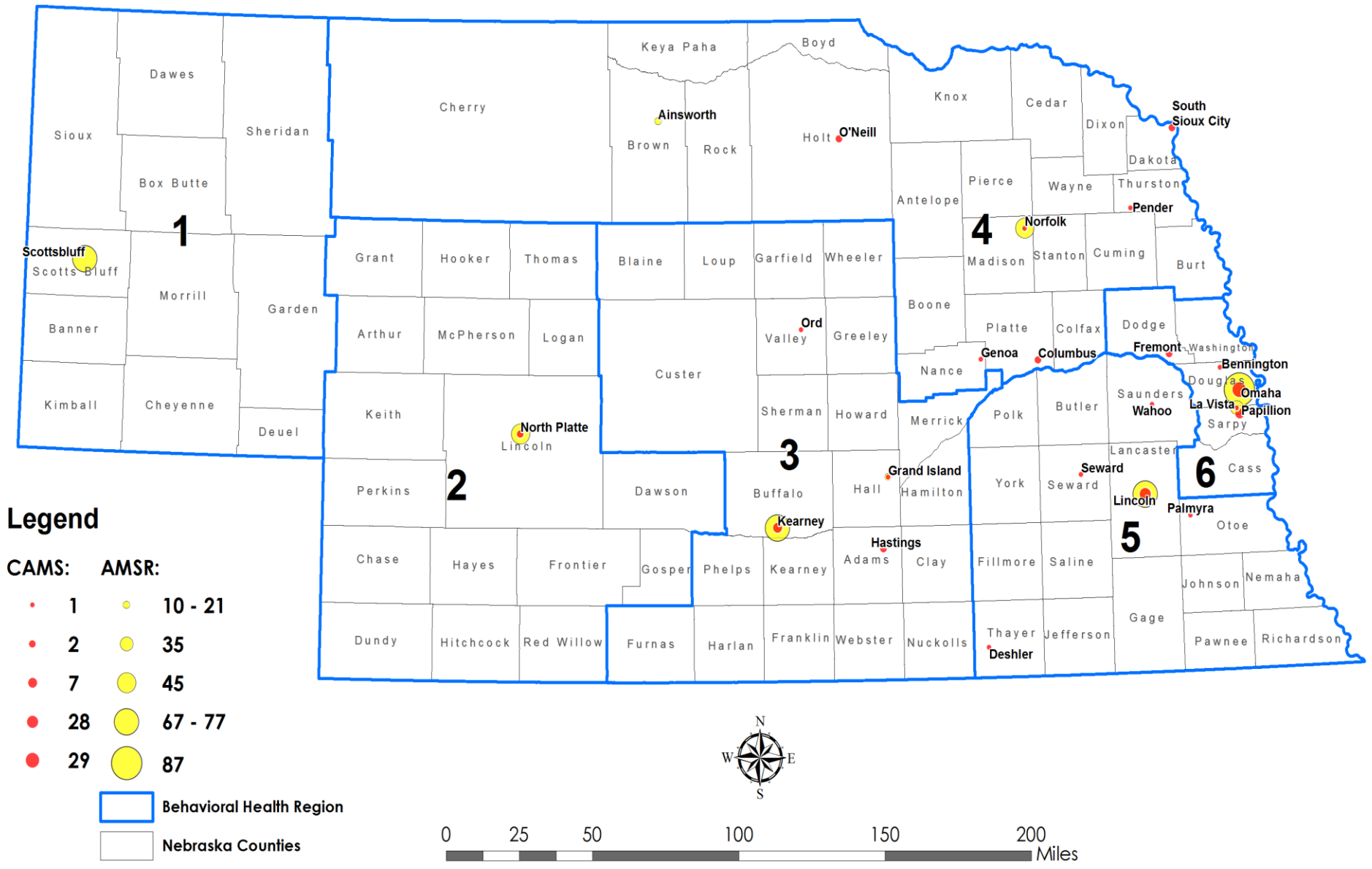


Kognito Training by Location and ESU (4/1/15 – 9/30/17)



Kognito Training by ESU
(4/1/15 – 9/30/17)

CAMS & AMSR Trainees by City (10/1/14 – 9/30/17)



Legend

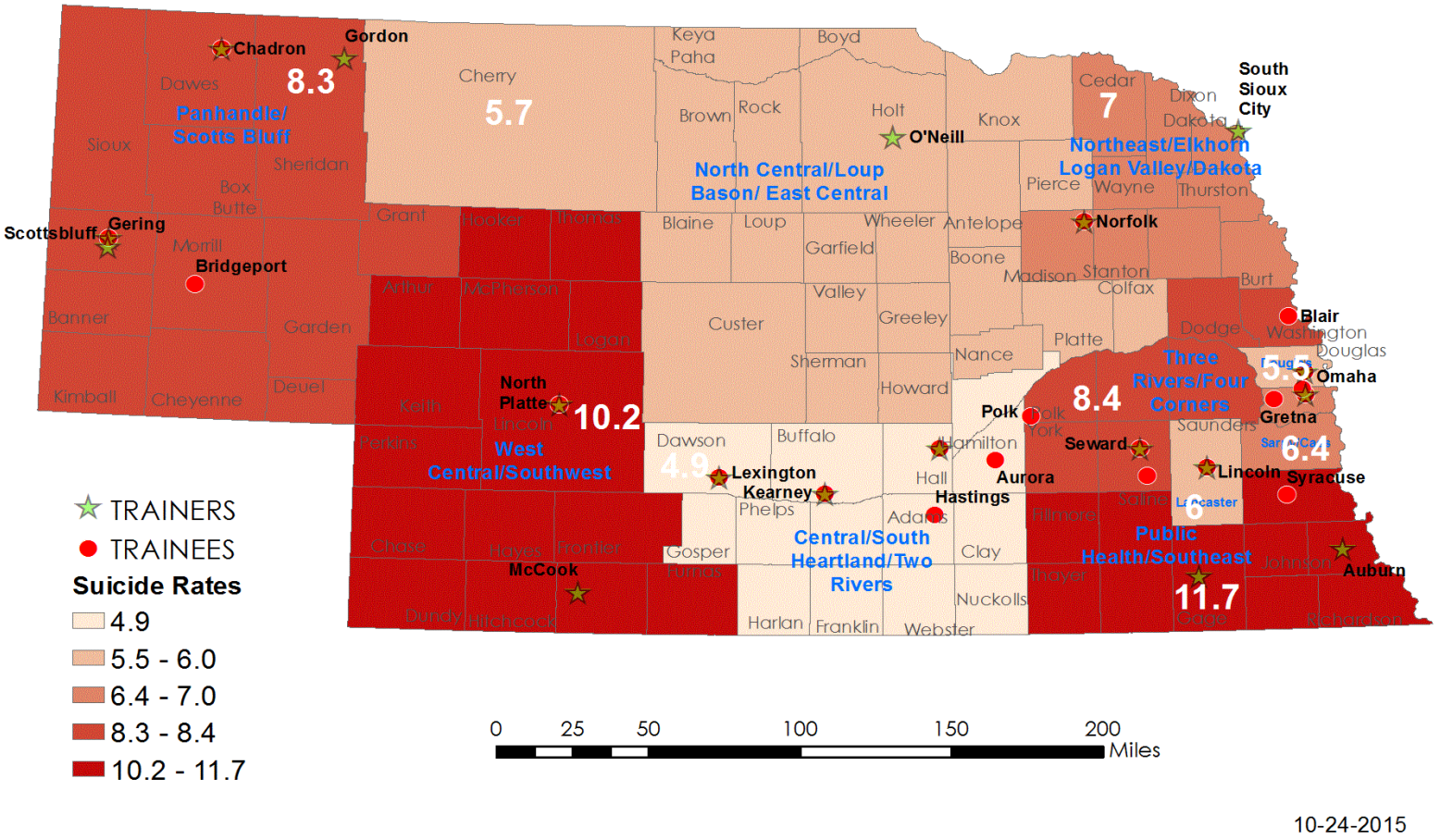
CAMS:	AMSR:
1	10 - 21
2	35
7	45
28	67 - 77
29	87

Behavioral Health Region

Nebraska Counties

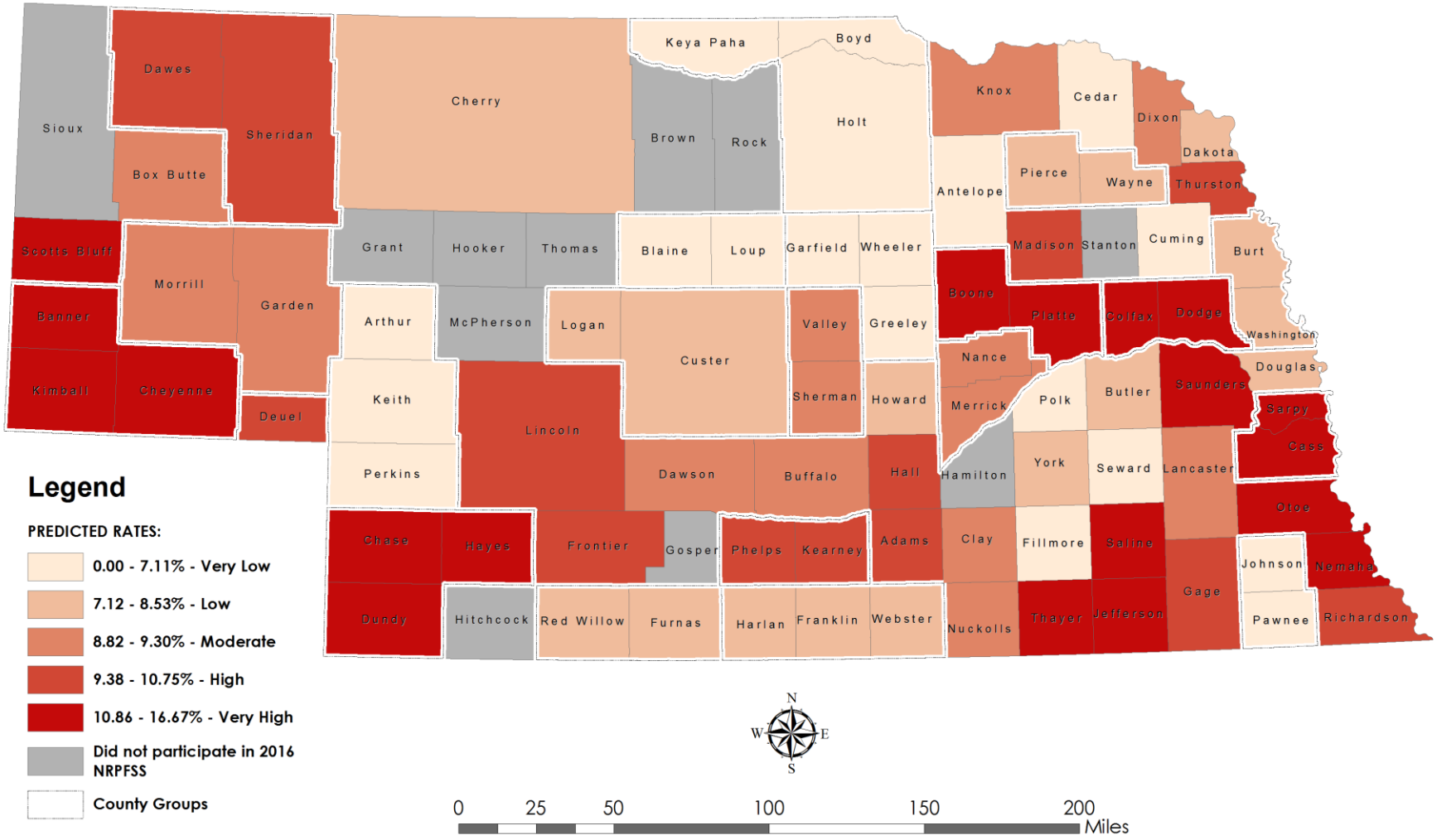
SUICIDE RATES BY HEALTH DEPARTMENT

TRAINERS & TRAINEES YEAR 1

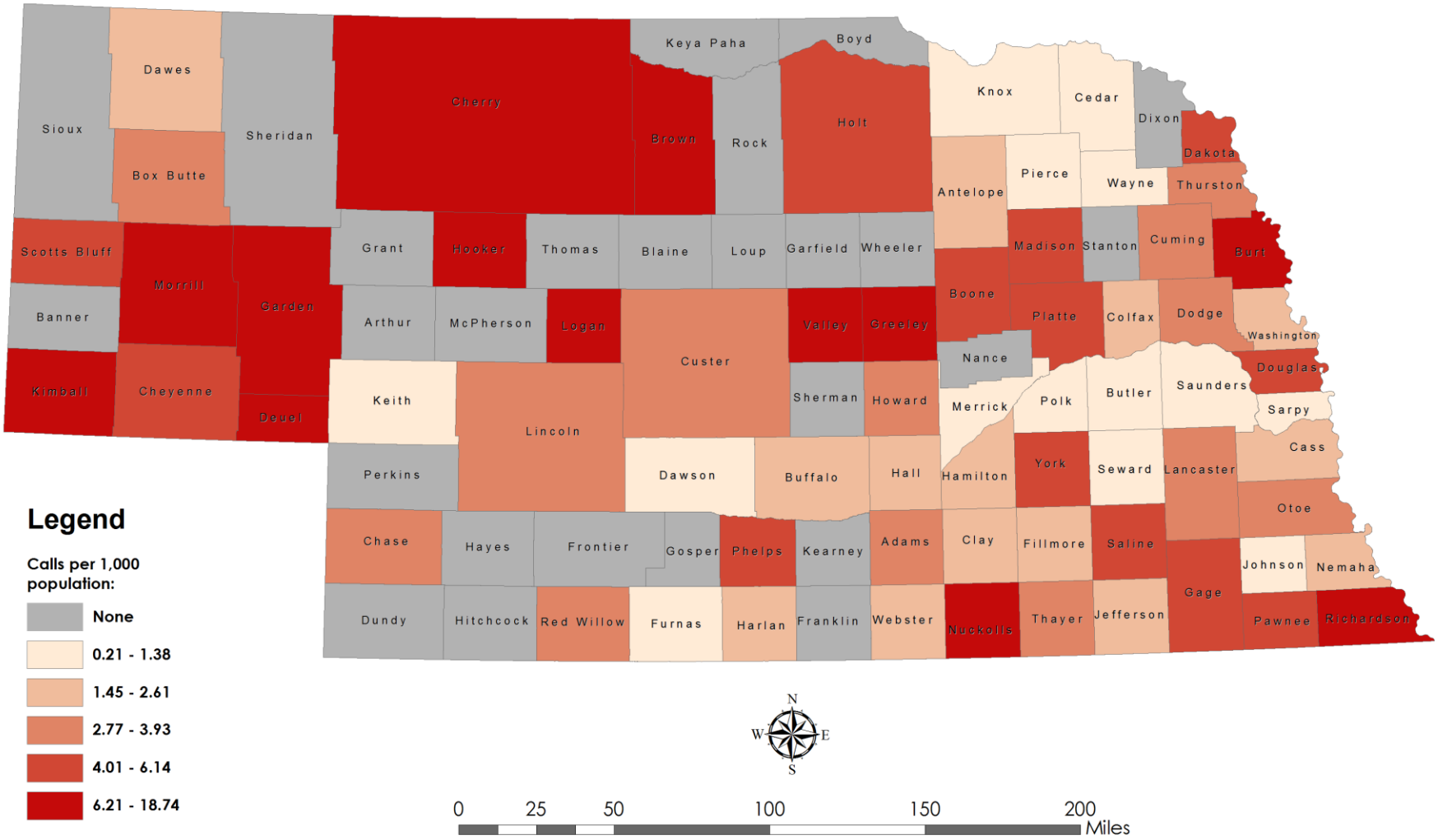


10-24-2015

NRPFSS Risk Areas



Boys Town Call Data by County



RISK/CALL IMPLICATIONS

	Low Risk	High Risk
Low Calls	Cedar County Johnson County Keith County Polk County Seward County	Banner County Dundy County Hayes County Sarpy County Saunders County
High Calls	Burt County Greeley County Logan County	Kimball County Nuckolls County Richardson County

CHOCTAW NATION

- **Barbara Plested, Project Evaluator**

QUESTIONS TO CONSIDER

- What are ways that you have used NOE or local evaluation data to make programmatic decisions?
- How can you use data to tell a story about the success of your program?

CLOSING/QUESTIONS

- **Questions?**

- **For additional information contact:**

  Taylor Moore, PhD

  404-320-4425

  taylor.moore@icf.com

- **Thank you for your participation!**

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