

Best Practices Registry (BPR) Application Guide

This application guide is designed to be used while logged into the online [BPR application submission portal](#). It will help you prepare and submit a program or intervention to the BPR for review and possible listing. The application guide provides detailed information to help you answer each question in all three sections (A, B, and C) of the application. Visit sprc.org/bpr-submission to access the portal.

For technical assistance or questions about the application, email us at sprcbpr@ou.edu.
References should be put in footnotes.

Section A: Demographic Information

Section A asks for demographic information about the program or intervention, the developers, and the submitter.

- **Question A1:** Program or intervention name. Please make sure to spell out all acronyms. Do not shorten the name or use abbreviations.
- **Question A2:** Developer(s) name, organization, email, and phone. This question accommodates several names if there is a development team. In some instances, the person submitting this application is also a developer of the program or intervention. In this case, their name and information should appear in both A2 and A3.
- **Question A3:** Submitter name, organization, location of organization and email.
 - A submitter is a person who submits a suicide prevention program or intervention to the registry to be reviewed.
 - You must complete this section even if the submitter is a developer.
 - Submitter organization is typically the same as the developer but is not required to be the same.
 - Location is the primary location of the organization associated with the program or intervention; if there are multiple locations, please choose the main location you would like to have listed.
- **Question A4:** Someone who is authorized to submit an application, has been designated by the program or intervention developer(s) to do so, and will serve as the primary contact for Best Practices Registry staff.

Section B: Program or Intervention Information and Evaluation

Section B asks for information about the program or intervention, including a summary and details about the program or intervention goals, activities, outputs and outcomes, and evidence of effectiveness. Reviewers will refer to this section throughout the review process to verify the content of the application. This section must be detailed and comprehensive; provide easily accessible links/materials; and provide clear evidence of effectiveness. Some questions are qualifying (i.e., the application may be disqualified based on the answers given). Some questions in this section may also be scored as complete or incomplete; disqualified, minimal, adequate, or exemplary.

- **Question B1:** Program or intervention summary. A concise summary of the program or intervention that includes goals, outcomes measured, population served, and implementation activities. The answer box has limited space, so please be succinct. If the program or intervention is accepted for the BPR, this summary will appear with the program or intervention listing.
- **Question B2-a:** This section asks for detailed information (more than is provided in the summary above) about the program or intervention's goals, activities, outputs, outcomes, and evidence of effectiveness. This will help the reviewers understand how the program or intervention is effective in preventing suicide, how it affects behavior, and how it achieves intended goals.
 - 1. Goals - What does the program or intervention aim to do, change, or create? (List in bulleted form.)
 - 2. Basic components include:
 - Inputs - e.g., staff, materials, equipment, funding
 - Activities - e.g., instruction or training, coalition building, delivery of services or interventions
 - Outputs - e.g., measures that result directly from the activities such as the number of program participants
 - Outcomes - e.g., increased skill level with coping strategies, decreased suicidal ideation or suicide attempts
 - 3. Evaluation - Describe how the intended impact and success of the program or intervention was evaluated, including but not limited to quantitative, qualitative, or mixed methods studies. Evaluation may also include various types of data collection methods, e.g., interviews, focus groups, experiments, or surveys.
 - Describe the instruments used to measure effectiveness
 - Provide details about outcomes and quantify the impact measured
- **Question B2-b:** In this question, submitters will be asked to provide three supporting documents to help demonstrate evidence of effectiveness of their program or intervention (e.g., peer-reviewed articles, publications, reports to funders, governmental reports, or study evaluations). Although there are no mandatory types of documentation (e.g., a minimum number of peer-reviewed articles), the evidence you supply here must support and align with the information you provide throughout the application, particularly in Section B. Be sure your documentation clearly demonstrates effectiveness with the groups and settings you indicate in your application. If three individual links to supporting documentation are not included, the application will be disqualified.
 - You can use a cloud drive (e.g., Dropbox, Google Drive, Basecamp, or Box) to create links to the supporting documents you'll need to provide. Share each document by pasting its link into the appropriate text box. Please be sure the links you provide can be opened without special access or passwords. Use permanent links whenever possible.
- **Question B3:** Indicate what year the program or intervention was most recently updated. If it has been longer than five years, the application will be disqualified. Examples of updates include: a full review and revision to reduce stigmatizing language or imagery; alignment with current subject matter standards; inclusion of updated literature and frameworks.

- **Question B4:** This question asks for links to demonstrate the program or intervention's online presence, (e.g., Facebook page, LinkedIn profile, etc.). If the program does not have an online presence, the application will be disqualified.
- **Question B5:** This question asks the submitter to indicate populations the program or intervention has shown effectiveness with, as detailed in question B2. We encourage programs and interventions to continue to measure impact on a variety of populations and settings. It's important to include culturally defined and community defined evidence, as well as empirically defined evidence.
- **Question B6:** This question asks how the program or intervention would be categorized. The categories and their definitions are as follows:
 - An Education or Training Program or Intervention is intended to communicate increased knowledge, awareness, attitudes, or skills to reduce suicides (e.g., developing skills to identify warning signs of suicide).
 - A Screening Program or Intervention would use a standardized tool to identify individuals at risk for suicide and may include other intervention activities (e.g., screening older adults for suicide risk).
 - An Information or Outreach and Education or Training submission must provide evidence that the design is able to change specific behavior to qualify as a program or intervention (e.g., using social media to promote suicide prevention).
 - A Treatment or Direct Services Program or Intervention would include services for those with suicidal ideation, suicidal thoughts, or behaviors, lived experience, or in bereavement (e.g., providing cognitive behavioral therapy).
 - An Environment or Systems Program or Intervention would focus on changing the environment rather than individual behavior (e.g., cigarette tax, policies protecting physicians seeking mental health care).
- **Question B7:** This question asks about the minimum education level required for individuals who are **implementing** (not receiving) the program or intervention. Please select only the minimum requirement.
- **Question B8:** Please indicate (yes or no) if training is required to implement the program or intervention. Training is defined as an opportunity for an individual to learn how to implement the program.
- **Question B9:** This question asks about how the program or intervention can be delivered (e.g., in person, virtually, a hybrid of the two, or in another format).
- **Question B10:** Please indicate the minimum number of hours required for an individual to be trained to deliver/implement the program or intervention.
- **Question B11:** Please indicate if there is a train-the-trainer option for the program or intervention. A train-the-trainer model aims to prepare instructors to present information effectively, respond to participant questions, and lead activities that reinforce learning (Centers for Disease Control and Prevention, n.d.).
- **Question B12:** The BPR guidelines align with the Centers for Disease Control and Prevention's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, which details the strategies with the best available evidence to reduce suicide. Programs or interventions that

submit to be listed on the BPR must choose one or more strategies from this package and, in the documentation provided in Question B2, show evidence of alignment with the selected strategy or strategies. The strategies are as follows:

- Promoting connectedness (e.g., peer norm programs, community engagement activities)
 - Teaching coping and problem-solving skills (e.g., social-emotional learning programs, parenting skill and family relationship programs)
 - Identifying and supporting people at risk (e.g., gatekeeper training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts)
 - Strengthening access and delivery of suicide care (e.g., coverage of mental health conditions in health insurance policies, reduction of provider shortages in underserved areas, safer suicide care through system changes)
 - Lessening harms and prevent future risk (e.g., postvention, safe reporting and messaging about suicide)
 - Creating protective environments (e.g., reduce access to lethal means among persons at risk of suicide, improve organizational policies and culture, create community-based policies to reduce excessive alcohol use)
 - Strengthening economic supports (e.g., household financial security, housing stabilization policies)
- **Question B13:** The BPR guidelines align with SPRC's Comprehensive Approach to Suicide Prevention, which comprises nine strategies for suicide prevention and mental health promotion that can be advanced through an array of possible activities (i.e., programs, policies, practices, and services). Programs or interventions submitted for BPR listing must choose one or more elements from this approach, and in the documentation provided in Question B2, show evidence of alignment with that element. The elements are:
 - Identify and Assist
 - Increase Help-Seeking
 - Effective Care/Treatment
 - Care Transitions/Linkages
 - Respond to Crisis
 - Postvention
 - Reduce Access to Means
 - Life Skills and Resilience
 - Connectedness
- **Question B14:** The BPR guidelines align with the IOM Spectrum of Mental, Emotional, and Behavioral Intervention (aka the IOM Continuum of Care). Programs or interventions submitted to the BPR must show evidence of which prevention level(s) the program or intervention best fits into. The levels are:
 - Promotion: Strategies used to develop skills-based positive attributes, such as self-regulation, self-efficacy, goal setting, and positive relationships, that promote mental, emotional, and behavioral (MEB) development. Consists of approaches that focus on the societal, community, and individual and family levels.
 - Prevention: Strategies offered prior to the onset of a disorder that are intended to prevent or reduce the risk for its development. Consists of approaches at the universal, selective, and indicated levels.
 - Treatment: Given to an individual who is demonstrating MEB health challenges or has been diagnosed with an MEB disorder. Consists of case identification and treatment of disorders.

- Maintenance: Care given to prevent relapse, recurrence, or further deterioration of MEB health status. Consists of long-term treatment and aftercare.
- **Question B15:** The BPR guidelines were developed with evidence-based frameworks such as the [Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention](#), CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, [SPRC's Comprehensive Approach to Suicide Prevention](#), the IOM Spectrum of Mental, Emotional, and Behavioral Intervention (aka IOM Continuum of Care), and the Mental Health Media Guide. Programs or interventions will be required to indicate which topics or factors included in these frameworks (summarized below) that the program or intervention addresses.
 - *Reduce risk factors (including upstream factors):* Thoughts of suicide, prior suicide attempts, knowing someone who died by suicide, chronic diseases, mental disorders, disability, access to lethal means, alcohol use, illicit drug use, poverty, social isolations, stress resulting from prejudice/discrimination, stress resulting from attitudes towards gender/sexual identity, trauma or historical trauma, loss of identity, adverse childhood experiences (ACEs), neighborhood violence, disruption in medical care/coverage.
 - *Promote protective factors (including upstream factors):* Coping and problem-solving skills, health education, screening, and support for those at risk for suicide, cultural identity, connections, and community, family engagement, economic stability, stable housing policies, physical education and opportunities for physical activity, wellness (nutritional, environmental, workplace, social and emotional climate), safe and secure physical environment.
 - *Improve community factors:* Stigma reduction, connectedness, protective environment, positive expectations, policies, and practices to reduce bullying, support for learning, positive social norms, supportive relationships, opportunities for skill building.
 - *Improve suicide care (postvention):* Care and support to individuals affected by suicide deaths and attempts. Promoting healing and implementing community strategies to help prevent further suicides. Conducting interventions after a suicide, often consisting of support for survivors of suicide loss who may also be at risk, with the intention of preventing contagion (suicide risk associated with the knowledge of another person's suicidal behavior, either firsthand or through the media). Materials that provide guidance on how institutions should respond in the immediate aftermath of suicide or materials about addressing the long-term needs of those bereaved by suicide.
 - *Improve health care system quality:* Suicide prevention promotion as a core component of health care services, therapeutic or psychological counseling, faith-based care, and other needed psychological and social services; access to effective mental health treatments or interventions intended to address an individual or population's suicide risk, risk factors for suicide, or suicide attempt; access to and delivery of quality suicide care; provider response to crisis and improved patient care transition; effective transitions in care to help reduce suicide risk among individuals receiving health or behavioral health services.
 - *Improve communication about suicide:* Research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors; responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide; other communication about suicide strategy.
 - *Improve provider (e.g., physicians, mental health professionals) attitudes, knowledge, and skills about suicide:* Community and clinical service provider trainings on the prevention of suicide and related behaviors, stigma reduction strategies, effective clinical

and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

- **Question B16:** This question asks about implementation. Has the program or intervention been implemented in the intended setting with the intended populations within the last five years?
- **Question B17:** This question addresses materials associated with the program or intervention, such as program manuals, trainer’s manuals, fidelity monitoring forms, presentations/slide sets, brochures, etc. Submitters will be asked to provide a direct link to the actual content so reviewers will have access to adequately review the literature to ensure it aligns with guidance in the Mental Health Media Guide and other safe language guidelines.
 - **All** suicide prevention programs and interventions listed on the BPR should include a safety protocol or plan for safety that specifies what should happen when a participant is identified as having a mental health crisis. This includes upstream suicide prevention programs or interventions as well as programs or interventions for clinical and hospital settings.
- **Question B18:** In this question, submitters will list the resources needed to implement the program or intervention, such as laptops, overhead projectors, videos, classrooms, trainers, etc.
- **Question B19:** In this question, submitters will be asked about the language the program or intervention has shown effectiveness with, and will select only the languages that the program or intervention was tested for efficacy in. Evidence for this efficacy must be provided in Question B2.
- **Question B20:** The [Surgeon General’s Call to Action to Implement the National Strategy for Suicide Prevention](#) encourages everyone to engage individuals with lived experience in all aspects of suicide prevention efforts. Submitters will describe how they included individuals with lived experience in the program or intervention (e.g., in the planning, design, implementation and evaluation).
- **Question B21:** In this question, submitters will indicate what type of evidence was collected to demonstrate the program or intervention’s effectiveness.
 - Community-defined evidence. Community-defined evidence is a set of practices that yield positive results and have reached a level of acceptance by the community. A community could be a workplace, neighborhood, school, or could be geographically or culturally defined.
 - Empirically defined evidence. Empirically defined evidence is generated from observation, experience, or the scientific method. A researcher develops a hypothesis and conducts an experiment to test it. The findings may or may not support the hypothesis.
- **Question B22:** The submitter will be asked to indicate the type of study designs that were used to gather evidence of impact. Study designs include quantitative, qualitative, or mixed methods designs.
 - Outcomes are the short to mid-term results that occur (hypothetically) because of the program or intervention. An outcome could be a reduction in suicidal ideation.

- An impact is a long-term result that occurs (hypothetically) because of the program or intervention. An impact could be a reduction in the number of suicides within a community.
- **Question B23:** A description of how the study design was developed will be provided in this question.
 - Does the study design involve key partners, including the focus population? Who was involved? How were measurements decided? Why was this particular study design selected? A description of who was involved (key partners), the decision-making process or justification for study design selection, and information on how the measures (outcome variables) were selected should be provided.
- **Question B24:** This question will ask if the program or intervention was designed to be **delivered by** people from a specific group. Submitters will choose from a list of groups of people such as mental health providers, teens, experts with lived experiences, community lay people, or tribal providers.

SECTION C. Other Information About the Program

Section C will request additional information about the program or intervention that would be helpful for others to learn once it is listed in the BPR.

- **Question C1:** Input the year the program or intervention was originally created or copyrighted.
- **Question C2:** Indicate if there is a cost to purchase, license, or implement the program or intervention.
- **Question C3:** This question asks about the setting for implementation of the program or intervention (e.g., online, in a school, in a hospital or via public health efforts).
- **Question C4:** Submitters will indicate here if there is a minimum age requirement for the individuals **implementing** the program or intervention.
- **Question C5:** Submitters will indicate in this question if there is a minimum number of hours required to implement the program or intervention (e.g., two 8-hour days, one 4-hour window, etc.).
- **Question C6:** This question asks about the time commitment required for participants of the program or intervention. For example, how many different times do the participants meet over the course of their involvement with the program or intervention? What would the total hours of participation add up to?
- **Question C7:** Submitters will indicate if the program or intervention is currently listed on any other registry and provide the name(s) of the registry(s).
- **Question C8:** This question asks how the submitter heard about the BPR and the new online submission application.
- **Question C9:** This question is in a text box format for submitters to provide any additional information they want the BPR reviewers to be aware of regarding the program or intervention.

Other Helpful Information

- Reviews can take up to 15 weeks, but typically take much less time. Submitters will receive an email to the email address provided on the application letting them know if the program or intervention has been accepted as soon as the three reviews are complete.
- BPR listings will consist of information pulled directly from the application, including websites and social media pages. The program or intervention contact information provided in the application will allow interested parties to connect with you directly if they would like more information.
- Please be sure the Program or Intervention Information and Evaluation section contains evidence and supporting documentation for efficacy with each population/audience the application has indicated (e.g., if a clinical intervention BPR application indicates it was designed for veterans, the Information and Evaluation section needs to include evidence of intended outcomes with veterans).
- If a program or intervention indicates that it was designed for multiple populations/audiences and has evidence to support that efficacy, **and** the content of the program or intervention is the same for all audiences, one BPR application can be submitted.
- If the content of a program or intervention has been altered specifically to be used for a particular population, and efficacy has been proven after that change, then that submission would be separate, and it would have its own listing on the BPR.
- If an additional program or intervention related to the original submission (such as a train-the-trainer program) has been developed, utilized, and evaluated, it should be submitted to the BPR separately.

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