Data-Driven Prevention Planning Model
Adapted for Suicide Prevention

The model assumes:
A broad coalition of stakeholders has been formed
The coalition has identified suicide prevention as the area of focus
The coalition is sufficiently organized and has the infrastructure necessary to take on a project.
A Strengths, Weaknesses, Opportunities, and Threats (SWOT) assessment can help to ensure this

Step 1: Establish clear vision and framework for prevention – The coalition needs to develop a shared vision for preventing suicide and should adopt a public health model or framework as recommended by the National Strategy for Suicide Prevention. The coalition may define preventing suicide as being limited to interventions with people who are at acute risk for suicide. However, a more comprehensive, public health approach suggests a definition that would include efforts to mitigate risk factors and enhance protective factors in individuals long before they become at risk for suicidal behaviors.

At this point the Planning Model branches into three arms. These assessments can be made simultaneously. However, coalitions with limited resources and capacity may need to follow the three arms sequentially.

Step 2, Branch 1: Assess incidence/prevalence, risk/protection, and demographics; prioritize populations and risk/protective factors – In this step, the coalition’s goal is to develop a common understanding of suicidal behaviors in its “community of interest.” Consideration is given to available data on suicide, suicide attempts, and suicidal ideation, as well as the antecedent risk and protective factors that seem to be most prevalent. Qualitative assessments can help answer questions when quantitative data are not available. On the basis of these data, the coalition must select priority populations and the risk and protective factors that seem most important, understanding that everything cannot be done for every subpopulation at once. Coalitions should bear in mind that the National Strategy recommends a comprehensive approach to suicide prevention across the lifespan.

Step 2, Branch 2: Assess community and local readiness for prevention – While suicide prevention may be a priority for coalition members, it is important to understand the extent to which the political, economic, and social climates in the community are conducive to engaging in suicide prevention. This assessment is crucial. It prevents coalitions from moving ahead only to be surprised by barriers they could have anticipated and avoided or removed had they planned more carefully. The following scale from the National Institute on Drug Abuse is useful for assessing readiness of any particular sector or stakeholder group. Periodic reassessments over time will give a planning coalition some indication whether readiness is increasing among key stakeholders.

**Community Readiness Scale**
- Community tolerance
- Denial
- Vague awareness
- Preplanning
- Preparation
- Initiation
- Institutionalization
- Confirmation/expansion
- Professionalization

Step 2, Branch 3: Assess community and local resources – Although most coalitions long for a generous line item in the state or local government budget, lack of such funding should not be considered an insurmountable barrier. Even in tough fiscal times, there are indigenous resources in communities with which to advance suicide prevention. In the long run, these resources are often the most effective in accomplishing the goals of the coalition. Increasingly though, suicide prevention funding is becoming available from state and federal grant programs. Even with government funding, a broad-based coalition should seek creative ways to leverage non-traditional resources to support their projects. An important resource in the community are other agencies working on known risk and protective factors shared with suicide, e.g., family violence prevention, juvenile justice, agencies on aging, faith-based organizations, etc. Hence, the coalition needs to do a thorough review of resources in their community. SPRC has a community assessment tool to help coalitions through this process ([http://www.sprc.org/library/catool.pdf](http://www.sprc.org/library/catool.pdf)).

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Once the three arms of Step 2 have been completed, coalition members need to collate the results before proceeding to Step 3.

**Step 3: Compare populations, risk/protection, and resources** – Using results obtained in Step 2, coalitions must develop a problem statement specifying the population(s) and risk/protective factors they are going to address. This will be the result of an integration of need (data), feasibility (readiness) and available resources, and will be used to guide the development of the plan (Step 4).

We recommend simultaneously undertaking the next two tasks. Coalitions will have to prioritize when implementing multi-faceted programs with limited resources.

**Step 4, Branch 1: Promote readiness for prevention** – As mentioned earlier, community readiness is key to the success of any prevention effort. Some communities have an environment that is very favorable for suicide prevention. Even these communities will benefit from ongoing efforts to strengthen and broaden this readiness. Involving key community leaders in the planning process will help. Education and advocacy are other important approaches that increase community readiness.

**Step 4, Branch 2: Implement programs to address risks, enhance protection and fill gaps** – Coalitions must choose interventions that, based on their logic models and evaluations, are likely to achieve the identified goals among the target population(s). The Best Practices Registry for Suicide Prevention (http://www.sprc.org/featured_resources/bpr/index.asp) is a source of ever-increasing information about interventions that have been shown to reduce suicidal behaviors or in other ways advance the National Strategy. Ideally, interventions should be targeted at multiple levels simultaneously. For instance, if youth suicide prevention is the goal, interventions should address students, teachers, school administrators, community resources, and parents at a minimum. Another way to think about the various levels at which interventions should be targeted is a schema developed by Cohen and Swift, published in *Injury Prevention*.3 It defines six discreet levels:

<table>
<thead>
<tr>
<th>Level of Spectrum</th>
<th>Definition of Level</th>
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<tbody>
<tr>
<td>1. Strengthening Individual Knowledge and Skills</td>
<td>Enhancing an individual’s capability of preventing injury or illness and promoting safety</td>
</tr>
<tr>
<td>2. Promoting Community Education</td>
<td>Reaching groups of people with information and resources to promote health and safety</td>
</tr>
<tr>
<td>3. Educating Providers</td>
<td>Informing providers who will transmit skills and knowledge to others</td>
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<tr>
<td>4. Fostering Coalitions and Networks</td>
<td>Bringing together groups and individuals for broader goals and greater impact</td>
</tr>
<tr>
<td>5. Changing Organizational Practices</td>
<td>Adopting regulations and shaping norms to improve health and safety</td>
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<tr>
<td>6. Influencing Policy and Legislation</td>
<td>Developing strategies to change laws and policies to influence outcomes</td>
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To the extent possible, coalitions should be engaging their communities on all six levels to achieve optimal gains. After selecting appropriate interventions, coalitions must develop an action plan that identifies responsibilities, resources, and timelines for each intervention, and then, monitor progress.

**Step 5: Monitor data to evaluate policy, funding, and program decisions** – This is an essential step in the public health model. This usually involves gathering data of some sort to measure either the extent to which interventions are completed (e.g., numbers of individuals trained), or some outcome measure associated with the prevalence of risk or protective factors targeted by the intervention (e.g., suicidal ideation, perceptions of social support, connections to school or family, etc.). Suicide itself is usually, though not always, difficult to use as an outcome measure, since there are usually many other variables that can influence suicide rates but are nearly impossible to control during the course of the intervention. Also, the relative infrequency of suicide makes it very difficult to determine whether any change observed was due to the intervention or simply attributable to random variation. Therefore, evaluation activities must be tailored for each prevention program with data collection processes designed specifically to support the evaluation plan. Clear logic models describing how the intervention produces desired outcomes help ensure alignment between program goals and the evaluation plan. Someone with an understanding of biostatistics should guide the evaluation efforts.

**Continuous Improvement** – While this model is drawn linearly, there is an implicit understanding that the evaluation results, and even less formal lessons from the planning and intervention process will be used for continuously improving the quality of the interventions and the effort overall.

To download a copy of this document, visit: http://www.sprc.org/library/datadriven.pdf

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