

Out of the Lab and Onto Our Streets

Findings from Three National Evaluation Efforts on the Use and Implementation of Evidence-based Practices in Community-based Service Settings

What are we talking about today?

- Prevention and treatment best practice adoption/implementation among front-line child and youth support agents (human service providers, gatekeepers, etc.)
- Data presented today are drawn from evaluations of three major Center for Mental Health Services Initiatives

What are the three initiatives?

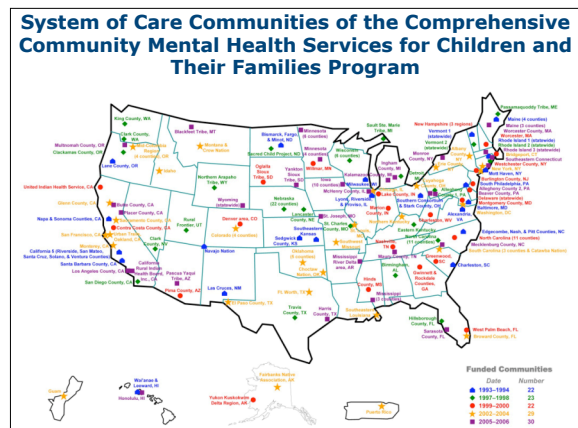
- The Comprehensive Community Mental Health Services for Children and Their Families Program
- The Donald J. Cohen National Child Traumatic Stress Initiative
- The Garrett Lee Smith Suicide Early Intervention and Prevention Program

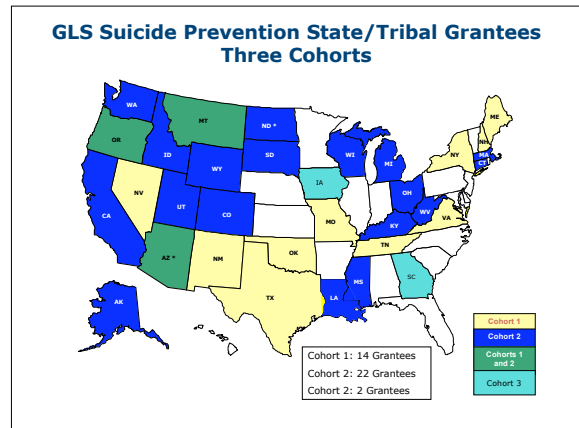
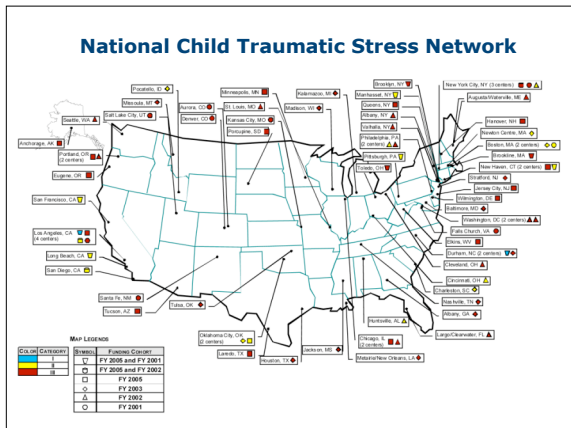
What are the three initiatives?

Initiative	Purpose
The Comprehensive Community Mental Health Services for Children and Their Families Program (CMHI)	To encourage the development of home and community-based "systems of care" in States, political subdivisions of States, American Indian tribes or tribal organizations, and territories, that meet the needs of children and adolescents with serious emotional disturbances and their families.
The Donald J. Cohen National Child Traumatic Stress Initiative (NCTSI)	To improve access to care, treatment, and services for children and adolescents exposed to traumatic events across the country; and to encourage and promote collaboration between academic researchers and service providers to develop and disseminate related and effective practices.
The Garrett Lee Smith State/Tribal Suicide Early Intervention and Prevention Program (GLS-S/T)	To support States and Tribes in developing and implementing State-wide or Tribal youth suicide prevention and early intervention strategies, grounded in public/private collaboration.

More Initiative Information

Initiative	Initial Public Law Authorization	Sites funded to date	Sites currently funded	Year Mandated Evaluation Began
CMHI	Alcohol Drug Abuse and Mental Administration reorganization Act; 1992; PL 102-321	126	59	1993
NCTSI	Children's Health Act; 2000; PL 102-310	77	44	2004
GLS-S/T	Garrett Lee Smith Memorial Act; 2004; PL 108-355	38	38	2005





National Evaluation Efforts

- All three national evaluations:
 - are multi-site
 - are multi-level
 - are multi-component
 - include emphasis on understanding best practice and its implementation

Specific Study Components for Presentation Today

Initiative	Study Component/Data Collection Activity	Driving Research Questions
CMHI	Evidence-based Practice Study	<ul style="list-style-type: none"> What are practitioner's knowledge, attitudes, and use of EBPs? What practitioner factors are associated with the use of EBPs? How do administrators/practitioners assess their agency's readiness for change? What organizational indicators are associated with implementation of EBPs? What is family knowledge of and service experience with EBPs?
NCTSI	Adoption of Methods and Practice Study	<ul style="list-style-type: none"> What types of trauma-informed practices, including EBPs, are most widely adopted within the Network? What actors (administrators, clinicians, evaluators) are involved in the adoption and implementation process? How are practices introduced to such actors? What supports facilitate adoption/implementation? What barriers hinder adoption/implementation? What is the timeframe for implementation of practices including EBPs?
GLS-S/T	Gatekeeper Training Utilization	<ul style="list-style-type: none"> What is the intended utilization of gatekeeper skills/knowledge among mental health providers, as compared to non-mental health providers? What is the actual utilization of gatekeeper training skills/knowledge among mental health providers, as compared to non-mental health providers? What are the perceived barriers and facilitators of gatekeeper skills and knowledge among mental health providers?

Implementation Factors for Evidence-based Practices within Children's Mental Health Systems of Care

CMHI Systems of Care

Authors: Kurt Moore, Carolyn Lichtenstein, John Fluke, Michelle DiMeo

The Survey

- The EBP survey combines the Evidence-Based Practices Attitudes Survey (EBPAS; Arons, 2004) and the Organizational Readiness for Change-Staff version (ORC-S; Lehman et al., 2002).
- The survey was administered on-line and by paper & pencil between late September 2007 and February 2008.
- There were a total of 110 complete and 119 incomplete responses.

CMHI Systems of Care

Respondent Attributes

- **Gender:** 30% of survey completers declined to identify their gender; 22% chose male, 48% female.
- **Age:** Mean age 43
- **Education:** 76% were Master's level.
- **Profession, licensure:** 42% identified themselves as a Clinician/Therapist; 71% were licensed.
- **Years in practice:** Mean of 11 years

CMHI Systems of Care

Definition of Evidence-based Practice

- Evidence-based practice in psychology is the integration of the best available **research** with **clinical expertise** in the context of **patient characteristics, culture, and preferences** (Sackett, Straus, Richardson, Rosenberg & Haynes, 2000).

CMHI Systems of Care

Survey item: If you were to define "evidence-based practice," how might you define it?

Responses that mentioned:

- Research = 97
- Clinical Expertise = 1
- Patient Characteristics = 9

Responses including:

- One correct component = 89
- Two correct components = 9
- Three correct components = 0
- No correct components = 11

CMHI Systems of Care

Advantages of Using EBPs 236 were described

<i>Research & Practice Effectiveness</i>	92	EBPs have solid research to support effectiveness. These practices have been proven to help.
<i>Resource Efficiency</i>	22	Insurance pays for and grant funds support. Saves time.
<i>Structure</i>	19	Therapy is laid out for the therapist, includes manual and tools. There are clear guidelines to follow regardless of clinician training or expertise.

CMHI Systems of Care

Disadvantages of Using EBPs 196 were described

<i>Client Characteristics Not Integrated</i>	66	Ignore youth/family needs and differences. May not be culturally competent.
<i>Resource Inefficiency</i>	24	Costly to implement and sustain. Considerable time is required to be proficient at multiple EBPs.
<i>Research and Practice Problems</i>	23	Long-term psychotherapy outcomes are difficult to measure. Experimental research designs can be flawed.
<i>Too Structured</i>	23	EBP discourages innovation. There is not enough freedom to customize techniques.

CMHI Systems of Care

Implementation of EBPs

- Respondents reported not fully implementing 85% of the EBPs described.
- Top 3 reasons were:
 - Adapting practices to fit youth/family needs
 - Lack of training/experience
 - Agency/organizational issues

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Reason #1 For Not Fully Implementing EBPs:
Adapting practices to fit youth/family needs

- One respondent explained that the last family she/he used Trauma-focused Cognitive Behavioral Therapy (TF-CBT) with already had strong behavioral management skills, so she/he omitted most of that treatment module and just reinforced and reviewed.
- Sixteen responses noted the use of elements of an EBP in conjunction with other practices, but did not state why.
- Several respondents noted that they use a mixture of treatment approaches.

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Reason #2 For Not Fully Implementing EBPs:
Lack of training/experience

- Several respondents noted that they had never received a manualized training and were not certain they knew the full treatment protocol.
- Another respondent admitted they were still unsure how the practice was really supposed to work.

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Reason #3 For Not Fully Implementing EBPs:
Agency/organizational issues

- A common response was that agency policies dictated treatment practices.
- Respondents described a lack of tools, technologies, and managerial support for full implementation.

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Summary

- The 'definition' responses may indicate a widespread problem for EBP.
- Most of these practitioners are unable and/or unwilling to fully implement EBP.
- Practitioner knowledge, beliefs, and attitudes may constitute a large barrier to full implementation.
- Perceived disadvantages were often the flip side of perceived advantages.

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Next steps

- We plan to sort these data by the specific EBP the respondents report using, and look for commonalities and differences in implementation issues.
- We plan to look for relationships between reported organizational characteristics and attitudes toward/use of EBP.
- We will use these results to inform future substudies.
- Other suggestions?

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**Evidence-based, Trauma-informed
Practices and Resources: Adoption and
Implementation in the National Child
Traumatic Stress Network**

NCTSI Cross-site Evaluation

Adoption of Methods and Practices Study NCTSI Cross-site Evaluation (2004-Present)

- **Purpose of study**
 - To assess adoption/implementation of trauma-informed practices including EBPs among funded NCTSI center staff and partners
 - To identify contextual factors associated with adoption and implementation
- **Methodology and data sources**
 - The General Adoption Assessment Survey (GAAS)
 - ✓ Annual Web-based survey of NCTSI administrators, evaluators and human service providers to determine frequently adopted trauma-informed products, and related factors influencing adoption and implementation
 - The Adoption and Implementation Factors Interview (AIFI)
 - ✓ Annual telephone interview conducted with a subset of NCTSI centers to collect additional in-depth, qualitative information about factors that facilitate or hinder adoption and implementation
- **Current Focus: GAAS Survey**
 - Second annual GAAS survey administered August 2007 to early January 2008

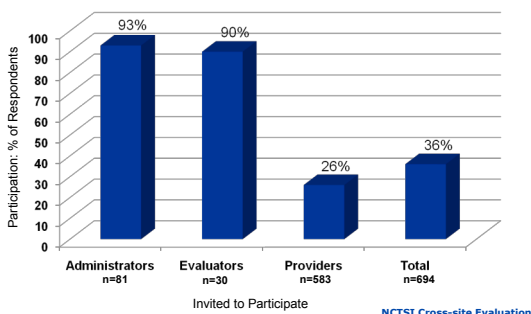
NCTSI Cross-site Evaluation

The GAAS Survey

- **30-minute Web-based survey**
 - Annotated list of 126 trauma-related products including EBPs
 - Questions about adoption/implementation of the specific practices and products endorsed by three types of respondents
 - Survey branches into three versions
 - ✓ Administrators
 - ✓ Evaluators
 - ✓ Human service providers
- **2007 GAAS administration**
 - Timeframe: August 2007 to early January 2008
 - Four-stage e-mail invitation/recruitment process (Dillman, 2000)
 - 694 respondents invited, 36% response rate
 - Differences in participation by role

NCTSI Cross-site Evaluation

Variation in GAAS Participation By Role



NCTSI Cross-site Evaluation

Adoption/Implementation Definitions

- **Adoption.** Agency or individual's act of identifying a practice or resource of potential value (e.g., an EBP) and deciding to implement or use it
- **Implementation.** A specified set of activities designed to put into practice an activity, resource or method, and to incorporate it into the routine operations of an agency's or individual's professional services (e.g., into routine mental health service delivery).
- **Engagement Methods.** Resources that introduce a practice or related resource to an individual or organization and provide an opportunity to adopt it.
- **Facilitators.** Factors that support the implementation of a practice or related resource over time.
- **Barriers.** Factors that present obstacles to or hinder the implementation of a practice or related resource over time.

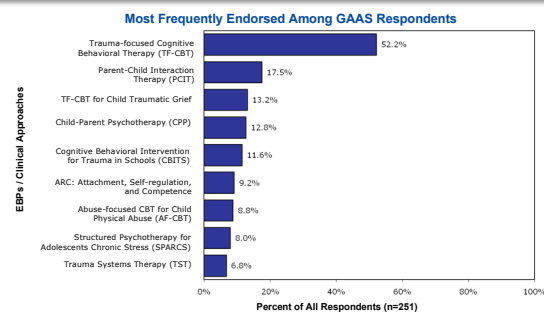
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GAAS Results: Endorsements By Product Category

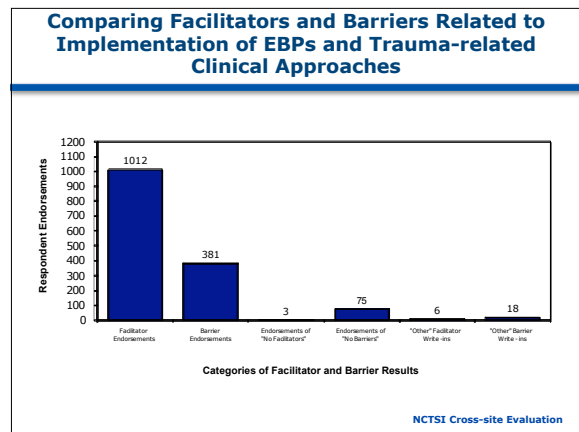
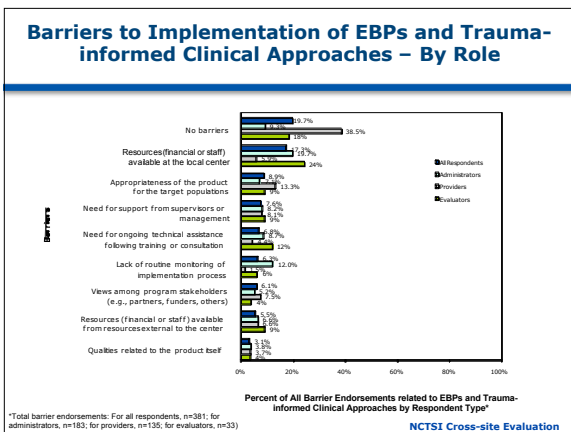
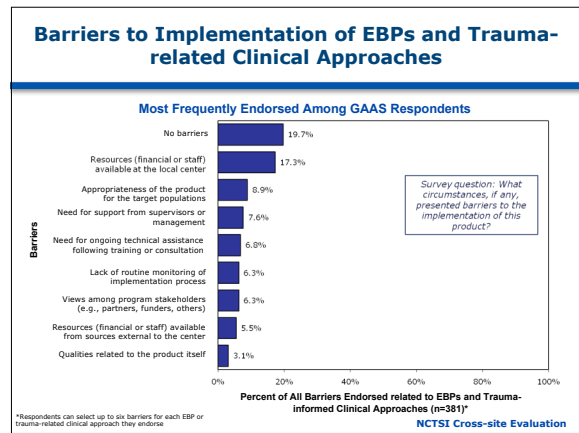
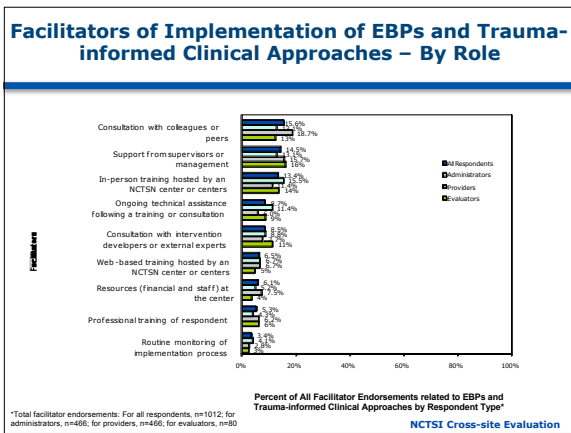
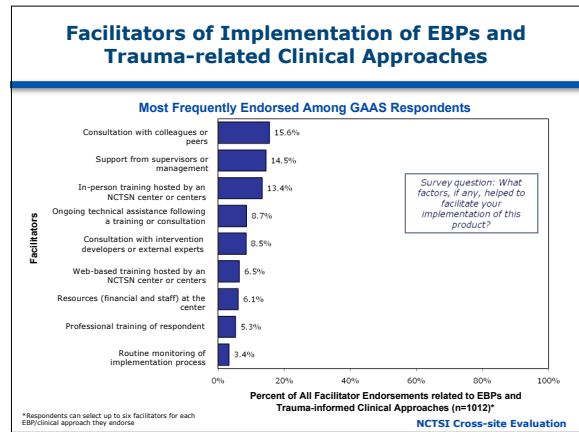
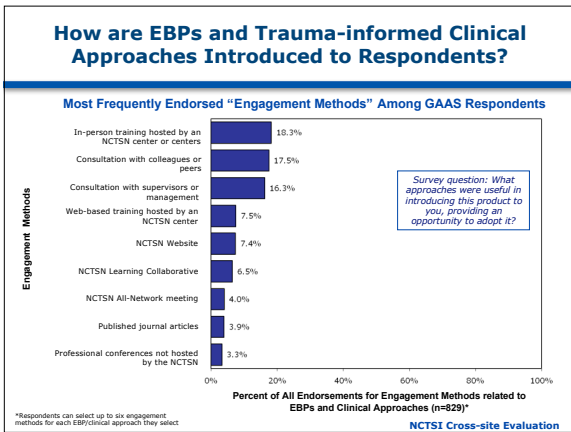
Assessment Measures	Percent of Respondents (n=251)
UCLA PTSD Index for DSM-IV	61%
Child Behavior Checklist for Ages 6-18 (CBCL 6-18)	56.6%
Trauma Symptom Checklist for Children-Abbreviated (TSCC-A)	56.2%
Child Behavior Checklist for Ages 1.5-5 (CBCL 1.5-5)	53%
Clinical Interventions (EBPs) & Trauma-informed Approaches	Percent of Respondents (n=251)
Trauma-focused Cognitive Behavioral Therapy (TF-CBT)	52.2%
Parent-Child Interaction Therapy (PCIT)	17.5%
TF-CBT Traumatic Grief (TG-CBT)	13.2%
Child-Parent Psychotherapy (CPP)	12.8%
Information Resources	Percent of Respondents (n=251)
Complex Trauma in Children and Adolescents	23.9%
Understanding Child Traumatic Stress	20.3%
Psychological First Aid Field Operations Guide, 2nd Edition	13.2%
Culture & Trauma Brief: Culturally Competent Trauma-informed Services	10.8%
Training/Technical Assistance Materials	Percent of Respondents (n=251)
TF-CBT Web: A Web-Based Learning Course for TF-CBT	43.8%
Learning Collaborative Toolkit	17.1%
Cops, Kids and Domestic Violence: A Training Video	13.2%
Administration and Scoring of the UCLA PTSD Reaction Index	10.8%

NCTSI Cross-site Evaluation

EBPs and Trauma-informed Clinical Approaches



NCTSI Cross-site Evaluation



Barriers to Implementation of EBPs and Trauma-related Clinical Approaches: Selected Qualitative Responses

Related to EBPs/Clinical Approaches

Factors related to...

The product

"This intervention needs a formal training curriculum" (Child-Parent Psychotherapy)

Individuals: clinical population

"Families unavailable for full implementation." (Trauma Systems Therapy)

Individuals: clinical staff

"Difficulties with presentation of change to existing staff" (Parent-Child Interaction Therapy)

Program-level resources and factors

"Have had a hard time getting enough referrals to implement practice" (Parent-Child Interaction Therapy)

Related specifically to TF-CBT

Factors related to...

The product

"90-minute sessions"

Individuals: clinical population

"Lack of client follow-through"
"Multiple demands at the same time related to acuity of client needs"

Individuals: clinical staff

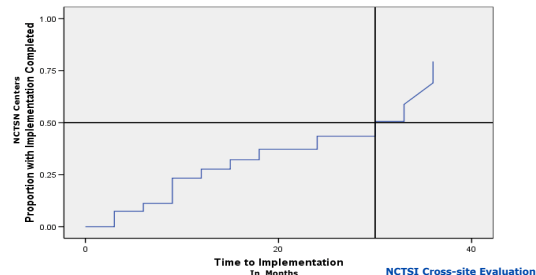
"Some staff resistance"

Program-level resources and factors

"Not enough qualified therapists for all our needs"
"Child care for younger children during parent sessions"

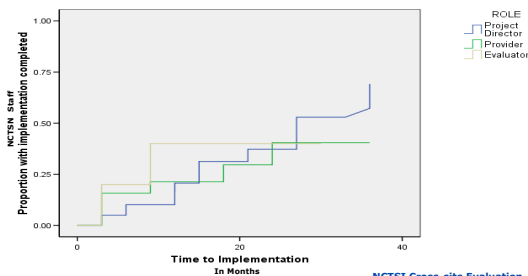
NCTSI Cross-site Evaluation

Estimated Time to Implement Trauma-focused Cognitive Behavioral Therapy (TF-CBT)



NCTSI Cross-site Evaluation

Estimated Time To Implement TF-CBT: Perceptions By Professional Role



NCTSI Cross-site Evaluation

Summary

- Respondents endorsed 99% of the 126 trauma-informed products and practices listed in the GAAS, suggesting diverse needs among NCTSN target populations and stakeholders, and effective dissemination efforts to enhance availability of products
- TF-CBT endorsed by over 50% of all respondents, suggesting successful dissemination of this EBP and/or relatively wide applicability for a variety of service settings and demographic and clinical populations
- Resources of the NCTSN designed to disseminate evidence-based, trauma-informed resources were significantly more frequently endorsed by respondents than potentially similar resources offered in other contexts (e.g. in-person training and Web-based training).
- Respondents perceive greater quantity of factors that facilitate implementation of EBPs/clinical approaches than factors presenting barriers
- Findings are a fairly strong indication that resources developed by NCTSN to disseminate trauma-informed practices/EBPs, including training offered in person and via the Web, have led to increased adoption and implementation

NCTSI Cross-site Evaluation

Summary (continued)

- Technical assistance following a training is not only a critical resource needed to support implementation, but it is a somewhat inconsistently provided resource—one that should be made available more frequently.
- Support from supervisors and management—also critically important (the 3rd most frequently selected engagement process and 2nd most frequently selected facilitator; the lack of this resource was among the 10 most frequently selected barriers to implementation)—not always available.
- Based on the length of time GAAS respondents report implementing TF-CBT, we estimate that 65% of centers typically complete the implementation of TF-CBT by 36 months, or after about 3 years; about 50% of the centers typically implement TF-CBT after about 30 months—or about 2.5 years
- Little difference in perceptions based on professional role related to length of time required to implement TF-CBT

NCTSI Cross-site Evaluation

Next Steps

- AIFI Interviews
 - 45-minute, semistructured interview
 - Respondents: administrators, providers, clinical supervisors
 - Subset of NCTSN centers
 - Designed to elicit information related to the following domains
 - ✓ Practice implementation history and status
 - ✓ Organizational culture and characteristics
 - ✓ Resources
 - ✓ Internal support infrastructure
 - ✓ Network support
 - ✓ Past experience
 - ✓ Organizational readiness
 - ✓ Staff attitudes (appeal, likelihood of adoption, openness, divergence from current practices) (based on Hoagwood & Pezzulo, 2004)

NCTSI Cross-site Evaluation

Training Retention and Utilization: The impact of suicide prevention training activities on youth-serving professionals and their communities

Cross-site Evaluation of Garrett Lee Smith (GLS) Suicide Early Intervention and Prevention Program

Gatekeeper Training Measures

- **Training Exit Survey**
 - Administered to all trainees immediately following the training
 - Assesses content, satisfaction, and intended utilization
- **Training Utilization and Penetration Interviews (TUP)**
 - 30 minute semi-structured telephone interview
 - Administered to a sample of trainees 2 months post-training
 - Assesses content, utilization, and perceived impact of training
 - Average sample size = 7.5 individuals
 - Individual answers can be linked to Training Exit Survey

GLS-S/T Cross-site Evaluation

Trainings Used for TUP Interviews

- **Applied Suicide Intervention Skills (ASIST) Training**
 - 4 trainings; 26 respondents; 50% were MH providers
 - 2 day training for professionals and "lay" persons
 - Builds knowledge and skills to respond to suicidality
- **Assessing and Managing Suicide Risk**
 - 2 trainings, 20 respondents; 75% were MH providers
 - 1 day training for clinicians
 - 24 core competencies for risk assessment and client management
- **"Home Grown"**
 - 5 trainings; 34 respondents; 35% were MH providers
 - Target audience and training times vary
 - Generally include information on suicidality, risk assessment, and response

GLS-S/T Cross-site Evaluation

TUP Participant Overview

- **90 Interviews**
 - 70% employed in mental health field

OF THE 40 MH PROVIDERS:

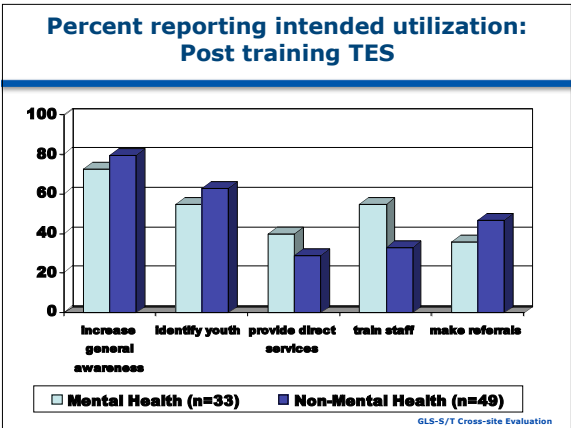
- **38% received training related to suicide prevention in last year**
- **95% had prior exposure to information on suicide prevention**
- **95% reported desire for additional training**
 - 38% Refresher Training
 - 25% Assessment, diagnosis, treatment
 - 18% Population-specific (youth, elderly, co-occurring disorders)
 - Other: Available resources, emerging evidence, ToT

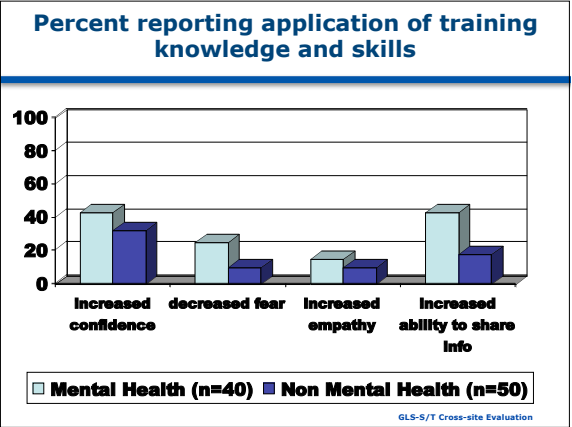
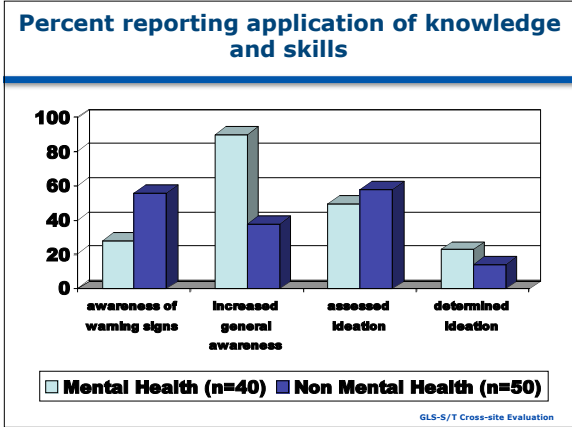
GLS-S/T Cross-site Evaluation

TUP: Mental Health Providers

Looking at the intended vs. actual utilization of MH providers, as compared to non-MH providers...

GLS-S/T Cross-site Evaluation





MH Providers: Utilization of Skills

- Trainees report heightened awareness of warning signs for suicide
 - "I think I have a much better understanding and consistent format for when I'm working with a youth who may be displaying warning signs. I think I'm much better at being able to recognize those. And then also knowing what to do and what ones to act upon as far as that are more imminent versus those that just need to be monitored and maybe more of an intervention on a school, from a counseling standpoint."
- Trainees report better listening skills, increased empathy
 - "I mean the training did gear me towards being able to be more patient and listening and hearing what they have to say opposed to okay, you've got a problem, let's fix it. Just listening to what's going on.... More patience I guess."

GLS-S/T Cross-site Evaluation

MH Providers: Utilization of Skills

- Trainees report increased comfort with the topic of suicide and confidence in their ability to respond
 - "I think it's two pronged. I think it's I have more information that I ask about and I can draw from, both getting information from the client and information that I already have within myself. And secondly, I feel a stronger sense of confidence. That doesn't mean that I don't go in with a client who is demonstrating suicidal ideation and not think to myself oh my goodness, I've got another situation to deal with. But I go in with more confidence in the sense that okay, I have this client, I know what to do, it is going to be a bit scary, it always is, and yet I feel more confident in my abilities to provide appropriate services."
- Mental health clinicians report benefit of evaluating personal attitudes and beliefs about suicide
 - "Talking about how we respond to somebody that we may feel is suicidal or has expressed suicidal ideations, and some of the things that go on with us emotionally and how those can impact our reactions and ultimately our decisions in terms of dealing with these individuals."

GLS-S/T Cross-site Evaluation

MH Providers: Utilization of Skills

- Trainees report less anxiety around suicide
 - "I was like a deer in the headlights before, and now I feel very comfortable addressing it...I think that I'm more just at ease when somebody says that to me. I used to be very high stress, like what do I do, what do I do. And now I feel more confident and at ease and I'm not, it's not such a taboo issue anymore. I often have teachers who hear kids say something and they come to me freaking out because they don't know what to do and I feel like I know how to handle it and I can do this."

GLS-S/T Cross-site Evaluation

MH Providers: Utilization of Skills

- Trainees are better equipped to assess whether someone is suicidal, and are more direct in their questioning.
 - "I had a habit of saying 'are you thinking about harming yourself' or trying to buffer the question. I guess maybe I wasn't aware that I thought it would damage the rapport with the client... But now I've realized by directly asking 'are you thinking about suicide' is actually comforting because it tells the client that you're comfortable with the subject. It's not something to be ashamed of, and it's something that they can talk about openly and you're able to handle it. I mean it sends a better message. So that's one thing that I've used over and over is to remember to ask often, ask directly, and I've definitely been more aware of risk factors since then."

GLS-S/T Cross-site Evaluation

MH Providers: Utilization of Skills

- **Trainees feel more knowledgeable and better able to discuss the subject of suicide.**
 - *"I just think I feel more comfortable and confident in what I'm saying. I have more information to discuss. And again, just making people aware of the importance and the statistics about teen suicide and how we can prevent this if people just become aware and take seriously warning signs that they recognize."*
- **Colleagues are the primary beneficiaries of training information**
 - *"I think that it has raised my value in their eyes and they're more free to ask me a question or to kind of link to me or to draw from that, if that makes any sense at all. I think it's given me a higher level of credibility, which makes me more available for them for other colleagues."*

GLS-S/T Cross-site Evaluation

MH Providers: Other relevant feedback

- **Practice is important**
 - Trainees learn from role play; those who didn't have it, want it.
 - Practice and experience cited as a facilitator of suicide prevention
- **There is a need for culturally-relevant training curriculum**
 - *"I believe there could be additions more specifically tailored to native people, even to our reservation's community members in the sense of bringing cultural, that cultural healing process into it and recognizing that, and then also a spirituality component that may be for some people the one thing that gets them through ..."*
- **Training opportunities should be expanded and made available to other populations**
 - *"I think this would be even more effective if just regular community people were more involved, people that interact with youth, like lifeguards or a youth minister or someone that's going to be interacting with kids kind of in those fun situations besides more professionally....I think it would really benefit the community."*

GLS-S/T Cross-site Evaluation

MH Providers (n=40): Barriers to Suicide Prevention

- **Stigma and lack of understanding – 48%**
 - *"A lot of times people are afraid to ask for help when that's one of their thoughts because it's just something that's not talked about in society, or talked about in their family or their religious beliefs and they feel like it's so wrong that they feel guilty and they feel mad at themselves for even thinking about it. So I think it's that block that people have of not feeling like they can come and talk to someone about it and middle school kids, they're smart enough to know that if they come and tell a counselor that that counselor has to talk to their parents about it."*

GLS-S/T Cross-site Evaluation

MH Providers (n=40): Barriers to Suicide Prevention

- **Lack of services – 23%**
 - *"I think one of the biggest barriers is the fact that we don't have an inpatient adolescent center in the community. We have to send people out of the county. And we have great therapists, but we don't have any wrap around care unless the student is involved in the juvenile system and just has tons of things going on. There's not a lot of immediate care for a teen unless we send them to the hospital, which isn't always the best step. And then we have a therapist and they can't get in for four weeks. Well, what does the family do for the next month?"*

GLS-S/T Cross-site Evaluation

MH Providers (n=40): Barriers to Suicide Prevention

- **Reaching adolescents – 18%**
 - *"But I think the barrier is always going to be getting your foot in the door with the people who are most at crisis and the largest population of folks most at risk are teens, especially boys, and especially in that 16 to 25-year-old bracket. And sometimes getting your foot in the door with them is pretty tricky. You can't always just walk through that door and be able to help. So I think just getting access to the people most in need is always the biggest challenge"*
 - *"Yeah. I would say something that could be a barrier here would be with time available to go into the classroom to talk about that topic. Sometimes that can be a challenge because of the different standards that are trying to be met in the different content areas, like math, social studies, language arts, so I think that's kind of a priority."*

GLS-S/T Cross-site Evaluation

MH Providers (n=40): Barriers to Suicide Prevention

- **Clinician/Agency resistance to change – 13%**
 - *"After I went to the training I said to my supervisor, 'I went to this training and I have some materials if you want to share this with the team,' and she said no, I don't really think it's an issue with these clients. But really it is. But she dismissed the whole idea. So that's a barrier."*
- **Cost of training – 10%**
 - *"To do this training it's expensive in my opinion. And it may be nationally they don't see that as expensive. But we do a lot of training for our community and across the state in suicide prevention and we don't charge anywhere near what they would have to pay if they go through this. And I think that's unfortunate because I think that's going to shut the door to this training. When again they want to get the word out they need to make it as inexpensive for people as they can possibly do that and starting off with the kind of prices that they've got and then adding on the cost of the trainer is, it's just undoable for most agencies... We're dirt poor here."*

GLS-S/T Cross-site Evaluation

**MH Providers (n=40):
Facilitators of Suicide Prevention**

▪ **The training itself – 50%**

- *"I think it's been a great help. It's, again, more confidence, I feel more adequate in my skills, it was kind of a fine tuning, being able to respond in a situation like the crisis or emergency room and actually use the technique was kind of neat to see how it worked out and to know that it does work if used properly. I believe in the education and prevention area, that it does bring about awareness to everybody in there, whoever you're talking to."*

GLS-S/T Cross-site Evaluation

**MH Providers (n=40):
Facilitators of Suicide Prevention**

▪ **Agency policies and resources – 30%**

- *"We do aggressively train staff and we make it a requirement that people get training. We require all staff to complete a competency on suicide risk assessment within a month after they are hired here. And then they have to go to an annual competency. But at least in terms of being aware of it, it's part of our assessment, there's a screening tool that's part of our assessment that all clinicians have to complete. We do a peer review, and we also do a chart audit every month of 100 charts to make sure that on a random basis as we're looking at assessments and ongoing discussion of suicide that it's being done so the providers on a monthly basis get feedback on the percent compliance of asking about and assessing for suicide risk at the initial assessment, and if an individual has indicated thoughts or previous attempts that they document on each subsequent session that they are talking about suicide risk."*

GLS-S/T Cross-site Evaluation

**MH Providers (n=40):
Facilitators of Suicide Prevention**

▪ **Supportive supervisor / colleagues – 28%**

- *"Well, I'm really just, I mean I guess my supervisor is supportive of whatever I do from whatever I learned. I mean she's not telling me exactly how I need to interact with my clients. So I can take everything that I've learned and use it. So there's no barriers..."*
- *"I think the environment is conducive. I think I'm in a school where it's high risk kids, so I think the people that work in that environment really want to help those kids in any way they can. So I think that that's what you're getting at."*

▪ **Having a specific model or steps to follow – 25%**

- *"I think the fact that they've organized the information into a very nice concise package is very valuable, that we're going to be giving out a consistent message and that it's a sound message. As I said before, a lot of what they said was information that I'd been taught already before and have learned to apply before. But it has never been put into a package the way this has."*

GLS-S/T Cross-site Evaluation

**MH Providers (n=40):
Facilitators of Suicide Prevention**

▪ **Local suicide or tragic event – 18%**

- *"Or the other thing is if you have a suicide at your school, then they say wow, we need to have, we need to be able to identify things here quicker. So those are the kinds of things too that I think make a difference. And that's sad because we didn't prevent that one."*

▪ **Practice – 13%**

- *"I think with experience, you just feel more comfortable talking about it and nothing that someone says kind of shocks you. And I think when you don't react in a shocked way that people are much more willing to continue to talk. So if they mention I'm thinking about killing myself and you react in a nice calm kind of okay, tell me about that. Let's talk about it, and you're not like you can't do that and kind of the shocked look on your face, you really wouldn't say that, but the shocked look on your face, I think it's easier for them. So I think with experience and having training like this and having practice in the trainings, the role plays, that's definitely beneficial."*

GLS-S/T Cross-site Evaluation

**TUP: Summary of findings from
Mental Health Providers**

- Providers report anxiety around treating suicidal clients, and that the training increases their comfort and confidence.
- Trainings that have role play components and provide specific steps are reported to be most useful and effective.
- Stigma and lack of services are the primary barriers to suicide prevention in the community.
- Agency policies can facilitate or inhibit individual efforts for suicide prevention: policies which encourage professional development and collegial sharing of information are primary facilitators of suicide prevention.
- Tragic events are opportunities for prevention and providers and program planners should be prepared.
- Trained providers want additional trainings.
- Experience is the best teacher.

GLS-S/T Cross-site Evaluation