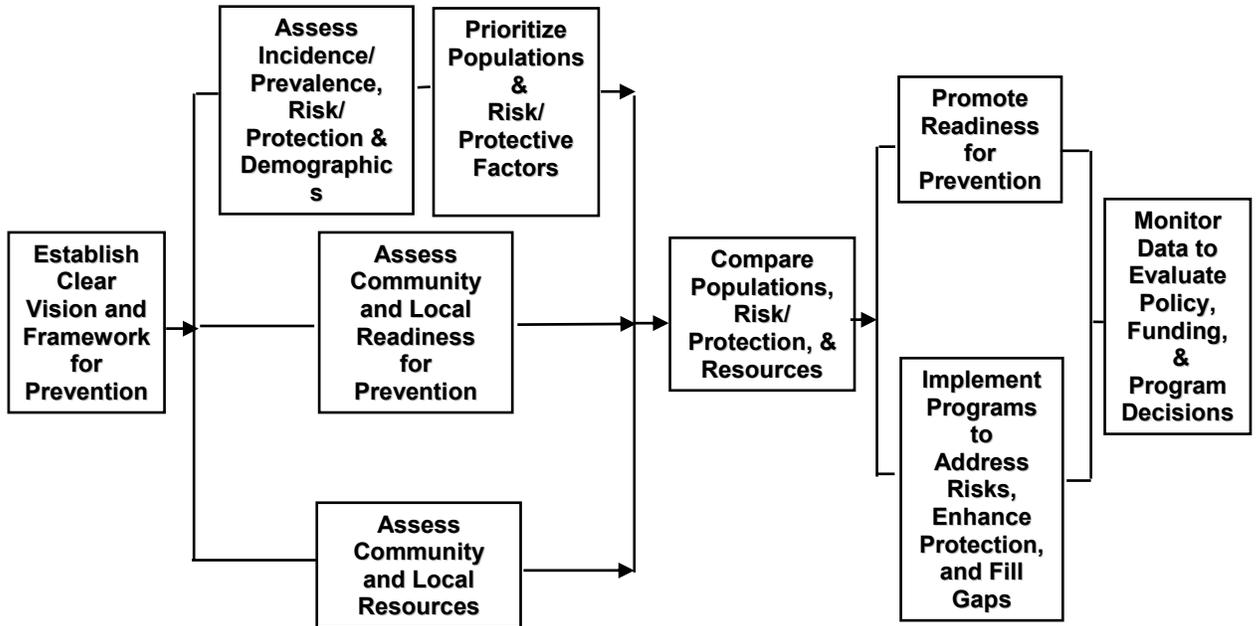




Data-Driven Prevention Planning Model



Adapted from Richard Catalano and David Hawkins, U of Washington.

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Suicide Prevention Resource Center





Data-Driven Prevention Planning Model

This model has been developed by Richard Catalano and David Hawkins at the University of Washington. To start, the model is based on certain assumptions:

1. A broad-based coalition of stakeholders has been formed
2. The coalition has identified suicide prevention as the area that it would like to focus on
3. The coalition is sufficiently organized and has the infrastructure necessary to take on a project. A Strengths, Weaknesses Opportunities and Threats (SWOT) assessment can ensure this

Step 1: Establish clear vision and framework for prevention – The coalition needs to decide on the prevention model that it would like to frame its efforts in. The National Strategy for Suicide Prevention¹ recommends using the public health model. The coalition must also set as a goal the prevention of suicides, not merely a response to them.

At this point the Planning Model branches into 3 arms. These assessments can be made simultaneously. However, coalitions with limited resources and capacity may need to follow the 3 arms sequentially.

Step 2 branch 1: Assess incidence/prevalence, risk/protection and demographics, Prioritize populations & risk/protective factors – Consideration is given to available data on suicide and/or suicide attempts. Qualitative assessments can help answer questions when quantitative data are not available. Local data would help define the coalition's priority population and aspect of suicide prevention. Coalitions must bear in mind that the National Strategy recommends a comprehensive approach to suicide prevention across the life course.

Step 2 branch 2: Assess local readiness for prevention – While suicide prevention may be a priority for coalition members, it is important to ensure that the political, economic and social climate in the community is conducive to engaging in suicide prevention. This assessment is crucial. It prevents coalitions from moving ahead only to be surprised by barriers it could have anticipated and removed had it planned more carefully.

Step 2 branch 3: Assess resources – Even in tough fiscal times, there are inherent resources in communities. While funding may often be difficult to obtain, a broad-based coalition can find many creative ways to leverage non-traditional resources to carry out their projects. An important resource in the community is another agency working on known risk and protective factors for 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 that helps coalitions through this process.

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

¹ National strategy for suicide prevention: Goals and objectives for action. Rockville, MD: US Dept. of Health and Human Services, Public Health Service, 2001.





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Step 3: Compare populations, risk/protection, & resources - Using results obtained in Step 2, coalitions must develop a problem statement specifying the population and risk/protective factor they are going to address. This is usually an integration of need (data), feasibility (readiness) and available resources, resulting in the creation of a project plan. The project plan must be supported by appropriate logic models.

Again, the authors recommend simultaneous undertaking of 2 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 need their readiness to be reinforced. 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 – Despite going through an exhaustive planning process, carrying out the plans can be challenging. Coalition members need to assign clear responsibility for tasks involved in implementing the program and ensure that the program is implemented as planned.

Step 5: Evaluate – This is an essential step in the public health model. The authors recommend monitoring data for evaluation. Here, data does not necessarily refer to total numbers of suicides or suicide attempts. Programs must be cautious about basing their success on reducing the total number of suicide deaths or attempts because these numbers are often influenced by a number of external factors that prevention programs can rarely control for and they are often too small to be statistically meaningful. Hence, evaluation must be tailored specifically for the program and data collected for evaluation must be linked to the objectives of that program. Clear logic models provide important guidance for the evaluation step.

Finally, while this model is linear, there is an implicit assumption that the evaluation results will inform planning and improvements for the next phase of the program.

