News from the CDC: making evaluation findings actionable for suicide prevention practice

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The economic and human cost of suicidal behavior to individuals, families, communities, and society makes suicide a serious public health concern. In the USA, it is estimated that deaths resulting from suicide create a financial burden of over 26 billion dollars a year in medical costs and work loss [1], and in 2009, nearly 14 % of high school students—or three students in a classroom of 20—reported seriously considering suicide in the past year [2, 3]. The Centers for Disease Control and Prevention's (CDC) Division of Violence Prevention (DVP) in the National Center for Injury Prevention and Control is committed to promoting a public health approach for addressing suicide proactively through suicide *prevention* (in particular, primary prevention, or preventing suicide *before* it ever occurs) and using a population approach to improve health on a large scale. These approaches augment efforts that treat suicide through clinical, individual-level, treatment-focused interventions.

While research on effective suicide prevention strategies is still in development [4], a gap persists between emerging knowledge from preliminary studies and the application of these findings to improve suicide prevention practice [5]. Creation of *actionable knowledge*, based on knowledge exchange theory and the knowledge transfer literature [6–8], is one emerging process for translating research and evaluation findings into action to improve practice.

Broadly defined, actionable knowledge is the creative intersection between what we know and putting what we know into everyday practice [9, 10]. It has roots in the business [11, 12] and knowledge transfer literatures [6–8] and provides a bridge between important research or evaluation findings and action in practice settings. This bridge has the potential to be a powerful tool for public health's work in improving suicide prevention practice, increasing program readiness for more rigorous evaluation and effectiveness research, and eventually ensuring widespread adoption of effective suicide prevention strategies to impact population health.

The adapted framework DVP has begun to use for developing actionable knowledge (http://www.cdc.gov/ViolencePrevention/pdf/ASAP_Suicide_Issue1-a.pdf) comes from the knowledge transfer literature [6–8] and includes four key steps [6, 13]: (1) Determine the action (“What do we want our

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audience to do?”); (2) Specify your audience (“Who do we want to take action?”); (3) Determine the best method of packaging your message (“How should the message be delivered?”); and (4) Establish your desired impact and how you will measure whether your goals are achieved (“With what effect?”).

From 2009 to 2011, DVP had an opportunity to use this framework through an interagency agreement with the Substance Abuse and Mental Health Services Administration. DVP provided technical assistance and support to three Garrett Lee Smith Memorial Act grantees for their youth suicide prevention efforts. In order to ensure that the findings and lessons learned from these program evaluations would be widely disseminated and integrated into suicide prevention practice, DVP used this framework and worked closely with the grantees to develop actionable knowledge products based on their findings. This had the additional benefit of helping build the capacity of suicide prevention researchers for translating their evaluation findings for suicide prevention practice.

The three grantees created very different actionable knowledge products based on their unique findings and audiences.

- The Tennessee Lives Count initiative created the *Gatekeeper Training Implementation Support System* (www.gatekeeperaction.org), an online resource that provides tools to support effective implementation and evaluation of gatekeeper training programs.
- The Native American Rehabilitation Association's *Life Is Sacred Native Youth Suicide Prevention Program* developed several tools with information for service providers and families on factors that put youth at risk for and protect them from suicide (http://www.sprc.org/library_resources/items/Life-is-Sacred-Native-Youth-Suicide-Prevention-materials).
- The Maine Youth Suicide Prevention Program (MYSPP) developed the *MYSPP Early Identification and Referral Data Toolkit* (http://www.sprc.org/library_resources/items/youth-suicide-prevention-referral-and-tracking-toolkit), an online resource that provides guidance and actionable tools for collecting early identification and referral data on students at risk for suicidal behavior in schools.

The knowledge–action gap is one of the most challenging barriers for public health practice, including suicide prevention [14]. The Tennessee Lives Count initiative, Life Is Sacred Native Youth Suicide Prevention Program, and Maine Youth Suicide Prevention Program used a four-step actionable knowledge framework, informed by the knowledge transfer literature, to create three very different actionable products. Each of these products is designed to make program evaluation findings accessible, useful, and relevant for application in the field. It is hoped that by facilitating a process for systematically translating research and program evaluation findings while taking into consideration the perspectives and needs of the audience, this emerging framework will provide an opportunity for

narrowing the gap between knowledge and action, therefore improving public health practice.

The conclusions in this report are those of the authors and do not necessarily represent the official position of CDC.

1. Centers for Disease Control and Prevention (CDC). Web-Based Injury Statistics Query and Reporting System (WISQARS) [Online]. National Center for Injury Prevention and Control, CDC (producer). Available from: www.cdc.gov/injury/wisqars/index.html 2011. Accessed Jan 2012
2. Centers for Disease Control and Prevention (CDC). Youth risk behavior surveillance—United States, 2009. *Surveillance Summaries*, June 4. MMWR 2010; 59 (No. SS-5).
3. U.S. Department of Education, National Center for Education Statistics. Characteristics of public, private, and Bureau of Indian Education elementary and secondary teachers in the United States: results from the 2007–08 schools and staffing survey 2009: (NCES 2009-324).
4. Mann J, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, Hegerl U, Lonnqvist J, Malone K, Marusic A, Mehlum L, Patton G, Phillips M, Rutz W, Rihber Z, Schmidtke A, Shaffer D, Silverman M, Takahashi Y, Varnik A, Wasserman D, Yip P, Hendin H. Suicide prevention strategies: a systematic review. *J Amer Med Assoc*. 2005;294:2064-2075.
5. White J. Preventing suicide in youth: taking action with imperfect knowledge. University of British Columbia, 2005: 1.
6. Lavis JN, Robertson D, Woodside JM, McLeod CB, Abelson J. How can research organizations more effectively transfer research knowledge to decision makers. *Millbank Q*. 2003;81:221-248.
7. Conklin A, Hallsworth M, Hatziaandreu E, Grant J. *Briefing on linkage and exchange: facilitating diffusion of innovations in health services*. Cambridge: Rand; 2008.
8. Jack S, Tonmyr L. Knowledge transfer and exchange: disseminating Canadian child maltreatment surveillance findings to decision makers. *Child Ind Res*. 2008;1:51-64.
9. Blood MR. Only you can create actionable knowledge. *Acad Manag Learn Edu*. 2006;5:209-212.
10. Tenkasi RV, Hay GW. Actionable knowledge and scholar-practitioners: a process model of theory-practice linkages. *Syst Pract Action Res*. 2004;17:177-206.
11. Argyris C. Actionable knowledge: design causality in the service of consequential theory. *J Appl Behav Sci*. 1996;32:390-406.
12. Argyris C. *Knowledge for action: a guide to overcoming barriers to organizational change*. San Francisco: Jossey-Bass Inc.; 1993.
13. Reardon R, Lavis J, Gibson J. *From research to practice: a knowledge transfer and planning guide*. Toronto: Institute for Work and Health; 2006.
14. Dearing JW. Applying diffusion of Innovation theory to intervention development. *Res Soc Work Pract*. 2009;19:503-518.