Addressing the Intersection of Suicide, Overdose, and Adverse Childhood Experiences

Guidance for Adapting *Community-Led Suicide Prevention* for Local Health Departments

Community-Led Suicide Prevention

EDC Education Development Center

NACCHO National Association of County & City Health Officials

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Education Development Center (EDC) is a global nonprofit that designs, implements, and evaluates programs to improve education, promote health, and expand economic opportunity worldwide, with a focus on underserved populations. EDC is a leader in suicide prevention and the author of the website Community-Led Suicide Prevention.

The National Association of County and City Health Officials (NACCHO) aims to improve the health of communities by strengthening and advocating for local health departments (LHDs). NACCHO serves the nearly 3,000 LHDs across the U.S. by providing cutting-edge, skill-building professional resources and programs, seeking health equity, and supporting effective local public health practice and systems.

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Introduction

Suicide, overdose, and adverse childhood experiences (ACEs) are three urgent public health challenges in the United States (American Public Health Association, 2022). These issues are often intertwined and share many risk and protective factors. They can also have serious health implications with long-term, multi-generational impacts on individuals, families, and communities. Prevention of suicide, overdose, and ACEs requires understanding and addressing their shared risk and protective factors. For more information on this interrelationship, see the National Association of County and City Health Officials (NACCHO) issue brief *Suicide, Overdose, and Adverse Childhood Experiences During the COVID-19 Pandemic: A Primer for Local Health Departments*.

Defining ACEs

Preventing and addressing these intertwined issues at their roots also necessitates using a definition of ACEs that includes negative or unstable personal environments, beyond the original ACEs from the Kaiser-Permanente study.[1] Those ACEs were limited to types of child abuse, neglect, and household dysfunction. The expanded definition used in this guide encompasses additional experiences that may occur inside or outside the home, such as food insecurity, bullying, teen dating violence, and witnessing community violence (Centers for Disease Control and Prevention, 2021). These ACEs can be affected by individual, family, and community factors.

Working on suicide, overdose, and ACEs together, particularly via their shared risk and protective factors (see Figure 1 on page 6), offers an opportunity to target each issue using many different entry points. In turn, this process increases the impact of interventions and the reach of resources.

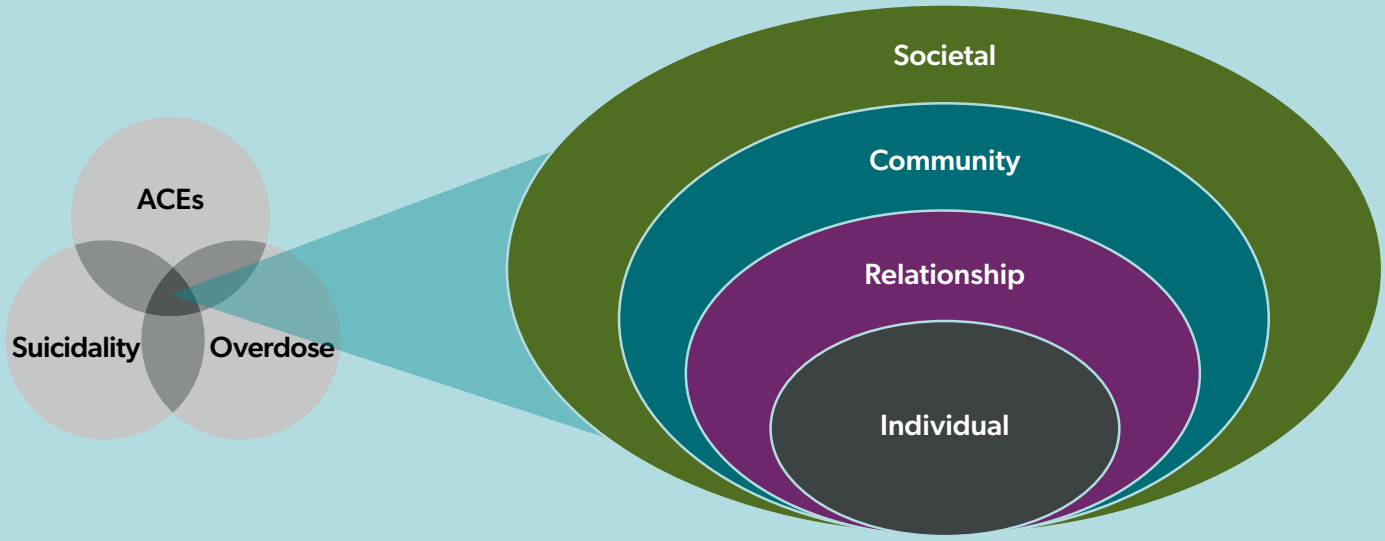
To learn more about addressing shared risk and protective factors across health and behavioral health issues, see Connection Labs: Exploring Elements of Shared Risk & Protective Factor (SRPF) Approaches.

Communities often have different organizations addressing factors considered to be shared risk and protective factors for suicide, overdose, and ACEs, although they may not identify their efforts as addressing shared factors. These organizations often work independently to reduce risk factors and increase protective factors related to suicide, overdose, and ACEs.

Community-led models guided by evidence-informed prevention frameworks may be an effective way to work at the intersection of suicide, overdose, and ACEs. Community coalitions provide opportunities for individual organizations to increase their awareness and understanding of other organizations' efforts and identify opportunities to work together for greater impact. For example, a local church may hold regular events to increase community connectedness, a primary care physician in a health center may provide instructions to families on safe storage of medicine, and a school district may incorporate educational content on healthy coping and conflict resolution. If the church, health center, and school district collaborate, they are more likely to reach a wider range of community members with the same resources.

[1] For more information on the original ACEs, see Felitti et al., 1998.

Figure 1. Shared Risk and Protective Factors for Suicide, Overdose, and ACEs



Shared Risk Factors

Societal Level

- » High access to substances
- » Easy access to lethal means
- » Low access to care/services

Community Level

- » Low community connectedness

Relationship Level

- » Bullying
- » Financial and work stress (in caregivers)
- » Social isolation
- » Minimal support
- » Trauma, abuse, and neglect

Individual Level

- » Behavioral health
- » Physical health problems/special needs
- » Poor coping skills
- » Trauma

Shared Protective Factors

Societal Level

- » Access to physical and mental health care
- » Availability of evidence-based treatments
- » Reduction of access to lethal means/doses

Community Level

- » School connectedness

Relationship Level

- » Connection to a caring adult
- » Positive friendships and peer networks

Individual Level

- » Conflict resolution skills
- » Good coping skills
- » Healthy relationship skills
- » Strong parenting Skills

Local health departments (LHDs) often serve as a central point through which multi-sector collaborating organizations can address their community's needs and implement cross-cutting and upstream prevention strategies to promote health in their communities. LHDs can play a significant role by partnering with and/or supporting community coalitions through the following:

- Providing access to community data on suicide, overdose, ACEs, and shared risk and protective factors
- Providing resources and staff with expertise who can support community strategic planning efforts
- Strengthening coalitions through administrative support, membership, and/or leadership
- Incorporating questions on suicide, overdose, ACEs, and shared risk and protective factors into community health or needs assessments
- Developing and sharing with the community reports on shared risk and protective factors that show trends, areas for growth, and disparities across different subsets of the community
- Developing and implementing health education and prevention programs that address shared risk and protective factors

This guidance document, *Addressing the Intersection of Suicide, Overdose, and Adverse Childhood Experiences: Guidance for Adapting Community-Led Suicide Prevention for Local Health Departments*, provides information for adapting the key elements of the *Community-Led Suicide Prevention Toolkit* (*CLSP Toolkit*) to assist LHDs and organizations in taking a community-led approach to working at the intersection of suicide, overdose, and ACEs.

Working at this intersection is a multi-phased process that requires engaging different entities and partners. As a result, it involves significant coordination throughout the phases of visioning, planning, implementation, and evaluation. The visioning and planning processes alone can take six months to a year to complete depending on factors such as the community's needs, funding, and partner time and energy.

The CLSP framework and toolkit were inspired by the report *Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention*, developed by the Transforming Communities Priority Group of the National Action Alliance for Suicide Prevention. The CLSP framework presents seven key elements with practical steps to bring community partners together to develop, implement, and sustain comprehensive, community-based suicide prevention. The *CLSP Toolkit* aims to help communities create policies, programs, and services that reduce suicide and improve individual, family, and community health. In addition, the toolkit contains a *Getting Started Guide,* a *Strategic Planning Worksheet*, and links to other tools and resources.

Where relevant, this guidance document also refers readers to the *Suicide, Overdose, and Adverse Childhood Experiences Toolkit* (*SPACECAT Toolkit*) to learn more about strengthening the capacity of LHDs to address the intersection of suicide, overdose, and ACEs prevention in their communities. The *SPACECAT Toolkit* was written specifically to help LHDs translate data from the results of their *Suicide, Overdose, and Adverse Childhood Experiences Prevention Capacity Assessment Tool* (known as SPACECAT) into public health action. The *SPACECAT Toolkit* contains eight sections that are mapped to each of the key capacity domains in the assessment tool. Each section provides information and guidance, including key takeaways, worksheets or tip sheets, and links to other tools and resources.

This document provides guidance on adapting each of the elements listed below from the CLSP Toolkit:

- **Unity Element:** How to Develop Broad-Based Support for a Shared Vision
- **Data Element:** How to Use Data to Guide Action and Improve Efforts
- **Planning Element:** How to Use a Strategic Planning Process
- **Fit Element:** How to Align Activities with Community Culture and Needs
- **Integration Element:** How to Use Multiple Complementary Approaches
- **Communication Element:** How to Communicate Clearly, Safely, and Consistently
- **Sustainability Element:** How to Create Long-Lasting Change

Unity Element:
How to Develop Broad-Based Support for a Shared Vision

A key component of working at the intersection of suicide, overdose, and ACEs is collaborating with partners from different settings who work with varying populations. The CLSP Unity element encourages the involvement of a broad range of partners, which allows for the development of a shared vision and planning, implementation, and evaluation activities that have a wider impact.

When considering partners, include internal teams at your health department, individual organizations, community coalitions, and advisory groups who work on suicide, overdose, and/or ACEs. Choose partners who will be committed to working at the intersection of the three issues and addressing shared risk and protective factors. Identify strategies, approaches, and activities based on input from partners who support prevention of suicide, overdose, and/or ACEs at the local and state levels as well as including people with lived experience.

Lived Experience

- **Suicide:** Includes people who have or have had thoughts of suicide, survived a suicide attempt, lost a loved one to suicide, and/or provide or have provided significant help to a person with suicidal experiences
- **Substance use:** Includes people who use or have used substances, have a substance use disorder (SUD), identify as in recovery, have survived an overdose, have lost someone to an overdose, and/or provide or have provided significant help to a person with an SUD
- **ACEs:** Includes people who self-report they have experienced ACEs (e.g., childhood abuse or neglect, food insecurity, growing up in a household with substance use, and/or experiencing violence)

Consider Potential Partners

A list of potential partners is available in the *SPACECAT Toolkit*, Domain 1: Networked Partnerships, under Key Takeaway #1: Assess community strengths and stakeholders. Consider the following additional community sectors and individuals at different jurisdictional levels (e.g., state, regional, or local):

- Community coalitions (community health, suicide, substance use, early childhood)
- Local agencies managing Medicaid
- Local community-based businesses
- Mayor's office or town officials
- People with lived experience of suicidality, overdose, and/or ACEs, including loved ones
- Community and regional philanthropic organizations

- State Health Department, Office of Suicide Prevention, Divisions of Substance Use, Behavioral Health, or Mental Health
- Veteran-serving organizations
- Other organizations with access to data on suicide, overdose, and ACEs and their shared risk and protective factors

Facilitate Consistent Communication across Suicide, Overdose, and ACEs Prevention Partners

The intersection of suicide, overdose, and ACEs brings together different priorities, people, groups, and frameworks. It is important to understand the different perspectives, approaches, and even language related to all three issues.

You may find it helpful to form a community work group focused on a consistent and effective approach to communication. This type of group is most effective if it includes some members who are working primarily in one area (e.g., ACEs prevention via early education) and others who are working at the intersection (e.g., mental health outpatient facility).

In the group, identify and discuss conceptual frameworks, concepts, assumptions, terminology, acronyms, and roles to gain understanding and work toward alignment. For example, the field of *suicide prevention* generally refers to all efforts intended to reduce the problem of suicide, and it is common for one person or group to coordinate both prevention and treatment strategies. In contrast, *substance use prevention efforts* and *treatment programs* often are administered by different units or organizations and operate from distinct conceptual frameworks.

Achieving mutual understanding and having ongoing communication among partners are essential for creating a common vision across partners. Consider the following steps for building a culture of open, consistent, and effective communication:

1) Host a launch meeting where partners representing different sectors can share their individual priorities. Have partners present key data where possible. Note commonalities and differences.

2) Compile brief descriptions of the work each sector is doing, including key concepts and frameworks. Store them in a folder that is easy to navigate and that all partners can refer to as needed over time.

3) Decide on group agreements that address the potential for misunderstandings among partners. These agreements could include explaining all acronyms used during meetings, providing foundational information before in-depth group discussions, and building opportunities for questions during meetings.

Help Your Community Heal from Tragedy before Starting Prevention Activities

If your community has recently lost someone to suicide or overdose, has had instances of community violence, or has learned about cases of child abuse or neglect, take time to heal before moving into other prevention planning and activities. This healing time is particularly important when the case is high profile, involves someone well-known in the community, or relates to a group of connected cases. In part, this is because suicide and overdose can lead to a ripple effect or "contagion." With suicide, contagion can happen especially when a death is publicized in an unsafe way and leads to other suicide deaths or attempts. For more information on preventing suicide through safe messaging, see the Communication element in this document, on page 33.

Acknowledge complex feelings such as guilt, anger, and grief. Provide support and resources to people impacted by these traumas and losses before starting formal strategic planning efforts. Strategic planning can be exciting and energizing, but it is often time-consuming and challenging. Your efforts are more likely to be successful when participants have the support they need to heal first and then focus on the work ahead. So, start by reaching out to people in your local community, such as your local child advocacy center, LOSS (Local Outreach to Suicide Survivors) Team, or critical incident team for help with the healing process.

For more information on supporting your community in the aftermath of suicide, overdose, or community violence, see the following resources:

- CLSP resources on suicide postvention
- Coping with Community Violence Together
- National Child Traumatic Stress Network
- Grief Recovery After a Substance Passing
- SAMHSA Opioid Overdose Prevention Toolkit (see pages 18–19 for information for overdose survivors and their families)

For more information on working with partners at the intersection of suicide, overdose, and ACEs, see the *SPACECAT Toolkit*, Domain 1: Networked Partnerships and Domain 2: Multilevel Leadership.

For more information on working with partners in suicide prevention, see the CLSP Unity element.

Data Element:
How to Use Data to Guide Action and Improve Efforts

Data is important for understanding the scope of suicide, overdose, and ACEs in a community, as well as unique shared risk and protective factors, specific geographic considerations, and disproportionately affected populations. Data can also help you assess whether you are achieving your goals over time, make adjustments, and stay accountable to partners and funders. The guidance in this section relates to the CLSP Data element.

While data sources for suicide and overdose are sometimes more straightforward than those for ACEs, it is important to understand the data landscape of all three issues in your communities. For a review about substance use data, see Drugs & Drug Overdoses: Data & Alerts, and for suicide data, see the CLSP Data element.

Integrate Youth and Adult ACEs Data at the Individual, Family, and Community Levels

It can be challenging to understand what the data about ACEs looks like in real time in your community. Data is not often collected on a large scale that asks youth about their current or recent exposure to ACEs. Much of the current data on individual- and interpersonal-level ACEs is collected from adults whose responses are both retrospective and subjective. For example, one of the most widely used tools is the Behavioral Risk Factor Surveillance System (BRFSS), which only assesses ACEs by asking adults about experiences they had between birth and age 18.

However, data from adults can be useful in planning for and addressing the impact of ACEs on suicide and overdose prevention, particularly when combined with data that is collected directly from youth, such as through the Youth Risk Behavior Survey (YRBS), and with data on adverse community environments (also known as *community-level ACEs*) that impact both youth and adults. Adverse community environments may include factors such as violence and poor housing quality and affordability and can be captured using proxy data (e.g., the number of families enrolled in WIC). Adverse community environment data also has the added benefit of highlighting precursors to suicide and overdose. For more information on the relationship of ACEs and adverse community environments, see The Pair of ACEs: Knowledge to Action Brief.

By understanding ACEs in both youth and adults, at the community level as well as individual and family levels, a more complete understanding of the current ACEs landscape can emerge. This in turn allows for a better understanding of the ways in which suicide, overdose, and trauma may be intersecting and the risk and protective factors that may be present across the lifespan.

When collecting ACEs data from adults or youth, keep in mind the impact that the questions may have on them. Recalling experiences that may be considered ACEs can bring up complex feelings and lead to people thinking about what happened through a new lens.

- Emphasize that participation in the data collection is voluntary.
- Provide accurate information about the relationship between ACEs and their possible outcomes.
- Use safe messaging to convey that ACEs do not always lead to suicide and overdose.
- Provide a list of up-to-date resources for those who may need additional support.

Engage Schools in the Collection of Shared Risk and Protective Factor Data

Mandated reporter requirements and concerns about being unable to meet the needs of students once those needs are revealed have left some schools across the educational spectrum feeling uncertain about how best to collect sensitive data from youth.

To address schools' limitations and concerns in advance, clarify to students that surveys are anonymous and schools are unable to respond to needs that may be disclosed in the surveys. However, schools can provide in-school resource sheets for students to receive after completing the survey or consider offering follow-up support in the days or weeks following administration of a survey. As the data is reviewed and analyzed, schools can collaborate with partners and the LHD to offer programming or services to strengthen protective factors that complement the risk factors most common in their students.

While it is important to collect both risk factor data and protective factor data, the latter may feel more achievable to school administrators and staff. For example, one LHD worked with a school to collect data only on positive childhood experiences (PCEs). This data provided information on protective factors such as relationships, safe and stable environments, social and civic engagement, and opportunities for emotional growth. Visit positiveexperiences.org for more information about the original PCE study and the Healthy Outcomes from Positive Experiences (HOPE) framework.

Leverage Comprehensive Statewide Assessments

Many state health departments and other community organizations conduct community

needs assessments (CNAs) or have State Epidemiological Workgroups (SEOW). Determine what data your state health department's CNA may already collect on suicide, overdose, and ACEs; the intersection of the three; and the shared risk and protective factors.

If you have questions that are not currently captured in existing CNAs or other data collection, consider asking whether the agency or organization is willing to include them. If they are not, you may need to consider developing your own survey or other needs assessment and/or seek out relevant proxy data. To make this step doable across the three issues of suicide, overdose, and ACEs, as well as their intersection, focus first on the priority populations you identify based on your systems-level data, as well as underserved or under-resourced populations.

Share Ownership of Risk and Protective Factor Data

Shared risk and protective factor data typically exists in different administrative data sets (e.g., criminal justice data, vital statistics, substance use disorder treatment data, and child welfare data). In most cases, these data sets are not linked. It can be helpful to form a local data workgroup to share ownership of risk and protective factor data. Such groups can exist within local government or coalitions and should include representatives from different agencies that manage relevant data sets. When considering the formation of such groups, it is important to understand and plan for common challenges associated with shared ownership of data, such as the following:

- Clarity about representation of communities and subcommunities in data (e.g., data that is representative of the whole state versus a specific demographic group served by an agency)
- Data privacy and protection laws and policies
- Ethical considerations related to data linkages, such as community engagement to determine linkage priorities[2]
- Concerns about how other agencies will use data
- Logistics in providing access to data for external partners
- Time, staff, and buy-in necessary to consistently share data

The following steps can assist in developing a data workgroup and creating shared ownership that feels both manageable and useful:

1) Identify types of indicators to be tracked:
    - Risk and protective factors (e.g., students reporting social isolation and difficulties in relationships with their peers and parents, reported experiences of co-occurring mental health conditions in behavioral health surveys or hospital records)

[2] For additional ethical considerations, see NIH Workshop on the Policy and Ethics of Record Linkage: Workshop Summary

- » Process metrics related to programming or policies that have been implemented (e.g., number of students who participate in a program and number of policies implemented)

2) Identify existing partners and potential new partners who have access to each type of risk and protective factor data.

3) Ask those partners to intentionally track relevant data and provide updates.

4) Discuss how partners can share their collected data with other partners and any needed data-sharing agreements or security measures (e.g., a quarterly de-identified report, a shared password-protected Excel workbook)

5) Host periodic meetings to discuss trends related to risk and protective factor data, as well as program or policy implementation and participation. Discuss any differences or themes in trends with each data indicator being tracked.

6) Gather qualitative data on risk and protective factors of interest. When possible, join coalitions and groups that are already established as opposed to scheduling additional focus groups or developing new groups. Use this qualitative data to deepen your understanding of the risk and protective factors of interest and inform how you and your partners will address these factors in your community over time.

7) Support partners' and local coalitions' data collection and analysis efforts, even if those efforts are not being shared. Recognize staff who have skills, knowledge, and resources to engage in different forms of data collection. If possible, offer training and resources to their staff to further develop their skills and enhance their knowledge related to data collection and analysis.

8) Where you have implemented programs, policies, or other practices, monitor chosen risk and protective factor data alongside implementation of prevention strategies. Note how risk and protective factor data does or does not change as different strategies are implemented.

Use Data to Assess Progress and Make Changes

Measuring key shared risk and protective factors is important in noting change and keeping momentum going since it can take five or more years to start seeing reductions in overall suicidality, deaths due to suicide, rates of substance use, and overdoses. Consider using indicators of shared risk and protective factors, such as the ones listed in Table 1 below, to assess progress.

Table 1: Shared Risk and Protective Factor Indicators

Risk and/or Protective Factor	Indicator
Social connectedness	» Families who report being active in a faith-based community » Use of programs that address connectedness (e.g., Sources of Strength) » Number of students reporting connectedness with a trusted, caring, non-parent adult » Funding for mentorship programs
School connectedness	» Number of high school students reporting increased levels of school connectedness » Funding for mentorship programs » Youth access to extracurricular activities
Reducing access to lethal means	» Number of lock boxes distributed » Legislation passed affecting access to firearms » Use of programs that address safe environments (e.g., Nurse-Family Partnership)
Coping skills	» Number of young people reporting that they have improved coping skills » Use of programs that address coping skills (e.g., Handle with Care, Nurse-Family Partnership)
Economic stability	» Number of public assistance recipients » Use of food banks and food pantries

Get creative in thinking about how you can define and evaluate shared risk and protective factors in your community. Encourage your partners to think outside the box when it comes to outcomes and success of programs. For example, an after-school mentorship program may initially be designed to provide supervision and decrease criminal behavior. However, it may be helpful to consider looking at this program through additional lenses: Does this program allow parents to work different shifts? Does that contribute to reducing poverty and homelessness? Secondary outcomes are just as important as the ones for which the program was first initiated.

For more on this topic, the issue brief *Evaluating Shared Risk and Protective Factor Approaches: Learning from Colorado and Utah* recommends a process for defining risk and protective factors and determining the data sources that can give you the information you need. It also provides examples and ideas to consider when evaluating and tracking shared risk and protective factors.

Evaluate the Impact of Layered Approaches on Multiple Outcomes

If you are not yet ready to address shared risk and protective factors, you may be able to "layer" (add) one or more prevention activities that address one or two different issues onto an existing activity that addresses another issue. For example, at syringe service programs, you could conduct suicide risk screenings or gather information about ACEs or experiences of other violence and then connect individuals to resources to address these experiences. See the Integration element in this document on page 30 for more information about layered approaches.

When evaluating a layered approach, consider how you are looking at the impact of the activities across suicide, overdose, and ACEs, and how making changes in one issue may increase impact in the other two issues. Design evaluation questions and plans that consider both overlapping and individual factors for the three areas.

Questions to Ask When Evaluating a Layered Approach

What are the most important shared risk and protective factors to measure related to these programs? See the SPACECAT Shared Risk Factors and Shared Protective Factors diagrams.

- What short-term outcomes can we measure now while we seek to decrease rates of suicide, overdose, and ACEs over the long term?
- Do current program evaluation tools monitor impacts on these shared risk and protective factors?
- If not, how can any pre- and post-surveys, assessments, or program evaluation tools be strengthened to measure impacts on shared risk and protective factors?
- Are program evaluation reports explicitly describing the impacts of programming on shared risk and protective factors? Do any of the evaluation methods address the connection between suicide, overdose, and ACEs?

Tracking Data

As you track program impacts across suicide, overdose, and ACEs, consider creating a logic model that demonstrates how your existing inputs (i.e., products, resources, staff time, and funding) and outputs (i.e., programs, strategies) can contribute to changes in both intermediate and long-term outcomes.

Design your logic model so that the shared risk and protective factors you have identified are the focus of your intermediate outcomes. As you evaluate your programs for intermediate and long-term outcomes, be realistic about when you can expect to see changes, remembering that big changes rarely happen quickly.

See CLSP Planning Key Area 2, Step 6 for an example of a logic model.

Additional data sources and resources related to data on suicide, overdose, and/or ACEs are in the *SPACECAT Toolkit*, Domain 4: Data and Surveillance, including its External Resources lists.

Planning Element: How to Use a Strategic Planning Process

When conducting strategic planning at the intersection of suicide, overdose, and ACEs, be sure to consider how these topics can be addressed as one by working on their shared risk and protective factors. Planning includes considerations for developing a strategic plan, using data to choose goals and objectives, and putting a plan into action. The guidance in this section relates to the CLSP Planning element.

Strategic planning takes a commitment of time and effort on the part of LHDs and their partners. Expect to spend, on average, three to six hours on each of the steps of the process outlined below. Plan accordingly so that everyone you would like to have involved can contribute meaningfully. The following are the key phases in the planning process.

1) **Develop a vision or purpose.** Vision statements should be group-driven products that are clear, intentional, and inspiring. They are not the same as a mission or goal. They do not project a reality that you think you need to catch up to and should not simply align with the path of least resistance. Consider working with your partners to develop shared answers to a question such as, "What do we want our community's response to suicide, overdose, and ACEs to look like in three to five years?" Alternatively, a purpose can help you understand what the need or justification for this work is. It answers the question, "Why is it important for us to address suicide, overdose, and ACEs in our community?"

2) **Identify priority populations that would benefit from a coordinated approach to suicide, overdose, and ACEs.** Since there are multiple populations that might benefit, determine which ones are the most important for you to reach. For the various populations in your community, look at the data and needs regarding suicide, overdose, and ACEs and consider the following questions:

   a. Which ones would benefit most from a coordinated approach to suicide, overdose, and ACEs? List each group with higher risk by their common characteristic, such as their race, type of work, or residential area.

   b. For each group, which subgroup(s) are most heavily affected? List them.

   c. Which individuals and organizations from these subgroup(s) are part of your coalition or advisory group? If none, conduct outreach to increase their representation.

3) **Identify and understand blocks and barriers to achieving your vision or purpose.** To be able to move forward effectively, it is important to identify potential challenges you may encounter. As a planning group, consider questions such as, "What is blocking us from moving forward with our vision?" or "What challenges must we face to make progress?" When thinking of these potential blocks, try to avoid thinking of a barrier as a "lack" of something. Instead, dig deeper to find the underlying cause and identify what *is* present. For example, instead of "lack of up-to-date research," reframe the barrier as "outdated research that impedes innovation."

4) **Select strategic directions or priorities that allow your community to address the blocks and barriers while moving closer toward your shared vision or purpose.** Strategic thinking allows you to focus your action where change needs to happen, try new approaches, and think long term and proactively. It allows you to address challenges in more than one way and to consider how to move from your current state toward your vision or purpose, while addressing identified barriers along the way. To prompt strategic thinking, review your shared vision, priority populations, and potential blocks or barriers. Then consider, "What innovative, substantive actions will address these barriers and move us toward our vision?" When brainstorming ideas, consider using words ending

in "-ing" to indicate movement and desire to make an impact (e.g., "identifying and developing champions" or "empowering communities to take ownership").

5) **Set measurable objectives that align with your strategic directions and priorities, and implement actions that will help you make progress with those objectives.** Ask your group what it would look like if you really mobilized behind your strategic directions over the next two to three years. How would you know you were making progress? What would you see? These are your objectives. From there, identify measurable actions for the next 12 months that would help you work toward achieving those objectives, paying special attention to actions that address shared risk and protective factors for your identified priority populations.

For guidance on making goals SMARTIE and developing action plans for each goal, see the *SPACECAT Quick Start Guide*, pages 48–61.

As you move through these different phases, be sure to communicate proactively to keep your partners engaged.

> **For more information on the Planning element,** including how to consider bringing intersection work into your health department's broader strategic plans, see the *SPACECAT Toolkit*, Domain 5: Shared Planning and Strategic Plans, NACCHO's *Developing a Local Health Department Strategic Plan: A How-To Guide*, and the CLSP Planning element.

Fit Element:
How to Align Activities with Community Culture and Needs

The Fit element focuses on aligning activities with your community's culture and needs via three main considerations: *assessing community readiness*; *involving diverse population*, including people with lived experience; and *incorporating the local community context and culture*. The guidance in this section relates to the CLSP Fit element.

Assess and Address Level of Readiness

Community readiness involves the following steps:

1) Assess how ready the community is to address the intersection of suicide, overdose, and ACEs

2) Determine how to proceed if there are different levels of readiness for each issue

3) Consider how to increase your community's level of readiness to better address the intersection of the three issues

Two common challenges that arise when communities try to understand their readiness surrounding intersecting issues are gathering information and dealing with differing degrees of readiness across issues.

Assessing Readiness

It may feel daunting to assess community readiness related to all three issues: suicide, overdose, and ACEs. There are so many variables that could be beneficial to understand. It is not necessary, or even advisable, to try to assess every aspect of these complex and overlapping issues. Instead, identify the shared risk and protective factors across the three issues that seem most relevant for your community and focus on understanding those variables. Consider using national and local news articles, data summaries, research reports, and press releases as tools in discussions with partners and in your community. Gather feedback using broad questions such as the following from CLSP Fit Key Area 3, Step 1:

- Are you seeing similar trends, concerns, challenges, etc., within your settings or regions? If you are a provider, what about the populations you serve?
- What do you believe is contributing to these issues within your settings, regions, and/or populations?
- In what ways can you increase community connections and strength?
- How has your community responded to a suicide or overdose death in the past? How did that response impact the community?
- What beliefs, traditions, or aspects of your environment must be considered when you address these challenges?

Compare your community's answers between the three issues of suicide, overdose, and ACEs. Consider similarities and differences in trends, priorities, language used, concerns, and challenges. Look for the areas where there is overlap and think about how you can leverage these interconnections as you proceed.

Addressing Different Degrees of Readiness: A Layered Approach

What if your assessment reveals a high level of readiness to address one or two of the issues but not all three? What if there is a low level of readiness to address one or two of the issues? What if there is high readiness for one prevention approach (e.g., crisis intervention), but not for another (e.g., primary prevention)? Consider the following:

- Try a layered approach, which involves incorporating additional prevention activities (for other issues) into existing ones. For example, you could provide suicide gatekeeper training to certified peer specialists who support substance use and recovery programs. More information related to layering is covered in the Integration element section of this document on page 30.

- Start by addressing risk and protective factors and engaging in activities where there is high readiness and resources. Even if the focus is on just suicide, overdose, or ACEs, remember that you may be making progress toward addressing the other issues simply by focusing on a shared risk and protective factor. For example, developing a mentorship program may be mainly focused on connectedness for the purpose of preventing ACEs, which might be the driving force in your community now. However, connectedness also reduces the risk of suicide and substance use, regardless of whether these issues are identified as top priorities in your community.

- Identify a list of shared risk and protective factors and prevention and intervention activities you would like to address over time. Apply lessons learned and information gained from existing, possibly unrelated, activities with high levels of community buy-in to increase readiness to take on other risk and protective factors and activities.

Involve Diverse Populations and Incorporate Local Community Context and Culture

In some communities and cultural groups, it can be difficult or even forbidden to talk about suicide, overdose, and ACEs. Challenges also occur when a significant portion of the population does not have strong skills in speaking English but most materials are in English and providers communicate in English.

To help address these challenges, prioritize finding and uplifting champions within your community with whom you and your community members can connect regarding suicide, overdose, and ACEs, and their shared risk and protective factors. Anyone can be a champion. The strongest champions are those who can connect with communities using the common dialect, cultural values and perspective, and resources. Champions can also be helpful in cultural translation of resources, particularly when considering different dialects that impact effectiveness at reaching subgroups. For more information about champions, see the *SPACECAT Toolkit*, Domain 2: Multilevel Leadership.

Seek meaningful input on your program conceptualization, implementation, and evaluation from people who have lived experience with these *overlapping* issues (see the box on lived experience in the Unity element on page 10 above). People with lived experience can also be good champions.

However, keep in mind that some people with lived experience have gone through trauma related to suicide, overdose, or ACEs. Discuss with these individuals how ready or willing they feel to share their perspectives and in what ways. For example, does the person feel comfortable sharing their opinions in a conversation or a written survey about a local food pantry's accessibility? Does the person feel comfortable providing input at a meeting about a policy to facilitate temporary firearm ownership transfer?

Uplifting the voices of people with lived experience is one way to recognize the role of trauma in your community and respond in a way that feels safe and empowering to them rather than retraumatizing. There are also several other trauma-informed principles that can be integrated into your work. Many resources on these principles exist. For more information, see *Principles of an Anti-Racist, Trauma-Informed Organization*.

Recognize the Role of Historical Trauma and Health Inequity

Historical trauma, discrimination, prejudice, and ongoing health inequities play an important role in suicide, overdose, and ACEs. There are many resources beyond the scope of this guidance document that explore the relationships of health equity with suicide, overdose, and ACEs, both separately and at their intersection. A link to some of those resources is included at the end of this section.

In addition to connecting with your community and engaging people with lived experience, the following strategies provide opportunities for health departments to begin to address the impact of these experiences on intersection work and outcomes:

- Explicitly acknowledge historical trauma and its relevance in your community.
- Incorporate questions on historical trauma into needs assessments or surveys, such as "How is past trauma affecting people's lives now?" One example might be that people feel reluctant to seek health and mental health services. Other examples of questions might include:
  - In what ways is the community trying to address the historical trauma it has experienced?
  - How is the community trying to find ways to heal?
- Incorporate questions on equity into needs assessments or surveys, acknowledging how a particular subset of the community might be experiencing more barriers than other groups regarding protective factors such as mental health care access. Also consider asking if specific groups are being adequately reached or served with prevention

services. For example, "Are Latinx clients being offered suicide screenings at lower rates than their White counterparts?"

- Ask community partners who represent or collaborate closely with communities that have experienced historical trauma for feedback on how historical trauma might be impacting current risk factors.

- Consider how your health department's data practices and programmatic choices could be overlooking key groups in your community or contributing to the trauma and inequality in other ways. Ask yourself and key partners questions such as the following:

  - Whose voice is not reflected here?

  - If we are missing voices, why do we think they are not contributing?

  - Whose voice do we absolutely need?

  - What will it take to engage these missing voices?

If you have been focusing primarily on one area regarding suicide, overdose, or ACEs, consider the needs of your priority populations in the other two areas. Select strategic directions and implement actions that address shared risk and protective factors in ways that fit with your community's culture and context.

> **For more information on integrating your community's uniqueness into your approach, the way health equity plays a role, engaging people with lived experience,** and a resource list, see the *SPACECAT Toolkit*, Domain 7: Health Disparities.

Integration Element: How to Use Multiple Complementary Approaches

Choosing evidence-informed strategies and approaches that work with the diverse populations and settings in your community is key in addressing the intersection of suicide, overdose, and ACEs. The Integration element involves selecting and weaving together strategies and approaches to positively impact all three areas and to maximize the impact of funding, time, and programming. This element also involves making progress toward goals and objectives identified during the strategic planning process. The guidance in this section relates to the CLSP Integration element and the *SPACECAT Toolkit*, Domain 6, Evidence-Based Strategies.

Find Strategies that Address Shared Risk and Protective Factors

Start by choosing an evidence-informed strategy, or mix of strategies, that addresses one or more risk and protective factor(s) *shared by suicide*, overdose, and ACEs. The strategies should match the needs of your communities of focus.

The following three CDC resources include evidence-based strategies for suicide, overdose, and ACEs, respectively:

- Suicide Prevention Resource for Action
- Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States
- Adverse Childhood Experiences Prevention Resources for Action

Note that although these resources highlight a number of evidence-based strategies, each resource provides a different level of specificity, and none can provide a detailed set of approaches for your particular community. For more information about selecting a mix of approaches, see the CLSP Integration element and the *SPACECAT Toolkit*, Domain 6, Evidence-Based Strategies.

Layer Activities

It may be difficult to jump directly into working at the intersection of suicide, overdose, and ACEs prevention, especially when community readiness differs between them, you have limited or directed resources, and/or leadership has a low level of readiness. In these cases, it can be helpful to add, or *layer*, new prevention activities onto existing activities to address a second or third issue. In this way, you can work toward addressing shared risk and protective factors without recreating the wheel. For example, many of the things you are already doing to address suicide may also be able to address substance use and ACEs with some relatively small or simple changes to existing programming.

When using a layered approach, consider starting with the issue for which there is the most excitement and the greatest number of existing robust activities. Build on programs that are already strong. Encourage people to continue the work they are already doing and address current challenges. Work with them to add activities, resources, evaluation methods, or targeted outreach strategies to address one or two of the other issues. This could be as simple as introducing a new evaluation measure to a mental health program or engaging a new partner to refer people to substance use services after they leave jail.

You can also collaborate with partners to enhance existing activities. The following are two examples:

- At suicide prevention gatekeeper trainings, add content on overdose prevention as well as resources for people who have experienced ACEs or other violence.

- At distribution sites for free or low-cost gun locks or safes, provide information and resources about ACEs as well as collect medications that are no longer needed in order to prevent overdoses.

Evaluation of a layered approach while keeping shared impact in mind can yield results that can be disseminated to increase readiness. See the Data element in this document on page 13 for more information to assist you in evaluating a layered approach.

Consider Additional Partners Needed

You may need to collaborate with new partners to gain access to locations where your priority populations often spend time. For example, if you are working with African American parents, barber shops may be an important setting to engage. If you realize that many cases of suicide, overdose, and child maltreatment deaths are associated with recent unemployment, consider collaborating with a local employment services organization.

See the Unity element in this document on page 9 for more information on partnering.

Minimize Harm after Suicide, Overdose, and ACEs

After a suicide, overdose, or ACE, intervention to lessen immediate and long-term harm and to prevent future risk is an important, evidence-based strategy. Work with partners to support and enhance access to evidence-based therapies for those impacted by ACEs in order to decrease the risk of suicidality or substance use, among other issues. Consider creating postvention plans, such as a protocol that offers school-sponsored supportive services for students, staff, and parents after a suicide or overdose death. For information on postvention, see the resources in the section "Help Your Community Heal from Tragedy" in the Unity element on page 12.

> **For more information on strategies for working at the intersection** of suicide, overdose, and ACEs and their shared risk and protective factors, see the *SPACECAT Toolkit*, Domain 6: Evidence-Based Strategies.

Communication Element: How to Communicate Clearly, Safely, and Consistently

Communication is a key part of prevention programs on suicide, overdose, ACEs, and their shared risk and protective factors. The guidance in this section relates to the CLSP Communication element, but this section also includes some different content. It addresses the following three important aspects of communication:

- Ensuring safe messaging for the specific issues and populations involved
- Developing culturally appropriate strategic communication campaigns to increase awareness of the issues in the general public and specific populations
- Monitoring the community's understanding of your messages

For information about communicating with prevention partners, see the Unity element in this document on page 9.

Ensure Safe and Effective Messaging

Internal and external messaging related to suicide, overdose, and ACEs must be both safe and effective. Messaging can include a variety of formal avenues (e.g., documents, speeches); informal avenues (e.g., talking points, conversations, written descriptions about partner efforts); communication campaigns; and media guidelines.

Unsafe messages can harm your relationships with key partners and audiences, particularly those with lived experience.

Unsafe messages contain the following:

- Words or images that retraumatize individuals or are known to cause substance-using or suicidal thoughts to resurface (e.g., showing an adult threatening a child, someone using drugs intravenously, or someone harming themselves).
- Ideas that undermine prevention (e.g., scare tactics) and make harmful behaviors seem commonplace, inevitable, hopeless, or glamorous.
- Words or images that blame the victim or shame and stigmatize people who are impacted.
- Words or images that might contribute to suicide contagion (when a suicide attempt or death is associated with a greater than expected increase in suicide-related behavior in a community following that suicide attempt or death). See the beginning of CLSP Communication Key Area 2 for more information about suicide contagion.

The following are characteristics of safe messages:

- Created by or with people who have lived experience
- Tell a person's story only with their permission and input, even if it was already shared in the news or a large event
- Support prevention and promote hope
- Highlight the uniqueness of each individual and individual situation
- Promote positive social norms that are comforting or calming to the viewer (e.g., show people out in nature or diverse families spending time together in healthy ways)

Safe messages may also include the following:

- Words or images that show healthy choices and behaviors
- Words or images that promote connectedness

- Accurate information about resources or next steps a person can take to support a loved one
- Accurate data that promotes positive community norms (e.g., 50% of youth are not drinking alcohol rather than 50% of youth are drinking alcohol)

Safe messages promote images people associate with protective factors and positive outcomes (i.e., recovery) as opposed to risk factors and negative outcomes. For example, include images of people with expressions associated with feeling hopeful instead of expressions associated with feeling depressed.

It is important to avoid any language that implies a certain behavior or condition is inevitable because of certain risk factors, group membership, or history. For example, many people who experience ACEs do not develop mental health or substance use issues from them. Likewise, many people who belong to groups that have high rates of suicide or overdose do not become suicidal or use substances.

Table 2: Sample Language

Use	Instead of	Because
» Person with a substance use disorder (SUD) » Person with an opioid use disorder (OUD) » Person who uses drugs » Person in recovery » Person who previously used drugs	» Addict » User » Substance or drug abuser » Junkie » Former addict » Reformed addict » Clean	» Using person-first language shows that the person "has" a problem (an illness), not "is" a problem. » The terms in the second column elicit negative associations and individual blame.
» Child who experienced ACEs » Person who survived sexual abuse » Family facing economic hardship	» Victim » Abused child » Neglectful parent	» Using person-first language shows that the person "has" a problem, not "is" a problem. » The terms in the second column elicit negative associations and individual blame.

Use	Instead of	Because
» Died by suicide » Lost their life to suicide » Fatal or nonfatal suicide attempt » Survived a suicide attempt » Person with suicidal thoughts	» Committed suicide » Completed or failed suicide » Successful or unsuccessful attempt » Suicidal person	» The first column uses person-first language, showing that the person "has" a problem (an illness), not "is" a problem. » "Committed suicide" has a punitive connotation. » "Completed or failed suicide" and "Successful or unsuccessful attempt" can be seen as implying that dying by suicide is positive.

Think carefully about your communication goals. It is important to focus on the whole picture, not just the negative or traumatic aspects. Talk about positive childhood experiences (PCEs) as well as ACEs. Convey hope, connection, and healing, and emphasize that change can occur. Include information and messages about protective factors and positive outcomes, such as those shown in the following examples:

- "Roughly half of transgender and nonbinary students found their school to be gender-affirming, and those who did reported lower rates of attempting suicide" (The Trevor Project, 2023).
- "Suicide can touch anyone, anywhere, and at any time. But it is not inevitable. There is hope" (SAMHSA, 2023).

When providing messaging to decision-makers, such as policymakers or funders, you may wish to emphasize the scope of the problem in your community to underscore the need for support. Combine this with actions the decision-makers can take to address the problem and the impact their actions can have, including small actions or short time frames. For example:

- "With your support, in a year, we could see X."
- "$Y could fund programs that would help Z# of people build resilience, a key protection against overdose and suicide."

Provide examples of real-world successes in addressing shared risk and protective factors. These stories provide models for what you might ask your decision-makers to invest in and can help put a human story behind numbers and statistics.

Resources

For safe messaging guidelines for overdose, see:

- Overdose Cluster Response Messaging: A Guide for Public Health and Prevention Organizations
- Overdose Lifeline: Remove the Stigma

For effective messaging for ACEs, see Blog: 5 Ways to Create Compelling Messages about Childhood Trauma Using Data.

For information on positive community norms, see Promoting Positive Community Norms: A Supplement to CDC's Essentials for Childhood: Steps to Create Safe, Stable, Nurturing Relationships and Environments.

For safe messaging for suicide prevention, see CLSP Communication Key Area 2, including the Framework for Successful Messaging.

For effective messaging at the intersection of suicide, overdose, and ACEs, see Message Framework.

Consider Whether to Develop Strategic Communication Campaigns

Communication campaigns require resources and should always be incorporated into a larger comprehensive approach. Discuss with partners whether a campaign aligns with your efforts and will help you achieve the cross-sector goals you have set.

The following are some questions you might ask to determine whether to include strategic communication campaigns in your efforts:

- Do we have a community need across these risk and protective factors that can best be addressed through a campaign?
- Can the campaign effectively be incorporated into larger prevention efforts?
- Are there similar campaigns already being promoted in our community that may dilute or be confused with a campaign on shared risk and protective factors?
- Can we incorporate culturally appropriate messaging about shared risk and protective factors into existing campaigns?
- Do we have the time, resources, and support needed to promote a campaign?

Monitor Your Community's Understanding

If you engage in a prevention campaign, make sure to put in place a plan to monitor whether the campaign is having the intended effect. Following are some potential questions to assist in monitoring:

- Does your community understand the messages from the campaign and how they relate to suicide, overdose, and ACEs? What has contributed to their understanding?
- Has the campaign had unequal impact related to the three areas? For example, has it motivated behavior change or readiness related to ACEs but not suicide or overdose?
- Do community members understand the connections between the three areas and how prevention strategies can be used to address them together?

To determine the answers to these questions, consider joining existing meetings in your community and seeking observations from partners. If some questions remain unanswered, consider incorporating questions into existing assessments, developing an additional written survey, or conducting individual interviews and focus groups.

Resources

Evaluation Profile for Implementing an Overdose Communication Campaign. This guide provides an example for developing and evaluating a communication campaign. Although it focuses on overdose, the guidance may also be used for cross-sector work because the steps and logic model are written in language that can be applied to the other two issues.

Also see CLSP Communication Key Area 3, Step 6.

Sustainability Element: How to Create Long-Lasting Change

Community efforts that address the intersection of suicide, overdose, ACEs, and/or shared risk and protective factors are only likely to lead to significant change if they are sustained over time. The Sustainability element addresses three key aspects of sustainability:

- Maintaining strong commitment and involvement from partners
- Achieving consistent funding
- Implementing policy and practice change

The guidance in this section relates to the CLSP Sustainability element and specifically covers maintaining sustained partner commitment (CLSP Sustainability Key Area 1) and implementing policy and practice change (CLSP Sustainability Key Area 3). For information on developing and maintaining funding, see the *SPACECAT Toolkit*, Domain 3: Managed Resources.

Maintain Strong Commitment and Involvement from Partners

Ongoing tracking of suicide, overdose, ACEs, and shared risk and protective factor data will be a helpful tool in motivating partners to sustain your efforts. So, too, will the groundwork you have laid by developing and maintaining strong and diverse partnership engagement (see the Unity element in this document on page 9).

One way to understand how new programs, policy changes, and/or advocacy are contributing to change and how sustainable these efforts feel is to gather testimonials from community partners. Set up periodic group check-in times to discuss these issues as well as relevant data that you (or they) have collected or accessed.

Ask partners how they interpret the data and what changes you need to consider in order to continue addressing shared goals. For example, if you have seen an increase in reporting about substance abuse on multiple community surveys, is that because the incidences are going up or because stigma has decreased and there is increased awareness, acceptance, and willingness to report? If it is the latter, how can you leverage that information to secure ongoing funding, engage additional partners, or expand your efforts to another population of focus?

Pay attention to changes occurring in one area but not in the other two and explore why that might be. For example, if you are seeing a reduction in ACEs and in overdose deaths but not in suicide deaths despite having strategies addressing all of these shared issues, what might be causing that discrepancy? Consider the following:

- Are suicidal overdoses declining, but suicides by other methods rising, and therefore obscuring the impact of your work at the intersection of suicide and overdose?
- Do the current strategies need to be revisited, adjusted, or even stopped?
- What additional strategies might be needed to better address the issues collectively?

Meaningful prevention outcomes do not happen overnight. To keep positive momentum going, celebrate small successes and short-term outcomes at the intersection of the three areas, such as a school that is training staff in anticipation of a new program or the revision of printed materials that use more positive images placed in a local shelter. Be sure to celebrate the small wins within each of your subcommittees as well. For example, if there is a subcommittee dedicated to youth mental health, celebrate its commitment to meeting monthly despite competing pulls on each member's time.

Implement Policy and Practice Change

It is important to understand the ways in which current policies align with preventing shared risk factors and increasing shared protective factors. Familiarize yourself with any existing policies at the state and local levels that address upstream issues that can underlie suicide, overdose, and ACEs, such as the following:

- Policies that strengthen household financial security (e.g., livable wages, tax credits, childcare or food subsidies).
- Workplace policies that help families, (e.g., paid leave and consistent but flexible work schedules).
- Policies that improve employment opportunities for women and parents' ability to obtain high-quality childcare. These kinds of policies provide a multi-generational strategy that can also prevent ACEs by, for example, decreasing stress and depression in parents. (Fortson et al., 2016; Niolon et al., 2017)

It is also important to understand which current policies contradict best practice when working with these issues and support the people who are advocating for change.

Although your LHD is not allowed to advocate for public policies directly, you can still share information with other local entities, such as coalitions, organizations, and schools, which may assist them in their efforts. For example, you can provide local level incidence and prevalence data on shared risk and protective factors of suicide, overdose, and ACEs to an organization advocating for a change in policy related to harm reduction or family leave. You may also be able to provide evaluation data and help build local partners' capacity to translate and use data in ways that benefit policy and advocacy work.

Review Examples of Policies and Practices That Have Been Implemented at the Local Level

Intersection of More than One Topic

The nondiscrimination ordinances or plans of Decatur, Georgia, and Millington, Tennessee, both include prohibitions of discrimination on the basis of sexual orientation and gender identity for services, activities, and programs. These prohibitions of discrimination contribute to protective factors such as enhancing health equity and addressing disparities, providing safe environments, and increasing access to quality care for LGBTQ+ individuals in these cities.

Suicide

Model School District Policy on Suicide Prevention from the American Foundation for Suicide Prevention. This model can be adapted by individual school districts and is LGBTQ-inclusive.

For more information on implementing suicide prevention policy, see CLSP Sustainability Key Area 3.

Overdose

North Carolina Essential Actions to Address the Opioid Epidemic: A Local Health Department's Guide includes strategies for policy promotion and examples of policies on pages 24–29.

ACEs

Children's Trust of South Carolina uses the Empower Action Model, a framework for preventing ACEs and promoting well-being. When implemented well, this model can assist community systems and leaders with developing policies, procedures, and action plans that increase protective factors.

For more information on ACEs prevention policies, see the *Adverse Childhood Experiences Prevention Policy Toolkit*. Although this toolkit's focus is on state public health agencies, much of the information can inform local ACEs policy strategies.

Develop Additional Policies at the Local Level

Be a supporter, catalyst, and partner in creating needed policies in your local community. The following are some examples:

- A community mental health center could set a policy requiring all providers to screen new clients for suicide, substance use, and ACEs at their first appointment and incorporate this information into treatment planning and wraparound services.
- A health center could require all providers to screen patients for suicide, substance use, ACEs, and certain risk and protective factors (e.g., firearm in the home) at every annual physical exam. They could use this information to connect patients to community resources.
- A children and family services department could require its social workers to provide every new client with an overview of the available community resources related to suicide, overdose, and ACEs, such as mental health services, substance use treatment centers, and domestic violence shelters.
- A school district could require all staff to receive training about suicide, overdose, and ACEs and how to refer students for screening and assessment.

Encourage coalitions, organizations, and schools that want to develop policies to reach out to relevant local and state departments (health, behavioral health, education) to obtain guidance on developing local policies. Many state departments provide model policies on a variety of health and wellness areas.

For help with the assessment of your overall sustainability needs, see Program Sustainability Assessment Tool.

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EDC Education Development Center

Community-Led Suicide Prevention

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