Developing Partnerships in Rural Communities:

At the Intersection of Suicide Prevention, Overdose, and Adverse Childhood Experiences

Introduction

This worksheet is designed to help rural health departments determine how to partner with organizations, work groups, and individuals in their community to address the intersection of suicide, overdose, and adverse childhood experiences (ACEs). The following sections discuss risk and protective factors, related data sources that may be relevant to your rural community, and other topics to consider in your current and future partnerships aimed toward prevention.

Risk and Protective Factors

The shared risk and protective factors for suicide, overdose, and ACEs listed in the chart below occur across communities. Some risk and protective factors are more prevalent in rural populations. **Check off the ones that are relevant for your community** and consider how you know this. For example, do you have data that show the prevalence?

Shared Risk Factors	Shared Protective Factors
Societal Level ☐ High access to substances ☐ Easy access to lethal means (e.g., firearms*) ☐ Low access to care/services*	**Societal Level** ☐ Access to physical and mental health care ☐ Availability of evidence-based treatments ☐ Reduction of access to lethal means/doses
Community Level ☐ Low community connectedness	**Community Level** ☐ School connectedness*
Relationship Level ☐ Bullying ☐ Financial and work stress (in caregivers) ☐ Social isolation* ☐ Minimal support ☐ Trauma, abuse, and neglect	**Relationship Level** ☐ Connection to a caring adult ☐ Positive friendships and peer networks*
Individual Level ☐ Behavioral health ☐ Economic security* ☐ Physical health problems/special needs ☐ Poor coping skills ☐ Trauma*	**Individual Level** ☐ Conflict resolution skills ☐ Good coping skills* ☐ Healthy relationship skills* ☐ Strong parenting skills
*Starred items are often more prevalent in rural populations.	

More information about risk and protective factors in rural communities is discussed at the Rural Health Information Hub. Additional information about the intersection of suicide, overdose, and ACEs is available in the guidance document *Addressing the Intersection of Suicide, Overdose, and Adverse Childhood Experiences: Guidance for Adapting Community-Led Suicide Prevention for Local Health Departments* (*Addressing the Intersection*).

Data Sources

Following is a list of data sources that may help your rural health department to better understand suicide, overdose, ACEs, and related risk and protective factors. **Check off the data sources that you can currently access**. For ones that you cannot access, contact your local or county substance use and suicide prevention specialists or your state health department to request assistance in obtaining access to the data. At your state health department, ask to speak with someone who may have data on suicide and overdose surveillance, injury and violence prevention, or mental health.

- ☐ State health department data
  - ○ Suicide attempts and deaths
  - ○ Overdoses and overdose deaths
- ☐ County or local community data
  - ○ Suicide attempts and deaths
  - ○ Overdoses and overdose deaths
- ☐ Local hospital or health care system data
- ☐ County or local department of family or social services for ACEs data
- ☐ Community Resilience Estimates (county-level shared risk and protective factors)
  - ○ Economic and household social vulnerability factors, such as poverty and living arrangements
  - ○ Housing availability
  - ○ Education level
  - ○ Veterans
- ☐ Economic Research Service (ERS): State Fact Sheets (shared risk and protective factors; click on the state you're interested in)
  - ○ Income
  - ○ Household food insecurity
  - ○ Unemployment
- ☐ KIDS COUNT (shared risk and protective factors)
  - ○ Economic well-being
  - ○ Family and community
  - ○ Health insurance
  - ○ Mental health
- ☐ Medicare Part D Opioid Prescribing
- ☐ Local or state youth prevention surveillance surveys
- ☐ Youth Risk Behavior Survey (YRBS; if you can't find enough local data)
- ☐ National Syndromic Surveillance Program (NSSP; community participation varies by location)
- ☐ Suicide Indicator Tool (Association of State and Territorial Health Officials' interactive tool to explore data sources on suicide indicators at various geographic levels)
- ☐ Other: _____
- ☐ Other: _____

Which pieces of data would be helpful that you do not already have? From what sources might you obtain this data? **List below three specific data points and their potential sources**. These sources could be ones that you already have access to or that you could access by engaging with other organizations.

Please note: The space available for responses to the open-ended questions is limited in the print version. The digital version allows for multi-line answers with scrolling for some answers.

1.

2.

3.

Partnerships

In this section, work through Steps A–G to examine potential partnership opportunities and future collaborations to advance your work.

A. Who are **effective partners for you to work with** to address the risk and protective factors above?

- In column 1, list the name of each current and potential partner.
- Within each partner's row, mark "Yes (Y)" or "No (N)" for each asset that they may contribute to a partnership (columns 2–8).
- For ideas of other possible partners, see pages 10–11 in the resource *Addressing the Intersection*.
- If columns 2–8 have more No's than Yes's for that partner, mark **N** in column 9 since these organizations or individuals are not likely to be effective partners in this work.

Partnership Analysis Assets Table

1. Current or potential partner organization, individual, or role	2. Inside information about a community of interest	3. Access to the groups most at risk for SOA*	4. Needed skills	5. Local influence	6. Resources	7. Potential funding	8. Lived experience‡	9. Partner status: Current (C), potential (P),or will not ask (N)
	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐C ☐P ☐N
	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐C ☐P ☐N
	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐C ☐P ☐N
	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐C ☐P ☐N
	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐C ☐P ☐N

*SOA = Suicide, overdose, and ACEs

‡Lived experience = Individuals who have (1) experienced suicidality, substance use, or ACEs; (2) survived a suicide attempt or overdose; (3) lost a loved one to suicide or overdose; or (4) provided substantial support to a person with direct suicidal experiences, a substance use disorder, or one or more ACEs

For partners with more Yes's than No's, mark **C** for currently existing partners or **P** for potential partnerships you would like to pursue. Complete the boxes below to help you determine how to continue current partnerships or develop new ones with potential partners.

Partner Name: _____

Possible barriers and how to overcome them:

Partner Name: _____

Possible barriers and how to overcome them:

Partner Name: _____

Possible barriers and how to overcome them:

Partner Name: _____

Possible barriers and how to overcome them:

Partner Name: _____

Possible barriers and how to overcome them:

- Now that you have written possible barriers and how to overcome them for each potential partner, revisit column 9 in the Partnership Analysis Assets Table above. Decide if you want to change any of your potential partners from **P** (potential) to **N** (will not ask).

B. For ideas on **engaging people and organizations** and gaining their trust and buy-in, see Building Community Partnerships. As a government agency, building trust may be especially important. Consider these questions and write your ideas in the space below:

- How will you engage with people and organizations?
- How will you build trust with them?

C. How will you **address equity** in each partnership? Examples may include:

- Building a common understanding of equity and strategies to address it
- Reviewing composition and participation of members
- Acknowledging and addressing power dynamics
- Evaluating and adjusting decision-making processes

These examples are from the Centers for Disease Control and Prevention's (CDC's) *A Practitioner's Guide for Advancing Health Equity*, "Developing Partnerships and Coalitions to Advance Health Equity," on pages 14–17. See more detailed strategy descriptions there. In the space below, enter your ideas about how to address equity in your partnerships.

D. When accessing data from the sources noted in the Data Sources section above and/or connecting data from different sources, it is important to protect individuals' privacy. **Data-sharing agreements** (DSAs) are one way to do this. DSAs must balance the desire for real-time shared data at the local level with the need for data protection.

When crafting DSAs with your partners, include the following information:

- The people, roles, and organizations that have access to the shared data
- Whether individual data or only aggregate data will be provided
- The types of demographic data to be included (e.g., age and race but no zip codes)
- The smallest number of cases that will be shared (e.g., only ACE datasets that have at least 100 positive cases)
- The time interval at which new datasets will be shared with external partners (e.g., every 3 months, 6 months, or 1 year; in areas with small populations, consider longer time intervals to allow datasets to be large enough to protect privacy.)
- The circumstances that would require a person to remove themselves from reviewing and/or analyzing data to help protect data anonymity
- The behaviors to be used or avoided by those with access to data (e.g., not discussing the data outside of these individuals with direct access)

Using the examples above, answer the following questions:

Which of your current and potential partners from the chart on page 4 have data that you would like to access? How would those partners benefit from sharing data with your local health department? For example, which of your data sources might they be interested in? How could your prevention activities benefit their audiences?

What staff roles in your local health department should have access to the shared data? Who in your partnering organizations should have access to the data?

What limitations (i.e., time, place, frequency, or size) will you place on data sharing?

E. What **resources** can your partners contribute? Check off all of the relevant resources. On the line following each resource, list the key partners that can contribute.

- ☐ Staff: _____
- ☐ Data: _____
- ☐ Funding: _____
- ☐ Meeting spaces: _____
- ☐ Communications between organizations: _____
- ☐ Media relations: _____
- ☐ Refreshments (i.e., food, coffee): _____
- ☐ Training, CEUs, certifications: _____
- ☐ Other: _____
- ☐ Other: _____

F. How can you get creative in **funding efforts** across suicide prevention, overdose, and ACEs (e.g., by combining different funding sources that you and your partners already have across different issues)?

G. If your community has multiple partners, coalitions, task forces, or similar groups involved in related work, you can create efficiency by **encouraging the groups to work together**, such as on suicide prevention and substance use. For example, if you are a convener of one or more of the groups, you could partner with the leadership from the other groups to form an executive committee among three task forces addressing suicide, overdose, and ACEs in unique ways.

List the groups that might work together and who you might engage with to bring them together.

Immediate Next Steps

Using the information that you have gathered from Steps A–G, prioritize and list the action steps you will take next. Weave together all the information you have gathered in this sheet to determine how you will work with current and/or potential partners in your community to improve the prevention of suicide, overdose, and ACEs. Consider developing an approximate timeline for taking these action steps.

List your three next steps:

1.

2.

3.