SPACECAT | SUICIDE, OVERDOSE, AND ADVERSE CHILDHOOD EXPERIENCES PREVENTION CAPACITY ASSESSMENT TOOL

Suicide, Overdose, and Adverse Childhood Experiences Prevention Capacity Assessment Tool (SPACECAT)

2021

astho™
CDC Centers for Disease Control and Prevention
NACCHO National Association of County & City Health Officials
The National Connection for Local Public Health

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Introduction

Preventing adverse childhood experiences (ACEs), suicide, and overdose involves cross-sector collaboration focused on impacting risk and protective factors at the individual, relationship, community, and societal levels. The Association of State and Territorial Health Officials (ASTHO), in collaboration with the Centers for Disease Control and Prevention (CDC) and National Association of County and City Health Officials (NACCHO), developed the Suicide, Overdose, and Adverse Childhood Experiences Prevention Capacity Assessment Tool (SPACECAT) to help state, territorial, and local health agency staff identify opportunities to work at the intersection of these public health issues to maximize resources and impact.

Target Audience: The SPACECAT is for state, territorial, and local health agencies and their ACEs, suicide, and overdose leadership and staff. Please note that ACEs leadership and staff include individuals working to prevent or mitigate the impact of potentially traumatic events that occur in childhood (0-17 years). This involves state, territorial, and local health agency staff that work on programs that specifically address ACEs, as well as those that focus on child maltreatment prevention and/or address risk and protective factors for ACEs (e.g., economic mobility, community connectedness).

Purpose: Prevention of these public health issues often involves cross-sector partnerships and collaboration with community partners at the local level. Health agencies may serve as a convener of these stakeholders rather than directly implementing programs and services. The SPACECAT is an internal (within your health agency) collaborative self-assessment to assist local, state, and territorial health agencies in taking inventory of their capacity to address ACEs, suicide, and overdose. The SPACECAT should spur discussion and reflection on the intersection and overlap between ACEs, suicide, and overdose, including the strengths and weaknesses of the agency's current capacity to advance prevention in these areas.

Value: The SPACECAT data will benefit health agencies by allowing them to inventory their current capacity to address the intersection of ACEs, suicide, and overdose. The SPACECAT assists in identifying assets and challenges, providing insight for strategic planning, program improvement, technical assistance requests, and future funding opportunities to explore. The SPACECAT will also assist ASTHO, CDC, NACCHO, and other relevant partners in better understanding the impacts of COVID-19 on the capacity to address shared risk and protective factors for social and behavioral health outcomes and it will inform technical assistance and capacity building activities across sectors. Please visit ASTHO's website to learn more about SPACECAT and supplemental resources (e.g., informational videos and process roadmap to complete the SPACECAT).

Data Access: All responses from the survey will be kept confidential. All reports will aggregate data trends (e.g., state/territorial, local, national, and regional), and identifiable information such as agency

name will be redacted to protect agency privacy. Participating agencies will receive an individual response summary after submitting the SPACECAT.

Tool Logistics:

- The SPACECAT should take approximately one hour to fill out depending on robust discussions among your team when completing. Please factor in additional time to gather the necessary information to answer some of the prompts. You may defer sections of the SPACECAT to colleagues if necessary.
- Complete only one response per agency. Please collaborate with colleagues, as needed, to complete the different sections of the SPACECAT.
- The SPACECAT uses hover-over definitions to provide further information; a blue word indicates examples or definitions are available.
- Respondents may save their responses and continue the SPACECAT later by clicking on the "Next" button at the bottom of each page. However, to ensure that responses save, only use the back button within the SPACECAT, and do not use the back button on your internet browser.
- Questions may require radio buttons or checklists. Radio buttons allow your agency to select only one answer, while a checklist allows multiple answers to be selected.
- Throughout the SPACECAT, questions prefaced with "As a team" are a reminder to collaborate on questions encompassing ACEs, suicide, and overdose in the matrix.
- Please answer the SPACECAT in its entirety. However, if your agency is unsure of the answer to a question, please leave it blank. Note: ALL questions left blank will be coded as "unsure."

Companion Documents:

- Glossary: This document serves as a glossary for participants to reference when completing the SPACECAT.
- Capacity Scale: The SPACECAT uses a four-point capacity scale. Familiarizing yourself with the scale beforehand will be helpful.
- Notetaking template: This document is a template to take notes as your team completes the SPACECAT.
- Roadmap: This document provides concrete resources and examples outlining how to navigate the SPACECAT and the necessary steps for completion.
- Health Agencies Address the Intersection for Maximum Impact – Part 1: This video provides validated statements from health agencies that pilot-tested the SPACECAT.
- Proactive Approaches to Completing the SPACECAT—Part 2: This video navigates best practices for completing the SPACECAT and reviews the scales and glossary attachments.
- Reasons to Love the SPACECAT – Part 3: This final video spotlights state, territorial, and local health agency staff discussion

Questions: If you have questions about the SPACECAT content or function, please contact ASTHO's Social and Behavioral Health team at SBH@astho.org

Section I: Background

Q1 **Please select your agency type.**

- o State, Territorial, or Freely Associated State health agency (1)
- o Local health department (2)

Display This Question:

If Q1 = State, Territorial, or Freely Associated State health agency

Q2 **Please select your agency.**

- o Alabama Department of Public Health (1)
- o Alaska Department of Health and Social Services (2)
- o American Samoa Department of Health (3)
- o Arizona Department of Health Services (4)
- o Arkansas Department of Health (5)
- o California Department of Public Health (6)
- o Colorado Department of Public Health and Environment (7)
- o Connecticut Department of Public Health (8)
- o Delaware Department of Health and Social Services (9)
- o District of Columbia Department of Health (10)
- o Florida Department of Health (11)
- o Georgia Department of Public Health (12)
- o Government of the Federated States of Micronesia (13)
- o Guam Department of Health and Social Services (14)
- o Hawaii State Department of Health (15)
- o Idaho Department of Health and Welfare (16)
- o Illinois Department of Public Health (17)
- o Indiana State Department of Health (18)
- o Iowa Department of Public Health (19)
- o Kansas Department of Health & Environment (20)
- o Kentucky Department for Public Health (21)
- o Louisiana Department of Health (22)
- o Maine Center for Disease Control and Prevention (23)
- o Maryland Department of Health (24)
- o Massachusetts Department of Public Health (25)
- o Michigan Department of Health & Human Services (26)
- o Minnesota Department of Health (27)
- o Mississippi State Department of Health (28)
- o Missouri Department of Health & Senior Services (29)
- o Montana Department of Public Health & Human Services (30)
- o Nebraska Department of Health & Human Services (31)
- o Nevada Division of Public & Behavioral Health (32)
- o New Hampshire Department of Health & Human Services (33)

- New Jersey Department of Health (34)
- New Mexico Department of Health (35)
- New York State Department of Health (36)
- North Carolina Division of Public Health (37)
- North Dakota Department of Health (38)
- Northern Mariana Islands Commonwealth Health Corporation (39)
- Ohio Department of Health (40)
- Oklahoma State Department of Health (41)
- Oregon Health Authority Public Health Division (42)
- Pennsylvania Department of Health (43)
- Puerto Rico Department of Health (44)
- Republic of Palau Ministry of Health (45)
- Republic of the Marshall Islands Ministry of Health (46)
- Rhode Island Department of Health (47)
- South Carolina Department of Health & Environmental Control (48)
- South Dakota Department of Health (49)
- Tennessee Department of Health (50)
- Texas Department of State Health Services (51)
- United States Virgin Islands Department of Health (52)
- Utah Department of Health (53)
- Vermont Department of Health (54)
- Virginia Department of Health (55)
- Washington State Department of Health (56)
- West Virginia Bureau for Public Health (57)
- Wisconsin Department of Health Services (58)
- Wyoming Department of Health, Public Health Division (59)

Display This Question:

If Q1 = Local health department

Q3 **Please select your state, territory, or freely associated state.**

- Alabama (1)
- Alaska (2)
- American Samoa (3)
- Arizona (4)
- Arkansas (5)
- California (6)
- Colorado (8)
- Commonwealth of the Northern Mariana Islands (9)
- Connecticut (10)
- Delaware (11)
- District of Columbia (12)
- Federated States of Micronesia (13)
- Florida (14)
- Georgia (15)
- Guam (16)
- Hawaii (17)
- Idaho (18)
- Illinois (19)
- Indiana (20)
- Iowa (21)
- Kansas (22)
- Kentucky (23)
- Louisiana (25)

- o Maine (26)
- o Maryland (27)
- o Massachusetts (28)
- o Michigan (29)
- o Minnesota (30)
- o Mississippi (31)
- o Missouri (32)
- o Montana (33)
- o Nebraska (34)
- o Nevada (35)
- o New Hampshire (36)
- o New Jersey (37)
- o New Mexico (38)
- o New York (39)
- o North Carolina (41)
- o North Dakota (42)
- o Ohio (43)
- o Oklahoma (44)
- o Oregon (45)
- o Republic of Palau (46)
- o Pennsylvania (47)
- o Puerto Rico (48)
- o Republic of the Marshall Islands (49)
- o Rhode Island (50)
- o South Carolina (51)
- o South Dakota (52)
- o Tennessee (53)
- o Texas (54)
- o Utah (55)
- o Vermont (56)
- o Virgin Islands (57)
- o Virginia (58)
- o Washington (59)
- o West Virginia (60)
- o Wisconsin (61)
- o Wyoming (62)

Display This Question:

If Q1 = Local health department

Q4 **Please provide the name of your local agency.**

_____

Q5 **Please select whether your agency has staff that works part-time or full-time in these areas.**

	Part-time (1)	Full time (2)	Staffing in progress (3)	No designated staff and none in progress (4)
ACEs prevention (1)	☐	☐	☐	☐
Suicide prevention (2)	☐	☐	☐	☐
Overdose prevention (3)	☐	☐	☐	☐
Cross-cutting prevention position that encompasses ACEs, suicide, and/or overdose (4)	☐	☐	☐	☐

Risk Factors and Protective Factors

ACEs, suicide, and overdose are preventable. While these issues are complex and do not have one cause, these issues are connected and share some of the same root causes. Several factors may increase (i.e., risk factors) or decrease the risk (i.e., protective factors) for experiencing these issues. Prevention requires understanding and addressing the overlapping causes as well as the factors that put people at risk for and/or protects them from experiencing these issues. The following questions aim to identify your agency's capacity to address the **risk factors and protective factors** that your ACEs, suicide, and overdose programs are working on based on each level of the Social-Ecological Model.

For the following questions, please refer to the following scale to define your agency's capacity and/or the capacity of the community/local programs that your agency funds in different areas. We recommended downloading the capacity scale for reference throughout the SPACECAT.

0 = Not Applicable (N/A): Your agency does not perform this work directly. However, the health agency may support other partners at the community or local level who perform this work
1= No Capacity: No efforts are currently underway (e.g., due to lack of funding or other reasons).
2= Limited Capacity: Preliminary efforts and plans are underway (e.g., an action plan).
3= Some Capacity: Have assessed and developed initial responses, but important program gaps or challenges remain.
4= Full Capacity: Have targeted initiatives for those in need. Your agency has addressed most gaps and challenges related to implementing strategy.
*Please leave any questions **blank** if you are **unsure** about the answer.

Q6. **As a team, please estimate your agency's capacity to address shared risk and protective factors at each functional group of the social-ecological model for ACEs, suicide, and overdose. Given the overlapping nature of shared risk and protective factors, please note that these can be interpreted as the lack or presence of for some factors.**

Individual and Relationship

	ACEs Prevention (1)					Suicide Prevention (2)					Overdose Prevention (3)				
	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full
Physical abuse	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Sexual abuse	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Emotional abuse	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Parental separation or divorce	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Emotional neglect	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Physical neglect	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Physical or intellectual disability	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Family history of trauma (e.g., suicide, overdose)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Familial support	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Educational attainment	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Access to basic needs (e.g., food, shelter)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Resiliency	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Self-Efficacy	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Spirituality	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Violence in the household	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Substance misuse in the household	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Mental illness in the household	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Parental incarceration	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Community and Societal

	ACEs Prevention (1)					Suicide Prevention (2)					Overdose Prevention (3)				
	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full
Financial challenges (e.g., unemployment)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Housing instability	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Food insecurity	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Providing social support	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Providing extracurricular activities	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Reducing the stigma associated with help-seeking behaviors	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Enhancing health equity and addressing disparities	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Teaching life skills (e.g., effective coping strategies and problem-solving skills)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Access to quality medical care and mental health services	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Availability of lethal means (e.g., firearms or medications)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Q7. **Are there any other risk or protective factors that your organization works on to prevent ACEs, suicide, and overdose?**

_____

_____

_____

_____

_____

Section II: Infrastructure Capacity

Infrastructure capacity includes multiple components that affect program capacity, implementation, and sustainability. Key components are networked partnerships, multilevel leadership, managed resources, data, strategic plans, and shared planning. See the Suicide Prevention Resource Center Infrastructure Capacity for more information.

Networked Partnerships: Networked partnerships are strategic partnerships at all levels (national, state, local) across sectors (health systems, public safety) with multiple types of organizations (government, nonprofit) that enhance coordination, extend reach, foster champions, and contribute to sustainability.

For the following questions, please refer to the following scale to define your agency's capacity level in different areas. We recommended downloading the capacity scale for reference throughout the SPACECAT.

0 = Not Applicable: Your agency does not perform this work directly. However, the health agency may support other partners at the community or local level who perform this work
1= No Capacity: No efforts are currently underway (e.g., due to lack of funding or other reasons).
2= Limited Capacity: Preliminary efforts and plans are underway (e.g., an action plan).
3= Some Capacity: Have assessed and developed initial responses, but important program gaps or challenges remain.
4= Full Capacity: Have targeted initiatives for those in need. Your agency has addressed most gaps and challenges related to implementing strategy.
*Please leave any questions **blank** if you are **unsure** about the answer.

Q8 **As a team, consider the level of capacity each program area has demonstrated in operating different partnerships.**

	ACEs Prevention (1)					Suicide Prevention (2)					Overdose Prevention (3)				
	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full
Partnerships with public sectors at your same jurisdictional level (e.g., state public health and state education; local public health and county mental health) (1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Partnerships across different jurisdictional levels (e.g., state to regional level) (2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Public-private partnerships (e.g., nonprofit organizations, for-profit companies, or health systems) (3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Q9 **As a team, consider the following question: What is the overall level at which your agency coordinates activities with critical partners to prevent ACEs, suicide, and overdose?**

	No joint activities with our key partners (1)	Loose coordination of some activities with our key partners, occasionally planning activities in collaboration (2)	Close coordination and regular collaboration with key partners, but **without a common work plan** (3)	Close coordination and regular collaboration with key partners **under a common work plan** (4)
ACEs prevention (1)	0	0	0	0
Suicide prevention (2)	0	0	0	0
Overdose prevention (3)	0	0	0	0

Q10 **As a team, please select the types of public/private partners with whom your agency coordinates for ACEs, suicide, and overdose prevention activities (select all that apply):**

	No coordination (1)	ACEs prevention (2)	Suicide prevention (3)	Overdose prevention (4)
Healthcare organizations (1)	☐	☐	☐	☐
Behavioral/mental healthcare organizations (2)	☐	☐	☐	☐
Primary and secondary schools (3)	☐	☐	☐	☐
Institutions of higher education (4)	☐	☐	☐	☐
State or community level nonprofit/philanthropic organizations (5)	☐	☐	☐	☐
National level nonprofit/philanthropic organizations (6)	☐	☐	☐	☐
Law enforcement/public safety organizations (7)	☐	☐	☐	☐
Criminal and juvenile justice systems (8)	☐	☐	☐	☐

	No coordination (1)	ACEs prevention (2)	Suicide prevention (3)	Overdose prevention (4)
Faith-based organizations (9)	☐	☐	☐	☐
For-profit businesses (10)	☐	☐	☐	☐
Media organizations (11)	☐	☐	☐	☐
Community-based coalitions (12)	☐	☐	☐	☐
Family support/parenting organizations (13)	☐	☐	☐	☐
Veteran serving organizations (14)	☐	☐	☐	☐
Medicare and/or Medicaid (15)	☐	☐	☐	☐
State public health (16)	☐	☐	☐	☐
Local public health (17)	☐	☐	☐	☐
Children, family, and adult social service organizations (e.g., child welfare agencies) (18)	☐	☐	☐	☐
Employment service organizations (e.g., labor and unemployment offices) (19)	☐	☐	☐	☐
Housing service organizations (e.g., homeless services, community development offices) (20)	☐	☐	☐	☐

Multilevel Leadership: Multilevel leadership includes the people and processes that make up leadership at all levels that interact and collaborate to impact the program. Please leave any response **blank** if you are **unsure** about the answer.

Q11 **As a team, please select the statements that are true for each program area in your organization.**

	None (1)	ACEs prevention (2)	Suicide prevention (3)	Overdose prevention (4)
Leaders of this topic interact across multiple sectors (e.g., maternal and child health, housing, and Medicaid) (1)	☐	☐	☐	☐
Leaders of this topic interact at all levels (e.g., state, territory, county, and city) (2)	☐	☐	☐	☐

Managed Resources: Managed resources refers to effectively monitoring resources as they are needed. Such resources may include but are not limited to sustained funding, funding sources, staffing, training, and internal resource sharing. Note: Sustained funding is a reliable, recurrent funding source.

Q12a. Do you have a sustained funding source for any of the following program areas?

- ❑ ACEs prevention
- ❑ Suicide prevention
- ❑ Overdose prevention
- ❑ ⊗ None of the above

Q12b. Do any of the following program areas engage in internal resource sharing (e.g., in-kind contributions, shared staffing) with any other program areas?

- ❑ ACEs prevention
- ❑ Suicide prevention
- ❑ Overdose prevention
- ❑ ⊗ None of the above

Q13 **As a team, please indicate the funding sources used for ACEs, suicide, and overdose prevention work within your agency. Select all that apply. Please leave the response blank if you are unsure about the answer.**

	None (1)	ACEs prevention (2)	Suicide prevention (3)	Overdose prevention (4)
Local government (1)	☐	☐	☐	☐
State government (2)	☐	☐	☐	☐
Philanthropic organizations (e.g., regional, state, and local foundations) (3)	☐	☐	☐	☐

For-profit/private	☐	☐	☐	☐
Federal Funding Sources				
	None (1)	ACEs prevention (2)	Suicide prevention (3)	Overdose prevention (4)
Centers for Disease Control and Prevention (4)	☐	☐	☐	☐
Health Resources and Services Administration (5)	☐	☐	☐	☐
Substance Abuse and Mental Health Services Administration (6)	☐	☐	☐	☐
U.S. Department of Education (7)	☐	☐	☐	☐
U.S. Department of Justice (8)	☐	☐	☐	☐
U.S. Department of Housing and Urban Development (9)	☐	☐	☐	☐
Administration for Children and Families (10)	☐	☐	☐	☐
National Institutes of Health (11)	☐	☐	☐	☐
Department of Defense (12)	☐	☐	☐	☐
Veterans Affairs (13)	☐	☐	☐	☐
Other, please specify: _____ (14)	☐	☐	☐	☐

Data and Surveillance: This section refers to strategies that routinely track and monitor ACEs, suicide, and overdose. According to CDC, public health surveillance is "the ongoing, systematic collection, analysis, and interpretation of health-related data essential to planning, implementation, and evaluation of public health practice."

Q14 **As a team, consider the following question: Does your agency use data to address the intersection of ACEs, suicide, and overdose prevention?**

- o Yes (1)
- o No (2)
- o In progress (3)
- o I don't know (4)

Display This Question:

If Q14 = Yes or In Progress

Q15 **As a team, explain how has your agency used data to address the intersection of ACEs, suicide, and overdose prevention (e.g., surveillance data to inform programs and services, program monitoring, and evaluation of existing programs)?**

_____

_____

_____

_____

_____

Display This Question:

If Q14 = Yes or in progress

Q17 **As a team, please indicate how you are using surveillance data in each program area. Select all that apply. Leave the response blank if you are unsure about the answer.**

	None (1)	ACEs prevention (2)	Suicide prevention (3)	Overdose prevention (4)
Use **risk factor surveillance data** to inform programmatic work (e.g., Behavioral Risk Factor Surveillance System, Youth Risk Behavior Survey) (1)	☐	☐	☐	☐
Use **morbidity surveillance data** to inform programmatic work (e.g., National Medical Services information System data) (2)	☐	☐	☐	☐
Use **mortality surveillance data** to inform programmatic work (e.g., National Vital Statistics System, Fatality Review data, Vital Records Death Data, National Violent Death Reporting System(3)	☐	☐	☐	☐
Use **syndromic surveillance data** to inform programmatic work (e.g., Drug Overdose Surveillance and Epidemiology System, National Syndromic Surveillance Program BioSense Platform data, Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes)	☐	☐	☐	☐

Shared Planning and Strategic Plans: The Public Health Accreditation Board defines strategic planning as "a process for defining and determining an organization's roles, priorities, and direction" and serves as "a guide for making decisions on allocating resources and taking action to pursue strategies and priorities." Strategic plans are formal written documents developed among program staff and partners to be responsive and dynamic, responding to contextual influences such as changes in the science, health agency priorities, funding levels, and external support from the public and leadership. In addition, shared planning is informal communication and collaboration that promotes cross-sectoral action and goal setting among program staff and partners.

Q18 **Do you have an agency strategic plan that addresses any of the following topics? Select all that apply.**

- ☐ Injury and violence (1)
- ☐ Family and child health (2)
- ☐ Shared risk and protective factors (3)
- ☐ ACEs (4)
- ☐ Overdose (5)
- ☐ Suicide (6)
- ☐ ⊗None of the above (7)

Q19 **As a team, consider this question: What level of coordination within your agency occurs across formally written strategic plans to prevent ACEs, suicide, and overdose?**

- o No coordination at all (1)
- o Minimal coordination within our agency (e.g., occasional ad-hoc planning meetings) (2)
- o Some coordination within our agency (e.g., quarterly or bi-annual scheduled planning meetings) (3)
- o Significant coordination within our agency (e.g., bi-weekly or monthly scheduled planning meetings) (4)
- o Not applicable (5)

Q20 **As a team, consider this question: What level of shared planning occurs for ACEs, suicide, and overdose to inform your programmatic work?**

- o No shared planning at all (1)
- o Minimal shared planning, occasionally planning activities in collaboration (2)
- o Some shared planning, regular collaboration within our agency, but **without a common plan** (3)
- o Significant shared planning, regular collaboration within our agency, but **with a common plan** (4)

o Not applicable (5)

Q21 **As a team, consider this question: What challenges does your agency face in addressing ACEs, suicide, and overdose prevention? Please select all that apply. Leave the response blank if you are unsure about the answer.**

	None (4)	ACEs prevention (1)	Suicide prevention (2)	Overdose prevention (3)
Resources (e.g., funding, staff) (1)	☐	☐	☐	☐
Subject matter expertise (2)	☐	☐	☐	☐
Internal coordination across programmatic areas (3)	☐	☐	☐	☐
External coordination across state/local sectors (4)	☐	☐	☐	☐
Data (5)	☐	☐	☐	☐
Competing priorities (e.g., Covid-19 response) (6)	☐	☐	☐	☐
Stakeholder support and ongoing engagement (e.g., academic institutions, law enforcement, community leaders) (7)	☐	☐	☐	☐
Communication/messaging across programmatic areas (8)	☐	☐	☐	☐
Communication/messaging across state/local sectors (9)	☐	☐	☐	☐
Training (10)	☐	☐	☐	☐
Policymakers (e.g., county commissioners) (11)	☐	☐	☐	☐
Stigma (12)	☐	☐	☐	☐
Other, please specify: _____ (13)	☐	☐	☐	☐

Q22 **As a team, consider this question: What are the initiatives your agency is prioritizing in ACEs, suicide, and overdose prevention?**

o ACEs prevention initiatives (1) _____

o Suicide prevention initiatives (2) _____

o Overdose prevention initiatives (3) _____

Section III: Topical Capacity

Topical capacity refers to multiple strategies that work together to form a comprehensive public health response.

For the following questions, please refer to the following scale to define your agency's capacity in different areas. We recommended downloading the capacity scale for reference throughout the SPACECAT.

0 = Not Applicable: Your agency does not perform this work directly. However, the health agency may support other partners at the community or local level who perform this work
1= No Capacity: No efforts are currently underway (e.g., due to lack of funding or other reasons).
2= Limited Capacity: Preliminary efforts and plans are underway (e.g., an action plan).
3= Some Capacity: Have assessed and developed initial responses, but important program gaps or challenges remain.
4= Full Capacity: Have targeted initiatives for those in need. Your agency has addressed most gaps and challenges related to implementing strategy.

*Please leave any questions **blank** if you are **unsure** about the answer.

ACEs Prevention – Best Available Evidence: This section refers to evidence-based strategies focused on preventing ACEs before they occur. See CDC's Preventing Adverse Childhood Experiences for more details.

Q23 **As a team, please specify your agency's capacity to implement ACEs prevention efforts at each level of intervention.**

	N/A (0)	No capacity (1)	Limited capacity (2)	Some capacity (3)	Full capacity (4)
Primary prevention efforts that aim to **stop ACEs from occurring in the first place** by reducing risk factors and promoting protective factors (1)	o	o	o	o	o
Secondary prevention efforts that aim to **identify individuals at high risk for ACEs** (e.g., early screening and assessment) (2)	o	o	o	o	o
Tertiary prevention efforts that aim to **reduce the health impact of ACEs** (3)	o	o	o	o	o

Q24 **As a team, please specify your agency's capacity for each of the following ACEs interventions.**

	N/A (0)	No capacity (1)	Limited capacity (2)	Some capacity (3)	Full capacity (4)
Strengthen economic supports to families through financial security and family-friendly work policies (e.g., paid family leave, subsidized child care, assisted housing mobility) (1)	o	o	o	o	o
Promote social norms that protect against violence and adversity (e.g., public education campaigns, bystander approaches, men and boys as allies) (2)	o	o	o	o	o
Ensure a strong start for children (e.g., early childhood home visitation, high-quality childcare, preschool enrichment with family engagement) (3)	o	o	o	o	o
Teach skills (e.g., social-emotional learning, healthy relationship skill programs, and parenting skills and family relationship approaches) (4)	o	o	o	o	o
Connect youth to caring adults and activities (e.g., mentoring programs and after-school programs) (5)	o	o	o	o	o
Intervene to lessen immediate and long-term harms (e.g., family-centered treatment, treatment to prevent problem behavior) (6)	o	o	o	o	o

Suicide Prevention – Best Available Evidence: This section refers to evidence-based strategies focused on preventing suicide. For more details, see CDC's Prevention Strategies: Suicide for more information.

Q25 **As a team, please specify your agency's capacity to implement suicide prevention efforts at each level of intervention.**

	N/A (0)	No capacity (1)	Limited capacity (2)	Some capacity (3)	Full capacity (4)
Primary prevention efforts that aim to **stop suicide from occurring in the first place** by reducing negative risk conditions and promoting protective factors (1)	o	o	o	o	o
Secondary prevention efforts that aim to **identify individuals at increased risk for suicide** (e.g., through early screening and gatekeeper training) (2)	o	o	o	o	o
Tertiary prevention efforts that aim to **reduce the health impact of suicide and suicide attempts**, including care for those who have experienced suicide-related behaviors and postvention (3)	o	o	o	o	o

Q26 **As a team, please specify your agency's capacity for each of the following suicide interventions.**

	N/A (0)	No capacity (1)	Limited capacity (2)	Some capacity (3)	Full capacity (4)
Strengthen economic supports (e.g., unemployment benefit programs) (1)	o	o	o	o	o
Strengthen access and delivery of suicide care (e.g., reduce provider shortages in underserved areas, mental health parity) (2)	o	o	o	o	o
Create protective environments (e.g., reducing access to lethal means among persons at risk of suicide) (3)	o	o	o	o	o
Promote connectedness (e.g., peer norm programs, community engagement) (4)	o	o	o	o	o
Teach coping and problem-solving skills (e.g., using social-emotional learning programs) (5)	o	o	o	o	o
Identify and support people at risk (e.g., crisis intervention) (6)	o	o	o	o	o

Lessen harms and prevent future risk (e.g., postvention; safe reporting and messaging about suicide) (7)	0	0	0	0	0

Overdose Prevention – Best Available Evidence: This section refers to evidence-based strategies focused on preventing fatal overdose. For more details, see CDC's Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States.

Q27 **As a team, please specify your agency's capacity to implement overdose prevention efforts at each level of intervention.**

	N/A (0)	No capacity (1)	Limited capacity (2)	Some capacity (3)	Full capacity (4)
Primary prevention efforts that aim to **stop an overdose from occurring in the first place** by reducing negative risk conditions and promoting protective factors (1)	0	0	0	0	0
Secondary prevention efforts that aim to **identify individuals at high risk for overdose** (e.g., through early screening and assessment) (2)	0	0	0	0	0
Tertiary prevention efforts that aim to **reduce the health impact of overdose** (3)	0	0	0	0	0

Q28 **As a team, please specify your agency's capacity for each of the following overdose interventions.**

	N/A (0)	No capacity (1)	Limited capacity (2)	Some capacity (3)	Full capacity (4)
Increase capacity of Medical Examiners/Coroners/Toxicologists (e.g., training on standardization of drug-related death classification, increasing forensic workforce) (1)	0	0	0	0	0
Use Naloxone tracking and administration data to identify hot spots (3)	0	0	0	0	0
Collaborate with the hospital, healthcare, or emergency systems (e.g., access to timely data EHR/PDMP integration, E.D. data, EMS data; quality improvement initiatives, CDC guideline concordance) (4)	0	0	0	0	0
Support and educate public safety/first responders (e.g., training on Naloxone	0	0	0	0	0

administration, Good Samaritan Laws, or substance use disorder) (6)					
Implement mass media awareness campaigns (7)	0	0	0	0	0
Implement Prescription Drug Monitoring Programs (8)	0	0	0	0	0
Distribute Naloxone and provide overdose education (9)	0	0	0	0	0
Increase treatment access by working with health insurers/payers (e.g., removing prior authorization, lock-in programs, coverage of non-opioid pain management treatment) (10)	0	0	0	0	0
Support linkage to care (e.g., peer support, transportation, housing services) (11)	0	0	0	0	0
Expand access to substance use treatment (e.g., integrating MAT into primary care, buprenorphine waiver, accessibility, co-locating treatment in high-risk settings) (12)	0	0	0	0	0

Health Disparities: This section refers to prioritizing populations disproportionately affected by ACEs, suicide, and overdose. CDC defines health disparities as "differences in health outcomes and their causes among groups of people." For example, females and racial/ethnic minority groups are at a greater risk for experiencing ACEs and have been linked to increased risk for depression, asthma, cancer, and diabetes.

Q29 **As a team, please indicate each program area's level of capacity to address health disparities by populations disproportionally affected by ACEs, suicide, and overdose.**

	ACEs Prevention (1)					Suicide Prevention (2)					Overdose Prevention (3)				
	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full
Identify priority populations through a needs assessment (1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Implement targeted initiatives based on needs assessment (2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Collaborate with justice systems and their involved populations (3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Q30 **As a team, please indicate each program area's level of capacity to address health disparities with each population disproportionally affected by ACEs, suicide, and overdose.**

	ACEs Prevention (1)					Suicide Prevention (2)					Overdose Prevention (3)				
	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full
Protective services and children in foster care (1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Communities experiencing concentrated poverty (2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Communities experiencing concentrated violence (3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Individuals who identify as Lesbian, Gay, Bisexual, Transgender, or Queer (4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Veterans and military service members (5)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Individuals who have a serious physical health condition or disability (6)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Individuals with a mental health/behavioral health condition (e.g., substance use disorder) (7)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Individuals who have previously experienced an overdose (8)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Survivors of suicide loss (9)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Individuals with prior suicide attempts (10)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Individuals experiencing homelessness (11)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rural and frontier populations (12)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Racial and ethnic minorities (13)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
American Indian/Alaskan Native and tribal populations (14)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Immigrant populations (15)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Q31 **As a team, consider to what extent you intentionally incorporate the perspective of people with lived experience (e.g., families and/or involved youth, persons in recovery, survivors of suicide) to inform programmatic decisions and your overall work.**

	N/A (0)	Never (1)	Sometimes (2)	Always (3)
ACEs prevention (Q31_1)	0	0	0	0
Suicide prevention (Q31_2)	0	0	0	0
Overdose prevention (Q31_3)	0	0	0	0

Workforce capacity: This section refers to the education and training of 1) mental or behavioral health providers within the jurisdiction of the health agency, 2) providers external to the jurisdiction of the health agency, and 3) health agency staff. Providers include social workers, peer support specialists, and other medical professionals to prevent, identify, treat, and mitigate harms for ACEs, suicide, and overdose.

Q32 **Please specify the level of capacity in each program area.**

	ACEs Prevention (1)					Suicide Prevention (2)					Overdose Prevention (3)				
	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full	N/A	None	Limited	Some	Full
Support providers in identifying and reducing stigma (1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support providers in providing patient-centered care, giving referrals, and coordinating continuity of care (2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Promote strategies identifying individuals at risk through screening and assessment (3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support hospital, healthcare, or emergency systems to identify, monitor, and develop initiatives to prevent injury or violence (4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support non-traditional provider settings (e.g.,	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

homeless shelters, schools) (5)															
Strengthen the integration of behavioral/mental health and physical health care (6)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Train health agency staff in evidence-based prevention strategies (7)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Train health agency staff in trauma-informed care (8)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cross-train health agency staff on the intersection of ACEs, suicide, and overdose (9)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Q33 **As a team, consider the following question: What has been your agency's most significant success over the past year related to the intersection of ACEs, suicide, and overdose prevention?**

_____

_____

_____

_____

_____

Q34 **How does your agency work with partners at the community or local level to address the intersections between ACEs, suicide, and/or overdose (e.g., community coalitions, formal partnership agreements or memorandum of understanding, subcontracts with Chief business officers, information sharing or referral protocols, funding)?**

_____

_____

_____

_____

_____

Q35 **Within one year, does your team intend to apply the information learned from the SPACECAT to address the intersections between ACEs, suicide, and overdose in your agency?**

- o Yes
- o No
- o Unsure

Q36 **Please explain how you intend to apply the information learned. If you selected no or unsure, please explain why.**

_____

_____

_____

_____

_____

Please enter your agency's point of contact. ASTHO will use this contact information to follow up regarding your agency's response. ASTHO will NOT include contact information in any reporting.

- o Name (1) _____
- o Email address (2) _____

Thank you for participating in the SPACECAT! We look forward to sharing key findings and recommendations with your health agency in the near future. Your response will help inform advancing the prevention of ACEs, suicide, and overdose. If you have any questions, please reach out to ASTHO at SBH@astho.org.