NCTSN The National Child Traumatic Stress Network

NCTSN Change Collaborative on Trauma-Informed Suicide Prevention and Healing:

Strengthening Community- and Clinic-Based Healing, Connection, and Wellbeing for Youth, Families, and Communities Most Impacted by Suicide and Trauma

Overview and Background

To prevent the suicide of young people and promote healing, we must strengthen community- and clinic-based healing, connection, and wellbeing. This highlights the importance of the community in driving the direction for, and positive changes to, suicide prevention and response systems. It was developed over the course of a year as we engaged in dialogues with staff from the National Center for Child Traumatic Stress (NCCTS), National Child Traumatic Stress Network (NCTSN) organizations, and community and family partners. In the spirit of this work, a series of Community Think Tanks were held during the summer and fall of 2023 -bringing together NCTSN Centers and community and family partners to help shape this project. All work done in the Collaborative will continue to demonstrate our commitment to equity, anti-racism, and values-based work.

> *"The greatness of a community is most accurately measured by the compassionate actions of its members"*
> - Coretta Scott King

The National Center for Child Traumatic Stress (NCCTS) is leading this Change Collaborative, seeking to support communities and their NCTSN Category III centers in achieving this mission. Working together, participating teams will identify their own pathways and processes – based on their own unique community strengths and needs – that promote healing, connection, and wellbeing for young people.

The Mission of this Collaborative

The mission of this Collaborative is for all participating teams to deepen meaningful partnerships (as defined by communities and families) between communities, families, and the clinics in ways that communities and families feel seen, heard, and valued. These partnerships promote connection, wellbeing, and healing for the youth, families, and communities most impacted by trauma and suicide in ways that ultimately prevent suicide.

The Purpose of this Collaborative Change Framework

This Collaborative Change Framework (CCF) establishes the vision for a community-driven, collaborative approach to suicide prevention for young people. We endeavor to create a system that provides the support and connections that young people need in their community so that risks of suicide are reduced and young people remain safe, healthy, and well. A key aspect of this is striving to understand the communities being served in meaningful ways as we collectively strive to eliminate the structural and institutional racism that has created the systems, organizations, and conditions that hold oppression in place and result in such significant disparities.

This CCF was co-designed over the course of a year and included expertise in a multitude of ways.

THE KEY VALUES OF EQUITY, ANTI-RACISM, AND VALUES-BASED WORK WILL GUIDE THE EFFORTS OF THE *NCTSN CHANGE COLLABORATIVE ON TRAUMA-INFORMED SUICIDE PREVENTION AND HEALING* THROUGH OUR COMMITMENT TO:

INCLUSIVITY

Creating a safe space for each participant to show up as their full and most authentic selves. We recognize that all of us are not one identity in isolation, but our multiple identities intersect to create who we are.

ELEVATING

Elevating the need for knowledge and experiences regarding historically marginalized and oppressed groups. Specifically, communities who are most impacted and most vulnerable to trauma, suicide risk, and suicide.

INTERSECTIONALITY

Highlighting the importance of race, culture, identity, and trauma. These aspects of individuals' experiences will be named and are intended to be inclusive of a range of factors we know are crucial and meaningful to the discussion of trauma-informed suicide prevention.

INTEGRATION

Many come to this space with both professional (e.g., clinicians, advocates, etc.) and personal identities (e.g., individuals with lived experiences related to trauma and suicide). We encourage all to show up and speak from their entire perspective, as they feel led and comfortable.

The Challenge We Face

The intersection of race, culture, identity, and community influence an individual's experiences with suicide prevention and healing, underscoring the need for culturally centered and community-based approaches to mental health and suicide prevention. Some identified barriers to effective suicide prevention and intervention include limited access to mental health services, miscommunication within healthcare systems, and systemic disparities in care quality. Community-based solutions offer promising avenues for addressing these challenges. Training and resources are vital for equipping clinicians, community members, and families with the knowledge and tools needed to provide anti-racist, culturally responsive, and trauma-informed care. Building partnerships between healthcare providers, community organizations, and families can help bridge gaps in care and improve outcomes for youth at risk of suicide.

Suicide is a serious public health concern that claims the lives of individuals across a range of identities and age groups. Suicide is the 10th leading cause of death in the U.S. and the second leading cause of death among adolescents and young adults. While suicide occurs across all age groups, the suicide prevalence among children and adolescents is on the rise, particularly among young people of color post the COVID-19 pandemic. Further, there are clear links between suicide and trauma, and communities of color are among the most impacted. Thus, the significance and urgency for improved suicide prevention and intervention is evident.

Prevalence in Children and Adolescents

- **Leading causes of death** Suicide is the second leading cause of death for people between the ages of 10-24 and the third leading cause of death for youth ages 10 to 19. [1,2]

- **Significance in high school students** 8.9 percent of youth in grades 9-12 reported that they had made at least one suicide attempt in the past 12 months.[2]

- **Increasing suicide rates and attempts in pre-adolescents (ages 9-12)** Rates have increased in this age group and are now the fifth leading cause of death. Approximately 17% of preadolescents with suicidal ideation transition to attempting suicide. Male gender, child maltreatment, attention-deficit/hyperactivity disorder, and depression are associated with risk, whereas parental support may be protective against suicidal ideation.[3]

Most Impacted Populations

- **Increasing suicide rates** Suicide rates are increasing faster in black youth than any other racial/ethnic group.[4] Rates are highest among non-Hispanic American Indian or Alaska Native populations (23.9 per 100,000).[5]

- **Student populations** Female students attempted almost twice as often as male students. American Indian or Alaska Native students reported a more than 3 times higher rate of attempts than white students.[2]

- **Higher prevalence in rural areas** Overall suicide rates were inversely related to county urbanization level, with the most rural counties experiencing the highest rate (20.6 per 100,000).[5]

Connection Between Suicide and Trauma

- **Link between suicide-related outcomes and trauma history** Research shows people with a history of trauma and PTSD have a higher risk of suicidal thoughts, suicide attempts, and suicide.[6]

- **Link between trauma and suicide for youth** Traumatic stress is frequently associated with an increased risk of suicidal thoughts, attempts, and self-harm in adolescence and young adulthood.[7]

- **More exposed to trauma, the greater suicide-related outcomes** There is a dosage affect for trauma exposure and related suicidal thoughts and behavior, in that the more potentially traumatic events experienced, the greater likelihood and greater frequency of suicidal thoughts, behavior and even self-harm with no suicidal intent.[7]

Suicide and Trauma in Communities of Color

- **Communities of color are among those most impacted by trauma** Communities of color are disproportionately affected by traumatic experiences, including PTSD.[8] According to a 2011 study, individuals who identify as Black have an 8.7% lifetime prevalence rate of PTSD, which is the highest among other groups. Similarly, U.S. Latinos and Native Americans/Alaska Natives are disproportionately affected by PTSD.[9]

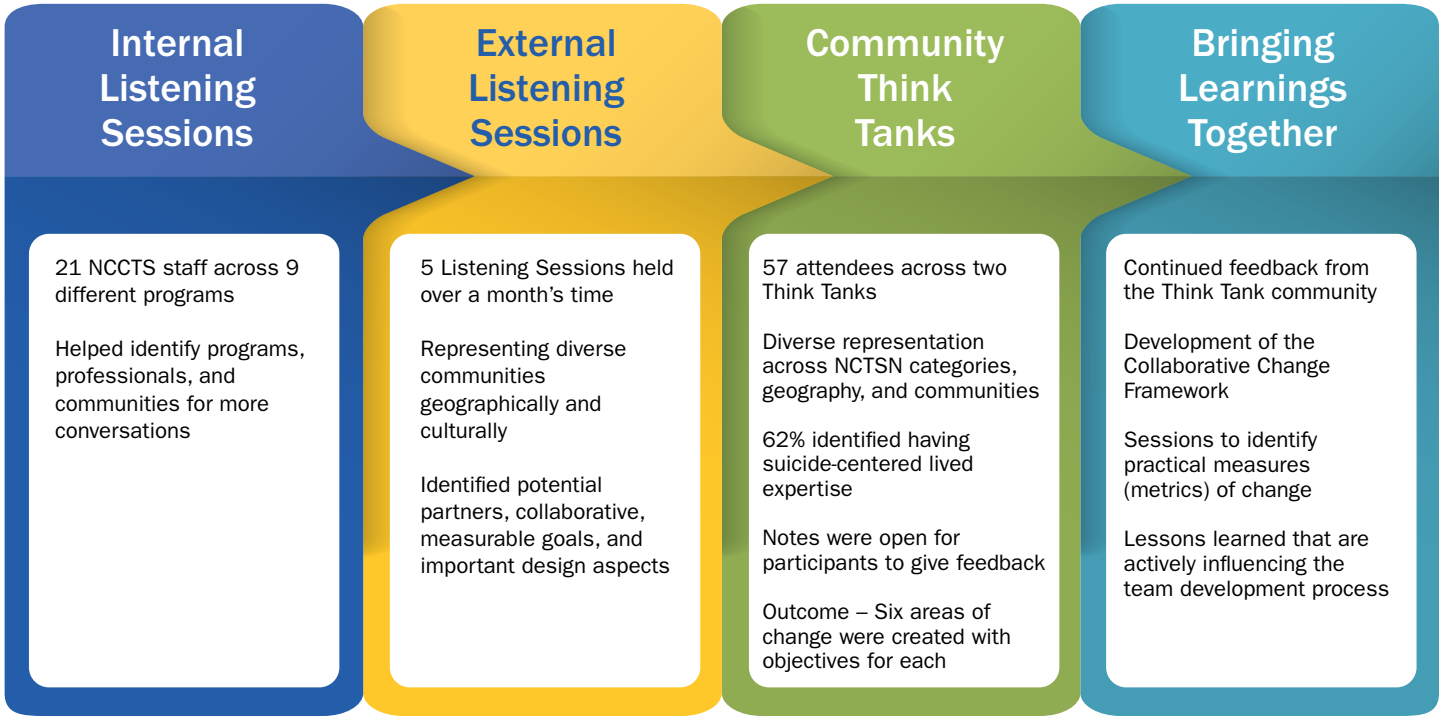
- **Communities of color are significantly impacted by suicide** Suicide-related outcomes are a major public health challenge in communities of color in the United States.[10]

- **Communities of color experience a range of barriers to prevention and intervention** For communities of color, there are well-documented inequities in health care that foster distrust in health care systems, limiting opportunities for prevention, identification, and timely intervention (Arredondo, 2019).[11]

The Opportunity

This Collaborative provides a unique opportunity for community partners, young people, families, and providers to develop, test, and implement practices, strategies, and approaches that strengthen community- and clinic-based healing, connection, and wellbeing for youth, families, and communities most impacted by trauma and suicide. With coaching and support from a diverse group of partners, including those most impacted by suicide, participating teams will engage in an established process for transformational change. The Collaborative's flexibility invites each community to define what improvements are needed and what makes the most sense for them to test and implement. The methodology is designed to embody the values of this work, with intentional focus on inclusion, intersectionality, equity, racial justice, meaningful partnership, and the power and expertise of all voices and experiences.

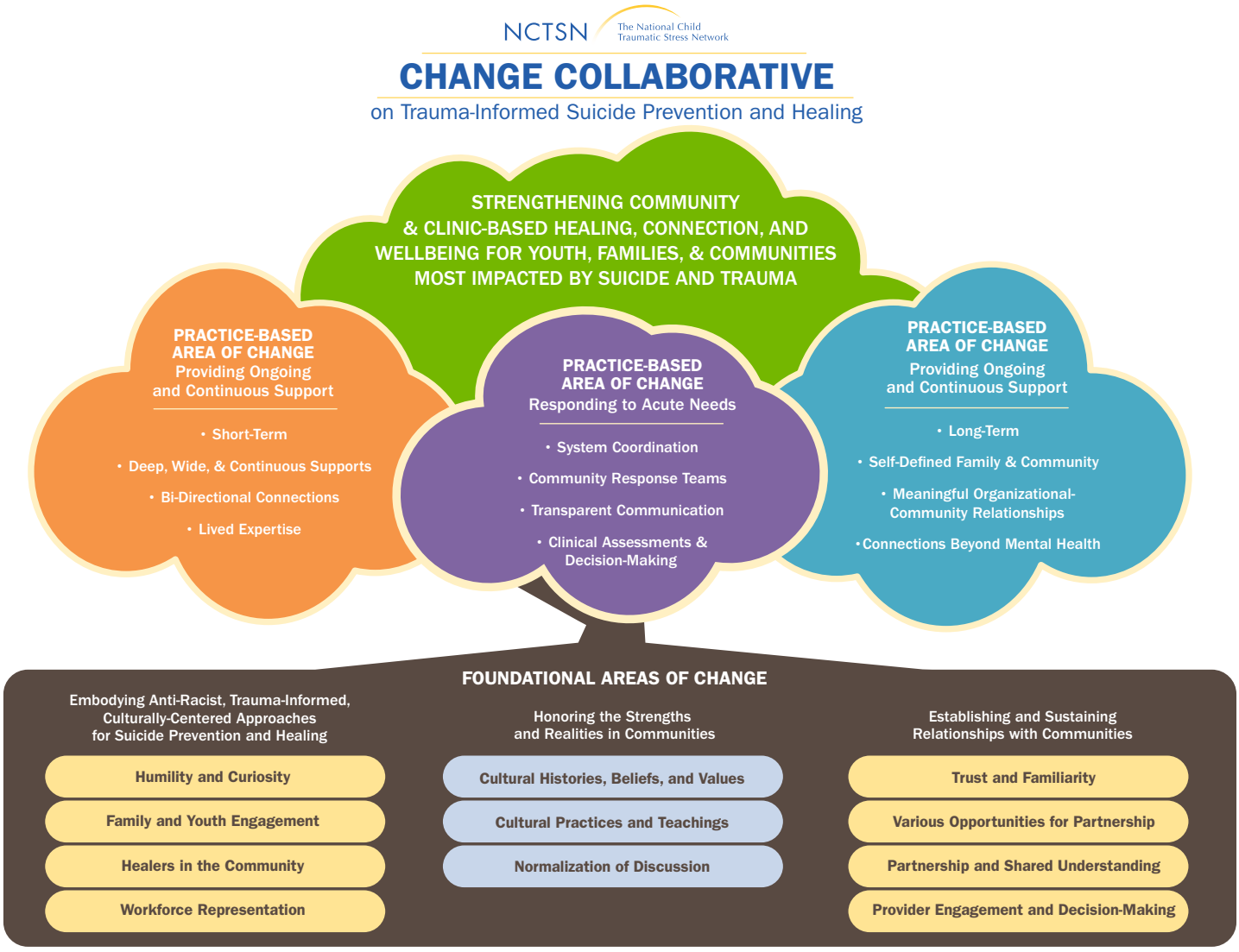
LEARNING FROM COLLABORATORS



This CCF now provides an ideal vision to guide participating teams as they assess their strengths and challenges, identify opportunities for improvement, decide what changes to test, and determine how they will track their progress over time. It is not a prescriptive how-to guide; instead, it has key areas that outline what teams will need to address, honoring the unique strengths, opportunities, and challenges each community faces.

How this CCF is Organized

The CCF is divided into six areas of focus. Although these areas are interrelated and interconnected, for the purposes of this Collaborative they have been separated somewhat artificially into distinct areas to help teams prioritize and move quickly towards implementation. The figure below represents the interplay between these areas.



The first three areas of focus are foundational areas of change, as they require singular focus while also serving as the basis for all work done in suicide prevention. The next three areas of focus are practice-based areas: describing what it looks like when providers, families, and young people are responding to clinical needs. Taken together, these six areas of focus describe what it takes to strengthen community- and clinic-based healing, connection, and wellbeing for youth, families, and communities most impacted by trauma and suicide.

As an essential note, all work done by teams in this Collaborative will not only address all six areas of focus but will do so in ways that model and uphold the mission and values described above. In developing this framework, we recognize that the language itself may pose a challenge as different team members, including young people, families, community partners, and providers may have a different understanding of some of the terms or concepts. To that end, an additional goal of this framework is to help establish a common language that can be shared to support and sustain the work completed by teams and their partners.

The strategies that teams ultimately test, implement, and sustain will be the concrete strategies derived directly from the Objectives under each Area of Change listed below. For every Objective, teams should continually ask themselves: What strategies can we test in this area that will support healing, connection, and wellbeing for young people in our community?

FOUNDATIONAL AREA OF CHANGE 1
HONORING THE STRENGTHS AND REALITIES IN COMMUNITIES

Cultural Histories, Beliefs, and Values
Understand and honor cultural histories, beliefs, and values as sources of strength and healing as well as potential trauma.

Cultural Practices and Teachings
Identify, value, honor, and use cultural practices and teachings to co-develop plans of connection and service and provide continuous support and follow up.

Normalization of Discussion
Normalize discussions about suicide and suicide prevention in schools, religious spaces, community spaces, and with families and other community and system partners.

FOUNDATIONAL AREA OF CHANGE 2
EMBODYING ANTI-RACIST, TRAUMA-INFORMED, CULTURALLY CENTERED APPROACHES FOR SUICIDE PREVENTION AND HEALING

Humility and Curiosity
Promote humility, curiosity, openness, and respect in learning about the community, history, culture, faith, family, and beliefs that shape recovery in the community's eyes.

Family and Youth Engagement
Engage, uplift, and shift power to families and youth directly, proactively, and in ways that are meaningful and valued by them.

Healers in the Community
Uplift healers, who are defined by the community, and identify, engage, and include them as active members of the healing team.

Workforce Representation
Ensure that the community sees itself reflected in the workforce that is serving and supporting them.

FOUNDATIONAL AREA OF CHANGE 3
ESTABLISHING AND SUSTAINING RELATIONSHIPS AND BELONGING WITH AND WITHIN COMMUNITIES

Trust and Familiarity
Build relationships (familiarity and earning trust) with communities when there isn't an identified problem.

Various Opportunities for Partnership
Build continuous relationships and trust through mutually beneficial opportunities for partnership (e.g., advisory boards, community boards, community events, etc.).

Partnership and Shared Understanding
Authentically partner with community leaders and members in every aspect of program development to co-design clinical interventions and service delivery, beginning with a shared understanding of trauma and healing.

Provider Engagement and Decision-Making
Center the expertise of young people and families to define interventions for both prevention and response (not just when issues become crises).

PRACTICE-BASED AREA OF CHANGE 4
RESPONDING TO ACUTE NEEDS

System Coordination Coordinate response among systems in real-time during crises, including plans for a response that include systems.	**Community Response Teams** Create, engage, and support Community Crisis Response Teams within the agency response.	**Transparent Communication** Communicate transparently while deepening relationships with families and young people.	**Clinical Assessments and Decision-Making** Infuse community strengths, beliefs, values, and knowledge into clinical assessments and decision-making in partnership with families and young people.

PRACTICE-BASED AREA OF CHANGE 5
PROVIDING ONGOING AND CONTINUOUS SUPPORT - SHORT-TERM

Deep, Wide, and Continuous Supports: Ensure that post-crisis supports are deep and wide (six month post focus) (wide= variety of options and diversity of how/where/when; deep= rootedness (trees that survive storms)= strong roots and strong soil=need both	**Bi-Directional Connections:** Support bi-directional connections that are anchored in reciprocity and quality, rather than time-limited and transactional	**Lived Expertise:** Center lived experience perspectives in voice in every effort with a supported pool of lived experts

PRACTICE-BASED AREA OF CHANGE 6
PROVIDING ONGOING AND CONTINUOUS SUPPORT - LONG-TERM

Self-Defined Family and Community: Invite and advocate for young people to define "who" they consider family and "who" they consider community.	**Connections Beyond Mental Health:** Develop and promote connections with other partners and community members outside of mental health and human services.	**Meaningful Organizational-Community Relationships:** Promote relationships between the program and the community in which the program enriches and helps heal the community soil.

> *"Tell them that this is survival. This is hope. This is a life through language and never forget how hard it was to get here, to turn your back on your demons. But if the pen is mightier than the sword, then it is mightier than any mental illness that has tried to kill you. So tonight, don't write me a suicide note. Put a period where there could be a comma. Write me a survivor story. I promise you'll be here tomorrow."*
>
> - Aniyah Smith, *Healing*

References

1. Ehlman, D. Y. (2022). Changes in suicide rates - United States, 2019 and 2020. Morbidity and Mortality Weekly Report, 71(8), 306-312.

2. American Foundation for Suicide Prevention. (2022, October 14). Suicide statistics. Retrieved from American Foundation for Suicide Prevention: https://afsp.org/suicide-statistics/

3. Liu, R. W. (2022). Prevalence and correlates of suicidal and nonsuicidal self-injury in children: A systematic review. JAMA Psychiatry, 79(7), 718-726. doi: https://doi.org/10.1001/jamapsychiatry.2022.1256/

4. Lifeline, 9. S. (2022, October 20). Black Mental Health. Retrieved from 988 Lifeline: https://988lifeline.org/help-yourself/black-mental-health/

5. Ehlman, D. Y. (2022). Changes in suicide rates - United States, 2019 and 2020. Morbidity and Mortality Weekly Report, 71(8), 306-312.

6. Martin, M. D. (2016). Child abuse and the prevalence of suicide attempts among those reporting suicide ideation. Social Psychiatry and Psychiatric Epidemiology, 51(11), 1477–1484. doi: https://doi.org/10.1007/s00127-016-1250-3

7. Miller, A. B.-S. (2013). The relation between child maltreatment and adolescent suicidal behavior: A systematic review and critical examination of the literature. Clinical Child and Family Psychology Review, 16(2), 146–172. doi: https://doi.org/10.1007/s10567-013-0131-5

8. Pumariega, A. J. (2022). Trauma and US minority children and youth. Current psychiatry reports, 24(4), 285-295.

9. Roberts, A. L. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. Psychological medicine, 41(1), 71-83.

10. Centers for Disease Control and Prevention, N. C. (2022). Web-based injury statistics query and reporting system (WISQARS). Retrieved from www.cdc.gov/injury/wisqars

11. Arredondo, P. (2019). Eliminating race-based mental health disparities: Promoting equity and culturally responsive care across settings. New Harbinger Publications.

Acknowledgements

George S. Ake, Ph.D., Susan Badeau Megan Camp, Shannon CrossBear, Greg Donovan, Dorothy Haskell, MSW, LCSW, Erica Hochberger, LICSW, Terresa Humphries-Wadsworth, Kristen Kaseeska, MPH,, Micha Kirsch-Ito, Rafiah Maxie-Cole, MSW, LCSW, Ingrid E. Murrle, LMFT, Susie Reynolds Reece, Sally Schuss, Jennifer Stajduhar, M.S. Ed, LPC, NCC, Nicholas Tise, MPH, Angela M. Tunno, Ph.D., M.S., Victoria Waugh-Reed Sally Weinstein, Ph.D.

The authors of this document would like to thank the participants of the NCTSN Community Think Tanks on Suicide Prevention for their guidance and valuable feedback.

Suggested Citation

Busby, D., Agosti, J., Houston, F. (2024). NCTSN Change Collaborative on Trauma-Informed Suicide Prevention and Healing: Strengthening Community- and Clinic-Based Healing, Connection, and Wellbeing for Youth, Families, and Communities Most Impacted by Suicide and Trauma. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.