Wisconsin's Injury and Violence Prevention Plan: Strategies and Approaches for Action

2026–2030

WISCONSIN DEPARTMENT of HEALTH SERVICES

University of Wisconsin Population Health Institute
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Dear Colleagues,

The Wisconsin Department of Health Services (DHS) and the University of Wisconsin Population Health Institute (UWPHI) are grateful to have had the opportunity to develop this plan together that prioritizes input from local and state level partners, individuals affected by injury and violence, and experts in the field. We believe that only by working together can we achieve meaningful reductions in injuries, experiences of violence, and violent deaths in our state. This state strategic plan intends to do just that; help focus prevention efforts across sectors by highlighting specific strategies to achieve meaningful reductions over the next five years.

Developed over the course of many months, this plan represents the cooperative effort of many communities. The planning team reached a wide range of people through a variety of methods and partnerships to assure representation of those impacted by injury and violence. The strategic plan development process emphasized finding shared values, which are key to moving injury and violence prevention practice and policy forward.

The strategies identified in this plan are aimed at strengthening both the personal and collective contexts in which injuries and violence occur. We hope that everyone sees a strategy that matters to the places they serve, work, live, and learn in. It is also our hope that everyone finds value in this plan, adopts it, and champions it within their work.

Sincerely,

Paula Tran

State Health Officer and Administrator of the Division of Public Health

Wisconsin Department of Health Services

Sheri Johnson, Ph.D

Director

University of Wisconsin Population Health Institute

Table of contents

Acknowledgments

This report was supported through an interagency agreement between the Wisconsin Department of Health Services (DHS) and the University of Wisconsin Madison School of Medicine and Public Health Population Health Institute (UWPHI). The project was led by Rebecca Gonnering, Injury and Violence Prevention Program Coordinator at DHS, in collaboration with Dr. Abra Vigna and Dr. Elizabeth Feder at UWPHI and UBUNTU Research and Evaluation.

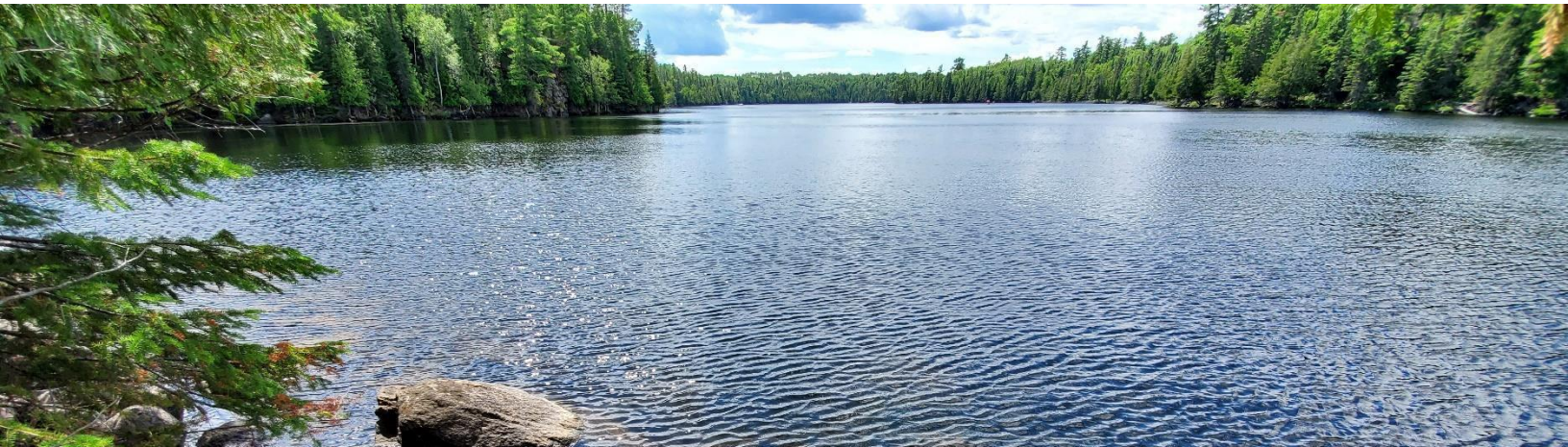
This report was made possible by the collective efforts of many individuals and agencies who supported this project with their time and expertise.

We would like to take this opportunity to thank the various individuals and agencies who graciously supported this project:

- Black and Brown Womyn Power Coalition, Inc.
- Child Advocacy Centers of Wisconsin
- Children's Hospital of Wisconsin, Inc.
- End Abuse Wisconsin
- Medical College of Wisconsin
- Mental Health America
- Office of Children's Mental Health
- Wisconsin Coalition Against Sexual Assault

A sincere thanks also goes to all the staff at UWPHI and DHS who provided review and supported the development of this plan in its many stages:

Julianne Dwyer	Kate McCoy
Teale Greylord	Christy Niemuth
Anne Hansen	Maggie Northrop
Korey Hokenson	Alisa Pykett
Pamela Imm	Deirdre Sperry
Sara Lindberg	Spencer Straub
Olivia Little	Paula Tran



Forward!

Each year, individuals and organizations across Wisconsin are changing lives as they work tirelessly to prevent injuries and experiences of violence. This plan asks us to imagine the impact we could have if we worked collectively; each in our own way, but toward the same goals.

This inaugural five-year strategic plan charts a path for coordinated efforts to reduce injuries and violence across our state. It incorporates the priorities and insights of both Wisconsin residents and experts from each region.

This document begins with an executive summary of the plan and the process used to create it. Then we present the official strategic plan followed by the full report of the planning process.

The first section includes the full, five-year strategic plan for injury and violence prevention in Wisconsin.

The second section describes the project background and methods. We outline the plan's constraints and the plan development process, including who was engaged and how.

The third section dives into the process used to identify community priorities, presenting detailed findings from each data collection method and an exploration of tensions that arose in this process.

The fourth section outlines the state's role in advancing this plan, as requested by community partners carrying out injury and violence prevention work.

Finally, the appendices provide technical information, including data summaries that describe patterns in the five most recent years of available data.

Executive summary

Introduction

Injury and violence are serious public health concerns requiring urgent attention both nationally and in Wisconsin. For 2023, the CDC (Centers for Disease Control and Prevention) reports unintentional injury is the leading cause of death among Americans aged 1 to 44. Suicide is the second leading cause of death among Americans aged 1 to 44, and homicide is the fourth leading cause of death in the same age group. The story these data tell is striking. In the first half of life, more Americans die from injuries and violence than any other cause (CDC WISQARS Data Reports).

In 2023, unintentional injury was the third leading cause of death in Wisconsin. Suicide was the eighth leading cause of death. Homicide, while not a leading cause of death in Wisconsin overall, is a concern for Wisconsin communities.

Firearms are also of particular interest for prevention efforts because they remain the most used method in both suicides and homicides in Wisconsin.

Furthermore, there are disparities in injury rates by age, race, sex, and geography. For example, nearly 61% of those who died by homicide in Wisconsin in 2023 were Black Wisconsinites, and the number of Wisconsin women who died by firearm increased 140% between 2018 and 2022 and then decreased 31% in 2023. What these data show is the need for coordinated, sustained efforts across sectors for the prevention of multiple types of injury and violence in Wisconsin.

This plan intends to do just that; help focus prevention efforts across sectors by highlighting specific strategies to achieve meaningful reductions over the next five years.

Purpose

- Elevate injury and violence as a public health priority in Wisconsin to drive prevention efforts across the state
- Identify the injury and violence topics of highest priority to Wisconsinites
- Define concrete strategies and approaches for prevention guided by community input
- Support more effective connections and coordination across sectors to make the most of limited resources

DHS' role in developing and implementing the plan

DHS is one of many state agencies involved in preventing injury and violence. As a publicly funded organization guided by state mandates, DHS has the responsibility and resources to provide structure to the work. As a government institution, it also has a responsibility to provide services in a manner responsive to the needs of its communities. However, the people of Wisconsin represent diverse communities, and developing a plan to coordinate efforts is complicated. This plan is therefore intended to be a guide to aid collaboration across sectors, across agencies, and across communities.

Strategies in this plan are intentionally broad to allow for self-determination and adaptability to different community contexts. This is also a living document intended to be updated as the needs of communities change over time.

Key findings

Over the course of a yearlong process, Wisconsinites were engaged in developing this strategic plan through interviews, focus groups, world cafés, surveys, and two public feedback sessions. Wisconsinites were asked to share their insights, concerns, and priorities for injury and violence prevention efforts in our state. What we heard was a resounding desire to focus prevention efforts on **five topic areas within the field of injury and violence**:

- Child maltreatment and abuse
- Intentional firearm injuries
- Intimate partner assault (which includes domestic, sexual, and intimate partner violence)
- Self-harm and suicide
- Unintentional drug overdoses

We also learned how Wisconsinites wanted to carry out this important work and what they needed from the state to do it. Themes that arose in interviews and focus groups were then verified through a statewide survey.

These themes became the five strategies promoted in this plan.

Strategies

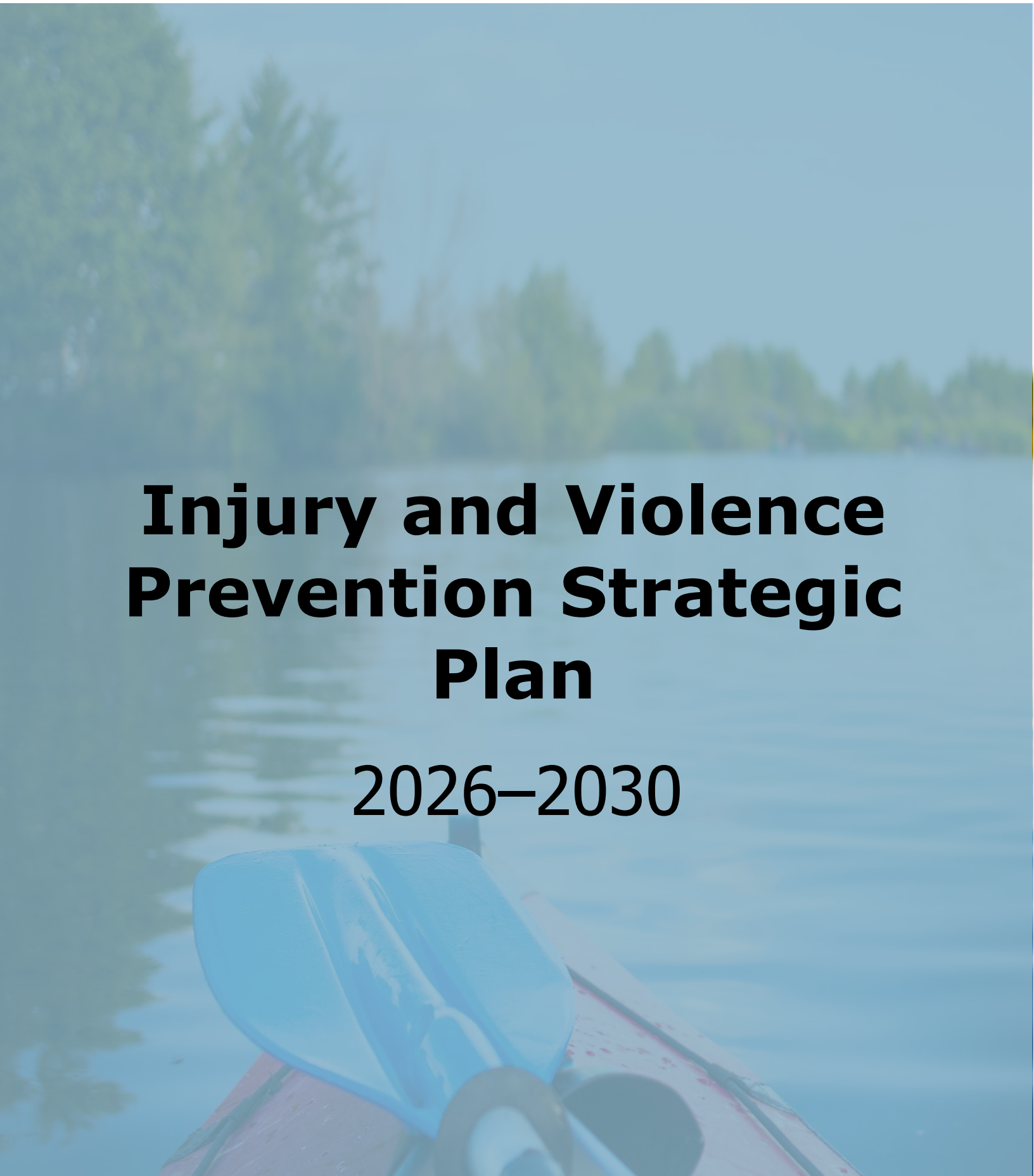
Strategies are the actions taken to achieve the goal of preventing injury and violence across the five topic areas within the field of injury and violence. The five strategies are:

- **Strategy one:** Ensure safe and protective childhood environments.
- **Strategy two:** Foster a strong sense of belonging and connection to culture and community.
- **Strategy three:** Build shared skills to cope with distress, fear, and grief.
- **Strategy four:** Expand access to risk reduction and healing resources at every age.
- **Strategy five:** Work together for a shared future.

Each strategy is paired with an approach. Approaches are specific ways to advance each strategy.

Conclusion

Injury and violence are urgent public health concerns in Wisconsin that require commitment of financial resources, public will, and community engagement. By working together, we can make the vision of a safe and healthy Wisconsin a reality for all. Join us in building this future for all Wisconsinites.



Injury and Violence Prevention Strategic Plan

2026–2030

Creating a shared vision for injury and violence prevention

Strategic planning is beneficial because it improves relationships with stakeholders and partners, provides a clear mission and a plan for change, and clarifies how we expect to create the change we want to see.

This plan draws perspectives from across Wisconsin to foster a shared sense of purpose and ownership of this plan among stakeholders, ensuring that everyone understands how their work contributes to the larger objectives.

This plan is the result of a year's long effort to bring together partners and hear their concerns, priorities, fears, and hopes. Partners reviewed recent injury data, engaged in in-depth discussions, and ranked options. They ultimately described a vision of strategically coordinated efforts that focus primarily on improving childhood and family experiences and secondarily intervening to reduce harm from injuries, especially those caused by violence, across the lifespan.

To achieve this vision, this plan outlines the types of injury and violence Wisconsinites want action on over the next five years, the five strategies agencies and individuals can use for coordinated action, and sample approaches to advance the selected strategies.

Section overview

This section outlines the full strategic plan, including:

- A mission and vision for injury and violence prevention in Wisconsin.
- The five topic areas Wisconsinites most want addressed through this plan.
- Five strategies to use to drive down injury and violence among the selected topic areas.
- Approaches to use for advancing each strategy.
- Recommendations to consider when implementing programs.
- The role of the state in advancing this plan.

Strategic plan mission and vision

The following statements were written with community input and are based on evidence-based practices. They represent what injury and violence prevention should look like according to Wisconsinites and how they want the state to support this work.

Mission statement

Provide statewide leadership to reduce injury and prevent violence at each stage of the lifespan, advancing strategies and approaches that reflect the priorities of the diverse peoples of Wisconsin and result in improvements across the selected injury and violence topic areas

To support this mission and vision, the state will provide leadership by:

- Coordinating statewide multisectoral injury and violence prevention work.
- Coordinating federal and state funds to advance this strategic plan.
- Making data accessible to community partners.
- Creating resources for public education regarding the costs and benefits of investing in injury and violence prevention and the ways in which our lives are connected.
- Providing guidance to communities on communicating public health goals, including suggestions for a unifying message.
- Connecting people with different funding sources to support collective innovation.
- Improving collaboration within and across state agencies and programs to work more effectively with limited resources.
- Ensuring public behavioral health services are timely, accessible, sufficient, and responsive to all members and cultures within the community.

Vision statement

All Wisconsinites have the resources to prevent, avoid, and heal from injury and violence across the lifespan.

This includes:

- Safe and protective childhood environments.
- A strong sense of belonging and connection to culture and community.
- Skills and supports to cope with distress, fear and grief.
- Access to risk reduction and healing resources across the lifespan.
- Easy access to culturally matched healing and rehabilitative systems when harm occurs.

Starting to address big problems

When speaking with Wisconsinites, it was clear they wanted this plan to focus on the prevention of five types of injury and violence. The topics are shown here in alphabetical order and do not represent a ranking or prioritization.

The topics that participants most wanted addressed in this plan were:

- Child maltreatment and abuse.
- Intentional firearm injuries.
- Intimate partner assault, (which includes domestic, sexual, and intimate partner violence).
- Self-harm and suicide.
- Unintentional drug overdoses.

This list is not all-inclusive of the many interests and topics within the field of injury and violence prevention. This plan focuses instead on the topics Wisconsinites felt could have the most impact across the lifespan or were deemed most urgent to address.

This plan outlines concreate strategies and approaches to use. Each strategy is intentionally broad to allow communities to tailor each to their specific needs.

Overview: Five strategies to use

Selected approaches for advancing these strategies

Strategy one: Ensure safe and protective childhood environments

Approach: Equip caregivers with resources to support children and families. Ensure that every family has access to safe shelter, nutritious food, support for healing from trauma, respite resources, and essential safety equipment.

Strategy two: Foster a strong sense of belonging and connection to culture and community

Approach: Support community specific approaches to creating a sense of belonging, connection, and social cohesion through youth engagement, leadership, mentoring, and multi-age programs.

Strategy three: Build shared skills to cope with distress, fear, and grief

Approach: Equip caregivers, families, and professionals with skills, techniques, and resources to cope with and manage emotions. Teach healthy relationship skills, build social and emotional skills, teach nonviolent conflict resolution and de-escalation techniques, improve access to mental health supports, and reduce stigma associated with mental health.

Strategy four: Expand access to risk reduction and healing resources at every age

Approach: Increase access to prevention and treatment, health care, (especially culturally driven behavioral health); expand access to fall prevention and risk reduction measures, violence interruption services, case management, and rehabilitation services for people at high risk of engaging in violence; and reduce access to lethal means.

Strategy five: Work together for a shared future

Approach: Enhance understanding of our interconnected lives, and the impact injury and violence has on our communities. Focus on improving collaboration, program planning, and data sharing among agencies and community partners. Build opportunities for shared experiences in the community where people can come together in safe ways. Foster empathy and active listening skills, volunteerism and community engagement, youth leadership, and intergenerational programs.

Strategy one: Ensure safe and protective childhood environments

Approach: Equip caregivers with resources to support children and families

When families are supported with resources to manage caregiving responsibilities, they are less stressed, can balance work and family obligations, and can focus on building family bonds and connectedness.

Unfortunately, financial stress, caregiving responsibilities, and challenges balancing work and home can take a toll. Supporting families and children can buffer them from the impacts of stress and can prevent them from ever experiencing harm.

Supporting families and children includes affordable and safe housing, affordable child care and health care, family medical leave, parental leave, and paid time off. Supporting families benefits everyone.

Agencies should select approaches that advance access to:

- Safe **shelter.**
- Nutritious **food.**
- Support in **healing from trauma.**
- Resources for caregivers when they need **respite.**
- Essential **safety equipment** for caregivers and children.

Sample efforts that advance this strategy:

- Working with employers to educate them on the use of family friendly workplace policies such as paid time off (PTO) or paid parental leave
- Supporting food and nutrition support programs such as farm-to-table programs at schools and early education centers
- Promoting access to culturally matched parenting support services for families
- Funding a respite center for caretakers of small children, adults with disabilities, or elders
- Enhancing interagency collaboration to distribute free safety resources that prevent injury in childhood**,** such as gates, helmets, car seats, and playground upgrades
- Increasing awareness of the benefits of subsidized child care or affordable health care

Strategy two: Foster a strong sense of belonging and connection to culture and community

Approach: Support culturally or community specific approaches to creating a sense of belonging, connection, and social cohesion

A strong sense of belonging to one's family, community, culture, or heritage can help prevent injury and experiences of violence and can help buffer the impacts of injury and violence when they occur.

A sense of belonging often comes from strong relationships with others who can help support us in times of need.

Communities with a strong sense of social cohesion (trust, connectedness to one another, and shared norms) have also been shown to have less community violence.

Additionally, ancestral, cultural, and community traditions that connect people to the land and to one another are powerful sources of resilience.

Agencies should select approaches that:

- Engage **youth and adults** across the lifespan.
- Create a sense of **belonging and promote social cohesion.**
- Affirm one's **dignity.**
- Promote respect and the **redeemability of all people.**

Sample efforts that advance this strategy:

- Creating culturally specific youth leadership programs to meet the needs of communities
- Connecting youth with positive peers and role models
- Implementing culturally or community specific suicide and substance use prevention curriculums or programs
- Affirming and inclusive workplace policies
- Connecting seniors with community-based organizations
- Educating the public about the connections between cultural identity and well-being via campaigns
- Holding community events celebrating the many cultures that contribute to a particular community

Strategy three: Build shared skills to cope with distress, fear, and grief

Approach: Equip caregivers and families with skills, techniques, and resources to cope with and manage emotions

Effective communication skills, relationship skills, and non-violent conflict resolution skills are important to prevent many types of injury and violence. Without shared skills for addressing conflict, we can become overwhelmed, behave impulsively, and sometimes aggressively.

De-escalation training is also an important tool when working in high stress environments such as law enforcement, schools, and community response teams to suicide or gun violence.

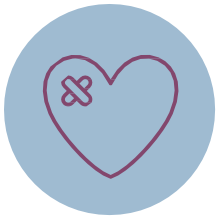
Agencies should select approaches that:

- **Build social and emotional intelligence in children and adults.**
- **Teach caregivers and children** emotional regulation skills.
- Teach and **model nonviolent conflict resolution** skills.
- **Shift social norms** away from those that accept violence or allow indifference to violence and promote positive norms about masculinity and femininity**.**
- **Improve access** to mental health supports and reduce stigma associated with mental health care.

Sample efforts that advance this strategy:

- Offering parenting education classes that focus on strategies for recognizing and moving emotions through the body without hurting oneself or others
- Drafting policies for teaching and using nonviolent conflict resolution skills in all educational environments
- Sponsoring office spaces for mental health clinicians along bus lines or areas walkable to communities that often experience transportation barriers
- Creating social norming campaigns regarding trust, how to communicate your needs, and reinforcing the idea that relationships may not last forever
- Improving capacity building with caregiving staff at assisted living facilities about how to solicit consent with nonverbal individuals and how to manage emotions if frustrated with a resident

Strategy four: Expand access to risk reduction and healing resources at every age



Approach: Increase access to prevention, treatment, health care, and risk reduction measures

Injuries can increase during adolescence for several reasons: reduced supervision and increased freedom, access to lethal means, poor decision-making due to lack of experience, and limited impulse control. Increasing access to trusted community members who can provide support when tensions rise; equipment for safely storing firearms and other lethal means; overdose reversal medications; and targeted case management can help prevent injury and violence.

Schools, courts, and whole communities can work to understand how trauma shapes brain development and adopt policies to support healing when trauma occurs.

Agencies should select approaches that:

- **Provide preventative health care** and culturally driven behavioral health.
- **Incorporate fall prevention programming** and resources.
- **Offer risk reduction** services and resources.
- **Expand violence interruption services**, case management, and rehabilitation services for people at high risk of engaging in violence.

Sample efforts that advance this strategy:

- Training community health workers to ensure older adults have resources to age safely at home
- Engaging people with lived experience in all types of injury and violence prevention
- Working to build or strengthen civilian-led crisis response services

Strategy five: Work together for a shared future

Approach: Enhance understanding of our interconnected lives, and the impact injury and violence has on our communities

Collaboration offers a wealth of possibilities. Challenges arise from separate funding streams which create a false sense of distinct work when all injuries and violence are interconnected. To build connections across sectors, agencies, and within communities, we must creatively find ways to show up for one another. This needs to happen in and across all sectors.

For DHS, this means fostering connections within and between state agencies and assisting communities in identifying potential partnerships. Efforts will include suggesting partnerships, providing guidance on collaboration, and communicating the mutual benefits that can be achieved.

Agencies should select approaches that:

- **Enhance understanding** of our interconnected lives and promote community cohesion.
- **Improve collaboration** and data sharing among agencies and community partners.
- **Advocate** for primary prevention.
- **Enhance data and surveillance** for PACEs, sexual violence, intimate partner violence, and alcohol-related injuries.
- **Promote** injury and violence prevention as a population-based effort.

Sample efforts that advance this strategy:

- Collaborating across funding streams to advance shared goals. For example, people working in the areas of sexual violence prevention could pool resources with those working in child maltreatment to offer parenting education classes or trainings to support staff in doctors' offices, dental clinics, and adult day care centers
- Collaborating between counties in the same region to develop educational materials on the shared benefits of pooling funding for regional transportation systems, keeping domestic violence agencies open, or ensuring non-police mobile crisis units are available and equipped with overdose prevention resources
- Partnering with community health workers to pilot educational materials about the benefits of prevention

Recommendations to consider when implementing an Injury and Violence (IVP) Prevention program

Focus group participants provided essential guidance on how to implement this plan to ensure that smaller population groups and areas are not forgotten or ignored.

First, they uplifted **the importance of assessing impact, not just sheer numbers.** For example, as of 2023, Black Wisconsin residents made up about 7% of Wisconsin's total population but accounted for 25% of firearm related deaths. Similarly, the proportion of people of color who die from gun-related injuries remains very high compared to the proportion of white people who die from gun-related injuries. Participants also stressed the importance of prevention services across topic areas.

Second, all groups **stressed that focusing on healing includes addressing intergenerational and institutional harms**. For some, this means ensuring the availability of culturally matched resources; for others, it relates to the tenor of institutional partnerships and service delivery.

Third, focus group participants encouraged all agencies to **view young people as leaders** with valuable insights and important contributors to decision-making.

Fourth, they recommended focusing on **addressing the root causes of patterns in injury and violence,** rather than focusing solely on interventions that target changing individual behavior.

Finally, they emphasized agencies should engage with communities on their terms and **build trust in a way that is meaningful to the community.**

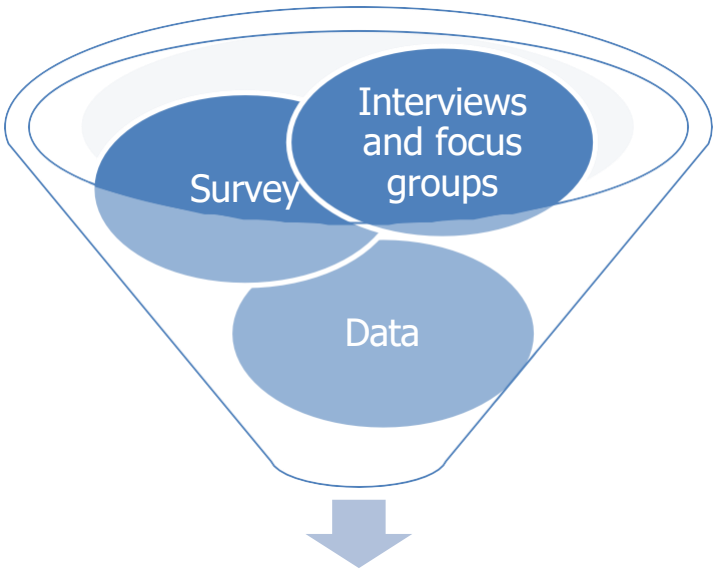
Wisconsinites also want IVP programs and practitioners to guide their decision-making on the community values of:

- Flexibility.
- Fairness.
- Cultural humility.
- Self-determination.

Project background and methods

Project background

This strategic plan collects and summarizes the collective wisdom of residents across Wisconsin to guide collective efforts in preventing injury and violence for the next five years.



Section overview

The following pages provide background information on the strategic planning process, including details on the methods used to collect a range of perspectives and the role the state will have in supporting this work.

Wisconsin's IVP State Plan

Step one: Looking at data

Injury data from a variety of data sources was summarized and shared with focus group participants.

Sources commonly used by DHS' Injury and Violence Prevention Program include death records, Wisconsin inpatient hospital and emergency department discharge data, and the Wisconsin Violent Death Reporting System. These data can be seen and queried by the public.

Surveillance of nonfatal injuries is conducted mostly by review of hospital discharge data.

Other sources of data for injury include the National Syndromic Surveillance System, Behavioral Risk Factor Survey, Youth Risk Behavior Survey, and other national and local surveys.

Some violent injuries (often referred to as intentional injuries) may be less likely to appear in health care data due to stigma, fear, access to care, or other reasons. For injuries related to domestic violence, sexual violence, and child maltreatment for instance, other sources may provide additional information. These sources may include violent crime reports and Child Protective Services (CPS) records.

Unintentional injuries: list of common causes

(commonly available in health care discharge records)

- Burns
- Drowning
- Cutting or piercing objects
- Falls
- Firearm
- Machinery
- Motor vehicle traffic
- Natural or environmental factors (such as extreme heat, flash
- Other transportation (not involving motor vehicles in traffic)
- Overexertion
- Poisoning
- Struck by or against an object or person (such as sports injuries or assault)
- Suffocation, strangulation and choking

Intentional injuries: any cause

(information available through violent crime reports, CPS records, health care data, and various national and local survey data)

- Self-harm or suicide
- Assault or homicide
- Domestic violence
- Sexual violence
- State violence
- Child maltreatment or neglect

Looking for disparities: Who you are and where you live matter

Who you are and where you live should not predict the type of injuries you experience, but they do.

Racism, sexism, ageism, and homophobia for example, may impact people separately or they may interact resulting in poorer health outcomes that affect some communities more than others.

Additionally, economic, social, and legal conditions can also negatively influence a person's health outcomes.

A review of combined years of data for 2019–2023 (using death records for mortality data and hospitalization and emergency department (ED) discharge records for nonfatal injury) reveals differences by age, race, gender, urbanicity, and region of the state. The box on the right summarizes a few highlights.

These data suggest that interventions may be more effective if they are targeted to those experiencing greater need. For example, fall interventions could focus on those 65 and older.

Data highlights

- Death rates from poisoning (drug and non-drug poisoning) were greatest among those aged 35 to 44.
- Black and American Indian Wisconsinites had the highest age-adjusted rates of poisoning death with rates three times greater compared white residents.
- Suicide rates were the highest among American Indian Wisconsinites.
- Nonfatal self-harm rates (both ED and hospitalizations) were highest among youth ages 10–24.
- Unintentional motor vehicle traffic-related death and hospitalization rates were significantly higher based on rural county residency. In contrast, ED rates (treated and released) were significantly higher among urban county residents.
- Males had higher rates of assault deaths and hospitalizations compared to females. Females had higher rates of ED visits with assault compared to males.
- Black females had the highest assault rate (ED, hospitalizations, and deaths) compared to females of other racial groups.

Step two: Consider what is missing

Injury counts and rates are likely underestimates, especially related to intentional injury.

Nonfatal injuries are likely underestimated due to a variety of factors. Statewide health care data are limited to ED visits and hospitalizations. Primary care and urgent care clinics and community health care clinics do not report to the state health department. Injuries in these places are not captured in injury counts and rates.

Access to care including transportation and insurance can also restrict use of health care services and lead to underestimating the full extent of nonfatal injury.

> "There are lots of folks who are experiencing violence in their homes, and they're not going to the doctors. There are several people who are being shot and not going to doctors or contacting law enforcement."—Focus group participant

In terms of nonfatal intentional injuries, people impacted by these events may experience feelings of shame, embarrassment, or fear and may not seek care or report the nature of their injury. Underestimation of specific types of intentional injury is greater for certain types, such as child abuse and neglect and sexual violence.

Other data sources can help paint a broader picture of the burden on populations. These sources often include violent crime data, CPS reports, and anonymous national or local surveys.

Consider sexual violence

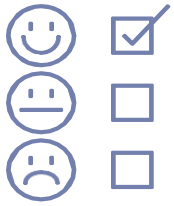
This is a commonly underreported event both in health care and in police reports. National Intimate Partner and Sexual Violence Survey (2023–2024) responses from women ages 18 and older suggests that about 551,000 Wisconsin women have experienced rape in their lifetime.

The same survey suggests that 209,000 Wisconsin men have experienced unwanted sexual contact in their lifetime.

Step three: Engage people across the state

Over the course of seven months, in partnership with UBUNTU Research and Evaluation, UWPHI completed the following activities:

- Compiled the last five years of statewide injury and violence data to provide data to drive decisions
- Interviewed 16 administrators and community partners
- Engaged 43 people virtually and in-person through focus groups, including some in a world café format
- Collected survey data from 730 participants across all five DHS regions and across different sectors, including governmental public health, nonprofits, health systems, and others; see Appendix F for demographic information
- Hosted two virtual feedback sessions on the draft plan, attended by 140 people.



Key informant interviews

UWPHI staff had 16 in-depth discussions with injury and violence prevention professionals. Experts were consulted as an initial step in the process to gain a holistic and in-depth understanding of each injury area.

Key informants were identified by IVP Program leadership for their expertise in injury and violence prevention. See Appendix B for links to questions asked via intensive interviews and Appendix C for a summary of the interviews.

We spoke with staff from the following organizations:

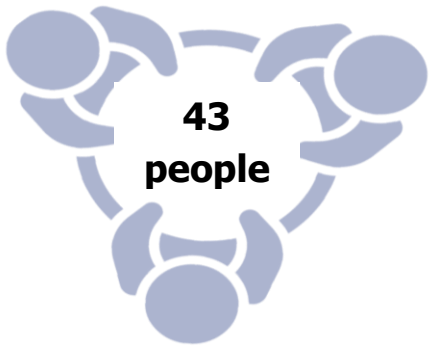
- Office of Children's Mental Health
- Wisconsin Coalition Against Sexual Assault
- Child Advocacy Centers
- Black and Brown Womyn Power Coalition
- Mental Health America
- Children's Hospital of Wisconsin, Inc.
- Medical College of Wisconsin
- End Abuse Wisconsin
- Wisconsin Department of Health Services

We interviewed experts in:

- Community violence.
- Sexual and domestic violence.
- Sex trafficking.
- Childhood injury.
- Child abuse and maltreatment.
- Substance use.
- Risk reduction.
- Injury epidemiology.
- Mental health.
- Suicide prevention.

Focus group discussions

In-depth discussions allowed residents to grapple with conflicting priorities and values, illuminating some of the tensions inherent in strategic planning. Members of groups disproportionately impacted by injury and violence were strongly represented in these discussions.



Of the 43 people who attended:

- **33%** identified as **Black** or African American.
- **20%** identified as **Indigenous.**
- **31%** identified as **lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, two spirit, plus (LGBTQIA2S+).**
- **28%** identified as a **rural community** member.
- **40–70%** worked in **organizations that serve these communities.**

Forty-three residents participated in focus groups held by UWPHI and UBUNTU Research and Evaluation, respectively. Residents were invited through organizational listservs. Participants signed up via a Qualtrics survey wherein they indicated if they identified as a member of, worked for an organization that served, or participated in advocacy efforts on behalf of one of the groups that are disproportionately represented in injury data (See Appendix B for data collection protocols and Appendix D for the full details of responses to the participant demographic questions, the highlights of which are summarized above).

If participants indicated they held any of the listed affiliations, they were invited to participate in one of the identity-specific focus groups and given the option to attend an open focus group.

Four of the six focus groups were held online, and two were held in person. Two of the focus groups were held in the world café format to accommodate a larger group.

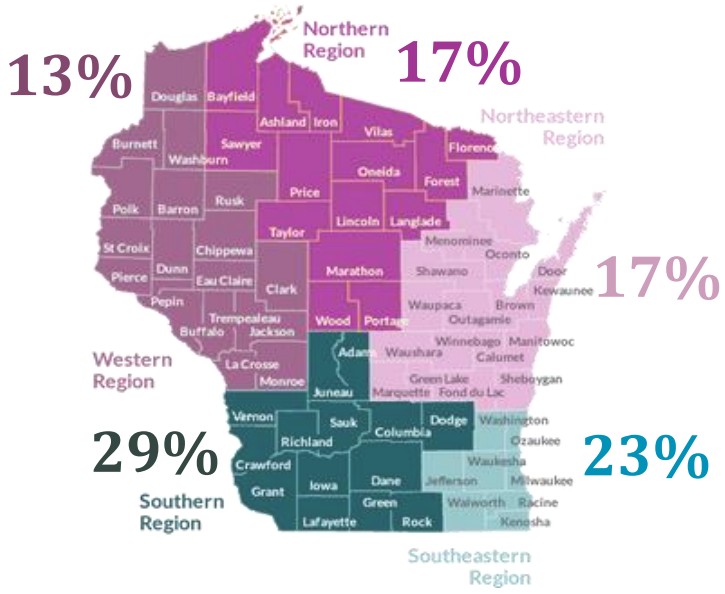
In all formats, participants had the opportunity to view selected summary injury data.

Engaging people across the state: Survey data

Surveys were completed by 730 people who live and work in every region of Wisconsin, allowing us to assess priorities from a larger group of people.

The survey invitation was sent through organizational listservs. Survey participants live and work in all five regions of the state, primarily working in the government, nonprofit, and health care sectors. One in five identified as a survivor of violence, and over half indicated they work at an organization that serves Black, Indigenous, or people of color.

- Roughly **20%** identified as **survivors of violence.**
- **64%** work at organizations that **serve survivors of violence.**
- **75%** work at organizations that serve **formerly incarcerated people.**
- **60–72%** work at organizations that **serve Black, Indigenous, and people of color.**



The survey was designed to gather broader perspectives for comparison with what we heard through in-depth discussions with experts and residents. Respondents were asked to rank priority injury areas, reasons to justify decision-making, and selected strategies. They were invited to write in additional concerns not represented in the closed-choice nature of survey questions. Questions were randomly presented, and options were shuffled for each respondent to ensure the final summaries didn't simply reflect the initial order in which options were provided. See Appendix B for links to the full survey.

Feedback sessions

Two feedback sessions were advertised through organizational listservs and at the 2025 statewide Substance Abuse Prevention conference hosted by DHS.

At each hour-long session, 30 minutes were dedicated to reviewing slides that covered the highlights of the plan, and 30 minutes were spent in facilitated breakout spaces discussing the following questions:

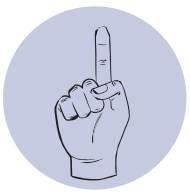
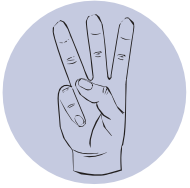
- What does this draft plan get right?
- What does this draft plan get wrong?
- What absolutely needs to change?
- What would be a nice, but not essential, change that would make you more enthusiastic about this plan?

Attendees were also asked to respond to a poll indicating their degree of consent to this strategic plan. See the following image.

At the first session, everyone selected a score of 3 or higher. At the second session, all but two participants selected a score of 3 or higher, indicating the plan's overall acceptability. The feedback provided informed revisions to the draft plan.

Demographic data were not collected from attendees.

Lack of consensus | Consensus

0	1	2	3	4	5
					
No way! I strongly object.	I see major concerns. We need to discuss this further.	I still have reservations and would like to discuss some minor issues.	I'm not in full agreement, but I'm willing to move forward.	Good idea or plan, I'm happy to move forward with it.	It's a great idea or plan. I fully support it and will champion it!

Project background and methods: Conclusion

The consensus across all methodologies is to strategically focus the bulk of new resources on ensuring safe childhoods without taking away existing resources which prevent injuries among adults and elders without caretaking responsibilities.

During in-depth discussions, available data were reviewed and weighed against personal experience and expertise. Lively discussions ensued on why certain injury areas or strategies should be prioritized over others; how effort should be divided between universal prevention and targeted interventions; and how to manage the tensions of creating a plan to guide a range of individuals with diverse priorities.

Ultimately, the consensus across the three data sources was that **addressing factors that impact children is the most effective approach for reducing all other injuries across the lifespan.**

Further, while most resources should focus on universal prevention in childhood, one-fourth should remain devoted to targeted interventions across the lifespan.

Themes that arose in interviews and focus groups were verified through surveys and are summarized into the following statement:

If we **work together for a shared future**, we can **ensure safe and protective childhood environments** by:

- **Building skills** to cope with distress, fear, and grief.
- **Expanding access** to risk reduction and healing resources at every age.
- **Fostering** a strong sense of belonging and connection to culture and community.

This statement became the foundation for strategies identified in the state plan.

Community-driven priorities

Process for identifying priorities

Over the course of eight months and via interviews, focus groups, world cafés, and surveys, we asked community members, administrators, and leaders from community organizations:

- Which **injury areas** should we prioritize for prevention efforts as a state?
- Why do you want to **prioritize specific injury areas** over others?
- Which of the following **strategies for reducing injuries** would you prioritize over others?
- What **types of leadership are most needed** from state leaders to advance these priorities?

Section overview

In this section, we share summaries of the answers we heard throughout data collection. To review the data summaries, see the appendices.

Injury area priority discussions

Most people walked in advocating for the injury area they know best or that is most relevant to them.

After the group discussion, most agreed that childhood experiences impact their injury areas and should be prioritized in a five-year plan.

Focus group participants were asked about their priorities before and after a data presentation. While many expressed surprise at the prevalence of falls-related injuries across the lifespan, few adjusted their list of priority injury areas to include falls.

The group discussions that followed about how to justify priorities for the strategic plan consistently led to a consensus that the plan should emphasize working on **universal prevention by focusing resources largely—but not exclusively—on ensuring safe childhoods.** This priority also emerged in the survey data.

> **I'm thinking about suicide, poisoning, and motor vehicles together**. I can see how all of them can come back to just not really feeling like you have a future.—Focus group participant

> **If we're talking about Black people, I would definitely prioritize firearms. If we're talking about everybody, I would prioritize poisoning.** Just because of what I mentioned before, the poisoning may be responsible for other injuries." —Focus group participant

Key informants were selected for their expertise in one area and, in isolation, maintained that area as their priority or justification for decision-making.

The few who were interviewed in pairs had some back-and-forth, but mostly remained aligned with their initial assessments of importance.

Injury areas of most urgency to participants

Consistently, results point to the injury prevention strategy of protecting and preserving mental health by assuring safe childhoods.

The most urgent injury priorities identified included:

- Child maltreatment and abuse.
- Intimate partner assault.
- Self-harm and suicide.
- Intentional firearm injuries.
- Unintentional drug overdoses.

On the following page, the results of injury-area priorities are ranked by urgency, with child maltreatment and abuse almost unanimously at the top across all data-collection methods.

The following is a full list of other priorities participants wrote in:

- Agricultural industry
- Systemic violence
- Racism in health care
- Violence against health care workers
- ATV/UTV accidents in children
- Farming accidents, especially among children
- Reckless driving
- Sex trafficking
- Teen bullying and depression

When asked about priority populations for injury prevention resources, a majority of those surveyed agreed that **increased resources should be allocated to the communities most affected by injuries,** while also emphasizing the need for sufficient attention to rural areas.

Priority area rankings

Survey participants ranked injury areas into the following categories, indicating how urgently that area should be prioritized to reduce injury and violence.

Most urgent

- **Child maltreatment and abuse**
- **Intimate partner assault** (including domestic violence, sexual violence, intimate partner violence, and teen dating violence)
- **Self-harm and suicide** (by any means)
- **Intentional firearm injuries** (includes school shootings, mass shootings, and domestic terrorism)
- **Unintentional drug overdoses**

Medium urgency

- Unintentional firearm injuries
- Community violence (like bar fights and gang affiliated violence)
- Injuries from elder falls
- Alcohol poisoning
- Motor traffic injuries

Least urgent

- Nondrug poisoning
- Injuries from fires, burns, and chemicals
- Injuries from falls among children
- Drowning
- Climate change-related injuries (heat, floods, wildfire smoke, etc.)

Discussions on how to justify decision-making in the plan

People were prompted to consider why an issue should be prioritized, to think beyond personal interest, and identify the values to guide decision-making.

During key informant interviews and focus groups, participants discussed reasons they feel should guide the prioritization of injury and prevention strategies. Survey participants were given the list of reasons generated in these discussions to rank.

This task proved difficult. As an open-ended question, most people identified a reason important to them or prioritized whatever impacts the most people.

However, as conversations continued and members discussed how many injuries later in life are related to experiences in childhood, most discussions ended on the consensus to **prioritize injuries affecting children because they have long-lasting effects and impact many people. This concern was also a top response in the survey.**

> **Prioritize what is more linked to other injury areas:** Domestic abuse is linked to child abuse, gun death, drug and alcohol death or injury, and suicide. And this causes generational injury and many other negative impacts**.** —Focus group participant

> Focus on interventions with a high return on investment: **parenting and the conditions of the first five years of life.** —Focus group participant

> **Focus on children and adolescents** to build political will. **—**Survey participant

> **Increase funding for hospital-based violence prevention programs** to intervene before it multiplies. —Focus group participant

Tensions and contradictions

The most challenging aspect of creating a plan is reaching a consensus among those who contribute to it. The following are some of the tensions and contradictions that arose as people contributed their perspectives to this plan.

- Most people wanted to use data to make decisions but also distrusted it as an accurate reflection of actual numbers and injury causes.
- While sheer numbers were considered important, people felt that intentional injuries were more urgent to address than unintentional ones, even though available data suggest most injuries may be unintentional.
- There was urgency to address injuries that happen at disproportionate rates to different populations, and to address the ones that cause the most injuries.
- Although falls are the leading cause of death from unintentional injury, most deaths associated with falls are among those aged 65 and older, and there is a greater sense of urgency to put resources toward younger people to have the most impact. It appeared that many people were unaware of how avoidable falls can be and how effective simple interventions are for reducing falls and their severity across the lifespan.

> Counties are not touching anything that references DEI (diversity, equity, and inclusion, and if we go in that direction, pockets of the state will opt out of working to advance the plan. **How can we be intentional in narrative without compromising the reality of the situation or alienating folks?** – Key informant

> [Be] true to the public health approach. **You have to go to where the problem is the worst.** Don't try to placate other individuals who may not agree with the public health approach. – Key informant

Strategizing on behalf of children was the top selected value around which to build a strategic plan

In the survey, participants were asked to organize values in order of importance. The options were programmed to appear in random order to avoid biasing the findings. The findings shown here mirror the bulk of sentiments shared during the interviews and discussed in the focus groups.

In all methods, participants were invited to offer additional criteria they felt should be considered in the development of this strategic plan.

Other significant reasons include:

- **Injuries affecting the elderly, children, and disabled**, as these groups need the most protection.
- Injuries disproportionately impacting **historically under-resourced communities.**

Top decision-making criteria

1. Whatever **hurts children** the most
2. Whatever injury **kills the largest number** of people
3. Whatever injury is the **deadliest**
4. Whatever most reduces **quality of life**
5. Whichever injuries are the **most unfairly distributed**
6. Whatever we stand the best chance of reducing in the **next five years**
7. Whatever is **most burdensome on our health system**

Relative urgency of different prevention strategies

> Focus on **access to basic needs** first, because it would take care of a lot. — Focus group participant

Survey participants ranked evidence-informed strategies into the following categories, indicating how urgently the strategy should be prioritized to reduce injury and violence.

Most urgent

- **Prevent trauma and childhood adversity, promote resource-rich and supportive caregiving** (includes stable housing, food security, and access to mental health care)
- **Improve coping skills** so that people don't self-medicate or get violent with others
- **Improve connectedness** to reduce the despair and disconnection that can lead to violence against oneself or others (for example, after-school programming, youth leadership, community building events)
- **Increase access to strategies that reduce harm** (for example, crisis care, violence intervention, Narcan, fentanyl testing strips)
- **Increase belonging and connectedness at every age** (for example, multi-generational community resources)
- **Reduce access to lethal means**

Medium urgency

- Increase knowledge of nonviolent problem-solving skills.
- Work on changing the culture around help-seeking behaviors.
- Push for parent education that emphasizes increasing tolerance for uncomfortable feelings.
- Work on changing norms that emphasize aggression as power and jealousy as love.

Least urgent

- Focus on the link between alcohol and injury.
- Promote responsible and moderate substance use.
- Ensure homes and workplaces are safe structures for each stage of life.
- Increase knowledge about injury risks and strategies for prevention.
- Increase access to safety materials like car seats and helmets.

Insights from those most impacted by injury and violence

Within identity-specific focus groups, many participants spoke about their distrust of the state as a trusted leader.

Working from the philosophy that those closest to the problem are also closest to the solution, and in line with the recommendation that the state follow the lead of communities, UBUNTU Research and Evaluation gathered the following recommendations from members of groups that experience unusually high rates of injury and violence, highlighting unfair circumstances.

Speaking from the burden of harm caused by federal and state governments, many members of these groups expressed limited hope that their perspectives would be considered.

The following suggestions emerged from the inquiry: If this plan did represent you, what would you emphasize to improve the collaborative relationship with the state?

- **Assess the impact of the injuries and violent experiences,** not just the sheer number of people injured.
- **Address intergenerational and institutional harms to facilitate healing.**
  - Prioritize culturally matched resources.
  - Consider how the state shows up in partnerships and services and adjust toward greater humility.
- **Embrace the insights of young people.**
  - Bring young people into decision-making roles.
- **Address the root causes** of patterns in injury and violence.
- **Engage with communities on their terms.**
  - Prioritize building trust in a manner meaningful to the community.

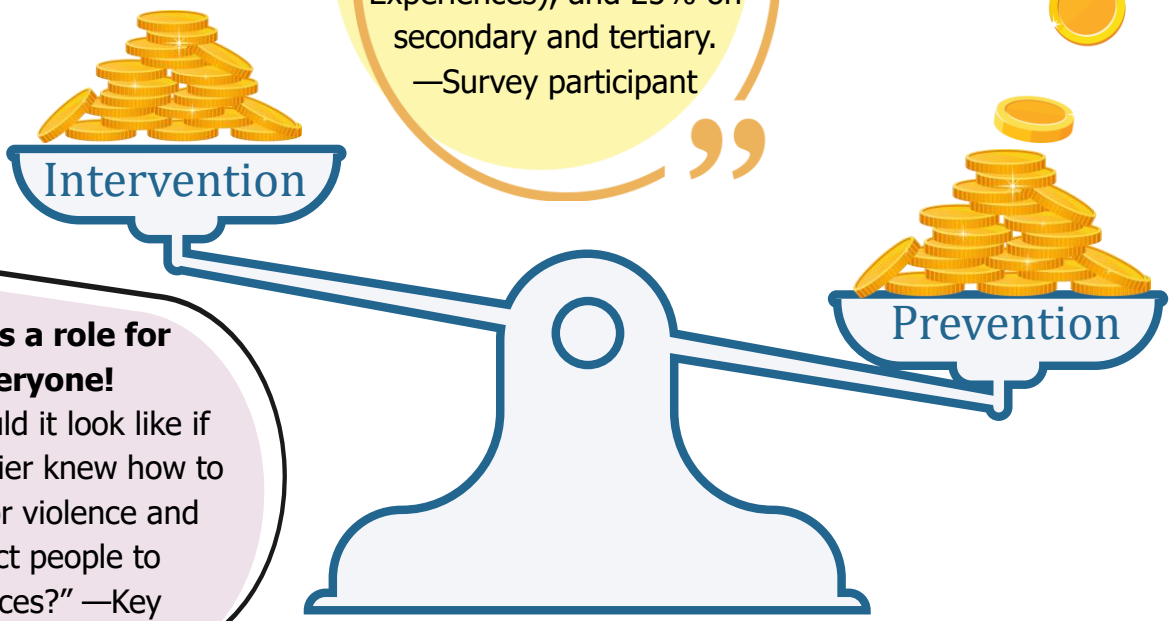
Conclusion: Prioritize prevention, but also invest in intervention and healing

While most discussions and survey data focused on improving childhood conditions, participants did not overlook the importance of ensuring safety throughout the lifespan and investing in intervention, healing, and rehabilitation.

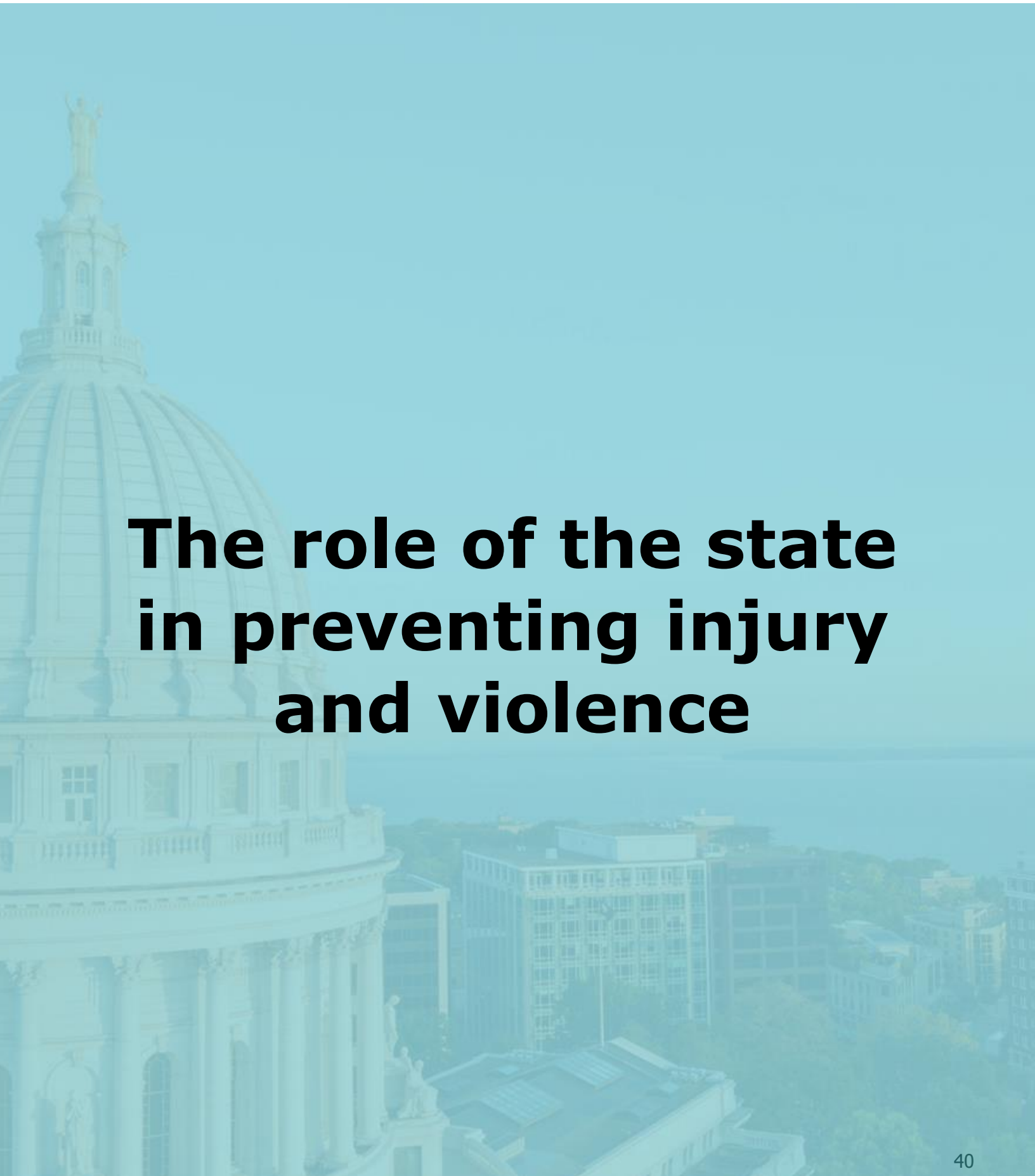
Respondents consistently shared a vision of creating communities where people look after one another.

> You can work on those long-term plans while doing those easy fixes. **You don't have to pick one or the other.** And as long as we're focusing on both short and long-term goals, I think that's very effective. —Survey participant

> **Frontload primary prevention (75%) to address ACES** (Adverse Childhood Experiences), and 25% on secondary and tertiary. —Survey participant



> **There is a role for everyone!** What would it look like if every cashier knew how to screen for violence and connect people to resources?" —Key informant



The role of the state in preventing injury and violence

State government is one partner in the ecosystem of injury and violence prevention

Outside of funding, which hinges on tax dollars or grants becoming available, the people we spoke with highlighted a need to build on the strengths of state government without constraining the wisdom of local initiatives. Overall, we heard a desire for DHS to perform the role of navigator, boldly setting the course for statewide prevention work.

- **Lead efforts** to advance this statewide vision and policy platform and coordinate shared actions to prevent, intervene, and heal from injuries and violence.
- **Guide communication** about the linkages between childhood experiences, the risk for injury across the lifespan, and the shared benefits of prioritizing efforts to reduce the unequal burden of injury and violence.
- Utilize sponsored conferences to promote the importance of prevention while fostering collaboration across issue areas by **serving as a matchmake**r, building bridges, and integrating disparate efforts toward shared goals.
- Harness in-house skills to the benefit of all. This would involve **enhancing inter- and intra-agency collaboration, problem-solving, and data sharing**, as well as investing in strengthening relationships with community-based organizations.
- **Provide people outside of state government with assistance in understanding data**. Since few organizations can afford data analysts, a significant service the DHS offers is creating one-page or two-page data summaries that provide a statewide overview of an injury or violence topic area, an argument for investing in prevention, and helpful information for funding applications. These are made available on the DHS website.

The state will provide direction, structure, and resources, including funding when available

State government is one of many actors involved in preventing injury and violence. As a publicly funded organization guided by state mandates, DHS has the responsibility and resources to provide structure to the work. As a government institution, it also has a responsibility to provide services in a manner responsive to communities' needs. DHS is dedicated to doing what it can to support community-led efforts.

As an executive agency, DHS will provide leadership by:

- **Coordinating federal and state funds** to advance this strategic plan.
- **Collecting, managing, and making data accessible** to community partners.
- **Creating resources for public education** regarding the costs and benefits of investing in prevention and the ways in which our lives are connected.
- **Providing guidance** to communities on how to communicate public health goals, including suggestions for a unifying narrative.
- **Coordinating** statewide multisectoral injury and violence prevention work.
- **Connecting people** with different funding sources to support collective innovation.
- **Improving collaboration within and across state agencies and programs** to work more effectively with limited resources.
- **Ensuring public behavioral health services are timely, accessible, sufficient, and responsive responsive to all members and cultures within the community.**

Appendices

Appendix A: Risk and protective factors for violence

Risk Factors

Individual Level:

- History of violence or victimization
- Substance use
- Aggressive behavior and acceptance of violence
- Early sexual initiation or involvement with sexually aggressive peers
- Hyper-masculinity and traditional gender role adherence
- Emotional distress and deficits in social-cognitive abilities

Relationship/Family Level:

- Family history of conflict and violence
- Childhood abuse and neglect
- Poor parent-child relationships and lack of support
- Association with delinquent or hyper-masculine peers
- Involvement in a violent or abusive relationship

Community/Societal Level:

- Poverty and limited economic opportunities
- High rates of violence and crime
- Easy access to drugs and alcohol
- Weak community sanctions against violence
- Discrimination and marginalization

Protective Factors

Individual Level:

- Resilience and the ability to regulate emotions
- Social and emotional competence
- Positive self-esteem and self-worth

Relationship/Family Level:

- Strong and supportive parent-child relationships
- Parental knowledge of child development and parenting skills
- Concrete support for parents
- Positive and healthy family communication patterns

Community/Societal Level:

- Strong community and social connections
- Positive school and neighborhood environments
- Access to resources and opportunities
- Community involvement and cohesion
- Cultures and religions that promote non-violence

Source: Wilkins, N., Tsao, B., Hertz, M., Davis, R., Klevens, J. (2014). **Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence**. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Oakland, CA: Prevention Institute.

Appendix B: Data access and data collection protocols

Multiple data sources were used to help guide and inform strategic plan development. Including publicly accessible data from:

- WISH (Wisconsin Interactive Statistics on Health) Injury-Related Health Outcomes query modules
- Suicide data dashboard
- Self-Harm data dashboards
    - Self-Harm: Data Dashboard
- Wisconsin Violent Death Reporting System data dashboards

UWPHI completed surveys, focus groups and interviews to inform the development of the strategic plan. Access copies of the data collection protocols.

These include:

- Recruitment flyer.
- Focus Group protocol.
- Virtual /World café protocol.
- Interview questions.
- Online survey.

Appendix C: Key informant interviews summary and SWOC

16 key informants interviewed with expertise in:

- Children's mental health
- Mental health
- Community violence
- Youth violence
- Sexual and domestic violence and sex trafficking
- Children's injury and maltreatment
- Substance use and risk reduction
- Injury epidemiology
- Suicide prevention

Strengths:

- The WISH module has a lot of relevant data across divisions and bureaus.
- The Wisconsin Violence and Injury Prevention Partnership (WIVIPP) has representation across a wide swath of issues.
- Key informants have clear priorities in mind.

Opportunities:

- DHS can manage data and share best practices among the state's IVP practitioners.
- DHS can build community networks by showcasing ongoing work and acting as a connector.
- DHS can watch for opportunities to advocate for evidence-based policies, especially after school shootings.

Weaknesses

- Some programs and divisions lack the resources to analyze and share WISH data with community partners.
- Concerns exist about DHS's ability to analyze and report essential data, with perceptions of reduced data availability.
- People outside the government often have a limited understanding of DHS's scope and impact.
- Priorities often mirror personal expertise or focus mainly on injuries and violence.
- Data and programs are siloed, hindering collaboration, especially with children's and housing data. Communities need diverse data for comprehensive insights.

Challenges:

- Workers in issue-specific organizations often miss the interconnectedness of their fates and the benefits of collaborating on shared risks.
- Funding is restrictive, focused on specific issues, hindering shared solutions for multiple areas. Options for such initiatives are unavailable.
- Funding restrictions prevent prevention initiatives.
- The IVP program at DHS has only one full-time state employee, who is highly capable.
- The shared risk and protective factor framework aids understanding, but it is hard to turn into a five-year plan.
- All approaches to prioritizing injury areas and populations are biased, which complicates decision-making.
- Federal actions can disrupt plans, creating uncertainty for the next four years.

Appendix D: Demographics of focus group participants

The following table summarizes how focus group participants identified themselves.

Table 1. Demographics of focus group participants

The following table summarizes how focus group participants identified themselves.

Most impacted groups	This is one of my identities	I work for an organization that serves this group	I am part of a coalition that advocates for this group
Black or Brown	33%	39%	28%
Indigenous	22%	44%	33%
LGBTQIA2S+	31%	50%	19%
Rural	28%	44%	28%
Unhoused	9%	64%	27%
Formerly incarcerated	0%	57%	43%
Elder	7%	64%	29%
Child Wisconsinites	0%	55%	45%

Appendix E: Focus groups summary

In every format, focus group participants voiced concerns about the lack of data related to sexual violence, state violence, domestic violence, and the impact of alcohol on various types of injuries.

Discussions regarding which injuries to prioritize often revealed a disconnect between the values participants deemed important and the issues they ultimately chose to focus on.

Each focus group provided valuable insights into the significant challenges faced by members of the minority groups represented in each space.

UBUNTU Research and Evaluation hosted five identity-specific focus groups. Three took place in-person at various community hotspots over meal hours in Milwaukee, one occurred at the Wisconsin Public Health Association annual conference, and one was virtual.

Aside from the in-person recruitment at the Wisconsin Public Health Association conference, recruitment primarily occurred electronically or by word of mouth. Data were analyzed within and across identity–specific groups to identify commonalities and culturally specific recommendations

Appendix F. Demographics of survey respondents

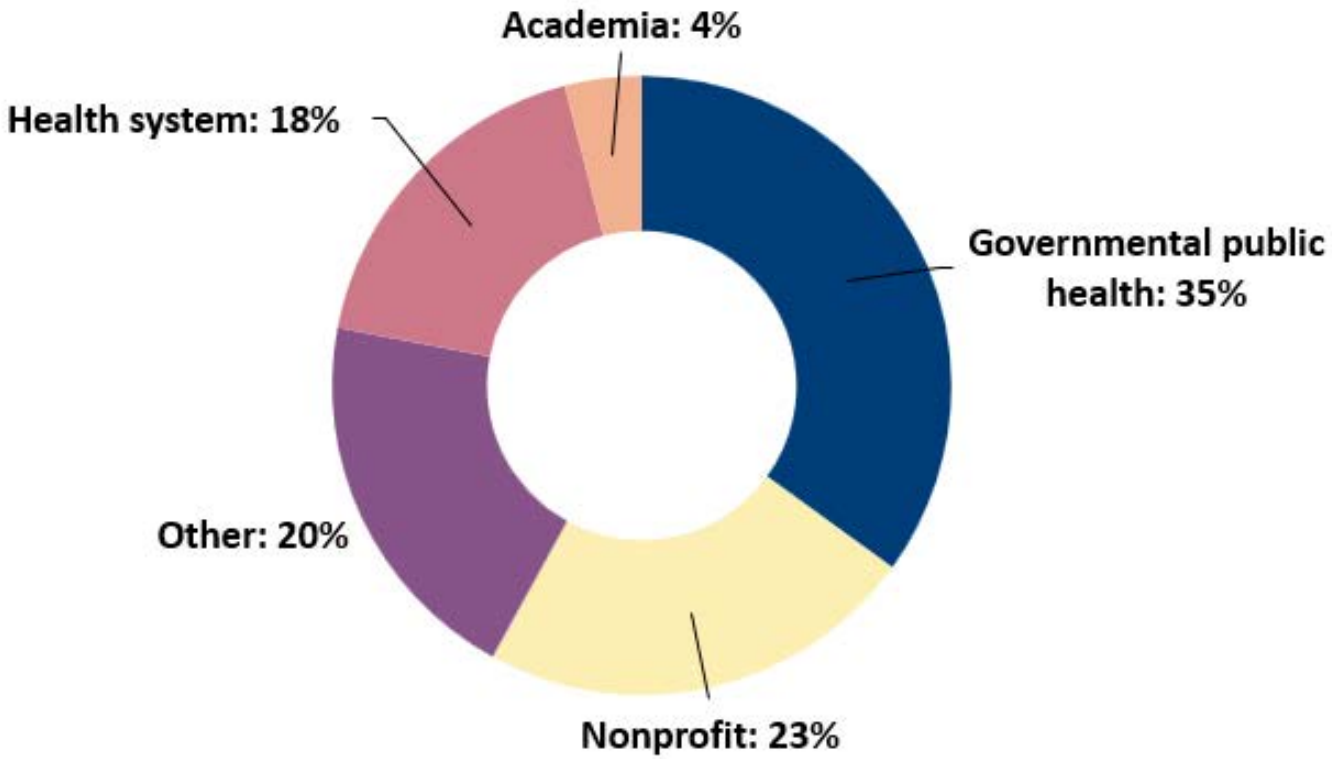
Connections to most impacted populations

Table 1. Demographics of survey respondents

The following table summarizes how survey respondents identified themselves.

Most impacted groups	This is one of my identities	I work for an organization that serves this group	I am part of a coalition that advocates for this group
Survivors of violence	18%	64%	19%
LGBTQIA2S+	16%	60%	24%
Black or Brown	14%	66%	20%
Elders	13%	68%	19%
People with disabilities	13%	69%	18%
Native or Indigenous	9%	72%	19%
Substance-dependent	6%	65%	29%
Formerly incarcerated	5%	75%	20%
Unhoused people	5%	71%	23%
Children	4%	68%	28%

Work sector represented in the survey



Appendix G: Survey findings

Chart 1. Survey respondents reported level of urgency felt for different injury areas

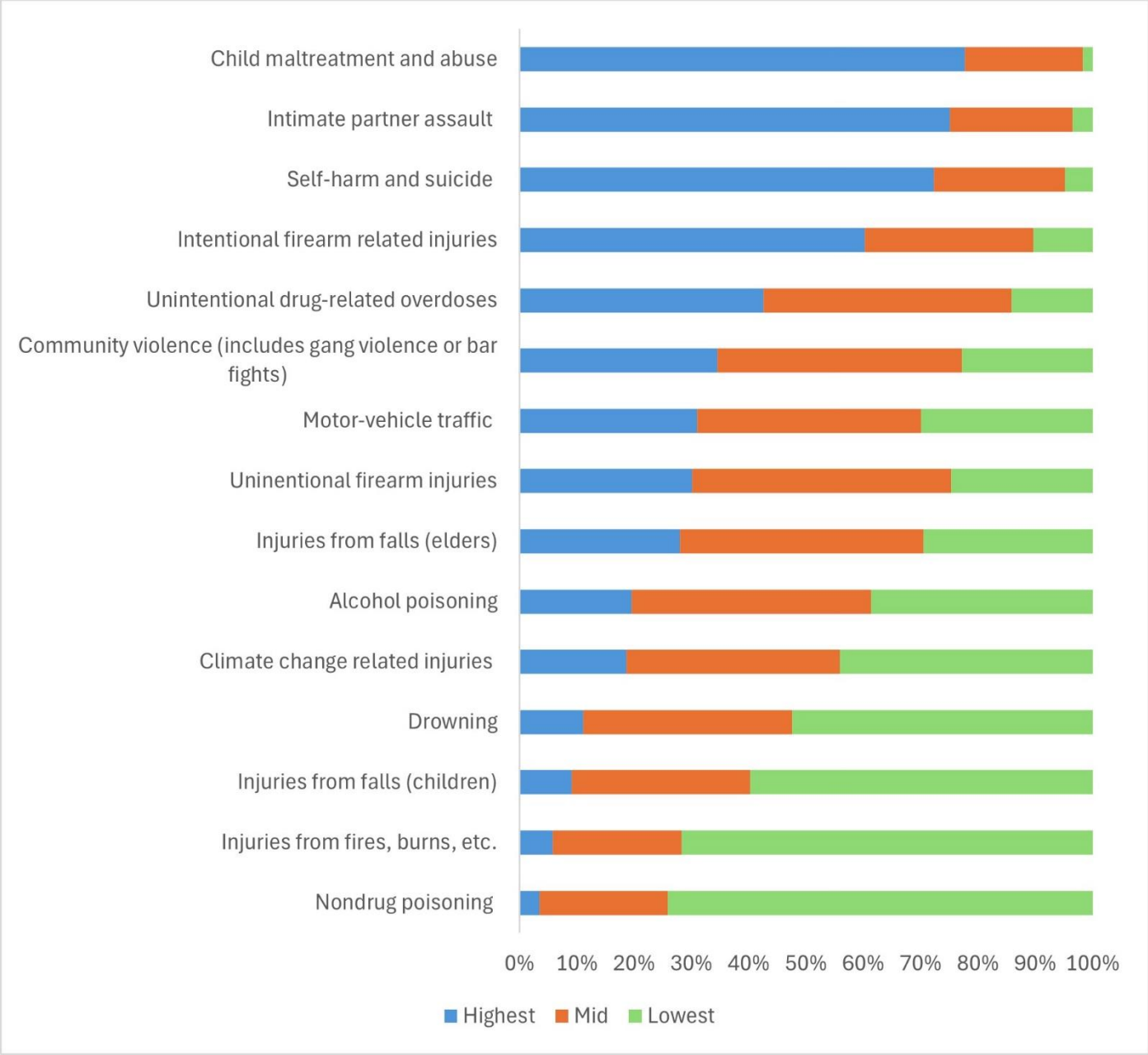
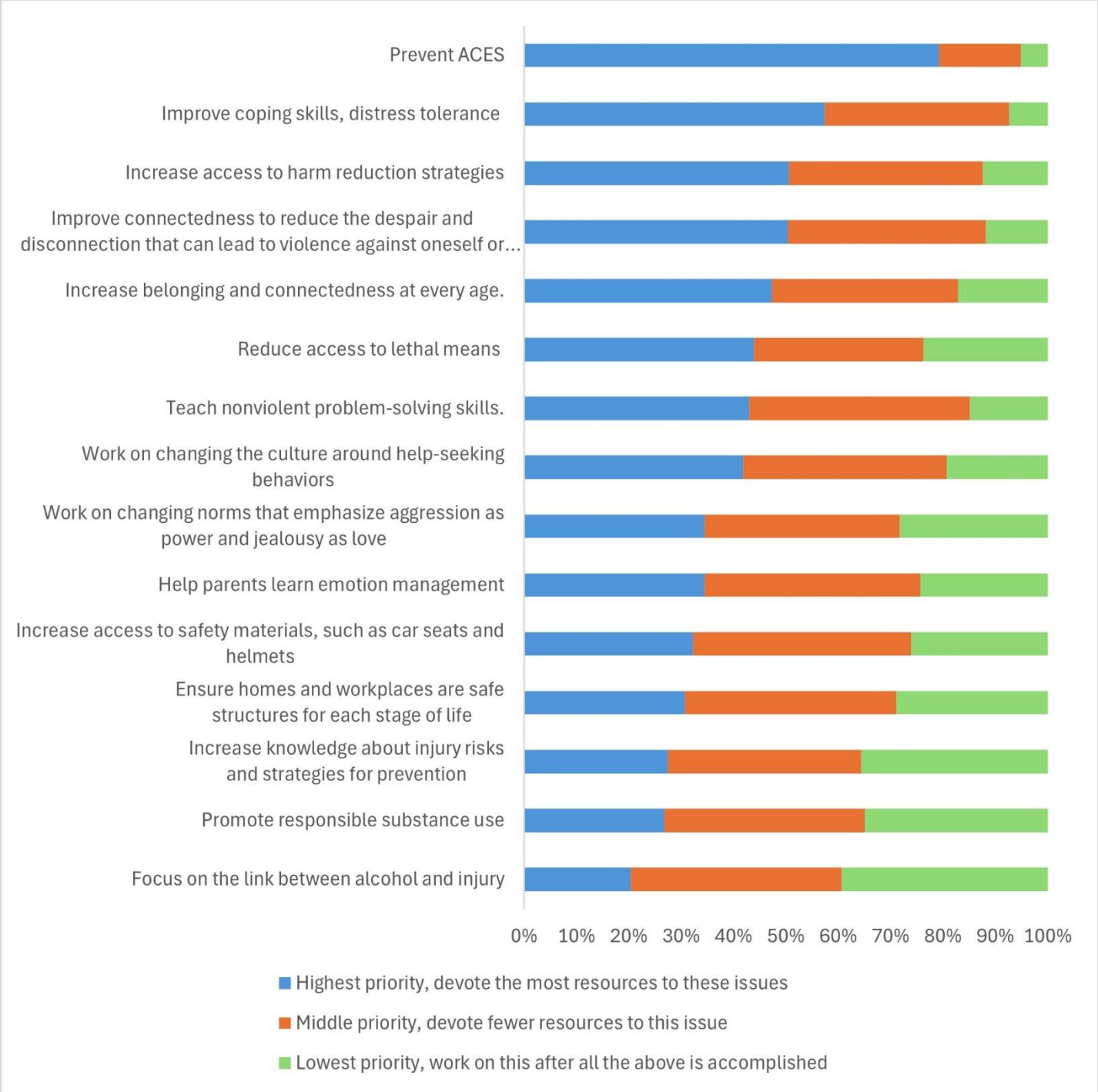


Chart 2: Survey respondents indicated how community members felt different prevention strategies should be prioritized. Highest priority indicates community members feel the most resources should be devoted to these issues.



References

Cultural continuity and suicidality of Tribal members
https://sprc.org/tribal-resources

Suicide Prevention Resource Center. (2022). American Indian and Alaska Native populations [Webpage]. https://sprc.org/about-suicide/scope-of-the-problem/racial-and-ethnic-isparities/american-indian-and-alaska-native-populations/

Suicide Prevention Resource Center. (2013). Risk and protective factors: American Indian and Alaska Native populations [Issue Brief]. https://sprc.org/online-library/risk-and-protective-factors-american-indian-and-alaska-native-populations/

Social and emotional learning

Cavioni, V., Conte, E., Cefai, C., and Ornaghi, V. (2025). Timmy's Trip to Planet Earth: The Long-Term Effects of a Social and Emotional Education Program for Preschool Children. Children, 12(8), 985. https://doi.org/10.3390/children12080985

Community-level interventions for combatting loneliness

Meehan, D. E., Clare, P., Grunseit, A., and Merom, D. (2025). Community-level determinants of loneliness and social isolation: a population-based cohort study across younger and older adults. Frontiers in Public Health, 13, 1526166.

The relationship between ACES and falls in the elderly

Tan, H., Liu, M., Ren, H., Zhou, J., Guo, Y., and Jiang, X. (2025). Associations of adverse childhood experiences with falls and fall risk factors among middle-aged and older adults in China. American Journal of Preventive Medicine, 68(5), 998-1009.

Injury Prevention Toolkit: https://www.dhs.wisconsin.gov/injury-prevention/injury-prevention-toolkit.pdf

Other Wisconsin strategic plans with similar goals

- Wisconsin State Health Improvement Plan: 2023-2027
- Wisconsin Suicide Prevention Plan: Strategies for Action and Hope
- Wisconsin's Children's System of Care Strategic Plan: 2024 -2030
- Wisconsin Council on Mental Health 2023-2028 Strategic Plan
- Sexual Violence Prevention Program State Action Plan
- State Council on Alcohol and Other Drug Abuse Strategic Plan for 2023-2027