State Suicide Prevention Infrastructure Recommendations

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Introduction

Since its inception in 2002, the Suicide Prevention Resource Center (SPRC) has worked with state suicide prevention leaders to help them build a strong prevention infrastructure at the state level. Such an infrastructure is essential for advancing suicide prevention efforts. Indeed, the Substance Abuse and Mental Health Services Administration (SAMHSA) notes that "the absence of [a strong state] infrastructure almost certainly compromises suicide reduction efforts to a significant degree."[1]

In 2018, SPRC began a project to articulate the critical infrastructure elements all states need to have in place for effective and sustained suicide prevention efforts. After conducting an environmental scan, SPRC formed an advisory panel composed of experts from the public and private sectors to share their experience in this area. Working in small groups, the panel developed a set of recommendations for states that reflect current research and practice on the development of a state-level infrastructure for suicide prevention and related areas, including public health and mental health. These recommendations are presented in this document, organized into six areas that represent the essential elements of a state infrastructure for suicide prevention.

For more information on the challenge of suicide, learn about the scope of the problem and the costs of suicide.

Why Were the Recommendations Developed?

Although state health departments and offices of suicide prevention must be able to fulfill a number of functions, the current infrastructure in many states has significant limitations. Suicide prevention, mental health, and substance misuse prevention often receive less attention and funding than other public health problems.[2] Unlike mental health and substance misuse prevention, there is not even a designated federal funding stream for suicide prevention in all states (i.e., no suicide prevention block grant). Resources are diverse and often change. As a result, the suicide prevention infrastructure in most states is often limited and underfunded, making it difficult to impact suicide rates and to achieve sustainability.

The recommendations presented in this document were developed to help state leaders establish a solid foundation for suicide prevention and guide policy making, funding and administrative decisions, with a view toward improving sustained suicide prevention efforts across the country. They provide a backbone for supporting the principles and activities laid out in the National Action Alliance's (Action Alliance's) Transforming Communities report, and the Center for Disease Control and Prevention's (CDC's) *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*. The information may also be useful to all others who support suicide prevention efforts at the federal, state and local levels, including funders, suicide prevention coordinators, community organizations, advocates, and researchers.

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[1] Substance Abuse and Mental Health Services Administration: *National Strategy for Suicide Prevention Implementation Assessment Report*. HHS Publication No. SMA17−5051. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2017.
[2] Centers for Disease Control and Prevention: *State of the States of Suicide Prevention.* In press. Atlanta, GA: Centers for Disease Control and Prevention.

How Were the Recommendations Developed?

The recommendations were developed based on a review of the research literature and input from national experts and stakeholders, including consultation with state suicide prevention leaders.

The development process included:

- A literature review and an environmental scan of how other health fields have identified and/or recommended key infrastructure components at the state level
- Key informant interview with a representative from the Safe States Alliance, which has developed similar guidance for state injury prevention programs
- Consultation with state suicide prevention coordinators across the country via focus groups to identify key components of state suicide prevention infrastructure, common elements across states, and feedback on initial recommendations
- Guidance from an advisory group of national experts from diverse public and private organizations who brought experience in infrastructure development, suicide prevention, and state policy and administration. The lives of many advisory group members had been personally impacted by suicide.

How Can the Recommendations Be Used?

The recommendations can help state leaders assess the status of their current suicide prevention infrastructure to identify gaps and needed resources to improve the foundation for suicide prevention in their state. They can also be used to identify and engage important partners, support the development of action plans, and build a strong infrastructure to support and sustain suicide prevention efforts. Lastly, they provide a framework for a public health approach to suicide prevention, encouraging states to regularly examine the current extent of suicidal behavior, evidence-based prevention efforts, funding, and personnel in order to identify and address needs.

Are These Recommendations Appropriate for Tribal Nations?

Although the recommendations were primarily developed with states in mind, many may be relevant to infrastructure in tribal nations. These recommendations would need to be tailored by individual tribal nations to fit their community, context, culture, and governmental structure.

Summary Recommendations for State Suicide Prevention Infrastructure

Essential Elements	Recommendations
Authorize	★ Designate a lead division or organization ★ Identify and secure resources required to carry out all six essential functions ★ Maintain a state suicide prevention plan that is updated every 3-5 years *To further strengthen your infrastructure:* + Authorize the designated suicide prevention agency to develop, carry out, and evaluate the suicide prevention plan + Require an annual report to the legislature or governor on the state of suicide and prevention efforts, the extent and effectiveness of any statute or rule related to suicide, and emerging needs
Lead	★ Maintain a dedicated leadership position ★ Identify and fund core staff positions, training, and technology needed to carry out all six essential functions ★ Develop capacity to respond to information requests from officials, communities, the media, and the general public *To further strengthen your infrastructure:* + Where interests intersect, establish a formal connection between the relevant government divisions or offices + Build staff capacity to effectively communicate across multiple audiences and formats + Develop division/agency commitment to spur cross-discipline collaboration and integrate programs across funding sources
Partner	★ Form a statewide coalition representation from broad public and private sectors ★ Adopt a shared vision and language across partners *To further strengthen your infrastructure:* + Build partner capacity to integrate suicide prevention efforts into their structures, policies, and activities + Develop written agreements with partners detailing each party's commitment

Essential Elements	Recommendations
Examine	★ Ensure that sufficient funding and personnel are allocated to support high quality, consistent, privacy-protected suicide morbidity and mortality data collection and analysis ★ Identify, connect with, and strengthen existing data sources ★ Ensure that high-risk and underserved populations are represented in data collection ★ Develop the skills and a plan for regularly analyzing and using data to inform action at the state and local levels *To further strengthen your infrastructure:* + Link data from different systems while protecting privacy
Build	★ Build a multi-faceted, lifespan approach to suicide prevention across the state, in concert with the state plan: » Understand, develop, and enforce expert-informed policies and regulations that support suicide prevention » Strengthen the crisis system and policies, including mobile response and hotlines » Establish policies and model practices in preparation for post-suicide response, including in the event of a suicide cluster » Promote "upstream" strategies that proactively prevent suicide risk and enhance protective factors ★ Designate sufficient funding to carry out or support a multi-faceted approach ★ Develop the ability to evaluate and share results *To further strengthen your infrastructure:* + Embed expectations for suicide prevention within relevant state-funded contracts
Guide	★ Ensure the ability to plan, provide, and evaluate guidance for state, county, and local efforts ★ Identify and allocate resources needed to support consultation and capacity-building training for state, county, and local efforts *To further strengthen your infrastructure:* + Identify and maintain an updated list of available trainings that meet relevant state requirements or recommendations

Recommendations for State Suicide Prevention Infrastructure

This section presents recommendations for the development of a strong state infrastructure to support effective suicide prevention (see sidebar for definition). The recommendations have been organized into six areas, representing the essential, or core elements of a state suicide prevention infrastructure:

- Authorize
- Lead
- Partner
- Examine
- Build
- Guide

State Suicide Prevention Infrastructure: Working Definition

A state's concrete, practical foundation or framework that supports suicide prevention-related systems, organizations, and efforts, including the fundamental parts and organization of parts that are necessary for planning, implementation, evaluation, and sustainability.

These six elements are critical to supporting the implementation of comprehensive, effective, and sustained suicide prevention efforts. Because states are diverse in terms of existing infrastructure, available resources, and other factors, steps deemed to be most essential are listed first, followed by additional actions that will lead to improved results.

Authorize

As suicide is both a public health issue and a mental health issue, suicide prevention activities may fall under the responsibility of a number of different state-level departments and agencies, and may also be conducted by many other government and non-government organizations. Because these entities may have multiple priorities, we recommend designating a lead agency or entity that is asked to prioritize suicide prevention, and that can provide administrative support and ensure continuity of effort. Without this designation, partners may be unsure where suicide prevention activities fall, and whether a particular division has the authority to make related decisions or requests.

Identifying and authorizing a lead division or organization that can provide centralized suicide prevention leadership will maximize coordination of efforts among all groups involved in suicide prevention and contribute to a more comprehensive approach. If more than one entity is currently responsible for suicide prevention, it is critical to establish close collaboration and

designate one entity as the lead, while maintaining momentum and support in the other entities. This lead entity should be responsible for facilitating coordination with other agencies and organizations.

Recommendations:
Designate a lead division or organization. Several different models may be considered. For example, the lead entity could be one of the following:

- A program within a dedicated state agency or department (e.g., state health department, state mental health authority)
- A government-appointed council or coalition
- A nonprofit agency appointed by the state
- A public-private coalition (see Partner)

Designating a government department as a lead entity can have several advantages, including easier access and collaboration within state divisions, and links to those with authority over state contracts. Management by an independent, non-governmental organization can be useful in facilitating collaboration across government agencies and private sector contributors, and in conducting activities not appropriate for state entities to pursue, such as lobbying.

Identify and secure resources needed for all six essential functions. Suicide prevention efforts must often braid together different funding streams and continuously find new funding sources to support their infrastructure and programs. To address this challenge, states should regularly identify the level of funding needed and secure one or more state-level sources of dedicated funding for suicide prevention.

One way to do so is to ensure that the state budget includes a line item for suicide prevention, including a leadership position and core staffing (see Lead). States should also authorize the pursuit of outside funding, such as funding from non-government agencies, foundations, and others in the private sector. The funding should be sufficient to support all six essential elements of the state infrastructure for suicide prevention.

Maintain a state suicide prevention plan that is updated every 3-5 years. As originally called for in the *National Strategy for Suicide Prevention*, each state should maintain a regularly updated and comprehensive plan that guides and coordinates suicide prevention activities, including measurable outcomes. As described in Build, below, the plan should use a multifaceted, lifespan approach across the state. Development of the plan should be guided by input from a broad range of stakeholders, including from partner groups (see Partner).

The plan should help focus and coordinate suicide prevention efforts in the state and guide the implementation of activities in collaboration with national and local partners. To promote continuity, the plan should be integrated with the state crisis plan. To ensure that the plan continues to meet the needs of the state's population and also reflects national priorities, it should be reviewed and revised every three to five years.

To further strengthen your infrastructure:

Authorize the lead agency to develop, carry out, and evaluate the state suicide prevention plan. Having specific authority to lead suicide prevention efforts can help the state agency or organization in many ways, such as in easing access to suicide surveillance data, working with other state agencies and partners,[3] raising funds or in-kind resources, and supporting the enactment of policies that can have a greater impact on suicide prevention. Such authorization could be through legislation or an executive order stating that the agency will have access to such services and cooperation from other state government offices so as to enable the agency to carry out its suicide prevention duties, for example.

Require an annual progress and needs report to the legislature or governor. An annual report is useful in the following ways:

- Providing public transparency on suicide prevention efforts

- Acting as a reminder of suicide prevention to decision-makers

- Helping to maintain momentum among suicide prevention personnel and coalitions by keeping them accountable

- Serving as a useful planning and evaluation tool for those conducting suicide prevention activities

- Providing a foundation for state plan updates

An annual progress and needs report to the legislature or governor serves as an update on the state of suicide and prevention efforts and emerging needs. It should include an analysis on the extent and effectiveness of any statute or rule related to suicide. Even if an annual report is not required, creating one and/or conducting an evaluation of the state plan are important processes to keep efforts on track and maintain accountability.

Lead

Suicide prevention efforts are more likely to succeed when spearheaded by experienced, capable leaders who combine knowledge of suicide prevention with skills in program administration, coalition building, goal setting, communication, and other foundational areas.

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[3]Daniel D. Stier, JD, Melisa L. Thombley, JD, MPH, Melvin A. Kohn, MD, MPH, & Rebecca A. Jesada, JD. (2012). The Status of Legal Authority for Injury Prevention Practice in State Health Departments. *American Journal of Public Health*, *102*(6), 1067–1078.

Recommendations:

Maintain a dedicated leadership position. A strong foundation for state suicide prevention requires leadership from a designated person—whether he or she be a suicide prevention coordinator, director, branch or department manager, or another leader. Whenever possible, state leadership in suicide prevention should be a full-time position, focusing only on suicide prevention efforts.

The position should be supported by dedicated funding that allows for continuity and sustained efforts over time. Grant funding is not sufficient, as time-limited grants may create turnover or fluctuation in funding. One way to obtain more consistent funding is through state legislation that provides for a full-time state suicide prevention coordinator with an ongoing appropriation. If existing statutes already provide funding for a coordinator, any existing sunset clauses should be removed.

Dedicate core staff positions, training, and technology needed to carry out all six essential functions.

Core staffing. A single person alone cannot have full responsibility for overseeing all aspects of implementing suicide prevention work. It must be done in collaboration with various partners (see Partner) and with support from dedicated core staff. The suicide prevention coordinator (or other designated leader) should be supported by a team of staff trained in both suicide prevention and specialized areas such as data management and analysis, program management, and training. The Suicide Prevention Resource Center's (SPRC's) Core Competencies for Suicide Prevention Program Managers provides additional detail on needed skills.

Depending on the geographic size and population of the state, these personnel should include regional coordinators, as well as a dedicated portion of time of an epidemiologist and a data manager. Additional support from administrative support staff, even if just a portion of someone's time, will facilitate execution of routine office tasks and free up the suicide prevention leader to focus on oversight and coordination of the statewide suicide prevention system. Lastly, access to an evaluator will help programs to identify and fix problems with delivery of efforts, as well as to measure impact.

Ongoing staff training and networking. To successfully lead suicide prevention activities, staff leading prevention efforts must continuously update their skills and new staff must be trained in suicide prevention and program management. In turn, these personnel play a key role in building the capacity of partners, local programs, and other stakeholders, including students, professionals, grassroots organizations, and the general public.

Connecting with other states' suicide prevention leadership as well as national organizations (e.g., SPRC) will foster staff's learning and support innovation. This might include, for example,

supporting travel to conferences and sharing innovations from the state for others' learning via conference presentations, webinars, or electronic documents created locally or by national organizations.

Technology. From delivering training and consultation remotely to distant areas of the state, to allowing partners to communicate easily, to storing and analyzing data, there are a variety of technological needs that will facilitate high quality suicide prevention activities while reducing overall costs.

Develop capacity to respond to information requests from officials, communities, the media, and the general public. A key function of state suicide prevention programs is to serve as a source of information for responding to requests for information from a wide range of stakeholders across the state, including legislators, state officials, and the media, as well as local community members and stakeholders. This requires being able to provide clarification and commentary on data and events, while also answering suicide prevention questions, whether through their own expertise or through connecting with researchers and other local or national experts.

To further strengthen your infrastructure:

Where interests intersect, establish a formal connection between the relevant government divisions or offices. This could be via MOU/inter-agency agreement or a sitting task force. Such connections will:

- Ensure shared understanding of the different systems, funding mechanisms and priorities (e.g., Regional Prevention Networks, Community Mental Health Centers, various block grants)

- Promote greater investment in a data-driven, public health approach to suicide prevention and the collection, use, and sharing of suicide prevention data

- Coordinate related efforts (such as reducing access to lethal means of suicide and publicizing drug take-back programs, creating safe school environments and supporting bullying prevention policies, promoting mental health in immigrant communities, and treating people with co-occurring suicidality and substance misuse issues).

Build staff capacity to effectively communicate across multiple audiences and formats. As highlighted in the National Action Alliance for Suicide Prevention's *Framework for Successful Messaging*, effective suicide prevention communication should be strategic and recovery-oriented, and should pay attention to safety concerns. Soliciting feedback from individuals who have been personally impacted by suicide (people with "lived experience" or "lived expertise") can help thoughtfully shape successful communication campaigns. State leaders should use these principles when crafting campaigns, presentations, and other materials. They should also

educate spokespeople on ways to work with the media to avoid suicide contagion and reduce discrimination.

Develop division/agency commitment to spur cross-discipline collaboration and coordinate programs across funding sources. Too often, suicide prevention and related efforts are siloed in different departments or separate offices within the same division. This may result in efforts that duplicate each other or go in conflicting directions.

To maximize efficiency and impact, senior leaders in the agency or division should drive collaboration between related disciplines across state agencies. Separate funding streams can benefit from big-picture coordination, ensuring that the areas of priority need are addressed when seeking funding, as well as in program implementation. Internal and external champions and people with lived experience can help motivate leadership to prioritize suicide prevention across related sectors.

Partner

As described in the *National Strategy for Suicide Prevention*, suicide prevention requires a multifaceted approach that focuses on risk and protective factors at individual, family, community, and societal levels. As a result, prevention efforts are more likely to succeed when they involve multiple partners from the public and private sectors to increase the capacity and effectiveness of suicide prevention efforts, as well as their reach and impact.

The benefits associated with these collaborations can include the following:

- Access to resources (including trained personnel, data, and funding)
- Increased ability to reach key populations, including underserved and high-risk groups
- Reduction of duplicative or conflicting efforts
- New opportunities to share knowledge and collaborate on program and policy efforts

Recommendations:

Form a statewide coalition with broad public and private sector representation. There are several models of coalition structure and leadership to consider, including a self-run independent body, a state commission, and a group that has another organization (e.g., a nonprofit or the state lead organization) providing administrative support. Leadership development and any needed funding must be kept in mind in order to sustain the coalition. Written by-laws will help the group function smoothly. Lastly, if lobbying activities prohibit state officials from being coalition members, maintain two-way communication with key state legislators, the governor, and other elected officials who are champions for suicide prevention.

Diverse partners on a state coalition may include (but are not limited to):

- State health or public health departments, particularly offices addressing topics such as injury and violence prevention, maternal and child health, behavioral health (if they have a division or office in this department), adolescent health, community health, and vital statistics
- State mental health and substance abuse agencies
- Other relevant state government agencies, such as those focusing on education, law enforcement, criminal justice, veterans' services, minority health, health equity, unemployment, housing, social services, Medicaid, and child protection
- Health, mental health, and substance abuse providers, including large health care systems, hospitals, crisis centers, hospital associations, and first responders
- Military and veteran partners, such as National Guard posts' suicide prevention coordinators, Army and Air Force Reserves, Veterans' Affairs Medical Centers' suicide prevention teams
- State tribal liaison, or other Native American or Alaska Native tribal partner(s)
- Stakeholders and advocates, including representatives of higher risk groups, such as lesbian, gay, bisexual, and transgender organizations; and underserved populations, such as racial minority groups
- People personally impacted by suicide, such as suicide attempt and loss survivors, whose primary role is to represent that perspective
- Non-government organizations, such as schools, colleges, the faith community, and nonprofit organizations dedicated to health promotion
- Community-based organizations, including local crisis centers
- Private organizations and businesses
- Researchers and academic institutes
- Private foundations
- News media
- Others who represent key sectors in the state

Adopt a shared vision and language. When bringing together partners from diverse sectors, backgrounds, and goals, it is critical to develop a shared high-level vision for suicide prevention, such as agreeing to work toward implementing the state plan or a section of it, and to develop a common language. As noted above (see Lead), suicide prevention leads often play a key role in helping to build partners' capacity in suicide prevention basics. This includes, among other areas, describing terminology that is respectful of people impacted by suicide and using data to inform priorities and resource allocation.

Having a common vision and language will allow the coalition to develop a shared framework for action that specifies how different partners may participate. Many of the details can be worked out through the process of developing a state plan, but when working with a new

partner, or in the interim between plan cycles, describing shared goals is crucial. A useful resource for this is SPRC's Virtual Learning Lab: State Suicide Prevention Partnerships module.

To further strengthen your infrastructure:

Build partner capacity to integrate suicide prevention efforts. Having a breadth of partners can provide access to new sectors that can help advance suicide prevention across the state. Leveraging this access by building partners' own capacity and embedding suicide into their structures and policies will provide added reach without increasing staffing levels, as well as support sustainability of efforts. The Action Alliance's Transforming Communities report, Unity section, details additional ways that partners can support suicide prevention sustainability.

Develop written agreements with partners detailing each partner's commitment. While a handshake agreement may be seen as sufficient as long as both parties' staff stay the same, putting details into writing will not only help maintain agreements through changes in leadership and other personnel, but will also help partners clarify intentions and hold each entity accountable. Examples of written agreements include memoranda of understanding, memoranda of agreement, and data sharing agreements.

Examine

State suicide prevention efforts must be data driven in order to be effective, and in order to determine effectiveness and continuously improve, the efforts must be evaluated. As a result, capabilities related to data collection, analysis, use, evaluation design, and dissemination are needed. No single source can provide all data needed to understand the suicide problem, including data on suicide deaths, attempts, thoughts, and related risk and protective factors in the state.

For this reason, suicide prevention leads and coalitions must also be able to access, compile, analyze, and use existing data collected by multiple entities at the local, state, and federal levels, as well as understand which data are appropriate for use in evaluation. This will allow the state to do the following:

- Collect better data on suicidal behaviors
- Identify populations at risk
- Select the most appropriate strategies
- Monitor impact
- Disseminate information to decision makers, local programs, and others to advance suicide prevention efforts across the state

Regular analysis of this data will also help to identify new emerging needs and inform new prevention efforts.

Recommendations:

Allocate sufficient funding and personnel to support high quality, privacy-protected suicide morbidity and mortality data collection and analysis. These resources must support hardware, software, and personnel needs for a well-functioning data system. They include access to the state epidemiologist or another data analyst who has the capabilities required to collect data from different sources, perform targeted analyses, and develop action reports. Improving suicide data collection systems and training for partners like coroners and medical examiners can assist in getting rich and complete morbidity and mortality data.

Identify, connect with, and strengthen existing data sources. As data related to state-level suicide prevention efforts often reside in various systems, it is critical to identify and connect with multiple existing state data collection sources, such as those described in SPRC's online course, Locating and Understanding Data for Suicide Prevention. It's also important for the state to help strengthen and support systems within their purview. These data sources include:

- State Violent Death Reporting System, included in CDC's National Violent Death Reporting System (NVDRS) and its Web-based Injury Statistics Query and Reporting System (WISQARS™)
- CDC national surveys: The Youth Risk Behavior Surveillance System (YRBSS), and optional add-on questions for the Behavioral Risk Factor Surveillance System (BRFSS)
- State-sponsored health surveys
- The National Survey on Drug Use and Health (NSDUH) conducted by SAMHSA, which provides state-level estimates of adult suicidal ideation, plans, and attempts
- State and/or local Child Fatality Review Teams (CFRTs), a data collection effort funded by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB)
- State and/or local Suicide Fatality Review Committee, if one exists in your state
- For states with small to medium population and where NVDRS still in its initial stages, suicide deaths data available from medical examiners or coroners (coroner/medical examiner reports, death certificates), local law enforcement (police reports)
- Suicide attempt data available from hospitals and emergency departments (e.g., claims, discharge and syndromic surveillance data) and from Poison Control
- State contacts (often in the state health department) for the National Syndromic Surveillance Program (NSSP) BioSense Platform,[4] which provides public health officials with a common cloud-based health information system for collecting, evaluating,

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[4] Centers for Disease Control and Prevention. National Syndromic Surveillance Program (NSSP): BioSense Platform. Retrieved on April 9, 2019 from https://www.cdc.gov/nssp/biosense/index.html.

storing, and sharing real-time information about suicidal ideation and attempts from participating hospitals

It is also important to identify and connect with other data sources within the state. Examples include:

- Community-level sources (e.g., funeral homes, crisis response services, first responders)
- Organizations and individuals with a role in serving veterans and active duty service members (e.g., Veteran's Commission, veteran-serving agencies, VA suicide prevention coordinators, military base suicide prevention coordinators, National Guard and Reserve psychological health directors)
- Federal suicide prevention and related grantees, who may be collecting their own data
- Youth-serving state systems (juvenile justice, child welfare, mental health), crisis systems, adult corrections systems
- Public and private mental health care systems

Ensure that high-risk and underserved populations are represented in data collection. Well-established, large datasets may not always adequately include underserved communities. In these cases, it's important to make efforts to ensure that underserved communities are better represented (e.g., by targeted recruitment, oversampling, or other methods). When data on underserved populations cannot be obtained reliably or in a large enough number through such channels, the state suicide prevention program should work to address these gaps through stakeholder conversations about other data options, including alternate existing sources and/or the creation of new ones.

Partners who represent specific communities can help in a number of ways:

- Locating existing data on their specific population(s)
- Exploring gaps in traditional data sources
- Supporting data collection among their key audience via qualitative methods such as focus groups and key informant interviews
- Providing data and insight themselves

In particular, states should actively consult with and include tribes and urban Indian groups in conversations about appropriate ways to ensure accurate data on suicidal behaviors is collected, protected, and only shared with tribal permission. State leaders should also consult with other affected stakeholders on the best data collection methods and ways of sharing analyses.

Develop the skills and a plan for regularly analyzing and using data to inform action at the state and local levels. Data is critical to informing the broad state plan and specific programming decisions at the state and local levels. It is also important for strategically prioritizing populations, geographic areas, partners to engage, and risk and protective factors to

address. Process, impact, and outcome data evaluation must be planned and examined appropriately so data reflect barriers and true progress rather than coincidence or findings with insufficient strength.

State programs must therefore develop the capacity to integrate findings from diverse sources and nimbly address emerging trends/patterns while not being pulled off course by current events or brief changes to real-time data (such as a suicide that gains public attention or a short-term but sharp increase in suicides) that could propel them to prematurely change course on prevention activities.

In addition, state leadership must be able to respond to data requests and disseminate key findings to partners and the general public (e.g., via reports, presentations, fact sheets, infographics, and social media). Some states have created a data dashboard that provides surveillance data and other information and resources to legislators, local health departments, the media, and other audiences. The data should also be made available at the local level and to grassroots agencies while protecting privacy.

To further strengthen your infrastructure:

Link data from different systems while protecting privacy. In order to get richer data in a number of areas (e.g., suicide deaths and attempts, needs of high-risk populations, system improvement opportunities, risk and protective factors), states can connect data from different systems through available linking variables. Using linking variables may require additional investments in technical and legal infrastructure (MOUs, BAAs) as there may be challenges to sharing data across systems.

Some examples of data system connections include:

- Linking health care claims database and vital statistics data to show trends in diagnoses and suicide deaths
- Linking state mental health system records, death certificates, and criminal justice system records to identify groups of offenders who have unmet mental health needs
- Securely sharing data between health providers' differing medical record systems about individuals at high risk for suicide in order to identify areas for improvement of patient care coordination

Build

A key function of state suicide prevention programs is to oversee the implementation and evaluation of suicide prevention programming. To maximize resources available for program implementation, state-level efforts must include a combination of strategies that are supported

by the best available evidence, are most appropriate for their context and populations, and are best able to reach groups at increased risk, such as American Indian/Alaska Native populations, service members and veterans, working-age men, and lesbian, gay, bisexual and/or transgender (LGBT) individuals.

Recommendations:

Build a multifaceted, lifespan approach across the state, in concert with the state plan. This requires investment, engagement, and collaboration by multiple components of state government as well as the private sector. Suicide is a complex problem that needs a combination of approaches at various levels, including the following:

- Strategies to build positive social connections and life skills
- Identification of individuals at risk
- Support for help-seeking
- Effective care for suicide risk
- Crisis response
- Lethal means safety (including firearms)
- Post-suicide support (also called "postvention")

While some of these strategies focus on individual behavior change, others may involve changes to policies, regulations, or voluntary practices of governments or other institutions.

Programming should address suicide prevention across the lifespan, and include strategies that build protective factors prior to crises occurring, as well as other types of approaches that have long-term impact. Conducting strong suicide prevention efforts in a small number of regions needs to be brought to scale throughout the state, particularly in all geographic areas with high suicide rates and/or numbers of deaths, in order to successfully lower suicide rates.

Understand, develop, and enforce expert-informed policies and regulations that support suicide prevention. Consider how legislation and policy could stabilize, sustain, and spur growth in parts of your suicide prevention strategy. Be sure to build in accountability and compliance measures; state leaders can use regulatory measures put in place by accrediting bodies, such as The Joint Commission (TJC) and the Commission on Accreditation of Rehabilitation Facilities (CARF), as examples. Compliance can be monitored by the state quality assurance team, which can withhold funding from those who are not meeting standards.

Lawmakers should request input on draft bills from state suicide prevention leads and experts, suicide prevention advocates and nonprofits, those who have been personally touched by suicide, and communities or sectors that would be directly impacted by the legislation. Drafting or amending state agency regulations or internal policies (e.g., a law enforcement agency's "general orders") provides alternate mechanisms for improving suicide prevention infrastructure that may be easier to accomplish than legislative changes. National advocacy groups are

helpful sources for tracking state suicide prevention legislation in other states and may have policy agendas, both of which can suggestion ideas for legislative and policy improvements.

Examples of laws, policies, and enforcement in the area of school-related training:

- Law: Suicide Prevention Education Act - requires all educators to complete XX hours of suicide prevention every YY years.
- Regulation: Expert panel members define the suicide prevention courses that meet the requirement.
- Enforcement: School Districts keep records of teacher attendance. Compliance is monitored by School District Accreditation review and by the Professional Teaching Standards Board (or similar institution) with sanctions defined and imposed by those institutions.

Strengthen the crisis system and policies, including mobile response and hotlines. Ensure that suicidal crises are included in crisis response policies at the state, county/community, and organizational levels, and that systems and sufficient resources are in place to support local response. This includes the National Suicide Prevention Lifeline's local crisis centers and other suicide prevention and crisis hotlines, mobile outreach teams, crisis facility alternatives (like crisis stabilization programs), suicide prevention efforts in emergency rooms, and intensive follow-up support for people leaving acute mental health care. The key components that should be part of a state crisis system are listed in the National Action Alliance for Suicide Prevention's [Crisis Now](#) report.

Establish policies and model practices in preparation for post-suicide response, including in the event of a suicide cluster. This area encompasses several activities, including guiding communities, schools, and organizations toward tools or models for developing protocols to follow in the immediate and near-term aftermath of a suicide ("postvention" protocols). In some states or counties, this may include teams of professionals, such as a Critical Incident Team, and/or peer specialists, such as a LOSS Team, focusing on support to families, friends, and loved ones in order to ease grief and prevent additional deaths. In others it may include local suicide prevention leaders.

It also includes maintaining a list of such resources, responding to questions from those groups, and helping to connect them with each other. Connections with school systems can help put in place youth-oriented postvention plans. States should also develop a plan for the rare event of multiple, potentially related suicides, including helping the community to make decisions about how to identify vulnerable individuals and disseminate information safely, and working proactively with the media on reporting practices that do not further inflame suicide contagion.

Promote "upstream" strategies that proactively prevent suicide risk and enhance protective

factors. In addition to intervening with individuals who are thinking about suicide or are at an acute crisis point, building protective factors at various structural levels (e.g., adopting coping skills programming, encouraging supportive workplace policies and culture, passing legislation that strengthens economic stability, helping regions strengthen seniors' feelings of connection to family and community), is crucial to preventing suicidal feelings before they begin, lessening the burden on and cost of crisis supports and treatment systems.

Preventing known risk factors for suicide, such as adverse childhood experiences and trauma, and access to lethal means of suicide, can also reduce risk for other negative outcomes, including violence and substance misuse. These "upstream" intersections can help to strengthen connections and collaborations with other state agencies, partners, and stakeholders, leveraging shared resources to achieve improvements across multiple health areas.

Designate sufficient funding for a multifaceted approach. Funding to support one or two strategies, or a few regions of the state is often not sufficient to make an impact. To ensure sustainable impact, funds must be provided beyond grants, as gains made by grant funding may be lost when they end. As noted above (in Partner) partnerships can provide some resources, but state funds are essential to promote continuity, comprehensiveness, and sufficient reach.

Develop the ability to evaluate and share results. All programming, as well as the combined impact of state plan implementation, must be evaluated regularly to ensure that it is achieving intended measurable outcomes, and updated as appropriate to address limitations and new developments. Evaluations should not be limited to summarizing what activities have been done, but must also look at changes in risk and protective factors, as well as longer-term trends in state suicide deaths and attempts. The evaluation will be more accurate and useful if there is leadership by an evaluator in concert with the state suicide prevention lead. Findings must be used not only for program improvement but also to report outcomes to stakeholders and garner continued support.

To further strengthen your infrastructure:

Embed expectations within relevant state-funded contracts. As contracts are renewed, states can provide guidance or require agencies within their authority (such as mental health, substance misuse, homelessness, and corrections services) to enact best practices for suicide prevention, such as continuous quality improvement measures, trauma-informed approaches, job skills, evidence-based screening, assessment, treatment, and follow-up best practices. Contracts can also require competency and training on these approaches for staff in relevant roles.

Guide

State suicide prevention programs play a critical role in providing consultation and training to local health departments and many others at the state and local levels.

Recommendations:

Ensure the ability to plan, provide, and evaluate guidance for state, county, and local efforts. The lead organization or a designee should be able to assess community needs (via state-level data and/or community needs assessments), provide the needed assistance, and evaluate the outcomes of their assistance. With fellow state divisions' efforts, the designated lead should help to build leaders' capacity as well, and senior agency leadership should support the designee's expertise and guidance.

While specific needs will vary by audience, at a minimum, the state should be prepared to provide consultation and training on major topic areas on which local and state suicide prevention efforts are likely to need support. These include the following:

- Data collection and surveillance
- Evidence-based interventions
- Postvention (see Build)
- Strategic planning
- Evaluation

Other key topics for consultation and training are lethal means safety and effective messaging. The National Action Alliance for Suicide Prevention's [Transforming Communities](#) report provides useful guidance on community suicide prevention-focused topics. State leaders should also help local efforts learn about available evidence-based trainings (e.g., for mental health providers, community members, first responders, etc.) and get guidance on questions. Importantly, state leaders and coalitions are critical facilitators of people across the state being able to connect with each other on shared interests, such as through webinar conversations, listservs, statewide or regional conferences, and specialized meetings. Finally, the state lead must have plans and mechanisms in place for evaluating the results of these efforts.

Identify and allocate resources needed to guide state, county, and local suicide prevention efforts. As described under Authorize, it will be necessary to ensure that funding and staff for consultation and training mechanisms (e.g., webinar platform, websites, discussion boards, in-person meeting and training venues and logistics) are available. Linking suicide prevention to other key issues currently at the forefront of attention and for which funding is being allocated (e.g., opioid crisis, substance misuse, adverse childhood experiences) may assist in securing

funds. Regarding training in particular, the ability to offer appropriate continuing education credits will enhance uptake, but requires administrative support.

In-kind resources and access to audiences and information should be sought through existing and new partners as described in Partner, as well as through non-traditional partners. With support from the state lead, these partners can help assess and meet the needs of audiences who may be otherwise hard to reach. For example, partnering with large industry/employers could yield information about their workforce's mental health needs, could open doors for consulting on how to enact of suicide prevention-oriented policies in their workplaces, and could embed annual trainings for supervisors, employee assistance programs, and staff in industry-appropriate workplace suicide prevention training.

To further strengthen your infrastructure:

Maintain an updated list of trainings that meet state requirements or recommendations. Many states recommend or require training in suicide prevention for specific professionals (e.g. teachers, school staff, health providers, etc.). Training may need to meet state requirements or recommendations with regard to the following:

- Evidence base
- Accuracy of content
- Measures of application in work environment
- Adherence to best practices
- Evaluation strength

In conjunction with national resources such as SPRC's listing of trainings with evidence of effectiveness, and the CDC's Preventing Suicide: A Technical Package of Policy, Programs, and Practices, state suicide prevention leadership can determine criteria and offer lists of trainings that are recommended for those professionals.

Some states have convened a group of suicide prevention experts to identify a menu of trainings appropriate for particular groups (e.g., school teachers/administrators), so that the relevant professionals would have a vetted list to choose from. These lists should be updated regularly to ensure they take new research into account.