SPRC 2022 State and Territorial Suicide Prevention Needs Assessment

Aggregate Technical Report

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The Suicide Prevention Resource Center (SPRC) would like to thank all representatives from participating states and territories for their comprehensive and thoughtful responses to the 2022 State and Territorial Suicide Prevention Needs Assessment. The information you have provided will help SPRC support states and territories in the development of suicide prevention infrastructure. SPRC acknowledges the contributions of all state and territorial suicide prevention leaders in the development of suicide prevention infrastructure throughout the nation. Your efforts are helping to save lives.

SPRC would also like to thank all internal partners who contributed to the 2022 State and Territorial Suicide Prevention Needs Assessment survey, reports, and associated materials. These resources provide essential information on our nation's strengths and areas for growth in suicide prevention infrastructure development.

Resources and Support

National and local partners are encouraged to use the information provided in this report to guide their suicide prevention efforts. Additional information and resources specific to state and territorial infrastructure development are available at https://sprc.org/state-infrastructure.

For additional SPRC resources and support related to suicide prevention, please visit us at https://www.sprc.org/.

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Background and Methods

Background

Between April 19 and May 27, 2022, Suicide Prevention Resource Center (SPRC) and its partner Social Science Research and Evaluation, Inc. (SSRE) conducted the 2022 State and Territorial Suicide Prevention Needs Assessment (SNA) with 54 suicide prevention coordinators or equivalent suicide prevention leads from the 50 U.S. states, the District of Columbia, and 3 U.S. territories. The purpose of the SNA is to help SPRC better understand state[1] suicide prevention needs, track changes in state suicide prevention infrastructure development over time and provide valuable information to states on their own progress and on suicide prevention infrastructure and programming in the nation. Findings from the SNA will also help SPRC identify and develop future suicide prevention learning opportunities, supports, and resources for states.

The assessment invited state suicide prevention representatives to assess and describe their state's suicide prevention strengths, needs, barriers, and successes. It included seven sections–one for each of the six essential elements in SPRC's *Recommendations for State Suicide Prevention Infrastructure* (Infrastructure Recommendations) – (1) Authorize, (2) Lead, (3) Partner, (4) Examine, (5) Build, and (6) Guide – and a concluding section on the tools associated with the recommendations. Throughout the assessment, respondents were asked to assess the presence of each recommendation within their state according to the level of work and sustainability currently taking place. Respondents were also given the opportunity to detail the major barriers and/or successes in these areas, as well as identify any support, tools, or resources SPRC could provide to help their state further strengthen suicide prevention efforts.

Methods

The SNA was conducted as an online questionnaire. All representatives were contacted via email and asked to participate. The assessment could be completed either by one designated individual or by a team (working together and submitting a single formal response). Respondents could complete the assessment all at once or submit partial answers and return to complete it later.

Forty-five of the 54 invited state representatives responded and agreed to participate in the SNA (83% response rate). One response was disqualified due to incomplete data, while three respondents completed it partially and 41 completed it fully. The final analytic sample consisted of 44 of 54 potential respondents (81% participation rate).

[1] The term "state" is used in this report as a short-hand reference to states, the District of Columbia, and U.S. territories.

Results

Infrastructure Element Progress Scores and Rates

Respondents were asked to assess the presence in their state of each of the six essential elements in SPRC's Infrastructure Recommendations according to the related level of work and sustainability taking place. Multiple items for each element were scored using either a 4-point rubric scale ranging from a low of 0 (indicating no presence of the element measure) to a high of 4 (indicating a high presence of the element measure) or on a summative basis where the existence of a particular element measure scored 1 point. Summary scores were computed for each element, and overall, across elements, for the 41 states that answered all scored items. The maximum potential scores were 165 across all elements, 24 for Authorize, 24 for Lead, 24 for Partner, 20 for Examine, 48 for Build, and 25 for Guide.

Differences in potential maximum scores for individual elements are due to the number of questions used to assess each element. The Build section, in particular, had the highest potential score because the section contained multiple items to assess state implementation of 10 high-level strategies from SPRC's Comprehensive Approach to Suicide Prevention and the Center for Disease and Control and Prevention's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*.

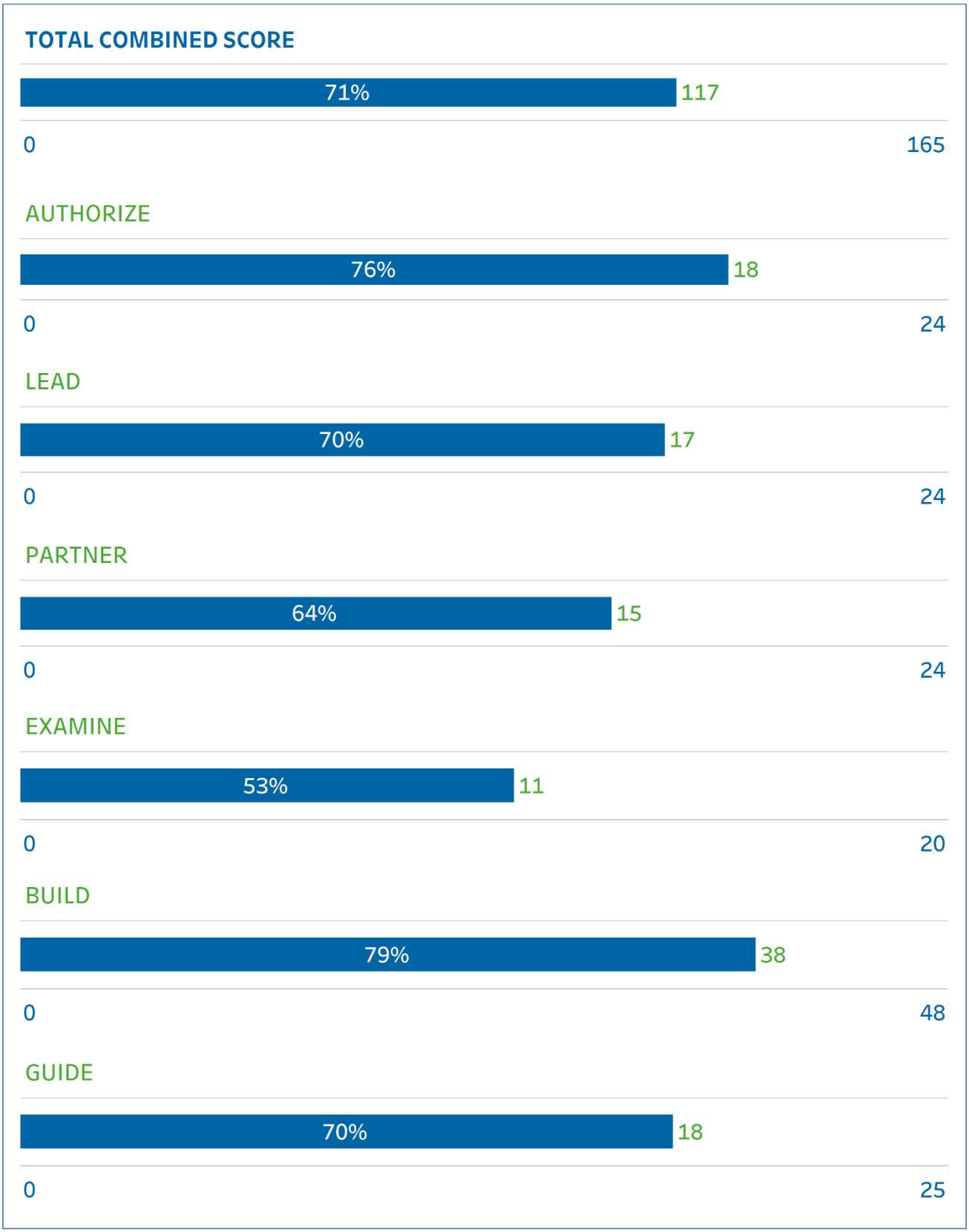
Table 1 below and Figure 1 on the following page display the total progress scores and rates for all states that completed all scored items both overall (TOTAL) and for each of the six essential elements. Progress rates are based on self-reported state assessments of the presence of each of the six elements. Progress rates range from 0% (no recommendations in place) to 100% (all recommendations in place with sustainable infrastructure). On average, states achieved a total infrastructure progress rate of 71% (progress score of 117 out of a possible 165). Infrastructure element progress rates in descending order were: Build – 79%, Authorize – 76%, Lead (70%), Guide – 70%, Partner – 64%, and Examine – 53%.

Table 1: Infrastructure Element and Total Progress Scores and Rates
(N=41)

Infrastructure Element	Potential Score Range	Progress Score[(a)]	Progress Rate
Authorize	0-24	18	76%
Lead	0-24	17	70%
Partner	0-24	15	64%
Examine	0-20	11	53%
Build	0-48	38	79%
Guide	0-25	18	70%
TOTAL COMBINED SCORE	**0-165**	**117**	**71%**

[(a)] Progress scores have been rounded to the nearest whole number for ease of reporting. Detailed actual scores were used to generate progress rates.

Figure 1: Infrastructure Element and Total Summary Scores and Rates
(N=41)



The following six sections contain results for each of the essential elements.

Items that contributed to infrastructure element progress scores and rates are identified by an "Ⓢ" next to the section headings.

Infrastructure Element #1 – AUTHORIZE

Authorize was the second highest-rated infrastructure element, with a 76% progress rate (progress score of 18 out of a possible 24).

Lead Agency and Authorization Ⓢ

Most states (89%, 39 of 44[2]) indicated that their state has a designated lead suicide prevention agency or office, and all but one of those states (97%, 38 of 39) reported that the agency is authorized/designated to create and carry out the state suicide prevention plan.

Establishing and Sustaining State Budget Line Items Ⓢ

As shown in Table 2, only half of states (50%, 22 of 44) reported that they had an established state budget line item for suicide prevention (41% indicated that it is sustainably in place).

Table 2: AUTHORIZE – State Progress toward Establishing and Sustaining State Budget Line Items for Suicide Prevention

(N=44)

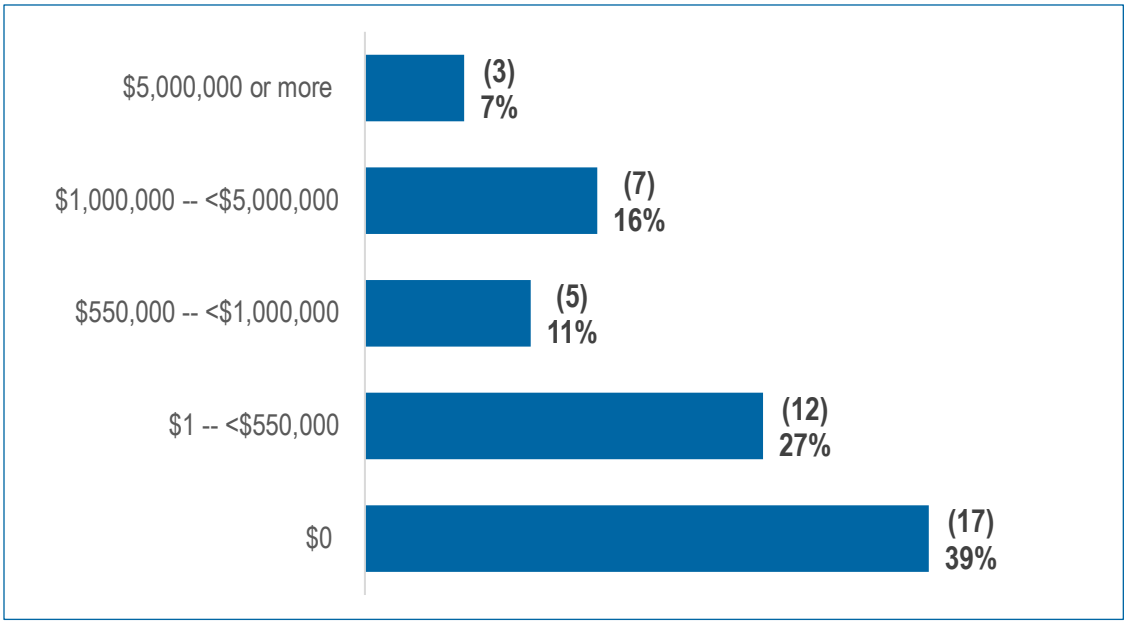
	Percent	Count
Not yet in place / Unaware of any work to get this in place	9%	4
Planning steps to get this in place	23%	10
Actively working to get this in place	18%	8
This is in place, but it is not yet sustainable	9%	4
This is sustainably in place	41%	18
	Total	44

Budgeted State Funding for Suicide Prevention

Over one-third of states (39%, 17 of 44) lack any designated budget line items for suicide prevention and two-thirds of the 27 states **with** designated funding reported that the budgeted amount was under $1,000,000 (63%, 17 of 27). See Figure 2.

[2] Responses on individual items are based on potential responses from all 44 respondents.

Figure 2: AUTHORIZE – Value of Budgeted State Funding for Suicide Prevention
(N=44)



Major Sources of Outside Funding to Support Suicide Prevention Infrastructure

States were asked to identify major sources of funding, outside of state budget line items, that currently support suicide prevention infrastructure. As shown in Table 3, all but one state (98%, 43 of 44) indicated that they receive outside funding for their suicide prevention efforts. The most frequently identified sources were *Community Mental Health Services Block Grants* (50%, 22 of 44) and the *Garrett Lee Smith Suicide Prevention State or Tribal Grant* (48%, 21 of 44), followed by both *Substance Abuse Prevention Treatment Block Grants* and *Zero Suicide Grants* (32%, 14 of 44).

Half of respondents (50%, 22 of 44) identified other sources of outside funding beyond those listed in the response options, including Vibrant and SAMHSA 988 grants and/or cooperative agreements related to the transition to the 988 dialing code for the National Suicide Prevention Lifeline (9 responses), State Opioid Response Grants (3), CDC Preventive Health and Health Services Block Grants (3), COVID-19 Emergency Response for Suicide Prevention Grants (2), and funding related to the CDC National Violent Death Reporting System (2).

Table 3: AUTHORIZE – Major Sources of Outside Funding to Support Suicide Prevention Infrastructure
(N=44)

Multiple responses possible	Percent	Count
CCBHC (Certified Community Behavioral Health Clinic Expansion) Grants	11%	5
Child and Maternal Wellness Block Grant	27%	12
CDC Comprehensive Community Suicide Prevention Grant	23%	10
CDC Injury or Violence Prevention Grant	25%	11
Community Mental Health Services Block Grants (MHBG)	50%	22
Garrett Lee Smith (GLS) Suicide Prevention State or Tribal Grant	48%	21
Garrett Lee Smith (GLS) Suicide Prevention Campus Grant	9%	4
National Strategy for Suicide Prevention (NSSP) Grant	7%	3
National Foundation Funding	2%	1
Private Donations	20%	9
State or Community Foundation Funding	16%	7
State Medicaid or Medicare Dollars	11%	5
Substance Abuse Prevention and Treatment Block Grants (SABG)	32%	14
Zero Suicide Grants	32%	14
Other[(a)]	50%	22
We do not have any other major sources of funding (outside of state budget line items)	2%	1

[(a)] Other responses provided by more than one respondent were: Vibrant and SAMHSA 988 grants and/or cooperative agreements related to full implementation of the 988 dialing code for the National Suicide Prevention Lifeline (9), State Opioid Response Grants (3), CDC Preventive Health and Health Services Block Grants (3), COVID-19 Emergency Response for Suicide Prevention Grants (2), and funding related to the CDC National Violent Death Reporting System (2).

Regular Update of State Suicide Prevention Plan Ⓢ

Eighty percent of states (80%, 35 of 44) indicated that they update their state suicide prevention plan every 3-5 years. Of the nine states that do not regularly update their plans, five reported that they are currently updating their plan, two plan to begin updating it within the next year, and two have no current plans to update it.

Formal Support/Endorsement of Data-Driven Strategic Planning Ⓢ

Eighty-nine percent of states (89%, 39 of 44) indicated that state leadership provides formal support and/or endorsement of data-driven strategic planning (e.g., providing a letter of support for planning efforts or signing off on the state plan).

Annual Report to State Leadership Ⓢ

Just under half of states (45%, 20 of 44) indicated that their state provides an annual report on suicide prevention to the legislature and/or governor.

Barriers and Successes in the Past 12 Months – Strengthening the Authorize Element

Respondents were asked to identify both barriers and successes that their state had experienced related to strengthening each of the six essential elements in SPRC's Infrastructure Recommendations. As shown in Table 4, the *lack of any/sufficient funding* (14 comments) was the most frequently identified **barrier** to strengthening the Authorize element, followed by *strained staff capacity* (9), *competing priorities* (8), and *challenges related to the state prevention plan (not consistently updated, lengthy review process*) (7). Barriers in this

area were largely associated with funding (insufficient, difficult to locate and diversify, unstable, not allocated to priorities) and staffing (strained capacity, insufficient levels, turnover, hiring challenges).

Table 4: AUTHORIZE – Barriers to Strengthening the Authorize Element
(N=41)

Funding (26 related comments)	
14	No or insufficient state funding
6	Unstable, time-limited, grant-based funding
3	Difficulty identifying diverse funding sources
2	Funding not allocated to areas and issues of priority/need
1	Inability of state to advocate, uncoordinated advocacy groups
Staffing (19 related comments)	
9	Strained staff capacity
6	Insufficient staffing levels
4	Staff turnover, difficulty hiring
Leadership and Legislature (10 related comments)	
6	Inconsistent champions, no designated state suicide prevention lead, lack of political will
4	Lack of support from leadership, fragmented, conflicting goals
Coordination, Communication, and Visibility (8 related comments)	
5	Role confusion, uncoordinated efforts
3	No mechanism to report to legislature/governor, no website
Data and Accountability (8 related comments)	
3	Not able to access or share data across agencies
3	No annual suicide prevention report, no evaluation
2	Limited data collection, outcomes not being tracked
Priorities (8 related comments)	
8	Competing priorities (over-emphasis on 988)
State Suicide Prevention Plan (7 related comments)	
7	State plan not consistently updated, lengthy review process
COVID-19 Pandemic (2 related comments)	
2	Lingering economic and implementation impacts from COVID-19

Collaboration within and between state agencies (11 comments) and having *suicide prevention positions/programming included in state budget* (11) were the most common **successes** reported in strengthening the Authorize element. Successes clustered around the themes of coordination, communication, and visibility (collaboration within and between state agencies, visible efforts such as Zero Suicide, heightened awareness of issues such as 988, data collaborations and infrastructure); funding (positions and/or programming included in state budget, secured federal funding, braiding of funding streams); and, the existence of a strong suicide prevention network (presence of various task forces, coalitions, and councils, community engagement and local leadership, emphasis on workforce development) (see Table 5).

Table 5: AUTHORIZE – Successes in Strengthening the Authorize Element
(N=42)

Coordination, Communication, and Visibility (29 related comments)	
11	Collaboration within and between state agencies
8	Visible efforts (Zero Suicide, Governor's Challenge)
6	Heightened awareness (988, data-supported need, prioritized issue)
4	Data collaborations and data infrastructure
Funding (19 related comments)	
11	Suicide prevention positions/programming included in state budget
5	Secured federal funding (e.g., 988 implementation grant)
3	Braiding funding streams
Strong Suicide Prevention Network (19 related comments)	
8	Presence of governor's task force, state suicide prevention coalition, advisory councils
7	Community engagement and local leadership
4	Emphasis on workforce development, capacity building, and training
State Suicide Prevention Plan (11 related comments)	
9	State suicide prevention plan developed/submitted/regularly updated
2	Emphasis on primary prevention and shared risk and protective factors
Leadership and Administration Support (7 related comments)	
4	Political will/support
3	Supportive and stable leadership
Accountability (6 related comments)	
3	Annual suicide prevention report
3	Highlighting successes of prevention efforts
Designated Lead Agency (4 related comments)	
4	State has designated a lead suicide prevention agency

Infrastructure Element #2 – LEAD

Lead (70% progress rate, progress score of 17 out of a possible 24) was a middle-rated infrastructure element.

Suicide Prevention Coordinator Support Ⓢ and Additional Funded Positions Ⓢ

While most states (86%, 38 of 44) have a half-time or greater full-time equivalent (0.5 – 1.0 FTE) suicide prevention coordinator or similar role, fewer (59%, 26 of 44) fund additional staff positions.

State Emphasis on Professional Development for Suicide Prevention Staff

Over three-quarters of respondents indicated that their state places either *a great deal* (50%, 22 of 44) or *a fair amount* (27%, 12 of 44) of emphasis on actively supporting the professional development of suicide prevention staff (e.g., support staff education and training in suicide prevention, fund staff attendance at suicide prevention conferences, support staff participation in SPRC-funded events) (see Table 6).

Table 6: LEAD – Emphasis Placed by State on Actively Supporting Professional Development of Suicide Prevention Staff
(N=44)

	Percent	Count
None	2%	1
Very Little	7%	3
Some	14%	6
A Fair Amount	27%	12
A Great Deal	50%	22
	Total	44

Funding Technological Support to Carry Out Activities in State Plan

Respondents were asked to rate their state's progress toward adequately funding the technological support necessary to carry out the activities listed in their state suicide prevention plan (e.g., maintaining relevant websites or webpages, investing in technology necessary for remote trainings and meetings, purchasing necessary supplies and resources for in-person and virtual collaboration). While most felt that this funding was in place either sustainably (36%, 16 of 44) or not yet sustainably (25%, 11 of 44), one-third indicated that they had not yet taken action beyond planning to get such support in place (32%, 14 of 44) (see Table 7).

Table 7: LEAD – State Progress toward Adequately Funding Technological Support to Carry Out Activities in State Plan
(N=44)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	11%	5
Planning steps to get this in place	20%	9
Actively working to get this in place	7%	3
This is in place, but it is not yet sustainable	25%	11
This is sustainably in place	36%	16
	Total	44

Establishing Capacity to Respond to Information Requests

State progress toward establishing sufficient staff and/or professional network capacity to respond to information requests from officials, communities, the media, and the general public was more advanced, with the majority of respondents (70%, 31 of 44) indicating that this was already in place in their state (see Table 8).

Table 8: LEAD – State Progress toward Establishing Sufficient Staff and/or Professional Network Capacity to Respond to Information Requests
(N=44)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	5%	2
Planning steps to get this in place	7%	3
Actively working to get this in place	18%	8
This is in place, but it is not yet sustainable	27%	12
This is sustainably in place	43%	19
	Total	44

Addressing Critical Issues in the Framework for Successful Messaging

Respondents were asked which critical issues defined in the National Action Alliance for Suicide Prevention's *Framework for Successful Messaging* on suicide prevention their state is actively addressing. As displayed in Table 9, only 7% of states (3 of 44) reported that they were not actively addressing any of the issues. The majority were addressing *following available best practice suicide prevention messaging guidelines* (86%, 38 of 44), followed closely by *promoting a positive suicide prevention narrative* (80%, 35 of 44), *minimizing unsafe suicide prevention messaging practices* (66%, 29 of 44), and *developing strategic communication campaigns* (64%, 28 of 44).

Table 9: LEAD – Critical Issues from the *Framework for Successful Messaging* Being Actively Addressed
(N=44)

Multiple responses possible	Percent	Count
Developing strategic communication campaigns	64%	28
Promoting a positive suicide prevention narrative	80%	35
Following available best practice suicide prevention messaging guidelines	86%	38
Minimizing unsafe suicide prevention messaging practices	66%	29
None of the above	7%	3

Formal Suicide Prevention Partnerships S

The majority of respondents (70%, 31 of 44) reported that their state had established formal suicide prevention partnerships between government divisions or offices.

Braided Funding to Support Prevention Efforts S

Just over half of responding states (57%, 25 of 44) are using braided funding to support relevant suicide prevention efforts (e.g., using opioid misuse and suicide prevention dollars to support a drug take-back campaign).

Barriers and Successes in the Past 12 Months – Strengthening the Lead Essential Element

Lack of dedicated funding for staff (10 comments) was the most frequently identified barrier to strengthening the Lead element, followed by insufficient staffing levels (7), insufficient technology/technical support (7), and lack of coordination within and between state and local levels (6). Barriers in this area were largely associated with funding (lack of dedicated funding for staff, insufficient funds for programs and services, no/insufficient state funding, unstable,

time-limited, or grant-based funding) and staffing (insufficient levels, hiring challenges, strained capacity, workforce turnover, retirement, or burnout) (see Table 10).

Table 10: LEAD – Barriers to Strengthening the Lead Element
(N=40)

Funding (21 related comments)	
10	Lack of dedicated funding for staff
4	Insufficient funds for programs and services
4	No or insufficient state funding
3	Unstable, time-limited, grant-based funding
Staffing (21 related comments)	
7	Insufficient staffing levels
5	Bureaucratic/logistical difficulty hiring
5	Strained staff capacity
4	Workforce crisis (turnover, retirement, burnout)
Coordination, Communication, and Visibility (12 related comments)	
6	Lack of coordination within and between state and local levels
2	Lack of statewide communication strategy
2	Lack of adherence to framework for successful messaging
1	Lack of state legislation/policy
1	Ensuring equitable access to materials and messages
Technology and Technical Support (7 related comments)	
7	Insufficient technology/technical support
Priorities (5 related comments)	
5	Suicide prevention not prioritized, competing priorities (988, COVID-19)
Data and Accountability (3 related comments)	
2	No or limited support from Epidemiologists and Data Managers
1	Lack of real-time or near real-time data for response
Contracting and Procurements (2 related comments)	
2	Difficulty contracting with community partners
Other Comments	
2	No barriers present
1	No designated lead suicide prevention agency

Collaboration within and between state agencies (13 comments) was the most frequently identified **success** in strengthening the Lead element, followed by *visible efforts such as communications campaigns and promotion of successful messaging framework* (9), securing *staff positions dedicated to suicide prevention* (8), and the presence of *strong statewide task forces/coalitions/councils* (7). Successes clustered largely around coordination, communication, and visibility (see Table 11).

Table 11: LEAD – Successes in Strengthening the Lead Element
(N=39)

Coordination, Communication, and Visibility (31 related comments)	
13	Collaboration within and between state agencies
9	Visible efforts (communications campaigns, promotion of successful messaging framework)
4	Developed communications strategic plan, media collaborations
4	Heightened awareness (988 rollout)
1	Data collaborations and data infrastructure
Strong Suicide Prevention Network (14 related comments)	
7	Presence of governor's task force, state suicide prevention coalition, advisory councils
4	Strong partnerships between state and local levels
2	Strong champions for suicide prevention within state
1	Emphasis on workforce development, capacity building, and training
Staffing (11 related comments)	
8	Staff positions dedicated to suicide prevention
2	Dedicated and committed staff/team
1	Diverse and representative staff
Leadership and Administration Support (5 related comments)	
3	Political will/support
2	Supportive leadership
State Suicide Prevention Plan (5 related comments)	
3	State suicide prevention plan developed/submitted/regularly updated
2	Data-driven strategic planning and evaluation support
Designated Lead Agency (3 related comments)	
3	State has designated a lead suicide prevention agency
Funding (3 related comments)	
3	Secured funding for prevention positions/programming
Strong Technology (2 related comments)	
2	Online training registration system, comprehensive website

Infrastructure Element #3 – PARTNER

Partner was the second lowest-rated infrastructure element, with a 64% progress rate (progress score of 15 out of a possible 24).

Integration of Suicide Prevention Efforts by Partnering State Agencies or Departments

Respondents were asked to describe the degree to which suicide prevention efforts are integrated into the structures, policies, and activities of partnering state agencies or departments (e.g., integrating suicide risk screenings into systems, incorporating gatekeeper trainings into staff responsibilities, requiring the collection of suicide-related data, maintaining suicide-specific policies and protocols). As shown in Table 12, responses varied considerably. Only 14% of respondents (6 of 42) indicated that such partner integration was sustainably in place, while most (45%, 19 of 42) were actively working to get it in place.

Table 12: PARTNER – Integration of Suicide Prevention Efforts by Partnering State Agencies or Departments
(N=42)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	5%	2
Planning steps to get this in place	12%	5
Actively working to get this in place	45%	19
This is in place, but it is not yet sustainable	24%	10
This is sustainably in place	14%	6
	Total	42

Statewide Suicide Prevention Coalitions – Establishment Ⓢ, Lifespan Focus Ⓢ, and Sector Representation Ⓢ

Over three-quarters of states (83%, 35 of 42) have a statewide suicide prevention coalition, with over half (57%, 24 of 42) reporting that it is sustainably in place (see Table 13).

Table 13: PARTNER – Progress toward Establishing a Statewide Suicide Prevention Coalition
(N=42)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	2%	1
Planning steps to get this in place	5%	2
Actively working to get this in place	10%	4
This is in place, but it is not yet sustainable	26%	11
This is sustainably in place	57%	24
	Total	42

Of the 35 states with a statewide coalition, almost all (94%, 33 of 35) reported that the coalition is focused on the entire lifespan. Additionally, 100% of states with a statewide coalition (35 of 35) were working to develop or had already established broad public and private sector coalition representation, with 49% (17 of 35) reporting that such representation was sustainably in place (see Table 14).

Table 14: PARTNER – Statewide Suicide Prevention Coalition Progress toward Having Broad Public and Private Sector Representation
(N=35)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	0%	0
Planning steps to get this in place	0%	0
Actively working to get this in place	20%	7
This is in place, but it is not yet sustainable	31%	11
This is sustainably in place	49%	17
	Total	35

Mutually Agreed-Upon Goals for Suicide Prevention across Partners Ⓢ

Half of all states (50%, 21 of 42) reported having set mutually agreed-upon goals for suicide prevention across partners, with 38% having them sustainably in place (see Table 15).

Table 15: PARTNER – Progress toward Setting Mutually Agreed-Upon Goals for Suicide Prevention across Partners
(N=42)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	2%	1
Planning steps to get this in place	12%	5
Actively working to get this in place	36%	15
This is in place, but it is not yet sustainable	12%	5
This is sustainably in place	38%	16
	Total	42

Signed Partnering Agreements

Only 19% of states (8 of 42) reported having signed partnering agreements in place defining the roles of each partner in suicide prevention (e.g., memoranda of understanding, memoranda of agreement, data sharing agreements), while most (45%, 19 of 42) have neither planned nor worked toward getting such agreements in place (see Table 16).

Table 16: PARTNER – Progress toward Having Signed Partnering Agreements Defining Roles in Suicide Prevention
(N=42)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	45%	19
Planning steps to get this in place	17%	7
Actively working to get this in place	19%	8
This is in place, but it is not yet sustainable	7%	3
This is sustainably in place	12%	5
	Total	42

Communication Between States and Tribes or Tribal Health Boards

Twenty-eight respondents reported that there are federally recognized tribes or tribal health boards within the geographic borders of their state. These respondents were asked to characterize the level of **communication** related to suicide prevention between their state and those tribes or tribal health boards. As displayed in Table 17, most respondents indicated that their communication with tribes/tribal health boards is *fair* (39%, 11 of 28), *poor* (29%, 8 of 28), or *extremely poor* (14%, 4 of 28).

Table 17: PARTNER – Communication Between States and Tribes or Tribal Health Boards
(N=28)

	Percent	Count
Extremely Poor	14%	4
Poor	29%	8
Fair	39%	11
Good	14%	4
Excellent	4%	1
	Total	28

Collaboration Between States and Tribes or Tribal Health Boards

The 28 respondents who indicated that there are federally recognized tribes or tribal health boards within the geographic borders of their state were also asked to describe the level of **collaboration** related to suicide prevention between their state and those tribes/tribal health boards. As displayed in Table 18, most respondents indicated that their collaboration with tribes/tribal health boards could be best characterized as *awareness (knowledge of each other's activities)* (36%, 10 of 28) or *none (no awareness or interaction)* (25%, 7 of 28).

Table 18: PARTNER – Collaboration Between States and Tribes or Tribal Health Boards
(N=28)

	Percent	Count
None (no awareness or interaction)	25%	7
Awareness (knowledge of each other's activities)	36%	10
Networking (back and forth sharing of information)	18%	5
Coordination (common and often interactive efforts)	18%	5
Collaboration (shared goals and decision-making)	4%	1
	Total	28

Actions Taken to Ensure Cultural Responsiveness

Respondents were asked to identify actions their state has taken to make sure their prevention efforts are culturally responsive. As shown in Table 19, all states reported taking action to ensure cultural responsiveness, with 88% (37 of 42) *researching and understanding the cultural context of communities reached by strategies or interventions*, 81% (34 of 42) *including members of populations served in strategic planning efforts*, 71% (30 of 42) *creating an open dialogue whereby members of populations served can share cultural considerations key to prevention*, and 67% (28 of 42) *tailoring/developing interventions and resources to address populations served*.

Table 19: PARTNER – Actions State Has Taken to Ensure Cultural Responsiveness within Prevention Efforts
(N=42)

Multiple responses possible	Percent	Count
Researching and understanding the cultural context of communities reached by strategies/interventions (target populations)	88%	37
Including members of populations served (e.g., communities of color, rural communities, tribal communities) in strategic planning activities	81%	34
Tailoring and/or developing interventions and resources to address the values, beliefs, culture, and language of the populations served	67%	28
Creating an open dialogue whereby members of populations served can share cultural considerations key to prevention	71%	30
Other	17%	7
None of the above	0%	0

Barriers and Successes in the Past 12 Months – Strengthening the Partner Element

Building and maintaining a diverse coalition (12 comments) was the most frequently identified **barrier** to strengthening the Partner element. Barriers in this area were largely associated with diversity and inclusion (building/maintaining a diverse coalition, identifying

diverse/representative partners, lack of culturally responsive materials/services, lack of commitment to equity), coordination and communication (lack of written agreements, lack of awareness/coordination with tribal entities, lack of coordination and redundancy of efforts, tensions between state/local/tribal entities, lack of statewide communication strategies and/or coalitions/advisory teams), and staffing (workforce turnover/retirement/burnout, insufficient staffing, strained capacity) (see Table 20).

Table 20: PARTNER – Barriers to Strengthening the Partner Element
(N=40)

Diversity and Inclusion (21 related comments)	
12	Building and maintaining diverse coalition
4	Identifying diverse and representative partners
4	Lack of culturally responsive materials and services
1	Lack of commitment to equity
Coordination and Communication (13 related comments)	
5	Lack of written agreements
2	Lack of awareness and coordination with tribal entities
2	Lack of coordination (redundancy of efforts)
2	Tensions between state, local, and tribal entities
1	Lack of statewide communication strategy
1	Lack of statewide coalition or advisory team
Staffing (10 related comments)	
4	Workforce crisis (turnover, retirement, burnout)
3	Insufficient staffing levels
3	Strained staff capacity
COVID-19 Pandemic (4 related comments)	
4	Pandemic disrupted momentum
Priorities (4 related comments)	
4	Competing interests/priorities
Sustainability (4 related comments)	
4	Coalition sustainability, continued involvement
Funding (3 related comments)	
2	No or insufficient state funding
1	Unstable, time-limited, grant-based funding
Other Comments	
3	No barriers present
1	No or limited data on diverse populations
1	Political divisiveness

The *presence of state taskforces/coalitions/advisory councils* (13 comments) and *strong partnerships between state and local levels* (12) were the most common **successes** reported in strengthening the Partner element. Successes clustered around the themes of strong suicide prevention networks and coordination, communication, and visibility (collaboration within/between state agencies, visible efforts, heightened awareness, written agreements, strong communications strategy, and data collaborations/infrastructure) (see Table 21).

Table 21: PARTNER – Successes in Strengthening the Partner Element
(N=41)

Strong Suicide Prevention Network (25 related comments)	
13	Presence of governor's task force, state suicide prevention coalition, advisory councils
12	Strong partnerships between state and local levels
Coordination, Communication, and Visibility (20 related comments)	
8	Collaboration within and between state agencies
4	Visible efforts (Governor's Challenge, community events)
3	Heightened awareness (facilitates engagement)
2	Written agreements (MOAs, partnering agreements)
2	Strong communications strategy (positive messaging)
1	Data collaborations and data infrastructure
Diversity and Inclusion (11 related comments)	
11	Increased interest and work on diversity and inclusion
State Suicide Prevention Plan (6 related comments)	
5	Commitment to shared goals and approaches
1	Data-driven strategic planning and evaluation support
Infrastructure Development (3 related comments)	
3	Collaborative infrastructure development (988, crisis response)
Funding (2 related comments)	
2	Secured funding for prevention positions/programming
Leadership and Administration Support (2 related comments)	
2	Political will, supportive leadership
Staffing (2 related comments)	
2	Diverse and representative staff

Infrastructure Element #4 – EXAMINE

Examine was the lowest-rated infrastructure element, with a 53% progress rate (progress score of 11 out of a possible 20).

Statewide System for Collecting and Analyzing Suicide Death Data

As displayed in Table 22, most respondents (71%, 30 of 42) indicated that their state has a statewide system in place for collecting and analyzing suicide death data (50% indicating that it is sustainable).

Table 22: EXAMINE – State Progress toward Having a Statewide System in Place for Collecting and Analyzing Suicide Death Data
(N=42)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	0%	0
Planning steps to get this in place	17%	7
Actively working to get this in place	12%	5
This is in place, but it is not yet sustainable	21%	9
This is sustainably in place	50%	21
	Total	42

Standards for Timeliness of Mortality Reporting Ⓢ

Sixty percent of states (60%, 25 of 42) have developed standards related to the timeliness of mortality reporting (e.g., all coroner data finalized within one year of suicide death).

Linking Data from Different Systems

Comparatively few respondents (19%, 8 of 42) reported that their state had successfully linked data from different systems (e.g., connecting state mental health system records with death certificate records, securely sharing data between different medical record systems). Only 7% (3 of 42) indicated that this was sustainable. Over one-third (36%, 15 of 42) reported that there had been no efforts to establish such linkages. See Table 23 for details.

Table 23: EXAMINE – State Progress toward Linking Data from Different Systems
(N=42)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	36%	15
Planning steps to get this in place	19%	8
Actively working to get this in place	26%	11
This is in place, but it is not yet sustainable	12%	5
This is sustainably in place	7%	3
	Total	42

Establishing a Near Real-Time Data System for Suicidal Ideation and Attempts Ⓢ

There was variability in progress toward establishing a system for collecting and analyzing near real-time statewide data for suicidal ideation and attempts, with 45% of states (19 of 42) having established such a system (21% have it sustainably in place), 12% (5 of 42) actively working to establish it, 29% (12 of 42) planning steps to establish it, and 14% (6 of 42) having neither planned to nor worked toward establishing it (see Table 24).

Table 24: EXAMINE – State Progress toward Establishing a System for Collecting and Analyzing Near Real-Time Statewide Data for Suicidal Ideation and Attempts
(N=42)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	14%	6
Planning steps to get this in place	29%	12
Actively working to get this in place	12%	5
This is in place, but it is not yet sustainable	24%	10
This is sustainably in place	21%	9
	Total	42

State-Level Interactive Dashboard with Near Real-Time Morbidity Data Ⓢ

Only 26% of states (11 of 42) reported having a state-level interactive dashboard with near real-time suicide morbidity data.

Ensuring Data Representation of Populations that Are High Risk and Underserved Ⓢ

Just 31% of respondents (13 of 42) reported that their state ensures that populations that are at high risk and underserved are sufficiently represented in their suicide-related data (12% sustainably). Most are either actively working (36%, 15 of 42) or planning steps (21%, 9 of 42) to get this in place, while 12% (5 of 42) have not initiated work on this issue. See Table 25.

Table 25: EXAMINE – State Progress toward Ensuring that Populations that Are High Risk and Underserved Are Sufficiently Represented in Suicide-Related Data
(N=42)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	12%	5
Planning steps to get this in place	21%	9
Actively working to get this in place	36%	15
This is in place, but it is not yet sustainable	19%	8
This is sustainably in place	12%	5
	Total	42

State-Supported Suicide Prevention Evaluation

Respondents were asked to identify the types of state-supported suicide prevention evaluation efforts that have occurred in their state within the past year. As shown in Table 26, 64% of states (27 of 42) had engaged in *process* evaluation efforts to ensure that strategies and/or interventions are being implemented as intended, while 55% (23 of 42) had engaged in *formative* evaluation efforts to inform implementation, 45% (19 of 42) had engaged in *outcome* evaluation efforts to assess their achievement of previously set objectives, and 40% (17 of 42) had engaged in *impact* evaluation efforts to assess long-term impacts on goals and suicide rates. Just under one-fifth of states (19%, 8 of 42) indicated that none of the listed evaluation efforts had occurred during the past year.

Table 26: EXAMINE – State-Supported Evaluation Efforts that Have Occurred During the Past Year
(N=42)

Multiple responses possible	Percent	Count
Formative evaluations to ensure strategies/interventions are feasible, appropriate, and acceptable prior to full implementation (conducting pilot evaluations)	55%	23
Process evaluations to ensure strategies/interventions are being implemented as intended	64%	27
Outcome evaluations to determine whether strategies/interventions are helping to achieve set objectives	45%	19
Impact evaluations to determine strategy/intervention impacts on long-term goals and suicide rates	40%	17
None of the above	19%	8

State Sharing and/or Use of Evaluation Results

Most respondents (88%, 37 of 42) indicated that their state was using and/or sharing evaluation results. As shown in Table 27, the most common use was *informing/making changes to state suicide prevention plans* (69%, 29 of 42), followed by *making changes to specific strategies/interventions* (62%, 26 of 42). Approximately half of respondents reported *developing regular suicide prevention reports for state leaders* (57%, 24 of 42), *developing regular suicide prevention reports for the public* (52%, 22 of 42), and *involving key community stakeholders in interpretation of evaluation outcomes* (48%, 20 of 42).

Table 27: EXAMINE – State Sharing and/or Use of Evaluation Results
(N=42)

Multiple responses possible	Percent	Count
Involving key community stakeholders in interpretation of evaluation outcomes	48%	20
Using evaluation results to inform/make changes to state suicide prevention plans	69%	29
Using evaluation results to make changes to specific strategies/interventions	62%	26
Developing regular suicide prevention reports for state leaders	57%	24
Developing regular suicide prevention reports (including infographics, annual highlights, success stories, etc.) for the public	52%	22
Other	10%	4
None of the above	12%	5

Barriers and Successes in the Past 12 Months – Strengthening the Examine Element

A *lack of time/resources/personnel/funding* devoted to supporting data efforts (14 comments) was the most frequently identified **barrier** to strengthening the Examine element. Barriers clustered primarily around the themes of data infrastructure/capacity (limited time, resources, personnel, and/or funding; no or limited access to evaluation support; limited technical support; low levels of data and evaluation literacy) and accessing data (data lag, logistical challenges related to sharing data, resistance to sharing data across systems/agencies) (see Table 28).

Table 28: EXAMINE – Barriers to Strengthening the Examine Element
(N=41)

Data Infrastructure and Capacity (24 related comments)	
14	No or limited time, resources, personnel, or funding
5	No or limited access to evaluator
3	Limited technical support (creating dashboards, centralized data systems)
2	Low levels of data and evaluation literacy
Accessing Data (18 related comments)	
8	Data lag (not timely; not real-time)
6	Logistical challenges (MOUs, Data Use Agreements, IRB)
4	Resistance to sharing data across systems/agencies
Data Gaps and Inconsistencies (9 related comments)	
7	Inconsistent coding, collection, and definitions
2	Data are not being collected/reported
Priorities (6 related comments)	
4	Limited focus on evaluation
2	Competing priorities to data collection, analysis, and reporting
Data Comprehensiveness and Inclusivity (5 related comments)	
5	Limited or no data on certain populations and groups
Linking Data Systems (2 related comments)	
2	Linking and analyzing data from different sources
Presenting and Communicating Data (2 related comments)	
2	Lengthy approval processes to publicly share data
Other Comments	
1	No barriers present

While *strong state-level and state/local-level data partnerships between partners such as state agencies, hospitals, and universities* (12 comments) was identified as the most common **success** in strengthening the Examine element, successes were largely associated with data infrastructure development (advancements in centralized systems and syndromic surveillance, enhanced data presentation capabilities, epidemiological and/or evaluation support) (see Table 29).

Table 29: EXAMINE – Successes in Strengthening the Examine Element
(N=40)

Data Infrastructure Development (25 related comments)	
9	Advancements in centralized systems and syndromic surveillance
8	Enhanced data presentation capabilities (data dashboards, state profiles)
8	Epidemiological and/or evaluation support (staff, contractors, partners)
Strong Data Partnerships (12 related comments)	
12	Strong state-level and state/local-level data partnerships (state agencies, hospitals, universities)
Coordination and Data Sharing (8 related comments)	
6	Presence of data workgroups and formal structures (fatality review boards, epidemiological workgroups)
2	Enhancing data sharing agreements and data linkages
Supportive Environment (7 related comments)	
5	Increased awareness of importance of suicide prevention and associated data
2	Political will, supportive leadership
Expanded Indicators/Datasets of Interest (4 related comments)	
4	Broader inclusion of data sources, indicators, and populations
Funding (3 related comments)	
3	Secured funding to support data infrastructure (research, staff)

Infrastructure Element #5 – BUILD

Build was the highest-rated infrastructure element, with a 79% progress rate (progress score of 38 out of a possible 48).

Strategic Planning Activities

All respondents indicated that their state suicide prevention coalition or office of suicide prevention had engaged in at least one of the six activities in SPRC's Strategic Planning Approach to Suicide Prevention within the past two years. Almost all respondents indicated that their state had *used data or other evidence to describe their state's suicide problem and context* (98%, 41 of 42) and/or *chosen short and long-term data-based goals* (90%, 38 of 42), while 79% had *identified key risk and protective factors* (33 of 42), 74% had *selected or developed strategies/interventions that address identified risk and protective factors* (31 of 42), 71% had *planned for strategy/intervention evaluation* (30 of 42), and 60% had *evaluated strategies/interventions over time* (25 of 42). See Table 30 for details.

Table 30: BUILD – State Strategic Planning Activities in the Past Two Years
(N=42)

Multiple responses possible	Percent	Count
Use data or other sources to describe your state's suicide problem and its context	98%	41
Choose short and long-term goals based on available data to guide suicide prevention efforts	90%	38
Identify key risk and protective factors for suicide in your state	79%	33
Select or develop strategies and interventions that address identified risk and protective factors	74%	31
Plan for evaluation of your strategies and interventions	71%	30
Evaluate and improve strategies/interventions over time	60%	25
None of the above	0%	0

Promotion within State Plan of Comprehensive Ⓢ and Lifespan Ⓢ Approaches

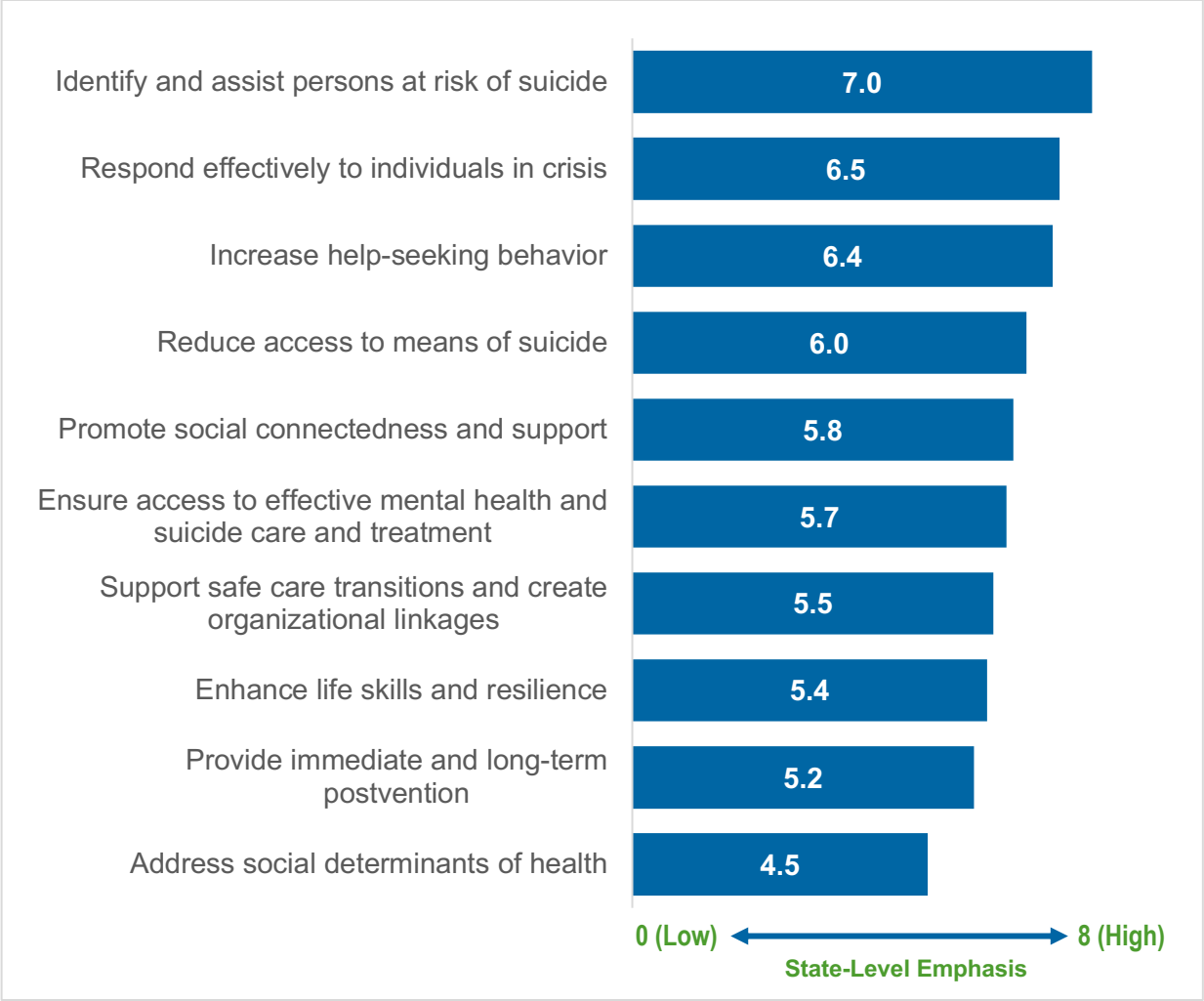
Almost all states (95%, 40 of 42) indicated that their state suicide prevention plan promotes a *comprehensive* approach to suicide prevention–one that involves a variety of suicide prevention strategies across all levels of prevention–while 93% (39 of 42) indicated that their plan promotes a *lifespan* approach to suicide prevention–one that calls for suicide prevention strategies to reach diverse populations across ages and demographics.

State Emphasis on Addressing High-Level Strategies Ⓢ

Respondents were asked to assess the level of emphasis that their state suicide prevention coalition or suicide prevention office places on addressing 10 high-level strategies from SPRC's Comprehensive Approach to Suicide Prevention and the Center for Disease and Control and Prevention's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, considering factors such as the relative amount of funding focused on the strategy, the number of activities implemented to address the strategy, and the level of effort expended to implement those activities. Level of emphasis was assessed on a sliding scale of 0 (low) to 8 (high).

As shown in Figure 3, states place the greatest emphasis on *identifying and assisting persons at risk of suicide* (7.0), followed by *responding effectively to individuals in crisis* (6.5) and *increasing help-seeking behavior* (6.4). Strategies least likely to be addressed are *addressing social determinants of health* (4.5), *providing immediate and long-term postvention* (5.2), and *enhancing life skills and resilience* (5.4).

Figure 3: BUILD – State Emphasis on Addressing High-Level Strategies
(N=42)



Developing Funding Necessary to Adequately Support a Comprehensive Approach

Respondents were asked to describe their state's progress toward developing the funding necessary to adequately support a comprehensive approach to suicide prevention that involves a variety of strategies across all levels of prevention. As shown in Table 31, comparatively few states (27%, 11 of 41) reported that their state has such funding in place (only 10% sustainably), while most are actively working on securing such funding (41%, 17 of 41) and approximately one-third have not advanced beyond planning (32%, 13 of 41).

Table 31: BUILD – State Progress toward Developing the Funding Necessary to Adequately Support a Comprehensive Approach to Suicide Prevention
(N=41)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	10%	4
Planning steps to get this in place	22%	9
Actively working to get this in place	41%	17
This is in place, but it is not yet sustainable	17%	7
This is sustainably in place	10%	4
	Total	41

Embedding Suicide Prevention Requirements into State-Funded Contracts

Almost half of states (49%, 20 of 41) reported that their state has embedded suicide prevention requirements into state-funded contracts (e.g., requiring community mental health centers receiving state dollars to screen for patient suicide risk, requiring staff of local mental health authorities receiving state funding to train providers in counseling on access to lethal means).

Social Determinants of Health

Respondents were asked to identify which of eight social determinants of health their state suicide prevention office or coalition is currently addressing and to identify other determinants of health they are addressing. As displayed in Table 32, 86% of respondents (36 of 42) indicated that their state is addressing at least one determinant, with adverse childhood experiences (ACEs) (62%, 26 of 42) most frequently addressed.

Table 32: BUILD – Social Determinants of Health Currently Being Addressed by State Suicide Prevention Office or Coalition
(N=42)

Multiple responses possible	Percent	Count
ACEs (Adverse Childhood Experiences)	62%	26
Education access and quality	33%	14
Financial/job security	19%	8
Food insecurity	14%	6
Housing insecurity	29%	12
Neighborhood and community environment	43%	18
Systemic discrimination	31%	13
Violence	45%	19
Other	7%	3
None of the above	14%	6

Core Elements of Effective Crisis Care

Respondents were asked to identify which of four core elements of effective crisis care are currently represented by their state's crisis infrastructure. As shown in Table 33, while almost all respondents (95%, 40 of 42) indicated that their state's crisis infrastructure currently includes a *24/7 regional or statewide crisis call center*, fewer identified representation of *24/7 mobile crisis outreach and support* (74%, 31 of 42), *residential crisis stabilization programs for individuals who need support and observation* (69%, 29 of 42), or *use of trauma-informed*

principles within crisis care (67%, 28 of 42). No states indicated that none of these core elements are currently represented in their state's crisis infrastructure.

Table 33: BUILD – Core Elements of Effective Crisis Care Currently Represented by State Crisis Infrastructure
(N=42)

Multiple responses possible	Percent	Count
Regional or statewide crisis call centers available on a 24/7 basis	95%	40
Mobile crisis outreach and support available on a 24/7 basis	74%	31
Residential crisis stabilization programs for individuals who need support and observation	69%	29
The use of trauma-informed principles within crisis care	67%	28
None of the above	0%	0

Coordinating Crisis Services

Respondents were asked to assess their state's progress toward coordinating services across statewide crisis call centers, mobile crisis outreach, and residential crisis stabilization programs (e.g., sharing data across crisis services, effectively connecting crisis call center clients with mobile crisis outreach, implementing protocols for referring clients from mobile crisis outreach to crisis stabilization programs). Just 26% of respondents (11 of 42) reported that their state had achieved such coordination (12% sustainably), while most are actively working toward (52%, 22 of 42) or planning (21%, 9 of 42) such coordination. See Table 34.

Table 34: BUILD – State Progress toward Coordinating Crisis Services
(N=42)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	0%	0
Planning steps to get this in place	21%	9
Actively working to get this in place	52%	22
This is in place, but it is not yet sustainable	14%	6
This is sustainably in place	12%	5
	Total	42

Support and Resources for Developing and Carrying Out Messaging on the 988 Crisis Line

Respondents were separately asked about the types of support from national partners and additional resources that would be most helpful to their efforts to develop and carry out messaging on the 988 Suicide & Crisis Lifeline. *Training and/or technical assistance to support states in developing cultural competence and equity in 988 messaging* was identified by 73% of respondents as a potentially helpful support from national partners (see Table 35) and 85% felt that *key messages that can be tailored and incorporated into state-level campaigns* would be a helpful resource (see Table 36).

Table 35: BUILD – Support from National Partners that Would Be Most Helpful in Developing and Carrying Out 988 Messaging
(N=41)

Multiple responses possible	Percent	Count
National calls/meetings of state suicide prevention leaders to share 988 messaging ideas	37%	15
Webinars or other online learning events on 988 messaging hot topics	44%	18
Creation of 988 messaging success stories from the field	24%	10
Training/technical assistance to support states in developing cultural competence and equity in 988 messaging	73%	30

Table 36: BUILD – Resources that Would Be Most Useful in Developing and Carrying Out 988 Messaging
(N=41)

Multiple responses possible	Percent	Count
Key messages that can be tailored and incorporated into state-level campaigns	85%	35
Branded style guides	29%	12
Useable graphics/images	63%	26
PowerPoint materials	22%	9
Policy briefs	12%	5
One-pagers	51%	21
Videos	17%	7

Targeted State-Level Prevention Strategies

Respondents were asked to detail which **specific** populations their state-level prevention strategies—programs, services, campaigns, and/or policies—are **designed to reach**. Acknowledging that many initiatives may reach multiple populations, whether intended or unintended, respondents were asked to only answer based on whether they have state-level prevention strategies **intentionally targeting** the populations listed. Almost all states reported having strategies intentionally targeting *age-based* populations (98%, 40 of 41), followed by *occupational* populations at high risk (93%, 38 of 41), *lived experience* populations (88%, 35 of 40), *location-based* populations (80%, 33 of 41), and *racial, ethnic, and other populations that are historically marginalized* (76%, 31 of 41). The most frequently targeted populations were *youth 10-17* (95%), *military/veterans* (93%), and *young adults 18-24* (88%). See Table 37.

Table 37: BUILD – Populations Specifically Targeted by Suicide Prevention Strategies

Multiple responses possible	Percent	Count
AGE-BASED POPULATIONS (N=41)		
Children Under 10	41%	17
Youth 10-17	95%	39
Young Adults 18-24	88%	36
Adults 25-44	71%	29
Middle-Aged Adults 45-64	76%	31
Older Adults 65+	63%	26
We do not currently have targeted state-level strategies for these populations	2%	1
LOCATION-BASED POPULATIONS (N=41)		
Rural Communities	78%	32
Suburban Communities	41%	17
Urban Communities	59%	24
We do not currently have targeted state-level strategies for these populations	20%	8
OCCUPATIONAL POPULATIONS AT HIGH RISK (N=41)		
Agricultural/Farming/Forestry Industry	54%	22
Construction Industry	41%	17
Emergency Response (firefighters, emergency medical services)	59%	24
Law Enforcement	56%	23
Detention/Correctional Staff	37%	15
Healthcare Professionals	61%	25
Military/Veteran	93%	38
Mining/Quarrying/Oil-Gas Extraction Industry	7%	3
Veterinarian Professionals	12%	5
We do not currently have targeted state-level strategies for these populations	7%	3
LIVED EXPERIENCE POPULATIONS (N=40)		
Impacted Families and Friends	68%	27
Individuals with Serious Mental Illness	58%	23
Suicide Attempt Survivors	73%	29
Suicide Loss Survivors	78%	31
Individuals with Substance Use Disorder	63%	25
We do not currently have targeted state-level strategies for these populations	13%	5
RACIAL, ETHNIC, AND OTHER POPULATIONS THAT ARE HISTORICALLY MARGINALIZED (N=41)		
Asian American	29%	12
Black/African American	44%	18
Indigenous/Native American	49%	20
Latin American	37%	15
Immigrant/Refugee population	29%	12
Individuals with Disabilities	34%	14
Individuals with Serious Physical Health Problems	24%	10
Lesbian, Gay, Bisexual	61%	25
Transgender	54%	22
We do not currently have targeted state-level strategies for these populations	24%	10

Involvement of Priority Populations in Suicide Prevention Activities

All respondents indicated that they involve members of populations they are trying to reach through targeted initiatives (priority populations) in suicide prevention activities. As shown in Table 38, the most common way priority populations were involved was through them *helping to identify unique community needs, challenges, and/or strengths* (83%, 34 of 41), followed by *providing ongoing feedback on activity practices, effectiveness, and/or opportunities for improvement* (66%, 27 of 41), *helping to implement targeted activities* (61%, 25 of 41), and *helping to choose prevention activities* (59%, 24 of 41). It was less common for priority populations to *provide ongoing feedback on policies being drafted or implemented* (39%, 16 of 41) or to *help collect, analyze, and/or evaluate data* (41%, 17 of 41).

Table 38: BUILD – Involvement of Priority Populations in Suicide Prevention Activities

(N=41)

Members of target populations… *(Multiple responses possible)*	Percent	Count
Help collect, analyze, and/or evaluate data	41%	17
Help to identify unique community needs, challenges, and/or strengths	83%	34
Help to choose prevention activities	59%	24
Provide ongoing feedback on activity practices, effectiveness, and/or opportunities for improvements	66%	27
Provide ongoing feedback on policies being drafted or implemented	39%	16
Help to implement targeted activities	61%	25
Other	7%	3
None of the above	0%	0

Barriers and Successes in the Past 12 Months – Strengthening the Build Element

Reaching and engaging centered groups and communities (10 comments) was the most frequently identified **barrier** to strengthening the Build element. Barriers clustered primarily around the themes of coordination of services and activities (coordinating crisis services, lack of coordination within/between state and local levels, lack of a designated lead suicide prevention agency/coalition), staffing (strained capacity, insufficient levels, workforce turnover), engaging groups and communities, and funding (none/insufficient, unstable/time-limited/grant-based, lack of dedicated funding for staff) (see Table 39).

Table 39: BUILD – Barriers to Strengthening the Build Element
(N=34)

Coordination of Services and Activities (13 related comments)	
7	Challenging to coordinate crisis services
4	Lack of coordination within and between state and local levels
2	No designated lead suicide prevention agency/coalition
Staffing (11 related comments)	
8	Strained staff capacity
2	Insufficient staffing levels
1	Workforce crisis (turnover)
Engaging Groups and Communities (10 related comments)	
10	Reaching and engaging centered groups and communities
Funding (9 related comments)	
5	No or insufficient funding
3	Unstable, time-limited, grant-based funding
1	Lack of dedicated funding for staff
COVID-19 (4 related comments)	
4	Impact of COVID-19 pandemic
Data and Accountability (4 related comments)	
4	Lack of data for planning and evaluation
Implementing a Comprehensive Approach (3 related comments)	
3	Not able to implement a comprehensive approach to suicide prevention
Other Comments	
3	No barriers present
1	Competing priorities (over-emphasis on 988)
1	Difficulty contracting with community partners
1	Ensuring equitable access to materials and services (culture, geography)

Direct and indirect outreach and engagement of centered groups and communities and *planning and preparation for the rollout of the national 988 mental health crisis and suicide prevention services lifeline* (7 comments each) were the most frequently identified successes in strengthening the Build element. Successes were largely associated with the existence of a *strong suicide prevention network* (presence of task forces/coalitions/councils, emphasis on workforce development, partnerships), *coordination, communication, and visibility* (collaboration within/between state and local agencies/entities, heightened awareness and momentum, visible efforts), *engagement with centered groups and communities* (direct/indirect outreach and engagement, data-driven strategic planning and evaluation support), and *enhanced implementation* (targeted initiatives, comprehensive/lifespan-focused approach) (see Table 40).

Table 40: BUILD – Successes in Strengthening the Build Element
(N=34)

Strong Suicide Prevention Network (11 related comments)	
5	Presence of governor's task force, state suicide prevention coalition, advisory councils
3	Emphasis on workforce development, capacity building, and training
3	Establishing and strengthening partnerships
Coordination, Communication, and Visibility (9 related comments)	
3	Collaboration within and between state and local agencies and entities
3	Heightened awareness and momentum
3	Visible efforts (communications campaigns, Governor's Challenge)
Engagement with Centered Groups and Communities (9 related comments)	
7	Direct and indirect outreach and engagement
2	Data-driven strategic planning and evaluation support
Enhanced Implementation (8 related comments)	
6	Implementation of targeted initiatives
2	Implementation of a comprehensive, lifespan-focused approach
Enhanced Infrastructure/Coordination in Crisis Services (7 related comments)	
7	Planning and preparation for 988 rollout
Enhanced Surveillance and Data Infrastructure (2 related comments)	
2	Data-informed planning and implementation
Funding (2 related comments)	
2	Braided/flexible funding to support local efforts
Staffing (2 related comments)	
2	Diverse, representative, and experienced staff

Infrastructure Element #6 – GUIDE

Guide (progress score of 18 out of a possible 25) was a middle-rated infrastructure element, with a 70% progress rate.

Formally Assessing State's Regional and/or Community Suicide Prevention Needs

Respondents were asked to assess their state's progress toward formally assessing the state's regional and/or community suicide prevention needs (e.g., analyzing and comparing regional/community data, conducting community needs assessments). As displayed in Table 41, progress varied considerably, with just over one-third of respondents (37%, 15 of 41) reporting that their state was formally assessing prevention needs (17% sustainably). The same percentage was actively working to get a process for assessing community needs in place (37%, 15 of 41). Just over a quarter (27%, 11 of 41) had not advanced past planning steps to begin assessing community needs.

Table 41: GUIDE – State Progress toward Formally Assessing Regional and/or Community Suicide Prevention Needs
(N=41)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	5%	2
Planning steps to get this in place	22%	9
Actively working to get this in place	37%	15
This is in place, but it is not yet sustainable	20%	8
This is sustainably in place	17%	7
	Total	41

Allocating Funding and Resources Necessary to Guide Evidence-Informed Programming S

As shown in Table 42, progress toward allocating the funding and resources necessary (e.g., through education, training, policy support, funding disbursements) to guide state, county, and local groups in implementing evidence-informed suicide prevention programming was also mixed, with 44% of respondents (18 of 41) reporting that their state has allocated such support (20% indicating that it is sustainable), 34% (14 of 41) actively working to get it in place, and 22% (9 of 41) having not advanced past planning.

Table 42: GUIDE – State Progress toward Allocating Funding and Resources Necessary to Guide State, County, and Local Groups in Implementing Evidence-Informed Suicide Prevention Programming
(N=41)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	12%	5
Planning steps to get this in place	10%	4
Actively working to get this in place	34%	14
This is in place, but it is not yet sustainable	24%	10
This is sustainably in place	20%	8
	Total	41

Local-Level Suicide Prevention Coalition Establishment S and Structure

Most states (83%, 34 of 41) have local-level (community, county, and/or regional) suicide prevention coalitions. Of the 34 states with local-level coalitions, 47% (16 of 34) reported that the coalitions are formed independently of the state but can choose to sign up for and use state-supported trainings, resources, and/or funding opportunities, 26% (9 of 34) that they are formed independently and do not receive any direct guidance, leadership, or funding from the state, and 6% (2 of 34) that they are formed as a result of state-level bylaws, policies, or mandates, and receive direct guidance, leadership, and/or funding from the state. The remaining 21% (7 of 34) reported some other structure.

Community Sectors Actively Supported by the State

Table 43 displays the community sectors that states reported actively supporting in implementing evidence-based suicide prevention programs, practices, or policies. Almost all states reported supporting *K-12 Schools* (93%, 38 of 41) and *healthcare and mental healthcare* (90%, 37 of 41), while other frequently supported sectors included *military/veteran bases or organizations* (83%, 34 of 41), *local crisis centers* (71%, 29 of 41), *higher education*

(68%, 28 of 41), and *first responder agencies (fire, EMS, law enforcement)* or *private sector* entities *(local nonprofits, organizations, and/or businesses)* (61%, 25 of 41 each). One-fifth or fewer states reported supporting *job and unemployment services* (20%, 8 of 41), *assisted living/retirement facilities* (17%, 7 of 41), *local organizations serving minority populations* (15%, 6 of 41), *transportation* (15%, 6 of 41), and *housing authorities/housing assistance agencies* (12%, 5 of 41).

Table 43: GUIDE – Community Sectors Actively Supported by States in Implementing Evidence-Based Suicide Prevention Efforts

(N=41)

Multiple responses possible	Percent	Count
Assisted Living / Retirement Facilities	17%	7
Child and Family Services	51%	21
Correction and Rehabilitation	46%	19
Faith-based Institutions	46%	19
First Responder Agencies (fire, EMS, law enforcement)	61%	25
Healthcare and Mental Healthcare	90%	37
Higher Education	68%	28
Housing Authorities / Housing Assistance Agencies	12%	5
Job and Unemployment Services	20%	8
K-12 Schools	93%	38
Lived Experience Groups/Organizations (e.g., suicide loss survivor groups, suicide attempt survivor groups, Local Outreach of Suicide Survivor Teams)	51%	21
Local Crisis Centers	71%	29
Local Government Agencies	51%	21
Private sector (local non-profits, organizations, and/or businesses)	61%	25
Public Health Departments	54%	22
Military/Veteran Bases or Organizations	83%	34
Media Organizations	24%	10
Social Services	51%	21
Substance Abuse Services	54%	22
Transportation	15%	6
Tribal Governments or Agencies	27%	11
Local organizations serving minority populations	15%	6
Others who represent key sectors in local communities	12%	5
None of the above	0%	0

Support Provided to Communities at Least Annually

As shown in Table 44, the most common types of support identified as being provided by states to communities at least annually were *ongoing technical assistance* (93%, 38 of 41), *statewide trainings/conferences* (85%, 35 of 41), both *guidance on best practices* and *providing state-level data* (83%, 34 of 41), and *local/regional trainings* (80%, 33 of 41). Fewer states were *providing local/regional-level data back to communities* (68%, 28 of 41), *disseminating news* (61%, 25 of 41), and both *providing funding opportunities* and *providing guidance on strategic planning* (56%, 23 of 41).

Table 44: GUIDE – Support Provided to Communities at Least Annually
(N=41)

Multiple responses possible	Percent	Count
Disseminating state and national news to communities	61%	25
Offering local or regional trainings	80%	33
Offering statewide trainings or conferences	85%	35
Providing funding opportunities (e.g., mini-grants, RFPs, scholarships)	56%	23
Providing guidance on best practices in suicide prevention	83%	34
Providing guidance on strategic planning	56%	23
Providing local/regional-level data back to communities	68%	28
Providing state-level data to communities	83%	34
Providing ongoing technical assistance (e.g., answering questions, directing communities to available resources)	93%	38
None of the above	0%	0

Community-Level Prevention Strategies

The high-level suicide prevention strategies most frequently implemented by communities are *identifying and assisting persons at risk of suicide* (68%, 28 of 41), *responding effectively to individuals in crisis* (44%, 18 of 41), *reducing access to means of suicide* (39%, 16 of 41), and *ensuring access to effective mental health and suicide care and treatment* (37%, 15 of 41). Far fewer states (10%, 4 of 41) reported community efforts to *enhance life skills and resilience*, while only 2% (1 of 41) *address social determinants of health* (see Table 45).

Table 45: GUIDE – High-Level Suicide Prevention Strategies Most Frequently Implemented by Communities
(N=41)

Multiple responses possible	Percent	Count
Identify and assist persons at risk of suicide	68%	28
Increase help-seeking behavior	20%	8
Ensure access to effective mental health and suicide care and treatment	37%	15
Support safe care transitions and create organizational linkages	22%	9
Respond effectively to individuals in crisis	44%	18
Provide immediate and long-term postvention	20%	8
Reduce access to means of suicide	39%	16
Enhance life skills and resilience	10%	4
Promote social connectedness and support	24%	10
Address social determinants of health (e.g., housing insecurity, job insecurity, adverse childhood experiences (ACEs)]	2%	1
None of the above	2%	1

Tracking Trainings Meeting State Requirements or Recommendations

Over three-quarters of states (78%, 32 of 41) identify and maintain an updated list of available trainings that meet state requirements or recommendations specific to suicide prevention (e.g., trainings that can be used to meet state K-12 suicide prevention training requirements).

Barriers and Successes in the Past 12 Months – Strengthening the Guide Element

Insufficient staffing levels and *no or limited funding and/or resources for local efforts* (6 comments each) were the most frequently identified **barriers** to strengthening the Guide element. Barriers clustered primarily around the themes of staffing (insufficient levels, strained capacity, workforce turnover) and funding (no or limited funding/resources for local efforts, no or insufficient funding overall) (see Table 46).

Table 46: GUIDE – Barriers to Strengthening the Guide Element
(N=35)

Staffing (13 related comments)	
6	Insufficient staffing levels
4	Strained staff capacity
3	Workforce crisis (turnover)
Funding (11 related comments)	
6	No or limited funding/resources for local efforts
5	No or insufficient funding
Assessment (5 related comments)	
5	Assessing community needs
Coordination of Services and Activities (5 related comments)	
3	Lack of coordination within and between state and local levels
2	No or limited local suicide prevention infrastructure (coalitions)
Engaging Groups and Communities (3 related comments)	
3	Reaching and engaging centered groups and communities
Implementing a Comprehensive Approach (3 related comments)	
3	Not able to implement a comprehensive approach to suicide prevention
2	Lack of a guiding plan or leader for suicide prevention
Priorities (2 related comments)	
2	Competing priorities
Other Comments	
4	No barriers present
1	Lack of data for planning and evaluation

The provision of *education and assistance to communities and organizations* (14 comments) and *collaboration within and between state and local agencies and entities* (10) were the most frequently identified successes in strengthening the Guide element. Successes were largely associated with training/technical assistance and coordination/communication/visibility (see Table 47).

Table 47: GUIDE – Successes in Strengthening the Guide Element
(N=35)

Training and Technical Assistance (14 related comments)	
14	Education and assistance to communities and organizations
Coordination, Communication, and Visibility (13 related comments)	
10	Collaboration within and between state and local agencies and entities
2	Visible efforts (communications campaigns, Governor's Challenge)
1	Heightened awareness and momentum (988 rollout)
Strong Suicide Prevention Network (9 related comments)	
6	Presence of governor's task force, state suicide prevention coalition, advisory councils
3	Establishing and strengthening partnerships, community engagement
Funding (6 related comments)	
3	Suicide prevention positions/programming included in state budget
3	Discretionary funding (Zero Suicide, COVID-19 supplement, GLS)
Enhanced Implementation (4 related comments)	
3	Implementation of targeted initiatives (youth screening)
1	Implementation of a comprehensive, lifespan-focused approach
Enhanced Surveillance and Data Infrastructure (4 related comments)	
3	Data sharing between state and local levels
1	Suicide mortality review
Leadership and Administration Support (2 related comments)	
2	Political will/support
Other Comments	
1	Expanded suicide prevention staffing

Using the Infrastructure Recommendations

Respondents were asked a set of questions about their experiences with SPRC's Infrastructure Recommendations.

- **Familiarity with the Infrastructure Recommendations**: Seventy-eight percent (78%, 32 of 41) of respondents were either "very familiar" (56%) or "extremely familiar" (22%) with the recommendations; 22% (9 of 41) were "somewhat familiar" with them. No respondents were “not very familiar” or “not at all familiar” with the recommendations.
- **Use of the Infrastructure Recommendations and/or Related Tools:** The majority of respondents (59%, 24 of 41) indicated that they had used the recommendations or any of the related tools (e.g., the *Getting Started Guide for State Suicide Prevention Infrastructure*, *Recommendations for State Suicide Prevention Infrastructure: Essential Elements Assessment Tool*).

  The 24 respondents who reported using the recommendations or related tools were asked to describe how they had used the tools both **individually** to guide state infrastructure development and **as a state suicide prevention team**. On an **individual** level, all respondents reported using the tools, most frequently to *guide their personal thinking and decision-making in infrastructure development* (88%, 21 of 24), *forward or distribute the tools to partners* (75%, 18 of 24), and *inform their discussions with state decision-makers or*

advocacy leaders (71%, 17 of 24) (see Table 48). All but one respondent reported using the tools at the **state suicide prevention team** level, most frequently to *guide state thinking and decision-making in infrastructure development* (71%, 17 of 24) (see Table 49).

Table 48: Individual Use of the Infrastructure Recommendation Tools to Guide State Infrastructure Development
(N=24)

Multiple responses possible	Percent	Count
I have used the tools on my own to guide my thinking and decision-making in infrastructure development	88%	21
I have used the tools to help me prepare for/speak with state decision-makers or advocacy leaders	71%	17
I have forwarded or distributed the tools to partners	75%	18
I have inserted the tools into my own presentations	33%	8
Other	8%	2
None of the above	0%	0

Table 49: State Prevention Team Use of the Infrastructure Recommendation Tools to Guide State Infrastructure Development
(N=24)

Multiple responses possible	Percent	Count
We have used the tools within our **state office of suicide prevention (or equivalent agency)** to guide our thinking and decision-making in infrastructure development	71%	17
We have used the tools within our **state suicide prevention coalition** to guide our thinking and decision-making in infrastructure development	46%	11
We have used the tools with **external partner(s) outside of a state coalition** to guide our thinking and decision-making in infrastructure development	29%	7
We have used the tools to provide guidance in supporting local, community-level efforts	42%	10
We have used the tools to model our state efforts on other states' infrastructure examples/successes	38%	9
Other	8%	2
None of the above	4%	1

- **Additional Supports for Infrastructure Development:** Respondents were asked to identify any support, tools, or resources their state needs to continue making progress in infrastructure development. As shown in Table 50, many states felt that they did not necessarily need new opportunities but instead needed to access existing supports. However, new, and enhanced resource ideas were identified by multiple respondents, including *topic-specific assistance (e.g., advocacy and state funding models, postvention, integrating cultural competence and lived experience)* (15 comments), *state-to-state peer networking and learning* (4 comments), *identification of funding opportunities* (3 comments), and *succinct summaries (e.g., research reviews, literature reviews, single-page briefs)* (3 comments).

Table 50: Support for Continuing Progress in Infrastructure Development
(N=31)

No Additional Tools or Resources/Continued Support (15 related comments)	
8	None needed at this time, state needs to use existing resources
7	Continued support, tools, and technical assistance
Topic-Specific Assistance (15 related comments)	
4	Advocacy and state funding models
3	Postvention
2	Integrating cultural competence and lived experience
1	Building and maintaining coalitions/partnerships
1	Coordinating suicide prevention and crisis services
1	Engagement with populations at high risk
1	Evaluating existing state infrastructure
1	Overview of state, county, and local levels and the roles each can play
1	Tribal engagement
Peer Networking and Learning (4 related comments)	
4	State-to-state sharing and learning opportunities
Funding Opportunities (3 related comments)	
3	Identification of funding opportunities
Succinct Summaries (3 related comments)	
2	Consolidated research summaries and literature reviews
1	Single page briefs with supporting hyperlinks
Other Comments	
1	Lists of free training opportunities

Conclusion

Thank you to everyone who contributed to the 2022 SNA. The information in this report will help SPRC support states and territories in the development of suicide prevention infrastructure. For more information on developing state suicide prevention infrastructure in your state or territory visit https://sprc.org/state-infrastructure.