2021 State and Territorial Needs Assessment

Call to Action and Summary of Priority Areas

BACKGROUND

Suicide is the 10th leading cause of death in the United States, with steady increases in the suicide rate from 2000 to 2018. While slight decreases were noted in the overall U.S. suicide death rate in 2019, the U.S. rate remains at 13.93/100,000 individuals, substantially above the 2000 rate of 10.4/100,000. Recent increases have been observed in many subpopulations, including African American, indigenous, youth, adult male, and rural populations.[1]

The Suicide Prevention Resource Center (SPRC), with its partner Social Science Research and Evaluation (SSRE), conducted the first annual State and Territorial Needs Assessment (SNA) in Summer 2021 to assess the suicide prevention needs, challenges, strengths, infrastructure, and capacity of U.S. states and territories.

Based on the SNA results, SPRC has identified four priority areas to strengthen suicide prevention efforts in the United States, including calls to action for your state or territory.

State and Territorial Leaders Call to Action

1. Invest in the development of state and territorial funding and capacity for suicide prevention
2. Increase formal leadership and partnerships supporting suicide prevention
3. Develop state and territory-wide community representation and participation in suicide prevention
4. Strengthen state and territorial data systems and evaluation processes in suicide prevention

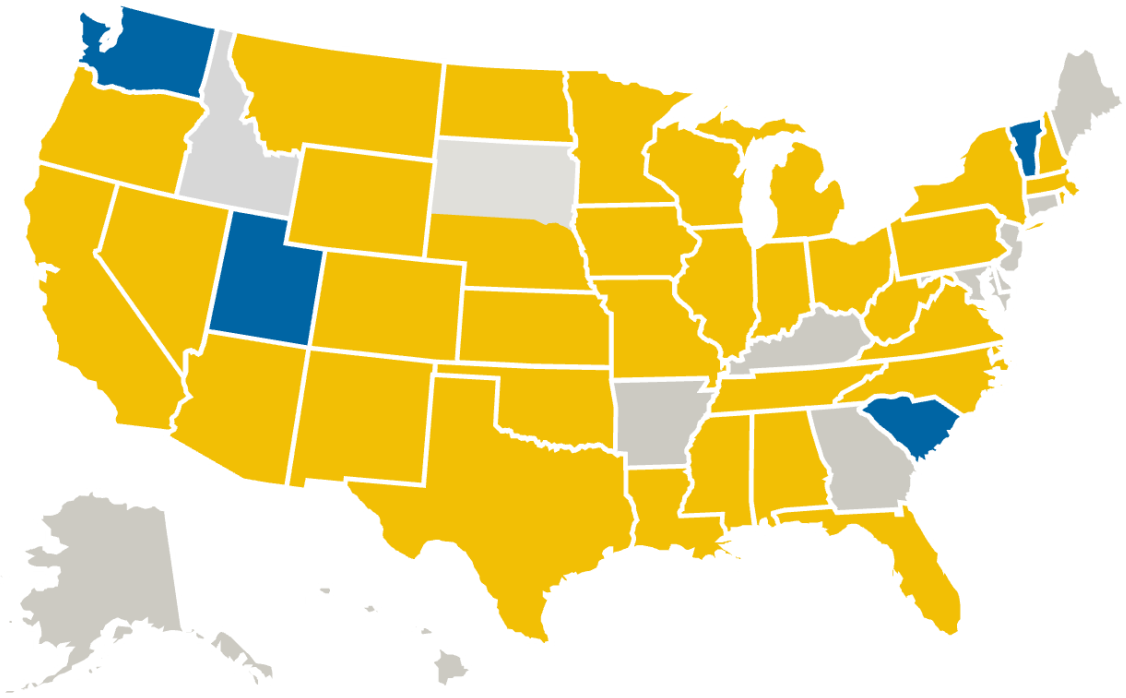
Suicide Prevention Champions Call to Action

1. Read the full SNA report to identify national areas of need and success: ow.ly/OcuU50H5Lap
2. Coordinate with your state or territory's suicide prevention agency(ies) to learn about your unique needs and strengths in suicide prevention: sprc.org/states
3. Use SPRC's suicide prevention infrastructure microsite to guide the development of infrastructure in your state or territory: sprc.org/state-infrastructure
4. Call on your state or territory leaders to support the development of sustainable suicide prevention infrastructure: ow.ly/o24O50H5L7X

SNA Participation

The SNA was sent to designated suicide prevention contacts in all 50 U.S. states, the District of Columbia, and 3 U.S. Territories (Guam, Northern Mariana Islands, and Puerto Rico). Responses were received from 38 states and 2 territories (74% of those invited). Representatives were encouraged to consult with their colleagues before submitting their survey responses. Only one survey response was submitted per state/territory (see map below).

2021 PARTICIPATION MAP



Map Key:

- Yellow = states with completed surveys
- Blue = states with partially completed surveys
- Gray = states that did not complete surveys
- **Symbols** = territories with completed surveys

Participating Territories

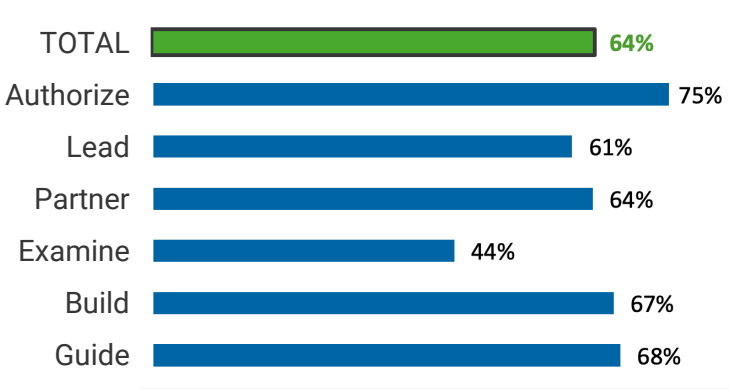
Northern Mariana Islands

Guam

National Suicide Prevention Infrastructure Progress

SPRC's State Suicide Prevention Infrastructure Recommendations provides six essential elements for effective suicide prevention: Authorize, Lead, Partner, Examine, Build, and Guide. Respondents were asked a series of scored questions in the survey to assess their progress in achieving the essential elements. Progress score results are shown in Figure 1. Nationally, U.S. states and territories have achieved a 64% progress rate across all six essential elements. Read the full SNA report for additional details on the scoring method and national progress within each essential element.

FIGURE 1: State/Territorial Progress in Achieving the Six Essential Elements (N=36)



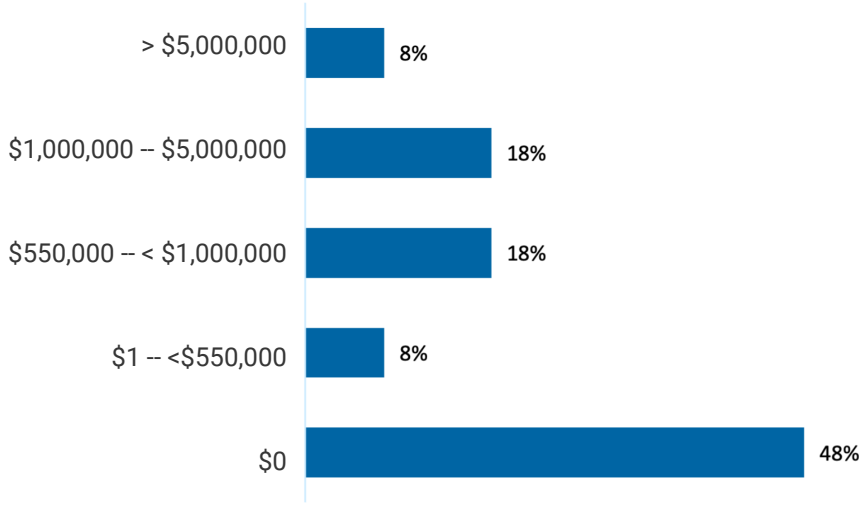
NATIONAL NEEDS IN DEVELOPING EFFECTIVE SUICIDE PREVENTION

All respondents completed a series of quantitative and qualitative questions related to their challenges, strengths, needs, and successes across the six essential elements. Data representing priorities for suicide prevention infrastructure development are presented below.

Priority Area 1: Develop designated funding and capacity for suicide prevention

State and territory funding for suicide prevention is limited, with 48% of states and territories (19) lacking any designated budget line items for suicide prevention. Fifty percent of those with designated suicide prevention funding (10 of 20) have annual budgets under $1,000,000, and 35% of those with designated funding (7) share that this is not yet sustainable. The dollar value of designated funding for suicide prevention is shown in Figure 2.

Figure 2: Value of State/Territorial Suicide Prevention Budget Line Items (N=39)

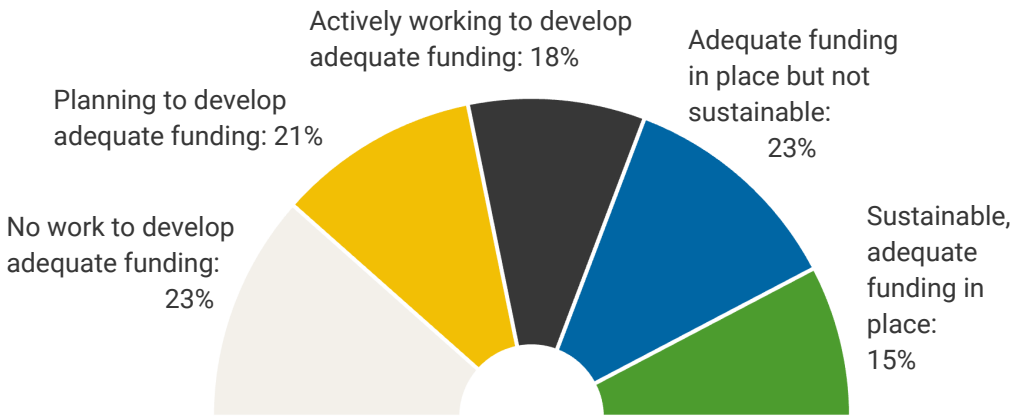


[There is a] lack of infrastructure . . . and stability . . . at state agencies due to dependency of positions on a certain grant and no guarantee of a job beyond life of grant.

States and territories described a heavy reliance on short-term grants to ensure administrative and staff needs were met, with 62% (24) reporting insufficient funding to adequately support the administration and technology necessary to support their suicide prevention efforts (Figure 3). Only 41% of states and territories (16 of 39) reported supporting suicide prevention efforts with formally funded partnerships that address shared risk and protective factors.

Eighty-seven percent of states and territories (34 of 39) reported having a suicide prevention coordinator (or similar position) in place while 36% (14) did not fund any additional staff positions. States and territories described inconsistent funding sources restricting their abilities to hire, retain, and invest in staff capacity. Limitations in staff funding were seen as inhibiting abilities to carry out suicide prevention efforts.

Figure 3: State/Territorial Progress toward Adequately Funding Suicide Prevention Administration and Technology (N=39)



To strengthen suicide prevention, funding for staff positions and capacity development must be prioritized.

Priority Area 2: Grow partner and leader support for suicide prevention

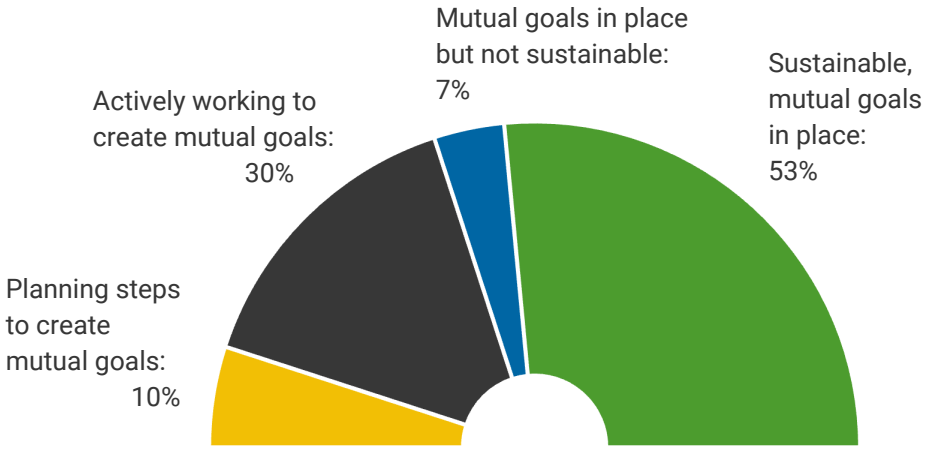
Seventy-seven percent (30 out of 39) of states and territories reported having a state- or territory-wide suicide prevention coalition bringing together public and private sector partners to guide suicide prevention efforts. However, only 53% of states or territories with coalitions (16) reported having mutual goals sustainably guiding these joint prevention efforts (Figure 4). Conflicting priorities, competing interests over funding sources, and a lack of overall coordination between key prevention stakeholders limit coalitions' abilities to share data and resources and implement a comprehensive approach to suicide prevention.

Eighty-nine percent (34 of 38) of states and territories shared that their suicide prevention plans promote a comprehensive approach to suicide prevention. But a lack of formal leader support to invest in long-term prevention efforts hampered efforts to implement the prevention strategies necessary for that approach. Ten states specifically described challenges in gaining buy-in from state legislatures.

[A challenge is] decision-makers wanting easy quick fixes rather than investment in sustainable, long-term community efforts.

[Visit sprc.org for more information on a Comprehensive Approach.]

Figure 4: State/Territorial Progress toward Setting Mutual Coalition Goals (N=30)



Everyone has their priority issue, and we can't do everything . . . . [We are] working to get buy-in on a collective impact model.

* **To increase reach and strategy implementation necessary to effectively prevent suicide, steps must be taken to formalize partnerships dedicated to suicide prevention and ensure full leadership investment in comprehensive, long-term prevention.**

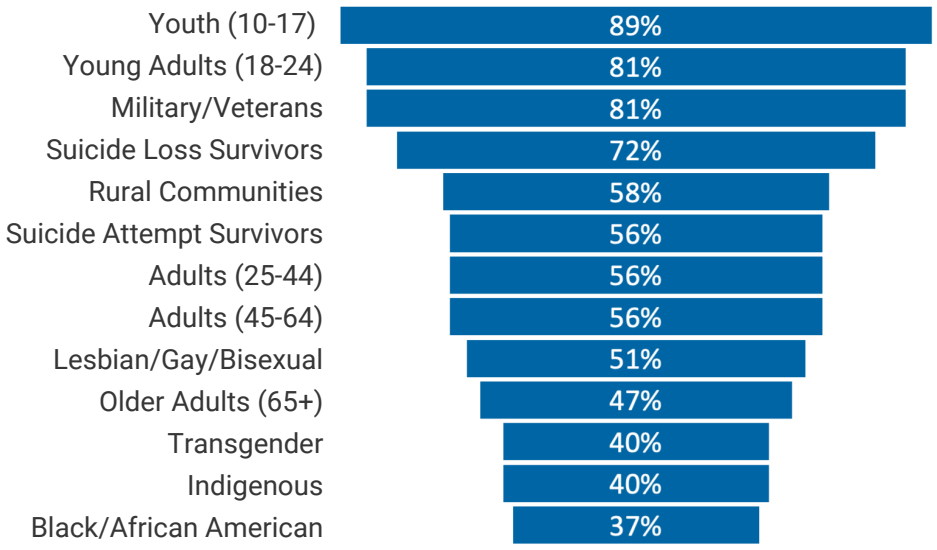
Priority Area 3: Increase community representation and participation in suicide prevention

Forty-five percent of states and territories (17 of 38) reported that they were actively working to increase data representation. But only 16% of states and territories (6) reported that populations that are high risk and underserved were sufficiently represented in the data informing their suicide prevention efforts.

States and territories were asked to identify which populations they were intentionally trying to reach through state-level suicide prevention strategies. Some populations known to be at high risk for suicide were being consistently reached. However, other populations at growing or long-term high risk for suicide were not being consistently reached (Figure 5).

Visit the full SNA report for information on all populations being reached by states and territories.

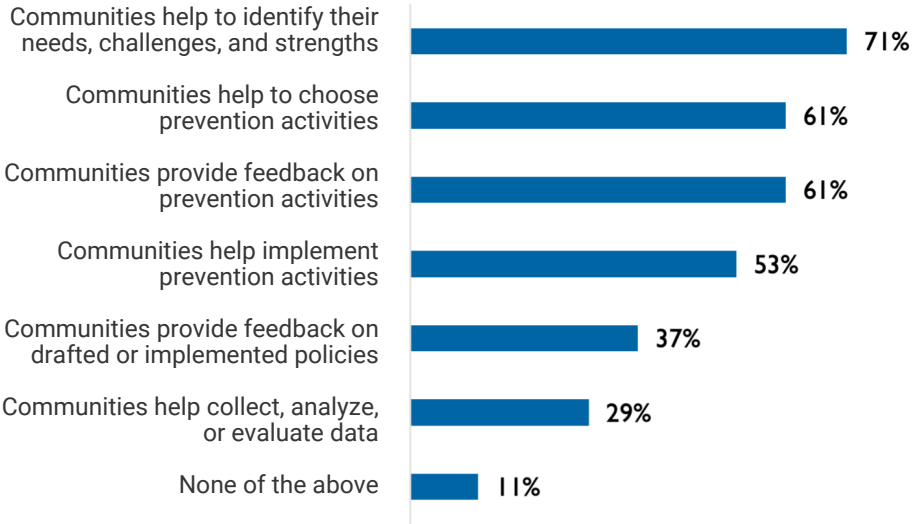
Figure 5: Percent of States/Territories Reaching Select Populations with Targeted Efforts (N=36)



[A challenge is] having a coordinated strategy for involving people from diverse backgrounds; no infrastructure for community driven prevention efforts.

States and territories showed active steps to ensure populations they were seeking to reach were actively involved in prevention efforts. Seventy-one percent (27) reported including representatives of populations they were seeking to reach in the identification of state and territorial needs. However, states and territories were much less likely to involve these populations in the collection or analysis of data to inform prevention (29%) or to inform the development and implementation of suicide prevention-related policies (37%) (Figure 6).

Figure 6: Percent of States/Territories Involving Populations in Activities (N=38)



[A challenge is] doing a better job understanding the needs of different communities and how they approach suicide prevention . . . seems like some communities do not feel engaged with our current plan . . .

In order to strengthen the reach and effectiveness of prevention strategies across the U.S., states and territories should build processes and practices that address data representation gaps and strengthen opportunities for diverse population representation in all suicide prevention activities.

Priority Area 4: Strengthen suicide prevention data systems and evaluation processes

States and territories described significant challenges around accessing and using suicide-related data. Only 45% (17) reported having a sustainable state- or territory-wide data system for collecting and analyzing suicide death data, and only 30% (11) reported successfully linking different data systems together to inform prevention efforts (such as linking state mental health data with death record data) (Figures 7 and 8).

Figure 7: State/Territorial Progress toward Establishing Data Systems (N=38)

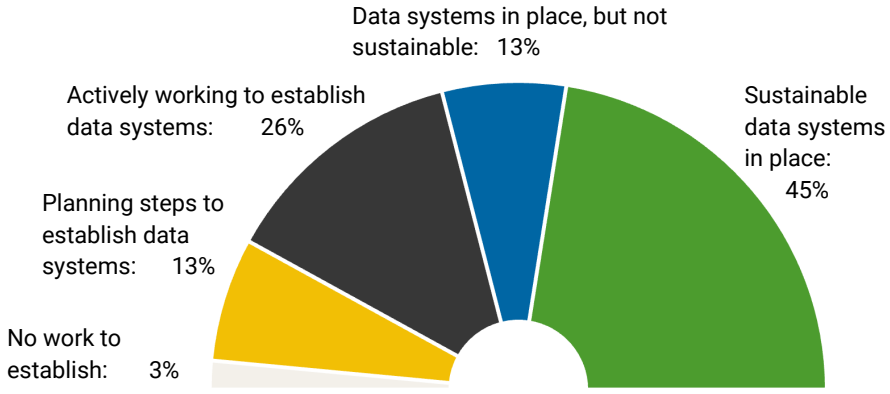
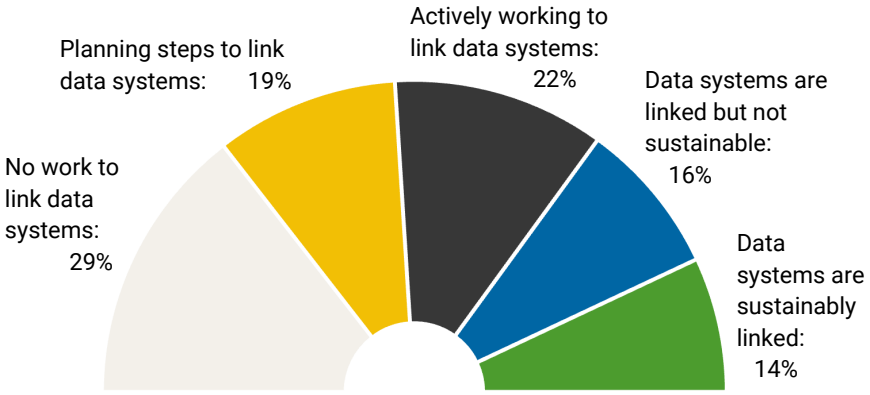


Figure 8: State/Territorial Progress in Linking Suicide-Related Data Systems (N=37)



. . . honestly the biggest barrier is capacity and staff time. We don't have the staff (or funding to support staff) to do the technical work involved in linking data across systems and ensuring accurate data sets. This takes a lot of work and time to do correctly.

States and territories were asked what types of suicide prevention evaluation activities they had conducted in the past year. Only 46% (17 of 37) were conducting evaluations to identify whether they were achieving state- and territorial-level suicide prevention goals and/or impacting suicide prevention rates, leaving 54% (20) without data to demonstrate the outcomes of their investments in suicide prevention strategies. Data and evaluations are key to understanding the effectiveness of prevention strategies, gathering support for initiatives, and improving efforts over time.

To strengthen overall suicide prevention efforts, significant investment must be made to improve existing data sources, develop new data sources, and increase suicide prevention staff and/or partner capacity in conducting evaluations across all U.S. states.

To learn how you can support the development of suicide prevention infrastructure in your state, visit SPRC's *Recommendations for State Suicide Prevention Infrastructure* (sprc.org/state-infrastructure) and state suicide prevention pages (sprc.org/states).

CITATION

1: NCHS Vital Statistics System for numbers of deaths.1999 - 2019, United States Suicide Injury Deaths and Rates per 100,000 All Races, Both Sexes, All Ages. ICD-10 Codes: X60-X84, Y87.0,*U03 Bureau of Census for population estimates. National Center for Injury Prevention and Control, CDC (2021).