SPRC 2023 State and Territorial Suicide Prevention Needs Assessment

Aggregate Technical Report

SUBMITTED TO:
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Acknowledgements

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 2023 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 2023 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 12 and May 31, 2023, the Suicide Prevention Resource Center (SPRC) and its partner, Social Science Research and Evaluation, Inc. (SSRE), conducted the 2023 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 three 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 allowed 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 Infrastructure Recommendations. Throughout the assessment, respondents were asked to assess the presence of each recommendation in their state according to the level of work currently taking place and its sustainability. Respondents were also given the opportunity to detail their 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. Respondents could complete the assessment all at once or submit partial answers and return to complete it later. The assessment could be completed either by one designated individual or by a team working together and submitting a single formal response. Representatives were strongly encouraged to gather input from fellow suicide prevention staff, state suicide prevention coalition members, and other key partners to inform their response.

Fifty (50) of the 54 invited state representatives responded and agreed to participate in the SNA (93% response rate). One response was disqualified due to incomplete data. The final analytic sample consisted of 49 completed responses out of 54 potential respondents (91% 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 currently taking place and its sustainability. Responses to select items were scored using either a 4-point rubric scale, which ranged from a low of 0 (no presence of the element) to a high of 4 (indicating a high presence of the element), or on a summative basis in which the existence of a particular element scored 1 point. Summary scores were computed for each element, and overall across elements, for the 49 states that answered all scored items. The maximum potential scores were 165 across all elements and 24 for Authorize, 24 for Lead, 24 for Partner, 20 for Examine, 48 for Build, and 25 for Guide. Progress rates were also computed, ranging from 0% (no recommendations in place) to 100% (all recommendations in place with sustainable infrastructure).

Individual elements had different maximum scores and rates due to the different number of questions used to assess each element. The Build section had the highest potential score because it contained multiple questions 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 *Suicide Prevention Resource for Action*.

Table 1 below and Figure 1 on the following page display the 2023 progress scores and rates both overall (TOTAL SCORE) and for each of the six essential elements, for all 49 states that completed all scored items. On average, states achieved a total infrastructure progress rate of 71% (progress score of 117 out of a possible 165). In descending order, infrastructure element progress rates were: Build–80%, Authorize–72%, Lead–71%, Guide–71%, Partner–64%, and Examine–57%.

Table 1: 2023 National Infrastructure Total and Element Progress Scores and Rates

(N=49)

Infrastructure Element	Potential Score Range	Progress Score[(a)]	Progress Rate
Authorize	0-24	17	72%
Lead	0-24	17	71%
Partner	0-24	15	64%
Examine	0-20	11	57%
Build	0-48	38	80%
Guide	0-25	18	71%
TOTAL 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: 2023 National Infrastructure Total and Element Progress Scores and Rates
(N=49)

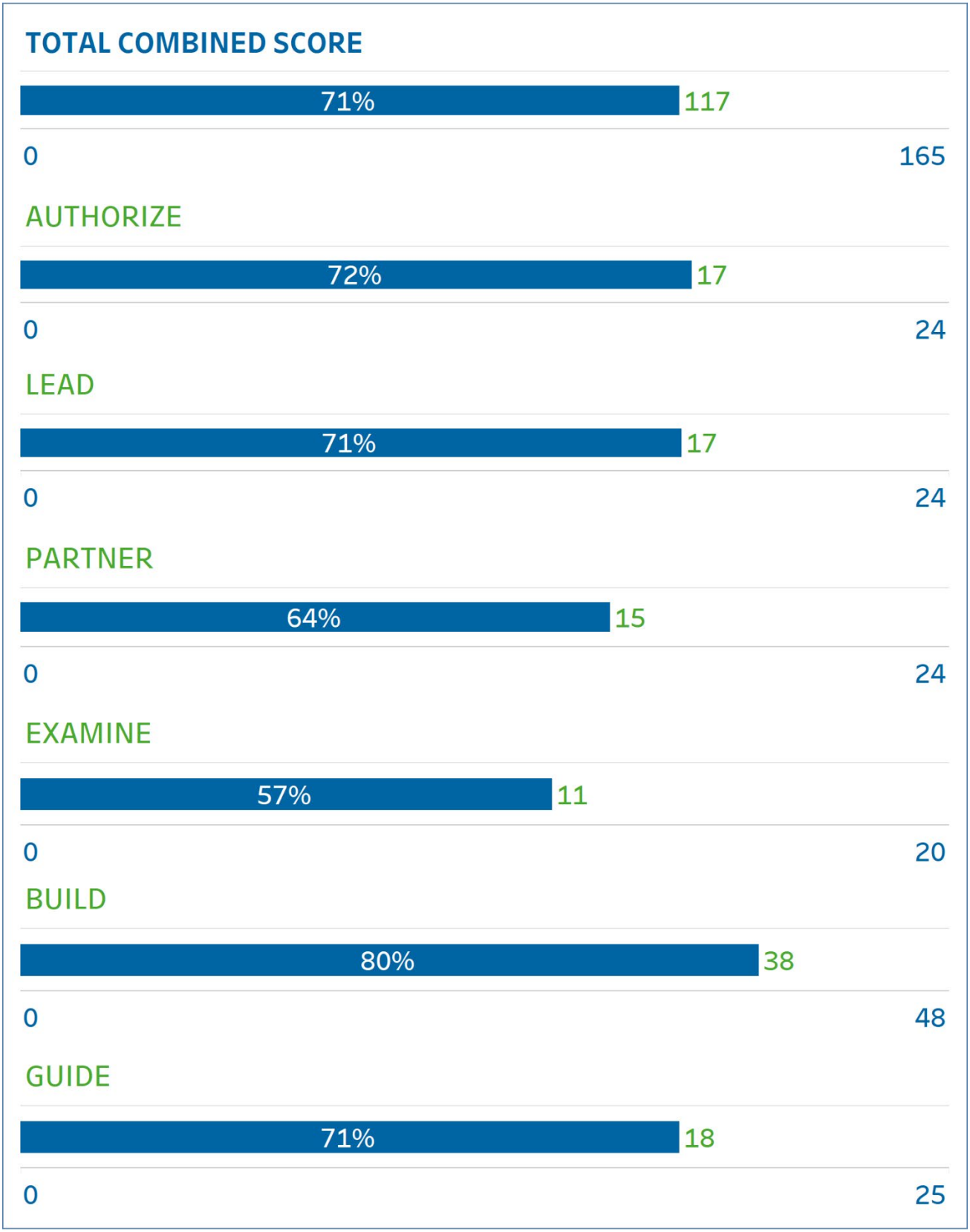
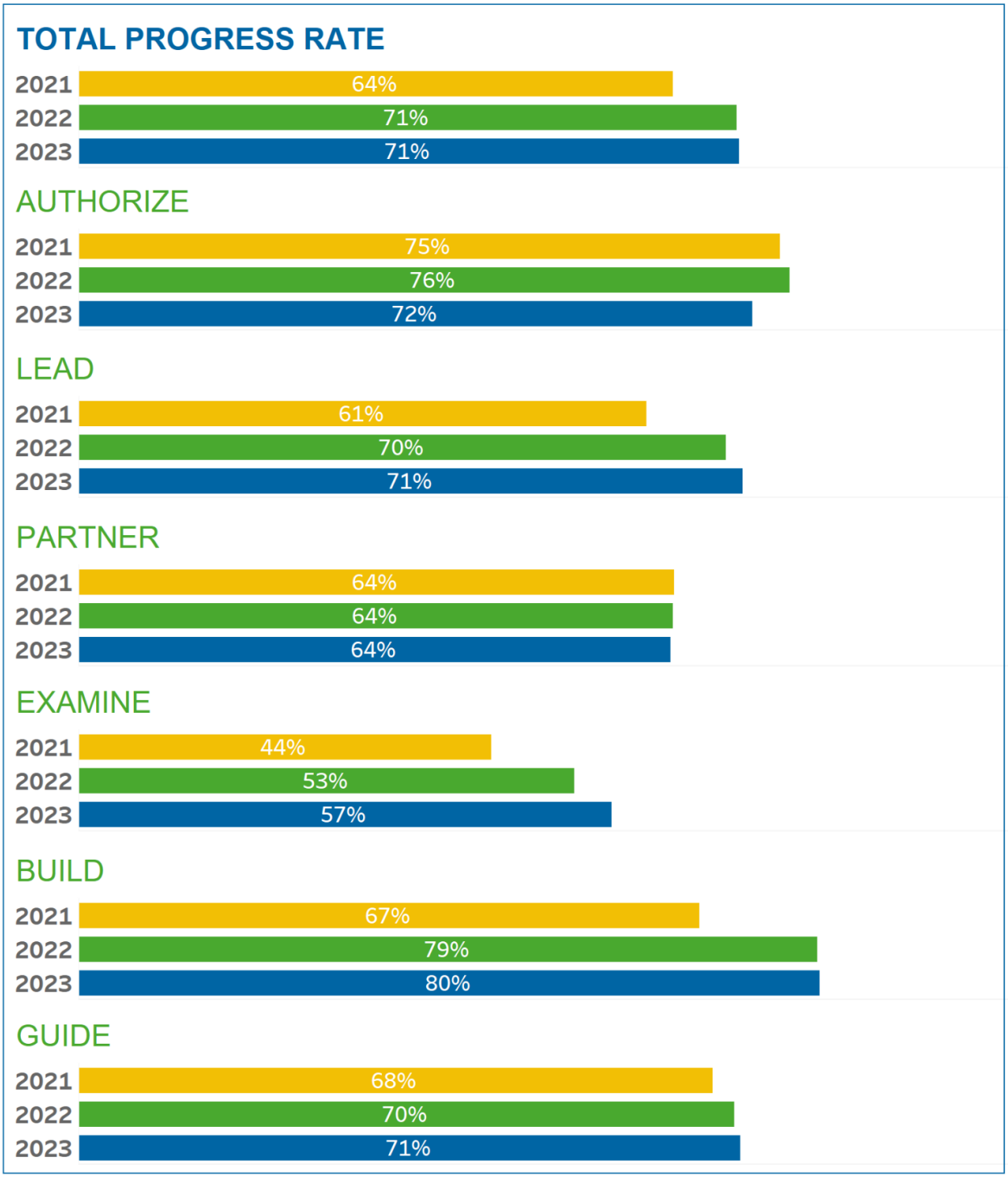


Figure 2 below displays three-year trends (2021, 2022, 2023) in progress rates, both overall (TOTAL PROGRESS RATE) and for each of the six essential elements. After increasing from 64% in 2021 to 71% in 2022, the total progress rate remained consistent at 71% in 2023. While most individual element scores also remained consistent between 2022 and 2023, the Authorize rate decreased (76% to 72%) and the Examine rate increased (53% to 57%).

Figure 2: Trends in National Infrastructure Progress Rates (2021, 2022, 2023)

(2021 – N=36, 2022 – N=41, 2023 – N=49)



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 72% progress rate (progress score of 17 out of a possible 24). The Authorize progress rate fell between 2022 (76%) and 2023 (72%).

Lead Agency and Authorization Ⓢ

Most states (90%, 44 of 49[2]) indicated that their state has a designated lead suicide prevention agency or office, and the majority of those states (91%, 40 of 44) 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, just over half of states (55%, 27 of 49) reported that they had an established state budget line item for suicide prevention (37% indicated that it is sustainably in place).

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

(N=49)

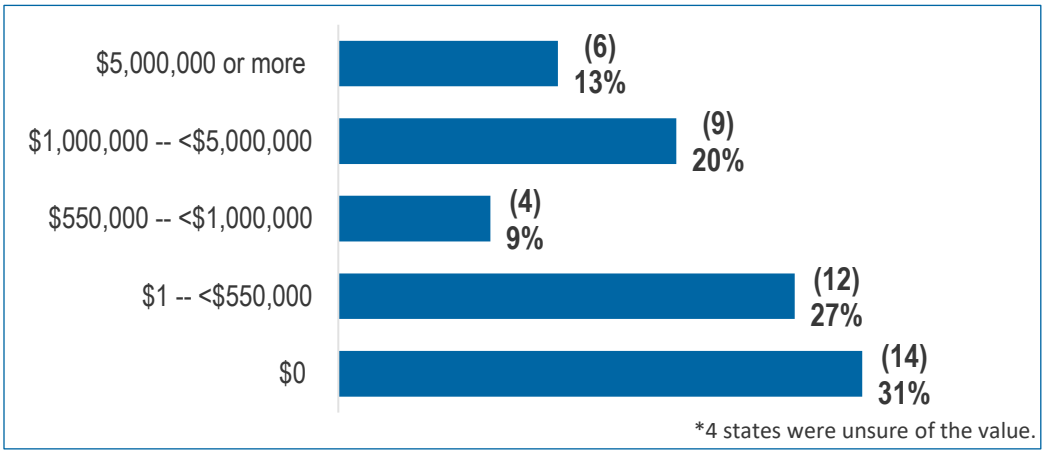
	Percent	Count
Not yet in place / Unaware of any work to get this in place	14%	7
Planning steps to get this in place	12%	6
Actively working to get this in place	18%	9
This is in place, but it is not yet sustainable	18%	9
This is sustainably in place	37%	18
	Total	49

Budgeted State Funding for Suicide Prevention

Close to one-third of states (31%, 14 of 45) lack any designated budget line items for suicide prevention. Among the 31 states **with** designated funding, many reported that the budgeted amount was under $1,000,000 (52%, 16 of 31). See Figure 3.

[2] Denominators for calculating percentages are based on all 49 respondents unless otherwise noted (due to respondents not answering the question or skip logic in the SNA instrument).

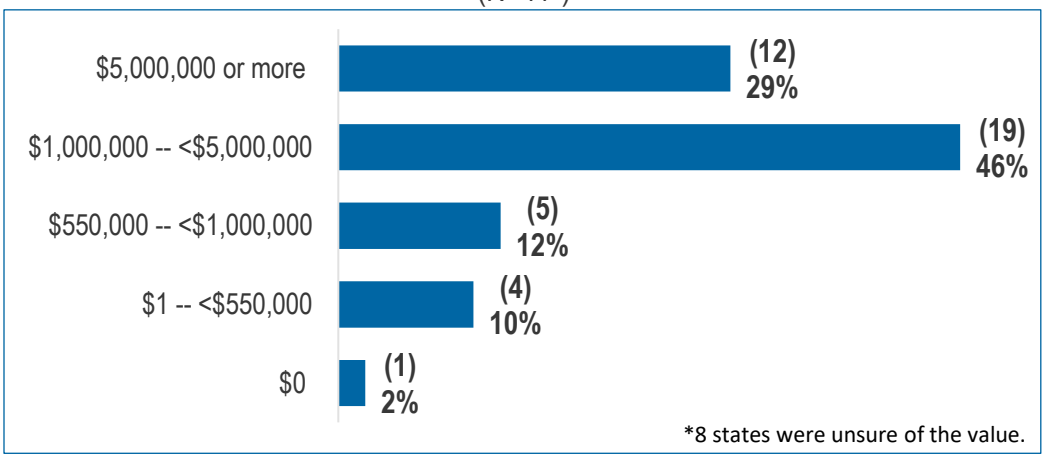
Figure 3: AUTHORIZE – Value of Budgeted State Funding for Suicide Prevention
(N=45*)



Major Sources of Outside Funding to Support Suicide Prevention Infrastructure

States were also asked about major sources of funding outside of state budget line items that support their suicide prevention infrastructure. All but one responding state (98%, 40 of 41) indicated that they receive outside funding for their suicide prevention efforts, with most (76%, 31 of 41) reporting the value of such funding to be above $1,000,000 annually. See Figure 4.

Figure 4: AUTHORIZE – Value of Outside Funding for Suicide Prevention
(N=41*)



As shown in Table 3, the most frequently identified major sources of funding outside of state budget line items were both *Cooperative Agreements for States and Territories to Build Local 988 Capacity* and *Community Mental Health Services Block Grants (MHBG)* (59%, 29 of 49), followed by *Garrett Lee Smith (GLS) Suicide Prevention State or Tribal Grant* (51%, 25 of 49). Thirty-five percent of respondents (35%, 17 of 49) identified other sources of outside funding beyond those listed in the response options, including the following sources cited by two or more states: CDC Preventive Health and Health Services Block Grant (PHHSBG) (4 responses), SAMHSA Mental Health Awareness Training Grant (MHAT) (4), SAMHSA Project Advancing Wellness and Resiliency in Education (Project AWARE) (3), SAMHSA State Opioid Response (SOR) Grant (3), American Rescue Plan Act (ARPA) (2), and U.S. Department of Veterans Affairs (VA) Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) (2).

Table 3: AUTHORIZE – Major Sources of Outside Funding to Support Suicide Prevention Infrastructure
(N=49)

Multiple responses possible	Percent	Count
CCBHC (Certified Community Behavioral Health Clinic Expansion) Grants	24%	12
CDC Comprehensive Suicide Prevention Grant (CSP)	29%	14
CDC Injury or Violence Prevention (IVP) Grant	22%	11
Cooperative Agreements for States and Territories to Build Local 988 Capacity	59%	29
Community Mental Health Services Block Grants (MHBG)	59%	29
Garrett Lee Smith (GLS) Suicide Prevention State or Tribal Grant	51%	25
Garrett Lee Smith (GLS) Suicide Prevention Campus Grant	16%	8
Maternal and Child Health Services Block Grant (MCHB)	31%	15
National Strategy for Suicide Prevention (NSSP) Grant	6%	3
National Foundation Funding	0%	0
Private Donations	27%	13
State or Community Foundation Funding	22%	11
State Medicaid or Medicare Dollars	8%	4
Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grants (formerly the Substance Abuse Prevention and Treatment Block Grants)	33%	16
Zero Suicide Grants	33%	16
Other[(a)]	35%	17
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: CDC Preventive Health and Health Services Block Grant (PHHSBG) (4 responses), SAMHSA Mental Health Awareness Training Grant (MHAT) (4), SAMHSA Project Advancing Wellness and Resiliency in Education (Project AWARE) (3), SAMHSA State Opioid Response (SOR) Grant (3), American Rescue Plan Act (ARPA) (2), and U.S. Department of Veterans Affairs (VA) Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) (2).

Regular Update of State Suicide Prevention Plan

Seventy-one percent of states (71%, 35 of 49) indicated that they update their state suicide prevention plan every 3-5 years. Of the 14 states that do not regularly update their plan, six reported that they are currently updating their plan, six 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

Seventy-eight percent of states (78%, 38 of 49) 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 over half of states (51%, 25 of 49) 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* (13 comments) was the most frequently identified **barrier** to strengthening the Authorize element,

followed by *lack of communication and coordination within and between state and local levels* (10), *no state budget line item for suicide prevention* (7), *lack of state legislation, policy, and/or support* (7), and *strained staff capacity and/or workload* (7). Barriers in this area were largely associated with funding; leadership, policy, and the sociopolitical environment; and staffing.

Table 4: AUTHORIZE – Barriers to Strengthening the Authorize Element
(N=46)

Funding (25 related comments)	
13	No or insufficient funding
7	No state budget line item for suicide prevention
5	Absence of sustainable funding sources
Leadership, Policy, and Sociopolitical Environment (17 related comments)	
7	Lack of state legislation, policy, and/or support
6	No suicide prevention coordinator position or lead agency/office
4	Lack of support from leadership
Staffing (17 related comments)	
7	Strained staff capacity, workload
6	Insufficient staffing levels
4	Difficulty identifying, recruiting, hiring, and retaining staff
Partnership and Coordination (10 related comments)	
10	Lack of communication and coordination within and between state and local levels
Priorities (6 related comments)	
6	Suicide prevention not prioritized, competing priorities
State Bureaucracy (6 related comments)	
3	Lengthy state approval and contracting processes
3	Structure and organization of state government agencies
State Suicide Prevention Plan (5 related comments)	
5	State suicide prevention plan (not in place, delayed, not updated)
Assessment, Surveillance, and Evaluation (3 related comments)	
3	Lack of data for planning and evaluation

Secured funding for suicide prevention positions/programming (13 comments), *collaboration within and between state and local agencies and entities* (11), and *political will and supportive leadership* (11) were the most common **successes** reported in strengthening the Authorize element. Successes clustered around the themes of partnership and collaboration; funding; and leadership, policy, and sociopolitical environment (see Table 5).

Table 5: AUTHORIZE – Successes in Strengthening the Authorize Element
(N=46)

Partnership and Coordination (26 related comments)	
11	Collaboration within and between state and local agencies and entities
8	Robust partnerships and stakeholder support
7	Presence of Governor's Task Force, State Suicide Prevention Coalition, Advisory Council
Funding (18 related comments)	
13	Secured funding for suicide prevention positions/programming
3	Braiding funding streams
2	Numerous state and federal funding opportunities
Leadership, Policy, and Sociopolitical Environment (17 related comments)	
11	Political will, supportive leadership
3	Suicide prevention coordinator position or lead agency/office
3	Suicide prevention legislation and policy
State Suicide Prevention Plan (9 related comments)	
9	State suicide prevention plan developed/submitted/regularly updated
Awareness, Promotion, Communication, and Marketing (7 related comments)	
7	Heightened awareness, visibility, and momentum (campaigns, 988 Lifeline, Governor's Challenge)
Staffing (5 related comments)	
3	Staff positions dedicated to suicide prevention
2	Strong suicide prevention staff/team
Crisis Response (4 related comments)	
4	Expansion/coordination of crisis response services

Infrastructure Element #2 – LEAD

Lead (71% progress rate, progress score of 17 out of a possible 24) was a middle-rated infrastructure element. The Lead progress rate remained largely stable between 2022 (70%) and 2023 (71%).

Suicide Prevention Coordinator Support Ⓢ and Additional Funded Positions Ⓢ

While most states (90%, 44 of 49) have a half-time or greater full-time equivalent (0.5 – 1.0 FTE) suicide prevention coordinator or similar role, fewer (63%, 31 of 49) fund additional staff positions (average = 3.9 additional half-time to full-time equivalent positions in these states).

State Emphasis on Professional Development for Suicide Prevention Staff

The majority of respondents indicated that their state places either *a great deal* (41%, 20 of 49) or *a fair amount* (39%, 19 of 49) 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=49)

	Percent	Count
None	4%	2
Very Little	4%	2
Some	12%	6
A Fair Amount	39%	19
A Great Deal	41%	20
	Total	49

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). Most felt that this funding was in place either sustainably (31%, 15 of 49) or not yet sustainably (31%, 15 of 49), while 20% were actively working to get it in place (20%, 10 of 49), and 18% (9 of 49) indicated that they had not yet taken action beyond planning to get such support in place (18%, 9 of 49) (see Table 7).

Table 7: LEAD – State Progress Toward Adequately Funding Technological Support to Carry Out Activities in State Plan
(N=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	12%	6
Planning steps to get this in place	6%	3
Actively working to get this in place	20%	10
This is in place, but it is not yet sustainable	31%	15
This is sustainably in place	31%	15
	Total	49

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 slightly more advanced, with the majority of respondents (69%, 34 of 49) 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=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	8%	4
Planning steps to get this in place	4%	2
Actively working to get this in place	18%	9
This is in place, but it is not yet sustainable	29%	14
This is sustainably in place	41%	20
	Total	49

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 one state reported that they were not actively addressing any of the issues. The vast majority were addressing *promoting a positive suicide prevention narrative* (88%, 43 of 49), followed closely by *following available best practice suicide prevention messaging guidelines* (86%, 42 of 49), *developing strategic communication campaigns* (84%, 41 of 49), and *minimizing unsafe suicide prevention messaging practices* (82%, 40 of 49).

Table 9: LEAD – Critical Issues from the *Framework for Successful Messaging* Being Actively Addressed
(N=49)

Multiple responses possible	Percent	Count
Developing strategic communication campaigns	84%	41
Promoting a positive suicide prevention narrative	88%	43
Following available best practice suicide prevention messaging guidelines	86%	42
Minimizing unsafe suicide prevention messaging practices	82%	40
None of the above	2%	1

Formal Suicide Prevention Partnerships Ⓢ

The majority of respondents (71%, 35 of 49) reported that their state had established formal suicide prevention partnerships between government divisions or offices.

Braided Funding to Support Prevention Efforts Ⓢ

Approximately two-thirds of responding states (65%, 32 of 49) are using braided funding (i.e., aligning funding from multiple agencies or funding streams to support agreed-upon initiatives) 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

Difficulty identifying, recruiting, hiring, and retaining staff (19 comments) was the most frequently identified **barrier** to strengthening the Lead element, followed by *insufficient staffing levels* (9), *lack of dedicated funding for staff positions* (8), *insufficient technology/technical support* (7), and *no or limited time, resources, personnel, or funding to perform assessment,*

surveillance, and/or evaluation tasks (6). Barriers in this area were largely associated with staffing and funding (see Table 10).

Table 10: LEAD – Barriers to Strengthening the Lead Element
(N=46)

Staffing (33 related comments)	
19	Difficulty identifying, recruiting, hiring, and retaining staff
9	Insufficient staffing levels
5	Strained staff capacity, workload
Funding (21 related comments)	
8	Lack of dedicated funding for staff positions
5	No or insufficient funding
5	Unstable, time-limited, grant-based funding
3	Lack of braided funding efforts (siloed funding streams)
Suicide Prevention Infrastructure (10 related comments)	
7	Insufficient technology/technical support
3	Limited statewide/regional/local infrastructure (especially in rural areas)
Assessment, Surveillance, and Evaluation (6 related comments)	
6	No or limited time, resources, personnel, or funding
Partnership and Coordination (5 related comments)	
5	Lack of communication and coordination within and between state and local levels
Leadership, Policy, and Sociopolitical Environment (5 related comments)	
3	No suicide prevention coordinator position or lead agency/office
2	Lack of state legislation, policy, and/or support
Priorities (5 related comments)	
5	Suicide prevention not prioritized, competing priorities
State Bureaucracy (4 related comments)	
2	Lengthy state approval and contacting processes
2	Structure and organization of state government agencies
Other Comments	
1	No barriers present

Staff positions dedicated to suicide prevention (12 comments) was the most frequently identified **success** in strengthening the Lead element, followed by *heightened awareness, visibility, and momentum (campaigns, 988 Lifeline, Governor's Challenge)* (11), and *collaboration within and between state agencies* (10). Successes clustered largely around partnerships and coordination; awareness, promotion, communication, and marketing; and staffing (see Table 11).

Table 11: LEAD – Successes in Strengthening the Lead Element
(N=45)

Partnership and Coordination (23 related comments)	
10	Collaboration within and between state agencies
7	Presence of Governor's Task Force, State Suicide Prevention Coalition, Advisory Council
6	Robust partnerships and stakeholder support
Awareness, Promotion, Communication, and Marketing (21 related comments)	
11	Heightened awareness, visibility, and momentum (campaigns, 988 Lifeline, Governor's Challenge)
7	Promotion of Framework for Successful Messaging
3	Strong communications team/processes
Staffing (20 related comments)	
12	Staff positions dedicated to suicide prevention
8	Strong suicide prevention staff/team
Programming and Implementation (8 related comments)	
8	Toolkit development, training, direct service provision
Funding (7 related comments)	
7	Secured funding for suicide prevention positions/programming
Leadership, Policy, and Sociopolitical Environment (5 related comments)	
4	Political will, supportive leadership
1	Suicide prevention coordinator position or lead agency/office
State Suicide Prevention Plan (3 related comments)	
3	State suicide prevention plan developed/submitted/regularly updated

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), and no change between 2022 (64%) and 2023 (64%).

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. Sixteen percent of respondents (16%, 8 of 49) indicated that such partner integration was sustainably in place, while most (43%, 21 of 49) were actively working to get it in place.

Table 12: PARTNER – Integration of Suicide Prevention Efforts by Partnering State Agencies or Departments
(N=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	12%	6
Planning steps to get this in place	6%	3
Actively working to get this in place	43%	21
This is in place, but it is not yet sustainable	22%	11
This is sustainably in place	16%	8
	Total	49

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

Over three-quarters of states (78%, 38 of 49) have a statewide suicide prevention coalition, with over half (59%, 29 of 49) reporting that it is sustainably in place (see Table 13).

Table 13: PARTNER – Progress Toward Establishing a Statewide Suicide Prevention Coalition
(N=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	4%	2
Planning steps to get this in place	8%	4
Actively working to get this in place	10%	5
This is in place, but it is not yet sustainable	18%	9
This is sustainably in place	59%	29
	Total	49

Of the 38 states with a statewide coalition, all but one (97%, 37 of 38) reported that the coalition is focused on the entire lifespan (all ages from youth to older adults). Additionally, all but one of the states with a statewide coalition (97%, 37 of 38) were working to develop or had already established broad public and private sector coalition representation, with 45% (17 of 38) 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=38)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	0%	0
Planning steps to get this in place	3%	1
Actively working to get this in place	24%	9
This is in place, but it is not yet sustainable	29%	11
This is sustainably in place	45%	17
	Total	38

Mutually Agreed-Upon Goals for Suicide Prevention Across Partners Ⓢ

Just over half of states (55%, 27 of 49) reported having set mutually agreed-upon goals for suicide prevention across partners, with 35% having them sustainably in place (see Table 15).

Table 15: PARTNER – Progress Toward Setting Mutually Agreed-Upon Goals for Suicide Prevention Across Partners
(N=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	6%	3
Planning steps to get this in place	8%	4
Actively working to get this in place	31%	15
This is in place, but it is not yet sustainable	20%	10
This is sustainably in place	35%	17
	Total	49

Signed Partnering Agreements S

Only 29% of states (14 of 49) have 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), and approximately one-quarter (27%, 13 of 49) 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=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	27%	13
Planning steps to get this in place	27%	13
Actively working to get this in place	18%	9
This is in place, but it is not yet sustainable	14%	7
This is sustainably in place	14%	7
	Total	49

Communication Between States and Tribes or Tribal Health Boards

Thirty-four (34) 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 indicated that their communication with tribes/tribal health boards is *fair* (32%, 11 of 34) or *poor* (35%, 12 of 34).

Table 17: PARTNER – Communication Between States and Tribes or Tribal Health Boards
(N=34)

	Percent	Count
Extremely Poor	6%	2
Poor	35%	12
Fair	32%	11
Good	24%	8
Excellent	3%	1
	Total	34

Collaboration Between States and Tribes or Tribal Health Boards

The 34 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 *networking (back and forth sharing of information)* (24%, 8 of 34), *awareness (knowledge of each other's activities)* (35%, 12 of 34), or *none (no awareness or interaction)* (24%, 8 of 34).

Table 18: PARTNER – Collaboration Between States and Tribes or Tribal Health Boards

(N=34)

	Percent	Count
None (no awareness or interaction)	24%	8
Awareness (knowledge of each other's activities)	35%	12
Networking (back and forth sharing of information)	24%	8
Coordination (common and often interactive efforts)	18%	6
Collaboration (shared goals and decision-making)	0%	0
	Total	34

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 but one state reported taking action to ensure cultural responsiveness, with 92% (45 of 49) *researching and understanding the cultural context of communities reached by strategies or interventions*, 82% (40 of 49) *including members of populations served in strategic planning efforts*, 80% (39 of 49) *creating an open dialogue whereby members of populations served can share cultural considerations key to prevention*, and 76% (37 of 49) *tailoring/developing interventions and resources to address populations served*.

Table 19: PARTNER – Actions State Has Taken to Ensure Cultural Responsiveness in Prevention Efforts

(N=49)

Multiple responses possible	Percent	Count
Researching and understanding the cultural context of communities reached by strategies/interventions (target populations)	92%	45
Including members of populations served (e.g., communities of color, rural communities, tribal communities) in strategic planning activities	82%	40
Tailoring and/or developing interventions and resources to address the values, beliefs, culture, and language of the populations served	76%	37
Creating an open dialogue whereby members of populations served can share cultural considerations key to prevention	80%	39
Other	22%	11
None of the above	2%	1

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

Building and maintaining a diverse coalition (11 comments), *strained staff capacity and/or workload* (10), and *lack of culturally responsive materials and services* (8) were the most frequently identified **barriers** to strengthening the Partner element. Barriers in this area were largely associated with diversity, equity, and inclusion; and partnership and coordination (see Table 20).

Table 20: PARTNER – Barriers to Strengthening the Partner Element
(N=45)

Diversity, Equity, and Inclusion (30 related comments)	
11	Building and maintaining a diverse coalition
8	Lack of culturally responsive materials and services
5	Engaging centered groups and communities
4	Incorporating lived experience voices and perspectives
2	Non-diverse leadership and staffing
Partnership and Coordination (26 related comments)	
5	Lack of statewide coalition or advisory team
4	Communicating and coordinating with agencies in rural areas
4	Lack of shared goals across agencies and levels
3	Coordination with tribal entities
3	Lack of communication and coordination within and between state and local levels
3	Virtual and remote meetings, scheduling
2	Lack of written agreements
2	Low stakeholder engagement/responsiveness
Staffing (16 related comments)	
10	Strained staff capacity, workload
4	Difficulty identifying, recruiting, hiring, and retaining staff
2	Insufficient staffing levels
Funding (4 related comments)	
2	No or insufficient funding
2	Restrictions on how grant dollars can be spent
State Bureaucracy (4 related comments)	
2	Lengthy state approval and contracting processes
2	Structure and organization of state government agencies
Priorities (2 related comments)	
2	Suicide prevention not prioritized, competing priorities
Other Comments	
1	No barriers present

The *presence of state taskforces/coalitions/advisory councils* (11 comments), an *increased focus on diversity, equity, and inclusion* (10), and *heightened awareness, visibility, and momentum around campaigns and other health promotion messaging* (10) were the most common **successes** reported in strengthening the Partner element. Successes clustered around the themes of strong suicide prevention networks and collaboration efforts; diversity, equity, and inclusion; and awareness, promotion, communication, and marketing (see Table 21).

Table 21: PARTNER – Successes in Strengthening the Partner Element
(N=45)

Strong Suicide Prevention Networks and Collaboration Efforts (36 related comments)	
11	Presence of Governor's Task Force, State Suicide Prevention Coalition, Advisory Council
9	Robust partnerships and stakeholder support
7	Collaboration with tribes and tribal health boards
5	Collaboration within and between state and local agencies and entities
4	Shared goals across agencies and levels
Diversity, Equity, and Inclusion (14 related comments)	
10	Increased focus on diversity, equity, and inclusion
2	Incorporating lived experience voices and perspectives
2	Partnering with culturally responsive organizations
Awareness, Promotion, Communication, and Marketing (10 related comments)	
10	Heightened awareness, visibility, and momentum (campaigns, 988 Lifeline, Governor's Challenge)
Crisis Response (6 related comments)	
6	Expansion/coordination of crisis response services
Enhanced Surveillance and Data Infrastructure (5 related comments)	
5	Data, surveillance, and reporting infrastructure development
State Suicide Prevention Plan (5 related comments)	
5	State suicide prevention plan developed/submitted/regularly updated
Funding (4 related comments)	
4	Secured funding for suicide prevention positions/programming
Leadership, Policy, and Sociopolitical Environment (4 related comments)	
3	Political will, supportive leadership
1	Suicide prevention legislation and policy

Infrastructure Element #4 – EXAMINE

While Examine was the lowest-rated infrastructure element, with a 57% progress rate (progress score of 11 out of a possible 20), the rate increased from 53% in 2022 and 44% in 2021.

Statewide System for Collecting and Analyzing Suicide Death Data S

As displayed in Table 22, most respondents (84%, 41 of 49) indicated that their state has a statewide system in place for collecting and analyzing suicide death data (61% indicated that it is sustainable).

Table 22: EXAMINE – State Progress Toward Having a Statewide System in Place for Collecting and Analyzing Suicide Death Data
(N=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	0%	0
Planning steps to get this in place	6%	3
Actively working to get this in place	10%	5
This is in place, but it is not yet sustainable	22%	11
This is sustainably in place	61%	30
	Total	49

Standards for Timeliness of Mortality Reporting S

Just over half of states (59%, 29 of 49) 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

Few respondents (22%, 11 of 49) 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) and only 10% (5 of 49) indicated that this was sustainable. Approximately one-third (31%, 15 of 49) 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=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	31%	15
Planning steps to get this in place	18%	9
Actively working to get this in place	29%	14
This is in place, but it is not yet sustainable	12%	6
This is sustainably in place	10%	5
	Total	49

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

Progress toward establishing a system for collecting and analyzing near real-time statewide data for suicidal ideation and attempts varied, with 47% of states (23 of 49) having established such a system (22% have it sustainably in place), 24% (12 of 49) actively working to establish it, 10% (5 of 49) planning steps to establish it, and 18% (9 of 49) 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=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	18%	9
Planning steps to get this in place	10%	5
Actively working to get this in place	24%	12
This is in place, but it is not yet sustainable	24%	12
This is sustainably in place	22%	11
	Total	49

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

Only 31% of states (15 of 49) reported having a state-level interactive dashboard with near real-time suicide morbidity and mortality data.

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

Just 39% of respondents (19 of 49) reported that their state ensures that populations that are at high risk and underserved are sufficiently represented in their suicide-related data (22% sustainably). Others are either actively working (37%, 18 of 49) or planning steps (12%, 6 of 49) to get this in place, while 12% (6 of 49) 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=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	12%	6
Planning steps to get this in place	12%	6
Actively working to get this in place	37%	18
This is in place, but it is not yet sustainable	16%	8
This is sustainably in place	22%	11
	Total	49

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 in the past year. As shown in Table 26, 61% of states (30 of 49) had engaged in *process* evaluation efforts to ensure that strategies and/or interventions are being implemented as intended, while 59% (29 of 49) had engaged in *outcome* evaluation efforts to assess their achievement of previously set objectives, 47% (23 of 49) had engaged in *formative* evaluation efforts to inform implementation, and 27% (13 of 49) had engaged in *impact* evaluation efforts to assess long-term impacts on goals and suicide rates. Just under one-fifth of states (18%, 9 of 49) 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=49)

Multiple responses possible	Percent	Count
Formative evaluations to ensure strategies/interventions are feasible, appropriate, and acceptable prior to full implementation (conducting pilot evaluations)	47%	23
Process evaluations to ensure strategies/interventions are being implemented as intended	61%	30
Outcome evaluations to determine whether strategies/interventions are helping to achieve set objectives	59%	29
Impact evaluations to determine strategy/intervention impacts on long-term goals and suicide rates	27%	13
None of the above	18%	9

State Sharing and/or Use of Evaluation Results

Most respondents (88%, 43 of 49) indicated that their state was using and/or sharing evaluation results. As shown in Table 27, the most common use was *making changes to specific strategies/interventions* (67%, 33 of 49), followed by *informing/making changes to state suicide prevention plans* (57%, 28 of 49), and *developing regular suicide prevention reports for the public* (55%, 27 of 49). Under half of respondents reported *developing regular suicide prevention reports for state leaders* (49%, 24 of 49) and *involving key community stakeholders in interpretation of evaluation outcomes* (45%, 22 of 49).

Table 27: EXAMINE – State Sharing and/or Use of Evaluation Results
(N=49)

Multiple responses possible	Percent	Count
Involving key community stakeholders in interpretation of evaluation outcomes	45%	22
Using evaluation results to inform/make changes to state suicide prevention plans	57%	28
Using evaluation results to make changes to specific strategies/interventions	67%	33
Developing regular suicide prevention reports for state leaders	49%	24
Developing regular suicide prevention reports (including infographics, annual highlights, success stories, etc.) for the public	55%	27
Other	8%	4
None of the above	12%	6

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

A lack of time/resources/personnel/funding related to supporting data efforts (22 comments) was the most frequently identified **barrier** to strengthening the Examine element, followed by *data lag* (15). Barriers clustered primarily around the themes of data infrastructure/capacity (limited time, resources, personnel, funding, data linkages, technical support), accessing data (data lag, logistical and partnering challenges related to sharing data), presenting and communicating data to stakeholders, and data comprehensiveness and inclusivity (see Table 28).

Table 28: EXAMINE – Barriers to Strengthening the Examine Element
(N=44)

Data Infrastructure and Capacity (34 related comments)	
22	No or limited time, resources, personnel, or funding related to supporting data efforts
9	Establishing and linking data systems
3	Limited technical support (creating dashboards, centralized data systems)
Accessing Data (20 related comments)	
15	Data lag (not timely; not real-time)
5	Difficulty accessing data / creating data partnerships (MOUs, Data Use Agreements)
Presenting and Communicating Data (17 related comments)	
9	Barriers to disseminating data to stakeholders
4	Effectively communicating key data points and data utilization
4	Low levels of data and evaluation literacy
Data Comprehensiveness and Inclusivity (15 related comments)	
12	Limited or no data on certain populations and groups
3	Inconsistent coding, collection, and definitions
Priorities (7 related comments)	
7	Evaluation not prioritized / competing priorities
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* (14 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, epidemiological and/or evaluation support, presence of data workgroups and formal structures) (see Table 29).

Table 29: EXAMINE – Successes in Strengthening the Examine Element
(N=45)

Data Infrastructure Development (27 related comments)	
11	Advancements in centralized systems, linking data, and syndromic surveillance
10	Epidemiological and/or evaluation support (staff, contractors, partners)
6	Presence of data workgroups and formal structures (fatality review boards, epi workgroups)
Partnership and Coordination (16 related comments)	
14	Strong state-level and state/local-level data partnerships (state agencies, hospitals, universities)
2	Enhancing data sharing agreements and data linkages
Data Dissemination and Reporting (13 related comments)	
13	Enhanced data dissemination (data dashboards, report, state and community profiles)
Expanded Indicators/Datasets of Interest (9 related comments)	
9	Broader inclusion of data sources, indicators, and populations
Leadership, Policy, and Sociopolitical Environment (3 related comments)	
3	Political will / Supportive leadership
Funding (3 related comments)	
3	Secured funding / pooled resources to support data infrastructure (research, staff)

Infrastructure Element #5 – BUILD

Build was the highest-rated infrastructure element, with an 80% progress rate (progress score of 38 out of a possible 48), representing little change from 79% in 2022.

Strategic Planning Activities

Almost all respondents (96%, 47 of 49) reported 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. Most indicated that their state had *used data or other evidence to describe their state's suicide problem and context* (96%, 47 of 49) and/or *chosen short and long-term data-based goals* (92%, 45 of 49), while 88% (43 of 49) had *selected or developed strategies/interventions that address identified risk and protective factors* and 84% (41 of 49) had *identified key risk and protective factors*. Far fewer had *planned for strategy/intervention evaluation* 63% (31 of 49) and/or *evaluated strategies/interventions over time* (47%, 23 of 49). See Table 30 for details.

Table 30: BUILD – State Strategic Planning Activities in the Past Two Years
(N=49)

Multiple responses possible	Percent	Count
Use data or other sources to describe your state's suicide problem and its context	96%	47
Choose short and long-term goals based on available data to guide suicide prevention efforts	92%	45
Identify key risk and protective factors for suicide in your state	84%	41
Select or develop strategies and interventions that address identified risk and protective factors	88%	43
Plan for evaluation of your strategies and interventions	63%	31
Evaluate and improve strategies/interventions over time	47%	23
None of the above	4%	2

Promotion Within State Plan of Comprehensive Ⓢ and Lifespan Ⓢ Approaches

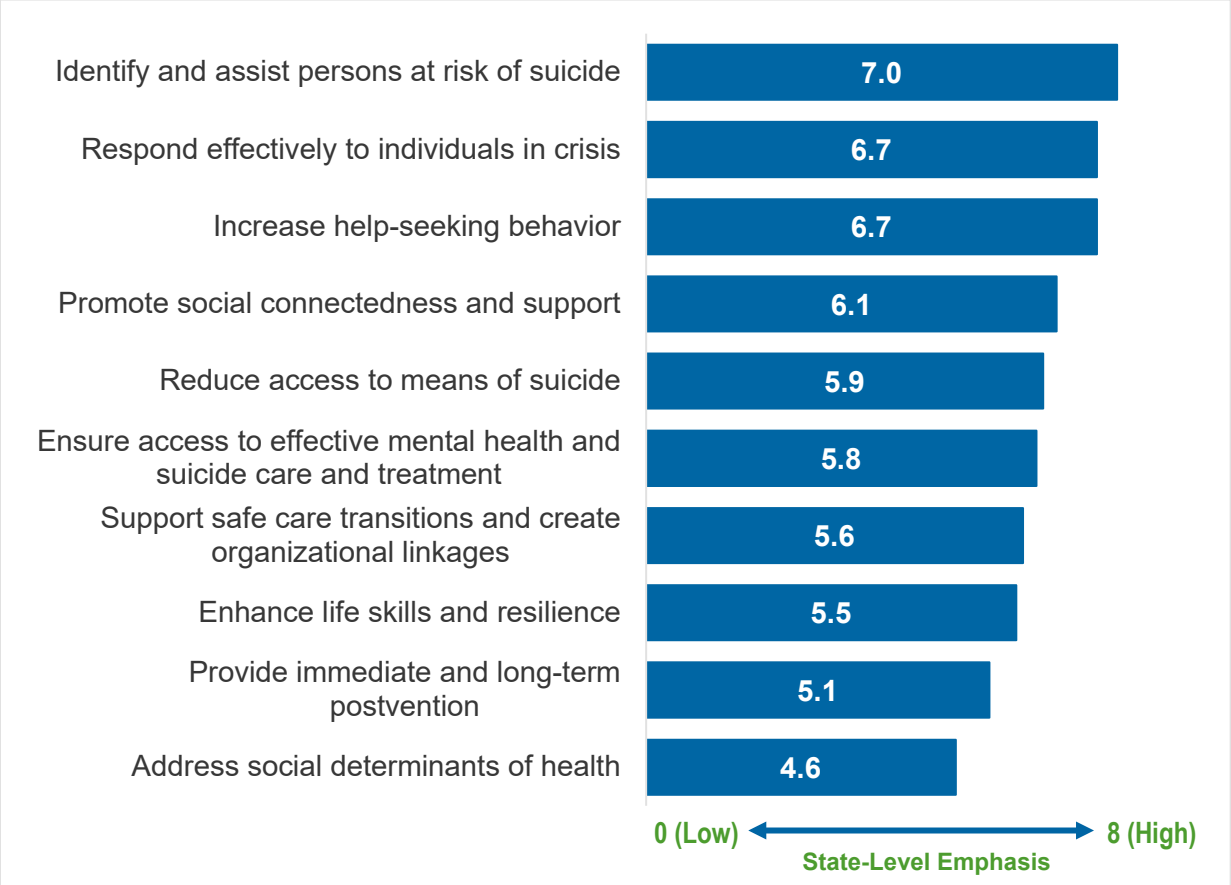
Most states indicated that their state suicide prevention plan promotes a *comprehensive* approach to suicide prevention that involves a variety of suicide prevention strategies across all levels of prevention (90%, 44 of 49) and also promotes a *lifespan* approach to suicide prevention that calls for suicide prevention strategies to reach diverse populations across ages and demographics (90%, 44 of 49).

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 *Suicide Prevention Resource in Action*, 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 5, states place the greatest emphasis on *identifying and assisting persons at risk of suicide* (7.0), followed by *responding effectively to individuals in crisis* (6.7) and *increasing help-seeking behavior* (6.7). Strategies least likely to be addressed are *addressing social determinants of health* (4.6), *providing immediate and long-term postvention* (5.1), and *enhancing life skills and resilience* (5.5).

Figure 5: BUILD – State Emphasis on Addressing High-Level Strategies
(N=49)



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 (29%, 14 of 49) reported that their state has such funding in place (only 6% sustainably), while most are actively working on securing such funding (49%, 24 of 49) and 22% (11 of 49) have not advanced to or beyond planning.

Table 31: BUILD – State Progress Toward Developing the Funding Necessary to Adequately Support a Comprehensive Approach to Suicide Prevention
(N=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	16%	8
Planning steps to get this in place	6%	3
Actively working to get this in place	49%	24
This is in place, but it is not yet sustainable	22%	11
This is sustainably in place	6%	3
	Total	49

Embedding Suicide Prevention Requirements into State-Funded Contracts

Just over half of states (55%, 27 of 49) 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, 88% of respondents (43 of 49) indicated that their state is addressing at least one determinant, with adverse childhood experiences (ACEs) (78%, 38 of 49) most frequently addressed.

Table 32: BUILD – Social Determinants of Health Currently Being Addressed by State Suicide Prevention Office or Coalition

(N=49)

Multiple responses possible	Percent	Count
ACEs (Adverse Childhood Experiences)	78%	38
Education access and quality	37%	18
Financial/job security	20%	10
Food insecurity	14%	7
Housing insecurity	24%	12
Neighborhood and community environment	51%	25
Systemic discrimination	27%	13
Violence	49%	24
Other	10%	5
None of the above	12%	6

Core Elements of Effective Crisis Care S

Respondents were asked to identify which core elements of effective crisis care are currently represented by their state's crisis infrastructure. As shown in Table 33, while almost all respondents (96%, 47 of 49) indicated that their state's crisis infrastructure currently includes a *24/7 regional or statewide crisis call center*, fewer identified the *use of trauma-informed principles within crisis care* (78%, 38 of 49), *988 text/chat services provided by regional or statewide crisis call centers* (73%, 36 of 49), *24/7 mobile crisis outreach and support* (71%, 35 of 49), or *residential crisis receiving/stabilization programs for individuals who need support and observation but not ED holds or inpatient stays* (67%, 33 of 49). Only one state indicated that none of these 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=49)

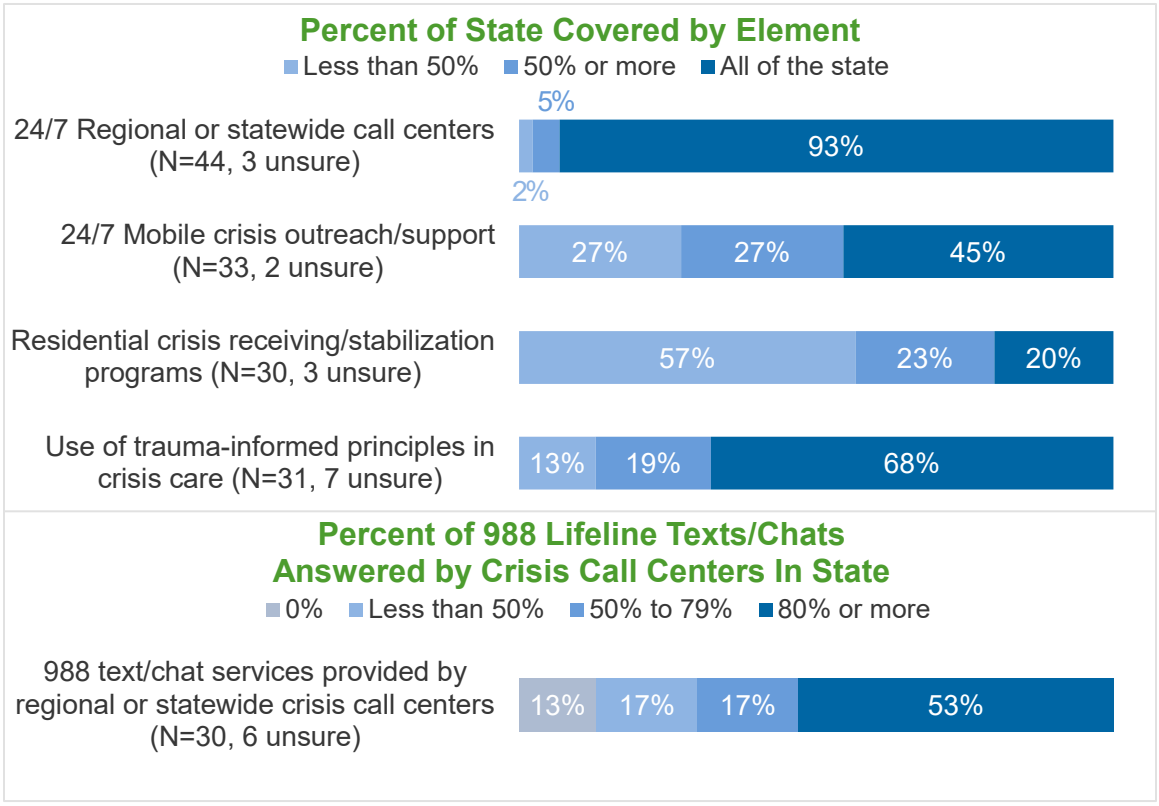
Multiple responses possible	Percent	Count
Regional or statewide crisis call centers available on a 24/7 basis	96%	47
Mobile crisis outreach and support available on a 24/7 basis	71%	35
Residential crisis receiving/stabilization programs for individuals who need support and observation but not ED holds or inpatient stays	67%	33
The use of trauma-informed principles within crisis care	78%	38
988 text/chat services provided by regional or statewide crisis call centers	73%	36
None of the above	2%	1

Geographic Coverage of Crisis Care Elements

Respondents who indicated that these elements of effective crisis care were currently represented by their state's crisis infrastructure were asked to assess the relevant geographic coverage of the service elements. For the first four elements, the questions asked about the availability and/or distribution of the element across the geographic areas of the state. For the fifth element – 988 Lifeline text/chat services provided by regional or statewide crisis call centers – the question asked about the percentage of 988 Lifeline texts/chats that are answered by crisis centers in the state.

As displayed in Figure 6, the geographic reach of these elements varied widely, with 93% of states with regional or statewide crisis call centers available on a 24/7 basis reporting that these centers cover *all* of their state's geographic area (41 of 44), followed by 68% (21 of 31) for use of trauma-informed principles in crisis care, 45% (15 of 33) for mobile crisis outreach and support available on a 24/7 basis, and 20% (6 of 30) for residential crisis receiving/stabilization programs for individuals who need support and observation but not ED holds or inpatient stays. Just over half of states with 988 Lifeline text/chat services provided by regional or statewide crisis call centers (53%,16 of 30) reported that 80% or more of the texts/chats are answered by crisis call centers in their state.

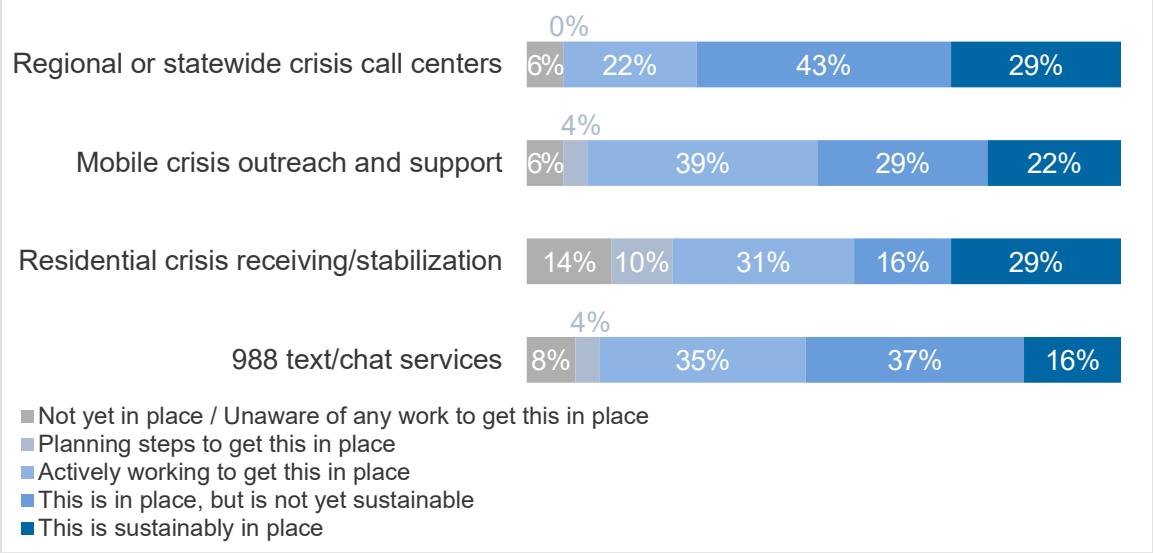
Figure 6: BUILD – Geographic Coverage of Crisis Care Elements



Funding Core Elements of Crisis Care

Respondents were asked to rate their state's progress toward developing a sustainable funding structure to adequately support four of the elements discussed above (states were not asked to assess funding related to the more conceptual diffusion of trauma-informed principles in crisis care). Most states (71%, 35 of 49) reported having a funding structure in place to adequately support regional or statewide crisis call centers and 53% (26 of 49) reported such structure to support 988 Lifeline text/chat services. Comparatively fewer states reported structure to adequately support mobile crisis outreach and support (51%, 25 of 49) and residential crisis receiving/stabilization (45%, 22 of 49). See Figure 7.

Figure 7: BUILD – State Progress Toward Funding Core Elements of Crisis Care
(N=49)



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). Forty-one percent of respondents (41%, 20 of 49) reported that their state had achieved such coordination (18% sustainably), while a large portion are actively working toward (39%, 19 of 49) or planning (14%, 7 of 49) such coordination. See Table 34.

Table 34: BUILD – State Progress Toward Coordinating Crisis Services
(N=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	6%	3
Planning steps to get this in place	14%	7
Actively working to get this in place	39%	19
This is in place, but it is not yet sustainable	22%	11
This is sustainably in place	18%	9
	Total	49

Collaborative Planning and Implementation of Crisis Services

Respondents were asked to assess their state's progress toward having a coalition, advisory board, or other group that engages multiple partners in planning and implementing crisis services. As shown in Table 35, while over half of respondents (57%, 28 of 49) reported that their state has such a collaborative structure in place (33% sustainably), more than one-quarter have not progressed past planning steps to get this in place (27%, 13 of 49).

Table 35: BUILD – State Progress Toward Collaborative Planning and Implementation of Crisis Services

(N=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	14%	7
Planning steps to get this in place	12%	6
Actively working to get this in place	16%	8
This is in place, but it is not yet sustainable	24%	12
This is sustainably in place	33%	16
	Total	49

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, intentionally or unintentionally, respondents were asked to answer based solely on whether they have state-level prevention strategies **intentionally targeting** the populations listed. Almost all responding states reported having strategies intentionally targeting *occupational* populations at high risk (98%, 48 of 49), followed by *age-based* populations (96%, 47 of 49), *location-based* populations (82%, 40 of 49), *lived experience* populations (82%, 40 of 49), and *racial, ethnic, and other populations that are historically marginalized* (82%, 40 of 49). The most frequently targeted populations were *military/veterans* (94%) and both *youth 10-17* (92%) and *young adults 18-24* (92%). See Table 36.

Table 36: BUILD – Populations Specifically Targeted by Suicide Prevention Strategies

Multiple responses possible	Percent	Count
AGE-BASED POPULATIONS (N=49)		
Children Under 10	41%	20
Youth 10-17	92%	45
Young Adults 18-24	92%	45
Adults 25-44	82%	40
Middle-Aged Adults 45-64	76%	37
Older Adults 65+	71%	35
We do not currently have targeted state-level strategies for these populations	4%	2
LOCATION-BASED POPULATIONS (N=49)		
Rural Communities	80%	39
Suburban Communities	43%	21
Urban Communities	59%	29
We do not currently have targeted state-level strategies for these populations	18%	9
OCCUPATIONAL POPULATIONS AT HIGH RISK (N=49)		
Agricultural/Farming/Forestry Industry	59%	29
Construction Industry	45%	22
Emergency Response (firefighters, emergency medical services)	76%	37
Law Enforcement	76%	37
Detention/Correctional Staff	47%	23
Healthcare Professionals	63%	31
Military/Veteran	94%	46
Mining/Quarrying/Oil-Gas Extraction Industry	10%	5
Veterinarian Professionals	8%	4
We do not currently have targeted state-level strategies for these populations	2%	1
LIVED EXPERIENCE POPULATIONS (N=49)		
Impacted Families and Friends	71%	35
Individuals with Serious Mental Illness	47%	23
Suicide Attempt Survivors	67%	33
Suicide Loss Survivors	78%	38
Individuals with Substance Use Disorder	57%	28
We do not currently have targeted state-level strategies for these populations	18%	9
RACIAL, ETHNIC, AND OTHER POPULATIONS THAT ARE HISTORICALLY MARGINALIZED (N=49)		
Asian American	27%	13
Black/African American	51%	25
Indigenous/Native American	45%	22
Latin American	43%	21
Immigrant/Refugee population	24%	12
Individuals with Disabilities	39%	19
Individuals with Serious Physical Health Problems	31%	15
Lesbian, Gay, Bisexual	65%	32
Transgender	57%	28
We do not currently have targeted state-level strategies for these populations	18%	9

Involvement of Priority Populations in Suicide Prevention Activities

As shown in Table 37, the most common way that states reported involving members of populations they are trying to reach through targeted initiatives (priority populations) in suicide prevention efforts was through having them *help identify unique community needs, challenges, and/or strengths* (86%, 42 of 49), followed by *helping to implement targeted activities* (73%, 36 of 49), *providing ongoing feedback on activity practices, effectiveness, and/or opportunities for improvement* (69%, 34 of 49), and *helping to choose prevention activities* (65%, 32 of 49). It was less common for priority populations to *help collect, analyze, and/or evaluate data* (39%, 19 of 49) or *provide ongoing feedback on policies being drafted or implemented* (39%, 19 of 49).

Table 37: BUILD – Involvement of Priority Populations in Suicide Prevention Activities

(N=49)

Members of target populations… *(Multiple responses possible)*	Percent	Count
Help collect, analyze, and/or evaluate data	39%	19
Help to identify unique community needs, challenges, and/or strengths	86%	42
Help to choose prevention activities	65%	32
Provide ongoing feedback on activity practices, effectiveness, and/or opportunities for improvements	69%	34
Provide ongoing feedback on policies being drafted or implemented	39%	19
Help to implement targeted activities	73%	36
Other	4%	2
None of the above	8%	4

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

Ensuring equitable reach/access to materials and services (11 comments), the *lack of sufficient funding* (11), and challenges related to *engaging centered groups and communities* (10) were the most frequently identified **barriers** to strengthening the Build element. Barriers clustered primarily around the themes of diversity, equity, and inclusion (ensuring equitable reach/access to materials and services, engaging centered groups and communities, lack of culturally responsive materials and services, incorporating lived experience voices and perspectives) (see Table 38).

Table 38: BUILD – Barriers to Strengthening the Build Element
(N=42)

Diversity, Equity, and Inclusion (26 related comments)	
11	Ensuring equitable reach/access to materials and services
10	Engaging centered groups and communities
3	Lack of culturally responsive materials and services
2	Incorporating lived experience voices and perspectives
Staffing (15 related comments)	
7	Strained staff capacity, workload
6	Difficulty identifying, recruiting, hiring, and retaining staff
2	Insufficient staffing levels
Funding (13 related comments)	
11	No or insufficient funding
2	Restrictions on how grant dollars can be spent
Partnership and Coordination (11 related comments)	
8	Challenging to coordinate/expand crisis services
3	Difficulty coordinating and allocating limited resources
Assessment, Surveillance, and Evaluation (5 related comments)	
5	Lack of data for planning and evaluation
State Bureaucracy (3 related comments)	
3	Lengthy state approval and contracting processes
Priorities (3 related comments)	
3	Suicide prevention not prioritized, competing priorities
Leadership, Policy, and Sociopolitical Environment (1 related comment)	
1	Lack of state legislation and policy, support
Other Comments	
1	No barriers present

Expansion and/or coordination of crisis response services (16 comments) was the most frequently identified **success** in strengthening the Build element. Successes were largely associated with partnerships and collaboration, crisis response, and programming and implementation (see Table 39).

Table 39: BUILD – Successes in Strengthening the Build Element
(N=44)

Partnership and Coordination (18 related comments)	
7	Collaboration within and between state and local agencies and entities
6	Presence of Governor's Task Force, State Suicide Prevention Coalition, Advisory Councils
5	Robust partnerships and stakeholder support
Crisis Response (16 related comments)	
16	Expansion/coordination of crisis response services
Programming and Implementation (15 related comments)	
6	Implementation of targeted initiatives
6	Toolkit development, training, direct service provision
3	Implementation of a comprehensive, lifespan-focused approach
Diversity, Equity, and Inclusion (12 related comments)	
9	Increased focus on diversity, equity, and inclusion
3	Incorporating lived experience voices and perspectives
Awareness, Promotion, Communication, and Marketing (8 related comments)	
8	Heightened awareness, visibility, and momentum (campaigns, 988, Governor's Challenge)
Funding (7 related comments)	
7	Funding/resources for local efforts/coalitions
Enhanced Surveillance and Data Infrastructure (6 related comments)	
6	Data-informed planning and implementation
Leadership, Policy, and Sociopolitical Environment (6 related comments)	
6	Suicide prevention legislation and policy

Infrastructure Element #6 – GUIDE

Guide (progress score of 18 out of a possible 25) was a middle-rated infrastructure element, with a 71% progress rate. The Guide progress rate remained largely stable between 2022 (70%) and 2023 (71%).

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

Respondents were asked to rate 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 40, only 20% of respondents (10 of 49) reported that their state was formally assessing prevention needs (4% sustainably), while just under half (47%, 23 of 49) were actively working to get a process for assessing community needs in place, and approximately one-third (33%, 16 of 49) had not advanced past planning steps to begin assessing community needs.

Table 40: GUIDE – State Progress Toward Formally Assessing Regional and/or Community Suicide Prevention Needs
(N=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	18%	9
Planning steps to get this in place	14%	7
Actively working to get this in place	47%	23
This is in place, but it is not yet sustainable	16%	8
This is sustainably in place	4%	2
	Total	49

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

As shown in Table 41, progress toward allocating the funding and resources (e.g., education, training, policy support, funding disbursements) necessary to guide state, county, and local groups in implementing evidence-informed suicide prevention programming varied, with 55% of respondents (27 of 49) reporting that their state has allocated such support (12% indicating that it is sustainable), 22% (11 of 49) actively working to get it in place, and 22% (11 of 49) having not advanced past planning.

Table 41: GUIDE – State Progress Toward Allocating Funding and Resources Necessary to Guide State, County, and Local Groups in Implementing Evidence-Informed Suicide Prevention Programming
(N=49)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	10%	5
Planning steps to get this in place	12%	6
Actively working to get this in place	22%	11
This is in place, but it is not yet sustainable	43%	21
This is sustainably in place	12%	6
	Total	49

Local-Level Suicide Prevention Coalition Establishment Ⓢ and Structure

Most states (82%, 40 of 49) have local-level (community, county, and/or regional) suicide prevention coalitions. Of the 40 states with local-level coalitions, 50% (20 of 40) 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, 25% (10 of 40) reported that coalitions are formed independently and do *not* receive any direct guidance, leadership, or funding from the state. Four states (10%, 4 of 40) reported the presence of local-level coalitions formed as a result of state-level bylaws, policies, or mandates; two of these four states indicated that these coalitions receive direct guidance, leadership, and/or funding from the state and two indicated that these coalitions do *not* receive such state support. The remaining 15% (6 of 40) reported some other structure for their local-level coalitions.

Support Provided to Communities at Least Annually

As shown in Table 42, the most common types of support identified as being provided by states to communities at least annually were *guidance on best practices* (96%, 47 of 49), both *local/regional trainings* and *ongoing technical assistance* (94%, 46 of 49), and both *statewide trainings/conferences* and *state-level data to communities* (86%, 42 of 49). Fewer states were *providing local/regional-level data back to communities* (67%, 33 of 49), both *disseminating news* and *providing guidance on strategic planning* (65%, 32 of 49), and *providing funding opportunities* (61%, 30 of 49).

Table 42: GUIDE – Support Provided to Communities at Least Annually

(N=49)

Multiple responses possible	Percent	Count
Disseminating state and national news to communities	65%	32
Offering local or regional trainings	94%	46
Offering statewide trainings or conferences	86%	42
Providing funding opportunities (e.g., mini-grants, RFPs, scholarships)	61%	30
Providing guidance on best practices in suicide prevention	96%	47
Providing guidance on strategic planning	65%	32
Providing local/regional-level data back to communities	67%	33
Providing state-level data to communities	86%	42
Providing ongoing technical assistance (e.g., answering questions, directing communities to available resources)	94%	46
None of the above	2%	1

Consultation and Support for Community-Level Prevention Strategies

The high-level suicide prevention strategies for which states most frequently provide community-level consultation and/or support are *identifying and assisting persons at risk of suicide* (65% of respondents, 32 of 49, indicated that this was one of the top three strategies on which they consult/support), *reducing access to means of suicide* (37%, 18 of 49), and both *ensuring access to effective mental health and suicide care and treatment* and *responding effectively to individuals in crisis* (35%, 17 of 49). Far fewer states identified *supporting safe care transitions and creating organizational linkages* (12%, 6 of 49) and *addressing social determinants of health* (4%, 2 of 49) as one of the top three strategies on which they frequently provide consultation and/or support (see Table 43).

Table 43: GUIDE – High-Level Suicide Prevention Strategies for which States Most Frequently Provide Community-Level Consultation and/or Support
(N=49)

Up to 3 responses possible	Percent	Count
Identify and assist persons at risk of suicide	65%	32
Increase help-seeking behavior	29%	14
Ensure access to effective mental health and suicide care and treatment	35%	17
Support safe care transitions and create organizational linkages	12%	6
Respond effectively to individuals in crisis	35%	17
Provide immediate and long-term postvention	29%	14
Reduce access to means of suicide	37%	18
Enhance life skills and resilience	18%	9
Promote social connectedness and support	22%	11
Address social determinants of health (e.g., housing insecurity, job insecurity, adverse childhood experiences [ACEs])	4%	2
None of the above	4%	2

Community Sectors Actively Supported by the State

Table 44 displays the community sectors that states reported actively supporting in implementing evidence-based suicide prevention programs, practices, or policies. Almost all responding states reported supporting *K-12 Schools* (96%, 47 of 49) and *military/veteran bases or organizations* (92%, 45 of 49). Other frequently supported sectors included *healthcare and mental healthcare* (84%, 41 of 49), *higher education* (73%, 36 of 49), and both *first responder agencies (fire, EMS, law enforcement)* and *local crisis centers* (71%, 35 of 49). Far fewer states reported supporting *local organizations serving minority populations* (18%, 9 of 49), both *housing authorities/housing assistance agencies* and *transportation* (12%, 6 of 49), and *job and unemployment services* (8%, 4 of 49).

Table 44: GUIDE – Community Sectors Actively Supported by States in Implementing Evidence-Based Suicide Prevention Efforts
(N=49)

Multiple responses possible	Percent	Count
Assisted Living / Retirement Facilities	22%	11
Child and Family Services	59%	29
Correction and Rehabilitation	47%	23
Faith-based Institutions	47%	23
First Responder Agencies (fire, EMS, law enforcement)	71%	35
Healthcare and Mental Healthcare	84%	41
Higher Education	73%	36
Housing Authorities / Housing Assistance Agencies	12%	6
Job and Unemployment Services	8%	4
K-12 Schools	96%	47
Lived Experience Groups/Organizations (e.g., suicide loss survivor groups, suicide attempt survivor groups, Local Outreach of Suicide Survivor Teams)	59%	29
Local Crisis Centers	71%	35
Local Government Agencies	49%	24
Private sector (local non-profits, organizations, and/or businesses)	55%	27
Public Health Departments	61%	30
Military/Veteran Bases or Organizations	92%	45
Media Organizations	33%	16
Social Services	49%	24
Substance Abuse Services	57%	28
Transportation	12%	6
Tribal Governments or Agencies	24%	12
Local organizations serving minority populations	18%	9
Others who represent key sectors in local communities	6%	3
None of the above	0%	0

Tracking Trainings Meeting State Requirements or Recommendations

Most states (82%, 40 of 49) 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

The *lack of funding/resources for local efforts and community coalitions* (11 comments) and *strained staff capacity* (9) were the most frequently identified **barriers** to strengthening the Guide element. Barriers clustered primarily around the themes of funding, staffing, and diversity, equity, and inclusion (see Table 45).

Table 45: GUIDE – Barriers to Strengthening the Guide Element
(N=41)

Funding (20 related comments)	
11	No or limited funding/resources for local efforts/community coalitions
7	No or insufficient funding
2	Restrictions on how grant dollars can be spent
Staffing (20 related comments)	
9	Strained staff capacity, workload
6	Difficulty identifying, recruiting, hiring, and retaining staff
5	Insufficient staffing levels
Diversity, Equity, and Inclusion (15 related comments)	
6	Engaging diverse stakeholders and partners
6	Ensuring equitable reach/access to materials and services
3	Lack of culturally responsive materials and services
Assessment, Surveillance, and Evaluation (7 related comments)	
7	Lack of data for planning and evaluation
Leadership, Policy, and Sociopolitical Environment (6 related comments)	
3	Lack of state legislation and policy, support
3	Lack of support from leadership
Suicide Prevention Infrastructure (6 related comments)	
6	Limited statewide/regional/local infrastructure (especially in rural areas)
Partnership and Coordination (3 related comments)	
3	Lack of communication and coordination within and between state and local levels
Priorities (2 related comments)	
2	Suicide prevention not prioritized, competing priorities
Other Comments	
1	No barriers present

The provision of *education and assistance to communities and organizations* (15 comments) and *collaboration within and between state and local agencies and entities* (12) were the most frequently identified **successes** in strengthening the Guide element. Successes were largely associated with partnership and coordination, training and technical assistance, and funding (see Table 46).

Table 46: GUIDE – Successes in Strengthening the Guide Element
(N=42)

Partnership and Coordination (23 related comments)	
12	Collaboration within and between state and local agencies and entities
6	Presence of Governor's Task Force, State Suicide Prevention Coalition, Advisory Councils
5	Robust partnerships and stakeholder support
Training and Technical Assistance (15 related comments)	
15	Education and assistance to communities and organizations
Funding (12 related comments)	
10	Funding/resources for local efforts/coalitions
2	Funding for suicide prevention positions
Awareness, Promotion, Communication, and Marketing (6 related comments)	
6	Heightened awareness, visibility, and momentum (campaigns, 988 Lifeline, Governor's Challenge)
Leadership, Policy, and Sociopolitical Environment (4 related comments)	
4	Suicide prevention legislation and policy
Diversity, Equity, and Inclusion (3 related comments)	
3	Increased focus on diversity, equity, and inclusion
Other Comments	
1	Unsure

Using the Infrastructure Recommendations

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

- **Familiarity with the Infrastructure Recommendations**: Over half of respondents were either "very familiar" (37%, 18 of 49) or "extremely familiar" (18%, 9 or 49) with the recommendations; 37% (18 of 49) were "somewhat familiar" with them, 8% (4 of 49) were “not very familiar,” and none were “not at all familiar.”
- **Use of the Infrastructure Recommendations and/or Related Tools:** The majority of respondents (61%, 30 of 49) 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 30 respondents who reported using the Infrastructure 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 but one respondent reported using the tools most frequently to *guide their personal thinking and decision-making in infrastructure development* and/or *forward or distribute the tools to partners* (80%, 24 of 30) (see Table 47). All but one respondent also reported using the tools at the **state suicide prevention team** level, most frequently to *guide state thinking and decision-making in infrastructure development* (70%, 21 of 30) (see Table 48).

Table 47: Individual Use of the Infrastructure Recommendation Tools to Guide State Infrastructure Development
(N=30)

Multiple responses possible	Percent	Count
I have used the tools on my own to guide my thinking and decision-making in infrastructure development	80%	24
I have used the tools to help me prepare for/speak with state decision-makers or advocacy leaders	53%	16
I have forwarded or distributed the tools to partners	80%	24
I have inserted the tools into my own presentations	50%	15
Other	7%	2
None of the above	3%	1

Table 48: State Prevention Team Use of the Infrastructure Recommendation Tools to Guide State Infrastructure Development
(N=30)

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	70%	21
We have used the tools within our **state suicide prevention coalition** to guide our thinking and decision-making in infrastructure development	43%	13
We have used the tools with **external partner(s) outside of a state coalition** to guide our thinking and decision-making in infrastructure development	33%	10
We have used the tools to provide guidance in supporting local, community-level efforts	37%	11
We have used the tools to model our state efforts on other states' infrastructure examples/successes	43%	13
Other	7%	2
None of the above	3%	1

- **Additional Supports for Infrastructure Development:** Respondents were asked to identify any technical assistance, training, tools, or resources their state needs to continue making progress in infrastructure development. As shown in Table 49, many states (13) felt that they did not necessarily need new supports but instead needed to access existing ones. However, new and enhanced resource ideas were identified by multiple respondents, including *topic-specific assistance (e.g., diversity, equity, inclusion, and centered populations; data, surveillance, assessment, and evaluation)* (32 comments) and *state-to-state peer networking and learning opportunities* (9).

Table 49: Support for Continuing Progress in Infrastructure Development
(N=43)

Topic-Specific Assistance (32 related comments)	
9	Diversity, equity, inclusion, and centered populations
8	Data, surveillance, assessment, and evaluation
4	Advocacy, legislation, and state funding models
4	State suicide offices, coalitions, and advisory councils
3	State strategic plan for suicide prevention
3	Enhancing state infrastructure (strategic plan, workforce development)
1	Postvention
Peer Networking and Learning (9 related comments)	
9	State-to-state sharing and learning opportunities
Funding (1 related comment)	
1	Identification of funding opportunities
Succinct Summaries (1 related comment)	
1	Consolidated research summaries and literature reviews
Update SPRC Website (1 related comment)	
1	Update information/materials on SPRC website
No Additional Tools or Resources / Continued Support (13 related comments)	
7	Continued support, tools, and technical assistance
6	None needed at this time / State needs to use existing resources

Conclusion

Thank you to everyone who contributed to the 2023 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.