SPRC 2021 State and Territorial Suicide Prevention Needs Assessment

Aggregate Technical Report

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BACKGROUND

Between May 26 and July 6, 2021, the Suicide Prevention Resource Center (SPRC) and its partner, Social Science Research and Evaluation, Inc., (SSRE) conducted a State and Territorial Suicide Prevention Needs Assessment (SNA) with 54 suicide prevention coordinators from the 50 U.S. states, the District of Columbia, and three U.S. territories.

The primary purpose of the SNA is to help SPRC better understand state[1] suicide prevention needs, track changes over time in state suicide prevention infrastructure development and provide valuable information back to states on their own progress, and on suicide prevention infrastructure and programming in the nation as a whole. Findings from the SNA are also expected to assist SPRC in the identification and development of future learning opportunities, supports, and resources for state suicide prevention coordinators.

The assessment allowed suicide prevention coordinators to assess and describe their state's suicide prevention strengths, needs, challenges, and successes. It comprised seven sections—one for each of the six essential elements in SPRC's *Recommendations for State Suicide Prevention Infrastructure*[2] (Infrastructure Recommendations): (1) Authorize, (2) Lead, (3) Partner, (4) Examine, (5) Build, and (6) Guide—and a concluding section on the tools associated with the recommendations. Throughout the assessment, respondents were asked to assess the presence of each infrastructure recommendation within their state according to the level of work/sustainability currently occurring. They were also afforded the opportunity to detail the major challenges and/or successes in these areas, as well as identify any support, tools, or resources that SPRC could provide to assist their state in further strengthening related suicide prevention efforts.

METHODS

The SNA was conducted as an online questionnaire. All state suicide prevention coordinators or equivalent state lead were contacted via email and asked to participate. The assessment could be completed either by one designated individual or by formulating responses for the site as a team and submitting one formal response. Respondents could complete the assessment all at once or submit partial answers and return to complete it later.

Forty-one (41) of the 54 invited state suicide prevention coordinators responded (76% response rate). One respondent opted out of the assessment, 36 completed it fully, and 4 completed it partially (74% participation rate).

In addition to generating aggregate SPRC reports, each participating state prevention lead was provided with a comprehensive summary of their state's progress in comparison to all participating states and a full summary of their individual response across all items.

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

[2] https://sprc.org/state-infrastructure

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/sustainability currently occurring. Responses to select items were scored using a 4-point rubric scale ranging from a low of 0 (indicating no presence of the element measure) to a high of 4 (indicating a high presence of the element measure). Summary scores were then computed for each element and overall across elements for the 36 states that answered all scored items. The maximum potential scores were 140 across all elements: 24 for Authorize, 24 for Lead, 12 for Partner, 20 for Examine, 48 for Build, and 12 for Guide. Differences in potential maximum scores for individual elements is due to the number of questions used to assess each element. The Build section, in particular, had the highest potential score because the section contained multiple items to address 10 high-level strategies from SPRC's Comprehensive Approach to Suicide Prevention[3] and the Center for Disease and Control and Prevention's *Preventing Suicide: A Technical Package of Policies, Programs, and Practices*[4].

Table 1 below and Figure 1 on the following page display the total progress scores and rates for all states that completed all scored items both overall (TOTAL) and for each of the six essential elements. Progress rates are based on self-reported state assessments of the presence of each of the six essential elements in SPRC's Infrastructure Recommendations. Progress rates range from 0% (no recommendations in place) to 100% (all recommendations in place with sustainable infrastructure). On average, states achieved a TOTAL infrastructure progress rate of 64% (progress score of 89 out of a possible 140). Infrastructure element progress rates in descending order were: Authorize – 75%, Guide – 68%, Build – 67%, Partner – 64%, Lead – 61%, and Examine – 44%.

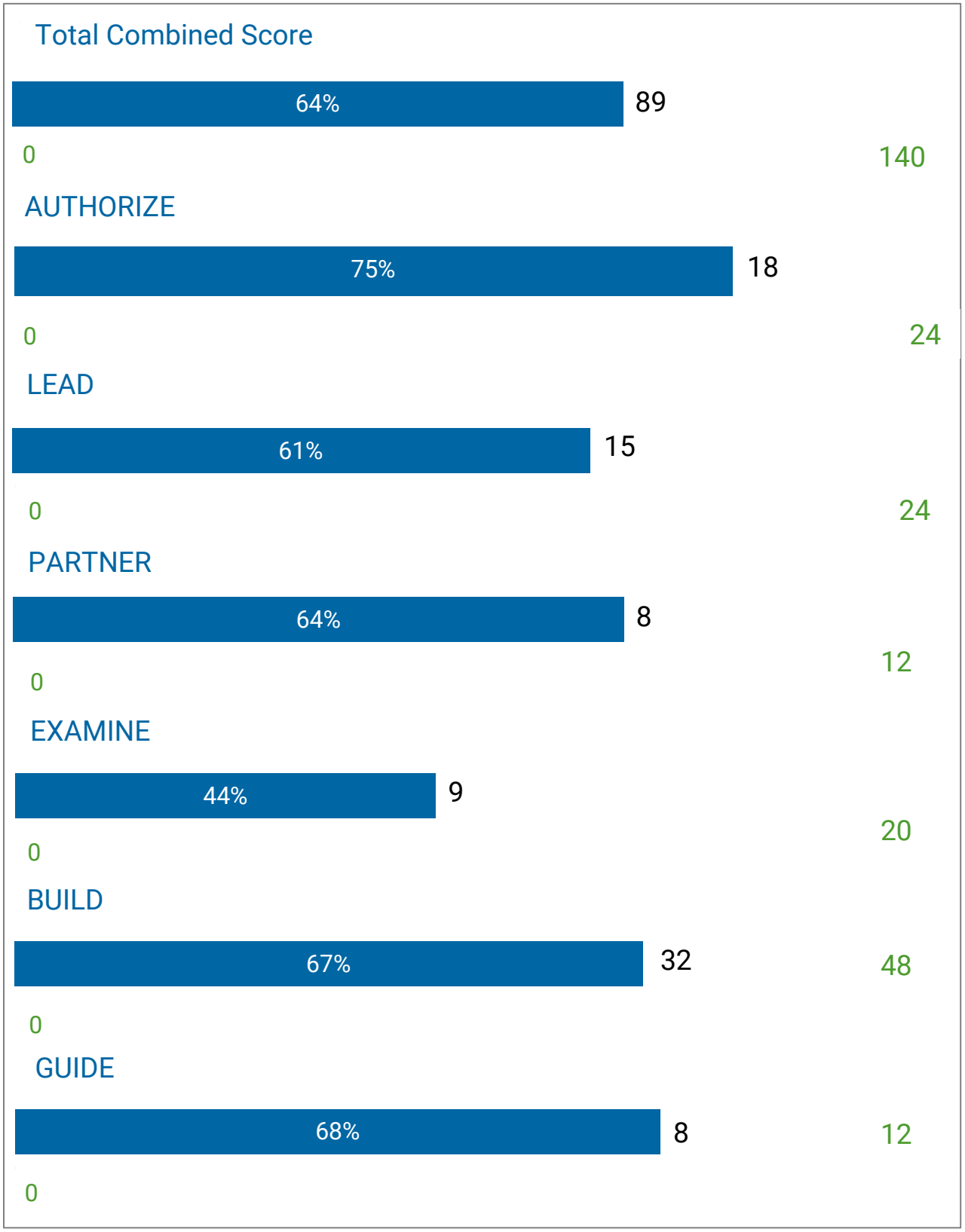
Table 1: Infrastructure Element and Total Progress Scores and Rates
(N=36)

Infrastructure Element	Potential Score Range	Progress Score	Progress Rate
Authorize	0-24	18	75%
Lead	0-24	15	61%
Partner	0-12	8	64%
Examine	0-20	9	44%
Build	0-48	32	67%
Guide	0-12	8	68%
TOTAL COMBINED SCORE	**0-140**	**89**	**64%**

[3] https://www.sprc.org/effective-prevention/comprehensive-approach

[4] https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf

Figure 1: Infrastructure Element and Total Summary Scores (N=36)



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 "(SCORED)" within headings.

Infrastructure Element #1 – AUTHORIZE

Authorize was the highest rated infrastructure element, with a 75% progress rate (progress score of 18 out of a possible 24).

Lead Agency and Authorization (SCORED)

Ninety percent of states (90%, 36 of 40[5]) indicated that their state has a designated lead suicide prevention agency or office, and all but one of those states reported that the agency is authorized/designated to create and carry out the state suicide prevention plan.

Establishing and Sustaining State Budget Line Items (SCORED)

As displayed in Table 2, almost half of states (48%, 19 of 40) indicated that they currently *did not* have an established state budget line item for suicide prevention. Approximately one-third of states (35%, 14 of 40) reported having established and sustainable state budget line-item funding.

Table 2: AUTHORIZE – State Progress toward Establishing and Sustaining State Budget Line Items for Suicide Prevention
(N=40)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	28%	11
Planning steps to get this in place	10%	4
Actively working to get this in place	10%	4
This is in place, but it is not yet sustainable	18%	7
This is sustainably in place	35%	14
	Total	**40**

Value of Established State Budget Line Item Funding

Of the 20 states who reported that they *did have* an established state budget line item and knew the value of the allocation, most reported that the budgeted amount was either between $550,000 and <$1,000,000 (35%, 7 of 20) or between $1,000,000 and $5,000,000 (35%, 7 of 20), while other states were at the opposite ends of the funding spectrum, with 15% (3 of 20) reporting a value between $1 and <$550,000 and 15% (3 of 20) reporting a value more than $5,000,000. Most states with an established state budget line item reported that the allocation was used to fund state suicide prevention staff position(s) (91%, 19 of 21), while just over half reported that the funding provided support for state coalitions, advisory boards, or councils (52%, 11 of 21).

Challenges and Successes – Developing and Maintaining State-Level Funding

Lack of buy-in from the state legislature/leadership (10 comments) and *competing priorities for state dollars* (9) were the most common challenges to developing and maintaining state-level funding for suicide prevention. Challenges clustered around the themes of competing priorities, inconsistent or insufficient funding, lack of support for suicide prevention, and restrictive infrastructure (see Table 3).

[5] Responses on individual items are based on potential responses from all 40 respondents.

Table 3: AUTHORIZE – Challenges in Developing and Maintaining State-Level Funding for Suicide Prevention
(N=33)

Competing Priorities / Inconsistent or Insufficient Funding (36 related comments)	
9	Competing priorities for state dollars
8	Inconsistent funding (dependent on grants)
8	Insufficient funding (budget crisis, decreases in funding amounts)
7	No dedicated state-level funding
4	COVID-19 impacted funding/legislation
Lack of Support for Suicide Prevention (10 related comments)	
10	Lack of buy-in from state legislature/leadership; limited advocates/champions
Restrictive Infrastructure (4 related comments)	
2	Insufficient staffing (limited time, turnover)
2	Siloed efforts, lack of coordination, no lead agency

Receipt of federal funding to support and enhance state efforts (9 comments) and having a *supportive legislature and leadership* (7) were the most common successes identified in developing and maintaining state-level funding for suicide prevention. Success in this area was associated with receipt of funding and/or coordination of multiple funding streams, developing a facilitative and collaborative infrastructure, and garnering support for suicide prevention (see Table 4).

Table 4: AUTHORIZE – Successes in Developing and Maintaining State-Level Funding for Suicide Prevention
(N=30)

Receipt and/or Coordination of Funding (17 related comments)	
9	Receipt of federal funding (block grants, discretionary grants) to support and enhance state efforts
6	Receiving designated suicide prevention funding from the state (budget line item)
2	Successfully able to coordinate or braid diverse funding streams
Facilitative and Collaborative Infrastructure (16 related comments)	
5	State has formally designated a lead agency, office, and/or staff position for suicide prevention
4	Collaboration/coordination between state agencies and/or between state and local levels
4	Strong coalitions (statewide coalition, local coalitions)
3	Annual suicide prevention progress report to the state legislature
Support for Suicide Prevention (15 related comments)	
7	Supportive legislature and leadership
4	Increased awareness of need for suicide prevention (state agency leadership, legislature, governor)
4	Increased interest/attention around implementation of 988

State Suicide Prevention Plan (SCORED)

Eighty percent of states (80%, 32 of 40) indicated that they update their state suicide prevention plan every three to five years and 83% (33 of 40) 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).

Challenges and Successes – Creating, Monitoring, or Updating the State Suicide Prevention Plan

Insufficient staffing (11 comments) was the most common challenge to creating, monitoring, or updating the state suicide prevention plan. Challenges clustered around the themes of restrictive infrastructure and competing priorities (see Table 5).

Table 5: AUTHORIZE – Challenges in Creating, Monitoring, or Updating the State Suicide Prevention Plan
(N=36)

Restrictive Infrastructure (40 related comments)	
11	Insufficient staffing (lack of dedicated staff, turnover)
8	Limited monitoring and evaluation (lacking, low accountability, limited fiscal support)
8	Difficult soliciting input and feedback from stakeholders
7	Insufficient funding (limited financial support for creating, implementing, and updating plan)
6	Limited data availability (challenges linking data systems, lack of data sharing agreements, data lag)
Competing Priorities / Time Commitment / Lengthy Process (20 related comments)	
8	Competing priorities (internal and external)
7	Limited time to create, monitor, and update state suicide prevention plan
3	Lengthy approval processes (delays)
2	COVID-19 delays

Having an engaged group of stakeholders and partners (20 comments) and *having recently created or updated the state plan* (14) were the most common successes associated with creating, monitoring, or updating the state plan. Success in this area was largely associated high levels of engagement and support and having finalized, updated, and/or expanded the focus of the plan (see Table 6).

Table 6: AUTHORIZE – Successes in Creating, Monitoring, or Updating the State Suicide Prevention Plan
(N=38)

High Levels of Engagement and Support (22 related comments)	
20	Engaged group of stakeholders and partners (Advisory Group; Statewide Coalition)
2	Enhanced suicide prevention awareness, visibility, and prioritization
Finalized or Updated Plan / Expanded Focus (21 related comments)	
14	Created/updated Suicide Prevention Plan (developed process for updates/revisions)
5	Expanded focus on priority areas (diversity, equity, inclusion; lived experience; special populations; implementation; sustainability)
2	Incorporation of monitoring and evaluation component
Receipt of Funding (3 related comments)	
3	Secured funding (to create, implement, and update plan)
Facilitative Infrastructure (2 related comments)	
2	Good access to data

Annual Report to State Leadership (SCORED)

Just over half of states (58%, 23 of 40) indicated that their state provides an annual report on suicide prevention to the legislature and/or governor.

SPRC Support, Tools, or Resources for the Authorize Element

States identified obtaining *templates and examples (e.g., draft legislation, tips for engaging leadership, recommendations on funding and staffing levels)* (12 comments) and assistance related to *funding and sustainability (e.g., leveraging support from legislatures)* (10) as the most common supports needed to help the state further strengthen their Authorize element efforts (see Table 7).

Table 7: AUTHORIZE – Support to Help Strengthen Authorize Element Efforts
(N=33)

12	**Templates and examples** (draft legislation, job descriptions, state Advisory Council composition, tips for engaging leadership, funding and staffing level recommendations, sample state suicide prevention plans)
10	**Funding and sustainability** (grant writing, advocacy on how block grants can be used, how to leverage support from legislatures, sustainability strategies, using Medicaid funding)
6	**Topic-specific content** (means safety; postvention; upstream prevention; working with tribal communities; incorporating peer voice/supports; connecting suicide to equity, health, racism, social determinants of health)
5	**Success stories** (how states developed infrastructure and political will, securing a state budget line item)
4	**Connections to other states** (communities of practice, informal networking opportunities)
3	**Technical assistance** (state suicide prevention plan development/review)

Infrastructure Element #2 – LEAD

Lead (61% progress rate, progress score of 15 out of a possible 24) was the second lowest rated infrastructure element.

Suicide Prevention Coordinator Support (SCORED)

While most states (87%, 34 of 39) have a half-time or greater full-time equivalent (0.5 – 1.0 FTE) suicide prevention coordinator or similar role, fewer (64%, 25 of 39) fund additional staff positions.

Challenges and Successes – Hiring and Maintaining State-Level Staff

Insufficient, undedicated, and inconsistent funding (20 comments) and *staff burnout* (7) were the most common challenges to hiring and maintaining state-level suicide prevention staff. Challenges clustered around the themes of funding, recruiting and hiring staff, and maintaining staff (see Table 8).

Table 8: LEAD – Challenges in Hiring and Maintaining State-Level Suicide Prevention Staff
(N=31)

Insufficient Funding (20 related comments)	
20	Insufficient funding/Lack of dedicated funding/Inconsistent Funding
Recruiting and Hiring Staff (14 related comments)	
5	Workforce shortage in relevant areas
3	Non-competitive salaries
2	Difficult to recruit for time-limited (grant) positions
2	Difficulty hiring during COVID-19
1	Burdensome hiring process
1	Difficulty recruiting diverse workforce members
Maintaining Staff (7 related comments)	
7	Staff burn-out (workload, vicarious trauma, turnover)

The ability to maintain existing staff members (9 comments), specifically those described as *talented and competent* (7), and *adding new staff members* (7) were the most common successes reported in hiring and maintaining state-level suicide prevention staff. Successes clustered around the themes of staff stability and competency, adding staff members, and receiving funding to support staff (see Table 9).

Table 9: LEAD – Successes in Hiring and Maintaining State-Level Suicide Prevention Staff
(N=24)

Staff Stability / Competency (16 related comments)	
9	Able to maintain existing staff members
7	Talented and competent staff members
Added Staff Members (7 related comments)	
7	Added new staff members
Receipt of Funding (5 related comments)	
5	Secured funding for staff

Funding Technological Support to Carry Out Activities in State Plan (SCORED)

While state progress toward adequately funding the technological support necessary to carry out the activities listed in state suicide prevention plans was fairly equally distributed across the progress spectrum, only 15% of states reported that "this is sustainably in place" (see Table 10) and close to half (44%, 17 of 39) had not yet taken action beyond initial planning to get this in place.

Table 10: LEAD – State Progress toward Adequately Funding Technological Support to Carry Out Activities in State Plan
(N=39)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	23%	9
Planning steps to get this in place	21%	8
Actively working to get this in place	18%	7
This is in place, but it is not yet sustainable	23%	9
This is sustainably in place	15%	6
	Total	39

Establishing Capacity to Respond to Information Requests (SCORED)

State progress toward establishing sufficient staff and/or professional network capacity to respond to information requests from officials, communities, the media, and the general public was more advanced, with the majority of respondents (66%, 26 of 39) indicating that this was already in place in their state (see Table 11).

Table 11: LEAD – State Progress toward Establishing Sufficient Staff and/or Professional Network Capacity to Respond to Information Requests
(N=39)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	8%	3
Planning steps to get this in place	23%	9
Actively working to get this in place	3%	1
This is in place, but it is not yet sustainable	38%	15
This is sustainably in place	28%	11
	Total	39

Challenges and Successes – Following Messaging Guidelines or Providing a Positive Narrative

Counterproductive media reporting (e.g., sensationalistic, scare tactics) (10 comments) was the most commonly identified challenge to following safe suicide prevention messaging guidelines or providing a positive suicide prevention narrative (e.g., actions to prevent suicide, sharing that prevention works and recovery is possible, telling stories of hope). Challenges in this area were largely associated with inconsistent and/or potentially harmful messaging, lack of engagement and support for safe messaging, and restrictive infrastructure (see Table 12).

Table 12: LEAD – Challenges in Following Safe Suicide Prevention Messaging Guidelines or Providing a Positive Suicide Prevention Narrative
(N=30)

Inconsistent/Potentially Harmful Messaging (17 related comments)	
10	Reporting in the media (sensationalistic, not adhering to best practices, misrepresenting data, scare tactics)
5	Lack of coordinated approach to messaging
2	Limited messaging that centers hope and recovery (peer voice)
Lack of Engagement and Support for Safe Messaging (9 related comments)	
5	Challenges engaging and partnering with media
4	Lack of support (competing priorities, bureaucracy)
Restrictive Infrastructure (5 related comments)	
5	Insufficient staffing (lack of dedicated communications staff)
Insufficient Funding (2 related comments)	
2	Insufficient Funding (limited resources for messaging)

Strong partnerships with organizations serving specific populations, coalitions, and state communication offices (10 comments) and having a *coordinated approach to safe messaging* (10) were the most common successes reported in following safe suicide prevention messaging guidelines or providing a positive suicide prevention narrative. Successes clustered around the themes of engagement and support for safe messaging, education and awareness efforts, and facilitative infrastructure (see Table 13).

Table 13: LEAD – Successes in Following Safe Suicide Prevention Messaging Guidelines or Providing a Positive Suicide Prevention Narrative
(N=35)

Engagement and Support for Safe Messaging (16 related comments)	
10	Strong partners (organizations serving specific populations, coalitions, state communication offices)
6	Successfully engaging and partnering with media (receptive to education)
Education and Awareness Efforts (15 related comments)	
15	Development of education and training materials on safe messaging (webinars, social media)
Facilitative Infrastructure (10 related comments)	
10	Coordinated approach to safe messaging (single point of contact, knowledgeable staff)

Formal Suicide Prevention Partnerships (SCORED)

Approximately two-thirds of respondents (64%, 25 of 39) reported that their state had established formal suicide prevention partnerships between government divisions or offices.

Braided Funding to Support Prevention Efforts (SCORED)

Less than half of responding states (41%, 16 of 39) are using braided funding to support relevant suicide prevention efforts (e.g., using opioid misuse and suicide prevention dollars to support a drug take-back campaign).

SPRC Support, Tools, or Resources for the Lead Element

States identified obtaining *topic-specific content (e.g., braided funding)* (7 comments), assistance related to *funding and sustainability (e.g., optimizing funding, sustaining positions)* (5), and *technical assistance (e.g., establishing relationships with other state agencies)* (5) as the most common supports needed to help the state further strengthen their suicide prevention leadership (see Table 14).

Table 14: LEAD – Support to Help Strengthen Lead Element Efforts
(N=24)

7	**Topic-specific content** (braided funding, evidence-based programs for middle-aged white men and elderly)
5	**Funding and sustainability** (optimizing funding; sustaining positions; adding suicide prevention as a specific category in MHBG, SABG, and Medicare/Medicaid)
5	**Technical assistance** (establishing relationships with other state agencies, working with upper leadership)
4	**Templates and examples** (draft legislation, sample partnership agreements, sample job descriptions)
3	**Success stories** (how other states achieved success)
3	**Training** (leadership development, training leaders, core competencies)
2	**Connections to other states** (communities of practice, state leadership meetings)

Infrastructure Element #3 – PARTNER

Partner was a mid-rated infrastructure element, with a 64% progress rate (progress score of 8 out of a possible 12).

Statewide Suicide Prevention Coalition – Establishment (SCORED)

Over three-quarters of states (77%, 30 of 39) have a statewide, lifespan-focused suicide prevention coalition.

Statewide Suicide Prevention Coalition – Sector Representation (SCORED)

Of the 30 states with statewide, lifespan-focused suicide prevention coalitions, over 80% indicated that they have established broad public and private sector coalition representation, with 60% (18 or 30) reporting that it is "sustainably in place" (see Table 15).

Table 15: PARTNER – Statewide Suicide Prevention Coalition Progress toward Having Broad Public and Private Sector Representation
(N=30)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	0%	0
Planning steps to get this in place	7%	2
Actively working to get this in place	10%	3
This is in place, but it is not yet sustainable	23%	7
This is sustainably in place	60%	18
	Total	30

Statewide Suicide Prevention Coalition – Goals (SCORED)

States with statewide, lifespan-focused suicide prevention coalitions were less likely to report that their coalition had set mutually agreed-upon goals for suicide prevention, with 60% indicating that they have set such goals (see Table 16).

Table 16: PARTNER – Statewide Suicide Prevention Coalition Progress toward Setting Mutually Agreed-Upon Goals for Suicide Prevention
(N=30)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	0%	0
Planning steps to get this in place	10%	3
Actively working to get this in place	30%	9
This is in place, but it is not yet sustainable	7%	2
This is sustainably in place	53%	16
	Total	30

Challenges and Successes – Adopting Shared Goals Across Partners

Competing interests/priorities (14 comments) and *lack of coordination* (8) were the most commonly identified challenges to adopting shared goals across partners. Challenges in this area were largely associated with competing priorities and lack of support and restrictive infrastructure (see Table 17).

Table 17: PARTNER – Challenges in Adopting Shared Goals Across Partners
(N=31)

Competing Priorities / Lack of Support (18 related comments)	
14	Competing interests/priorities (competition for funding, different agendas)
4	No formal participation agreements
Restrictive Infrastructure (13 related comments)	
8	Lack of coordination (multiple workgroups and coalitions, no designated lead, no authority)
5	Limited capacity, resources, bandwidth among partners to send representatives and maintain participation
Challenging Externalities (2 related comments)	
2	COVID-19 disrupted progress/momentum

The development of *strong coalitions and partnerships (statewide coalition, local coalitions, diverse partners)* (16 comments) and having a *shared commitment to suicide prevention* (9) were the most common successes reported in adopting shared goals across partners. Successes clustered around the themes of facilitative infrastructure and shared commitment and support for suicide prevention (see Table 18).

Table 18: PARTNER – Successes in Adopting Shared Goals Across Partners
(N=34)

Facilitative Infrastructure (23 related comments)	
16	Strong coalitions and partnerships (statewide coalition, local coalitions, diverse partners)
5	Leveraging momentum and elements of state and national plans and other efforts in the state
2	Key personnel (trusted)
Shared Commitment and Support for Suicide Prevention (12 related comments)	
9	Shared commitment to the issue
3	Supportive legislature and leadership

Actions Taken to Ensure Cultural Responsiveness

Respondents were asked to identify actions that their state has taken to ensure cultural responsiveness within their prevention efforts. As displayed in Table 19, 85% (33 of 39) had included members of populations served in strategic planning efforts, 69% had engaged in efforts to research and understand the cultural context of communities reached by strategies or interventions, and just over half (54%, 21 of 39 respectively) had tailored/developed interventions and resources to address populations served and/or created an open dialogue whereby members of populations served can share cultural considerations key to prevention. Almost all states (95%, 37 of 39) reported that they had taken at least one of the listed efforts to ensure cultural responsiveness.

Table 19: PARTNER – Actions State Has Taken to Ensure Cultural Responsiveness within Prevention Efforts
(N=39)

Multiple responses possible	Percent	Count
Researching and understanding the cultural context of communities reached by strategies/interventions (target populations)	69%	27
Including members of populations served (e.g., communities of color, rural communities, tribal communities) in strategic planning activities	85%	33
Tailoring and/or developing interventions and resources to address the values, beliefs, culture, and language of the populations served	54%	21
Creating an open dialogue whereby members of populations served can share cultural considerations key to prevention	54%	21
None of the above	5%	2

SPRC Support, Tools, or Resources for the Partner Element

States identified obtaining *templates and examples (e.g., draft written agreements with partners, MOUs)* (8 comments) and *topic-specific content (e.g., engaging with other cultures, engaging Bureau of Indian Affairs [BIA] and the Indian Health Service [IHS])* (7) as the most common supports needed to help the state further strengthen their suicide prevention partnerships (see Table 20).

Table 20: PARTNER – Support to Help Strengthen Partner Element Efforts
(N=23)

8	**Templates and examples** (draft written agreements with partners, MOUs, examples of innovative partnerships, examples of cultural responsiveness efforts, culturally sensitive materials)
7	**Topic-specific content** (engaging other cultures, equity, cultural inclusion, cultural responsiveness, engaging BIA and IHS, formalizing public/private partnerships, intersectionality between suicide and occupations)
4	**Technical assistance** (forming partnerships, guided interview question development, strategic planning, creating shared vision and language among partners)
3	**Success stories** (outcomes of work with specific populations, developing a diverse partner network)
2	**Funding** (funding for cultural adaptations and translations of evidence-based practices)
1	**Connections to other states** (communities of practice)

Infrastructure Element #4 – EXAMINE

Examine was the lowest rated infrastructure element, with a 44% progress rate (progress score of 9 out of a possible 20).

Statewide System for Collecting and Analyzing Suicide Death Data (SCORED)

As displayed in Table 21, there was variability in state progress toward having a statewide system in place for collecting and analyzing suicide death data, with 58% of respondents (22 of 38) indicating that their state has such a system in place and 45% indicating that it is sustainable.

Table 21: EXAMINE – State Progress toward Having a Statewide System in Place for Collecting and Analyzing Suicide Death Data
(N=38)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	3%	1
Planning steps to get this in place	13%	5
Actively working to get this in place	26%	10
This is in place, but it is not yet sustainable	13%	5
This is sustainably in place	45%	17
	Total	38

Challenges in Establishing a System for Collecting and Analyzing Suicide Death Data

Respondents who indicated that their state did *not* yet have a statewide suicide death data system in place (42%, 16 of 38) were asked to identify their major challenges in establishing a system. *Data lag (delays, embargo, bureaucracy)* (4 comments) and *difficulty accessing data (no access, no data sharing agreement)* (3) were the most commonly identified challenges, and challenges clustered around the themes of difficulty accessing data and challenges analyzing data (see Table 22).

Table 22: EXAMINE – Challenges among States without a Statewide Suicide Death Data System in Establishing a System for Collecting and Analyzing Suicide Death Data
(N=13)

Difficulty Accessing Data (9 related comments)	
4	Data lag (delays, embargo, bureaucracy)
3	Difficulty accessing data (no access, no data sharing agreement)
2	Siloed data systems
Challenges Analyzing Data (6 related comments)	
2	Challenging to analyze data (missing data, data suppression)
2	Difficulty linking data (privacy laws)
2	Insufficient staffing (lack of dedicated staff, evaluator)
Difficulty Collecting Data (1 related comment)	
1	Lack of data on specific populations (LGBTQ+)

Standards for Timeliness of Mortality Reporting (SCORED)

Half of states (50%, 19 of 38) have developed standards related to the timeliness of mortality reporting (e.g., all coroner data will be finalized within one year of suicide death).

Linking Data from Different Systems (SCORED)

Comparatively few respondents (30%, 11 of 37) 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 14% (5 of 37) indicated that this was sustainable. Close to one-third (30%, 11 of 37) 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=37)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	30%	11
Planning steps to get this in place	19%	7
Actively working to get this in place	22%	8
This is in place, but it is not yet sustainable	16%	6
This is sustainably in place	14%	5
	Total	37

Challenges and Successes – Establishing Partnerships Key to Accessing and Linking Data

Lack of data sharing agreements (10 comments), *agencies protective of data* (8), *insufficient staffing* (8), and *lack of a centralized data system* (8) were the most commonly identified challenges to establishing partnerships key to accessing data and linking data across systems. Challenges in this area were most commonly associated with difficulty accessing data and restrictive infrastructure (see Table 24).

Table 24: EXAMINE – Challenges in Establishing Partnerships Key to Accessing Data and Linking Data Across Systems
(N=30)

Difficulty Accessing Data (24 related comments)	
10	Lack of data sharing agreements
8	Agencies protective of data (ownership, bureaucracy)
6	Confidentiality/Privacy (legality)
Restrictive Infrastructure (16 related comments)	
8	Insufficient staffing (no dedicated epidemiologist, limited time, turnover)
8	No centralized data system (difficulty linking datasets)
Insufficient Funding (4 related comments)	
4	No funding for linking and retrieving data

States felt the partnerships that have been most helpful in accessing data and linking data across systems were *interagency workgroups* (12 comments), *partnerships with vital records, coroners, National Violent Death Reporting System (NVDRS) participation* (12), and *partnerships with Health Departments* (11). Beneficial partnerships clustered around the themes of physical and behavioral health agencies, interagency partnerships, and vital records (see Table 25).

Table 25: EXAMINE – Successes in Establishing Partnerships that Have Been Most Helpful in Accessing Data and Linking Data Across System
(N=28)

Physical and Behavioral Health Agencies (19 related comments)	
11	Partnerships with Health Department (morbidity data, BRFSS, YRBS)
5	Partnerships with Mental Health Department
3	Partnerships with hospitals and health systems (VA)
Interagency Partnerships (12 related comments)	
12	Interagency Workgroups (Office of Epidemiology, Advisory Council Data Workgroup, State-University Partnerships, State Epidemiological Outcomes Workgroup)
Vital Records (12 related comments)	
12	Partnerships with vital records, coroners, NVDRS participation
Regulatory and Enforcement Agencies (2 related comments)	
2	Partnerships with Enforcement/Regulatory agencies (law enforcement, PDMP)

Establishing a Near Real-Time Data System for Suicidal Ideation and Attempts (SCORED)

Only 31% of respondents (12 of 38) reported that their state has a system for collecting and analyzing near real-time statewide data for suicidal ideation and attempts, while 18% (7) are "actively working to get this in place" and 50% (19 of 38) have not begun the work beyond planning (see Table 26).

Table 26: EXAMINE – State Progress toward Establishing a System for Collecting and Analyzing Near Real-Time Statewide Data for Suicidal Ideation and Attempts
(N=38)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	16%	6
Planning steps to get this in place	34%	13
Actively working to get this in place	18%	7
This is in place, but it is not yet sustainable	18%	7
This is sustainably in place	13%	5
	Total	38

Challenges and Successes – Collecting and Analyzing Near-Real Time Statewide Data

Insufficient staffing (11 comments) and *coding and documentation challenges* (10) were the most commonly identified challenges to collecting and analyzing near real-time statewide data for suicidal ideation and attempts. Challenges clustered around the themes of restrictive infrastructure, technical challenges, limited support and cooperation, and difficulty accessing data (see Table 27).

Table 27: EXAMINE – Challenges in Collecting and Analyzing Near Real-Time Statewide Data for Suicidal Ideation and Attempts
(N=29)

Restrictive Infrastructure (15 related comments)	
11	Insufficient staffing (limited time, lack of dedicated staff)
4	No centralized data system
Technical Challenges (10 related comments)	
10	Coding and documentation challenges (definitions, cause of death, interpretation, change from ICD9 to ICD10)
Limited Support and Cooperation (9 related comments)	
7	Lack of cooperation (little willingness to share, limited participation by hospitals/counties)
2	Limited support (low buy-in; competing priorities)
Difficulty Accessing Data (8 related comments)	
8	Limited data access and data sharing (agreements not in place)
Insufficient Funding (2 related comments)	
2	Insufficient funding (cost)

Having a *syndromic data system with access to near real-time data* (12 comments) was the most commonly identified success in collecting and analyzing near real-time statewide data for suicidal ideation and attempts. Successes were largely associated with access to data, followed by support and funding (see Table 28).

Table 28: EXAMINE – Successes in Collecting and Analyzing Near Real-Time Statewide Data for Suicidal Ideation and Attempts
(N=26)

Access to Data (19 related comments)	
12	Syndromic system in place/Access to near-real time data
5	Interagency data sharing agreements (vital statistics, medical examiner, law enforcement)
Support for Suicide Prevention (5 related comments)	
3	Support from state legislators, leadership
2	COVID-19 (facilitated formation of data sharing agreements due to interest about pandemic and suicide)
Receipt of Funding (4 related comments)	
4	Funding (ED-SNSRO [CDC], FASTER [CDC], Zero Suicide grant [SAMHSA], GLS [SAMHSA])
Facilitative Infrastructure (1 related comment)	
1	Staffing (dedicated epidemiology staff)

State-Level Interactive Dashboard with Near Real-Time Morbidity Data (SCORED)

Only 21% of states (8 of 38) reported having a state-level interactive dashboard with near real-time suicide morbidity data.

Ensuring Data Representation of Populations that are High Risk and Underserved (SCORED)

Just 16% of respondents (6 of 38) reported that their state ensures populations that are high risk and underserved are sufficiently represented in their suicide-related data. Most are either "actively working to get this in place" (45%, 17 of 38) or "planning steps to get this in place" (24%, 9 of 38). See Table 29.

Table 29: EXAMINE – State Progress toward Ensuring Populations that Are High Risk and Underserved Are Sufficiently Represented in Suicide-Related Data
(N=38)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	16%	6
Planning steps to get this in place	24%	9
Actively working to get this in place	45%	17
This is in place, but it is not yet sustainable	5%	2
This is sustainably in place	11%	4
	Total	38

Challenges and Successes – Ensuring Data Representation for Populations that Are High Risk and Underserved

Data gaps and inconsistencies (e.g., tribal populations under-represented, special populations data not consistently collected/documented) (14 comments) was the most commonly identified challenge to ensuring populations that are high risk and underserved are sufficiently represented in suicide-related data. Challenges clustered primarily around the theme of technical challenges, including data gaps and inconsistencies and data suppression (see Table 30).

Table 30: EXAMINE – Challenges in Ensuring Populations that Are High Risk and Underserved Are Sufficiently Represented in Suicide-Related Data
(N=31)

Technical Challenges (17 related comments)	
14	Data gaps and inconsistencies (Tribal populations under-represented; data on race/ethnicity, gender identity, sexual orientation, veteran status not consistently collected/documented)
3	Data suppression (low counts for specific populations)
New Area of Focus (5 related comments)	
5	New area of focus (still learning, just starting, defining and identifying relevant populations)
Difficulty Accessing Data (4 related comments)	
4	Limited data access and data sharing (don't have access to all data sources)
Insufficient Funding (4 related comments)	
4	Insufficient funding (data entry, data analysis)
Restrictive Infrastructure (3 related comments)	
3	Insufficient staffing (limited time and capacity)
Limited Support (3 related comments)	
3	Limited support and buy-in (political climate)

The ability to *build capacity and awareness (e.g., developing methodologies for analysis, interpretation, reporting, and use; starting to apply an equity lens for reporting)* (9 comments) was the most commonly identified success in ensuring populations that are high risk and underserved are sufficiently represented in suicide-related data, along with *increased interest in accurately collecting and reporting these data* (5) and building related *technical capacity (e.g., strong epidemiological support, interagency data linkages)* (5). Successes were largely associated with building capacity and awareness as well as engagement and support (see Table 31).

Table 31: EXAMINE – Successes in Ensuring Populations that Are High Risk and Underserved Are Sufficiently Represented in Suicide-Related Data
(N=26)

Building Capacity and Awareness (9 related comments)	
9	Building capacity and awareness (developing methodologies for analysis, interpretation, reporting, and use; developing mortality dashboard; data mapping; starting to apply an equity lens for reporting)
Engagement and Support (9 related comments)	
5	Increased interest in accurately collecting and reporting these data
2	Diverse and engaged stakeholders and partners
2	Forming new relationships and partnerships
Facilitative Infrastructure (5 related comments)	
5	Technical capacity (strong epidemiological support; interagency data linkages; ability to parse data into different groups; data systems filtering and sorting)
Access to Data (4 related comments)	
4	Access to interagency data (data sharing agreements in place)

State-Supported Suicide Prevention Evaluation

Respondents were asked to identify the types of state-supported suicide prevention evaluation efforts that have occurred in their state within the past year. As displayed in Table 32, 54% of states (20 of 37) had engaged in *process* evaluation efforts to ensure that strategies/interventions are being implemented as intended, while 43% (16 of 37 respectively) had engaged in *formative* efforts to inform implementation and/or *outcome* efforts to access objective achievement. Fewer (24%, 9 of 37) had engaged in *impact* evaluation efforts to assess long-term impacts on goals and suicide rates. Over one-third of states (38%, 14 of 37) indicated that none of the listed evaluation efforts had occurred during the past year.

Table 32: EXAMINE – State-Supported Evaluation Efforts that Have Occurred During the Past Year
(N=37)

Multiple responses possible	Percent	Count
Formative evaluations to ensure strategies/interventions are feasible, appropriate, and acceptable prior to full implementation (conducting pilot evaluations)	43%	16
Process evaluations to ensure strategies/interventions are being implemented as intended	54%	20
Outcome evaluations to determine whether strategies/interventions are helping to achieve set objectives	43%	16
Impact evaluations to determine strategy/intervention impacts on long-term goals and suicide rates	24%	9
None of the above	38%	14

Challenges and Successes – State-Level Evaluation

Insufficient funding (no or limited support for evaluation, allocation restrictions) (13 comments) and *insufficient staffing* (8) were the most commonly identified challenges at the state level related to evaluation. Challenges clustered primarily around the themes of insufficient funding and restrictive infrastructure (see Table 33).

Table 33: EXAMINE – Challenges at the State-Level around Evaluation
(N=26)

Insufficient Funding (13 related comments)	
13	Insufficient funding (no or limited support for evaluation; funding restrictions on how dollars can be spent)
Restrictive Infrastructure (8 related comments)	
8	Insufficient staffing (time; lack of dedicated evaluation staffing; limited expertise with evaluation)
Challenges Accessing Data (5 related comments)	
5	Difficulty collecting/retrieving data (COVID, low provider enthusiasm for data collection, fragmented data, cost)
Limited Support (4 related comments)	
4	Limited support (not an area of focus)

The ability to *contract an evaluation team* (9 comments) and *incorporate evaluation measures into logic models, state plans, and grantee contracts* (7) were the most commonly identified state-level evaluation successes, along with *interagency data sharing and reporting* (6). Successes were largely associated with contracting external professionals, embedding evaluation in plans and contracts, and interagency cooperation (see Table 34).

Table 34: EXAMINE – Successes at the State-Level around Evaluation
(N=24)

Contracting External Professionals (9 related comments)	
9	Contracted evaluation team (strong evaluators)
Embedding Evaluation in Plans and Contracts (7 related comments)	
7	Incorporation of evaluation measures into logic models, state plans, and grantee contracts
Interagency Cooperation (6 related comments)	
6	Interagency data sharing and reporting
Receipt of Funding (4 related comments)	
4	Funding (grant-supported evaluation)

SPRC Support, Tools, or Resources for the Examine Element

States identified obtaining *templates and examples (e.g., draft legislation supporting evaluation, model dashboards)* (12 comments) and *topic-specific content (e.g., building robust evaluations, tips for increasing survey response rates)* (7) as the most common supports needed to help the state further strengthen its data collection, analysis, evaluation, and reporting efforts (see Table 35).

Table 35: EXAMINE – Support to Help Strengthen Examine Element Efforts
(N=18)

12	**Templates and examples** (example tools, draft legislation supporting evaluation, self-assessment checklists, sample evaluation reports, sample infographics, model dashboards, sample data use agreements)
7	**Topic-specific content** (building robust evaluations, using evaluation findings to allocate or maintain funding, how other states are evaluating their state plan, cultural responsiveness in evaluation, tips for increasing survey response rates)
3	**Connections to other states** (communities of practice on improving evaluation in states)
2	**Funding** (strategies for sustainable evaluation funding, legislation)
2	**Technical assistance** (developing outcome evaluations, adopting a data-driven approach)
1	**Success stories** (how states are demonstrating success implementing their state plan)

Infrastructure Element #5 – BUILD

Build was a mid-rated infrastructure element, with a 67% progress rate (progress score of 32 out of a possible 48).

Strategic Planning Activities

Respondents were asked to identify which of the six activities in SPRC's Strategic Planning Approach to Suicide Prevention[6] their state suicide prevention coalition or office of suicide prevention engaged in within the past two years. Almost all respondents (97%, 37 of 38) indicated that their state had used data or other evidence to describe their state's suicide problem and context, while the large majority had also chosen short and long-term data-based goals (89%, 34 of 38), identified key risk and protective factors (79%, 30 of 38), and selected or developed factor-based strategies and interventions (76%, 29 of 38). Fewer had planned for strategy/intervention evaluation (66%, 25 of 38) or evaluated strategies/interventions over time (50%, 19 of 38). One state indicated that none of these strategic planning activities had occurred in their state during the past two years. See Table 36 for details.

Table 36: BUILD – State Strategic Planning Activities in the Past Two Years
(N=38)

Multiple responses possible	Percent	Count
Use data or other sources to describe your state's suicide problem and its context	97%	37
Choose short and long-term goals based on available data to guide suicide prevention efforts	89%	34
Identify key risk and protective factors for suicide in your state	79%	30
Select or develop strategies and interventions that address identified risk and protective factors	76%	29
Plan for evaluation of your strategies and interventions	66%	25
Evaluate and improve strategies/interventions over time	50%	19
None of the above	3%	1

Promotion of a Comprehensive Lifespan Approach within State Plan (SCORED)

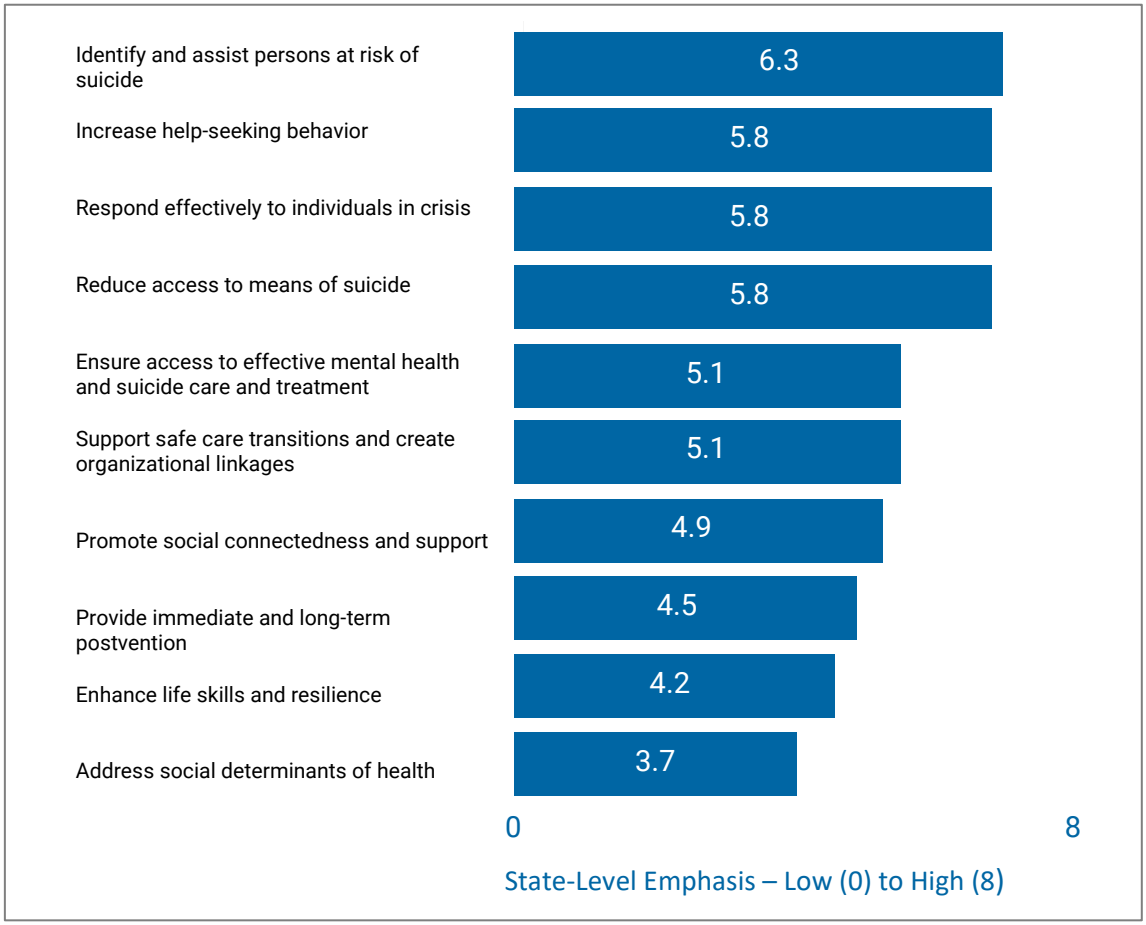
Most states (89%, 34 of 38) indicated that their state suicide prevention plan promotes a comprehensive, lifespan approach to suicide prevention—one that involves a variety of suicide prevention strategies across all levels of prevention.

State Emphasis on Addressing High-Level Strategies (SCORED)

Respondents were asked to assess the level of emphasis that their state suicide prevention coalition or suicide prevention office places on addressing 10 high-level strategies from SPRC's Comprehensive Approach to Suicide Prevention and the Center for Disease and Control and Prevention's *Preventing Suicide: A Technical Package of Policies, Programs, and Practices*, considering factors such as the relative amount of funding focused on the strategy, the number of activities implemented to address the strategy, and the level of effort expended to implement those activities. Level of emphasis was assessed on a sliding scale of 0 (low) to 8 (high). As displayed in Figure 2, states place the greatest emphasis on *identifying and assisting persons at risk of suicide* (6.3), followed by *increasing help-seeking behavior* (5.9), and *responding effectively to individuals in crisis* (5.8). Strategies addressed the least are *addressing social determinants of health* (3.7), *enhancing life skills and resilience* (4.2), and *providing immediate and long-term postvention* (4.5).

[6] https://www.sprc.org/resources-programs/strategic-planning-approach-suicide-prevention

Figure 2: BUILD – State Emphasis on Addressing High-Level Strategies



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. As displayed in Table 37, by far the most commonly addressed determinant was adverse childhood experiences (ACEs) (72%, 26 of 36). One-fifth of states (19%, 7 of 36) indicated that their state suicide prevention office or coalition is currently not addressing any of the listed social determinants of health.

Table 37: BUILD – Social Determinants of Health Currently Being Addressed by State Suicide Prevention Office or Coalition
(N=36)

Multiple responses possible	Percent	Count
ACEs (adverse childhood experiences)	72%	26
Education access and quality	28%	10
Financial / Job security	28%	10
Food insecurity	19%	7
Housing insecurity	33%	12
Neighborhood and community environment	39%	14
Systemic discrimination	25%	9
Violence	42%	15
None of the above	19%	7

Challenges and Successes – Implementing a Comprehensive Approach to Suicide Prevention

Insufficient funding (cost, resources to coordinate across state agencies) (15 comments) and *insufficient staffing (limited time and capacity)* (10) were the most commonly identified challenges to implementing a comprehensive approach to suicide prevention (i.e., an approach that involves a variety of strategies across all levels of prevention). Challenges clustered primarily around the themes of insufficient funding, restrictive infrastructure, and limited support (see Table 38).

Table 38: BUILD – Challenges Implementing a Comprehensive Approach to Suicide Prevention
(N=31)

Insufficient Funding (15 related comments)	
15	Insufficient funding (cost, resources to coordinate across state agencies)
Restrictive Infrastructure (10 related comments)	
10	Insufficient staffing (limited time and capacity)
Limited Support (8 related comments)	
5	Unsupportive political climate (strong gun culture), bureaucracy, competing priorities in state
3	Lack of awareness and support
Lack of Authority (6 related comments)	
6	No mandate/authority in areas that need to be addressed (no lead agency)
Lack of Access to Data (2 related comments)	
2	Lack of access to data for planning and evaluation

Cross-agency and cross-level (state and local) collaboration (8 comments), *support and commitment from stakeholders and leadership)* (7), having a comprehensive *state suicide plan* (6), and *funding* support (6) were the most commonly identified successes in implementing a comprehensive approach to suicide prevention. Successes were associated with facilitative infrastructure, collaboration and cooperation, support for suicide prevention, and receipt of funding (see Table 39).

Table 39: BUILD – Successes Implementing a Comprehensive Approach to Suicide Prevention
(N=27)

Facilitative Infrastructure (13 related comments)	
6	State suicide prevention plan (reflects comprehensive approach)
4	Coalitions (statewide coalition, local coalitions)
2	Staff (knowledgeable, diverse, committed)
1	Leveraging momentum from other state efforts (State health improvement plan)
Collaboration and Cooperation (8 related comments)	
8	Cross-agency and cross-level (state and local) collaboration
Support for Suicide Prevention (7 related comments)	
7	Support and commitment (stakeholder involvement, leadership)
Receipt of Funding (6 related comments)	
6	Funding (federal funding, braiding funding streams, state budget line items)

Core Elements of Effective Crisis Care (SCORED)

Respondents were asked to identify which of four core elements of effective crisis care are currently represented by their state's crisis infrastructure. As displayed in Table 40, while most respondents (92%, 35 of 38) indicated that their state's crisis infrastructure currently includes a 24/7 regional or statewide crisis call center, fewer identified representation of the use of trauma-informed principles within crisis care (74%, 28 of 38), a 24/7 mobile crisis outreach and support (68%, 26 of 38), or residential crisis stabilization programs for individuals who need support and observation (66%, 25 of 38). One state indicated that none of these core elements are currently represented in their state's crisis infrastructure.

Table 40: BUILD – Core Elements of Effective Crisis Care Currently Represented by State Crisis Infrastructure
(N=38)

Multiple responses possible	Percent	Count
Regional or statewide crisis call centers available on a 24/7 basis	92%	35
Mobile crisis outreach and support available on a 24/7 basis	68%	26
Residential crisis stabilization programs for individuals who need support and observation	66%	25
The use of trauma-informed principles within crisis care	74%	28
None of the above	3%	1

Challenges and Successes – Supporting Crisis System Infrastructure

Inconsistent and fragmented systems across the state (18 comments) and *high associated costs* (12) were the most commonly identified challenges to supporting crisis system infrastructure. Challenges clustered primarily around the themes of restrictive infrastructure, cost and insufficient funding, and lack of authority (see Table 41).

Table 41: BUILD – Challenges in Supporting Crisis System Infrastructure
(N=32)

Restrictive Infrastructure (24 related comments)	
18	Inconsistency across state/fragmented systems (limited rural infrastructure, no statewide coverage)
6	Workforce shortage (recruitment and retention of trained personnel, limited capacity)
Cost / Insufficient Funding (12 related comments)	
12	High cost (inadequate funding, expensive to implement)
Lack of Authority (6 related comments)	
6	No authority (crisis infrastructure handled at the local level, lack of interagency cooperation and communication)
Lack of Support (2 related comments)	
2	Lack of political will (stigma)

The *addition of services (additional call centers, mobile crisis services, expansion of telehealth services)* (16 comments) and *receipt of funding* (13) were the most commonly identified successes in supporting crisis system infrastructure. Successes were associated with facilitative infrastructure, receipt of funding, support for suicide prevention, and collaboration and cooperation (see Table 42).

Table 42: BUILD – Successes in Supporting Crisis System Infrastructure
(N=31)

Facilitative Infrastructure (18 related comments)	
16	Adding services (additional call centers, mobile crisis services, expansion of telehealth services)
2	Improved National Suicide Prevention Lifeline answer rate
Receipt of Funding (13 related comments)	
13	Funding (state and federal 988 funding, mobile crisis response funding)
Support for Suicide Prevention (7 related comments)	
4	Support and commitment (stakeholder involvement, leadership)
3	Increased attention to issue (988 discussions)
Collaboration and Cooperation (5 related comments)	
5	Increased collaboration between suicide prevention and mobile crisis (relationship with 911)

Targeted State-Level Prevention Strategies

Representatives were asked to detail which *specific* populations their state-level prevention strategies—programs, services, campaigns, and/or policies—are *designed to reach*. Acknowledging that many initiatives may reach multiple populations, whether intended or unintended, respondents were asked to only answer based on whether they currently have state-level prevention strategies *intentionally targeting* the populations listed. Almost all states reported having strategies intentionally targeting age-based populations (97%, 35 of 36), followed by 83% for high-risk occupational (30 of 36), 81% for lived experience (29 of 36), 66% for racial/ethnic/minority (23 of 35), and 61% for location-based (22 of 36) populations. The most commonly targeted populations were youth ages 10-17 (89%), young adults ages 18-24 (81%), military/veterans (81%), and suicide loss survivors (72%). See Table 43.

Table 43: BUILD – Populations Specifically Targeted by Suicide Prevention Strategies

Multiple responses possible	Percent	Count
AGE-BASED POPULATIONS (N=36)		
Children Under 10	33%	12
Youth 10-17	89%	32
Young Adults 18-24	81%	29
Adults 25-44	56%	20
Middle-Aged Adults 45-64	56%	20
Older Adults 65+	47%	17
We do not currently have targeted state-level strategies for these populations	3%	1
LOCATION-BASED POPULATIONS (N=36)		
Rural Communities	58%	21
Suburban Communities	42%	15
Urban Communities	42%	15
We do not currently have targeted state-level strategies for these populations	39%	14
HIGH-RISK OCCUPATIONAL POPULATIONS (N=36)		
Agricultural/Farming/Forestry Industry	36%	13
Construction Industry	22%	8
First Responders	58%	21
Healthcare Professionals	42%	15
Military/Veteran	81%	29
Mining/Quarrying/Oil-Gas Extraction Industry	8%	3
Veterinarian Professionals	11%	4
We do not currently have targeted state-level strategies for these populations	17%	6
LIVED EXPERIENCE POPULATIONS (N=36)		
Impacted Families and Friends	67%	24
Individuals with Serious Mental Illness	53%	19
Suicide Attempt Survivors	56%	20
Suicide Loss Survivors	72%	26
We do not currently have targeted state-level strategies for these populations	19%	7
RACIAL/ETHNIC/MINORITY POPULATIONS (N=35)		
Asian American	14%	5
Black/African American	37%	13
Indigenous/Native American	40%	14
Immigrant/Refugee population	17%	6
Latinx American	26%	9
Lesbian, Gay, Bisexual	51%	18
Transgender	40%	14
We do not currently have targeted state-level strategies for these populations	34%	12

Involvement of Priority Populations in Suicide Prevention Activities

Respondents were asked how they involve members of populations that they are trying to reach through targeted initiatives (priority populations) in suicide prevention activities. As displayed in Table 44, the most common involvement of priority populations identified was through them helping to identify unique community needs, challenges, and/or strengths (71%, 27 of 38), followed by both helping to choose prevention activities and providing ongoing feedback on activity practices, effectiveness, and/or opportunities for improvement (61%, 23 of 38 respectively), and helping to implement targeted activities (53%, 20 of 38). It was less common for priority populations to provide ongoing feedback on policies (34%, 14 of 38) or help collect, analyze, and/or evaluate data (29%, 11 of 38). Four states (11%) indicated that priority populations were not involved in these efforts.

Table 44: BUILD – Involvement of Priority Populations in Suicide Prevention Activities
(N=38)

Members of target populations… *(Multiple responses possible)*	Percent	Count
Help collect, analyze, and/or evaluate data	29%	11
Help to identify unique community needs, challenges, and/or strengths	71%	27
Help to choose prevention activities	61%	23
Provide ongoing feedback on activity practices, effectiveness, and/or opportunities for improvements	61%	23
Provide ongoing feedback on policies being drafted or implemented	37%	14
Help to implement targeted activities	53%	20
None of the above	11%	4

SPRC Support, Tools, or Resources for the Build Element

States identified *topic-specific content (e.g., return on investment for strategies)* (8 comments) and *templates and examples (e.g., strategic and implementation plans)* (5) as the most common supports needed to help the state further strengthen its strategic planning processes or prevention strategy implementation (see Table 45).

Table 45: BUILD – Support to Help Strengthen Build Element Efforts
(N=18)

8	**Topic-specific content** (return on investment for strategies; working with transient, homeless, and commercial sex workers; how to engage end users, incorporating lived experience, upstream approaches)
5	**Templates and examples** (strategic plan examples, implementation plan examples)
3	**Technical assistance** (engaging priority populations such as LGBTQ+, strengthening diversity in coalitions)
2	**Funding** (strategies for sustainable funding)
1	**Connections to other states** (regional meetings)
1	**Success stories** (implementation successes)

Infrastructure Element #6 – GUIDE

Guide was the second highest rated infrastructure element, with a 68% progress rate (progress score of 8 out of a possible 12).

Allocating Funding and Resources Necessary to Guide Evidence-Informed Programming (SCORED)

As displayed in Table 46, just under half of respondents (47%, 18 of 38) indicated that their state has allocated the funding and resources necessary (e.g., through education, training, policy support, funding disbursements) to guide state, county, and local groups in implementing evidence-informed suicide prevention programming (21% indicating that it is sustainable).

Table 46: GUIDE – State Progress toward Allocating Funding and Resources Necessary to Guide State, County, and Local Groups in Implementing Evidence-Informed Suicide Prevention Programming
(N=38)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	11%	4
Planning steps to get this in place	26%	10
Actively working to get this in place	16%	6
This is in place, but it is not yet sustainable	26%	10
This is sustainably in place	21%	8
	Total	38

Local-Level Suicide Prevention Coalitions (SCORED)

Approximately three-quarters of states (76%, 29 of 38) have local-level (community, county, and/or regional) suicide prevention coalitions.

Local-Level Suicide Prevention Coalition Structure

Of the 29 states with local-level coalitions, 48% reported that the coalitions are formed independently of the state but can choose to sign up for/utilize state-supported trainings, resources, and/or funding opportunities; 34% that they are formed independently and do not receive any direct guidance, leadership, or funding from the state; and 7% that they are formed/have been formed as a result of state-level bylaws, policies, or mandates, and receive direct guidance, leadership, and/or funding from the state (10% reported some other structure).

Community-Level Prevention Strategies

The three high-level suicide prevention strategies most frequently implemented by communities are identifying and assisting persons at risk of suicide (79%), responding effectively to individuals in crisis (61%), and increasing help-seeking behavior (47%) (see Table 47).

Table 47: GUIDE – High-Level Suicide Prevention Strategies Most Frequently Implemented by Communities
(N=38)

Multiple responses possible	Percent	Count
Identify and assist persons at risk of suicide	79%	30
Increase help-seeking behavior	47%	18
Ensure access to effective mental health and suicide care and treatment	29%	11
Support safe care transitions and create organizational linkages	3%	1
Respond effectively to individuals in crisis	61%	23
Provide immediate and long-term postvention	11%	4
Reduce access to means of suicide	26%	10
Enhance life skills and resilience	5%	2
Promote social connectedness and support	16%	6
Address social determinants of health (e.g., housing insecurity, job insecurity, adverse childhood experiences (ACEs)]	8%	3
None of the above	0%	0

Challenges and Successes – Supporting Community-Level Suicide Prevention Efforts

Insufficient funding (12 comments) was the most commonly identified challenge to supporting community-level suicide prevention efforts. Challenges clustered primarily around the themes of restrictive infrastructure and insufficient funding (see Table 48).

Table 48: GUIDE – Challenges in Supporting Community-Level Suicide Prevention Efforts
(N=29)

Restrictive Infrastructure (16 related comments)	
5	Decentralized/independent coalitions (difficult identifying groups doing the work, communication challenges)
5	Limited ability to provide technical assistance and support to communities (state staffing, time)
4	Limited local capacity, data, and infrastructure (no suicide prevention coalitions)
2	Local staffing challenges (bandwidth, capacity, turnover at local level, burnout)
Insufficient Funding (12 related comments)	
12	Insufficient Funding (limited ability to support local level positions and initiatives)
Limited Prevention Capacity (5 related comments)	
5	Limited awareness/knowledge of suicide prevention at the local level (reactive versus proactive)
Low Alignment Between State and Local Levels (3 related comments)	
3	Lack of synergy between state and local levels
Lack of Engagement and Support (2 related comments)	
2	Difficulty identifying and maintaining champions at local level

The *availability of statewide training and technical assistance* (16 comments) were the most commonly identified successes in supporting community-level suicide prevention efforts. Successes were associated with facilitative infrastructure and relationship building (see Table 49).

Table 49: GUIDE – Successes in Supporting Community-Level Suicide Prevention Efforts
(N=24)

Facilitative Infrastructure (16 related comments)	
16	Statewide training and technical assistance availability (gatekeeper training, annual conferences, listserv, community awareness events, educational materials)
Relationship Building (9 related comments)	
7	Building relationships with local communities
2	Strong existing partnerships with local communities and providers

Tracking Trainings Meeting State Requirements or Recommendations (SCORED)

Approximately three-quarters of states (76%, 29 of 38) 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).

SPRC Support, Tools, or Resources for the Guide Element

States identified *templates and examples (e.g., blueprint for constructing a community coalition)* (6 comments), *funding* (e.g., innovative ways to fund local efforts) (5), and *topic-specific content (e.g., means reduction)* (5) as the most common supports needed to help the state better assist local communities in suicide prevention (see Table 50).

Table 50: GUIDE – Support to Help Strengthen Guide Element Efforts
(N=17)

6	**Templates and examples** (blueprint for how to construct a community coalition, prevention messaging templates, essential elements of local prevention, draft legislation)
5	**Funding** (innovative ways to fund local efforts, identification of state and local funding opportunities)
5	**Topic-specific content** (means reduction, ways to demonstrate and communicate the value of upstream prevention, ways local communities can support suicide prevention, lists of evidence-based strategies, fidelity of implementation at local level)
1	**Connections to other states** (communities of practice)
1	**Technical assistance** (engaging local communities)

USING THE INFRASTRUCTURE RECOMMENDATIONS

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

- Sixty percent (60%, 23 of 38) of respondents were either "very familiar" (47%) or "extremely familiar" (13%) with the Infrastructure Recommendations, while 40% (15 of 38) were either "not very familiar" (3%) or "somewhat familiar" (37%) with them.
- The majority of respondents (71%, 27 of 38) indicated that they had used the Infrastructure Recommendations or any of the related tools (e.g., *Getting Started Guide for State Suicide Prevention Infrastructure*[7], *Recommendations for State Suicide Prevention Infrastructure: Essential Elements Assessment Tool*[8]).
- All respondents indicated that they had *personally* used the Infrastructure Recommendation tools to guide state infrastructure development, most commonly to *guide personal thinking and decision-making in infrastructure development* (89%, 24 of 27) and/or by *forwarding or distributing the tools to partners* (78%, 21 of 27) (see Table 51).

Table 51: Individual Use of the Infrastructure Recommendation Tools to Guide State Infrastructure Development
(N=27)

Multiple responses possible	Percent	Count
I have used the tools on my own to guide my thinking and decision-making in infrastructure development	89%	24
I have used the tools to help me prepare for/speak with state decision-makers or advocacy leaders	41%	11
I have forwarded or distributed the tools to partners	78%	21
I have inserted the tools into my own presentations	37%	10
None of the above	0%	0

- As shown in Table 52, state prevention teams were somewhat less likely to have used the tools, with 11% (3 of 27) indicating that their team had not done so at all. The most common application was in *guiding state thinking and decision-making in infrastructure development* (59%, 16 of 27).

[7] https://www.sprc.org/sites/default/files/State%20Infrastructure_Getting%20Started%20Guide.pdf

[8] https://www.sprc.org/sites/default/files/State%20Infrastructure_Essential%20Elements%20Assessment%20Tool.pdf

Table 52: State Prevention Team Use of the Infrastructure Recommendation Tools to Guide State Infrastructure Development
(N=27)

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	59%	16
We have used the tools within our state suicide prevention coalition to guide our thinking and decision-making in infrastructure development	44%	12
We have used the tools with external partner(s) outside of a state coalition to guide our thinking and decision-making in infrastructure development	41%	11
We have used the tools to provide guidance in supporting local, community-level efforts	33%	9
We have used the tools to model our state efforts on other states' infrastructure examples/successes	41%	11
None of the above	11%	3

Respondents were also asked to identify any support, tools, or resources that their state needs to continue making progress in infrastructure development. As shown in Table 53, respondents identified the need for additional support related to *funding (e.g., working with legislators to enhance political will)* (6 comments), *templates and examples (e.g., additional infrastructure development tools for early steps)* (4), *topic-specific content (e.g., coordinating services, developing evaluation plans)* (2), and *success stories* (1).

Table 53: Support to Help Continue Progress in Infrastructure Development
(N=10)

6	**Funding** (financial resources, working with legislators to enhance political will)
4	**Templates and examples** (additional infrastructure development tools for early steps - Partner, Examine, Build, Guide)
2	**Topic-specific content** (coordinating services, developing evaluation plans)
1	**Success stories**