

State Suicide Prevention Plans and Leadership Guidance

State-level coordination of suicide prevention is important to ensure that prevention strategies implemented within communities address the people at highest risk for suicide and are comprehensive in scope. State suicide prevention plans have emerged as a key tool in the assessment, prevention, and intervention efforts necessary to reduce suicide.

This document is based on SPRC's extensive experience working with state suicide prevention leaders and provides direction to help states develop a strong state suicide prevention plan. We recommend that you use this document in conjunction with *Recommendations for State Suicide Prevention Infrastructure* ([Infrastructure Recommendations](#)), which describes the essential elements of state infrastructure, and with the [Comprehensive Approach to Suicide Prevention](#), which sets forth a combination of strategies to address suicide prevention across the lifespan.

This document details the key elements and characteristics that serve as the underpinning for effective state suicide prevention plans.

Key Elements and Characteristics

Plans should be data driven, while strategies may be flexible.

To effectively allocate resources, states should use available data to identify and prioritize high-risk populations and settings. States should also take steps to identify and close gaps in data collection, paying close attention to whether information about minority and underserved populations is being collected. Plans should include data that:

- Identify populations with high numbers and/or rates of suicide attempts and deaths (e.g., American Indian/Alaska Natives, Hispanic and LGBTQ+ youth, veterans and the military, and men in midlife)
- Point to geographic areas and settings where risk of suicide is high (e.g., rural areas, behavioral health care settings, correctional settings)
- Characterize patterns of suicide deaths and attempts, including which risk factors are associated with different populations (e.g., people with mental illness or substance abuse disorders, people who were recently discharged from inpatient/emergency departments, people with prior attempts)

SPRC's *Data Infrastructure: Recommendations for State Suicide Prevention* ([Data Supplement Recommendations](#)) provides concrete guidance and resources to encourage the creation of an infrastructure that will support data-driven planning and decision-making.

Examples: [Connecticut's state plan](#) (pages 9–14) provides a broad overview of suicide in Connecticut and identifies populations with high rates/numbers of suicides. It has a

specific section (pages 29–44) for groups at higher risk that includes recommendations for each identified group. [Mississippi's state plan](#) provides a comprehensive data overview (pages 12–24) that includes risk factors for each of the identified populations. Goal 3 of this plan (page 27) calls for the implementation of data systems to identify individuals at risk for suicide across the lifespan.

Plans should adopt a public health approach.

Suicide prevention plans should take a public health approach that includes identifying risk and protective factors in populations, partnering across sectors, addressing the entire lifespan, and working across the spectrum of prevention, intervention, and postvention. Components of the public health approach for suicide prevention include the following:

- Using universal approaches, including environmental strategies such as reducing lethal means and enhancing life skills
- Identifying evidence-based practices and programs for prevention and treatment
- Training the existing behavioral health workforce on identifying, screening, assessing and treating individuals with suicidal thoughts and behaviors
- Providing continuity of care so that people at high risk can safely transition from acute care settings to outpatient care

State objectives and goals for identified areas of focus need to be flexible enough to address unique group factors (e.g., culture, geographic location, race, ethnicity).

Example: [New Hampshire's state plan](#) (pages 3–6) identifies the clinical and public health underpinnings for a comprehensive suicide prevention plan. [California's state plan](#) (pages 9–22) includes populations at higher risk of suicide and details risk and protective factors for suicide risk. [Utah's state plan](#) identifies populations at increased risk for suicide and strategies to reach these groups.

Plans should be comprehensive but set priorities.

Plans should set out to [build](#) integrated and coordinated suicide prevention activities across multiple sectors and settings, addressing both risk and protective factors. Plans should also account for differences within the different regions of the state and the needs of special populations. They should also incorporate monitoring the types of activities for effectiveness over time with measurable goals and objectives.

Example: [Oregon's state plan](#) (pages 16–19) includes activities in multiple settings for effective prevention. [Washington's plan](#) includes comprehensive recommendations for each goal and key agencies and stakeholders who will help accomplish the recommendation.

Plans should incorporate a collaborative effort through one convening body.

Suicide prevention cannot be a one-person or single-agency effort. Behavioral health and public health agencies are well primed to take on a leadership role and convene stakeholders, build

capacity (e.g., support coalitions, develop training resources) and expand suicide prevention efforts. [Partnerships](#) with public and private organizations, such as coalitions, task forces, or multi-agency work groups, can build commitment and ownership.

Ultimately, organizations working in the areas of health, mental health, substance abuse, education, justice, veterans, health care, and aging, as well as other agencies, school systems, and private sector groups, need to be involved and play a role in developing and implementing the plan. Engagement from groups at the highest risk for suicide (e.g., representatives from AI/AN and LGBTQ+ communities, suicide attempt survivors, and survivors of suicide loss) are essential participants in any planning effort. Ideally, a convening agency with at least one position to support suicide prevention in the state should serve as the lead author and manage a state's suicide prevention plan to ensure a coordinated effort.

Example: [Minnesota's plan](#) contains a list of task force members and subcommittee members from diverse backgrounds including state and local government, nonprofit organizations, higher education, and behavioral health and health care systems.

Plans should promote best practices for strategic and safe communications.

Communication efforts should promote hope and resilience, awareness of the warning signs for suicide, and knowledge of how to connect individuals in crisis with assistance and care. Refer to the [Framework for Successful Messaging](#) to develop messages that are strategic, safe, and in line with best practices. Plans should promote best practices for effective suicide prevention communication in alignment with the [Lead](#) element of the Infrastructure Recommendations.

Example: [South Carolina's state plan](#) has a "Considering the Language" section (pages 10-14) that includes preferred language usage for suicidal behavior.

Plans should promote accountability and be regularly evaluated, updated, and revised.

State suicide prevention plans should be living documents. Data on suicide and suicide attempts, including suicidal behavior among people receiving care in behavioral health care systems, should be monitored and analyzed on an annual basis. Annual action plans should identify who is responsible for carrying out the different elements of the plan, and suicide prevention leaders should assess progress at least annually.

Periodically ([every three to five years](#)) those involved in statewide suicide prevention work should gather to look at the impact the plan has had, review updated data and resources, and update and/or revise the plan. State plans may include accountability measures such as annual public reporting on progress and impact. The field is still learning how best to prevent suicide. A commitment to learning that seeks improvement but does not blame is important.

Example: Idaho's state plan contains an [addendum](#) with a comprehensive action plan that includes its mission, vision, goals, measurable outcomes to track, and a timeline.