SPRC 2024 State and Territorial Suicide Prevention Needs Assessment

Aggregate Technical Report

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September 2024

SAMHSA/CMHS Grant No. 1H79SM083028

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 2024 State and Territorial Suicide Prevention Needs Assessment (SNA). The information they provided will help SPRC support states and territories in developing sustainable suicide prevention infrastructure. SPRC acknowledges the contributions of all state and territorial suicide prevention leaders to the development of suicide prevention infrastructure throughout the nation. Their efforts are helping save lives.

SPRC would also like to thank all internal partners who contributed to the 2024 SNA reports and other 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 sprc.org/state-infrastructure.

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

Contents

Figures

Tables

Background and Methods

Background

Between April 10 and May 29, 2024, the Suicide Prevention Resource Center (SPRC) and its partner, Social Science Research and Evaluation, Inc. (SSRE), conducted the 2024 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 over time in suicide prevention infrastructure development, and provide valuable information to states on their own progress and on suicide prevention infrastructure and programming in the nation as a whole. Findings from the SNA will also help SPRC identify and develop future suicide prevention learning opportunities, supports, and resources.

The assessment asked 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 focused 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 states further strengthen suicide prevention infrastructure.

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 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, individuals with suicide-centered lived experience, and other key partners to inform their responses.

All of the 54 invited state representatives responded to the SNA request, indicating their consideration of the opportunity (100% response rate). One respondent opted out of the assessment, while 53 completed it fully (98% 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 53 states that answered all scored items. The maximum potential score was 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 Centers for Disease Control and Prevention's *Suicide Prevention Resource for Action*.

Table 1 below and Figure 1 on the following page display the 2024 progress scores and rates both overall (TOTAL SCORE) and for each of the six essential elements, for all 53 states that completed all scored items. On average, states achieved a total infrastructure progress rate of 74% (progress score of 123 out of a possible 165). In descending order, infrastructure element progress rates were Build–81%, Authorize–76%, Lead–76%, Guide–75%, Partner–68%, and Examine–61%.

Table 1: 2024 National Infrastructure Total and Element Progress Scores and Rates

(N=53)

Infrastructure Element	Potential Score Range	Progress Score[(a)]	Progress Rate
TOTAL SCORE	**0-165**	**123**	**74%**
Authorize	0-24	18	76%
Lead	0-24	18	76%
Partner	0-24	16	68%
Examine	0-20	12	61%
Build	0-48	39	81%
Guide	0-25	19	75%

[(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: 2024 National Infrastructure Total and Element Progress Scores and Rates
(N=53)

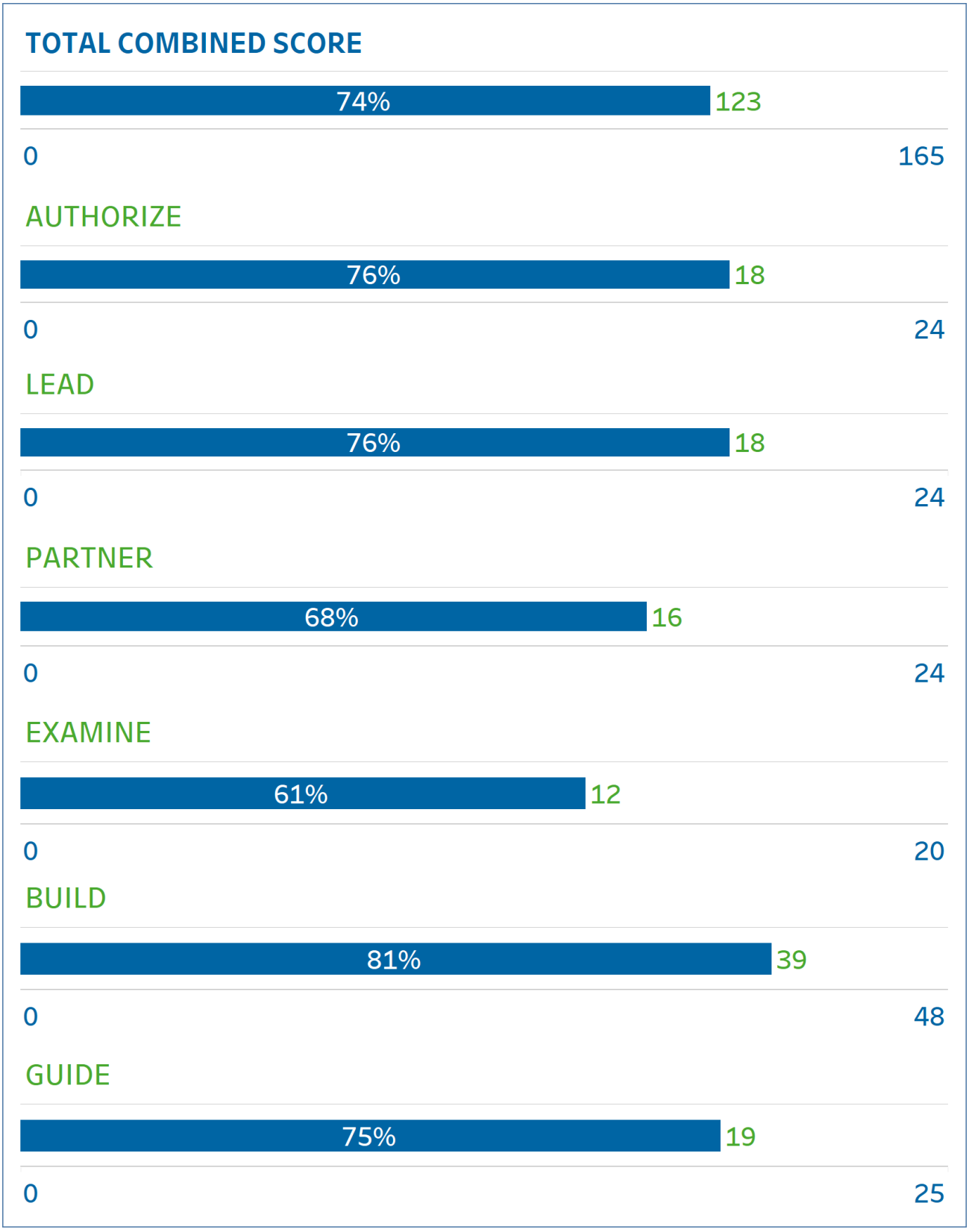
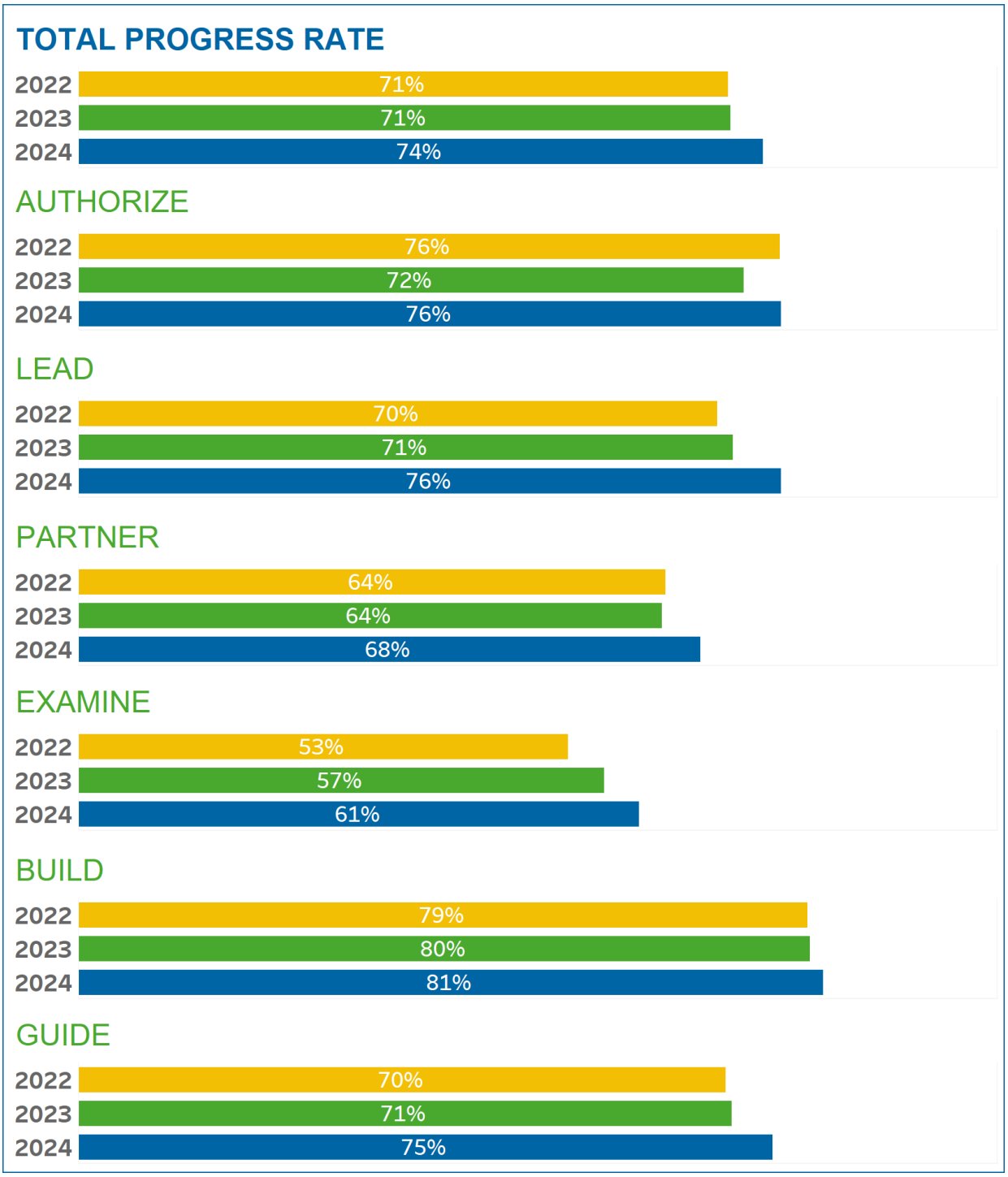


Figure 2 below displays three-year trends (2022, 2023, 2024) in progress rates, both overall (TOTAL PROGRESS RATE) and for each of the six essential elements. After remaining consistent at 71% in 2022 and 2023, the total progress rate increased to 74% in 2024 and all individual element scores also increased.

Figure 2: Trends in National Infrastructure Progress Rates (2022, 2023, 2024)
(2022 – N=41, 2023 – N=49, 2024 – N=53)



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 "SS" next to the section headings.

Infrastructure Element #1 – AUTHORIZE

Authorize was one of the two second highest-rated infrastructure elements, with a 76% progress rate (progress score of 18 out of a possible 24). The Authorize progress rate was 76% in 2022 and 72% in 2023.

Lead Agency and Authorization SS

Most states (92%, 49 of 53[2]) indicated that their state has a designated lead suicide prevention agency or office, and the majority of those states (94%, 46 of 49) reported that the agency is authorized/designated to create and carry out the state suicide prevention plan.

Establishing and Sustaining State Budget Line Items SS

As shown in Table 2, over half of states (60%, 32 of 53) reported that they had an established state budget line item for suicide prevention (38% indicated that it is sustainably in place).

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

(N=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	13%	7
Planning steps to get this in place	13%	7
Actively working to get this in place	13%	7
This is in place, but it is not yet sustainable	23%	12
This is sustainably in place	38%	20
	Total	53

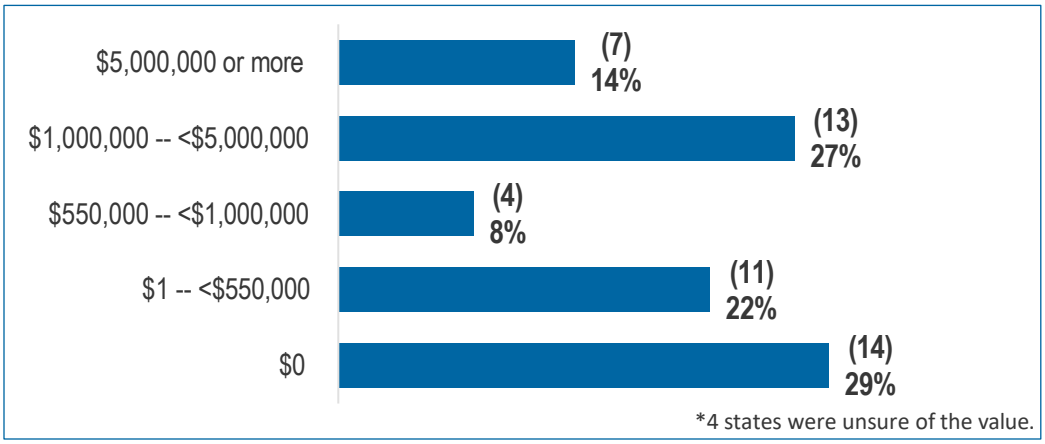
Budgeted State Funding for Suicide Prevention

Over one-quarter of states (29%, 14 of 49) lack any designated budget line items for suicide prevention. Among the 35 states **with** designated funding, many reported that the budgeted amount was under $1,000,000 (43%, 15 of 35). See Figure 3.

[2] Denominators for calculating percentages are based on all 53 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=49*)

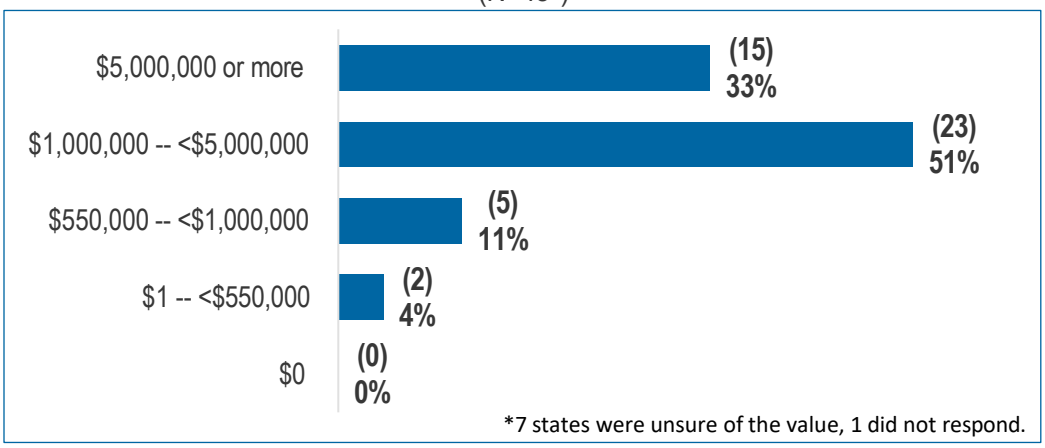


Major Sources of Outside Funding to Support Suicide Prevention Infrastructure

States were also asked about major sources of funding outside of state budget line items that support their suicide prevention infrastructure. All responding states (100%, 45 of 45) indicated that they receive outside funding for their suicide prevention efforts, with most (84%, 38 of 45) 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=45*)



As shown in Table 3, the most frequently identified major sources of funding outside of state budget line items were *Cooperative Agreements for States and Territories to Build Local 988 Capacity* (75%, 39 of 52), *Community Mental Health Services Block Grants (MHBG)* (62%, 32 of 52), and *Garrett Lee Smith (GLS) Suicide Prevention State or Tribal Grant* (60%, 31 of 52). Thirty-seven percent of respondents (37%, 19 of 52) identified other sources of outside funding beyond those listed in the response options, including the following sources cited by two or more states: SAMHSA Project Advancing Wellness and Resiliency in Education (Project AWARE) (6 responses); Other state funding (4); CDC Preventive Health and Health Services Block Grant (PHHSBG) (3); SAMHSA Mental Health Awareness Training (MHAT) Grant (3); SAMHSA State Opioid Response (SOR) Grant (3); State data collection funding, CDC National Violent Death Reporting System (VDRS) (2); 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=52)

Multiple responses possible	Percent	Count
CCBHC (Certified Community Behavioral Health Clinic Expansion) Grants	33%	17
CDC Comprehensive Suicide Prevention Program (CSP)	37%	19
CDC Injury or Violence Prevention (IVP) Grant	13%	7
Cooperative Agreements for States and Territories to Build Local 988 Capacity	75%	39
Community Mental Health Services Block Grants (MHBG)	62%	32
Garrett Lee Smith (GLS) Suicide Prevention State or Tribal Grant	60%	31
Garrett Lee Smith (GLS) Suicide Prevention Campus Grant	21%	11
Maternal and Child Health Services Block Grant (MCHB)	29%	15
National Strategy for Suicide Prevention (NSSP) Grant	10%	5
National Foundation Funding	4%	2
Private Donations	25%	13
State or Community Foundation Funding	23%	12
State Medicaid or Medicare Dollars	10%	5
Substance Abuse Prevention and Treatment Block Grants (SABG)	37%	19
Zero Suicide Grants	38%	20
Other[(a)]	37%	19
We do not have any other major sources of funding (outside of state budget line items)	0%	0

(a) Other responses provided by more than one respondent were: SAMHSA Project Advancing Wellness and Resiliency in Education (Project AWARE) (6 responses); Other state funding (4); CDC Preventive Health and Health Services Block Grant (PHHSBG) (3); SAMHSA Mental Health Awareness Training (MHAT) Grant (3); SAMHSA State Opioid Response (SOR) Grant (3); State data collection funding, CDC National Violent Death Reporting System (VDRS) (2); 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-nine percent of states (79%, 42 of 53) indicated that they update their state suicide prevention plan every 3-5 years. Of the 11 states that do not regularly update their plan, four reported that they are currently updating their plan, four plan to begin updating their plan within the next year, and three have no current plans to update their plan.

Formal Support/Endorsement of Data-Driven Strategic Planning

Seventy-nine percent of states (79%, 42 of 53) 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 (57%, 30 of 53) 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 or sufficient funding* (14 comments) was the most frequently identified **barrier** to strengthening the Authorize element,

followed by *no or inconsistent state budget line item for suicide prevention* (10), *lack of state legislation, policy, and/or support* (9), and both *absence of sustainable funding sources* (8) and *lack of communication and coordination within and between state and local levels* (8). 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=51)

Funding (35 related comments)	
14	No or insufficient funding
10	No or inconsistent state budget line item for suicide prevention
8	Absence of sustainable funding sources
3	Restrictions on how dollars can be pooled and allocated
Leadership, Policy, and Sociopolitical Environment (22 related comments)	
9	Lack of state legislation, policy, and/or support
6	Lack of stable leadership and/or leadership vacancies
4	No suicide prevention coordinator position or lead agency/office
3	Lack of support from leadership
Staffing (19 related comments)	
6	Strained staff capacity, workload
5	Difficulty identifying, recruiting, hiring, and retaining staff
3	Lack of dedicated and sustainable state suicide prevention positions
3	Insufficient staffing levels
2	Heavy reliance on volunteer workforce
Partnership and Coordination (8 related comments)	
8	Lack of communication and coordination within and between state and local levels
State Bureaucracy (6 related comments)	
3	Lengthy state approval and contracting processes
3	Structure and organization of state government agencies
State Suicide Prevention Plan (6 related comments)	
6	State suicide prevention plan (not in place, delayed, not updated, implementation)
Assessment, Surveillance, and Evaluation (5 related comments)	
5	Challenges collecting, organizing, and sharing data
Priorities (3 related comments)	
3	Suicide prevention not prioritized, competing priorities
Other Comments	
3	No barriers identified

Collaboration within and between state and local agencies and entities (13 comments), *funding for suicide prevention positions/programming* (13), *staff positions dedicated to suicide prevention* (13), and *state suicide prevention plan developed/submitted/regularly updated* (12) were the most common **successes** reported in strengthening the Authorize element. Successes clustered around the themes of partnership and coordination; funding; leadership, policy, and sociopolitical environment; staffing; and state suicide prevention plan (see Table 5).

Table 5: AUTHORIZE – Successes in Strengthening the Authorize Element
(N=51)

Partnership and Coordination (25 related comments)	
13	Collaboration within and between state and local agencies and entities
8	Presence of Governor's Task Force, State Suicide Prevention Coalition, Advisory Council
4	Robust partnerships and partner support
Funding (18 related comments)	
13	Funding for suicide prevention positions/programming
3	Multiple grants and funding sources
2	State budget line item for suicide prevention
Leadership, Policy, and Sociopolitical Environment (14 related comments)	
6	Political will, supportive leadership
5	Suicide prevention legislation and policy
3	Suicide prevention coordinator position or lead agency/office
Staffing (13 related comments)	
13	Staff positions dedicated to suicide prevention
State Suicide Prevention Plan (12 related comments)	
12	State suicide prevention plan developed/submitted/regularly updated
Awareness, Promotion, Communication, and Marketing (6 related comments)	
6	Heightened awareness, visibility, and momentum (campaigns, 988 Lifeline, Governor's Challenge)
Crisis Response (5 related comments)	
5	Expansion/coordination of crisis response services
Other Comments	
3	No successes identified

Infrastructure Element #2 – LEAD

Lead (76% progress rate, progress score of 18 out of a possible 24) was one of the two second highest-rated infrastructure elements. The Lead progress rate increased from 70% in 2022 and 71% in 2023.

Suicide Prevention Coordinator Support and Additional Funded Positions

While most states (92%, 49 of 53) have a half-time or greater full-time equivalent (0.5 – 1.0 FTE) suicide prevention coordinator or similar role, fewer (68%, 36 of 53) fund additional staff positions (average = 6 additional half-time to full-time equivalent positions in these states).

State Emphasis on Professional Development for State-Level Suicide Prevention Staff

The majority of respondents indicated that their state places either *a great deal* (53%, 28 of 53) or *a fair amount* (30%, 16 of 53) of emphasis on actively supporting the professional development of state-level 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=53)

	Percent	Count
None	2%	1
Very little	6%	3
Some	9%	5
A fair amount	30%	16
A great deal	53%	28
	Total	53

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 (43%, 23 of 53) or not yet sustainably (32%, 17 of 53), while 8% were actively working to get it in place (4 of 53), and 17% (9 of 53) indicated that they had not yet taken action beyond planning to get such support in place (see Table 7).

Table 7: LEAD – State Progress Toward Adequately Funding Technological Support to Carry Out Activities in State Plan
(N=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	9%	5
Planning steps to get this in place	8%	4
Actively working to get this in place	8%	4
This is in place, but it is not yet sustainable	32%	17
This is sustainably in place	43%	23
	Total	53

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 (79%, 42 of 53) 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=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	6%	3
Planning steps to get this in place	2%	1
Actively working to get this in place	13%	7
This is in place, but it is not yet sustainable	32%	17
This is sustainably in place	47%	25
	Total	53

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 three states reported that they were not actively addressing any of the issues. The vast majority were addressing *following available best practice suicide prevention messaging guidelines* (94%, 50 of 53), followed closely by *developing strategic communication campaigns* (92%, 49 of 53), *promoting a positive suicide prevention narrative* (87%, 46 of 53), and *minimizing unsafe suicide prevention messaging practices* (79%, 42 of 53).

Table 9: LEAD – Critical Issues From the *Framework for Successful Messaging* Being Actively Addressed

(N=53)

Multiple responses possible	Percent	Count
Developing strategic communication campaigns	92%	49
Promoting a positive suicide prevention narrative	87%	46
Following available best practice suicide prevention messaging guidelines	94%	50
Minimizing unsafe suicide prevention messaging practices	79%	42
None of the above	6%	3

Formal Suicide Prevention Partnerships

The majority of respondents (81%, 43 of 53) 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 (66%, 35 of 53) 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 (18 comments) was the most frequently identified **barrier** to strengthening the Lead element, followed by *unstable, time-limited, grant-based funding* (8), *lack of communication and coordination within and between state and local levels* (8), *no or insufficient funding* (6), and *limited statewide/regional/local suicide prevention infrastructure, especially in rural areas* (5). Barriers in this area were largely associated with staffing, funding, and suicide prevention infrastructure (see Table 10).

Table 10: LEAD – Barriers to Strengthening the Lead Element
(N=52)

Staffing (25 related comments)	
18	Difficulty identifying, recruiting, hiring, and retaining staff
3	Insufficient staffing levels
2	Strained staff capacity, workload
2	Limited support and professional development for staff and leadership
Funding (19 related comments)	
8	Unstable, time-limited, grant-based funding
6	No or insufficient funding
5	Lack of dedicated funding for staff positions
Suicide Prevention Infrastructure (12 related comments)	
5	Limited statewide/regional/local infrastructure (especially in rural areas)
4	Insufficient technology/technical support
3	Insufficient media and messaging capacity, infrastructure, and support
Partnership and Coordination (8 related comments)	
8	Lack of communication and coordination within and between state and local levels
Leadership, Policy, and Sociopolitical Environment (4 related comments)	
3	Lack of state legislation, policy, and/or support
1	No suicide prevention coordinator position or lead agency/office
State Bureaucracy (4 related comments)	
3	Lengthy state approval and contracting processes
1	Structure and organization of state government agencies
Assessment, Surveillance, and Evaluation (3 related comments)	
2	No or limited time, resources, personnel, or funding
1	Data lag (not timely; not real-time)
Priorities (2 related comments)	
2	Suicide prevention not prioritized, competing priorities
Other Comments	
1	No barriers identified

Collaboration within and between state and local agencies and entities (15 comments) and *staff positions dedicated to suicide prevention* (12) were the most frequently identified **successes** in strengthening the Lead element, followed by *secured funding for suicide prevention positions/programming* (9), *heightened awareness, visibility, and momentum (campaigns, 988 Lifeline, Governor's Challenge)* (8), and *robust partnerships and partner support* (7). 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=51)

Partnership and Coordination (26 related comments)	
15	Collaboration within and between state and local agencies and entities
7	Robust partnerships and partner support
4	Presence of Governor's Task Force, State Suicide Prevention Coalition, Advisory Council
Awareness, Promotion, Communication, and Marketing (17 related comments)	
8	Heightened awareness, visibility, and momentum (campaigns, 988 Lifeline, Governor's Challenge)
5	Strong communications team/processes
4	Promotion of *Framework for Successful Messaging*
Staffing (13 related comments)	
12	Staff positions dedicated to suicide prevention
1	Strong suicide prevention staff/team
Funding (9 related comments)	
9	Secured funding for suicide prevention positions/programming
Capacity Building, Technical Assistance, and Professional Development (6 related comments)	
6	Training and professional development
Programming and Implementation (5 related comments)	
5	Toolkit development, education, and direct service provision
Leadership, Policy, and Sociopolitical Environment (4 related comments)	
4	Political will, supportive leadership
State Suicide Prevention Plan (1 related comments)	
1	State suicide prevention plan developed/submitted/regularly updated
Other Comments	
3	No successes identified

Infrastructure Element #3 – PARTNER

Partner, with a 68% progress rate (progress score of 16 out of a possible 24), was the second lowest-rated infrastructure element. The 2024 rate is above the 2022 and 2023 rates (64% respectively).

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, close to half indicated that such partner integration was in place either sustainably (17%, 9 of 53) or not yet sustainably (30%, 16 of 53), while 28% were actively working to get it in place (15 of 53), and 11% were planning steps to get it in place (6 of 53). Another 13% (7 of 53) indicated that they had not yet taken action to get such partner integration in place.

Table 12: PARTNER – Integration of Suicide Prevention Efforts by Partnering State Agencies or Departments
(N=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	13%	7
Planning steps to get this in place	11%	6
Actively working to get this in place	28%	15
This is in place, but it is not yet sustainable	30%	16
This is sustainably in place	17%	9
	Total	53

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

Well over three-quarters of states (83%, 44 of 53) have a statewide suicide prevention coalition, with more than two-thirds (68%, 36 of 53) reporting that it is sustainably in place. Only three states have not moved past planning to get a coalition in place (see Table 13).

Table 13: PARTNER – Progress Toward Establishing a Statewide Suicide Prevention Coalition
(N=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	4%	2
Planning steps to get this in place	2%	1
Actively working to get this in place	11%	6
This is in place, but it is not yet sustainable	15%	8
This is sustainably in place	68%	36
	Total	53

Of the 44 states with a statewide coalition, all but three (93%, 41 of 44) 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 (98%, 43 of 44) were working to develop or had already established broad public and private sector coalition representation, with 45% (20 of 44) 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=44)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	0%	0
Planning steps to get this in place	2%	1
Actively working to get this in place	23%	10
This is in place, but it is not yet sustainable	30%	13
This is sustainably in place	45%	20
	Total	44

Mutually Agreed-Upon Goals for Suicide Prevention Across Partners

Almost two-thirds of states (64%, 34 of 53) reported having set mutually agreed-upon goals for suicide prevention across partners, with 43% having them sustainably in place (see Table 15).

Table 15: PARTNER – Progress Toward Setting Mutually Agreed-Upon Goals for Suicide Prevention Across Partners
(N=53)

	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	25%	13
This is in place, but it is not yet sustainable	21%	11
This is sustainably in place	43%	23
	Total	53

Signed Partnering Agreements

While just under half of states (42%, 22 of 53) 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), approximately one-quarter (28%, 15 of 53) 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=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	28%	15
Planning steps to get this in place	15%	8
Actively working to get this in place	15%	8
This is in place, but it is not yet sustainable	23%	12
This is sustainably in place	19%	10
	Total	53

Communication Between States and Tribes or Tribal Health Boards

Thirty-six (36) respondents reported that there are state or 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 *poor* (33%, 12 of 36), *fair* (25%, 9 of 36), or *good* (33%, 12 of 36), and none indicated that it is *excellent*.

Table 17: PARTNER – Communication Between States and Tribes or Tribal Health Boards
(N=36)

	Percent	Count
Extremely poor	8%	3
Poor	33%	12
Fair	25%	9
Good	33%	12
Excellent	0%	0
	Total	36

Collaboration Between States and Tribes or Tribal Health Boards

The 36 respondents who indicated that there are state or federally recognized Tribes or Tribal health boards within the geographic borders of their state were also asked to describe the level of **collaboration** related to suicide prevention between their state and those Tribes/Tribal health boards. As displayed in Table 18, most respondents indicated that their collaboration with Tribes/Tribal health boards could be best characterized as *awareness (knowledge of each other's activities)* (31%, 11 of 36) or *networking (back and forth sharing of information)* (25%, 9 of 36). Another 22% (8 of 36) reported *no* collaboration *(no awareness or interaction)*.

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

(N=36)

	Percent	Count
None (no awareness or interaction)	22%	8
Awareness (knowledge of each other's activities)	31%	11
Networking (back and forth sharing of information)	25%	9
Coordination (common and often interactive efforts)	22%	8
Collaboration (shared goals and decision-making)	0%	0
	Total	36

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 85% (45 of 53) *including members of populations served in strategic planning efforts*, 83% (44 of 53) *researching and understanding the cultural context of communities reached by strategies or interventions*, 81% (43 of 53) *creating an open dialogue whereby members of populations served can share cultural considerations key to prevention*, and 77% (41 of 53) *tailoring/developing interventions and resources to address populations served*.

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

(N=53)

Multiple responses possible	Percent	Count
Researching and understanding the cultural context of communities reached by strategies/interventions (target populations)	83%	44
Including members of populations served (e.g., communities of color, rural communities, Tribal communities) in strategic planning activities	85%	45
Tailoring and/or developing interventions and resources to address the values, beliefs, culture, and language of the populations served	77%	41
Creating an open dialogue whereby members of populations served can share cultural considerations key to prevention	81%	43
Other	13%	7
None of the above	2%	1

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

Lack of shared goals across agencies and levels (11 comments) and *collaboration and coordination with Tribal entities* (11) were the most frequently identified **barriers** to

strengthening the Partner element, followed by *building and maintaining a diverse coalition* (9), *strained staff capacity and/or workload* (8), and *no or insufficient funding* (7). Barriers in this area were largely associated with partnership and coordination (see Table 20).

Table 20: PARTNER – Barriers to Strengthening the Partner Element
(N=51)

Partnership and Coordination (41 related comments)	
11	Lack of shared goals across agencies and levels
11	Collaboration and coordination with Tribal entities
5	Low partner engagement/responsiveness
4	Communicating and coordinating with agencies in rural areas
4	Limited capacity, infrastructure, and resources at the local level
3	Lack of statewide coalition or advisory team
3	Lack of communication and coordination within and between state and local levels
Diversity, Equity, and Inclusion (19 related comments)	
9	Building and maintaining a diverse coalition
3	Lack of culturally responsive materials and services
3	Engaging centered groups and communities
2	Political will and legislative barriers
2	Limited diversity among leadership and staffing
Staffing (14 related comments)	
8	Strained staff capacity, workload
4	Difficulty identifying, recruiting, hiring, and retaining staff
2	Insufficient staffing levels
Funding (10 related comments)	
7	No or insufficient funding
2	Competition for funding and siloing of efforts
1	Restrictions on how grant dollars can be spent
State Bureaucracy (3 related comments)	
3	Lengthy state approval and contracting processes
Priorities (2 related comments)	
2	Suicide prevention not prioritized, competing priorities
Suicide Prevention Infrastructure (2 related comments)	
2	Insufficient technology and reporting infrastructure
Other Comments	
5	No barriers identified

The *expansion of coalitions and partnerships* (12 comments) and *collaboration within and between state and local agencies and entities* (10) were the most common **successes** reported in strengthening the Partner element, followed by a *focus on diversity, equity, and inclusion* (9), *collaboration with Tribes and Tribal health boards* (8), *presence of state taskforces/coalitions/advisory councils* (8), and *heightened awareness, visibility, and momentum around campaigns and other health promotion messaging* (8). Successes clustered primarily around the theme of strong suicide prevention networks and collaboration efforts (see Table 21).

Table 21: PARTNER – Successes in Strengthening the Partner Element
(N=51)

Strong Suicide Prevention Networks and Collaboration Efforts (45 related comments)	
12	Expansion of coalitions and partnerships
10	Collaboration within and between state and local agencies and entities
8	Collaboration with Tribes and Tribal health boards
8	Presence of Governor's Task Force, State Suicide Prevention Coalition, Advisory Council
4	Robust partnerships and partner support
3	Shared goals across agencies and levels
Diversity, Equity, and Inclusion (17 related comments)	
9	Focus on diversity, equity, and inclusion
6	Diverse representation on coalitions and partnerships
2	Partnering with culturally responsive organizations
Awareness, Promotion, Communication, and Marketing (8 related comments)	
8	Heightened awareness, visibility, and momentum (campaigns, 988 Lifeline, Governor's Challenge)
Capacity Building, Technical Assistance, and Professional Development (6 related comments)	
6	Training and technical assistance
Crisis Response (4 related comments)	
4	Expansion/coordination of crisis response services
State Suicide Prevention Plan (2 related comments)	
2	State suicide prevention plan developed/submitted/regularly updated
Enhanced Surveillance and Data Infrastructure (1 related comments)	
1	Data, surveillance, and reporting infrastructure development
Funding (1 related comments)	
1	Secured funding for suicide prevention positions/programming
Leadership, Policy, and Sociopolitical Environment (1 related comments)	
1	Political will, supportive leadership
Other Comments	
1	No successes identified

Infrastructure Element #4 – EXAMINE

While Examine was the lowest-rated infrastructure element, with a 61% progress rate (progress score of 12 out of a possible 20), the rate increased from 53% in 2022 and 57% in 2023.

Statewide System for Collecting and Analyzing Suicide Death Data

As displayed in Table 22, most respondents (87%, 46 of 53) indicated that their state has a statewide system in place for collecting and analyzing suicide death data (60% 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=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	2%	1
Planning steps to get this in place	4%	2
Actively working to get this in place	8%	4
This is in place, but it is not yet sustainable	26%	14
This is sustainably in place	60%	32
	Total	53

Standards for Timeliness of Mortality Reporting

Almost two-thirds of states (62%, 33 of 53) 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

Forty percent of respondents (40%, 21 of 53) 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), with 19% (10 of 53) indicating that this is sustainable. Approximately one-fifth (21%, 11 of 53) 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=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	21%	11
Planning steps to get this in place	11%	6
Actively working to get this in place	28%	15
This is in place, but it is not yet sustainable	21%	11
This is sustainably in place	19%	10
	Total	53

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

Progress toward establishing a system for collecting and analyzing near real-time statewide data for suicidal ideation and attempts varied, with 51% of states (27 of 53) having established such a system (25% have it sustainably in place), 23% (12 of 53) actively working to establish it, 15% (8 of 53) planning steps to establish it, and 11% (6 of 53) 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=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	11%	6
Planning steps to get this in place	15%	8
Actively working to get this in place	23%	12
This is in place, but it is not yet sustainable	26%	14
This is sustainably in place	25%	13
	Total	53

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

Only 40% of states (21 of 53) 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

Just 42% of respondents (22 of 53) reported that their state ensures that populations that are at high risk and underserved are sufficiently represented in their suicide-related data (25% sustainably). Others are either actively working (32%, 17 of 53) or planning steps (21%, 11 of 53) to get this in place, while 6% (3 of 53) 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=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	6%	3
Planning steps to get this in place	21%	11
Actively working to get this in place	32%	17
This is in place, but it is not yet sustainable	17%	9
This is sustainably in place	25%	13
	Total	53

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, 74% of states (39 of 53) had engaged in *process* evaluation efforts to ensure that strategies and/or interventions are being implemented as intended, while 64% (34 of 53) had engaged in *outcome* evaluation efforts to assess their achievement of previously set objectives, 36% (19 of 53) had engaged in *formative* evaluation efforts to inform implementation, and 26% (14 of 53) had engaged in *impact* evaluation efforts to assess long-term impacts on goals and suicide rates. Just under one-fifth of states (19%, 10 of 53) 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=53)

Multiple responses possible	Percent	Count
Formative evaluations to ensure strategies/interventions are feasible, appropriate, and acceptable prior to full implementation (conducting pilot evaluations)	36%	19
Process evaluations to ensure strategies/interventions are being implemented as intended	74%	39
Outcome evaluations to determine whether strategies/interventions are helping to achieve set objectives	64%	34
Impact evaluations to determine strategy/intervention impacts on long-term goals and suicide rates	26%	14
None of the above	19%	10

State Sharing and/or Use of Evaluation Results

Most respondents (89%, 47 of 53) 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* (70%, 37 of 53), followed by *informing/making changes to state suicide prevention plans* (68%, 36 of 53), and *developing regular suicide prevention reports for the public* (64%, 34 of 53). Close to half of respondents reported *developing regular suicide prevention reports for state leaders* (53%, 28 of 53) and *involving key community stakeholders in interpretation of evaluation outcomes* (51%, 27 of 53).

Table 27: EXAMINE – State Sharing and/or Use of Evaluation Results
(N=53)

Multiple responses possible	Percent	Count
Involving key community stakeholders in interpretation of evaluation outcomes	51%	27
Using evaluation results to inform/make changes to state suicide prevention plans	68%	36
Using evaluation results to make changes to specific strategies/interventions	70%	37
Developing regular suicide prevention reports for state leaders	53%	28
Developing regular suicide prevention reports (including infographics, annual highlights, success stories, etc.) for the public	64%	34
Other	15%	8
None of the above	11%	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 (19 comments) and *data lag* (14) were the most frequently identified **barriers** to strengthening the Examine element, followed by *limited or no data on certain populations and groups* (9), and *difficulty accessing data and/or creating data partnerships* (8). 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), and data comprehensiveness and inclusivity (see Table 28).

Table 28: EXAMINE – Barriers to Strengthening the Examine Element
(N=51)

Data Infrastructure and Capacity (32 related comments)	
19	No or limited time, resources, personnel, or funding related to supporting data efforts
7	Establishing and linking data systems
6	Limited technical support (creating dashboards, centralized data systems)
Accessing Data (22 related comments)	
14	Data lag (not timely; not real-time)
8	Difficulty accessing data / creating data partnerships (memoranda of understanding, data use agreements)
Data Comprehensiveness and Inclusivity (16 related comments)	
9	Limited or no data on certain populations and groups
7	Inconsistent coding, collection, and definitions
Presenting and Communicating Data (11 related comments)	
7	Barriers to disseminating data to partners
2	Effectively communicating key data points and data utilization
2	Low levels of data and evaluation literacy
Priorities (6 related comments)	
6	Data and evaluation not prioritized / competing priorities
Other Comments	
3	No barriers identified

Enhanced data dissemination (16 comments) and *strong state-level and state/local-level data partnerships* (14) were identified as the most common **successes** in strengthening the Examine element. Successes were largely associated with data infrastructure development, data dissemination and reporting, and partnership and coordination (see Table 29).

Table 29: EXAMINE – Successes in Strengthening the Examine Element
(N=51)

Data Infrastructure Development (28 related comments)	
10	Advancements in centralized systems, linking data, and syndromic surveillance
9	Epidemiological and/or evaluation support (staff, contractors, partners)
9	Presence of data workgroups and formal structures (fatality review boards, epi workgroups)
Data Dissemination and Reporting (16 related comments)	
16	Enhanced data dissemination (data dashboards, reports, state and community profiles)
Partnership and Coordination (14 related comments)	
14	Strong state-level and state/local-level data partnerships (state agencies, hospitals, universities)
Expanded Indicators/Datasets of Interest (9 related comments)	
9	Broader inclusion of data sources, indicators, and populations
Leadership, Policy, and Sociopolitical Environment (4 related comments)	
4	Political will / Supportive leadership
Funding (2 related comments)	
2	Secured funding / pooled resources to support data infrastructure (research, staff)
Other Comments	
3	No successes identified

Infrastructure Element #5 – BUILD

Build was the highest-rated infrastructure element, with an 81% progress rate (progress score of 39 out of a possible 48), representing small but incremental change from 79% in 2022 and 80% in 2023.

Strategic Planning Activities

All but one respondent (98%, 52 of 53) 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* (98%, 52 of 53), while 91% had *selected or developed strategies/interventions that address identified risk and protective factors* (48 of 53), and 89% had *chosen short and long-term data-based goals* (47 of 53) and/or *identified key risk and protective factors* (47 of 53). Fewer had *planned for strategy/intervention evaluation* (77%, 41 of 53) and/or *evaluated strategies/interventions over time* (62%, 33 of 53). See Table 30 for details.

Table 30: BUILD – State Strategic Planning Activities in the Past Two Years
(N=53)

Multiple responses possible	Percent	Count
Use data or other sources to describe your state's suicide problem and its context	98%	52
Choose short and long-term goals based on available data to guide suicide prevention efforts	89%	47
Identify key risk and protective factors for suicide in your state	89%	47
Select or develop strategies and interventions that address identified risk and protective factors	91%	48
Plan for evaluation of your strategies and interventions	77%	41
Evaluate and improve strategies/interventions over time	62%	33
None of the above	2%	1

State Plan's Promotion of Comprehensive and Lifespan Approaches

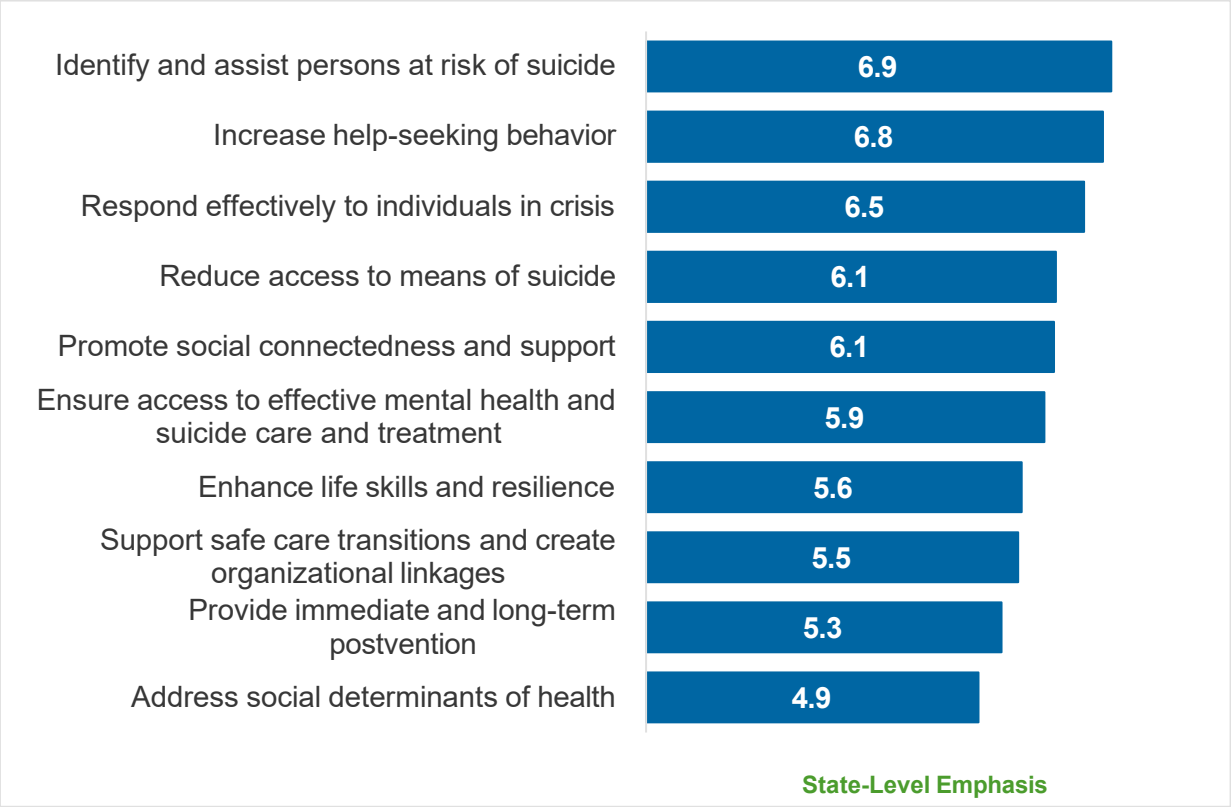
Most states indicated that their state suicide prevention plan promotes a *comprehensive* approach to suicide prevention that involves a variety of suicide prevention strategies across all levels of prevention (94%, 50 of 53) and also promotes a *lifespan* approach to suicide prevention that calls for suicide prevention strategies to reach diverse populations across ages and demographics (94%, 50 of 53).

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 Centers for Disease Control and Prevention's *Suicide Prevention Resource for 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* (6.9), followed by *increasing help-seeking behavior* (6.8) and *responding effectively to individuals in crisis* (6.5). Strategies least likely to be addressed are *addressing social determinants of health* (4.9), *providing immediate and long-term postvention* (5.3), *supporting safe care transitions and creating organizational linkages* (5.5), and *enhancing life skills and resilience* (5.6).

Figure 5: BUILD – State Emphasis on Addressing High-Level Strategies
(N=53)



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, approximately one-third of states (34%, 18 of 53) reported that their state has such funding in place (17% sustainably), and while most others are actively working on securing such funding (49%, 26 of 53), 17% (9 of 53) 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=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	9%	5
Planning steps to get this in place	8%	4
Actively working to get this in place	49%	26
This is in place, but it is not yet sustainable	17%	9
This is sustainably in place	17%	9
	Total	53

Embedding Suicide Prevention Requirements Into State-Funded Contracts

Just over half of states (53%, 28 of 53) 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, 83% of respondents (44 of 53) indicated that their state is addressing at least one determinant, with adverse childhood experiences (ACEs) (74%, 39 of 53) most frequently addressed.

Table 32: BUILD – Social Determinants of Health Currently Being Addressed by State Suicide Prevention Office or Coalition
(N=53)

Multiple responses possible	Percent	Count
ACEs (Adverse Childhood Experiences)	74%	39
Education access and quality	34%	18
Financial/job security	25%	13
Food insecurity	21%	11
Housing insecurity	28%	15
Neighborhood and community environment	57%	30
Systemic discrimination	34%	18
Violence	57%	30
Other	11%	6
None of the above	17%	9

Core Elements of Effective Crisis Care

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, almost all respondents (98%, 52 of 53) indicated that their state's crisis infrastructure currently includes a *24/7 regional or statewide crisis call center*, and over 80% also identified having *24/7 mobile crisis outreach and support* (85%, 45 of 53), *988 text/chat services provided by regional or statewide crisis call centers* (85%, 45 of 53), the *use of trauma-informed principles within crisis care*

(83%, 44 of 53), and *residential crisis receiving/stabilization programs for individuals who need support and observation but not emergency department (ED) holds or inpatient stays* (81%, 43 of 53). 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=53)

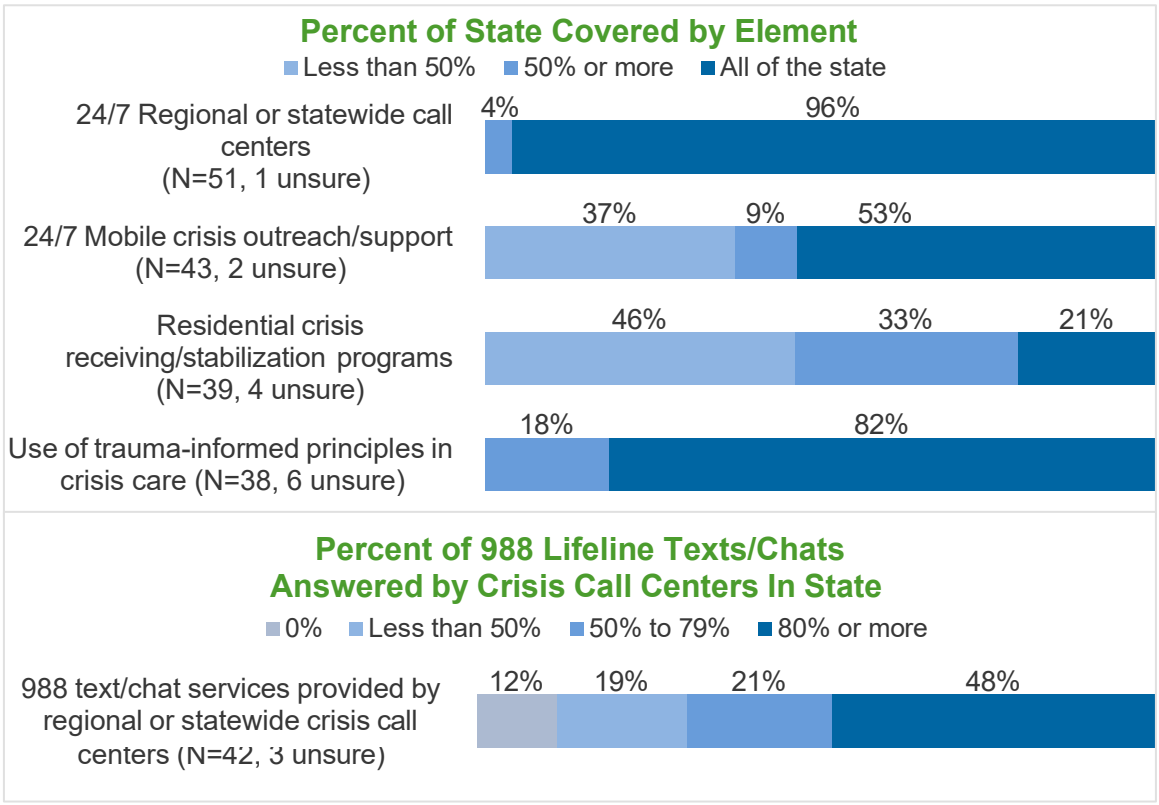
Multiple responses possible	Percent	Count
Regional or statewide crisis call centers available on a 24/7 basis	98%	52
Mobile crisis outreach and support available on a 24/7 basis	85%	45
Residential crisis receiving/stabilization programs for individuals who need support and observation but not ED holds or inpatient stays	81%	43
The use of trauma-informed principles within crisis care	83%	44
988 text/chat services provided by regional or statewide crisis call centers	85%	45
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 96% 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 (49 of 51), followed by 82% (31 of 38) for use of trauma-informed principles in crisis care, 53% (23 of 43) for mobile crisis outreach and support available on a 24/7 basis, and 21% (8 of 39) for residential crisis receiving/stabilization programs for individuals who need support and observation but not ED holds or inpatient stays. Just under half of states with 988 Lifeline text/chat services provided by regional or statewide crisis call centers (48%, 20 of 42) reported that 80% or more of the texts/chats are answered by crisis call centers in their state.

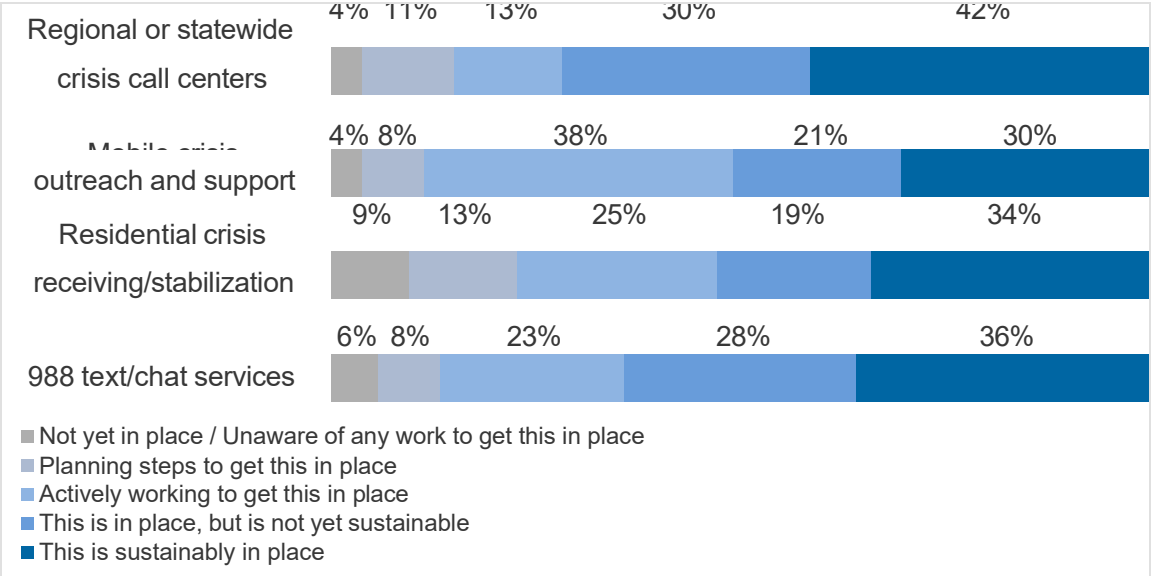
Figure 6: BUILD – Geographic Coverage of Crisis Care Elements



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 (72%, 38 of 53) reported having a funding structure in place to adequately support regional or statewide crisis call centers and 64% (34 of 53) reported such structure to support 988 Lifeline text/chat services. Comparatively fewer states reported structure to adequately support residential crisis receiving/stabilization (53%, 28 of 53) and mobile crisis outreach and support (51%, 27 of 53). See Figure 7.

Figure 7: BUILD – State Progress Toward Funding Core Elements of Crisis Care
(N=53)



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-two percent of respondents (42%, 22 of 53) reported that their state had achieved such coordination (19% sustainably), while a large portion are actively working toward (43%, 23 of 53) such coordination. See Table 34.

Table 34: BUILD – State Progress Toward Coordinating Crisis Services
(N=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	8%	4
Planning steps to get this in place	8%	4
Actively working to get this in place	43%	23
This is in place, but it is not yet sustainable	23%	12
This is sustainably in place	19%	10
	Total	53

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 (51%, 27 of 53) reported that their state has such a collaborative structure in place (40% sustainably), one-quarter have not progressed past planning steps to get this in place (25%, 13 of 53).

Table 35: BUILD – State Progress Toward Collaborative Planning and Implementation of Crisis Services
(N=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	17%	9
Planning steps to get this in place	8%	4
Actively working to get this in place	25%	13
This is in place, but it is not yet sustainable	11%	6
This is sustainably in place	40%	21
	Total	53

Focused 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 designed to reach *occupational* populations at high risk (98%, 52 of 53), followed by *age-based* populations (94%, 50 of 53), *lived experience* populations (91%, 48 of 53), *location-based* populations (89%, 47 of 53), and *racial, ethnic, and other populations that are historically marginalized* (79%, 42 of 53). The most frequently targeted populations were *military/veterans* (94%), *youth 10-17* (92%), and *young adults 18-24* (92%), followed by *rural communities* (89%) and *suicide loss survivors* (87%). See Table 36.

Table 36: BUILD – Populations for Which States Have Focused State-Level Suicide Prevention Strategies

Multiple responses possible	Percent	Count
AGE-BASED POPULATIONS (N=53)		
Children under 10	42%	22
Youth 10-17	92%	49
Young adults 18-24	92%	49
Adults 25-44	79%	42
Middle-aged adults 45-64	79%	42
Older adults 65+	75%	40
We do not currently have targeted state-level strategies for these populations	6%	3
LOCATION-BASED POPULATIONS (N=53)		
Rural communities	89%	47
Suburban communities	55%	29
Urban communities	68%	36
We do not currently have targeted state-level strategies for these populations	11%	6
OCCUPATIONAL POPULATIONS AT HIGH RISK (N=53)		
Agricultural/farming/forestry industry	70%	37
Construction industry	51%	27
Emergency response (firefighters, emergency medical services)	79%	42
Law enforcement	75%	40
Detention/Correctional staff	55%	29
Healthcare professionals	66%	35
Military/Veteran	94%	50
Mining/quarrying/oil-gas extraction industry	17%	9
Veterinarian professionals	11%	6
We do not currently have targeted state-level strategies for these populations	2%	1
LIVED EXPERIENCE POPULATIONS (N=53)		
Impacted families and friends	79%	42
Individuals with serious mental illness	62%	33
Suicide attempt survivors	74%	39
Suicide loss survivors	87%	46
Individuals with substance use disorder	53%	28
We do not currently have targeted state-level strategies for these populations	9%	5
RACIAL, ETHNIC, AND OTHER POPULATIONS THAT ARE HISTORICALLY MARGINALIZED (N=53)		
Asian American	26%	14
Black/African American	58%	31
Indigenous/Native American	51%	27
Latin American	38%	20
Immigrant/Refugee population	19%	10
Individuals with disabilities	43%	23
Individuals with serious physical health problems	19%	10
Lesbian, gay, bisexual	64%	34
Transgender	60%	32
We do not currently have targeted state-level strategies for these populations	21%	11

Involvement of Priority Populations in Suicide Prevention Activities

As shown in Table 37, the most common way that states reported involving priority populations in suicide prevention efforts was through having them *help identify unique community needs, challenges, and/or strengths* (85%, 45 of 53), followed by *providing ongoing feedback on activity practices, effectiveness, and/or opportunities for improvement* (77%, 41 of 53), *helping to implement targeted activities* (74%, 39 of 53), and *helping to choose prevention activities* (64%, 34 of 53). It was less common for priority populations to *provide ongoing feedback on policies being drafted or implemented* (51%, 27 of 53) or *help collect, analyze, and/or evaluate data* (49%, 26 of 53).

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

(N=53)

Members of priority populations… (Multiple responses possible)	Percent	Count
Help collect, analyze, and/or evaluate data	49%	26
Help to identify unique community needs, challenges, and/or strengths	85%	45
Help to choose prevention activities	64%	34
Provide ongoing feedback on activity practices, effectiveness, and/or opportunities for improvements	77%	41
Provide ongoing feedback on policies being drafted or implemented	51%	27
Help to implement targeted activities	74%	39
Other	9%	5
None of the above	8%	4

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

Challenges related to *engaging centered groups and communities* (12 comments), *no or insufficient funding* (11), and *strained staff capacity and/or workload* (10) were the most frequently identified **barriers** to strengthening the Build element. Barriers clustered primarily around the themes of diversity, equity, and inclusion (engaging centered groups and communities, ensuring equitable reach/access to materials and services, lack of culturally responsive materials and services, incorporating lived experience voices and perspectives), staffing (strained staff capacity/workload, difficulty staffing positions, insufficient staffing levels), and funding (none or insufficient, restrictions on how grant dollars can be spent) (see Table 38).

Table 38: BUILD – Barriers to Strengthening the Build Element
(N=49)

Diversity, Equity, and Inclusion (24 related comments)	
12	Engaging centered groups and communities
7	Ensuring equitable reach/access to materials and services
3	Lack of culturally responsive materials and services
2	Incorporating lived experience voices and perspectives
Staffing (18 related comments)	
10	Strained staff capacity, workload
6	Difficulty identifying, recruiting, hiring, and retaining staff
2	Insufficient staffing levels
Funding (14 related comments)	
11	No or insufficient funding
3	Restrictions on how grant dollars can be spent
Partnership and Coordination (9 related comments)	
9	Challenging to coordinate/expand services
Assessment, Surveillance, and Evaluation (6 related comments)	
6	Lack of data and information for planning and evaluation
Leadership, Policy, and Sociopolitical Environment (5 related comment)	
5	Lack of state legislation and policy, support
State Bureaucracy (3 related comments)	
3	Lengthy state approval and contracting processes
Other Comments	
5	No barriers identified

Implementation of focused initiatives for priority populations (16 comments) was the most frequently identified **success** in strengthening the Build element, followed by *expansion and/or coordination of crisis response services* (11), *toolkit development, training, and/or direct service provision* (8), and *collaboration within and between state and local agencies and entities* (8). Successes were largely associated with programming and implementation, partnerships and coordination, and crisis response (see Table 39).

Table 39: BUILD – Successes in Strengthening the Build Element
(N=49)

Programming and Implementation (29 related comments)	
16	Implementation of focused initiatives for priority populations
8	Toolkit development, training, direct service provision
5	Implementation of a comprehensive, lifespan-focused approach
Partnership and Coordination (15 related comments)	
8	Collaboration within and between state and local agencies and entities
5	Robust partnerships and partner support
2	Presence of Governor's Task Force, State Suicide Prevention Coalition, Advisory Councils
Crisis Response (11 related comments)	
11	Expansion/coordination of crisis response services
Diversity, Equity, and Inclusion (8 related comments)	
5	Increased focus on diversity, equity, and inclusion
3	Incorporating lived experience voices and perspectives
Awareness, Promotion, Communication, and Marketing (5 related comments)	
5	Heightened awareness, visibility, and momentum (campaigns, 988, Governor's Challenge)
Funding (5 related comments)	
5	Funding/resources for local efforts/coalitions
Enhanced Surveillance and Data Infrastructure (3 related comments)	
3	Data-informed planning and implementation
Leadership, Policy, and Sociopolitical Environment (2 related comments)	
2	Suicide prevention legislation and policy
Staffing (2 related comments)	
2	Staff positions dedicated to suicide prevention
Other Comments	
3	No successes identified

Infrastructure Element #6 – GUIDE

Guide (progress score of 19 out of a possible 25) was a middle-rated infrastructure element, with a 75% progress rate. The Guide progress rate increased between 2022 (70%), 2023 (71%), and 2024 (75%).

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 26% of respondents (14 of 53) reported that their state was formally assessing prevention needs (13% sustainably), while just under half (42%, 22 of 53) were actively working to get a process for assessing community needs in place, and approximately one-third (32%, 17 of 53) 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=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	13%	7
Planning steps to get this in place	19%	10
Actively working to get this in place	42%	22
This is in place, but it is not yet sustainable	13%	7
This is sustainably in place	13%	7
	Total	53

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

As shown in Table 41, progress toward allocating the funding and resources (e.g., funding and grant disbursements, education, training, policy support) necessary to guide state, county, and local groups in implementing evidence-informed suicide prevention programming varied, with 60% of respondents (32 of 53) reporting that their state has allocated such support (25% indicating that it is sustainable), 23% (12 of 53) actively working to get it in place, and 17% (9 of 53) 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=53)

	Percent	Count
Not yet in place / Unaware of any work to get this in place	9%	5
Planning steps to get this in place	8%	4
Actively working to get this in place	23%	12
This is in place, but it is not yet sustainable	36%	19
This is sustainably in place	25%	13
	Total	53

Local-Level Suicide Prevention Coalition Establishment SS and Structure

Most states (85%, 45 of 53) have local-level (community, county, and/or regional) suicide prevention coalitions. Of the 45 states with local-level coalitions, 62% (28 of 45) 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, and 18% (8 of 45) reported that coalitions are formed independently and do *not* receive any direct guidance, leadership, or funding from the state. Six states (13%, 6 of 45) reported the presence of local-level coalitions formed as a result of state-level bylaws, policies, or mandates; five of these six states indicated that these coalitions receive direct guidance, leadership, and/or funding from the state, and one indicated that these coalitions do *not* receive such state support. The remaining 7% (3 of 45) 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 *state-level data to communities* (96%, 51 of 53), *ongoing technical assistance* (94%, 50 of 53), *guidance on best practices* (91%, 48 of 53), *local/regional trainings* (89%, 47 of 53), and both *statewide trainings/conferences* and *local/regional data back to communities* (87%, 46 of 53). Fewer states were *disseminating state and national news to communities* (70%, 37 of 53), *providing guidance on strategic planning* (68%, 36 of 53), and *providing funding opportunities* (66%, 35 of 53).

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

(N=53)

Multiple responses possible	Percent	Count
Disseminating state and national news to communities	70%	37
Offering local or regional trainings	89%	47
Offering statewide trainings or conferences	87%	46
Providing funding opportunities (e.g., mini-grants, RFPs, scholarships)	66%	35
Providing guidance on best practices in suicide prevention	91%	48
Providing guidance on strategic planning	68%	36
Providing local/regional-level data back to communities	87%	46
Providing state-level data to communities	96%	51
Providing ongoing technical assistance (e.g., answering questions, directing communities to available resources)	94%	50
None of the above	2%	1

Consultation and Support for Community-Level Prevention Strategies

The high-level suicide prevention strategy for which states most frequently provide community-level consultation and/or support is *identifying and assisting persons at risk of suicide* (74% of respondents, 39 of 53, indicated that this was one of the top three strategies on which they consult/support), followed by *responding effectively to individuals in crisis* (42%, 22 of 53), and *ensuring access to effective mental health and suicide care and treatment* and *responding effectively to individuals in crisis* (40%, 21 of 53). Far fewer states identified *promoting social connectedness and support* (19%, 10 of 53), *supporting safe care transitions and creating organizational linkages* (13%, 7 of 53), *enhancing life skills and resilience* (6%, 3 of 53), or *addressing social determinants of health* (6%, 3 of 53) 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=53)

Up to 3 responses possible	Percent	Count
Identify and assist persons at risk of suicide	74%	39
Increase help-seeking behavior	28%	15
Ensure access to effective mental health and suicide care and treatment	40%	21
Support safe care transitions and create organizational linkages	13%	7
Respond effectively to individuals in crisis	42%	22
Provide immediate and long-term postvention	30%	16
Reduce access to means of suicide	34%	18
Enhance life skills and resilience	6%	3
Promote social connectedness and support	19%	10
Address social determinants of health (e.g., housing insecurity, job insecurity, adverse childhood experiences [ACEs])	6%	3
None of the above	2%	1

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* (94%, 50 of 53) and most indicated *military/veteran bases or organizations* (81%, 43 of 53). Other frequently supported sectors included *healthcare and mental healthcare* (74%, 39 of 53), *lived experience groups/organizations* (70%, 37 of 53), *first responder agencies (fire, EMS, law enforcement)* (68%, 36 of 53), *higher education* (68%, 36 of 53), *local crisis centers* (68%, 36 of 53), *private sector (local non-profits, organizations, and/or businesses)* (66%, 35 of 53), and *public health departments* (66%, 35 of 53). Far fewer states reported supporting *assisted living/retirement facilities* (19%, 10 of 53), *transportation* (19%, 10 of 53), *housing authorities/housing assistance agencies* (15%, 8 of 53), and *job and unemployment services* (15%, 8 of 53).

Table 44: GUIDE – Community Sectors Actively Supported by States in Implementing Evidence-Based Suicide Prevention Efforts
(N=53)

Multiple responses possible	Percent	Count
Assisted living / Retirement facilities	19%	10
Child and family services	57%	30
Correction and rehabilitation	53%	28
Faith-based institutions	49%	26
First responder agencies (fire, EMS, law enforcement)	68%	36
Healthcare and mental healthcare	74%	39
Higher education	68%	36
Housing authorities / Housing assistance agencies	15%	8
Job and unemployment services	15%	8
K-12 schools	94%	50
Lived experience groups/organizations (e.g., suicide loss survivor groups, suicide attempt survivor groups, local outreach of suicide survivor teams)	70%	37
Local crisis centers	68%	36
Local government agencies	62%	33
Private sector (local non-profits, organizations, and/or businesses)	66%	35
Public health departments	66%	35
Military/veteran bases or organizations	81%	43
Media organizations	34%	18
Social services	40%	21
Substance abuse services	57%	30
Transportation	19%	10
Tribal governments or agencies	25%	13
Local organizations serving minority populations	26%	14
Others who represent key sectors in local communities	15%	8
None of the above	2%	1

Tracking Trainings Meeting State Requirements or Recommendations SS

Most states (87%, 46 of 53) 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

Strained staff capacity and workload (14 comments), the *lack of data for planning and evaluation* (10), and *limited statewide, regional, and/or local suicide prevention infrastructure, especially in rural areas* (9) were the most frequently identified **barriers** to strengthening the Guide element. Barriers clustered primarily around the themes of staffing (e.g., strained capacity, challenges maintaining staffing); diversity, equity, and inclusion (e.g., engaging diverse partners, ensuring equitable reach/access to materials and services, lack of culturally responsive materials and services); funding (e.g., limited, restricted); and assessment, surveillance, and evaluation (lack of data for planning and evaluation) (see Table 45).

Table 45: GUIDE – Barriers to Strengthening the Guide Element
(N=48)

Staffing (17 related comments)	
14	Strained staff capacity, workload
3	Difficulty identifying, recruiting, hiring, and retaining staff
Diversity, Equity, and Inclusion (16 related comments)	
8	Engaging diverse partners
5	Ensuring equitable reach/access to materials and services
3	Lack of culturally responsive materials and services
Funding (14 related comments)	
8	No or insufficient funding
5	No or limited funding/resources for local efforts/community coalitions
1	Restrictions on how grant dollars can be spent
Assessment, Surveillance, and Evaluation (10 related comments)	
10	Lack of data for planning and evaluation
Suicide Prevention Infrastructure (9 related comments)	
9	Limited statewide/regional/local infrastructure (especially in rural areas)
Leadership, Policy, and Sociopolitical Environment (3 related comments)	
2	Lack of state legislation and policy, support
1	Lack of support from leadership
Partnership and Coordination (3 related comments)	
3	Lack of communication and coordination within and between state and local levels
Priorities (3 related comments)	
3	Suicide prevention not prioritized, competing priorities
State Bureaucracy (1 related comments)	
1	Lengthy state approval and contracting processes
Other Comments	
4	No barriers identified

The provision of *education and assistance to communities and organizations* (18 comments) was the most frequently identified **successes** in strengthening the Guide element. Successes were largely associated with partnership and coordination (e.g., data sharing and dissemination, collaboration and support, and goal sharing), training and technical assistance, and diversity, equity, and inclusion (e.g., increased community outreach and engagement) (see Table 46).

Table 46: GUIDE – Successes in Strengthening the Guide Element
(N=48)

Partnership and Coordination (24 related comments)	
6	Data sharing and dissemination within and between state and local levels
5	Collaboration within and between state and local agencies and entities
4	Expansion of coalitions and partnerships
4	Robust partnerships and partner support
3	Shared goals across agencies and levels
2	Presence of Governor's Task Force, State Suicide Prevention Coalition, Advisory Councils
Training and Technical Assistance (18 related comments)	
18	Education and assistance to communities and organizations
Diversity, Equity, and Inclusion (11 related comments)	
7	Increased community outreach and engagement
3	Increased focus on diversity, equity, and inclusion
1	Incorporating lived experience voices and perspectives
Suicide Prevention Infrastructure (5 related comments)	
5	Enhanced statewide/regional/local capacity and infrastructure
Funding (4 related comments)	
4	Funding/resources for local efforts/coalitions
Awareness, Promotion, Communication, and Marketing (2 related comments)	
2	Heightened awareness, visibility, and momentum (campaigns, 988 Lifeline, Governor's Challenge)
State Suicide Prevention Plan (2 related comments)	
2	State suicide prevention plan developed/submitted/regularly updated
Crisis Response (1 related comments)	
1	Expansion/coordination of crisis response services
Other Comments	
2	No successes identified

Using the Infrastructure Recommendations

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

- **Familiarity with the Infrastructure Recommendations**: Most respondents were either "extremely familiar" (21%, 11 of 53) or "very familiar" (49%, 26 of 53) with the recommendations, while 30% (16 of 53) were "somewhat familiar" with them and none were either “not very familiar” or “not at all familiar.”
- **Use of the Infrastructure Recommendations and/or Related Tools:** The majority of respondents (58%, 31 of 53) indicated that they and/or their state colleagues or partners 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 31 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, most reported using the tools to *guide their personal thinking and decision-making in infrastructure development* (81%, 25 of 31) and/or *forward or distribute the tools to partners* (77%, 24 of 31) (see Table 47). At the **state suicide prevention team** level, the Infrastructure Recommendations and/or related tools were most frequently used to *guide state thinking and decision-making in infrastructure development* (71%, 22 of 31) (see Table 48).

Table 47: Individual Use of the Infrastructure Recommendations Tools to Guide State Infrastructure Development
(N=31)

Multiple responses possible	Percent	Count
I have used the tools on my own to guide my thinking and decision-making in infrastructure development	81%	25
I have used the tools to help me prepare for/speak with state decision-makers or advocacy leaders	58%	18
I have forwarded or distributed the tools to partners	77%	24
I have inserted the tools into my own presentations	45%	14
Other	10%	3
None of the above	3%	1

Table 48: State Prevention Team Use of the Infrastructure Recommendations Tools to Guide State Infrastructure Development
(N=31)

Multiple responses possible	Percent	Count
We have used the tools within our **state office of suicide prevention (or equivalent agency)** to guide our thinking and decision-making in infrastructure development	71%	22
We have used the tools within our **state suicide prevention coalition** to guide our thinking and decision-making in infrastructure development	58%	18
We have used the tools with **external partner(s) outside of a state coalition** to guide our thinking and decision-making in infrastructure development	26%	8
We have used the tools to provide guidance in supporting local, community-level efforts	35%	11
We have used the tools to model our state efforts on other states' infrastructure examples/successes	32%	10
Other	6%	2
None of the above	0%	0

- **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, several states (11) 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., state plan and strategic planning, including integration of the National Strategy for Suicide Prevention; policy, legislation, and*

leadership support; diversity, equity, inclusion, and centered populations; data, surveillance, assessment, and evaluation; enhancing state infrastructure) (33 comments) and *state-to-state peer networking and learning opportunities* (7).

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

Topic-Specific Assistance (33 related comments)	
9	State plan and strategic planning (integration of *National Strategy for Suicide Prevention*)
7	Policy, legislation, and leadership support
6	Diversity, equity, inclusion, and centered populations (engagement)
4	Data, surveillance, assessment, and evaluation
4	Enhancing state infrastructure (coordination and capacity)
2	Postvention
1	Means safety
Peer Networking and Learning (7 related comments)	
6	Examples of other state and local efforts
1	State-to-state sharing and learning opportunities
Funding (3 related comment)	
3	Grants and funding
No Additional Tools or Resources / Continued Support (11 related comments)	
6	None needed at this time / State needs to use existing resources
5	Continued support, tools, and technical assistance

Conclusion

Thank you to everyone who contributed to the 2024 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.