The State of State, Territorial, and Tribal Suicide Prevention:

Findings from a Web-Based Survey

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

The State of State, Territorial, and Tribal Suicide Prevention: Findings from a Web-Based Survey

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Contact Information

For comments or questions, visit www.cdc.gov/cdc-info

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Background

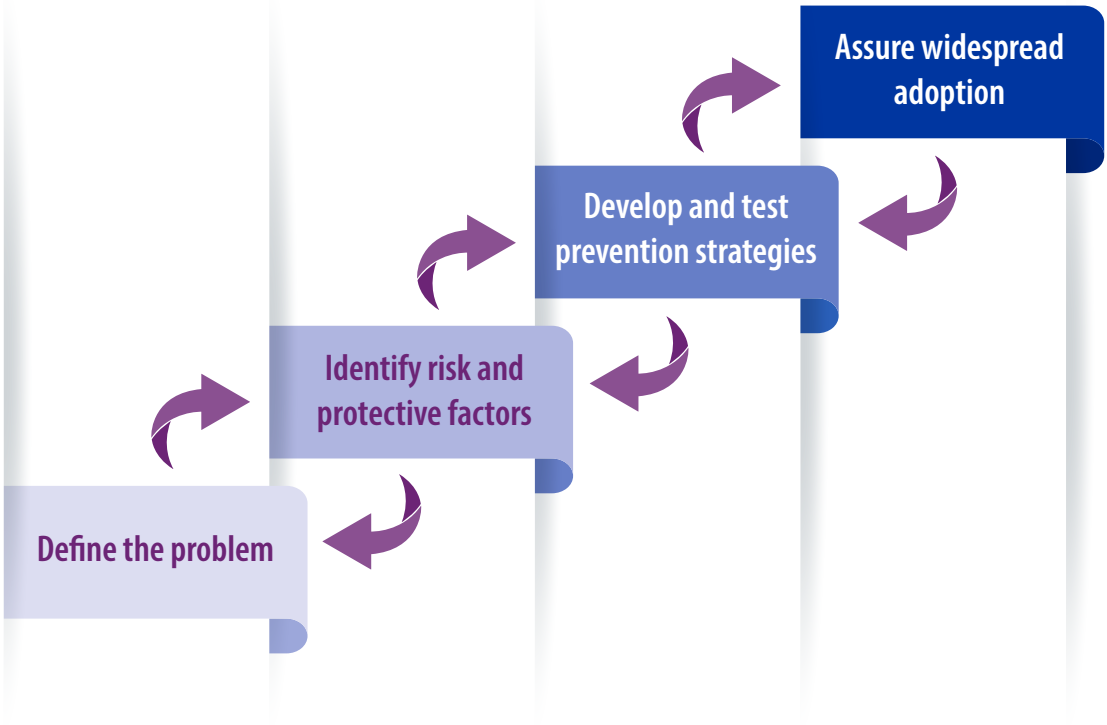
Suicide is the 10th leading cause of death in the United States and took the lives of more than 47,500 people in 2019.[1] Suicide rates increased 33% between 1999 and 2019 but suicides are part of a much larger problem.[2,3] In 2019, 12 million American adults seriously considered suicide, 3.5 million planned a suicide attempt, and 1.4 million attempted suicide.[3] Among high school youth, 19% seriously considered suicide.[4] Despite these grim statistics, there is good news. Suicide is preventable, and in 2019 suicide rates declined for the first time in over a decade.[1]

There is no single cause of suicide. Reducing suicide requires a comprehensive public health approach that is data driven; addresses multiple risk and protective factors at the individual, relationship, community, and societal levels; and relies on multi-sectoral partnerships working across multiple settings.[5]

The public health approach consists of four steps:

1. Using data to define, understand, and monitor the problem (e.g., determining the "who," "what," "when," "where," and "how")
2. Identifying factors that increase and decrease risk of suicide and that provide insight into the "why"
3. Developing and testing "what works" (i.e., best practices) to prevent suicide
4. Widely disseminating and implementing programs, practices, and policies with the best available evidence[5]

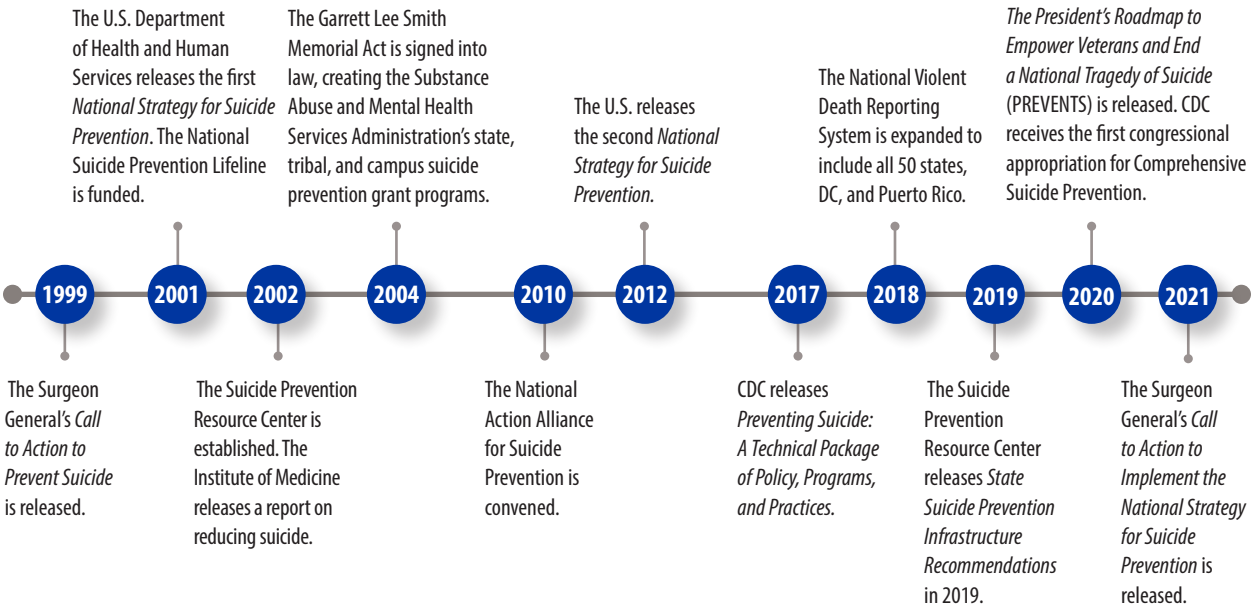
The Public Health Approach



The public health approach was widely adopted as the way to prevent suicide from at least 1999, with the release of The Surgeon General's Call to Action to Prevent Suicide.[6,7] Using this document as a foundation, in 2001 the U.S. Department of Health and Human Services released the first National Strategy for Suicide Prevention (NSSP).[8] The release of the NSSP served as a catalyst for state strategic planning efforts across the country. A range of national suicide prevention activities have taken place since then, including, but not limited to funding of the National Suicide Prevention Lifeline (NSPL) in 2001;[9] establishment of the Suicide Prevention Resource Center (SPRC) in 2002;[10] an Institute of Medicine (IOM) report, Reducing Suicide: A National Imperative[11] also in 2002; the signing into law of the Garrett Lee Smith Memorial Act creating the Substance Abuse and Mental Health Services Administration's widely implemented state, tribal, and campus suicide prevention grant programs;[12] the convening of the National Action Alliance for Suicide Prevention (NAASP), the public-private partnership tasked with advancing the NSSP, in 2010;[13] and the NSSP revision in 2012, intended to guide suicide prevention activities in the United States until 2022.[14]

In 2017, the Centers for Disease Control and Prevention (CDC) released Preventing Suicide: A Technical Package of Policy, Programs, and Practices.[15] This report is a collection of interventions that describes the best available evidence to guide and inform suicide prevention decision-making in states and communities.[15] It is a compilation of a core set of seven strategies to achieve and sustain reductions in suicide, focused on risk and protective factors across the individual, relationship, community, and societal levels. The seven strategies are: 1) Strengthening economic supports, 2) Strengthening access and delivery of suicide care, 3) Creating protective environments, 4) Promoting connectedness, 5) Teaching coping and problem-solving skills, 6) Identifying and supporting people at risk, and 7) Lessening harms and preventing future risk.[15]

Key National Suicide Prevention Accomplishments



Other major accomplishments include the 2018 expansion of the National Violent Death Reporting System (NVDRS) to all 50 states, DC, and Puerto Rico,[16] release of SPRC's State Suicide Prevention Infrastructure Recommendations in 2019,[17] and the CDC's first congressional appropriation for Comprehensive Suicide Prevention in 2020.[18] Also in 2020, the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) was released,[19] and the National Suicide Hotline Designation Act was signed into law.[20] Finally, coming full circle, the Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention was released in 2021.[21]

In addition to these accomplishments, the suicide prevention field is working toward a shared national goal, to reduce suicide rates 20% by 2025.[22]

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Despite the above accomplishments and many more not shown, suicide rates have increased greatly since 1999. To gain a better understanding of the current infrastructure and prevention landscape among states, territories, and tribes (STT); to identify gaps in resources; and to inform comprehensive prevention in the future, CDC conducted an environmental scan in 2018. The scan had six main objectives:

1. Identify, document, and synthesize information about STT policies, programs, infrastructure, and other activities to prevent suicide
2. Describe STT climate around suicide prevention
3. Identify barriers and facilitators to implementing suicide prevention strategies
4. Identify how the above factors (e.g., infrastructure, barriers, programs) may relate to variation in suicide rates
5. Provide insight into suicide rate increases
6. Share lessons learned with the field to inform future preventive action

Results from the environmental scan will be reported in three parts, in alignment with the scan's components:

1. Quantitative findings from an online survey
2. Findings from a review of state suicide prevention plans
3. Qualitative findings from key informant interviews and online survey

Report findings may serve as a baseline for additional assessment activities carried out by CDC or its partners in the future. Results can inform suicide prevention infrastructure and prevention activities necessary to reduce rates of suicide across the United States.

Findings from a Web-Based Survey

Web-Based Survey Background

To gain a better understanding of the current infrastructure and suicide prevention landscape among states, territories, and tribes (STT), to identify resource levels, and to inform comprehensive prevention in the future, the Centers for Disease Control and Prevention (CDC) conducted an environmental scan. The scan objectives are outlined in *The State of State Suicide Prevention* background.

This report highlights key findings from one component of the scan activities, a web-based survey. Results from the scan's other components (a review of state suicide prevention plans and qualitative findings from key informant interviews and online survey) will be reported in future releases. *The State of State Suicide Prevention* background also provides an overview of key national suicide prevention accomplishments as well as activities (e.g., *National Strategy for Suicide Prevention* (NSSP)[14]) that informed measures in each of the component parts.

The goal of the scan is to inform the field and also to serve as a baseline when tracking changes in suicide prevention infrastructure and prevention through additional assessment activities. Results can inform suicide prevention infrastructure and prevention activities necessary to reduce rates of suicide across the United States.

This report highlights key findings from a web-based survey. Results can inform suicide prevention infrastructure and prevention activities necessary to reduce rates of suicide across the United States.

Web-Based Survey Methods

Respondents

Up to three representatives per jurisdiction representing all 50 states, the District of Columbia (DC), the five permanently inhabited territories (Commonwealth of Northern Mariana Islands, American Samoa, Guam, Puerto Rico, and U.S. Virgin Islands), and a selection of 15 tribes were invited via email to complete the survey. The tribes were selected with support from Indian Health Services, based on rates of suicide (high, medium, low), experience of a suicide cluster, current or prior suicide prevention grant funding, rural and urban settings, and geographic region. Survey respondents were suicide prevention coordinators or their equivalents, grant project directors or other state officials, and/or delegates acting on behalf of their jurisdiction to fulfill suicide prevention roles.

This report includes survey results from all 50 states and DC. A selection of state results from each survey domain (described below) are highlighted. Briefer results are presented for territories and tribes because of the small number of respondents and, in some cases, significant missing data. The number of tribes represented in these results increased from the initial selection of 15 tribes due to sharing of the survey, with other tribes/tribal organizations (referred to as tribes hereafter), beyond the initial group.

Survey Format

The web-based survey consisted of 54 closed- and open-ended questions (Appendix 1). The survey covered 10 domains[i] that CDC subject matter experts considered critical based on a review of the literature and the public health approach to suicide prevention:

1. Awareness of recent suicide trends
2. Data sources
3. Infrastructure
4. Prevention planning
5. Collaboration
6. Legislation/policy
7. Prevention readiness/capacity
8. Populations addressed
9. Risk and protective factors addressed
10. Barriers and facilitators

The survey was piloted for comprehension, ease of completion, response categories, amount of text per page, and the logic of skip patterns. Four suicide prevention public health experts assessed the survey's content validity by examining the survey items and response categories for accuracy, missing concepts, comprehension, and the extent to which domains of interest were assessed. Prior to recruitment, an information collection request was prepared, submitted, and approved by the Office of Management and Budget. Survey data collection took place in July and August of 2018.

Analysis

The survey was hosted in Epi Info.[ii] Data were downloaded from Epi Info into Microsoft Excel format and then imported into IBM Statistical Package for the Social Sciences (SPSS) Statistics (2017; Release 25) for analysis. Descriptive analyses were conducted. Percentages and averages were calculated based on the total number of jurisdictions represented by respondents (51 for states plus DC, 36 for tribes, and 4 for territories).

In the reporting of results below, the words *states*, *territories*, and *tribes* refer to the respondents weighted to the state, territorial, and tribal level, respectively. Weighting was done by averaging responses across respondents for each jurisdiction, as applicable.

For survey items where respondents were asked to select "all that apply," only affirmative responses are shown, and results may sum to more than 100% (other responses included "No," "Not sure or Don't know," legitimate skip, or missing). For survey items requiring a single response, only affirmative responses are reported, so results will typically *not* sum to 100%. Each question varies in the degree of missing data (not shown).

i Ordering of the domains has been altered from the domains in the survey instrument (Appendix I).

ii Epi Info is a suite of statistical software for epidemiologic inquiry developed by Centers for Disease Control and Prevention https://www.cdc.gov/epiinfo/.

Domain-specific Methods

Domain 1: Awareness of Recent Suicide Trends

To gain insight into the level of general awareness of state suicide trends in recent years, respondents were asked how suicide rates had changed in their state in the past five years. Response options were on a 5-point Likert scale: 1—"decreased greatly," 2—"decreased somewhat," 3—"stayed about the same," 4—"increased somewhat," 5— "increased greatly" and an option for "not sure or don't know." Response ratings 1 and 2 were combined into a decrease category and response categories 4 and 5 were combined into an increase category. CDC's Web-based Injury Statistics Query and Reporting System (WISQARS)[23] was used to calculate changes in suicide rates for persons aged 10 years and older for each state and DC for the years 2013-2017 (Appendix II). These data were used to validate state responses regarding changes in suicide rates (See Domain 1 results). Any rates that changed less than 5% were considered having stayed the same. Any increase in rates greater than 5% was considered an increase, and a decline of more than 5% was considered a decrease in rates.

Domain 2: Data Sources

Respondents were asked which data sources they use to track suicide, suicide attempts, and risk and protective factors. Respondents were given a list of options and could check all that apply. The data source options for tracking *suicide* were vital statistics or death certificates, National Violent Death Reporting System (NVDRS), fatality review team (may be for children or adults or both), STT epidemiology work group (or similar group), or other. The data source options for tracking *suicide attempts* were hospital discharge data, emergency department (ED) data, emergency medical services (i.e., first responder data), syndromic surveillance data, and other. The data source options for tracking *risk and protective factors* were the Youth Risk Behavior Surveillance System (YRBSS), other school surveys, Behavioral Risk Factor Surveillance System (BRFSS), National Survey on Drug Use and Health (NSDUH), local surveys administered by local government or partner organizations, and other (See Domain 2 results).

Domain 3: Infrastructure

Respondents were asked a series of questions to identify the extent of their STT's current staffing and resources and were asked to report their STT's suicide prevention budget. To provide additional context for understanding funding for suicide prevention, respondents were provided with a list of 16 activities and asked to select those that their budgets supported. Respondents were also asked to rate the likelihood (5 item scale from "very unlikely" to "very likely") that their STT could reduce suicide rates 20% by 2025[22] at current resource/funding levels (See Domain 3 results).

Domain 4: Prevention Planning

To better understand STT prevention planning, respondents were asked about suicide prevention plans and achievement of goals set forth in the NSSP.[14] Respondents were asked if they evaluate their strategic plan and, if so, how much of a priority it is from 1—"not a priority" to 5—"essential." It was prohibitive to ask about all goals and objectives within state-specific suicide prevention plans; however, because many plans were modeled after the NSSP, respondents were asked to rate their STT's progress towards achieving each of the NSSP's 13 goals. Respondents were also asked whether their STT was currently implementing any of the seven *CDC Preventing Suicide Technical Package* strategies (See Domain 4 results).

Domain 5: Collaboration

Survey respondents were also asked to rate the level of activity and influence of various *champions* (e.g., survivors of suicide loss [i.e., friends and family members of a person who died by suicide], community-based prevention/nonprofit organizations, community mental health/behavioral health organizations, suicide prevention coalitions) and *sectors* (i.e., state-level departments and/or community entities) in their suicide prevention efforts. Respondents rated the activity level of 15 pre-determined champions on a scale of 1 to 5, with 1 being "not active at all" and 5 being "very active." Respondents rated the influence level of 15 champions on a scale of 1 to 5 with 1 being "not influential at all" and 5 being "extremely influential" (See Domain 5 results).

Domain 6: Legislation/Policy

The survey asked respondents about suicide prevention legislation or policies passed within the past five years across multiple settings and sectors (See Domain 6 results).

Domain 7: Prevention Readiness/Capacity

Survey respondents were asked to select the stage that best described their STT's readiness for suicide prevention action from the *Stages of Community Readiness* model.[24] Stages of readiness were defined as:

1. "No awareness:" issue not recognized as a problem
2. "Denial/resistance:" issue recognized but not as occurring locally
3. "Vague awareness:" local concern recognized but no immediate motivation to confront
4. "Preplanning:" recognition of concern but efforts unfocused
5. "Preparation:" active planning and modest community support
6. "Initiation:" effort justified by community and activities underway
7. "Stabilization:" activities supported by leadership with trained and experienced staff
8. "Confirmation/expansion:" efforts in place, community supports expansion, local evaluation
9. "High level of community ownership:" sophisticated knowledge, evaluation, and application of model to other issues[24]

Survey respondents were also asked to describe their STT capacity, based on staffing, funding, and expertise, to implement a public health approach to suicide prevention, specifically pertaining to routine surveillance and monitoring, data-driven strategic planning, implementation of evidence-based programs and practices, evaluation of programs and practices, and dissemination of "what works" (i.e., best practices) to stakeholders. Response options were analyzed on a 5-point scale from no capacity to strong capacity (See Domain 7 results).

Domain 8: Populations Addressed

Survey respondents were asked to identify the populations their STT was either currently working with or the focus of a program that addresses suicide. Respondents were provided a list of 16 populations (including "other"), covering various age groups, racial/ethnic groups, veterans/active duty military, people experiencing homelessness, persons involved in the criminal justice system, people with lived experience, survivors of suicide loss, and first responders (See Domain 8 results).

Domain 9: Risk and Protective Factors Addressed

Survey respondents were provided with a list of 20 common risk factors for suicide cited in the literature and asked to select the factors that their STT specifically addressed. Similarly, survey respondents were provided with a list of seven common protective factors for suicide and asked to select the factors that they were specifically addressing in their suicide prevention efforts (See Domain 9 results).

Domain 10: Facilitators and Barriers

Survey respondents were asked to identify barriers and facilitators affecting their STT's suicide prevention efforts. Respondents were provided a list of 19 facilitators and 18 barriers considered by CDC suicide prevention subject matter experts to potentially impact prevention programming and asked to select which affect their state's suicide prevention efforts (See Domain 10 results).

Results

A total of 138 individuals responded to the survey. Of the 138 respondents, 87 respondents were from states, six from territories, and 45 from tribes. Among respondents, 48.8% were from state, territorial, or tribal mental/behavioral health agencies, and 27.9% were from state, territorial, or tribal health/public health agencies (Table 1). The remainder of respondents (23.3%) were based in other agencies (e.g., human services) or non-governmental organizations. Most respondents (78.4%) reported working in suicide prevention for five or more years.

State Results

The state results below refer to respondents weighted to the state level.

Domain 1: Awareness of Recent Suicide Trends

Nearly 63% of states were accurate in their perceptions of recent suicide trends. The average rating by respondents was 3.8 (SD=0.64; range 2-5; data not shown) indicating a response roughly corresponding to "increased somewhat."

Domain 2: Data Sources

States used an average of 3.0 data sources to track suicide (SD=0.9; range 1-4; Table 2a), 1.8 to track suicide attempts (SD=1.0; range 0-4), and 3.2 to track risk/protective factors (SD=1.2; range 0-5). States most frequently reported using vital statistics data (i.e., mortality data) to track suicide (88.2%; Table 2b); the next most frequently used source was NVDRS (70.6%). Death certificates, fatality review team data, and epidemiology work groups were each reported to be used by roughly two-thirds of states.

Over half of the states reported using hospital discharge (56.8%; Table 2b) and ED (50.9%) data to track suicide attempts. Tracking risk and protective factors for suicide was most commonly done through use of YRBSS (88.2%) and BRFSS (68.6%). Fifty-one percent of states reported using NSDUH to track risk and protective factors.

Domain 3: Infrastructure

Staffing

Thirty-two states reported having a specific unit or office dedicated to suicide prevention (62.7%; Table 2b). The number of staff ranged from zero to nine, with an average number of 2.9 (data not shown). Nearly one-quarter (23.5%) reported that their state had just one staff person (percent time not indicated; data not shown), which was the most frequent response.

Budget and Funding

Reported annual budgets ranged from no dedicated funding to $4,900,000 (Table 2b). Nearly one-quarter (21.6%) of states reported no suicide prevention budget. When asked about other sources of funding apart from state appropriations, the average number of other funding sources reported was two (SD=1.6; range 0-8; data not shown). Substance Abuse and Mental Health Services Administration's (SAMHSA) Garrett Lee Smith (GLS) State/Tribal Youth Suicide Prevention and Early Intervention Grant Program was a frequently reported funding source, reported by 45.1% (n=23; data not shown) of states. Other federal funding sources (e.g., National Institutes of Health, CDC, Indian Health Service, Veterans Affairs) were also reported.

Budgeted Activities

An average of nine suicide prevention activities were supported by state budgets (SD=3.7, range 3-11 activities; data not shown). Suicide prevention activities most frequently funded by states included developing suicide prevention materials (84.3%; Table 2b), training (80.4%), and staffing (80.4%). The average rating of the likelihood of whether a state could reduce suicide rates 20% by 2025 at current resource/funding levels was 2.1 (SD=1.1, range 1-4; data not shown), indicating "somewhat unlikely." Few states (11.8%; Table 2b) reported that it was "somewhat likely" and none reported that it was "very likely."

Domain 4: Prevention Planning

Suicide Strategic Plan

Nearly all states (90.2%; Table 2b) reported having a suicide prevention strategic plan, and the majority also reported that their plan had been updated in the past five years. States reported using multiple sources of information to inform their strategic plan development (e.g., surveillance systems, guidance documents, the *CDC Preventing Suicide Technical Package*, National Strategy for Suicide Prevention, stakeholder input).

Nearly three-quarters of states reported that they evaluated their strategic plan (74.5%; Table 2b). States rated the priority of evaluation in their state an average of 3.5 (SD=1.0, range 1-5; data not shown), corresponding to a rating between "somewhat a priority" and "high priority."

National Strategy Goal Achievement

Progress toward National Strategy for Suicide Prevention Goals 1, 3, 5, and 7 had average ratings of 3 or greater (Table 2a), indicating that "moderate to a lot of progress" is being made in the state.

Prevention Strategies and Approaches

Most (82%) states were familiar with the *CDC Preventing Suicide Technical Package* (data not shown). States were asked whether their state was currently implementing any of the seven *CDC Preventing Suicide Technical Package* strategies. The strategy reported most frequently (88.2%; Table 2b) was "Identify and support people at risk," which emphasizes care of and attention to vulnerable populations through proactive case finding and effective response, crisis intervention, and evidence-based treatment. The strategy least often reported (15.7%) was "Strengthen economic supports," which aims to buffer the risks associated with economic and financial strain by strengthening economic support systems.

Domain 5: Collaboration

Champion Activity and Influence Level

States rated the activity level of the 15 champions an average of 3.5, corresponding to a "moderately active" to "active" rating. Two-thirds of states rated the activity level of their champions an average of 3.0 or greater, corresponding to a rating of approximately "moderately active" (data not shown). The champions receiving the highest average activity rating ($\bar{x}$) were nonprofit organizations ($\bar{x}$=4.2; Table 3) and survivors of suicide loss ($\bar{x}$=4.2). The champions receiving the lowest average activity rating were business leaders ($\bar{x}$=2.1), tribes/tribal leaders/tribal members ($\bar{x}$=2.3), and faith-based/religious groups ($\bar{x}$=2.7).

States rated the influence level of champions an average of 3.3, corresponding to "somewhat influential." The champions receiving the highest average influence rating ($\bar{x}$) were survivors of suicide loss ($\bar{x}$=3.9; Table 3), nonprofit organizations ($\bar{x}$=3.9), and military/veteran groups ($\bar{x}$=3.8). The champions receiving the lowest average influence ratings were business leaders ($\bar{x}$=2.2), tribes/tribal leaders/tribal members ($\bar{x}$=2.3), and faith-based/religious groups ($\bar{x}$=2.8).

Sector Activity and Influence Level

States rated the activity level of the 23 sectors an average of 3.0, corresponding to "moderately active." The sectors receiving the highest average activity rating were crisis services ($\bar{x}$=4.3; Table 3), behavioral health ($\bar{x}$ =4.1), and public health ($\bar{x}$=4.1). The sectors receiving the lowest average activity rating were housing authority ($\bar{x}$=1.4), labor/unemployment ($\bar{x}$=1.5), tribal council ($\bar{x}$=1.7), and health insurers ($\bar{x}$=1.9).

States rated the influence level of the sectors an average of 3.0, corresponding to "somewhat influential." The sectors receiving the highest average influence rating were the legislative branch ($\bar{x}$=4.0; Table 3), governor's office ($\bar{x}$=3.9), crisis services ($\bar{x}$=3.8), and behavioral health ($\bar{x}$=3.8). The sectors receiving the lowest average influence ratings were housing authority ($\bar{x}$=1.6), labor/unemployment ($\bar{x}$=1.7) and tribal council ($\bar{x}$=2.1).

Domain 6: Legislation/Policy

About three-quarters of states (76.5%) reported that their state had passed legislation about K-12 suicide prevention in the past five years (Table 2b). Legislation/policies impacting military/veterans were reported by over a third of states (37.3%). Between 35-40% of states reported that their state had passed one or more policies related to crisis support services, mental health parity/insurance coverage, funding for suicide prevention, and public awareness campaigns.

Domain 7: Prevention Readiness/Capacity

On average, states rated their suicide prevention readiness as 6.1 (SD=1.7, range 3-9; data not shown), corresponding to the "initiation" stage where prevention activities are underway. About 40% of states reported that their states were in later stages of readiness (Stages 7-9), indicating possible involvement in activities that mobilize leaders and partners, create systems, coordinate efforts, or integrate knowledge throughout all systems (Table 2b). Over 40% of states reported their state was in the middle stages (Stages 4-6), denoting "preplanning," "preparation," and "initiation." No states reported that communities or leaders in their state lacked recognition of suicide as a problem (Stage 1) or that there was little recognition of suicide as a problem occurring in their community (Stage 2).

The average capacity ratings (out of five; Table 2a) for implementing five public health activities, ranged from 3.1 ("Evaluation of programs and practices") to 3.4 ("Implementation of evidence-based programs;" "Routine surveillance and monitoring of the problem"), indicating a rating between 3—"modest capacity" and 4—"good capacity."

Domain 8: Populations Addressed

Youth (age 10-24 years) was the most frequently reported population addressed (96.1%; Table 2b), followed by veterans or active duty military (94.1%), college students (92.2%), and survivors of suicide loss (92.2%). States reported working with people experiencing homelessness the least (35.3%).

Domain 9: Risk and Protective Factors Addressed

States reported addressing an average of 15.4 (SD=4.6, range 1-20; data not shown) risk factors (out of 20). Substance use/misuse (92.2%; Table 2b), suicidal thoughts (90.2%), and mental illness (90.2%) were selected as the most common risk factors addressed by states. Between 80-87% of states reported that their state addressed prior suicide attempts, involvement with bullying, adverse childhood experiences, access to lethal means among people at risk, being a suicide loss survivor, lack of access to behavioral-mental health care, and stigma of help-seeking. The risk factor addressed least was financial problems (56.9%).

States reported addressing an average of 5.8 (SD=1.7, range 0-8; data not shown) protective factors (out of eight). The factor addressed most frequently was promoting help-seeking (90.2%; Table 2b). The protective factor addressed least was promoting cultural values that discourage suicide (56.9%).

Domain 10: Facilitators and Barriers

The average number of facilitators for suicide prevention reported was 12.6 (SD=3.5, range 3-17; data not shown). The five facilitators reported most frequently were the NSSP (92.2%; Table 2b), other federal/national guidance materials (90.2%), increased awareness about suicide prevention as a public health issue (88.2%), partnerships or collaborations across key sectors (86.3%), and coalitions or task forces to address suicide prevention priorities (84.3%). States did not report the following facilitators as common facilitators to suicide prevention: adequate staff to implement strategic plan, clarified authority for suicide prevention at the state level, evaluation of the strategic plan, and federal or local legislation/policy.

The average number of barriers reported was 8.7 (SD=3.2, range 1-16; data not shown). The five barriers reported most often were insufficient federal funding dedicated to suicide prevention (88.2%; Table 2b), insufficient state funding dedicated to suicide prevention (88.2%), lack of adequate staff to implement strategic plan (78.4%), lack of surveillance resources to track and monitor suicide attempts (72.5%), and lack of state legislation/policy (70.6%).

Territorial and Tribal Results

The territorial and tribal results will refer to respondents weighted to their jurisdictional level.

Territorial and Tribal Infrastructure

When asked about their jurisdiction's infrastructure, two out of three territories and 13 out of 19 tribes reported having a specific unit or office dedicated to suicide prevention (data not shown). Two territories reported a suicide prevention budget of $100,000 to under $250,000 (Table 4), and one reported $550,000 to under $1,000,000. Two tribes reported not having a suicide prevention budget. Five tribes reported budgets in the lowest category above zero ($1 to $100,000), and two tribes reported budgets in the highest category ($1,000,000 to $2,900,000). Based on responses from three territories and 18 tribes, the average number of other funding sources reported by territories was 1 (SD=1, range 0-2; data not shown) and by tribes was 1.4 (SD=0.6, range 0-2).

When asked to rate the likelihood that their jurisdiction can reduce suicide by 20% by 2025 at current resource/funding levels, two territories reported that it was "very unlikely," and one territory indicated that achieving this goal was "very likely" (Table 4). The average likelihood rating reported from a total of 15 tribes was 3.1 (SD=1.1, range 1-5; data not shown), indicating "not sure or unlikely." Six tribes (16.7%; Table 4) reported that it was "very unlikely" or "somewhat unlikely" that their tribe can reduce suicide by 20% by 2025 at current resource/funding levels, and one reported that it was "very likely" (2.8%).

Territorial and Tribal Prevention Strategies and Approaches

When asked about having a suicide prevention plan, 75% (3; data not shown) of territories and 33.3% (12) of tribes reported having a strategic plan. Territories and tribes were asked whether they were currently implementing any of the seven strategies in the *CDC Preventing Suicide Technical Package* (Table 4). All strategies were noted as being implemented among at least one territory and at least one tribe, with a range between 25-50% implementation of the strategies among territories and a range of 2.8% to 38.9% among tribes.

Territorial and Tribal Prevention Readiness/Capacity

On average, a total of 11 tribes rated their tribe's readiness as 4.4 (SD=2.1, range 3-9; data not shown) corresponding to the "preplanning" stage. Five tribes (13.9%; Table 4) indicated stage 3, "vague awareness." Only one territory answered the question, indicating stage 9, "high level of community ownership."

Among territories, the overall average capacity to implement specific public health activities was 3.7 (data not shown). The greatest capacity for territories was for data-driven strategic planning ($\bar{x}$=4.3) and routine surveillance ($\bar{x}$=4.0). Among tribes, the overall average capacity was 3.1 (data not shown), with the greatest capacity rating for implementation of evidence-based programs ($\bar{x}$=3.8) and the lowest capacity rating for routine surveillance ($\bar{x}$=2.6).

Territorial and Tribal Facilitators and Barriers

Tribes and territories were asked to identify the facilitators (out of 19) and barriers (18) to their jurisdiction's suicide prevention efforts. The average number of facilitators indicated by territories was 9.5 (SD=7.7, range 4-15; data not shown) and by tribes was 7.3 (SD=4.0, range 2-14). The facilitators reported most frequently by tribes were federal funding dedicated to suicide prevention (41.7%; Table 4), increased awareness about suicide prevention as a public health issue (30.6%), and STT funding dedicated to suicide prevention (30.6%).

The average number of barriers indicated by territories was 9.0 (data not shown; SD=5.7, range 5-13) and by tribes was 8.4 (SD=4.6, range 0-17). The four barriers reported most frequently by tribes were lack of surveillance resources to track and monitor suicide attempts (33.3%; Table 4), lack of adequate staff to implement strategic plan (30.6%), and lack of coordination/integration of services between STT partners (30.6%).

Discussion

Overall, results from this survey suggest variation in suicide prevention infrastructure, capacity, and prevention activities across all domains. Several key themes emerged from the results: 1) modest infrastructure 2) modest public health capacity; and 3) prevention gaps. The State Suicide Prevention Infrastructure Recommendations (referred to hereafter as *SPRC Infrastructure Recommendations*) may help to provide insight and interpretation of survey findings.[17] These recommendations were developed by SPRC after a literature review and consultation with experts from 21 state and national organizations, state suicide prevention leaders, specialists in state government, and those personally touched by suicide. The *SPRC Infrastructure Recommendations* is organized into six areas that represent the essential elements of state infrastructure for suicide prevention and are a useful framework for this discussion.

The following discussion refers to state responses. The discussion of territories and tribal responses is presented separately, further below, due to a briefer scope of responses reported and given the differing context in which territorial and tribal suicide prevention often takes place.

Infrastructure

Results indicate gaps in infrastructure. According to the *SPRC Infrastructure Recommendations*, suicide prevention requires a designated lead agency to develop, carry out, and evaluate the state suicide prevention plan. In addition, it advises that a strong foundation for suicide prevention has dedicated leadership from a designated full-time person, where possible, and that that person should have core staff to carry out all of the necessary functions for suicide prevention work (e.g., surveillance, program management, training, etc.).[17] Results here indicated that two-thirds of states had a dedicated unit or office for suicide prevention, but nearly one-quarter of states reported only a single supported staff person, indicating potential gaps in the ability to carry out suicide prevention functions.

SPRC Infrastructure Recommendations also suggests states should designate sufficient resources to carry out a comprehensive approach to suicide prevention. Survey results highlighted nearly 40% of state respondents reporting budgets ≤$100,000. Indeed, a lack of state and federal funding was noted as a key barrier to state suicide prevention. This finding is important, as state budgets with a specific line item for suicide prevention may provide greater potential for sustainability of suicide prevention activities. According to *SPRC Infrastructure Recommendations*, "state funds are essential to promote continuity, comprehensiveness, and sufficient reach" of suicide prevention efforts.[17] Results indicate that grant funding may be used to supplement state funding, or take the place of it in some cases. However, evidence exists from the GLS Youth Suicide Prevention Program that when grant funding is no longer available, gains made under such funding can be lost.[25]

Capacity

Related to gaps in infrastructure, capacity of states to carry out routine surveillance, data-driven strategic planning, program implementation, evaluation, and dissemination was rated as modest. Similarly, average readiness for suicide prevention action was rated as in the "initiation stage" with activities underway. Perhaps most telling as a potential indicator of the state of state suicide prevention was the low likelihood rating (i.e. very unlikely or somewhat unlikely) among half of states related to being able to meet the goal of a 20% reduction in suicide by 2025.

Lack of surveillance resources was noted as a common barrier to suicide prevention.

Lack of surveillance resources was noted as a common barrier to suicide prevention. This finding is important, as access to high-quality data for monitoring suicide, suicide attempts, and risk and protective factors, along with capacity to analyze data, can support a public health approach to suicide prevention. Results suggest that states are using multiple data sources to monitor suicide but are using fewer data sources to track suicide attempts. This finding may reflect challenges in accessing such data, as healthcare-based suicide attempt data are typically less readily available compared to mortality data. As more states begin using ED syndromic surveillance, a system of near real-time tracking of ED visits for nonfatal suicide attempts, respondents may report increased utilization of data sources to track suicide morbidity.

In order to expand capacity, the *CDC Preventing Suicide Technical Package* and the *SPRC Infrastructure Recommendations* suggest inclusion of broad-based, multisectoral coalitions or partnerships that can leverage the respective resources of these partners to advance suicide prevention work across states and local communities.[26] Moreover, because suicide is not caused by any single factor and prevention cannot focus on mental health concerns alone, broad partnerships are needed.[26] Therefore, business leaders, housing, labor/employment, justice, and social service champions and sectors, to name a few, may be positioned to implement programs and policies that strengthen economic supports and promote upstream prevention. In addition, health insurance plans that provide benefits for mental health care on par with physical health benefits may help reduce suicide risk, so the health insurance sector is another potential partner to support a comprehensive approach to prevention.[15] Results suggest average ratings of champions and sectors, with more traditional partners (e.g., survivors of suicide loss, behavioral health, and crisis services) receiving higher ratings and less traditional, but nevertheless important, partners receiving lower ratings (e.g., business).

Additional areas for improvement in partnerships are with tribal and faith-based communities. States reported that tribal communities were not very active partners. This finding may be related to tribal communities often having separate funding and separate infrastructure; however, state and tribal suicide prevention may benefit from mutual collaboration. Faith-based partners do participate in national suicide prevention efforts, as evidenced by the activity of the Action Alliance Faith Communities Task Force;[27] however, greater partnership at the state level may help expand prevention capacity by reaching more people. According to the Action Alliance, these groups are contributing to suicide prevention by "increasing hope, supporting emotional well-being, and fostering the development of positive social connections."[27] Results here point to opportunities for expansion of suicide prevention partnerships in the future.

Lastly, related to partnerships and increased capacity, legislation and policy help to stabilize, sustain, and spur growth in suicide prevention, according to *SPRC Infrastructure Recommendations*. These recommendations highlight how building partnerships with lawmakers can invite opportunities to provide input and feedback on suicide prevention legislation. Survey results suggest that additional attention to legislation/policy may be needed to expand the reach of suicide prevention efforts. For example, states may benefit from assessing their data, including the prevalence of risk factors and policy, to address them and then identify areas in which to educate decision makers about gaps and opportunities for prevention. Further research to evaluate the impact of specific legislation on suicide rates can also highlight areas to focus efforts.

Prevention

With regard to suicide prevention programmatic activities, *SPRC Infrastructure Recommendations* suggests that a key function of a state suicide prevention office is to oversee the implementation and evaluation of suicide prevention programming that includes a combination of strategies that are supported by the best available evidence.[17] SPRC's examples of such strategies largely map to the *CDC Preventing Suicide Technical Package* strategies.[15]

Most states reported implementing many prevention activities, but it is unknown whether budgets are sufficient to effectively carry out the activities.

Most states reported implementing many prevention activities, but it is unknown whether budgets are sufficient to effectively carry out the activities. Most states reported implementation of most of the seven broad strategies in the Technical Package (e.g., teaching coping and problem-solving skills, identifying and supporting people at risk), except "Strengthening Economic Supports," which had low endorsement. Knowing that economic support is lacking is important when considering how to strengthen prevention efforts, as the strain of job loss, housing concerns, and other financial stressors can add to suicide risk among adults.[28-30] Additionally, few respondents reported approaches addressing provider shortages in underserved areas, organizational policies promoting suicide prevention, and upstream prevention of adverse childhood experiences (e.g., through parenting skills and family relationship programs). Unfortunately, the survey did not ask about the level of evidence, of the types of policies, programs, and practices endorsed. More information about this and about the extent and fidelity of implementation and evaluation could shed important light on prevention effectiveness.

Another way to assess prevention activities is through examination of progress toward state suicide prevention goals. Since assessing progress on 50 state-specific suicide prevention plans was beyond the scope of the survey and given that many state plans are based on the NSSP, CDC assessed state progress towards NSSP goals. Results indicated that states are making, on average, "moderate progress" across goals and that the most progress is being made related to training community and clinical services providers on suicide prevention. This training is an important part of a comprehensive approach to suicide prevention. Areas for improvement include evaluating the impact and effectiveness of suicide prevention interventions and systems; synthesizing and disseminating findings; and promoting and supporting research on suicide prevention.

Another important aspect of suicide prevention is using data to identify populations disproportionately affected by suicide. Results of this survey suggest that states have activities focusing on a range of such populations. It is unclear, however, the extent to which states are using available data, or need improved data, to prioritize high-burden populations and whether prevention activities align with data or with funding. Results indicated that funding, programming, and policy focused on youth suicide prevention. The most commonly reported prevention strategy activity was identifying and supporting people at risk, specifically, gatekeeper training. This training typically focuses on teaching school personnel and other adults in the community how to identify youth at risk. Among respondents who reported that their state had passed legislation or policy to prevent suicide, respondents from approximately three-quarters of states reported passage of legislation for K-12 suicide prevention. These prevention measures are critical to keeping youth safe, especially as the rates among youth, particularly those 10-14, continue to climb at a concerning pace.[2] To complement these measures, effective prevention activities targeting people across the life course are needed. With suicide trends increasing among groups across the lifespan, for example among middle-aged adults, expanded focus could also go a long way towards making an impact on suicide.

Tribes and Territories

American Indian/Alaska Native (AI/AN) populations have the greatest rates of suicide, particularly among youth.[23] Addressing this population is critical. Suicide prevention budgets for tribes and territories varied widely, ranging from 0-$2.9 million per year among tribes and between $100,000-$999,000 among territories. Tribes and territories vary tremendously in size, cultural traditions, location, and suicide risk in the population, and there is no one-size-fits-all approach for these groups, which is seen in the indicators described below.

Survey responses related to capacity, readiness, and likelihood of reducing suicide rates 20% by 2025 provide some understanding of the tribal suicide prevention landscape. The average capacity to carry out the public health approach for suicide prevention in tribes was reported as modest overall, with greater average capacity for implementation of evidence-based programs and less average capacity related to routine surveillance and monitoring of suicides. Surveillance challenges may occur for several reasons. First, while the National Vital Statistics System (NVSS) collects suicide mortality data on AI/AN populations, error exists with regard to coding of race/ethnicity on the death certificate, especially among AI/AN.[31] Additionally, NVSS does not provide data on suicide rates among tribes, so a true understanding of the problem is limited. Some successes have been noted, fortunately. One tribe, the White Mountain Apache (not surveyed here), has had success developing suicide surveillance and implementing effective prevention strategies and may serve as a model for other tribes with similar contexts and resources.[32] The success of the White Mountain Apache tribe has been attributed to elder involvement in suicide prevention program advisory boards and in the delivery of culturally-based suicide prevention interventions, indicating the importance of culture and connectedness in implementing successful suicide prevention programs.[32]

In terms of readiness to carry out suicide prevention activities, data were sparse, but about a quarter of tribes reported being in the very early stages of readiness, reporting "vague awareness" of suicide prevention in their communities or "preplanning." Interestingly, about an equal proportion of tribes reported that reductions in suicide by 20% by 2025 were very or somewhat unlikely versus somewhat or very likely. To help fill in some of the gaps and understand this mix of results, we can look at barriers and facilitators to suicide prevention. The lack of federal or tribal funding, lack of staffing, lack of surveillance resources, and lack of partnerships and leadership were noted by at least a quarter of tribes. However, some tribes did point to federal and tribal funding (41.7% and 30.6%, respectively) as a facilitator to suicide prevention. This mix may indicate a potential bifurcation in the sample between tribes with more and less funding or could indicate that funding is helpful but not enough.

Territories reported good capacity overall and in the areas of data driven strategic planning and routine surveillance. Again, only a few territorial respondents reported so these findings must be interpreted with caution. There are large limitations in understanding the problem of suicide in territories, given data and surveillance limitations. One exception to this limitation is Puerto Rico, which has been represented in the National Violent Death Reporting System since 2016 and has improved ability to look at contributing circumstances of suicide. CDC has recently worked with both Puerto Rico and the U.S. Virgin Islands in the aftermath of Hurricanes Maria and Harvey. Gatekeeper training and train-the-trainer events were held for community members and for health and behavioral health professionals to begin to identify and support people at risk. This training is an important step in keeping residents safe and building capacity. Other strategies are also important. Half of territories responding reported implementation of strategies to strengthen economic supports, promote connectedness, and identify and support people at risk. Fewer endorsed other strategies from the *CDC Preventing Suicide Technical Package* (e.g., lessening harms and preventing future risk), indicating potential gaps in a comprehensive approach to prevention. Additionally, more information about extent of implementation and sufficiency of funds is needed.

While data on suicide prevention readiness were sparse, further information can be gleaned from reported barriers and facilitators. Half of territories reported the presence of a strategic plan and increased awareness of suicide as a public health issue as facilitators and the lack of policy/legislation as barriers to suicide prevention. Again, some mixed results were evident, with half reporting surveillance resources as a facilitator and half reporting such resources as a barrier.

While *SPRC Infrastructure Recommendations* was developed for states, much of the information may apply to tribes and territories, such as designating a lead organization; maintaining a dedicated leadership position; forming a coalition with broad representation; allocating resources to examine data; building a lifespan approach to prevention; and planning, providing, and evaluating guidance for prevention efforts.[17]

Limitations

This web-based survey had multiple limitations. The cross-sectional survey design meant that the survey captured only a snapshot in time, although several questions attempted to capture changes or events in the past five years. Additionally, the survey contained skip patterns that resulted in respondents sometimes skipping large portions of the survey, which may make the amount of missing information appear artificially high. Similarly, some questions required a "yes" or "no" response to multiple items (for example, in a long list). In many instances, only the "yes" responses were selected by respondents and the remainder left blank, so it was unclear whether the responses were meant to be "no" or were truly missing. While the survey was an efficient way to gain a better understanding of suicide prevention activities, surveys can introduce biases such as but not limited to non-response bias, self-report bias, and recall bias.

The sensitive nature of the topic and/or respondents' perceptions about favorable responses could also impact responses. To minimize the influence of bias, data are reported in aggregate. The survey designers chose breadth over depth, and so we were not able to gauge many important details about suicide prevention infrastructure and activities (e.g., implementation fidelity or reach of prevention activities). Despite this limitation, survey results may provide valuable information for future suicide prevention planning and decision-making, much of which has not been collected before. It also may provide a baseline for additional assessments in the future.

States, territories, and tribes had multiple respondents acting in official roles, so data from multiple respondents were averaged to count as one for each jurisdiction for data analysis. This approach assumed that knowledge across respondents was equivalent. A limited number of respondents were asked to speak on a wide variety of topics related to suicide prevention across their state, and in doing so, important local context and knowledge may have been missed. However, the individuals invited to participate were pre-identified as those likely to have the most information and expertise, ideally minimizing knowledge gaps in survey responses. Finally, the number of respondents for tribes and territories severely limited what we could learn about suicide prevention in these populations.

Conclusions

Given the rise in suicide rates between 1999 and 2016,[33] CDC sought to conduct an environmental scan of suicide prevention infrastructure and activities across states, territories, and tribes in order to better understand the strengths and opportunities for improvement. This report presents an overview of the suicide prevention landscape across multiple domains, depicts a diverse array of resources and activities and identifies some key areas for improvement.

Evaluating the impact and effectiveness of suicide prevention interventions and broadly disseminating these results is important. The *CDC Preventing Suicide Technical Package* is one resource for documenting and disseminating activities with the best available evidence. Rigorous evaluation of existing and innovative programs, practices, and policies can expand the evidence base of best practices to prevent suicide and also uncover strategies that do *not* impact suicide, suicide attempts, or risk and protective factors. Finally, more information is needed to understand the extent to which state plans align with the NSSP and rely on the best available evidence.

Apart from results suggesting the need for improvements across suicide prevention domains, states, territories, and tribes reported wide-ranging activities and attention to their populations, often on modest budgets. Current suicide rates indicate that states, territories, and tribes, backed by a strong national response, must continue to use data and science to guide effective prevention approaches to save lives.

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Tables

Table 1. Survey of State, Territorial, and Tribal Suicide Prevention Characteristics of Respondents,[a] United States—July 2018-August 2018

Respondents (N=138)

Characteristics of Respondents	Frequency (n)	Percent
Agency Type		
STT mental/behavioral health agency	67	48.8
STT health/public health agency	39	27.9
Other governmental agencies or nongovernmental organizations	32	23.3
Experience working in suicide prevention		
Less than 5 years	30	21.6
At least 5 years	108	78.4

Note: STT = state, territory, tribe
[a] Unweighted responses

Table 2a. Survey of State Suicide Prevention Activities Summary Findings (Average, Standard Deviation, and Frequency), United States—July 2018-August 2018

Survey Item	States (N=51)[a] $\bar{x}$[b]	SD	n
Number of data sources used			
Suicide	3.0	0.9	48
Suicide attempts	1.8	1.0	42
Risk and protective factors	3.2	1.2	49
Capacity			
Data-driven coordinated strategic planning	3.3	1.0	51
Dissemination of what works to stakeholders	3.3	0.8	51
Evaluation of programs and practices	3.1	1.0	51
Implementation of evidence-based programs	3.4	1.0	51
Routine surveillance and monitoring of the problem	3.4	1.0	51
Progress towards 2012 National Strategy for Suicide Prevention Strategic Goals			
Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings	3.2	0.8	50
Goal 2: Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors	2.9	0.9	50
Goal 3: Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery	3.2	0.8	50
Goal 4: Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide	2.8	0.9	50
Goal 5: Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors	3.0	0.8	50

Survey Item	$\bar{x}$[b]	SD	n
Goal 6: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk	2.8	1.0	50
Goal 7: Provide training to community and clinical service providers on the prevention of suicide and related behaviors	3.5	0.7	50
Goal 8: Promote suicide prevention as a core component of health care services	2.9	0.8	50
Goal 9: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors	3.0	0.8	50
Goal 10: Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides	2.9	0.9	50
Goal 11: Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action	2.8	0.9	50
Goal 12: Promote and support research on suicide prevention	2.3	0.9	50
Goal 13: Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings	2.5	0.9	49

[a] Refers to the respondents weighted to the state level.
[b] Average

Table 2b. Survey of State Suicide Prevention Summary Findings by Frequency and Percent of "Yes" or Affirmative Responses, United States—July 2018-August 2018

States[a] (N=51)

Survey Item		
State Infrastructure[b]	**Yes (n)**	**Percent**
State has unit/office dedicated to suicide prevention	32	62.7
Data Sources[b]	**Yes (n)**	**Percent**
Suicide		
Death certificates	33	64.7
Epidemiology work groups	32	62.7
Fatality review team reports	33	64.7
National Violent Death Reporting System	36	70.6
Vital statistics	45	88.2
Suicide attempts		
Emergency department	26	50.9
Emergency medical services	8	15.7
Hospital discharge	29	56.8
Syndromic surveillance	11	21.6
Risk and protective factors		
Behavioral Risk Factor Surveillance System	35	68.6
Local surveys	26	51.0
National Survey on Drug Use and Health	26	51.0
Other school surveys	25	49.0
Youth Risk Behavior Surveillance System	45	88.2
Funding[c]	**Frequency (n)**	**Percent**
State appropriations		
0	11	21.6
$1 - $100,000	8	15.7
$100,000 - <$250,000	5	9.8
$250,000 - <$400,000	3	5.9
$400,000 - <$550,000	7	13.7
$550,000 - <1,000,000	4	7.9
$1,000,000 – $4,900,000	7	13.7

Survey Item		
Funding[c] *(continued)*	**Frequency (n)**	**Percent**
Number of other funding sources		
None	8	15.7
One	21	41.2
Two	10	19.6
Three or more	1	0.02
Other funding source amount		
<$550,000	16	31.4
$550,000 - <$1,000,000	13	25.5
$1,000,000 - $5,900,000	11	21.6
Activities Budgeted[b]	**Yes (n)**	**Percent**
Community-based service delivery	20	39.2
Convening a conference, annual meeting, etc.	29	56.9
Convening of local SP coalitions/taskforces	28	54.9
Convening state SP coalition/task force	27	52.9
Developing SP materials (e.g., briefs, fact sheets, annual reports)	43	84.3
Grants to local communities	23	45.1
Implementation of community-based prevention programs	34	66.7
Legislation/policy development	14	27.5
Program evaluation	32	62.7
Research	8	15.7
Staffing	41	80.4
SP plan evaluation	23	45.1
Surveillance activities	27	52.9
Training	41	80.4
Work within clinical systems to improve suicide risk detection, treatment, and care transitions	33	64.7
Other	6	11.8
Likelihood of reducing suicide rates 20% by 2025[c]	**Frequency (n)**	**Percent**
Very unlikely	21	41.2
Somewhat unlikely	6	11.8
Neither	14	27.5
Somewhat likely	6	11.8
Very likely	0	0.0

Survey Item		
Suicide strategic plan[b]	**Yes (n)**	**Percent**
Has a plan	46	90.2
Updated plan within last 5 years	41	80.4
Evaluated plan	38	74.5
Strategies[d] and approaches used[b]	**Yes (n)**	**Percent**
Strengthen economic supports	*8*	*15.7*
Strengthen household financial security	5	9.8
Housing stabilization policies	7	13.7
Strengthen access to and delivery of suicide care	*37*	*72.5*
Coverage of mental health conditions in insurance policies	17	33.3
Reduce provider shortages in underserved areas	17	33.3
Safer suicide care through systems change	36	70.6
Create protective environments	*40*	*78.4*
Reduce access to lethal means among people at risk of suicide	40	78.4
Organizational policies and culture	23	45.1
Community-based policies to reduce excessive alcohol use	20	39.2
Promote connectedness	*38*	*74.5*
Peer-norm programs	33	64.7
Community engagement activities	34	66.7
Teach coping and problem-solving skills	*39*	*76.5*
Social-emotional learning programs	36	70.6
Parenting skill and family relationship programs	25	49.0
Identify and support people at risk	*45*	*88.2*
Gatekeeper training	45	88.2
Crisis Intervention	47	92.2
Treatment for people at risk of suicide	41	80.4
Treatment to prevent re-attempts	32	62.7
Lessen harms and preventing future risk	*41*	*80.4*
Postvention	42	82.4
Safe messaging and reporting about suicide	40	78.4
Legislation/Policies recently passed[b,e]	**Yes (n)**	**Percent**
Setting		
College/university	15	29.4
K-12	39	76.5

Survey Item		
Legislation/Policies recently passed[b,e] *(continued)*	**Yes (n)**	**Percent**
Setting[b] (continued)		
Military/veteran support	19	37.3
Workplace	3	5.9
Specific policies		
Behavioral health service delivery	16	31.4
Crisis support services	20	39.2
Funding/appropriations for SP	19	37.3
Graduate training requirements in SP	6	11.8
Health/Mental health provider training/continuing education for SP	15	29.4
Lethal means legislation	13	25.5
Mental health parity/insurance coverage	20	39.2
Prevention planning/implementation/evaluation	13	25.5
Public awareness campaigns/events	18	35.3
Public/private partnership development (e.g., commission, task force, coalition)	11	21.6
SP capacity or infrastructure (not including funding)	14	27.5
Other	5	9.8
Prevention readiness[c]	**Frequency (n)**	**Percent**
Stage 1 or 2 (no awareness/denial or resistance)	0	0.0
Stage 3 (vague awareness)	2	3.9
Stage 4 (preplanning)	8	15.7
Stage 5 (preparation)	7	13.7
Stage 6 (initiation)	6	11.8
Stage 7 (stabilization)	9	17.6
Stage 8 (confirmation/expansion)	9	17.6
Stage 9 (high level of community ownership)	2	3.9
Populations addressed[b]	**Yes (n)**	**Percent**
American Indian-Alaska Natives	25	49.0
Other racial/ethnic minorities	40	78.4
Sexual and/or gender minorities	42	82.4
Children under 10 years old	29	56.9
Youth aged 10-24	49	96.1
College students	47	92.2
Adults aged 25-34	45	88.2
Middle aged adults (35-64 years)	44	86.3

Survey Item		
Populations addressed[b] *(continued)*	**Yes (n)**	**Percent**
Older adults (≥65 years)	43	84.3
First responders	38	74.5
People experiencing homelessness	18	35.3
People involved with the criminal justice system	35	68.6
People with lived experience	45	88.2
Survivors of suicide loss	47	92.2
Veterans/Active duty military	48	94.1
Other	9	17.6
Risk factors[b]	**Yes (n)**	**Percent**
Access to lethal means among people at risk	42	82.4
Adverse childhood experiences	41	80.4
Being a suicide loss survivor	41	80.4
Criminal-legal problems	32	62.7
Financial problems	29	56.9
Health problems (e.g., pain, chronic illness, terminal illness)	34	66.7
Historical trauma (e.g., violence, resettlement, destruction of culture)	34	66.7
History of interpersonal violence (e.g., dating violence, intimate partner violence, sexual violence)	30	58.8
Involvement with bullying	41	80.4
Job/school problems	38	74.5
Lack of access to behavioral-mental health care	41	80.4
Mental Illness	46	90.2
Prejudice/discrimination (e.g., regarding sexual orientation)	34	66.7
Prior suicide attempts	44	86.3
Relationship problem/loss	34	66.7
Social isolation	35	68.6
Stigma of help-seeking	43	84.3
Substance use/misuse	47	92.2
Suicidal thoughts	46	90.2
Other	6	11.8

Survey Item		
Protective factors[b]	**Yes (n)**	**Percent**
Building life skills (e.g., problem solving, coping, conflict resolution)	42	82.4
Promoting connectedness/social integration	40	78.4
Promoting cultural values that discourage suicide	29	56.9
Promoting help-seeking	46	90.2
Promoting individuals' self-esteem	40	78.4
Promoting sense of purpose in peoples' lives	40	78.4
Promoting tolerance of peoples' differences	34	66.7
Other	6	11.8
Facilitators[b]	**Yes (n)**	**Percent**
Adequate staff to implement strategic plan	18	35.3
Availability of surveillance resources	31	60.8
Clarified authority for SP at the state level	22	43.1
Coalitions to address SP priorities	43	84.3
Coordination of services between state partners	38	74.5
Evaluation of the strategic plan	21	41.2
Federal funding dedicated to SP	38	74.5
Federal legislation/policy	17	33.3
Implementation of the strategic plan	40	78.4
Increased awareness of suicide as a public health issue	45	88.2
Local legislation/policy	15	29.4
National Strategy for Suicide Prevention (NSSP)	47	92.2
Other federal/national guidance materials	46	90.2
Partnerships or collaborations across key sectors	44	86.3
State funding dedicated to SP	33	64.7
State legislation/policy	36	70.6
State level SP leadership	41	80.4
State strategic plan for SP	41	80.4
Other	3	5.8

Survey Item		
Barriers[b]	**Yes (n)**	**Percent**
Insufficient federal funding dedicated to SP	45	88.2
Insufficient state funding dedicated to SP	45	88.2
Lack of a SP strategic plan	6	11.8
Lack of adequate staff to implement strategic plan	40	78.4
Lack of awareness efforts about suicide as a public health issue	21	41.2
Lack of coalitions or task forces to address suicide	17	33.3
Lack of coordination of services between state partners	31	60.8
Lack of evaluation of the strategic plan	25	49.0
Lack of federal guidance materials	6	11.8
Lack of implementation of the strategic plan	20	39.2
Lack of local legislation/policy	27	52.9
Lack of partnerships or collaborations across key sectors	23	45.1
Lack of state guidance materials	6	11.8
Lack of state legislation/policy	36	70.6
Lack of state level SP leadership	19	37.3
Lack of surveillance resources	37	72.5
No clear authority for SP at the state level	15	29.4
Other	6	11.8

Note: SP = suicide prevention

[a] Refers to the respondents weighted to the state level.

[b] Respondents were asked to select all that apply. Only "Yes" responses are captured here, therefore percentages may add to more than 100%. Other responses were either "No," "Not sure or Don't know," legitimate skips, or missing.

[c] Respondents were asked to select one response. Only affirmative responses are captured here, and percentages may not add up to 100%. Other responses can be accounted for due to legitimate skips or missing.

[d] Strategies as outlined in the *CDC Preventing Suicide Technical Package*.

[e] In the 5 years prior to survey.

Table 3. Survey of State Suicide Prevention Activity and Influence Ratings by Champion and Sector, United States—July 2018- August 2018

States (N=51)[a]

	Activity Rating		Influence Rating	
	n	$\bar{x}^b$ (SD)	n	$\bar{x}^b$ (SD)
Champion				
Business leaders	45	2.1 (0.9)	43	2.2 (1.0)
Community health organizations	46	3.5 (0.9)	46	3.2 (0.9)
Faith-based/religious groups	48	2.7 (0.8)	47	2.8 (1.1)
Community mental/behavioral health organizations	47	4.0 (0.9)	47	3.6 (0.9)
Nonprofit organizations	49	4.2 (0.8)	48	3.9 (0.8)
Educators/schoolteachers	47	3.5 (0.9)	46	3.2 (0.8)
LGBTQ groups	47	3.2 (1.1)	43	3.1 (1.0)
Local suicide prevention coalitions	46	3.9 (0.8)	47	3.5 (0.8)
Military/Veteran groups	50	3.9 (0.9)	47	3.8 (0.9)
People with lived experience	49	3.5 (1.0)	46	3.6 (1.1)
Rural residents or groups	47	3.2 (1.1)	41	3.2 (1.0)
STT suicide prevention coalitions	47	4.0 (1.0)	46	3.6 (1.1)
Survivors of suicide loss	49	4.2 (1.0)	48	3.9 (1.0)
Tribes/Tribal leaders/Tribal members	45	2.3 (1.2)	41	2.3 (1.2)
Other	9	3.9 (1.3)	9	3.8 (1.3)
Sector				
Active duty military	47	3.3 (1.0)	44	3.2 (1.1)
Adult justice system	45	2.3 (0.9)	44	2.5 (1.0)
Behavioral health	49	4.1 (0.8)	48	3.8 (0.8)
Business/Private sector	46	2.0 (0.7)	44	2.4 (1.0)
Community-based service sector	38	3.6 (1.0)	44	3.3 (0.9)
Crisis services	49	4.3 (1.0)	49	3.8 (0.9)
Education	48	3.8 (0.9)	47	3.5 (0.9)
Faith-based or religious organizations	47	2.8 (0.8)	45	2.7 (0.9)
Family services/other social services	46	3.0 (0.9)	45	2.9 (0.9)
First responders	46	3.2 (0.9)	45	3.1 (0.9)
Governor's Office	48	3.1 (1.1)	47	3.9 (1.0)

	Activity Rating		Influence Rating	
	n	$\bar{x}^b$ (SD)	n	$\bar{x}^b$ (SD)
Sector *(continued)*				
Health insurers	44	1.9 (0.9)	40	2.6 (1.2)
Healthcare	47	3.4 (0.8)	46	3.5 (0.9)
Housing authority	43	1.4 (0.6)	39	1.6 (0.8)
Juvenile justice system	48	2.8 (1.1)	47	2.7 (0.9)
Labor/unemployment	44	1.5 (0.8)	41	1.7 (1.0)
Legislative branch	47	3.2 (0.9)	47	4.0 (0.9)
News media	49	2.9 (1.0)	47	3.2 (1.1)
Public health	46	4.1 (0.9)	46	3.7 (1.0)
Tribal Council	38	1.7 (1.0)	36	2.1 (1.3)
Tribes/Tribal organizations	44	2.2 (1.2)	43	2.4 (1.3)
Veterans Affairs	48	3.9 (0.9)	46	3.7 (0.9)
Other	1	4.0 (--)	1	3.0 (--)

Note: Rating scale ranges: 1-"not active at all" to 5-"very active," and 1-"not influential at all" to 5-"very influential;" LGBTQ= lesbian, gay, bisexual, transgender and queer or questioning; STT=state, territory or tribe

[a] Refers to the respondents weighted to the state level.

[b] Average

Table 4. Survey of Territorial and Tribal Suicide Prevention Summary Findings by Frequency and Percent of 'Yes' or Affirmative Responses, United States—July 2018-August 2018

Survey Item	Territories (N=4)[a]		Tribes (N=36)[b]	
Budget[c]	**Frequency (n)**	**Percent**	**Frequency (n)**	**Percent**
0	0	0	2	5.6
$1 - $100,000	0	0	5	13.9
$100,000 - <$250,000	2	50.0	2	5.6
$250,000 - <$400,000	0	0	3	8.3
$400,000 - <$550,000	0	0	1	2.8
$550,000 - <$1,000,000	1	25.0	0	0.0
$1,000,000 – $2,900,000	0	0	2	5.6
No response	1	25.0	21	58.3
Likelihood of reducing suicide rates 20% by 2025[c]	**Frequency (n)**	**Percent**	**Frequency (n)**	**Percent**
Very unlikely	2	50.0	1	2.8
Somewhat unlikely	0	0	5	13.9
Not sure	0	0	4	11.1
Somewhat likely	0	0	6	16.7
Very likely	1	25.0	1	2.8
No response	1	25.0	19	52.8
CDC Strategy[d,e]	**Yes (n)**	**Percent**	**Yes (n)**	**Percent**
Strengthen economic supports	2	50.0	1	2.8
Strengthen access to and delivery of suicide care	1	25.0	11	30.6
Create protective environments	1	25.0	11	30.6
Promote connectedness	2	50.0	9	25.0
Teach coping and problem-solving skills	1	25.0	14	38.9
Identify and support people at risk	2	50.0	11	30.6
Lessen harms and prevent future risk	1	25.0	8	22.2

Survey Item	Territories (N=4)[a]		Tribes (N=36)[b]	
Prevention Readiness[c]	**Frequency (n)**	**Percent**	**Frequency (n)**	**Percent**
Stage 1 or 2 (no awareness/denial or resistance)	0	0	0	0
Stage 3 (vague awareness)	0	0	5	13.9
Stage 4 (preplanning)	0	0	4	11.1
Stage 5 (preparation)	0	0	0	0
Stage 6 (initiation)	0	0	1	2.8
Stage 7 (stabilization)	0	0	0	0
Stage 8 (confirmation/expansion)	0	0	1	2.8
Stage 9 (high level of community ownership)	1	25.0	1	2.8
No response	3	75.0	24	66.7
Facilitators[d]	**Yes (n)**	**Percent**	**Yes (n)**	**Percent**
Adequate staff to implement strategic plan	1	25.0	6	16.7
Availability of surveillance resources	2	50.0	3	8.3
Clarified authority for SP at the state level	1	25.0	1	2.8
Coalitions to address SP priorities	1	25.0	8	22.2
Coordination of services between state partners	1	25.0	6	16.7
Evaluation of the strategic plan	1	25.0	4	11.1
Federal funding dedicated to SP	1	25.0	15	41.7
Federal legislation/policy	1	25.0	3	8.3
Implementation of the strategic plan	1	25.0	5	13.9
Increased awareness of suicide as a public health issue	2	50.0	11	30.6
Local legislation/policy	0	0.0	2	5.6
National Strategy for SP	2	50.0	6	16.7
Other Federal/national guidance materials	1	25.0	5	13.9
Partnerships or collaborations across key sectors	1	25.0	9	25.0
STT funding dedicated to SP	1	25.0	11	30.6
STT legislation/policy	0	0.0	3	8.3
STT level SP leadership	0	0.0	7	19.4
STT strategic plan for SP	2	50.0	4	11.1
Other	0	0	0	0

Survey Item	Territories (N=4)[a]		Tribes (N=36)[b]	
Barriers[d]	Yes (n)	Percent	Yes (n)	Percent
Insufficient federal funding for SP	1	25.0	9	25.0
Insufficient STT funding dedicated to SP	1	25.0	9	25.0
Lack of a SP strategic plan	1	25.0	6	16.7
Lack of adequate staff to implement strategic plan	1	25.0	11	30.6
Lack of awareness efforts about suicide as a public health issue	0	0.0	8	22.2
Lack of coalitions or task forces to address suicide	1	25.0	9	25.0
Lack of coordination of services between STT partners	1	25.0	11	30.6
Lack of evaluation of the strategic plan	1	25.0	4	11.1
Lack of federal guidance materials	0	0.0	4	11.1
Lack of implementation of the strategic plan	1	25.0	5	13.9
Lack of local legislation/policy	2	50.0	6	16.7
Lack of partnerships or collaborations across key sectors	1	25.0	10	27.8
Lack of STT guidance materials	1	25.0	7	19.4
Lack of STT legislation/policy	2	50.0	4	11.1
Lack of STT level SP leadership	1	25.0	9	25.0
Lack of surveillance resources	2	50.0	12	33.3
No clear authority for SP at the state level	1	25.0	9	25.0
Other	0	0.0	1	2.8

Note: SP=suicide prevention STT= state, territory or tribe

[a] Refers to the respondents weighted to the territorial level.

[b] Refers to the respondents weighted to the tribal level.

[c] Respondents were asked to select one response. Only affirmative responses are captured here, and percentages may not add up to 100%. Other responses can be accounted for due to legitimate skips.

[d] Respondents were asked to select all that apply. Only "Yes" responses are captured here; therefore percentages may add to more than 100%. Other responses were either "No," "Not sure or Don't know," legitimate skips, or missing.

[e] Strategies as outlined in the CDC Preventing Suicide Technical Package.

Table 5. Average Ratings of Overall Capacity to Implement Public Health Approach to Suicide Prevention in Territories and Tribes, United States—July 2018-August 2018

	Territories[a] (N=4)		Tribes[b] (N=36)	
Capacity	**n**	**$\bar{x}$[c] (SD)**	**n**	**$\bar{x}$[c] (SD)**
Routine surveillance and monitoring of the problem	3	4.0 (1.0)	20	2.6 (0.9)
Data-driven coordinated strategic planning	3	4.3 (1.5)	20	2.8 (1.0)
Evaluation of programs and practices	3	3.7 (1.5)	20	3.3 (1.1)
Implementation of evidence-based programs	3	3.3 (1.6)	20	3.8 (1.0)
Dissemination of what works to stakeholders	3	3.3 (1.5)	20	3.2 (1.0)

[a] Refers to the respondents weighted to the territorial level.
[b] Refers to the respondents weighted to the tribal level.
[c] Average

Appendices

Appendix I. State of the State, Territory, and Tribal (S/T/T) Suicide Prevention Survey

Form Approved
OMB No. 0920-0879
Expiration Date 01/31/2021

Instructions

This survey is meant for state, tribal, or territorial health department and behavioral health staff, grant managers, and coalition or advisory group leaders. It will help the Centers for Disease Control and Prevention's (CDC) Division of Violence Prevention conduct an environmental scan with all 50 states, Washington D.C., US territories and select tribes to understand how these entities address suicide prevention, now, and in the past five years. Your feedback is important to us and will help CDC's Division of Violence Prevention to improve suicide prevention technical assistance to states, territories, and tribes and develop recommendations to improve public health response to prevent suicide. When you see "S/T/T," this refers to you if you are a representative of a state, Washington D.C., territory, or tribe.

Completing the survey is voluntary and will take approximately 30 minutes.

CDC will not publish or share any identifying information about individual respondents. Data collected from this survey will be reported only in aggregate form. There are no known risks or direct benefits to you from participating or choosing not to participate, but your answers will help CDC improve state, tribal and territorial suicide prevention. As you complete the survey, you may find that you need to gather some information from your records. Also, you are able to move forward and backwards in the survey. You are able to exit the survey and return to complete it.

CDC estimates the average public reporting burden for this collection of information as 30 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0879).

I. About Your State/Territory/Tribe (S/T/T)

1. What is your State or Territory?

- ○ Alabama
- ○ Alaska
- ○ American Samoa
- ○ Arizona
- ○ Arkansas
- ○ California
- ○ Colorado
- ○ Commonwealth of Northern Mariana Islands
- ○ Connecticut
- ○ Delaware
- ○ District of Columbia
- ○ Florida
- ○ Georgia
- ○ Guam
- ○ Hawaii
- ○ Idaho
- ○ Illinois
- ○ Indiana
- ○ Iowa
- ○ Kansas
- ○ Kentucky
- ○ Louisiana
- ○ Maine
- ○ Maryland
- ○ Massachusetts
- ○ Michigan
- ○ Minnesota
- ○ Mississippi
- ○ Missouri
- ○ Montana
- ○ Nebraska
- ○ Nevada
- ○ New Hampshire
- ○ New Jersey
- ○ New Mexico
- ○ New York
- ○ North Carolina
- ○ North Dakota
- ○ Ohio
- ○ Oklahoma
- ○ Oregon
- ○ Pennsylvania
- ○ Puerto Rico
- ○ Rhode Island
- ○ South Carolina
- ○ South Dakota
- ○ Tennessee
- ○ Texas
- ○ U.S. Virgin Islands
- ○ Utah
- ○ Vermont
- ○ Virginia
- ○ Washington
- ○ West Virginia
- ○ Wisconsin
- ○ Wyoming

2. If you represent a Tribe, which one?

3. Within what S/T/T agency are you based?

- ○ Health department
- ○ Mental/behavioral health
- ○ Human services
- ○ Not based within an S/T/T agency
- ○ Other S/T/T agency (please specify)

[If response is "Not based within an S/T/T agency, go to Q4, otherwise, SKIP to Q5]

4. If you are not based in a S/T/T agency, in what type of organization are you based?

5. Please describe your current responsibilities related to suicide prevention?

6. **How long have you been in your current position?**

- ○ Less than a year
- ○ 1 year
- ○ 2 years
- ○ 3 years
- ○ 4 years
- ○ 5 years
- ○ 6 years
- ○ 7 years
- ○ 8 years
- ○ 9 years
- ○ 10 years
- ○ 11 years
- ○ 12 years
- ○ 13 years
- ○ 14 years
- ○ 15 years
- ○ 16 years
- ○ 17 years
- ○ 18 years
- ○ 19 years
- ○ 20+ years

7. **How long have you worked in suicide prevention in total?**

- ○ Less than a year
- ○ 1 year
- ○ 2 years
- ○ 3 years
- ○ 4 years
- ○ 5 years
- ○ 6 years
- ○ 7 years
- ○ 8 years
- ○ 9 years
- ○ 10 years
- ○ 11 years
- ○ 12 years
- ○ 13 years
- ○ 14 years
- ○ 15 years
- ○ 16 years
- ○ 17 years
- ○ 18 years
- ○ 19 years
- ○ 20+ years

8. **Are you the office suicide prevention coordinator or equivalent in your S/T/T?**

- ○ Yes
- ○ No

[If "No", SKIP to #24]

II. Suicide in Your State/Territory/Tribe (S/T/T)

9. **How have the rates of suicide changed in your S/T/T in the past 5 years?**

1	2	3	4	5	
Decreased greatly	Decreased somewhat	Stayed about the same	Increased somewhat	Increased greatly	Not sure/don't know

10. **How have the rates of suicide attempts changed in your S/T/T in the past 5 years?**

1	2	3	4	5	
Decreased greatly	Decreased somewhat	Stayed about the same	Increased somewhat	Increased greatly	Not sure/don't know

11. What data sources does your S/T/T use to routinely track suicide?

Vital statistics or Death certificate data

- o Yes
- o No
- o Not sure or Don't know

National Violent Death Reporting System (NVDRS)

- o Yes
- o No
- o Not sure or Don't know

Fatality review team (may be for children or adults or both)

- o Yes
- o No
- o Not sure or Don't know

S/T/T epidemiology work group (or similar group)

- o Yes
- o No
- o Not sure or Don't know

Other (please describe):_____

12. What data sources does your S/T/T use to routinely track suicide attempts?

Hospital discharge data

- o Yes
- o No
- o Not sure or Don't know

Emergency department data

- o Yes
- o No
- o Not sure or Don't know

Emergency Medical Services (i.e. first responder data)

- o Yes
- o No
- o Not sure or Don't know

Syndromic surveillance data* *(*Definition of Syndromic Surveillance: A real-time data system in which chief complaint data from emergency departments flows in every 24-48 hours. Chief complaint, triage note, and discharge diagnosis code data can be queried to monitor suicidal thoughts and suicide attempt-related ED visits).*

- o Yes
- o No
- o Not sure or Don't know

Other (please specify):_____

13. What data sources does your S/T/T use to track risk and protective factors?

Youth-risk Behavior Surveillance System (YRBSS)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other school surveys

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Behavioral Risk Factor Surveillance System (BRFSS)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

National Survey of Drug Use and Health (NSDUH)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Local surveys administered by local government or partner organizations

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other (please specify):_____

III. State/Territory/Tribe (S/T/T) Infrastructure

14. Does your S/T/T have a specific unit or office dedicated to suicide prevention?

- ○ Yes
- ○ No

[If "No", SKIP to #16]

15. How many staff are supported?

- ○ <1
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ Other (please specify): _____

16. What is your S/T/T suicide prevention budget?

- ○ Zero
- ○ $1-$100,000
- ○ 100-249k
- ○ 250-399k
- ○ 400-549k
- ○ 550--699k
- ○ 700-849k
- ○ 850-999k
- ○ 1-1.9m
- ○ 2-2.9m
- ○ 3-3.9m
- ○ 4-4.9m
- ○ 5-5.9m
- ○ 6-6.9m
- ○ 7-7.9m
- ○ 8-8.9m
- ○ 9-9.9m
- ○ 10m+

17. What other sources of funding do you currently have? [Check all that apply]

- ○ None
- ○ Garrett Lee Smith (GLS) Memorial Act Funding (SAMHSA)
- ○ GLS Campus Suicide Prevention funding
- ○ Native Connections (SAMHSA)
- ○ Zero Suicide funding (SAMHSA)
- ○ National Institute of Mental Health Zero Suicide grants
- ○ Indian Health Services Zero Suicide grants
- ○ Methamphetamine and suicide prevention initiative (IHS)
- ○ National Strategy grants (SAMHSA)
- ○ Other Federal government (e.g. NIH, CDC, IHS, VA) suicide prevention grants, cooperative agreements, block grants, contracts (If yes, please describe): _____
- ○ Other State/Territorial/Tribal support (e.g. discretionary funds) (If yes, please describe): _____
- ○ Foundation support (Which one): _____
- ○ Private sector/business support (If yes, please describe): _____
- ○ Other (Please describe): _____

18. What is the total budget for these other sources of funding? If you don't know, please take your best guess.

- ○ Zero
- ○ $1-$100,000
- ○ 100-249k
- ○ 250-399k
- ○ 400-549k
- ○ 550--699k
- ○ 700-849k
- ○ 850-999k
- ○ 1-1.9m
- ○ 2-2.9m
- ○ 3-3.9m
- ○ 4-4.9m
- ○ 5-5.9m
- ○ 6-6.9m
- ○ 7-7.9m
- ○ 8-8.9m
- ○ 9-9.9m
- ○ 10m+

[If responded "0/None" to #16 and #17, SKIP to #20]

19. Based on your responses, your current funding is *[insert total from #16 and #18]*. Is this correct?

- ○ Yes
- ○ No *[If the current funding does not appear correct in Question 19, then please check your responses in questions #16 and #18 and revise.]*

20. If no funding at all ($0) dedicated specifically to suicide prevention, please describe how suicide prevention operates in your S/T/T:

[SKIP to #22]

21. Which of the following general activities related to suicide prevention does your current budget (indicated in #19) support?

Staffing

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Legislation/policy development

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Convening of S/T/T suicide prevention coalition/taskforce

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Convening of local suicide prevention coalitions/taskforces

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Convening of a S/T/T suicide prevention conference, annual meeting, etc.

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Grants to local communities

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Work within clinical systems to improve suicide risk detection, treatment, and care transitions (e.g. zero suicide)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Developing suicide prevention materials (e.g. briefs, fact sheets, annual reports)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Implementation of community-based prevention programs

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Community-based service delivery

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Program evaluation

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Surveillance activities

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Training

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Research

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Suicide prevention plan evaluation

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other (Please specify):_____

22. The nation's goal is to reduce suicide rates 20% by 2025. How likely is it that your S/T/T can reduce suicide by 20% at current resource/funding levels?

Very likely	Somewhat likely	Not sure or unlikely	Somewhat unlikely	Very unlikely

23. In the past, has your S/T/T ever received funding from the following sources? [Check all that apply]

- ○ None
- ○ State, territorial, tribal Garrett Lee Smith (GLS) Memorial Act Funding (SAMHSA)
- ○ National Institute of Mental Health Zero Suicide grants
- ○ Indian Health Services Zero Suicide grants
- ○ Zero Suicide funding (SAMHSA)
- ○ GLS Campus Suicide Prevention funding
- ○ Native Connections (SAMHSA)
- ○ Methamphetamine and suicide prevention initiative (IHS)
- ○ National strategy grants (SAMHSA)
- ○ Other Federal government (e.g. NIH, CDC, IHS, VA) suicide prevention grants, cooperative agreements, block grants, contracts (if yes, please describe): _____
- ○ Other State/Territorial/Tribal support (e.g. discretionary funds) (if yes, please describe): _____
- ○ Foundation support (which one): _____
- ○ Private sector/business support (if yes, please describe): _____
- ○ Other (Please describe): _____

IV. State/Territory/Tribe (S/T/T) Suicide Prevention Plan

24. Does your S/T/T [or organization] have a suicide prevention strategic plan?

- ○ Yes
- ○ No

[If "No", SKIP to #29]

25. In what year was your first S/T/T strategic plan developed?

- ○ <1980
- ○ 1980 to 1989
- ○ 1990 to 1999
- ○ 2000 to 2009
- ○ 2010 to 2016

26. Has your S/T/T strategic plan recently been updated?

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, please indicate range]

- ○ <1980
- ○ 1980 to 1989
- ○ 1990 to 1999
- ○ 2000 to 2009
- ○ 2010 to 2016

27. Which of the following informed the development of your current strategic plan?

S/T/T suicide mortality data

- ○ Yes
- ○ No
- ○ Not sure or Don't know

S/T/T suicide attempt data

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Risk factor data

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Needs identified by coalition or advisory members

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Needs identified by other stakeholders

- ○ Yes
- ○ No
- ○ Not sure or Don't know

S/T/T guidance documents (e.g. prior plan)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

National Strategy for Suicide Prevention

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Action Alliance's Transforming Communities document

- ○ Yes
- ○ No
- ○ Not sure or Don't know

CDC's "Preventing Suicide: A Technical Package of Policy Programs and Practices"

- ○ Yes
- ○ No
- ○ Not sure or Don't know

SAMHSA's National Registry for Evidence-based Programs and Practices

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other (Please describe): _____

28. Do you evaluate your strategic plan?

- ○ Yes
- ○ No

[If Yes, how much a priority is it?]

Not a priority	Low priority	Somewhat a priority	High priority	Essential

V. About Your Suicide Prevention Champions and Sectoral Engagement

29. How active and influential are each of the following community champions in your suicide prevention efforts?

How active response options:
1 – Not active at all
2 – Not very active
3 – Moderately active
4 – Active
5 – Very Active

How influential response options:
1 – Not at all influential
2 – Slightly influential
3 – Somewhat influential
4 – Very influential
5 – Extremely influential

	How active is this group?						How influential is this group?					
Champions	1	2	3	4	5	Don't Know	1	2	3	4	5	Don't know
Survivors of suicide loss (friend or family member of someone who died by suicide)												
People with lived experience (i.e. people who struggle with suicidal thoughts or attempts)												
Tribes/Tribal leaders/ Tribal members												
Rural residents or groups												
Military/Veteran groups												
LGBTQ groups												
Nonprofit organizations												
Community health organizations												
Community mental/behavioral health organizations												
S/T/T suicide prevention coalitions												
Local suicide prevention coalitions												
Educators/school teachers												
Business leaders												
Faith-based/religious groups												
Other (please specify): _____												

30. How active and influential are each of the following S/T/T *sectors* in your suicide prevention efforts?

	How active is this sector?						How influential is this sector?					
Sector	**1**	**2**	**3**	**4**	**5**	**Don't Know**	**1**	**2**	**3**	**4**	**5**	**Don't know**
Education												
Healthcare												
Behavioral Health												
Public Health												
Crisis Services (e.g. hotlines, centers)												
Family Services / Other Social Services												
Faith-based or Religious Organizations												
Tribes / Tribal Organizations												
First Responders (e.g. Police, EMS, Fire Department)												
Juvenile Justice System												
Adult Justice System												
Housing Authority												
Labor / Unemployment												
Active Duty Military												
Veteran's Affairs												
News Media												
Business / Private Sector												
Health Insurers												
Governor's Office												
Legislative Branch												
Tribal Council												
Community-based Service Sector												
Other (describe): _____												

31. Overall, how well coordinated are these sectors in suicide prevention efforts?

Not coordinated	Slightly coordinated	Fairly coordinated	Coordinated	Very coordinated

32. How has coordination changed across the S/T/T sectors in the past five years?

Much Worse	Somewhat worse	Stayed the same	Somewhat better	Much better

VI. State/Territory/Tribe (S/T/T) Policies and Legislation Promoting Suicide

33. How do legislators/tribal council members in your S/T/T typically get information about the problem of suicide?

Legislators/tribal council members don't get this information

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Community meetings/town hall-style events

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Planned advocacy days at the State Capitol

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Routine reports provided to legislators or tribal leaders

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Attending S/T/T suicide prevention coalition or advisory meetings

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Ad hoc requests

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Legislative hearing

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other (please describe)_____

34. In the past 5 years has your S/T/T passed any suicide prevention legislation or policies related to improvements in the following areas or in the following settings? [Check Yes/No]

Policy Type	Yes	No	Not sure or Don't Know
No suicide prevention legislation passed			
K-12 suicide prevention			
College/University suicide prevention			
Workplace policies			
Graduate training requirements in suicide prevention			
Mental health parity/insurance coverage			
Military/Veteran support			
Health/Mental health provider training/continuing education for suicide prevention			
S/T/T suicide prevention capacity or infrastructure (not including funding)			
S/T/T prevention planning/implementation/evaluation			
Public-private partnership development (e.g. commission, task force, coalition, etc.)			
Funding/Appropriations for suicide prevention			
Lethal means legislation			
Crisis support services			
Public awareness campaigns/ events			
Behavioral health service delivery			
Other, please describe: _____			

VII. Your State/Territory/Tribe (S/T/T's) Readiness for Suicide Prevention

35. Which category *best* describes your S/T/T's stage of readiness for suicide prevention action? [Select one]

- ○ **No awareness**—Suicide is not generally recognized by communities or leaders as a problem.
- ○ **Denial/resistance**—There is little recognition that suicide might be occurring in one's own community. The problem is seen as one faced by others, not locally.
- ○ **Vague awareness**—Communities have minimal knowledge about their suicide problem and there is no immediate motivation or willingness to respond.
- ○ **Preplanning**—There is recognition of the problem of suicide and the need to act. Some efforts are being considered however, they are not yet focused or coordinated.
- ○ **Preparation**—Leaders have emerged and are gathering information about the problem and having conversations with community members.
- ○ **Initiation**—Information has been gathered, partners have convened, and plans are in place to begin prevention efforts.
- ○ **Stabilization**—Activities are coordinated. Staff are trained and experienced. Partners meet routinely. Prevention efforts are ongoing. Evaluation is being considered.
- ○ **Confirmation/ Expansion**—Prevention efforts are coordinated and ongoing with monitoring and evaluation. Community members feel comfortable using services and are supportive of prevention efforts. Efforts are underway to expand collaboration to related issues or risk factors. State/local data are regularly obtained.
- ○ **High level of community ownership**—Knowledge about the suicide problem, causes, and consequences in the community is widespread. Prevention is ongoing and coordinated. Monitoring and evaluation guides new directions.

36. How would you describe your S/T/T's overall capacity (staffing, funding, expertise) to implement a public health approach to suicide prevention including:

Routine surveillance and monitoring of the problem?

No capacity	Little capacity	Modest capacity	Good capacity	Strong capacity

Data-driven coordinated strategic planning?

No capacity	Little capacity	Modest capacity	Good capacity	Strong capacity

Implementation of evidence-based programs and practices?

No capacity	Little capacity	Modest capacity	Good capacity	Strong capacity

Evaluation of programs and practices?

No capacity	Little capacity	Modest capacity	Good capacity	Strong capacity

Dissemination of what works to stakeholders?

No capacity	Little capacity	Modest capacity	Good capacity	Strong capacity

VIII. Populations and Their Risk and Protective Factors

37. Which populations are you currently working with to address suicide in your S/T/T?

Children under 10

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Youth 10-24

- ○ Yes
- ○ No
- ○ Not sure or Don't know

College students

- ○ Yes
- ○ No
- ○ Not sure or Don't know

People 25-34

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Middle aged adults 35-64

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Older adults 65+

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Veterans/Active duty military

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Sexual and/or gender minorities

- ○ Yes
- ○ No
- ○ Not sure or Don't know

American Indian/Alaska Natives

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other racial/ethnic minorities

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Homeless

- ○ Yes
- ○ No
- ○ Not sure or Don't know

People involved with the criminal justice system

- ○ Yes
- ○ No
- ○ Not sure or Don't know

People with lived experience (i.e. people who struggle with suicide thoughts or attempts)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Survivors of suicide loss (i.e. friends/family members who died by suicide)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

First responders

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other (Please describe):_____

38. Has your S/T/T's attention to particular at-risk populations changed in the past 5 years?

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, how?] _____

39. Which risk factors are you specifically addressing in your suicide prevention efforts?

Prior suicide attempts

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Suicidal thoughts

- ○ Yes
- ○ No
- ○ Not sure or Don't know

History of interpersonal violence (including dating violence, intimate partner violence, sexual violence)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Relationship problem/loss

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Job/school problems

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Financial problems

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Criminal/legal problems

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Involvement with bullying

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Prejudice/discrimination (e.g., regarding sexual orientation)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Historical trauma (e.g., violence, resettlement, destruction of culture)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Stigma of help-seeking

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Adverse childhood experiences

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Substance use/abuse

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Mental illness

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Access to lethal means among people at risk

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Being a suicide loss survivor (or a friend or family member's suicide)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Social isolation

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Health problems (including pain, chronic illnesses, terminal illness)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of access to behavioral/mental health care

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other (Please specify):_____

40. Which protective factors are you specifically addressing in your suicide prevention efforts?

Promoting connectedness/social integration

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Building life skills (problem solving, coping, conflict resolution)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Promoting tolerance of peoples' differences

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Promoting help-seeking

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Promoting cultural values that discourage suicide

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Promoting individuals' self-esteem

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Promoting sense of purpose in peoples' lives

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other (Please specify):_____

41. Has your S/T/T's attention to particular risk and protective factors changed in the past 5 years?

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, how?] _____

IX. Existing Programs and Practices

In 2017, CDC released ***Preventing Suicide: A Technical Package of Policy, Programs, and Practices*** that describes the best available evidence for suicide prevention for states and communities.

42. Are you familiar with this document?

- ○ Yes
- ○ No
- ○ Not sure or Don't know

43. The next few pages cover the seven evidence-based strategies found in the technical package. For each strategy, assess if your STT implements the strategy, and if so, check each of the approaches that are used and specify the program, practice, or policy.

Does your STT implement the strategy to:

Strengthen economic supports (e.g. financial support after job loss, housing stabilization policies)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, which approaches are used?]

- ○ Strengthen household financial security
- ○ Housing stabilization policies
- ○ Other:_____

Specify Program, Practice, or Policy: _____

Does your STT implement the strategy to:

Strengthen access to and delivery of suicide care (e.g. coverage for mental health conditions in insurance policies, safer suicide care through systems change [zero suicide], reduce rural provider shortages)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, which approaches are used?]

- ○ Coverage for mental health conditions in insurance policies
- ○ Safer suicide care through systems change
- ○ Reduce provider shortages in underserved areas
- ○ Other:_____

Specify Program, Practice, or Policy: _____

Does your STT implement the strategy to:

Create protective environments (e.g. reduced access to lethal means among people at risk, organizational policies that support a help-seeking culture and mental wellness, community policies to reduce excessive alcohol use)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, which approaches are used?]

- ○ Reduced access to lethal means among people at risk
- ○ Organizational policies that support a help-seeking culture
- ○ Community policies to reduce excessive alcohol use
- ○ Other:_____

Specify Program, Practice, or Policy: _____

Does your STT implement the strategy to:

Promote connectedness (e.g. peer norm programs, community engagement activities)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, which approaches are used?]

- ○ Peer norm programs
- ○ Community engagement activities
- ○ Other:_____

Specify Program, Practice, or Policy:_____

Does your STT implement the strategy to:

Teach coping and problem-solving skills (e.g. socio-emotional learning programs, parenting)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, which approaches are used?]

- ○ Social-emotional learning programs
- ○ Parenting skill and family relationship programs
- ○ Other:_____

Specify Program, Practice, or Policy:_____

Does your STT implement the strategy to:

Identify and support people at risk of suicide (e.g. gatekeeper programs, crisis intervention, evidence-based treatment for people at-risk, treatment to prevent re-attempts)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, which approaches are used?]

- ○ Gatekeeper training
- ○ Crisis intervention
- ○ Treatment for people at risk of suicide
- ○ Treatment to prevent re-attempts
- ○ Other:_____

Specify Program, Practice, or Policy:_____

Does your STT implement the strategy to:

Lessen harms and prevent future risk (e.g. safe reporting and messaging, postvention)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, which approaches are used?]

- ○ Postvention
- ○ Safe messaging and reporting about suicide
- ○ Other:_____

Specify Program, Practice, or Policy:_____

44. How much did the technical package influence your decision to implement the above strategies?

1	2	3	4	5
Not at all	Slightly	Somewhat	Moderately	A lot

45. The section below asks about your efforts to address the goals of the 2012 *National Strategy for Suicide Prevention*.

How much progress have you made toward each goal?

Rate each from 1 to 5 where:
1 – No progress
2 – Little progress
3 – Moderate progress
4 – A lot of progress
5 – Goal achieved

_____ ***Goal 1*** Integrate and coordinate suicide prevention activities across multiple sectors and settings

_____ ***Goal 2*** Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors

_____ ***Goal 3*** Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery

_____ ***Goal 4*** Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide

_____ ***Goal 5*** Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors

_____ ***Goal 6*** Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk

_____ ***Goal 7*** Provide training to community and clinical service providers on the prevention of suicide and related behaviors

_____ ***Goal 8*** Promote suicide prevention as a core component of health care services

_____ ***Goal 9*** Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors

_____ ***Goal 10*** Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides

_____ ***Goal 11*** Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action

_____ ***Goal 12*** Promote and support research on suicide prevention

_____ ***Goal 13*** Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings

X. Barriers and Facilitators to Suicide Prevention

46. Please identify the barriers or things that have hindered or stalled your S/T/T suicide prevention efforts.

Lack of local legislation/policy

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of federal guidance materials

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of S/T/T guidance materials

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of a suicide prevention strategic plan

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of implementation of the strategic plan

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of S/T/T legislation/policy

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of local legislation/policy

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of adequate staff to implement strategic plan

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of evaluation of the strategic plan

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Insufficient S/T/T funding dedicated to suicide prevention

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of S/T/T level suicide prevention leadership

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Insufficient federal funding dedicated to suicide prevention

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of surveillance resources (to track and monitor suicide/attempts)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of coalitions or task forces to address suicide prevention priorities

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of partnerships or collaborations across key sectors

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of coordination/integration of services between S/T/T partners

- ○ Yes
- ○ No
- ○ Not sure or Don't know

No clear authority for suicide prevention at the S/T/T level

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Lack of awareness efforts about suicide prevention as a public health issue

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other (Please describe):_____

47. Have these barriers changed in the past 5 years?

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, please describe how:] _____

48. Has your S/T/T experienced a suicide cluster or possible cluster in the past 5 years?

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, what impact has this cluster had on suicide prevention efforts in your S/T/T?]

- ○ No impact
- ○ Impact
- ○ New legislation
- ○ Focus on new populations
- ○ Change in approach
- ○ Increased resources
- ○ Other (please specify):_____

49. Has your S/T/T experienced a natural disaster(s) since 2013?

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If yes, what impact has this had on suicide or suicide prevention?] _____

[If yes, what impact has this had on suicide prevention efforts in your S/T/T?]

- ○ No impact
- ○ Impact
- ○ New legislation
- ○ Focus on new populations
- ○ Change in approach
- ○ Increased resources
- ○ Other (please specify):_____

50. Has the opioid epidemic impacted suicide or suicide prevention in your S/T/T?

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If yes, what impact has this had on suicide prevention efforts in your S/T/T?]

- ○ No impact
- ○ Impact
- ○ New legislation
- ○ Focus on new populations
- ○ Change in approach
- ○ Increased resources
- ○ Other (please specify):_____

51. Please identify the facilitators or things that have helped your S/T/T suicide prevention efforts in the past 5 years?

Federal funding dedicated to suicide prevention

- ○ Yes
- ○ No
- ○ Not sure or Don't know

S/T/T funding dedicated to suicide prevention

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Federal legislation/policy

- ○ Yes
- ○ No
- ○ Not sure or Don't know

S/T/T legislation/policy

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Local legislation/policy

- ○ Yes
- ○ No
- ○ Not sure or Don't know

National Strategy for Suicide Prevention

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other Federal/national guidance materials (e.g. Action Alliance materials)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

S/T/T level suicide prevention leadership

- ○ Yes
- ○ No
- ○ Not sure or Don't know

S/T/T strategic plan for suicide prevention

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Implementation of the strategic plan

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Adequate staff to implement strategic plan

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Evaluation of the strategic plan

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Availability of surveillance resources (to track and monitor suicide/attempts)

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Coalitions or task forces to address suicide prevention priorities

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Partnerships or collaborations across key sectors

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Coordination/integration of services between S/T/T partners

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Clarified authority for suicide prevention at the S/T/T level

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Increased awareness about suicide prevention as a public health issue

- ○ Yes
- ○ No
- ○ Not sure or Don't know

Other

- ○ Yes
- ○ No
- ○ Not sure or Don't know

*[If Yes, please describe]:*_____

52. Have these facilitators changed over the past 5 years?

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, please describe how?] _____

53. Has your S/T/T experienced any other significant events in the past 5 years that may have accelerated or stalled suicide prevention activity?

- ○ Yes
- ○ No
- ○ Not sure or Don't know

[If Yes, please describe the event and its impact:] _____

54. Is there anything else related to your S/T/T suicide prevention efforts that you'd like to comment on that we have not asked (e.g. other programs you implement, links to reports, websites, other...)? _____

THANK YOU FOR YOUR TIME AND EFFORT IN RESPONDING TO THIS SURVEY!

Appendix II. Age-Adjusted Suicide Rates Among Persons ≥10 years, United States—2013 and 2017

State	% Change	2013 Age Adjusted Rate per 100,000	2017 Age-Adjusted Rate per 100,000
Alabama	**16.0**	**16.7**	**19.4**
Alaska	**17.8**	**26.8**	**31.6**
Arizona	3.9	20.2	21.0
Arkansas	**20.3**	**20.0**	**24.1**
California	3.0	11.8	12.2
Colorado	**9.7**	**21.6**	**23.7**
Connecticut	**21.2**	**10.1**	**12.2**
Delaware	*-5.6*	*14.4*	*13.6*
District of Columbia	**9.9**	**6.7**	**7.4**
Florida	1.8	16.0	16.3
Georgia	**13.8**	**13.9**	**15.8**
Hawaii	**30.3**	**13.5**	**17.5**
Idaho	**20.6**	**22.4**	**27.0**
Illinois	**13.1**	**11.5**	**13.1**
Indiana	**14.8**	**16.6**	**19.1**
Iowa	4.9	16.8	17.6
Kansas	**30.4**	**17.0**	**22.1**
Kentucky	**9.9**	**18.0**	**19.8**
Louisiana	**23.6**	**14.4**	**17.7**
Maine	**8.1**	**20.3**	**21.9**
Maryland	**9.0**	**10.6**	**11.6**
Massachusetts	**15.8**	**9.5**	**11.0**
Michigan	**10.0**	**14.9**	**16.4**
Minnesota	**14.9**	**14.1**	**16.2**
Mississippi	**15.1**	**15.2**	**17.4**
Missouri	**18.5**	**18.2**	**21.6**
Montana	**21.2**	**27.7**	**33.5**
Nebraska	**26.1**	**13.6**	**17.2**
Nevada	**9.3**	**21.8**	**23.8**
New Hampshire	**46.0**	**14.9**	**21.7**
New Jersey	**5.4**	**9.4**	**9.9**
New Mexico	**14.7**	**23.6**	**27.0**
New York	**1.9**	**9.4**	**9.6**
North Carolina	**13.9**	**14.6**	**16.6**
North Dakota	**20.4**	**19.9**	**23.9**
Ohio	**16.0**	**14.9**	**17.3**
Oklahoma	**10.6**	**20.1**	**22.2**
Oregon	**13.0**	**19.6**	**22.1**
Pennsylvania	**13.7**	**15.4**	**17.5**
Rhode Island	-2.1	14.1	13.8
South Carolina	**15.7**	**16.3**	**18.9**
South Dakota	**22.1**	**21.3**	**26.0**
Tennessee	**10.2**	**17.9**	**19.7**
Texas	**14.5**	**13.6**	**15.5**
Utah	**6.0**	**25.0**	**26.5**
Vermont	**7.1**	**20.0**	**21.4**
Virginia	**6.5**	**14.6**	**15.5**
Washington	**20.1**	**16.3**	**19.6**
West Virginia	**28.8**	**19.2**	**24.7**
Wisconsin	**7.8**	**16.7**	**18.0**
Wyoming	**24.8**	**24.9**	**31.1**

Note: Rates that changed <5.0% were considered having stayed the same; increase >5.0% (**bold font**) was considered an increase; decline >5.0% (*italic font)* was considered a decrease.

Source: CDC's Web-based Injury Statistics Query and Reporting System (WISQARS)

www.cdc.gov/suicide