

State and Territorial Suicide Prevention Plans and Leadership Guidance

Strong coordination at the state or territorial level is crucial for effective suicide prevention. A coordinated approach can help states and territories implement broad and comprehensive strategies across communities and ensure that the voices of racial and ethnic minority groups and other populations that may be at higher risk for suicide are heard and reflected in prevention efforts. State and territorial suicide prevention plans serve as critical tools for the assessment, prevention, and intervention efforts needed to reduce suicide at the state, territorial, and community levels. These plans can help states and territories take a thoughtful and systematic approach to suicide prevention rather than a crisis management approach.

Drawing on SPRC's extensive experience working with state and territorial suicide prevention leaders, this document provides guidance for developing a strong state or territorial suicide prevention plan. It details the key elements and characteristics that underpin effective state or territorial suicide prevention plans.

We recommend that you use this document in conjunction with:

- *Recommendations for State Suicide Prevention Infrastructure* ([Infrastructure Recommendations](#)), which describes the essential elements of state or territorial suicide prevention infrastructure.
- The [Comprehensive Approach to Suicide Prevention](#), which sets forth a combination of strategies for addressing suicide prevention across the lifespan.
- The [State and Territorial Suicide Prevention Needs Assessment \(SNA\)](#), which examines the suicide prevention infrastructure and capacity of states and territories each year. If your state or territory has recently completed the assessment, you will have personalized results. If your state or territory has not recently participated, you can review the national SNA results.

Key Elements and Characteristics

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

To effectively allocate time and resources, states and territories should use available data to identify and prioritize populations and settings that are at higher risk for suicide. States and territories should also take steps to identify and close gaps in data collection, paying particular attention to whether information about minority and underserved populations is being collected. Plans should include data that does the following:

- Identifies populations with high numbers and/or rates of suicide attempts and deaths as well as populations showing significant increases in suicide attempts and deaths (e.g., American Indian and Alaska Native, Black, Hispanic, and LGBTQIA2S+ youth, youth with disabilities, veterans and the military, and men in midlife)
- Points to geographic areas and settings where the risk of suicide is high (e.g., rural areas, behavioral health care settings, correctional settings)
- Characterizes patterns of suicide deaths and attempts, including identifying the risk factors associated with different populations (e.g., people with mental illness or substance use disorders, people recently discharged from inpatient hospital stays or emergency departments, people with prior suicide attempts)

SPRC's [Data Infrastructure: Recommendations for State Suicide Prevention \(Data Supplement Recommendations\)](#) provides concrete guidance and resources to help states and territories create suicide prevention infrastructure that supports data-driven planning and decision-making. To further support data collection efforts, SPRC's [Beyond Numbers: Navigating Data for Suicide Prevention](#) online course offers guidance to states and territories as they build their suicide prevention data capacity and work to promote equity in data-related efforts.

Examples: [Connecticut's state plan](#) (pages 42–69) identifies populations with high rates and numbers of suicides. It provides risk and protective factors and specific recommendations for each group at higher risk of suicide. [Maryland's state plan](#) (pages 12-15) uses data to identify evolving and emerging trends that may increase risk factors and impact suicide rates.

Plans should adopt a public health approach.

Suicide prevention plans should take a public health approach that includes [identifying risk and protective factors](#) in populations, partnering across sectors, addressing the entire lifespan, and working across the spectrum of prevention, intervention, and postvention. A public health approach to suicide prevention includes:

- Using universal approaches, including enhancing life skills, and environmental strategies such as reducing lethal means
- Identifying evidence-based practices and programs for prevention and treatment
- Training the existing behavioral health workforce to identify, screen, assess, and treat individuals experiencing suicidal thoughts and behaviors
- Providing continuity of care to help people at high risk for suicide safely transition from acute care settings to outpatient care

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

Example: [Virginia's state plan](#) describes the public health framework the state uses in suicide prevention planning, including applying the social ecological model, incorporating social determinants of health, and identifying shared risk and protective factors (pages 9-14). The plan also includes strategies for suicide prevention, intervention, and postvention (pages 15-22).

Plans should be comprehensive but set priorities.

Effective suicide prevention plans [Build](#) integrated and coordinated suicide prevention activities in multiple sectors and settings, addressing both risk and protective factors. They also account for the needs of special populations and consider ways to represent all parts of the state or territory. Successful plans incorporate strategies for monitoring the effectiveness of suicide prevention activities over time using measurable goals and objectives. Plans should also align with the actionable strategies in the current *National Strategy for Suicide Prevention* that directly address the state or territory's identified needs. This approach ensures relevant strategies are prioritized to maximize the effectiveness of available resources.

Example: [Kansas's state plan](#) (pages 18-31) includes goals for the state's strategic direction as well as objectives, actions and activities, a timeline, and a plan for partner involvement. [Iowa's state plan](#) (pages 12-18) includes a work plan with strategies and action steps, a timeline, and a list of who is responsible for each action step.

Plans should be a collaborative effort coordinated by one convening body.

Suicide prevention cannot be a one-person or single-agency effort. Behavioral health and public health agencies are well-positioned to take a leadership role, which can mean convening partners, building capacity (e.g., creating support coalitions, developing training resources), and expanding suicide prevention efforts. [Partnerships](#) with public and private organizations, such as coalitions, task forces, or multi-agency work groups can build commitment and ownership.

Organizations working in the areas of health, mental health, substance misuse prevention and treatment, education, justice, veterans' services, health care, and aging, as well as other agencies, school systems, and private sector groups need to be involved in developing and implementing a state or territorial suicide prevention plan. Engaging groups at the highest risk for suicide (e.g., representatives from American Indian and Alaska Native and LGBTQIA2S+ communities, etc.) and those with suicide-centered lived experience is essential to any planning effort. Ideally, a convening agency with at least one position to support suicide prevention in the state or territory should serve as the lead author and manage the state or territory's suicide prevention plan to ensure a coordinated effort.

Example: [Missouri's state plan](#) contains a list of Missouri Suicide Prevention Network members and those who served on the state plan subcommittee. Members come from diverse backgrounds, including state government, nonprofit organizations, higher education, and behavioral health and health care systems. [Oregon's Youth Suicide Intervention and Prevention Plan](#) includes a section on partner input methodology (pages 29-32). This section describes the state's use of qualitative and quantitative methods, including discussion groups, semi-structured formative interviews, and online surveys to collect information and guide the plan.

Plans should promote best practices for safe and strategic communication.

Plans should promote best practices for effective suicide prevention communication in alignment with the [Lead](#) element of the Infrastructure Recommendations. The language used in the plan should be inclusive, following plain language guidelines and best practices for accessibility. Consider using images that speak to the priority populations in the plan, especially those disproportionately affected by suicide deaths and attempts. Communication efforts should promote hope and resilience, awareness of the warning signs for suicide, and knowledge of how to connect individuals in crisis with assistance and care. Refer to the [Framework for Successful Messaging](#) for help developing messages that are strategic, safe, and aligned with best practices.

Example:

[Nebraska's state plan](#) has a "Ways to Get Involved" section (pages 44-45) that includes a call to action encouraging individuals to learn the warning signs of suicide, have conversations about suicide and behavioral health, and change their language around suicide to be less stigmatizing. This section also suggests ways people can become more involved with suicide prevention in their daily lives.

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

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

Periodically ([every three to five years](#)) those involved in state- or territory-wide suicide prevention work should gather to look at the plan's impact, review new data and resources, and update and/or revise the plan. State and territorial plans may include accountability measures such as annual or biannual public reporting on progress and impact. The field is continually learning new strategies for preventing suicide in a changing world. A commitment to learning and growth that seeks improvement without blame helps support these efforts.

Example: [Minnesota's state plan](#) (page 46) calls for the state to create an annual action plan, a communications plan, and an evaluation plan that outlines how the state will assess the plan using a continuous quality improvement model as well as other methods. [Indiana's state plan](#) contains a "What comes next?" section (page 18) that details the state's intention to convene quarterly meetings to ensure effective implementation of the state plan. Many state and territorial plans list the plan's beginning and ending years.

Conclusion

A comprehensive, coordinated approach to suicide prevention is key to ensuring a strong state or territorial suicide prevention plan. Using the above key elements and characteristics will aid state and territorial suicide prevention leaders in creating a plan that emphasizes a strategic approach to suicide prevention for long-term success.