State Suicide Prevention Planning:
A CDC Research Brief

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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Introduction

The 2001 release of the National Strategy for Suicide Prevention focused attention on the need for "coordination of resources…at all levels of government—Federal, State, tribal, and community"—to address the public health problem of suicide mortality and morbidity (U.S. Public Health Service, 2001, p.27). For several years, and in some cases for nearly a decade, states have been formulating state-level suicide prevention plans and finding ways to implement the activities called for in those plans.

Although states have progressed in planning state-level suicide prevention activities, state planning groups—usually made up of survivors, practitioners, and state agency personnel—face substantial challenges. To date, little empirical information has been available to provide guidance to these state planning groups. Planners seek advice on how to construct their efforts so that they can implement the activities planned. In addition, they want assurance that those activities will be effective in decreasing suicidal behavior. Finally, because key milestones have not yet been identified, planning groups want guidance on how to monitor progress, track implementation, and assess the overall impact of their activities.

In response to these needs, the Centers for Disease Control and Prevention (CDC) conducted a research study to describe the key ingredients of successful state-based suicide prevention planning. The study's major objectives were to document the processes involved in developing state suicide prevention plans; compile these findings into a template for decision making based on lessons learned; and share these findings with state groups engaged in creating suicide prevention plans and with those groups already implementing prevention activities. The results of this study do not provide a universal blueprint for suicide prevention, but the insights garnered provide states with valuable information for effective planning, implementation, and evaluation.

Methods

The study collected data in two phases. In Phase I, researchers conducted qualitative, open-ended interviews with key participants in 42 states identified as having some state-level suicide prevention planning activity. The participants were typically representatives from state public health or mental health departments who knew about their state's history with suicide prevention efforts.

For Phase II, seven case-study states were chosen. These states represented the broadest possible range of experiences, including different phases of plan development, activities planned, target populations, and geographic distribution. In-depth, individual interviews were conducted with five to seven participants from each of the seven case-study states. These participants were typically agency representatives or suicide prevention coordinators, survivors, task force or advisory committee members, and legislators, if appropriate. Multiple versions of the interview were developed and tailored for the various participants. The version used in each interview was selected based on the role and position of the individual participant in the state planning/implementation process. The interviews focused on six key areas: history of suicide prevention efforts in the state; governmental or non-governmental support; leadership; implementation and evaluation of suicide prevention programs; challenges and successes; and the future outlook for suicide prevention in the state. In all, 38 in-depth interviews were conducted.

Purpose of This Research Brief

This research brief summarizes the major findings of the state suicide prevention planning study, identifies the key issues pertaining to the planning process, and offers suggestions for addressing these issues. The brief does not prescribe a model; rather, it illustrates opportunities for decision making at specific points in the planning and implementation process. It provides suggestions for negotiating those decisions based on an individual state's planning perspective, unique contingencies, and desired outcomes. Results suggest that developing and gaining support for a state-based suicide prevention plan, and moving the plan toward implementation, are complex processes and that no single model for success exists.

Summary of Major Findings

Four key factors emerged as decision points in facilitating successful planning and implementation. This section presents a brief summary of the findings about the four factors, and the sections that follow discuss each factor in-depth. Tables 1 and 2 (pages 3 and 9) provide a summary of issues to consider when making decisions about these factors.

Table 1. Key questions to consider during the planning process

Formal structure—schedules, agendas, voting requirements and processes, limited membership	• More efficient decision making • Greater legitimacy, possibility for government support	• Less responsive to community needs, priorities • Less flexible and less adaptable to new challenges
Informal structure—more flexible schedules, less structured process for decision making, open membership	• More inclusive, more buy-in from community, grassroots • More creative, adaptable	• Roles and responsibilities not clearly defined, less efficient decision making • Less stability: leadership may rely too heavily on individual champions • Less official legitimacy
Public health focus	• Population-level focus • Reflects the multiple dimensions, complexity of suicide prevention efforts • More support for resources to build partnerships across fields, strengthen social fabric to develop coordinated prevention strategies	• Difficult to measure success, benchmarks not established • Complexity of the issue is off-putting to some constituents and/or potential partners who may prefer quick fix strategies
Mental health focus	• Brings important clinician perspective to the table • Mental health resources are key tools	• Individual-level focus • More support for resources for direct intervention services • May divert focus from other key issues or partners
Yes	• Provides greater visibility and official legitimacy, increases likelihood of buy-in from state agencies • Offers clear pathway for seeking government funding • Requirements such as annual reporting may help keep efforts accountable and on track	• Funding is often not attached • Any legislation can come with restrictions and requirements that limit the scope of prevention efforts and/or the flexibility of the leadership group • May discourage grassroots participation and sense of community ownership
No	• More community control and grassroots involvement • More flexibility, fewer restrictions on scope and fewer structural and procedural requirements • Non-governmental funding/support is less vulnerable to shifting political priorities	• No clear pathway for seeking government funding • Less visibility and official legitimacy, potentially less buy-in from state agencies • No built-in oversight, accountability

Keys to Successful Planning and Implementation

Establish a leadership group

Frame the issue of suicide

Consider seeking legislative support

Move from planning to implementation

- ***Establishing a leadership group.*** All of the states that participated in this study had some type of leadership group for their planning processes. Membership, level of participation, structure, and mandate of such groups varied dramatically. Some leadership efforts began with grassroots activism, while others started with a legislatively mandated task force. Study results indicate that, while both approaches have potential for success, each carries a distinct set of challenges that should be considered carefully.

- ***Framing the issue.*** Most states involve their public health and mental health agency or department in suicide prevention efforts. Framing suicide as either a public health or mental health problem was found to be quite complicated. How the issue is framed can influence the planning and implementation process.

- ***Seeking legislative support.*** Many states seek legislative support as a first step in their planning. Legislative support may provide legitimacy to the effort, but it does not ensure funding and may impose specific requirements on the functioning and direction of the leadership group. Findings suggest that states need to carefully consider their vision and goals for suicide prevention before seeking legislative action.

- ***Moving from paper to practice.*** Despite those involved in the planning process being highly engaged, states experienced difficulties moving from paper to practice. Developing explicit evaluation criteria and activities was challenging. Limited resources affected all points of the process, but many states identified creative ways to accomplish the work despite less-than-ideal financial circumstances.

Establishing a Leadership Group

Study interviews revealed that many suicide prevention efforts benefit from the work and dedication of champions who build momentum at the beginning of the planning process. Although the contributions of such individuals are invaluable, states interested in sustaining their suicide prevention efforts must establish a leadership group. States reported that these leadership groups—variously labeled task forces, advisory councils, or coalitions—provide the structure and continuity necessary to address challenges that invariably arise in planning and implementation.

> Leadership groups provide a necessary level of structure and continuity to address the challenges that invariably arise in the planning and implementation process.

Study results highlight several important decisions about the way the group functions, which will affect the way the group accomplishes its work. Planners must decide on the level of formalization: Will leadership roles, meeting schedules, and agendas be defined? Planners must also decide on membership and representation: Who will participate in the process, will the group strive to include underrepresented populations, will the group include both community members and state agency representatives, and how will new members be educated about the issue and integrated into the process? Finally, planners must determine how decisions will be made by the group: Will priorities be set, will there be a voting process, and, if so, who will be eligible to vote? Findings indicate that the structure of the group can change over time to meet new challenges in the environment.

Decisions about the leadership group should be made deliberately and be based on the explicit goals of the prevention efforts in that state. For example, a state developing a basic plan in response to a legislative mandate might benefit from a formal structure, including membership by appointment and specific procedural and voting requirements. Study results suggest that this structure can foster a consensus-driven process, which may yield the most timely and broadly applicable plan. Formalized processes may lead to greater legitimacy and to a higher probability of state agency involvement and sustainability. However, if the state's goal is to address the needs of underserved populations affected by suicide or to garner the energies and resources of a wide range of grassroots advocates, a less structured, more inclusive process might be appropriate. States with these goals reported greater success when efforts were made to include all interested parties from the outset. That way, decisions are driven by community dialogue. Furthermore, states reported that, when requesting involvement from underserved populations, not lumping unrelated groups together under the minority umbrella was important. The concerns and priorities of various groups may be quite different and may be lost in such a grouping.

Study results suggest that having a less formalized structure increases the likelihood of overall buy-in and commitment of grassroots group members. Also, because this structure allows for greater flexibility, less formalized groups can be creative in adapting to meet challenges. However, without a traditional

structure, roles and responsibilities are typically less clearly defined. This lack of clarity can bar participation by state agency representatives, especially if suicide prevention is not explicitly part of agency staff's official duties. In addition, a fluid structure may diminish the group's stability, thus reducing the chances of securing sustainable funding.

> In many states, tension develops between defining suicide as a mental health or public health problem.

Based on study findings, the planning groups that successfully maintain their momentum over time have good collaboration between active community members and committed state agency staff, hold regular meetings, and have clearly designated leadership roles. Collaboration between the public and private sectors is an essential element because state agency personnel can access official data, policies, and resources that community members cannot. Community members can actively lobby for a cause and are not restricted in their ability to bring concerns to the public and state legislators. Active collaboration with good communication between these two sectors allows the planning process to take advantage of different opportunities or to change course quickly when a particular avenue becomes blocked.

Framing the Issue of Suicide

Once suicide is established as a state-level issue, state planners have to fundamentally agree on how to conceptualize the nature of the suicide problem in the state and how suicide prevention should fit into the state's infrastructure. According to study results, framing the issue can be a significant challenge in the planning process. Developing effective plans and activities to prevent suicide requires that the planners have a common understanding of the factors that may put people at risk for suicide and the factors that may protect against such risk.

The planning committee representatives that were interviewed approached the problem of suicide from different perspectives. Some viewed suicide as a biologically-based brain disease. Others focused on societal or environmental factors that may influence suicidal behavior. The process of defining the problem can be time consuming and emotionally charged, but this dialogue is extremely important because it allows diverse stakeholders to be heard. However, the debate should not be allowed to immobilize or derail the planning process. Setting a specific amount of time for this discussion can be helpful.

Ultimately, the planning group's understanding and definition of suicide has substantial implications for prevention activities and for the development of support and resources for the effort. Study data suggest that in many states tension develops between those who define suicide as a mental health problem—primarily individual-level, focused on direct intervention services—and those who define it as a public health problem—primarily population-level, focused on a multidisciplinary approach to addressing the needs of communities. A group primarily focused on individual-level issues

and mental health interventions may emphasize mental health service delivery to the exclusion of developing the broad-based community networks that are necessary for sustained change and primary prevention. While there is no correct way to proceed, planning groups do need to understand the effects of how the issue is framed.

The study results suggest that a state's approach to prevention should address the wide range of factors related to suicidal behavior, including social support, mental illness, substance abuse, economic factors, and community and personal risk and resiliency. Certain constituencies may prefer more or less emphasis on particular aspects, and the planning group must be guided by both empirical evidence and the realities and needs of the state's stakeholders.

Regardless of how the issue of suicide is framed, prevention planners should know the benefits of including the knowledge and resources of a broad range of fields. Results of this study show that several states have struck an effective balance by incorporating input from a wide array of constituencies, including educators, justice officials, clergy, and public health and mental health representatives. These efforts develop and maintain strong, active ties with the various community sectors through regular, collaborative meetings and cosponsored trainings and events.

Legislative support for suicide prevention can be quite advantageous but should not be sought without a clear analysis of the goals for suicide prevention in the state, an understanding of the types of possible legislation, and the pros and cons associated with legislation.

Seeking Legislative Support

Individuals or groups interested in statewide suicide prevention often see gaining legislative support for their efforts as a logical step. Legislative support can offer a sense of legitimacy to the effort, which can be extremely important in gaining support from state agencies and in increasing public visibility of the issue. Results from this study, however, suggest that costs may be associated with legislative support, and advocates should be aware of these costs before deciding whether, when, and how to pursue such an agenda.

States often connect legislative support with the assumption or hope that funds will be allocated for planning or implementation at some point in the future. Although some suicide prevention programs do receive state funding for their efforts, such support is by no means guaranteed. More commonly, mandates that require a study of suicide in the state and/or the formation of a statewide planning group come without funding. Also, like most other human service initiatives in uncertain economic times, state financial support for suicide prevention is tenuous, can include additional requirements that detract from prevention work, and cannot be solely relied upon to sustain prevention efforts.

Study results indicate that legislative support or funding often comes with specific requirements. For example, if a planning group is formed by legislative mandate, there are often requirements about who participates and how the work will be accomplished. Such requirements may facilitate the

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participation of key state agency representatives, but they may also create difficulty in replacing individuals who do not have time to attend, are not qualified, or are uninterested in being part of the committee. Requirements may also shift the driving force and control away from grassroots advocates, which could pose a problem in states that have identified engaging grassroots activists as a priority.

A reporting requirement in the form of an annual progress report to the legislature may also be attached to legislation. Study findings indicate that this task may be cumbersome to staff, but it may also be beneficial in encouraging planners to assess accomplishments and set specific goals for the future.

Before seeking legislative support for suicide prevention, planners should analyze the goals for suicide prevention in the state and have a clear understanding of the types of possible legislation and the pros and cons associated with each. States that have been most successful in navigating legislative initiatives are those that have clearly determined why they are seeking legislation; what type of support they are seeking, such as declaration of suicide as a problem, development of a planning council, or funding for a particular initiative; and at what point in the process legislation would be most helpful. Once those determinations are made, states have several options, including cultivating a champion within the legislature and working with legislative aides or within groups already created by legislation to develop proposals according to a shared vision for statewide suicide prevention.

Moving from Paper to Practice

Many state groups found creating a planning document to be relatively straightforward, but the politics and logistics of moving from paper to practice presented significant challenges. These challenges centered on three factors: maintaining participant continuity from planning through implementation, dealing with the reality of limited resources, and struggling to demonstrate effectiveness without benchmarks against which to measure progress (Table 2).

Even after the plan is written, the structure of the suicide prevention leadership group remains critical. States whose planning groups have disbanded have encountered real difficulties in maintaining momentum. Despite the highest levels of motivation and commitment in a group, the logistics of implementing a statewide initiative become quickly overwhelming if the work is left to a single agency representative without the support of an organized group of experienced advocates. In states that have formed entirely new groups to proceed with implementation, much time has been lost in educating new members about the complexity of the issues involved in suicide prevention. While some changes may be necessary

Table 2. Learning from experience: tips from participating states on moving from PLAN to ACTION

Maintaining continuity	• Starting with all new players is not the most efficient/effective route to implementation. • Maintaining some continuity of participation from the planning leadership group while moving into the implementation stage is important—provides a unified vision of work to be accomplished. • Relying on one individual to implement the plan single-handedly is unrealistic because of the resources and partnerships needed to accomplish prevention goals.
Addressing the funding issue	• Too little money is *always* an issue—unavoidable economic/political reality. • Much can be accomplished without money by making creative connections and partnerships and by using existing resources.
Measuring success	• Although reducing suicide rates is the ultimate goal of suicide prevention work, this is a long-term goal that is achieved incrementally and that requires a long time frame to measure success. • Intermediate benchmarks need to be established, including active, visible networks of support/collaboration for suicide prevention within and across state agencies, such as public health, mental health, justice, and education.

because of competing commitments of the members, the study suggests that maintaining some degree of continuity between the group that developed the plan and the group that will move the plan forward is important. States benefit from the continued involvement and input of key community and agency representatives who can offer shared knowledge, significant resources, and networks of influence.

Study results show that, although some states have successfully secured financial support for the planning and/or implementation stages of their suicide prevention efforts, most do not yet have renewable sources of funding. Still, several states have completed their plans and are moving toward implementation with little or no funding. Prevention goals can be accomplished incrementally even without a "golden egg."

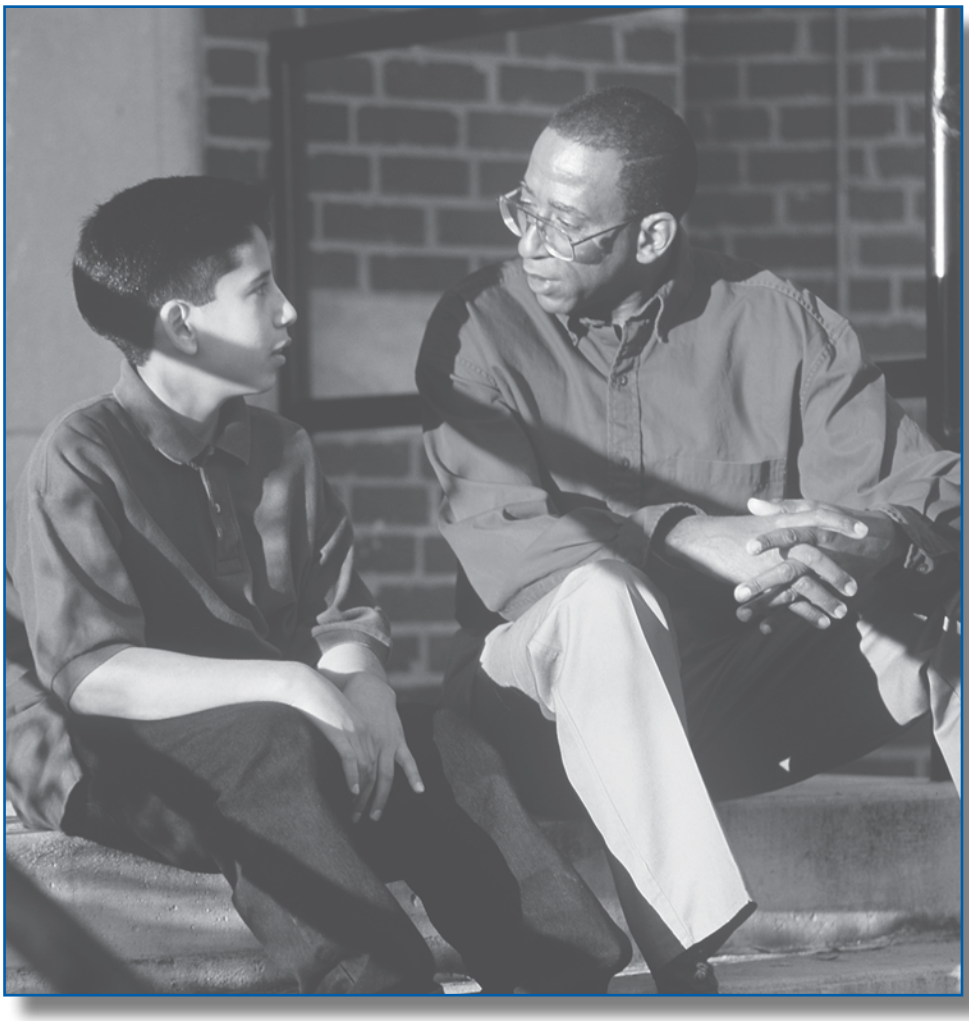
States that have been most successful in moving forward with limited resources have typically had group members and advocates who thought creatively and saw connections between the work of suicide prevention and the work of other state-level initiatives. These states have actively built collaborations with local universities and colleges that might be interested in related research projects or have asked individuals and partner organizations to volunteer their skills, such as media, statistical analysis, and public speaking, as ways to begin implementing suicide prevention at little to no cost. Individuals or groups who are interested in the issue of suicide, or those who have been personally affected, may be willing to help with a variety of tasks, such as copying, stuffing envelopes, making phone calls, securing meeting space, writing letters, facilitating meetings, designing brochures, creating newsletters, or giving presentations.

Furthermore, individual members of leadership groups have incorporated suicide prevention into their own work. Even those professionals whose work is not immediately related to suicide prevention, such as clergy members, law enforcement, and teachers, have found ways to integrate it into their occupations. This integration might be accomplished informally by bringing up suicide prevention in casual conversation both inside and outside of the work environment and by linking suicide prevention with issues, such as alcohol abuse, or target populations, such as students, with whom they work. For example, if a state's mental health department supports educational programs aimed at strengthening the family, a component on preventing suicide by building emotional resiliency could be included in the curriculum.

Finally, results show that a major roadblock to implementation is a lack of explicit criteria for success or definite evaluation strategies to track progress or impact. Although the ultimate goal of suicide prevention is to reduce suicidal injury and death, study results indicate that intermediate benchmarks by which groups can document progress could empower states to move forward with their plans. Intermediate benchmarks could include such activities as 1) consistently connecting suicide prevention to other issues to which the public, state agencies, the legislature, or the educational system are already committed or 2) developing networks of support for suicide prevention throughout the layers of state agency personnel. The specific benchmarks that state groups develop may vary depending on how they have framed the issue, as discussed earlier, and what types of stakeholders have been involved in the process. More work is needed at the national level to assist in developing these intermediate benchmarks as well.

Conclusion

State suicide prevention strategies must be developed within the context of social, economic, and political realities. Results of this study confirm choices and challenges that may be very familiar to individuals involved in the processes of planning and implementation. This study provided the opportunity to compare the experiences of several states, discover common ground, and gather recommendations about navigating state suicide prevention planning and implementation. The key decision points identified in the study—developing a leadership group, framing the issue, seeking legislative support, and moving from plan to implementation—are points in the process at which planners need to be particularly aware of their state's prevention goals and specific contingencies in order to set the course for suicide prevention efforts. Note that each of these decisions can be revisited throughout the process as goals and contingencies change. The findings in this report offer guidance for making those initial decisions and illustrate opportunities for course correction that may be needed as the planning and implementation processes unfold.



Linking Suicide to Related Issues: An Example From a State That Put Limited Funding to Work

"We put together a youth listening conference. We ask school counselors and teachers to pull together a team of youth who want to [participate]. The youth form a committee and select issues they want to present and who they want to be a part of the panel to hear their views. We have legislators, sports personalities, [community members], juvenile court judges—people who have some ability to make changes in the community. The kids give a presentation, and the panel meets during the year to look at the issues the kids brought out. This is a way for kids to identify issues that they need help with. This is sort of ... just going back to that theme of trying to hit youth risk behaviors at the root. [The kids] will talk about suicide or talk about teen pregnancy, but the focus of their discussion is what were the environmental conditions leading up to that. Very often, the listening conference is the way the [state suicide prevention leadership group] gets information. We've had some schools [invest in suicide prevention training] as a response to listening conferences—they have written grants and gotten people on board."

Reference

U.S. Public Health Service. National Strategy for Suicide Prevention: goals and objectives for action. Washington, D.C.: Department of Health and Human Services; 2001.

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