State Mental Health Agency Role Implementing National Suicide Prevention Guidelines

NRI's 2024-2025 State Profiles *January 2026*

Highlights from 50 States and D.C. Responding to the Crisis Component of NRI's 2024-2025 State Profiles, with Supplementary Historic Information from the Crisis Component of NRI's 2022 State Profiles

"Suicide is an urgent and growing public health crisis. More than 49,000 people in the United States died by suicide in 2022. That's one death every 11 minutes."[i]

The 2024 National Strategy for Suicide Prevention (NSSP) is a ten-year approach to suicide prevention that addresses gaps in the field, relying on partnerships at the national, state, tribal, local, and territorial levels across the public and private sectors of health. Its goal is to address suicide by identifying and supporting people with increased risk of suicide through treatment and crisis intervention, preventing reattempts, promoting recovery, and supporting survivors of suicide loss.[ii]

As part of states' efforts to provide a continuum of crisis services, many states have programs specifically designed to reduce suicidality, often focusing on specific populations with elevated risk of suicide. Forty-three states have aligned or are in the process of aligning their suicide prevention work with the NSSP, and 43 states coordinate their suicide prevention work with 988 Lifeline call centers.

Responsibility for Suicide Prevention within State Government

Suicide prevention initiatives are often the responsibility of the state mental health agency (SMHA). In 40 states, the SMHA has primary responsibility for suicide prevention efforts, while in 27 states, the responsibility of suicide prevention initiatives is shared by multiple state agencies and departments. Of the 47 states reporting data, the following state agencies have responsibility for suicide prevention: the Department of Health (26 states), the Department of Education (17), the Department of Veterans Affairs (12), Law Enforcement (corrections, public safety, attorney general's office, etc.) (8), the Department of Transportation (5), the Department of Aging/Senior Services (4), specific offices overseeing services for youth (3), and the Department of Agriculture (2).

SMHA is Primarily Responsible for Suicide Prevention
40 States

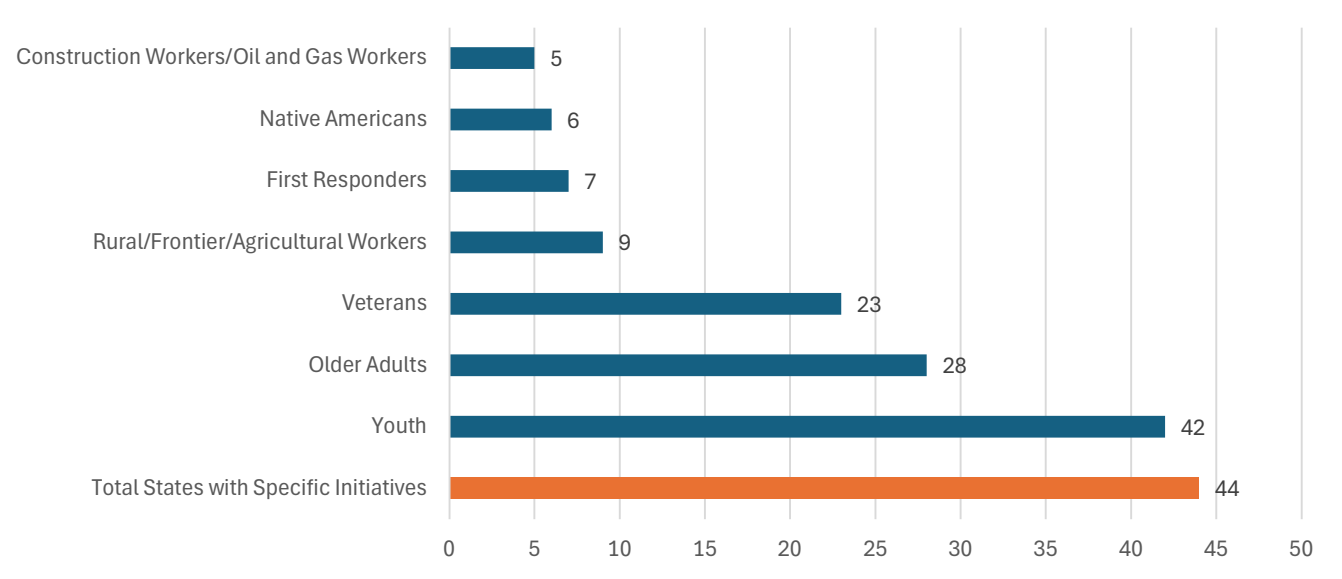
Targeted Suicide Prevention Initiatives
45 States

Aligned State Suicide Prevention work with NSSP
43 States

Suicide Prevention Initiatives for Specific Populations

Forty-five states have suicide prevention initiatives directed at specific populations with statistically elevated risks of suicide. As Figure 1 shows, there are programs specifically for youth (42 states), older adults (28), and veterans (23). In a small number of states, there are programs serving individuals living in rural and remote areas, including agricultural workers (9); first responders (7); Native Americans (6); and construction or oil and gas workers (5).

Figure 1: Suicide Prevention Initiatives by Number of States for Specific Populations



Engaging Individuals with Lived Experience

Forty-three states engage individuals with lived experience to improve their state's suicide prevention efforts, most commonly by including them in some aspect of the state's planning process (40 states). In 19 states, this involves working with advisory boards, coalitions, or outside groups that include individuals with lived experience. In 10 states, individuals with lived experience are engaged in service delivery. Seven states are training peers in suicide prevention skills, such as Mental Health First Aid.

Identifying the Needs of High-Risk Populations

Forty-one states are identifying the needs of high-risk populations. Thirty-two states are tracking the issue in some way with 25 states indicating that they either maintain a suicide data dashboard or have a suicide specific data collection system. Twenty of these states collect demographic data. Three states are using epidemiologists to assess the data to determine risks and trends. Nineteen states reported that they were reaching out to high risk populations.

Including Community Voices in Suicide Prevention Strategies

Forty-two states are working with their communities to bring community voices together to understand the interests and concerns of a diverse group of stakeholders. Fifteen states work with or support focus groups or local community groups focused on suicide prevention. Four states conduct surveys to inform their suicide prevention efforts.

Staff Included in the Suicide Prevention Workforce

Forty-two states provided information about the types of staff included in their SMHAs' suicide prevention workforce. The state counts that follow are based on self-reporting to an open-ended question and likely underreport the types of positions. These positions include clinicians (25 states), suicide prevention coordinators or program managers (19), peers (12), staff focused on youth (8), epidemiologists (6), program evaluators and social science researchers (5), 988 call takers (5), staff focused on veterans (5), and volunteers (4).

Barriers Engaging Youth and Young Adults with Lived Experience

Seventeen states experienced barriers engaging youth and young adults with lived experience in their suicide prevention efforts, with six states reporting resistance by youth to engage or participate in activities, and five identifying stigma as a barrier. Other barriers include funding restrictions for compensating youth participation (2 states); confidentiality requirements when trying to gather input from youth (2); staff capacity, including staff turnover (2); difficulties identifying appropriate youth organizations with which to work (1); and the need to continually recruit youth as participants age out (1).

Federal Resources and Supports that Would Help States Advance Their Suicide Prevention Objectives

Thirty-three states suggest that additional federal resources or supports would help them advance their suicide prevention objectives, of which 27 suggested that additional funding for suicide prevention would be helpful. Nine states would like more resources to collect and analyze data. Seven states would like more resources to market existing suicide prevention and crisis services, while four would like more resources to support postvention services that address the aftermath of a suicide completion or attempt. Four states would like additional resources to support crisis care. Three states would like help supporting their suicide prevention infrastructure. Three would like help with workforce development. Only three states indicated they do not need additional resources to advance their suicide prevention objectives.

Additional Funding Sources Outside of SAMHSA Grants

In addition to SAMHSA grants, 33 states received additional funding to support suicide prevention initiatives, including state general funds (25 states); CDC suicide prevention grants (7); one-time SAMHSA Transformation Transfer Initiative (TTI) funds (5); private funding, including foundations and donations from businesses (3); Opioid Settlement Funds (1); cannabis taxes (1); and 988 taxes (1).

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[i] 2024 National Strategy for Suicide Prevention. (2024, April 15). HHS.gov. https://www.hhs.gov/programs/prevention-and-wellness/mental-health-substance-use-disorder/national-strategy-suicide-prevention/index.html

[ii] Ibid.