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Legal Mapping of State and Territorial Infrastructure to Prevent Suicides

2025

Introduction

In 2023, suicide ranked as the second-leading cause of death for people ages 10-34 across the United States, and more than 49,000 suicides occurred across all age groups that year. Contributors to suicide may include employment or financial challenges, health concerns, and lack of social connectedness, among other risks. Recent research shows that 13.5 million adults seriously thought about suicide and more than 108 million adults know someone who died by suicide. Firearms are involved in more than half of suicide fatalities (54.6%).

Specific population groups continue to experience higher rates of suicide than the general population. This includes people who live in rural areas, older adults, American Indians and Alaska Natives, people with disabilities, veterans, and people who identify as part of a sexual minority group. Additionally, many professions experience significantly higher rates of suicide than the general working-aged population, including:

- Mining, oil, and gas workers.
- Construction workers.
- Agricultural employees.
- Transportation or warehousing employees.
- First responders like firefighters and police.

Communities can implement layered intervention strategies to effectively decrease the likelihood of suicide, as outlined in the National Strategy for Suicide Prevention. These strategies can help prevent suicide risk in the first place as well as prevent suicide among people at increased risk. The Centers for Disease Control and Prevention's (CDC) Suicide Prevention Resource for Action outlines seven strategies with the best available evidence to prevent suicides:

1. Strengthen economic supports.
2. Create protective environments.
3. Improve access to and delivery of suicide care.
4. Promote healthy connections.
5. Teach coping and problem-solving skills.
6. Identify and support people at highest risk of suicide.
7. Lessen harms to prevent future risk.

ASTHO, with support from CDC, developed an interactive resource visualizing state and territorial laws as of January 1, 2025, related to the presence of suicide prevention commissions or offices, their legislatively mandated tasks, and jurisdictional infrastructure to review suicide fatalities. The resource allows for searching for state laws related to the following questions:

ASTHO recently highlighted policy resources and opportunities to improve financial stability for families.

- Does jurisdictional law establish a suicide prevention office or coordinator?
  - Where is the coordinator or office located?
  - Are there required duties for the suicide prevention office or coordinator?
    - What are the required duties for the suicide prevention office or coordinator?
- Does jurisdictional law establish a suicide prevention taskforce, council, or other advisory body?
  - Does the statute or regulation designate certain representatives who are required to be on the taskforce, council, or other advisory body?
- Does jurisdictional law establish a council, taskforce, or other advisory body focused on suicide prevention among a specific high-risk population?
  - What are the high-risk populations of focus for the jurisdiction?
- Does jurisdictional law establish a committee or other body that reviews suicide fatalities?
  - What population(s) is/are the focus of the committee or other body that reviews suicide fatalities?
  - Does the statute or regulation require the suicide fatality review committee (of any scope) to collect data on suicide attempts?
  - Does the statute or regulation require a suicide fatality review committee (of any scope) to share data or information with a jurisdiction's suicide prevention coordinator, office, taskforce, council or other advisory body?

To address the many factors associated with suicide, multiple federal agencies support different aspects of suicide prevention work in states and territories through grant programs to implement the strategies listed above. Funding programs include CDC's Comprehensive Suicide Prevention program, SAMHSA's Garrett Lee Smith Suicide Prevention program, and the SAMHSA's Veteran Suicide Prevention Technical Assistance Center, which includes fatality review support.

The restructuring of federal agencies and reduced federal staffing for prevention and crisis services creates uncertainty around the future of some of these programs. This uncertainty highlights the importance of strong state- or territorial-level infrastructure to sustain prevention efforts despite changes in federal funding. Jurisdictions with the infrastructure supports identified by this project are better positioned to use available data from fatality reviews and health behavior surveys to implement the effective interventions outlined by CDC and focus on the populations most at risk of suicide.

Suicide Prevention Offices, Commissions, or Other Directives

Legislatively mandated coordinating bodies for suicide prevention efforts support jurisdictional readiness that align with the Suicide Prevention Resource Center's best practices for prevention infrastructure. Key recommendations from the center include:

- Authorizing one organizational division or unit as the lead on suicide prevention efforts in the jurisdiction.
- Maintaining a dedicated leadership position to take on key responsibilities that support the work.
- Partnering with multisector stakeholders to generate a shared vision and responsibility for implementation.
- Examining funding, data, and priorities for prevention.
- Building comprehensive lifespan prevention strategies that address the specific and unique needs of the jurisdiction.
- Guiding and improving implementation of those strategies based on evaluation results.

These offices or commissions are well-positioned to recommend implementation strategies aligned with the evidence outlined in CDC's Suicide Prevention Resource for Action. They are also able to tailor those strategies to the specific needs and context of their jurisdictions and those most at risk of suicide. These offices or commissions are also able to strategically apply for federal funding that aligns to their priority focus areas and may be able to request state funding support for their efforts.

As of January 1, 2025, 12 jurisdictions had laws establishing a suicide prevention office or coordinator, with most (eight jurisdictions) of these offices or coordinators sitting in health departments. Notably, while the vast majority of states did not have laws designating an office or responsible agency staff member, another 11 jurisdictions did assign a significant number of responsibilities to a suicide prevention program or area of an agency, or a related program (e.g., an office of violence prevention). For example, Nevada law establishes a statewide program for suicide prevention and requires a coordinator with specific qualifications, while Minnesota law assigns suicide prevention responsibilities directly to the commissioner of health instead of a specific suicide prevention office or coordinator.

ASTHO also explored the existence of suicide prevention task forces, commissions, or other advisory bodies in statute or regulation and found that 12 jurisdictions have laws establishing these entities. However, jurisdictions may be able to operate these bodies without a specific law authorizing it or otherwise requiring it; ASTHO located three jurisdictions where an executive order was the basis for a suicide prevention council or commission. Separately, seven jurisdictions have laws that establish a population-focused suicide prevention body, with the majority (five jurisdictions) focused on youth suicides.

Suicide Fatality Reviews

Fatality reviews examine the circumstances around a variety of deaths. Historically, fatality review processes have been utilized to address a wide variety of manners and causes of death within specific populations. Federal programs have supported fatality reviews to explore the circumstances of maternal, infant, or child deaths. Additionally, reviews have focused on deaths from violence or abuse, occupational hazards or accidents, overdoses, and suicides. Though nearly every state collects some data on suicide fatalities to report to CDC through the National Violent Death Reporting System, jurisdictions can choose to expand upon that data collection, include a multidisciplinary review of trends in the data, and make systemic recommendations for improvements to the prevention and crisis systems. The National Center for Fatality Review and Prevention provides research-based guidance on best practices for the systemic review of suicide fatalities.

Reviewing the circumstances of a suicide can help clarify the context in which the death occurred, identify contributing risk factors, and inform prevention recommendations and potential opportunities for intervention in similar future circumstances. Fatality review committees are typically a multidisciplinary team that may include coroners or medical examiners, first responders, case workers, law enforcement, health care systems, human services, people with lived experience, public health, mental health providers, and others. Upon completion of the fatality review, a committee may draft data-driven recommendations for the community to consider or implement to prevent future suicides. Additionally, fatality review teams may be able to quickly provide context and a better understanding around and community response to suicide clusters.

Fatality review teams can exist at all levels of government — city, county, or state — and occur through various methods, from informal multi-disciplinary collaboration to formal review committees required by executive order, statute, or regulation. For this resource, ASTHO explored statutes requiring the review of suicide fatalities, whether a review solely focused on suicide fatality review or some other fatality review process that included suicide as one of many reasons for death to be reviewed.

ASTHO reviewed committees established by law and found that — as of January 1, 2025 — 30 jurisdictions had a law establishing a committee, body, team or other review process for some portion of suicide fatalities. Approaches and areas of focus varied among jurisdictions, with some jurisdictions operating statewide teams and others focusing on local review, with or without state-level support. Only one jurisdiction, Illinois, has a law that specifically directs the collection of data on suicide attempts as part of a fatality review, in this case as part of the state's domestic violence fatality review process. And of those 30 jurisdictions with a specific review process, the vast majority did not explicitly require sharing data or other information with any existing suicide prevention office or advisory body. However, four states did specifically require some connection — including annual recommendations or direct consultation — between a suicide prevention body or agency and the fatality review process.

Conclusion

Suicide is a public health problem requiring a comprehensive solution. Prevention strategies are most effective when implemented with a layered and multisector approach rooted in local data that demonstrates which populations, areas, ages, and occupations may benefit most from the intervention. Many states and territories have enacted policies to support strong suicide surveillance and prevention infrastructure, such as the use of fatality reviews and designated offices or commissions tasked with reducing suicide rates. State and territorial health agencies (S/THAs) can use this infrastructure to recommend, implement, and seek funding for evidence-based policies, programs, and practices that prevent suicides. Further, S/THAs may consider using policy to improve their suicide attempt and mortality data by standardizing fatality review processes and procedures for team alignment and increased collaboration among public health, health care, and public safety partners and implement best practices. By building infrastructure to support reviewing suicide attempts or fatalities and using that data to inform recommendations for prevention and crisis system improvements, S/THAs can work toward preventing suicides, improve health outcomes for people at risk of suicide, and prevent the impact of grief and trauma a suicide death can cause within communities.

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