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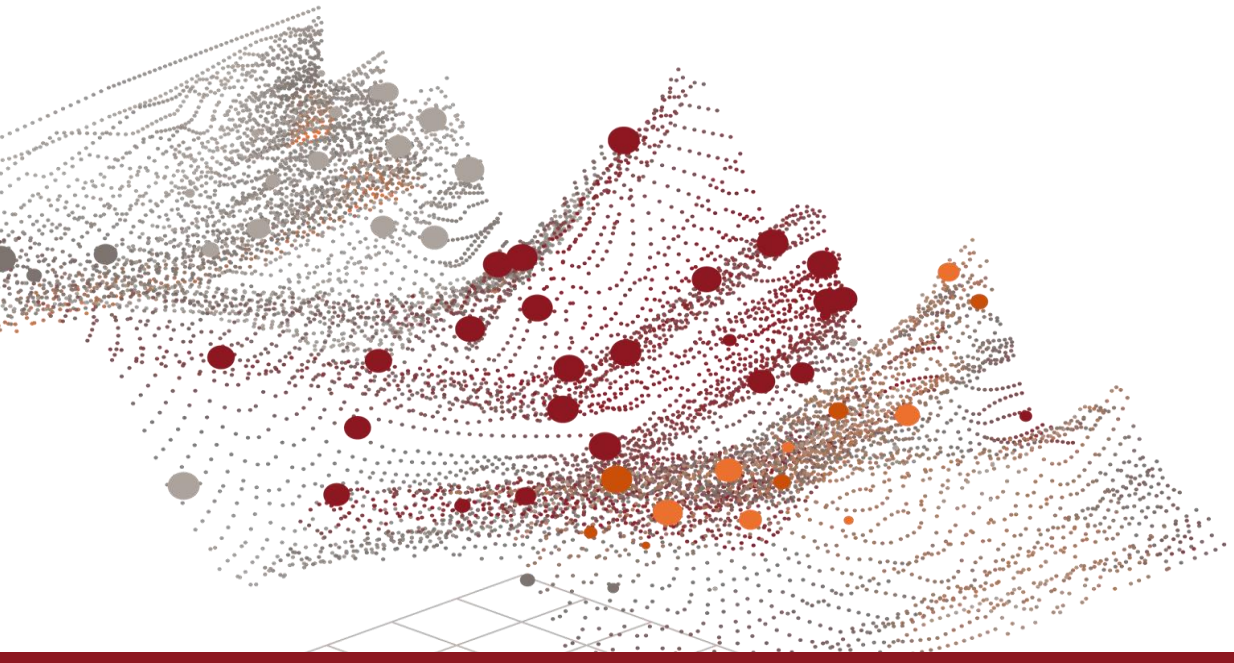
FINAL REPORT
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Youth Mental Health and Suicide Prevention in the Intermountain West:

Analysis of Political, Environmental, Social, and Technology Conditions

Presented by:
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Regional Cross-Cutting Themes

Regional PEST Analysis Overview

Key Political Implications

SIMILARITIES

Broad bipartisan support and minimal ideological opposition across all five states

Schools function as the **primary delivery platform** statewide

Geographic variation driven by **capacity—not political will**

Sustainability risk tied mainly to funding stability

DIFFERENCES

Centralized, mature systems: Colorado, Utah

Local-control models: Idaho, Wyoming, Montana

Access constraints strongest in Idaho and Wyoming (e.g., parental consent)

Key Economic Implications

SIMILARITIES

Rurality drives high costs and low economies of scale across all states

Heavy reliance on federal/grant funding

School-based systems are core but financially unstable

Workforce shortages increase costs and limit capacity

DIFFERENCES

More stable funding base: Utah

Highly grant-dependent/fragile systems: Idaho, Montana, Wyoming

Innovative financing: Wyoming (988 trust fund)

Greater fiscal capacity but instability pressures: Colorado

Key Social Implications

SIMILARITIES

Elevated youth suicide risk and strong rural disparities across all states

Persistent stigma and low help-seeking, especially in rural areas

Severe and uneven workforce shortages

Schools act as primary access points

DIFFERENCES

Improving trends: Colorado, Utah

Persistently high risk/structural challenges: Montana, Wyoming, Idaho

Data strength varies: strong (Colorado) vs. limited/suppressed (Idaho, Wyoming)

More explicit subgroup disparities in Colorado (LGBTQ+) and Montana (American Indiana/Alaska Native)

Key Technological Implications

SIMILARITIES

Strong 988 and crisis infrastructure across all states

Telehealth is essential for rural access

Widespread use of school-based and digital prevention models

Technology expands access but is constrained by workforce and funding limits

DIFFERENCES

Highly integrated systems: Utah, Colorado

Fragmented/capacity-limited systems: Idaho, Wyoming, Montana

Innovation leaders: Utah (SafeUT), Colorado

Strong evidence-based scaling in schools: Montana

Regional Summary

The region shows strong policy alignment and growing technological capacity, but all systems are constrained by rural geography, workforce shortages, and unstable funding. Differences are driven primarily by system maturity and governance (Colorado/Utah vs. Idaho/Montana/Wyoming) rather than political will.

Youth Mental Health and Suicide Prevention PEST Analysis - Wyoming

Wyoming PEST Analysis Overview

Key Political Implications

Broad political alignment: Suicide prevention is widely recognized as a priority

Incremental policy pathway: Emphasis on training, guidance, and pilot programs over mandates

Capacity-driven risk: Implementation varies significantly by county infrastructure

Funding instability: Reliance on short-term appropriations constrains long-term planning

Geographic disparities: Frontier areas face the greatest vulnerability due to limited governance capacity

Legislative roadblocks: Parental consent laws increase implementation complexity and risk.

Key Economic Implications

High-cost system: Frontier geography drives persistently high per capita service costs

Crisis stability vs. system vulnerability: The 988 model strengthens crisis response, but broader services remain funding-sensitive

Reliance on external funding: Prevention and youth services depend heavily on federal and time-limited funding streams

Need for density-sensitive policy: Sustaining progress will require funding models aligned with rural cost structures

Key Social Implications

Elevated risk: Youth suicide rates exceed national averages and vary widely across counties

Data constraints: Suppression limits local targeting and planning

Method concentration: Firearm access remains a dominant risk factor

Gender disparities: Different prevention strategies are needed for male vs. female youth

Cultural barriers: Stigma continues to suppress help-seeking behavior

Access variability: Crisis and school-based services improve reach but remain uneven

Workforce gaps: Telehealth mitigates, but does not eliminate, structural capacity challenges

Key Technological Implications

Strong crisis infrastructure: 988, text lines, and reporting platforms provide robust emergency response capacity

Technology-dependent access: Telehealth and digital coordination tools are essential for rural service delivery

Uneven capacity: Geographic distribution and workforce constraints limit consistent service access

System vulnerability: Reliance on key organizations and grant-funded initiatives introduces risk

Integrated but fragmented ecosystem: Multiple platforms exist, but coordination across domains (crisis, prevention, care delivery) remains complex

Political Environment

Overview

Wyoming consistently reports among the **highest suicide rates nationally**, including elevated risk among youth and young adults. State leadership broadly recognizes suicide prevention as a public health priority; however, political responses emphasize **local control, community-driven implementation, and workforce training** rather than centralized mandates (Wyoming Department of Health [WDH], 2025; Suicide Prevention Resource Center [SPRC], 2026). Overall, Wyoming's political environment is supportive but incremental, shaped by rural capacity constraints, limited workforce, and fiscal caution.

Support for youth suicide prevention is strong, but policy action prioritizes local flexibility over statewide mandates (WDH, 2025; SPRC, 2026).

Geographic Variation in Political Capacity

Political feasibility varies significantly by county type:

- **Urban counties (Laramie, Natrona):** Greater administrative capacity, larger school systems, and stronger engagement with state agencies (U.S. Census Bureau, 2023).
- **Rural counties:** Supportive but constrained by workforce shortages, geographic dispersion, and limited administrative staffing (WDH, 2025).
- **Frontier counties:** Minimal governance infrastructure; rely heavily on state leadership and regional intermediaries (Health Resources and Services Administration [HRSA], 2024).

Policy and Legislative Context

Wyoming's State Suicide Prevention Plan (2024–2028) provides a coordinated, evidence-informed framework prioritizing youth and rural populations (WDH, 2024). Key policy features include:

- Emphasis on **cross-agency coordination and community leadership** (WDH, 2024).
- **Jason Flatt Act** mandates recurring suicide prevention training for educators (WDE, 2019).
- Administrative **expansion of student suicide prevention instruction** (2024), following unsuccessful legislative efforts to mandate it (News From The States, 2026).

Emphasis on suicide prevention instruction in 2024 was simultaneously met with parental rights legislation, limiting schools from providing mental health services without explicit permission (Wyoming HB 0190). Implementation varies geographically, with urban districts better positioned to operationalize new requirements, while rural and frontier areas depend on state guidance and staffing capacity (WDE, 2019; HRSA, 2024).

Wyoming advances suicide prevention through administrative action and training requirements rather than comprehensive statutory mandates (News From The States, 2026).

Governance and Election Dynamics

Wyoming's governance model is **administratively centralized but operationally decentralized**:

- State leadership (WDH) provides coordination and strategy.
- Implementation occurs through counties, schools, and community partners (WDH, 2025).
- The Suicide Prevention Advisory Council supports continuity across election cycles.

Legislative culture emphasizes **fiscal restraint and local autonomy**, favoring pilot programs and agency guidance over large-scale mandates (News From The States, 2026). Funding remains **heavily reliant on federal grants and short-term appropriations**, raising concerns about long-term sustainability (SPRC, 2026).

Leadership and Coalition Strength

State leadership has elevated suicide prevention through initiatives such as **WY We Care**, emphasizing workforce training and community engagement (Wyoming Public Media, 2026). Collaborative initiatives include:

- PROSPER programs linking schools, law enforcement, health providers, and communities (PROSPER Together, 2026).
- Broad, bipartisan coalitions including state agencies, nonprofits, educators, and advocacy organizations such as the American Foundation for Suicide Prevention (AFSP) Wyoming (AFSP, 2026; WDH, 2025).

Coalition strength varies by geography:

- Urban counties: Stronger and more stable partnerships.
- Rural counties: Often rely on a small number of local leaders.
- Frontier counties: Limited formal coalition infrastructure (HRSA, 2024).

Political Summary

Wyoming's political environment is supportive but cautious—favoring locally implemented, incremental solutions over statewide mandates. Long-term progress will depend on translating policy momentum into durable funding and strengthening implementation capacity, particularly in rural and frontier communities (SPRC, 2026; WDH, 2024).

Economic Environment

Overview

Wyoming has made targeted investments in youth mental health and suicide prevention, particularly through early financing of crisis response infrastructure. However, the state's economic environment

remains structurally constrained by extreme rurality, a small population base, workforce shortages, and revenue volatility tied to extractive industries (WyoFile, 2024; Wyoming Legislature, 2023).

With fewer than 600,000 residents distributed across a large geographic area—and only two metropolitan counties—Wyoming faces limited economies of scale and substantial regional variation in service access and costs (U.S. Census Bureau, 2023).

Cost Structure and Rural Constraints

Population density is the primary driver of service cost. Most Wyoming counties meet federal frontier or rural criteria, which are associated with:

- High fixed costs (transportation, mobile crisis response, broadband, staffing).
- Low utilization across large geographic areas.
- Persistent provider shortages.

Wyoming's geography creates unavoidable cost inefficiencies—services must be maintained across large areas even when demand is low (HRSA, 2024).

These conditions make youth mental health services **inherently high cost on a per capita basis**, particularly outside urban centers (HRSA, 2024; USDA Economic Research Service [ERS], 2023).

Crisis System Investments

Wyoming has demonstrated relative innovation in stabilizing crisis services:

- HB 65 (2023) established the 988 Suicide and Crisis Lifeline, an advisory board, and a 988 System Trust Fund (Wyoming Legislature, 2023).
- The Trust Fund generates ongoing revenue through investment earnings.
- State and federal appropriations maintain service continuity.

Despite incomplete capitalization, this model provides **greater fiscal stability for crisis response systems** than in many comparable rural states (WyoFile, 2024).

Education-Linked Mental Health Services

Schools serve as primary access points for youth mental health care, particularly in rural and frontier communities. Key investments include:

- $10 million (2024) for a two-year K–12 Mental Health Services Grant Program (Wyoming Department of Education, 2024).
- Participation in Project AWARE, supporting school-based services and prevention programming (Wyoming Department of Education, 2020).

However, these efforts remain:

- Supplemental and grant-based, rather than embedded in core education funding.
- Vulnerable to workforce shortages, small district size, and long travel distances.

School-based services expand access but remain vulnerable due to reliance on time-limited funding and constrained workforce capacity (Wyoming Legislature, 2025).

These factors increase per-student costs and create dependence on short-term funding (Wyoming Legislature, 2025).

Funding Structure and Fiscal Resilience

Wyoming's youth mental health system relies on state general funds, federal grants and block funding, Medicaid financing, and trust fund earnings (notably the 988 system). While the 988 Trust Fund improves crisis system stability, broader fiscal resilience is limited by:

- A narrow tax base.
- Dependence on energy revenues.
- Budget pressures affecting state agencies, including health services (Wyoming Public Media, 2026).

Rural and frontier designations help attract supplemental funding but do not fully offset structural cost barriers (HRSA, 2024; U.S. Department of Agriculture Economic Research Service [USDA ERS], 2023).

Economic Summary

Wyoming's youth mental health system is high-cost and geographically constrained but comparatively innovative in crisis financing. Long-term sustainability will depend on protecting prevention and education-linked services from fiscal volatility while adopting funding strategies responsive to frontier conditions.

Social Environment

Youth Suicide Trends

Available data indicate **elevated and uneven youth suicide rates across Wyoming**, with substantial data suppression at the county level due to small population sizes. County-level data from 2021–2025 are unavailable for 18 of 23 counties; among those reported, **Carbon County had an exceptionally high rate (108.7 per 100,000)** (Anne E. Casey Foundation, n.d.). Across a longer window, youth suicide rates among individuals aged 10–24 averaged **19.7 per 100,000 (2010–2020)**—approximately **double the national rate**. Rates were highest among:

- Young adults (20–24): 30.5 per 100,000
- Adolescents (15–19): 24.4 per 100,000

Widespread data suppression masks the full geographic scope of youth suicide risk, limiting precision for county-level targeting (Wyoming Department of Health, 2021).

Frontier counties consistently experienced higher rates than rural counties, with **Johnson (39.9)** and **Fremont (33.2)** among the highest, compared to **Albany (9.5)** as the lowest reported. Over half of counties had suppressed data (Wyoming Department of Health, 2021). **Firearms were the leading cause of suicide** among youth aged 10–24 during this period (Wyoming Department of Health, 2021). Gender and age disparities are also significant:

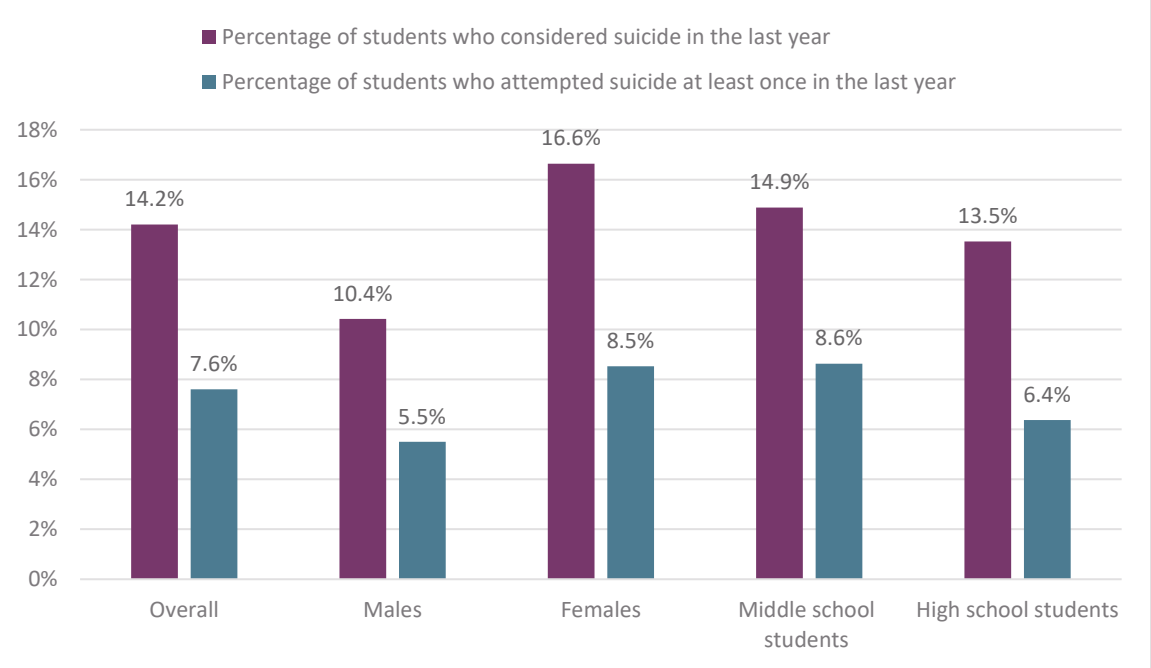
- Males have higher suicide mortality rates.
- Females have nearly double the self-harm hospitalization rate (92.1 vs. 48.3).
- Youth ages 15–19 have the highest hospitalization rates (103.8), followed by 20–24-year-olds (79.2).

More recent statewide data (2014–2023) continue to show high overall suicide prevalence, with **85% of deaths among men** and **72% involving firearms in 2023** (Wyoming Department of Health, 2023).

Student and Youth Experience

Statewide survey data from the **Prevention Needs Assessment (PNA)** provide insight into youth mental health experiences (Figure 1). Administered biennially to students ages 11–19, the PNA tracks self-reported mental health, suicide ideation and attempts, risk perception, and community context. Recent data show **persistent levels of suicidal ideation and attempts among middle and high school students.**

Figure 1. Suicidal ideation and attempts among Wyoming middle and high school students, 2024



Source: https://www.pnasurvey.org/ExploreData

Gaps remain in publicly available postsecondary data (Wyoming Department of Health; University of Wyoming). While the **University of Wyoming participates in the National College Health Assessment**, findings are not publicly disaggregated, limiting visibility into postsecondary mental health trends.

Stigma, Norms, and Help-Seeking

Qualitative and media sources (Holscher, 2023; Killough, 2022) highlight a strong cultural stigma around mental health care in Wyoming, often described as **"cowboy culture."** This norm:

- Emphasizes self-reliance and emotional suppression.
- Frames help-seeking as weakness.
- Contributes to **isolation, hopelessness, and reduced service use.**

These dynamics are particularly salient for male youth and rural populations.

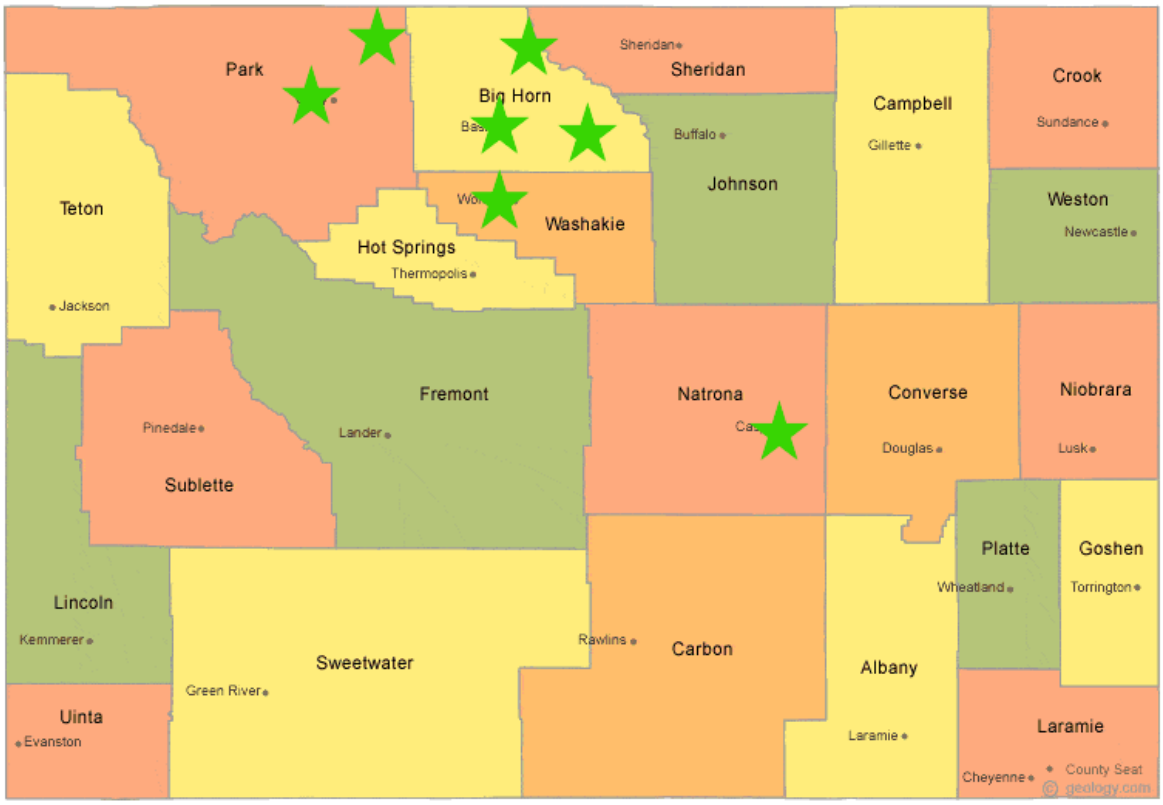
Stigma around help-seeking remains a critical barrier, reinforcing risk factors and delaying intervention.

Service Utilization and Access Points

Crisis service utilization reflects ongoing need:

- **988 Lifeline calls:** 623 (Jan), 631 (Feb), 577 (Mar) (988crisisline.org)
- **Seven walk-in crisis centers**, with **six clustered in north-central Wyoming** (Figure 2)

Figure 2. Location of walk-in crisis centers



School-based programs expand service access, particularly in rural areas:

- **Project AWARE** (13 counties)
- **Wind River Cares** (Fremont County)
- **Big Horn County Community Mental Health Project**

Crisis infrastructure and school-based services expand reach but remain unevenly distributed across regions.

These initiatives provide counseling, telehealth, referrals, and prevention programming, though availability varies geographically.

Workforce and System Capacity

Wyoming has expanded telehealth capacity to address geographic barriers:

- **Over 2,500 telehealth providers** support rural service delivery (Wyoming Behavioral Institute).

However, workforce shortages persist, and reliance on remote care underscores ongoing structural challenges in in-person service access.

Social Summary

Wyoming faces persistently high youth suicide risk shaped by geography, culture, and access constraints. While crisis services and school-based programs provide important entry points, gaps in data, workforce capacity, and help-seeking behavior continue to limit system effectiveness.

Technological Environment

Overview

Wyoming's technological landscape for youth mental health is shaped by extreme rurality, a small population (~580,000), and high suicide burden (Table 1). As mentioned in the political environment section above, Wyoming has enacted key legislation supporting technology-enabled prevention and response, including the **Jason Flatt Act (2014)**, **Safe2Tell Wyoming Act (2016)**, and **HB 65 (2023)** establishing the 988 infrastructure, alongside a **$10M 988 trust fund and $2.4M transitional funding**.

Crisis Response Technologies

Wyoming has built a **strong in-state crisis response infrastructure** supported by technology:

- **988 Lifeline** operated by in-state centers (Wyoming LifeLine and Central Wyoming Counseling Center), with **~90%+ in-state answer rates** and **15,000+ calls in year one** (988 in Wyoming).
- **Crisis Text Line ("WYO")**: text-based crisis support via SMS (text "WYO" to 741-741).
- **Safe2Tell Wyoming**: anonymous reporting system using the P3 Intel mobile app, generating **1,500+ tips with ~62% leading to intervention** (Safe2Tell Wyoming).

Access and Service Delivery Technologies

Technology plays a central role in expanding access across rural and frontier regions:

- **Wyoming PAL**: same-day psychiatric consultation line for pediatric providers, based on the Massachusetts Child Psychiatry Access Program (MCPAP) model (Wyoming PAL).
- **Care Solace (WDE)**: care coordination platform matching families to providers, typically within one week (Care Coordination).

Telehealth, care navigation platforms, and provider consultation lines are critical to overcoming geographic barriers—but depend on workforce capacity and sustained funding.

- **Project AWARE**: school-based services expanded to 13 districts, with reported gains in social connectedness (46.3% of students) and improved graduation rates (Project AWARE).
- **Tele-counseling platforms** (Uwill, META Teletherapy) expanding in community colleges.

Additionally, the **Wyoming Behavioral Institute** provides **acute psychiatric care (81 beds)** and teletherapy programs (Wyoming Behavioral Institute).

Prevention, Training, and Digital Tools

Wyoming uses a mix of **evidence-based programs and digital toolkits**:

- **Sources of Strength** (evidence-based suicide prevention and mental health promotion program model historically listed on SAMHSA's National Registry of Evidence-based Programs and Practices) implemented across multiple districts.
- **PROSPER Training Program**: 3,000+ residents trained (self-reported outcomes) (PROSPER Wyoming).
- **Jason Flatt Act training modules** [Question, persuade, and refer (QPR) training, Youth Mental Health First Aid] for educators.
- **Prevention Management Organization of Wyoming (PMOW)**: statewide prevention coordination using SAMHSA's Strategic Prevention Framework (PMOW).

System Coordination and Administrative Infrastructure

Statewide coordination is supported by:

- **Wyoming Suicide Prevention Program** (https://health.wyo.gov/publichealth/mch/youthandyoungadult-health).
- **Wyoming 2-1-1** resource navigation platform (2,800+ services) (https://wyoming211.org).
- **Care Management Entity** delivering wraparound services for youth with serious emotional disturbance.

These systems integrate administrative, knowledge-sharing, and referral functions across agencies.

Table 1. Wyoming technology resource matrix

Technology	Domain	Age	URL	Evidence	Scale
Wyoming 988 (WYLL + CWCC)	Crisis	All	wyominglifeline.org	Deployed (~90% in-state)	~15,000 calls/yr
Crisis Text Line "WYO"	Crisis	10+	crisistextline.org	Deployed (platform evidence)	Statewide
Wyoming Behavioral Institute	Service Delivery	5-17	wbihelp.com	Evidence-based therapies (CBT/DBT)	81 beds; multi-district tele IOP
Safe2Tell Wyoming + P3 Intel app	Cyberbullying / Crisis	K-12	safe2tellwy.org	Deployed	1,500+ tips in first 2 yrs
Wyoming 2-1-1	Access	All	wyoming211.org	Deployed	2,800+ resources
WDE Project AWARE	Service Delivery	K-12	edu.wyoming.gov/healthsafety/project-aware	SAMHSA-evidenced; WY outcome reported	13 districts, 380+ students
WDE Care Solace	Access	K-12 + families	edu.wyoming.gov/healthsafety/care-coordination	Deployed	Statewide
Uwill (Western WY CC) / META (Central WY CC)	Service Delivery	16-30	meta.app	Deployed (vendor data)	~3,000 WWCC students
PMOW	Administrative / Knowledge	All (youth-heavy)	pmowyo.org	Evidence framework (SAMHSA SPF)	All 23 counties
Sources of Strength (WY)	Digital / Knowledge (peer)	K-12	sourcesofstrength.org	RCT evidence (Wyman 2010+)	Multi-district
PROSPER Training	Toolkits	Adults	prospertogether.net/Wyoming	Self-reported only	3,000+ trained

Technology	Domain	Age	URL	Evidence	Scale
Jason Flatt Act modules (QPR, YMHFA)	Toolkits	Educators	edu.wyoming.gov	Components evidence-based	All WY teachers (statute)
WY Suicide Prevention Program	Administrative	All	health.wyo.gov/publichealth/mch/youthandyoungadult-health	Evidence-informed plan	Statewide
Wyoming PAL	Access	0-20	wyaap.org	Evidence-based model (MCPAP)	Statewide
WDH Care Management Entity	Service Delivery	Youth SED	health.wyo.gov/behavioralhealth	Evidence-based wraparound	Medicaid eligibility

Technology Summary

Wyoming's technological ecosystem is relatively strong in crisis response and increasingly robust in telehealth-enabled access. However, long-term effectiveness depends on strengthening workforce capacity, improving coordination across platforms, and stabilizing key organizational partners.

Youth Mental Health and Suicide Prevention PEST Analysis – Montana

Montana PEST Analysis Overview

Key Political Implications

Strong Policy Support; Yet Capacity Constraints Exist: Bipartisan commitment and policy frameworks exist, but limited admin capacity constrains implementation

Schools Are Primary Implementation Platform: Statutory requirements set schools as central to prevention, rely on ed systems for delivery

Decentralized Governance Needs Coordination: Distributed implementation across local entities increases the need for strong state coordination and cross-sector alignment

Funding and Policy Stability Vulnerable to Political Cycles: Biennial sessions and reliance on federal funding create variability in continuity and long-term planning

Regional Disparities Shape Implementation Feasibility: Urban areas are well-positioned for scale, while rural and frontier regions depend heavily on state support due to limited local capacity

Key Economic Implications

Structural Cost Is Barrier to Scale: High fixed costs and low-density limit efficient scaling, especially outside urban areas

Reliance on Time-Limited Federal Funding: Prevention and crisis systems depend on grants, constraining long-term sustainability

Workforce Shortages Increase Costs and Instability: Provider scarcity raises costs and restricts service delivery, particularly in rural and frontier areas

Education Sector as Unstable Financing Base: Schools are key access points, but funding remains short-term and non-structural

Fiscal Pressure Limits State Investment: Medicaid growth and competing demands reduce funding for prevention efforts

Key Social Implications

High Suicide Rate, Limited Early Detection: Elevated rates and firearm access increase risk, often without prior intervention opportunities.

Schools as Critical but Strained Access Points: Declining program availability and staffing shortages limit school-based support.

Persistent Barriers to Help-Seeking: Cost, distance, and stigma continue to suppress service utilization.

Primary Care as a Core Access Strategy: Integrated care models play a central role in expanding reach and reducing stigma.

Severe Workforce Shortages Drive Inequities: Provider scarcity disproportionately affects rural and frontier communities.

Key Technological Implications

Infrastructure Is Strong, Demand Is High: High-performing 988 and crisis services operate in a context of persistently elevated suicide risk.

Telehealth Essential for Statewide Coverage: Telepsychiatry enables reach across all counties but depends on workforce and broadband capacity.

Evidence-Based Digital Interventions a Major Strength: Montana has scaled multiple RCT-backed programs, particularly in school-based settings.

Access Gaps Persist in Rural and Tribal Communities: Shortage areas, infrastructure limitations, and disparities reduce equitable utilization.

Technology Needs Complementary System Capacity: Without workforce and funding stability, technology alone cannot close access gaps.

Political Environment

Overview

Montana's political environment reflects **sustained recognition of suicide prevention as a public health priority**, driven by persistently high suicide rates—especially among youth and rural populations (Montana Department of Public Health and Human Services [DPHHS], 2025; American Foundation for Suicide Prevention [AFSP], 2023). While **legislative support is strong**, implementation is constrained by **limited administrative capacity** and **reliance on federal and grant-based funding**. Overall, the environment is **supportive but capacity sensitive**.

Policy & Legislative Context

- Montana maintains a **State Suicide Prevention Strategic Plan**, emphasizing **multi-sector coordination** across prevention, intervention, and postvention, with priority populations including youth, Indigenous communities, and rural residents (DPHHS, 2025).
- **Education policy is central**: Senate Bill 369 (2025) mandates **annual suicide prevention training** for school staff and formalizes district responsibilities under §20-7-1310 (Montana Legislature, 2025; Montana Code Annotated §20-7-1310, 2025).

Schools are the primary policy vehicle for youth suicide prevention, positioning responsibility across education and health systems.

Governance & Political Dynamics

- Governance is **decentralized**, with DPHHS leading statewide coordination while implementation occurs through **local health departments, schools, and community organizations** (DPHHS, 2025).
- The Office of Public Instruction plays a key role in **training oversight and implementation within schools** (Montana Office of Public Instruction [OPI], 2025).
- **Biennial legislative sessions** create variability in funding and policy continuity, making programs **sensitive to election cycles and budget shifts** (Montana Public Radio, 2025).

Political Leadership & Coalition Strength

- Leadership is **bipartisan and cross-sector**, with DPHHS as the primary administrative driver and legislative committees advancing school-based policies (Montana Legislature, 2025; Montana Public Radio, 2025).
- Strong statewide coalitions—including state agencies, universities, tribal partners, and nonprofits support coordinated efforts (DPHHS, 2025).
- Coalition strength varies significantly by region (Table 2) due to **workforce and infrastructure disparities** (AFSP, 2023).

Table 2. Regional variation in political capacity

Context	Capacity & Governance	Implementation Feasibility	Coalition Strength
Urban Counties	Higher administrative capacity; proximity to state agencies (U.S. Census Bureau, 2023)	Stronger implementation of training and initiatives	More stable, institutionalized coalitions
Rural Counties	Lean staffing; limited provider availability (DPHHS, 2025)	Relies on state guidance and regional partnerships	Often person-dependent, less stable
Frontier Counties	Minimal governance infrastructure; highly resource constrained (HRSA, 2024)	Major barriers due to staffing and geographic isolation	Limited or absent; dependent on state/regional support

Political Summary

Montana's political environment strongly prioritizes youth suicide prevention through bipartisan support, statewide planning, and school-based policy mandates, but implementation is constrained by decentralized governance, limited capacity, and reliance on federal funding. Capacity varies widely by region, with rural and frontier areas facing greater dependence on state leadership and regional partners due to limited local infrastructure.

Economic Environment

Overview

Montana's youth mental health system operates within a **high-cost, resource-constrained economic environment**. While the state has made **targeted investments through federal funding, partnerships, and legislation**, the system remains **structurally fragile** due to limited state fiscal capacity, workforce shortages, rising Medicaid behavioral health costs, and heavy reliance on **time-limited federal grants** (DPHHS, 2025; Montana Free Press, 2026).

Extreme rurality shapes all economic conditions: Montana remains one of the most sparsely populated states, with **fewer than eight people per square mile**, driving significant variation in service costs, provider access, and efficiency across regions (U.S. Census Bureau, 2023).

Cost Structure & Rurality

- Most counties qualify as **rural or frontier**, where geographic isolation increases costs for **transportation, broadband, mobile crisis services, and minimum staffing levels** (HRSA, 2024; USDA Economic Research Service [ERS], 2023).
- Low population density reduces service volume, limiting opportunities for **cost efficiency** and increasing **per capita costs** of prevention programs (HRSA, 2024).

Fixed costs remain high regardless of utilization, making prevention inherently more expensive than in urban states.

Investment Landscape

- Prevention and early intervention rely heavily on **federal funding streams**, including CDC and SAMHSA Garrett Lee Smith grants, supporting coalitions, tribal partnerships, and youth programming (DPHHS, 2025).
- Crisis infrastructure (e.g., 988, Montana Crisis Line) has expanded but remains **financially unstable**, with no dedicated state funding mechanism (Montana Free Press, 2026; National Alliance on Mental Illness [NAMI] Montana, 2025).
- Rural and frontier investments prioritize **access (telehealth, mobile crisis, regional models)** rather than efficiency, requiring **ongoing subsidy** (Montana Rural Health Initiative, 2024).

Education-Linked Funding

- Schools are a key delivery setting, supported by **short-term grants** (e.g., Project AWARE), which fund counseling, prevention, and referral systems but are **not embedded in permanent school finance structures** (SAMHSA, 2021; Montana Office of Public Instruction [OPI], 2024).
- Rural and frontier schools face **higher per-student costs**, driven by small enrollments, provider shortages, and travel constraints (Montana Rural Health Initiative, 2024).

School-based mental health infrastructure is critical—but financially non-permanent and vulnerable to disruption.

Funding Structure & Fiscal Resilience

- Financing is **fragmented**, combining federal grants, Medicaid, limited state funds, and local contributions (DPHHS, 2025).
- Fiscal pressures—especially **rising Medicaid behavioral health costs**—limit the state's ability to sustain prevention investments (Montana Free Press, 2026).
- Rural designations unlock supplemental federal funding but **do not fully offset the structural costs of sparsity** (HRSA, 2024; USDA ERS, 2023).

Strategic Outlook

Sustained progress will require **density-sensitive financing approaches** that explicitly account for rural cost structures, along with **more durable state funding mechanisms** to stabilize prevention and school-based systems. Without these shifts, Montana's youth mental health infrastructure will remain **high-cost, grant-dependent, and vulnerable to funding disruption**.

Economic Summary

Montana's youth mental health system operates in a high-cost, resource-constrained environment shaped by extreme rurality, where low population density drives high per capita service costs and limits efficiency. While supported by federal funding and targeted investments, the system remains fragile due to workforce shortages, fragmented financing, and heavy reliance on time-limited grants, leaving prevention, crisis services, and school-based supports vulnerable to funding instability.

Social Environment

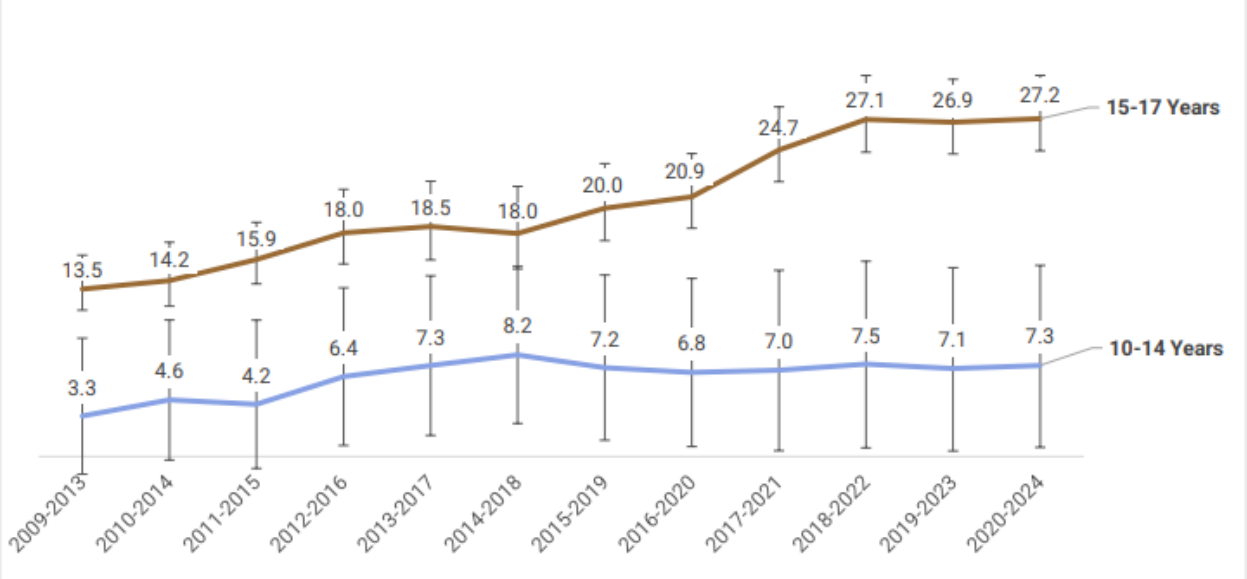
Overview

Montana's social environment is characterized by **elevated youth suicide risk, persistent behavioral health needs, and uneven access to care**, shaped by rural isolation, workforce shortages, and social norms influencing help-seeking. This section examines patterns in suicide and self-harm, youth experiences in school and postsecondary settings, and the role of stigma, access barriers, and primary care in shaping service uptake and early intervention (Montana Department of Public Health and Human Services, n.d.; Montana Free Press and Eagleton, 2026; Integrative Psych, 2025).

Behavioral Health Need & Risk Profile

- Youth suicide rates are **more than double the national average** (11.6 vs. 4.7 per 100,000), with **older teens (15–17) at highest risk** (See Figure 3; Montana Department of Public Health and Human Services, n.d.).
- **Firearms account for 60% of youth suicides**, often involving **unlocked, loaded household weapons**, and many cases lack prior visible warning signs or screening (MDPHHS, 2026).
- Nonfatal self-harm rates have declined since 2022 but remain significant; **drug poisoning drives most hospitalizations** (MDPHHS, 2025).

Figure 3. Age-specific youth suicide rates per 100k residents in Montana, 2009-2024 (5-year combined rates)

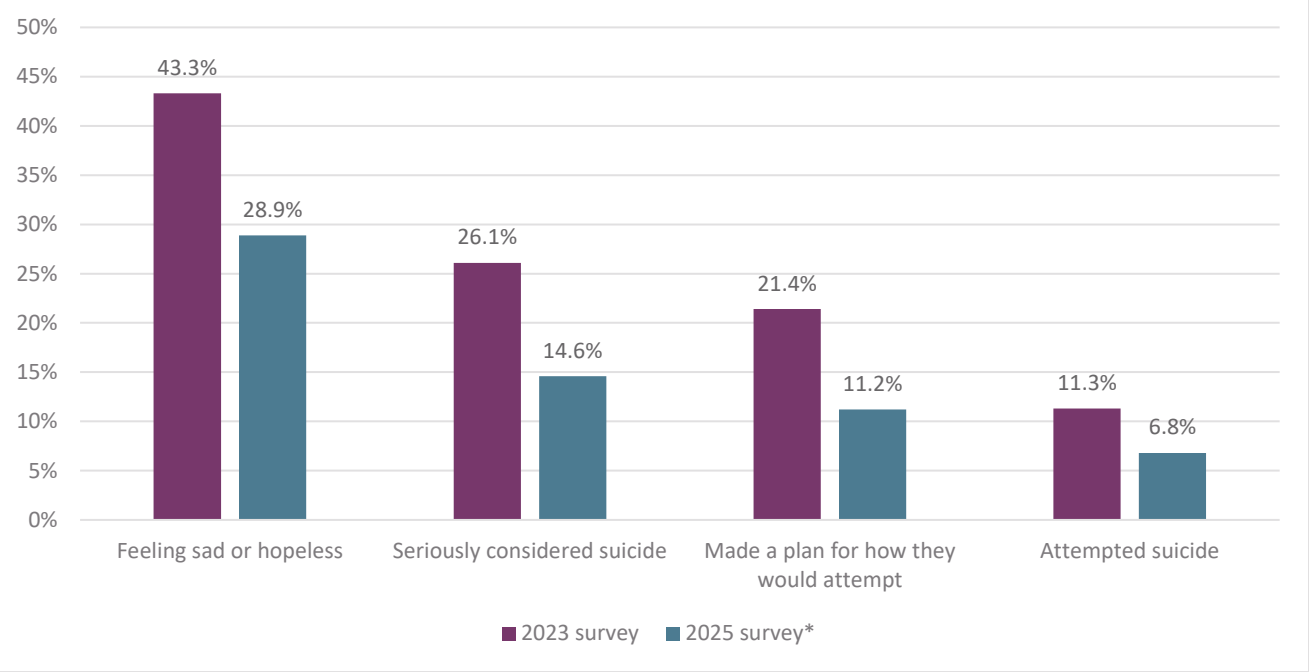


Source: Montana Department of Public Health and Human Services

Youth & Student Experience

- Preliminary Youth Risk Behavior Survey (YRBS) data suggest **modest improvement in student mental health**, but rates remain **above national averages** (See Figure 4; Montana Office of Public Instruction, 2026).
- School-based supports have **declined**:
  - **Universal mental health programs dropped** from ~85% (2022) to 76% (2024).
  - **Trauma-informed practices dropped** from ~86% to **70.6%.**
- Key barriers: **funding (77.6%) and staffing (71.2%) shortages** (Montana Superintendent of Public Instruction, 2026).
- Postsecondary students report **high stress, anxiety, and isolation**, with over half of Montana State University students indicating mental health impacts academic performance.

Figure 4. Percentage of high school students in Montana answering yes to questions about mental health and suicidal ideation during the 2023 and 2025 YRBS surveys



Source: Montana Office of Public Instruction, 2026

Help-Seeking, Stigma, and Access

- Major barriers to care include **cost (67%), travel distance (47%), and stigma (42%)** (according to a 2025 Montana Free Press and Eagleton poll; Montana Free Press and Eagleton, 2026).
- Rural norms often **normalize hardship and isolation**, reducing perceived need to seek care (Zolnikov, 2019).

Primary care is a critical, lower-stigma entry point for behavioral health services.

- **Integrated primary care models** expand access and reduce stigma, with:
  - 54% of Medicaid enrollees receiving behavioral health care solely in primary care.
  - 81% receiving some care through primary care settings (Montana Healthcare Foundation, 2024).

Workforce & Structural Constraints

- 60% of Montanans live in mental health shortage areas, and 39 of 56 counties lack a psychiatrist (Integrative Psych, 2025).
- Geographic isolation and transportation barriers compound access challenges, especially for youth.

Social Summary

Montana faces persistently high youth suicide rates and widespread behavioral health needs, driven by firearm access, social isolation, and workforce shortages, particularly in rural and frontier communities. While some indicators of youth mental health show improvement, access to care remains constrained by cost, stigma, and provider scarcity, limiting early intervention and sustained service uptake.

Technological Environment

Overview

Technologies in Montana span multiple domains (**crisis, access, service delivery, digital interventions, and school-based tools**) across emergency, acute, and chronic needs. Montana has historically ranked among the **highest in the nation for suicide**, with youth rates roughly **triple the national average**, reinforcing the need for scalable technological solutions. State investments (e.g., Montana Legislature, 2023) and adoption of crisis systems and screening tools (Table 3) have contributed to **recent declines in youth suicide deaths** from 2021 to 2023.

Technology is central to Montana's response, but demand remains extremely high due to persistently elevated suicide risk.

Crisis & Access Infrastructure

- Montana 988 operates with a **97% in-state answer rate**, among the highest nationally (DPHHS, May 2024).
- Crisis Text Line usage has grown rapidly (**105%+ increase**), and peer supports (Warmline) expand pre-crisis access.
- MAPP-Net provides **real-time psychiatric consultation** to primary care providers, extending specialist expertise statewide.

Service Delivery & Telehealth

- Telepsychiatry is a cornerstone: Frontier Psychiatry serves **800+ patients weekly across all 56 counties**, with evidence of **reduced hospitalizations** (Halvik, et al., 2025).
- Longstanding telemedicine networks and regional inpatient services (e.g., Billings Clinic, Shodair) support acute care.

Evidence-Based Digital & School-Based Interventions

- Strong evidence-based programs include:
  - **YAM** (50% reduction in suicide attempts; Wasserman et al., 2015).

- **Screening Linked to Care (SLTC)** (73% reduction in suicidality among screened students).
- **Project YES** (statewide rollout of RCT-backed digital interventions).

Montana is notable for deploying multiple RCT-backed interventions at scale, particularly in school settings.

- School and community programs (e.g., Project AWARE, SaferMT Tip Line) expand awareness, screening, and response capacity.
- Tribal programs incorporate culturally grounded approaches, with some supported by **ongoing RCTs**.

Structural Constraints

- 51 of 56 counties are Mental Health Professional Shortage Areas, limiting service delivery **even with technology**.
- Broadband and geographic barriers **constrain frontier utilization**, creating gaps between availability and access.
- Disparities persist for American Indian youth, who experience suicide rates roughly twice as high as non-Native youth.

Table 3. Montana technology resource matrix

Technology	Domain	Age	URL	Evidence	Scale
Montana 988 (3 centers)	Crisis	All	dphhs.mt.gov/suicideprevention/988	Deployed (97% in-state answer)	~10,000 calls/yr
MT Crisis Text Line "MT" to 741741	Crisis	12+	dphhs.mt.gov/BHDD	Deployed	105%+ growth
MHA-MT Warmline / MT Youth United	Access	9–25 + adult	mhaofmt.org/warmline	Deployed (peer-support evidence)	Statewide
Montana 211	Access	All	montana211.org	Deployed	Statewide
Frontier Psychiatry / OnCall	Service Delivery	5–25+	frontier.care	RCT-grade (JAMA Netw Open 2025; 38% ↓ hosp.)	800+ pts/week, all 56 counties
Billings Clinic Psych + Youth PHP	Service Delivery	5–17	billingsclinic.com	Collaborative Care evidence	44 beds, regional MT/WY

Technology	Domain	Age	URL	Evidence	Scale
MAPP-Net	Access	Provider-facing (0–21)	mtpal.org	Evidence-based model (MCPAP peer-reviewed)	Statewide
Project YES (SSI rollout)	Digital Intervention	11–19	frontier.care/blog/montana-makes-history	Strong RCT base (Schleider 2022)	First-in-nation statewide
RBHI Screening Linked to Care	Digital Intervention / Access	Gr 3–12	rbhi.org	Program outcomes published	29,000+ screens; ~40% of MT schools
Youth Aware of Mental Health	Knowledge / Digital	13–17	montana.edu/crre/youthawareofmentalhealth.html	Strong RCT (SEYLE/Lancet 2015; 50% ↓ attempts)	11–14K MT students since 2016
Project AWARE Montana	Toolkits / Knowledge	K-12	opi.mt.gov	MHFA/MTSS evidence-based	70,000+ adults trained
SaferMT Tip Line (STOPit)	Cyberbullying / Crisis	K-12	safermt.com	Deployed	82 schools, 16 districts
CAST-S toolkit	Toolkits	K-12 personnel	sprc.org/wp-content/uploads/2022/11/CAST-S-2022.pdf	Evidence-informed	Statewide
Jason Foundation MT PD	Knowledge	K-12 educators	jasonfoundation.com	Deployed (statutory requirement)	All MT teachers
Tribal programs (PSOH, Little Holy One, SNEP)	Service Delivery / Knowledge	AI/AN 10–24	sprc.org/grantees	Mixed: some RCT (Little Holy One NIH-funded)	7 MT + 1 WY reservations

Technological Summary

Montana's youth mental health technology ecosystem is extensive and evidence-informed, spanning crisis response, telehealth service delivery, and school-based digital interventions, with strong performance in crisis access and growing implementation of validated programs. However, extreme rurality, workforce shortages, and infrastructure constraints limit equitable access and consistent utilization, particularly in frontier and tribal communities, despite recent investments and innovation.

Youth Mental Health and Suicide Prevention PEST Analysis – Idaho

Idaho PEST Analysis Overview

Key Political Implications

Broad support, limited access: Prevention is politically supported, but access remains constrained.

Legislative roadblocks: Parental consent laws increase implementation complexity and risk.

System expansion limitations: Governance structures reinforce local control and limit system expansion.

Geographic variability: Capacity and coalition strength vary significantly by geography.

A path forward: Feasible near-term strategies center on training and prevention.

Key Economic Implications

Economic uncertainty: System is highly dependent on federal funding.

Reduced economies of scale: Rural geography increases cost and complexity.

Weakened stability: State budget cuts threaten service stability.

Schools as drivers: School-based programming primary driver of youth mental health awareness.

Economic instability: Sustainable financing mechanisms are lacking.

Key Social Implications

Rates Well Above Average: Youth suicide rates exceed national averages.

Limited Data: Data gaps limit statewide visibility of the state of youth mental health **and the ability to design support systems**.

Limited Training Opportunities: Workforce shortages are severe and geographically uneven.

Varied Demand for Help: Help-seeking demand is growing but varies by locale.

Key Technological Implications

Expanding Infrastructure: Crisis infrastructure is robust and expanding.

Funding-Dependent Prevention: School-based prevention is well developed but depends on federal funding.

Rural Access: Tele-mental health medicine is essential for rural access.

Enhanced System Reach: Nonprofits enhance system reach through digital tools and navigation platforms.

Political Environment

Overview

Idaho's political environment reflects strong formal commitment to suicide prevention alongside statutory constraints that limit youth access to mental health care, creating a complex and sometimes contradictory policy landscape (Idaho Department of Health and Welfare [IDHW], 2025; Idaho Education News, 2025). While statewide planning and school-based mandates support prevention, parental consent laws, funding instability, and governance norms shape implementation feasibility (Suicide Prevention Resource Center [SPRC], 2024; IDHW, 2025).

Geographic Variation in Political Capacity

- **Urban counties** have stronger administrative infrastructure and closer proximity to state leadership, supporting policy implementation (U.S. Census Bureau, 2023).
- Larger provider networks in urban areas enable more flexibility in navigating policy constraints (U.S. Census Bureau, 2023).
- **Rural counties** face workforce shortages and coordination challenges that limit implementation capacity (IDHW, 2024).
- **Frontier counties** rely heavily on state systems due to minimal local governance and service infrastructure (Health Resources and Service Administration [HRSA], 2024).

Statewide Policy Context

Prevention is prioritized statewide, but youth access to services is structurally constrained by policy.

- Idaho formally recognizes suicide prevention as a **public health priority**, supported by statewide planning and cross-sector collaboration (IDHW, 2025; SPRC, 2024).
- High suicide rates **sustain political attention** and justify continued prevention investment (IDHW, 2025).
- Policy tensions—**particularly around youth autonomy**—create friction between prevention goals and service access (Idaho Education News, 2025; ACLU of Idaho, 2024).
- Structural constraints **limit confidential access** to care for minors, shaping service utilization patterns (ACLU of Idaho, 2024).

Policy and Legislative Context

- The **Statewide Suicide Prevention Plan** (2024–2028) provides a comprehensive public health framework for prevention, intervention, and postvention (SPRC, 2024).
- **School-based mandates** (Idaho Code §33136) institutionalize training and district-level prevention policies (Idaho Code §33136, 2025).
- SB 1329 (parental consent) **requires caregiver approval** for most services, restricting youth access to care (Idaho Code §321015, 2024).

- The law introduces **legal ambiguity** and risk for providers, particularly in confidential or crisis contexts (Idaho Education News, 2025).

Governance and Election Dynamics

Governance emphasizes local control and limits on state involvement in youth care decisions.

- IDHW leads coordination, with the Idaho Suicide Prevention Action Collective (ISPAC) facilitating **cross-sector planning and monitoring** (SPRC, 2024).
- The Department of Education **plays a central role** in implementing school-based prevention strategies (Idaho State Department of Education, 2026).
- Political priorities emphasize **parental rights and regulatory restraint**, shaping policy design and implementation (Idaho Education News, 2025).
- Federal and time-limited funding sources **create instability across election cycles** and budget periods (IDHW, 2025).

Leadership and Coalitions

- Bipartisan support is most consistent for **prevention-focused initiatives** such as training and awareness (Idaho Code §33136, 2025).
- State-level leadership is anchored in IDHW and supported through ISPAC's cross-sector coordination (SPRC, 2024).
- Coalition **infrastructure is stronger in urban areas** with larger institutions and advocacy organizations (American Foundation for Suicide Prevention [AFSP], 2025).
- Rural and frontier coalition efforts are **more fragmented** and dependent on individual leaders or regional intermediaries (HRSA, 2024).

Political Summary

Idaho's political environment supports suicide prevention in principle but constrains youth access through statutory and governance conditions. Sustainable progress depends on resolving access barriers and stabilizing funding structures (IDHW, 2025; SPRC, 2024).

Economic Environment

Overview

Idaho's youth mental health system operates within a constrained economic environment shaped by federal funding dependence, workforce shortages, and recent budget reductions (Idaho Capital Sun, 2026; IDHW, 2026). Rurality and low population density further increase service costs and limit financial sustainability (HRSA, 2024; U.S. Census Bureau, 2023).

Population Density and Cost Structure

- Rural and frontier geography **increases costs** for transportation, workforce coverage, and infrastructure (HRSA, 2024; USDA Economic Research Service [ERS], 2023).
- Limited population density **reduces economies of scale** and provider availability (U.S. Census Bureau, 2023).
- High fixed costs persist even in areas with low utilization, **increasing per-capita expenditures** (HRSA, 2024).
- Geographic dispersion **complicates workforce deployment** and service coordination across regions (USDA ERS, 2023).

Existing and Emerging Investments

- State prevention infrastructure is centered within IDHW and supported by federal grants (IDHW, 2024).
- The 988 crisis system has experienced **increasing demand**, requiring additional staffing and infrastructure (Idaho Capital Sun, 2026).

Core systems are expanding but rely heavily on short-term federal funding.

- Federal funding streams (CDC, SAMHSA) support prevention and crisis expansion but are **time-limited** (IDHW, 2024).
- Lack of a dedicated funding mechanism for 988 creates **ongoing sustainability concerns** (KBOI news, 2026).

Education-Linked Funding

- Programs like Project AWARE **embed mental health supports within schools**, especially in rural districts (SAMHSA, 2022; Idaho State Department of Education, 2024).
- School-based programs serve as **primary access points** for youth services in underserved areas (IDHW, 2024).
- Funding remains **grant-dependent** and not integrated into state education formulas (Idaho Department of Labor, 2025).
- Small district size and geographic dispersion increase per-student costs and **vulnerability to disruptions** (Idaho Department of Labor, 2025).

Funding Sources and Fiscal Resilience

- System funding is concentrated in federal grants, Medicaid, and limited state appropriations (IDHW, 2025).
- Medicaid rate reductions and managed care changes **threaten provider viability** (Idaho Capital Sun, 2025).

The funding base is narrow, unstable, and increasingly under strain.

- Recent budget cuts **disproportionately affect discretionary programs** like suicide prevention (Idaho Capital Sun, 2026).
- Rural funding designations provide supplemental support but **do not offset structural underinvestment** (HRSA, 2024).

Economic Summary

Idaho's economic environment is characterized by high costs, limited funding diversity, and low fiscal resilience. Sustained investment and rural-adjusted financing models are critical for long-term system stability.

Social Environment

Overview

Idaho's social environment reflects high levels of youth mental health need, with elevated suicide rates and significant geographic disparities (United Health Foundation, 2026; CDC, n.d.). Data limitations, workforce shortages, and uneven help-seeking behaviors further constrain effective response.

Behavioral Health Indicators

- Suicide is the second leading cause of death among Idaho youth, exceeding national averages (Idaho Suicide Prevention Program, 2023; United Health Foundation, 2026).
- Rates are significantly higher in rural and frontier communities compared to urban areas (CDC, 2026).
- Males account for the majority of suicide deaths, while females have higher rates of attempts and ER visits.
- Firearms are the leading method, contributing to lethality and outcome disparities.

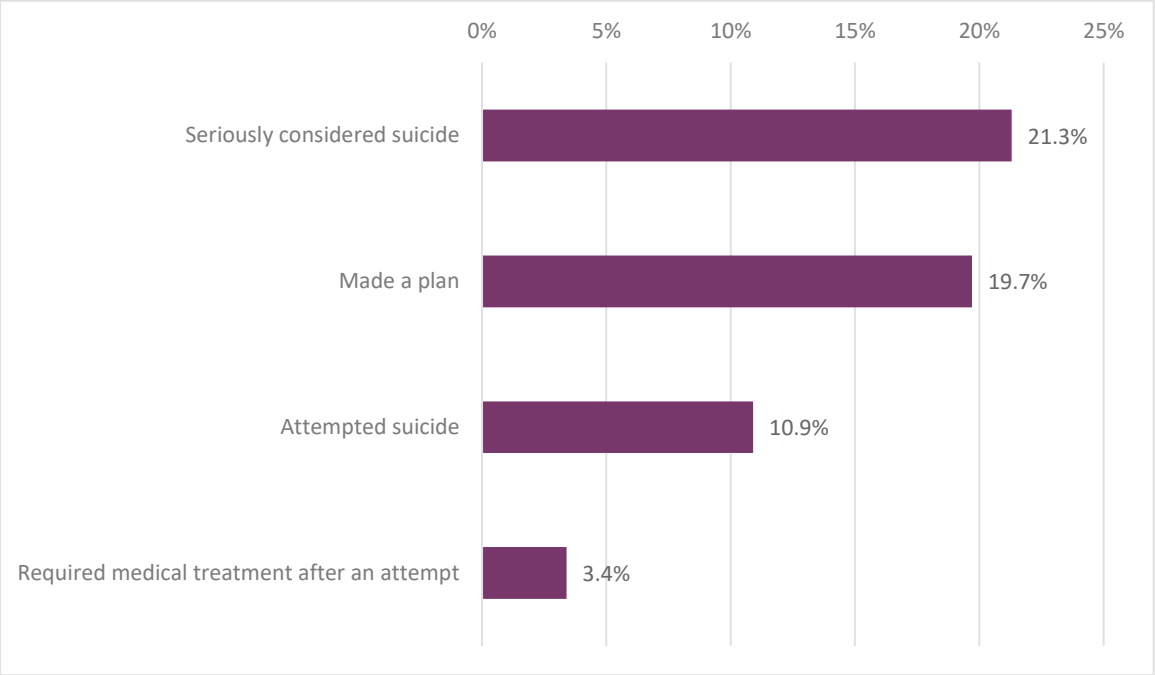
Student and Youth Experience

- Withdrawal from the Youth Risk Behavior Survey reduces availability of standardized statewide behavioral data (Chang, 2022).
- Alternative surveys are locally administered, limiting comparability and statewide insight (Blue Cross of Idaho Foundation, 2023).
- Local data indicate high prevalence of depression and suicidal ideation among students (Blue Cross of Idaho Foundation, 2023).
- Postsecondary institutions report substantial increases in counseling demand following the pandemic (Dawson, 2023).

Limited statewide data obscures full understanding of youth mental health needs.

- The Jed Foundation's JED Campus program is currently active on the Boise State and College of Western Idaho campuses.
- The Youth Risk Behavior Survey details suicidal ideation behavior among Idaho high school students in the past 12 months (Figure 5).

Figure 5. Percentage of students in Idaho who answered yes to Youth Risk Behavior Survey questions about suicide, 2021

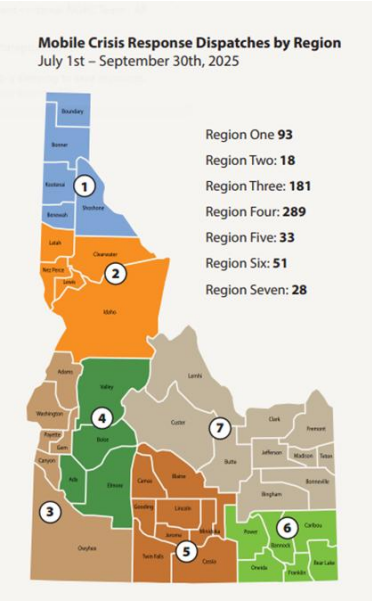


Source: CDC Youth Risk Behavior Survey

Stigma, Norms, and Help-Seeking

- Crisis hotline contacts are high, with strong rates of de-escalation and referral (Idaho Crisis & Suicide Hotline, 2026).
- Mobile crisis deployment reduces reliance on emergency departments and law enforcement (Idaho Crisis & Suicide Hotline, 2025).
- Service utilization varies across regions, reflecting uneven awareness and access (Idaho Crisis & Suicide Hotline, 2025, Figure 6).
- Cultural norms and stigma may continue to influence help-seeking behavior in rural areas (IDHW, 2024).

Figure 6. Mobile Crisis Responses



Workforce and Demographic Trends

- Idaho exceeds recommended counselor-to-student ratios, indicating insufficient school-based staffing (Flandro, C., 2025).
- Mental health professional shortages exist statewide, with severe deficits in rural counties (Woolcock et al., 2025).
- Limited in-state training pathways contribute to workforce attrition and outmigration (Zado, 2025).
- Emerging models like Certified Behavioral Health Clinics (CCBHC) may expand access but could increase workforce competition (Idaho Behavioral Health Association, 2024).

Social Summary

Idaho's social environment reflects high need, uneven access, and limited data visibility. Strengthening workforce capacity and data systems is essential to addressing persistent disparities.

Technological Environment

Overview

Idaho's technological ecosystem includes crisis systems, school-based prevention programs, telehealth services, and nonprofit-led digital tools (Table 4) that collectively support youth mental health efforts (IDHW, 2024). However, access, workforce limitations, and policy constraints limit system-wide effectiveness.

Crisis Infrastructure

Statewide crisis infrastructure is strong but constrained by policy and capacity.

- The 988 hotline provides 24/7 support via calls, texts, and chat (Idaho Crisis & Suicide Hotline, 2026).
- Mobile response teams and youth crisis centers expand emergency stabilization capacity (IDHW, 2024).
- Crisis demand is increasing, requiring expanded staffing and infrastructure (Idaho Crisis & Suicide Hotline, 2026).
- Parental consent requirements may limit utilization among minors in crisis situations (Idaho Education News, 2025).

Prevention and School-Based Technology

- Idaho Youth Suicide Prevention Program delivers evidence-based interventions statewide (Idaho State Department of Education, 2026).
- Programs include QPR, Sources of Strength, and other evidence-supported models (SAMHSA, 2022).

- Project AWARE expands mental health infrastructure in selected districts (SAMHSA, 2022).
- Implementation depends heavily on federal grant funding and district participation (IDHW, 2024).

Service Delivery and Telehealth

- Tele-mental health services like Idaho Youth Ranch provide statewide access to therapy, particularly in rural regions (Idaho Youth Ranch).
- Medicaid managed care (Magellan) centralizes behavioral health service coordination.
- YES system provides structured care for youth with serious emotional disturbance (IDHW, 2024).
- Workforce shortages and broadband variability limit full effectiveness of telehealth expansion (HRSA, 2024).

Telehealth expands access but does not fully address workforce shortages.

Nonprofit and Digital Supports

- Nonprofits provide training, awareness campaigns, and prevention programming (Speedy Foundation; Jason Foundation).
- Digital tools and apps support crisis access and peer intervention (Jason Foundation).
- Navigation platforms like 211 improve access to services and referrals (IDHW, 2024).
- Availability and utilization vary across regions, particularly in rural areas (IDHW, 2024).

Table 4. Idaho technology resource matrix

Technology	Domain	Age	URL	Evidence	Scale
Idaho Crisis & Suicide Hotline / 988	Crisis	All	idahocrisis.org	Deployed	1,500+ youth 5–17 calls yr1
Youth Crisis Centers / MRTs	Crisis / Service Delivery	5–17	yes.idaho.gov/crisis-resources	Deployed	4+ YCCs statewide
IYSPP (Idaho Lives Project)	Service Delivery / Knowledge	K-12 + to 24	iyspp.sde.idaho.gov	Deployed with evaluation	Statewide (3 regional coordinators)
Sources of Strength (ID)	Digital / School Intervention	Mid/HS	sourcesofstrength.org	RCT evidence (Wyman 2010)	School cohorts via SDE
HOPE Squad (ID)	Peer Intervention	Gr 4–12	hopesquad.com	Peer-reviewed (Wright-Berryman)	Boise SD (22,500) + others
Idaho AWARE Project	Service Delivery / Knowledge	K-12	idahoschoolmentalhealth.org/idaho-aware-project	Framework evidence-informed	Statewide

Technology	Domain	Age	URL	Evidence	Scale
Jason Foundation ID / "A Friend Asks" app	Digital / Toolkit	Mid/HS	jasonfoundation.com	Deployed-only	Statewide PD
Speedy Foundation	Knowledge / Toolkits	HS+	thespeedyfoundation.org	Components evidence-based (QPR/MHFA)	Statewide + UT/NV/CA
Idaho Youth Ranch TeleMental Health	Service Delivery (telehealth)	9–24	youthranch.org/telementalhealth	Evidence-based modalities (TF-CBT/DBT/EMDR/PLL)	785 youth in 2024
IBHP / Magellan of Idaho	Administrative / Access	All (YES for youth)	magellanofidaho.com	Deployed (covers EBTs: MST/MDFT/FFT)	Sole MCO since 7/1/2024
YES (Youth Empowerment Services)	Administrative / Service Delivery	<18 (EPSDT to 21)	yes.idaho.gov	Evidence-informed (CANS, HFW)	Statewide SED
211 Idaho CareLine	Access / Knowledge	All	healthandwelfare.idaho.gov/services-programs/211	Deployed	Statewide I&R
St. Luke's Children's PHP/IOP + telepsych	Service Delivery	12–17+	stlukesonline.org	Deployed (EB clinical modalities)	Treasure Valley + Twin Falls/Hailey

Technological Summary

Idaho's technological environment provides a strong foundation for prevention and crisis response but is constrained by access and workforce limitations. Greater integration with policy and workforce strategies is needed to maximize impact.

Youth Mental Health and Suicide Prevention PEST Analysis – Colorado

Colorado PEST Analysis Overview

Key Political Implications

Strong Infrastructure, Reduced Risk: Strong statutory and governance infrastructure reduces political risk.

Sustained Support: Bipartisan support is stable and sustained.

Capacity is the Key: Capacity—not ideology—drives geographic differences between urban, rural, and frontier counties.

Competing Priorities: Fiscal pressures are the primary emerging constraint, competing with other initiatives.

An Urban Advantage: Colorado is well-positioned for scaling and system integration, especially in urban areas.

Key Economic Implications

Federal Reliance: Strong investment environment but heavy reliance on federal funding.

Cost Disparities: Urban-rural cost disparities shape system design, complicate workforce deployment, and coordination.

Growing Needs: Medicaid behavioral health cost growth is a major fiscal pressure.

Unstable Funding: School-based services, which serve as the primary access point for youth services, lack stable funding integration.

An Uncertain Future: Long-term sustainability of prevention efforts remains uncertain due to healthcare costs and workforce shortages.

Key Social Implications

Improving, but Elevated: Youth suicide rates are improving but still elevated, especially in rural and frontier counties.

Continued Disparities: Rural and frontier disparities persist both in terms of suicidality and mental health.

Marginalized Groups: LGBTQ+ youth face significantly scrutiny in help-seeking, especially if certain faith-based organizations are involved.

Cowboy Culture: Stigma continues to limit help-seeking, specifically in rural populations where self-reliance and stoicism culture discourage it.

Possible Improvements. Workforce shortages constrain system capacity, though recent investments may be changing this.

Key Technological Implications

Advanced Technology: Colorado has a highly developed technology ecosystem.

A Comprehensive System: Crisis systems are comprehensive and widely utilized.

Expanding Access: Telehealth and digital tools expand access, especially in rural and frontier areas.

Focused on the Evidence: Evidence-based programs are deeply integrated into the state ecosystem.

Use of Data in Decision Making: Infrastructure supports coordination and data-driven decision-making.

Political Environment

Overview

Colorado's political environment for youth mental health and suicide prevention is highly supportive, with strong statutory authority, stable governance structures, and sustained bipartisan engagement (Colorado Department of Public Health and Environment [CDPHE], 2024). This mature policy landscape reduces ideological barriers but introduces emerging fiscal pressures that may constrain future expansion (Colorado Health Institute, 2024).

Statewide Political Context

- Suicide prevention is embedded across behavioral health, education, and public health systems through statutory authority (Colo. Rev. Stat. §25-1.5-112, 2024).
- The Office of Suicide Prevention (OSP) provides centralized leadership and coordination across sectors (CDPHE, 2024).
- Bipartisan legislative support has remained consistent, particularly for prevention-oriented initiatives (Colorado General Assembly, 2019).
- Policy emphasis frames suicide prevention as a shared cross-system responsibility rather than a siloed issue (CDPHE, 2024).
- Political opposition to youth mental health initiatives is minimal relative to peer states (CDPHE, 2024).

Urban, Rural, Frontier Variability

- Urban counties benefit from dense policy networks and proximity to state agencies, enabling early adoption and scaling of initiatives (CDC, 2024; Colorado Department of Local Affairs, 2025).
- Larger administrative systems in urban areas support participation in pilots and innovation efforts (CDC, 2024).

Capacity—not political will—is the primary driver of geographic variation.

- Rural counties rely on regional or multi-county implementation models due to limited staffing (Colorado Rural Health Center, 2022).
- Frontier counties depend heavily on state-directed frameworks with minimal local policy infrastructure (Colorado Department of Health Care Policy & Financing [HCPF], 2025; Health Resources and Services Administration [HRSA], 2024).
- Variation reflects administrative capacity rather than ideological differences across regions.

Policy and Legislative Context

- State law mandates a statewide suicide prevention plan spanning multiple systems (Colo. Rev. Stat. §25-1.5-112, 2024).

- HB19-1120 institutionalized school-based mental health education and training requirements (Colorado General Assembly, 2019).
- The Suicide Prevention Commission was extended for an additional decade, reinforcing long-term commitment (CDPHE, 2024).
- Youth mental health is integrated into both education and public health policy frameworks.
- Statutory clarity enables long-term planning and cross-system coordination.

Colorado has one of the most comprehensive statutory frameworks for suicide prevention.

Governance and Election Dynamics

- The Office of Suicide Prevention functions as a permanent coordinating entity across agencies (CDPHE, 2024).
- Collaboration spans Behavioral Health Administration (BHA), education systems, and local coalitions, supporting continuity across administrations.
- Annual legislative cycles are increasingly shaped by competing priorities such as housing and workforce (Colorado Health Institute, 2024).
- Budget constraints may limit expansion despite strong policy alignment.
- Election dynamics influence funding levels more than policy direction.

Leadership and Coalitions

- Executive leadership (CDPHE, OSP) anchors statewide coordination (CDPHE, 2024).
- Legislative champions consistently support prevention framed around public safety and education (Colorado General Assembly, 2019).
- Cross-sector collaboration is codified in statute and widely implemented (Colo. Rev. Stat. §25-1.5-112, 2024).
- Urban areas host dense coalition networks with strong institutional backing.
- Rural and frontier coalitions are more variable and dependent on key individuals (Colorado Rural Health Center, 2022).

Political Summary

Colorado's political environment provides a highly favorable foundation for youth mental health investment, with strong governance and bipartisan support. Future constraints are more likely to arise from fiscal pressures than from political opposition.

Economic Environment

Overview

Colorado's youth mental health system is supported by sustained investment and strong institutional capacity but remains structurally fragile due to reliance on federal funding, workforce shortages, and rising Medicaid costs (Colorado Office of Suicide Prevention [OSP], 2024; Colorado Springs Gazette, 2026). Economic conditions diverge sharply between urban and rural areas, shaping both cost structures and sustainability.

Population Density and Cost Structure

Dual economic systems: efficient urban delivery vs. high-cost rural provision.

- Urban areas benefit from economies of scale and higher service utilization (U.S. Census Bureau, 2023).
- Rural and frontier regions face high per-capita costs due to distance and low population density (HRSA, 2024).
- Fixed costs (transportation, broadband, staffing) remain high regardless of utilization levels.
- Geographic dispersion complicates workforce deployment and service coordination (USDA Economic Research Service [ERS], 2023).
- Cost structures vary significantly across regions, requiring differentiated financing approaches.

Existing and Emerging Investments

- OSP operates with a mixed funding base, with over half derived from federal grants (OSP, 2024).
- 988 system consolidation improved access but lacks a dedicated revenue stream (Behavioral Health Administration, 2025).
- Rural Health Transformation Program will inject >$200M in federal funds beginning in 2026 (HCPF, 2026).
- Investments prioritize access expansion rather than long-term sustainability.
- Federal funding dominates both innovation and system maintenance.

Education-Linked Mental Health Funding

- Federal grants support school-based mental health staffing and training (Colorado Department of Education, 2024).
- Programs like Project AWARE expand access but operate outside core funding formulas (BHA, 2026).
- Schools function as primary access points for youth services.
- Rural districts face higher per-student costs due to small enrollments and geographic dispersion.
- Funding instability creates vulnerability to program discontinuation.

Funding Sources and Fiscal Resilience

Diverse funding streams exist but lack stability.

- System relies on state funds, federal grants, Medicaid, and limited philanthropy (OSP, 2024; Suicide Prevention Resource Center [SPRC], 2026).
- Medicaid behavioral health costs are increasing, driving budget pressures and constraining long-term sustainability efforts (Colorado Springs Gazette, 2026).
- Estimated $850M–$1B state budget shortfall constrains future investment.
- Rural and frontier funding depends on federal designation-based subsidies (HRSA, 2024).
- Fiscal resilience is uneven and vulnerable to policy and economic shifts.

Economic Summary

Colorado's economic environment supports robust youth mental health infrastructure but remains vulnerable due to funding instability and rising costs. Sustainable financing will require alignment with geographic cost realities and reduced reliance on federal grants.

Social Environment

Overview

Colorado's social environment reflects improving youth mental health trends alongside persistent disparities across geography and population groups (CDPHE, 2025). While overall indicators show progress since 2020, rural, frontier, and LGBTQ+ populations continue to experience elevated risk.

Behavioral Health Indicators

Statewide improvement masks persistent geographic disparities.

- Youth suicide rates have declined significantly since a peak in 2020 (CDPHE, 2025).
- Rural and frontier counties consistently report higher suicide rates than urban areas (CDPHE, 2024).
- Firearm-related suicides are more common in rural areas (Colorado Health Institute, 2021).
- Geographic disparities remain a defining feature of risk distribution.

Student and Youth Experience

- Healthy Kids Colorado Survey shows declines in sadness, ideation, and planning (Colorado Rare Disease Advisory Council, 2024).
- Table 5 shows three relevant questions from the Colorado Healthy Kids Survey examining differentiation in responses between students living in urban, rural, and frontier counties.

Table 5. Select Questions from the Colorado Healthy Kids Survey Broken out by Health Statistics Regions.

Health Measure	State Average	Notable Discrepancies	Urbanicity
Percentage of students who attempted suicide one or more times during the past 12 months	5.5%	Region 7: 7.1%	Rural and Frontier
		Region 9: 8.0%	Rural and Frontier
		Region 13: 6.5%	Rural and Frontier
		Region 17: 10.1%	Rural, Frontier, Urban
Percentage of students who seriously considered attempting suicide during the past 12 months	11.1%	Region 7: 13.9%	Rural and Frontier
		Region 9: 16.2%	Rural and Frontier
		Region 11: 12.9%	Rural and Frontier
		Region 17: 16.4%	Rural, Frontier, Urban
Percentage of students who would contact a crisis line if they were concerned about their own or someone else's well-being or mental health	22.9%	Region 6: 19.3%	Rural and Frontier
		Region 8: 14.1%	Rural and Frontier
		Region 9: 19.7%	Rural and Frontier
		Region 14: 19.4%	Urban
		Region 17: 19.9%	Rural, Frontier, Urban

- LGBTQ+ youth report substantially higher rates of suicidal ideation.
- Regional variation shows higher risk in rural/frontier areas.
- Crisis line willingness varies significantly by region.
- Postsecondary data indicate ongoing mental health challenges among college students (Colorado College, 2021). Key findings from the Healthy Minds Survey demonstrate these trends (Table 6).

Table 6. Select Items from the Healthy Minds Survey, Colorado College, 2021

Measure	Percentage of Students
Overall depression, including major and moderate	39%
Suicidal ideation in the past year	15%
Non-suicidal self-injury in the past year	35%
Perceived public stigma: agrees with “Most people would think less of someone who has received mental health treatment”	25%

(Colorado College, 2021)

- The Jed Foundation's JED Campus initiative is active on the Aims Community College and Colorado State University Campuses.

Stigma, Norms, and Help-Seeking

- Stigma is particularly pronounced in rural and faith-based communities (Health Management Associates, 2018).
- LGBTQ+ youth face barriers due to community-level stigma, particularly in certain faith-based organizations (Health Management Associates, 2018).
- Rural norms emphasizing self-reliance may discourage help-seeking.
- 988 usage is high, with over 30,000 calls in early 2026.
- Crisis centers are disproportionately located in urban areas, limiting access elsewhere.

Workforce and Demographic Trends

- Colorado faces a projected shortage of over 4,400 mental health workers (Colorado Rural Health Center, 2025).
- Shortages are most severe in rural and frontier areas.
- Some evidence suggests stabilization due to recent investments (Colorado Evaluation and Action Lab, 2026).
- Provider distribution remains uneven across regions.
- Workforce capacity directly limits service access and expansion.

Workforce shortages remain a critical constraint despite recent investments.

Social Summary

Colorado's social environment reflects meaningful progress alongside persistent disparities in risk and access. Addressing geographic and demographic inequities remains central to improving outcomes.

Technological Environment

Overview

Colorado has one of the most advanced youth mental health technology ecosystems in the region, supported by strong legislative action and system integration (Table 7). Technology plays a central role in crisis response, service delivery, and prevention, though disparities in access and utilization remain.

Crisis Infrastructure

- 988 Colorado provides statewide crisis response with over 364,000 calls in its first year.
- Safe2Tell operates as a long-standing anonymous reporting system for youth.
- Crisis systems are integrated across call, text, and mobile response.

- Youth and young adults represent a significant share of utilization.
- Crisis infrastructure is among the most mature nationally.

Access and Service Delivery

Innovative service models expand access, particularly through telehealth.

- I Matter provides free therapy sessions to youth statewide.
- Second Wind Fund supports specialized suicide prevention therapy.
- Telehealth providers (e.g., Hazel Health) expand school-based access.
- Children's Hospital Colorado provides high-volume specialized care.
- Access models prioritize scalability and early intervention.

Digital Interventions and Knowledge

- Sources of Strength is implemented in 250+ schools with strong RCT evidence.
- Training programs support pediatricians and providers statewide.
- Digital campaigns (e.g., Man Therapy) show evidence of effectiveness.
- Programs emphasize prevention, resilience, and early identification.
- Colorado leads in integrating evidence-based interventions into systems.

Evidence-based programs are widely deployed and evaluated.

Administrative and System Infrastructure

- Behavioral Health Administration serves as the central coordinating body.
- Office of School Safety supports bullying and digital safety efforts.
- Youth Mental Health Corps expands workforce through peer support roles.
- Healthy Kids Colorado Survey provides statewide data infrastructure.
- Systems emphasize integration across agencies and service domains.

Table 7. Colorado technology resource matrix

Technology	Domain	Age	URL	Evidence	Scale
I Matter	Access / Service Delivery	≤18 (≤21 SpEd)	imattercolorado.org	Evidence (Butler/DU program evaluation, not RCT)	10,899 youth; 50,000+ sessions
Safe2Tell	Crisis / Cyberbullying	K-12	safe2tell.org	Deployed-only (20-yr AG reports)	31,177 reports (2024-25)

Technology	Domain	Age	URL	Evidence	Scale
988 Colorado	Crisis	All (14% 18-25)	988colorado.com	Deployed-only	364,213+ calls Yr1
Below the Surface	Crisis / Knowledge	Teens	coloradocrisisservices.org/below-the-surface	Deployed-only	Statewide
Second Wind Fund	Service Delivery	≤19	thesecondwindfund.org	Deployed-only	10,000+ youth since 2002
Sources of Strength (CO)	Digital Intervention / Knowledge	11-18	sourcesofstrength.org	Strong RCT evidence (Wyman 2010, 2023, 2025 - 29% ↓ attempts)	250+ CO schools
Hazel Health	Service Delivery	K-12	hazel.co	Program evaluation (Clemson)	Multi-district (Aurora, Jeffco)
Children's CO Pediatric MH Institute	Service Delivery	0-18	childrenscolorado.org/psych	Program research	14,400 pts (2025)
Partners for Children's MH	Knowledge / Toolkits	Provider-facing	pcmh.org	Deployed-only	700+ pediatricians
Mental Health CO School Toolkit	Toolkits	K-12	cde.state.co.us/healthandwellness/mhrb/schoolmentalhealthtoolkit	Deployed-only	Statewide
CO School-Based Health Centers	Service Delivery / Access	5-21	cdphe.colorado.gov/sbhc	Deployed-only (nat'l SBHC evidence)	~72 SBHCs
CO Follow-Up Project	Service Delivery	Incl. ≤19	cdphe.colorado.gov/suicide-prevention	Deployed-only	28,000+ follow-ups, 80 hospitals
CO Office of School Safety	Administrative / Cyberbullying	K-12	oss.colorado.gov	Deployed-only	Statewide

Technology	Domain	Age	URL	Evidence	Scale
Man Therapy	Digital Intervention	18-54	mantherapy.org	RCT evidence (Mohatt 2023)	National; CDPHE-originated
CO Youth Mental Health Corps	Service Delivery	18-24	servecolorado.colorado.gov/ymhc	Deployed-only	Statewide 2024+

Technological Summary

Colorado's technological environment provides a robust and integrated foundation for youth mental health services. Continued focus on equitable access and workforce alignment will be critical to maximizing impact.

Youth Mental Health and Suicide Prevention PEST Analysis – Utah

Utah PEST Analysis Overview

Key Political Implications

Strong Policy Infrastructure: Statutory and administrative systems provide foundation for prevention and coordination.

Low Political Risk Environment: Bipartisan and cross-sector support ensures continuity and minimizes disruption across election cycles.

Capacity-Driven Variation: Differences in outcomes driven by local implementation capacity rather than political will.

Schools as Core Delivery Systems: Legislative mandates position schools at the center of prevention efforts statewide.

Sustainability as Primary Challenge: Long-term success depends on maintaining stable funding alongside strong governance structures.

Key Economic Implications

Relatively Strong Funding Base: Utah's use of ongoing appropriations for crisis services provides greater stability than many peer states.

Urban-Rural Cost Divide: Service delivery costs vary widely, requiring differentiated financing models.

Medicaid as a Key Driver: Growth in behavioral health utilization is increasing fiscal pressure on the system.

School Funding Vulnerability: Education-linked mental health programs remain exposed to annual budget fluctuations.

Sustainability Challenges Ahead: Long-term stability depends on balancing growth, cost pressures, and diversified funding sources.

Key Social Implications

High Youth Need: Suicide and self-harm remain major drivers of demand for services.

Improving Trends with Persistent Risk: Some indicators are improving, but underlying need remains substantial.

Stigma as a Barrier: Social norms continue to limit help-seeking, especially among youth.

Strong Awareness Infrastructure: Programs like SafeUT provide effective entry points into care.

Workforce Constraints: Limited provider availability continues to restrict access and scalability.

Key Technological Implications

Highly Developed Technology Ecosystem: Utah's integration of crisis, school, and digital systems is among the most advanced in the region.

Strong Crisis Access: SafeUT and 988 provide widely accessible, high-utilization crisis entry points.

Effective School Integration: Technology is embedded into school-based prevention and response systems.

Expanding Telehealth Capacity: Digital tools are improving access, particularly in rural areas.

Evaluation Gaps Remain: Some programs lack rigorous outcome evaluation despite strong adoption.

Political Environment

Overview

Utah's political environment for youth mental health and suicide prevention is highly established and strongly enabling, with institutionalized policy frameworks, sustained legislative engagement, and stable cross-sector coordination (Utah State Board of Education [USBE], 2026; Suicide Prevention Resource Center [SPRC], 2025). While political risk is low, implementation challenges remain tied to geographic variation in capacity and long-term funding sustainability.

Statewide Political Contextd3

- Suicide prevention is explicitly prioritized as both a public health and education issue within state policy frameworks (USBE, 2026; SPRC, 2025).
- High suicide rates have driven sustained legislative and administrative action across multiple systems (SPRC, 2025).
- Cross-sector coordination is embedded across public health, education, and community systems.
- Permanent administrative structures support continuity across administrations.
- Political opposition to prevention-focused initiatives is minimal.

Urban, Rural, Frontier Variability

Geographic variation reflects differences in capacity rather than political support.

- Urban counties benefit from proximity to state agencies and early access to pilot initiatives (Utah Department of Health [UDOH], 2021).
- Strong administrative infrastructure supports rapid implementation in urban areas.
- Rural counties emphasize flexibility and local adaptation of statewide initiatives (Utah Association of Counties, 2025).
- Frontier counties depend heavily on state-directed systems due to limited local infrastructure (UDOH, 2021).
- All regions share alignment with state priorities despite differing implementation capacity.

Policy and Legislative Context

- The State Suicide Prevention Plan (2022–2026) provides a public health–oriented framework for prevention and intervention (Utah Suicide Prevention Coalition, 2022).
- Utah Code §53G-9702 mandates comprehensive school-based suicide prevention programming (Utah Code §53G9702, 2024).
- Ongoing professional development for school staff is required under statute (Utah Code §53G9704, 2024).

- Schools are positioned as primary prevention environments statewide.
- Policies prioritize integrated, system-wide responsibility across sectors.

Governance and Election Dynamics

- Governance is coordinated through the Utah Department of Health and Human Services [UDHHS] and USBE, ensuring alignment between policy and implementation (SPRC, 2025; USBE, 2026).
- Dedicated suicide prevention coordinators support system integration.
- Legislative support has remained stable across election cycles.
- Utah has not enacted restrictive policies limiting youth access to care, unlike some peer states.
- Continued reliance on current funding sources (e.g., state appropriations, federal grants) introduces long-term sustainability considerations.

Centralized governance enables consistency, but funding remains a long-term consideration.

Leadership and Coalitions

- The Utah Suicide Prevention Coalition convenes cross-sector stakeholders statewide (Utah Suicide Prevention Coalition, 2022).
- Hope Squad represents a nationally recognized, Utah-origin prevention model (Hope4Utah, 2026).
- Coalition engagement spans public health, education, nonprofits, and community organizations (SPRC, 2025).
- Urban areas host the strongest coalition networks.
- Rural and frontier coalitions are more variable and dependent on individual leaders.

Political Summary

Utah's political environment provides a highly favorable and stable foundation for youth mental health and suicide prevention efforts. Future challenges are less about policy alignment and more about ensuring equitable implementation and sustainable funding across diverse local contexts.

Economic Environment

Overview

Utah's youth mental health system benefits from relatively stable state investment and early adoption of crisis system funding, but faces growing fiscal pressure from population growth, Medicaid costs, and workforce constraints (Utah Legislature, 2024; Deseret News, 2026). These pressures are amplified by stark urban–rural differences in cost structures and service delivery needs.

Population Density and Cost Structure

- Nearly 90% of residents live in the Wasatch Front corridor, enabling efficient service delivery (U.S. Census Bureau, 2023; Kem C. Gardner Policy Institute, 2024).
- Rural and frontier regions face higher per-capita costs due to low population density (Health Resources and Services Administration [HRSA], 2024).
- Fixed costs (transportation, workforce coverage, infrastructure) remain high across low-density areas.
- Geographic dispersion creates challenges for workforce deployment and service access (USDA Economic Research Service [ERS], 2023).
- Economic conditions vary significantly across regions, requiring differentiated strategies.

Existing and Emerging Investments

Utah has made strong state investments, particularly in crisis systems.

- The state appropriated approximately $17.8 million for crisis response systems, including 988 and mobile crisis services (Utah Legislature, 2024).
- Early adoption of 988 has supported high in-state response capacity.
- Infrastructure is anchored within Utah Department of Health and Human Services [UDHHS] and the Office of Substance Use and Mental Health.
- Federal funding and Medicaid remain critical for system expansion (UDHHS, 2023).
- Planned expansions remain sensitive to reimbursement and federal funding variability.

Education-Linked Mental Health Funding

- Schools serve as a primary delivery system for youth mental health supports (USBE, 2023).
- Project AWARE and similar programs provide targeted infrastructure support (SAMHSA, 2022).
- Funding is largely supplemental and not embedded in school finance formulas.
- Legislative scrutiny has increased as budget pressures grow (Deseret News, 2026).
- Rural districts face higher costs due to small populations and reliance on shared providers (Kem C. Gardner Policy Institute, 2024).

Funding Sources and Fiscal Resilience

- Funding sources include state appropriations, Medicaid, federal grants, and block funding (UDHHS, 2025).
- Medicaid plays a growing role in financing behavioral health services.
- Rising utilization has intensified budget pressures.

Mixed funding sources provide stability but increase long-term vulnerability.

- Rural funding depends heavily on federal designation-based eligibility (HRSA, 2024).
- Fiscal resilience varies based on geography and service type.

Economic Summary

Utah's economic environment supports strong youth mental health infrastructure but faces increasing fiscal pressures tied to growth and cost dynamics. Long-term sustainability will require balancing stable state investment with innovative financing approaches that reflect geographic realities.

Social Environment

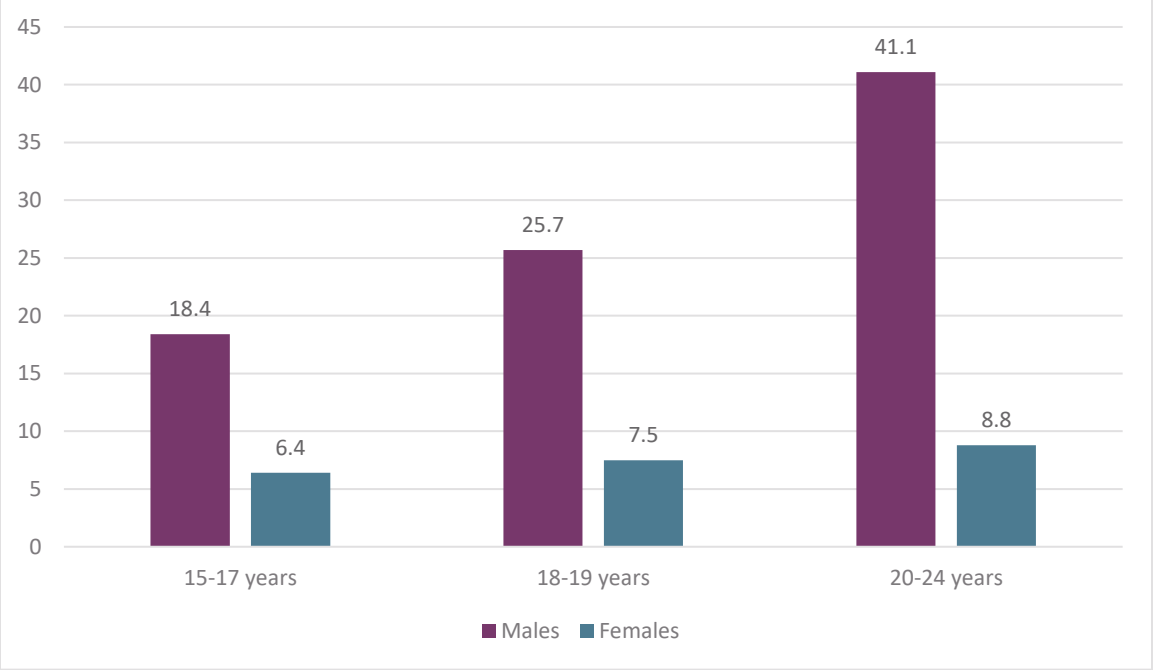
Overview

Utah's social environment reflects high levels of youth mental health need, particularly among adolescents, alongside recent improvements in some behavioral health indicators. Persistent challenges include stigma, workforce shortages, and disparities in help-seeking and access (UDHHS; Weber, 2024).

Behavioral Health Indicators

- Suicide is a leading cause of death among youth aged 10–24 in Utah (see Figure 7; UDHHS, 2024).
- Males experience substantially higher suicide rates than females.

Figure 7. Suicide by Age Group and Sex, 2021-2023, per 100,000 Population



Source: Utah Department of Health and Human Services

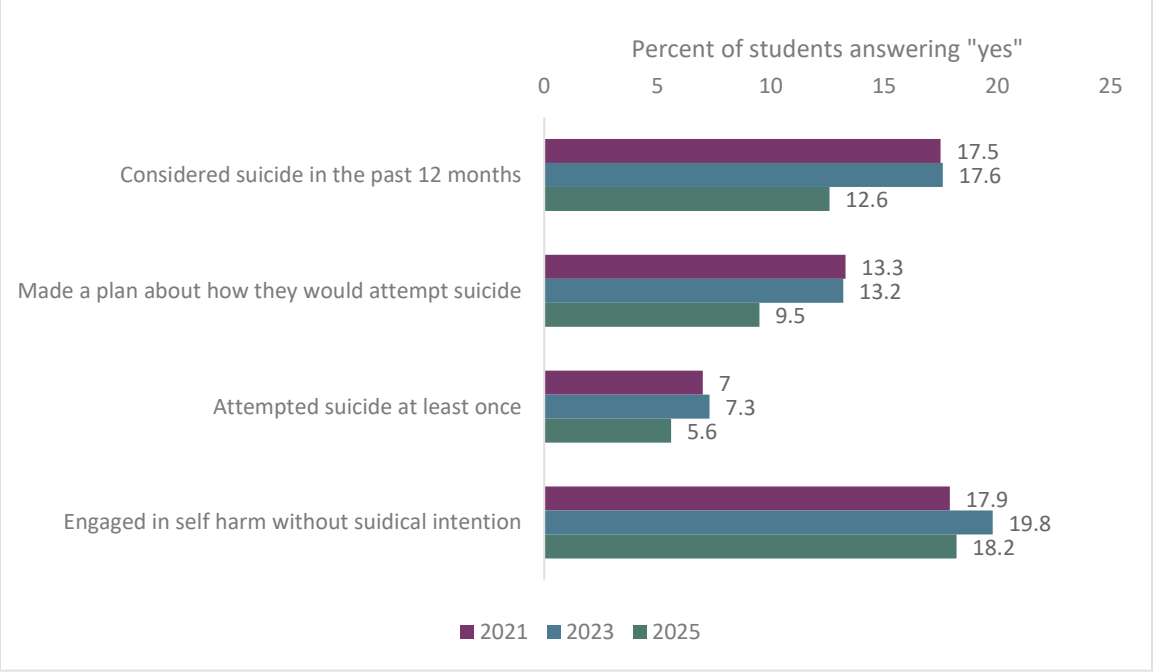
- Firearms are the leading method of suicide across youth and young adults.
- Youth account for a majority of self-harm hospitalizations (Utah Department of Health and Human Services, n.d.).
- Trends reflect persistent need despite prevention efforts.

Student and Youth Experience

Youth mental health indicators are improving, but self-harm remains elevated.

- Suicidal ideation and attempts have declined since 2023 (see Figure 8; Utah Department of Health and Human Services, 2025).

Figure 8. Select Items from the Utah Prevention Needs Assessment Survey, 2021, 2023, and 2025



Source: Utah Department of Health and Human Services

- Self-harm without suicidal intent remains relatively stable.
- Postsecondary students report high levels of distress and mental health challenges (Brown, 2019).
- Students frequently report feelings of loneliness, sadness, and overwhelm.
- Disparities persist across populations and age groups.

Stigma, Norms, and Help-Seeking

- Many youth report difficulty discussing mental health with adults (Weber, 2024).
- Peer-led models like Hope Squad aim to reduce stigma and increase awareness.

- SafeUT provides a statewide confidential platform for crisis support and reporting (Huntsman Mental Health Institute, 2025).
- Over 1.9 million individuals have access to SafeUT services.
- Usage data indicate high demand for crisis intervention and early warning systems.

Stigma continues to limit help-seeking, despite strong awareness systems.

Workforce and Demographic Trends

- Utah has one of the highest student-to-counselor ratios (~500:1) (Alberty & Contreras, 2024).
- Mental health professional supply remains below recommended levels.
- Legislative action has begun addressing workforce shortages (Utah Legislature, 2023).
- Rural training programs are emerging to address geographic gaps.
- Workforce capacity remains a limiting factor for system expansion.

Social Summary

Utah's social environment reflects both progress and persistent challenges in youth mental health. Addressing stigma and workforce capacity will be critical to translating improved indicators into sustained outcomes.

Technological Environment

Overview

Utah's technological environment is highly developed, with strong integration of crisis response systems, school-based programs, and digital platforms supporting youth mental health (Table 8). Technology plays a central role in access, early intervention, and system coordination, though gaps remain in evaluation and rural reach.

Crisis Infrastructure (SafeUT & 988)

- SafeUT provides 24/7 crisis chat, tip reporting, and counselor engagement statewide (Huntsman Mental Health Institute, 2025).
- Over 1.9 million individuals have accessed SafeUT services (Huntsman Mental Health Institute, 2025.
- 988 Utah handles high call volumes with strong in-state response rates.
- Integrated systems enable rapid response and emergency intervention.
- Data demonstrate high utilization across both K–12 and higher education.

Utah has a nationally recognized, technology-driven crisis response system.

School-Based and Peer Models

- HOPE Squad is widely implemented and supported by peer-reviewed research (Hope4Utah, 2026).
- Programs focus on peer identification and early intervention.
- School-based prevention systems are integrated with state policy mandates.
- Peer-led approaches reduce stigma and improve help-seeking.
- Models like HOPE Squad and SafeUT that were developed in Utah have scaled nationally.

Clinical, Telehealth, and Crisis Services

- Huntsman Mental Health Institute Youth Crisis Care programs provide 24/7 stabilization services (Brandt, 2025).
- Intermountain telehealth and mobile response systems extend reach to rural areas.
- School-based telehealth improves continuity of care and reduces instructional disruptions.
- Pediatric behavioral health demand has increased significantly.
- Infrastructure supports acute and long-term service delivery.

Clinical and telehealth systems expand access across the state.

Administrative and Digital Ecosystem

- UDHHS oversees multiple youth-focused behavioral health programs.
- Programs include YESS, Project AWARE, and Healthy Minds Utah.
- Digital screening and referral tools support early identification.
- Public awareness campaigns (Live On Utah) extend prevention messaging.
- System emphasizes coordination across treatment, prevention, and data systems.

Table 8. Utah technology resource matrix

Technology	Domain	Age	URL	Evidence	Scale
SafeUT app	Crisis / Cyberbullying	K-12 + higher ed	safeut.org	Peer-reviewed (Rothwell 2025; Frontiers Psych 2023)	1.9M covered; 499 emergency interventions; 24K+ chats FY25
SafeUT Frontline / NG	Crisis	First responders / NG	safeut.org	Operational data	368 Frontline chats FY24
988 Utah / Lifeline	Crisis	All	988.utah.gov	Deployed + operational	~115K calls FY25, 92% in-state

Technology	Domain	Age	URL	Evidence	Scale
HOPE Squad	School Peer Gatekeeper	Gr 4-12	hopesquad.com	Peer-reviewed (Wright-Berryman 2018/2019/2022)	2,500+ schools; 41 UT districts
HMHI Youth Crisis Care	Crisis / Service Delivery	5-17(18)	healthcare.utah.edu/hmhi	Operational (new July 2025)	12-bed 24/7
Intermountain Primary Children's BH (Lehi 12-bed; Taylorsville)	Service Delivery	0-18	intermountainhealthcare.org/childrens-health/behavioral-health	Operational	Regional capacity
Intermountain SMR (telehealth mobile crisis)	Crisis / Service Delivery	Youth	Primary Children's SMR line 1-833-SAFE-FAM	Operational	15 of 29 counties
Intermountain School-Based Telehealth	Service Delivery	K-12	intermountainhealthcare.org	Program data (96% return-to-class)	15,000 school-days saved Yr1
Live On Utah	Knowledge / Toolkits	All (youth-tailored)	liveonutah.org	Reach metrics only	20K+ trained
DHHS SUMH YESS / UYHP / Project AWARE	Service Delivery	10-26	sumh.utah.gov/services/treatment/child-mental-health	Programmatic (SAMHSA-funded)	Grant scale
CALL-UP psych consult line	Access	Provider-facing	sumh.utah.gov	Deployed	Statewide
Healthy Minds Utah screening	Digital Intervention / Access	All youth	sumh.utah.gov	Deployed	Statewide

Technological Summary

Utah's technological environment provides a highly integrated and accessible system for youth mental health and crisis response. Continued progress will depend on strengthening evaluation and ensuring equitable access across geographic regions.

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