NEW YORK STATE

Governor Andrew M. Cuomo

New York State Suicide Prevention Task Force Report

Communities United for a Suicide Free New York

April 2019

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Preface

Governor Andrew M. Cuomo initiated The New York State Suicide Prevention Task Force following the announcement in the 2017 State of the State address. It was formed in November of 2017.

The Task Force convened a diverse group of experts to review current services and policies, identify gaps and promising solutions, and make recommendations to facilitate greater access, awareness, collaboration and support of effective suicide prevention activities. The Task Force divided its work into three work groups: Youth and Families, Adults, and Data Systems. In recognition of differential risks within specific populations, the Task Force also focused on three higher risk cohorts, and enlisted the participation of culturally competent topic experts in those areas: Latina youth, LGBTQ, and veterans.

The Task Force urges the Governor to launch a New York State initiative – Communities United for a Suicide Free New York – to unify activities and jump-start progress to reduce suicides. The Task Force recommendations will strengthen local communities' capacity, with New York State support, to provide the most effective suicide prevention practices and build more connected, resilient communities. Competent communities are essential to address powerful differences in local risk factors and tailor programming to address local needs and populations at risk, including supporting families and individuals experiencing specific economic adversities (e.g., upstate dairy farmers, displaced city cab drivers). The recommendations of the Task Force span four domains: (1) Foundations for Public Health Suicide Prevention Approaches, (2) Health System Competencies and Pathways to Care, (3) Surveillance Data Methods/Tools, and (4) Infusion of Cultural Competence Throughout Suicide Prevention Activities. The Task Force suggests that this initiative be launched to inspire State and local groups and convey the necessity of comprehensive, unified prevention activities to make progress toward the aspirational goal of a suicide free New York.

Acknowledgements

The work of suicide prevention cannot be fully summarized in a report or encapsulated within a single task force. Suicide prevention begins in the hearts and minds of all those touched by its effects, and it occurs through coordinated efforts among community members. This task force was assembled to strengthen those efforts, specifically by determining how elements of state and local government, providers, clinicians, families, and individuals can work together to get closer to the aspirational goal of zero suicides.

The Task Force would like to acknowledge formally those that gave their time to this effort, whose tireless, daily work promotes suicide prevention. The Task Force recognizes that success will only be found when all of us are united, educated, and fully engaged in addressing this critical issue, with unwavering attentiveness to the unique challenges and disparities that individuals experience across our state.

Task Force Membership*

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The Voice of a Suicide-Attempt Survivor

by **Misha Kessler**

“In 2011, as a university student in Washington, D.C., I was in the midst of a severe depressive episode. Each new day brought new evidence that, in my self-imposed isolation, I was unloved, unwanted, and unworthy. In my mind, I was worse than useless, because I was actively burdening those around me. Week after week, month after month, as I failed to “choose” happiness over sadness, to "choose" strength over weakness, I spiraled into hopelessness.

In my depressed mind, I decided that my only sensible option was to remove myself from the equation. In the midst of my suicide attempt, I thought of my friends; my depressed mind questioned, “What friends?” I thought of my family; my depressed mind told me I would be doing them a favor by freeing them of my presence.

Too often, this is what the conversation about suicide misses. To an individual who can only feel despair– to someone who is convinced that they are unworthy of life– suicide is a solution. To someone who has never experienced it, it is unthinkable, but when chronic emotional pain becomes all that one feels, options dwindle and desperation prevails.

Treatment and crisis intervention is often faced with a challenge of confronting something that simultaneously may be considered irrational– the individual's misperceptions about themselves– and rational– the individual's desperate search for a solution. This requires that mental health professionals seek new ways to directly and humanely engage, intervene, and guide individuals onto their unique recovery path. It necessitates the creation and expansion of personalized crisis services that meet the individual 'where they stand.'

Ultimately, I lived through my attempt because I found myself in an adequate, consistent, unified crisis care system– a system that helped transition me from my active crisis, to intervention, to recovery, to routine care, with follow-up from caring and communicative providers.

However, I only began my healing once I was financially able to pursue costly services. I only grew in my resilience when I found a therapist who valued treatment personalization and our treatment alliance. I only thrived once I actively sought- and was graciously met with- unceasing empathy from the support networks which orbited my recovery.

We are faced with a moral imperative: If we are to save lives, we must consider the barriers to care which often go unaddressed. We must find new ways to reach out to individuals who desperately seek solutions for their struggles. We must provide the solutions that they seek, in ways that address and circumvent those barriers. This is how we will reach our goal of Zero Suicide.”

Executive Summary

Recent Trends & the Need for Action

Suicides have increased significantly across the United States, including in New York State. In June 2017, the Centers for Disease Control released a disturbing report (Stone D, et al. 2018) revealing the extent of these trends. In the first 15 years of this century, suicide rates in the U.S. population increased by 27.5%.[1] Over that period, these increases were seen across all age groups and genders (with the exception of men ages 75 or older). New York State was no exception to the national trend, with state suicide rates increasing 29.1% from 1999 to 2016.[2]

Although New York State has one of the lowest per capita rates in the nation, we have one of the highest overall losses of life due to our large population, losing approximately 1,700 New Yorkers each year to suicide. These trends indicate an urgent need to strengthen and extend suicide prevention programming.

Nationally, during a period when many leading causes of early death are decreasing (i.e., cancer, heart disease, motor vehicle accidents), suicide rates began increasing in the early 2000s and accelerated with the Great Recession of 2008.[3] While suicides have increased among youth and young adults, the largest increases have occurred among men and women in the middle years (i.e., ages 35 – 64), with information from national data sources[4] revealing correlations between suicide in middle life and co-occurring financial, familial, and physical health challenges.

Paralleling national trends, suicides among New Yorkers have increased markedly during the Great Recession. Suicide rates are higher in regions experiencing long-term challenges that adversely affect individuals, families, and communities, for example, job growth stagnation and loss of wages. Those effects become apparent when comparing the rates and means of suicide deaths between nonmetropolitan and metropolitan areas. Whereas metropolitan regions of New York State saw rate increases of 27.9% from 1999 until 2012, slightly decreasing thereafter, nonmetropolitan regions have seen continued rate increases, reaching a high in 2016.[5] However, the overall burden of suicide in terms of total lives lost remains higher in the population-dense New York City metropolitan area.

Further analysis reveals concerning trends regarding sub-populations and at-risk communities. For example, suicide rates in 2016 were highest among individuals 50 – 54 years of age (13.0 per 100,000), yet this age group has received relatively little focus in suicide prevention. Other communities including LGBTQ, Latina females, veterans, city cab drivers, and farmers all experience specific and unique challenges related to suicide and suicidal behavior. Finally, while our focus remains on suicide, opiate-related deaths have surged in tandem with suicide deaths across New York State since 2000, representing a crisis in loss of life and an imperative to action in our communities.

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[1] From 10.4 per 100,000 to 13.26 per 100,000, age-adjusted. CDC WISQARS 2018

[2] From 6.26 to 8.08 per 100,000. CDC WISQARS 2018

[3] CDC WISQARS 2018

[4] The National Violent Death Reporting System

[5] In 2016, suicides in nonmetropolitan regions reached a high of 13.46 per 100,000 population. CDC WISQARS 2018

Ultimately, these trends demonstrate the fundamental interconnectedness of suicide with economic and social challenges, alongside mental health and substance use problems. Mindful of these trends, the Task Force sought to identify opportunities for synergies in prevention activities, such as the opportunity to apply lessons-learned from the opiate crisis, as well as the inclusion and promotion of perspectives from across New York State's many varied and diverse sub-populations. These opportunities illustrated a need for new strategies and approaches that tailor their efforts to account for economic, social, and cultural factors of suicide risk. This report affirms the need to engage diverse partners across New York State in our mission to strengthen suicide prevention efforts.

Task Force: Members, Mission, and Process

The Task Force brought together a diverse group of stakeholders to ensure broad representation across sectors involved in suicide prevention activities. The Task Force members included representatives from state and local government, non-profits, providers, advocates, individuals with lived experience, and academics. In recognition of powerful social and cultural factors that create differential risks within specific populations, the Task Force also focused on three higher risk cohorts, and enlisted the participation of culturally competent topic experts in those areas: Latina adolescents, LGBTQ, and veterans. This list of subgroups is by no means exhaustive, and other sub-populations at elevated risk are worthy of additional focus.

It became clear that virtually every member of the Task Force, if not all, had been personally impacted by the suicide of a family member or close affiliate.

A profound moment in the work of the Task Force occurred during initial introductions, when it became clear that virtually every member, if not all, had been personally impacted by the suicide of a family member or close affiliate. This moment served to underscore the broad impact of suicide across our communities (despite relatively low frequency) and forged a shared commitment to the Task Force mission and work.

The charge to the Task Force was to enhance the efforts of the New York State Suicide Prevention Plan by (a) examining current programs, services, and policies related to suicide prevention and identifying gaps; (b) making recommendations to facilitate greater access, awareness, collaboration and support of effective suicide prevention activities.

Key Themes in the Task Force Recommendations

The recommendations of the Task Force are structured along four domains, which are briefly summarized below.

Domain 1: Strengthen Foundations for Public Health Suicide Prevention Approaches

This is a critical component to drive and support progress in suicide prevention. Systematic use of public health prevention approaches has been shown to reduce numerous major health problems, such as infectious diseases. Several communities across the state have effectively applied elements of public health prevention to address local suicide prevention needs, such as monitoring suicide deaths and self-harm using local surveillance data and proactively extending services to at-risk groups and formulating long-term prevention planning.

A public health prevention approach also uses strategically-focused interventions to reduce defined risk factors while strengthening protective factors. Research has shown that high quality prevention programs that reduce risk factors linked to suicidal behavior (e.g., substance use; early school problems) also reduce the likelihood of suicidal behavior. More work is needed to prepare local communities with resources and expertise to assess their local needs, identify and implement research-informed prevention programs. Several Task Force recommendations are designed to jump-start State and community actions to facilitate the implementation of comprehensive public health prevention initiatives using established best practices. The following is a summary of recommendations to be explored further in this report pertaining to the strengthening of foundations for a public health suicide prevention approach.

1. **The State Will Create a Regional Suicide Prevention Framework -** Adapt the public health prevention approach to inform core elements of a framework that emphasizes the collaboration of local government agencies, with support from the Office of Mental Health (OMH) and the Suicide Prevention Center of New York State (SPCNY). The framework would include the following components:
    - Each region to use local data to identify community-specific prevention needs, create workgroups to identify specific needs of sub-populations at risk, and create a coordinated “real-time” outreach system consisting of key partners such as law enforcement, emergency departments, and mobile crisis response.
    - Leveraging the new NYS Health Connector Suicide and Self-Harm Dashboard to pilot data review, identify trends, target resources, and share examples of a successful collaboration-review process. This new resource assembles the most relevant data for suicide prevention at one website, broken down by county across New York State
    - Establishment of a regional advisory group in which local county leaders could engage local partners in building active suicide prevention coalitions. By adopting this framework, local communities would have the opportunity to receive a NYS designation as a **Communities United to Prevent Suicide Partner.**
2. **The Task Force Recommends Strategic Investment in Research-Informed Prevention Programs Targeting Risk and Protective Factors -** Issues such as the reduction of bullying, cyberbullying, and interpersonal violence are best addressed through programming that builds positive climates in schools and other community settings that increase social connectedness, help-seeking skills, and emotional regulation. To address the urgent need for prevention programs that build adult coping skills and social connectedness, the Task Force recommends that the New York State Suicide Prevention Council monitor research and new programs to identify candidates for pilot work such as that being performed at New York based universities.

3. **The Office of Mental Health (OMH) Will Develop a Suicide Prevention Training to be Completed by All State Employees –** As one of the mandatory trainings administered through the Statewide Learning Management System (SLMS), the training would provide information on how to recognize signs of depression and distress as well as how to respond toward the goal of creating safer work places and neighborhoods. As we create a stronger public suicide prevention response, a vital component is the community at large. Engaging individual community members is our avenue toward truly creating a suicide free New York. The training could be subsequently offered to counties and local communities to be shared with the wider workforce.
4. **The State Should Convene an Inter-Agency Workgroup to Coordinate Broader Prevention Approaches to Address Suicide and Opioid Overdose Deaths –** Given the enormous amount of premature mortality associated with suicide and opioid overdose deaths, State agencies should identify steps to advance synergistic prevention activities. State and Local Government should consider the possibility of "braided" funding as an alternative to what has historically been siloed funding to identify more efficient and broader reaching prevention approaches.

Domain 2: Build Health System Competencies and Pathways to Care

Supporting health and behavioral healthcare providers in the adoption of a systematic approach to suicide prevention – sometimes referred to as the Zero Suicide model – across New York State communities is key to reducing suicide rates. In addition to promoting access to services, support for providers and healthcare systems to effectively identify those at risk and to adopt and utilize the most effective treatments can advance suicide prevention efforts. Research supports the effectiveness of suicide specific treatments to reduce suicidal behavior, particularly among individuals at high risk for suicide. Task Force recommendations focus on strengthening pathways to care and building the competence of health care systems, including building on the nationally-recognized work led by OMH's Suicide Prevention Office. The following is a summary of recommendations to be explored further in this report pertaining to building health system competencies and pathways to care.

"She made me an appointment as quickly as she could, had me do a mental health assessment, and was refreshingly blunt with me about how serious the situation was. Not only was she not trying to handle me with kid gloves, she also was determined to get me help by offering me options/ ideas and asking which route I'd prefer versus what she recommended so we could meet in the middle."

Ashley Shoemaker, *on seeking help from a primary care physician*

5. **The State Should Encourage the Expanded Use of the "Zero Suicide Model" -** The OMH Suicide Prevention Office with assistance from State agencies, will provide regulatory technical assistance and support to health and behavioral healthcare providers in the adoption of systematic suicide safer care including the delivery of screening, increased detection, care pathways and follow-up monitoring for those at elevated risk through technical assistance, training, and implementation support.
6. **Localities Should Integrate Suicide Prevention into Comprehensive Crisis System planning -** As part of a comprehensive system review and service planning process with regions and localities to develop and enhance crisis systems now underway by OMH, and modeled after the "Crisis Now" approach, OMH will ensure that all county plans address suicide prevention services.
7. **Localities Should Identify and Share Core Elements of Best Practice Clinical Care for Suicide Specific Services Tailored to Age -** Localities will develop components and standards for clinical care for key constituent groups, drawing on specific examples of strong local programming provided through State technical assistance and support.
8. **The State Should Include Suicide Prevention as Part of the Governor's Transformation of the State's Medicaid System to a Value-Based Payment (VBP) Model -** VBP contemplates a change in reimbursement of health care services from a system that rewards volume to a system that rewards quality and improved outcomes. OMH should define what "value" means through coordination of expert recommendations and promoting the most effective services, ongoing performance measurement, and access. In addition, New York State should use this information to ensure reimbursement of the most critical and effective services.
9. **Focus on Increasing and Enhancing Suicide Prevention Core Competencies of All Healthcare and Support Services Workers -** To facilitate and increase the capacity of primary care settings, home health providers, emergency responders, and crisis workers to conduct evidence-based assessments of mental health problems and suicide risk along with appropriate response and follow-up. Training could be tailored to the needs of various providers and the populations served. Ongoing skill development to manage mild to moderate behavioral health needs in practices has the potential to reduce crises and smooth pathways to care.
10. **The State Will Provide Technical Assistance to Localities and develop a framework for community integrated programming responding to community specific needs -** Technical assistance would include guidelines that address both practical and ethical considerations in the development of collaboration and communication protocols which are so critical.

Domain 3: Improve Surveillance Methods/Tools and Access to Timely Data

The ability of New York communities to track regional trends in suicide deaths and related behaviors (e.g., suicide attempts, overdoses) is critical in implementing a high-quality public health prevention approach. For instance, several communities throughout the State have utilized data when responding to multiple suicides over a short time period and used that data to identify specific high-risk groups for follow-up and longer-term prevention programming. The ability to address these clusters underscores the importance of timely data for surveillance and planning. Unfortunately, current gaps in data availability are slowing local planning and suicide prevention efforts. In response, the Task Force offers a series of recommendations to improve availability and use of surveillance data.

Several exemplary suicide prevention activities ongoing in New York State are a product of a combined local and State initiatives. Many of these examples illustrate how communities can strengthen local prevention services, engage high-risk groups, and create strategic plans essential to build more connected and resilient communities. One essential role for local communities is identifying recent trends in suicide attempts and deaths to optimize services, fill gaps, and put in place policies and strategies to prevent future deaths. The following is a summary of recommendations to be explored further in this report pertaining to improving surveillance methods/tools and access to timely data.

11. **The State and Localities Should Work Together to Improve the Accuracy and Completeness of Core Suicide Surveillance Data Reporting -** To be done through providing support to the Offices of the Medical Examiner and County Coroner for death reporting and coordinated continuous Quality Improvement efforts to improve the accuracy and completeness of New York Violent Death Reporting data. Implement standards for classifying deaths and case investigation methods and reporting for underreported demographic data.
12. **The State Should Increase Access to Data that Informs State and Local Suicide Prevention -** This combined with supporting a culture of data-informed suicide prevention at the local level through the provision of a centralized clearinghouse in the form of an interactive "Suicide Dashboard" for the most relevant state and county-level suicide-related surveillance data.
13. **The State Should Improve Data Timeliness to Facilitate Both Rapid Emergency Response and Long-term Surveillance Efforts -** Support the use of a "near real-time data" surveillance system for communities and review current work flows for State suicide death reporting, including toxicology reporting, to make recommendations on reducing the data lag.
14. **The State Should Foster and Support Data Sharing Across the Datasets that are Most Relevant to Suicide Prevention -** Identify methods to allow sharing and linkage of records between agencies for public health surveillance. State agencies should move toward utilizing one universal reporting system for licensed providers to be used for tracking suicide attempts and deaths.

Domain 4: Infusion of Cultural Competence Throughout Suicide Prevention Activities

The need for cultural competence was acknowledged throughout the development of the Task Force recommendations, but as time passed, it became apparent that cultural competence stands on its own as a recommendation. Without consideration of the unique cultural and societal factors that impact suicidal behavior, we can't effectively develop the programs and resources needed to create a suicide free New York.

Competence to address the needs of New York State's diverse population is required across the full range of suicide prevention activities. In addition to tailoring services to address differences in race, gender, sexuality, and nationality, it includes competence of State agencies to differentiate programming needs of more rural and urban communities; competence within local coalitions to engage representatives of their diverse communities; recognition of the methods needed to reach each generation; and selection and tailoring of programming to suit needs of groups at elevated risk for suicide. As a starting-point, the Task Force conducted additional work focused on three sub-group populations: Latina Adolescents, LGBTQ community, and Veterans, and generated specific recommendations for each. This summary includes a sampling of those recommendations with the full list included later in the report.

15. **Incorporate the Use of Technology into Program Development and Design -** Input from diverse populations and generational cohorts indicates that technology can provide opportunities to bridge communication gaps and allow individuals to feel more connected. Identifying how technology can bridge those gaps, such as the development of mobile applications for crisis services as well as therapeutic and support services, should be increasingly explored.
16. **The State should incentivize improving the completeness of key demographic data for suicide deaths and attempts, including race/ethnicity, veteran, sexual minority status in administrative data sets -** This information is critical to the goal of reducing disparities.

"Shortly after my boyfriend died by suicide, I began to experience my own feelings of suicidal despair. I felt terribly guilty about those feelings, and the sense of failure and shame around my suicidality only served to contribute to my despair and my inability to reach out. I told very few people I was feeling this way.

At the time, I didn't understand that being a survivor of suicide loss puts a person at a higher risk for suicide themselves. I just thought there was something wrong with me and that I was disappointing all of my friends and family members.

Around this same time, I joined a private Facebook group for spouses and partners of those who have died by suicide. It's a large group, with close to 3000 members. I began to notice how common it was for us to feel suicidal ourselves. Seeing that helped me to understand that it was a symptom of our loss and our grief. Immediately, I identified and felt a great deal of empathy and compassion for the others who were suffering this same way. I wanted all of them to live through this loss, I wanted all of them to know that their lives mattered and they were needed in this world. I know for certain that this is part of how I began to learn to have empathy and compassion for myself, as well."

Chelise Stroud, *on how social media can be an important tool for those at risk*

Latina Adolescents

Latina adolescents attempt suicide at a significantly higher rate than non-Latina adolescents. In a review of data since 1999, it was noted that the risk of completed suicides among Latina adolescents has nearly doubled. A primary prevention approach provides best-practice care and support while working to prevent suicide attempts from occurring altogether. Recommendations for this population incorporate the central role family and culture play in both risk and protective factors.

17. **The State Should Support the Development of Community Forums with Key Stakeholders -** Local government leaders, school leaders, large employers of Latinos, and local clergy should raise awareness of the elevated risk among Latina adolescents. This will support the creation of community partnerships aimed at developing a coordinated community response. The group could emphasize the elevated rates of suicide attempts and the growing rates of completed suicides among Latina adolescents as well as increase the use of Spanish-language media and the availability of documents in Spanish.
18. **The Increased risk to the Latina adolescent community should be highlighted -** To be done through inclusion in the updated NYS Suicide Prevention plan as well as Local Mental Health Services Plans.
19. **The State and Localities Should Encourage and Support all primary care providers caring for children around the adherence to the latest American Academy of Pediatrician's Guidelines for Adolescent Depression in Primary Care (GLAD-PC) -** This includes universal screening for children 12 years old and older, as well as ongoing treatment and monitoring.

"I've had multiple experiences where mental health professionals, both of color and not, have shown me their understanding of how my ethnicity and other identities inform my experiences. Not having to spend the session educating the mental health practitioner about my culture allows me to delve deeper into my specific needs at the present moment. Not needing to code-switch or alter the language I use to express my feelings makes a difference in how I feel after the session and in the long-term. It's crucial that a consumer feel like they can be their true self in therapy because this might be one of the very few places where you have that privilege. These experiences were vastly different from non-competent care as I was not encouraged to continue treatment with them and felt unsupported by a system that can be very daunting and hard to access at times. I think humility, sensitivity, or compassionate are preferable to "competency" because demonstrating that you have a vested interest and making a genuine effort to understand better where I am coming from shows that you're an empathetic individual who wants to make sure my treatment is as tailored to my life as possible."

Dior Vargas, *on the importance of Cultural Sensitivity*

LGBTQ Community

Lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) individuals have a higher rate of suicide ideation and attempts than non-LGBTQ persons. Thus, LGBTQ suicide is a growing and important public health concern. Given the diversity in subsets that populate the LGBTQ community, any actions taken must reflect these diverse cultural needs. Recommendations include the application of best practices in the collection and utilization of sexual orientation and gender identity (SOGI) data for all deaths throughout the State; promoting culturally competent services for diverse LGBTQ communities in collaboration with crisis and suicide prevention hotlines, schools, and religious and community leaders.

20. **Increase opportunities for training and technical assistance on cultural competence for LGBTQ to include:**

- **Crisis and Suicide Prevention Hotline Services for LGBTQ -** Encouraging crisis and suicide prevention hotlines to provide culturally competent services for diverse LGBTQ communities and ensure that programs are following the recommendation to assess suicide risk by promoting accreditation as well as train the trainer.
- **Identify Best-Practices for School Policies and Programming -** Encourage local coalitions to promote and support practices for schools and other youth - and family - serving organizations in addressing bullying; and require that teachers, staff, and administrators all complete diversity and inclusion training.

21. **The State Should Support the Development of Trainings for Health Care Systems -** Health care provider education settings (e.g., physician, social work programs) should address strategies to collect Sexual Orientation and Gender Identity (SOGI) data from LGBTQ patients across cultures, and methods to create welcoming and affirming environments (e.g., affirmed name/pronouns, more inclusive language, all gender restrooms, affirming images, recognizing intersecting identities, etc.).

22. **New York State will work with local communities to increase the collection of accurate data on LGBTQ suicide -** In order to inform planning, intervention, the development of prevention strategies, and research accurate data is required.

23. **The Task Force Recommends that OMH should support a partnership with the Family Acceptance Project -** This partnership will support the development of family education trainings as well as provide a bridge to work with faith communities.

24. **The Task Force Recommends that New York State Pass the Gender Expression Non-Discrimination Act -** To create a culture of safety for LGBTQ communities, especially since affirming legislation is related to a reduction in suicide attempts among sexual minority youth.

Veterans

Suicide rates among Veterans at both the state and national levels are significantly higher when compared to non-Veterans. While measuring suicide prevalence among this population can be complex given the disparity in demographics (e.g., age, disability status, combat experience), common risk factors include chronic pain, mood disorders, and substance abuse. Recommendations include supporting the NYS Division of Veterans' Affairs (DVA) in efforts to identify veterans who are eligible to receive VA benefits; increasing the presence of mental health support services during periods of transition; and increasing the competency of civilian healthcare workers to provide treatment to veterans.

25. **All State Agencies Should Support the efforts of NYS Division of Veterans' Affairs to Identify Veterans Eligible to Receive United States Department of Veterans Affairs (VA) Benefits -** Among the strategies, the State should develop a strategy for state agencies to ask all customers the following question: "Have you ever served in the military?" and obtain permission to share contact information with the NYS Division of Veterans' Affairs. If permission is not given, agencies should provide a pamphlet encouraging the individual in accessing VA eligibility counseling. The State should develop a data solution to surveil state agencies to flag information in state databases and funnel to DVA.

26. **Increase the Collaboration Between New York State Agencies on Workforce Development -** New York State agencies should collaborate and focus on workforce development at transitional events. In addition, OMH and the State Division of Veterans' Affairs should have an increased presence at Yellow Ribbon and deployment events as the transition period from active military to veteran status has been identified as a time of elevated suicide risk.

27. **The State and Localities Should Engage Veterans, families, and the wider community in conversations about the development of strategies to both improve the dissemination of information and resources designed to decrease isolation and better support veterans and their families -** Through the use of regional coalitions, education provided by the Suicide Prevention Office, and the use of a targeted social media campaign, the general public can be engaged in the effort to reduce the prevalence of veterans who die by suicide.

Report Recommendations

The recommendations of the Task Force are organized around four domains: A) Strengthen Foundations for Public Suicide Prevention Approaches B) Build Health System Competencies and Pathways to Care and C) Improve Surveillance Methods/Tools and Access to Timely Data and D) Infusion of Cultural Competence Throughout Suicide Prevention Activities. Recommendations specific to three at-risk populations — Latina adolescents, LGBTQ, and veterans — are included in the section on cultural competence.

A. Strengthen Foundations for Public Health Suicide Prevention Approaches

Building stronger foundations to extend public health prevention approaches has potential to jump-start progress in suicide prevention. Coordinated activities are needed between New York State and local communities. State contributions are essential to catalyze activities by providing technical assistance, identifying and coordinating resources from different State agencies (e.g., mental health, substance abuse), strategic funding, and monitoring overall progress and regional needs for planning. Most suicide prevention activities occur at the local level, and local work is essential to identify gaps and tailor programming. Local communities have a key role to play in bringing together partners and implementing programming.

1. **The State will identify core elements of a regional suicide prevention framework based on the public health prevention approach using surveillance and a range of interventions; incorporate them into technical assistance through OMH and The Suicide Prevention Center (SPCNY). This will include the formation of regional advisory groups comprised of local county leaders throughout the state to identify actionable and sustainable motivators and methods to engage partners in building active local suicide prevention coalitions.**

    a. Local communities should promote suicide prevention by forming key partnerships for regional coordination, data review/surveillance and planning. Key elements should include:

        i. Through technical assistance from State agencies, create and support a culture of using data at a county level to identify trends in suicide deaths and attempts to inform planning and targeting of resources.

        ii. Bring in key partners (State government partners, law enforcement, crisis response, schools, healthcare, behavioral healthcare, non-profits, media, consumers and/or survivors, families, faith-based organizations) to be involved in the review and planning process.

        iii. Leverage the new NYS Health Connector Suicide and Self-Harm Dashboard to pilot data review and share examples of a successful collaboration-review process. This resource assembles the most relevant data for suicide prevention at one website, broken out by county across the State. Identify the best local approach for a 'real-time' surveillance system for suicide deaths/attempts to create a coordinated outreach system.

    b. Emphasize the importance of local government agencies such as mental health, health, substance abuse, and law enforcement as critical to leverage expertise and provide coordinating personnel and continuity.

        i. Leverage state-wide organizations of local government agencies to build local leadership.

    c. Emphasize the engagement of diverse cultural and high-risk groups and a need for the tailoring of programming to local community needs.

    d. Provide State guidance to schools on the development of model comprehensive policies for suicide prevention, intervention and postvention as a basis for any suicide prevention planning and programming.

e. Operationalize with examples of best practices such as Chemung County's approach, which emphasizes coordination and a range of prevention programming: training in risk detection and referral, extension of clinical services in community settings, secondary and primary prevention programs.

f. Use local data and knowledge of the community to identify local prevention needs and matching with research-informed prevention programming.

   i. Encourage collaborations between school districts, regional Boards of Cooperative Educational Services of New York State (BOCES), the Office of Alcoholism and Substance Abuse Services (OASAS) providers, Aging Services and other technical assistance organizations to support prevention programming.

   ii. Create workgroups to identify suicide prevention needs of sub-populations identified by the community (e.g., LGBTQ youth, Latina youth and families, veterans).

   iii. Link prevention to the placement of clinical services in key community settings (e.g., schools, primary care offices, courts) to reduce barriers to care and link to prevention efforts.

   iv. Build collaborations with large regional youth mental health treatment and residential services.

g. Invite the advisory group to evaluate the Suicide Prevention Model/Framework with benchmarks. The Task Force recommends the formation of a subcommittee of experts and local stakeholders to develop criteria and a process for local communities to engage in a structured planning and resource coordination process to receive a **NYS designation as a partner in Communities United to Prevent Suicide.**

2. **The State should make strategic investments in research-informed prevention programs that target risk and protective factors for suicidal behavior: (a) social-isolation/connectedness; (b) problem behaviors including substance use and antisocial behaviors; (c) coping skills, help-seeking.**

Williamsville School District: Responding to the Tragedy of a Student Suicide

Williamsville Central School District is a public school district in New York that serves the village of Williamsville, as well as the towns of Amherst, Cheektowaga, and Clarence.

After the death of a student, Williamsville School District's counselors and staff took action to support a grieving school community. Led by the Assistant Superintendent for Student Services, the district started by seeking expert input on how best to respond in the immediate aftermath of a student suicide—called a postvention response. But it also wanted to be more preventive in its approach. An important step was joining the Suicide Prevention Coalition of Erie County and creating a Schools Committee with school leaders. The committee prioritized the building of local capacity and competency to meet the needs of students and their families for suicide prevention, intervention, and postvention. They brought nationally recognized suicide prevention best practices and evidence based programming to schools, raised the level of awareness among school leaders county-wide, and developed the infrastructure and partnerships to sustain a long-term initiative.

Since that loss, Williamsville School District provided parent resources for awareness and prevention, developed student led positive social messaging campaigns, planned for universal staff awareness training, provided training in suicide response to crisis teams, engaged in dialog with local mental health providers, and reviewed school policies on intervening when a student is at risk for suicide.

How This Response to Tragedy Illustrates Best Practices in School Responses to Student Suicides:

- All school staff received training on risk factors and warning signs.
- All members of the school became involved, demonstrating a "Caring, Competent School Community" approach.
- Student peer leaders received suicide prevention education and were engaged in social marketing campaigns to improve teen culture around help-seeking and positive coping.
- School leaders sought support and collaboration from community mental health and suicide prevention stakeholders.
- School safety leaders considered suicide postvention response in ongoing crisis team development and training.
- School policies for intervening when a student is at risk for suicide were reviewed and updated.

a. For youth, this includes programs that reduce school behavior problems such as the Good Behavior Game; build a positive school climate and reduce interpersonal violence (Partnerships in Education and Resilience); build social connectedness, and enhance help-seeking skills, such as Sources of Strength programming and emotion-regulation skills through tools such as Dialectical Behavior Therapy (DBT)-informed curriculum.

b. Prioritize new strategies to reduce bullying and cyber-bullying, which are problems that schools are struggling to address and research shows can have long-term adverse impact on emotional well-being and health including increasing risk for suicidal behavior.

c. Promote the sharing of examples between localities of successful prevention implementation-sustainability as 'data' to encourage other communities/regions.

d. The Task Force recommends the New York State Suicide Prevention Council examine common elements of Evidence Based Practices to make recommendations to adapt programs for specific populations.

e. To address the urgent need for prevention programs that build adult coping skills and social connectedness, engage the help of the New York State Suicide Prevention Council to monitor research and new programs to identify candidates for pilot work (e.g., University of Rochester work on reducing isolation in older adults).

Recognizing the Impact of Peer Victimization and Bullying

Peer victimization through bullying is associated with adverse social-emotional effects for children and adolescents. Rapidly changing social media and cyberbullying pose significant challenges for schools, families, and communities.

- Peer victimization includes verbal harassment, physical threats, and involves the intention to cause harm on the part of the perpetrator (van Geel, Vedder, & Tanilon, 2014).
- Homophobic name-calling is a prevalent form of peer victimization in middle school (Meyer, 2010).
- Peer victimization through physical and cyber bullying increases risk for depression, which may endure into adulthood (Klomek, Sourander, & Gould, 2011).
- Bullying is one of many psycho-social factors that can increase risk for suicidal thoughts and behaviors (van Geel, Vedder, & Tanilon, 2014).

Comprehensive bully prevention programs that are implemented with fidelity have proven effectiveness, with effects on decreased perpetration and victimization ranging from 15 – 25% (Ttofi & Farrington, 2011).

- Program elements that increase effectiveness include teacher training, whole-school anti-bullying policy, parent training and greater intensity and duration.
- Programs based on the school-wide Olweus model (1993) show the greatest consistent positive effects (Ttofi & Farrington, 2011).

The Task Force recommends that OMH include bully prevention resources (e.g., stopbullying.gov) within its technical assistance package for communities, and incorporate bully prevention within the developing public health framework. The investment of additional State resources for teacher and parent trainings are needed to assist communities in addressing new challenges from cyber-bullying and continue gains from state policies implementing bullying programs.

3. **One avenue toward engaging the wider community in suicide prevention is through workforce education. OMH will develop a suicide prevention training to be administered through the Statewide Learning Management System (SLMS) as one of the mandatory trainings for NYS employees.**
   a. The training would address the issues of suicide risk as well as how to respond to coworker, family member, or neighbor who may be exhibiting signs of distress for employees who are not in the mental health field.
   b. The training could be subsequently offered to counties and local communities to be shared with the wider workforce.
4. **Given the enormous amount of premature mortality associated with suicide and opioid overdose deaths, NYS agencies will identify steps to advance synergistic prevention activities.**
   a. Identify shared risk and protective factors and prevention approaches promising in reducing suicidal behavior and opioid addiction.
   b. Pilot 'braided' funding as an alternative to what historically has been siloed funding to identify new efficient, broader prevention approaches.

**Note: Promising local practices illustrated in this report are a few among many across the state that contain principles for suicide safer communities.*

Chemung County, New York: Community Coalition Response to Youth Suicides*

Several teen suicides in Chemung County in 2004 – 2005 spurred creation of a Community Suicide Response Task Force to guide out-reach, make prevention recommendations, and promote safe media messaging. A team led by the Mental Hygiene Department investigated and discovered a pattern of shared risk-taking behaviors among the decedents– information that was used to formulate intervention for other at-risk teens.

A part-time suicide prevention coordinator position was created, as well as an annual suicide prevention walk. The coalition created a crisis response protocol, sponsored training of youth and adults at risk and referral resources which resulted in 3500 community members trained, as well as research-informed suicide prevention in schools. The coalition reviewed local data on suicide deaths and attempts to inform planning. To address barriers to mental health services, satellite clinics were established in school settings. No additional teens died by suicide in Chemung County for over a decade after 2004 – 2005, suggesting that this community response contributed to reducing suicide contagion and may have prevented more deaths.

How This Example Illustrates Best Practices in Public Health Prevention

- All sectors of the community (i.e., law enforcement, media, healthcare) were involved in planning and implementing the prevention and response effort (CDC 1988). In response to deaths, they conducted outreach to affected peers and investigated common risk factors.
- Promoted responsible media reporting of suicide deaths.
- Coalition use of data to guide prevention planning.

Comprehensive Crisis System as a Safety Net

In 2016, the National Action Alliance for Suicide Prevention's Crisis Services Task Force issued a white paper outlining the role of crisis services in preventing suicides, including a set of recommendations on the core elements of a comprehensive crisis service network. Entitled "Crisis Now: Transforming Services is Within Our Reach"; the paper describes the many common features of emergency and crisis response services that characterize many public health and mental health systems across the nation. The report's authors make a call to action with a series of steps that communities and states can take to develop a comprehensive crisis care system that can improve lives and reduce deaths by suicide for the many individuals who still fall through the cracks of our systems of care.

The four core elements of crisis care that are brought to attention by the task force include:

1. Regional or statewide crisis call centers,
2. Centrally-deployed, 24/7 mobile crisis response,
3. Residential crisis stabilization programs, and
4. Essential crisis care principles and practices, including:
   - Embracing recovery
   - Significant role for peers
   - Trauma-informed care
   - Suicide safer care/Zero suicide
   - Safety and security for staff and consumers
   - Crisis response partnerships with law enforcement

(National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach.)

Under Governor Cuomo's leadership, the State Office of Mental Health has answered the call to action by the Crisis Services Task Force, and is undergoing a comprehensive system review and service planning process with regions and localities to develop and enhance crisis systems. To date, this has included a regional crisis system inventory, guidance and technical assistance to localities and regions in designing a comprehensive crisis service networks, and development of additional revenue streams for crisis services to provide more financial sustainability to programs across the state. Additionally, NYS has launched a partnership with the National Crisis Text Line, highlighting 24/7 access to anonymous text-based support for New Yorkers in crisis. These efforts will not only help reduce avoidable hospitalizations and emergency department visits in the near term, but more importantly will help improve recovery outcomes and reduce suicides in New York State.

B. Build Health System Competencies and Pathways to Care

New York State and local communities working in tandem can strengthen competencies of healthcare providers and systems and better serve individuals who are suicidal or at high risk of suicidal behavior. In addition to behavioral health services, strategic activities can support primary care, other medical specialties, as well as providers that serve populations at high risk in the community such as isolated seniors. Coordinated actions of State and local communities can reduce barriers to care and promote communication and coordination of services to enhance impact.

5. **The OMH Suicide Prevention Office with assistance from State agencies will support and expand efforts at integrating suicide prevention into health and behavioral healthcare settings, sometimes referred to as the "Zero Suicide model."**
   a. This means supporting health and behavioral healthcare providers in the adoption of systematic suicide safer care delivery through technical assistance, training and implementation support.
   b. Systematic suicide safer care delivery includes screening, increased detection, and care pathways and follow-up monitoring for those at elevated risk.
6. **Localities should integrate suicide prevention efforts in a comprehensive crisis system.**
   a. As part of a comprehensive system review and service planning process with regions and localities to develop and enhance crisis systems, and modeled after the "Crisis Now" approach, OMH will ensure that all county plans address suicide prevention services.
7. **Localities should identify and share core elements of best practice clinical care for suicide specific services tailored to age; support via payment arrangements for new models such as Value-Based Payment (VBP) in which providers are reimbursed based on patient health outcomes.**

a. Health care is notorious for the slow pace of making effective interventions widely available and consistently delivered. Target regulatory, financing and programmatic barriers to hasten adoption.

b. State agencies will provide guidance for health systems and providers on reporting suicide attempt and intentional self-harm diagnosis codes (ICD-10) to allow for tracking trends across the State.

c. Incorporate support and encouragement for health systems to track individuals with suicide attempts who receive care in their systems in order to highlight the need for optimal transitional care and access to evidence-based interventions.

d. Localities will develop components and standards for clinical care for key constituent groups/ages, drawing on specific examples of strong local programming provided through State technical assistance and support.

i. For youth, a comprehensive approach such as Columbia University Child/Adolescent Psychiatry Community services framework which collaborates with families, pediatricians, primary care offices, and specialists.

- Home-based intervention and psycho-education for families and caregivers; suicide-specific treatment approaches such as Dialectical Behavioral Therapy (DBT); outreach to engage high-risk disengaged youth (Person in Need of Supervision -PINS, homeless); school-based services to increase access; collaboration with regional youth mental health treatment and residential services.
- Encourage collaborations between school districts, regional Boards of Cooperative Educational Services of New York State (BOCES), the Office of Alcoholism and Substance Abuse Services (OASAS) providers, colleges, shelters, hospital emergency departments, and other technical assistance organizations.

ii. For adults, utilize OMH technical assistance to identify suicide-specific treatments (e.g., DBT, Cognitive Behavioral Therapy - CBT tailored interventions) and training opportunities for local providers.

- Develop partnerships with substance abuse treatment agencies, agencies that serve high-risk groups in community (e.g., homeless, isolated seniors)

8. Include suicide prevention as part of the Governor's transformation of the State's Medicaid System to a Value-Based (VBP) Model. VBP contemplates a change in reimbursement of health care services which is based on outcomes.

a. OMH would coordinate expert recommendations to promote the most effective services, ongoing performance measurement, and access.

b. State agencies would ensure reimbursement of the most critical and effective services.

9. The State will develop training guidelines that incorporate core competencies for healthcare providers as well as address the benefits of training the general public.

a. Create and share training recommendations for local communities to strengthen the suicide prevention competence of the healthcare workforce and general public.

i. Tailor training recommendations to the needs of providers and populations served.

ii. Incorporate training to build competencies in evidence-based assessment of mental health problems and suicide risk in medical providers, home visitors, emergency medical services, crisis and emergency department staff, substance use treatment providers and behavioral health workers.

b. Support and expand programming aimed at building behavioral health capacity that includes suicide prevention competency in primary care settings. This requires ongoing knowledge and skills development to manage mild to moderate behavioral health needs in practices and may include phone and face-to-face consultations.

i. Building capacity is an important, concrete step taken by the State to expand the competence of primary care providers with potential to reduce crises and smooth pathways to care.

ii. Examine potential for linkages with tele-psychiatry initiatives.

iii. Support evaluation of these programs.

c. OMH and the Suicide Prevention Center (SPCNY), in conjunction with State Education Department and other relevant stakeholders, should create recommendations for required core competencies for health care training programs.

i. 20% of States mandate that health care providers complete suicide prevention training and an additional 15% recommend training. Adapt best practices for New York State.

10. **The State will provide technical assistance to localities to develop a framework for county/community integrated programming responding to community-specific needs to include the development of ethical and practical guidelines to promote communication among healthcare, families and community organizations.**

a. Identify healthcare system(s), county and regional agencies to coordinate.

b. Develop collaborations between emergency departments, crisis services, and other health care providers (e.g., health and mental health centers) to ensure rapid follow-up after discharge and to provide alternatives to emergency department care and hospitalization when appropriate.

c. Local needs assessment for culturally tailored services (e.g., culturally attuned programming for Hispanic/Latino youth and families).

d. Build in information sharing at key transition and intake points

e. Involve families, pediatricians and other healthcare providers

f. Standards for communication with families and key youth-serving settings following suicidal behavior

g. Incorporate cultural competence, language accessibility, translation services.

C. Improve Surveillance Methods/Tools and Access to Timely Data

Timely, high quality suicide surveillance data are foundational to all of the State's efforts at preventing suicide death and attempts. Reliable data critically allow for defining the burden of the epidemic, tracking trends, identification of communities at risk, and evaluation of prevention strategies.

Because the State collects, houses and manages several databases relevant to suicide surveillance, it has a particularly important role to play in this domain. For example, death certificates capture essential demographic information in suicide deaths; hospitals record suicide attempts and self-inflicted injuries among those who received hospital and emergency room care; and the New York Violent Death Reporting System collects a vast array of information on suicide deaths, including some of the circumstances surrounding those deaths. However, even though communities may not be involved in overseeing state-level data bases, they have a crucial role to play in 1) accurately generating community-level data sent "upstream" to the State for aggregation and in 2) creating local partnerships that support a culture of data-informed suicide prevention and implementing evidence-based and best practice programming.

Current priority gaps in the NYS suicide surveillance system:

Data Quality (accuracy and completeness): Having complete and accurate data on suicide deaths and attempts, including demographic and circumstances data, are essential to NYS suicide prevention. While certain demographic data, such as age and sex, and to a lesser extent

race and ethnicity, are collected routinely; other characteristics, such as sexual minority (LGBTQ) and veteran status are often missing from records. Circumstances surrounding suicide deaths include documenting a host of important information that may be collected by medical examiner/coroner offices and law enforcement, such as the method of death, toxicology reports that screen for the presence of drugs and alcohol at the time of death, personal issues affecting mental health, and whether there was a history of prior suicide attempts. Ensuring timely, standardized data collection and reporting from many different organizations involved remains a major challenge in New York State. Furthermore, county budgets have not been able to keep pace with the increased volume associated with suicide and opioid deaths, along with the associated rising costs of performing certified autopsies and toxicology. In some cases, death reporting budgets have been materially reduced.

Data Access and Dissemination: Access to "actionable data" at the county level historically has been a major challenge with no coordinated effort to centralize datasets most germane to suicide surveillance in the State. Each dataset is typically managed and reported by a single custodian agency or bureau within an agency, each with its own rules surrounding data access. New York City, for instance, has its own system for death reporting, distinct from the rest of the state. Additionally, certain information may not be readily shared due to privacy protections. For example, federal law broadly protects patient health information, including suicide attempt data, and has special protections for substance use treatment records; and state mental hygiene law has additional restrictions on sharing treatment records.

Data Timeliness: To respond appropriately, communities require timely data on both fatal and non-fatal suicide attempts that meet their needs. For example, counties have called for real-time data so that mobile crisis teams can support families following a suicide attempt or when facing a suicide contagion. Healthcare systems typically engage in quality improvement project cycles using data to track progress every 60-90 days. Unfortunately, suicide death data can take 18- 24 months to be made widely available–way too long for quality improvement.

Primary Care: Preventing Suicides Through the Detection and Treatment of Depression

Mark went to see his primary care physician, Dr. Thatcher, due to low back pain and difficulty sleeping. At his doctor's office, Mark completed a brief depression questionnaire in the waiting room and acknowledged feeling depressed and no longer enjoying things over the last several weeks. He also reported occasional thoughts about killing himself but adamantly denied any intention of acting on those thoughts, citing the impact on his wife and children. In addition to a pain management plan, Dr. Thatcher diagnosed Mark with clinical depression and explained that his practice has a team-based approach to depression care. Though he could prescribe an antidepressant medication, he wanted Mark to work with Andrea, the depression care manager at the practice.

Andrea met with Mark during his initial visit where she performed a suicide risk assessment. She also worked with Mark on developing a safety plan, a prioritized set of actions taken to help manage suicidal urges, including keeping the environment safe. Mark agreed to temporarily store his guns with his brother-in-law and to have Andrea share the safety plan with his wife. Mark continued with therapy with Andrea weekly for the next several weeks. Andrea tracked his progress with the depression questionnaire he completed at his first appointment and with medication monitoring by Dr. Thatcher.

How This Example Illustrates Best Practices in Suicide Safer Care Delivery:

- Dr. Thatcher's practice utilized a team-based approach for depression care, called Collaborative Care, shown to be far more effective in treating depression when compared to usual care.
- Dr. Thatcher and Andrea received training on assessment and caring for suicidal patients.
- Following expert guidelines, the practice routinely screens for depression, including a question on suicide, for all patients 12 years and older, a critical first step.
- The practice had a well thought out plan for patients who screen positive for suicidal thoughts.
- Andrea did a thorough suicide risk assessment, the foundation for a sound care plan.
- She also worked collaboratively with Mark to reduce suicide risk factors and enhance protective factors by creating a safety plan, temporarily removing firearms from the home, scheduling regular ongoing contact, and involving family members with Mark's permission.

Data segregation: While some progress has been made linking datasets, many that could be synergistically harnessed to enhance the State's suicide surveillance capacity remain siloed or inaccessible. An enormous amount of energy and resources has been put into modernizing New York's health information datasets, including both EHR networks (Health Information Exchanges) and administrative/claims databases, such as the All Payer Database (APD), Statewide Planning and Research Cooperative System (SPARCS), and New York State Medicaid. However, they often remain either unlinked or have yet to be systematically leveraging to support suicide prevention.

11. Improve the accuracy and completeness of core suicide surveillance data reporting.

The Task Force learned that New York State's County Coroner and Medical Examiner system, the foundation for reliable death reporting, in the face of opioid and suicide epidemics, needs strengthening. Despite progress by the State in moving electronic filing of death certificates, additional steps need to be taken to ensure early identification of the most serious and emerging threats to the health of New Yorkers.

a. Explore additional funding earmarked to explicitly support Medical Examiner and County Coroner death reporting, including suicide and opioid overdose deaths, prioritizing the most pressing needs statewide.

i. NYS Department of Health (DOH), with partners, will coordinate ongoing continuous Quality Improvement efforts to improve accuracy and completeness of New York Violent Death Reporting data, including data derived from death certificates, medical examiner/coroner offices, and law enforcement. Identify methods to improve coding on death certificates to ensure suicides are accurately captured.

- Develop a centralized state office to improve completion of the death certificate: assisting with standardizing causes of death to produce accurate counts; providing technical assistance/training to medical examiner and county coroners in interpretation and coding of autopsy/toxicology results and the completion of death certificates; and collecting data for suicide case fatality reviews.
- Develop, train, and support implementation of standards for classifying deaths as accidental and undetermined including overdose deaths.
- Identify and support state-wide use of best practices for collecting under-reported demographic data (e.g. race/ethnicity, veteran and sexual orientation and gender identity) for suicide death and attempt records.
- Provide ongoing training for key New York Violent Death Reporting agencies for counties, including New York City, aimed at standardizing case investigation methods and reporting for underreported demographic data.
- Develop legislation that allows coroners and medical examiners to access medical records, information from Qualified Entities, and data from the prescription monitoring program to understand past medical history.
- Support through the provision of technical assistance on best practices the piloting of local/regional suicide fatality reviews.

12. The State Should Increase access to data that informs state and local suicide prevention and support a culture of data informed suicide prevention at the local level.

a. NYS Department of Health (DOH) will provide a centralized clearinghouse in the form of an interactive "Suicide Dashboard" for the most relevant state and county-level suicide-related surveillance data.

b. The State will provide technical assistance and training to community groups on the dashboard, including the 57 counties with existing suicide prevention coalitions.

c. With technical assistance from OMH, and in accordance with all state and federal laws surrounding confidentiality, communities will pilot suicide fatality reviews in select areas whereby a multidisciplinary group of professionals and community members evaluate the circumstances leading to suicides to improve community and service systems and

to take action to prevent suicide. Summarize and disseminate findings in an annual report to community stakeholders aimed at policy changes that improve community suicide prevention.

d. Develop a plan for the sharing of regional best practices in the use of data informed suicide prevention across the State, such as at the annual NYS Suicide Prevention Conference, the annual conference of mental hygiene directors, and other appropriate venues.

e. Create an advisory panel of county mental hygiene directors to provide feedback and guidance to the State in incentivizing implementation at the local level of recommendations contained in this plan and to disseminate best practices to other counties.

f. Qualified Entities are regional health information networks that tie together electronic medical and pharmacy records so participating providers can share patient specific data, such as discharge summaries, lab tests, diagnoses, and pharmacy records to allow improvements in coordinated care. The State should work with Health Information Exchanges to make suicide-prevention relevant data more accessible to end users. For example, while adhering to all applicable federal and state privacy laws, health and behavioral healthcare providers should be able to quickly ascertain if an individual has received treatment for a mental illness, or has had a suicide attempt in the past. Consent forms need to be incorporated into mental health and substance use disorder practices to allow sharing of this data.

13. The State Should Improve Data Timeliness: Support timely data that meets both community need for rapid emergency response and long-term surveillance aimed at understanding trends.

a. Support use of a “near real-time data” surveillance system for communities

b. The State and New York City health departments should collaborate to develop, test, and disseminate a common syndromic definition for suicide attempts to allow near real-time reporting in emergency rooms statewide.

c. Review of other databases, including emergency medical services transport, SafeACT rapid reporting, and data available at the community level such as 911 dispatches, as potentially useful models of real-time data reporting that supports a local response.

d. Review current work flows for State suicide death reporting, including toxicology reporting, and make recommendations on reducing the data lag (see above).

e. Creation of centralized NYS laboratory for standardized toxicology reporting

f. Counties should work with their data providers such as coroners/medical examiners, behavioral health providers, and hospital emergency departments to identify local issues affecting the timeliness and quality of data collection.

14. The State should foster and support data sharing across the datasets most relevant to suicide prevention.

a. Several databases managed by New York State contain information highly relevant to suicide prevention—for example, the All Payer Database, Statewide Planning and Research Cooperative System (SPARCS), Vital statistics, Medicaid, New York Incident Management Reporting System (NIMRS). Methods to allow sharing and linkage of records between agencies for public health surveillance purposes need to be identified.

b. Rather than having state agencies rely on separate parallel reporting systems for tracking suicide attempts and deaths, efforts should be made to utilize one universal system to be used by the State and its licensed providers.

D. Infusion of Cultural Competence Throughout Suicide Prevention Activities

Incorporating the need for cultural competence in all stages of suicide prevention activities increases effectiveness on all levels. Assuring that diverse communities are involved in both State and local level planning creates a potential framework that allows for reaching more populations. Ethnicity, gender, sexual orientation, age, socio economic status, and community are among the considerations for program development and delivery. The conversation must encompass how technology can be used to reach populations that are isolated as well as youth for whom no programming should exclude the use of technology and more specifically social media.

15. **Incorporate the use of technology into program development and design.**
    a. Gather input from diverse populations with a multi-generational view on how the use of technology allows individuals to feel more connected.
    b. Focus on the development of applications for crisis and therapeutic support services.
16. **The State should incentivize improving the completeness of key demographic data for suicide deaths and attempts, including race/ethnicity [veteran and sexual minority status], in administrative data sets. This information is critical to the goal of reducing disparities.**

Considerations and Contexts for Treatment – the Whole Person

by **Antoine B. Craigwell** | DBGM, Inc.

"There are beliefs, distortions and assumptions about mental health that are held by certain cultures and must be factored into treatment for any psychiatric disorder. My approach is to first seek out the cultural factors that may be impacting the depression or the mental illness and then guide the client to understanding its role in their mental health. This can be a sensitive process and must be done with utmost care and respect because in many instances those beliefs are connected to family and cultural issues. Once this is accomplished, then we can move forward with the rest of the work," said Sean Carrington, vice president of Staff Development and Employee Relations with NYC-based Harlem United.

In his treatment practices, Carrington advocates for including cultural competency in prima facie interactions with clients. Two aspects of cultural competency, with significant influence on people of color, are the combined effects of racism, and intergenerational and contemporaneous trauma, which focus on the effects of slavery, post-slavery, and micro aggressions chipping away at a client's sense of self.

Therapists/clinicians incorporating cultural competency/awareness in their treatment modalities, are more likely to effect better therapeutic results, and ensure the client is able to come to terms with their past, not only in their lifetime, but reconciling with issues transmitted through generations. The therapist can assist the client by revisiting and encouraging awareness of the "whole person" as a treatment method, which includes working through ingrained shame, stigma and distrust of mental health care. It is important that the therapist/clinician also have an awareness of their own conscious and unconscious biases that may have an effect on their perceptions and judgments while working with a client. The clinician also needs to be aware of the impact of the physical environment where they work, that it be welcoming and respectful of the community they serve.

Special Population Recommendations

Latina Adolescents: A Population at Elevated Risk

Over the last two decades, it has consistently been observed that Latina adolescents attempt suicide at a significantly higher rate than their non-Latina peers.18 This alarming health disparity holds true nationally as well as in New York State, with 15.1% and 14.6% of Latina adolescents, respectively, reporting a suicide attempt during the last year. 19 While rates of suicide deaths (i.e. lethal attempts) are comparable to their non-Hispanic White, Black and Asian peers, it is important to underscore that non-lethal suicide attempts are often highly traumatic, disruptive events for the individual adolescent and their family. In addition, risk of completed suicides among Latina adolescents has nearly doubled since 1999, indicating a rising lethality of suicide attempts.

As clear markers of distress, suicide attempts - even non-lethal ones - deserve a robust community response: a community response that both provides best-practice care and support for those impacted as well as a state and community response that works to prevent attempts from happening in the first place – i.e., a primary prevention approach. The recommendations that follow were developed with this call to action in mind for this at-risk population where culture and family interplay as central suicide risk and protective factors.

17. **Targeting communities with the larger Latina adolescent populations in New York State (see side bar below), The State should convene and facilitate community forums with key stakeholder groups—**such as county government leadership, social service agencies and health care providers with ties to the Latino community, school district and Parent Teacher Association (PTA) leaders, large employers of Latinos, and local clergy. The goal is to raise awareness around the issue of elevated rates of suicide attempts, and rising rates of completed suicides, among Latina adolescents. This will support the creation of community partnerships aimed at developing a coordinated community response, including at a minimum developing an inventory of community resources to make available to stakeholders.

    a. Even when supportive services are available, Spanish-speaking only parents or other primary caregivers may not know about them, if informational materials appear in English only. Similar to **Governor Cuomo's Executive Order 26** for state agencies, community groups should make vital documents available in languages other than English, including Spanish, and raise awareness among Latino families of local resources by publicizing them through Spanish-language media.

    b. Create a digital clearinghouse devoted to housing resources available to communities working to reduce suicide deaths and attempts among Latina adolescents, including how to access trainings and best-practice programs.

18. **Strategies to highlight increased risk to the Latina adolescent community should be combined with improved data collection and utilization by local communities in planning suicide prevention services for improved outcomes within this community.**

    a. In concert with the NYS DOH Prevention Agenda 2019-2024 cycle, highlight the prevention of suicide attempts and deaths, (especially in communities with relatively large Latina adolescent populations) in the 2019 Local Mental Health Services Plans.

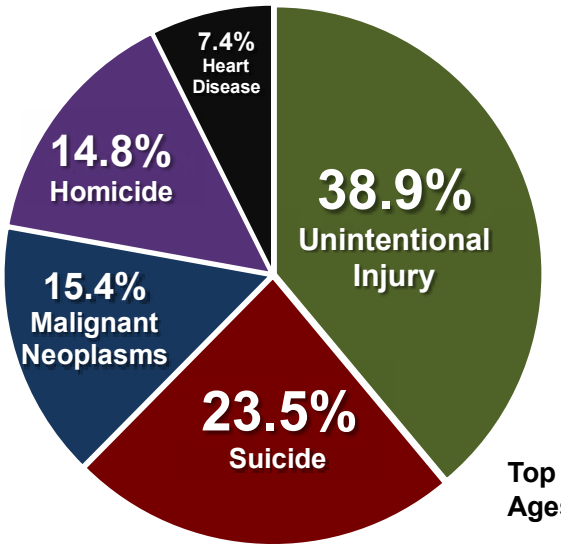
    b. Highlight the elevated rates of suicide attempts and the growing rates of completed suicides among Latina adolescents, including in the next revision of the NYS Suicide Prevention Plan and at the annual NYS Suicide Prevention Conference in Albany.

19. **The State and Localities Should Encourage and Support all primary care providers caring for children around adherence to the latest American Academy of Pediatricians' *Guidelines for Adolescent Depression in Primary Care (GLAD-PC),*** including universal screening for children 12 years old and older, as well as ongoing treatment and monitoring. Selective screening in other settings may also be useful among appropriately trained professionals as a natural extension of their current roles—e.g. guidance counselors working with individuals struggling in school or pastoral counselors supporting distressed families within their congregations.

Sidebar On Geography With Map

New York's Latina adolescent population (ages 10-19) is comprised of over 265,000 individuals (CDC Wonder 2016). While much of the population resides within the 5 boroughs of New York City, there are 23 counties outside the City with populations greater than 500, including populations that number approximately 5,000 or greater in Suffolk, Nassau, Westchester, Orange, Monroe, and Erie Counties. In addition to geographic diversity, there is significant subethnic heterogeneity among the New York State Latino population, reflecting broad immigration patterns from the Caribbean, Central and South America.

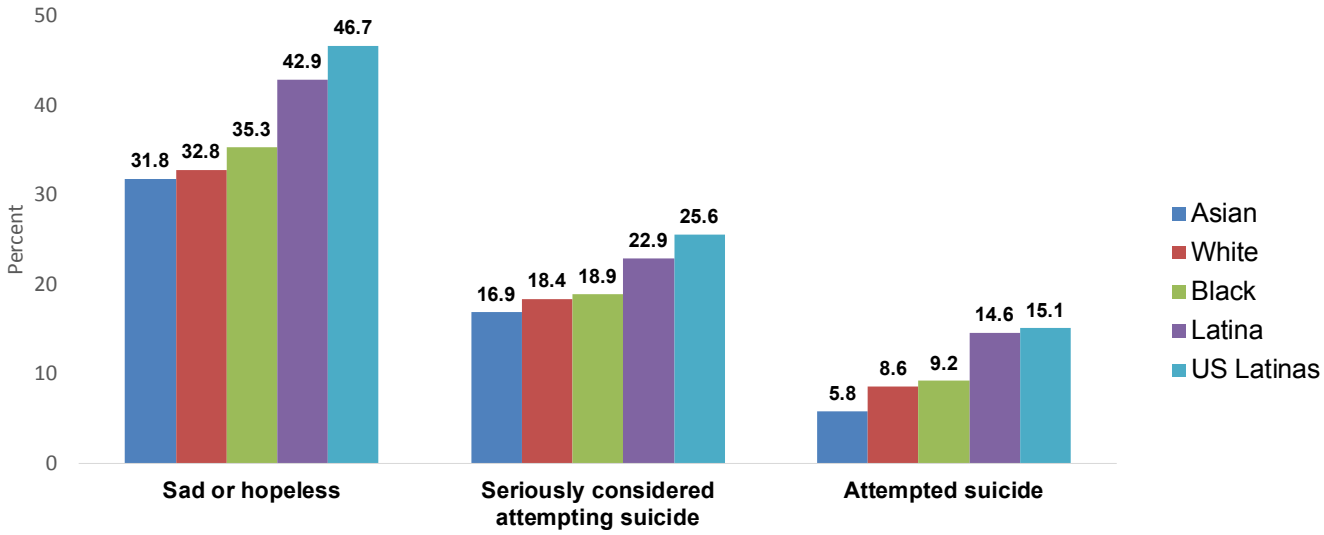
Latina adolescent suicide deaths



- Suicide is the **2nd leading cause** of death among Latina adolescents in New York State.
- There were **35 deaths** of Latina adolescents over the **past 10 years.**
- Rate of **2.6 per 100,000** population.

Top 5 Leading Causes of Death, Latinas, Ages 15-19, 2006-2015

Latina adolescents attempt suicide at a higher rate than any other youth group.



LGBTQ

Lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) suicide is a growing and important public health concern. LGBTQ individuals have a higher burden for suicide attempts and ideation than non-LGBTQ persons.[1-11]Prevalence of **attempting suicide** is **4.6%** for the general US population, [i] **10-20%** among LGB persons, and **39-55%** among trans individuals.[3, 12, 13] LGBTQ communities include diverse sets of populations with common experiences (e.g., minority stress), great distinctions (e.g., medically necessary treatments), and strengths (e.g., advocacy and creativity).[14] Action taken on the key recommendations listed below must consider: (a) the diverse cultural needs of the LGBTQ communities based on intersections of age, racial/ethnic identity, religious affiliation, and sexual orientation and gender identity, among other salient identities, (b) actions that will enhance knowledge, awareness, and skills to reduce implicit biases that impact policy development, professional training, and community institutions (e.g., healthcare and education), and (c) strategies to promote LGBTQ strengths among individuals and communities. Coordination between New York State and local communities can promote a culture of respect and acceptance for diverse LGBTQ populations, and contribute to enhanced prevention activities.

20. **Increase training expectations and opportunities to incorporate LGBTQ in cultural competence trainings, technical assistance, and regulatory review.**

    a. It is critical to encourage crisis and suicide prevention hotlines to provide culturally competent services for diverse LGBTQ communities. Crisis Prevention Centers, especially those with text and chat messaging available, play an important role in suicide prevention. To ensure that crisis and suicide prevention programs are following the recommendation to assess suicide risk, it is important to promote accreditation as well as Train the Trainer.

    b. Statewide mandated training on cultural competence (as found on Statewide Learning Management System) should be updated to include LGBTQ communities and OMH Field Offices need to include expectations around LGBTQ competency training in their licensing visits to agencies. Thus, professional education settings will provide trainings on LGBTQ competence (i.e., knowledge, awareness, and skills), unique experiences based on LGBTQ diversity, and promote inclusive language in schools and public settings.

    c. Schools are key settings for education, promoting youth-adult bonds, family education, and creating a culture of diversity and acceptance. It is important to identify best-practices for school policies and programming and encourage local coalitions to promote; support practices for schools and other youth- and family-serving organizations in addressing bullying; and require that teachers, staff, and administrators complete diversity and inclusion training to help them recognize their own biases, strategies to negotiate conflicting beliefs, and to encourage schools to provide continuing education on diverse cultural histories.

    d. Incorporate into OMH Suicide Prevention Office (SPO) coalition training: strategies and recommendations for local coalitions to engage with religious and community leaders for collaborative training in cultural competency as well as implicit bias and to use messaging to promote acceptance in families and prevent bullying.

    e. Create and disseminate information on community as well as on-line resources to match specific population needs (e.g., community, connection, healthcare information, family support, salient identities). Developing trainings that encourage LGBTQ self-advocacy as well as communication of their unique needs in healthcare and other settings.

21. **LGBTQ competencies in health care systems need to be improved across the board** (e.g., providers, staff, and administrators). It is essential to collect Sexual Orientation Gender Identity (SOGI) data in electronic medical records and use basic procedures to promote trust and communication between health care systems and LGBTQ communities.

a. The State should support the development and dissemination of trainings for health care systems and health care provider education settings (e.g., physician, social work programs) to address: (a) Strategies to collect SOGI data from LGBTQ patients across cultures and (b) Creating welcoming and affirming environments (e.g., preferred name/pronouns, more inclusive language, all gender restrooms, affirming images, recognizing intersecting identities, etc).

   i. Healthcare systems must determine how often SOGI information should be systematically collected, what barriers to collecting this data exist, and develop experiential trainings that not only teach, but monitor how SOGI data is collected. OMH will review regulations and explore training opportunities as well as soliciting input from the LGBTQ communities about how best to operationalize this including the education of LGBTQ patients about how this data will promote more affirming health care practices.

22. **There is a critical need for accurate data on LGBTQ suicide to inform planning, intervention, prevention strategies, and research**. Once LGBTQ suicide and death data is available, state/local policy makers and researchers will be able to investigate means of death, suicide rates, and strategies to tailor suicide prevention approaches to unique subgroups (e.g., LGBTQ, people of color, age cohorts), etc. Toward that goal, local communities can increase the accuracy in the following ways:

    a. Identify and support state-wide use of best practices for collecting information on sexual orientation and gender identity (SOGI) for all NYS deaths.

    b. Support the New York State Inter-Agency Task Force that is working to identify and support best practices for obtaining SOGI information.

    c. Ensure that SOGI data is available for the National Violent Death Reporting System (NVDRS) and death certificates; thus, medical examiners, county health officials coroners, and law enforcement offices will require training to collect and code SOGI data. Similarly, it is equally important to collect SOGI data in electronic medical records to improve care and ensure that data is available for death records.

23. **OMH should support a partnership with the Family Acceptance Project.** Based on converging evidence that minority stress is a risk factor for LGBTQ suicidal behavior and family support/acceptance are key protective factors, OMH should support a partnership with the Family Acceptance Project to develop family education trainings as well as provide a bridge to work with faith communities. A more aspirational goal toward LGBTQ suicide prevention is to identify a range of strategies to strengthen social connectedness and parental acceptance among LGBTQ communities more broadly.

24. **The Task Force recommends that New York State Pass the Gender Expression Non-Discrimination Act.** New York State has already made progress working toward LGBTQ equality and promoting LGBTQ rights; yet, there are still opportunities to craft and support legislation to protect LGBTQ communities. While there are a handful of cities and counties that prohibit discrimination based on gender identity and gender expression, passing the Gender Expression Non-Discrimination Act is a critical step toward creating a culture of safety for LGBTQ communities, especially since affirming legislation is related to a reduction in suicide attempts among sexual minority youth.

Veterans

Suicide rates among Veterans in New York State are comparable to nationwide statistics, and both are disproportionately high when compared to non-Veterans.[15] Measuring the prevalence of suicide is particularly complex given disparities in factors such as age, cohort, rank, disability status, and combat exposure. Risk factors include emotional distress, chronic pain, mood disorders, and substance use. [16] Suicide rates are shown to be higher among Veterans that do not utilize Veterans Health Administration (VHA) services. New York state ranks 5th in the nation for the size of its Veteran population and yet most of the Veterans in the State do not receive VA healthcare.[17]

25. **Most Veterans in New York State do not receive their healthcare through the VA system. New York State will address the need to increase access to enrollment into the VA system for those who are eligible while improving the competency of civilian healthcare workers in providing treatment and meeting the specific needs of Veterans for those who do not receive VA services.**

    a. New York State will develop mechanisms to better identify Veterans and provide information on VA benefits.

        i. New York State will identify a strategy for state agencies to ask all customers the following question: “Have you ever served in the military?” and obtain permission to share their contact information with the NYS Division of Veterans’ Affairs (DVA). If permission is not given, state agencies will be able to provide a pamphlet encouraging the individual in accessing VA eligibility counseling. There is potential for NYS Information Technology Services (ITS) to develop a data solution to surveil state agencies to flag information and funnel to the DVA.

        ii. Provide support for the work of the DVA call center, which ultimately assists respondents in scheduling appointments with Veteran Benefit Advisors who are local to the caller.

        iii. Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES-Medicaid) is a Health Insurance Portability and Accountability Act (HIPAA)-compliant, web-based portfolio of tools designed to support quality improvement and clinical decision-making in the New York State Medicaid population. OMH will explore the utilization of PSYCKES to identify those with Veteran status to identify those individuals during visits to such locations as emergency rooms and homeless shelters.

    b. State agencies will coordinate to develop a curriculum for healthcare workers to increase their understanding of the unique needs of the Veteran population.

26. **New York State agencies will increase collaboration at events designed for individuals experiencing the transition period from active military to veteran status as this has been identified as a time of high risk. These events are an opportunity to provide mental health support as well as assist individuals in obtaining benefits. In addition, OMH and the New York State Division of Veterans’ Affairs will increase their presence at Yellow Ribbon and deployment events.**

27. **New York State will address the need to engage and educate the veterans, families, and the wider community as well as decrease isolation by veterans in the following ways:**

    a. OMH will coordinate trainings with the State Division of Veterans’ Affairs. OMH offers a number of suicide prevention trainings each year, many of which may benefit those working with veterans.

    b. Improve the dissemination of information to Veterans and their support systems through the development of a social media campaign. The development of online content should include information for veterans, families, and friends on mental health and resources. This campaign could be launched on Veterans Day as a collaborative effort of state, federal, and military agencies.

    c. Promote Veterans-Focused Suicide Prevention community conversations in each of the REDC regions annually, bringing relevant stakeholders together in a collaborative effort to decrease isolation in the Veterans community.

Notes on Implementation

The Office of Mental Health will coordinate a multi-agency steering committee to guide the implementation of Suicide Prevention Task Force recommendations across New York State. This steering committee will align Task Force recommendations with the New York State Prevention Agenda, the suicide prevention activities of Local Governmental Units (LGUs), facilitate data sharing, and be responsible for the direction of statewide, regional and local actions to prevent suicide.

Appendix A

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Appendix B

Literature Review

Hispanic Adolescent Females and Suicide Risk (Caroline Silva, Ph.D., University of Rochester School of Medicine & Dentistry)

As of 2010, the Hispanic[1] population in the United States (U.S.) reached 50.5 million, making Hispanics the largest ethnic or racial minority group in the country.[1] Although Hispanics have historically been at decreased risk for suicide compared to other ethnic or racial groups, risk has steadily risen since 2000, especially among Hispanic adolescent females.[2]

Results from the 2015 national school based Youth Risk Behavior Survey indicated that Hispanic adolescent females (grades 9-12) in the U.S. reported the highest prevalence of seriously considering attempting suicide (25.6%), making a suicide plan (20.7%), and attempting suicide (15.1%) in the last year compared to non-Hispanic female and Hispanic/non-Hispanic male peers.[3] Furthermore, the prevalence of suicide attempts that had to be treated by a doctor or nurse was also highest among Hispanic adolescent females (4.5%), indicating greater potential lethality of these attempts. Interestingly, prevalence of suicidal behaviors seems to be lower among female adolescents (aged 12 to 17) in Puerto Rico (11%).[4]

In 2016, the rate of suicide among Hispanic adolescent females (aged 13 to 19) was 3.36 per 100,000 in the U.S.[5] This rate was lower than suicide rates among non-Hispanic females (4.83 per 100,000), Hispanic males (7.38 per 100,000), and non-Hispanic males (13.29 per 100,000) of the same age.[5] Notably, as with non-Hispanic adolescent females, suicide rates among Hispanic adolescent females have almost doubled since 1999, whereas rates have only shown a slight increase among Hispanic/non-Hispanic adolescent males.

Risk Factors

Studies have found that depression and being born in the U.S. are associated with increased suicide ideation among Hispanic adolescent females.[6] Beyond this, however, problematic interpersonal relationships seem to be particularly linked with suicide ideation in this population. Among a nationally representative sample of Hispanic female high school students, suicide ideation was associated with having a suicidal friend, lower perceived father support, and overall parental caring.[7] Among Mexican American adolescent females (but not males), having friends who were disconnected from school has also been associated with increased odds for suicide ideation.[4] Furthermore, family dysfunction due to drug use and violence has also been associated with suicide ideation among Hispanic adolescent females,[8] whereas acculturation gap and immigration stress have not.

Quality of relationships is also especially relevant for suicide attempts among Hispanic adolescent females. Low levels of parental care and family connectedness have been associated

[1] The term Hispanic is used throughout this article as it refers to persons specifically of Spanish-speaking origin or ancestry in the United States. The term Latino/a, on the other hand, refers to persons of Latin American origin or ancestry, which includes Brazil and Haiti (but excludes Spain and Europe). Although distinct, the two terms are often used interchangeably in the literature.

with greater odds of suicide attempts, as well as ideation, in this population.[7] Suicide attempts have also been associated with having a suicidal friend, as well as lower perceived teacher and parental support among this population.[7] Low levels of mother-daughter mutuality (i.e., reciprocal empathy and engagement) has also been found to predict higher internalizing and externalizing behavior among Hispanic adolescent females, which, in turn, predicted attempts.[7]

Similarly, parent-adolescent conflict has been associated with higher levels of internalizing behaviors and lower self-esteem among adolescent Hispanic females, which in turn were associated with suicide attempts.[12] Indeed, researchers have concluded that Hispanic adolescent females with a recent suicide attempt had done so following a breakup with a boyfriend or an intense fight with their mother.[7] Importantly, Hispanic adolescent females with a history of a suicide attempt were also more likely to report negative coping skills, such as withdrawal and wishful thinking.[7]

Protective Factors

Familism, a social value that places the needs of the family before those of the individual, seems to be related to suicide resiliency among Hispanic adolescent females. Familism has been identified as a protective factor against parent-adolescent conflict for Hispanic adolescent females.[12] Familism has also been associated with a greater likelihood that a Hispanic adolescent female belongs to a tight-knit family (i.e., high cohesion and low conflict) than an intermediate (i.e., moderate-to-low cohesion and moderate-to-high conflict) or loose-knit family (i.e., low cohesion and high conflict). In turn, Hispanic adolescent females are less likely to have attempted suicide if in a tight-knit family compared with other family environment types.[14] Although familism seems to serve a protective factor for Hispanic adolescent females, it also has been linked to increased internalizing behavior;[12] thus, may not always be beneficial.[15]

Quality of parental relationships seems to have a more consistent role in protecting against suicide ideation and behaviors among Hispanic adolescent females. For example, parental interest in school life and parental caring was negatively associated with suicide ideation among Hispanic adolescent females.[8] Better mother-daughter relationships due to greater cultural involvement,[16] and greater mother-daughter mutuality[12] are associated with a reduced likelihood of a suicide attempt history among Hispanic adolescent females. Hispanic adolescent females without prior suicide attempts also report using emotion regulation and problem solving coping skills more frequently to cope with social conflict than those with a history of attempts.[12]

Barriers to Care and Suicide Prevention Interventions

Hispanic adolescent females and males report less favorable attitudes toward help-seeking at school if upset than their non-Hispanic White counterparts.[17] They also report less favorable attitudes toward seeking help from an adult for a suicidal friend.[7] Problematically, although school engagement is associated with disclosure of suicide ideation or seeking help among Hispanic male adolescents in Hispanic representative schools, it is not for females.[18]

Hispanic youth are also less likely to seek out advice from a friend for another suicidal friend or to characterize those who die by suicide as mentally ill.[19] Hispanic adolescents (aged 12-17) are also less likely to report mental health service use than non-Hispanic White peers,[20] even when controlling for need for care and ability to secure services. It has been suggested that low mental health literacy, stigma, and beliefs about treatment may be barriers to mental health care for

Hispanics.[21] Culturally-tailored approaches may be needed to impact attitudes about suicide and help-seeking among Hispanics.

One culturally-tailored prevention intervention is Familias Unidas,[22] a family-based intervention designed to prevent and reduce risky behaviors (e.g., drug/alcohol use and risky sexual behavior) among Hispanic adolescents by improving family functioning. Familias Unidas consists of eight multi-parent group sessions focused on parenting-skills, followed by four family sessions. Familias Unidas has been shown to prevent and reduce conduct problems, risky behaviors, and internalizing symptoms (e.g., depression) among Hispanic adolescents compared to prevention-as-usual/community controls.[7, 8, 23] Although not designed as a suicide prevention program, Familias Unidas has also significantly reduced suicide attempts among Hispanic adolescents with low levels of baseline parent-adolescent communication.[27]

The need for suicide prevention interventions for Hispanic female adolescents has spurred various efforts, although the efficacy of these interventions has not been tested. Dialectical Behavior Therapy (DBT), for example, has been culturally-tailored for treating Hispanic adolescent females and their parents. Specifically, supplemental dialectical corollaries (i.e., extreme patterns) and treatment targets have been proposed for DBT with this population.[28] These dialectical corollaries include: "old school versus new school" and "overprotecting versus underprotecting." Respective treatment targets include: incorporating aspects of both cultures and modifying maladaptive parental cognitions.

Another untested program is Life is Precious, a community-based after-school program in New York City aimed at reducing suicidal behavior among Hispanic female adolescents (ages 12-18) with a history of suicide ideation or attempts.[29] Life is Precious helps adolescents and families address risk factors by building communication skills, providing academic support, fostering creative expression, and providing wellness support (health foods and exercise). Unlike Familias Unidas, parental/familial participation is not required. Participation is on a drop-in basis with no set curriculum, although participants must be receiving mental health treatment. Although an uncontrolled study, during the program period (1-24 months), suicide ideation decreased and no participant attempted or died by suicide (N = 107).[29]

Other programs geared toward Hispanic adolescent females that may be beneficial but require further testing include (a) Project Wings, (b) a socio-cognitive behavioral treatment for suicidal behavior (SCTB-SB), and (c) an emergency room (ER) intervention. Project Wings is a 16-session school-based mental health group program designed to improve well-being among Hispanic adolescent females.[31] Although not designed to address suicidality specifically, Project Wings has demonstrated feasibility and trends toward reduced stress and depression, and increased connectedness.[32] SCBT-SB was piloted among Puerto Rican adolescents who have experienced a suicidal crisis for 3-6 months; initial results indicating improvements in or maintenance of low ideation, along with partial or total diagnosis remission and improvements in risk factors.[33] Finally, An ER intervention consisting of specialized ER care for mother-daughter dyads following a suicide attempt by female adolescents (a majority of which were Hispanic) has been associated with lower depression scores compared to standard ER care after 18 months.[34-36]

Conclusion & Recommendations

Hispanics are the largest ethnic/racial minority group in the U.S., and are expected to constitute over 25% of the population by 2060.[1] At the same time, suicide risk has increased drastically among Hispanics in the last two decades,[2] especially among women and adolescents. Preventing suicide among Hispanics must be considered a public health priority.

Hispanic youth and community leaders have suggested that culturally tailored prevention interventions for Hispanic youth should: (1) utilize multiple sustainable strategies (e.g., public awareness/educational outreach, skill-building activities), (2) raise awareness about depression in culturally meaningful ways, and (3) promote social connection and cultural enrichment.[36]

Importantly, Hispanic female adolescents have identified that providers who facilitated communication, promoted autonomy, and fostered emotional connection post-suicide attempt helped them become active agents in their treatment and recovery.[37] They also described restrictive care settings (e.g., emergency departments and inpatient units) more negatively than outpatient care. With this in mind, family-based outpatient interventions may therefore be beneficial for Hispanics female adolescents,[42] particularly those that promote cultural engagement and familial/social connection.

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Appendix C

Literature Review

The Burden for Suicidal Behavior among LGBTQ Communities and Promising Suicide Prevention Efforts (Megan C. Lytle, Ph.D., University of Rochester Medical Center)

Overview of LGBTQ Populations: Lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) individuals are often referred to as a single unified group, yet LGBTQ communities include diverse sets of populations with some common experiences (e.g., minority stress) as well as many great distinctions (e.g., medically necessary treatments that require an ICD/DSM diagnosis). Aside from the methodological issues of lumping sexual orientation and gender identity (SOGI) together, there has been little consistency with regard to survey questions and item responses about SOGI.[1] For example, when inquiring about sexual orientation it is often preferred to ask about identity, attraction, and behavior as it is not unusual for individuals who engage in same-sex behaviors to not identify as LGBTQ. In terms of gender identity, it is important to ask questions about sex assigned at birth and current gender identity.[1-5] Although recommendations to improve the measure of SOGI have been developed, these methods have yet to be routinely implemented and may need further refinement due to evolving terminology and knowledge about these communities. [6]

With over 130 federal surveys developed (e.g., Behavior Risk Factor Surveillance System), as of 2016, only eleven federal surveys inquired about sexual orientation and six asked about gender identity. Despite discussions of including SOGI questions on the 2020 census survey, the questionnaire will only inquire about same-sex couples.[7] As a result, there are significant gaps in knowledge about the LGBTQ communities, in general. Though the proportion of LGBTQ adults in the U.S. is unknown, one of the best estimates stems from the 2016 Gallop Poll, which suggests that **4.1% of respondents self-identified as LGBT.**[8] In 2016, 7.3% of Millennials (1980-1998), 3.2% of Generation X (1965-1978), 2.4% of Baby Boomers (1946-1964, and 1.4% of Traditionalists (1913-1945) identified as LGBT.[8] While this identification has either remained consistent or increased, between 2012 and 2016, among younger generations (the proportion of LGBT Millennials increased from 5.8% to 7.3%), there has been a decline among older cohorts (the percentage of LGBT Traditionalists decreased from 1.8% to 1.4%).[8] Further, the proportion of LGBT individuals in each states varies between 2% (North Dakota) and 10.8% (District of Columbia), and it is estimated that 4.5% of New Yorkers identify as LGBT.[9]

Burden for Suicidal Behavior: LGBTQ individuals have a higher burden for attempting suicide and reporting suicidal ideation than non-LGBTQ persons.[6,10] While the suicide rate among LGBTQ populations in the U.S. is difficult to study since death certificates, National Violent Death Reporting System, and numerous population-based studies do not inquire about gender identity or sexual orientation,[11] European studies indicate that **LGB persons are 2-8 times more likely to die by suicide** than heterosexual persons and **transgender individuals are 5-19 time more likely to die by suicide** than cisgender individuals.[12-24]

The U.S. prevalence for **attempting suicide** within the general population (15-54 years of age) is **4.6%, 10-20%** among LGB persons, and **39-55%** among trans individuals (18-54 years of age).[25-27]

However, it is important to note that population-based studies with subsamples of LGB persons may underestimate the proportion of LGB individuals due to mistrust and insufficient questions while community-based samples with respondents recruited directly from LGB venues may not be representative of diverse LGB communities.[77] A systematic review and meta-analysis comparing these methods found the prevalence for suicide attempts among LGB individuals was 11% when population based methods were used and 20% when community based methods were used.[77] Findings from a systematic review that focused on population-based data, indicates that compared to their heterosexual peers LGB individuals had a risk ratio of 2.47 for suicide attempts (1.28 times higher risk among gay and bisexual men, 1.82 higher risk among lesbian and bisexual women).[15] Little data is available on the burden for suicide among queer and questioning individuals since these identities are not always included as item responses and even when data is available, these groups are often excluded from analyses or lumped with LGB persons. One of the few studies to investigate the distinct experiences of LGBQ subgroups found that compared to their heterosexual peers, individual who questioned their sexual orientation were 4 times more likely to endorse suicide planning.[15]

Population Specific Risk Factors: Mental health disorders (e.g., depression), hopelessness, having a relative or friend die by suicide, childhood abuse, isolation, interpersonal conflict, and substance use are just some of the many risk factors linked to suicide.[28,32] In addition to these more universal risk factors, suicidal ideation and attempts among LGBTQ populations have also been linked to family rejection, internalized stigma, victimization, and minority stress.[14,33-37] Specifically, LGB young adults who experienced high levels of family rejection were eight times more likely to attempt suicide in comparison to individuals who reported less family rejection. In addition, suicide attempt risk factors among LGB youth include parents insulting their children, parents discouraging gender nonconforming behavior, and parental psychological abuse.[35]

Among LGBT adults, the odds of attempting suicide were greater among those who endorsed interpersonal trauma and/or discrimination, even after controlling for age, gender, and income.[38] And one of the few studies to examine suicide attempts across age groups indicates that LGB individuals entering their middle years (30-44 years of age) had the greatest odds of endorsing a serious suicide attempt compared to younger LGB adults (18-29 years of age) and older LGB adults (45-59 years of age).[34] These findings are consistent with 2016 population based data which indicated the suicide rate among young adults (18-34) was 15.89 per 100,000, 18.62 among those in their middle years (35-64), and 16.66 among adults 65 years of age and older.[16]

Aside from age, there are significant differences in suicidal behaviors based on ethnic and religious identities. Indeed, Asian, Black, Latino, and Multiracial LGB individuals were more likely to attempt suicide in comparison to their White peers.[3,13] Similarly, trans individuals who identified as racial/ethnic minorities had greater odds of attempting suicide than White trans persons, even after controlling for discrimination.[4] And in comparison to their LGBQ Christian peers, LGBQ Jewish individuals may have lower odds of suicidal ideation while Atheist/Agnostic LGBQ persons may have greater odds for suicidal ideation.[12]

Protective Factors: Several suicide theories propose that *lack of belongingness* is linked to suicidal behaviors.[17-19] Likewise, most protective factors against suicidal ideation and suicide attempts among LGBT persons center on the idea of *connectedness*. Specifically, caring adults (e.g., teachers, adult relatives, religious leaders, adults in community), supportive environments (e.g., gay-straight alliances, safe school, and affirming religious communities), and perceived

family support may protect LGBT individuals against suicidal ideations and suicide attempts.[44-47] Among trans persons, having supportive relationships (especially with parents), affirming documentation (e.g., identification with correct name and gender), protection from transphobia, and completion of necessary medical transition procedures were factors that reduced the risk for suicidal ideations and suicide attempts; however, being in the process of a medical transition was linked to greater risk for attempting suicide.[47]

Promising Settings and Strategies for Intervention: Due to stigma, bias, and barriers to care, persons frequently turn to the Internet for health information,[48] and members of LGBT groups often seek support, document their struggles, and post suicide notes online.[49-51] Thus, one promising prevention approach for LGBTQ adult is web based preventions. E health tools have the potential to provide access or supplement mental health services since they are affordable and anonymous.[52] In addition, web- and text-based approaches have the added potential of minimizing LGBTQ-specific barriers to care. For instance, chat and text messaging help individuals protect themselves from being misgendered based on their appearance and may defend against potential dysphoria (e.g., the sound of their voice). Although social media may offer a less formal source of support than e-health tools, it can help LGBTQ individuals, especially those in more rural areas or less affirming communities, to connect with broader LGBTQ social networks. Thus, social networks and e-health tools may bolster the sense of belonging among LGBTQ individuals. Among the few LGBTQ specific suicide and crisis prevention resources available include:

1) *The Trevor Project* (TTP) is a suicide prevention organization for LGBTQ youth between 13-24 years of age. TTP has a hotline that is accessible 24/7, chat and text services that are both provided 7 days a week for seven hours each day, a monitored LGBTQ affirming social network, and a support center for questions and answers, among other resources and educational trainings. https://www.thetrevorproject.org/get-help-now/#sm.0000ipd4ew7oncuotpu18wyexu5n7
2) The *Trans Lifeline* offers support for trans individuals from trans persons. This resource is currently available 18 hours a day. https://www.translifeline.org/
3) The *It Gets Better Project* (IGBP) and IGBP's *You Are Important* app were created in response to increases in LGBT suicides and infer that suicides will decrease if youth realize that issues get better over time.[53] Despite good intentions, the IGBP and You Are Important app are not monitored nor evidence based, and they offer an impersonal style of suicide prevention (access to inspiring and hopeful messages). A study of the IGBP suggests that LGBT youth want guidance on how to overcome difficult situations and *interventions that address the diversity within LGBT communities.*[54] https://itgetsbetter.org/ and https://itunes.apple.com/nz/app/you-are-important-depression/id862861837?mt=8

Conclusions: LGBTQ suicide is a growing and important public health concern. Though the National Strategy for Suicide Prevention,[55] Joint Commission,[56] and Healthy People 2020[57,58] have goals to reduce suicidal behaviors among LGBTQ adults and to promote well being; there is a paucity of knowledge about LGBTQ suicidal behaviors and very few suicide prevention interventions for LGBTQ communities.[1] Until population-based studies consistently include questions about SOGI, the true burden of suicide among LGBTQ communities will remain

unknown. In addition, to improving federal surveys and encouraging researchers to inquire about SOGI just like any other demographic variable (e.g., age, race, and sex), it is important to work towards developing a culture of safety that ensures LGBTQ persons feel safe enough to answer SOGI inquiries on population-based surveys. Developing a culture of safety and respect may not only facilitate the collection of more representative data by minimizing mistrust, it will address barriers to care and it has the potential to slowly reduce minority stress. While this may seem like a lofty goal, it is important to recognize the progress that has occurred in the past 20 years. Significant advances towards limiting legalized discrimination (e.g., marriage equality), increased insurance coverage for medically necessary treatments, and greater awareness of the unique strengths and needs of LGBTQ individuals.[59] In addition to promoting inclusion and diversity, one of the most promising suicide prevention strategies for LGBTQ communities is strengthening connectedness among family, friends, and social networks.

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Appendix D

Literature Review

Suicide in Veterans: Relevance for New York State Suicide Prevention Efforts (Kim Van Orden, Ph.D.
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Veterans in New York State

New York state ranks 5th in the nation for the size of its Veteran population: in 2017, the size of the Veteran population in NYS was 912,499 individuals, representing 4% of the nation's Veterans (population in 2017 of 21,369,602).[1] Most Veterans in NYS do not receive VA healthcare (72.5%), a proportion that is comparable to statistics for the nation as a whole, and even fewer have a service-connected disability (12.6%), a factor that may influence benefit eligibility.[2] Veterans in NYS are predominantly male (94.4%) and half of Veterans in NYS are age 65 or older (50.7%).[2] Most characteristics of the Veteran population in NYS (for years 2009-2013)[2] do not significantly differ from the characteristics of the national Veteran population, including: the unemployment rate (5.8%), the uninsured rate (3.8%), and the median household income ($54,555). There are 2,542 homeless Veterans in NYS and 138,670 Veteran owned businesses in NYS. For additional statistics and graphical depictions, please see Attachments One and Two. *The size of the Veteran population in New York State, including that most do not receive VA healthcare, underscores the importance of considering Veterans in statewide suicide prevention efforts. The comparability of our state's Veterans (per the statistics described above) to the Veteran population of the nation suggests that nationwide statistics on suicide in Veterans are likely to provide useful information to prevention efforts in NYS.*

An Overview of Suicide in Veterans

Characterizing the scope of the problem of suicide in Veterans is highly complex given significant heterogeneity in the population. There is no single "type" of Veteran and not all Veterans are at equivalent risk for suicide.[3] Factors that contribute to heterogeneity and differing risk include the age at which one becomes a veteran (separation from service), the type of separation (e.g., routine versus non-routine), service-related disability status, cohort/era (WWII, Vietnam, etc.), self-perception of Veteran status, enlisted versus officer status, eligibility for VA services, and receipt of VA services. Many of these factors are linked to suicide risk (see below). *Thus, all conclusions about suicide among Veterans broadly must be interpreted cautiously.* Similarly, making comparisons about suicide in Veterans versus civilians must be done with caution given that there are many differences between Veterans and civilians in addition to military service, including the average age of the population (Veterans are significantly older than non-Veterans, median age 64 versus 44) and the proportion of women (Veterans are predominantly male, 91%). Thus, differences between Veterans and non-Veterans must attend, at a minimum, to demographic differences between the populations. The most recent data compiled by the U.S. Department of Veteran Affairs (hereafter referred to as "VA") indicates that Veterans are at elevated risk for suicide when accounting for differences in age and sex: risk for suicide is 22 percent higher among Veterans when compared to U.S. non-Veteran adults.[4] *These data indicate that Veteran status is a risk factor for suicide and that targeting Veterans as a high risk population in NYS suicide prevention efforts has the potential to reach a large number of adults at risk.*

A note regarding terminology: some reports from VA use the term "suicidal self-directed violence" to capture both non-lethal and lethal suicidal behavior. In this summary, the terms suicide attempt and suicide death are used instead to refer to non-lethal and lethal suicidal behavior, respectively.

Prevalence, Subgroups, and Risk Factors

Suicide is a significant public health and clinical problem across the lifespan in both Veterans and non-Veterans. However, the magnitude of the problem varies across the lifespan and conclusions drawn about which age group is most affected depends on the statistic considered – ranks, raw numbers, and rates. These differences become even more salient when attempting to compare Veterans and non-Veterans because the patterns regarding ranks, raw numbers, and rates vary between Veterans and non-Veterans. In the general population (for 2015), suicide was the 10th leading cause of death (rank). Considering ranks for leading causes of death by age groups, suicide ranked second for youth and young adults ages 10-34 (behind unintentional injury), with suicide falling lower in the rank as age increases (and the prevalence of other causes of death increase). For the next set of statistics, we will consider men only given that the bulk of suicide deaths are among men[5] and patterns for raw numbers versus rates differ for women (these complexities by gender are beyond the scope of this review). Regarding raw numbers for 2015, in the general population, the bulk of suicide deaths (raw numbers) occur among those in the middle years, followed by older adults, young adults, and youth. In contrast, in the general population, rates (which are a function of the size of the population) increase with age (see Figure 1). For the Veteran population, the pattern differs: rates are highest in the youngest Veterans (ages 18-29) and decrease with age (until age 80 when rates rise), while raw numbers are lowest in young adults and highest in the middle years through age 69 (see Figure 2). In 2014, 65% of Veterans who died by suicide were ages 50 or older. At first glance, these patterns may suggest that the distribution of the problem by age

differs in the Veteran population. However, it is important to keep in mind that the Veteran population has a greater proportion of older adults (median age 64 in Veterans vs. 44 in non-Veterans), which likely accounts (in large part) for these differing patterns. Another important consideration is that rates of suicide in female Veterans increased 62.4% from 2001-2014, while

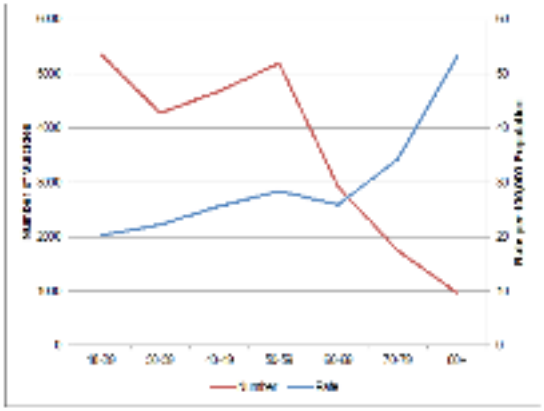

Figure 1. Comparison of counts and rates by age group for male non-Veterans (2014)

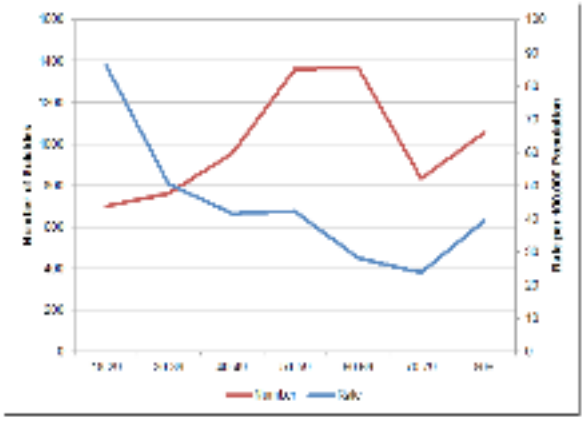

Figure 2. Comparison of counts and rates by age group for male Veterans (2014)

rates in male Veterans increased 29.7%, indicating a need to attend to risk among female Veterans.[3] Risk is also elevated in Veterans who identify as sexual minorities as well as those who identify as transgender.

In addition to demographics, Veterans and non-Veterans differ in numerous other ways, including access to a nationwide health system (though not all veterans are eligible), exposure to different/unique stressors (including combat, access to firearms, and stresses related to military culture), greater likelihood of certain health conditions (including PTSD, pain, sleep disturbances), and possibly individual differences (e.g., personality) that make one more likely to choose military service (in cohorts without mandatory service). *However, there is no reason to conclude (based on available data) that causal mechanisms in the trajectory towards suicide are different for Veterans.*

Prevalence of suicide also differs for different subgroups of Veterans, as evidenced by differing rates according to: younger age at becoming a Veteran (separation from active duty), non-routine discharge,[4] not receiving VHA health services (both by choice and eligibility), disability status (including service-related disability), and era/cohort effects (i.e., war/conflict during time of service). Combat exposure and deployment to war zones is associated with suicide risk in some studies but not others,[5] which may be explained by the fact that exposure to combat is a heterogeneous phenomenon and may be measured differently across studies. Homelessness is linked to greater risk for suicide ideation and behavior among Veterans.[6,7] Exposure to trauma before military service may also increase suicide risk after service.[8] A recent study demonstrated that some types of non-routine discharges were associated with increased risk for psychiatric disorders and suicide risk: In particular, veterans receiving VHA services with discharges classified as "disqualified" or "misconduct" had 2.8 times greater risk of reporting suicide ideation in the year following discharge compared to routinely discharged veterans.[9] *Focusing on Veterans in higher risk subgroups may aid in identification of those at greater risk, which is especially germane to NYS prevention efforts given that many of the Veterans in these groups may be less likely to receive services through the VA.*

Suicide risk factors that may more prevalent in Veterans include PTSD (but see below), chronic pain, functional impairment, and emotions such as guilt and shame.[10] Regarding the latter, the concept of "moral injury" (e.g., violating one's moral code through an act such as killing a child) is receiving attention by researchers and clinicians as a military stressor that may not respond to traditional evidence-based exposure-based psychotherapies for PTSD and that may be particularly linked to suicide risk. Traumatic brain injury (TBI) is more common in Veteran populations and has also been linked to elevated risk for suicide.[11] Risk factors such as mood disorders, insomnia, nightmares, and substance abuse are not are unique to Veterans, but have been shown to be strong predictors of suicide risk in this population as well.[12] The comorbidity of a depression diagnosis and PTSD may be an especially pernicious combination for suicide risk in Veterans.[13] The transition from active duty to veteran status may be a particularly high-risk time—and a period especially germane to NYS efforts—as Veterans begin to engage with VHA (or choose not to). The VA Office for Suicide Prevention recommends that providers working with Veterans recently discharged from active duty work with the Veteran to identify sources of social support during the transition time.

VA Suicide Prevention Efforts

The VA has made suicide prevention a priority, with resources dedicated to clinical services among those receiving VHA care as well as research on suicide in Veterans. VA suicide prevention campaigns have been shown to be associated with increases in use of crisis support services (e.g., Veterans' Crisis Line) for Veterans, suggesting effectiveness of these efforts.[5] Resources and strategies most central to VA prevention efforts, as well as those deemed potentially relevant to NYS efforts are described below.

- Each VHA facility has a dedicated Suicide Prevention Coordinator, tasked with coordinating clinical efforts to promote suicide prevention among the Veterans served in that facility.
- The VA and DOD have a shared set of Clinical Practice Guidelines for providing healthcare with active duty personnel and Veterans to prevent suicide.
- Since 2008, the Office of Suicide Prevention has maintained a registry of VHA suicide attempts and deaths reported by the Suicide Prevention Coordinators (SPCs) in each VA Medical Center. This active surveillance registry is called the VA-Suicide Prevention and Application Network (SPAN). It was established with three major goals: to coordinate the identification and reporting of suicide attempts and deaths within and across VHA facilities; to facilitate the identification of individuals at high risk to allow the targeting of interventions; and to support both program planning and evaluation.
- Population-based screening is conducted by the Department of Defense, including Post-Deployment Health Assessments that are completed immediately upon return from deployment, and again three months later during the Post-Deployment Health Re-Assessment. These assessments included validated screening instruments for depression (PHQ-2), post-traumatic stress disorder (PHQ-4), and alcohol abuse (AUDIT-C). This screening process may be relevant for identifying suicide risk in NYS Veterans, especially those who do not receive VHA services.
- VA established a toll-free, confidential Veterans Crisis Line at 1-800-273-8255 (1-800-273-TALK) that is available nationwide. The hotline was established in 2007 and is staffed 24 hours a day, seven days a week. VA also offers a texting service at #838255. Veterans and their families can also chat online with trained counselors at www.VeteransCrisisLine.net. Registration with VA or enrollment in VA health care is not necessary.
- VA is a leader in promoting evidence-based practices for mental health, including suicide prevention. Safety Planning is considered a best practice nationwide for addressing suicidal crises; safety planning was initially developed for use in VA and has since been broadly disseminated outside VA as well. Strong research evidence supports safety planning. Guides to implementing safety planning are available that are accessible outside of VA for both adults and older adults:
    - https://www.mentalhealth.va.gov/communityproviders/clinic_suicideprevention.asp
    - https://www.mirecc.va.gov/visn16/collaborative-safety-planning-manual.asp
- A useful resource for mental health professionals outside VA who treat Veterans is the VA Community Provider Toolkit, which contains information to orient professionals to military culture, increase awareness of available resources, and provide information on how to connect Veterans with VA. The site includes information on suicide prevention: https://www.mentalhealth.va.gov/communityproviders/clinic_suicideprevention.asp

- Given VA's nationwide administrative and healthcare databases, efforts that would be difficult to implement elsewhere are possible given the large amount of administrative and healthcare data. Specifically, strategies for identifying Veterans at elevated risk for suicide using innovative statistical modeling ("machine learning") that is used to create algorithms for risk stratification have been developed and are used to identify Veterans at increased risk for suicide and outcomes such as hospitalization for suicide risk.[9,10] The program is called Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET).
- Lethal Means safety: access to firearms is associated with suicide deaths in Veterans and non-Veterans. The VA provides information on lethal means safety practices: https://www.mirecc.va.gov/lethalmeanssafety/safety/
- The HOME Program. The VA Home Based Mental Health Evaluation (HOME) program was designed to engage Veterans in care following discharge from a psychiatric hospital (a time of heightened risk). VHA's approach to integrating primary medical care and mental health care emphasizes co-location and connecting Veterans in need with behavioral health providers. This is contrast with "collaborative care" depression (and suicide prevention) models used in many civilian primary care practices to provide mental health care *within* primary care by adding care managers (typically social workers or nurses) who conduct screening, on-going assessment, and behavioral interventions such as behavioral activation or problem solving therapy. These models also typically include psychiatric consultation for PCP's for more challenging cases. Collaborative care is effective in the treatment of depression and reduction of suicide ideation (outside VA), but is not standard practice in VA, though it is sometimes used.[11] Given that primary care is a common setting for Veterans with suicide risk to present for care, the role of collaborative care in suicide prevention in Veterans is one potential area to be addressed both within and outside VHA.

Conclusions: Reaching Veterans outside VHA could have a large impact in NYS

Suicide in Veterans is a complex issue. Available data suggest that suicide mortality among Veterans who use VHA services is declining, a trend that does not hold for those Veterans not using VHA services.[3] This suggests that targeting NYS suicide prevention efforts to Veterans in NYS who are not receiving VA services and who may be at risk for suicide could be an impactful use of resources. Some of these Veterans may be eligible for VA services; understanding why these Veterans are not using available services could inform intervention efforts. Possible reasons include unawareness of eligibility, beliefs that one should not access such services, inaccessibility due to transportation problems or geographic distance, inaccessibility due to wait times or other service barriers, or desire for community providers. Interventions could potentially address these barriers and improve linkage with VA services. Linkage could also include services beyond healthcare, such as volunteer programs through VA, to address risk factors such as social isolation. Volunteer programs outside VA, including national programs through the Corporation for National and Community Service, also prioritize work with Veterans (https://www.nationalservice.gov/focus-areas/veterans-and-military-families). While a larger number of Veterans not receiving VHA care may be eligible for services but receive healthcare elsewhere (e.g., an employer sponsored plan) and others may be ineligible due to a number of reasons (e.g., serving for limited times prior to 9/11), some may be at elevated risk due to factors

that lead to their ineligibility, such as misconduct or criminal behavior. Non-VA efforts may be especially impactful for these Veterans.

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Appendix E

Other References and Resources

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