



Office of
Mental Health

1,700
Too Many



New York State's
Suicide Prevention Plan
2016-17

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Mental Health**

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New York State's Suicide Prevention Plan 2016-17

OMH Suicide Prevention Office
September 2016

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Foreword



Office of Mental Health

ANDREW M. CUOMO
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ANN MARIE T. SULLIVAN, M.D.
Commissioner

MARTHA SCHAEFER
Executive Deputy Commissioner

July 1, 2016

Dear New Yorkers:

We are pleased to share with you *1700 Too Many: The 2016-2017 New York State Suicide Prevention Plan*, a proposal which addresses the tragic suicide epidemic affecting all New Yorkers.

Every year families and friends across America lose over 42,000 loved ones to suicide. Despite an enduring commitment to suicide prevention, New York State, like the nation, has witnessed a steady rise in suicides over the last decade. Suicide is now the 10th leading cause of death for all ages, and it casts a long shadow on individuals, families, and communities. As detailed in the Plan, suicide deaths in this country each year exceed deaths from motor vehicle accidents, homicides, and breast cancer. In 2014 (the most recent data available), 1700 New Yorkers died by suicide. We must act now to reduce suicides in our state.

With a problem as complex as suicide, no one solution will be enough. Ensuring access to quality mental health services for those in need is necessary but not sufficient. Well-coordinated, collective efforts offer the most promise. Our health and behavioral health systems, schools, and communities need to collectively work to reduce suicide deaths in our state using the best available information and practices. This is what our plan proposes.

We want to underscore three key characteristics of the 2016-2017 New York State Suicide Prevention Plan:

- *Transparency* - the Plan identifies three core strategies along with associated guiding principles that serve to prioritize activities to prevent suicide.
- *Accountability* - Plan progress will be reviewed against clearly articulated benchmarks at the annual New York State Suicide Prevention Conference; formal feedback will be sought from the community and Suicide Prevention Council; and
- *Iterative* - our knowledge base around effective suicide prevention interventions is constantly evolving. Any plan must allow for learning, innovation and change.

Working together, we can bring hope and recovery to those struggling with taking their own lives. Together we can advance suicide prevention in New York State.

Thank you to all those working with us to achieve our goal.

Ann Marie T. Sullivan, M.D.
Commissioner

Jay Carruthers, M.D.
Director, Suicide Prevention Office

Executive Summary

Suicide is a significant public health problem in the United States and New York State. In 2014 (the most recent data available), 42,773 persons died by suicide in this country.¹ Over the last decade, the nation witnessed the number of annual suicide deaths surpassing deaths by motor vehicle accidents, homicides, and most recently breast cancer. Since 1999 rates of leading causes of death, such as heart disease, stroke, and cancer, have been decreasing, but according to a recent report by the Centers for Disease Control and Prevention (CDC), the suicide death rate in the US increased by 24%.²

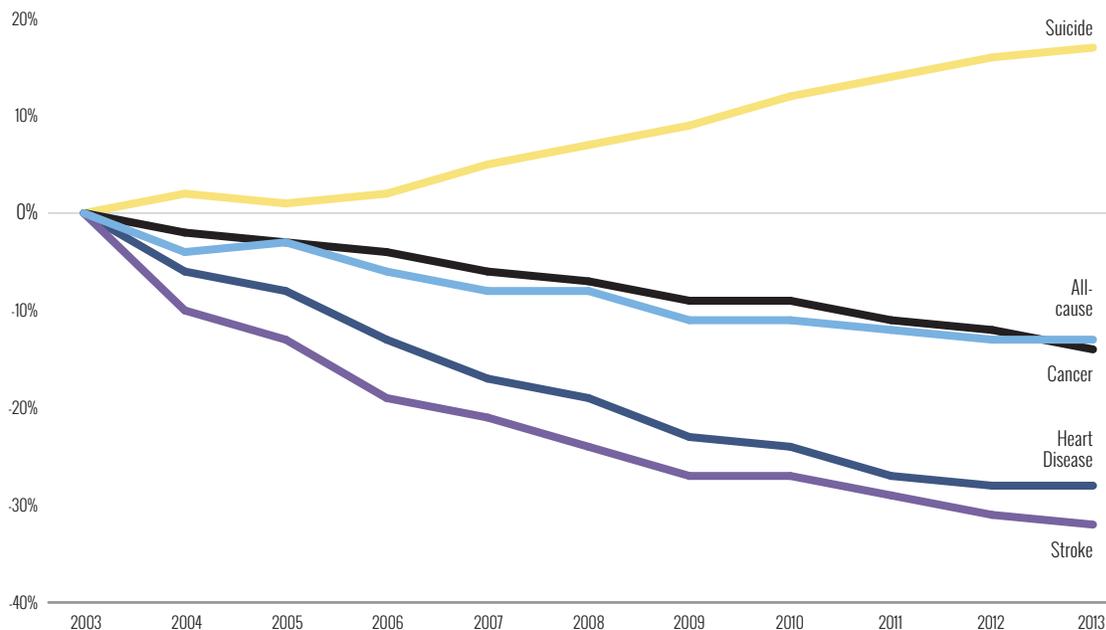
Suicide is the 10th leading cause of death among all age groups in this country³—with devastating consequences for individuals, families, communities and society at large.

One suicide is too many. In 2014, 1,700 New Yorkers died by suicide.¹

All states are faced with the challenge of implementing strategies that reverse the sobering trend. In 2012, the National Action Alliance for Suicide Prevention, a public-private partnership, in concert with the U.S. Surgeon General's Office, released *The National Strategy for Suicide Prevention (NSSP)* to guide the nation's efforts to decrease suicides over the next decade.⁴ In 2014, New York was one of only four states to be awarded the NSSP Substance Use and Mental Health Services Administration (SAMHSA) grant focused on integrating suicide prevention into healthcare settings and providing suicide prevention specific training to healthcare providers.

1,700 Too Many is New York State's plan to materially advance suicide prevention in the state. Statistically rare and yet shockingly common, suicide is a complex problem that calls for coordinated community, public health and healthcare system approaches. Through our collective action, suicide is preventable. There is hope.

Figure 1: Percent Change in Age-Adjusted Death Rates Since 2003 by Cause of Death, 2003-2013

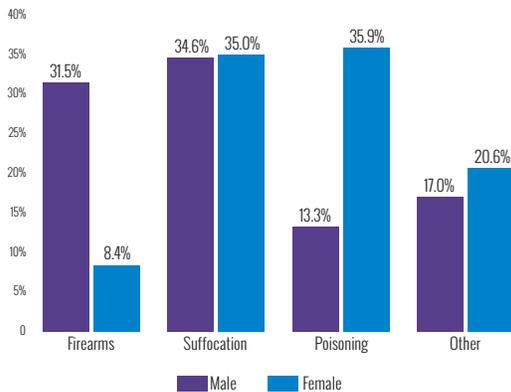


Lethal Means of Suicide

In 2014, the most prevalent lethal means of suicide in the state were suffocation (37%), firearms (28%), and poisoning (17%).³ Given the difficulty of distinguishing between deliberate or accidental overdoses, the percentage of suicide deaths by poisoning is likely an underestimate. Hence, of the 1,937 deaths classified as accidental overdoses that year, some may have been intentional overdoses.³

Lethal means of suicide in the state differ from national trends where more than half of all suicides are by firearms.³ Between 2012 and 2014, both genders were similar in their use of suffocation as preferred lethal means, with marked difference in use of firearms and poison. Men were more likely to use firearms, while women were more likely to use poison (See Figure 3).³

Figure 3: Percent of Suicide Deaths by Means and Gender



Demographics

Gender

Consistent with national trends, approximately 75% of New York State suicides are by men.³ Use of more lethal means, and reluctance to seek help may contribute to the higher suicide rate among men.⁷ In the year before a suicide, only 35% of men nationwide sought mental health treatment compared to 58% of women. Yet, 78% of men who died by suicide, on average, visited their primary care provider within a year prior to their death signaling an opportunity for suicide prevention in primary care settings.⁸

Race and Ethnicity

Similar to national trends, whites have the highest rates of death by suicide. In 2014, 84% of New York State suicides were among whites, 7% were among African Americans and 7% were among Hispanics.³

Age

Consistent with national trends, New Yorkers 45-64 years old have the highest rates of death by suicide ranging from 11.6 per 100,000 among 60-64 year olds to 14.9 per 100,000 among 50-54 year olds.⁹

High Risk Populations: Suicide Across the Lifespan in New York State

Youth

Though the suicide death rate is lower among youth than other age cohorts, 5.3 per 100,000 among 15-19 year olds and 8.7 per 100,000 among 20-24 year olds³—the number of suicide attempts is much higher. Suicide is the second leading cause of death among the state's 15-24 year olds.³

Middle-aged Men

Men, ages 45-64, have the highest suicide death rate in New York State and nationally. Within this demographic the suicide rate is 18.3 per 100,000, more than twice the rate for the state's population as a whole. White middle-aged men account for 89.3% of these deaths (22.3 per 100,000).³

Elderly

The suicide rate for individuals aged 75 and older is 8.4 per 100,000.³ Though similar to the state's rate, the elderly are considered a high risk group, because attempts among its members are more likely to result in death. National estimates suggest that there is one suicide death for every four attempts, compared to 25 attempts for the general population and 100-200 for youth.¹

Individuals in the Justice System

While statewide rates for suicide deaths of incarcerated individuals are not available, the average rate of death by suicide between 2000 and 2013 for adult inmates in jails nationwide was 41 per 100,000. The rate climbs to 80 per 100,000 for white inmates and 86 per 100,000 for inmates not yet convicted.¹⁰ Nationally, incarcerated youth age 17 or younger have a 49 per 100,000 suicide

death rate.¹⁰ Youth in adult facilities are 36 times more likely to die by suicide than youth in juvenile facilities.¹⁴ This statistic is of concern to New York State, because it is one of only two states that prosecutes all youth ages 16 and 17 in the adult criminal justice system.¹¹

Veterans and Active Military

The suicide rate among New York State veterans increased to 26.6 per 100,000 in 2011 (most recent data available). Veterans account for 15.3% of the state's suicide deaths.¹² Nationally, suicide rates have trended higher among those receiving care outside of the Veteran's Health Administration (VHA).¹³ While the VHA treats large numbers of veterans in the state, not all are eligible or choose to access these services.

Risk Factors Associated with Suicide

Mental Illness

Consistent with research on individuals with mental health disorders, i.e., depression, bipolar disorder, and schizophrenia, the suicide rate for those served in the New York State public mental health system is 38.8 per 100,000,¹⁴ almost five times the rate of the general population.

Alcohol and Drug Use

Substance use disorders are common in individuals who die by suicide, occurring in 19-63% of all suicides.¹⁵ While statewide figures are not available, in New York City between 2007 and 2008, 33% of those who died by suicide had been drinking at the time of death, and 39% of those who died by intentional poisoning tested positive for one or more opioids.¹⁶

History of Trauma

Adverse childhood experiences, and specifically trauma, have been linked to suicidal behavior.^{17,18} Of particular concern is research that suggests this risk endures well beyond childhood and early adulthood.^{19,20} While estimates vary, one study found that individuals exposed to several adverse childhood experiences, including childhood trauma, are over 20 times more likely to attempt suicide.¹⁷

History of Suicide Attempts

Individuals who attempt suicide are at 30-40 times increased risk to die by suicide than someone without a history of suicide attempts.²¹ A history of suicidal behavior, particularly recent behavior, is one of the strongest predictors of further suicidal behavior including suicide death.

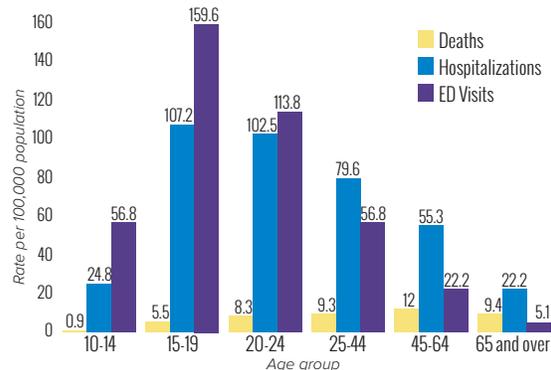
Non-Suicidal Self-Injury (NSSI)

Although occurring without intent to die, NSSI is a recognized risk factor for suicide, particularly among adolescents and young adults. One longitudinal study of college students found individuals reporting a history of NSSI were greater than 2.5 times more likely to engage in suicidal behavior than controls. It has been suggested that NSSI may be a "gateway" behavior to suicide, reducing inhibition to suicidal behavior through repeated NSSI.²²

Suicide Attempts

The number of suicide deaths does not fully capture the extent of the problem of suicidal behavior. For every suicide death, there are 25 non-fatal suicide attempts.¹ Among adult New Yorkers surveyed between 2008 and 2009 about past health behavior, 4% (539,000) reported thoughts of suicide, 0.6% (90,000) reported planning a suicide attempt, and 0.4% (56,000) reported an actual attempt.²³ Many of these attempts were severe enough to require major medical attention.⁹ In 2012, there were 11,383 hospitalizations (58.2 per 100,000) and 8,340 emergency department visits (42.6 per 100,000) for self-harm injuries which cost over a quarter of a billion dollars in visit charges.^{5,9}

Figure 4: Deaths, Hospitalizations and Emergency Department Visits by Age in New York State, 2010 - 2012



Women are 22-34% more likely than men to make an attempt and be hospitalized or treated in the emergency department for self-inflicted injuries.⁹ Adolescents and young adults make more attempts and have the highest rates of hospitalization and emergency department visits for self-inflicted injuries than any other age cohort.⁹ On the Youth Risk Behavior Survey,²⁴ 13.7% of New York State high school students reported seriously considering a suicide attempt, 7.1% reported one or more suicide attempts, and 2.4% reported an attempt resulting in an injury or overdose that required medical treatment. Of individuals identifying as lesbian, gay, bisexual, transgender & questioning, (LGBTQ) in New York City, 8.3% reported a serious suicide attempt.^{25,26} Attempts were higher for LGBTQ aged 45-59 (16%) and for LGBTQ Latinos (13%). Nationally, LGBTQ adolescents were four times more likely to have attempted suicide than their non-LGBTQ peers, and the attempts are four to

six times more likely to result in injury, poisoning, or overdose that requires treatment from a health care professional.⁵

Suicide Loss Survivors: Impact on Loved Ones

The experience of suicide loss is traumatic, and the impact on family members and friends long-lasting. People who experience suicide loss are 65% more likely to attempt suicide than if they experienced a death by natural causes.²⁷ In addition, they are 80% more likely to drop out of school or to lose their jobs.²⁴ It is typical for suicide loss survivors to feel extreme guilt, anger, confusion, and distress.²⁸ Parents who lose a child to suicide typically have higher rates of depression, anxiety, physical problems and divorce. Children of parents who died by suicide are at increased risk of taking their own lives.²⁸

New York State Suicide Statistical Overview

- 1,700 New Yorkers died by suicide in 2014. Only four states in the country had a higher number.
- Middle-aged men have the highest rate and largest burden of death.
- Three out of four suicides are by men.
- Women are more likely to make an attempt/be hospitalized/ treated in the ED for attempts.
- Most prevalent means of suicide death: suffocation (37%), firearms (28%), and overdoses (17%).
- Individuals in the public mental health system have almost five times the suicide rate (38.8 per 100,000) of the New York State general population (8.6 per 100,000).
- Nearly one-half of those receiving care in the public mental health system who died by suicide received outpatient mental health care less than 30 days prior to their death.
- Nearly two-thirds of 1,585 New York clinicians surveyed reported little or no specialized training in suicide-specific interventions.

“Feeling stigma from many of my colleagues as well as the community at large, I reached out to the suicide loss survivor community. It was there that I found my footing. Since then, it has been my mission to help those grieving a suicide.”

Vanessa McGann, Ph.D., Suicide Loss Survivor

Part II: New York State OMH Suicide Prevention Infrastructure

New York State's longstanding commitment to suicide prevention spans nearly 30 years. Over the past three decades, many initiatives and partnerships have laid the foundation for the state's current suicide prevention infrastructure. Despite periods of economic austerity, New York's financial commitment to suicide prevention has remained constant, establishing it as a forerunner among other states in the nation. New York State leaders and experts from academia, community organizations, and local and state government have made significant contributions to the field of suicide prevention.

The New York State Office of Mental Health (OMH) has played a central role in suicide prevention in the state. In 2014, OMH conducted a review of all OMH supported suicide prevention activities. In addition to providing a comprehensive overview of projects, which included a well-established community and gatekeeper training infrastructure, it called for:

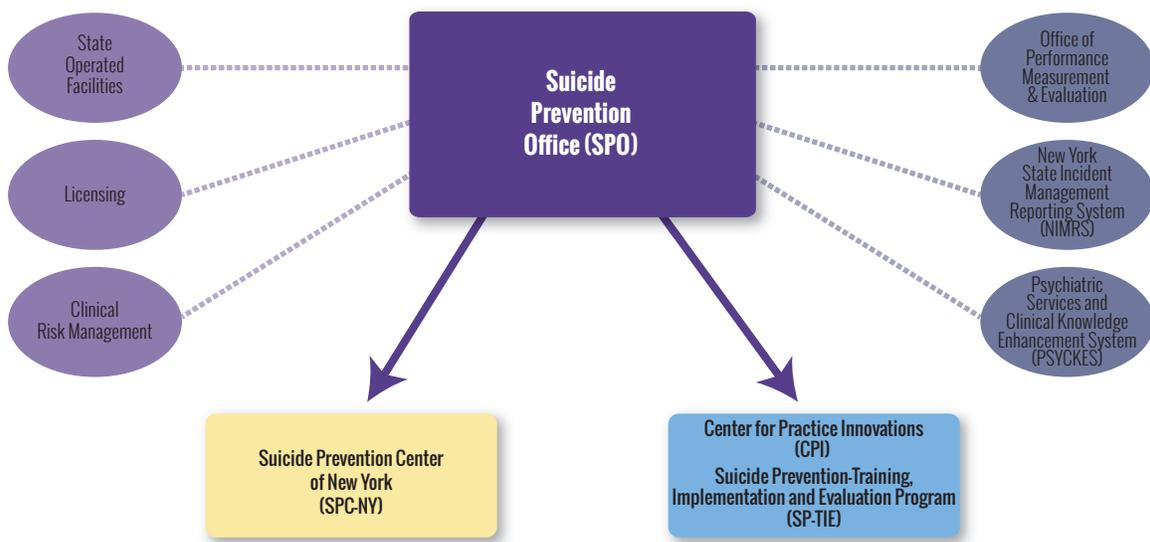
1. Improved coordination and alignment of state-wide initiatives,
2. Additional investment in suicide prevention clinical trainings, and
3. The establishment of the Suicide Prevention Office.

The OMH Suicide Prevention Office (SPO)

The Suicide Prevention Office (SPO) was created in 2014 to coordinate all OMH-sponsored suicide prevention activities. SPO aims to strengthen suicide safer care across health care settings starting with behavioral health, followed by primary care, emergency rooms, and substance use disorder treatment settings, while continuing to support and strengthen the existing community-based infrastructure. SPO's main partners in this endeavor are the Suicide Prevention—Training, Implementation, and Evaluation (SP-TIE) program within the Center for Practice Innovations and the Suicide Prevention Center of New York (SPC-NY).

SPO's efforts to date have focused on collaboration and coordination across the OMH system, including licensing, state operated facilities, and field offices; review of suicide deaths of individuals serviced by OMH; development of a statewide suicide surveillance system; and establishing a learning collaborative to provide technical assistance to early adopter provider systems interested in implementing current best practices of the Zero Suicide model (see description below).

Figure 5: Office of Mental Health Suicide Prevention Organization Chart



Suicide Prevention Center of New York (SPC-NY)

Founded in 2009 by OMH, SPC-NY is the community-based presence of suicide prevention within the state. It advances statewide and county-specific suicide prevention initiatives. SPC-NY has developed a strong community-based infrastructure that supports local efforts to prevent suicide, including promoting suicide prevention in schools, early identification through gatekeeper trainings, and local support for individuals through fostering competent caring communities. SPC-NY has supported the development and growth of suicide prevention coalitions in 44 counties across the state and the training of over 30,000 individuals as gatekeepers since 2012. When a community is affected by a suicide death, SPC-NY, through its collaborative efforts with local OMH field offices and local organizations, facilitates postvention responses and activities to address the loss and limit contagion effect.

Suicide Prevention-Training, Implementation, and Evaluation (SP-TIE)

Established in 2014 at New York State Psychiatric Institute, SP-TIE is an initiative within the Center for Practice Innovations (CPI), a joint program of OMH and Columbia University. SP-TIE's mission is to increase the capacity of clinicians in the state to assess, manage and treat suicidal individuals. SP-TIE, in coordination with the SPO, selects, develops, implements and evaluates evidence-based suicide prevention clinical interventions. It is responsible for developing suicide safer care clinical training approaches and materials for clinicians across the state (e.g. risk assessment, safety planning, and evidenced-based interventions), identifying and targeting gaps in expertise and training, and conducting ongoing evaluation for both SP-TIE and SPC-NY training offerings.



“[Suicide is] not an easy topic to discuss and because we, as a culture, don’t know how to approach it, it’s easily swept under the rug. I get it: we’re afraid of death. But avoiding it and pretending it doesn’t exist is nothing more than willfully perpetuating ignorance.”

Dese’Rae L. Stage, Suicide Attempt Survivor



Part III: The New York State Suicide Prevention Strategy

New York's 2016-17 Suicide Prevention Strategy described below uses a multifaceted systems approach that targets both health/behavioral healthcare and community settings, with a commitment to continuous-use data to inform and evaluate the effort over time.

Building on the strength of the current foundation for suicide prevention, the New York State strategic framework is divided into three main domains or strategies:

1. Prevention in Health and Behavioral Healthcare Settings—Zero Suicide in New York State,
2. Lifespan Prevention Approach in Competent, Caring Communities, and
3. Suicide Surveillance and Data-Informed Suicide Prevention.

Successful suicide prevention in New York State depends on advancements in all strategies.

Each of the following sections contains a narrative description followed by a prioritized list of lettered goals, serving as guiding principles. The plan will be reviewed annually to track progress using measurable benchmarks for transparency and accountability. Feedback and recommendations will be sought from a newly formed Suicide Prevention Council with representation from experts in the field, advocates, and persons with lived experience.

Strategy 1: Prevention in Health and Behavioral Healthcare Settings—New York State Implementation of Zero Suicide

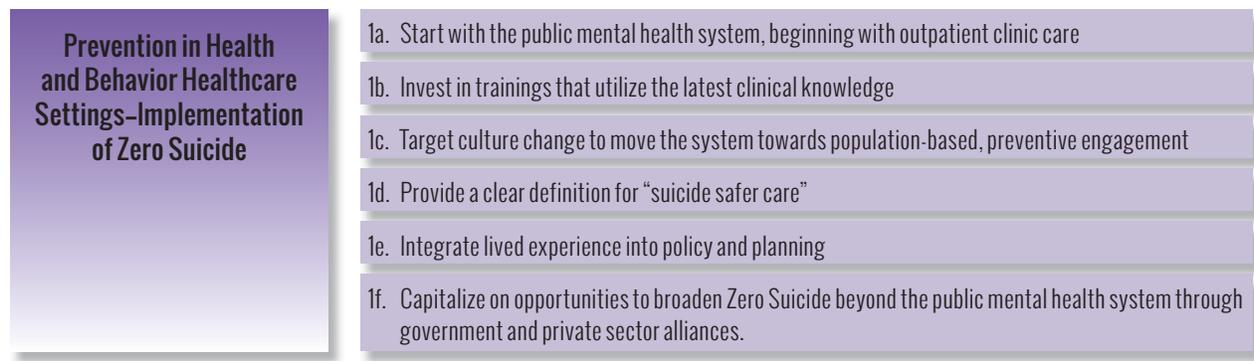
The promise of Zero Suicide²⁹ depends on successfully re-engineering healthcare systems in such a way that identifies those in distress and delivers timely intervention. Zero Suicide implementation in New York State offers a strategic approach for reaching significant portions of the high-risk populations highlighted in Part I of this report. However, we are also keenly aware that successful implementation of Zero Suicide has been limited to early adopter behavioral health agencies. State-level implementation is still in its infancy.

We believe the following six guiding principles are the keys to successful adaptation and scaling of the Zero Suicide model in New York State.

1a: Start with the Public Mental Health System, Beginning with Outpatient Clinic Care

Large-scale change begins where there is leadership. OMH is well positioned to provide that leadership, including through its regulatory authority and management of its large state operated network of hospitals and clinics, as well as its use of suicide surveillance data. Nearly 730,000 people are served by the New York State public mental health system each year. OMH licenses 429 outpatient clinics with 880 satellite locations, 101 hospital inpatient units, six private psychiatric hospitals and 22 Comprehensive Psychiatric Emergency Programs. Furthermore, OMH operates 24 state-run psychiatric centers (hospitals)

Figure 6: Strategy 1 Guiding Principles



The Zero Suicide Model Rests on Three Bedrock Observations

1. Most suicide deaths occur among people recently discharged from care.
 - Suicide prevention must be a core responsibility of healthcare systems.
2. New knowledge about detecting and treating suicidality is not commonly used.
 - We must apply new knowledge to clinical practice.
3. Suicide prevention in healthcare requires a systematic clinical approach.
 - Not the “heroic efforts” of crisis staff and individual clinicians.

Seven Elements of Zero Suicide

1. Leadership-driven, safety-oriented culture committed to reduce suicides among people under care.
2. Develop a workforce with suicide-specific expertise.
3. Identify and assess suicide risk among people receiving care.
4. Individualized pathway of care, including safety planning with lethal means reduction.
5. Use evidence-based treatments that target suicidal thoughts and behaviors.
6. Care transitions: follow-up contact and support, especially after acute care.
7. Apply a data-driven CQI to inform system.

and over 90 outpatient clinics. OMH is committed to integrating the latest standards of care for suicidal individuals into its licensing standards for all OMH-licensed inpatient and outpatient programs, such as those articulated in The Joint Commission’s Sentinel Event Alert on “Detecting and treating suicide ideation in all settings.”³⁰

OMH surveillance data and analyses³¹ strongly suggest focusing initial Zero Suicide implementation on outpatient clinics where the bulk of suicidal clients receive care. In reviewing claims data for 2,583 individuals from 2012-2014, nearly 73% (N=1886) of those with suicide attempts or who died by suicide were seen in an outpatient mental health setting less than six months prior to their suicidal behavior and 61% (N=1571) had outpatient contact less than 30 days prior. Of the 201 individuals who died by suicide, 68% (N=136) received outpatient care less than six months prior; 49% (N=99) less than 30 days prior. In comparison, only 24% (N=624) had an ED visit and 39% (N=1010) had a psychiatric hospitalization less than six months prior to their suicide event. Outpatient public mental health clinics will have an opportunity to receive robust Zero Suicide implementation support through participation in the PSYCKES (Psychiatric Services and Clinical Knowledge Enhancement System) Suicide Prevention Continuous Quality Improvement Project.

1b: Invest in Trainings that Utilize the Latest Clinical Knowledge

While the density of suicidal individuals is greatest in clinical settings, clinicians are often ill-equipped to assess and treat these clients. Formal professional training devotes little time to training on suicide-specific assessments and interventions. In a clinician survey administered to 1,585 New York State providers in 2014,³² 64% reported little or no specialized training in suicide-specific interventions, and over half (56%) could not identify demographic groups that have elevated risk for suicide. About 20% reported they were not comfortable asking direct and open questions about suicide with their clients, and 12% indicated that they would not bring up the topic of suicide even if the client’s record or actions suggested the client was at risk. Furthermore, about 33% reported they did not feel they had sufficient training to assist suicidal clients, and 43% stated they did not feel confident in their ability to manage client suicidal ideation and behavior with an evidence-based approach. Nearly 50% reported a need for greater training in risk assessment and suicide-specific treatments. These findings are consistent with the eagerness shown by clinicians across the state to participate in suicide-specific training. We have offered four webinars on different aspects of suicide prevention in the past six months and all webinars have reached the maximum number of participants (300) within one to two days of opening enrollment.

1c: Target Culture Change to Move the System Toward Population-based, Preventive Engagement

Successful Zero Suicide implementation calls for significant culture change. A prerequisite for successful large-scale system transformation is creating a sense of urgency.³³ Over the last decade, the number of suicides each year in the US has overtaken the number of deaths from homicide, motor vehicle accidents, and most recently breast cancer. However, the clinician survey data from 2014 suggest suicide is not widely recognized as a major public health problem among mental health providers.

Beyond raising awareness within the public mental health system, OMH will target the following areas aimed at supporting a shift toward a more population-based clinical approach to suicide safer care:

- ◆ Systematic screening for improved detection rather than what some have characterized as a “don’t ask, don’t tell” status quo.
- ◆ Intensive, collaborative engagement aimed at reducing risk for those individuals identified as at substantial risk.
- ◆ Treating suicidal ideation and behavior as a “separate comorbid illness” with suicide-specific evidence-based treatments (i.e. treating the underlying mental illness or substance use disorder alone represents substandard care for suicidal individuals).
- ◆ Recognition that many individuals may be “one acute stressor away” from suicide even when not endorsing suicidal ideation at their most recent assessment.

The above areas represent a profound shift in current clinical practice where standards of care have historically been driven by mental health service delivery rather than an explicit goal of reducing suicides.

1d: Provide a Clear Definition for “Suicide Safer Care”

The basic elements of suicide safe care are known, though not widely practiced: routine screening for suicidal ideation and behavior; comprehensive assessment for those that screen positive; a suicide care pathway for those at risk that includes increased engagement and monitoring with use of suicide-specific treatments; and increased attention to care transitions. OMH seeks to advance suicide

safer care through licensing standards, direct provider communication and training support. Care of suicidal individuals has historically been driven by a focus on contributing mental health diagnoses rather than with the explicit goal of addressing suicide.

State-wide Implementation of Zero Suicide

In late summer of 2016, OMH is initiating one of the largest-scale Zero Suicide implementation projects in the nation. Over 300 state



operated or community licensed mental health clinics, serving a high risk population, have the opportunity to participate in a two-year Suicide Prevention CQI Project that integrates principles of Zero Suicide. PSYCKES (Psychiatric Services and Clinical Knowledge Enhancement System), a web-based application, will be used to support the project and measure outcomes. Participating clinic staff will receive

training and technical assistance in evidence-based practices from the Center for Practice Innovations' Suicide Prevention-Training, Implementation and Evaluation (SP-TIE) group.

1e: Integrate Lived Experience into Policy and Planning

Those with lived experience—including suicide loss and attempt survivors—have an important contribution to make in shaping care for suicidal individuals, namely by decreasing isolation, offering hope, and reducing stigma. Excerpts from powerful loss and attempt survivor stories (see Appendix 1 for longer stories), placed throughout this document, underscore this point. Much remains to be learned about how to safely and effectively integrate peer supports into suicide safer care. The evolving literature in this area will be an important source of guidance. OMH will also seek additional feedback from those with lived experience serving on the New York State Suicide Prevention Council.

1f: Capitalize on Opportunities to Broaden Zero Suicide Beyond the Public Mental Health System

Spreading implementation of Zero Suicide beyond behavioral health and into the broader health care system, into settings such as primary care and emergency departments, settings in frequent contact with suicidal individuals, can vastly expand impact.⁸ For example, there are a number of efforts underway in New York State to establish integrated behavioral health services in medical settings, including the New York State Department of Health Advanced Primary Care (APC) initiative for commercial payers, the Delivery System Reform Incentive Payment (DSRIP) Program 3.a.i integration under New York State Medicaid, the OMH Project TEACH offering pediatricians child psychiatrist consultation and behavioral health referral support, and the New York State Office of Alcoholism and Substance Abuse Services Screening, Brief Intervention, and Referral to Treatment (SBIRT) program in primary care and emergency departments. Each of these initiatives offers a potential opportunity to spread Zero Suicide beyond the New York State public mental health system.

Strategy 2: Prevention Across the Lifespan in Competent, Caring Communities

Community settings offer opportunities to detect and intervene with high risk populations, including some of which may not be easily reached through the health and behavioral healthcare system. New York State is seeking to develop programming that covers the lifespan. From school-aged children to young and middle-aged adults to seniors, the collective goal is to reduce risk factors and bolster protective factors among those at risk.

Primary prevention strategies—those that prevent individuals from becoming suicidal in the first place—and secondary prevention strategies—those that intervene at the earliest stages of suicidal crises offer critically important avenues for reducing the number of suicide deaths in New York State. By targeting the antecedents of suicide and broadly promoting mental health and supportive social connection, several lines of evidence suggest that “upstream” interventions can potentially leave large populations less vulnerable to suicide.³⁴⁻³⁷

This expanded focus on addressing “upstream” risk and protective processes—before individuals develop entrenched problems or become suicidal—represents a meaningful expansion of the suicide prevention paradigm. Evidence is growing that suicidal behavior can be reduced by successful interventions that promote emotional, social and behavioral health. For example, the Good Behavior Game, implemented by teachers in 1st and 2nd grade classrooms, reduced suicide attempts 15 years later by nearly one-half,³⁵ showing the potential suicide prevention impact from enhancing children’s skills for managing their behavior and emotions. Upstream approaches may be particularly important for older adults because of the lethality of suicidal behavior in that segment of the population. Among this population, interventions targeting social isolation seem promising and are currently under investigation for suicide prevention effects.³⁸

The following four principles illustrate the New York State approach in supporting the development of Competent, Caring Communities with the ultimate goal of leaving community members less vulnerable to suicide across the lifespan.

Figure 7: Strategy 2 Guiding Principles



2a: Develop, Support, and Strengthen Community Coalitions as the “Backbone” of Local Suicide Prevention Infrastructure

Suicide prevention cannot succeed without community involvement and leadership. As former Surgeon General Regina Benjamin stated, “Preventing suicide is everyone’s business.” As members of a family, school, business, neighborhood, faith community, friends and our government, we need to work together to solve this problem.³⁹ Community coalitions harness the passion and power of New York State communities, bringing together a diverse stakeholder group committed to reducing suicide deaths in their communities. For example, the Coalition of Erie County has embraced Zero Suicide and has taken the message to primary care providers. In 2015, it held a successful event attended by over 70 primary care providers who had the opportunity to learn about county level suicide data from the medical examiner, and to hear from both the health and mental health commissioners’ commitment to work together to reduce deaths. The event also provided practical tools on screening and referral of suicidal patients. This year, the event will include a 45 minute QPR (Question, Persuade, Refer) training tailored to primary care providers.

SPC-NY is strengthening coalitions in the 44 counties where they currently exist and creating or revitalizing them in the 13 counties of the state where they have been inactive. Coalition membership is diverse but may include representatives from county

government, coroner/medical examiner offices, law enforcement, corrections, probation, courts, school administrators, religious institutions, health and behavioral health care providers, funeral directors, and social services. See Appendix 4 for a list of suicide prevention coalitions.

2b: Create Suicide Safer School Communities

New York State has 733 school districts rich in cultural, linguistic, economic and geographic diversity.⁴² Its 4,792 public and charter schools enroll 2.8 million students. A number of factors have moved youth suicide onto the forefront of administrators and school-based planning teams, including several high profile youth suicide deaths in the state and an increase in student referrals for depressive symptoms and suicidal ideation in recent years.⁴³ The latest Youth Risk Behavior Survey data show the continued prevalence of this public health problem, finding that nearly 14% of New York State high school students reported seriously considering suicide in the past year, and 7% said they had attempted suicide.²⁴

Although there is growing recognition of the opportunity schools have to prevent and respond to youth suicidal behavior and deaths,⁴⁴ school-based mental health professionals report feeling under-prepared to effectively organize and engage in such efforts.^{45,46} While the suicide rate in youth is relatively low, the number of suicide attempts is high. Evidence-based programming that invests in

New York State Coalition Academy

The New York State Suicide Prevention Coalition Academy model was developed by integrating knowledge from existing coalition research, as well as lessons learned from existing coalitions. Drawing on the Communities That Care model⁴⁰ developed by Hawkins and Catalano and the Suicide Prevention Resource Center’s A Strategic Planning Approach to Suicide Prevention,⁴¹ the academy’s goal is to guide communities toward the development and implementation of locally supported best practice interventions. Currently, 35 existing and 13 new coalitions are participating in the academy being held May 1 - December 1, 2016.

The Coalition Academy consists of eight discrete modules, which include individualized consultation, live webinars and access to library of best practice tools.

Central to the coalition framework is:

1. Intentional use of local data to target resources and interventions to high risk community members and groups.
2. Selecting interventions, measuring progress, identifying postvention teams and protocols, recognizing and responding to suicide clusters, and implementing means-restriction projects.
3. Initiating successful collaborations with suicide prevention partners.
4. Providing support to local behavioral health organizations adopting Zero Suicide.

youth development, along with suicide prevention, can provide protective effects that endure well into adulthood.³² New York State is committed to providing guidance and technical assistance to support creating suicide safer school environments that support children and adolescents to develop the skills for lifelong resilience to suicide risk.

OMH supports three evidenced-based programs for schools: Creating Suicide Safety in Schools,⁴⁷ Sources of Strength,³⁷ and Lifelines Trilogy⁴⁸ programs. The Creating Suicide Safety in Schools (CSSS) Workshop is a one-day workshop that uses a problem-solving approach to build school professionals' confidence and facilitate improved readiness in the event of a suicidal crisis. The workshop empowers school staff to establish realistic short-term plans that bring them closer to achieving a broad, long-term vision. Through an ecological model and public health perspective framework, information about the problem of youth suicide and the facts about effective prevention program characteristics are presented in six broad categories:

1. Policies, procedures, and standardized protocols,
2. Staff training,
3. Promotion of student protective factors,
4. A plan for helping a student at risk,
5. Plan for after a suicide death, and
6. Engaging with parents and community resources.³⁶

Sources of Strength is a universal public health-oriented suicide prevention program^{37,49} developed to utilize the influence of natural adolescent opinion leaders (Peer Leaders) working in partnership with adults, who provide mentoring and guidance. In secondary schools, Peer Leaders nominated by school staff and students are trained in the Sources of Strength curriculum to develop positive coping norms and resources and increase their connections to capable adults. They are trained to conduct activities designed to spread those norms and practices through their naturally occurring social networks, to increase school-wide healthy coping practices and to connect peers to adults, particularly students who are suicidal and/or isolated. The overall objective is to decrease suicidal behavior and, long-term, suicide mortality. A randomized trial of Sources of Strength in 18 high schools found that four months of peer leader activities increased school-wide coping norms

Sources of Strength in New York State

Over the past ten years, with support from the New York State Office of Mental Health, Professor Peter Wyman at the University of Rochester and his team have focused on bringing the Sources of Strength program to predominantly rural schools in New York State where mental health resources are lacking and youth suicide rates are highest. Wyman's research to date has shown that Sources of Strength increases peer leaders' positive coping skills and connectedness to adults, and that their activities, in turn, strengthen the school-wide culture and behaviors surrounding help-seeking and suicide.

"By engaging peer leaders, and encouraging them to build healthy coping practices, better connections with adults, and the strengths to avoid problematic behaviors, we empower them to become effective change agents," says Wyman. "We then prepare adults in each school to be effective mentors for their peer leader teams. The final step is to help peer leaders employ strategies to get their friends on board, and promote a culture change through their school. These activities have included poster campaigns, cafeteria activities, and videos for social media."⁵⁰

Approximately 23,000 high schools students in New York State have been exposed to Source of Strength since 2008.

and youth-adult connections and is the first peer leader program to change social-ecological protective factors associated with lower suicidal behavior.³⁷

The Lifelines Trilogy of Workshops is a program that educates administrators, faculty and staff, parents, and students on the facts about suicide and their roles in suicide prevention, intervention, and postvention. The goals of Lifelines are to increase the likelihood that:

1. members of the school community can more readily identify potentially suicidal adolescents, know how to initially respond to them, and how to rapidly obtain help for them, and;
2. troubled adolescents become aware of and have immediate access to helping resources and seek such help as an alternative to suicidal behaviors.⁴⁸

The primary challenge to providing the above programs is the number of school districts across the state—over 700, including the largest in the nation in New York City. SPC-NY is exploring cost-effective ways to expand delivery capacity of school-based suicide prevention programs to as many school districts as possible.

2c: Utilize Postvention as Prevention

Postvention is a series of planned interventions with those affected by suicide in order to facilitate the grieving process, stabilize the environment, reduce the risk of negative behavior and limit the risk of contagion. Postvention response is particularly important because of the high percentage of people who die by suicide after a friend or family member succumbs to suicide. Many schools and communities struggle with the occurrence of multiple suicides in short periods of time and often request assistance or support. SPC-NY provides technical assistance in this area. Given the current limited postvention literature, OMH hopes to foster research toward identification and dissemination of best practices. SPC-NY is coordinating a statewide taskforce to develop a consistent approach to postvention on the community level. Working with local and national experts, the taskforce is developing a toolkit for community stakeholders and a guidance document on the principles and pillars of a solid postvention response. As part of the Coalition Academy, communities are being encouraged to develop community postvention teams to expand their postvention response capacity. A number of communities around the state currently have active teams, each reflective of local circumstances and conditions while maintaining a consistent structure and set of principles.

2d: Deliver Targeted Gatekeeper Trainings

Gatekeeper training involves educating natural helpers in the community to recognize warning signs for suicide and how to respond appropriately. A gatekeeper should be able to provide a link or open the gate between a person with suicidal thoughts and a mental health professional. Since 2012, over 30,000 New Yorkers have participated in gatekeeper trainings. In 2015 alone, over 6,500 persons participated in trainings. Given the demand for gatekeeper trainings, a targeted approach has been developed to best utilize resources. Hence, the Coalition Academy will introduce counties to providing targeted gatekeeper training in response to the specific needs identified through the analysis of local data. In addition, as part of the state's commitment to reduce the number of deaths of individuals served in the public mental health system, gatekeeper trainings will be offered to non-clinical staff working in outpatient mental health clinics.

Currently Sponsored Gatekeeper Training Programs:

QPR: Question, Persuade, Refer—a 60 minute program designed to help recognize and refer someone at risk.

SafeTALK—a half day training that prepares anyone over the age of 15 to become a suicide-alert helper.

ASIST: Applied Suicide Intervention Skills Training—a two-day training to develop “Suicide first-aid” skills.

“As a school social worker, I often felt isolated in the field. The coalition helped me to stay connected with other prevention providers to address the needs of teens that are often hurting and ‘invisible’ to many others.”

Mary Plonka LMSW, CASAC, Coalition Member for Cattaraugus County

Strategy 3: Surveillance and Data-Informed Suicide Prevention in New York State

Preventing suicide is difficult, in part, because of the inherent challenges of measuring progress. First, statistics are most powerful when applied to large populations. While shockingly common, suicide remains statistically rare, what statisticians refer to as a low base-rate phenomenon. Second, population-derived suicide risk factors have not translated readily into accurate prediction at the individual level.⁵¹ Third, the one to two years it generally takes for states to release the most definitive counts of suicides in a given year is too much of a lag for quality improvement initiatives, which require much faster data collection and reporting cycles in order to allow timely midcourse corrections. Finally, while we have made great strides in recent years, there is still no clear consensus within the field of suicide prevention

on how best to approach measuring progress and which metric is used may depend on the setting and a number of other factors.

All of the above challenges underscore the need to continuously enhance and improve suicide surveillance data.²³ The success of both healthcare and community-based suicide prevention initiatives depend on leveraging the best information available and presenting it to stakeholders in a readily “actionable” form. New York State is fortunate to have a good foundational surveillance infrastructure on which to build.

The following principles illustrate the New York State approach to enhancing and improving suicide surveillance data and using it to guide quality improvement initiatives.

Figure 8: Strategy 3 Guiding Principles



3a: Enhance and Improve Suicide Surveillance Data

3a.1: Mine Existing Datasets for Valuable Suicide Surveillance Data

“Loads of data, little analysis” is a common lament. A priority of the OMH SPO has been to make better use of existing datasets that can deepen our understanding of suicidal behavior and inform suicide prevention programming. The New York State Incident Management Reporting System (NIMRS) is a web-based platform that tracks “incidents” across all state operated and licensed provider programs. Providers must report incidents, including non-lethal and lethal suicide attempts, within 24 hours of discovery for all clients currently enrolled or within 30 days of discharge. While NIMRS-reported suicide surveillance data is limited only to those cared for in the OMH system, it provides a relatively rich source of information on suicidal behavior in a more timely fashion

than death certificate-derived data. Much of what we know about suicides that occur in the New York State public mental health system comes from NIMRS data analysis.

3a.2: Explore Opportunities for “Crosswalk” Analyses that Combine Datasets.

States like Ohio, South Carolina, and Kentucky have led the nation in conducting crosswalk analyses that combine records from social services, criminal justice, and Medicaid claims with death certification data, raising the standards for suicide surveillance. In 2015, OMH conducted a NIMRS Medicaid crosswalk analysis, looking at emergency department, hospitalization and outpatient behavioral health utilization prior to death. New York State plans to expand the analysis beyond the public mental health system.

3a.3: Take advantage of New York's Recent Entry into the National Violent Death Reporting System

The National Violent Death Report System (NVDRS) is a CDC-supported program that requires participant states to combine data mainly from death certificates, coroner or medical examiner reports, and police investigations. Secondary sources include data from child fatality reviews, intimate partner violence reviews, crime labs, supplementary homicide reports, and hospital data. NVDRS has become the gold standard in suicide surveillance, given the rich analytic capacity that comes with entry. Thirty-two states currently participate in the NVDRS with six to eight additional states to be added in 2016-17. New York State was awarded entry into the system in 2014 with formalized suicide reporting anticipated in early 2017.

3b: Disseminate Surveillance Data to Stakeholders in Readily Usable Forms to Support Quality Improvement Work

It is clear that sharing data in a timely, visual way highlights areas for improvement and can help end-users improve performance. To that end, in 2016 NIMRS data will be disseminated in two novel ways:

3b.1: Alert System

An alert system will be created so that providers caring for any individual with a NIMRS recorded suicide attempt in the prior year will receive a notification of the past attempt, encouraging assessment and increased engagement and monitoring in light of the increased risk.

3b.2: Portal

A portal will be created for providers and regulators to access summaries of NIMRS non-lethal and lethal

suicide attempts, providing an excellent source of quality improvement data.

3b.3: PSYCKES Enhancement

A PSYCKES application enhancement will flag suicide attempt history, allow access to safety plans, and notify providers of ED visits and hospitalizations of at risk individuals.

3c: Perform In-depth Reviews of Suicides Occurring Within the Public Mental Health System

A lot can be learned from conducting analyses of suicide deaths using data generated from NIMRS, NVDRS, and crosswalk analyses, but these high-level data sources do not capture important aspects of patient-level clinical care delivery. In-depth records review can provide this important perspective and highlight gaps in care to be targeted in New York's quest to advance suicide safer care.

3d: Promote a Research Agenda that Leverages the Use of Technology and Large Scale Trials

All stakeholders, including New York State and the federal government, must support research that advances ethical suicide prevention research combining the latest survey methods, clinical assessment, technology and study scale aimed at reducing the significant number of lives lost to suicide. Advances in technology offer a promising way to overcome the aforementioned problems at the beginning of this section. Combining big data from administrative and healthcare datasets along with social media data may not only offer a means to generate more accurate risk profiles at the individual level, but also timely interventions that can be tested at scale.⁵²


“The efforts of the Suicide Prevention Network of Delaware County have fostered and strengthened relationships with our schools, college, community residents and area businesses about the importance of mental wellness. Suicide prevention will remain a priority in Delaware County for the New York State Prevention Agenda”.

Rene' M. Stratton, Program Coordinator and Coalition Lead, Delaware County Public Health Services



Summary

New York State OMH has an ambitious goal for suicide prevention across the state in the coming years. The 2016-17 plan outlines the short-term strategy for making progress toward longer-term goals. This strategy focuses on suicide prevention in health, behavioral health, and community settings and will leverage state data and the unique expertise of each of its partners to achieve its goals. The plan will be presented during the first annual statewide suicide prevention conference September 12-13, 2016. This conference will highlight current initiatives within OMH's suicide prevention plan, garner support among stakeholders, and establish the agenda for the coming year.

New York State has one of the lowest suicide rates in the nation. We believe it is a reflection of all the collaborative work that has been conducted by communities, providers, public health professionals, suicide prevention experts and policy makers across the state. However, the burden remains high, and 1,700 suicide deaths each year is too many. More coordinated action must be taken to address the significant public health problem of suicide in our communities. This plan represents an important step toward materially reducing the burden of suicide in New York State.

1,700 Too Many

First Annual Statewide Suicide Prevention Conference
September 12-13th, 2016, in Albany, New York

1,700 Too Many will be a forum for the suicide prevention community across New York State to:

- Introduce attendees to the New York State Suicide Prevention Plan;
- Facilitate communication and exchange of ideas, programs, research and projects; and
- Recognize individuals and organizations for their outstanding leadership and contribution to New York State suicide prevention at the SPC-NY's Annual Award Ceremony.

Suicide Prevention Council

A core group of New York State suicide prevention stakeholders will convene at the end of the conference to review progress to date, provide feedback, and make recommendations on how to strengthen the New York State Suicide Prevention Plan.

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Appendix 1: Suicide Survivor Stories

Fred Meservey, Suicide Loss Survivor

The Loss - While we all use the platitude, that day “was the worst day of my life;” I know January 26, 2004 was the worst day of mine. Bonnie, my beloved wife of over 32 years, attempted suicide in our home, culminating in her passing on January 30. A clinical social worker herself, Bonnie was suffering from severe depression and anxiety. In these darkest moments of her life, she believed she was failing those people who depended on her – me, our two sons, the children and families she provided services to, and her work colleagues.

After Bonnie’s passing and her funeral, my sons returned to their lives, and the loss became more intense and extreme. Not only had I lost my lover, my best friend, and closest confidante, but I had lost my future—my dreams for our life together. I had also lost my sense of safety and order in the world. Like many survivors of suicide loss, I got caught in protracted and complicated grief; I was diagnosed with Post-Traumatic Stress Disorder (PTSD). In the immediate weeks following Bonnie’s passing, I encountered recurrent flashbacks, chronic insomnia, overwhelming guilt, sadness and crying, and found no pleasure in life. Each day, I went through the motions of life and returned to an empty house that mirrored my internal emptiness.

Healing and Recovery - In my healing and recovery journey, I have been blessed to meet countless other survivors of suicide loss. Many of these courageous, resilient and even heroic people have served as inspirations to me – inspirations that out of the most seemingly devastating and hopeless situations, hope can be found. And, I did find hope, and have been following an admit-

tedly bumpy and winding pathway to healing and recovery, but, a pathway that is lit by amazing beacons of hope. Most of my Beacons of Hope are from the loving, caring, and compassionate people who have helped me and have lifted me when I fell, patted me on the back when I made strides forward, and occasionally administering “a swift kick” when I needed it. These Beacons include the man who was my primary physician at the time. He monitored me closely after I told him of my loss, temporarily putting me on an antidepressant and a sleep medication to help me through the immediate aftermath of Bonnie’s death. He courageously asked me about whether I had my own suicidal ideations and raised appropriate concerns about some precipitous weight loss. I found three amazing social work therapists, who guided me through my grief process, helped me identify life strategies to manage my PTSD symptoms, and who helped alleviate my personal guilt. The first therapist gently convinced me that there was nothing immoral about seeking and finding happiness in life; that, moving on and seeking joy and fulfillment was not a betrayal to Bonnie. In addition to the professional help, I was blessed to have friends who lifted me, hugged me, and gave me more food than I could possibly ever eat. While many survivors work in environments where people don’t know what to say and how to respond to such tragedies, I was fortunate to work in an environment with people who did know how to respond and who literally took me under their wing and gave me solace, healing and hope each and every day. I worked in a state agency with a Commissioner who took me into his office and prayed with me. I also chose to participate in a Suicide

Survivor Support group whose facilitators and members allowed me to bare the most intense and gruesome part of my pain as frequently as I needed. On my first visit, one of the facilitators told me, “I was a broken man.” I was. But, in that remarkable environment of mutual healing and support, I grew stronger, and, in time, I was able to support others on their healing journey. Suffice it to say, that on my last night with the Support Group, my facilitator said to me, “Fred, you are not broken anymore. You are in a place where hope, joy and happiness have re-entered your life.”

I also found healing, recovery and hope in my relationship with my faith and God. Prayer and meditation helped soothe me and allowed me to go on with life. My journey of healing and hope allowed me to become a volunteer in suicide prevention and postvention, and to eventually pursue a 5-year professional job with the Suicide Prevention Center of New York. While those volunteer and professional experiences sometimes “pushed my buttons” and triggered some unanticipated PTSD reactions, I had become strong and resilient enough to manage them and to find hope. Without the professional guidance, and support of friends, family, volunteers, and caring colleagues, I could never have devoted part of my life to suicide prevention and postvention. I have remarried and have found daily joy and happiness with my wife and new lover, best friend, and confidante, Penny. I am deeply thankful and will be eternally grateful to Penny and to all those wonderful people who were my Beacons of Hope on my journey of healing and recovery. May their lives be blessed as they have blessed mine.

Diana R., Suicide Loss Survivor

May 17th of 2015 marked the 30th anniversary of the death of my sister Altheia Margaret Bell. Like many survivors who have lost a loved one due to suicide, sometimes it seems like just a brief few moments ago, while other times it seems like several lifetimes have passed since that day. I have learned to allow feelings of loss and grief, when they rightfully arise, to peacefully co-exist with the rest of my life. For the most part this works. It is only during those rare and precious times such as anniversaries, birthdays, and milestones that our three adult children have achieved that the deep heartache cascades like heavy ocean waves hitting hard against the shoreline of my soul. The key has been to allow myself to rely on the jetties—built over the years before her death and after—that have served as a buffer and provided the social and emotional supports that have been needed to move through these experiences.

My sister was actually my cousin, she was my fathers' niece. She came to live with our family when I was five and she was 10. Looking back, there was much in her life that weighed heavily on the side of putting her at major risk for suicide. She was born to a mom who was heavily addicted to alcohol, involved off and on with prostitution. She met and fell in love with my mother's nephew while he was on leave from the Marine. Barely on the other side of deployments to Vietnam, at the age of 17 and 20, they married bound for South Carolina. A military wife, she endured many stressors such as relocations, giving birth to a second child three weeks after her husband left for deployment, a marital affair, separation, a near divorce and a highly ambivalent reconciliation; and the tragic murder of her best friend.

Just six weeks prior to her death, in what turned out to be my last visit yearly spring visit, I observed several things that were troubling to me. Typically warm, bubbly, and someone who loved children, she was

very distant and showed little interest in playing with my son 14-month-old son. She had been let go from her first paid job and expressed feelings of failure as well as being pressured by my brother-in-law to "get over it". After her death I learned that 2 days before she took her life, she had received a letter from unemployment rejecting her request for benefits. At the airport, I begged her to take some time to come for a visit. I left with this very awful feeling in the pit of my stomach that I was never going to see her again. I reassured myself that she was just going through a tough time and things would get better once she found another job. Six weeks later and less than 2 weeks after her 35th birthday, our phone rang on a Sunday morning. In that split second, our entire world changed. What I learned was that on Friday evening, at approximately 11:25 p.m., my sister shot herself and their dog Chralie. A suicide note can be a double-edged sword. On the one hand, it can sometimes provide a much-needed context. On the other hand, it can be excruciatingly painful. In our case, it was a crushing glimpse into the inner despair, self-depreciation and emotional suffering that she had kept so carefully hidden from us. Given this, I believe that had she not had a gun so readily available to her, she might still be alive. This has served as a major catalyst for me to become an ardent supporter of organizations such as New Yorkers against Gun Violence and support groups such as Parents of Murdered Children. As a social work professional, while I had dealt with clients who had attempted or completed suicide, my sister had never expressed feelings of depression or sought treatment. She had been through so much and had always managed to come through it all. So, despite my feelings of foreboding, never did I ever think that she might have been at risk for taking her own life.

There are so many aspects to getting through the aftermath of a suicide—the lives of a father and two children,

a sister and brother and parents and so many others, forever altered by indescribable trauma. Ruling out a homicide while living in a house that no longer feels like home with no place else to go. Learning how to walk after your legs just got cut off. After the initial shock and a period of deep despair, extreme guilt set in—why didn't I call her that week? How could I have not picked up on the depth of despair she must have been feeling? Deep sadness and bewilderment—why didn't she call me? Why didn't she say goodbye? Depression—difficulty getting out of bed in the morning, loss of appetite, emotional flatness. Anger, abandonment - we were in this lifetime together—how could she abandon me like this? Rage—She loved her children more than anything in this world. How could she have done this to them? Done this to me? To herself? One of the saddest moments I experienced was at her wake when her neighbor told me that my sister had wanted to go for help, but that she was afraid it would affect her husband's chances of future promotions. A military wife herself she noted that the military frowned on counseling, viewing it as an indication that a serviceman did not have his marriage or household under his command, a sign of a character flaw that could undermine leadership ability.

As a social work professional, I thought I should be able to handle my grieving process on my own. It took me 18 months to recognize that I needed to go into grief counseling. It took longer to make the decision to come back into my body. It was not that I wanted to die. It was more I was not sure I wanted to live if it meant being in so much pain. Through working with a pastoral/spiritual counselor, I found spiritual solace, strength and courage within myself and reclaimed my passion. For the past 25 years, through teaching courses on death, loss, and the grieving process, I have met amazing individuals. I have also served as a member of a family outreach

team and presenter for the American Foundation on Suicide Prevention on loss of a sibling due to suicide. It was almost 15 years after my sister's death during a speech that I did on suicide in the military and brain injury before I found myself able to discuss the interrelationship between the stressors

my sister experienced as a member of a military family and her suicide. Unconsciously I had been keeping this "secret" on her behalf – just as she had felt obligated to do herself. I feel very passionately that we have a responsibility to ensure that military spouses/partners and their children

are recognized as hidden casualties of military service and that we must do everything we can to bring them into the light and to provide the supports and services to which they are entitled.

Joyce, Suicide Loss Survivor

Phillip and I have been married thirty-three years this May. We had two perfect boys. In and about 2007, Michael's second year in college, our unremarkable life was about to take a sudden unpredictable turn... I remember Michael's first admission. The psychiatrist was trying to explain mental illness to us, giving us the number for the Mental Health Association. Here our journey of mental illness begins- countless hospitaliza-

tions, medication changes, suicide attempts and... suicide.

In 2011 our oldest son Matthew completed suicide. How can this happen to us. Losing Matthew to suicide brought on so many emotions. The most debilitating is the guilt, the 'what ifs'. As hard as I tried, I couldn't silence the questions in my head. Through faith, friends and family our lives goes on.

No one's journey is the same. We can empathize with each other, but to truly understand how I feel is not possible. It was at last year's International Survivors of Suicide Loss Day that I finally began to feel like I wasn't alone and that Matthew's death wasn't my fault. No matter the triumphs or tribulations, the heartache or pure happiness. I always try to remind myself that today I am exactly where I am supposed to be.

Josh Rivedal, Suicide Loss and Attempt Survivor

Excerpt from Journal: "I'm twenty-six years old and thinking about dying... I don't really want to die. I just want the emotional pain to stop... and I don't know how to do that. And two guys in my life—my father and grandfather—each didn't know how to make their own terrible personal pain stop and now both are...dead. My grandfather, Haakon, killed himself in 1966 because of the overwhelming post traumatic stress he suffered after serving in World War II. My father, Douglas, killed himself in 2009, the catalysts being a divorce with my mother along with some long-term depression and other mental health issues.

Both my grandfather and father suffered their pain in silence because of the stigma surrounding talking about mental illness and getting help. I too felt that same stigma—like I'd be seen as "crazy" or "less of a man" if I talked about what I was going through. But I didn't want to die and so I had to take a chance. I started talking.

But this idea of keeping silent continued to bother me. I did some research while in my recovery and found out that each year, suicide kills over one million people worldwide... and that many of those one million

never speak up about their emotional pain because of stigma. I had to figure out a way to reach people like that. So, like any other actor, writer, or comedian living in New York City whose life dealt them a crappy hand, I created a one-man show... and it has toured universities and communities all over the world—and people are getting help. It's been five years since my crisis and life is definitely looking up. The acting and writing thing is going well, I now have a great wife; but most important I'm able to stay mentally well—all because I took a risk and told my story.

Safe and Effective Messaging for Suicide Prevention

- Do emphasize help-seeking and provide information on finding help.
- Do emphasize prevention.
- Do list the warning signs, as well as risk and protective factors of suicide.
- Do highlight effective treatments for underlying mental health problems.
- Don't glorify or romanticize suicide or people who have died by suicide.
- Don't normalize suicide by presenting it as a common event.
- Don't present suicide as an inexplicable act or explain it as a result of stress only.
- Don't focus on personal details of people who have died by suicide.
- Don't present overly detailed descriptions of suicide victims or methods of suicide.

To view the full set of guidelines, visit the Suicide Prevention Resource Center's website at: <http://www.sprc.org/sites/sprc.org/files/library/SafeMessagingrevised.pdf>

Christopher Lukas, Suicide Loss Survivor

When I was six and a half my mother killed herself. Luckily, I was not there when it happened, but unluckily, when I returned and was told that she had died, no one took the trouble to tell me that a) she had taken her own life and b) her death had nothing to do with any negative behavior on my part or any negative feelings I had toward her.

It took another ten years for me to learn how she had died and another ten years before I realized that a child

of six and a half can easily believe that someone's death is his fault.

In addition to the crazy silence around my mother's death, there was no opportunity for me to grieve openly. I was sent off to boarding school. No one took the trouble to coddle me and say, 'I'm sorry this had to happen to you.'

Almost 75 years later, I am still given to depression. I am still not sure that I

was a "good enough" son, husband, or father.

Children can learn from bad experiences but only if they are helped with the process; and I got no help until my last year in college. Times have changed, and it's probable that more people than not understand the magical thinking of children. But we can still do so much better supporting children, families and individuals in the aftermath of a suicide.

Vanessa McGann, PhD, Suicide Loss Survivor

I lost my sister Nadine to suicide over a decade ago; I still remember the day like it was yesterday—the repetitive questioning by the police, the momentary kindness of a firefighter as he leaned down and pet her dog, the intense fear of how her loss might shatter me... Like many psychologists, I did not have enough training in suicide assessment, intervention or postvention; I struggled

to find help for myself. Later, feeling stigma from many of my colleagues as well as the community at large, I reached out to the suicide loss survivor community. It was there that I found my footing. Since then, it has been my mission to help those grieving a suicide. Unfortunately clinicians, family members, friends and loved ones often need more support than they can find after this unique

and traumatic loss. In addition to doing a better job preventing suicides, we need to be better able to be there for those who are grieving a suicide. I miss my sister but I am also stronger since her loss. I am more open, more knowledgeable, more humble, and more appreciative of all the things life has to offer.

Dese'Rae L. Stage, Suicide Attempt Survivor

I struggled with self-injury for nine years and survived a suicide attempt catalyzed by an emotionally and physically abusive relationship. I was diagnosed with bipolar II disorder in 2004. It is these experiences, coupled with the loss of friends to suicide and a lack of resources for

attempt survivors, which prompted me to start working on a project: *Live Through This*, a collection of portraits and stories of suicide attempt survivors, as told by those survivors.

"Suicide" is a dirty word in this country. It's a sin. It's taboo. It's selfish. It's

not an easy topic to discuss and because we, as a culture, don't know how to approach it, it's easily swept under the rug. I get it: we're afraid of death. But avoiding it and pretending it doesn't exist is nothing more than willfully perpetuating ignorance.

Stella Padnos-Shea, Suicide Loss Survivor

In August 2002, my fiancé John died by suicide. I remember aspects of that day very clearly, particularly the assumption that I would never "be okay." Certainly, those early days and months, first couple of years, really, I often felt very sad, or elsewhere. I missed John so much. I also vaguely remember when a day

passed without my feeling distraught over John's death; I'd begun to find other activities and other people to populate my life. I still think of John and feel sad over the tragic way he died, but now I also recall what a loving, gentle young man he was. For the last five or so years, I've facilitated support groups at the New York

City Survivor Day and made outreach visits to new survivors; these activities help to continually create a positive meaning for all the suffering I felt, as well as to create a connection to others. I am grateful for the experiences and wonderful, brave people I've met due to John's death.

Appendix 2: Articles by New York State Suicide Prevention Experts

New York Suicide Prevention: Finding and Filling the Gaps

Eric Caine, PhD, University of Rochester Medical Center

One of the central themes of suicide prevention involves defining gaps—for example, gaps in services; gaps between agencies; and gaps in data collected, archived, analyzed, and most importantly, understood. If we ‘mind the gaps,’ there is a chance that suicide prevention efforts will prove effective. A series of steps can be taken to identify prevention-system gaps at several levels in a consistent, transparent fashion. A comprehensive approach requires coordinated and integrated prevention initiatives that seek to reach diverse populations across the life course, seeing that the varied institutions and settings of our communities offer unique opportunities to engage distinctive groups of persons. Every setting, whether geographically/socially specific (e.g., health and mental health care institutions and providers, schools, Veterans Centers, courts) or virtual (e.g., Twitter, Facebook, Snapchat), has sample biases—some groups will be encountered; other missed.

A key ingredient in any effort must be the development of some type of Coordinating Center (CC), a group or agency that is designated to serve as a champion for prevention. Effective suicide prevention requires major strategic decisions based on understanding effectively presented, well-analyzed, thoughtfully considered data. The CC is essential in collecting, synthesizing, and organizing information and then

relaying that information to those responsible for making decisions regarding suicide prevention activities so that they have the information necessary to inform their decision-making.

The CC must undertake two early, developmental tasks in parallel: 1) Developing an inventory of the stated mission and activities of agencies and organizations, even if they may not identify suicide prevention as a goal or an objective, and 2) Comparing the coverage of agencies and organizations with the burden of suicide and premature deaths in New York State. These tasks help to align efforts so that resources may be pooled and agencies and organizations may become greater than the sum of their parts while also facilitating mapping of suicide prevention efforts with need among specific demographic, geographic, and at-risk populations.

Several comments highlight elements of these efforts. While schools serve as one of the central pillars for youth oriented efforts, they must be tightly woven into a collaborative community framework and not viewed as islands detached from parents, extended families, and local activities. Indeed, suicide prevention among youth can be one creative way of reaching younger to middle aged adults—thus having ‘dual use’ potential.

There are multiple settings in communities through which persons pass while bearing heavy social, emotional, legal, and financial burdens. Planning and testing how best to engage such distress-fraught persons and families will provide a major opportunity for developing community-wide collaborative efforts, involving community partners and local governments as well as state agencies. At the same time, it is important to appreciate that many youth and men in their middle years avoid health providers – or see little need to contact them. For elders, on the other hand, primary care providers along with local aging services agencies offer major conduits for access to these populations.

Filling the gaps—using data to define groups of highest burden; building coalitions of agencies and community organizations; and mapping local communities to develop a geospatial approach to preventing suicide, attempted suicide, and risk-related premature deaths—requires sustained approaches to problem definition, planning, implementation, evaluation, and reappraisal. Creating a mosaic of prevention efforts consisting of both mental health and public health approaches adds to an overall set of comprehensively defined, collectively implemented, and commonly measured set of actions to save lives.

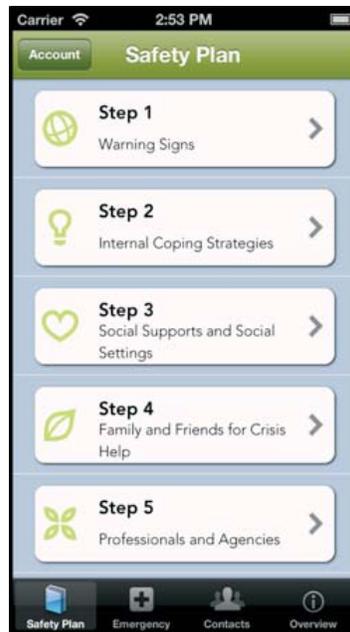
Safety Planning: A Tool to Manage Acute Suicide Crises

Barbara Stanley, PhD, Center for Practice Innovations at Columbia Psychiatry, New York State Psychiatric Institute

Individuals who grapple with suicidal feelings typically report that the amount of time when they are in danger of acting on their feelings is intense but relatively brief—lasting minutes to a few hours. Getting through these intense periods without acting on suicidal urges is difficult. The Safety Planning Intervention (SPI)¹ (www.suicide-safetyplan.com for downloading the form) is a clinical tool we developed to help individuals manage suicidal crises and not engage in suicidal behavior. The safety plan differs from a “no suicide contract” in that it is not a document that asks the individual to contract to staying alive. Instead, it provides the individual with assistance in fighting urges and strategies to stay alive.

The intent of the safety plan is to help individuals lower their imminent risk for suicidal behavior by using a pre-determined set of strategies including internal coping, distracting and social support strategies that can be used should suicidal thoughts re-emerge. The basic components of the safety plan include: (1) recognizing warning signs of an impending suicidal crisis; (2) employing internal coping strategies; (3) utilizing social contacts as a means of distraction from suicidal thoughts; (4) contacting family members or friends who may help to resolve the crisis; (5) contacting mental health professionals or agencies; and (6) reducing the potential use of lethal means. The plan is typically developed by a clinician and suicidal individual in a collaborative manner. Responses are personalized and recorded on a templated form. After completion of the safety plan, the clinician

discusses the likelihood of actually using the plan and addresses any potential barriers to use. Individuals keep their plans with them so that they can be readily used during times of escalating distress. Because the process is structured and straightforward, it can be carried out by a variety of clinicians including nurses, mental health technicians, social workers, psychologists, or physicians.



The Safety Planning Intervention is available as an app on both IOS and android operating systems and can be found by the name of Safety Plan.

The Safety Planning Intervention along with follow up has been tested in VA Emergency Departments where patients who are at

risk for suicide but did not require hospitalization were administered the safety plan and followed up on the phone after discharge. Individuals in Emergency Departments where the individual was delivered were compared with individuals in Emergency Departments where the intervention was not delivered and we found in our Safety plan group that there was a 45% lower rate of suicide behaviors and a significantly higher rate of treatment attendance in the six months following the emergency visit. One study reported that high quality safety plans are associated with fewer psychiatric hospitalizations² and another found that clinician-assisted (as opposed to self-administered) plans are most helpful.³ And finally, an interview study found that many individuals using “the plan felt it had “saved their lives.”⁴

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Attempt Survivor Peer Support as Part of a Statewide Suicide Prevention Strategy

Thomas Templeton, New York Association for Psychiatric Recovery Services

Suicide is a problem of epidemic proportions in the United States. Fortunately, there exists a relatively untapped suicide prevention resource in those with lived experience—peers who have first-person knowledge of suicidal behavior. Otherwise known as attempt survivors, these individuals are in a unique position to provide hopefulness to those at risk for suicide through a myriad of services that may employ them. For instance, peers can

- ◆ operate warm lines,
- ◆ lead mutual help groups (online or in person),
- ◆ staff mobile crisis teams, urgent care drop-in centers, and emergency departments,
- ◆ train first responders; and
- ◆ provide post-crisis support.

Despite a nationwide movement to integrate peers into the broad spectrum of crisis-related services, however, we have not effectively positioned them to improve our statewide efforts to reduce the burden of suicide. Presumably, some of that has to do with the dearth of research that clearly demonstrates that using peers as part of a suicide prevention strategy improves suicide-specific outcomes including reducing attempts and deaths.

There is, however, evidence that suggests consumer satisfaction goes up and emergency/inpatient costs go down as a result of peer-run crisis services. The latter is particularly salient in New York State given the current climate around Medicaid redesign and the Delivery System Reform Incentive Payment program (DSRIP), the goal of which is to reduce avoidable hospital use by 25% over five years.

It would stand to reason, therefore, that—due to its promise of cost savings—attempt survivor peer services should be better funded and incorporated into suicide prevention and aftercare efforts in the state.

But there is no reason to reinvent the wheel. Existing behavioral health peer programs can be augmented by adding suicide prevention resources. The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience, developed by the Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention, offers several practice recommendations relevant to peers in suicide prevention, including:

- u Establishing training protocols and core competencies for peer supports around suicidal experiences and methods for assessing them.

- ◆ Establishing plans and protocols for support when a peer experiences a mental health crisis.
- ◆ Evaluating peer supports and disseminating results to develop an evidence base for program funding and improvement.
- ◆ Establishing relationships between peer support groups or organizations and local crisis centers or hotlines.¹

Incorporating attempt survivor peer support makes good sense as part of a statewide suicide prevention strategy, as long as it is implemented in a thoughtful, well planned, well organized manner. Such efforts take advantage of a ready-made workforce—one that has been historically underutilized in this capacity—to help reduce the tragic impact of suicide on individuals and families across New York State.

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Upstream Interventions

Peter Wyman, PhD, University of Rochester Medical Center

The 2012 National Strategy for Suicide Prevention includes a strategic direction aimed at promoting healthy populations, to reduce the risk for suicidal behaviors and related problems such as substance abuse and depression.¹ This expanded focus on addressing “upstream” risk and protective processes—before individuals develop entrenched problems or become suicidal—represents a meaningful expansion of the suicide prevention paradigm. The 2012 NSSP illustrates a growing consensus among policy makers, practitioners, and researchers that significantly lowering suicide rates will require more focus on reducing risk factors for suicidal behavior in broad populations and strengthening protective factors that enhance resilience and wellbeing.²⁻⁴ Although creating an evidence base for effective ‘upstream’ suicide prevention is at an early stage, actionable information is available and more communities are incorporating ‘upstream’ approaches into their suicide prevention plans.

Why are upstream approaches needed as a part of comprehensive state or national suicide prevention strategy? For decades following the first national suicide prevention strategy in 1999, suicide prevention was largely synonymous with increasing identification and referral for treatment of suicidal or highly at risk individuals (e.g., depressed, substance abusing) and efforts to improve treatment effectiveness. Although those efforts have undoubtedly saved lives, recognition has grown that attention to high-risk groups is necessary but not the only strategy that is needed. First, relying on referrals to the mental health system will not suit many communities’ ability to provide accessible, effective services; and a portion of suicide deaths are due to

impulsive responses to crises and problems not readily identifiable beforehand. Second, in the history of public health, progress has accelerated by addressing root causes and behaviors, such as reducing heart disease deaths by encouraging lifelong habits of diet and exercise.

Evidence is growing that suicidal behavior can be reduced by successful interventions that promote emotional, social and behavioral health. For example, the Good Behavior Game implemented by teachers in 1st and 2nd grade classrooms reduced suicide attempts 15 years later by nearly one-half,⁵ showing the potential suicide prevention impact from enhancing children’s skills for managing their behavior and emotions. Another recent study found that children who participated in the Family Bereavement Program, after death of a parent, were less likely six and 15 years later to report either suicide ideation and/or a suicide attempt.⁶ Many effective programs for children and adolescents reduce mental health and substance use problems into early adulthood.⁷ An important next step is to gain knowledge linking specific interventions to reduced suicidal behaviors and mortality and how they work to reduce suicide risk.

Upstream approaches may be particularly important for older adults because of the lethality of suicidal behavior in that segment of the population.⁸ For older adults, many interventions are shown effective at reducing problems such as social isolation or physical illness, which are indirect causes for suicidal behavior. These encouraging findings suggest that large-scale efforts are warranted to study the suicide prevention impact of program such as those that engage older adults in

social networks or use of assistive technologies that help an older person maintain independence in the community.⁸ With a more developed knowledge base, upstream suicide prevention can become a comprehensive life span approach.

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The National Suicide Prevention Lifeline: A Resource for Caring and Competent Communities

By Madelyn Gould, PhD, MPH, Columbia University Medical Center

In 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA) began funding the first national crisis line with the mission of reaching and serving all persons at risk of suicide in the U.S. through a network of certified crisis call centers. This network, known since 2005 as the National Suicide Prevention Lifeline (Lifeline), has been subject since its inception to a series of evaluations led by Dr. Madelyn S. Gould of Columbia University/the New York State Psychiatric Institute and funded by SAMHSA and the National Institutes of Health (NIH). Reachable at 1-800-273-8255 (TALK) or <http://www.suicidepreventionlifeline.org/>, the Lifeline comprises over 160 crisis centers and fields approximately 4,000 calls per day as of 2016. Its services are available 24/7 and are provided by a mix of licensed clinicians and trained volunteers. Lifeline functions ubiquitously as a safety net for community, state and federal suicide prevention programs and behavioral health services in the United States.

SAMHSA and the Lifeline are committed to ongoing evaluation and improvement of Lifeline services. Selected evaluation findings are presented below.

- ◆ Seriously suicidal individuals do make use of telephone crisis services. Of 1,085 suicidal callers in 2003-2004, eight percent were in the midst of an attempt and 58% had made a prior attempt.¹
- ◆ Early evaluations indicated the need for enhanced training in risk assessment. Twelve percent of callers rated non-suicidal by hotline staff reported at follow-up that they had been suicidal either during or since their call.²
- ◆ Crisis hotlines provide effective care. Significant decreases in hopelessness, psychological pain, and intent to die were observed during the course of the telephone sessions.¹

- ◆ Suicidality can recur in the month following a crisis call, indicating a need for post-crisis follow-up. Of 380 suicidal callers interviewed an average of four weeks after their crisis call, 43.2% had had suicidal thoughts, 7.4% had suicide plans, and 2.9% had made suicide attempts since their call.¹
- ◆ Only a minority of callers made contact with outpatient mental health services in the month following their crisis call, again indicating a need for post-crisis follow-up. Of 151 suicidal callers provided with new mental health referrals during a crisis hotline call and interviewed four weeks later, 35.1% had either kept or made an appointment with a mental health service.¹
- ◆ Among suicidal hotline callers, perceptions about mental health problems (i.e., denial of the severity of the problem, and belief that it could be handled without treatment) were the most common reasons for not following through with referrals to mental health services.³
- ◆ Applied Suicide Intervention Skills Training (ASIST) for telephone crisis counselors improved caller outcomes. Callers who spoke with an ASIST-trained counselor appeared on monitors to be significantly less depressed, less suicidal, less overwhelmed, and more hopeful by the end of the crisis call than callers who spoke with a counselor in the wait-listed condition. However, shortcomings in risk assessment remained.⁴
- ◆ Telephone crisis counselors' behavior is guided by the Lifeline's 2011 Policy for Helping Callers at Imminent Risk of Suicide. Crisis helpers actively obtained callers' collaboration on an intervention during the vast majority (over 75%) of imminent risk calls, and initiated rescues without the caller's collaboration on a quarter of imminent risk calls.⁵
- ◆ Recipients of crisis center follow-up calls experience them as invaluable.

Nearly 80% of suicidal hotline callers who received follow-up calls from a Lifeline crisis center reported that the intervention stopped them from killing themselves either "a lot" (53.8%) or "a little" (25.8%). Moreover, callers who received a greater number of follow-up calls perceived follow-up as significantly more effective in preventing their suicide than other callers.⁶

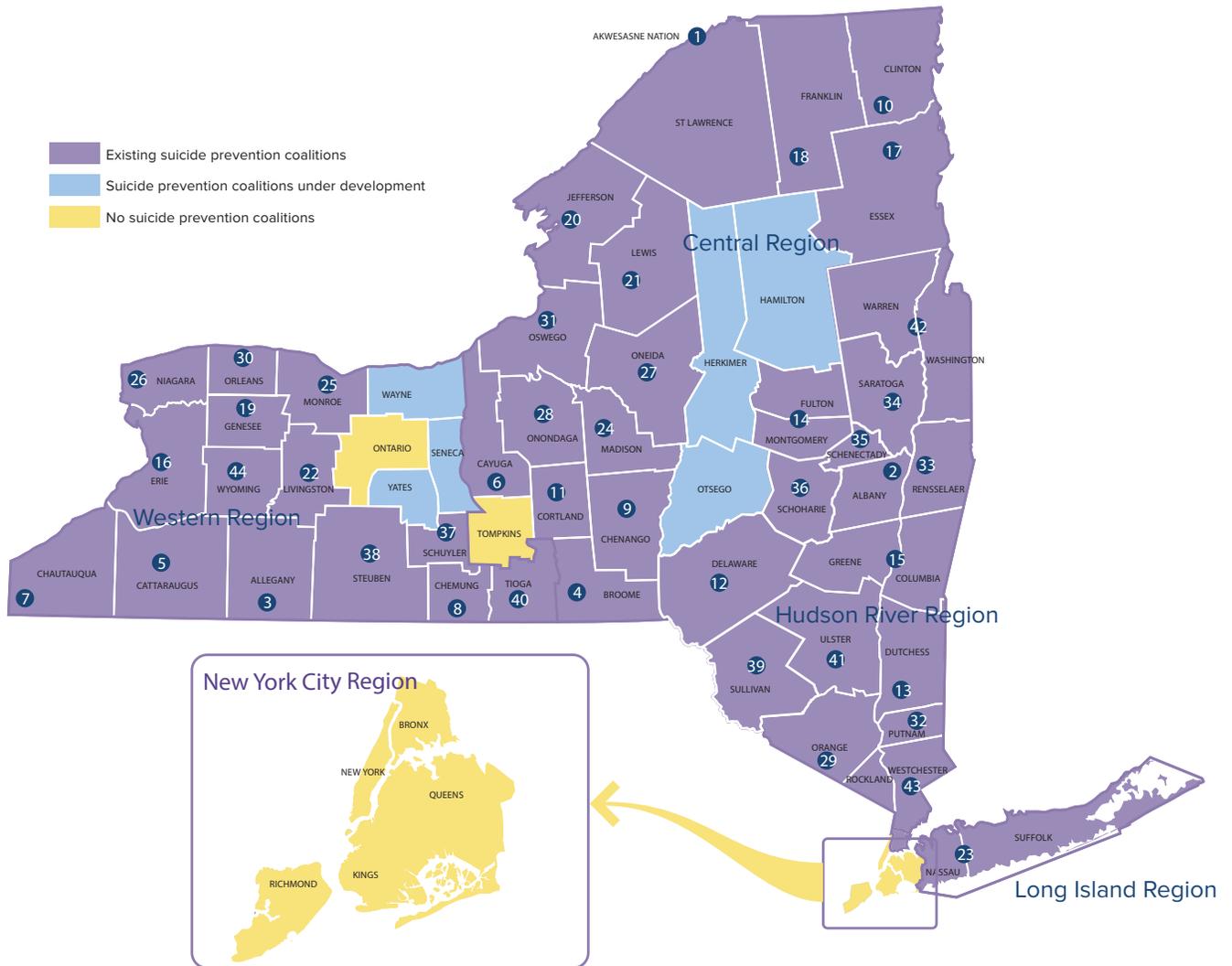
Ongoing evaluations are designed to address the following questions:

- ◆ What is the impact of Safety Planning Intervention training for telephone crisis counselors?
- ◆ What is the impact of telephone follow-up interventions provided by crisis center staff to patients discharged from Emergency Departments and inpatient psychiatric facilities after a suicide-related admission?
- ◆ What is the impact of Lifeline's online Simulation Training System on telephone crisis counselors' identification of an intervention with callers at imminent risk?
- ◆ What is the impact of crisis interventions provided via online chat?

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6. Unpublished findings.

Appendix 3: New York State Suicide Prevention Coalitions



1. Akwesasne Nation
2. Albany
3. Allegany
4. Broome
5. Cattaraugus
6. Cayuga
7. Chautauqua
8. Chemung
9. Chenango
10. Clinton
11. Cortland
12. Delaware
13. Dutchess
14. Fulton/Montgomery
15. Columbia/Greene

16. Erie
17. Essex
18. Franklin
19. Genese
20. Jefferson
21. Lewis
22. Livingston
23. Long Island [Nassau/Suffolk]
24. Madison
25. Monroe
26. Niagra
27. Oneida
28. Onondaga
29. Orange
30. Orleans

31. Oswego
32. Putnam
33. Rensselaer
34. Saratoga
35. Schnectady
36. Schoharie
37. Schyler
38. Steuben
39. Sullivan
40. Tioga
41. Ulster
42. Warren/Washington
43. Westchester
44. Wyoming

Appendix 4: Overview of New York State Suicide Prevention Strategy

Strategy 1: Prevention in Health and Behavior Healthcare Settings—Implementation of Zero Suicide

- 1a. Start with the public mental health system, beginning with outpatient clinic care
- 1b. Invest in trainings that utilize the latest clinical knowledge
- 1c. Target culture change to move the system towards population-based, preventive engagement
- 1d. Provide a clear definition for “suicide safer care”
- 1e. Integrate lived experience into policy and planning
- 1f. Capitalize on opportunities to broaden Zero Suicide beyond the public mental health system through government and private sector alliances.

Strategy 2: Prevention Across the Lifespan in Competent, Caring Communities

- 2a. Develop, support, and strengthen community coalitions as the backbone of local suicide prevention infrastructure
- 2b. Create suicide safer school communities
- 2c. Utilize postvention as prevention
- 2d. Deliver targeted gatekeeper trainings

Strategy 3: Surveillance and Data-informed Suicide Prevention

- 3a. Enhance and improve suicide surveillance data
- 3b. Disseminate surveillance data to stakeholders in readily usable forms to support quality improvement work
- 3c. Perform in-depth reviews of suicides occurring within the public mental system
- 3d. Promote a research agenda that leverages the use of technology and large scale trials

Appendix 5: Crosswalk of New York State Suicide Prevention Strategy and the National Strategy for Suicide Prevention

New York State Suicide Prevention Plan (2016)	National Strategy for Suicide Prevention (2012)
<p>Strategy 1: Prevention in Health and Behavior Healthcare Settings—New York State Implementation of Zero Suicide</p> <ul style="list-style-type: none"> 1a. Start with the public mental health system, beginning with outpatient clinic care 1b. Invest in trainings that utilize the latest clinical knowledge 1c. Target culture change to move the system towards population-based, preventive engagement 1d. Provide a clear definition for “suicide safer care” 1e. Integrate lived experience into policy and planning 1f. Capitalize on opportunities to broaden Zero Suicide beyond the public mental health system through government and private sector alliances. 	<ul style="list-style-type: none"> Goal 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk. Goal 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors. Goal 8. Promote suicide prevention as a core component of health care services. Goal 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.
<p>Strategy 2: Prevention Across the Lifespan in Competent, Caring Communities</p> <ul style="list-style-type: none"> 2a. Develop, support, and strengthen community coalitions as the backbone of local suicide prevention infrastructure 2b. Create suicide safer school communities 2c. Utilize postvention as prevention 2d. Deliver targeted gatekeeper trainings 	<ul style="list-style-type: none"> Goal 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings. Goal 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery. Goal 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors. Goal 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.
<p>Strategy 3: Surveillance and Data-informed Suicide Prevention</p> <ul style="list-style-type: none"> 3a. Enhance and improving suicide surveillance data 3b. Disseminate surveillance data to stakeholders in readily usable forms to support quality improvement work 3c. Perform in-depth reviews of suicides occurring within the public mental system 3d. Promote a research agenda that leverages the use of technology and large scale trials 	<ul style="list-style-type: none"> Goal 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action Goal 12. Promote and support research on suicide prevention. Goal 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Appendix 6: Recent Initiatives and Grants in New York State

OMH Initiatives and grants

Mini-Grants

Based on priorities identified at a series of regional forums held throughout the State, OMH provided funding in the form of small grants to grass-roots organizations and county coalitions from 2006 until 2014. The grants were highly regarded as a way to obtain funding for suicide prevention enhancements that simply was not available from other sources.

Life is Precious

In 2008, OMH funded three public awareness and education projects focused on suicide prevention among young Latina women to reverse the suicide attempt trend that emerged in latina adolescents between 1995 and 2007.

Sources of Strength

In 2008, the Suicide Prevention Office entered into a contract with the University of Rochester (U of R) to implement the nationally recognized evidence-based practice, Sources of Strength (SOS) in schools statewide. A new funding allocation from the New York State Legislature in 2015 has made it possible to expand SOS up to 64 schools throughout the state.

Garrett-Lee Smith SAMHSA Grant

In 2011, OMH received a Garrett-Lee Smith grant award from the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant funded four regional centers across the state to help coordinate trainings, support local initiatives and embed suicide prevention within agencies and systems of care by developing “competent and compassionate communities”.

OMH State Psychiatric Center Pilots

In 2012, four OMH operated state psychiatric centers participated in a multi-year suicide prevention pilot project. The pilot introduced elements of the Zero Suicide Model and provided the catalyst for the

development of the Suicide Safer Care Protocol.

National Strategy for Suicide Prevention (NSSP) Grant

OMH received the 3-year-National Strategy for Suicide Prevention (NSSP) grant from SAMHSA. As one of only four states receiving this grant, New York State established itself as a forerunner in the nation's field of Suicide Safer Care. The goals of the project are to 1) to promote suicide prevention as a core component of health care services; and 2) to promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behavior.

Zero Suicide Breakthrough Series

In 2015, New York State was one of six states to participate in the Zero Suicide Breakthrough Series, a ten-month project sponsored by the National Council for Behavioral Health in partnership with the Suicide Prevention Resource Center. The aim of the project was to improve implementation of Zero Suicide through data collection to identify key barriers, and develop strategies to address them.

NY Academy Suicide Safer Care (NYASSC)

In 2015, The New York Academy for Suicide Safer Care (NYASSC) was established to broadly disseminate the Zero Suicide Model to organizations willing to voluntarily raise their standard of suicide care. NYASSC works with outpatient organizations through participation in 9-12 months Learning Collaborative webinars and coaching calls.

Initiatives from other New York State agencies

New York State Department of Health (DOH) Bureau of Occupational Health and Injury Prevention has been helpful to OMH in analyzing injury data. The office monitors and addresses occupational illness and both occupational and non-occupational injury. It

keeps track of where, to whom and why injuries occur across the state and use this information to develop injury prevention programs.

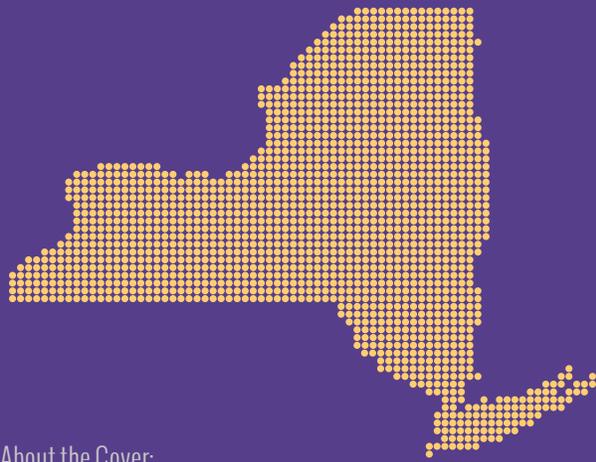
New York State Department of Health Prevention Agenda (2013-2018)

The Prevention Agenda 2013-2017 is a 5-year effort to make New York the healthiest state. Developed in collaboration with 140 organizations, the plan identifies New York's most urgent health concerns, and suggests ways local health departments, hospitals and partners from health, business, education and community organizations can work together to solve them. Suicide prevention is among the most frequent concern chosen to address.

The Advancing Prevention Project (APP)—

was launched in April 2014 by The New York Academy of Medicine (NYAM) through funding from The New York State Health Foundation. The objective of APP is to provide support and learning opportunities to New York State local health departments with implementing interventions for the Prevention Agenda (2013-2017) in the areas of Chronic Disease Prevention and/or Substance Abuse Prevention/Mental Health Promotion. An end result of the APP has been technical assistance to Local Health Departments (LHDs) who are focusing on suicide prevention.

New York State Office of Alcoholism and Substance Abuse Services (OASAS) Prevention Councils oversee community wide prevention through a system consisting of 165 provider organizations operating in a variety of settings. Although funded to address alcohol and substance use issues across the lifespan, many prevention providers are involved and support local suicide prevention coalition efforts. There is a deep understanding of the connection in risk between suicide and substance abuse prevention in communities across the state.



About the Cover:

The image on the cover of this report is a stylized map of New York comprised of exactly 1,700 dots, each representing one of the people who died by suicide in New York State in 2014.