County Suicide Prevention Planning Survey Guidance And Designation* Criteria

Overview of **Community United for Suicide Prevention* Designation

Problem Statement: Suicide is a major public health problem in the United States, including in New York State where approximately 1700 individuals die each year. It is the second leading cause of death for New Yorkers ages 15 to 34; and 11th overall (https://wonder.cdc.gov). Each year, more New Yorkers die by suicide than in motor vehicle accidents or homicides. Despite prevention efforts, the suicide rate in NYS has stubbornly increased by 25% over the last two decades. Suicide is a complex, multifaceted phenomenon. No one solution will "bend the curve", but with a coordinated community response, preventing suicide is possible.

Background: In November 2017, Governor Cuomo launched a suicide prevention task force to address the growing public health problem of suicide. The Task Force issued recommendations in a report on April 22, 2019 [https://omh.ny.gov/omhweb/resources/publications/suicide-prevention-task-force-report.pdf] called "Communities United for a Suicide Free New York."

Plan: In order to materially support implementation of recommendations contained in the Task Force report, The Office of Mental Health (OMH) with input from the Department of Health (DOH) and other partners, created a Designation Tool to provide guidance and coordination to county-level suicide prevention efforts. The Designation Tool has 3 domains:

- The development and strengthening of best practice public health suicide prevention approaches across the lifespan
- The integration of suicide prevention into local health and behavioral healthcare systems
- Active use of surveillance and quality improvement data to both inform efforts and evaluate progress and outcomes

Counties who demonstrate substantial activity in the 3 domains, along with attention to addressing disparities in risk and the unique cultural needs within each community, will meet criteria for receiving a *"Community United for Suicide Prevention"* designation from New York State. Those counties will be awarded the designation and receive recognition as a part of Suicide Prevention Month.

Additional guidance to inform the completion of this survey and additional resources for the development of a county-level suicide prevention framework can be found at the Suicide Prevention Center of New York's website at https://www.preventsuicideny.org/designation-tool/

Community Prevention Approach[1]: Counties follow a public health approach to coalition building, generating public awareness, implementing prevention strategies, and tracking progress across the lifespan.

1. Evidence-informed interventions are being used and are appropriate to ages and populations.[2]
    a. The coalition has established a process to examine local needs including data on suicide attempts and mortality, community risk (e.g., substance use), and protective factors, to develop prevention priorities.
    b. In selecting interventions for broad population groups (i.e., universal) or targeted high-risk groups, the coalition uses a process to identify effective programs and strategies to implement.
    c. Interventions for individuals already at risk could include programs such as means safety and identifying people at risk early through screening in non-healthcare spaces. [3]
    d. Population oriented programs could include programs to strengthen well established protective factors (e.g., social connectedness) or to reduce risk factors for suicide (e.g., evidence-informed interventions to reduce substance use or preventing and mitigating Adverse Childhood Experiences (ACESs) in broad community groups).
2. A formal public commitment is obtained from county leadership in the form of a resolution by the county legislature or community services board to promote and support suicide prevention strategies in all three domains (Public Health, Zero Suicide, and Data).
3. There is the existence of a lead entity or coalition that has primary responsibility for suicide prevention efforts in the county and/or region.
4. Coalition membership reflects the diversity of the community at large, in demographics and organizational representation.
    a. Membership should include a minimum of representation from: mental health, public health, health system/provider group, and people with lived experience (loss survivors and/or attempt survivors). Efforts should also be made to include additional partners such as: substance use disorder treatment provider(s), law enforcement, department of social services, veteran agencies, school districts, colleges, the coroner/medical examiner office, and the business community.
    b. The coalition includes a diverse representation of members from your target population throughout suicide prevention planning, implementation, and evaluation processes.
    c. Strategies are utilized to effectively reduce disparities.

[1] Although the term public health approach may at times be used interchangeably, this domain is entitled “community” instead of “public health” to avoid the connotation of government only led interventions when referring to non-clinical community level interventions.

[2] See examples of interventions identified in the New York State Prevention Agenda: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/wb.pdf

[3] Screening in non-healthcare spaces to identify at risk groups and connect them to supports: Youth (schools, youth criminal justice), Adults (Courts, settings indicating financial distress)

i. Available data on suicide risk and high-risk groups is used to include formal and/or informal institutions representing the diversity of the community. Community leaders - from churches, senior centers (area agencies on aging), and youth organizations, among others - are involved in and/or supporting coalition efforts.
ii. Creation of an open dialogue with group members to allow cultural considerations to be communicated, such as preferences regarding personal space, geography, familiarity, and terminology (i.e., culturally appropriate terminology).
iii. Group members are provided with materials on coalitions, group facilitation, and engagement of all groups.

5. School and university partnerships and presentations exist.
6. There is existence of media collaboration and public relations efforts to increase awareness. Some examples include (but are not limited to) the following:
    a. Dissemination of best practices guidelines on safe reporting – could be accomplished in the following ways:
        i. Invite media organizations to a coalition/leadership meeting during suicide prevention month for a refresher on media best practices
        ii. Send toolkits to local tv stations and papers
    b. Efforts to raise awareness through the promotion of American Foundation for Suicide Prevention (AFSP) or other independent walks or events
7. There is evidence of an effort to research and understand the cultural context of the community and needs of residents in the implementation and assessment of the following:
    a. Public health interventions
    b. Efforts to combat social isolation and hopelessness
    c. Identification of intersects for suicide prevention activities and points of crisis for specific populations
    d. Tailoring information and resources to respectfully address the target population's values, beliefs, culture, and language. Use of alternative formats (e.g., audiotape, large print, storytelling) whenever appropriate.
        i. Attention paid to language and vernacular
        ii. Depictions used of like-groups and activities of diverse groups
        iii. Information dissemination takes into consideration the technology gap, variation in literacy, and is placed in locations frequented by the target population.
    e. Inclusion strategies are utilized; description of policies and practices that ensure traditionally marginalized communities are being included (e.g. trauma responsive approaches, safe space policies, etc.)
8. A coordinated postvention effort or strategy exists.

Zero Suicide: Counties should be able to demonstrate a county-level and provider-level commitment to Zero Suicide by taking the following actions:

9. As referenced in the above section on Community Prevention, a formal public commitment should be obtained from county leadership in the form of a resolution by the county legislature or community services board that includes a

commitment to promoting and supporting adoption and implementation of the Zero Suicide model in health care across the county.

10. Development of a strategic plan to advance implementation of the Zero Suicide model which must include a commitment (in the form of letters) by key identified community providers to adopt the Zero Suicide model[4] – outlining a commitment by agency leadership to systematically prevent suicides among those who are receiving services, by implementing universal screening of individuals for suicide, put those who screen positive on a care pathway with evidence-based interventions, and follow-up monitoring – in the following settings:
    a. Behavioral health services (mental health clinics and substance use disorder settings)
    b. Emergency departments
    c. Primary care settings
    d. Crisis service system
    e. Medical / surgical settings (optional)
11. Effort to research and understand the cultural context of the community targeted by each program to address disparity and the engagement of high-risk groups. Ensure that there is equity in the efforts to apply Zero Suicide protocols.

Data: Counties are utilizing data to inform the development, implementation and evaluation of prevention strategies (among both clinical/Zero Suicide and community domains above) and are making efforts to increase and improve data collected on suicide attempts and deaths.

12. Data is used to identify high risk groups, follow trends, and develop and evaluate prevention strategies.
13. Data is used to identify population groups and the variability in access to services and suicide deaths.
14. Evidence of due diligence to track progress and impact of interventions using a family of three types of measures; input (what program or policy is being implemented); output (how many are participating); and intermediate (what effect did the participation have on attitude, behavior, policy).
15. Investments are made in coroner/medical examiner data collection that includes the circumstances surrounding suicide deaths.
16. Data sharing across participating agencies aimed at preventing suicide attempts and deaths, while in compliance with all applicable state and federal privacy laws (e.g. suicide fatality reviews).

[4] Note, some hospital accrediting agencies, such as the Joint Commission with its suicide prevention national patient safety goal, recently issued standards that incorporate principles of the Zero Suicide model in the form of systematic screening, care pathway development with use of evidence-based interventions, and monitoring after care.