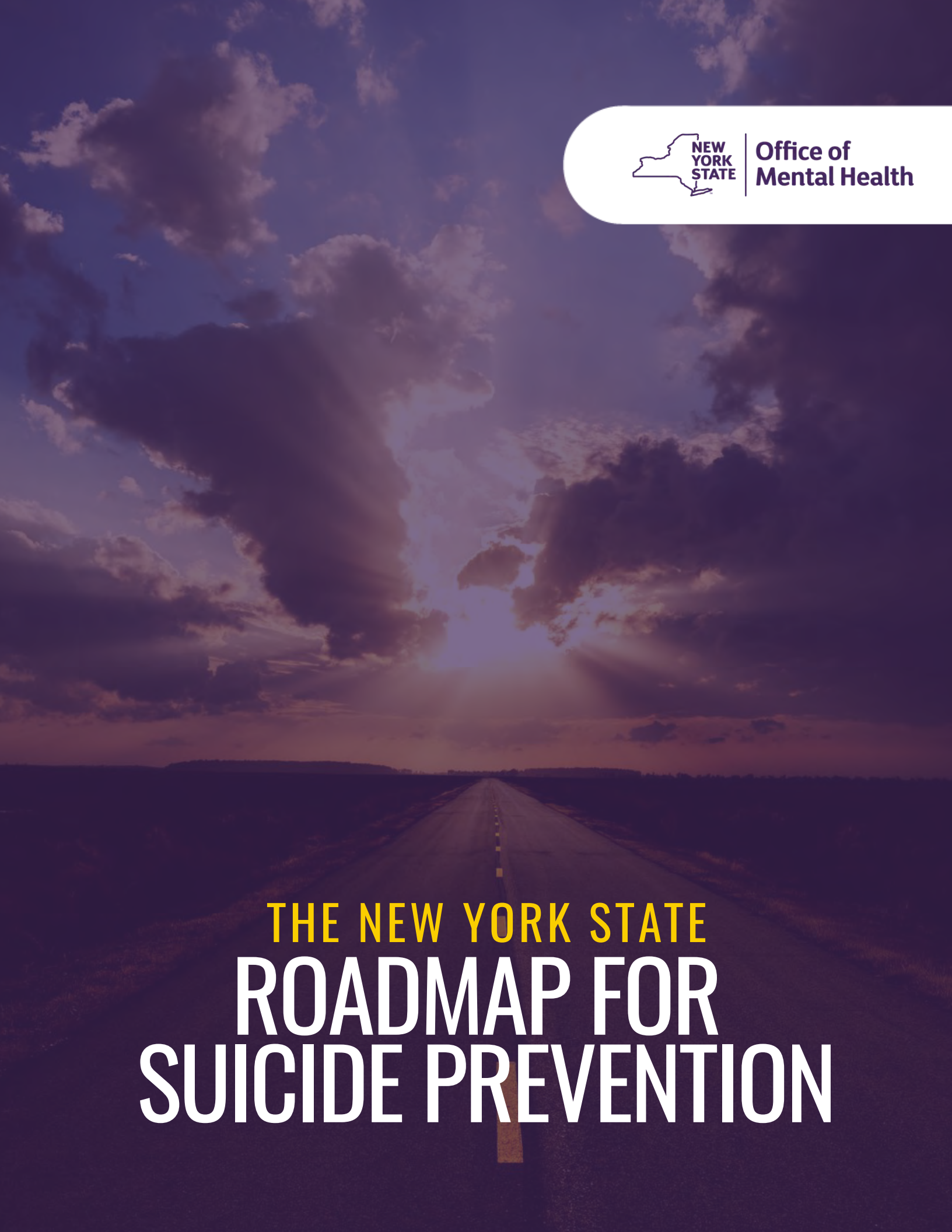

THE NEW YORK STATE ROADMAP FOR SUICIDE PREVENTION

NEW YORK STATE | Office of Mental Health

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***Note**: Page references here correspond to the PDF page position in this combined document, not the page numbers printed within each individual report.*

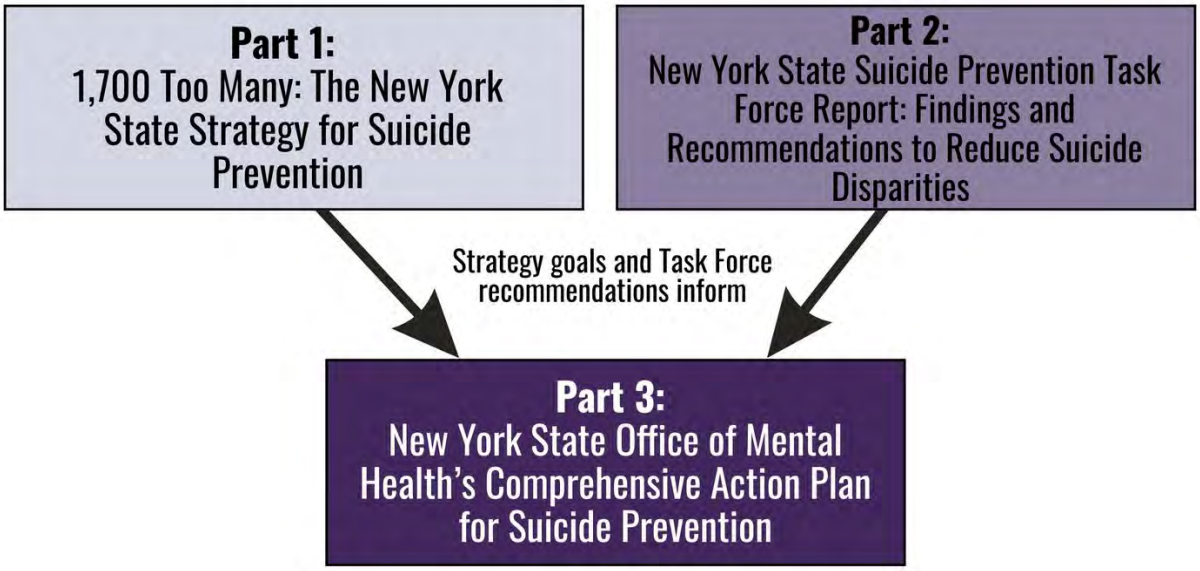
The New York State Roadmap for Suicide Prevention

In 2023, suicide ranked as the 15th leading cause of death in New York State and tragically took the lives of 1,717 New Yorkers. Behind these numbers are real lives lost, and a stark reminder that suicide affects all communities across the state and that a coordinated response is essential. The Roadmap for Suicide Prevention represents New York State's comprehensive efforts to achieve that response: a unified package of three interrelated documents, each serving a distinct function, and together forming a path forward for preventing suicide in New York State over the next four years.

The Roadmap was developed and informed by subject matter experts, community members, those with suicide-centered lived experience, current research findings, and in alignment with the National Strategy for Suicide Prevention with a universal goal of preventing suicide attempts and deaths among New Yorkers. It is grounded in the understanding that 'suicide prevention is everyone's business', and that it requires alignment across clinical, community, and public health approaches, with an intentional focus on those that face disparities and have a greater risk of suicide.

The three documents that comprise the Roadmap for Suicide Prevention are:

- ***1,700 Too Many: The New York State Strategy for Suicide Prevention*** – a strategy developed by the OMH Suicide Prevention Center of New York (SPCNY) and the NYS Suicide Prevention Council, with input from subject matter experts and individuals with lived experience. It establishes strategic directions and goals as the foundation to a comprehensive, statewide effort to advance suicide prevention across New York. Derived from the National Strategy for Suicide Prevention but tailored to NYS, the Strategy is intended to serve as broad guidance for all those involved in suicide prevention across the state. It aims to inspire and mobilize individuals, organizations, state agencies, and communities across the state to take meaningful action.
- ***New York State Suicide Prevention Task Force Report: Findings and Recommendations to Reduce Suicide Disparities*** – a report produced by a Task Force of selected suicide prevention experts over the course of 7 meetings (2024-2025). This report presents findings and recommendations focused on addressing disparities in suicide risk across New York. The recommendations are grounded in the latest evidence with the goal of ensuring that prevention efforts reach those who need them most. The report was developed with the research support of the New York State Psychiatric Institute.
- ***Turning Strategy into Action: The New York State Office of Mental Health's Comprehensive Action Plan for Suicide Prevention*** – an action plan derived directly from the goals of the NYS Strategy for Suicide Prevention and the recommendations from the NYS Suicide Prevention Task Force Report. This action plan translates statewide priorities into concrete approaches, paired with specific performance metrics to measure the progress being made over the next four years. It is the NYS Office of Mental Health's operational commitment to advancing suicide prevention across clinical, community, and public health settings.



The visual above illustrates the New York State Roadmap for Suicide Prevention, which integrates two foundational documents: Part 1, "1,700 Too Many: The New York State Strategy for Suicide Prevention," and Part 2, the New York State Suicide Prevention Task Force Report, which presents findings and recommendations to reduce suicide disparities. As the diagram depicts, the strategic goals and Task Force recommendations from these components collectively inform Part 3, the New York State Office of Mental Health's Comprehensive Action Plan for Suicide Prevention.

Together, these three documents form the Roadmap for preventing suicide across New York State.

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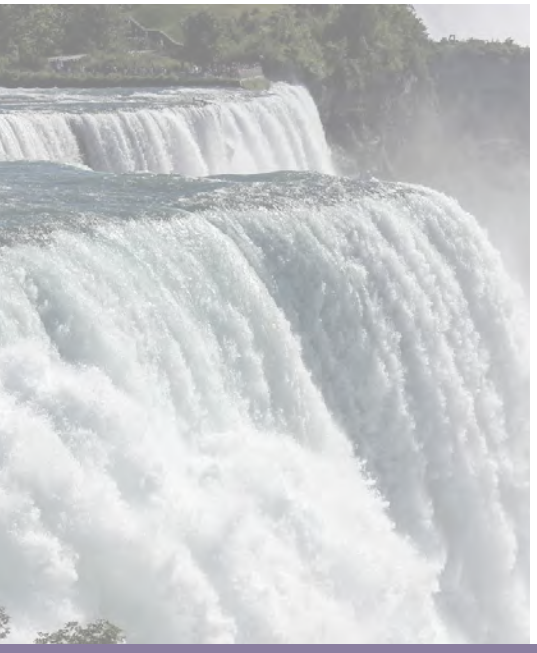
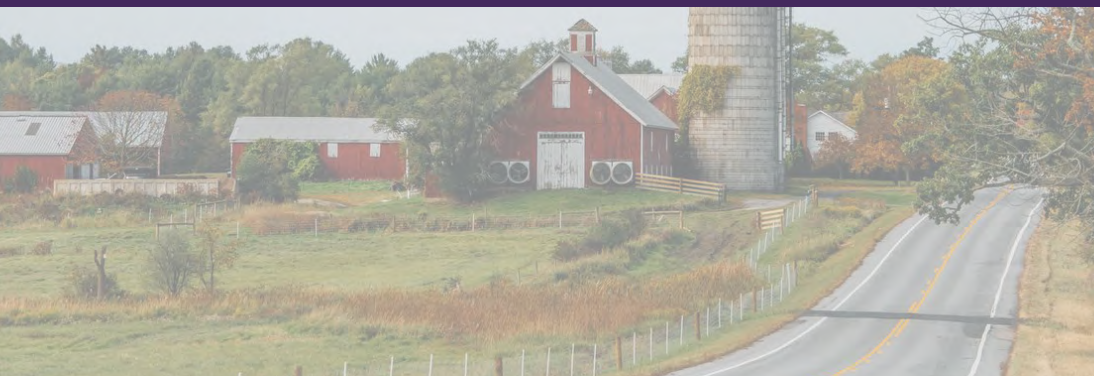
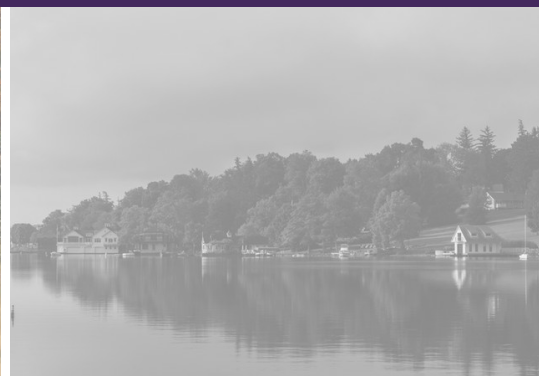
1,700 TOO MANY



NEW YORK STATE'S STRATEGY FOR SUICIDE PREVENTION

2026-2030





Dedication

1,700 Too Many: New York State's Strategy for Suicide Prevention is dedicated to the lives lost to suicide and to the families, friends, and communities who carry their memories forward. Their lives mattered. Their stories, love, and the advocacy of those who honor them continue to inspire action and change.

Introduction

1,700 Too Many: New York State's Strategy for Suicide Prevention (2026–2030) reflects New York State's Office of Mental Health's ongoing commitment to preventing suicide and reducing its profound impact on individuals, families, and communities. As the 15th leading cause of death in New York, suicide claimed 1,717 lives in 2023, underscoring the need for sustained, coordinated efforts for its prevention. This updated strategy acknowledges the complex factors that contribute to suicide and outlines a unified, cross-sector approach to prevention, support, and early intervention.

This 2026–2030 strategy builds on the foundation of the 2016-2017 plan, *1,700 Too Many: New York State's Suicide Prevention Plan.* The updated strategy acknowledges the continued loss of life to suicide and New York's ongoing efforts to advance prevention efforts using the latest knowledge and insights. It also aims to inspire and mobilize individuals, organizations, communities, and state agencies alike to take meaningful action across the state. Serving as a powerful reminder that each life lost is one too many, the title of the strategy acknowledges this truth while reaffirming the need for a sustained and coordinated response to reduce suicide across the state.

Aligned with the 2024 *National Strategy for Suicide Prevention* (NSSP), New York State's Strategy builds upon the NSSP's four strategic directions and introduces a fifth: Amplifying Support for Communities with Suicide Disparities in New York. In addition, New York has adapted the NSSP's 15 national goals into 20 state-specific goals that are tailored to local needs and designed to promote collaboration across public health, healthcare, community organizations, and individuals with suicide-centered lived experience. Together, these directions and goals offer a framework for coordinated action and lasting impact statewide.

This renewed strategy emphasizes strengthening data systems, addressing emerging disparities, and deepening collaboration among state agencies, healthcare systems, and community organizations. ***1,700 Too Many: New York State's Strategy for Suicide Prevention (2026–2030)*** reinforces the state's commitment to a coordinated, evidence-informed approach while empowering communities, elevating voices of those with suicide-centered lived experience and advancing the shared goal of building suicide-safer communities across New York.

Together, this Strategy, the New York State Suicide Prevention Task Force Report, and the New York State Comprehensive Action Plan make up the ***New York State Roadmap for Suicide Prevention***. Collectively, they reflect the state's commitment to a coordinated, community-informed approach to suicide prevention that drives meaningful, lasting change.

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Executive Summary

Suicide remains a significant public health issue in New York State, ranking as the 15th leading cause of death and tragically taking the lives of 1,717 New Yorkers in 2023. Although New York State has one of the lowest suicide rates in the nation, the emotional, social, and economic toll on individuals, families, and communities is still profound. Addressing this complex issue requires a coordinated, cross-sector approach that unites state agencies, county leaders, healthcare systems, schools, and communities, especially those most impacted by suicide, to reduce suicide and save lives.

In April 2024, the U.S. Department of Health and Human Services (HHS) released an updated **National Strategy for Suicide Prevention,** (NSSP), along with an accompanying Federal Action Plan. The NSSP provides a renewed framework to guide and strengthen suicide prevention efforts nationwide. In alignment with this updated national strategy, the New York State Office of Mental Health (NYS OMH), in collaboration with the New York State Suicide Prevention Council and a range of subject matter experts, including individuals with suicide-centered lived experience, has developed its own strategy, ***1,700 Too Many: New York State's Strategy for Suicide Prevention (2026–2030),*** to reflect current priorities, evidence, and community voices.

Building on the foundation of **New York State's 2016- 2017 Suicide Prevention State Plan**, ***New York State's Strategy for Suicide Prevention ("The Strategy")*** provides a statewide framework to reduce suicides through evidence-based and community-driven approaches. It emphasizes the importance of collaboration, equitable access to effective care, and tailored programs and interventions that meet the needs of diverse populations across the state.

The Strategy is organized around five strategic directions aligned with the structure of suicide prevention within OMH SPCNY and its advisory board, the New York State Suicide Prevention Council. This alignment ensures strong leadership, coordination, and accountability, and positions New York State to deepen its impact by building on existing infrastructure, enhancing collaboration, and driving sustainable progress.

Woven throughout the Strategy are three guiding themes: advancing suicide prevention for populations at higher or rising risk through effective use of data, centering the voices of those with lived experience to ensure efforts are relevant and accessible, and applying innovative research methods and data sources to strengthen accuracy and impact.

» CONTINUED ON NEXT PAGE

Grounded in these themes, the five strategic directions define New York State's approach to suicide prevention through coordinated action and sustained impact:

Strategic Direction #1: ***Strengthening the Foundation of Suicide Prevention Through Surveillance, Research, and Quality Improvement***
Enhancing the use of data to identify emerging trends, evaluate the effectiveness of interventions, and drive informed decision-making. Ensuring suicide prevention efforts remain evidence-based, responsive, and aligned with the evolving needs of New Yorkers, especially for those populations disproportionately impacted by suicide.

Strategic Direction #2: ***Ensuring Equitable Access to Suicide Prevention Care***
Transforming systems to ensure that every New Yorker can access timely, effective, and culturally responsive suicide prevention care. Strengthening the workforce, reducing structural and systemic barriers, and embedding equity across healthcare, crisis response, and community settings. Fostering collaboration, research, and innovation to ensure interventions are sustainable and responsive to the diverse needs of individuals and communities across the state.

Strategic Direction #3: ***Amplifying Support for Communities with Suicide Disparities in New York***
Addressing suicide risk among eight populations with suicide disparities based on national trends and state surveillance through targeted, data-informed, and community-driven strategies that reflect interest holder input. Ensuring approaches are culturally relevant, grounded in suicide-centered lived experiences, and responsive to those most impacted.

Strategic Direction #4: ***Expanding Effective Community-Driven Suicide Prevention***
Embedding suicide prevention into everyday life by fostering strong local partnerships, advancing education and training, promoting lethal means safety, and strengthening postvention support. Promoting a culture of shared responsibility by integrating suicide prevention across schools, workplaces, neighborhoods, and other community settings through proactive engagement and improved communication.

Strategic Direction #5: ***Advancing Clinical Suicide Prevention and Crisis Response***
Integrating evidence-based suicide prevention practices across healthcare settings and enhancing the capacity of crisis response systems to provide timely and effective support. Expanding access to specialized mental health services, promoting the use of proven treatment models, addressing disparities in care, and ensuring healthcare professionals are equipped through ongoing training.

Each strategic direction is supported by goals adapted from the NSSP and reframed for New York State. These goals are further advanced through specific objectives that outline specific actions, while *Resources to Consider* provide evidence-based and evidence-informed tools and examples to inform and support efforts to help achieve the outcomes described in *What Success Looks Like*.

The success of ***1,700 Too Many: New York State's Strategy for Suicide Prevention (2026–2030)*** depends on a skilled and supported workforce, robust data systems, and sustained leadership and commitment from state agencies and policymakers. Its greatest strength, however, lies in the collective efforts of communities, individuals, families, and those with suicide-centered lived experience, whose voices, insights, and compassion bring depth and meaning to this work.

Suicide prevention is a shared responsibility that extends across every part of society. It calls for a united, statewide effort where every New Yorker can contribute to building a culture of care, connection, and prevention. This Strategy offers an evidence-informed framework to guide action, empower communities and foster hope across the state.

The Voices of New Yorkers with Suicide-Centered Lived Experience

Integrating the voices of New Yorkers with suicide-centered lived experience—defined here as belonging to any one of the following three groups: individuals who themselves have experienced suicidal thoughts or behaviors, those bereaved by a suicide loss, and/or anyone who has supported a suicidal loved one—is a core value of the New York suicide prevention approach. In June of 2025, with help from our partners, OMH SPCNY reached out to a diverse group of New Yorkers with suicide-centered lived experiences. Individuals were invited to complete a brief survey that asked them to define what success looks like for suicide prevention in New York State from their perspective and to share feedback on the five strategic directions of this Strategy. Eighty-six individuals responded with an average completion time of 55 minutes! Select quotes from survey respondents are included throughout the Strategy.

A qualitative analysis of the responses revealed three core themes: the need for systemic improvement, education and training, and funding. Recommendations for systemic improvements encompassed an array of topics at the individual, family, and community levels. Well-trained professionals and informed community stakeholders were identified as essential in the implementation and evaluation of responsive and collaborative suicide prevention initiatives. The creation of community-peer support efforts was also suggested to promote mental health, reduce stigma, and respond to social isolation and loneliness. The importance of a statewide collaborative partnership approach inclusive of public and private sectors was identified as paramount to the equitable allocation and distribution of resources and funding for suicide prevention. **Suicide prevention was seen as a path to a community of care, awareness, connectiveness, and mental health promotion for all New Yorkers.**

In summary, respondents called for comprehensive suicide prevention that is relevant, accessible, equitable, and culturally sensitive to the communities being served. They highlighted the need for a person-centered approach through which individual's needs, values, and experiences are attended to with compassion and understanding.

> ***"I envision a State where people don't think of killing themselves because they have meaningful and rich lives; people are aware of a continuum of resources to address the drivers of suicide and believe that it is ok for people like themselves to access them; a broad spectrum of helpers (MH providers to Law Enforcement, Pastors, Teachers, Business Owners, Parents, Classmates, and Friends) hold nonjudgmental views of people who are struggling and are confident and competent in their abilities to assist; partnership by clinicians, policymakers, community leaders, and researchers to develop and deploy novel and effective interventions to reduce the risk of suicide throughout the suicidal pathway; and low- or no-barriers to accessing mental health and other resources throughout out the state."***
>
> *– Carl LoFaro, Suicide-Centered Lived Experience Survey Respondent*

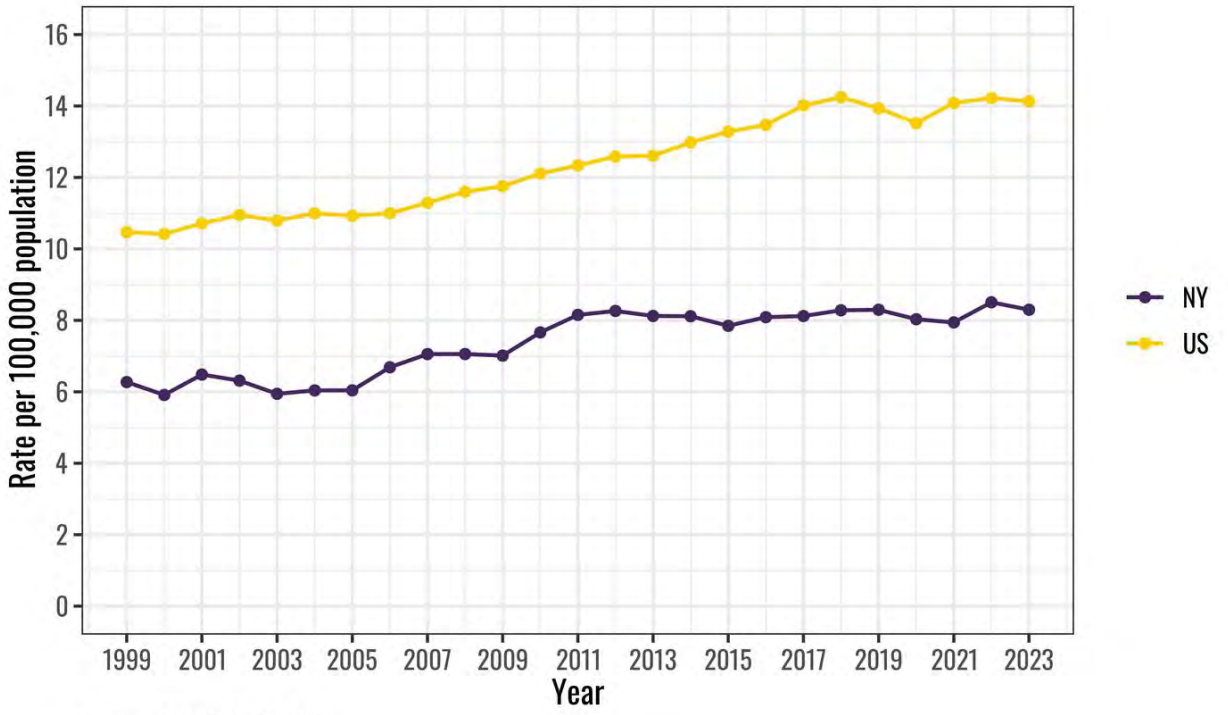
A Brief Summary of New York State Suicide Data

Suicide in New York State

New York State has one of the lowest suicide rates in the nation. In 2023, there were 8.8 suicides for every 100,000 New Yorkers, compared to the national rate of 14.7 per 100,000[1]. Only one other state and the District of Columbia had lower age-adjusted suicide rates in 2023. However, because of New York's large population, it ranks higher in the *number* of suicide deaths per year; in 2023, only 5 other states (TX, CA, FL, PA, OH) had more suicide deaths. In 2023, deaths by suicide in New York State cost $17.79 billion; of that, $10.09 million were medical costs and the rest were related to lost work productivity[2].

Figure 1 below shows age-adjusted suicide mortality rates in New York and the United States between 1999 and 2023.[1] Analysis of time trends showed that New York experienced a significant increase in suicide rates between 2004 and 2011 at an average annual percent change of 4.2%, with rates remaining stable afterwards. In the US, rates increased between 1999 and 2006 and between 2006 and 2017 but remained stable afterwards.

Figure 1: Age-adjusted Suicide Rates, NY and US, 1999-2023

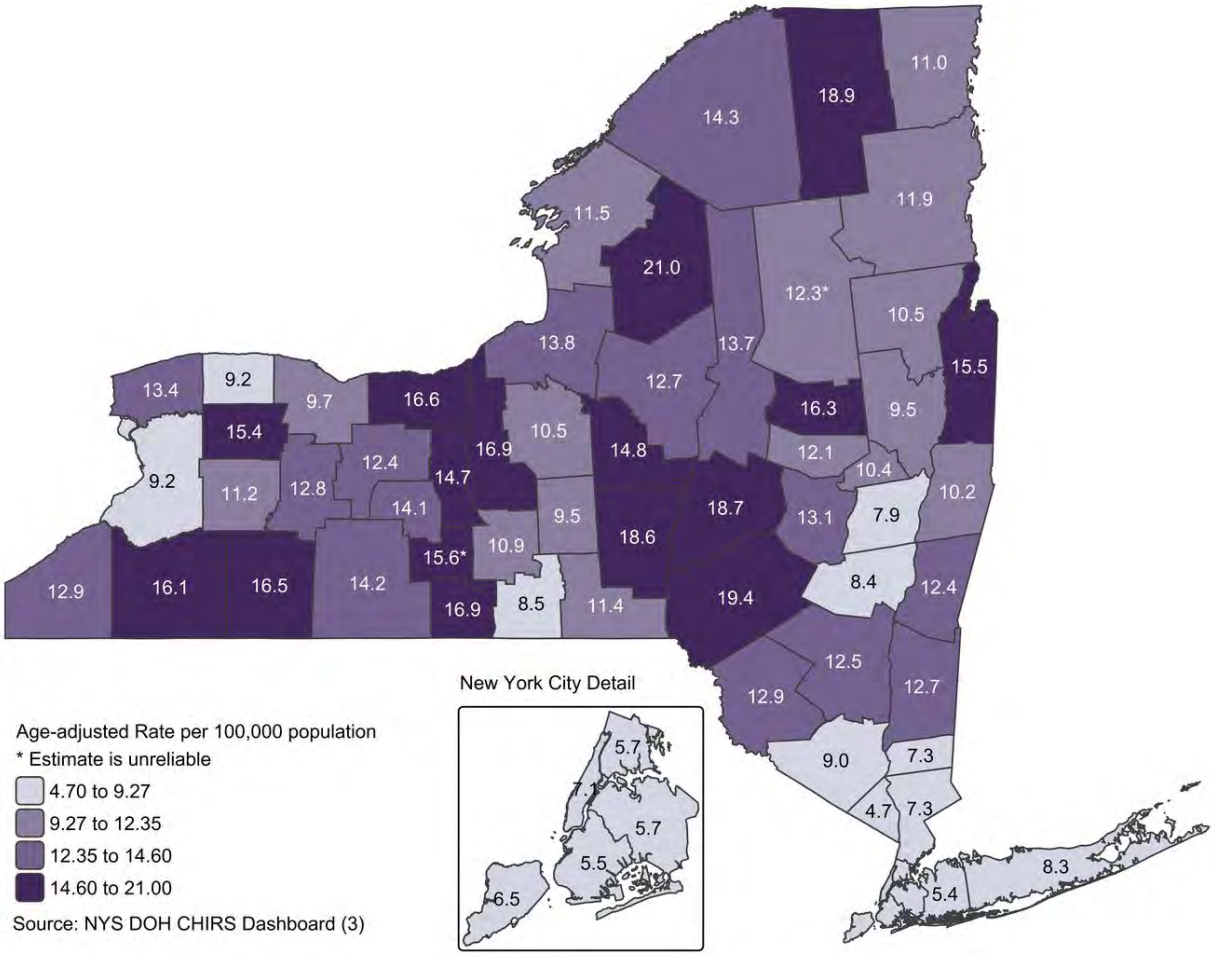


Source: CDC WONDER (1)

Geographic Distribution of Suicide Deaths

Suicide rates vary greatly by county and region (see Figure 2). New York State is geographically diverse with large and small cities, suburbs, and large expanses of rural areas. Among New York's regions, the Mohawk Valley has the highest suicide rate with a three-year (2020-2022) age-adjusted rate of 14.7 per 100,000 (NYS DOH CHIRS Dashboard[3]). Although New York City is the region with the lowest suicide rate (6.0 per 100,000 age-adjusted), it has the highest number of suicide deaths with 1,605 suicide deaths between 2020 and 2022.

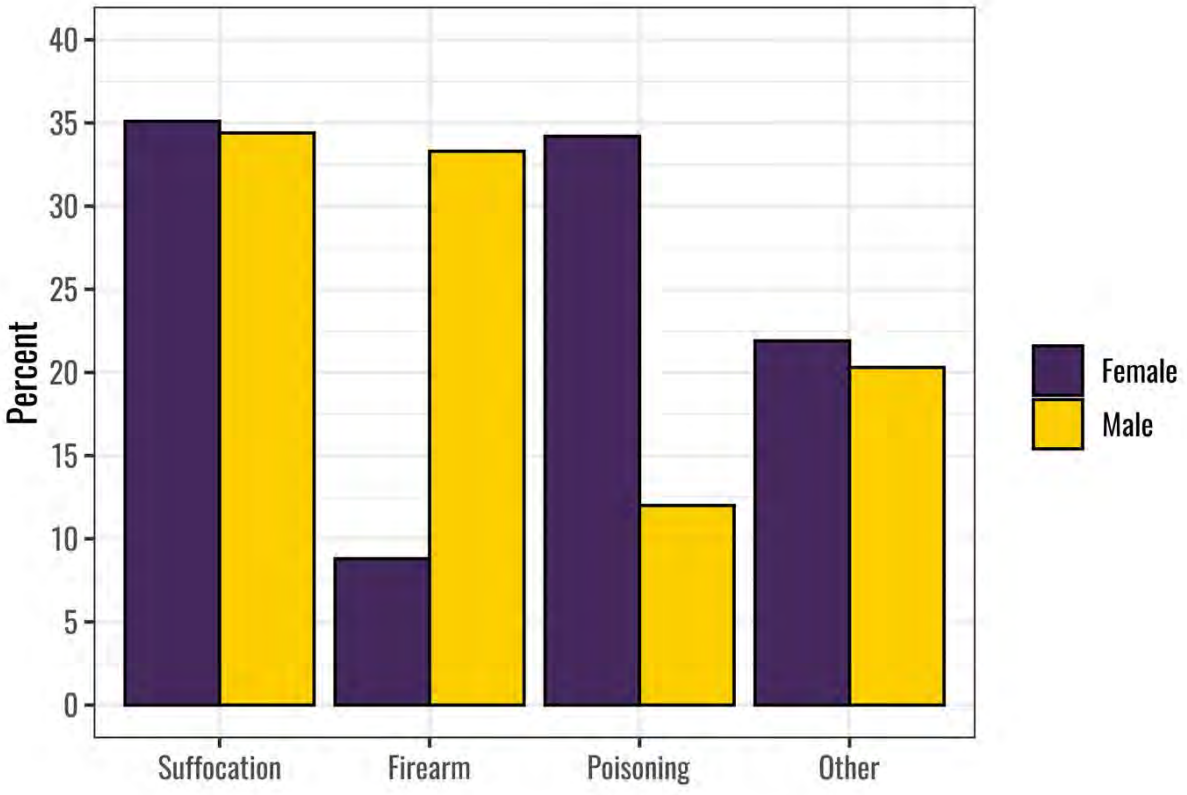
Figure 2: Age-adjusted Suicide Death Rate, 2020-2022



Lethal Means of Suicide

Between 2021 and 2023, the most prevalent lethal means of suicide in New York were suffocation (34.6%), firearm (27.7%), and poisoning (17.1%). New York differs from the United States, where firearms accounted for more than half of suicide deaths (54.9%) during that time period. Lethal means in New York differ by sex, particularly for firearms and poisoning (see Figure 3). Between 2021 and 2023, firearm suicides were more common among males, while poisoning suicides were more common among females[1].

Figure 3: Percent of Suicide Deaths by Lethal Means among Males and Females, 2021-2023



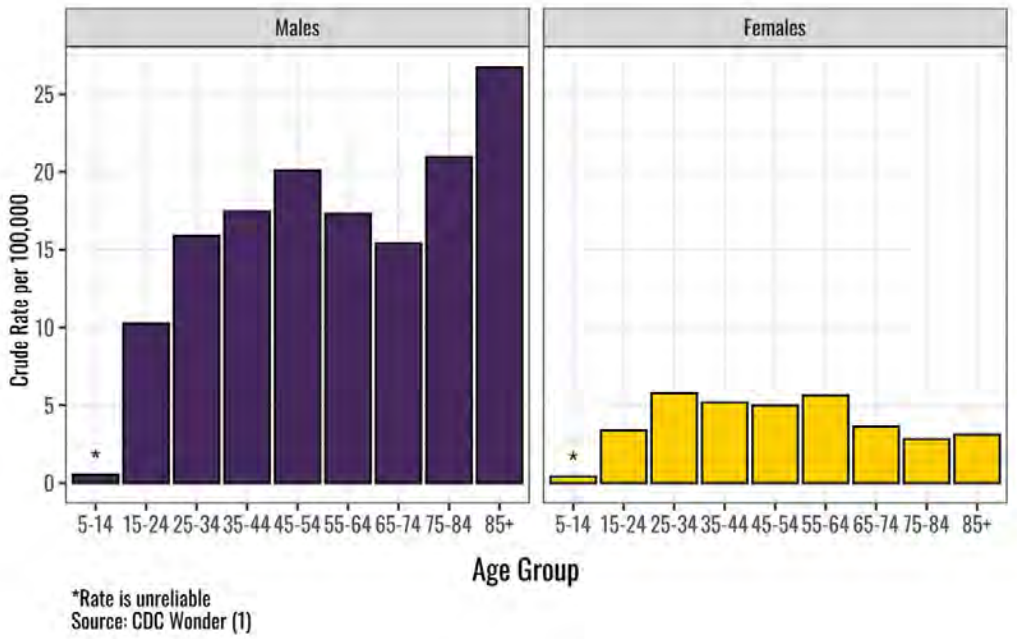
Source: CDC WONDER (1)

Demographics

Consistent with national trends, the suicide rate among males in New York (13.7 per 100,000 in 2021-2023)[1] is 3.5 times the rate among females (3.9 per 100,000 in 2021-2023)[1]. Higher risk among males is not explained by greater use of firearms – between 2021 and 2023 rates of non-firearm suicide were 2.6 times as high among males than females.

For both males and females in New York, suicide rates are low during childhood and higher during middle age. For males, rates increase again during old age and are highest for those age 85 and older (26.73 per 100,000 between 2021 and 2023)[1].

Figure 4: Suicide Rates by Age Group among Males and Females, 2021-2023



Between 2021 and 2023 and across all ages, age-adjusted suicide rates in New York were highest among non-Hispanic White persons (10.4 per 100,000), followed by non-Hispanic Asian (5.69 per 100,000), non-Hispanic Black (5.45 per 100,000), and Hispanic (5.20 per 100,000) persons, and non-Hispanic persons of more than one race (4.58 per 100,000). Nationally, high age-adjusted suicide rates are also seen among non-Hispanic American Indian or Alaska Native persons (26.32 per 100,000) and non-Hispanic Native Hawaiian or Other Pacific Islander persons (14.76 per 100,000) during the same time period[1]. Misclassification of race and ethnicity on death certificates has been documented[4] and may impact these estimates.

Selected Risk Factors

History of Suicide Attempts

A history of suicide attempt is the strongest risk factor for suicide death. For example, a California-based study found that patients visiting the Emergency Department for intentional self-harm (which includes suicide attempts) were more than 50 times as likely to die by suicide within one year as the general population[5]. However, it is important to note that most people who attempt suicide do not go on to die by suicide, underscoring the importance and potential impact of interventions for this group.

Mental Health Disorders

Mental health disorders such as depression, bipolar disorder, and schizophrenia are also strongly associated with heightened risk of suicide. For example, the suicide rate for those served in the New York State public mental health system between 2009 and 2012 was 38.8 per 100,000, almost five times the rate of the general population (https://omh.ny.gov/omhweb/dqm/bqi/suicideasaneverevent.pdf). Among New York decedents in the National Violent Death Reporting System (NVDRS), current mental health problems were identified in 59% of suicides between 2020-2022 with available circumstance information. Since mental health disorders may not be disclosed to others or discovered during investigation following a suicide death, the true percentage may be higher.

Alcohol and Drug Use

Like mental health disorders, substance use disorders are associated with heightened suicide risk. Between 2020 and 2022 in New York, alcohol dependence and other substance abuse problems were identified in 13.4% and 15.5% of suicide decedents, respectively, with circumstance information available in the NVDRS[6]. Alcohol and drug use are also associated with reduced inhibition, which could increase suicide risk in the short term[7].

Adverse Childhood Experiences

Adverse childhood experiences (ACEs), as well as other forms of trauma, have been associated with suicidal behavior. In the 2021 New York Behavioral Risk Factor Surveillance System survey, adults who reported experiencing more ACEs were more likely to report serious thoughts of suicide in the past year. Of particular concern is research that suggests this risk endures well beyond childhood and adolescence into adulthood. While estimates vary, one study found that individuals exposed to several adverse childhood experiences, including childhood trauma, were over 10 times as likely to report attempting suicide during adulthood[8].

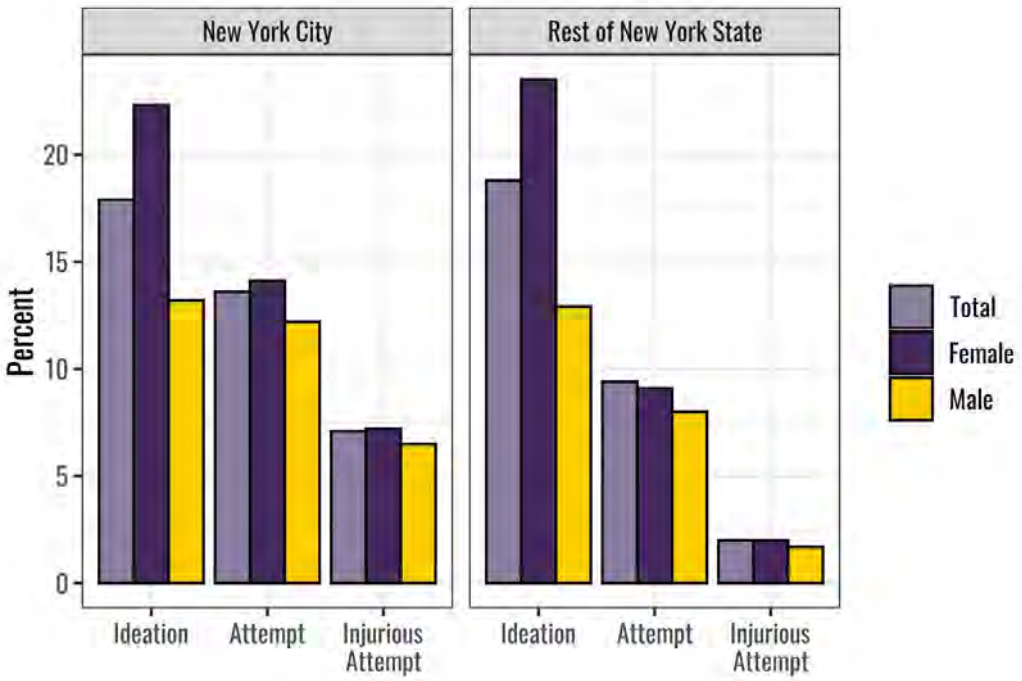
Non-Suicidal Self-Injury

Engaging in non-suicidal self-injury (NSSI), injuring oneself without the intent to die, 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 significantly more likely to experience subsequent suicidal ideation, plans, and attempts than those without a history of NSSI[9]. It has been suggested that NSSI may be a "gateway" behavior to suicide and that it may reduce inhibition to suicidal behavior[10].

Suicidal Thoughts and 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 an estimated 25 non-fatal suicide attempts. Suicidal thoughts and attempts tend to be more common among adolescents and youth than among adults, and more common among females than males. Among adult New Yorkers surveyed between 2022 and 2023, 4.80% reported serious thoughts of suicide in the past year, including 10.66% of 18-25 year-olds and 3.93% of those over age 25. Furthermore, 0.56% reported attempting suicide in the past year, including 2.08% of 18-25 year-olds and 0.33% of those over age 25[11] . In 2022 in New York, there were 4.4 hospitalizations for self-inflicted injuries for every 10,000 residents[12]. The NYS Department of Health syndromic surveillance program estimated that in 2023 there were over 63,000 emergency department visits related to suicide (including suicidal thoughts, suicide attempts, and intentional self-harm) to hospitals outside of New York City alone[13]. In the 2023 New York High School Youth Risk Behavior Survey, 17.9% of New York City (NYC) students and 18.8% of students in the rest of New York State (ROS) reported seriously considering suicide in the past year; 13.6% (NYC) and 9.4% (ROS) reported attempting suicide in the past year; and 7.1% (NYC) and 2.0% (ROS) reported making an attempt that had to be treated by a doctor or nurse[14].

Figure 5: Self-reported Suicidal Ideation and Attempts among New York High School Students, 2023



Source: YRBS Explorer (14)

Suicide Loss Survivors: Impact on Loved Ones

The experience of suicide loss is traumatic, and the impact on family members and friends is long-lasting. Traditional estimates have held that at least six people are bereaved by each suicide death, translating to over 295,000 loss survivors per year in the US[15]. People who experience suicide loss are 65% more likely to attempt suicide than those who experienced a death by natural causes. In addition, they are 80% more likely to drop out of school or lose their jobs. It is typical for suicide loss survivors to feel extreme guilt, anger, confusion, and distress. 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.

Summary

New York has one of the lowest suicide rates in the US but ranks highly in the number of suicide deaths each year. New York's suicide rate (8.8 per 100,000 population) has remained relatively stable for more than 10 years, is higher among males than females, and is higher during middle and old age compared to younger ages. New York's suicide rate varies geographically, with higher rates in more rural counties, a phenomenon that is largely accounted for by firearm suicides. However, suicide deaths do not fully capture the burden of suicidal behavior in New York. Suicidal thoughts and suicide attempts result in thousands of hospital visits each year, and in 2023 about 18% of high school students reported seriously considering suicide during the past year. Suicide also impacts hundreds of thousands of loss survivors each year. Prevention strategies that address risk factors for suicide, including prior attempts, mental health and substance use disorders, and adverse childhood experiences, as well those that identify and supporting those experiencing suicide risk, are crucial for reducing suicide in New York.

Strategic Direction 1

Strengthening the Foundation of Suicide Prevention through Surveillance, Research, and Quality Improvement

Strategic Direction 1 focuses on enhancing the foundation of knowledge that informs and drives suicide prevention efforts across the state. At its core, the goal is to strengthen the quality, integration, and application of suicide-related data, providing actionable insights that inform targeted interventions, reduce health disparities, and increase the reach and effectiveness of evidence-based strategies. Timely, accurate data is vital in tracking trends, identifying at-risk populations, and ultimately shaping a more effective and coordinated response to suicide. By improving the collection and use of data, New York State can develop more precise suicide prevention initiatives that reflect the specific needs of diverse communities. This enables more strategic, data-driven decisions aimed at reducing suicide risk across the state and ensure that resources are directed where most needed.

Together, the goals within this strategic direction envision timely and comprehensive data systems and practices that serve as the bedrock for informed and effective suicide prevention programs throughout New York State. Through a commitment to high-quality data, research, and continuous improvement, New York State aims to strengthen the reach and impact of suicide prevention efforts for all New Yorkers.

"Strengthening the data foundation is essential - but it becomes truly powerful when it is paired with real stories and lived experiences. Centering people, not just numbers, ensures that research and evaluation lead to prevention efforts that are responsive, equitable, and rooted in human connection. By weaving lived experience into data collection and interpretation, New York can build prevention strategies that reflect not only what is happening - but why it matters and who it impacts"

- Marianne Reid Schrom, John's Sister, Suicide-Centered Lived Experience Survey Respondent

Goal 1

Advance data quality and integration to facilitate comprehensive understanding of suicide and related mortality in New York.

Objective 1.1:

> Continue to improve the quality, timeliness, and scope of New York mortality and morbidity data, including data on suicidal thoughts and behaviors, as well as associated risk and protective factors.

Objective 1.2:

> Integrate data on suicide mortality, morbidity, and risk and protective factors across multiple sources to understand direct, upstream, and contextual-level contributors to suicide risk in New York.

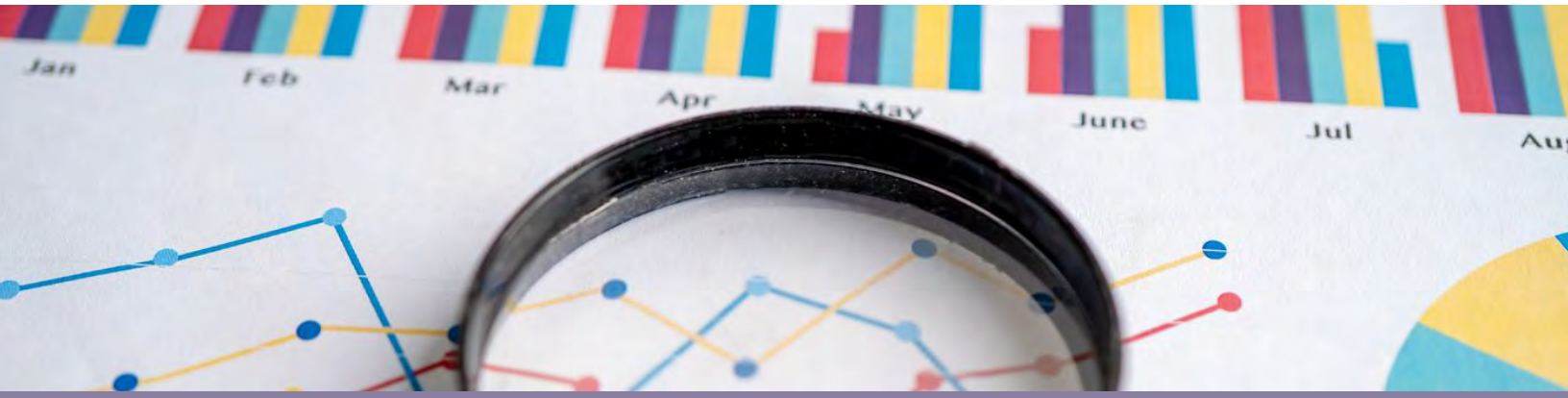
Objective 1.3:

> Integrate data on suicide morbidity and mortality with data on other causes of mortality and risk and protective factors to understand the complete mortality experience related to suicide risk in New York.

What Success Looks Like

New York State will generate comprehensive, high-quality, and timely suicide-related data that can be integrated and used to inform suicide prevention across the state. This includes ongoing improvements in the timeliness of New York's mortality data to ensure that the public release of finalized state mortality data is at least as timely as federal data, along with expanding the scope and quality of data related to health disparities, such as sexual orientation, gender identity, and race and ethnicity. In addition, strengthening our understanding of the connection between suicide risk and other causes of death (e.g. overdoses and accidents) will facilitate more integrated prevention approaches.

Increasing integration of data across state agencies can also yield new information to guide suicide prevention efforts. For example, a recent case study describes how the Utah Office of the Medical Examiner and Departments of Public Safety and Human Services linked data on suicide deaths with data on concealed carry permits and hospital and emergency department visits, which provided valuable information for firearm suicide prevention and enabled swift policy response[16]. When possible, incorporating novel data sources into integration efforts can help to enrich characterization of risk and may help inform innovative prevention strategies.



Advancements in New York's Suicide Data

The New York State Department of Health (NYS DOH) and New York City Department of Health and Mental Hygiene (NYC DOHMH) have made substantial achievements in the scope, timeliness, and quality of suicide data in recent years. In 2021, NYS DOH added suicide-related questions to the NY Behavioral Risk Factor Surveillance System survey, improving the ability to monitor the prevalence of suicidal thoughts, behaviors, and associated risk factors among New Yorkers. NYS DOH has also worked **with coroners and medical examiners** to understand the barriers and opportunities for improving reporting of drug overdose fatalities and suicides.

Both NYS DOH and NYC DOHMH conduct suicide-related syndromic surveillance to enable timely local responses to suspected changes in suicide behavior. Since 2019, NYS DOH has conducted suicide syndromic surveillance through the CDC's Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes and Comprehensive Suicide Prevention programs. Syndromic data are reported daily from all emergency departments (EDs) in the state, allowing them to monitor data in near real-time for changes and patterns. NYS DOH also distributes alerts of detected temporal spikes and spatial clusters to facilitate local community response. Likewise, NYC DOHMH uses syndromic surveillance data to respond to patterns in mental health-related ED visits, including suicide attempts and suicidal behavior. In addition, NYC DOHMH's MortalSS system tracks provisional suicide death data on a weekly basis, providing timely data to guide their suicide prevention and response strategies.

New York State has also made substantial achievements in record linkage at the individual level. For example, NYS DOH has linked mortality records to statewide hospital discharge data, enabling qualified users to address specific questions about hospital-based healthcare services received prior to death. In addition, New York's statewide **All-Payer Database** brings together information on healthcare utilization from multiple claims sources. Both NYS DOH and NYC DOHMH participate in the National Violent Death Reporting system, which links mortality records for suicides and other violent deaths to law enforcement and coroner/medical examiner reports, providing valuable contextual information about suicide deaths across the state.

Goal 2

Increase utilization of multiple data sources and dissemination of actionable information to address suicide risk among populations with suicide disparities in New York.

Objective 2.1:

> Increase awareness of available data among community interest holders to facilitate data-informed suicide prevention across New York State.

Objective 2.2:

> Enhance data sharing and dissemination of actionable information to interest holders concerning suicide risk among populations with suicide disparities in New York State.

What Success Looks Like

Community interest holders across New York State will have greater awareness of and access to actionable data to guide their suicide prevention efforts, including information on suicide risk among populations with suicide disparities. This will help communities design more targeted efforts to reduce these disparities and improve outcomes. Data will be disseminated to community partners, collaborators, and interest holders who will also receive training to support the translation of data into actionable prevention activities. Ideally, this process will involve two-way communication to ensure efforts are relevant, responsive, and tailored to the needs of each focus population.

Data Integration

Data integration can occur at multiple levels. At the individual level, records from different sources about a single person may be linked using personal identifiers. This requires substantial privacy protections and coordination between agencies or offices to facilitate, but can yield valuable insights into individual-level risk factors and precipitating events to inform prevention strategies (e.g., the Massachusetts Public Health Data Warehouse). Data may also be linked at the geographic level (e.g., county, zip code) when such geographic identifiers are included in the data source, allowing for characterization of area- or community-level risk. Additionally, data on a specific population can be brought together across multiple sources without performing formal linkage; this type of conceptual integration can aid in characterizing multiple aspects of suicide risk for a particular group. Beyond the potential value of individual record linkage, data integration at the geographic, community, and conceptual levels can help to advance population health by deepening our understanding of community risk. This approach can help to identify contextual-level risk factors and correlates of suicide- and mortality-related outcomes that may shape more effective community-level prevention strategies and help reduce health disparities.

Goal 3

Continually evaluate programs and advance implementation research to improve suicide prevention in New York.

Objective 3.1:

> Evaluate the short-term, intermediate, and long-term impacts of suicide prevention programs, including intended program outcomes, risk and protective factors, morbidity, and mortality.

Objective 3.2:

> Evaluate progress on goals set forth in the state strategy.

Objective 3.3:

> Advance implementation research to help increase the availability of high-quality programs and practices across New York.

What Success Looks Like

Achieving Goal 3 means that suicide prevention programs in New York State will be continuously evaluated to ensure quality, effectiveness, and impact. This includes both intended program effects and more downstream outcomes such as risk and protective factors, morbidity, and mortality. Efforts should also be made to evaluate progress toward the goals set forth in this strategy, ensuring activities align with state priorities and providing a framework for quality improvement. In addition, New York State will conduct research to better understand the factors that affect program adaptation and sustainability across various communities and contexts. To further advance suicide prevention activities, program evaluations and implementation research should, where appropriate, use novel methods to maximize benefits for all populations, especially those at elevated risk.

Goal 4

Conduct, promote, and support research that provides actionable information to guide suicide prevention in New York.

Objective 4.1:

> Conduct, promote, and support research that increases understanding of opportunities for suicide prevention and intervention among New Yorkers.

Objective 4.2:

> Conduct, promote, and support research that increases understanding and facilitates reduction of social disparities in suicide in New York.

What Success Looks Like

Successfully conducting, promoting, and supporting research will result in an increased understanding of opportunities for suicide prevention strategies and interventions in New York State. These opportunities may exist at multiple levels, including policies, institutional procedures and practices, community contexts, and individual risk and protective factors. Research that incorporates novel methods to increase validity will promote greater understanding of social disparities in suicidal behaviors and reflect the priority topics outlined in the National Strategy for Suicide Prevention, such as youth mental health, substance use and suicide risk, and peer support services. Involving individuals with suicide-centered lived experience in the research process, including shared decision-making about research priorities, can help ensure relevance and appropriate interpretation of results[17]. Insights from research will help illuminate social disparities in suicide across New York State and, together with Goal 8, will provide clear focus areas for action by community organizations, agencies, and other interest holders.

Spotlight Story

Harnessing Data to Drive Local Prevention Strategies

Submitted by Saratoga County Department of Health (SCDOH)

Data collection and analysis are critical for developing and evaluating any public health intervention, including suicide prevention. In early 2024, the epidemiology team at the Saratoga County Department of Health (SCDOH) began implementing a comprehensive suicide surveillance system with the goal of monitoring suicide fatalities and suicide attempts in the county.

Initially, this program relied on just two data sources: the Saratoga County Coroner's Office and the Electronic Syndromic Surveillance System. Over time SCDOH incorporated a variety of additional sources including a death records database developed and maintained by SCDOH staff, 988 call data provided by Vibrant Emotional Health, poison center call data thanks to our partnership with the Upstate New York Poison Center, and most recently, Emergency Medical Services. These data sources are complementary, with each providing distinct and valuable information.

These surveillance efforts led to the creation of a web-based, interactive data dashboard that is currently being used to develop and inform the suicide prevention strategies of our partners at the Saratoga County Department of Mental Health and the Suicide Prevention Coalition of Saratoga County whose members belong to local agencies and community organizations. Utilization of this data allows for the creation and eventual evaluation of more effective suicide prevention initiatives by our partners. While national suicide data and statistics are accessible, informative, and impactful, compiling and sharing this type of data at the county level results is an even more powerful tool for cultivating change in communities.

Resources to Consider

Suicide Fatality Review (SFR): SFR, also known as Suicide Mortality Reviews (SMRs) is a promising practice to generate actionable information for suicide prevention at the local level. SFR teams are composed of members from a variety of community sectors and are charged with reviewing information surrounding suicide deaths to identify policy recommendations and opportunities for prevention. An exemplary SFR model from Washington County, Oregon, included the systematic collection of risk factors and circumstances for each suicide death using a standardized form implemented during medical death investigations. For counties with a robust culture of medical death investigation, SFR has the potential to substantially increase data quality and timeliness and data-to-action efforts at the local level. More information, including a toolkit describing recommendations and prerequisites for establishing suicide mortality review committees, can be found here. SPCNY's Suicide Fatality Review Toolkit can also be requested here.

New York State Community Health Indicator Reports (CHIRS) Dashboard: Dashboards can provide valuable suicide-related data that can be used for state and local planning, while simultaneously adhering to agency policies regarding confidentiality. The CHIRS platform offers county-level data on a wide range of health indicators, including rates of suicide mortality and self-inflicted injury. This user-friendly tool helps stakeholders explore public health data to inform planning, identify trends, and target prevention efforts. Reports can be customized by county and topic to support data-driven decision-making.

CDC Mapping Injury, Overdose, and Violence Dashboard, Injury and Violence Data: This interactive tool provides state, county, and census tract level data on a range of injury and violence topics, including suicide. Users can explore trends, compare demographics, and visualize data in a variety of formats to support surveillance, research, and prevention planning.

A White Paper on Improving the Reporting of Drug Overdose Fatalities in New York State: High-quality and timely medical death investigations are crucial for improvements to data quality, scope, and timeliness. This white paper from the New York State Department of Health outlines the vital role that coroners and medical examiners play in identifying and reporting overdose deaths. Developed by the Coroner/Medical Examiner workgroup, the white paper identifies several challenges that hinder the completeness, accuracy, and timeliness of data from medical death investigations. Recommendations include the development of a comprehensive training program for all Coroner/Medical Examiners statewide and reimbursement for death record submissions. Increasing the consistency of medical death investigation across NY counties is a key step in improving data quality and implantation of interventions across the state. Subsequently, NYS DOH will partner with Syracuse University and subject matter experts to develop a cost-free, hands-on training to new and existing coroners, medical examiners, and forensic death investigators in NYS.

CDC Collaborating Office for Medical Examiners and Coroners (COMEC): COMEC works to improve the quality and consistency of death investigation data, supporting national efforts to better understand causes of death, including suicide. The office provides technical assistance, training, and resources to medical examiners and coroners, with the goal of strengthening surveillance and informing prevention strategies.

Strategic Direction 2

Ensuring Equitable Access to Suicide Prevention Care

Equitable access to suicide prevention care is a cornerstone of an effective and compassionate statewide strategy. It reflects a commitment to ensuring that every individual, regardless of their circumstance, can access timely, effective, and appropriate care when they are in crisis or at risk. In the context of suicide prevention, equitable access means more than simply expanding services; it means transforming systems to eliminate barriers and provide care that is accessible and responsive to individuals' needs.

Suicide risk is shaped by a complex interplay of personal, social, and systemic factors, not only mental health conditions. When individuals in need encounter delays, stigma, geographic isolation, or a lack of responsive and culturally attuned care, their risk is compounded. Addressing access means recognizing that different communities require different forms of support, and that the systems designed to provide care must be built with that variability in mind.

This strategic direction calls for systemic changes that embed suicide prevention into the fabric of everyday life, including healthcare, crisis response, and social services, and community-based programs. It emphasizes the importance of establishing and supporting a well-trained, diverse workforce, aligning policies and funding to support integrated care, and ensuring that interventions are responsive to the needs and experiences of the communities they serve. It also recognizes the critical role of research and cross-sector collaboration in identifying effective approaches and strategies, informing policy, and ensuring that promising practices are shared, adapted, and sustained. Achieving equitable access requires not only reducing logistical and structural barriers, but also addressing social and cultural barriers to care, including stigma and gaps in culturally responsive services.

By advancing systemic improvements that strengthen the responsiveness and accessibility of suicide prevention efforts, New York State can reduce disparities in care and ensure all communities receive the support they need.

"This is an enormous factor in reducing suicides as many lack access to quality care. I think we also need to do a better job of teaching how to deal with mental health struggles at an earlier age. In my opinion one of the root causes to our mental health crisis is that we [don't] teach people how to deal with a mental health crisis until they are in one. ...Imagine how many suicides we could prevent if we teach children coping skills and best practices at a young age."

- Dan Egan, Suicide-Centered Lived Experience Survey Respondent

Goal 5

Improve and expand access to effective, evidence-based suicide prevention initiatives by reducing barriers to care, using data-driven decision-making, and ensuring programs are responsive to the strengths, needs, and lived experiences of communities across New York State.

Objective 5.1:

> Increase access to suicide prevention resources and services through collaborative and integrated models, ensuring individuals in communities with limited access to care can receive support in settings such as workplaces through Employee Assistance Programs, primary care, telehealth services, and school-based programs.

Objective 5.2:

> Advance suicide prevention efforts by actively engaging and collaborating with communities and individuals, including those with suicide-centered lived experience, and integrating their perspectives and expertise into program design, policies, and initiatives. ***See also Goal 12.***

- **5.2.1:** Integrate feedback mechanisms that integrate community and suicide-centered lived experience into program design, implementation, and quality improvement.
- **5.2.2:** Expand leadership and advisory opportunities for individuals with suicide-centered lived experiences across state and local suicide prevention efforts.

Objective 5.3:

> Ensure suicide prevention efforts are responsive to population-specific needs by incorporating culturally relevant approaches, language access, and data-driven insights into program design and delivery.

- **5.3.1:** Integrate language access services and outreach strategies into suicide prevention efforts to effectively engage all individuals, including those with Limited English Proficiency and those that utilize American Sign Language (ASL).
- **5.3.2:** Integrate an understanding of intersecting social, economic, and health factors such as age, socioeconomic status, geographic location, race/ethnicity, sexual orientation, disability, and chronic conditions, into the design and delivery of suicide prevention strategies and interventions.
- **5.3.3:** Strengthen data collection, monitoring, and feedback systems to support continuous quality improvement and ensure interventions and resources are responsive to population-specific trends and disparities. ***See also Goal 2.***

Objective 5.4:

> Promote upstream protective factors to reduce suicide risk among populations across New York State by fostering family and community engagement and peer support.

- **5.4.1:** Build and support community networks and programming across New York State to increase social connectedness, promote mental well-being, and reduce isolation.
- **5.4.2:** Expand and invest in peer support programs, especially those that empower individuals with suicide-centered lived experience to provide mentorship, foster connection, reduce stigma and offer guidance. ***See also Goal 10, 11 & 12.***
- **5.4.3:** Strengthen opportunities for family engagement and the involvement of natural supports in suicide prevention efforts, helping to build protective environments across communities.

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Goal 5

Improve and expand access to effective, evidence-based suicide prevention initiatives by reducing barriers to care, using data-driven decision-making, and ensuring programs are responsive to the strengths, needs, and lived experiences of communities across New York State.

What Success Looks Like

In achieving Goal 5, suicide prevention efforts across New York State will be more accessible, collaborative, and responsive to the strengths, needs, and lived experiences of all communities. Programs, services, and interventions will be shaped by data and grounded in input from various communities, including individuals with suicide-centered lived experience. Collaboration with communities facing barriers to care, including those with limited access, Limited English Proficiency, or who use American Sign Language, will help guide the development of integrated, adaptable approaches that are culturally and linguistically responsive. Expanded peer support, family engagement, and community networks will help improve connection, resilience, and mental well-being. These efforts will ensure that all New Yorkers, regardless of identity, communication needs, or location, have access to timely, effective suicide prevention supports.

Goal 6

Address the social, economic, and environmental conditions that contribute to suicide risk across communities in New York State

Objective 6.1:

> Improve access to supports and programs that promote well-being and reduce suicide risk by strengthening local capacity and supporting community-driven solutions that reflect the strengths and cultural context of each community. ***See also Strategic Direction 3.***

- **6.1.1:** Work in collaboration with nonprofits and community organizations to support and sustain existing efforts that aim to improve access to housing, financial assistance, employment, education, transportation, and food security.

Objective 6.2:

> Strengthen cross-sector collaboration to leverage resources and expand suicide prevention efforts across New York State.

- **6.2.1:** Foster collaborations between state and local government agencies and private sector entities, including universities, businesses, insurers, and nonprofit organizations, to advance suicide prevention efforts through aligned funding, programs, and partnerships.

What Success Looks Like

Communities across New York State will experience improved access to essential supports and programs that promote stability, well-being, and reduce suicide risk. Cross-sector collaborations will help address key systemic contributors to suicide risk, such as housing instability, unemployment, and economic inequity, that contribute to suicide risk. Partnerships with nonprofits, community organizations, and the private sector will strengthen local capacity and expand resources in communities most impacted by disparities. Success will also mean that supports and programs are grounded in cultural values and lived experiences of the communities they serve, ensuring that local solutions are not only accessible but also appropriate and effective. These efforts will strengthen the social and economic conditions that support well-being and reduce suicide risk across the state.

Goal 7

Develop and support a healthcare and crisis response workforce that is well-trained, resourced, and equipped to provide equitable, responsive suicide prevention services across care settings and populations.

Objective 7.1:

> Ensure access to suicide prevention training and technical assistance that prepares healthcare professionals, including clinical and nonclinical staff, resident doctors, and graduate students in fields such as social work, nursing, and education, to effectively address and respond to individuals at risk, including those in crisis. ***See also Goals 19 & 20.***

- **7.1.1:** Regularly update suicide prevention and crisis response training programs by incorporating input from individuals with suicide-centered lived experience, community expertise and emerging best practices.

Objective 7.2:

> Establish and implement professional standards, protocols, and best practices for suicide prevention interventions, crisis response, and postvention that promote collaborative, patient-centered care and address barriers to accessing services.

- **7.2.1:** Establish ethical guidelines and best practices for the use of advanced technologies, such as artificial intelligence (AI) bots and algorithms, in suicide prevention services to prevent the amplification of disparities in care.

Objective 7.3:

> Increase the number of mental health and suicide prevention professionals in New York State who reflect the communities they serve, especially those at higher risk of suicide, through targeted recruitment, scholarships, and mentorship programs.

What Success Looks Like

Successfully achieving Goal 7 will result in a healthcare and crisis response workforce that is well-trained, equipped, and prepared to meet the needs of communities across New York State. Targeted recruitment, mentorship, and career development efforts will help build a workforce that reflects the diversity of New York State. Professionals across all levels of care will receive comprehensive training in suicide prevention and crisis response, along with skills to provide culturally responsive and patient-centered care. Together, these efforts will result in a healthcare system and workforce that are better prepared to meet the needs of all communities, helping to reduce suicide risk and improve outcomes statewide.

Goal 8

Increase support for academic and community-led research focused on advancing equitable, evidence-informed suicide prevention strategies, and strengthen cross-sector collaboration to improve the dissemination and practical application of research findings and promising practices.

Objective 8.1:

> Foster collaboration between academic institutions, community organizations, and government agencies to improve the dissemination of research findings, promising practices, and lessons learned from suicide prevention initiatives.

Objective 8.2:

> Support the research and evaluation of suicide prevention interventions and programs that address cultural, geographic, social, or economic factors that influence suicide risk.

Objective 8.3:

> Promote the translation of research findings and promising practices into policy, funding priorities, and system-level implementation through coordinated guidance, tool development, and technical assistance.

What Success Looks Like

Academic institutions, community organizations, and government agencies will engage in sustained, collaborative efforts to advance evidence-informed suicide prevention strategies across New York State. These partnerships will support the development, adaptation, and evaluation of interventions that reflect the cultural, geographic, and systemic contexts in which they are implemented. Findings from quantitative, qualitative, and community-based participatory research, promising practices, and lessons learned will be disseminated and translated into tools, policies, and system-level improvements that strengthen suicide prevention efforts. Community-informed research will guide the refinement of services and supports, ensuring they are relevant, effective, and scalable. Through continued investment and collaboration, these efforts will expand the state's capacity to advance innovative and effective suicide prevention that meets the needs of all New Yorkers.

Spotlight Story

The Role and Impact of the Black Mental Health Response Team (BMHRT)

Submitted by Nicole Brown, MFT, Program Director
Black Mental Health Response Team, BestSelf Behavioral Health

The Black Mental Health Response Team (BMHRT), a program of **BestSelf Behavioral Health** is indicative of the change in how mental health care is viewed and presented to Black and African American communities, offering culturally competent, accessible, and trauma-informed services. The creation of the Black Mental Health Response Team (BMHRT) was directly influenced by a racially motivated mass shooting, that occurred on the eastside of Buffalo on May 14, 2022, which left the Black community traumatized and scarred.

The team is the comprised of solely Black/African American clinicians, peers, and mental health staff who are personally connected to the community they serve, and they endeavor to provide culturally competent care but also to offer it in a manner that recognizes the lived experiences of the individuals and aims to address both short-term traumas, systemic issues, and disparities. The BMHRT offers a comprehensive range of services aimed at meeting the mental health needs of the Black community. This includes both traditional and non-traditional mental health services, outreach, engagement, and mental health messaging through various channels, all of which are provided with a focus on cultural competence.

Suicide Prevention at BestSelf: *BestSelf's continued commitment to mental health and client safety has led to our participation in the statewide Zero Suicide initiative, supported by a grant from the Office of Mental Health. This grant is helping us enhance our training and refine our processes so we can better identify individuals at risk for suicide and, most importantly, improve the care and outcomes for those who need it most.*

Resources to Consider

Crafting a Health Equity Centered Narrative (Build Healthy Places Network): This resource offers practical guidance for creating inclusive messaging that advances racial and health equity across sectors, emphasizing shared values, asset-based language, and clear communication to build trust and collaboration, which can inform culturally responsive suicide prevention strategies.

U.S. Department of Health and Human Services National CLAS Standards: The National Culturally and Linguistically Appropriate Services (CLAS) Standards provides a framework for healthcare organizations to advance health equity and reduce disparities. They emphasize respectful, responsive care, effective communication, diverse staffing, and meaningful community engagement.

Prevention Institute's Bringing Equity to Suicide Prevention Module: This module emphasizes that suicide prevention must center on the root causes of inequitable community conditions—such as historical marginalization, socioeconomic stressors, and structural injustice—and identifies populations at elevated risk (e.g., Indigenous people, LGBTQ+ youth, Black and Latino young men, rural residents, essential workers, older adults) who are disproportionately impacted. The module further advocates for data-informed, community driven, and culturally tailored interventions, rooted in local knowledge and trust, to equitably support high-risk groups in ways that standard evidence-based strategies may not address

Community Support Program Initiative (CSPI): A community-based initiative that integrates evidence-based practices and culturally infused suicide prevention training for communities with multiple cultural identities. This approach ensures that mental health and suicide prevention strategies are inclusive and responsive to the needs of diverse groups, including rural populations and veterans.

Creating a Community of Practice to Prevent Suicide Through Multiple Channels: Describing the Theoretical Foundations and Structured Learning of PC CARES: This article presents PC CARES (Promoting Community Conversations About Research to End Suicide), a community-based, culturally responsive suicide prevention model developed in partnership with rural Alaska Native communities. Grounded in adult learning theory and Indigenous knowledge systems, the intervention uses structured "learning circles" to engage community members in interpreting suicide-related research and collaboratively identifying locally relevant, strengths-based prevention strategies.

Strategic Direction 3

Amplifying Support for Communities with Suicide Disparities in New York

Addressing the needs of populations with suicide disparities is a cornerstone of New York State's comprehensive suicide prevention strategy. The NSSP identifies several populations for which disparities in suicide deaths and attempts are apparent nationwide[19]. This Strategy focuses on eight populations that align with those identified in the NSSP and reflect state-specific surveillance trends and stakeholder input. This Strategic Direction underscores the importance of focused actions that reflect the experiences and needs of these communities to reduce rates of suicidal thoughts, plans, and death.

Youth in New York grapple with disproportionately high rates of suicidal thoughts and attempts. Academic demands, social relationships, family dynamics, and the pervasive influence of social media can create significant mental health challenges during a time of rapid neurodevelopmental change[20]. Additionally, the long-lasting effects of adverse childhood experiences (ACEs) and systemic inequities can compound risk[21]. To address these challenges, tailored strategies are critical to meet youth where they are and support the development of individual protective factors and the creation of safe, nurturing environments. By prioritizing these efforts, we can mitigate the risk of youth suicide and empower future generations to navigate life's complexities with strength and confidence[22].

In addition to youth, Strategic Direction 3 prioritizes seven other key populations – Black youth, Hispanic youth, LGBTQIA+ youth, rural communities, Indigenous communities, veterans, and working aged men – with disparities in suicidal thoughts, attempts, and/or death, indicated by higher or increasing rates. Populations with suicide disparities often face complex, interconnected challenges, including upstream disadvantages and significant barriers to accessing interventions and care tailored to their needs[23]. At the same time, each of these groups is highly heterogeneous, including a wealth of diversity within them, with individuals identifying with more than one group.Therefore, this Strategic Direction follows the principle of targeted universalism, which acknowledges that while broad universal goals, such as reducing suicide attempt and death rates, are shared across all populations, individual communities can face distinct challenges that require tailored strategies. By focusing on specific needs, barriers, and stressors that contribute to elevated suicide risk within populations, a targeted universalism approach ensures that interventions are not one-size-fits-all. Instead, it emphasizes that the pathways to achieving universal outcomes, like reducing suicide, must be adaptable and responsive to the diverse strengths, experiences, and circumstances of each community[24].

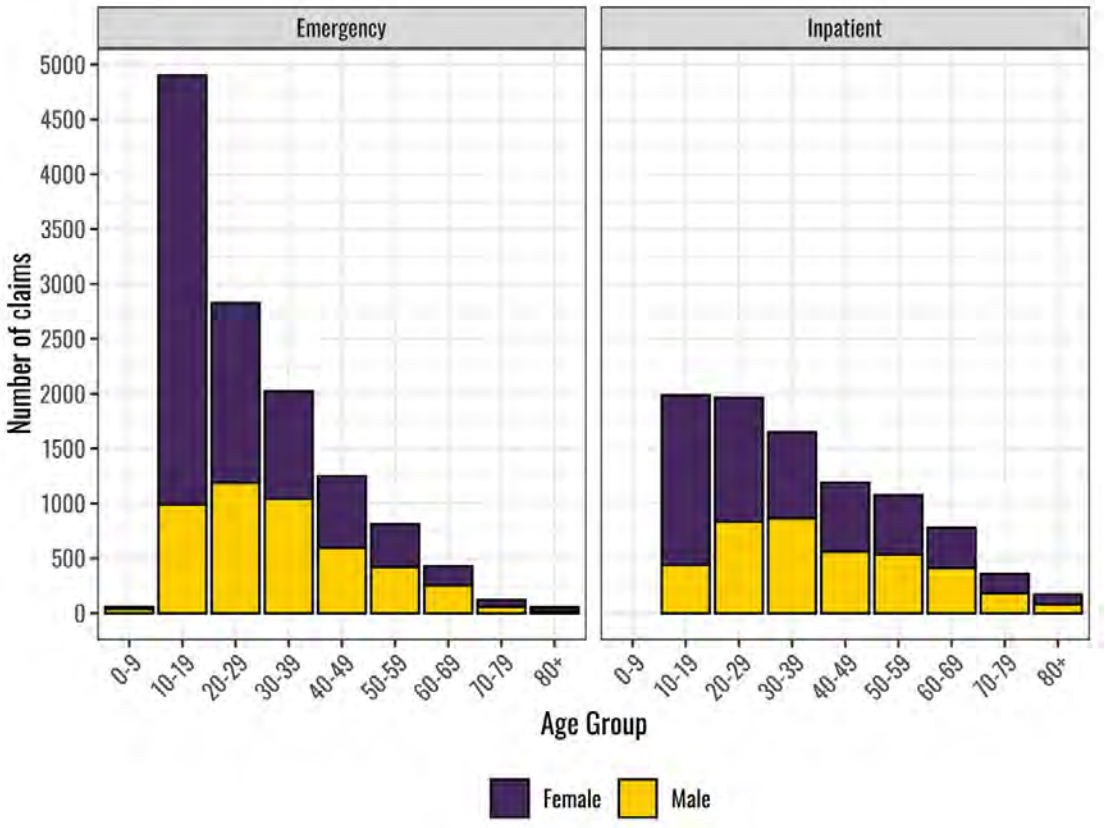
"I think that this seems like a great plan to follow through on, especially now that there are certain groups that we know have a higher suicide rate than others. While we know that mental health does not discriminate against anyone, we do know that it affects certain groups at a much higher rate and I like that we are actively working toward getting more supports to those groups of people."

- Anonymous Suicide-Centered Lived Experience Survey Respondent

Suicide-Related Outcomes Among Youth

Suicide has been among the top 3 causes of death among youth in New York in recent years and was the 2nd leading cause of death among 10-19 year-olds in 2023, accounting for 13.8% of deaths in that age group[1]. Moreover, youth, especially females, bear a disproportionate burden of suicidal thoughts and behaviors. The prevalence of self-reported suicidal thoughts and attempts is highest among youth and decreases after young adulthood. For example, in 2021, 16.8% of New York high school students in the YRBS (21.3% of females and 11.9% of males) reported that they seriously considered attempting suicide in the past year, while the corresponding percentages among adults in the BRFSS were 10.9% for 18-24 year-olds, 7.3% for 25-34 year-olds, and decreased incrementally to 1.5% for those age 65+. Furthermore, youth are disproportionately represented among emergency department and inpatient hospital claims for intentional self-harm. In 2023, 10-19 year-olds accounted for 21.4% of inpatient hospital claims and 39.2% of emergency department claims by New York hospitals (see Figure 6)*.

Figure 6: Emergency Department and Inpatient Hospital Claims for Non-fatal Intentional Self-Harm by Age Group and Sex, New York 2023



*Data from Statewide Planning and Research Cooperative System (SPARCS). This publication was produced from raw data purchased from or provided by the New York State Department of Health (NYSDOH). However, the conclusions derived, calculations, and views expressed herein are those of the author(s) and do not reflect the conclusions or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here.

Goal 9

Improve the availability and access to youth-specific suicide prevention trainings, information, and resources for schools, families, and organizations serving youth.

Objective 9.1:

> Increase accessibility and availability of youth-specific suicide prevention trainings and workshops for schools, youth-serving organizations, and families.

- **9.1.1:** Deliver suicide-specific trainings to school staff and other youth-serving professionals on recognizing warning signs in youth, conducting developmentally appropriate screenings, appropriate referral procedures, and responding effectively to crises.
- **9.1.2:** Ensure youth suicide prevention trainings and workshops are culturally relevant and responsive, tailored to reflect the needs of the youth being served.
- **9.1.3:** Promote and provide workshops for parents and caregivers on how to talk with youth about suicide, recognize warning signs, and access community resources and support.

Objective 9.2:

> Ensure that youth, families, caregivers, and community members have access to developmentally appropriate and culturally responsive suicide prevention information and resources, including crisis helplines and support services.

- **9.2.1:** Collaborate with youth-led and youth-serving organizations to develop and distribute community-informed materials that reflect the needs, identities, and languages of the populations they serve.

Objective 9.3:

> Integrate suicide prevention training into certification and continuing education requirements for youth-serving professionals, ensuring they are consistently equipped to recognize and respond to youth at risk.

What Success Looks Like

Success for Goal 9 means increasing the availability, accessibility, and use of culturally and developmentally appropriate suicide prevention trainings and resources for youth, families, and youth-serving professionals across New York State. Schools, community-based programs, and youth-serving organizations will deliver evidence-informed trainings that help staff recognize warning signs, respond to crises, and connect youth to timely support. Parents and caregivers will have greater access to workshops and tools that encourage open conversations about suicide and early intervention. Youth and families will find community-informed, multilingual resources and crisis helpline information in schools, health centers, and public spaces. Collaborations with youth-led organizations will ensure materials reflect lived experiences and needs. More professionals will be trained through both organizational efforts and licensure or credentialing requirements. Sustained advocacy and funding will strengthen this infrastructure, building a responsive, well-connected statewide support network.

Mitigating the Impact of Trauma *is* Suicide Prevention

Exposure to childhood trauma and abuse is one of the most persistent risk factors for suicide over the lifespan. Suicide prevention strategies must include both primary prevention programming aimed at reducing exposure to trauma and abuse as well as providing resources to mitigate the impact of trauma and abuse on communities in support of healing and recovery. OMH has funded an initiative called the New York State Trauma-Informed Network and Resource Center (NYS TINRC). The goal of the NYS TINRC is to advance an understanding of trauma and its impact, the use of trauma-informed principles across sectors and the lifespan, and the availability of trauma-informed care and supports throughout NYS. We envision a New York State where people, communities, and systems can realize healing and wellbeing from trauma and toxic stress.

Goal 10

Implement evidence-based programs that strengthen youth social connectedness.

Objective 10.1:

> Increase opportunities for youth to build positive relationships with supportive adults and peers through the implementation of evidence-based school- and community-based programming.

What Success Looks Like

Success for Goal 10 means the widespread implementation of evidence-based programs that foster social connectedness among youth within schools and across communities. These programs will empower youth to build networks of support amongst one another and strengthen relationships between youth and trusted adults. Mentoring programs and school-based support models will be introduced and scaled, particularly in communities impacted by social isolation and suicide disparities. Success will be marked by increased collaboration with schools, youth-serving organizations, and community partners to ensure that connection-building strategies are embedded in existing systems of support. Ongoing evaluation and sustained funding will drive continuous improvement, allowing these initiatives to evolve and grow, ultimately enhancing resilience, emotional well-being, and protective factors for youth.

Goal 11

Advance upstream suicide prevention by expanding early intervention strategies and strengthening protective supports for children and youth.

Objective 11.1:

> Expand the adoption of upstream (primary) prevention programs, such as Social-Emotional Learning (SEL) curricula, especially in elementary and early education settings, to help strengthen protective factors from an early age.

Objective 11.2:

> Provide trauma-informed training and practical tools to educators, school staff, and youth-serving organizations to help reduce the impact of adverse childhood experiences (ACEs), support youth emotional and behavioral health, and improve responses to youth with co-occurring challenges.

What Success Looks Like

Success for Goal 11 means the successful expansion and integration of upstream suicide prevention strategies that strengthen protective factors for children and youth. Schools and youth-serving organizations statewide will adopt evidence-based programs like Social-Emotional Learning curricula that foster resilience and emotional regulation, particularly in early education settings. Through widespread implementation of trauma-informed training, educators, school staff, and youth-serving professionals will be equipped with the skills and tools needed to support the emotional and behavioral health of youth, reducing the impact of ACEs and addressing co-occurring challenges. Success also means securing ongoing funding and resources to sustain these initiatives, ensuring that SEL and trauma-informed practices are embedded within school systems and youth programs for long-term impact. Through these efforts, children and youth will be provided with the foundation for emotional resilience, ultimately promoting better mental health outcomes across the state.

Spotlight Story

Suicide Safety in Schools (SSIS): A Mental Health Education Program for Onondaga County

Submitted by Onondaga County GLS Team

In 2019, the Suicide Prevention Center of New York (SPCNY) was awarded a Garrett Lee Smith grant to develop a collaborative network of service providers in Onondaga County. This initiative brought together Contact Community Services, along with several other providers, organizations, and school districts to strengthen suicide prevention efforts for youth. As part of this work, multiple school districts were trained using a multi-tiered system of support (MTSS) model, focusing on risk identification, assessment, safety planning, referrals, and postvention.

From this effort, Contact developed Suicide Safety in Schools (SSIS), a mental health education program providing crisis management and suicide prevention training to students, parents, educators, administrators and youth-serving community organizations. Using evidence-based practices, SSIS enhances awareness and preparedness across school communities. Launched in 2021, the program began with two Mental Health Educators (MHEs)—one embedded in a district and one serving countywide. Since the grant ended in 2024, continued funding from Onondaga County and local districts has expanded SSIS to 3 school-based MHEs and 2 countywide MHE, ensuring sustained suicide prevention efforts.

Resources to Consider

Resources for Youth:

Youth MOVE National: A youth-led, social justice nonprofit that empowers young people, especially those from historically underrepresented communities, to shape systems in mental health, juvenile justice, education, and child welfare through authentic advocacy and leadership. With a network of over 40 local chapters, the organization provides training, peer support, consulting, and tools like its Youth Advocate Leadership Academy and Y VOC assessment to amplify youth voices and drive policy and program changes.

The Jed Foundation: Help a Friend in Need: Provides resources for young people to recognize when friends are struggling with mental health and offers advice on how to support them in a compassionate and effective way

Seize the Awkward: Starting Tough Conversations about Mental Health: Encourages open dialogue around mental health by helping people initiate conversations with friends who may be struggling, aiming to reduce stigma and promote support.

Talking outLOUD: Teens & Suicide Loss, A Conversation: An award-winning documentary featuring five teens who've lost a parent or sibling to suicide.

NAMI Youth and Young Adult Resources: Offers mental health resources, support groups, and educational materials specifically designed for young people, promoting awareness and resilience.

Our Minds Matter: A peer-to-peer mental health education program in schools that empowers students to lead discussions about mental health, reduce stigma, and create supportive environments.

Resources for Parents & Caregivers:

EDC "After Your Child's Suicide Attempt": A one-hour film designed to support parents and caregivers in the aftermath of a child's suicide attempt, featuring both candid parent testimonies and expert guidance. It functions as a practical communication resource to normalize complex emotions, outline post-crisis care steps, and foster hope and connection.

AFSP Teens and Suicide: What Parents Should Know: This webpage outlines key risk factors, warning signs, and proactive steps parents can take to safeguard their teens, offering strategies to start caring, direct conversations, model mental wellness, and promptly connect struggling adolescents with help.

"What Every Parent & Caregiver Needs to Know: Recognizing Suicide Risk in Your Child" Brochure: An OMH SPCNY Brochure that empowers parents to identify warning signs and outlines clear steps for immediate action. It serves as a concise guide to support proactive parent engagement, encouraging calm presence, securing means of self-harm, notifying crisis teams, and developing safety plans with caregivers and professionals.

NAMI Family Members and Caregivers: NAMI's resource hub offers free, peer-led programs and practical tools to help families understand mental illness, improve communication, set boundaries, and build emotional resilience, strengthening both caregiver well-being and support for their loved ones.

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Resources to Consider

Resources for Schools and School-Based Mental Health Providers:

A Guide for Suicide Prevention in New York State Schools: A New York State-specific resource outlining strategies for preventing suicide in schools. It includes guidelines for school personnel to recognize warning signs, provide early intervention, and establish prevention programs.

After a Suicide: A Toolkit for Schools: A comprehensive guide designed to support schools in responding to a suicide within the school community. It provides practical steps for crisis management, communication, and supporting students, staff, and families after a suicide.

MHANY's School Mental Health Training Center: A New York State training center offering resources and professional development opportunities for school staff. It focuses on equipping educators and administrators with the skills to support student mental health and prevent suicide.

Model School District Policy on Suicide Prevention: A model policy providing schools with a framework for developing and implementing a suicide prevention strategy. It includes protocols for identification, intervention, and postvention, along with resources for staff training and student support.

NYSED Guide for Suicide Prevention for School Personnel: A guide from the New York State Education Department providing school personnel with guidelines on recognizing and responding to students at risk of suicide. It emphasizes the importance of school-wide prevention programs and creating a supportive environment for students.

The Collaborative for Academic Social Emotional Learning (CASEL): CASEL is an organization dedicated to integrating evidence-based social and emotional learning (SEL) into education from preschool through high school. CASEL offers resources to support systemic SEL implementation across classrooms, schools, families, and communities.

Resources for Higher Education:

SUNY Mental Health Resource Finder: Provides access to mental health support across New York, including crisis services, counseling, suicide prevention, peer support, and specialized resources for LGBTQIA+, BIPOC, veterans, and students with disabilities. It includes statewide and campus-specific programs like tele-psychiatry, crisis hotlines, and suicide prevention training. The platform also offers a directory of services by county and resource type.

The JED Foundation's Comprehensive Approach to Mental Health Promotion and Suicide Prevention: This framework outlines a strategic, multi-layered approach for schools and communities to enhance mental health support and suicide prevention efforts. It includes recommendations on fostering resilience, increasing help-seeking behaviors, strengthening community connections, and implementing policies that create protective environments for youth and young adults.

NAMI: Suicide Prevention for College Students: This resource provides insights into suicide risk factors among college students, including mental health challenges, substance use, and academic pressures. It outlines strategies for students, families, and institutions to recognize warning signs, seek help, and foster supportive campus environments.

Goal 12

Develop, implement, and improve access to comprehensive suicide prevention strategies that address the needs of communities with suicide disparities.

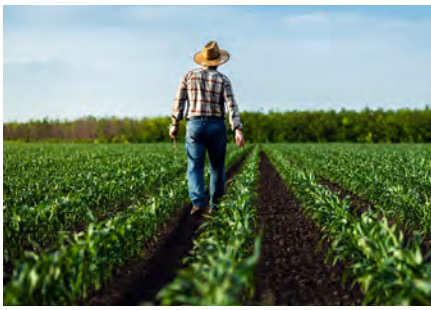
Developed in collaboration with specialized workgroups, subject matter experts, and individuals with lived experience, this section consists of one overarching goal with seven objectives. Each objective is dedicated to an identified population with suicide disparities based on national trends and state surveillance and supported by a set of sub-objectives. Although each objective focuses on a distinct population, we acknowledge that identity is multifaceted and that individuals may identify with multiple groups. Each objective concludes with a ***What Success Looks Like*** component, offering a vision of how it translates into real-world outcomes for the community it aims to support. However, it is important to note the cultural nuances and diversity within groups can further inform actions to be taken to achieve true success.











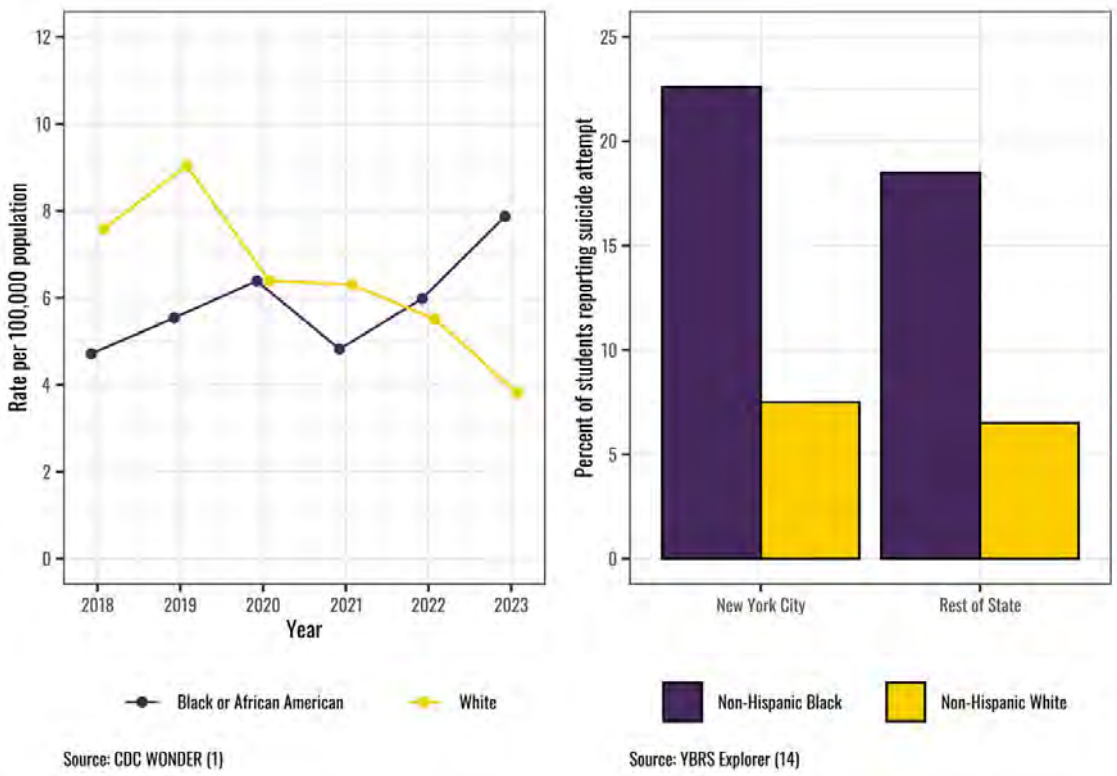
Goal 12

Objective 12.1: Black Youth

Suicide-Related Outcomes Among Black Youth

In recent years there has been mounting national concern over the increase in suicides among Black youth[25]. Nationwide, suicide rates among non-Hispanic Black youth age 15-24 climbed drastically between 2014 and 2021, at an average rate of 9.79% per year[1]. In contrast, rates among non-Hispanic white youth of the same age decreased starting in 2018, so that in 2023 rates among Black and White youth were similar (14.69 per 100,000). Although such trends are complicated by misclassification of race and ethnicity on death certificates[4] and changes to racial categories used over time, they warrant concern for suicide risk among Black youth in New York. Based on 2023 data released by the CDC, Black-White differences in suicide rates among New York youth are especially apparent among those age 12-23, for whom the suicide rate among Black youth is approximately 2.0 times the rate among White youth (7.87 vs. 3.81 per 100,000)[1]. Likewise, in the 2023 New York Youth Risk Behavior Survey, alarmingly high percentages of non-Hispanic Black high school students reported attempting suicide in the past year in both New York City (22.6% of non-Hispanic Black youth compared to 7.5% of non-Hispanic White youth) and the rest of the state (18.5% of non-Hispanic Black youth compared to 6.5% of non-Hispanic White students)[14]. Therefore, in line with national priorities (NSSP), these findings call for increases in suicide prevention among Black youth in New York.

Figure 7: Suicide Rates, 2018-2023 among non-Hispanic Black and White Youth ages 12-23 (left), and Self-reported Suicide Attempts among non-Hispanic Black and White Youth in the 2023 NY YRBS (right)



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Goal 12 Objective 12.1: Black Youth

Black youth under the age of 24 in New York State are facing rising suicide risk, underscoring the urgent need for focused prevention efforts. Contributing factors include disparities in mental health care, stigma around seeking support, and stressors related to inequality, discrimination and socioeconomic hardship. It is also important to recognize that the Black community is not monolithic, as diverse experiences, identities, and cultural contexts may shape both risk and resilience in different ways. To reduce risk and promote well-being, suicide prevention must be culturally responsive, accessible, and grounded in the lived experiences of Black communities and driven by its members. Efforts must also recognize that effective prevention for Black youth includes the engagement of and support for their families and caregivers. By expanding support systems, fostering resilience, and addressing systemic barriers, we can bridge gaps in care and help ensure that Black youth and their famlies have the resources and opportunities they need to thrive.

Objective 12.1.1:

> Improve availability and access to culturally relevant and responsive suicide prevention information and community-support resources for Black youth.

Objective 12.1.2:

> Improve community-based suicide prevention by incorporating perspectives and recommendations from the Black community, including Black youth, to ensure culturally responsive and effective interventions.

Objective 12.1.3:

> Address social determinants of health and systemic barriers contributing to increased suicide risk among Black youth, with the aim of reducing disparities and fostering improved mental well-being.

Objective 12.1.4:

> Promote upstream protective factors to reduce suicide risk among Black youth through healing-centered, community-driven strategies that address systemic barriers.

Objective 12.1.5:

> Increase awareness and understanding of the strengths, lived experiences, and challenges facing Black communities to better inform and improve suicide prevention activities, especially for Black youth.

Objective 12.1.6:

> Develop, implement, and sustain suicide prevention activities, programs, and initiatives that are culturally relevant, healing-centered, responsive to the diverse identities and lived experiences of Black youth.

Objective 12.1.7:

> Develop, improve, and expand suicide prevention clinical practices, policies, and interventions that are responsive to the needs of Black youth, particularly within schools, child welfare, juvenile justice, behavioral health, and other youth-serving systems.

Objective 12.1.8:

> Ensure Black youth receive crisis support and response strategies grounded in cultural responsiveness and inclusivity, with approaches that emphasize care and safety, while minimizing law enforcement involvement.

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Goal 12 Objective 12.1: Black Youth

What Success Looks Like

Success in preventing suicide among Black youth in New York means not only increasing access to culturally tailored mental health resources but also ensuring that youth know when and how to use these resources when needed. Simply providing access does not guarantee understanding or readiness to engage. Therefore, prevention efforts will prioritize education, engagement, and empowerment alongside access for both youth and their families. Efforts will reflect the lived experiences of Black youth and address the systemic and social factors contributing to suicide risk. Resources will be available in environments including, but not limited to, schools, community centers, faith-based spaces, and through social media. Creative forms of expression that connects individuals to their ancestry, like storytelling, music, and art, will help Black youth feel more connected to culturally relevant support and more confident in reaching out for help. Awareness campaigns will uplift Black voices, especially young people, and encourage honest, informed conversations about mental health (Obj. 12.1.1).

Programs will be designed with input from Black youth, families, and community leaders to ensure relevance and effectiveness. Advisory councils and focus groups will guide initiatives, fostering collaboration between mental health professionals, educators, and grassroots organizations. Black youth will have leadership opportunities in shaping and sustaining prevention strategies that reflect their strengths and needs (Obj. 12.1.2).

Prevention efforts will align with broader strategies to address social determinants of health, such as poverty, housing stability, education, employment, and neighborhood violence. Partnerships with social service agencies will expand access to job training, stable housing, and quality education (Obj. 12.1.3). Strengthening collaboration across child welfare, juvenile justice, education, and behavioral health systems will create a comprehensive network of resources, reducing suicide risk and promoting healing and long-term well-being (Obj. 12.1.6, 12.1.7).

Mentorship and afterschool programs will provide safe, supportive, and identity-affirming spaces, especially for Black LGBTQIA+ youth and those with disabilities, to foster healing, belonging, and social connection (Obj. 12.1.4). Public awareness campaigns and professional training for anyone interfacing with youth in a service-provision capacity will deepen understanding of the strengths, lived experiences, barriers, and challenges Black youth face, including racism, trauma, and socioeconomic disparities (Obj. 12.1.5).

Culturally responsive and healing centered care will be embedded across mental health and crisis response systems. Black youth will have access to school-based counseling, telehealth, and community mental health clinics, with a workforce that reflects their identities and understands their challenges. Healing practices rooted in Black culture, such as faith-based support, storytelling, and mindfulness, will be integrated into care (Obj. 12.1.6 & 12.1.7). Crisis response will prioritize community-based interventions, reducing reliance on law enforcement and emergency rooms to ensure accessible, respectful, and effective care (Obj. 12.1.8).

Success means Black youth have the support, resources, and opportunities to thrive mentally, emotionally, and socially within communities that uplift and protect their well-being.

Spotlight Story

HAVEN (Helping Alleviate Valley Experiences Now) – CONNECT

Submitted by Sherry Davis Molock, Ph.D., M.Div.

HAVEN (Helping Alleviate Valley Experiences Now) – CONNECT is a comprehensive depression and suicide intervention for Black youth designed to be integrated in predominantly Black churches. HAVEN – Connect has three components: Church Engagement, Faith Based Curriculum and Suicide/Depression Intervention. Church engagement involves developing partnerships with churches in New York City and Rochester to integrate the intervention into the life of the church.

The Faith Based Curriculum provides an educational overview on mental health education, risk and protective factors for suicide and the four core protective factors for the suicide prevention component of HAVEN-Connect. This information is integrated into sermons, Bible study and Sunday school lessons. Youth-Connect focuses on strengthening skills to grow and sustain four CORES or protective factors: Kinship (healthy bonds); Guidance (support from mentors; access to medical and mental health expertise); Purpose (goals, values, sense of belonging); and Balance (self-care and support).

In large part due to promising data collected in an OMH sponsored pilot that ended in 2022, investigators successfully applied for $1.5M in grant funding from American Foundation for Suicide Prevention to expand the program to 12 churches in NY state. To date, we have enrolled and collected baseline data on youth from 6 churches, implemented the program for youth and adults in 4 churches and have done 6-month follow-up assessments in 2 churches. The pastors have participated in the Faith Based Curriculum training and have implemented the “kick off” event, the delivery of a sermon that reflects principal components of the HAVEN-Connect Program.

Resources to Consider

SAMHSA: Black Youth Suicide Prevention: Offers a comprehensive approach to addressing the rising suicide rates among Black youth, focusing on mental health support, community involvement, and culturally competent interventions. The initiative emphasizes the importance of addressing systemic challenges and providing tailored resources.

Still Ringing the Alarm: An Enduring Call to Action for Black Youth Suicide Prevention: This report highlights the rising suicide rates among Black youth, emphasizing the role of institutional racism and unique socioecological factors that contribute to this crisis. It calls for urgent action, addressing barriers to culturally relevant research and interventions while advocating for systemic changes to reduce suicide risk for Black youth.

Black Emotional and Mental Health Collection (BEAM): BEAM envisions a world without barriers to healing for Black communities, and actively works toward that through education, training, advocacy, movement-building, and grantmaking . They offer free and affordable tools and services, including virtual wellness directories, peer support training, journal prompts, and culturally grounded mental-health programming, to help people recognize emotional needs, access care, and build self-care practice.

Soul Shop Movement: A faith-based initiative offering suicide prevention training for clergy, community leaders, and youth workers. It focuses on building safe spaces for individuals to discuss mental health and suicide while providing resources to help faith communities address these issues and offer support. Specialized programs are available for different groups, including Black and Hispanic churches.

Connect, Invest, Uplift: Protect Black Youth from Suicide Infographic: An infographic developed by the Suicide Prevention Resource Center (SPRC) that outlines simple, data-driven steps to protect Black youth from suicide. It serves as a communication tool to raise awareness and guide communities in supporting Black youth mental health.

The Future of Healing: Shifting from Trauma Informed Care to Healing Centered Engagement: An article by Dr. Shawn Ginwright that introduces the concept of healing-centered engagement as a progression beyond trauma-informed care. It serves as a framework to shift the focus from treating individual trauma to fostering collective well-being, cultural identity, and empowerment.

Goal 12

Objective 12.2: Hispanic Youth

Suicide-Related Outcomes Among Hispanic Youth

In recent years there has been increasing national and state attention to suicide among Hispanic youth, particularly girls. In 2017 the New York State Legislature's Puerto Rican/Hispanic Task Force published a report drawing attention to the issue and describing relevant legislative initiatives. In the New York Youth Risk Behavior Surveys combining 2019-2023, the prevalence of self-reported suicide attempts in the past year was significantly higher among students identifying as Hispanic or Latino compared to those identifying as non-Hispanic White in both New York City (10.5% vs. 6.7%) and New York State excluding New York City (11.3% vs. 6.2%)[14]. Likewise, according to CDC data[1], suicide rates among Hispanic or Latino youth age 15-24 in New York in 2023 were the highest they have been in the past 25 years, at 8.5 per 100,000 population. Furthermore, rates among Hispanic or Latino White youth were significantly higher than those among non-Hispanic White youth (11.0 vs. 5.2 per 100,000). Acknowledging the limitations to recording of race and ethnicity on death certificates noted above, these trends warrant additional attention to suicide risk among Hispanic youth in New York.

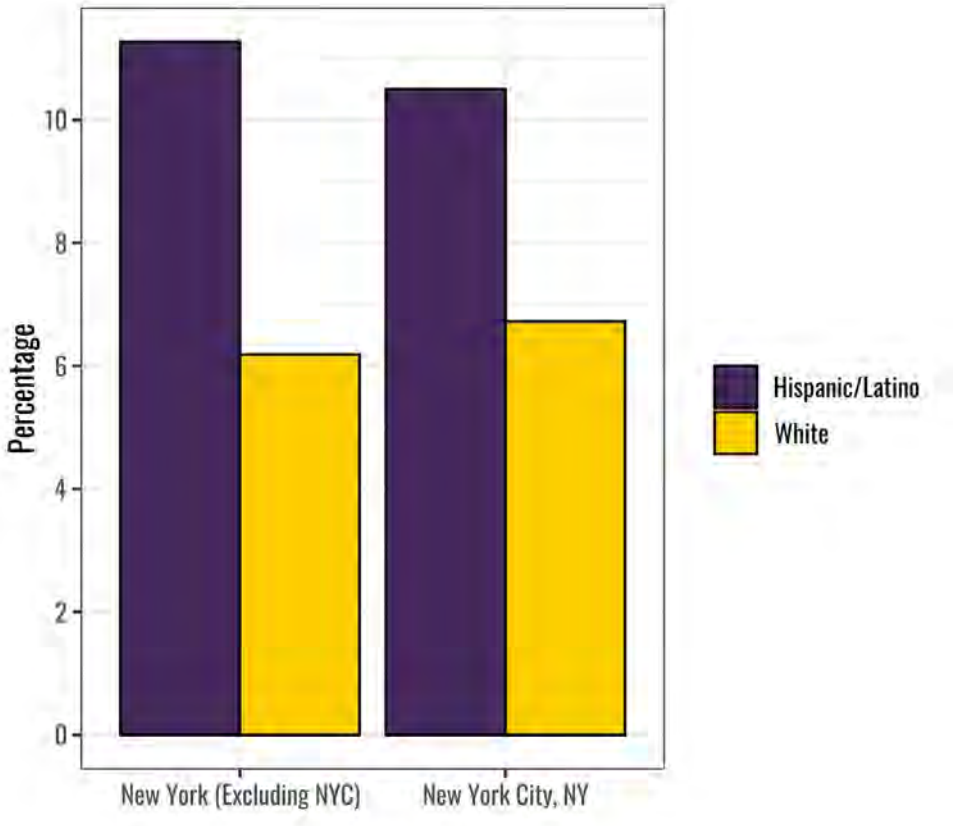

Figure 8: Prevalence of Self-Reported Suicide Attempt in the Past Year among NY High School Students, 2019-2023 YRBS

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Goal 12 Objective 12.2: Hispanic Youth

Hispanic youth in New York State face a growing risk of suicide, underscoring the urgent need for focused, culturally responsive prevention efforts. Barriers such as limited access to culturally relevant mental health care, stigma, language differences, and the stress of acculturation and discrimination contribute to their vulnerability. Too often, these challenges prevent Hispanic youth from accessing the supports they need. Recognizing the essential role families play in fostering youth well-being, prevention efforts must actively engage and support families alongside youth. By implementing culturally responsive, linguistically accessible, family-centered, and community-driven suicide prevention initiatives, we can reduce risk, strengthen resilience, and ensure Hispanic youth and their families receive the care, support and resources they deserve.

Objective 12.2.1:

- Enhance and expand access to culturally relevant suicide prevention information and community support resources specifically tailored to address the needs of Hispanic youth and their families.

Objective 12.2.2:

- Improve community-based suicide prevention efforts across New York State by incorporating voices, perspectives, and recommendations from the Hispanic youth community, including those with lived experience of suicidal ideation or behaviors.

Objective 12.2.3:

- Address social determinants of health and systemic issues that increase suicide risk among Hispanic youth, focusing on reducing disparities and promoting equity across their life span.

Objective 12.2.4:

- Promote upstream protective factors that build resilience and reduce suicide risk among Hispanic youth.

Objective 12.2.5:

- Increase awareness and understanding of the strengths, lived experiences, and challenges faced by Hispanic youth and their families to strengthen suicide prevention efforts that are culturally appropriate, accessible, and effective.

Objective 12.2.6:

- Develop, implement and evaluate focused suicide prevention initiatives, programs, trainings, and resources tailored to the needs of Hispanic youth and their families.

Objective 12.2.7:

- Improve and expand suicide prevention clinical programs, practices, and policies, especially within schools, child welfare, criminal and juvenile justice, behavioral health, and other systems serving Hispanic youth, with additional focus on integrating family engagement and inclusion in care.

Objective 12.2.8:

- Ensure that Hispanic youth and their families receive crisis support and response strategies that emphasize care and safety, are responsive to their needs and experiences, and reduce reliance on law enforcement involvement, .

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Goal 12 Objective 12.2: Hispanic Youth

What Success Looks Like

Success in preventing suicide among Hispanic youth means ensuring they and their families have access to culturally tailored, linguistically appropriate, and community-driven resources. Parents are meaningfully included in prevention efforts, recognizing the importance of ***familismo***, and addressing the acculturation gaps and family conflicts that can elevate suicide risk. Families have the tools and supports they need, with language access addressed directly to ensure parents are able to connect their children to care when needed. Bilingual materials reflect and validate the lived experiences of Hispanic families, addressing the impacts of immigration stress, discrimination, and family dynamics. Storytelling and culturally aligned messaging will reduce stigma and foster open conversations about mental health within the Hispanic community. Success also means understanding and honoring the distinct cultures, experiences, and needs of Hispanic subgroups, with this cultural understanding integrated across all strategies, interventions, and communications (Obj. 12.2.1).

Hispanic youth will shape suicide prevention initiatives through opportunities including, but not limited to, on-going focus groups and listening sessions, ensuring that programs and strategies remain grounded in their realities. Collaborations with Hispanic-led organizations, faith-based groups, and cultural institutions will guide the development and implementation of these programs (Obj. 12.2.2).

Addressing social determinants of health will reduce suicide risk by connecting families to essential resources like housing, food security, and employment. Schools will offer culturally tailored mental health programs, early intervention strategies, and bilingual, multicultural providers through telehealth, school-based services, and mobile units (Obj. 12.2.3 & 12.2.6).

Peer mentoring programs, safe spaces for cultural identity, and family-centered initiatives help strengthen connections within the community (Obj. 12.2.4). Suicide prevention training for educators, healthcare providers, and community leaders will ensure they are equipped with a deeper understanding of the strengths, needs, and cultural nuances within Hispanic communities. These trainings will enhance their ability to offer tailored support, improve care, and create a more inclusive, compassionate environment for individuals and families (Obj. 12.2.5).

Crisis support and clinical services will be expanded to ensure accessible, culturally responsive care, while also reducing the reliance on law enforcement during mental health crises. Bilingual helplines, mobile crisis teams, and culturally relevant emergency responders will provide timely, compassionate support. Suicide risk screenings and interventions will be trauma-informed and integrated across primary care, schools, and behavioral health settings (Obj. 12.2.7 & 12.2.8).

Success means that suicide prevention efforts for Hispanic youth are culturally tailored, community-driven, and effective in reducing risk, strengthening resilience, and fostering long-term well-being.

Spotlight Story

Comunilife's Life is Precious Program

Comunilife's Life is Precious Program
Submitted by Julie Laurence, LMSW, Vice President, and Beatriz Coronel, Assistant Vice President for Life is Precious Program

Comunilife's Life is Precious™ (LIP) program is the only program in NYS specifically designed to serve Latina adolescents who have experienced suicide ideation, and attempts, and suffer from depression. LIP was started in 2008, by Dr. Rosa Gil, in response to the alarming statistics released by the CDC about the high rates of suicide ideation and attempts among Latina adolescents. LIP was created, with community input, to address this crisis. What began as one LIP center in the Bronx has expanded to 8 program sites across New York State.

LIP serves Latina teens between the ages of 12-17 from a diverse Latinx population who nearly all live in some of NYS's lowest-income neighborhoods. LIP's cultural and gender responsive programming addresses risk factors with positive youth development activities, trauma-informed case management services, family engagement and a supportive community informed model. Our direct support services not only normalize mental health needs but build understanding and healing in safe and creative spaces.

LIP's accomplishments are measured by the positive results achieved by the youth. This is validated by an evaluation which has been conducted, since 2013, by the NYS Psychiatric Institute/Columbia University – NYS Center of Excellence for Cultural Competence. LIP has been recognized in 2024 by the National Suicide Prevention Resource Center and is included in their Best Practices Registry.

Resources to Consider

NAMI: Compartiendo Esperanza: Mental Wellness in Hispanic/Latin American Community: A program offering mental health resources and support for Hispanic and Latin American communities, focusing on cultural understanding and reducing stigma around mental health.

Life Is Precious™: A Latina suicide prevention program offering support to Latina teens in New York with locations in NYC, Poughkeepsie, Yonkers, Amsterdam, and Hempstead. This program provides wellness and creative arts therapy, academic workshops, and career mentoring, focusing on fostering resilience and emotional health among young Latina girls. The program is designed to help participants build a supportive community and become empowered, wise leaders.

Línea 988 de Prevención del Suicidio y Crisis: A dedicated platform offering mental health crisis support in Spanish. It provides immediate help for individuals experiencing suicidal thoughts or emotional distress through confidential communication. The service connects users with trained counselors and resources to support their mental well-being.

National Institute of Mental Health Publicaciones acerca niños y adolescents: This NIMH webpage provides a collection of free, downloadable resources tailored for youth, including interactive coloring books, activity-based guides to understanding the adolescent brain and stress management, and fact sheets on conditions like ADHD, bipolar disorder, depression, and trauma recovery in Spanish. These materials are designed to help Spanish-speaking children, teens, and their families recognize signs of mental health concerns, learn coping strategies, and know when to seek professional support.

National Alliance for Hispanic Health: This initiative provides trusted bilingual resources and community-driven programs to improve the physical and mental health for individuals and families. The platform also offers the bilingual “Su Familia Health Helpline” at 1-866-783-2645. This helpline is free and confidential, staffed by bilingual advisors, available Monday-Friday, 9am-6pm ET. Outside of those hours, a message can be left and a response within 24 hours is expected.

AFSP Mental Health Resources for Hispanic and Latinx Communities: AFSP offers a curated list of culturally targeted mental health and suicide prevention resources for the Hispanic and Latinx community. This page highlights culturally relevant supports, organizations, and educational materials to help connect individuals and families to trusted programs, bilingual services, and community-based initiatives.

Goal 12

Objective 12.3: LGBTQIA+ Youth

Suicide-Related Outcomes Among LGBTQIA+ Youth

Consistent with national findings, LGBTQIA+ youth in New York are disproportionately affected by suicide morbidity, including suicidal thoughts and behaviors. Both of New York's YRBS surveys (New York City and Rest of State)[14] asked about sexual orientation in 2021 and 2023 and about transgender identity in 2019 and 2021. Combining those years of data, students who reported identifying as lesbian, gay, bisexual, questioning, or something else were around three times as likely to report suicidal ideation in the past year (Rest of State: 36.7% vs. 12.6%; New York City: 34.6% vs. 10.9%) and more than 3 times as likely to report suicide attempt in the past year (Rest of State: 17.4% vs. 5.5%; New York City: 22.4% vs. 6.3%), compared to students who reported identifying as heterosexual or straight. Likewise, students who reported that they are transgender or who weren't sure whether they are transgender were two to three times more likely to report suicidal ideation in the past year (NYC: 46.6% vs. 14.1%; ROS: 36.0% vs. 16.5%) and three to four times more likely to report suicide attempt in the past year (NYC: 28.8% vs. 7.7%; ROS: 30.8% vs. 6.5%), compared to students who reported that they are not transgender.

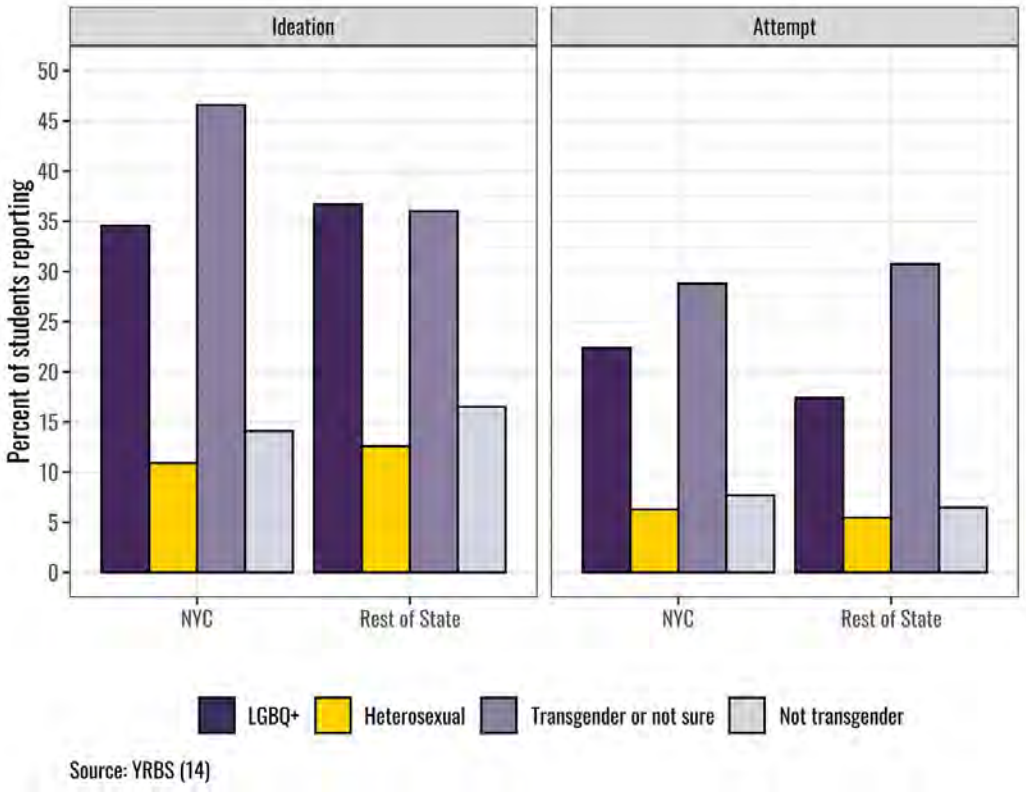

Figure 9: Prevalence of Self-reported Suicidal Ideation and Attempt in the Past Year by Sexual Orientation and Gender Identity among NY High School Students, YRBS

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Goal 12 Objective 12.3: LGBTQIA+ Youth

LGBTQIA+ youth in New York State face a heightened risk of suicide due to systemic barriers, stigma, discrimination, and limited access to affirming mental health care. The challenges of disclosing their LGBTQ+ identity, or "coming out," family and community rejection, and intersecting factors like race, ethnicity, and socioeconomic status further increase their vulnerability. Yet, LGBTQIA+ youth show immense resilience—strength that must be supported through targeted, culturally responsive suicide prevention efforts. By addressing these disparities and expanding affirming resources, we can ensure LGBTQIA+ youth receive the support they need to thrive.

Objective 12.3.1:

> Promote the development and dissemination of culturally relevant suicide prevention materials tailored to LGBTQIA+ youth.

Objective 12.3.2:

> Promote the incorporation of the voices and lived experiences of LGBTQIA+ youth into all suicide prevention program designs and implementations.

Objective 12.3.3:

> Promote initiatives to reduce disparities in access to mental health care for LGBTQIA+ youth by addressing systemic issues such as discrimination and financial barriers.

Objective 12.3.4:

> Support environments that celebrate LGBTQIA+ youth identity and promote social connections.

Objective 12.3.5:

> Increase awareness and understanding of the unique challenges faced by LGBTQIA+ youth, including family rejection and societal stigma, while promoting programs that address and mitigate these stressors.

Objective 12.3.6:

> Support the development and implementation of suicide prevention programs, initiatives, and resources for LGBTQIA+ youth, specifically designed to address the challenges they face.

Objective 12.3.7:

> Enhance and integrate suicide prevention clinical programs, practices, professional development, and policies within schools, child welfare, criminal and juvenile justice, behavioral health, and other systems serving LGBTQIA+ youth, ensuring culturally and structurally responsive care.

Objective 12.3.8:

> Incorporate comprehensive LGBTQIA+ best practices and resources into existing crisis response services to ensure they affirm and effectively respond to LGBTQIA+ identities and experiences.

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Goal 12

Objective 12.3: LGBTQIA+ Youth

What Success Looks Like

Success in preventing suicide among LGBTQIA+ youth means ensuring access to affirming, culturally responsive, and community-driven support. Suicide prevention resources will be widely available through partnerships with LGBTQIA+ organizations, social platforms, and trusted spaces, using evidence-based strategies to normalize mental health conversations, build resilience, and strengthen support networks (Obj. 12.3.1).

LGBTQIA+ youth will have opportunities to actively shape prevention efforts through program development, focus groups, and advisory boards, ensuring initiatives reflect their diverse identities and lived experiences (Obj. 12.3.2). LGBTQIA+ youth will have safe, supportive environments that celebrate their identities and strengthen social connections. Schools and communities will expand initiatives like GSAs, peer support networks, and mentorship programs to reduce isolation and promote belonging (Obj.12.3.4 & 12.3.6).

Schools and youth-serving organizations will incorporate LGBTQIA+-specific mental health supports, particularly in underserved areas, to improve access to affirming care. Additionally, reducing disparities in mental health care will involve increasing LGBTQIA+-affirming providers and integrating inclusive, trauma-informed suicide prevention practices across and within schools, child welfare, juvenile justice, crisis response, and behavioral health systems. Policies will ensure clinicians and emergency responders have the training and resources to provide respectful, affirming care, fostering trust and accessibility (Obj. 12.3.3, 12.3.7, & 12.3.8).

Raising awareness of challenges such as family rejection, stigma, and discrimination will be key to creating affirming spaces. Community education, family workshops, and advocacy efforts will equip families, educators, and providers with the tools to affirm youth identities, strengthen supportive relationships at home, and foster inclusion and systemic support (Obj. 12.3.5).

Success means LGBTQIA+ youth have the resources, support, and connections they need to thrive, with suicide prevention efforts that are culturally responsive, inclusive, and deeply rooted in their lived experiences. Success also means that LGBTQIA+ youth are met with acceptance at home and in their communities, where families, caregivers, and other supportive adults actively affirm their identities and create environments of belonging.

Spotlight Story

Perspective as Prevention: Statewide Experts Build Model Training for LGBTQIA+ Youth

Submitted by Nathaniel Gray, MSW, Founder & Principal Consultant, Gray Area Consulting

Through a collaborative effort between Gray Area Consulting, the Office of Mental Health's Suicide Prevention Center of New York (OMH SPCNY), and a team of statewide subject matter experts, a model training program is being developed as a powerful upstream suicide prevention resource for schools and youth-serving systems.

This evidence-based training will equip educators, counselors, and youth professionals to reduce suicide risk among LGBTQIA+ youth by replacing rejection with affirmation and connection.

What makes this model innovative is its approach: participants begin the training experience with perspective-taking exercises designed to deepen understanding and increase the impact and staying power of everything that follows. By grounding the training in this foundation, the team aims to support not just knowledge transfer but simple, tangible change to save lives. Drawing on the Family Acceptance Project's decades of research and informed by lived experience, the curriculum helps participants understand how everyday actions can either increase or decrease preventable, life-altering outcomes—including substance abuse, mental health challenges like anxiety, depression, and suicide, and youth involvement in foster care, juvenile justice, or homeless shelter systems.

By evoking the impact our everyday actions have, based on both research and real life, this training supports participants in becoming protective factors themselves—especially for queer and trans youth who may otherwise feel unseen or unsafe in school or community settings. The program also highlights the importance of inclusive policies, supportive language, and visible allyship in suicide prevention.

As this model training is finalized with OMH SPCNY, it is positioned to be built into train-the-trainer opportunities, and researched as another approach to reduce risk, build resilience, and create lasting community change for all youth across New York State.

Resources to Consider

The Family Acceptance Project: Focuses on helping families understand the impact of their acceptance or rejection on LGBTQIA+ youth's mental health and well-being.

Mental Health Promotion and Suicide Prevention for LGBTQIA2S+ Youth: A Resource Guide for Professionals, Families, and Communities: A comprehensive guide providing strategies for professionals, families, and communities to support mental health and prevent suicide among LGBTQIA2S+ youth.

The Trevor Project: A leading organization providing crisis intervention, suicide prevention, and mental health support for LGBTQIA+ youth.

AFSP: LGBTQ+ Mental Health and Suicide Prevention: This resource from the American Foundation for Suicide Prevention highlights the unique mental health challenges faced by LGBTQ+ individuals, particularly the heightened risk of suicide. It offers strategies for suicide prevention, including fostering acceptance, increasing awareness, and improving mental health support systems for the LGBTQ+ community

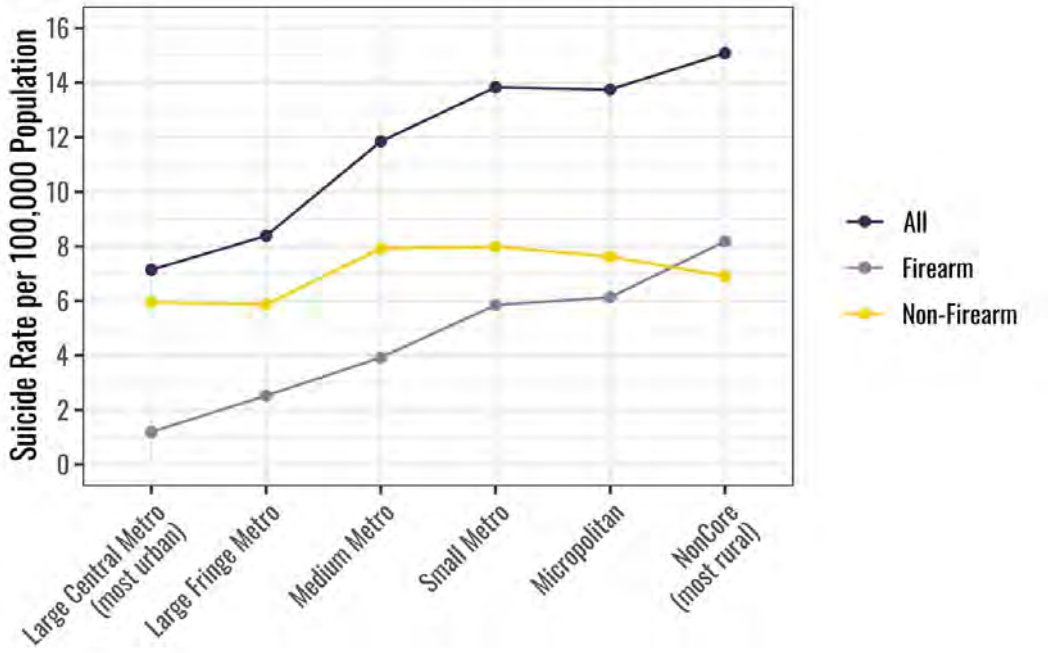
Goal 12

Objective 12.4: Rural Communities

Suicide-Related Outcomes Among Rural Communities

Rural communities are disproportionately affected by suicide mortality. Although the *number* of suicides in rural areas tends to be low because they are more sparsely populated, *rates* of suicide tend to be higher in more rural areas. In New York from 2021 to 2023[1], the suicide rate was 90% higher in the most rural counties compared to the most urban counties (12.9 vs. 6.8 per 100,000 population). Much of this urban-rural difference is attributable to firearm suicides; during the same years, firearm suicide rates in New York's most rural counties were 6.8 times as high as firearm suicide rates in New York's most urban counties (8.2 vs. 1.2 per 100,000). Little urban-rural gradient is seen in non-firearm suicides (see Figure 10 below).

Figure 10: Urban-Rural Differences in All, Firearm, and Non-Firearm Suicide in NY, 2021-2023



Source: CDC WONDER (1)

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Goal 12 Objective 12.4: Rural Communities

Rural communities in New York State are facing a troubling increase in suicide risk, highlighting the urgent need for targeted prevention initiatives. These areas, often characterized by low population density, limited infrastructure, and significant distance from urban centers, face unique challenges. Geographic isolation, limited access to mental health services and qualified mental health professionals,, and stigma surrounding help-seeking behaviors, exacerbate vulnerabilities in these areas. Effective solutions must center the voices of those with lived experience, especially individuals who reflect and represent rural communities, to ensure programs are meaningful, relatable, and grounded in real-life experiences. It is also essential to recognize that rural communities are not homogenous. They include many of the same populations with increased disparities outlined in this strategic direction, and individuals often face overlapping barriers to care. Addressing these intersectional needs, including cultural, linguistic, and social differences, is critical to building prevention strategies that are truly inclusive and responsive. By implementing tailored, accessible, and stigma-reducing programs shaped by rural voices and experiences, we can strengthen community resilience and ensure individuals, regardless of identity or geography, have access to the support they need.

Objective 12.4.1:

- Improve availability of and access to suicide prevention information, training, and community-based resources that are culturally and linguistically relevant and responsive to the diverse identities and needs of individuals living in rural communities.

Objective 12.4.2:

- Improve community-based suicide prevention efforts within rural communities by incorporating perspectives and recommendations from diverse community members, especially those with suicide-centered lived experience.

Objective 12.4.3:

- Address social determinants of health and systemic issues impacting suicide risk among those in rural communities across the lifespan.

Objective 12.4.4:

- Support and implement targeted initiatives and programs that strengthen upstream protective factors in rural communities aimed at reducing isolation and improving connectedness.

Objective 12.4.5:

- Increase awareness and understanding of strengths, values, and challenges within rural communities, including barriers related to the accessibility, availability, and acceptability of mental health resources and services, to better inform and improve suicide prevention activities.

Objective 12.4.6:

- Design, implement, and sustain comprehensive suicide prevention activities, programs, and initiatives in rural communities that elevate lived experience and intentionally address the diverse and intersectional needs of all its residents.

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Goal 12 Objective 12.4: Rural Communities

Objective 12.4.7:

> Develop, improve and expand suicide prevention clinical practices, policies, and interventions, particularly within schools, healthcare, social services and other community-based systems and organizations serving rural communities.

Objective 12.4.8:

> Ensure rural communities have access to crisis support and response strategies that are informed by lived experience, address geographic and logistical, geographic challenges, and supported by well-trained, appropriately equipped law enforcement and first responders.

What Success Looks Like

Success in rural suicide prevention means individuals and families have access to culturally and linguistically relevant, stigma-reducing mental health resources that encourage help-seeking and connect them with care (Obj. 12.4.1). Suicide prevention strategies that are developed in collaboration with local stakeholders and individuals with lived experience, who reflect the diverse identities within rural communities. These strategies are grounded in the unique realities of rural life and responsive to the intersectional barriers faced by residents related to geography, identity, language, and access (Obj. 12.4.2).

Efforts to address social determinants of health result in expanded access through integrated supports such as telehealth services, school-based programming, job training, financial counseling, and other resources that promote long-term economic and social stability (Obj. 12.4.3). These efforts also confront structural barriers that disproportionately impact rural communities, including limited broadband infrastructure and access, unreliable public transportation, and persistent workforce shortages that restrict the availability of qualified mental health professionals. Success in this area reflects a coordinated response to these challenges through sustainable staffing strategies, infrastructure improvements, and flexible service delivery models that increase access across the lifespan (Obj. 12.4.4).

Community-led initiatives foster belonging, reduce isolation, and strengthen informal supports through peer networks, mentoring, and partnerships with trusted local organizations, including faith-based institutions and cultural groups. Suicide prevention programming is informed by an understanding of local values and traditions, including sensitivity to pro-social firearm use such as hunting and sport shooting, while still addressing the increased prevalence of firearms in rural households and promoting safe storage and lethal means safety strategies (Obj. 12.4.5). Sustained, community-driven programs, shaped by trusted local leaders and informed by the realities of those with suicide-centered lived experience, ensure accessibility, engagement, and long-term impact (Obj. 12.4.6).

Clinically, suicide prevention policies and interventions are integrated across schools, healthcare settings, social services, and other community-based systems that serve rural populations. Clinical care is trauma-informed, culturally responsive and addresses specific needs of the community. Success also includes building local capacity for behavioral healthcare through improved staffing, coordinated care, and cross-system collaboration to ensure services are relevant, inclusive, and sustainable (Obj. 12.4.7). Crisis care is locally tailored and accessible, with 988 and mobile crisis teams adapted to meet the geographic and logistical challenges that are unique to rural settings. Law enforcement and first responders are also equipped, trained, and supported to mental health crises with compassion and effectiveness, in alignment with community needs and best practices (Obj. 12.4.8).

Together, these efforts reduce suicide risk, save lives, and help create a stronger, more connected, and more resilient rural mental health landscape.

Spotlight Story

Suicide Prevention Efforts in Chautauqua County

Submitted by Carri Raynor, Coordinator, Suicide Prevention Alliance of Chautauqua County

Chautauqua County is a rural county in Western New York, where access to mental health services can be limited, making community-based suicide prevention efforts essential. The Suicide Prevention Alliance of Chautauqua County has grown into a leader in suicide prevention and is now transitioning to 501(c)(3) nonprofit status to expand its impact. Through evidence-based training like Mental Health First Aid, safeTALK, ASIST, Talk Saves Lives, Sources of Strength, and Trauma-Responsive Care, we have embedded suicide prevention into schools, workplaces, and healthcare systems.

Our coalition is launching a countywide Local Outreach to Suicide Survivors (LOSS) Team to support survivors in the immediate aftermath of suicide loss and Lock & Talk CHQ, an initiative focused on means safety. We are restructuring support groups to better serve those affected by traumatic loss. Community partnership and engagement remain central, demonstrated through events like the Kick Cabin Fever Indoor Triathlon, Veterans Ride for Suicide Awareness, Raynor Memorial Golf Tournament, the Tri-County Walk Series, and the Stomp Out the Stigma 5K. We also co-host the Hope & Healing Conference, addressing mental health, suicide, addiction, recovery, and grief.

To strengthen our work, we are restructuring into four focus areas: Wellness, Education, Grief, and Veterans. Transitioning to nonprofit status will allow us to secure funding, expand programs, and create a sustainable model for coalitions statewide, reinforcing our commitment to saving lives.

Resources to Consider

The Rural Health Information Hub: A comprehensive online resource that provides information, tools, and support to help rural communities address health disparities, including databases, toolkits, funding opportunities, and evidence-based practices.

Rural Minds: A national nonprofit dedicated to ending the stigma around mental illness in rural communities by promoting awareness, providing resources, and fostering open conversations about mental health.

FarmNet: Offers free, confidential support to New York farm families and agricultural workers, including mental health counseling, financial consultation, and stress management services tailored to the unique challenges of rural and farm life.

Addressing Mental Health Needs in Rural and Indigenous Communities: An article discussing the disproportionately high suicide rates in rural and Indigenous communities, exacerbated by factors such as stigma, mental health workforce shortages, and diminished healthcare infrastructure, particularly following the COVID-19 pandemic.

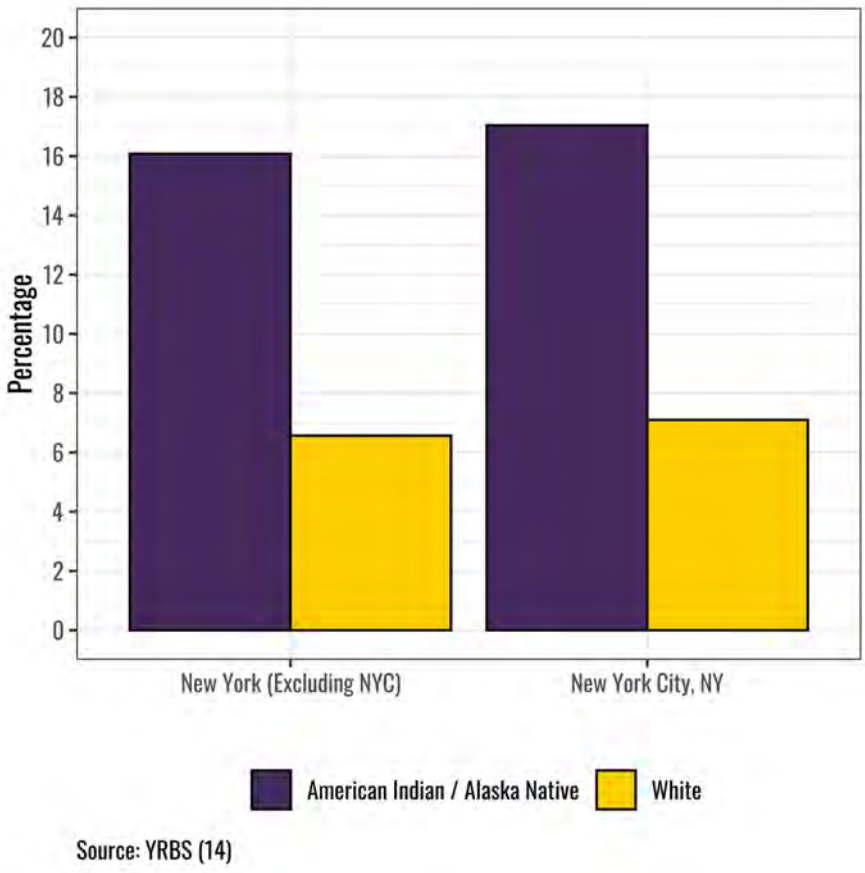
SAMHSA Rural Behavioral Health: This SAMHSA page outlines a comprehensive, equity-focused approach to improving behavioral health outcomes in rural America by emphasizing culturally responsive care, social determinants of health, and telehealth expansion. It highlights several grant and support programs that strengthen service delivery, workforce capacity, and recovery-oriented systems tailored to rural and tribal communities. Additionally, SAMHSA disseminates toolkits and regionally focused resources to help local providers and stakeholders implement best practices, integrate services, and overcome common rural challenges such as workforce shortages, limited broadband, and transportation barriers.

Goal 12

Objective 12.5: Indigenous Communities

Suicide-Related Outcomes Among Indigenous Communities

In the United States, people identified as American Indian or Alaska Native have the highest suicide death rates of any major racial and ethnic group, at 23.8 per 100,000 age-adjusted, compared to 14.1 per 100,000 for the country as a whole in 2023[1]. Geographically, suicide rates among American Indian and Alaska Native (AIAN) people over the past 5 years have been lower in east coast states and higher in western states. However, this may be affected by regional variation in misclassification of race on death certificates[26] and does not include AIAN decedents of more than one race. Furthermore, in the New York YRBS[14] surveys combining 2017 through 2023, the prevalence of self-reported suicide attempts in the past year was significantly higher among students identifying as AIAN compared to those identifying as white in both NYC (17.0% vs. 7.1%) and the rest of the state (16.1% vs. 6.6%). Although estimates for the rest-of-state sample are considered unstable because of the small number of respondents in the AIAN group, assessing prevalence among this group is necessary to understand health disparities in New York. Together, these trends warrant increased attention to suicide risk among Native populations in New York.



Source: YRBS (14)

Figure 11: Prevalence of Self-Reported Suicide Attempt in the Past Year among NY High School Students, 2017-2023 YRBS

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Goal 12 Objective 12.5: Indigenous Communities

Building relationships with Indigenous communities is essential to reducing suicides in New York State. This work must honor the sovereignty, cultural knowledge, and self-determination of Tribal Nations—who are sovereign governments, not simply communities at risk. Rather than imposing specific goals, it is essential that Indigenous communities lead their own suicide prevention initiatives, guided by their priorities and perspectives. The State's role is to offer support and technical assistance when requested and needed by the Tribal Nations. Fostering open communication and mutual information sharing can help ensure that resources, including guidance for non-Native clinical providers, are truly culturally responsive and grounded in the needs, strengths, and lived experiences of Indigenous communities. A collaborative approach built on trust, respect for sovereignty, and a clear understanding of historical relationships is critical to improving mental health outcomes and strengthening suicide prevention efforts of Indigenous peoples in New York.

Objective 12.5.1:

> Strengthen suicide prevention efforts in New York State by building relationships with Tribal Nations and Indigenous communities grounded in dignity, compassion, and respect.

Objective 12.5.2:

> Enhance and expand suicide prevention clinical practices, policies, and interventions delivered with systems serving Indigenous communities, including schools, healthcare, including behavioral health, social services, and other community-based care, to ensure effective, culturally responsive care, while increasing awareness and understanding of the strengths and challenges of Indigenous peoples.

What Success Looks Like

Success in preventing suicide among Indigenous communities in New York State depends on building enduring, respectful relationships with Tribal Nations, rooted in mutual trust and recognition of sovereignty. These relationships must center respectful dialogue and a shared understanding that Tribal Nations hold the ancestral knowledge, cultural wisdom, and lived experience necessary to guide healing within their own communities. While Tribal Nations lead the development of culturally grounded approaches, the State's role is to offer dedicated support through funding, technical assistance, and culturally responsive resources when requested and needed by the Tribal Nations (Obj. 12.5.1).

In parallel, success also means strengthening clinical practices, policies, and interventions within systems that serve Indigenous peoples. Efforts must recognize the critical distinction between Tribal Nations, which are sovereign governments with their own systems of care, and urban Indigenous populations, who often rely on non-Native providers and Western systems. The State will also provide support, when requested and needed, to assist Nations in strengthening their own culturally appropriate, holistic suicide prevention efforts. For Indigenous peoples living off-territory, success involves sustained collaboration with Tribal leaders and Indigenous organizations to ensure non-Native providers receive comprehensive, co-developed training on the historical, cultural, and systemic factors that influence mental health and suicide risk. Policies and interventions will be adapted to reflect Indigenous traditions and values, ensuring services are inclusive, accessible, and responsive (Obj. 12.5.2).

This collaborative approach will promote greater awareness and capacity among service providers, ensuring that suicide prevention efforts are both effective and culturally aligned with the needs of all Indigenous peoples in New York. Ultimately, success means Indigenous communities are empowered to lead their own suicide prevention efforts, with State support provided only when requested, and that Indigenous peoples living off-territory have access to care that is respectful, inclusive, and reflective of their cultural identities.

Spotlight Story

Unkechaug Nation 1658 Wellness Program Culturally Relevant Suicide Prevention

Submitted by Barry Miller and Samantha Smith

The Office of Mental Health applied for and received funding from SAMHSA's Transformative Transfer Initiative, for the purpose of implementing a community led suicide prevention program on the Unkechaug Nation territory on Eastern Long Island. Community members Barry Miller and Samantha Smith created the 1658 Wellness program, which uses culture and ancestral methods to promote healing, build relationships, and strengthen indigenous identity.

The 1658 Wellness program hosts multiple cultural classes (language, drumming, sewing, tribal history, connecting to the land, dancing, singing, beading, woodwork, jewelry making, etc.), traditional ceremonies, educational groups, and indigenous led counseling services. Reflective of indigenous cultures, the nature of this program builds on the intergenerational collectiveness of the community by encouraging anyone who is interested to join the classes. The 1658 Wellness program will feature the hard work of the youth participating in the cultural classes with a performance in the Nation's June 2025 Pow Wow.

Although the 1658 Wellness program is new, the initial impact at least anecdotally suggests the project is being positively received by youth participants and the community, with a formal evaluation underway. If successful, the approach of using traditional culture to restore health could serve as a blueprint for working with other indigenous groups across the state.

Resources to Consider

SPRC 2023 Tribal Communities Webinars: A series of webinars focused on building respectful, effective partnerships with tribal communities by highlighting culturally appropriate practices, community engagement strategies, and lessons learned from Native-led initiatives.

Culture Forward: A Strengths and Culture Based Tool to Protect Our Native Youth from Suicide: A strengths-based resource guide created in collaboration with Native communities to support suicide prevention efforts by centering Indigenous knowledge, resilience, and culturally grounded approaches to wellness.

Native and Strong Lifeline: The Nation's First 988 Crisis Line for Indigenous People: A dedicated crisis support line operated by Native counselors that is integrated with the national 988 system, providing culturally responsive, 24/7 support tailored to the needs of Indigenous people in Washington State.

The Wellbriety Journey to Forgiveness Documentary: This documentary explores the abuses of Indian Boarding Schools and the lasting intergenerational trauma experienced by Native communities. It provides critical context for understanding the factors that contribute to suicide risk among Indigenous peoples and highlights solutions and healing approaches led by Native leaders. The film is an important resource for anyone seeking to support culturally informed suicide prevention efforts.

Land-Based Intervention: A Qualitative Study of the Knowledge and Practices Associated with One Approach to Mental Health in a Cree Community: This qualitative study examines a "land-based intervention" in a Cree community, revealing how reconnecting Indigenous youth with the land, culture, and Elders builds cultural identity, intergenerational knowledge transfer, and stronger relationships.

Tribal-VHA Partnerships in Suicide Prevention Toolkit: A practical guide designed to support collaboration between Tribal Nations and the Veterans Health Administration, offering tools and strategies to enhance culturally appropriate suicide prevention services for Native veterans.

The Value of Lakota Traditional Healing for Youth Resiliency and Family Functioning: This study evaluates the impact of Oglala Lakota traditional healing on youth resiliency and family functioning in communities facing trauma, abuse, and behavioral challenges. It highlights the vital role of Indigenous traditions in fostering mental health and resilience among Native families.

Promoting Community Conversations About Research on Ending Suicide (PC CARES): A resource that builds communities of practice among local and regional service providers, community members, friends, and families to spark multilevel and sustained efforts for suicide prevention. In this model, learning circles supported by local facilitators foster personal and collective learning about suicide prevention in order to spur practical action on multiple levels to prevent suicide and promote health.

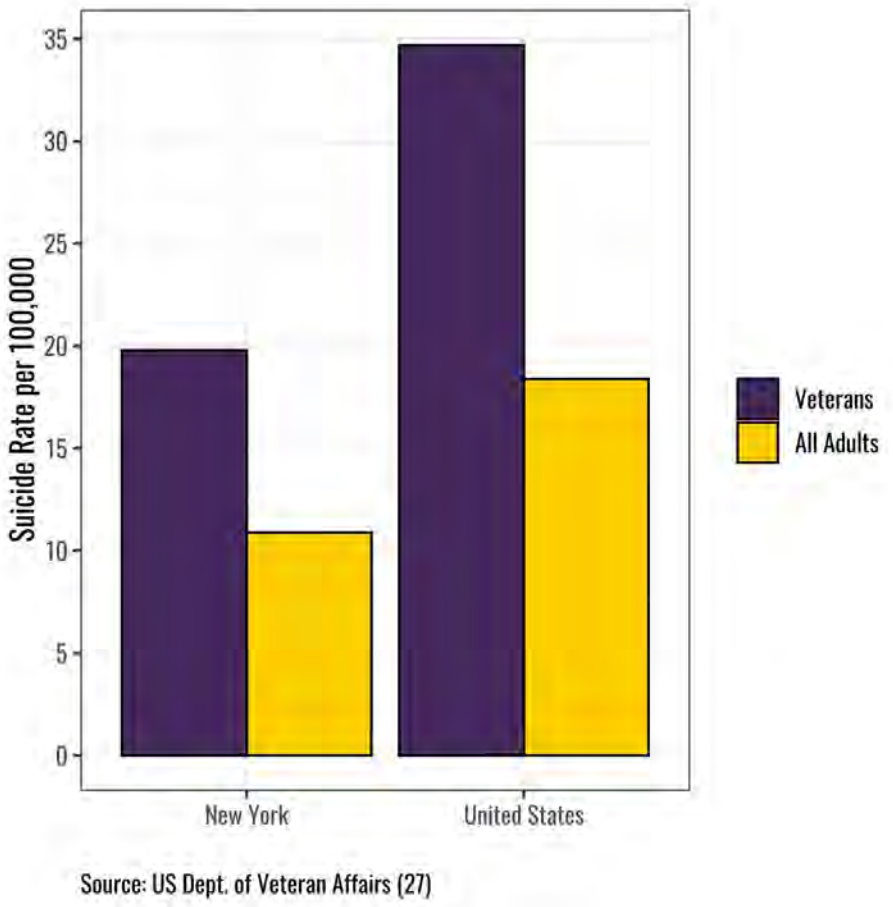
SPRC Resources for Tribal Communities: The Suicide Prevention Resource Center provides tribes with evidence-informed guidance, including Tribal Suicide Prevention Needs Assessments, suicide surveillance strategies, risk-and-protective-factors fact sheets, and capacity-building webinars and toolkits tailored for Native communities.

Goal 12

Objective 12.6: Veterans

Suicide-Related Outcomes Among Veterans

In New York as in the United States, veterans are disproportionately affected by suicide mortality. In 2022, the suicide rate among **New York veterans** was 19.8 per 100,000 adults, compared to 10.9 per 100,000 for adults statewide[27]. Veteran suicide rates in NY were lower than the national veteran suicide rate but higher than the suicide rate in the US general population. Rates were especially high among the youngest veterans, age 18-34, at 32.8 per 100,000; this is over three times the rate among 18-34 year-olds statewide. In New York, veteran suicides occur by firearm more often than do suicides among all adults (55.8% vs. 28.0%).



Source: US Dept. of Veteran Affairs (27)

Figure 12: Suicide Rate among Veterans and All Adults, NY and US, 2022

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Goal 12 Objective 12.6: Veterans

Veterans and military families in New York State face distinct challenges that contribute to heightened suicide risk. With suicide rates among veterans nearly twice that of civilians, many contend with the long-term impacts of trauma, moral injury, social isolation, food insecurity, and limited access to specialized support[28]. Addressing these challenges is not only a matter of public health, but a way to honor their service and commitment. By partnering with veteran-serving organizations to streamline services, reduce gaps in care, and eliminate redundancies, we can ensure that veterans and their families receive timely, effective, and culturally responsive support. These coordinated, community-driven efforts are essential to reducing suicide risk and fostering long-term resilience among veterans and their families.

Objective 12.6.1:

- Support existing community-based suicide prevention efforts for veterans living in New York State by working to incorporate perspectives and recommendations from veterans and their families, including those with suicide-centered lived experience.

Objective 12.6.2:

- Address social determinants of health and systemic issues impacting suicide risk among veterans and their families affected by suicide across the life span.

Objective 12.6.3:

- Enhance protective factors and foster connection to reduce suicide risk among veterans, including through veteran peer services and other supports.

Objective 12.6.4:

- Increase awareness and understanding of the unique barriers and challenges of military and veteran status to improve suicide prevention among service members, veterans, and their families.

Objective 12.6.5:

- Develop and implement comprehensive suicide prevention strategies for Veterans of all ages, from those newly transitioning to civilian life through later life stages, ensuring support across the entire lifespan for veterans and their families.

Objective 12.6.6:

- Ensure that veterans in New York State have access to crisis support and response services that are informed by lived experience and grounded in comprehensive, trauma-informed care.

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Goal 12 Objective 12.6: Veterans

What Success Looks Like

Success in preventing suicide among veterans in New York means increasing access to tailored mental health resources, ensuring prevention efforts are grounded in lived experience avoiding common stereotypical assumptions about "the veteran experience." Instead, efforts will honor and respect the unique experience of each individual veteran.

Resources will be available through a range of settings, including organizations prepared to serve Veterans, community centers, university-based clinics, telehealth, and online platforms, to ensure broad and accessible support. These resources will be co-developed with input from veterans, families, and organizations prepared to serve veterans to ensure relevance and effectiveness. Advisory councils and focus groups, including veterans with suicide-centered lived experience, those with less-than-honorable discharges, LGBTQIA+ veterans, BIPOC veterans, elderly veterans, and military families, will guide this work, fostering collaboration among mental health professionals, educators, social services, and other community organizations. Community-driven messaging will engage veterans and their families, promote connection, and encourage help-seeking (Obj. 12.6.1).

Mentorships, veteran peer programs, and community engagement opportunities will provide safe, supportive spaces for veterans and their families, especially those facing additional disparities such as service members newly transitioning to civilian life, LGBTQIA+ veterans, BIPOC veterans, and veterans with a less-than-honorable character of discharge from military service. Veterans will also have leadership opportunities within these programs to help shape services that reflect their needs and strengths (Obj. 12.6.3).

Public awareness campaigns will also be co-developed and feature credible messengers from the veteran community to amplify veteran voices and encourage help-seeking behavior, while emphasizing the importance of family involvement. These campaigns will also raise awareness of key barriers to care, including trauma, military-specific stressors, challenges in the transition from military to civilian life, also known as the "deadly gap," and the profound effects of social isolation (Obj.12.6.4).

Prevention strategies will align with broader efforts to address social determinants of health by strengthening partnerships with social service agencies to expand access to stable housing, nutritious food, employment and educational opportunities, and social connection. These efforts will place particular attention on often overlooked challenges such as food insecurity, which remains a significant concern for veterans (Obj. 12.6.2).

Strengthened collaboration across veteran-serving, healthcare, and behavioral healthcare systems will build an integrated network of supports that serves veterans and their families across all stages of life, from new veterans to those in later life stages. This network will provide access to effective suicide prevention resources, trauma-informed mental health care, veteran peer services, and community supports. Family involvement will be actively encouraged, fostering connectedness and promoting long-term stability and well-being (Obj. 12.6.5).

Culturally responsive, trauma-informed care will be embedded across mental health and crisis response systems, supported by a trained workforce attuned to the experiences of Veterans across their lifespan. Veterans will have access to tailored care through a variety of options and settings, including university-based clinics, telehealth, and community mental health services. Crisis response will prioritize community- and peer-led interventions, reducing reliance on law enforcement and emergency rooms, while simultaneously improving the military cultural responsiveness of law enforcement and emergency room personnel to ensure respectful and effective care when needed (Obj. 12.6.5 & 12.6.6).

Success means veterans and their families have the support, resources, and opportunities to thrive mentally, emotionally, and socially, within communities that honor and uplift their well-being.

Spotlight Story

Worried About a Veteran (WAV): A New York State Origin Story

Submitted by Kristen J. Vescera PhD, MPH, Associate Director of Education, VA Center of Excellence for Suicide Prevention

Worried About a Veteran (WAV) is a national initiative that empowers loved ones to prevent Veteran gun suicide. But before it's national launch, it started as a New York State (NYS) pilot program in 2022 when the Governor's Challenge to Prevent Suicide collaborated with Counseling on Access to Lethal Means (CALM) to help address Veteran gun suicide.

With initial funding from the NYS Health Foundation, WAV identified a gap and developed a unique approach to preventing Veteran gun suicide through empowerment of loved ones. Through interviews with Veteran spouses with lived experience and empirical research, WAV developed its initial content based on the needs of loved ones.

From its inception in NYS to its national launch, over 16,000 visitors came to the website, from NYS and across the country. Because WAV showed success as a pilot, it expanded nationwide in December 2024 with support from the Bronx Veterans Medical Research Foundation and additional funding from Face the Fight™.

WAV now provides resources for every step of a loved one's journey, including how to have successful conversations with Veterans about secure gun storage and an overview gun laws across all 50 states.

Since the national launch, WAV has reached over 630,000 users, with New York continuing to be among the top states for site traffic. By equipping loved ones to safely address lethal means, WAV has been helping to foster a culture of proactive suicide intervention for Veterans both in NYS and nationwide.

Resources to Consider

Joseph P. Dwyer Veterans Peer Support Project: A peer-to-peer support program for veterans in New York State that connects service members with fellow veterans to provide emotional support, reduce isolation, and ease the transition to civilian life—free of charge and confidential.

Onward Ops: A veteran transition support network that provides personalized, peer-guided assistance to service members before, during, and after their transition out of the military, helping them navigate resources related to employment, education, health, and housing.

Rocky Mountain MIRECC (Mental Illness Research, Education, and Clinical Center) for Suicide Prevention: A national leader in suicide prevention research and education within the VA system, focused on advancing evidence-based practices and improving mental health outcomes for veterans through innovative tools, training, and clinical support.

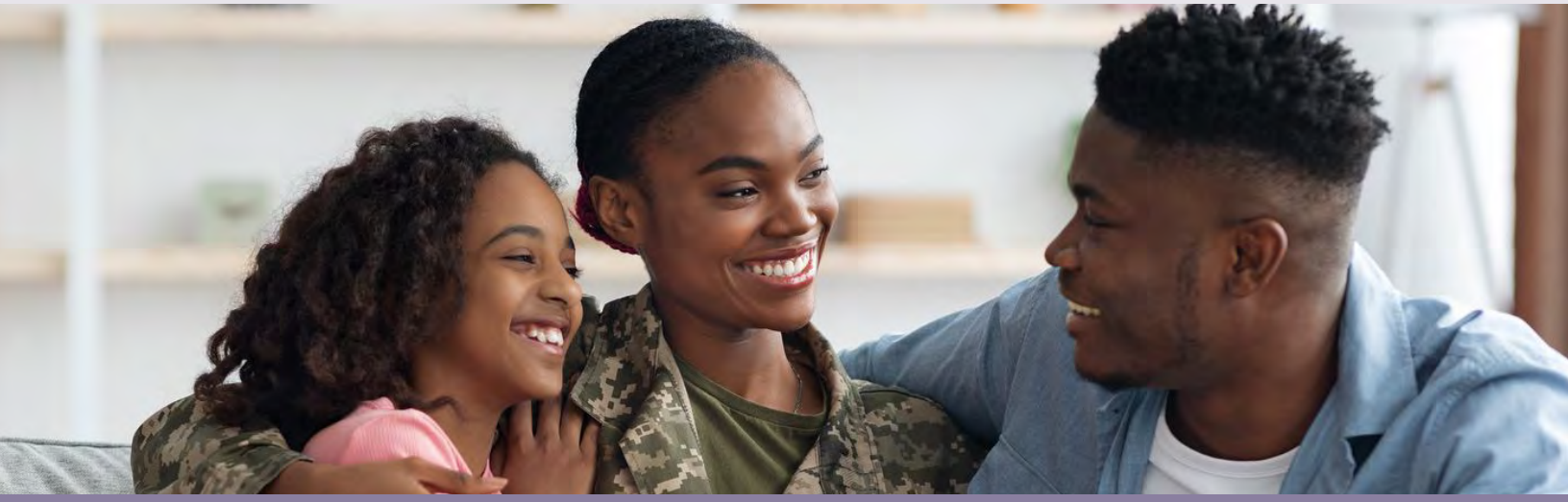
Don't wait. Reach Out: No mission should be fought alone. Life has its challenges. You don't have to solve them alone. That's true whether it's an everyday struggle, or something more complicated. This site was designed for Veterans to proactively seek support and resources.

Make the Connection: A VA campaign and website sharing real stories from veterans about overcoming mental health challenges, including suicidal thoughts, while offering resources, videos, and information on how to seek help and support.

New York State Department of Veteran Services - Suicide Prevention: A centralized hub offering suicide prevention resources and support services for veterans, their families, and service providers across New York, including connections to crisis lines, peer programs, and local initiatives.

AFSP Preventing Suicide in Military Families: A resource from the American Foundation for Suicide Prevention that provides education, tools, and support strategies tailored to military families, emphasizing connection, resilience, and ways to support a loved one at risk. Or connect with your local AFSP chapter for additional veteran programming through AFSP Find a local chapter.

Vets4Warriors: Vets4Warriors is a 24/7 confidential peer support program for Veterans and military families, staffed by those with lived military experience. It operates year-round through phone, chat, and email, offering ongoing support that helps Veterans navigate emotional, social, and logistical challenges before they escalate to crisis.

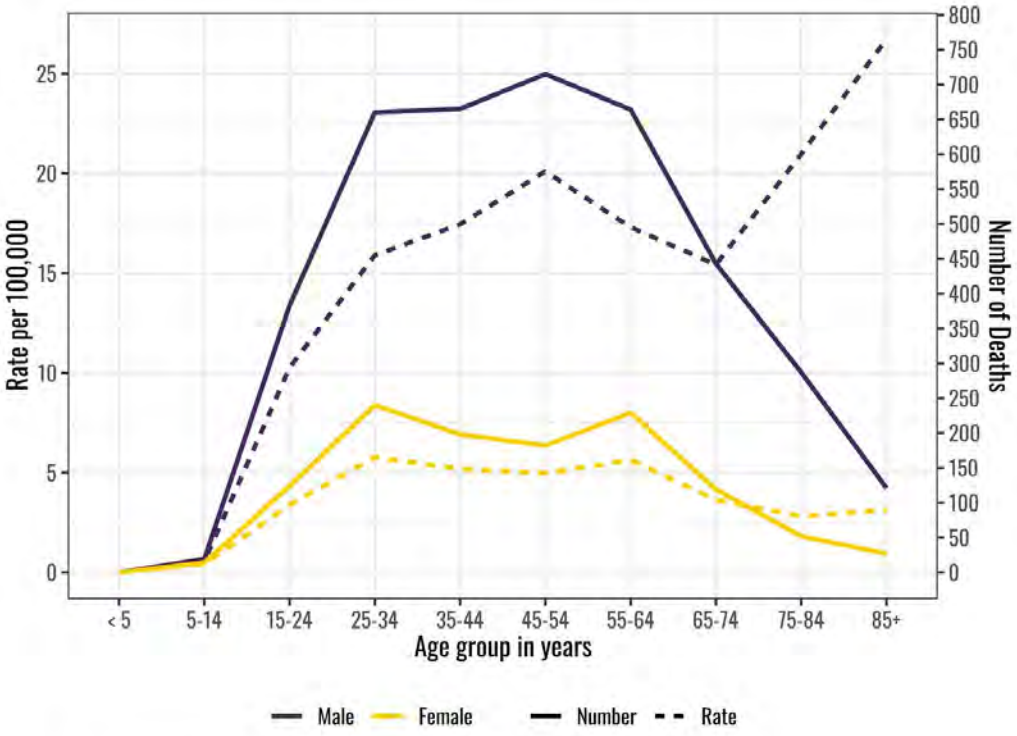


Suicide-Related Outcomes Among Working Age Men

Objective 12.7: Working-Age Men

In New York State, working-age men (males between 25 and 64 years old) are disproportionately affected by suicide mortality. From 2021 to 2023, the age-adjusted suicide rate among working-age males in New York was 17.7 per 100,000 population, compared to 5.4 among working-age females and 8.2 in the state as a whole[1]. Furthermore, large numbers of working-age males die by suicide each year in New York – an average of 900 per year between 2018 and 2023. **Both the number and rate** of suicides are elevated during mid-life and for males compared to females (see Figure 13 below). Working-age men also have a higher rate of suicide from firearms compared to the state as a whole (4.9 per 2.2 per 100,000 between 2021 and 2023).

Figure 13: Number and Rate of Suicides by Age Group and Sex in NY, 2021-2023



Source: CDC WONDER (1)

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Goal 12 Objective 12.7: Working Aged Men

Working-age men, defined as males between the ages of 25 and 64, in New York State face significant disparities in suicide rates, shaped by stressors such as job insecurity, financial strain, social isolation, relationship challenges, substance abuse, and the societal pressure tied to traditional masculine norms that often discourage seeking help. Many men are less likely to engage with traditional mental health services, often due to stigma, limited access to services, or the absence of resources that reflect their needs and experiences . Addressing these disparities requires targeted, evidence-informed suicide prevention efforts that embed mental health support into spaces where men naturally connect, such as workplaces, social settings, and community organizations. By improving availability and access to practical, stigma-reducing, and culturally relevant supports and programs, New York State can help reduce suicide risk among working-age men and foster an environment that promotes connection, resilience, and overall well-being.

Objective 12.7.1:

> Improve availability of and access to high quality, relevant suicide prevention information and resources for working-aged men.

Objective 12.7.2:

> Strengthen suicide prevention efforts by incorporating the perspectives and recommendations of working-aged men, including those with suicide-centered lived experience.

Objective 12.7.3:

> Identify and address social, economic, and structural barriers that contribute to suicide risk among working-aged men.

Objective 12.7.4:

> Promote and expand upstream protective factors that foster social connectedness, support networks, and a sense of belonging among working-aged men to help reduce suicide risk.

Objective 12.7.5:

> Improve awareness and understanding of the unique experiences and challenges faced by working-aged men to better inform suicide prevention activities.

Objective 12.7.6:

> Develop, implement, and sustain culturally relevant community-based suicide prevention programs tailored for working-aged men.

Objective 12.7.7:

> Improve and expand suicide prevention clinical practices, policies, and interventions that effectively address suicide risk among working-aged men.

Objective 12.7.8:

> Strengthen availability of and access to crisis support and response strategies that are responsive to the needs of working-age men.

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Goal 12 Objective 12.7: Working Aged Men

What Success Looks Like

Success in improving suicide prevention efforts for working-aged men in New York means increasing access to mental health resources that are practical, relevant, and tailored to their experiences. Prevention strategies will actively incorporate the voices of working-aged men, including those with suicide-centered lived experience, to ensure that supports resonate and are accessible. Outreach efforts will take place in familiar spaces, such as workplaces, social settings- including barber shops, gun ranges, and fraternal organizations- and male-centered online platforms and forums, helping to reduce stigma and normalize conversations around mental health (Obj. 12.7.1 & 12.7.2).

Programs will be intentionally designed to reduce barriers to care, encourage help-seeking behaviors, and foster social connectedness. A strong focus on community-driven approaches will create supportive networks, mentorship opportunities, and avenues for social engagement, helping men form meaningful relationships and build a stronger sense of belonging and purpose. Services and programs will also address stressors that commonly impact working-age men, such as job insecurity, financial pressures, substance use, and societal expectations, through tailored, stigma-reducing interventions. This will include sharing mental health resources in workplaces and trusted social spaces such as sports leagues and faith-based groups (Obj. 12.7.3, 12.7.4, 12.7.5, & 12.7.6).

Collaboration among healthcare providers, employers, and community organizations will build a coordinated network of supports that are accessible, culturally relevant, and responsive to the needs of working-age men. Crisis response teams and peer support programs will be widely available through discreet, low-barrier options such as text-based services, walk-in centers, and trusted community organizations. Policies that promote workplace mental health and flexible pathways to care will further embed and encourage mental wellness in everyday environments *(See also Goal 16)*. Success will be reflected in greater awareness, improved mental health literacy, and increased engagement with available resources (Obj. 12.7.6, 12.7.7, & 12.7.8).

Ultimately, through targeted interventions and supportive environments, working age-men across New York State will be empowered to prioritize their mental health, build meaningful connections, and seek help when needed, leading to reduced suicide risk and improved overall well-being.

Spotlight Story

NYS Laborers' HOPE LIVES Campaign

Submitted By Gwennan Bouchard, NYS Laborers-Employers Cooperation and Education Trust (LECET) Communications & Public Relations Manager

For many years, there has been a documented rise in substance use disorders and a growing mental health crisis in our nation and, more specifically, in the construction industry. It became clear that the NYS Laborers' Health & Safety Trust Fund had a clear responsibility to our membership and their families to take immediate and decisive action.

In 2023, the NYS Laborers' Health and Safety Trust Fund's **HOPE LIVES** campaign, an aggressive and highly visible marketing effort to raise mental health awareness in the construction industry, was officially launched. HOPE LIVES utilizes a variety of tools including job site posters, wearables, coffee cups, a dedicated outreach website and other points of contact to highlight the numerous mental health resources available to our members and their families.

All **HOPE LIVES** materials, including posters, shanty stickers, window clings and brochures are available in English, Spanish, Portuguese and Polish. Coffee cups highlighting the program website and available resources have been actively deployed at countless job sites, union halls and training centers.

HOPE LIVES continues to be our most successful, prolific and life-changing campaign to date. The **HOPE LIVES** program template has been utilized nation-wide throughout multiple LIUNA regions and adopted by several building trades and contractor associations, with the most recent being the Building Contractors Association. It is an honor to freely share all collateral with any union entity or management partner who requests it, and we take great pride and comfort in knowing the information is being widely shared.

Resources to Consider

ManTherapy: A unique mental health campaign that uses irreverent humor to engage men—especially working-age men—on topics like depression, anxiety, and suicidal thoughts, while connecting them to real tools and resources for support.

New York Capital Connect - Working Aged Men: A New York State initiative focused on addressing mental health and suicide prevention among working-aged men by promoting early help-seeking, challenging stigma, and providing links to support services.

Preventing Suicide among Men in the Middle Years: A CDC publication offering evidence-informed strategies and practical recommendations for preventing suicide among men aged 35–64, emphasizing outreach, social connection, and support tailored to the unique risk factors faced by this population.

Men and Suicide Fact Sheet: An educational resource that explores the disproportionately high rates of suicide among men, including contributing factors such as stigma, underdiagnosed mental health conditions, and limited help-seeking behaviors, while highlighting strategies for prevention.

See also Goal 16.

Strategic Direction 4

Expanding Effective Community-Driven Suicide Prevention

Suicide prevention is not just a set of policies or programs delivered in clinical settings. It is a shared responsibility that extends beyond the healthcare system and into the daily lives of those who live, work, learn, and gather in every community. To have lasting impact, suicide prevention efforts must be woven into the fabric of everyday life, reflected in our schools, workplaces, neighborhoods, and community spaces. Strategic Direction 4 focuses on building sustainable, community-driven approaches that embed suicide prevention across all aspects of society.

When communities are informed, engaged, and empowered, they play a critical role in addressing the social, emotional, and societal factors that contribute to suicide risk. For suicide prevention efforts to be truly effective, broad participation and integration within every system is required; efforts must be guided by shared knowledge, suicide-centered lived experience, and a collective commitment to suicide prevention care.

This strategic direction emphasizes proactive community engagement through the establishment of collaborative partnerships, promotion of lethal means safety, expansion of community education and training, integration of suicide prevention into the workplace, and development of compassionate postvention responses. Improved communication, both in public messaging and interpersonal conversations, is key to changing norms, reducing stigma, and supporting informed action. Addressing these elements together builds a comprehensive approach to suicide prevention, that meets people where they are, responds to diverse needs, and reinforces prevention at every level of community life[30].

By fostering strong partnerships and embedding prevention into all aspects of daily life, New York State can build a culture where suicide prevention and mental wellness are shared priorities — and where every community is equipped and ready to take action.

"This direction hits home for me because community-driven suicide prevention is where I've seen the most meaningful impact. Real prevention doesn't come from a top-down mandate—it comes from relationships, trust, and consistent presence. It's the small moments: a teacher who knows how to check in with a student, a coach who sees a shift in behavior, or a community member who feels confident enough to ask the hard question. That only happens when suicide prevention is embedded in the culture—not something extra, but something expected.

We need to continue building partnerships across sectors—faith leaders, libraries, local businesses, funeral homes, first responders, and grassroots groups. Everyone has a role. And we have to move upstream—this isn't just about responding to crisis, it's about creating environments where people feel connected, valued, and supported long before they reach a breaking point. We also can't forget about postvention. When a suicide does occur, how a community responds can either cause further harm or promote healing. Every single person in a community has the potential to be part of the solution—but only if we equip and empower them to act. That's what community-driven prevention looks like: local leadership, lived experience, and people who care enough to show up."

– Anonymous Suicide-Centered Lived Experience Survey Respondent

Goal 13

Establish effective, broad-based, collaborative, and sustainable suicide prevention partnerships.

Objective 13.1:

> Develop relationships and build partnerships that engage public and private sectors, community organizations and coalitions, local leaders and diverse community representatives, and individuals with suicide-centered lived experiences to expand suicide prevention efforts and improve outcomes.

Objective 13.2:

> Strengthen and sustain collaboration across state and local agencies to align programs, data, and resources in support of a coordinated, statewide approach to suicide prevention.

What Success Looks Like

Success for Goal 13 means a strong, coordinated network of suicide prevention partnerships will be established and sustained across New York State. Public and private sector organizations, county coalitions, state and local agencies, those with suicide-centered lived experiences, and local and diverse community representatives will work together to expand the reach and impact of suicide prevention efforts. These partnerships will foster trusted relationships across sectors, align resources, strengthen local and state systems of care, and ensure that prevention strategies are responsive to community needs. Through sustained collaboration and coordination, New York State will advance a comprehensive, statewide approach to suicide prevention and support long-term progress across all communities.

Spotlight Story

State Agency Partnerships: Office of Mental Health & Department of Labor

Submitted by New York State Department of Labor, Unemployment Insurance

At the New York State Department of Labor in their Unemployment Benefits Telephone Claims Center (TCC), our customers are calling because they need help navigating the complex world of unemployment. Think about it this way, when they need help the most – with money for food, shelter, and financial security at a time when they find themselves out of a job – our agents are there to answer their questions. This may mean there's an added layer of frustration and/or desperation right out of the gate with some of those calls resulting in threats to harm themselves. Recognizing this, the TCC partnered with our Employee Development & Growth through Education (EDGE) to develop a new program offering a series of trainings to help better prepare staff when they face those scenarios.

A critical first step for us has been for all staff to be offered the opportunity to take the Link to HOPE training and we're happy to say 200+ of them participated in April 2025. This training has given us a deeper understanding of suicide awareness and the easy steps we can take to help those in need. Since they took the course, staff have expressed how informative it was and meaningful it was for them personally. We have greatly valued this chance to leverage the expertise offered in the Link to Hope training, giving us a safe space to learn and share.

Resources to Consider

Suicide Prevention Resource Center (SPRC) Partnerships and Collaboration: An SPRC resource emphasizing the importance of partnerships and collaboration in suicide prevention strategies. It provides guidance on identifying potential partners, building effective collaborations, and ensuring coordinated efforts to achieve meaningful change in target populations.

Including Lived Experience in Suicide Prevention: Roses in the Ocean provides a set of guiding principles for organizations to authentically engage individuals with lived experience of suicide in prevention efforts. It emphasizes the value of incorporating personal insights to inform and enhance suicide prevention strategies, ensuring they are person-centered and effective.

Colorado-National Collaborative (CNC) for Suicide Prevention: The Colorado-National Collaborative (CNC) serves as a strong example of a multi-sector partnership in suicide prevention. The CNC focuses on aligning efforts across sectors to create a unified approach to suicide prevention and reduce suicide rates in Colorado.

Center for Health Care Strategies (CHCS): Through policy development, technical assistance, and cross-sector collaboration, CHCS supports state and community leaders in building more effective, person-centered systems of care. Their extensive library of tools, publications, and case studies includes resources on behavioral health, Medicaid, social needs, and care integration.

Goal 14

Promote lethal means safety among people at risk of suicide.

Objective 14.1:

> Educate and equip credible messengers and subject matter experts with the knowledge and tools to promote lethal means safety and encourage safe and secure storage of firearms, medications, poisons, ligatures, and other means.

Objective 14.2:

> Develop and implement community-responsive policies, programs, messaging, and best practices that increase time and distance between individuals at elevated risk of suicide and access to lethal means.

Objective 14.3:

> Partner with firearm organizations and other relevant community organizations to integrate suicide prevention into firearm safety education and promote responsible ownership practices.

What Success Looks Like

Achieving this goal will result in a comprehensive, coordinated approach to lethal means safety embedded across New York State. State and local agencies, community organizations, and trusted messengers, including firearm instructors, pharmacy technicians, schools, public defenders, and hospital staff, will be equipped with the knowledge and tools to implement best practices that increase time and space between individuals at elevated risk of suicide and access to firearms, medications, poisons, ligatures, and other lethal means. Tailored policies and programs will reflect the needs of communities, while partnerships with firearms and other relevant organizations will integrate suicide prevention into firearm safety programs and responsible ownership practices. These efforts will build statewide capacity to reduce access to lethal means during high-risk times, enhance safety across various settings, and ultimately save lives.

Spotlight Story

Firearm Safety Efforts in Erie County & Western New York

Submitted by Celia Spacone, Ph.D, Coordinator, Suicide Prevention Coalition of Erie County

Firearms account for a third of suicide deaths in Erie County and half nationwide. The Suicide Prevention Coalition of Erie County focuses on means reduction efforts highlighting firearm safety. This includes distribution of free gun locks, tabling at gun shows, and educational events for firearm owners. They provided educational gift bags for 1500 hunters when they picked up their doe tags and licenses.

In 2020, they worked with an intern from the Master's in Public Health Program of the University at Buffalo to develop a Firearm Storage Map. This interactive map for Erie and Niagara Counties shows icons for storage locations. Locations include firearm retailers and repair shops, firing ranges, and law enforcement agencies. With a click on an icon the user can see the address, phone number, cost and any details about subsequent retrieval processes. Usually, the process simply involves a background check. Upon request, several of the law enforcement agencies will even come to pick up the firearm in their district. At each location a firearm owner can voluntarily and temporarily arrange for safe storage of their firearm during times of personal or family stress. Many Coalition agencies post the link as has the Erie County Department of Mental Health. It's had over 10,000 views! There is also a short video with directions on how to use the map.

The map is currently being expanded to include Genesee, Orleans and Wyoming Counties.

Resources to Consider

Lethal Means & Suicide Prevention: A Guide for Community & Industry Leaders: National Action Alliance for Suicide Prevention's guide provides an overview of the role lethal means play in suicide and highlights actions taken by governments, organizations, and industries to reduce access to these means among individuals at risk. It aims to equip community and industry leaders with the knowledge and guidance needed to contribute to suicide prevention efforts.

AFSP Policy Priority: Lethal Means Safety: This AFSP resource outlines the importance of lethal means safety as a policy priority. It emphasizes the need for strategies that reduce access to firearms and other lethal means among individuals at risk for suicide, advocating for policies and practices that can save lives.

Life Side Ohio: Life Side Ohio is a partnership between the Ohio Suicide Prevention Foundation and firearm stakeholders, including retailers, veterans, and first responders, to conduct grassroots suicide prevention outreach tailored specifically to gun owners. It focuses on safe storage and lethal means education through listening-first engagement to reduce firearm suicide in Ohio.

SPCNY Make Your Home Suicide Safer Brochure: This brochure provides practical steps for individuals and families to reduce the risk of suicide in the home. It includes guidance on safely storing firearms and medications, creating a supportive environment, and recognizing warning signs of suicide.

Firearm Suicide Prevention & Lethal Means Safety: This resource from the VA emphasizes the importance of lethal means safety in preventing suicide among veterans. It provides information on safe storage practices, strategies to put time and distance between individuals in crisis and firearms, and resources for veterans and their families to reduce suicide risk.

Counseling on Access to Lethal Means (CALM): The CALM America website is designed to educate mental health professionals and others on strategies to reduce access to lethal means, such as firearms and medications, among individuals at risk for suicide. The CALM training emphasizes respectful, collaborative approaches to means reduction, aiming to increase the time and distance between at-risk individuals and potential methods of self-harm.

Goal 15

Strengthen community-based suicide prevention by implementing and supporting policies and programs in places where people live, work, learn, play, volunteer, and worship.

Objective 15.1:

> Build and strengthen the capacity of local coalitions, organizations, and community leaders to plan, coordinate, and sustain comprehensive suicide prevention efforts.

- **15.1.1:** Leverage existing state and local infrastructure to assess community strengths and gaps as well as inform data-driven suicide prevention planning.

Objective 15.2:

> Train community members, organizations, and local groups with the knowledge and skills to recognize warning signs, offer support, and connect individuals experiencing suicidal thoughts to appropriate resources.

Objective 15.3:

> Expand upstream community-based programs to target the common risk factors of co-occurring substance and mental health disorders, and strengthen protective factors such as resilience, social connectedness, and community support.

Objective 15.4:

> Implement suicide prevention policies, programs, and practices in community settings, ensuring prevention efforts are accessible and relevant.

- **15.4.1:** Support schools, youth-serving organizations, and higher education institutions in integrating suicide prevention into existing programs, curricula, and policies **(See also Goals 9, 10, & 11).**
- **15.4.2:** Promote suicide prevention awareness, training, and postvention planning across faith-based organizations, volunteer groups, and other key community settings, including workplaces **(See also Goal 16).**
- **15.4.3:** Expand the use of peer-delivered services and supports in community-based suicide prevention, ensuring individuals with lived experience are trained, supported, and integrated into prevention, intervention, and postvention efforts.

What Success Looks Like

Success means communities across New York State will lead the way in creating safer, more connected environments where suicide prevention is part of everyday life. Community leaders and local organizations and coalitions will have the capacity to plan, coordinate, and sustain prevention efforts that reflect local strengths, needs, and lived experiences. Suicide prevention policies, programs, and practices will be implemented in the places where people live, work, learn, play, volunteer, and worship, ensuring prevention efforts are visible, accessible, and able to reach all community members. People across these settings will be equipped to recognize suicide risk, provide support, and connect individuals to care. Efforts will also focus on upstream strategies that reduce isolation, strengthen protective factors against developing mental health and substance use disorder, and promote mental well-being through peer-led programs, volunteer opportunities, and other community-based initiatives. Through these community-driven efforts, suicide prevention will become an integral part of community life, expanding access to care, strengthening local support networks, and driving lasting reductions in suicide risk across New York State.

Spotlight Story

SUNY's Mental Health Resource Finder

Submitted by Julie Maio, Director of Student Mental Health & Wellness

With support from the NYS Office of Mental Health's Garrett Lee Smith Grant, SUNY developed and launched an online **Mental Health Resource Finder.** SUNY's Mental Health Resource Finder serves multiple purposes: it helps students understand the mental health services available on their campuses; connects them with off-campus supports; and highlights statewide and national resources tailored to the needs of underrepresented student groups. The Resource Finder is actively promoted through ongoing communication campaigns, including social media graphics and posts.

More generally, mental health is a vital component of overall well-being, and its importance within the SUNY system cannot be overstated. By creating accessible, inclusive, and stigma-free support systems, such as the Mental Health Resource Finder, SUNY demonstrates its continued commitment to supporting the mental health and well-being of our campus communities.

Resources to Consider

EDC Community-Led Suicide Prevention: An online resource designed to assist communities in developing and implementing suicide prevention strategies. It outlines seven key elements, including unity, data, planning, fit, integration, communication, and sustainability, offering step-by-step guidance and resources for each component to support community-driven initiatives.

CDC Suicide Prevention Resource for Action: This resource outlines evidence-based strategies for suicide prevention, including approaches to building partnerships across sectors such as healthcare, education, and community organizations. It provides actionable steps to implement effective suicide prevention initiatives and foster collaboration.

SPRC Recommendations for Local Suicide Prevention Infrastructure: A set of guidelines developed by SPRC to assist local entities in establishing, enhancing, and maintaining robust suicide prevention infrastructures. These recommendations align with Goal 6 of the National Strategy for Suicide Prevention, aiming to build and sustain effective suicide prevention frameworks at all governmental levels.

SPCNY Training Options: A comprehensive suite of evidence-based trainings, workshops, and online modules tailored for clinicians, healthcare professionals, educators, and community members offered through SPCNY. The offerings include programs like Link to Hope, Applied Suicide Intervention Skills Training (ASIST), safeTALK, and specialized workshops for school staff and administrators, all designed to equip participants with the skills necessary for effective suicide prevention, intervention, and postvention.

Moving Suicide Prevention Upstream: From Concept to Action: This resource reframes suicide prevention through a public health lens, urging a shift from crisis intervention to proactive upstream strategies that tackle root causes—like social disconnection, economic hardship, and trauma—via community-based and policy-level action. It equips practitioners and coalition leaders with actionable tools such as messaging guides, sustainability planning, and progress measurement, to embed upstream practices within state, Tribal, and local systems.

Goal 16

Develop and integrate suicide prevention, mental wellness, and crisis response into workplace values and culture through the implementation of sustainable organizational programs, practices, and policies that support and promote worker well-being at all levels.

Objective 16.1:

> Improve workplace culture and communications in ways that support mental health, eliminate stigma, and prioritize wellbeing while also integrating these priorities into the organization's core values and policies.

- **16.1.1:** Promote open and inclusive communication strategies that prioritize psychological safety and normalize mental health discussions.

Objective 16.2:

> Deliver evidence-based training for all staff, focusing on recognizing warning signs of mental distress, reducing stigma, and intervening effectively in crisis situations.

- **16.2.1:** Equip managers and supervisors with the skills to support employees effectively, foster open dialogue, and connect individuals to appropriate resources.

Objective 16.3:

> Ensure workplaces have established comprehensive crisis response protocols and postvention strategies that guide staff in addressing mental health crises and suicide-related incidents, support recovery, and minimize the impact on employee well-being and organizational culture.

Objective 16.4:

> Implement policies and programs that promote protective factors and reduce workplace stressors, including flexible work arrangements, manageable workloads, and initiatives that foster healthy boundaries between work and personal life.

Objective 16.5:

> Ensure all employees have access to mental health resources, such as employee assistance programs (EAPs), peer support networks, and confidential counseling services, to support their well-being.

What Success Looks Like

Successfully achieving Goal 16 will be reflected in the development of a comprehensive, supportive, and sustainable workplace where mental wellness and suicide prevention are deeply integrated into the organization's guiding principles, policies, and practices. This will foster a culture that prioritizes employee well-being, reduces mental health risks, and actively promotes protective factors at all organizational levels. These efforts will create a workplace environment where mental wellness and suicide prevention are seamlessly woven into daily operations. Employees will feel genuinely supported, valued, and empowered to maintain their mental health. Success will be demonstrated through positive employee feedback, increased engagement, reduced turnover, and a more resilient workforce that is better equipped to thrive, even in challenging times.

Resources to Consider

New York CARES UP: CARES UP is a wellness and resiliency program for uniformed personnel organizations. This model is intended for leaders at New York State uniformed personnel organizations and serves as a how-to-guide that includes helpful templates and resources to implement the program.

U.S. Department of Health and Human Services, Surgeon General's Report on Workplace Well-Being: A 2022 Surgeon General report that emphasizes the importance of workplace well-being as a key factor in mental health and suicide prevention. The report provides actionable insights and strategies for employers to implement well-being programs that promote employee mental health, reduce risk factors for suicide, and improve overall workplace culture.

The Action Alliance Workplace Suicide Prevention and Postvention: Resources focused on advancing suicide prevention efforts in the workplace. It provides toolkits and best practices to guide employers in creating supportive environments that prioritize mental health and reduce the stigma surrounding suicide prevention in the workplace.

How Employers Can Advance the 2024 National Strategy for Suicide Prevention: A blog post detailing the National Strategy for Suicide Prevention, with a specific focus on the role of workplaces in reducing suicide risk. It highlights strategies for workplaces to play an active role in prevention, including fostering mental health awareness, providing resources for employees, and building supportive work cultures.

Workplace Suicide Prevention: A comprehensive initiative focused on creating mentally healthy workplaces and preventing suicide among employees. It provides organizations with tools such as the "Quick Start Guide" to develop workplace suicide prevention plans. Key strategies include leadership development, reducing job strain, fostering communication, promoting self-care, providing specialized training, offering peer support, and ensuring access to mental health resources.

OMH BeWell Campaign: This New York State Office of Mental Health campaign is an accessible mental wellness hub, offering practical guidance on managing stress, building resilience, and understanding trauma. With user-friendly tips, calming strategies, and downloadable materials, it empowers individuals and communities to nurture their mental health and wellness in ways that work for them.

Goal 17

Develop and disseminate effective suicide prevention messaging informed by research and guided by best practices.

Objective 17.1:

> Convey clear, safe, and accessible suicide-related data and trends to a range of audiences to inform public health actions.

Objective 17.2:

> Raise public awareness of suicide warning signs, prevention, and the multiple factors that can influence suicide risk.

Objective 17.3:

> Engage with individuals with suicide-centered lived experience to develop, implement, and evaluate targeted communication efforts, including stories of help, hope, and healing, that promote help-seeking and offer guidance on supporting someone in crisis.

Objective 17.4:

> Partner with youth to develop, implement, and assess communication strategies that promote healthy engagement with social media and other digital platforms among young people.

Objective 17.5:

> Collaborate with news media, the entertainment industry, and journalism and mass communication schools to promote safe, accurate, and responsible reporting of suicide, encourage portrayals of positive mental health and coping strategies, and ensure that stories and content consistently share information about available suicide prevention and crisis resources.

Objective 17.6:

> Amplify awareness of the 988 Suicide & Crisis Lifeline and other crisis services through communications. ***See also Goal 20.***

What Success Looks Like

Success will be demonstrated through the development and implementation of research-based suicide prevention communication strategies that effectively engage and resonate with diverse audiences across New York State. These efforts will help shift public understanding around suicide and suicide prevention, fostering a culture where mental health is openly discussed, suicide is recognized as preventable, and individuals feel empowered to seek help and support others. Communications will consistently promote awareness of crisis and prevention resources, encourage help-seeking, and support responsible media portrayals of suicide and mental health. Increased awareness, more accurate reporting, and healthier engagement with digital platforms will expand the reach and impact of suicide prevention efforts, contributing to a stronger community capacity to prevent suicide and promote well-being statewide.

Spotlight Story

Using Voices of those with Lived Experience

Submitted by Emily Crumb

When I filmed the *Stories of Hope* video, I had no idea just how far my story would reach. The response was overwhelming—schools, individuals, and organizations reached out, sharing that my journey made them feel seen and encouraged them to seek support. It was then that I truly understood the power of digital storytelling: social media connects us at the exact moment we need hope the most.

After seeing my *Stories of Hope* video on Facebook, the Office of Community Relations and Engagement at SUNY Upstate Medical University invited me to speak at an event where I will be sharing my personal journey as a suicide attempt survivor and speaking about the importance of mental health awareness. By opening up about my experience, I hope to foster a supportive environment that encourages individuals to seek help, start conversations, and recognize that they are never alone.

I did not expect filming *Stories of Hope* to heal me as much as it did. Hearing my voice talking about my darkest moments made them real, leading to acceptance. For the first time, I realized it was okay to talk about it. This is my story. These experiences are part of me. And I survived.

Stories of Hope was the first time I allowed myself to be vulnerable transcribing my pain into words. For the first time, I realized it was okay to be honest about my struggles with depression because this is my story. These experiences are part of me. And I survived.

My journey from crisis to recovery has given me the chance to turn pain into purpose and to use my voice to advocate for mental health awareness and to stand as living proof that even the darkest moments can lead to powerful purpose.

Resources to Consider

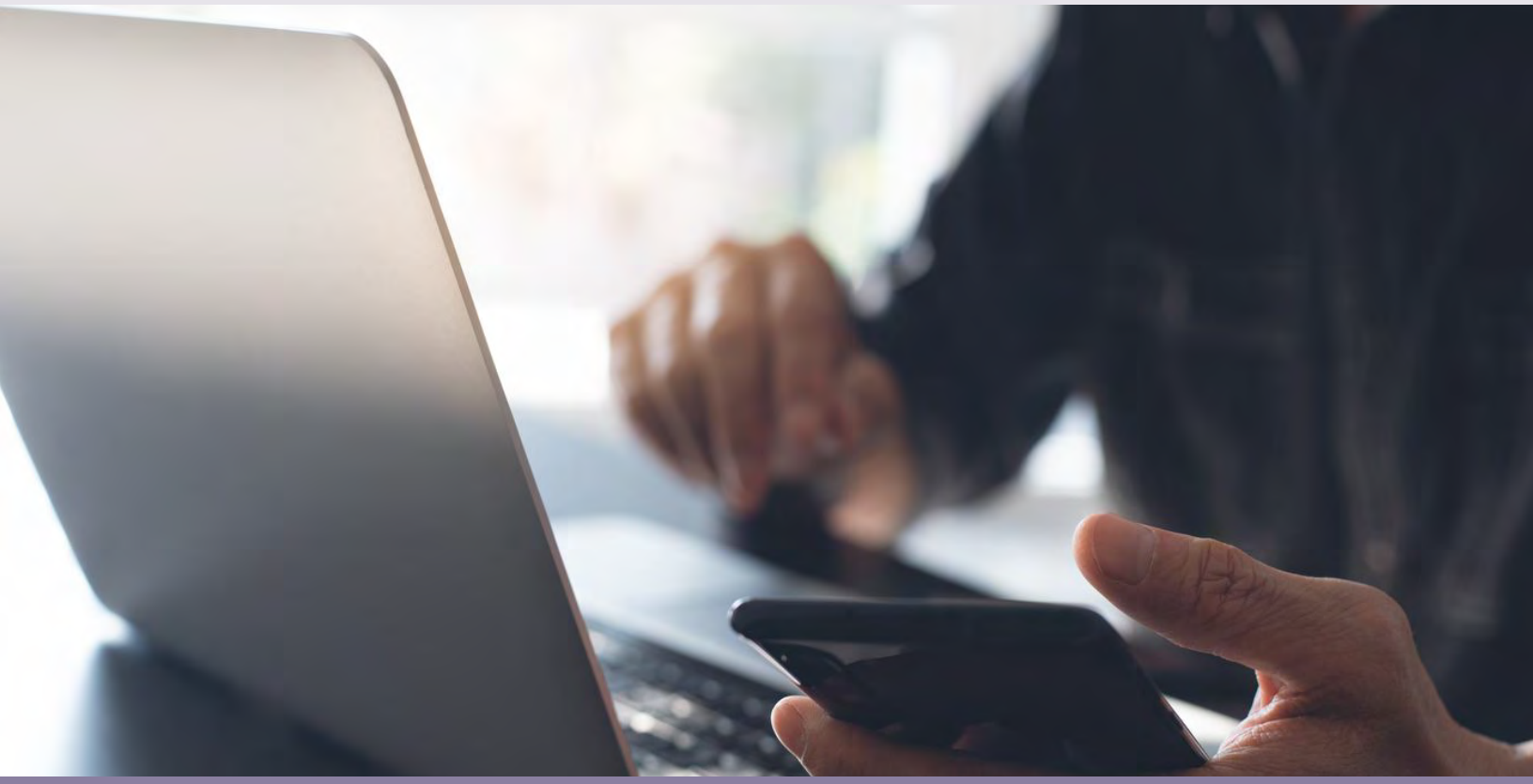
SAMHSA 988 Marketing Toolkit: A toolkit developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to assist partners in promoting the 988 Suicide & Crisis Lifeline. The toolkit provides resources such as messaging guidelines, digital and social media assets, and materials for outreach to help organizations effectively promote 988 and raise awareness about mental health crises and suicide prevention.

NYS Office of Mental Health 988 Marketing Toolkit: A resource developed by the New York State Office of Mental Health to support local outreach and education efforts for 988. The toolkit includes promotional materials, best practices for communication, and guidance on integrating 988 into mental health crisis response efforts across the state.

Reporting on Suicide Best Practices: A set of guidelines and best practices for journalists and media outlets when reporting on suicide. These guidelines aim to reduce the risk of suicide contagion, promote responsible reporting, and support public health efforts by encouraging sensitive and accurate coverage of suicide and mental health issues.

Suicide Prevention Messaging Framework: This resource offers a research-based framework for strategic, safe, and effective communication about suicide, emphasizing intentional planning, alignment with broader goals, coordination with supports and services, and clear, actionable messaging guided by safety guidelines

American Foundation for Suicide Prevention Marketing Toolkit: A toolkit from the American Foundation for Suicide Prevention providing resources for organizations to promote suicide prevention efforts. It includes social media templates, promotional tools, and guidelines to help partners effectively raise awareness, reduce stigma, and encourage engagement with suicide prevention resources.



Goal 18

Develop and implement postvention strategies and programs within organizations, communities, and healthcare settings to support healing and recovery following a suicide death, ensuring timely access to resources and support services.

Objective 18.1:

> Develop and implement postvention training, resources, and tailored guidance for each setting to ensure a proactive, comprehensive approach to postvention.

- **18.1.1:** Improve communication around and access to postvention resources, information, and training to ensure widespread availability and awareness of best practices and up-to-date research.
- **18.1.2:** Actively involve suicide attempt and loss survivors in the co-creation, implementation, and ongoing evaluation of postvention resources, guidelines, and protocols, ensuring that their lived experiences shape the development of effective, relevant, and compassionate support strategies.

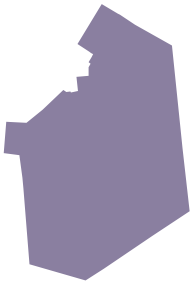
Objective 18.2:

> Offer comprehensive postvention support to individuals bereaved by suicide, ensuring ongoing compassionate care and emotional assistance.

What Success Looks Like

Successfully achieving Goal 18 will involve the widespread implementation of comprehensive postvention across organizations, communities, and healthcare systems throughout New York State. Professionals, caregivers, educators, and community leaders will be equipped with training, resources, and tailored guidance to provide effective, compassionate and effective support following a suicide attempt or death. Postvention resources will be informed by best practices, current research, and the lived experiences of survivors of suicide loss and attempts, ensuring they are culturally relevant, accessible, and responsive to community needs. Individuals bereaved by suicide will have access to continuous emotional support, fostering healing and connection. Through these efforts, postvention programs will strengthen local networks of care, reduce the risk of further trauma or suicides, and create compassionate spaces where survivors feel supported and empowered in their healing journey.

Spotlight Story



Lewis County Traumatic Loss Teams

Submitted by Carla M Hellinger,
Director of Lewis County Office for the Aging

Lewis County's Postvention efforts, led by the Lewis County Traumatic Loss Team (TLT), have become a cornerstone in the region's suicide prevention strategy. By providing immediate, compassionate support to those impacted by a sudden or traumatic loss, the TLT has effectively reduced the risk of further tragedies, promoting both healing and recovery within the community. The team, composed of dedicated volunteers, offers on-scene responses to assist family, friends, neighbors, coworkers, hospital staff, emergency responders, and law enforcement during critical moments.

These active responses help normalize the grieving process, alleviate stress, and connect individuals with essential resources in real time. The TLT's formal debriefings offer structured support for those coping with the immediate aftermath of a traumatic event, ensuring they receive the necessary tools to process their grief. By forging meaningful relationships with affected individuals and leaving behind resources for further support, the TLT has helped to stabilize environments in the wake of crises, effectively reducing the likelihood of suicide contagion.

The response from community members has been overwhelmingly positive, with many expressing deep gratitude for the team's presence and guidance during their most difficult times. These efforts have not only facilitated healing but have also set a powerful example of how postvention, when properly implemented, can be a proactive and preventative force in suicide prevention, strengthening the community's resilience.

Resources to Consider

SPRC Provide for Immediate and Long-Term Postvention: The Suicide Prevention Resource Center (SPRC) outlines postvention as a critical component of comprehensive suicide prevention. This includes providing immediate and ongoing support to individuals and communities affected by suicide loss. The resource highlights the importance of coordinated responses, reducing the risk of suicide contagion, and offering timely access to mental health support and other services to promote healing and resilience.

SPCNY Postvention Page: The Suicide Prevention Center of New York (SPCNY) provides postvention resources, tools, and guidance through their website. This includes best practices for schools, workplaces, and communities responding to suicide loss, as well as support materials to help individuals and groups navigate the emotional, logistical, and systemic impacts of a suicide death.

LOSS Teams: The official LOSS Team website offers information and resources about the Local Outreach to Suicide Survivors (LOSS) model, which provides immediate, peer-based support to suicide loss survivors at the scene. The site includes guidance on starting a LOSS Team, training materials, and success stories from communities using the model to foster healing and hope after a suicide.

AFSP After a Suicide: This interactive toolkit provides guidance for workplaces responding to a suicide death. It includes practical steps for postvention planning, supporting employees, managing communication, and promoting healing while reducing the risk of additional suicides. The toolkit is designed to help workplaces of all sizes respond with compassion and effectiveness.

The Impact of Suicide on Professional Caregivers: A Guide for Managers and Supervisors: Developed by the New York State Office of Mental Health, this guidance document provides a structured approach to postvention in a clinical setting. It includes how to address grief, debriefing staff and clients, supporting those affected by the death, and contact with family and other survivors of the suicide loss.

Strategic Direction 5

Advancing Clinical Suicide Prevention, Intervention, and Crisis Response

Strategic Direction 5 emphasizes the critical need to integrate comprehensive suicide prevention across all healthcare and crisis response settings. Individuals at risk of suicide often interact with multiple points of care — from primary care, behavioral health, and emergency departments to crisis call centers, mobile crisis teams, and crisis stabilization centers. It is critical that every part of these system are equipped to provide timely, effective, and coordinated suicide prevention and crisis care.

This approach requires the full integration of evidence-based, suicide-specific practices as a core component of healthcare. Providers must consistently identify, engage, treat, and follow individuals at risk, ensuring treatment continuity across care transitions and improving outcomes through suicide-specific interventions. Equally important is the strength of New York's crisis response system, including the expansion of 988 services, mobile crisis teams, and crisis stabilization centers. These services must be accessible across all communities and delivered in a trauma-informed, culturally responsive, and non-stigmatizing manner that aligns with community needs.

Ongoing training for healthcare professionals, crisis responders, and frontline staff is essential to building competence and confidence in delivering high-quality suicide prevention services. At the same time, strengthening system-wide data collection, including tracking suicide risk, attempts, deaths, and outcomes across care settings, will support continuous quality improvement and greater accountability throughout the organization.

A sustained commitment to improving clinical and crisis care is vital for reducing suicide risk, improving recovery outcomes, and building a healthcare system where mental health care is delivered with the same urgency and quality as physical health care. Through these efforts, New York State can expand access to life-saving services, ensure timely and effective crisis response, and foster a more coordinated, compassionate system of care for individuals at suicide risk.

> *"This means equipping first responders, educational institutions, law enforcement, medical professionals with the appropriate responses that support rather than further escalate a crisis. Focusing on emergency rooms to be more client friendly and efficient when it comes to handling individuals in crisis. Increase options for crisis response for youth that is efficient and supportive to the youth and their families."*
>
> *– Anne Nowak, Suicide-Centered Lived Experience Survey Respondent*

Goal 19

Implement and integrate effective suicide prevention services as a core component of health care.

Objective 19.1:

> Implement effective suicide-safer care services, practices, and protocols that identify, engage, treat, and support care transitions with individuals at risk of suicide, as the standard of care in healthcare settings.

Objective 19.2:

> Improve continuity of care and engagement for individuals at risk of suicide, including those with co-occurring substance use and mental health disorders, with a particular emphasis on transitions from crisis, emergency, and hospital settings to community-based care.

- **19.2.1:** Identify and promote culturally-responsive, community-based care and suicide-specific interventions that foster connection and support recovery, particularly for individuals who have survived a suicide attempt or struggle with suicidal thoughts.
- **19.2.2:** Promote and support the use of electronic health records to track and facilitate implementation of best practices for suicide prevention.

Objective 19.3:

> Ensure that healthcare professionals are competent in delivering high-quality and effective suicide prevention services through comprehensive, culturally and trauma-informed suicide prevention trainings as part of both their initial training and continuing education. ***See also Goal 7.***

Objective 19.4:

> Promote and provide resources for health care and behavioral health organizations to systemically track suicide risk, attempts, and deaths in their patient populations.

Objective 19.5:

> Promote and provide effective practices and interventions that encourage safe storage and other efforts to reduce access to lethal means for individuals at elevated suicide risk in health care settings.

Objective 19.6:

> Advance and implement suicide-safer care standards across behavioral health services and settings.

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Goal 19

Implement and integrate effective suicide prevention services as a core component of health care.

What Success Looks Like

Success in achieving Goal 19 will result in the coordinated integration of suicide prevention as a core component of healthcare services across New York State. Comprehensive, suicide-specific care practices, including universal suicide screening, comprehensive risk assessment, suicide-centered safety planning, counseling on access to lethal means, and access to suicide-specific treatment, will be consistently applied across all healthcare settings, following frameworks such as Zero Suicide. Healthcare providers will ensure smooth transitions from crisis, emergency, and hospital care settings to community-based services, with rapid follow-up tailored to individual needs and level of suicide risk.

Widespread adoption of suicide-safer care protocols in both behavioral and non-behavioral healthcare settings, including primary care, emergency departments, and medical facilities, will support more consistent, coordinated care for individuals at risk. Healthcare professionals will receive culturally relevant and trauma-informed suicide prevention training as part of both onboarding and continuing education, ensuring that all staff are equipped to provide effective, compassionate care.

Additionally, healthcare organizations will systemically track suicide risk, attempts, and deaths using electronic health records and Regional Health Information Organizations (RHIOs), supporting data-informed care coordination and continuous quality improvement. Healthcare systems will not only work to prevent suicide through proactive, coordinated care, but also provide ongoing support, including peer support programs that strengthen recovery pathways for individuals who have survived a suicide attempt or continue to experience suicide risk.

Through these efforts, suicide prevention will become an integral part of healthcare practice statewide, improving outcomes, reducing suicide risk, and saving lives.

Spotlight Story

Cayuga Health System's Zero Suicide Initiative

Submitted by Cayuga Health

Cayuga Health System (CHS) re-energized its Zero Suicide initiative in July 2023, launching a series of impactful activities to strengthen our suicide prevention efforts. We began with a Zero Suicide grand rounds, followed by the formation of implementation teams across all areas of the health system. Additionally, we completed organizational self-studies and expanded our steering committee to include individuals with lived experience, ensuring diverse perspectives in our approach. A workforce survey was conducted with over 400 responses, providing valuable insights into our staff's engagement and readiness.

As we prepare to go live with Epic, we've worked diligently to ensure that Epic's Zero Suicide resources are seamlessly integrated into our workflows, enhancing our ability to deliver evidence-based suicide prevention interventions. These efforts are contributing to a culture of safety and support within our organization and are expected to make a meaningful impact on suicide prevention in our community.

Resources to Consider

Zero Suicide Framework: A comprehensive, system-wide approach to suicide prevention in health and behavioral health care systems. It emphasizes leadership commitment, workforce training, identification and engagement of individuals at risk, evidence-based treatment, and continuous quality improvement to ensure safer care transitions and reduce suicide rates.

Zero Suicide Model Implementation and Suicide Attempt Rates in Outpatient Mental Health Care: Published in April 2025, this quality improvement study evaluated the association between implementing the Zero Suicide model and suicide attempt rates across multiple health systems. Analyzing data from over 55,000 to 450,000 individuals monthly, the study found that three of four systems experienced reduced suicide attempt rates following implementation, while a fourth maintained a lower sustained rate. The findings support the value of the Zero Suicide model in outpatient mental health care settings.

National Action Alliance for Suicide Prevention – Best Practices in Care Transitions: A set of evidence-based recommendations aimed at improving care transitions for individuals at risk of suicide, particularly during the critical periods from emergency departments and inpatient care to outpatient services. The guidelines focus on enhancing patient engagement, ensuring continuity of care, and reducing suicide risk during these vulnerable transitions.

Means Matter Campaign: An initiative that promotes reducing access to lethal means, such as firearms and medications, as a key strategy in suicide prevention. The campaign provides research, resources, and guidance for clinicians, communities, and families to implement means safety measures effectively.

Stanley-Brown Safety Planning Intervention: A brief, collaborative intervention between clinicians and individuals at risk of suicide. It involves developing a personalized safety plan that includes coping strategies, sources of support, and steps to reduce access to lethal means, aiming to mitigate acute suicide risk and enhance patient safety.

Suicide Prevention Toolkit for Primary Care Practices: A comprehensive SPRC toolkit designed to assist primary care providers in implementing suicide prevention practices. It includes assessment guidelines, safety planning resources, billing tips, and sample protocols to help integrate suicide prevention into routine primary care settings effectively.

Cultural Assessment of Risk for Suicide (CARS): A screening tool designed to measure cultural variations in suicide risk across different ethnic and sexual minority groups. By helping identify cultural risk factors, this tool supports behavioral health providers in working to tailor suicide prevention efforts to unique cultural contexts.

Goal 20

Improve the quality and accessibility of crisis care services across all communities in New York State, ensuring that individuals in every region have access to timely and effective behavioral health support during suicidal crises.

Objective 20.1:

> Enhance and expand the comprehensive crisis response system through targeted quality improvement initiatives to ensure equitable access to all levels of crisis support, including 988 crisis hotlines, mobile crisis teams, and crisis stabilization centers.

Objective 20.2:

> Establish new and strengthen existing bidirectional partnerships between 988 centers and 911 Public Safety Answering Points (PSAPs) to improve access to appropriate, effective and trauma-informed crisis response services.

Objective 20.3:

> Expand and strengthen mobile crisis teams across all 62 New York State counties to reduce law enforcement involvement and ensure appropriate, non-police responses for individuals contacting 988 or 911 with suicidal thoughts.

- **20.3.1:** Enhance outreach efforts to all communities, especially those that have limited access to mental healthcare, to raise awareness of available crisis support services while ensuring these communities feel safe, respected, and supported in accessing and utilizing these resources.

Objective 20.4:

> Enhance timely access throughout the crisis care continuum to comprehensive risk assessment, safety plan intervention, lethal means safety counseling, and follow-up care for individuals at risk of suicide.

Objective 20.5:

> Ensure that healthcare providers are fully informed about the services available through the comprehensive crisis response system, fostering seamless collaboration and support for individuals in crisis.

Objective 20.6:

> Ensure that 988 crisis counselors and other workers in crisis services provide effective, trauma-informed and responsive suicide prevention services to all residents, especially for individuals with substance use disorders and populations with suicide disparities.

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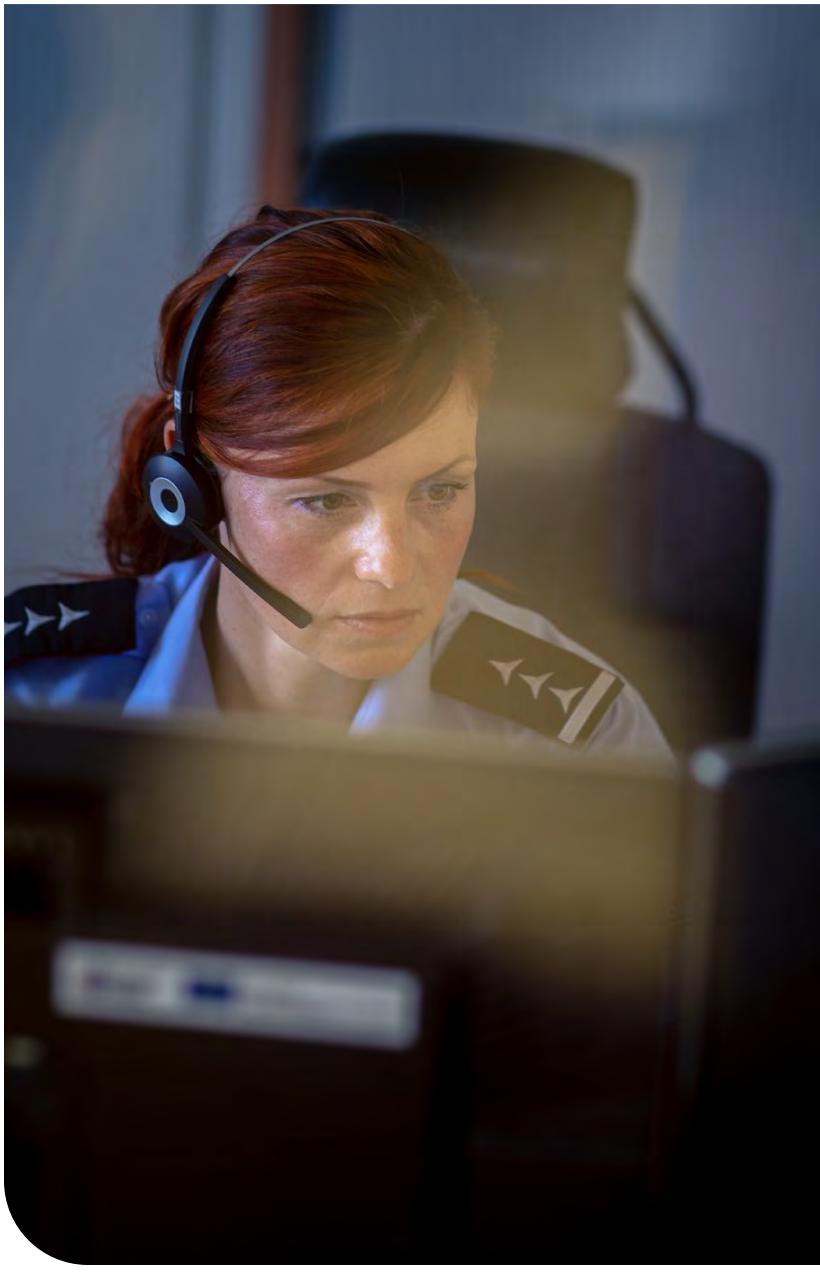
Goal 20

Improve the quality and accessibility of crisis care services across all communities in New York State, ensuring that individuals in every region have access to timely and effective behavioral health support during suicidal crises.

What Success Looks Like

Achieving this goal will establish a well-integrated crisis care system, ensuring that individuals across New York State receive timely, appropriate support during suicidal crises. Regardless of their background or location, all New Yorkers at risk of suicide will have immediate access to crisis services, including 988 crisis hotlines, mobile crisis teams, and crisis stabilization centers. Strengthened coordination between 988 and 911 will connect individuals to the most appropriate trauma-informed care, reducing unnecessary law enforcement involvement. Expanding mobile crisis teams, particularly in communities with limited access to care, will provide compassionate, non-police interventions, while crisis stabilization centers will increase access to short-term, intensive support and improve care transitions.

Crisis providers and responders will be equipped with training to effectively support individuals in suicidal distress, including individuals with substance use disorders and those from communities at higher risk of suicide. Healthcare providers will be informed and engaged with the crisis care system, helping to foster seamless coordination and support. Targeted outreach will raise awareness of available crisis services and build trust among those that have historically faced barriers to quality and responsive care. Through these efforts, New York State will expand access to life-saving crisis care, reduce suicide deaths, and ensure individuals in every community receive the support they need.



Spotlight Story

Expanding the 988 Suicide and Crisis Lifeline in New York State

Submitted by NYS Office of Mental Health Bureau of Crisis, Emergency, and Stabilization Initiatives

The 988 Suicide and Crisis Lifeline, formerly known as the National Suicide Prevention Lifeline, officially launched across the nation in July 2022. The 988 Lifeline has been offering an accessible means of communication for the millions experiencing emotional distress while de-stigmatizing seeking mental health support. Since the launch, New York State (NYS) has become a national leader in coordinated comprehensive crisis response services.

In NYS, fourteen 988 Contact Centers are operating 24/7/365 and responding to calls, chats, and texts in all 62 counties. Contact Centers have successfully been able to hire, train, and retain crisis counselors to meet the growing demand of New Yorkers seeking crisis support. By expanding the workforce and more rapidly answering a higher volume of calls, NYS has successfully managed an 80% increase in 988 call volume from 2023 to 2024.

In September 2024, Governor Hochul's office launched the statewide 988 Awareness Campaign for Suicide Prevention Month. Since then, 988 advertisements can be seen on billboards, Stewart Shops, Telemundo, LinkedIn, Facebook, Netflix, Hulu, college campuses, sporting arenas, public transportation, and other social media, music, and streaming platforms designed to reach a large diverse target audience.

Since the inception of the 988 Lifeline in July 2022 through February 2025, NYS has received 854,997 calls, 134,631 texts, and 128,753 chats. Most recently, in January 2025, NYS had the highest call volume in a one-month timeframe with 39,436 calls being routed to NYS Contact Centers. That same month, NYS also had its best in-state answer rate to date, answering 92% of calls originating in NYS.

Resources to Consider

New York State 988 Suicide & Crisis Lifeline: A confidential service connecting individuals to trained crisis counselors 24/7. It offers support for those experiencing suicidal thoughts, substance use issues, mental health crises, or emotional distress. Concerned individuals can also reach out on behalf of others.

SAMHSA National Guidelines for a Behavioral Health Coordinated System of Care: The document lays out a national vision and framework for transforming crisis response into a coordinated continuum, emphasizing integration, timely access, and quality outcomes across behavioral health, substance use, and co-occurring crises. It further defines overarching principles (e.g., person-centered, trauma-informed, developmentally-appropriate services) and provides updated guidance on implementation including data/quality improvement, financing, workforce, and technology to support jurisdictions in designing, developing, sustaining and scaling crisis systems.

Daniel's Law Task Force: The Daniel's Law Task Force is a multi-agency and interest holder group created under 2023 New York State laws and convened by the Office of Mental Health in partnership with OASAS. The task force is charged with assessing the state's behavioral health crisis response. Its final report, which includes insights, roadmaps, and tools for comparison, is available along with appendices, such as the below report.

Transforming New York State Crisis Response – NYSTEC Summary of Findings: A 2024 report highlighting the need for trauma-informed, community-based crisis services in New York State. The findings emphasize strategies that prioritize cultural responsiveness, harm reduction, and support across the lifespan.

Crisis Now: A national initiative providing a roadmap for transforming mental health crisis response systems. It emphasizes a comprehensive approach that includes 24/7 crisis call centers, mobile crisis teams, and crisis stabilization facilities to divert individuals from emergency departments and the justice system.

Conclusion

The strategic directions and goals laid out in this Strategy provide a roadmap for embedding suicide prevention into the daily work of healthcare providers, crisis responders, community organizations, workplaces, schools, and individuals across New York State. As New Yorkers navigate today's increasingly complex world, together we must form a safety net for those in need. Preventing suicide is not the work of any single initiative or organization. It requires an ongoing, collective effort to create systems and communities where every person is supported, valued, and connected - where "suicide prevention is everybody's business." Each of us has a responsibility, regardless of role or background, to take action, support one another, and help save lives.

About the Organizations That Contributed to This Document

The New York State Office of Mental Health's Suicide Prevention Center of New York (OMH SPCNY)

Established in 2009, the New York State Office of Mental Health's Suicide Prevention Center of New York (SPCNY) sits within the Office of Prevention and Health Initiatives. OMH's SPCNY is the lead entity in suicide prevention in New York charged with coordinating and advancing suicide prevention efforts for New York State. OMH SPCNY works to reduce suicide attempts and deaths across New York State by fostering collaboration, providing education, and supporting implementation of effective interventions within healthcare systems, schools, workplaces, and communities.

SPCNY leads a range of state and federally funded initiatives, focused on integrating systemic suicide prevention in healthcare settings, supporting community infrastructure to advance suicide prevention in communities and schools, with a focus on populations at elevated risk. SPCNY also supports community- and school-based suicide prevention through tailored training programs and resources for all New Yorkers, including clinicians, healthcare workers, educators, and community members statewide. These efforts also include the development and sharing of suicide prevention communications, such as public awareness campaigns designed to increase understanding of suicide risk and promote use of the 988 Suicide & Crisis Lifeline. Guided by data-driven strategies, SPCNY continuously refines its efforts, targeting impact and sustainability through the evaluation of suicide prevention programs and trainings.

The New York State Suicide Prevention Council

The New York State Suicide Prevention Council serves as an advisory body to the Office of Mental Health's Suicide Prevention Center of New York (SPCNY), with a mission "to advise and assist SPCNY in its work and to amplify its impact across the state."

Comprised of subject matter experts, including researchers, healthcare providers, individuals with suicide-centered lived experience, community leaders, representatives from state and county agencies, and members of various community organizations, the Council provides expert guidance, actionable recommendations, and diverse perspectives to inform SPCNY's statewide suicide prevention initiatives.

Council workgroups focus on key priority areas—healthcare, youth and schools, data, health equity, and community and coalitions—working collaboratively to strengthen prevention, intervention, crisis response, education, and advocacy across New York State. Members contribute their time on a voluntary basis, united by a shared commitment to creating a safer New York and advancing the ultimate goal of zero suicides. By harnessing collective expertise, the Council plays a vital role in supporting and amplifying effective, community-informed suicide prevention throughout New York State.

In partnership with county suicide prevention coalitions, SPCNY also provides expertise, resources, and technical assistance to build local capacity for suicide prevention. Additionally, following a suicide death, SPCNY offers postvention guidance and support to help communities heal, reduce the risk of contagion, and foster recovery.

Through innovative programs, trusted relationships, and by providing support and expertise across systems and communities, SPCNY strives to create a New York where fewer lives are lost to suicide, and where all communities are equipped to promote hope, connection, and healing. Visit **www.preventsuicideny.org** for more information.

Acknowledgements

Project Management Team

Kara Brodzinski, MA
Jay Carruthers, MD
Gregory Eves
Tricia Hartnett, MSW
Jenna Heise, MA, NBCC
Garra Lloyd-Lester
Paige Lorette, LMHC
Diana Paksarian, PhD, MPH
Alexi Saldamando, LCSW
Kristen Stanton, MS, CAS

Project Advisors & Support

NYS Office of Mental Health

Dana Cohen, MPA
Emily Derrenbacher
Robin Dickinson, MHA
Audrey Erazo-Trivino, PsyD
Katerina Gaylord, LMSW
Isabella Hou, MPH
Sabrina Howard, MPH
Rachel Jacobs
Stephanie Lao, MSW
Cohen Miles-Rath, MSW
Maureen Obie
Talia Santiago-Bonds
Loretta Santilli, MPH
Ashley Tyrell
Nadine Zesky

NYS Suicide Prevention Council Members

Michael Bauer, MS
Ariel Davis, MEd
Gabrielle Doyle, MA
Stephanie Gamble, PhD
Rosa Gil, PhD
Madelyn Gould, PhD, MPH
Nathaniel Gray, MSW
Ellen Greeley
James Hendon
Grace Hennessy, MD
Leah Hines
Rebecca Hoen, DrPH, MS
Shazia Hussain, MPH
Oscar Jiménez-Solomon, PhD, MPH
Ann Lanoue, RN, BSN, MBA
Julie Laurence, LMSW
Emily Leckman-Westin, PhD
Tatiana Ledneva, MS
Glenn Liebman
Kathleen Liedka
Shye Louis, MEd
Rashanna Lynch, MD
Misha Kessler
Sharon MacDougal, MBA, MS, MSW
LCSWR Scott MacLeod
Steve Miccio, CPRP
Pamela Morris-Perez, PhD
Christina Norman, PhD
Michael Paff, EdD, NCSP
Jessica C. Pirro, LMSW
Anthony R. Pisani, PhD, ABPP
Chandra Redfern, MS
Renee Rider, MEd
Mitchell Samet, PhD
Michael A. Scharf, MD
Trisha Schell-Guy
Victor Schwartz, MD
Christine Shields, LCSW-R
Brady Stephens, M.S.
Missy Stolfi, MEd
Mark K Su, MD, MPH
Melissa Tracy, PhD, MPH
Tomoko Udo, PhD
Katie Urtnowski, SPHR
Justice Walcott
Peter A. Wyman, PhD

» CONTINUED ON NEXT PAGE

Subject Matter Expert Reviewers

Hilary Avallone
Erica Baslow
Gilly Cantor, MPA
Beatriz Coronel, Assistant VP, Life is Precious
Ariel Davis, MEd
Gabrielle Doyle, MA
Samantha Fletcher, PhD, MSW
Karen Fuller, FPA-C
Stephanie Gamble, PhD
Nathanial Gray, MSW
Karen Heisig
Terri Morse, LMHC, CASAC-Master
Gregory Mruk, Executive Director, NY FarmNet
Deacon Gregory Owens
Michael Paff, EdD, NCSP
Anna Platz, MPH
Pamela Morris-Perez, PhD
Benjamin Pomerance, Esq.
Charles Rice
Caroline Silva, PhD
Tiara Springer-Love, LMSW
Chuck Strand, Rural Minds
Tony M. Trahan
Jeff Winston, Rural Minds

Suicide-Centered Lived Experience Reviewers

We extend our deepest gratitude to the individuals with suicide-centered lived experience who courageously shared their stories, insights, and feedback throughout the development of this Strategy. Their voices were essential in shaping an approach that is grounded in compassion, relevance, and the realities of those most impacted.

Glossary

Definitions below are derived from the 2024 National Strategy for Suicide Prevention[19], unless otherwise noted.

adverse childhood experiences (ACEs): Potentially traumatic events that occur in children's formative years (0–17), which could include experiencing violence, abuse, or neglect or growing up in an environment that undermines a child's sense of safety, stability, and bonding[31].

behavioral healthcare: mental health and substance use disorder services.

bereaved by suicide: Individuals who have been impacted by the loss of a loved one to suicide (also referred to as survivors of suicide loss).

care transitions: The period of time between inpatient and outpatient behavioral health care services, known to be a time of increased vulnerability and risk for patient suicide[32].

continuity of care: Process of ensuring ongoing care delivery and care coordination across providers and care teams.

continuous quality improvement: A data-informed process to measure implementation efforts over time and identify needed adjustments to reach success.

co-occurring disorders: A mental health condition and a substance use disorder (e.g., depression and alcohol abuse) occur together.

culturally responsive: A practice that acknowledges background and cultural differences to make adaptations tailored to meet an individual's needs.

culture: The integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith, or social group.

disparities: differences in outcomes and opportunities that are closely linked to social, economic, and environmental disadvantage. These can appear in many forms, but most commonly as social disparities, such as unequal access to education, housing, employment, and income, and health disparities, which are preventable differences in disease, injury, access to care, or overall health. Social disparities often contribute to or worsen health disparities by limiting the conditions that support well-being and quality of life[33].

equity: "the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation)[34]."

evidence-based programs: Programs, practices, activities, policies, procedures, and interventions that are guided by the best research evidence with practice-based expertise, evaluation, cultural competence, and the values of the persons receiving the services and that promote positive individual-level or population-level outcomes.

familismo: "Familismo refers to a strong sense of identification with, and loyalty to, nuclear and extended family. It also includes a sense of protection of familial honor, respect, and cooperation among family members. Through these values, individuals place their family's needs over their own personal desires and choices"[35].

lethal means: Objects, substances, or places someone may use to attempt suicide[36].

lethal means safety: "Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm" (e.g., medications, firearms, sharp instruments that can be used to inflict self-directed violence)[36].

morbidity: The state of having a disease or illness. Often used in research as morbidity rate to describe the frequency of those with disease or illness for specific populations.

mortality: The state of being mortal or susceptible to death. Often used in research as mortality rate to describe the frequency of deaths for specific populations.

peer support: A mutual process where individuals who share common experiences or face similar challenges come together as equals to give and receive help, drawing on the knowledge gained through lived experience. Peer support fosters connection, reduces isolation, and offers a space to learn from others who have navigated similar difficulties[37].

Glossary

populations with suicide disparities: refers to population groups that experience higher rates of suicidal thoughts, attempts, or deaths compared to the general population, or for whom rates are increasing. These elevated risks are often linked to social, economic, cultural, or environmental factors that increase vulnerability and reduce protective supports.

postvention: Policies, programs, practices, and supports implemented in the aftermath of a suicide loss, attempt, or crisis intended to reduce further risk for suicide.

protective factors: Individual, relationship, community, and environmental elements that make a negative outcome less likely.

Regional Health Information Organizations (RHIOs): Entities established to support the secure exchange of electronic health records (EHRs) among hospitals, physicians, and other health care providers. Their goal is to improve care coordination, enhance public health reporting, and ensure that accurate and timely health information is accessible across the health care system[38].

resilience: Capacities within a person or group that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

risk factors: Individual, relationship, community, and environmental elements that make a negative outcome more likely.

safe messaging: "Media or personal communications about suicide or related issues that do not increase the risk of suicidal behavior in vulnerable people, and that may increase help-seeking behavior and support for suicide prevention efforts"[35].

suicidal ideation: refers to thoughts about, consideration of, or preoccupation with death and suicide. These thoughts can range from fleeting or occasional to persistent and overwhelming. In some cases, they may include detailed planning to take one's own life[39].

safe/secure storage: Refers to the practice of securely storing or removing firearms, medications, cleaning products, and other potentially harmful household items to prevent access and reduce the risk of serious injury or suicide[40].

social determinants of health: The conditions in the environments where people are born, live, learn, work, play, worship, and age that influence a wide range of health outcomes, functioning, and quality of life. These factors shape individual and community well-being and can create or reduce health risks[41].

Social Emotional Learning (SEL): the process of developing the skills needed to understand and manage emotions, set and achieve goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions[42].

suicide attempt: a self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in death or injury[43].

suicide-centered lived experience: "Individuals with suicide-centered lived experience can include those who have had thoughts of suicide or attempted suicide, lost a loved one to suicide, or provided substantial support to a person with direct experience of suicide"[44].

suicide prevention infrastructure: Concrete, practical foundation or framework that supports suicide prevention-related systems, organizations, and efforts, including the fundamental parts and organization of parts that are necessary for planning, implementation, evaluation, and sustainability[45].

suicide-related indicators: Data related to suicide thoughts, nonfatal attempts, and deaths.

Glossary

suicide-safer care: A care approach in health and behavioral health services that ensures individuals at risk for suicide are identified, supported, and treated with evidence-based practices. It ensures embedding suicide prevention into every aspect of care through routine screening, safety planning, lethal means counseling, follow-up, and workforce training so that every interaction with the care system actively works to reduce suicide risk[46].

surveillance: The ongoing, systematic collection, analysis, and interpretation of health-related data essential to planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those responsible for prevention and control[47].

syndromic surveillance: An innovative public health monitoring approach that tracks symptoms reported by patients—often in emergency departments—before a diagnosis is confirmed. This system allows public health officials to detect, understand, and respond to emerging health events more quickly by identifying unusual patterns or increases in illness that may indicate a broader public health concern[48].

trauma-informed approach: A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization[49]. Referred to variably as trauma-informed care or trauma-informed approach.

upstream prevention: Also called primary prevention, refers to community-based efforts that address risk and protective factors before the onset of a crisis at the individual level. Such factors may include improving financial security and healthy connections, while decreasing exposure to trauma, racism, or disparate access to health care.

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NEW
YORK
STATE
Office of
Mental Health

New York State Suicide Prevention Task Force Report:

Findings and Recommendations to Reduce Suicide Disparities

September 2026

NEW YORK STATE | Office of Mental Health

NEW YORK STATE | New York State Psychiatric Institute

Center of Excellence for Cultural Competence

Columbia University Irving Medical Center

Contents

Introduction

New York State Suicide Prevention Task Force Report: Findings and Recommendations to Reduce Disparities

New York State is committed to strengthening suicide prevention efforts statewide, with a specific focus on reducing disparities in suicide risk and suicide-related outcomes and supporting populations that experience inequities in suicide prevention, including ethnoracially minoritized communities . To support this commitment, the New York State Office of Mental Health (OMH) reconvened the Suicide Prevention Task Force to build upon the groundwork laid by OMH's 2017 Suicide Prevention Task Force that put forth initial recommendations to strengthen local communities' capacity, with New York State support, to provide the most effective suicide prevention practices and build more connected, resilient communities. This report, New York State Suicide Prevention Task Force Report: Findings and Recommendations to Reduce Disparities, presents the Task Force's findings and actionable recommendations to address disparities in suicide risk across New York.

The New York State Suicide Prevention Task Force Report: Findings and Recommendations to Reduce Disparities serves as a companion to 1,700 Too Many: New York State's Strategy for Suicide Prevention (2026—2030). Both of these documents inform the Turning Strategy into Action: The NYS Office of Mental Health's Comprehensive Action Plan for Suicide Prevention, which translates the strategy's broad goals and the task force's recommendations focused into specific, measurable actions that will be implemented over the next four year.

The Task Force Report reflects the collective knowledge, expertise, and perspectives of the selected suicide prevention experts who contributed to its development. The Task Force met over the course of seven two-hour meetings (2024—2025) to discuss current suicide prevention activities, populations at risk, Zero Suicide Model, suicide prevention in children/youth, suicide prevention in the workplace, and suicide data in New York State. Membership included individuals with lived experience, youth and peer advocates, subject matter experts, representatives from community-based organizations, and professionals with expertise serving high-risk populations, including rural communities, BIPOC (Black, Indigenous, People of Color) youth, and working-aged men. The New York State Psychiatric Institute Center of Excellence for Cultural Competence supported the development of the recommendations derived directly from Task Force discussions and prepared the report with the latest research. The recommendations were prioritized based on their potential to reduce disparities in suicide risk, their feasibility, and the resources required for implementation.

Together, the New York State Suicide Prevention Task Force Report, the New York State Strategy for Suicide Prevention, and the New York State Comprehensive Action Plan collectively known as the **New York State Roadmap for Suicide Prevention**—reflect the state's commitment to a coordinated, community informed approach to suicide prevention that drives meaningful, lasting change.

1. Executive Summary

Suicide remains a significant public health challenge in New York State, requiring sustained, coordinated, and equity-driven action to reduce suicide risk, and prevent suicide attempts and deaths across communities. In recognition of persistent disparities in suicide risk and access to care, the New York State Office of Mental Health (OMH) reconvened the Suicide Prevention Task Force from May 2024 through April 2025 to strengthen statewide prevention efforts and identify actionable recommendations to address inequities in suicide prevention.

Building upon the foundation established by the 2017 Suicide Prevention Task Force, this report reflects the collective expertise of state leaders, researchers, clinicians, advocates, community representatives, and individuals with lived experience who came together to identify challenges, barriers, and opportunities for advancing equitable suicide prevention efforts across New York State. To inform its recommendations, the Task Force engaged in extensive discussions regarding populations disproportionately affected by suicide risk, suicidal thoughts and behaviors, and barriers to care, drawing on presentations from researchers, advocates, and individuals with lived expertise in the field of suicide prevention. The New York State Center of Excellence for Cultural Competence supported the process by reviewing current research and epidemiologic data on suicide prevention disparities, synthesizing evidence-informed prevention strategies, and drafting this report to reflect Task Force discussions, recommendations, and stakeholder input.

The Task Force identified several priority areas to guide its recommendations, including reducing stigma; addressing the social determinants of suicide; promoting meaningful engagement of individuals with lived experience; strengthening the behavioral health and crisis response workforce; improving access to culturally and linguistically responsive suicide prevention services; enhancing community-based prevention approaches; and strengthening the collection and use of data to identify and address disparities. Together, these priority areas reflect a comprehensive approach to reducing suicide prevention disparities through action at individual, community, healthcare system, and policy levels.

The recommendations presented in this report provide a framework for strengthening suicide prevention infrastructure, improving access to culturally and linguistically responsive care and supports, increasing workforce capacity, advancing community-based prevention, addressing root causes to suicide risk, and improving quality and use of data to guide action. Grounded in collaboration, equity, and shared responsibility, this report reflects New York State's longstanding commitment to saving lives, reducing suicide disparities, supporting healing, and building a future in which every individual and community can thrive.

1.1 Task Force Priority Areas

The Suicide Prevention Task Force identified the following priority areas to guide the recommendations, considerations, and aspirations in this report. The recommendations, considerations, and aspirations are grouped under specific strategies that were identified by the Task Force.

Table 1: Task Force Priority Areas

Task Force Priority Areas	Strategy
1. Reducing Stigma Support initiatives that reduce stigma surrounding mental health and suicidality, including social norms that discourage help-seeking and service use. This includes acknowledging and addressing how stigma is a major driver of suicide risk and disparities, acting as a barrier to care and contributing to distress, isolation, and heightened risk.	• Public awareness campaigns
2. Addressing Social Determinants of Suicide Integrate strategies that help individuals at risk for suicide and communities disproportionately affected by suicide identify, navigate, and buffer the impact of social and economic stressors, thereby supporting secondary prevention efforts. This includes strengthening social connectedness, improving access to resources, and enhancing other protective factors among individuals at risk. Additionally, promote multi-sectoral initiatives that enhance social and economic well-being at the population level to support broad-based suicide prevention.	• Bolster social supports • Strengthen economic supports
3. Meaningful Participation of Lived Experience Experts Elevate the voices of individuals with lived experience, recognizing their expertise and ensuring their active participation in all aspects of suicide prevention planning. This includes identifying risk factors and barriers to care, participating in peer-led and peer support initiatives, co-designing suicide prevention programs, services, and policies, and evaluating the effectiveness of prevention efforts.	• Lived experience expert participation
4. Developing a Diverse, Skilled, and Culturally Responsive Workforce Promote the development of a well-trained, diverse, and culturally responsive workforce across both mental health and non-mental health settings, including healthcare, schools, and workplaces.	• Expand and diversify the clinical workforce • Develop, enhance, and adapt suicide prevention training across settings • Suicide prevention training
5. Expanding Access to Culturally, Linguistically, and Structurally Responsive Suicide Care Address barriers that disproportionately affect certain populations in accessing suicide prevention care. Focus on improving the availability of services that are culturally, linguistically, and structurally responsive to meet the needs of diverse communities.	• Increase availability of services • Address financial barriers to access • Culturally and linguistically responsive services • Integrate suicide prevention into healthcare
6. Strengthening Community-Based Approaches Support the mental health of individuals and families where they live, work, play, learn, and worship. While clinical care is essential for many, non-clinical, holistic, workplace, faith-based, and community-driven interventions can play a critical role in engaging populations experiencing disparities in suicide risk that stem from multiple forms of social exclusion, such as racism, homophobia, and transphobia.	• School-based initiatives • Workplace initiatives • Community-based settings • Rural community initiatives • Faith based initiatives • Peer support networks • Community coalitions
7. Enhancing Data Collection and Utilization Expand data collection efforts to include more timely, detailed, and actionable data. This should not only focus on suicide outcomes but also capture risk and protective factors and evaluate the effectiveness of promising prevention practices.	• Timely and accessible surveillance data to identify and address disparities • Community-based and qualitative data • Data on risk and protective factors • Data Sharing • Evaluate effectiveness of programs/ interventions

2. Recommendations at a Glance

To address suicide prevention in New York State, the Suicide Prevention Task Force proposed equity-centered, and culturally responsive recommendations. Considerations for future actions and aspirations requiring additional resources were also identified and outlined in this section. This approach was guided by task force priority areas, and the recommendations are grouped under specific strategies identified by the Task Force.

2.1 Recommendations

The recommendations set forth below have been proposed by the Suicide Prevention Task Force and identified by the Office of Mental Health as actionable, and with current resources, can be accomplished by 2030.

Priority Area 1: Reducing Stigma

Public Awareness

- Disseminate information about the New York State 988 Suicide & Crisis Lifeline at a variety of community locations to promote awareness of services and supports (1).
- Utilize social media platforms to reduce stigma and raise awareness about available mental health resources (2).
- Determine how to tailor public awareness campaigns to address local community needs in New York State (3).
- Expand public awareness campaigns that reduce stigma to nontraditional settings where at-risk populations are likely to be reached (4).

Priority Area 2: Addressing Social Determinants of Suicide

Strengthen Economic Supports

- Conduct a review of evidence-informed strategies to address financial hardship—including housing instability, food insecurity, unemployment, and problem debt—as a social determinant of suicide, to inform future state prevention initiatives (5).

Priority Area 3: Meaningful Participation of Lived Experience Experts

Integrating Lived Experience in Suicide Prevention

- Amplify the voices of individuals with lived experience—particularly from disproportionately affected populations—within suicide prevention programming/efforts to inform equitable strategies and policies that improve access and quality of care (6).
- Collaborate with individuals with lived experience when evaluating suicide prevention programs (7).

Priority Area 4: Developing a Diverse, Skilled, and Culturally Responsive Workforce

Expanding, Diversifying and Retaining the Mental Health Workforce

- Develop partnerships with K–12 and higher education institutions to promote mental health career pathways, including internship and mentorship opportunities, with a focus on engaging students from low-income and ethnoracially diverse communities to strengthen workforce diversity (8).
- Explore state-sponsored recruitment and retention incentives for students from underrepresented communities to increase workforce diversity 9).
- Expand the use of paraprofessional staff to bridge service gaps and connect at-risk populations to mental health resources in rural and high-need areas, ensuring equitable service distribution (10).

Develop, Enhance, and Adapt Suicide Prevention Training Across Settings

- Promote that BOCES of New York State and other training and development centers adopt Community Gatekeeper and Brief Intervention suicide prevention trainings for individuals entering trade professions (11).
- Continue to promote warning sign identification and early intervention methods into suicide prevention training modules (12).
- Promote training on cultural humility as part of continuing education requirements for mental health professionals (13).
- Expand the availability of universal, tiered suicide prevention training for all school staff, including enhanced, role-specific training for school counselors and psychologists (14).
- Develop tools/materials to enhance trainings to improve awareness of warning sign identification for students with developmental and intellectual disabilities (15).

Suicide Prevention Training Delivery, Dissemination and Compliance

- Promote suicide prevention training through existing learning management systems, such as the New York Statewide Learning Management System (SLMS) for state employees, and track completion. Consider making the training a biannual requirement for all state personnel (16).
- Support the delivery of in-person suicide prevention and mental health trainings to mitigate depersonalization and loss of connection associated with standardized and online platforms (17).
- Offer suicide prevention training to key personnel in non-clinical settings to strengthen early identification and referral (18).
- Expand access to suicide prevention training for uniformed personnel through programs such as The CARES UP initiative (19).
- Promote mental health safety training in high-risk professions, such as construction (e.g. including suicide prevention within mandated OSHA courses) (20).

Priority Area 5: Expanding Access to Culturally, Linguistically, and Structurally Responsive Suicide Care

Availability of Services

- Expand telehealth availability in schools and community clinics to reduce barriers to mental health care access (21).
- Promote the adoption of Zero Suicide Framework and other evidence-based practices within hospital systems and across individual providers (22).

Culturally and Linguistically Responsive Services

- Ensure awareness of the language access initiatives that ensure mental health services provided by the state are available in the most common languages spoken in New York State (23).
- Collaborate with linguistically and ethnoracially diverse communities to develop culturally appropriate mental health resources and educational materials (24).
- Explore culturally grounded and trauma-informed models, including evidence-based practices to reduce disparities among most impacted populations (25).
- Modify the Office of Mental Health Request for Proposal (RFP) process to promote health equity. This can help diversify the range of interventions available and ensure that resources are allocated more effectively to underserved communities (26).

Integrating Suicide Prevention into Healthcare Settings

- Promote standardized screening for suicidal ideation and depression within primary care settings to identify individuals at risk (27).
- Explore and promote outreach models such as HealthySteps within primary care to reduce ACEs (adverse childhood experiences), a well-established driver of suicide risk, by embedding behavioral health services in pediatric practices to expand reach and reduce stigma by offering services to everyone (28).
- Develop guidance to ensure the Zero Suicide model is implemented in a culturally responsive manner (29).

Priority Area 6: Strengthening Community-Based Approaches

School-Based Initiatives

- Work with schools to develop and implement suicide screening protocols that use validated, suicide-specific screening tools to identify students at risk and support triage, care planning, and follow-up (30).
- Amplify materials developed in conjunction with the NYSED that encourage all NYS school districts to develop a suicide prevention policy (31).
- Partner with organizations such as OPWDD to explore ways to address suicide risk and stigma among neurodivergent individuals (32).

Workplace Initiatives

- Establish partnerships with organizations working in high-risk industries to encourage and promote mental wellness and help-seeking behavior (33).
- Partner with Department of Labor and unemployment offices to provide suicide prevention training and resources to staff assisting individuals who are unemployed, underemployed, or exiting the workforce, and at risk of suicide (34).

Community-based settings

- Train and support credible messengers to deliver outreach, share resources, and connect people to services through partnerships with local community-based, non-clinical organizations (35).
- Develop partnerships with organizations that provide non-clinical, culturally and linguistically responsive, community-based supports to promote mental health, prevent suicide, and support recovery (e.g., wellness programs, peer services, social supports, and skill-building opportunities) (36).

Rural Community Mental Health and Suicide Prevention Initiatives

- In rural areas, encourage suicide prevention coalitions to partner with local gun stores and hunting clubs to promote safe firearm storage and share suicide prevention resources (37).

Faith Based Initiatives

- Promote faith-based and culturally responsive suicide prevention and mental health efforts in churches, mosques, temples, and community centers to strengthen protective factors and connect individuals to support (38).

Suicide Prevention: Peer To Peer Support Models

- Promote peer support programs and networks for diverse groups who are considered at risk for suicide (39).
- Support the development and implementation of peer-support networks to provide community-driven and peer-led postvention interventions (40).

Priority Area 7: Enhancing Data Collection and Utilization

Timely and Accessible Surveillance Data to Identify and Address Disparities

- Continue to advocate with NYSDOH for more frequent updates to the NYS Suicide and Self-Harm Dashboard (41).
- Collaborate with medical examiner/coroners' offices to standardize medical suicide death investigation practices to improve the quality of suicide mortality data (42).

Community-based and Qualitative Data

- Promote suicide-related data transparency about how data is collected, used, stored and protected to build trust among vulnerable populations (43).

Data on risk and protective factors

- Explore partnerships in support of establishing fatality review committees to examine the circumstances of individual suicide deaths (44).

Evaluate effectiveness of programs/interventions

- Evaluate suicide prevention programs and initiatives (45).

3. Understanding and Addressing Suicide Prevention Disparities

3.1 Suicide Prevention Disparities

Although New York State's overall suicide rate has remained relatively stable since approximately 2012, this apparent stability masks persistent and consequential disparities in suicide prevention (New York State Office of Mental Health [NYS OMH], 2024).

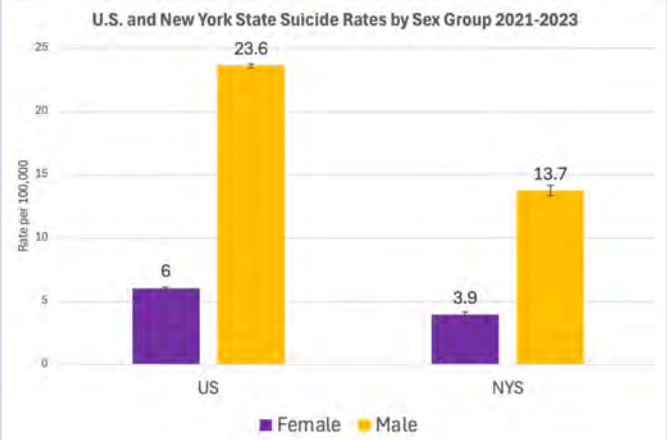
Disparities matter because they reflect preventable differences in who dies by suicide, who attempts suicide, who experiences serious suicidal ideation, whose risk is worsening over time, and who is least likely to receive timely and effective care. Together, these dimensions clarify that suicide prevention disparities are not a single phenomenon, but a set of overlapping inequities that may require different prevention strategies.

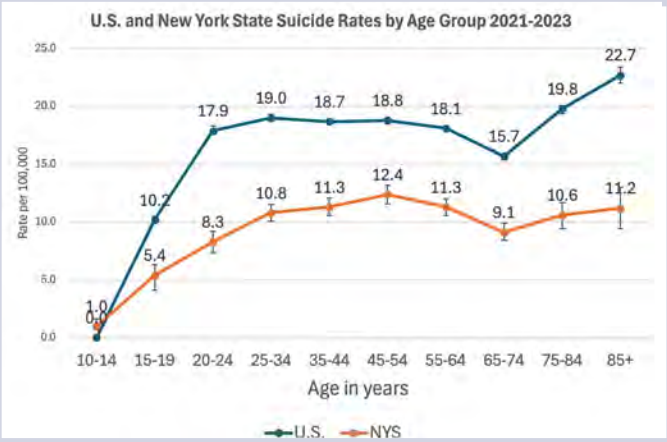
Disparities in Suicide Deaths

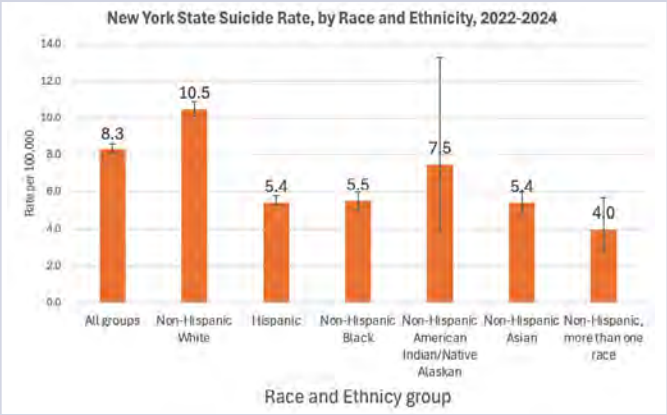
Deaths by suicide represent the most severe outcome and highlight missed opportunities for prevention. In New York State, suicide remains one of the leading causes of death. Yet this burden is unequally distributed across the population, underscoring the importance of addressing disparities in suicide risk and prevention (New York State Department of Health [NYS DOH], 2024).

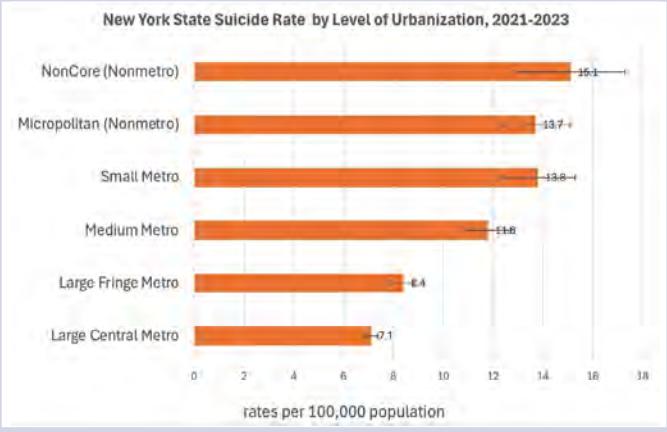
> "What are the signs of suicide prevention? How can they look different in specific populations? I do not think that everyone is aware of the signs, not even [just] in families as well, but in the workforce. I would say, what are the signs and specifically for different subsets of populations that are at increased risk?"
> - SPTF Member

Figure 1: Suicide Deaths by Sex, Race/Ethnicity, Age, and Urbanization









Source: Centers for Disease Control and Prevention, National Center for Health Statistics (2026), National Vital Statistics System, Mortality 2018–2024 on CDC WONDER Online Database.

Ethnoracial Identities

Important disparities in suicide mortality can be observed across ethnoracial groups. Nationally, American Indian and Alaska Native populations and non-Hispanic White individuals have the highest suicide death rates. Consistent with this pattern, non-Hispanic White individuals in New York State have higher suicide rates than other ethnoracial groups, including Hispanics, and non-Hispanic Blacks and Asians. The estimated suicide rate among non-Hispanic American Indian and Alaska Native individuals in New York State appears lower than that of White individuals; however, the small number of deaths limits interpretation of this estimate (see Figure 1 for details).

However, it is important to note that the elevated risk among White populations is not evenly distributed. Studies from New York State and across the United States indicate that suicide mortality among non-Hispanic White individuals is strongly patterned by socioeconomic and geographic disadvantage, with particularly high rates observed among men, rural residents, and individuals with lower educational attainment, lower income, and unemployment (Cammack et al., 2024; Kandula et al., 2023; Liu et al., 2023). These patterns underscore the importance of examining socioeconomic differences within racial and ethnic groups, rather than treating populations as homogeneous, as such differences can help identify subpopulations that may benefit from targeted prevention and outreach strategies.

Gender

Consistent with national patterns, men in New York State die at approximately 3.6 times the rate of women and account for the majority of suicide deaths statewide (NYS OMH, 2024; NYSDOH, 2024; CDC, 2025b).

Rural-Urban Continuum

Geographic disparities are also pronounced: suicide rates in rural areas of New York State are approximately twice those in urban settings (Harris et al., 2023; NYS OMH, 2021). New York State data further suggest a rural-urban gradient, with suicide rates increasing as the levels of rurality increase (see Figure 1). These patterns mirror national evidence and underscore the importance of place-based prevention strategies that address the social, economic, and service access challenges of rural communities (CDC, 2024).

Age

Age-related disparities warrant particular attention. Older adults—especially men aged 75 and older—experience significantly higher suicide mortality rates than younger and middle-aged adults, a pattern consistently documented in U.S. data (NYS DOH, 2024; Suicide Prevention Center of New York [SPC NY], n.d.; Garnett et al., 2023). Suicide also remains a leading cause of death among younger populations. In New York State, suicide is the third leading cause of death among adolescents aged 15–19 years and the fourth leading cause of death among young and middle-aged adults aged 20–44 years (NYS DOH, 2024). Together, these patterns underscore the need for age-specific and developmentally tailored prevention approaches.

Occupation and Socioeconomic Status

Occupational and socioeconomic factors further shape suicide mortality risk. Veterans suicide rates in New York State are substantially higher than those of the general population (NYS OMH, 2024). National data indicate that suicide risk is highest during the first year following separation from active duty (U.S. Department of Veterans Affairs [US DVA], 2024). Construction workers are among the occupations at highest risk for suicide. Nationally, suicide death rates among workers in construction and extraction occupations are more than twice the overall working-age population rate (Sussell et al., 2023).

In NYC, elevated suicide rates have been observed in higher-poverty neighborhoods in recent years (New York City Department of Health and Mental Hygiene [NYC DOHMH], 2021; NYC DOHMH, 2024). These local patterns mirror national findings showing higher suicide rates in counties facing socioeconomic disadvantage, including lower income, reduced access to health insurance, and limited broadband connectivity (Centers for Disease Control and Prevention [CDC], 2024).

Together, these findings highlight the importance of suicide prevention strategies that target populations and communities facing occupational, economic, and social disadvantage.

Disparities in Suicide Attempts

Disparities in suicide attempts occur far more frequently than deaths and signal severe psychological distress, often with lasting emotional, social, and economic consequences. They also represent a critical

point for prevention, where timely intervention can reduce the risk of future attempts and death.

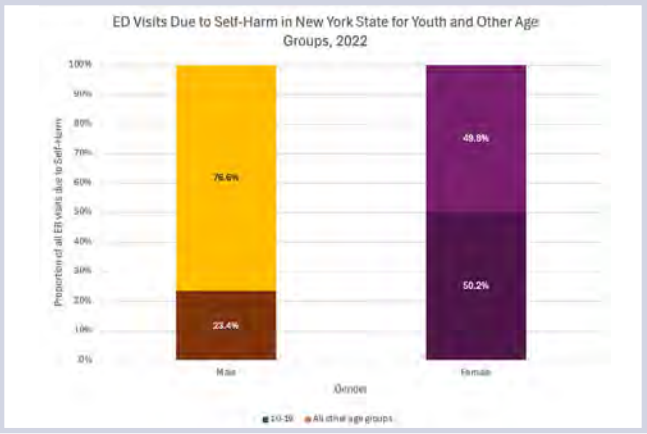
Gender

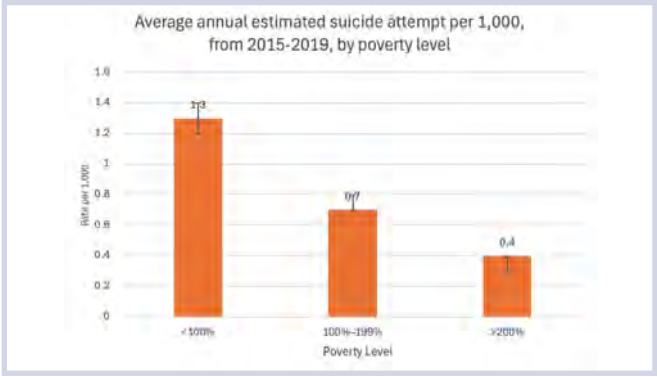
Patterns of suicide attempts differ from patterns of suicide mortality. Youth and young adults—particularly girls and women—are overrepresented among emergency department visits for self-harm and suspected suicide attempts. In New York State, youth aged 10–19 account for a disproportionate share of emergency department visits and hospitalizations due to self-harm. Among females presenting to the emergency department for self-harm, more than half of visits occur among girls aged 10–19, compared to approximately a quarter among males (New York State, n.d.; New York State Department of Health [NYS DOH], 2024b). National data shows sharp increases in emergency department (ED) visits for suspected suicide attempts among girls ages 12–17 during the COVID-19 period, with levels remaining elevated since pandemic onset (Yard, 2021).

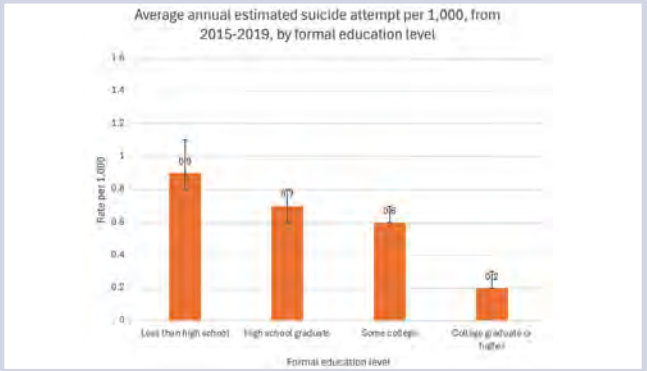
Ethnoracial Identities

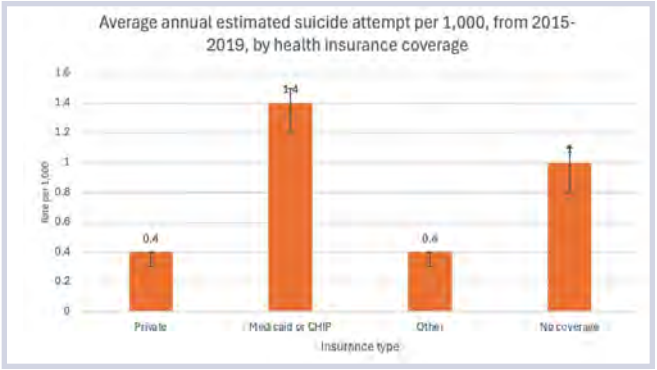
Nationally, patterns of adolescent suicidal behavior vary across ethnoracial groups. Recent Youth Risk Behavior Surveillance (YRBS) data point to elevated suicide attempt risk among Black youth. In 2021, Black or African American high school students reported the second-highest prevalence of past-year suicide attempts nationally (14%), exceeded only by American Indian and Alaska Native students (16%). Consistent with these national patterns, 2023 state-level YRBS findings showed elevated suicide attempt prevalence among Black youth in New York State, with 22.6% of Black or African American high school students in New York City and 18.5% in the remainder of the state reporting a suicide attempt in the previous 12 months (CITE). Among female students, Latina adolescents have historically reported higher prevalence of suicide attempts than their non-Hispanic White and non-Hispanic Black female counterparts. In 2021, Hispanic female high school were more likely than non-Hispanic White female students to report suicide attempts requiring medical treatment (Gaylor et al., 2023).

Figure 2: Suicide Attempts by Level of Sex, Education, Poverty and Insurance









Source: Centers for Disease Control and Prevention, National Center for Health Statistics (2026), National Vital Statistics System, Mortality 2018–2024 on CDC WONDER Online Database.

LGBTQ+ Identities

LGBTQ+ youth experience markedly elevated risk of suicide attempts. In New York City, students who identify as lesbian, gay, bisexual, or another sexual identity are several times more likely to report a suicide attempt in the past year compared with heterosexual students, and transgender or gender-questioning high school students report substantially higher rates of suicide attempts than their cisgender peers (NYC DOHMH, 2023). These patterns mirror national findings showing significantly higher prevalence of suicide attempts among sexual and gender minority youth (Ivey-Stephenson et al., 2020).

Socioeconomic Status

Suicide attempts disproportionately affect individuals experiencing socioeconomic disadvantages. National survey data from 2015–2019 show a substantially higher prevalence of suicide attempts among adults facing economic disadvantage (see Figure 2). Adults with lower educational attainment were more than four times more likely to report a past-year suicide attempt than college graduates. Additionally, adults living in poverty had the highest prevalence of past-year suicide attempts, followed by those with incomes between 100%–199% of the federal poverty threshold, compared to adults with incomes at or above 200% of the poverty threshold. Suicide attempts were also more prevalent among adults covered by Medicaid or CHIP and those without insurance, compared with those with private or other insurance (Ivey-Stephenson et al., 2022). Unemployment has also been identified as a risk factor for suicide attempts (Crosby et al., 2011; Kposowa et al., 2019).

Marked disparities in suicidal ideation are evident across age, gender identity, sexual orientation, and socioeconomic status. Young people experience the highest prevalence of past-year suicidal ideation, underscoring adolescence and young adulthood as critical periods for prevention (Samples et al., 2025).

Disparities in Serious Suicidal Ideation

Gender-related disparities are also pronounced. In New York City, female high school students are approximately twice as likely as male students to report suicidal ideation in the past year. (New York City Department of Health and Mental Hygiene [NYC DOHMH], 2023).

> "So, there's a big fear of harm in LGBTQ+ individuals that may be seeking help and there's a lack of access and support (sic) that are around these students."
> - SPTF Member

Disparities are especially stark for sexual and gender minority youth. In 2023, 41% of LGBTQ+ young people reported serious suicidal ideation, compared with 13% of cisgender and heterosexual youth, making LGBTQ+ youth more than three times as likely to report serious suicidal ideation (CDC, 2024). Socioeconomic gradients in suicidal ideation are also evident. Adults living in poverty, those covered by public insurance, and those without health insurance are more likely to report suicidal ideation than individuals with higher income or private insurance (Ivey-Stephenson et al., 2020).

Disparities in Trends Over Time

Disparities are not only about current levels of risk, but also about whose risk is worsening more rapidly. Trend data are critical for identifying emerging inequities that may be missed when focusing on statewide averages.

National trend data reveal important age and racial/ethnic differences in suicidal ideation and suicide attempts between 2015 and 2019. During that period, the prevalence of past-year suicidal ideation increased, and the rise was significantly larger among young adults aged 18–25 years than among older adults, indicating that younger cohorts experienced the most pronounced growth in suicidal thoughts over time (Samples et al., 2025). A review of recent data (2018-2023) further indicates that suicide rates for female youth are increasing at a faster rate relative to male youth (Carretta et al., 2024).

> "Risk factors for Latinx adolescents have to do with [the] process of immigration, acculturation stress, dysfunction of families, the family conflict pertaining to autonomy and dependence...More recently, new risk factors are the simplification of immigrants and [for the] Latinx population in particular, fear of deportation." - SPTF Member

Evidence from national surveillance and research shows that suicide risk among Black youth has increased markedly over recent decades. Between 1991 and 2019, national Youth Risk Behavior Survey data documented rising suicide attempts among Black adolescents, even as attempts among White adolescents remained flat or declined during parts of that period (Ivey-Stephenson et al., 2020). Analyses of national mortality data from 2003 to 2017 similarly showed significant upward trends in suicide death rates among Black children and teens, particularly those aged 15–17 (Sheftall et al., 2021). More recent analyses of national vital statistics data indicate that the suicide rate among Black adolescents increased by more than 140% between 2007 and 2020, representing the fastest rise of any racial or ethnic group (The Pew Charitable Trusts, 2024). CDC data showing that from 2018 to 2023 suicide rates among non-Hispanic Black persons increased significantly while rates among non-Hispanic White persons declined (Stone et al., 2024).

Although New York State's overall suicide rate has remained relatively stable since 2012, subgroup trends reveal important divergences. In New York City, suicide rates have increased among Latino residents — particularly Latino males — even as overall rates remain low, and rising trends have been observed among younger adults, such as males aged 18–24 and females aged 25–34 between 2013 and 2022 (NYC DOHMH, 2024).

Disparities in Access to Care

Disparities in suicide prevention are also evident in access to care, including whether people receive help early, receive care only in crisis settings, or receive no care at all.

Nationally, fewer than half of adults who experienced suicidal ideation received mental health care in the past year. Access to care varies substantially by race and ethnicity. Although Black and Hispanic adults report lower suicidal ideation than White adults, they are significantly less likely to receive mental health care when ideation occurs. Among adults with past-year suicidal ideation, approximately half of White adults received mental health care, compared with about one-third of Black adults and Hispanic adults, and roughly one-quarter of Asian or Pacific Islander adults (Bommersbach et al., 2022).

> "So, I think about the Healthy Steps model, which is an [ages] 0 to 3 model that embeds a developmental specialist right in the pediatrician's office. And it's any pediatrician, it doesn't have to be a hospital, and you can embed this specialist that provides universal access during well visits, and it's offered to everyone so it's non-stigmatizing. So, I feel like this is really where we need to be, where we have statewide access in a way that just feels organic."
> - SPTF Member

> "There's also been the recognition that the same populations that experience disparities in suicide prevention such as elevated ideation, attempts and deaths, and those with increasingly worsening trends over the last 20 years, are also the same populations that have disparities in access in the healthcare setting."
> - SPTF Member

Younger adults were also less likely than older adults to engage with outpatient or primary care services and more likely to encounter the health system through emergency departments, reflecting more episodic and crisis-driven patterns of care rather than ongoing, preventive engagement (Bommersbach et al., 2022; Samples et al., 2025). At the state level, most New York counties were classified as county-wide mental health providers shortage areas as of 2022, based on population-to-provider ratios, indicating widespread constraints on access to mental health (Forlenza & Coates, 2023).

> "Another thing that I hear often, even engaging in services, is the piece around not having people who look like or understand them. And there's a shortage, and many people within the Black community have tried to seek services and counseling. And again, not having people who look like them, and not having counselors, therapists, and psychologists who understand their perspective, and then having a yearlong waiting list to even get in." - SPTF Member

Conclusion

These data show that suicide prevention disparities in New York State and beyond are multifaceted. Some groups are more likely to die by suicide, others are more likely to attempt suicide or experience suicidal ideation, some are experiencing faster increases in risk over time, and others face systemic barriers to care. Reducing disparities therefore requires clarity about which outcome is being addressed and for whom, so that prevention strategies can be aligned with the specific inequities they are intended to reduce.

Table 2: Suicide Prevention Disparities at a Glance

Sources of Disparities	Highlights of Disparity Statistics
Suicide Deaths	
Sex	**Men**: 3.6x higher suicide rate than women (NYSOMH, 2024; NYSDOH, 2024).
Race/ethnicity	**Whites**: suicide rate is 10.5 x 100,000 (notably higher than for other ethnoracial groups (CDC, 2026)
Urban vs rural	**Rural**: rates are 2x higher than urban in NYS (Harris et al., 2023; NYS OMH, 2021).
Age	**Older men**: men age 85 and older that the highest rate of suicide in NYS (24 per 100,000) (Garnett et al., 2023) **Adolescents**: 3rd leading cause of death (NYS DOH, 2024)
Occupation	**Veterans**: suicide rate is 2x higher than the NYS state average rate (US DVA, n.d.). **Construction workers**: males 2x higher than working-age rate and female 3x higher (Sussell et al., 2023).
Poverty, unemployment, and socioeconomic conditions	**Poverty**: NYC neighborhoods with very high poverty had notably higher suicide rate than others (NYCDOHM, 2024; CDC, 2024). **Unemployment**: 1.6x more likely to die by suicide than those employed (Kposowa et al., 2019).
Suicide Attempts	
Age	**Female adolescents**: Youth ages 10–19 account for the largest share of NYS self-harm ED visits (>50% of female visits and ~23% of male visits occur in this age group) (New York State, n.d.; NYS DOH, 2024b).
Gender and sexuality	**Transgender**: Transgender high schoolers are 3x more likely to report suicide attempts than cisgender peers, and gender-questioning students are 2x as likely (NYS DOHM, 2023). **Sexuality**: compared to heterosexual students, bisexual (3x more likely), gay & lesbian (5x more likely), and other sexualities (3x more likely) are more likely to report a past-year suicide attempt (NYS DOHM, 2023).
Income, unemployment, and socioeconomic conditions	**Less than High School Education**: 4x more likely than college+ to report past-year suicide attempt **Poverty**: <100% FPL households are 2x more likely than 100-199% to report past-year suicide attempt **Public Insurance**: Medicaid/CHIP-insured are 3x more likely than private to report past-year suicide attempt (Ivey-Stephenson et al., 2022). **Unemployment**: Unemployed adults are 3x more likely than employed full time to report suicide attempts (Crosby et al., 2011).
Ideation	
Income, unemployment, and socioeconomic conditions	**Poverty**: <100% FPL households are 2x more likely than >200% to report past-year ideation **Public Insurance**: Medicaid/CHIP-insured are 2x more likely than private (Ivey-Stephenson et al., 2022) to report past-year ideation. Unemployment: Unemployed are 3x more likely to report a suicidal plan than those employed full-time (Crosby et al., 2011).
Gender and sexuality	**Female Adolescents**: New York City female high schoolers are 2x more to report suicidal ideation than males in the past year (NYC DOMH, 2023). **LGBTQ+**: LGBTQ+ high school students are 3x times more likely than cisgender and heterosexual students to seriously consider suicide in the last year (CDC, 2024; The Trevor Project, n.d.).

Trends	
Race/Ethnicity	**Black Adolescents**: suicide attempts rose 75% 1991-2017 among Black adolescents, while attempts for White adolescents remained flat or declined (American Psychological Association, 2020) Suicide rates for Black adolescents increase 144% 2007-2020, the fastest of any racial group (The Pew Charitable Trusts, 2024; Sheftall et al., 2021). **Latinos**: NYC Latino (particularly men) increased death rate when stable for white men (NYC DOHM, 2024).
Age	**Young Adults**: Age group (18-25) with largest national increase in suicidal ideation 2015-2019 (Samples et al., 2025). **Female Youth**: Suicide rates for female youth are increasing at a faster rate relative to male youth (Carretta et al., 2024).
Access to Care	
Race/Ethnicity	**Adults with Ideation**: Whites were notably more likely to receive mental health care (53%), compared Black people (36%), Hispanic people (37%) and Asian people or Pacific Islanders (29%) (Bommersbach et al., 2022).
Age	**Young adults**: Young adults are less likely than older adults to get access to primary care and are more likely to be admitted to an ED (Bommersbach et al., 2022; Samples et al., 2025).
Proximity	**County Shortages**: Most NY counties are suffering a shortage of mental health providers (Forlenza & Coates, 2023).

3.2. Understanding Suicide Prevention Disparities: Key Drivers

The disparities in suicide deaths, attempts, suicidal ideation, and access to care described in the previous section do not arise by chance. Rather, they reflect systematic differences in exposure to risk, protection, and opportunity across the life course, shaped by social, economic, cultural, and structural conditions. Understanding the factors that drive these disparities is essential for designing suicide prevention strategies that are not only effective overall, but also equitable—that is, capable of reducing excess risk among populations that have historically borne a disproportionate burden of suicidal distress and harm.

Below, key drivers of suicide prevention disparities are summarized. The drivers summarized below are not exhaustive, nor do they operate independently. Instead, they often co-occur, interact, and often reinforce one another over time, creating cumulative disadvantages. Importantly, the evidence reviewed here underscores that no group is inherently vulnerable to suicide. Rather, disparities in suicide deaths, suicide attempts, suicidal ideation, trends over time, and access to care seem to reflect, at least in part, differences in socioeconomic conditions, exposure to adversity, social connectedness, and access to protective resources shaped by broader social and policy contexts. At the same time, suicide risk is complex and multifactorial, and the causes of observed disparities are not yet fully understood.

Age and the Life Course

Suicide risk varies substantially across the life course, reflecting the fact that individuals face different social roles, stressors, and vulnerabilities at different stages of life. Reviews of the U.S. and international literature consistently demonstrate that the factors associated with suicide risk are not uniform across ages, underscoring the importance of age-responsive and developmentally informed prevention strategies (Steele et al., 2018; Beghi et al., 2021).

Among children and adolescents, suicide risk is strongly associated with early exposure to adversity and social stressors. Reviews of the evidence identify physical and sexual abuse, exposure to violence, bullying and peer victimization, academic difficulties, parental conflict, involvement with the juvenile justice system, and social isolation as key factors associated with suicidal ideation, attempts, and death by suicide in youth (Steele et al., 2018). These experiences can disrupt emotional development and weaken social connectedness during critical developmental periods, increasing vulnerability to suicidal distress.

> "Most of the theorizing around suicide has actually been done on adults rather than for young people. In fact, we test and take theories that were designed and developed for adults and then place them on young people, and then test them with, not very surprisingly, limited success."- SPTF Member

Among working-age adults, suicide risk is shaped by a different constellation of life-course experiences, many involving loss, instability, or role disruption. Elevated risk has been linked to military service, lower educational attainment, marital disruption, recent psychiatric hospitalization, arrest or incarceration, job loss, financial strain, and acute relationship conflict (Steele et al., 2018). These factors frequently coincide with major life transitions and economic stress, highlighting the need for prevention approaches that extend beyond clinical settings into employment, justice, and social service systems.

Among older adults, suicide risk reflects the cumulative effects of health decline, social loss, and reduced independence. Systematic reviews identify chronic medical conditions, disability, chronic pain, psychotropic medication use, financial stress, bereavement, living alone, and social isolation as factors consistently associated with suicide attempts and deaths by suicide in later life (Beghi et al., 2021). Older adults are also more likely than younger individuals to die by suicide rather than survive an attempt, underscoring the importance of early identification and prevention in this population (Beghi et al., 2021).

Together, this evidence demonstrates that age itself is not the driver of suicide risk. Rather, disparities across the life course reflect age-specific exposures to adversity and loss, as well as differences in how distress is recognized and addressed at different stages of life.

Generational and Cohort Influences

Beyond age, suicide risk is also shaped by cohort effects—that is, the shared social and historical conditions experienced by people born during the same period. Research on cohort effects emphasizes that suicide risk is influenced not only by how old people are, but also by the societal context in which they grew up and entered adulthood (Phillips, 2014).

For example, individuals born between approximately 1915 and 1945 experienced lower suicide rates across adulthood than later cohorts, while those born during the post–World War II "baby boom" have exhibited persistently higher suicide mortality as they aged (Phillips, 2014). More recent studies have identified cohort effects among younger populations, with suicide mortality increasing substantially among adolescents and young people since 1999, even after accounting for age and sex (Yu & Chen, 2019).

One societal change that has unfolded across recent birth cohorts is the sharp rise in economic inequality in the United States since the 1980s and 1990s. A substantial body of research links higher levels of income inequality to worse population health outcomes, including poorer mental health, through multiple pathways. These include reduced access to material resources that protect health, as well as psychosocial mechanisms related to relative deprivation, perceived social status, and status competition (Wilkinson & Pickett, 2009). Evidence from U.S. and international studies indicates that higher income inequality is associated with elevated suicide rates (Daly et al., 2013; Ribeiro et al., 2017). U.S. longitudinal and county-level analyses further suggest that income inequality functions as a contextual risk factor for suicide mortality, above and beyond individual income, with particularly pronounced associations in places characterized by limited economic opportunity and lower social mobility (Kim, 2016; Kuo & Kawachi, 2023). Similar relationships have been documented between income inequality and depression, as well as all-cause mortality, pointing to the broader population-health consequences of unequal social and economic conditions (Pabayo et al., 2013; Kondo et al., 2015). For cohorts entering adulthood amid rising inequality, stagnant wages, declining job security, and constrained upward mobility, these structural conditions may contribute to greater economic insecurity, diminished expectations of opportunity, and heightened feelings of hopelessness—factors that are relevant to suicide risk at the population level.

A second major societal shift affecting recent cohorts is the erosion of social cohesion and community institutions, the weakening of the social fabric. Over recent decades, the United States has experienced declines in civic participation, religious involvement, union membership, and other forms of collective life that historically provided social integration and informal support (Putnam, 2000; National Conference on

Citizenship, 2009). More contemporary assessments of community involvement indicate a dip from 2019-2021 through the onset of the COVID-19 pandemic, which has been rising in 2022-2023 as communities recover, but fluctuations in involvement are small in magnitude compared to the decades-long decline characterized in previous literature (AmeriCorps, 2023; US Census Bureau, 2023). At the same time, national surveys document rising levels of social isolation and loneliness, particularly among younger and working-age adults (Infurna et al, 2025; Herre & Acisu, 2025; Bruss et al, 2022). Social connection is a well-established protective factor against suicide, while loneliness and perceived social isolation are strongly associated with suicidal ideation (Killgore et al., 2020) and overall mortality (Holt-Lunstad et al., 2015). For more recent birth cohorts, growing up in an environment characterized by weaker community ties and fewer shared social institutions may increase vulnerability to suicidal distress, particularly when combined with economic strain and other stressors. These shifts help explain why suicide risk may be rising at a higher pace among newer cohorts.

> "[For] working aged men, we were talking a bit about how it's a hard population to connect with. There's a certain, sometimes with the vulnerable folks, social isolation that may occur over time as people may lose part of their friend groups. We talked a lot about where the natural areas that folks in that age range might be, where interventions or awareness campaigns could occur."
> - SPTF Member

Taken together, this evidence suggests that cohort effects in suicide risk likely reflect long-term societal changes that shape both material conditions and social connectedness. These findings suggest that prevention strategies may be strengthened by considering the broader social and economic contexts that shape experiences of different generations, in addition to individual-level risk factors.

Physical Health, Pain, and Medical Vulnerability

Suicide risk is strongly shaped by physical health status, particularly when illness or pain compromises functioning, independence, or quality of life. Large population-based studies show that diagnosis of severe physical conditions—including cancer, cardiovascular disease, chronic lung disease, and neurodegenerative disorders—is associated with a marked increase in suicide risk, especially in the months following diagnosis or treatment initiation (Nafilyan et al., 2023).

Chronic pain represents a particularly well-established pathway to suicide risk. Reviews consistently document higher rates of suicidal ideation, attempts, and death by suicide among individuals living with persistent pain (Racine, 2018). Pain-related contributors include sleep disruption, co-occurring depression and anxiety, functional impairment, and frequent episodes of uncontrolled pain, as well as psychosocial experiences such as hopelessness, perceived burdensomeness, and social withdrawal (Racine, 2018).

> "Loneliness and social disconnection and just speaking specifically regarding older people, there's so much about what we know concerning the risk factors for suicide in later life that is in one way or another, connected to this notion of social disconnection. Older people who have functional disability, health problems, sensory deficits and losses, because of being homebound or retired, or other things that lead to the issue of social disconnection."
> - SPTF Member

Disability and declining physical functioning further compound risk, particularly among older adults and individuals with multiple chronic conditions. Systematic reviews indicate that loss of autonomy and increasing dependence on others are common features in cases of suicide attempts and deaths among medically ill populations (Beghi et al., 2021). This evidence underscores the importance of integrating suicide prevention into medical care, pain management, and chronic disease treatment, particularly during periods of diagnosis, transition, or functional decline.

Psychological Trauma, Substance Use, and Mental Health

A large and consistent body of evidence links suicide risk to psychological trauma, substance use, and mental health experiences, especially when these exposures are chronic or co-occurring. Systematic reviews show that post-traumatic stress symptoms are strongly associated with suicidal ideation and attempts, even after accounting for other psychiatric conditions (Krysinska & Lester, 2010).

Childhood trauma is a particularly important risk factor for later suicide risk. Early exposure to abuse or adversity is associated with lasting psychological vulnerabilities and, among some populations, elevated suicide risk in adulthood. Furthermore, childhood trauma is linked to poorer sleep quality across both psychiatric and non-psychiatric populations, which can also increase suicide risk (Alter et al., 2021). Importantly, among veterans with major depressive disorder, childhood trauma was directly associated with increased suicide risk. These findings suggest that early adversity can shape long-term suicide vulnerability both directly and through its enduring effects on psychological functioning and stress regulation.

> "Supports [are] needed for youth that have been in [the] child welfare [system] and then [the] juvenile justice [system] and then are going to age out. That conversation flows from the funding [conversation], right? The sustainability of funding. We don't need a 3–4-year grant. It takes an average [of] seven years to change a culture. We need 10-15 years' worth of money."
> - SPTF Member

Substance use disorders are among the most robust predictors of suicidal behavior across the life course. Systematic reviews and meta-analyses consistently demonstrate strong associations between alcohol and drug use disorders and suicidal ideation, attempts, and death (Poorolajal et al., 2016). Individuals with substance use disorders face suicide mortality risks several times higher than those of the general population (Esang & Ahmed, 2018).

Importantly, trauma exposure, substance use, and mental health conditions are not evenly distributed across society. These experiences are more common among populations facing social and economic disadvantages, involvement with the justice system, or housing instability, helping to explain why suicide risk is concentrated in particular groups (Mikhail et al., 2018; Na et al., 2025; Rakesh et al., 2025).

One of the most persistent suicide disparities is by sex: men are substantially more likely to die by suicide, even though women often report higher levels of suicidal ideation and attempts. This pattern has been observed consistently across time and settings (CDC, 2024).

Systematic reviews and qualitative syntheses highlight how gendered social norms—particularly traditional masculine expectations—contribute to suicide risk among men. These norms often emphasize emotional suppression, extreme self-reliance, and narrow definitions of success and self-worth, shaping how men experience and express distress and reducing the likelihood of help-seeking during periods of crisis (Bennett et al., 2023; Scotti Requena et al., 2023). Quantitative studies further show that endorsement of traditional masculine norms, including emotional control, dominance, and self-reliance, is associated with higher levels of suicidal ideation and lower use of support services (Griffin et al., 2024; Scotti Requena et al., 2023; Eggenberger et al., 2024). Together, this body of evidence indicates that gendered norms can reduce social support, delay help-seeking, and intensify psychological distress, contributing to men's persistently higher suicide mortality.

Men also tend to have less routine contact with healthcare services, higher rates of substance use, and greater access to lethal means, increasing the likelihood that suicidal crises result in death rather than survival (Bilsker & White, 2011). These patterns reflect social expectations and institutional arrangements, rather than individual weakness, and highlight the need for prevention strategies that engage men in ways that align with their lived experiences.

Race, Ethnicity, and Culture

Racial and ethnic disparities in suicide risk are increasingly understood as the result of racism operating across structural, institutional, and interpersonal levels, rather than as a function of

inherent cultural characteristics. A recent systematic review focusing on Black youth found consistent evidence that structural racism—manifested through inequities in schools, policing, neighborhood conditions, and economic opportunity—is associated with higher levels of suicidal ideation, attempts, and suicide deaths (Bell et al., 2025). The strongest and most consistent evidence links suicide risk to racially patterned experiences within educational systems (e.g., discriminatory discipline and low school belonging) and public safety systems, including exposure to police violence, underscoring that suicide prevention cannot be separated from broader social institutions that shape daily life.

Within these structural contexts, interpersonal experiences of racism and discrimination further elevate suicide risk. A large meta-analysis found that exposure to racial discrimination is significantly associated with both suicidal ideation and suicide attempts across populations (Coimbra et al., 2022). Racial discrimination seems to increase suicide risk by increasing psychological distress, social isolation, diminished self-worth, and hopelessness.

For many racially and ethnically minoritized youth, acculturation stress represents a particularly salient mechanism linking racism to suicidality. A systematic review of studies among minoritized youth in high-income countries identified pressure to assimilate into the dominant culture—often accompanied by erosion of protective cultural identity, family cohesion, and community support—as a consistent risk factor for suicidal ideation and behavior (Rudes & Fantuzzi, 2022). This body of evidence emphasizes that it is not cultural identity itself that increases risk, but rather the stress of navigating racialized environments that devalue cultural difference.

Cultural expectations may further interact with these stressors in ways that heighten vulnerability during adolescence. For example, norms emphasizing strong family obligation or interdependence may become sources of conflict when youth face competing expectations for autonomy within dominant cultural contexts. Such intergenerational and cultural tensions—particularly when combined with discrimination, gendered expectations, and acculturation pressures—can contribute to psychological distress among some youth (Langhinrichsen-Rohling et al., 2009). Together, these findings underscore that racial and ethnic disparities in suicide risk reflect layered exposures, spanning structural inequities, interpersonal discrimination, and culture-related stressors.

> "[By asking] "how does your culture talk about this? How does your culture address this?" That's how you identify trusted messengers, and the language that communicates with people. Sometimes that stuff needs to be broken down if it is really a barrier to helping. Other times, there are culturally endorsed ways of talking about this that we are not using because we're coming from a more medicalized model."
> - SPTF Member

Social Determinants of Health and Structural Conditions

A growing body of evidence demonstrates that suicide risk is shaped by social determinants of health—the economic, social, environmental, and structural conditions in which people live and work, as well as the systems that govern access to resources and care.

Figure 3: Social Determinants of Health

Source: *Office of Disease Prevention and Health Promotion (ODPHP, n.d.). Healthy People 2030: Social Determinants of Health.*

> "There's a relative inability to help individuals feel a sense of hope or purpose when they do not have stability underneath them. When you talk about housing and rent costs, it's impossible to maintain relationships with the people that we are providing care for if we weren't able to know where they live. It would be impossible to maintain that relationship. So, I do think any kind of economic, or housing stability is just so critical to the needs of actually improving cascading social determinants of health issues and mental health care." - SPTF Member

Financial Hardship

Financial hardship is one of the most consistently documented social determinants of suicide risk. Population-level studies show that periods marked by higher unemployment, housing instability (e.g., evictions, foreclosures), personal debt defaults, poverty, income inequality, and reductions in social welfare spending are associated with increases in suicide rates (Fowler et al., 2015; Barnes et al., 2017). At the individual level, research consistently finds that people experiencing financial hardship—including unmanageable debt, unemployment and job loss, housing insecurity, and difficulty meeting basic needs such as food—are at substantially higher risk of suicidal ideation, suicide attempts, and suicide death (Richardson et al., 2013; Milner et al., 2013; Rojas & Stenberg, 2015; Elbogen et al., 2020; Naranjo et al., 2021; Ali et al., 2025; Na et al., 2025). These associations persist even after accounting for mental health conditions and other sociodemographic factors, indicating that financial hardship functions as an independent and powerful stressor. Importantly, the relationship between financial hardship and suicide is not confined to periods of economic recession; studies show that suicide risk linked to economic strain can persist during times of overall economic growth (Daly et a., 2013; Er et al., 2023). Together, this evidence underscores that financial hardship can accumulate over time, erode psychological resilience, and increase vulnerability to suicidal distress. Addressing financial hardship through housing stability, income supports, employment protections, and access to food and other basic needs may be therefore central to equitable and effective suicide prevention.

Social Context, Social Support and Loneliness

Social and community context play a central role in suicide risk because it shapes both exposure to harm and access to protection. Among adolescents and young adults, experiences of bullying—including verbal, physical, and cyber bullying—are consistently associated with increased risk of suicidal thoughts and attempts, highlighting schools and peer environments as critical sites for prevention (Kodish et al., 2016).

Across the life course, social support is a well-established protective factor. Reviews of the literature show that individuals with stronger perceived social support are less likely to experience suicidal ideation, attempt suicide, or die by suicide, while those with weaker support face elevated risk (Darvishi et al., 2024; Hu et al., 2023). Supportive relationships—whether from family, peers, or community institutions—can buffer stress, reduce isolation, and increase the likelihood of seeking help during periods of crisis.

Conversely, loneliness and perceived social isolation are strongly linked to suicidal ideation, particularly during periods of social disruption and stress. Evidence from recent studies underscores that feeling disconnected from others is itself a meaningful risk factor for suicidal distress, independent of clinical symptoms (Killgore et al., 2020). Together, this body of evidence reinforces that strengthening social connection and reducing isolation are not peripheral concerns, but central components of effective and equitable suicide prevention strategies.

Neighborhood, Occupation, and Environmental Exposures

Neighborhood and environmental conditions further shape suicide risk. Research shows that adolescents who perceive their neighborhoods as less safe and less cohesive are more likely to report suicidal thoughts and behaviors (Allen & Goldman-Mellor, 2018), with neighborhood and social cohesion having a likely protective mental health effect (Breedvelt et al, 2022).

Meta-analyses also link short-term exposure to particulate air pollution with increased suicide risk, suggesting that environmental stressors may influence mental health through neurobiological and stress-response pathways (Braithwaite et al., 2019).

Occupational and environmental exposures represent an additional structural dimension of suicide disparities. Systematic reviews indicate that pesticide exposure is associated with increased risk of suicidal ideation, attempts, and death (Wu et al., 2023). These risks disproportionately affect agricultural workers and rural communities, where occupational hazards intersect with geographic isolation and limited access to healthcare.

Finally, access to health care and system capacity plays a critical role in shaping suicide risk. National survey data show that adults insured through Medicaid or lacking insurance report substantially higher levels of suicidal ideation and attempts than those with private insurance, reflecting persistent gaps in access to timely and continuous mental health care (Cho & Lee, 2024). At the community level, suicide risk is higher in areas where mental health care is less accessible. Counties with limited availability of community mental health centers experience higher suicide mortality, suggesting that expansion of outpatient and crisis services may contribute to population-level reductions in suicide (Hung et al., 2020). Furthermore, suicide rates are higher in neighborhoods where residents face greater barriers to reaching available psychiatrists and therapists (e.g., distance, transportation constraints) (Tadmon & Bearman, 2023). Among youth, counties designated as mental health professional shortage areas have significantly higher suicide rates, underscoring the importance of increasing workforce capacity, particularly in high-need and underserved communities (Hoffmann et al., 2022).

Pathways: Intersectionality and Cumulative Disadvantage

Suicide prevention disparities are best understood as the result of intersecting and cumulative disadvantages, rather than isolated risk factors acting at a single point in time. Individuals facing multiple forms of marginalization—such as economic insecurity, discrimination, and health challenges—are often exposed to overlapping stressors that compound one another and increase suicide risk beyond what any single factor would predict (Crenshaw, 1999). The concept of cumulative disadvantage emphasizes how repeated exposure to socioeconomic adversity across the life course can shape psychological distress, constrain future opportunities, and increase vulnerability to poor mental health outcomes over time (Dannefer, 2003; Walsemann et al., 2008).

Longitudinal evidence demonstrates that these processes frequently operate through reciprocal and self-reinforcing pathways. For instance, worsening economic conditions increase the risk of depression and psychological distress, while mental health problems can in turn undermine income, assets, and employment stability—particularly among individuals with fewer baseline resources—creating cycles of disadvantage that deepen over time (Lund & Cois, 2018; Jiménez-Solomon et al., 2024). Evidence also suggests that prolonged exposure to adversity and chronic stress can alter emotional regulation and stress-response systems, contributing to elevated psychological distress and heightened suicide risk later in life (Mann & Rizk, 2020).

Together, these frameworks can help explain why suicide disparities often persist even when individual risk factors are addressed. They underscore the need for long-term, upstream, and structurally informed prevention strategies that simultaneously address mental health and intersecting factors of suicide risk.

Conclusion

Suicide prevention disparities are driven by a complex interplay of life-course experiences, generational context, physical and mental health, gendered social norms, racism and discrimination, and broader social and structural conditions. These factors accumulate and interact over time, producing predictable—and preventable—patterns of excess risk among certain populations.

3.3. Approaches to Reducing Disparities in Suicide Prevention

Reducing disparities in suicide requires more than identifying which populations are at higher risk. It requires clarity about the approaches that guide prevention goals, priority areas, and concrete actions. Suicide prevention disparities emerge from differential exposure to risk, unequal access to protective resources, and unequal reach of prevention systems. These patterns suggest that suicide prevention efforts may be strengthened by combining individual-level interventions with approaches that also consider social, economic, and structural influences on risk.

The **New York State Suicide Prevention Task Force Report: Findings and Recommendations to Reduce Suicide Disparities** is therefore guided by a set of complementary approaches that emphasize equity, specificity, and multilevel action: health equity, targeted universalism, multilevel prevention, and the social-ecological model. These approaches provide a framework for aligning population-level goals with strategies that respond to the lived realities of communities experiencing disproportionate suicide risk.

Health Equity

Health equity is the principle that all individuals and communities should have a fair and just opportunity to achieve optimal health, including freedom from preventable suicide risk (Prentice et al., 2024). In the context of suicide prevention, a health equity approach recognizes that disparities are not random; they reflect historical and ongoing patterns of marginalization, exclusion, and unequal access to resources to preserve mental health.

National data show that many groups experiencing worsening suicide trends are populations that have been historically marginalized by race, ethnicity, socioeconomic status, geography, or disability (U.S. Department of Health and Human Services [HHS], 2024). Health equity, therefore, requires prevention efforts to move beyond individual behavior change and to address conditions in people's environments—including social conditions and access to culturally responsive care—that shape long-term suicide risk (HHS, 2024).

> "The community knows what they need. They don't need us to go in there to say, "You need this, and you need this, and you need that". [The] Community is the expert in their concerns and their needs. I do think there is something to be said for this process around leveraging the voices of those that are affected and really focusing our efforts on getting their feedback. That's the way that you can build trust and engage, by asking the question." - SPTF Member

Advancing equity in suicide prevention also requires active collaboration with communities most affected by disparities. This includes engaging people with lived experience, partnering with community-based organizations, and ensuring that prevention strategies are responsive to community strengths and barriers.

Federal guidance highlights several core equity-oriented strategies relevant to suicide prevention, including:

- Incorporating lived experience into planning and implementation;
- Developing tailored strategies for populations facing disparities;
- Strengthening workforce diversity and cultural responsiveness; and
- Improving data systems to capture inequities better and evaluate what works for whom (HHS, 2024)

Targeted Universalism

Public health debates often frame prevention strategies as either universal or targeted. Universal approaches aim to reach entire populations regardless of risk (e.g., statewide crisis line availability), while targeted approaches focus on groups identified as especially vulnerable (e.g., specialized services for high-risk youth). Each approach has its own strengths and limitations.

Universal suicide prevention strategies are essential for achieving broad population impact and reducing stigma, but they may not adequately reach populations facing the greatest risk. In contrast, targeted approaches can provide more intensive and tailored support for high-risk groups, yet on their own may fall short of addressing the broader social and structural

conditions that produce vulnerability in the first place (McLaren, 2019; Fisher et al., 2022).

Targeted universalism offers a way to bridge this divide. Rather than choosing between universal and targeted approaches, targeted universalism establishes shared, universal goals—such as reducing suicide mortality statewide—while recognizing that different groups require different strategies to reach those goals, based on how they are situated within social, economic, and institutional structures (Powell et al., 2019).

This approach involves five core steps:

1. Defining a universal goal grounded in shared societal values;
2. Assessing overall population performance relative to that goal;
3. Identifying groups or places that are performing differently;
4. Examining the structural factors that help or hinder each group's progress; and
5. Implementing targeted strategies tailored to those conditions (Powell et al., 2019)

> "I think of culture and the need for culturally responsive approaches, and culture is not just where we were born. It has a lot to do with where the community that we live in [is located], the friends that we're associating with, so I love that perspective. When I think of approaches, I also think of the non-traditional approaches that do help in connecting with the individuals that you're working with, keeping in mind their lived experiences, where they live, where they're located. So, these are all crucial [I think], in getting to a preventative measure for them." - SPTF Member

Applied to suicide prevention in New York State, targeted universalism might involve setting a universal goal of reducing suicide deaths, attempts, and serious suicidal ideation, using surveillance data to identify populations with elevated or worsening trends, and then partnering with those communities to design prevention strategies that reflect their specific needs, strengths, and constraints. This approach avoids framing disparities as deficits and instead focuses on changing systems so that all groups can reach shared outcomes.

Multilevel Suicide Prevention

Suicide prevention efforts can also be organized according to their purpose along the prevention continuum, commonly described as primary, secondary, and tertiary prevention (Keyes et al., 2025). Each level plays a distinct role in reducing disparities.

Primary prevention aims to prevent suicidal thoughts or behaviors from emerging in the first place by reducing exposure to risk factors and strengthening protective factors. In the context of disparities, this includes policies and programs that address upstream drivers such as economic hardship, social isolation, community violence, and childhood adversities.

Secondary prevention focuses on early identification and intervention when suicidal ideation or known risk factors for suicide are present (e.g., depression, alcohol and substance use disorders). Screening in healthcare settings, crisis response services, and early treatment programs are central examples. For populations facing barriers to care, equity-focused secondary prevention requires improving access, cultural responsiveness, and trust in systems.

Tertiary prevention involves interventions after a suicide attempt or death to reduce recurrence, prevent additional harm, and support recovery among individuals, families, and communities. This includes post-attempt follow-up care, continuity of mental health treatment, and postvention services for those bereaved by suicide. Because a prior attempt is one of the strongest predictors of future suicide, equitable access to high-quality tertiary prevention is essential for reducing disparities (Bostwick et al., 2016).

These levels of prevention underscore that reducing suicide disparities require intervening before risk emerges, responding early when distress is identified, and sustaining support after crises occur.

The Social-Ecological Model (SEM) provides a complementary framework for understanding how suicide risk and protection are shaped by interacting influences across multiple levels: individual, relationship, community, and societal (Cramer & Kapusta, 2017; Ullman et al., 2021). Suicide risk does not arise from a single cause but from the cumulative interaction of factors across these levels.

At the individual level, risk and protection are shaped by mental health, physical health, trauma exposure, and coping resources. At the relationship level, family dynamics, peer relationships, social support, and experiences of loss or conflict play critical roles. The community level includes schools, workplaces, neighborhoods, healthcare systems, and local environments that can either buffer or amplify risk. Finally, societal-level factors—such as income inequality, structural racism, housing policy, labor conditions, and cultural norms—shape exposure to risk and access to protection across entire populations.

Importantly, disparities in suicide reflect unequal distributions of risk and protection across these levels. Comprehensive prevention strategies must therefore address not only downstream clinical factors but also upstream social and structural conditions. The logic-framework version of the SEM presented below illustrates how societal and community conditions shape relational environments and individual risk, highlighting multiple leverage points for equitable prevention.

Figure 4: Social-Ecological Model

Source: Adapted from Bronfenbrenner, U. (1979). The ecology of human development. Cambridge, MA: Harvard University Press.

Table 3. Social Ecological Model of Suicide Risk and Protective Factors

Societal	Community	Relationship	Individual
Protective Factors			
Economic & Policy Protections • Economic and social safety nets • Income supports and housing protections **Social Integration & Norms** • Social cohesion • Cultural, moral, or religious objections to suicide **Safety & Regulation** • Policies that reduce access to lethal means	**Service & Institutional Supports** • Accessible, affordable, high-quality behavioral and physical health care • Culturally responsive services **Educational & Community Connection** • School connectedness and positive school climate • Connection to community organizations and institutions **Social Environment** • Community cohesion and social trust	**Social Support & Caregiving** • Strong perceived social support and connectedness • Close, supportive relationships with family, peers, or partners • Positive parenting and caregiver support **Social Engagement** • Frequent and meaningful social interaction	**Psychological & Coping Resources** • Reasons for living and future orientation • Coping and emotional regulation skills • Help-seeking skills and mental health literacy **Identity & Meaning** • Cultural identity and meaning making
Risk Factors			
Structural & Economic Inequality • Income inequality • Poverty and economic insecurity • Unemployment and precarious work • Food insecurity **Housing & Legal Context** • Housing instability (eviction, foreclosure) • Criminal justice policies that increase exposure to trauma **Structural Discrimination & Harmful Norms** • Structural racism and institutional discrimination • Stigmatizing norms around mental illness and help-seeking • Harmful media portrayals of suicide • Easy access to highly lethal means	**Environmental & Community Stressors** • Community violence and exposure to trauma • Suicide clusters • Residential instability • Low neighborhood safety **Institutional Barriers** • Discrimination within schools, workplaces, and neighborhoods • Limited access to outpatient and crisis mental health care • Mental health workforce shortages • Stress of acculturation and loss of community belonging	**Interpersonal Loss & Conflict** • Family or loved one's suicide • Relationship loss, separation, or bereavement • High-conflict or violent relationships **Social Harm & Exclusion** • Bullying (verbal, physical, cyber) • Social exclusion and rejection • Interpersonal racism and discrimination • Low perceived social support	**Clinical & Psychological Vulnerability** • Prior suicide attempt • Depression and other mental illness • Substance use • Hopelessness, impulsivity, aggression • Sleep disturbance linked to trauma **Life-Course Adversity & Health** • Adverse childhood experiences and early trauma • Chronic pain and severe physical illness • Disability and functional impairment • Criminal or legal involvement **Work, Economic Stress & Isolation** • Job stress, low-skilled occupation • Financial hardship (e.g., debt, income loss, difficulty meeting basic needs) • Job loss or employment instability • Loneliness and perceived social isolation

Bringing the Approaches Together

Health equity, targeted universalism, multilevel prevention, and the social-ecological model are mutually reinforcing approaches. Together, they shift suicide prevention from a narrow focus on individual behavior to a systems-oriented strategy that addresses the conditions producing unequal risk. By grounding universal goals in equity, tailoring strategies to community contexts, intervening across the prevention continuum, and addressing risk at multiple levels, New York State can advance a suicide prevention strategy that is both effective and just.

4. Suicide Prevention Task Force Recommendations

Context, Rationale, and Task Force Perspectives

To strengthen suicide prevention efforts statewide, with particular attention to populations disproportionately affected by suicide risk, the New York State Suicide Prevention Task Force proposed culturally responsive recommendations aligned by priority areas and specific strategies identified by the Task Force.[1,2]

Priority Area 1: Reducing Stigma

Public Awareness Campaigns

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Disseminate information about the New York State 988 Suicide & Crisis Lifeline at a variety of community locations to promote awareness of services and supports (1).
- Utilize social media platforms to reduce stigma and raise awareness about available mental health resources (2).
- Determine how to tailor public awareness campaigns to address local community needs in New York State (3).
- Expand public awareness campaigns that reduce stigma to nontraditional settings where at-risk populations are likely to be reached (4).

Mental health stigma–including both external stigma (e.g., public, enacted, anticipated, structural) and internalized stigma (the belief that stereotypical and discriminatory beliefs are true of oneself) – is a powerful driver of suicide risk disparities. Stigma acts as a major barrier to accessing care and contributes to increased distress, isolation, and suicidal behavior (World Health Organization, 2014; Clement et al., 2015). Broad societal norms shape attitudes toward mental health and suicide, and these norms become internalized, leading individuals to fear judgment, or discrimination, if they seek help. Research shows that stigma has a significant negative effect on help-seeking, with internalized and treatment-related stigma most strongly associated with reduced service utilization (World Health Organization, 2014). In a large systematic review, stigma was identified as one of the top barriers to care (ranked fourth overall), disproportionately deterring help-seeking among youth, men, ethnically minoritized persons, and other groups (Clement et al., 2015). The consequences of stigma–such as social isolation, shame, hopelessness, and fear of discrimination–are themselves associated with elevated suicide risk (World Health Organization, 2014). Furthermore, perceived public stigma is strongly correlated with greater suicidal ideation among people with mental illness, sometimes to the extent that suicide is seen as a way to escape stigma (Carpiniello & Pinna, 2017).

> "I keep thinking of the benefit of campaigns that reiterate simple messages about what we can do [including] spreading national data points in presentations and communications, as well as creating statewide or inter-agency campaigns for youth and families to raise awareness." - SPTF member

> "If we're talking about stigma reduction, for folks that are facing a struggle, whether it's suicide or addiction or whatever, that is a different message than the more broad-based population stigma reduction that needs to be coming from the community."
> - SPTF member

1. Appendix A contains a list of considerations for future action, and aspirations that require additional time and financial investment, within each priority area.
2. Appendix B contains a summary of the supporting research evidence for the identified recommendations, considerations, and aspirations including a description of comparable programs or models implemented elsewhere or proposed by stakeholders and a discussion of potential implementation challenges or limitations.

> "It would be great to find out more about how a culture talks about suicide. That's how you identify trusted messengers. There are culturally endorsed ways of talking about this that we aren't using because we're coming from a more medicalized model. That's a voice that needs to be active in this messaging since the medical model doesn't reach an enormous number of people." - SPTF member

Conversely, reducing mental health stigma can facilitate help-seeking and recovery. Anti-stigma interventions have been associated with greater willingness to disclose problems and seek support (Dumesnil & Verger, 2009; Pirkis et al., 2019). For example, one study found that awareness of a large-scale anti-stigma campaign correlated with increased comfort in disclosing a mental health issue and higher intentions to seek help (Bell Canada, 2022; Booth et al., 2018). By challenging harmful norms and promoting more understanding attitudes, stigma-reduction efforts can remove a key obstacle that prevent individuals in crisis from accessing care, particularly when messaging is carefully framed, culturally grounded, and reinforced over time.

Given these implications, the New York State Suicide Prevention Task Force prioritized targeted stigma reduction, encouraging help-seeking, and expanding access to resources as central strategies for this strategic direction.

Priority Area 2: Addressing Social Determinants of Suicide

Strengthen Economic Supports

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Conduct a review of evidence-informed strategies to address financial hardship—including housing instability, food insecurity, unemployment, and problem debt—as a social determinant of suicide, to inform future state prevention initiatives. (5)

Financial hardship—including housing instability, food insecurity, unemployment, and debt—is a well-documented social determinant of suicide risk, making economic supports a critical upstream component of comprehensive suicide prevention, particularly given that acute financial shocks (e.g. eviction, job loss, unmanageable debt) can precipitate or exacerbate suicidal crises. Cross-sector collaboration is essential for addressing the multifaceted drivers of suicide. National and global frameworks, including the WHO's guidance, emphasize the need to engage sectors like housing, labor, education, and justice in suicide prevention (World Health Organization, 2025).

There is strong evidence that economic supports can reduce suicide risk, especially in low-income populations. For instance, a $1 increase in the minimum wage has been linked to a 6% reduction in suicide rates among individuals with a high school education or less (Kaufman et al., 2020). Expansions of the Earned Income Tax Credit (EITC) are also associated with lower rates of suicide attempts and deaths (Morgan et al., 2021). These findings indicate that direct financial support can buffer against the mental health consequences of economic stress.

Additionally, recent research shows that financial wellness interventions for individuals with behavioral health conditions such as financial coaching and, and peer-led financial education can improve financial stability and mental health outcomes, including suicidal ideation, suggesting that such interventions are both feasible and beneficial (Tsai et al, 2024; Jackson et al., 2022; Cook et al., 2024). For instance, United Kingdom-based HOPE program, which integrates psychosocial support with coaching on debt, housing, employment, and benefits has shown to reduce depression and suicidal ideation, particularly among men in financial crisis and elevated suicide risk (Jackson et al., 2022). Furthermore, a recent evaluation of social needs interventions in emergency departments also suggest housing stabilization can reduce recurrence of mental health crises (Soganda et al., 2025).

> "I'm not sure how comfortable people are talking about these resources. There may be some shame around discussing financial needs and available support. Honestly, I don't even know what resources exist." -SPTF member

> "In healthcare, some individuals cannot afford to visit their primary care provider. From an economic perspective, we need to consider how we can address the economic needs of communities." - SPTF member

Together, this evidence supports economic supports and financial wellness interventions not only as strategies to improve economic stability, but also as primary and secondary suicide prevention strategies with demonstrated mental health benefits.

Priority Area 3: Meaningful Participation of Lived Experience Experts

Integrating Lived Experience in Suicide Prevention

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Amplify the voices of individuals with lived experience—particularly from disproportionately affected populations—within suicide prevention programming/efforts to inform equitable strategies and policies that improve access and quality of care (6).
- Collaborate with individuals with lived experience when evaluating suicide prevention programs (7).

Meaningful integration of lived expertise in suicide prevention refers to including individuals with personal histories of suicidal ideation, suicide attempts, or suicide loss, as well as caregivers, as partners with real influence on decisions—not only as informants. Although suicidology has increasingly recognized this expertise as essential, most strategies continue to rely on clinical, academic, or administrative voices—with insufficient participation from those with lived experience (White, 2016; Sunkel & Sartor, 2022). As experts argue, this traditional exclusion can result in culturally insensitive, misaligned programs and policies that overlook critical barriers faced by disproportionately impacted populations (Finisse, 2023; Purdon et al., 2025). Indeed, tailored approaches are needed to address inequities in access, stigma, and trust, especially among communities such as LGBTQ+, racial/ethnic minorities, rural residents, and veterans (Finisse, 2023; Sartor, 2023), and are increasingly reflected in national expectations for behavioral health planning and governance.

> "The military did really poorly with mental health for a long period of time, and then they did a lot better. And what they did better is that folks from that community were helping others from that community. The VA doctors weren't making the difference; it was veterans reaching out to other veterans. Doctors were involved, but it's critical to have voices from those communities to help develop things along the way. This is one area where co-development is so very potent." - SPTF member

Over the past decade, efforts to embed lived experience in advisory, research, and evaluation roles have escalated—such as Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare and Medicaid Services (CMS) mandates requiring lived experience representation in behavioral health planning councils, and the National Action Alliance's Suicide Attempt Survivors Task Force emphasizing survivor leadership (Finisse, 2023; National Action Alliance Task Force, 2014). Yet implementation lags: many programs offer only token representation, with uneven compensation, lack of training, insufficient role clarity, and minimal sustainability (Krysinska et al., 2023; Sunkel & Sartor, 2022). A recent scoping review in Australia that mapped 42 studies on lived experience participation found inconsistent definitions, limited reporting of safety procedures, scarce description of advisory processes, and minimal evidence on suicide-related outcomes—highlighting a research-practice gap (Purdon et al., 2025) and underscoring the need for clear roles, equitable compensation, and trauma-informed supports.

> "I think historically we have done an okay job at having [those with] lived experience being informants in our processes; I don't think we've done a good job most of the time in coproduction. We very often will have an advisory group, but it's not usually the folks with lived experience that are on these calls. Some of that is the nature of how we move these processes, but I do think sometimes we miss things, certainly in terms of

> better diversity and inclusion, we've done a much better job when there are voices in the room as opposed to having people look over material as the voice of their people, which is a much worse strategy. I don't know that we are ready as a field to fully do coproduction, but we need to do better than just having an advisory panel, especially for something like stigma where small nuances in how you present things makes a huge difference. It's really easy to miss the mark. The more active involvement we have from the communities we're working with, the more likely we are to succeed." -SPTF member

> "The barriers that I have experienced is that populations of color are very skeptical of the medical system because of history. I think when it comes to mental health in general (and suicide) that opens up another can of worms. What I've seen works is having the youth voice present. Panels of youth talking about their lived experience. Really focusing on youth perspective."
> - SPTF member

Challenges include: unclear terminology ("lived experience," "peer," "survivor"), lack of standardized participation pathways, emotional burdens on lived experts, and power imbalances in professional settings (Krysinska et al., 2023; Purdon et al., 2025; Sunkel & Sartor, 2022). Bridging these gaps requires capacity-building, trauma informed support, equitable compensation, clear expectations, and mechanisms that ensure lived experience roles influence decisions rather than merely symbolize inclusion (Krysinska et al., 2023; Beames et al., 2021), including explicit safety and support procedures when discussing suicidal content.

> "One charge is to really solicit more input from the lived experience community. Australia is decades ahead of us in this aspect—they've spent the last 15 years creating a movement—encompassing individuals who have ever thought or attempted suicide, the bereaved, and anyone who's had to support a suicidal person. They've done a nice job of creating a movement of leveraging these voices for policy change." - SPTF member

To strengthen the integration of lived expertise in suicide prevention, the Suicide Prevention Task Force prioritized several strategies to include people with lived experience—particularly from disproportionately affected groups to guide strategies and policies and involve them in program evaluation to improve the relevance, cultural appropriateness, and accessibility of suicide prevention efforts.

Priority Area 4: Developing a Diverse, Skilled and Culturally Responsive Workforce

Expanding, Diversifying and Retaining the Mental Health Workforce

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Develop partnerships with K–12 and higher education institutions to promote mental health career pathways, including internship and mentorship opportunities, with a focus on engaging students from low-income and ethnoracially diverse communities to strengthen workforce diversity (8).
- Explore state-sponsored recruitment and retention incentives for students from underrepresented communities to increase workforce diversity (9).
- Expand the use of paraprofessional staff to bridge service gaps and connect at-risk populations to mental health resources in rural and high-need areas, ensuring equitable service distribution (10).

New York State is facing a shortage of mental health professionals at a time when the demand for care continues to grow. Attempts to strengthen the mental health workforce should address not only the number of providers available, but also how well they reflect the communities they serve. A growing body of research shows that racial, ethnic, and linguistic diversity among providers is linked to improved access to care and better outcomes for underserved populations (Grumbach & Mendoza, 2008; USDHHS, 2001). But despite modest increases in representation over the past two decades, ethnoracially minoritized persons remain underrepresented in mental health professions (Santiago & Miranda, 2014). This mismatch between provider demographics and community needs has implications for suicide prevention. Diverse providers are more likely to work in underserved areas and to deliver culturally responsive care (USDHHS, 2001). But progress has been slow, in part due to persistent barriers such as financial constraints, limited mentorship, and systemic racism within educational and workplace settings (Snyder et al., 2018; Hennein et al., 2022), as well as high turnover driven by workload, burnout, and limited workplace supports (Snyder et al., 2018; Hennein et al., 2022). When shortages are acute—especially in rural and high-need areas—evidence-informed task-sharing approaches (e.g., community health workers, peers, and other trained paraprofessionals) can help extend reach when paired with clear roles, training, and supervision.

> "That pipeline needs to start as early as possible. Folks don't consider mental health as a career choice, it is not on their radar. For those from low-income communities, getting higher education is a burden. We can't wait until they are already enrolled at a historically black college, we will be too late. We have tried to do more community outreach to high schools and middle schools to let them know what we do and provide resources. It was a cool experience to meet kids who had no idea that these professions existed, but cared about mental health. We need to get the word out early."
> - SPTF member

The New York State Suicide Prevention Task Force (SPTF) prioritized strategies that expand the pipeline into mental health careers, support providers throughout their professional journey, and ensure the mental health workforce reflects the state's diversity. With intentional investment, New York State can build a mental health workforce that is responsive to the needs of its communities.

Develop, Enhance, and Adapt Suicide Prevention Training Across Settings

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Promote that BOCES of New York State and other training and development centers adopt Community Gatekeeper and Brief Intervention suicide prevention trainings for individuals entering trade professions (11).
- Continue to promote warning sign identification and early intervention methods into suicide prevention training modules (12).
- Promote training on cultural humility as part of continuing education requirements for mental health professionals (13).
- Expand the availability of universal, tiered suicide prevention training for all school staff, including enhanced, role-specific training for school counselors and psychologists (14).

- Develop tools/materials to enhance trainings to improve awareness of warning sign identification for students with developmental and intellectual disabilities (15).

Suicide prevention training is an important tool for early identification, intervention, and referral across a wide range of settings. Many frontline workers, including those in education, healthcare, and trade professions, have limited exposure to suicide prevention best practices or receive training that is not tailored to their role or community context. This lack creates gaps in safety nets, particularly when staff lack clear guidance on what to do next and how to connect someone to timely supports. Research shows that approximately 45% of individuals who die by suicide have had contact with a primary care provider within one month of their death (Luoma et al., 2022), demonstrating the need for universal, high-quality suicide prevention training across all points of contact; not just in behavioral health, but in schools, primary care, trade settings, and community-based programs, with reinforced practice and clear referral pathways.

Additionally, training content often fails to address the cultural, linguistic, and situational realities of different communities. Standardized materials may overlook how suicide risk manifests among people with intellectual or developmental disabilities, for example, or how cultural stigma influences help-seeking behavior in ethnoracially minoritized populations. These blind spots can result in missed opportunities for early intervention, and can be reduced through role-specific, culturally responsive adaptation and ongoing support (e.g., consultation or supervision structures) that helps staff apply training in real-world situations.

> "Everyone who interacts with a student should have mandatory training. There is also so much talk about what good work kids can do. Is there more we can do with training peers? Look at expanding places where kids have connections. Speaking with a mental health professional is great but it is not the norm for most kids." - SPTF member

> "Trainings need to have synergy. Can't separate suicide prevention training from mental health first aid training. Kids spend the majority of the day in school, but you have extracurriculars, sports etc. where we also need to train adults." - SPTF member

> "What if suicide prevention awareness was added as a standard for educators to support academic success and well-being of each student?" - SPTF member

> "I know that recently nurses were trained in mental health. Maybe something similar could be pushed regarding suicide prevention for multiple disciplines." - SPTF member

To reduce these challenges, the Suicide Prevention Task Force prioritized a comprehensive, culturally responsive training strategy that spans sectors and professions to ensure more effective, inclusive training that reaches every point of contact.

Suicide Prevention Training Delivery, Dissemination and Compliance

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Promote suicide prevention training through existing learning management systems, such as the New York Statewide Learning Management System (SLMS) for state employees, and track completion. Consider making the training a biannual requirement for all state personnel (16).
- Support the delivery of in-person suicide prevention and mental health trainings to mitigate depersonalization and loss of connection associated with standardized and online platforms (17).
- Offer suicide prevention training to key personnel in non-clinical settings to strengthen early identification and referral (18).
- Expand access to suicide prevention training for uniformed personnel through programs such as The CARES UP initiative (19).

- Promote mental health safety training in high-risk professions, such as construction (e.g., including suicide prevention within mandated OSHA courses) (20).

As the need for suicide prevention training grows across communities and professions, this training must also reach the appropriate audience. Despite the availability of evidence-based training, uptake and implementation remain inconsistent across sectors. Many professionals lack access to training opportunities or don't receive guidance on how often or in what format such training should occur. For example, in a sample of 2,257 outpatient behavioral health clinicians in New York State, 65% reported fewer than four hours of formal suicide prevention training over their entire career, and only about 49% said they'd received sufficient training to effectively assist suicidal clients (Labouliere et al., 2021). Professions with elevated suicide risk (including those in construction, emergency services, and healthcare) operate under vastly different regulatory environments, leading to fragmented expectations around suicide prevention preparedness. Efforts to streamline training through existing systems, such as higher education institutions or state learning management platforms, offer potential for large-scale dissemination, but without consistent tracking, reinforcement, and refresher expectations, participation and skill retention can remain uneven. Ensuring that suicide prevention training is adopted, tracked, and reinforced across diverse workforces is critical in preventing suicide. This includes reaching non-clinical personnel, who are often trusted points of contact and may be the first to notice distress or receive disclosures, particularly in workplaces, schools, and community settings. Training is most effective when supported by organizational leadership, protected time, and clear expectations for use in practice.

> "The construction industry does have a couple of unique risk factors: long working hours, a lot of time away from families, a very physically demanding job with a lot of injuries (on or off the job) which subsequently relates to misuse of substances. Theres' financial difficulties that happen when people are laid off in different seasons. We are looking at those factors."
> - SPTF member

The New York State Suicide Prevention Task Force calls for strategies to ensure that suicide prevention training is effectively delivered, reinforced, and tailored across diverse professional sectors to equip a broad range of professionals with the skills needed to recognize and respond to suicide risk.

Priority Area 5: Expanding Access to Culturally, Linguistically, and Structurally Responsive Suicide Care

Availability of Services

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Expand telehealth availability in schools and community clinics to reduce barriers to mental health care access (21).
- Promote the adoption of Zero Suicide Framework and other evidence-based practices within hospital systems and across individual providers (22).

Access to mental health care services remains a significant challenge across the United States, especially for individuals in rural areas, those with low incomes, and other underserved populations. Barriers such as fragmented systems of care, uneven distribution of services, provider shortages, long travel distances, limited public transportation, limited digital access, stigma often prevent timely and consistent treatment. Expanding availability of services through strategies like telehealth, transportation support, and system-wide models such as Zero Suicide offers promising solutions.

> "Offering telehealth – making it more accessible to students, if even offering to use telehealth at school so it reduces that stigma or takes the burden off the family to have to find space for the student."
> - SPTF member

> "Access is more than starting a program; transportation is a barrier and it looks different in rural vs urban communities." - SPTF member

The New York State Suicide Prevention Task Force prioritized strategies that address various barriers to mental health services and promote a scalable universal suicide prevention approach to foster equity, including system-level models that improve identification, continuity, and follow-up across points of care.

Culturally and Linguistically Responsive Services

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Ensure awareness of the language access initiatives that ensure mental health services provided by the state are available in the most common languages spoken in New York State (23).
- Collaborate with linguistically and ethnoracially diverse communities to develop culturally appropriate mental health resources and educational materials (24).
- Explore culturally grounded and trauma-informed models, including evidence-based practices to reduce disparities among most impacted populations (25).
- Modify the Office of Mental Health Request for Proposal (RFP) process to promote health equity. This can help diversify the range of interventions available and ensure that resources are allocated more effectively to underserved communities (26).

Despite growing national efforts to reduce suicide, significant gaps remain in addressing the needs of racially, ethnically, and linguistically diverse individuals, particularly youth. Suicide rates have risen most sharply among Black and Latinx adolescents—particularly among young women—yet the field continues to rely on interventions developed primarily for White, English-speaking populations. Evidence shows that Black and Latinx youth not only report higher rates of suicide attempts but also often face more severe medical consequences and greater structural barriers to care (Meza & Bath, 2021). These disparities highlight the urgent need for suicide prevention strategies that are culturally responsive and linguistically appropriate, addressing the social determinants of health—such as racism, acculturative stress, and intergenerational conflict—that uniquely shape risk and resilience in minoritized communities. These gaps are compounded by a persistent mismatch between the cultural realities of minoritized youth and the design of mainstream suicide prevention systems, which often fail to reflect youths' lived experiences, family contexts, and pathways to help-seeking. Without deliberate investment in tailored interventions and inclusive systems of care, prevention efforts risk reinforcing inequities rather than alleviating them.

> "When we start thinking about cultural and linguistic diversity... If we have services in English, that doesn't help people who are hard of hearing or Spanish speakers." - SPTF member

> "We also need to address and overcome cultural roadblocks that may prevent people from seeking support." - SPTF member

> "It would be helpful to have a framework that includes different communities and different activities. A multicultural relational approach that you can use with any patient in front of you and that was the closest to give you an idea – what's important for them."- SPTF member

The New Yo"rk State Suicide Prevention Task Force (SPTF) prioritized strategies to ensure the provision of language and culturally accessible mental health services across NYS. The Task Force intended to expand upon already available services to meet the specific needs of ethnoracially minoritized populations in NYS.

Integrating Suicide Prevention into Healthcare Settings

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Promote standardized screening for suicidal ideation and depression within primary care settings to identify individuals at risk (27).
- Explore and promote outreach models such as HealthySteps within primary care to reduce ACEs (adverse childhood experiences), a well-established driver of suicide risk, by embedding behavioral health services in pediatric practices to expand reach and reduce stigma by offering services to everyone (28).

- Develop guidance to ensure the Zero Suicide model is implemented in a culturally responsive manner (29).

Suicide is a pressing public health issue, and integrating suicide prevention into healthcare settings is critical to save lives. Many individuals who die by suicide have had recent contact with healthcare providers—one large study found 83% had a health visit in the year before death, with about half seeing primary care providers and often without a documented mental health diagnosis (Ahmedani et al., 2014). These statistics highlight missed opportunities for identification and intervention. Primary care, pediatric clinics, and veteran health services are especially important touchpoints for at-risk populations (e.g., men of low socioeconomic status and living in rural areas, ethnoracial and LGBTQ youth, veterans), who may face stigma or systemic barriers in accessing specialty mental health care (Horowitz et al., 2020). Embedding suicide prevention into routine care in these settings helps normalize mental health conversations, reduce stigma, and reach underserved groups (Brodsky et al., 2018). Because these settings often represent the only point of healthcare contact for many individuals, failure to integrate suicide prevention into routine care perpetuates inequities in identification and follow-up. National frameworks, such as the U.S. National Strategy for Suicide Prevention, emphasize this integration, notably through models like Zero Suicide (Labouliere et al., 2018).

> "It comes down to systems detecting at risk individuals and providing interventions that have been shown to work. The healthcare system has some major holes, the Zero Suicide Model is about trying to plug some of those holes: asking consistently, providing interventions that work, reducing lethal means, and providing support for underlying mental health challenges." - SPTF member

Taken together, the literature underscores that integrating suicide prevention into healthcare requires not only evidence-based tools, but also alignment across workflows, electronic health records, financing structures, and implementation supports to ensure consistency, equity, and sustainability. The New York State Suicide Prevention Task Force prioritized several strategies that integrate suicide prevention into healthcare.

Priority Area 6: Strengthening Community-Based Approaches

School-Based Initiatives

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Work with schools to develop and implement suicide screening protocols that use validated, suicide-specific screening tools to identify students at risk and support triage, care planning, and follow-up (30).
- Amplify materials developed in conjunction with the NYSED that encourage all NYS school districts to develop a suicide prevention policy (31).
- Partner with organizations such as OPWDD to address suicide risk and stigma among neurodivergent individuals (32).

Youth suicide remains a leading cause of death for adolescents aged 15–24 in the United States and New York State. Black, Hispanics, LGBTQIA+, and female youth are disproportionately impacted (CDC, 2025). Schools serve as critical environments for identifying at-risk youth, fostering mental health awareness, and delivering early intervention. Because schools are one of the few systems with near-universal contact with youth, they play a uniquely powerful role in reducing disparities in detection and access to support. School-based suicide prevention programs—particularly those grounded in a tiered, evidence-based approach—can reduce suicide risk, improve student mental health literacy, and promote help-seeking behaviors (Breux & Samet, 2021; Wyman et al., 2019). The literature consistently highlights that the effectiveness of school-based suicide prevention is strengthened when schools are embedded within broader community systems, including families, healthcare providers, and local organizations.

> "There needs to be policies to support the socio-emotional learning initiatives in mental health and policies to protect those students that are in need." - SPTF member

> "We need parents to be educated on systems- Parents need help in understanding their child's mental health struggles and in finding and connecting to the right resources." - SPTF member

The New York State Suicide Prevention Task Force prioritized strategies to involve schools in providing suicide risk screening, engage in community asset mapping, and implement a tiered mental health curriculum. The Task Force also calls for advocacy and collaborations for resource sharing and access to suicide prevention efforts.

Workplace Initiatives

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Establish partnerships with organizations working in high-risk industries to encourage and promote mental wellness and help-seeking behavior (33).
- Partner with Department of Labor and unemployment offices to provide suicide prevention training and resources to staff assisting individuals who are unemployed, underemployed, or exiting the workforce, and at risk of suicide (34).

Workplace suicide prevention efforts are increasingly recognized as critical components of broader public health strategies. Evidence-based interventions targeting high-risk industries and employment contexts have emerged over the past two decades, though robust evaluations remain limited. A scoping review by Hallett et al. (2024) provides an analysis of global and cross-industry workplace suicide prevention interventions across various sectors. Most intervention mechanisms were aimed at a person's immediate environment and included assessment, treatment, referral, and/or crisis support. While some studies suggest that workplace interventions can reduce suicide risk and positively influence attitudes, the lack of randomized controlled trials limits the ability to make causal conclusions. According to a 2014 systematic review on workplace suicide prevention, very few workplace suicide prevention initiatives have been evaluated for effectiveness. Echoing Hallet et al.'s argument, the programs that were evaluated used observational or quasi-experimental designs, impacting their ability to make causal inferences about the role of interventions in reducing suicidality or its proximal risk factors (Milner et al. 2014). Milner et al. (2014) claim that most suicide prevention activities in the workplace evaluated were aimed at the secondary and tertiary levels (e.g., aiming to reduce risk and make sure help is available when needed) while failing to address factors at the primary level (e.g., modifiable risk factors for suicide in workplace settings). Those workplace risk factors associated with suicide include psychosocial job stressors, including low control over work, monotony of work, and high psychological demands. Relatedly, job loss and economic instability elevate risk in ways that extend beyond "workplace" settings, making points of contact such as Departments of Labor and unemployment offices potentially important dissemination sites for timely supports.

Recommendations like integrating suicide prevention into infrastructure contracts, expanding peer-led supports, and building community referral pathways align with both international best practices and early promising outcomes. In high-stigma occupations, peer-led approaches and confidential access points (e.g., EAPs clearly separated from HR) are frequently emphasized as mechanisms to increase willingness to seek help and reduce fear of negative consequences. Together, these interventions form a coherent, multi-level framework for advancing suicide prevention in the workplace.

> "When we think about how employers can help, I'd like to see more focus on how we can support each other and foster more human, compassionate relationships." -SPTF Member

> "It seems like the biggest impediment really is awareness. I feel like that has to be a critical starting point because I think there's a lot of workplaces that don't acknowledge or even understand that this is a problem that needs to be addressed. So, in the first instance, you have to get engagement to even understand this is an issue that impacts you as a workplace." - SPTF Member

The New York State Suicide Prevention Task Force prioritized strategies to address workplace culture and proposed ways to increase employee satisfaction and emotional well-being. Through promotion, broadening, and implementation of different strategies, services, and sustainable workplaces can serve as a preventative structure.

Community-Based Settings

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Train and support credible messengers to deliver outreach, share resources, and connect people to services through partnerships with local community-based, non-clinical organizations (35).
- Develop partnerships with organizations that provide non-clinical, culturally and linguistically responsive, community-based supports to promote mental health, prevent suicide, and support recovery (e.g., wellness programs, peer services, social supports, and skill-building opportunities) (36).

Outreach into community-based settings can play an important role in extending mental health and suicide prevention efforts beyond clinical environments, reaching individuals who may not engage with formal healthcare services. These interventions leverage local networks, peer support, and culturally relevant strategies. Evidence suggests that trusted community sites— such as faith-based organizations, barbershops, housing complexes, recovery groups, and cultural associations can serve as effective engagement points, particularly for populations facing stigma or structural barriers to formal care to address mental health needs at the population level. However, community-based approaches face notable challenges, including inconsistent funding, variable implementation capacity, and difficulties in evaluating effectiveness due to the diversity and complexity of strategies involved. Sustaining impact requires coordinated, adequately resourced efforts that are responsive to local needs while maintaining fidelity to evidence-based practices. Cross-sector partnerships particularly those linking health systems with community-based organizations or disability service systems have shown promise in improving coordination, reach, and engagement among underserved groups.

> "Supporting community-based and peer-led suicide prevention efforts can really make a difference."
> - SPTF member

The New York State Suicide Prevention Task Force (SPTF) emphasized the need to diversify the outreach focus and work with diverse community-based organizations to prevent and reduce suicidality. Establishing partnerships and collaborations with local community-based organizations can strengthen and expand efforts to prevent suicidality in New York State.

Rural Community Mental Health and Suicide Prevention Initiatives

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- In rural areas, encourage suicide prevention coalitions to partner with local gun stores and hunting clubs to promote safe firearm storage and share suicide prevention resources (37).

Rural residents face disproportionately high suicide rates compared to their urban counterparts, with particularly elevated risk among males, older adults, and Latino populations (CDC, 2024; Hirsch & Cukrowicz, 2014). Factors contributing to this disparity include geographic and social isolation, higher rates of firearm ownership, stigma around help-seeking, and limited access to mental health professionals (Farrigan, 2025; Weeks et al., 2023). Over 65% of non-metropolitan counties in the U.S. lack a single psychiatrist (Morales et al., 2020), forcing many residents to rely on under-resourced primary care settings for mental health needs. These challenges underscore the need for innovative, community-based, and geographically tailored interventions to support suicide prevention in rural areas. Workforce shortages, long travel distances, and limited broadband infrastructure further constrain access and reduce the feasibility of clinic-based or telehealth-only models in many rural regions.

In contrast to urban communities, rural communities can have higher geographic and social isolation, more access to firearms, higher rates of substance abuse, less access to mental health resources, and a culture that promotes individualism and rugged independence,

which may promote stigma associated with mental illness or help-seeking (Hirsch & Cukrowicz, 2014). Rural communities also have higher rates of poverty (Farrigan, 2025) and worse social determinants of health outcomes (Weeks et al., 2023). As a result, prevention strategies that leverage trusted local institutions such as firearm retailers, hunting clubs, agricultural networks, and other community hubs are increasingly emphasized as culturally congruent and acceptable entry points for suicide prevention in rural settings.

> "Living in a rural area can be a suicide risk factor for men over 60, but anybody with intersectionality like LGBTQ folks, they do not have a space or place to get together and feel welcomed or wanted. Same with Veterans. All rural areas are different". - SPTF member

> "In rural areas, there's often reluctance to ask for help—it's a "pull yourself up by your bootstraps" mentality." - SPTF member

The New York State Suicide Prevention Task Force (SPTF) prioritized initiatives that build upon existing infrastructure in rural communities to extend prevention efforts to harder-to-reach communities. Through these strategies, mental health services can be expanded to address the immediate and continuous needs of rural communities.

Faith-Based Initiatives

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Promote faith-based and culturally responsive suicide prevention and mental health efforts in churches, mosques, temples, and community centers to strengthen protective factors and connect individuals to support (38).

Faith-based communities (FBCs) are frequently cited in state-level suicide prevention plans as important collaborators in addressing suicide risk. Clergy and lay leaders often serve as the first or only point of contact for individuals struggling with suicidality (Kopacz et al., 2019), emphasizing the potential of faith leaders to serve as gatekeepers and first-line responders in recognizing and addressing suicidal distress. Involvement of FBCs has also been championed due to their unique engagement with individuals at risk of mental distress or suicidality, and the trust they often hold within communities (Kopacz et al., 2019). This gatekeeping role is particularly important in communities where mental health resources are limited or where stigma may prevent individuals from accessing formal services. FBC engagement can generally be categorized into six areas: training for individual faith leaders, broader community engagement, faith leaders as gatekeepers, culturally sensitive suicide prevention strategies, faith-based postvention support, and collaboration with behavioral health professionals (Kopacz et al., 2019). Despite widespread endorsement in state plans, implementation guidance remains limited, and few faith-based suicide prevention initiatives have undergone rigorous longitudinal evaluation, highlighting both the promise and the evidence gap in this area (Kopacz et al., 2019; Wortmann et al., 2023).

> "The things that I've seen that have the most promise is when trusted messengers, from or related to the community, share their experiences in a way that can involve people. So, whether that's folks coming in and sharing information, or barber shop initiatives, religious initiatives, getting people in the community in that people trust is important. To many people, I come in as a psychologist and an outsider. What I say doesn't matter, but what their priest or their barber might say. There's a role for us putting together good messaging, a lot of this work ends up being by and for the people in the community, because that's the only way people listen." - SPTF member

> "Importance of faith-based leaders, noting that many individuals in rural areas turn to their churches for emotional support before seeking professional help." - SPTF member

The New York State Suicide Prevention Task Force (SPTF) prioritized strategies to engage with crucial communities such as faith-based communities, by offering tangible tools, recognizing and propelling community leaders' work forward. These strategies would widen the response and reach potentially hard-to-reach community members by leveraging entities and leadership they already trust.

Suicide Prevention: Peer-to-Peer Support Models

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Promote peer support programs and networks for diverse groups who are considered at risk for suicide (39).
- Support the development and implementation of peer-support networks to provide community-driven and peer-led postvention interventions (40).

Peer support programs offer an alternative to traditional crisis and mental health services, particularly for individuals who may not engage with conventional care. Over time, its integration into healthcare has expanded, with governments and policy organizations supporting peer-led approaches across various health conditions, including suicide prevention. In 2024, the U.S. Surgeon General's national suicide prevention strategy recommended further research to identify suicide prevention peer support services that are effective for enhancing client self-efficacy, personal recovery, treatment engagement, and clinical outcomes. (U.S. Department of Health and Human Services (HHS), National Strategy for Suicide Prevention). Despite growing recognition of peer support's role in suicide prevention, further research is needed to better understand the effectiveness of different peer support models in reducing suicidality.

> "Training peer gatekeepers is a new approach: there are a few, but these programs show promise. Peer focused programs are effective. Sources of Strength creates peer leaders to spread messages of hope and support through school communities. Adolescents depend on their peers; and if they see their peers saying, "I'm struggling" and going to seek help, they change a norm in schools. Kids are really influenced by what their kids do." - SPTF member

> "The group agreed that having the ability to talk to peers could be useful and beneficial. When we talked about training models and approaches, we emphasized ensuring culturally relevant aspects of the content. Stories of hope and wellness—messaging around adversity and challenges." - SPTF member

The New York State Suicide Prevention Task Force (SPTF) prioritized strategies for peer support through peer networks, programs, and mentorship models.

Priority Area 7: Enhancing Data Collection and Utilization

Timely and Accessible Surveillance Data to Identify and Address Disparities

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Continue to advocate with NYSDOH for more frequent updates to the NYS Suicide and Self-Harm Dashboard (41).
- Collaborate with medical examiner/coroners' offices to standardize medical suicide death investigation practices to improve the quality of suicide mortality data (42).

Effective suicide prevention relies on timely and high-quality data that can guide interventions and inform public health responses. This lag impedes the ability of health systems and policymakers to respond to current trends. Improving the timeliness of suicide-related metrics could allow for faster identification of risk patterns and more immediate interventions.

> "If we can establish consistent data collection across sectors, it would allow for more effective case formulation and intervention strategies." - SPTF member

> "Communicate data in a way that removes judgement/blame/finger pointing. When people hear data, they stop listening. Charts/graphs aren't tangible to the community. [We] need to be mindful of the presentation. Today's presentation I appreciated. Plain language and opportunities for questions."
> - SPTF member

Strengthening surveillance systems also supports equity by improving the identification of disparities across geography, race and ethnicity, age, and other sociodemographic factors that are often obscured in delayed or incomplete data. The New York State Suicide Prevention Task Force (SPTF) prioritized strategies to strengthen the state's suicide surveillance infrastructure to ensure that data are timely, accessible, and actionable. With timely and user-friendly data, New York State can more effectively respond to shifting suicide risk and tailor prevention efforts to the populations and regions most in need.

Community-Based and Qualitative Data

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Promote suicide-related data transparency about how data is collected, used, stored and protected to build trust among vulnerable populations (43).

Efforts to strengthen suicide prevention rely on community-informed data collection methods that reflect both local realities and broader public health priorities. However, there are persistent challenges in obtaining consistent, representative data. Qualitative and community-driven research can provide valuable context and insight but face obstacles such as participant burden, inconsistent methodologies, and difficulties translating findings into policy action. Similarly, large-scale surveillance tools like the Youth Risk Behavior Survey (YRBS) face declining school participation, limiting their usefulness for identifying youth at risk across New York State. There is a need for approaches that build trust, improve data transparency, and address logistical and consent-related barriers to data collection, ensuring that both qualitative insights and quantitative surveillance meaningfully inform suicide prevention strategies. These challenges are especially salient when working with communities that have experienced historical surveillance, stigmatization, or punitive responses to disclosure.

> "There is a gap between what's happening on the ground and what's accessible. We need more data to address and target these specific populations. Until we have that, we don't have data to inform services for the population."
> - SPTF member

Mixed-methods approaches further support equity-informed prevention by elevating community voice, surfacing strengths alongside risks, and reducing reliance on deficit-based or purely epidemiologic indicators. The New York State Suicide Prevention Task Force (SPTF) prioritizes strategies that strengthen the use of community-based and qualitative data to ensure suicide prevention efforts are locally informed, culturally responsive, and actionable. By integrating both qualitative and quantitative approaches, New York State can better capture local needs and ensure prevention strategies are rooted in the lived experiences of those most affected.

Data on Risk and Protective Factors

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Explore partnerships in support of establishing fatality review committees to examine the circumstances of individual suicide deaths (44).

Having comprehensive data that captures both risk and protective factors across diverse populations is crucial for suicide prevention efforts. While factors like depression, hopelessness, and social support are well-established risks and protective factors, data collection systems often miss important contributors, such as loneliness or the circumstances surrounding suicide deaths. Many suicide behaviors are not captured in existing data collection systems, limiting understanding of patterns and opportunities for early intervention. Strengthening data collection—through improved provider reporting, expanded surveys, and suicide fatality reviews—is critical for building a clearer picture of how suicidal behaviors develop and for guiding more

effective prevention strategies. Greater standardization across systems would also improve comparability across jurisdictions and enhance the identification of disparities across race, ethnicity, disability status, geography, and other social determinants of health.

> "As far as data, I would be interested in suicide deaths as they intersect with trauma and the social determinants of health. Those are some really key places. "
> - SPTF member

The New York State Suicide Prevention Task Force (SPTF) prioritized strategies to emphasize the importance of documenting suicidal behavior and find a way to increase data collection, especially among minoritized populations.

Evaluate the Effectiveness of Programs/ Interventions

Recommendations (actionable, and with current resources, can be accomplished by 2030):

- Evaluate suicide prevention programs and initiatives (45).

Evaluating the effectiveness of suicide prevention initiatives is essential for identifying which strategies truly reduce risk and improve outcomes. However, efforts are often hindered by methodological challenges, inconsistent outcome measures, and a lack of rigorous study designs. Without systematic evaluation, it becomes difficult to determine impact, allocate resources efficiently, or adapt programs to meet the needs of diverse populations. Strengthening evaluation practices is critical to ensuring suicide prevention efforts are both evidence-based and responsive to real-world challenges.

> "Data needs to have a two-pronged approach, where we ask people to report, then we do something with the reporting." - SPTF member

This emphasis reflects the need to move beyond implementation alone toward continuous learning, accountability, and evidence-informed refinement of prevention strategies. The New York State Suicide Prevention Task Force (SPTF) strongly supports evaluating suicide prevention program effectiveness.

5. Closing Statement, Contributions, Acknowledgements

Closing Statement

This report details recommendations, considerations, and aspirations identified by the Suicide Prevention Task Force as promising strategies for improving suicide prevention outcomes for people that live in New York State. The priority areas describe multi-faceted, equity-centered approaches that guide the work that the Suicide Prevention Task Force has put forth in this document.

Contributions

Major contributions were made to this report by the members of the Suicide Prevention Task Force and the New York State Psychiatric Institute - Center of Excellence for Cultural Competence (NYSPI-CECC). A full roster of Suicide Prevention Task Force members can be found in Appendix C.

Acknowledgements

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6. Appendix A: Considerations and Aspirations

Considerations for future actions that will require additional resources and/or time as well as aspirations that will require additional financial investment are identified and outlined in this section.

Priority Area 1: Reducing Stigma

Public Awareness Campaigns

Considerations (require dedication of additional resources and/or time):

- Promote long-term statewide public awareness campaigns to increase awareness of suicide prevention.
- Expand the distribution of suicide prevention materials in pediatric offices, schools, and childcare facilities to reach parents and families or caregivers..
- Develop and communicate suicide prevention and stigma-reduction messaging that is culturally appropriate by partnering with trusted community members to reach individuals at risk.

Aspirations (will each require the dedication of additional fiscal resources):

- Establish suicide prevention ambassadors across all regions of NYS.

Priority Area 2. Addressing social determinants of suicide

Bolster Social Supports

Considerations (require dedication of additional resources and/or time):

- Collaborate with state agencies (e.g., Office for the Aging, OASAS, DOH) to scale and adapt evidence-informed programs and promising practices that address social isolation and loneliness among older adults, including home visiting, peer-led support, volunteer and cultural opportunities, and initiatives that foster social connection and inclusion both in-person and through tech-supported options).

Strengthen Economic Supports

Considerations (require dedication of additional resources and/or time):

- Increase awareness among state and county agencies and community-based organizations of the connection between financial hardship and suicide risk.

Aspirations (will each require the dedication of additional fiscal resources):

- Integrate screening for financial hardship into suicide risk screening initiatives to identify individuals at an elevated combined risk, particularly for those with recent suicide attempts or post-hospitalization.
- Develop and expand initiatives that address financial hardships, including housing instability, food insecurity, childrearing costs, and indebtedness, as key elements of comprehensive primary suicide prevention plans.
- Support community-based intervention models that address financial hardship among populations at elevated risk of suicide in future funding opportunities.

Priority Area 3. Meaningful participation of lived experience experts

Integrating Lived Experience in Suicide Prevention

Considerations (require dedication of additional resources and/or time):

- Organize stakeholder and community engagement sessions in rural areas with individuals who have lived experience to understand local strengths and barriers to accessing suicide prevention programs and services.

Aspirations (will each require the dedication of additional fiscal resources):

- Partner with community-based organizations to host workshops where mental health providers can learn about key cultural considerations for suicide prevention and mental health care directly from individuals with lived experience.

Priority Area 4. Developing a diverse, skilled and culturally responsive workforce

Expanding, Diversifying and Retaining the Mental Health Workforce

Aspirations (will each require the dedication of additional fiscal resources):

- Explore accelerated pathways to mental health licensure (LMHC, LMFT, LCSW, LMSW) for providers who received mental health training outside the United States.
- Promote workplace wellness services and behavioral health resources for the mental health workforce to mitigate stress from high caseloads and exposure to trauma, burnout, and turnover.

Develop, Enhance, and Adapt Suicide Prevention Training Across Settings

Considerations (require dedication of additional resources and/or time):

- Adapt suicide prevention training to address the needs of the specific industry context and cultural backgrounds of the target audience, including appropriate language and relevant risk factor examples.

Aspirations (will each require the dedication of additional fiscal resources):

- Advocate for mandatory cultural responsiveness training for all healthcare staff who interact with patients.
- Consider developing standards of clinical supervision that include screening, risk assessment, referral and care management support mechanisms.

Suicide Prevention Training Delivery, Dissemination and Compliance

Aspirations (will each require the dedication of additional fiscal resources):

- Develop strategic partnerships with the SUNY and CUNY systems to promote suicide prevention training for students enrolled in mental health, education and healthcare related undergraduate and graduate programs.
- Incorporate suicide prevention training into New York State clinical licensing requirements.

Priority Area 5. Expanding access to culturally, linguistically, and structurally responsive suicide care

Availability of Services

Aspirations (will each require the dedication of additional fiscal resources):

- Explore transportation solutions for populations facing geographic barriers to mental health and suicide prevention care.
- Support the development of a universal suicide prevention approach that ensures equitable access to care.
- Review possible funding opportunities for a statewide implementation of effective suicide prevention interventions in partnership with existing local services.

Financial barriers to access

Aspirations (will each require the dedication of additional fiscal resources):

- Encourage payers to establish billing codes for Zero Suicide practices to expand reimbursement for suicide prevention services.
- Encourage payers to expand commercial insurance coverage to include support for transportation and childcare needed to reach and engage in mental health services, as well as pre-natal and post-natal home visiting and doula services.
- Support expanding insurance coverage to include culturally relevant alternative complementary therapies, such as yoga, herbal treatments, and healing circles.

Culturally and Linguistically Responsive Services

Considerations (require dedication of additional resources and/or time):

- Identify and leverage existing resources to better understand access and quality mental health needs across diverse populations.
- Deploy mental health navigators or community health workers to assist individuals in accessing services in their

preferred language, particularly within immigrant and refugee communities.

Aspirations (will each require the dedication of additional fiscal resources):

- Consider developing and funding a statewide, culturally responsive suicide prevention framework that includes multilingual services, workforce development, and expanded access to culturally tailored interventions and treatment-adjacent programs.

Integrating Suicide Prevention into Healthcare Settings

Aspirations (will each require the dedication of additional fiscal resources):

- Incentivize healthcare providers to consistently apply suicide prevention protocols and conduct mental health screenings through a value-based care model.
- Explore the development of guidelines for "high risk flags" in electronic medical record (EMR) systems that allow providers to track individuals with an elevated risk for suicide.

Priority Area 6. Strengthening community-based approaches

School-Based Initiatives

Considerations (require dedication of additional resources and/or time):

- Explore and develop programs that actively engage parents and families in suicide prevention efforts (69).
- Develop a parent education and resource toolkit on suicide prevention, including multilingual and culturally relevant materials.
- Promote the importance of providing a comprehensive, tiered mental health and suicide prevention curriculum in schools.

Aspirations (will each require the dedication of additional fiscal resources):

- Encourage schools to conduct community asset mapping and establish sustainable partnerships with community behavioral health providers and other local organizations.
- Employ school community health liaisons to help connect students and families with community resources to address social and behavioral health needs.
- Integrate suicide prevention into the Professional Standards for Educational Leaders.

Workplace Initiatives

Considerations (require dedication of additional resources and/or time):

- Explore incorporating suicide prevention policies and workplace mental health best practices into state-funded construction and infrastructure contracts.
- Promote the importance of workplace cultures, policies, and strategies that normalize seeking help for financial, social, physical, and mental health concerns, prioritize psychological safety, and improve employee belonging.

Aspirations (will each require the dedication of additional fiscal resources):

- Expand access to the CARES UP initiative to strengthen supportive workplace culture, improve employee well-being, and tailor suicide prevention efforts to the unique needs of high-risk occupational groups, including construction workers, first responders, and law enforcement.
- Increase awareness of confidential resources in the workplace such as Employee Assistance Programs (EAPs) to overcome stigma and fear of speaking up about suicide. Integrate suicide screening and mental health supports into EAP offerings, such as bereavement support, childcare assistance, and reasonable accommodations.

Rural Community Mental Health and Suicide Prevention Initiatives

Considerations (require dedication of additional resources and/or time):

- Support and promote services and programs within rural communities, that help reduce the conditions that can increase suicide risk, such as isolation, financial stress, limited healthcare access, and housing or transportation barriers.

- Develop and fund mobile mental health units that travel to underserved areas, integrating various expertise from peer support specialists across the lifespan, clinicians and other mental health professionals.

Suicide Prevention: Peer-to-Peer Support Models

Aspirations (will each require the dedication of additional fiscal resources):

- Collaborate with peer support networks to develop a statewide peer-mentorship model for suicide prevention, incorporating training through Applied Suicide Intervention Skills Training (ASIST) and peer-support networks in workplaces and community spaces.

Community Coalitions

Aspirations (will each require the dedication of additional fiscal resources):

- Establish and fund community-based suicide prevention coalitions with dedicated staff and resources that host quarterly meetings to serve populations with suicide risk disparities and engage in strategic planning.

Priority Area 7. Enhancing data collection and utilization

Timely and Accessible Surveillance Data to Identify and Address Disparities

Considerations (require dedication of additional resources and/or time):

- Explore how models of systematic data collection and dissemination can be used for suicide prevention to improve the timeliness and usefulness of data.
- Promote the use of real-time data collection methods to facilitate immediate intervention efforts for healthcare providers.

Aspirations (will each require the dedication of additional fiscal resources):

- Utilize storytelling to share data findings with community partners in an accessible, non-judgmental way that translates data into clear, understandable insights for community audiences.

Community-based and Qualitative Data

Considerations (require dedication of additional resources and/or time):

- Explore how barriers to school participation in the Youth Risk Behavior Survey (YRBS) can be overcome.

Aspirations (will each require the dedication of additional fiscal resources):

- Conduct community-driven research initiatives, including qualitative interviews, to identify existing suicide prevention resources and gaps in services.
- Explore establishing a multicultural assessment tool to identify community strengths, protective factors, risk factors, and cultural considerations in suicide prevention.
- Encourage school district superintendents to collect suicide-related data and collaborate with the Department of Education to increase reporting on youth at elevated risk in New York State.

Data on risk and protective factors

Aspirations (will each require the dedication of additional fiscal resources):

- Educate providers on the importance of documenting and reporting all suicide behaviors (e.g. preparatory, aborted attempts), including the best ways to collect this data, in order to understand the path from suicidal ideation to suicide deaths among youth.
- Explore the methods to increase data collection on risk factors within populations with suicide risk disparities including persons with disabilities, older adults, Veterans, youth involved in the justice system, LGBTQIA+ individuals, indigenous communities, and BIPOC youth.
- Enhance data collection to understand how loneliness contributes to suicide risk and methods for intervention and advocate for the revision of annual surveys like the BRFSS to better measure loneliness and social isolation.

Data Sharing

Considerations (require dedication of additional resources and/or time):

- Convene state agency partners to discuss how to increase and improve data sharing across government entities.

- Consider how data use agreements can be implemented to aggregate depression and suicide screening data across primary care facilities statewide.

Aspirations (will each require the dedication of additional fiscal resources):

- Explore how to create mandated reporting mechanisms and centralized data repositories by including suicide metrics in the Statewide Longitudinal Data System (SLDS) which is currently being proposed.

7. Appendix B: Research Evidence for Recommendations, Considerations, and Aspirations

This section presents a summary of supporting research evidence for the recommendations, considerations, and aspirations that were put forth by the Task Force. This includes descriptions of comparable programs or models implemented elsewhere or proposed by stakeholders and a discussion of potential implementation challenges or limitations.

Priority Area 1: Reducing Stigma

Long-term Statewide Public Awareness Campaigns

A growing body of research supports moving from isolated, one-off awareness events to sustained, comprehensive campaigns. One-time events (e.g., an annual awareness day or short-term media blitz) can raise momentary attention but often yield only transient effects. In contrast, sustained campaigns allow for repeated exposure to key messages, reinforcement of knowledge over time, and normalization of help-seeking behaviors. They can also be continuously adapted based on audience feedback and outcomes. Evidence from real-world programs underscores the advantages of sustained efforts. For example, California's multi-year "Know the Signs" suicide prevention campaign ran multi-language messaging through various media and community organizations, resulting in broad engagement across diverse communities (CalMHSA, 2014, as cited in Pirkis et al., 2019). Including credible, community-based messengers is also important: having respected local figures or peer role models deliver messages increases audience trust and acceptance. Initiatives like "Man Therapy" (an online campaign using humor and male-tailored messaging to reach working-age men) and Indigenous youth programs that involve Elders or peers illustrate how culturally attuned messengers can improve outreach. In short, sustained campaigns with relevant content are more likely to penetrate harmful norms in heterogeneous populations such as New York State.

Several campaigns provide evidence on the feasibility and impact of sustained approaches. The Know the Signs campaign mentioned above not only maintained its efforts over multiple years but also measured outcomes, finding increases in knowledge of suicide warning signs and resources in the target population (CalMHSA, 2014). Another example is "Man Therapy," which uses a year-round interactive website and media outreach to engage men; evaluations of Man Therapy suggest it successfully attracts its target audience and can shift attitudes about seeking help (e.g., increased confidence to seek mental health care) (American Foundation for Suicide Prevention, 2020; see also Hammer et al., 2021). These programs demonstrate that ongoing, evolving campaigns can achieve population reach and influence attitudes. Importantly, they often employ peers and local champions in delivering messages – an evidence-based strategy for reducing stigma. For instance, community-driven efforts in Indigenous communities (involving youth leaders and Elders) have shown positive shifts in stigma and empowerment to seek help (Wyman et al., 2010; Rowe & Ansloos, 2024). Such examples align with Recommendation 1's emphasis on sustained, culturally resonant messaging delivered by trusted voices.

While public awareness campaigns can improve knowledge and attitudes, shifting deep-seated beliefs and behaviors remains challenging. Researchers caution that not all campaigns lead to increased help-seeking or reduced suicide rates (Pirkis et al., 2019). Effectiveness likely depends on message content, delivery method, and targeting. One limitation is that campaign messages are often not rigorously tested beforehand – a review found that few studies detail which specific messages were used, making it hard to know what content works best (Dumesnil & Verger, 2009). Poorly crafted messages can even backfire. For example, an Australian study found that certain anti-stigma statements (e.g., "people who die by suicide are not irresponsible") unexpectedly decreased help-seeking intentions, whereas a positive, specific message ("Seeing a mental health professional can help prevent suicide") significantly increased help-seeking intentions (Calear, Batterham, & Christensen, 2014). This underlines the need for careful message framing and audience testing. Additionally, sustained campaigns require sustained funding and political will. Short-term initiatives may fade out due to budget constraints, so building in evaluation data (e.g., showing increased calls to crisis lines or website visits) is crucial to make the case for ongoing support. There are also evidence gaps regarding long-term outcomes: few studies assess whether improved public

attitudes persist beyond the immediate campaign period. Despite these challenges, there is *consensu*s that a sustained campaign approach is preferable to one-off events, which often have a fleeting impact. A brief Mental Health Awareness Day each year might spark conversations, but without ongoing follow-up, it is unlikely to produce lasting change.

New York State 988 Suicide & Crisis Lifeline Information in Community Settings
This recommendation focuses on increasing awareness and use of crisis support by displaying the 988 Suicide & Crisis Lifeline number in everyday places. Visible 988 postings in community settings (stores, bars, libraries, hotels, etc.) serve as constant reminders of the availability of this hotline and encourage people in distress to reach out. Prominently featuring "988" in the environment can normalize help-seeking and ensure that individuals – or those who may be with them during a crisis – immediately know how to connect them to supports. Notably, public awareness of the new 988 lifeline remains low; a late-2024 national survey found that fewer than 1 in 5 Americans were aware of 988 (Annenberg Public Policy Center, 2024). Early evidence suggests that making crisis line information ubiquitous can improve utilization. Following the nationwide implementation of the 988 number in July 2022, data showed a significant increase in calls and texts to the Lifeline (Kaiser Family Foundation, 2023). Moreover, extensive research on crisis hotlines indicates that their use is associated with reduced immediate distress and suicidal urgency among callers, as well as improvements in callers' mood and feelings of hopefulness and safety (Miller et al., 2022). By widely posting 988 in high-traffic community locations, the goal is to reach people who might not otherwise seek mental health resources – providing them with a "lifeline" in moments of impulsivity or despair.

To maximize impact, 988 information should be displayed in both obvious and creative ways. Traditional signage (posters, wallet cards) can be complemented by novel formats like drink coasters in bars, grocery store bag inserts, or stickers on pharmacy prescription bags. Some communities have piloted such approaches; for example, an innovation project in Ventura County, California placed suicide prevention posters and coasters in bars and trained bar staff to recognize crises ("Bartenders as Gatekeepers") as a way to reach men at risk (Ventura County Behavioral Health, 2018). New York's recommendation similarly suggests placing materials at casinos or check-cashing sites to reach people under financial stress, or at gun shops to reach firearm owners (ideas raised during SPTF community discussions). Ensuring materials are provided in multiple languages and are culturally tailored (using images and wording that resonate locally) will improve their effectiveness. Partnerships with business owners, community leaders, and local influencers can facilitate placement and upkeep of the materials. It's also important to periodically refresh and redistribute the posters or stickers so that they remain noticeable over time (people may tune out signage that becomes "background" after a while).

Over time, pervasive 988 messaging could make the crisis line nearly as familiar as dialing 911 for emergencies. This familiarity may lower the threshold for distressed individuals to seek help, as they know exactly where to turn. Widespread 988 visibility also fosters a culture of preparedness – when friends or family see someone struggling, they too immediately know the number to call or share. A measurable outcome of success would be increased call and text volume to 988 from the specific areas or demographic groups targeted by the campaign. One challenge is evaluating impact: it may be hard to directly attribute changes in suicide rates or hospitalizations to a signage campaign. Instead, intermediate metrics like Lifeline utilization and public awareness levels will likely be used. Another consideration is ensuring that crisis line capacity keeps up with potential increased demand (to avoid long wait times for callers). Another big obstacle is that due to the possibility of police involvement upon using 988, communities often distrust these services (Balfour & Zeller, 2023). However, some states have implemented mobile community crisis teams, which have significantly reduced police involvement for those experiencing high levels of distress (Gonzalez et al., 2023). Overall, making 988 highly visible in the community is a low-cost, evidence-informed strategy to improve access to help for people in crisis.

Suicide Prevention Materials in Pediatric Offices, Schools, and Childcare Facilities
Recommendation 6 emphasizes reaching parents and caregivers who may be reluctant to engage in suicide prevention due to stigma or fears of judgment. Settings such as pediatricians' offices, schools, and childcare centers are natural touchpoints for parents, and they present opportunities to provide suicide prevention information in a non-threatening way focused on child well-being. By offering resources and education in these

family-centered environments, this approach aims to normalize conversations about mental health and equip parents to support their children. Engaging parents is critical because they play a key gatekeeping role in youth mental health. However, studies indicate that parental stigma – for example, a parent feeling that a child's mental health issue is a personal failing or a source of shame – can impede help-seeking for the child. Improving suicide literacy among parents and reducing their stigma can increase the likelihood that they will recognize warning signs and seek help for a youth in crisis (Burke et al., 2023). Additionally, many parents fear that raising the topic of suicide could put ideas in their child's head or lead to punitive consequences (such as involvement of child protective services). Providing guidance and reassurance in trusted settings (e.g., a pediatrician explaining that talking about suicide will not "plant" the idea in a child's mind) can help alleviate these fears and encourage proactive dialogue at home.

One example initiative is the distribution of a "Parents as Partners" suicide prevention guide by the American Foundation for Suicide Prevention (AFSP) in collaboration with the American Academy of Pediatrics (Academy of Pediatrics, 2025). This brief guide, given out in pediatric clinics and schools nationwide, educates parents on how to talk about mental health and suicide with their children and what resources are available. Early feedback suggests that parents found the information accessible and felt more empowered to speak up about these issues (AFSP, 2022, unpublished data). Another program in Australia provided workshops for parents on youth suicide prevention and stigma reduction; although formal evaluation is limited, some schools reported that after the training, students were more willing to report feelings of depression or suicidal thoughts to their parents or counselors (analogous outcomes reported in school-based mental health programs). These examples illustrate the feasibility of delivering suicide prevention content through pediatric and educational channels, and they hint at a positive impact on family communication and help-seeking.

Key to engaging parents is convenience and sensitivity. Any materials or trainings should be brief, practical, and integrated into routines that parents already have. For instance, pediatricians or school counselors can be trained to introduce suicide prevention materials during well-child visits or parent–teacher meetings in a non-alarming way (framing it as part of general health education). Schools could incorporate a short orientation for parents on supporting youth mental health, or host "mental health nights" with community experts. Materials given to parents should directly address common misconceptions – for example, clearly stating that talking about suicide does not cause suicide – and provide clear steps for getting help (such as calling 988 or contacting the school psychologist). It's important to ensure privacy and trust; parents should not feel labeled or scrutinized for engaging with the material. One way is to offer brochures discreetly (so that taking one doesn't make a parent feel exposed) and to frame participation as part of being an informed, proactive parent (rather than implying there is a problem in their child). Potential challenges include reaching parents who are less involved in school or healthcare visits and overcoming time constraints in busy pediatric practices. Nonetheless, by embedding suicide prevention into child-focused settings, Recommendation 6 leverages existing structures to reach parents who might otherwise avoid or overlook this topic due to stigma.

Culturally and Linguistically Appropriate Suicide Prevention Messaging

A one-size-fits-all campaign can fail to resonate with – or even alienate – certain groups. Ensuring that language, imagery, and message framing are inclusive and relevant to the target demographic can make campaigns far more effective. Cultural context significantly influences how people perceive mental health and help-seeking. For instance, within some Indigenous cultures, suicidal thoughts may be conceptualized in spiritual terms rather than medical ones, affecting how prevention messages should be framed. In rural areas, where values of independence and privacy are strong, reframing "mental health support" as general "community assistance" can increase trust and willingness to seek help (Rowe & Ansloos, 2024). Likewise, people from different cultures may have unique conceptions of mental illness and stigma; messaging must account for these nuances. Inclusive messaging also means avoiding jargon or clinical language that might not translate across different education levels and steering clear of imagery or statements that inadvertently reinforce stereotypes. By being attuned to cultural differences, campaigns can address specific beliefs about mental health and suicide that exist in subpopulations.

Numerous campaigns underscore the value of cultural tailoring. In California's multi-year "Each Mind Matters" stigma-reduction campaign, materials were produced in multiple languages and co-created with

community advisory groups to ensure cultural nuances were respected. An evaluation of that campaign found, for example, that the Spanish-language outreach (which used colloquial phrases and family-centric messaging) had a higher engagement rate among Latinx audiences than a direct translation of the English materials – indicating that cultural tailoring improved effectiveness. Similarly, in New York City, a project targeting mental health stigma in Chinese American communities chose to use the concept of "stress relief" and "family harmony" instead of labeling discussions as about "mental illness"; this approach successfully encouraged older immigrant adults to utilize counseling services, where a more direct mental health framing had previously failed. These examples illustrate how adjusting language and cultural framing can reduce stigma and open doors to help. National guidance also emphasizes this approach: the Suicide Prevention Resource Center notes that prevention efforts are more likely to succeed if grounded in the values and strengths of the target community (SPRC, n.d.). Overall, engaging community members in developing the messages – for instance, having young people help craft messages for a youth campaign, or consulting with faith leaders for messaging in religious communities – has proven to be a best practice for cultural relevance.

To implement this recommendation, campaign planners should actively collaborate with cultural representatives in message development. This might involve partnering with community leaders, ethnic or cultural organizations, and individuals with lived experience from the target population to co-create campaign materials. Pilot testing messages within the community can catch any unintended misinterpretations or offense before a full rollout. Imagery is also critical: using photographs or illustrations that reflect a community's members (in terms of race/ethnicity, age, dress, and settings) can increase relatability and trust. In communities where literacy or language is a barrier, oral storytelling, radio segments, or visual formats might be more effective than text-heavy brochures. Inclusivity also involves paying attention to translation quality: not just literal translation but conveying the intended meaning in culturally idiomatic ways. One challenge is that culturally specific campaigns may require more resources and multiple versions of materials to suit different groups. However, the payoff is potentially greater impact in reducing stigma among those who might otherwise be left unmoved by generic messaging. By making each audience feel that the campaign is "for us, by us," Recommendation 7's approach can improve engagement and help-seeking in communities facing elevated suicide risk.

Social Media, Podcasts, and Digital Storytelling
Social media, podcasts, and digital storytelling can effectively engage youth and reduce stigma. Campaigns like Bell Let's Talk in Canada were linked to increased mental health discussions and service use among youth (Booth et al., 2018). California's Directing Change invites youth to create short films on mental health, promoting peer-driven awareness. However, evidence on suicide outcomes is limited; one study found a rise in suicide-related tweets after a campaign but no significant change in suicide rates (Côté et al., 2021). While promising, these approaches should complement offline interventions and ensure safety through message monitoring and evaluation.

Adapting campaigns to urban or rural environments can increase relevance and impact. Rural populations often face greater stigma and may respond better to interpersonal outreach than mass media. Public health experts recommend local tailoring to fit cultural and geographic needs (SPRC, n.d.). Though formal evaluations are scarce, aligning messages with community norms—such as referencing farming stress in rural areas—can improve engagement.

"Meet People Where They Are" Approach
Reaching at-risk individuals in settings like bars, courts, or social services reflects a "meet people where they are" approach. Ventura County's bartender training and coasters project and the Gun Shop Project (which promotes suicide prevention via firearm retailers) illustrate the feasibility of using unconventional venues (Ventura County Behavioral Health, 2018). These programs show early promise but require contextual adaptation and further evaluation to understand impact and implementation challenges.

Suicide Prevention Ambassadors
Empowering trusted community figures as suicide prevention ambassadors leverages peer influence and credibility. Programs like Sources of Strength have demonstrated success in using peer leaders to shift norms in

schools (Wyman et al., 2010). Community-based gatekeeper training (e.g., for clergy or barbers) has also shown increased referrals and crisis recognition (Cross et al., 2011). Effective implementation requires training, sustained support, and local trust, aligning with broader public health principles of community engagement.

Priority Area 2: Addressing Social Determinants of Suicide

Bolster Social Supports

Social Isolation and Loneliness

Robust evidence underlines the value of programs targeting social isolation for reducing suicide risk in older adults. A meta-analysis found that social support interventions for at-risk individuals were associated with a significant reduction in suicide mortality. This effect was strongest in interventions involving regular, ongoing personal contact. For example, a pragmatic randomized trial in primary care (The Senior Connection study) showed that socially disconnected older adults who received peer companionship visits had greater reductions in depression, anxiety, and feelings of being a burden than those receiving care-as-usual (Conwell et al, 2020). Notably, while that peer intervention did not significantly decrease suicidal ideation, it improved key risk factors (mood and perceived burdensomeness) that are linked to suicidality (Conwell et al, 2020). Consistent with the importance of sustained contact, even low-cost "caring contacts" approaches have yielded positive results: in one trial, military personnel who received periodic caring text messages experienced a 40% relative reduction in suicide attempt rates over 12 months compared to those with standard care (Comtois et al., 2019). This broader evidence base suggests that feasible, outreach-oriented interventions can be effective in reducing suicide risk by enhancing social support.

There are several evidence-informed programs that could be scaled through interagency collaboration. Home visiting models – often implemented via local Offices for the Aging or community organizations – have demonstrated success in reaching isolated seniors. For instance, the Senior Connection peer companion program (delivered by a community aging services agency) proved feasible and effective at improving participants' mental health in a research trial (Conwell et al, 2020). Many counties already offer Friendly Caller or Friendly Visitor programs that pair volunteers with isolated older adults for regular check-ins; a recent study of a virtual friendly visiting program in Kentucky reported sustained reductions in loneliness among participating older adults (Gordon et al., 2024). Similarly, peer support groups and intergenerational initiatives (such as senior center mentorship programs) have shown promise in increasing social engagement. By collaborating with state agencies like NYSOFA, the Task Force can help adapt and expand these models statewide. Such collaboration could also leverage innovative approaches – for example, the introduction of companion technologies or virtual senior activity classes – which New York State has begun piloting to combat isolation. The prioritized strategy builds upon existing programs (home visits, peer support networks, volunteer-based outreach) that can be scaled up or modified to serve more at-risk older adults across urban and rural settings.

Despite their potential, initiatives to reduce isolation face several challenges. One issue is the variability in evidence quality: many studies of social support programs are quasi-experimental or combine social interventions with clinical care, making it hard to isolate the effect of increased social connection alone. Furthermore, while numerous programs report improvements in intermediate outcomes like loneliness or depression, relatively few have directly measured impacts on suicidal behavior (Lapierre et al., 2011). Reductions in loneliness or depressive symptoms are encouraging but do not always translate into fewer suicide attempts or deaths in the short term. Implementation barriers also exist. Reaching the most isolated older adults can be difficult due to transportation issues, technology gaps, or distrust of formal services – problems that are acute in rural areas. There may be stigma or reluctance among some seniors to admit to loneliness or to accept "help," requiring sensitive outreach and engagement. Programs reliant on volunteers (for home visits or calls) must invest in recruiting, training, and retaining those volunteers; high turnover or burnout can limit program consistency. Finally, scaling up evidence-based models demands sustainable funding and coordination across agencies. Ensuring fidelity when expanding programs to new communities – while tailoring interventions to local cultural contexts – is a complex task. These challenges highlight the need for ongoing evaluation and support as the state scales and adapts programs to reduce social isolation and suicide risk.

Volunteer-based social engagement strategies have shown clear benefits for older adults' mental health and connectedness. Community volunteering provides seniors with meaningful roles and regular social interaction, which in turn can alleviate loneliness and improve well-being. A recent randomized controlled trial in Hong Kong demonstrated that a structured volunteering program led to a significant decrease in loneliness among older adult volunteers after six months (Yeung et al, 2025). Consistent engagement in volunteer service is also associated with enhanced protective factors such as perceived social support, life satisfaction, and sense of purpose (Kim et al., 2020). Longitudinal research in the U.S. has found that older adults who volunteer tend to have better subsequent health and lower depression rates compared to those who do not volunteer (Kim et al., 2020). In practice, high-intensity volunteer programs like the AARP Experience Corps have yielded positive outcomes: older adults who served as tutors in the Experience Corps for two years had significantly fewer depressive symptoms than matched non-volunteers (Hong & Morrow-Howell, 2010). Nearly all participants in such programs report feeling more socially active and useful to others, indicating that volunteer roles can reinforce a sense of purpose and belonging. Research suggests that senior volunteer programs can reduce loneliness and improve mental health in older populations – outcomes that indirectly reduce suicide risk. Incorporating volunteer engagement into broader social support initiatives could therefore be a valuable supplemental strategy.

Strengthen Economic Supports

Economic Supports

Existing programs that strengthen economic supports offer models for implementation. Healthy Families New York (HFNY) uses home visits to provide parenting support and connections to services, which could include job training and economic assistance. While its impact on suicide specifically hasn't been studied, its potential to reduce stress is relevant. The ENGAGE model in NYC combines safety planning with referrals to free financial counseling. Early feedback suggests high acceptability, and similar cross-referral efforts exist elsewhere, including hotlines partnering with financial empowerment centers. These programs reflect the value of integrated approaches to reducing financial stress among individuals at elevated suicide risk.

Implementation challenges include securing sustained funding and demonstrating cost-effectiveness. Programs may struggle to attribute reduced suicides directly to economic interventions, requiring the use of intermediate outcomes like reduced stress or service uptake. Inter-agency collaboration is essential but can be complicated by differing mandates, data-sharing restrictions, and access barriers. Client engagement may also be hindered by stigma or distrust. Despite these hurdles, community-based economic supports remain a promising, practical strategy for addressing a major driver of suicide risk.

Addressing Financial Hardships

Though direct causal studies are limited, case examples like Colorado's Suicide Prevention Commission show the potential of partnerships to launch innovative programs—such as collaborations with workforce centers—that improve infrastructure and reach (Stone et al., 2017). Community-level research further supports the idea that coordination and strong social supports can contribute to lower suicide rates.

Several states and municipalities have piloted models, integrating suicide prevention into service settings not traditionally involved in mental health. Cross-sector convenings could produce actionable results, such as improved referral pathways or aligned funding strategies.

However, maintaining effective partnerships is challenging. Agencies have different priorities and limited capacity. Information-sharing is often hampered by privacy laws and siloed systems. Ensuring clear goals and accountability is critical to avoid inaction. Additionally, meaningful engagement of people with lived experience is essential for ensuring equity and relevance. Long-term systemic change—such as reducing poverty-related stress—takes time, and progress may be seen first through intermediate measures like increased support access or improved coordination. Still, the potential benefits are substantial: better-connected systems mean fewer people fall through the cracks due to unaddressed financial distress.

Integrating Financial Hardship into Suicide Risk Screening

Integrating financial hardship questions into suicide risk assessments may help identify individuals at elevated risk who would otherwise go unnoticed. Evidence shows that financial strain—including debt, eviction risk, and food insecurity—is strongly linked to suicidal behavior (Bergmans et al., 2020; Choi et al., 2023). For instance, Supplemental Nutritional Assistance Program (SNAP) participants had nearly three times higher odds of suicide attempts compared to non-recipients (Bergmans et al., 2020). Screening tools that include items on financial distress could increase the sensitivity of risk detection and enable earlier intervention.
Several health systems already screen for social determinants, suggesting this is feasible without disrupting care. The Veterans Health Administration, for example, flags financial strain as a suicide risk factor, and NYC's Financial Empowerment Centers have proposed training financial counselors to screen for suicide risk—an approach that supports bi-directional integration. While more research is needed on outcomes, this is considered a low-cost, high-reward strategy (Hughes & Hermansen, 2025).

Key limitations include the need for training to ask sensitive financial questions, and the risk of false positives. Screening must be paired with clear protocols for referral to financial or legal assistance. Despite these challenges, this approach is consistent with a proactive, upstream model of suicide prevention.

Financial Hardship in Prevention Plans
Expanding financial hardship interventions as part of primary suicide prevention is backed by strong evidence. Policies like higher minimum wages and Earned Income Tax Credit (EITC) expansion are associated with lower suicide rates and improved mental health among low-income populations (Kaufman et al., 2020; Morgan et al., 2021; Shields-Zeeman et al., 2021). A 2022 meta-analysis found that direct cash transfers yield modest but meaningful mental health gains (McGuire et al., 2022).

Programs like the Bridge Project, which provides unconditional cash assistance to new mothers, offer potential to reduce stress during high-risk periods. Universal free lunch programs can help reduce food insecurity and associated mental health stigma among children. Financial literacy and job training initiatives also target upstream drivers of suicide risk, like unemployment and poor financial management. While direct evidence linking these to suicide rates is limited, they address known risk factors and align with public health strategies.

Implementation requires careful evaluation, equitable access, and sustained funding. Programs may take time to show effects, and intermediate indicators like reduced stress or improved school performance should be used to track progress. Despite these challenges, this recommendation reflects a broad consensus that strengthening economic supports is essential to preventing suicide (Choi et al., 2023).

Priority Area 3. Meaningful Participation of Lived Experience Experts

Integrating Suicide Centered Lived Experience in Suicide Prevention

Informing Strategies and Policies
While randomized controlled trials are infeasible in governance contexts, a robust body of policy alignment and qualitative evaluation shows that lived experience inclusion correlates with more equitable, community-relevant policies (Finisse, 2023; Sunkel & Sartor, 2022). U.S. behavioral health funding rules mandating ≥50% representation from lived experience individuals or families reinforce this practice. A scoping review by Purdon et al. (2025) echoed the value of lived experience in decision-making—linking it to increased legitimacy, relevance, and stakeholder satisfaction.

Beames et al. (2021) further argue for the validity of integrating lived experience in higher-level scientific syntheses (like reviews or policy briefs), highlighting its ability to identify gaps in research questions, interpret implications with nuance, and enhance trust in findings. This approach underscores the broader need for fostering substantive participation of people with lived experience at strategic and systemic levels.

Successful models from Colorado's Suicide Prevention Commission and Connecticut's Suicide Advisory Board exemplify lived experience leadership in advisory roles. In Colorado, commissioners include attempt survivors

and subcommittees that address specific groups (Suicide Prevention Resource Center, 2020). In Connecticut, the Suicide Advisory Board is co-chaired by a loss survivor and state officials, reflecting power-sharing (Finisse, 2023). These examples highlight how inclusive design informs equity-focused planning and resource allocation.

On a national scale, the 988 Lifeline established a Lived Experience Committee that shaped messaging and service protocols, demonstrating feasibility at high system levels (Finisse, 2023). The National Action Alliance Task Force, led by suicide attempt survivors, produced The Way Forward report, effectively influencing national guidance on messaging, recovery support, and training (National Action Alliance Task Force, 2014).

Effective integration demands more than nominal inclusion. Multiple lived experience members from different backgrounds may help avoid tokenism. Providing orientation about governance norms, timelines, and jargon empowers participants (Krysinska et al., 2023). Compensation—financial or stipend-based—signifies value and improves access for those with economic barriers (Sunkel & Sartor, 2022). Meeting logistics matter: accessible venues, virtual options, interpretation, and trauma-informed facilitation could all support meaningful participation (Krysinska et al., 2023).

Evaluating Suicide Prevention Programs (Participatory Evaluation)
The Delphi consensus study led by Krysinska et al. (2023) produced 96 guidelines emphasizing lived experience involvement across the research and evaluation cycle, from planning to dissemination. Endorsed by ≥80% of both lived experience and researcher panels, these statements reflect shared support for co-production models. Other rapid reviews (Watling et al., 2022; Purdon et al., 2025) repeatedly highlight that participatory evaluation can enhance data interpretation, increase relevance, and strengthen accountability. Beames et al. (2021) also call for integration of lived experience in scientific data synthesis and evaluation—not only in qualitative areas, but across evidence-gathering systems—to ensure reviews convey practical relevance and align with users' needs.

Examples of authentic participatory evaluation include Australian studies where lived experience advisors shaped qualitative data collection, coding, and interpretation, improving richness and narrative validity (Purdon et al., 2025; Grattidge et al., 2025). In Tasmania and other regions, participatory advisory panels revised survey instruments to include culturally meaningful outcomes like hope, belonging, and empowerment. The SUPPORT study—a peer specialist–led suicide prevention intervention developed with VHA peer input—modeled a structure where veterans and lived experience members helped design evaluation tools, debrief findings, and recommend service refinements. Such models show that when lived experience contributors are embedded in evaluation teams, findings become more grounded, trusted, and actionable.

Participatory evaluation can be challenging: evaluative complexity increases when definitions of lived experience vary; projects often lack budgets for training or compensation; lived experience members may face emotional burden reviewing suicidal content; and institutional frameworks may not support co-governance of evaluation (Purdon et al., 2025; Krysinska et al., 2023). Organizations can mitigate these by offering training in research methods and ethics, peer mentorship, emotional support, equitable stipend/payment, and clear terms of reference. Transparency about roles and decision-making authority reduces power imbalances. Trauma-informed practices—such as debriefing, optional contributions, and self-care plans—are critical for sustainability (Krysinska et al., 2023; Purdon et al., 2025). Over time, dedicated investment in co-production capacity increases the rigor and utility of evaluation.

Community Workshops for Providers Led by People with Suicide Centered Lived Experience
Provider trainings co-led by lived experience experts have a measurable impact. In a pilot cluster-randomized trial, providers trained with lived experience presenters showed significantly reduced stigma and more accurate diagnostics compared to control groups (Kohrt et al., 2021). The Zero Suicide Model recommends including attempt survivors in clinician training, noting improved empathy, communication skills, and culturally informed understanding. Planning for clinician training should include safe-story protocols, preparatory training for speakers, diverse representation, interactive reflection, and payment for lived presenters.

People with Suicide Centered Lived Experience Led Sessions in Rural Areas
Rural engagement studies, including Grattidge et al. (2025), demonstrate that community sessions led by local individuals with lived experience surface important contextual insights: geographic isolation, cultural norms about self-reliance, and the role of trusted community institutions like churches, sports clubs, and fairs. Programs in North Carolina and Wyoming illustrate how partnering with local leaders (e.g., Black pastors or 4H clubs) improves trust and participation. Best practices include flexible scheduling, local facilitation, strength-based framing, and transparent follow-up—allowing communities to see how their input shapes programs.

Priority Area 4. Developing a Diverse, Skilled and Culturally Responsive Workforce

Expanding, Diversifying and Retaining the Mental Health Workforce

Internship and Mentorship Opportunities for High School and College Students
Promoting internship and mentorship opportunities for high school and college students interested in mental health careers is a promising strategy to diversify the future workforce. Research shows that early exposure to applied learning experiences can significantly influence a student's academic and professional trajectory. For example, a study of Native American undergraduates participating in a summer research program found that 97% of participants went on to earn science degrees, and half continued into graduate education (Holsti et al., 2015). Similar programs have demonstrated increased interest in public health and medical careers, and a stronger understanding of career pathways (Sopher et al., 2015; Duffus et al., 2014). By building confidence and creating connections to professional networks, these programs can help underrepresented students envision themselves in mental health careers. Expanding access to internship and mentorship programs could expand and diversify mental health by offering supportive entry points into the field.

There is little discussion of relevant programs included in the literature review. One example noted is the New York Leaders: Student Intern Program, a statewide initiative that places undergraduate and graduate students in internships across New York State agencies to build professional experience. However, there is limited publicly available documentation of how this or similar programs specifically support mental health career pathways or reach underrepresented populations.

The Sullivan Commission (2004) identified persistent barriers such as financial hardship, limited academic preparation, and unwelcoming learning environments as impediments to workforce diversity. While existing diversity initiatives have shown promise, their long-term impacts are not yet well-documented (Snyder et al., 2018), showing the need for more rigorous evaluation. Continued investment in pipeline programs, paired with efforts to track participant outcomes over time, can help strengthen the evidence base while addressing systemic inequities in access to mental health careers.

Partnerships with K-12 and Higher Education Institutions
Partnerships with public schools and universities provide a framework for launching strategies to promote careers in mental health that can lead to a more diverse workforce. Factors which may impact the development and success of these partnerships can include the cultural diversity of university/school staff, available resources, and incentives to work in the field of behavioral health (Patterson, 2006).

The U.S. Department of Health and Human Services (HHS) created fellowships and also seeks to host career fairs with partnering Historically Black Colleges and Universities (HBCUs) to provide professional opportunities to those interested in working in healthcare, among other industries (HHS, 2025). This is a concrete first step to expand reach to underserved communities and enable marginalized groups to become a part of the mental health workforce. Other strategies that have been used to build academic partnerships include research apprenticeships, fostering relationships between K-12 and college students, academic enrichment, and reward incentives such as scholarships. These are all influential components of an academic partnership that can help pave the way for minoritized youth and young adults to progress towards health professions (Patterson, 2006).

Amid a behavioral health provider shortage especially in low-income areas, Belansky et al. (2024) highlight recruitment strategies for creating a robust rural mental health workforce. Among these was a comprehensive hiring strategy which included a local community organization partnering with schools to identify hiring needs, assess cost effectiveness, and develop incentives such as loan repayment programs to recruit psychologists and school counselors. A survey of participants indicated the program is beneficial, particularly as a facilitator to address mental health and addiction issues (Ingman, Loecke, & Belansky, 2025). Another example includes the University of Hawai'i partnering with community health clinics to provide behavioral health services to the island's residents by using a service-learning approach to workforce development which includes structured trainee experiences in community settings (Helm et al., 2010). Effectiveness of the program is still being evaluated but preliminary analysis is promising (Chung et al., 2012).

Health career pipeline programs that engage high school students, particularly those from low-income groups and ethno-racially minoritized communities, also have the potential to reduce health disparities and improve community health outcomes in certain neighborhoods. The Health Career Academy (HCA) is a 3-year health career pipeline program where school students from marginalized groups are mentored by health professional students to help them learn about different healthcare career options, plan for how to reach career goals, and understand how healthcare workers care for patients. Another workforce pipeline is the partnership among the New York State Office of Addiction Services and Supports, Office of Mental Health (OMH), Department of Health Certified programs and the State University of New York (SUNY) to encourage people to obtain credentials in addiction studies to address the shortage of qualified addiction counselors. Programs such as these give individuals from low-income and ethnoracially minoritized groups a steppingstone to future careers in mental health care.

Recruitment of Ethnoracially Minoritized and Multilingual Providers

Cultural mistrust is the belief that individuals from other cultural groups will treat someone unfairly, and it often arises after experiences of discrimination. (Padilla et al., 2022). This is reflected in findings that African Americans with greater cultural mistrust tend to feel more negative feelings when therapy is provided by European American clinicians, and that reduced trust is linked to worse treatment outcomes and a lower likelihood of staying in care (Padilla et al., 2022). In this context, increasing ethnoracially minoritized providers may enhance engagement in suicide prevention pathways, as patient–provider race concordance has been linked to more suicide screening (Tran et al., 2025) and ethnic concordance has been associated with greater continuity of care (Alegría et al., 2013). Similarly, multilingual providers may reduce barriers for people with Limited English Proficiency (LEP), since language-concordant care generally improves outcomes (Diamond et al., 2019). For example, Spanish-speaking Latino adults with language-concordant physicians were just as likely as English-concordant Latinos to discuss mental health needs, suggesting that language-matched care can support communication for some groups (August et al., 2011). However, August et al. (2011) also found that Asian/Pacific Islander adults with language-concordant physicians were less likely to discuss mental health concerns than English-concordant patients, indicating that language matching alone is insufficient and must be paired with culturally responsive practices.

Several strategies have been used to diversify the mental health workforce. Clayborne et al. (2021) recommend "diversity pipeline" approaches, including early exposure programs, partnerships with diverse educational institutions, internships, and visible institutional commitments to diversity. For instance, the Tour for Diversity and Mentoring in Medicine (MIM) program created an early pipeline for underrepresented students through mentorship and networking led by under-represented minority (URM) professionals; 86% of applicants to its medical pathway program were accepted to medical school, and 98% of participating high school students enrolled in college (Clayborne et al., 2021). At a systems level, the Office of Minority Health and the CDC have supported similar pipeline partnerships with medical schools and colleges (Clayborne et al., 2021; Zhang et al., 2021). Additional recruitment and hiring practices shown to support workforce diversification include: (a) explicit equal opportunity and diversity statements, (b) diversity-focused marketing and community engagement, (c) targeted recruitment events (e.g., URM-focused virtual fairs) that expand applicant pools (Ojo & Hairston, 2021), (d) holistic review and reduced reliance on narrow screening criteria, and (e) data-driven evaluation of staff and client demographics to identify and correct disparities (Rosales et al., 2022).

Implementation barriers include structural, workforce, and equity-related challenges. Recruiting diverse providers requires long-term investment, adequate funding, and sustained institutional commitment (Clayborne et al., 2021). Retention is also critical: employee stability in behavioral health is influenced by fair pay, job security, career advancement, professional development, and discrimination-free workplaces (Buche et al., 2017). Without supportive policies, such as equitable compensation, mentorship, inclusive organizational culture, and regular assessment of staff satisfaction, diversity efforts may fail to be sustained. Moreover, language access infrastructure and culturally responsive training are needed alongside multilingual hiring, as language concordance alone does not guarantee improved engagement for all groups (August et al., 2011).

Recruitment and Retention Incentives to Increase Workforce Diversity

Financial incentives such as tuition coverage, loan forgiveness, guaranteed job placement, housing stipends, and relocation assistance can be important methods to attract healthcare professionals in underserved areas. In a scoping review of interventions promoting service in underserved areas, scholarships and loan repayment programs (such as those used by the National Health Service Corps (NHSC)) were shown to significantly increase deployment of providers to shortage areas. While some participants left after fulfilling obligations, many remained, demonstrating both recruitment and moderate retention benefits (Elma et al., 2022). However, long-term retention is not guaranteed: early evaluations of the NHSC found that while it successfully deployed over 1,100 behavioral health professionals to rural areas, around half stayed near their original placement site after completing their service obligation—suggesting that geographic location and community fit may limit long-term retention (Politzer et al., 2000).

New York State's participation in programs like the NHSC State Loan Repayment Program (SLRP) demonstrates the effectiveness of these incentives in supporting high-need populations in underserved areas. However, few public programs have explicitly focused on supporting students from MSIs, despite their potential to help diversify the workforce and serve historically underserved communities. Students attending MSIs often face additional structural barriers to entering the mental health workforce, including financial constraints, limited access to professional networks, and academic under-resourcing. Targeting incentives toward these students may help address equity gaps in workforce development, though more targeted program models and evaluations are needed.
Potential challenges include limited evidence on existing state-level programs that specifically recruit from MSIs, making it difficult to assess best practices. Additionally, while incentives may support short-term recruitment, they do not always guarantee long-term retention, particularly in rural or high-need areas where providers may face professional isolation, limited support infrastructure, or fewer career advancement opportunities. Program design must therefore account for factors beyond financial need, including mentorship, workplace conditions, and long-term career development.

Accelerated Pathways to Mental Health Licensure

With 137 million people in Health Professional Shortage Areas for mental healthcare (HPSAs) within the United States, there is an urgent need for more mental health practitioners, and in particular, diverse staff who can speak different languages (Health Workforce Shortage Areas, 2026). It is estimated that only 10% of health services psychologists in the United States provide services in languages other than English (Lin et al., 2021). Creating accelerated pathways to licensure for mental health providers trained in countries outside of the United States would not only address the lack of cultural and linguistic diversity in the mental health profession but also mitigate labor shortages in the field.

Many immigrants with advanced academic or health-related professional degrees are underemployed or working in jobs that underutilize their training and skill level (American Immigration Council, 2023). Recognizing this, some states such as Vermont and Georgia have passed bills to conduct studies to identify barriers to the licensing process and strategies to streamline it for immigrants. An analysis of Vermont's mental health professionals after this legislation was ratified highlighted that simplifying and standardizing licensure requirements will bolster the workforce without compromising competency (Office of Professional Regulation, 2024). In an example of tools to facilitate licensure, Michigan provides guides for the licensure and training of people with health professional credentials earned outside of the United States (Michigan Licensing and Regulatory Affairs, n.d.). There is a deficit in literature exploring alternate pathways to licensure for internationally trained mental health professionals in

the United States. 18 states have active legislation allowing internationally trained physicians to become licensed without accredited post-graduate training, and 17 have similar laws pending or proposed as of December 2025 (Federation of State Medical Boards, 2025). More research on the impact of these state initiatives is needed, as well as expansion in legislation to reach non-physician professionals.

One study characterized the distribution of international medical graduates (IMGs) versus their Canadian or American counterparts (CMSGs/USMGs) over the course of 1981-2001, documenting a substantial growth in IMGs over time that has likely continued to increase since, but there is little to no research on the impact of IMGs in the mental health treatment sphere (Hart et al., 2007). A study focusing on rural Critical Access Hospitals noted that most hired their first IMGs after pro-IMG legislation was rolled out in 1994, which may indicate that incorporating flexible licensure pathways for mental health professionals may have a similar booming effect today (Hagopian et al., 2004). More research is needed to understand the untapped potential of internationally trained mental health professionals, as well as the barriers we need to remove to facilitate American licensure.

Expand the Use of Paraprofessional Staff

Rural counties in the United States are more likely than urban areas to have a lack of behavioral health providers (Behavioral Health Workforce Brief, 2023). As of December 2023, more than half (169 million) of the U.S. population lives in a Mental Health Professional Shortage Area (Mental Health HPSA) (HRSA, 2023). Expanding integrated care and leveraging health support workers may help to address the behavioral health workforce shortage and inequity in service distribution.

Task sharing (also called task shifting) is a strategy used in global mental health to address unmet mental health needs in low-resource and rural settings, which distributes tasks across providers to allow them to work at peak capabilities (Hoeft et al., 2019). A systematic review found that task-sharing approaches have the potential to improve both access and quality of care when teams have clear communication and adequate training, support, and supervision from mental health specialists (Hoeft et al., 2019). This suggests that paraprofessional staff can meaningfully contribute to care delivery when properly integrated into care teams.

Community Health Workers (CHWs), also referred to as promotores, lay health workers, lay providers, indigenous paraprofessionals, peer support specialists, or natural helpers, represent a key group of paraprofessional providers in mental health care (Barnett et al., 2018). CHW-delivered mental health interventions can increase the availability of care in the context of severe workforce shortages (Barnett et al., 2018). A systematic review found that two-thirds of randomized controlled trials showed positive mental health outcomes for traditionally underserved populations receiving CHW-delivered interventions compared to control conditions (Barnett et al., 2018). This indicates that CHWs can be especially effective in improving access and outcomes for populations that are typically underserved by the formal mental health system.

Paraprofessional mental health staff represent a potential solution, specifically by optimizing this type of workforce by clearly outlining their roles and expanding their scope of practice, ensuring that they can effectively contribute to varied healthcare settings. For example, the Camden Coalition is a regional hub in New Jersey that used its health information and coordinated efforts with local providers and agencies to address challenges in determining which provider is responsible for managing a Medicaid beneficiary's care (Camden Coalition, 2026). Some states are also integrating Community Health Workers (CHWs) into the behavioral health field and can explore value-based models to fund CHWs as part of interdisciplinary care teams (NASHP, 2025).

However, there are important implementation challenges. Training, supervision, and fidelity monitoring are essential for CHW-delivered care to be effective (Barnett et al., 2018). Costs also matter. If CHWs require substantially more time and resources than master's-level clinicians, their use may not be cost-effective in settings that already have an adequate professional workforce (Barnett et al., 2018).

The literature identifies several evidence-informed practices to promote workforce diversity, including early exposure programs, targeted recruitment, financial aid, academic support, and curriculum reforms. Comprehensive pipeline programs that combine multiple supports (such as mentoring, tutoring, social services, and career

guidance) have been especially effective in helping underrepresented students enter and complete training in health fields (Snyder et al., 2018). While prior research confirms the importance of targeted recruitment, financial support, and mentorship for increasing diversity in the mental health workforce, the Snyder et al. report highlights additional factors critical to long-term success. These include the development of strategic plans with measurable goals and funding commitments. Programs that embed diversity efforts within broader organizational structures tend to produce more sustainable results. The report also points to a lack of systematic program evaluation as a persistent weakness across many diversity initiatives. Although short-term outcomes like increased enrollment are common, few programs track long-term effects such as licensure, retention, or advancement into leadership roles. Without this data, it is difficult to determine which interventions are most effective. To improve accountability and impact, New York State should incorporate robust evaluation mechanisms into its mental health workforce programs from the outset.

Develop, Enhance, and Adapt Suicide Prevention Training Across Settings

Community Gatekeeper and Brief Intervention Suicide Prevention Programs

Evidence suggests that brief intervention and gatekeeper-style trainings in the workplace can improve suicide-related attitudes and help-seeking behaviors in high-risk sectors like construction. The MATES in Construction program in Australia, for example, successfully implemented general awareness and gatekeeper training alongside support lines and case management to reach construction workers, a group often underserved by traditional mental health services (Hallett et al., 2024). These interventions focused on recognizing signs of distress, initiating conversations, and connecting peers to care. Similarly, the HEAR program was developed for medical students and later adapted for nurses to reduce stigma around mental health and increase service utilization, incorporating both educational training on depression and web-based screening for at-risk individuals. In the military, programs like the Israeli Defense Force Suicide Prevention Program have introduced policies such as reducing weapon availability to limit access to means, alongside education and training for soldiers. These interventions can vary in content, with most interventions aimed at training on recognizing signs of stress, mental illness, and suicidality (Hallet et al, 2024). Other workplace interventions include providing a peer support or buddy system, providing gatekeeper training, and promoting awareness campaigns (Hallet et al, 2024).

However, Hallett et al. (2024) note that while these interventions show promise, long-term effectiveness is not yet well established due to limited robust evaluation designs. The review emphasizes that education was the most common and consistent component of successful interventions. Additional studies (Milner et al., 2014; Nigatu et al., 2019) support the inclusion of work-based mental health strategies but underscore that most programs are not yet designed to address upstream, workplace-specific risk factors. Tailoring brief intervention training to trade professions through existing infrastructure like BOCES, which already delivers specialized training, presents a feasible and potentially impactful approach for early intervention and increased reach.

Universal Tiered Training for All School Staff

Universal, tiered suicide prevention training for all school staff, including custodians, teachers, administrators, coaches, and after-school program personnel, is essential for early recognition of suicide ideation, depression, and mental health challenges among students. Mirick (2025) evaluated a brief, one-hour virtual suicide prevention training for K-12 school personnel, the SOS Signs of Suicide for School Staff program. Surveying 4,493 participants, the study found high acceptability and feasibility, with 92.1% of school staff providing positive feedback. Training increased knowledge of suicide warning signs, confidence to engage students in caring conversations, and skills to safely connect youth to appropriate resources. Key features supporting learning included interactive elements, videos modeling student interactions, and incorporating youth voices with lived experience.

Separately, Walsh, Hooven, and Kronick (2013) studied a school-wide suicide risk awareness training implemented across five comprehensive high schools. Survey results from 237 school personnel showed significant gains in knowledge, confidence, and competence in recognizing and responding to at-risk youth. While training was well-received and deemed appropriate, the study highlighted challenges in increasing participation rates among all school staff. Together, these studies demonstrate that suicide prevention training is both acceptable and effective in improving staff preparedness.

While research supports the value of school-based suicide prevention training, there are limitations to consider. Much of the existing evidence is based on self-reported outcomes without rigorous evaluation designs, making it difficult to assess true effectiveness. Participation may be biased toward those already motivated to engage in the topic, and structural barriers, such as limited time and staffing constraints, can hinder implementation. Additionally, training may not fully address the needs of diverse school communities, including students with disabilities. Ongoing research and adaptation are needed to strengthen impact and reach.

Cultural Humility Training

Cultural humility is an approach that can help facilitate strong working alliances between therapists and diverse clients, leading to better therapy outcomes (Mosher et al., 2017). Within therapeutic contexts, cultural humility refers to providers' willingness to learn about another's culture and self-reflect on one's own cultural values (Bauer et al.,2025). Cultural humility has been positively associated with therapy outcomes and clients report better treatment outcomes with providers who take opportunities to have cultural discussions (Owen et al., 2016). Thus, implementing cultural humility trainings for providers can lead to providers' improved understanding of clients and the client's experiences and perspectives, as well as foster greater levels of comfort among clients.

A culturally humble approach can help promote empathy in providers and ensure that their risk assessment includes various factors, such as different types of discrimination, as possible determinants of psychological well-being (Benton, 2023). An important tool to further aid providers in fostering cultural humility is the Cultural Formulation Interview (CFI) which facilitates patient-provider communication. The CFI can be useful in helping providers build rapport with their clients and to enhance trust and anticipate barriers (Krishan Aggarwal et al., 2022).

Cultural humility functions as a relational buffer between clients and providers. Clients' perception of their counselors' higher level of cultural humility has been associated with lower racial microaggressions in counseling (Hook et al., 2016). A scoping review of 56 studies also found that including cultural humility principles in mental health services can help providers become more culturally attuned, in turn addressing structural barriers encountered by clients and enhancing the scope of mental health services (Konidaris et al., 2025).

Cultural humility training has also demonstrated benefits across specific populations that experience mental health disparities. For example, community mental health workers who completed cultural humility training showed significant post-test improvements in beliefs, attitudes, and behaviors related to working with gay and lesbian patients, as well as increased clinical preparedness for serving LGBTQ+ individuals (DeCesaris et al., 2024). Similarly, culturally adaptable curricula that embed cultural humility within the provider–client dyad have been proposed as effective strategies for improving cross-cultural care for immigrant populations, promoting greater engagement and empowerment (Chang et al., 2012; Bekteshi, 2024). In rural contexts, cultural humility trainings have been associated with post-training gains in provider knowledge, awareness, and skills related to cultural competency (Toledo-Chavez & Gabriel, 2023).

Despite these benefits, challenges remain in translating cultural humility training into sustained clinical practice. Some mental health professionals report uncertainty about applying skills learned in training to real-world care settings, highlighting a gap between post-test knowledge and day-to-day implementation (Miu et al., 2024; Owen et al., 2016). Nevertheless, a systematic review synthesizing 13 studies found a significant positive association between cultural humility and therapy outcomes, reinforcing its role as a core component of an effective therapeutic alliance (Orlowski et al., 2025).

Workplace Suicide Prevention Interventions

A scoping review by Hallett et al. (2024) provides an analysis of global and cross-industry workplace suicide prevention interventions across various sectors. Most intervention mechanisms were aimed at a person's immediate environment and included assessment, treatment, referral, and/or crisis support. While some studies suggest that workplace interventions can reduce suicide risk and positively influence attitudes, the lack of randomized controlled trials limits the ability to make causal conclusions. According to Hallett et al., "The studies that demonstrated reduced rates of suicide either used before-and-after study designs or compared rates to other,

similar populations." The review states that while organizational suicide prevention programs can have a positive impact on attitudes and beliefs towards suicide, there is little evidence on which elements are most likely to be effective. "The only common mechanism within effective interventions was education, either aimed at increasing knowledge for individuals or increasing awareness of signs of stress or suicidality in others" (Hallett et al., 2024). Researchers emphasize the need for tailored interventions and further research to identify the most effective program components and their impact on long-term suicide prevention outcomes.

Suicide Prevention Training Delivery, Dissemination and Compliance

Suicide Prevention Training for Personnel in Non-Clinical Settings

Offering suicide prevention training to personnel in non-clinical settings, such as human resources staff, community health workers (CHWs), aging services providers, and school employees, can expand the reach of early intervention strategies. Programs like QPR (Question, Persuade, Refer), ASIST (Applied Suicide Intervention Skills Training), Mental Health First Aid (MHFA), and Link to Hope, offer varied approaches that are adaptable by setting and time commitment. A review of 10 studies by Herron et al. (2015) found that QPR and ASIST demonstrated the strongest evidence for both efficacy and effectiveness in small community settings. ASIST, in particular, showed beneficial impacts when implemented in crisis call centers, with trained workers outperforming their untrained peers in 6 out of 23 key suicide prevention behaviors and leading to improved caller outcomes such as reduced distress and increased hope (Gould et al., 2013).

Evidence also supports the broader utility of these trainings. QPR has been shown to improve participants' attitudes, perceived social norms, and behavioral intentions to intervene, particularly among individuals with limited prior experience in suicide prevention (Aldrich et al., 2018; Tompkins & Witt, 2009). A large-scale QPR implementation by the Wyoming Department of Health trained over 5,400 individuals using CARES Act funding, demonstrating the feasibility of training non-clinical personnel statewide, though peer-reviewed evaluations of its long-term impact are lacking (Wyoming Dept. of Health, 2021). Mental Health First Aid has also been found to improve mental health knowledge and willingness to help, although a recent review noted limited evidence of long-term changes in helping behavior or outcomes for those receiving assistance (Forthal et al., 2023; Atanda et al., 2020). Evidence suggests that gains in attitudes and behavior often fade without reinforcement, and actual intervention may remain limited. One review found that attitudes frequently returned to baseline within months, and behavior change was inconsistent (Holmes et al., 2021). These findings highlight the need for ongoing support and refresher trainings to sustain impact.

Mental Health Safety Training in High-Risk Professions

Evidence for potential impact of the implementation of mental health safety training may have important preventative value for individuals in high-risk professions, given the elevated burden of mental health concerns and suicide risk in these populations (Nisbet et al., 2024). Individuals in high-risk professions include public safety personnel (PSP), such as, but not limited to, construction workers, paramedics, fire fighters, and law enforcement officers. The nature of work in these professions involves higher risk for exposure to potentially traumatic events (e.g., direct or indirect experiences of threatened or actual death, serious injury or sexual violence (Nisbet et al., 2024). Consistent with this, a review found PSP workers experience a higher prevalence of Post Traumatic Stress Disorder diagnoses, estimating prevalence at 23.2%, compared to approximately 9% across the general population (Edgelow et al., 2021; Carleton et al., 2018; Van Ameringen et al., 2008). Despite this elevated risk, existing mental health interventions tend to target specific diagnostic categories (e.g. social anxiety, depression), limiting their acceptability for individuals in high-risk professions who face cumulative and multi-faceted stressors (Nisbet et al., 2024). Additionally, elevated suicide risk among first responders has been linked to multiple occupational and contextual factors, including repeated exposure to hazardous and traumatic events, irregular and demanding shift schedules, pervasive mental health stigma, and professional norms that prioritize caring for others while discouraging attention to one's own mental health needs (Stanley et al., 2015). This underscores the need for, and acceptability of targeted mental health safety trainings tailored to unique occupational contexts of workers in high-risk professions.

The positive impact of implementing mental health safety training to individuals in high-risk professions is evidenced by a study conducted by Ioachim et al. (2025) on the effectiveness of the Before Operational Stress

program (BOS), an evidence-based mental health and resiliency training program designed to mitigate the effects of mental health disorders and posttraumatic stress injuries in PSP. Core themes of program impact were found across participants, including increased self-awareness and understanding of their mental health and well-being, and improved ability to recognize and manage their emotions and behaviors. In a similar study by Nisbet et al. (2024), researchers assess the effectiveness of a pilot 13-week, peer-led mental health training program administered to individuals in public safety sectors, including correctional facilities and emergency departments. Results of the study indicate most participants felt the program was helpful in improving their overall mental health and providing them with knowledge and/or skills to manage difficult emotions and situations. Additional support for the utility of resilience focused training comes from Mahaffey et al. (2021), who evaluated a disaster worker resiliency training program among workers exposed to repeated trauma during disaster response (e.g., paramedics and firefighters). The program emphasized early identification of participants traumatic stress symptoms, coping and help-seeking strategies, and proactive resilience-building. Participants demonstrated significant improvements across multiple well-being domains, including stress management coping skills, physical activity and spiritual growth. (Mahaffey et al., 2021).

Challenges to implementing mental health safety trainings in high-risk professions often reflect broader structural and organizational barriers rather than limitations of trainings themselves. Findings from the BOS program indicate that participants encountered stressors such as institutional betrayal, workplace stigmatization and unsupportive organizational cultures that limited their ability to fully integrate their skills learned through the program (Ioachim et al., 2025). Participants described experiencing inconsistent organizational messaging, in vocational demands were prioritized over their mental health and well-being. Additional implementation challenges were identified by Nisbet et al. (2024), regarding participant incentive or encouragement to engage in the mental health resiliency training program. Participants who were permitted to attend training during paid work hours or who received compensatory time off reported greater ability and willingness to engage and apply program content, suggestion organizational support plays a critical role in successful uptake. (Nisbet et al., 2024). Collectively, these findings underscore the importance of addressing mental health stigma, leadership practices and structural workplace policies during the implementation of mental health safety trainings and interventions.

Suicide Prevention Training in Various Settings

In addition to the studies outlined in the prior section, several other studies have explored the efficacy and challenges of suicide prevention training in various settings. One study by Marshall et al. (2014) compared the effectiveness of online suicide prevention training (e-CAMS) with traditional in-person CAMS training among VA mental health providers. The findings indicated high satisfaction with both training formats, although in-person participants reported stronger positive feedback. This underscores the importance of offering both online and in-person formats for greater engagement, especially considering the challenges of implementing e-learning across diverse settings.

Mishkind et al. (2023) evaluated the effectiveness of the VitalCog workplace suicide prevention gatekeeper training, delivered both in-person and virtually, across three years. Results from 1,244 pre- and post-training responses showed significant increases in participants' knowledge, confidence in identifying warning signs, and comfort with discussing suicide. Notably, the virtual training group performed just as well, if not better, than the in-person group, indicating the potential for virtual delivery to be just as effective in workplace settings.

Lastly, the NYCARESUP initiative, launched in 2022 by the New York State Office of Mental Health's Suicide Prevention Center, aims to reduce mental health risks among EMS personnel, first responders, corrections officers, and military veterans. While the initiative is expanding its reach, there is limited peer-reviewed research evaluating its overall effectiveness. However, the program's focus on building resilience, peer empowerment, and cultural change within agencies suggests a promising model for suicide prevention in high-risk, uniformed personnel.

Together, these studies and initiatives show the growing recognition of the need for comprehensive, accessible suicide prevention training across diverse sectors. Despite evidence supporting the positive impact of training programs, challenges remain in evaluating long-term outcomes and standardizing best practices across different contexts. Further research into the effectiveness of online and hybrid training formats, as well as evaluations of

large-scale state initiatives like Wyoming's QPR program, are important in refining these efforts and determining their sustained impact.

Priority Area 5. Expanding Access to Culturally, Linguistically, and Structurally Responsive Suicide Care

Availability of Services

Telehealth in Schools and Community Clinics

Telehealth has emerged as a critical strategy for expanding access to mental health care, particularly in communities facing significant barriers such as provider shortages and transportation challenges. It became especially prominent during the COVID-19 pandemic, when studies consistently demonstrated the effectiveness and acceptability of telehealth services across diverse populations (Chen et al., 2024; Hatef et al., 2024; Monaghesh & Hajizadeh, 2020). Telehealth reduces traditional barriers by enabling youth to access counseling and psychiatric consultations on-site at schools or from home, eliminating travel time and associated costs—both major obstacles to care. It also connects patients to specialized providers who may not be available locally, helping to mitigate the workforce shortages common in rural areas (Panchal et al., 2022).

However, the success of telehealth is influenced by several moderating factors. Technology access and digital literacy are essential: when families have the necessary devices, internet connectivity, and skills, telehealth can effectively overcome geographic and scheduling barriers, particularly in rural and hard-to-reach populations (Cummings et al., 2023). Youth preferences also play a role—while some adolescents prefer in-person interactions, many, especially those comfortable with technology, report favoring teletherapy due to its convenience and privacy. Nonetheless, disparities persist. Telehealth's effectiveness is limited in households lacking reliable internet or digital devices, and these technological gaps—more common among low-income and rural families—may contribute to racial and ethnic disparities in the use of tele mental health services (Hu et al., 2025).

Zero Suicide Framework

The Zero Suicide Framework has shown promising results in reducing repeated suicide attempts and prolonging the time to subsequent attempts. For example, an evaluation of its implementation within a large public mental health system in Australia found that individuals receiving multilevel care under the framework experienced fewer recurrent attempts and longer intervals between episodes (Stapelberg et al., 2021). The framework operates through seven core components—Lead, Train, Identify, Engage, Treat, Transition, and Improve—which together create a comprehensive, system-wide approach to suicide prevention (Framework | Zero Suicide). Key actions include universal screening for suicidal ideation, structured risk assessment, timely safety planning (such as restricting access to lethal means), evidence-based treatment for suicidality, and proactive follow-up contact with at-risk individuals.

Despite encouraging early findings, the evidence base for Zero Suicide Framework remains limited. Labouliere et al. (2018) highlighted that while several healthcare systems implementing Zero Suicide-like models have reported reductions in suicide deaths, these outcomes are largely correlational and preliminary. Establishing a causal relationship between the framework and reductions in suicide rates will require large-scale, controlled evaluations to more rigorously assess its effectiveness.

Transportation

Transportation barriers pose a significant challenge to accessing mental health care, particularly for individuals with lower incomes, the under- or uninsured, and those living in rural areas. In such communities, long travel distances and limited public transportation options can isolate residents from needed services, especially if they lack access to a private vehicle (Syed et al., 2013; Winton, 2022). These challenges often lead to delays or cancellations of mental health appointments (Transportation for Rural Mental Health Programs - RHIhub Toolkit, 2024). To address this, transportation services—such as shuttle or van programs operated by rural health networks—can play a critical role by pooling riders and linking distant patients to centralized care. These services help reduce the travel burden, improve treatment adherence and follow-up, and even mitigate stigma. For example, a neutral or unmarked vehicle may allow someone to attend therapy discreetly, without fear of being identified by others in a close-knit community. However, transportation solutions must account for mental health-related barriers as well: individuals

experiencing anxiety or depression may find travel—especially via public transportation—overwhelming. Therefore, shuttle and van programs should incorporate privacy considerations and supportive practices to ensure they are accessible and acceptable to those in need (Transportation for Rural Mental Health Programs - RHIhub Toolkit, 2024)

Financial Barriers to Access

Billing Codes or Zero Suicide

Zero Suicide (ZS) is a system-wide quality-improvement framework designed to coordinate evidence-based suicide prevention practices across health-care settings, making suicide prevention a core responsibility of care systems (Brodosky et al., 2018; Grumet & Jobes, 2024). Research shows that ZS has been associated with reductions in suicide and suicide-related behaviors, demonstrating its potential to improve patient safety and quality of care when implemented with fidelity (Grumet & Jobes, 2024). In New York State, higher fidelity to ZS organizational best practices in outpatient mental health clinics has been linked to a lower likelihood of suicide incidents, suggesting that strong implementation matters for outcomes (Layman et al., 2021). These benefits are especially relevant for adolescents, LGBTQ+ youth, and Black and Latino/a youth, who show elevated suicide-related risk factors in NYC public schools and thus may benefit most from reliable, scalable prevention systems (NYC Department of Health and Mental Hygiene, 2023).

Although the literature on how billing pathways are implemented within Zero Suicide systems is limited, and much of the available evidence comes from case examples and policy guidance rather than systematic empirical studies, many components of Zero Suicide already fit within existing clinical workflows. Clinical assessments and psychotherapy for people at elevated suicide risk are typically reimbursable through standard billing codes, and some training, monitoring, and oversight activities can be integrated into routine operations (Richardson et al., 2023). However, key ZS activities such as screening, safety planning, and follow-up contacts are often not reimbursed, even though they are central to suicide prevention (Richardson et al., 2023). Ideally, payers would offer alternative payment models that support Zero Suicide and suicide-specific care practices to incentivize this work, and it is in the best interests of managed care entities and accountable care organizations to invest in high-quality, effective suicide prevention (Thomas et al., 2022). Despite reimbursement gaps, organizations have continued to provide these services because they are low-cost and high-impact, indicating strong acceptability and perceived value among providers (Richardson et al., 2023). In addition, national guidance now exists on how to bill for suicide screening, assessment, and follow-up care, showing that payer-based financing for suicide prevention is technically feasible even if not yet widely used (Richardson et al., 2023).

At the same time, major implementation barriers remain, particularly around financing. Most ZS activities are embedded in standard practice and are nonbillable, including staff training, data collection, monitoring, and leadership time needed to sustain a culture of suicide-safer care (Richardson et al., 2023). The lack of specific billing codes for suicide prevention means that even when services such as case management are billed, reimbursement is often minimal, making long-term sustainability difficult (Richardson et al., 2023). National policy work has noted that insurers can create additional reimbursement codes for suicide-prevention procedures, suggesting that dedicated codes (including a bundled code or a small set of ZS-specific codes) could reduce the current patchwork approach and make financing more sustainable (U.S. Department of Health and Human Services, 2021). Importantly, evidence from the Centerstone Research Institute shows that enhanced crisis follow-up, a core ZS-aligned activity, produced an estimated $2.7 million in savings from prevented psychiatric hospitalizations, and the organization plans to use this evidence to advocate for billing changes to support these services (Richardson et al., 2023).

Employee Benefits

Robust health insurance coverage plays a critical role in suicide prevention by improving access to behavioral healthcare services. Evidence indicates that individuals without insurance face significantly higher suicide attempt risk compared to insured individuals; for instance, data from trauma centers across the U.S. found that uninsured trauma patients were more likely to attempt suicide than their insured counterparts (Temko et al., 2022). Broader analyses of national data further underscore the relationship between insurance coverage and suicidal behaviors. Using NSDUH data from 2010 to 2019, Cho & Lee (2024) found that individuals on Medicaid or without insurance

had higher rates of suicidal ideation and attempts than those with private insurance. While Medicare beneficiaries experienced reductions in suicide risk following the Affordable Care Act (ACA), no significant change was observed among the Medicaid or uninsured populations, highlighting the potential need to enhance benefits and access among these lower-coverage groups.

Additional research supports these trends: Patel et al. (2018) compared suicide rates in states that expanded Medicaid versus those that did not and found that while suicide rates increased nationally, the rate of increase was slower in expansion states than in non-expansion states. However, this benefit was not equitably distributed. Subgroup analyses showed minimal effects for Black individuals, women, and adults aged 45–64, and only White individuals showed statistically significant declines in suicide rates. These disparities underscore the fact that expanding insurance coverage alone may not be sufficient; structural inequities such as limited access to high-quality ambulatory care, housing insecurity, and unemployment continue to shape suicide risk among marginalized communities. To be effective, policies that promote expanded behavioral health benefits must also be accompanied by targeted efforts to reduce systemic barriers to care.

Traditional, Complementary, and Alternative Medicine (TCAM) Practices
Traditional, Complementary, and Alternative Medicine (TCAM) practices—including herbal medicine, acupuncture, mindfulness, and group-based healing—are increasingly used in the U.S., particularly among minority and immigrant populations who may not fully engage with Western mental health systems. Cultural conceptualizations of well-being among these groups often emphasize holistic integration of physical, mental, and spiritual health. For example, elderly Latino immigrants tend to define health through a mind-body-spirit framework (Ailinger & Causey, 1995; Weisman et al., 2005), while Southeast Asian approaches often involve restoring bodily balance and harmony (Gerber et al., 1999; Weisman et al., 2005). Among East and Southeast Asians, somatization of psychological distress is common, and traditional practices such as herbal remedies, acupuncture, and services from cultural practitioners (e.g., hanui in Korean medicine) remain prevalent (Handelman & Yeo, 1996; Nagata et al., 2015).

A growing body of research supports the therapeutic potential of TCAM, especially when integrated with Western modalities. A 2017 review by the Institute for Clinical and Economic Review found sufficient evidence supporting yoga, acupuncture, CBT, and mindfulness-based stress reduction for managing chronic pain—interventions that often produce fewer side effects than conventional treatments like opioids or surgery (Caffrey, 2017). More recently, a meta-analysis conducted during the COVID-19 pandemic found significant benefits of mindfulness meditation in reducing depressive symptoms (Fu et al., 2024). Despite their promise, these practices remain underutilized in clinical care, in part due to a lack of insurance coverage and stigma surrounding disclosure. Many individuals with unmet mental health needs, particularly those without private insurance, report turning to TCAM for support but face barriers when these services are not reimbursed (Agu et al., 2019; Yi et al., 2024). While TCAM users often report positive outcomes, variability in definitions and methodological limitations in the literature can complicate assessments of efficacy (Agu et al., 2019; Lin et al., 2021).

To better serve diverse communities, culturally tailored models that incorporate TCAM within mainstream systems are essential. Community-engaged approaches—such as collaborations with Indigenous healers, cultural elders, or other traditional authorities—can ensure that such practices are delivered in respectful, effective, and context-sensitive ways (Corso et al., 2022). Expanding insurance reimbursement to cover these culturally relevant interventions could enhance access, improve engagement among underserved groups, and ultimately support more inclusive and equitable mental health care.

However, policy and ethical concerns must also be carefully considered when expanding insurance coverage to non-evidence-based treatments. An illustrative case of these concerns can be found in Germany, where the public insurance coverage of homeopathic medicine is mired in political controversy due to the lack of scientific evidence supporting homeopathic efficacy and the potential for public funds to be diverted away from evidence-based care. Critics argue that covering therapies without robust clinical backing may mislead patients and delay effective treatment, raising ethical questions about informed consent and the responsible use of healthcare resources (Hruby, 2020; Leemhuis & Seifert, 2024). Any expansion of coverage should be grounded in a rigorous evaluation

of safety, efficacy, and cultural relevance to avoid inadvertently legitimizing unproven, ineffective or potentially harmful treatments.

Transportation and Childcare

Practical barriers such as lack of transportation and childcare significantly hinder access to mental health care, particularly for low-income populations, individuals with serious mental illness (SMI), and women with caregiving responsibilities. While telemedicine has expanded access, it does not fully eliminate transportation needs—especially for those requiring or preferring in-person care. Older adults, lower-income individuals, and non-English speakers are least likely to utilize telehealth, and areas with limited broadband access are less likely to support video-based visits (Chen et al., 2021). For many individuals requiring or preferring in-person care, reliance on public transportation or others for travel increases the likelihood of treatment dropout or missed appointments. Solutions such as expanding access to Medicaid's non-emergency medical transportation (NEMT) program and integrating it with paratransit services may help address these gaps, though evidence on whether such transportation assistance consistently reduces no-show rates remains mixed (Chen et al., 2021).

Childcare is another frequently overlooked but critical factor affecting healthcare engagement. Surveys of women receiving ambulatory care services in Texas found that more than one-third delayed at least one medical appointment due to childcare challenges, and over half of those who delayed care reported missing appointments entirely because of it (Gaur et al., 2024). A majority reported needing to leave appointments early to care for their children, and very few utilized formal childcare services—often citing safety and affordability as key concerns. Notably, nearly 88% said that on-site hospital childcare would help them attend appointments. A more recent study of women in a Texas safety-net healthcare system found that childcare barriers were associated with an 8.8% greater rate of healthcare nonadherence, even after adjusting for demographic and socioeconomic factors (Ganguly et al., 2025). Together, these findings highlight how logistical burdens compound access challenges, particularly for vulnerable populations. Policymakers seeking to address suicide risk should consider transportation and childcare assistance as part of a broader effort to promote economic security and reduce barriers to care—an approach aligned with emerging evidence linking supportive social policies to improved mental health outcomes (Purtle et al., 2025).

Policies impacting economic security can also reduce suicide risk: A review of public policies impacting suicide risk noted that economic security policies such as increases to minimum wage, greater unemployment benefits, and increasing SNAP eligibility, while not directly intended to impact suicide, do reduce suicide risk. Evidence is limited but does suggest that increasing sick leave reduces suicide risk (Purtle et al., 2025).

Culturally and Linguistically Responsive Services

Multilingual Mental Health Services

A growing body of U.S.-based research supports the need to provide multilingual support—particularly in Spanish, Chinese, and Arabic—in all state mental health services, including telehealth. Individuals with limited English proficiency (LEP) are significantly less likely to access mental health care, more likely to experience unmet needs, and often face lower quality care when language services are not available (Garcia et al., 2020; Ohtani et al., 2015). Language discordance contributes to miscommunication, lower satisfaction, inaccurate diagnoses, and decreased treatment adherence (Pandey et al., 2021; Flores, 2005). Conversely, when patients receive care in their preferred language, either through bilingual providers or qualified interpreters, studies show improved communication, better engagement, and more equitable outcomes (Flores, 2005; Karliner et al., 2007).

There is strong and growing evidence that culturally and linguistically responsive mental health services are essential to addressing suicide risk in ethnoracially diverse communities. Structural barriers such as limited-service availability, insurance coverage disparities, immigration-related fears, and systemic racism have long compromised access to mental health care for racially and linguistically minoritized populations (Office of the Surgeon General, 2001). Research consistently shows that culturally adapted interventions are more effective than non-adapted versions, especially when conducted in the client's native language. For example, a meta-analysis of 76 studies by Griner and Smith (2006) found that interventions in a client's native language were twice as effective as those conducted in English, and that matching therapists on ethnicity and language, or embedding cultural values into

treatment, significantly improved outcomes. Similarly, a large review by Hall et al. (2016) concluded that culturally adapted interventions consistently outperformed standard ones, although the effect sizes varied depending on factors such as therapist-client match, client age, acculturation level, and the setting of intervention.

This need extends to telehealth services, where language barriers remain a significant obstacle. LEP patients are less likely to use tele-mental health services, often due to the lack of language-concordant interfaces, appointment systems, and real-time interpretation (Rodriguez et al., 2021; Uscher Pines., 2023). Research shows that even basic access—like scheduling an appointment—can be compromised when clinics do not support common non-English languages (Usher-Pines et al., 2023). As the most linguistically diverse state in the U.S., New York must ensure that its mental health systems integrate multilingual support across both in-person and telehealth platforms to reduce disparities and improve outcomes for LEP populations (Pro et al., 2022; Twersky et al., 2024).

Culturally Appropriate Mental Health Resources and Educational Materials

Research strongly supports the need to co-create mental health resources with ethno-racially diverse communities to ensure cultural and linguistic appropriateness. Collaborative, community-based approaches, such as co-design and community-based participatory research, help tailor interventions to the cultural needs and preferences of the target population. Involving community members at every stage has been shown to improve trust, relevance, and engagement. For example, a systematic review by Shahnaz et al. (2025) found that co-designing mental health interventions with racially minoritized youth led to sustained stakeholder engagement, reduced power differentials, and greater trust through culturally tailored activities and communication. When services and materials are developed in partnership with the community, they more accurately reflect the community's language, values, and preferred healing practices, which can increase uptake and effectiveness (Tran & Tran, 2022; Shahnaz et al., 2025).

Using culturally appropriate language in mental health education is particularly important. Studies indicate that framing mental health discussions in culturally resonant terms—such as emphasizing wellness and recovery rather than stigmatizing clinical labels—makes resources more accessible and reduces stigma in minoritized communities (Tran & Tran, 2022). Culturally tailored messaging and accurate translations help diverse groups feel understood and respected, encouraging them to seek help. Likewise, integrating culturally relevant healing practices into mental health care (e.g., storytelling, faith-based support, talking circles, or indigenous healing ceremonies) has been shown to enhance acceptability and effectiveness for specific cultural groups (Bogic et al., 2023).

Many individuals from culturally diverse communities often turn to community elders, religious leaders, or traditional healers to cope with mental distress, rather than exclusively relying on clinical providers (Tran & Tran, 2022). By collaborating with these trusted community figures and honoring culturally grounded healing methods, mental health professionals can create educational materials and interventions that resonate more deeply with community members' lived experiences and worldviews. Overall, the literature emphasizes that culturally responsive, community-informed strategies are essential to improving mental health equity and outcomes in diverse populations (Bogic et al., 2023; Tran & Tran, 2022).

These findings are echoed in more recent studies that emphasize community engagement and cultural tailoring as key mechanisms of action. For instance, a mixed-methods study by Asnaani et al. (2022) found that many immigrant and ethnoracially minoritized communities place a premium on mental health services that reflect their values and structures, including a cautious approach to diagnosis and inclusion of community voices in care delivery. Bogic et al. (2023) demonstrated how cultural adaptation of suicide prevention strategies—such as the Caring Contacts intervention in American Indian and Alaska Native communities—led to increased engagement and broader detection of suicidal distress. Similarly, Meza and Bath (2021) argue that suicide prevention must incorporate cultural risk and protective factors, expand assessments to include racism and acculturation stress, and support structural adaptations such as inclusive research samples and workforce training. Taken together, this body of research supports the urgent need for state-level suicide prevention strategies to include multilingual services and to collaborate with ethnoracial communities to co-develop interventions that incorporate culturally grounded language and healing practices

Integrating Suicide Prevention into Healthcare Settings

Standardized Screening for Suicidal Ideation and Depression

Routine screening for depression and suicidal ideation in primary care is a foundational prevention strategy. Structured tools, like the PHQ-9, especially item 9 assessing suicidal ideation, outperform unstructured clinical judgment in detecting suicide risk (Simon et al., 2013). Studies show that positive responses to this item significantly predict future suicide attempts (Rossom et al., 2017).

Evidence from a large stepped-wedge trial across 19 clinics demonstrated that universal depression screening and risk-specific follow-up (e.g., safety planning) reduced suicide attempt rates by 25% within 90 days of a visit (Richards et al., 2024). The U.S. Preventive Services Task Force (USPSTF) recommends routine depression screening in primary care for adults and adolescents (Siu et al., 2016), providing a platform to integrate suicide risk detection.

Feasibility studies in systems like Parkland Health demonstrate that millions of patients can be screened using brief, integrated tools without major disruptions to care (Horowitz et al., 2020). Patients generally accept suicide risk screening, and clinicians grow more comfortable when trained to respond (Ballard et al., 2017).

However, screening must be paired with structured assessment and intervention. Alone, it may yield false positives or fail to capture those denying ideation. Prior guidelines cautioned about insufficient evidence for screening to reduce mortality (O'Connor et al., 2013), but more recent trials demonstrate reductions in proximal outcomes like suicide attempts (Richards et al., 2024). Thus, screening is a critical first step in a broader care pathway.

High-Risk Flags in Electronic Medical Record Systems

The U.S. Department of Veterans Affairs (VA) has implemented EMR "high-risk for suicide" flags as part of its REACH VET program, which uses predictive algorithms to identify the top 0.1% of patients at elevated suicide risk each month (Matarazzo et al., 2023). These patients are flagged for proactive engagement and enhanced care coordination. National evaluations show that REACH VET improved care engagement, including increased outpatient visits, documented safety plans, and a 5% reduction in suicide attempt rates (McCarthy et al., 2021).

Providers reached 98% of flagged individuals, demonstrating feasibility at scale. While predictive models carry limitations—such as false positives and the potential for alert fatigue—calibrating criteria and ensuring meaningful follow-up mitigate these risks (Berg et al., 2018). Ethical considerations include transparency with patients and rigorous data security.

Outside the VA, few systems use such flags. New York State could lead by piloting EMR alerts in large systems (e.g., Medicaid or state-run hospitals) and establishing protocols for response. Integration with quality improvement measures and risk monitoring infrastructure is key.

Zero Suicide Framework Serving Disproportionately Affected Populations

Zero Suicide is a comprehensive framework for healthcare-based suicide prevention, emphasizing leadership, workforce training, universal screening, safety planning, evidence-based treatments, and post-discharge follow-up (Brodsky et al., 2018). The Henry Ford Health System reported a reduction from an expected suicide rate of 89 per 100,000 to zero suicides for nine consecutive quarters after adopting a precursor to Zero Suicide (Hampton, 2010). Other systems have reported reductions in suicide attempts and longer time to recurrence after Zero Suicide implementation (Stapelberg et al., 2020). Multisite U.S. evaluations also show significant reductions in suicide-related behaviors (Labouliere et al., 2018).

While promising, most evaluations are correlational and lack randomized controls. Labouliere et al. (2018) emphasized the need for rigorous evaluation. Hence, the Task Force recommends expanding site visits to assess fidelity and identify opportunities for tailoring. Site visits can evaluate whether organizations are screening universally, following safety planning protocols, offering evidence-based care (e.g., CBT-SP, DBT), and engaging high-risk groups. They also provide feedback loops for continuous improvement (National Action Alliance for Suicide Prevention, 2018). Tailoring is essential: rural, youth, or ethnoracially diverse populations may require

cultural adaptations or alternative delivery models. Supporting implementation through technical assistance and policy incentives will help healthcare systems translate the Zero Suicide framework into practice.

Reimbursement
Aligning reimbursement with suicide prevention efforts is vital. Traditional fee-for-service models often fail to reimburse activities like suicide risk screening or follow-up calls, deterring uptake. Value-based care (VBC) models, such as those promoted by CMS, tie payments to outcomes and could reward providers for screening, safety planning, and follow-up (Zero Suicide Institute, 2020).

Medicaid and Medicare initiatives are beginning to integrate behavioral health metrics into VBC contracts, and experts recommend including suicide-related performance indicators (e.g., follow-up after suicide risk identification) in pay-for-performance models (SPRC, 2019). While empirical data remain limited, early adopters report improved uptake of behavioral health protocols under VBC (Miller et al., 2016).

HealthySteps
HealthySteps places behavioral health professionals in pediatric primary care teams to support families with developmental, behavioral, and psychosocial needs. Evaluations show increased screening for parental depression, improved child development outcomes, and higher family satisfaction (Minkovitz et al., 2007; Zero to Three, 2024). Though not designed as a suicide prevention model, HealthySteps addresses upstream determinants (e.g., early adversity, maternal mental health, child behavioral issues) that predict later risk. It also normalizes mental health services and increases early identification and referrals. Embedding such models statewide could strengthen long-term suicide prevention infrastructure.

Integrated Care
Integrated care for co-occurring disorders is a best practice supported by SAMHSA and numerous clinical trials. Co-located services reduce barriers to care, improve engagement, and reduce hospitalizations (SAMHSA, 2022). Substance use is a major risk factor for suicide and addressing it concurrently with mental health care can reduce impulsivity and crisis behaviors (Esposito-Smythers et al., 2011).

While full integration may face regulatory and funding challenges, braided financing models and shared facilities can improve care continuity. Behavioral health homes, CCBHCs, and dual-diagnosis clinics offer models for replication in New York State.

Integrating suicide prevention into healthcare systems is a necessary and evidence-informed approach. Recommendations such as universal screening, EMR flag systems, and Zero Suicide implementation are backed by promising data and real-world feasibility. Complementary strategies—like incentivizing care through VBC, embedding behavioral health in pediatrics, and co-locating dual-diagnosis services—fill crucial gaps.

Effective implementation will require leadership, financing, data systems, and attention to equity. Policymakers can accelerate progress by aligning mandates and incentives with these practices, supporting technical assistance, and reinforcing accountability through quality improvement initiatives. With these efforts, New York can move closer to a health system where every suicidal patient is identified, supported, and given a pathway to recovery.

Priority Area 6. Strengthening Community-Based Approaches

School-Based Initiatives

Standardized Suicide Screening in Schools
Standardized suicide risk screening in schools is a critical strategy for identifying at-risk students and connecting them to care. Schools are well-positioned to notice behavioral and emotional changes (Erbacher & Singer, 2018), and universal screening using validated tools can significantly increase detection. One study found that high schools using universal depression screening had over seven times greater odds of identifying students at risk for suicide than traditional referral methods (Sekhar et al., 2022).

Research has indicated that effective systems must include protocols for triage, safety planning, and follow-up (Davenport & Crepeau-Hobson, 2023). Tools like the C-SSRS are recommended for assessing suicide risk and guiding next steps (Posner et al., 2011; SAMHSA, 2020). Comprehensive implementation includes staff training, brief validated screeners (e.g., PHQ-9-Item #9, ASQ), clear assessment protocols, and coordinated follow-up (Katz et al., 2013; SAMHSA, 2020). While some debate universal vs. targeted screening, universal approaches may reduce disparities by limiting bias and reaching underserved groups, including BIPOC youth (Bright Futures/AAP, 2022; Mexa et al., 2021). Crucially, research finds that asking about suicide does not increase risk and may instead promote help-seeking (Mathias et al., 2012).

Parent Education and Resources

There is very little research on caregiver education related to suicide prevention. Nonetheless, caregivers have been identified by advocates and youth as playing a crucial role in young people's lives, making them an important target group when addressing suicidality in youth (Lozano-Rodríguez & Valero-Aguayo, 2017). Parenting styles have been linked to suicidality, particularly authoritarian styles (e.g., overcontrol, overprotection, negative family climate) and permissive or avoidant styles (e.g., low control, low expectations) (Singh & Behmani, 2018). Moreover, family conflict, absence of family support, and unmet family goals have also been associated with suicidality in youth (Randell et al., 2006). This body of scholarship underscores the importance of working alongside caregivers in suicide prevention.

Research on caregiver education for suicide prevention remains limited; however, several interventions have demonstrated effectiveness or benefits in reducing suicidality or associated risk factors. Online trainings have emerged as a feasible approach due to challenges in recruitment and retention of caregivers in suicide prevention educational efforts. One study evaluated LivingWorks Start with caregivers, an online interactive community training aimed at increasing awareness, developing basic intervention skills, linking youth experiencing suicidality to community resources, and providing suicide first aid (McKay et al., 2022). This 90-minute self-paced training is designed for individuals aged 13 and older and was found to increase self-efficacy, help-seeking behaviors, and suicide literacy.

In Australia, a parent empowerment training demonstrated carry-over effects on youth empowerment, as well as on their friends and peers (Tombourou & Gregg, 2002). Although the intervention focused primarily on suicide risk factors rather than suicide itself, it included components such as teaching parents assertiveness, conflict resolution and problem-solving skills, active listening, and factors associated with substance use, as well as strategies to foster hope and optimism. This intervention, known as PACE, was delivered through schools and showed a positive impact in reducing suicidality risk factors. In another intervention, It's Time to Talk About It: Family Training for Youth Suicide Prevention (ITT-FT), caregiver education related to youth suicide was associated with decreased stigma toward help-seeking among Latinx persons (Schuck et al., 2023).

Comprehensive, Multi-tiered Suicide Prevention Curriculum

Research supports comprehensive, multi-tiered suicide prevention curricula across all grade levels. Programs like *Sources of Strength and Signs of Suicide (SOS)* improve mental health awareness, help-seeking, and reduce suicide risk.

Sources of Strength is a peer-led program that shifts school norms and reduces suicide attempts. In a randomized trial, trained peer leaders promoted messages of hope and connectedness, leading to increased student willingness to seek help (Wyman et al., 2010). A later evaluation found a 29% reduction in new suicide attempts in participating schools (Wyman et al., 2019). The program follows a tiered approach:

This program's success is rooted in its tiered structure:

- Tier 1: Universal promotion of strengths-based messaging to all students,
- Tier 2: Training peer leaders and trusted adults as gatekeepers,
- Tier 3: Identification and referral of high-risk students for additional support.

Signs of Suicide combines education, screening, and its ACT model (Acknowledge, Care, Tell) to equip students to respond to distress (Aseltine & DeMartino, 2004; Schilling et al., 2016). Meta-analyses show that school-wide, tiered programs increase knowledge, boost help-seeking, and lower suicide attempts (Miller et al., 2022). Embedding curricula from elementary through high school with developmentally appropriate content promotes sustained prevention, especially when paired with a supportive school climate. Statewide requirements can help ensure equitable implementation (Wyman et al., 2019; Miller et al., 2022).

Suicide Prevention in the Professional Standards for Educational Leaders

There is no single empirical study that directly evaluates the integration of suicide prevention into the Professional Standards for Educational Leaders (PSEL). However, several empirical studies provide strong supporting evidence for this recommendation. Wirthlin et al. (2024) conducted a systematic analysis of suicide prevention policies across all school districts in the state of Utah and developed a new evaluation instrument, the School Suicide Policy Evaluation Tool (SSPET). After applying this tool, the authors found that although schools could report having suicide prevention policies in place, the lack of standardized content meant that these policies often failed to provide an actionable or implementable framework (Wirthlin et al., 2024). This proof-of-concept study demonstrated the utility of the SSPET in identifying critical gaps in school district suicide prevention policies and generating specific recommendations for improvement (Wirthlin et al., 2024). Notably, Utah school district policies received very low scores when evaluated against model criteria (median = 2.25 out of 36, where higher scores reflect more complete policies) (Wirthlin et al., 2024). Similarly, Dueñas et al. (2025) examined 282 schools in Catalonia, Spain, using a mixed-methods approach to collect both quantitative and qualitative data. Their findings revealed substantial disparities in the perceived effectiveness of existing suicide prevention guidelines, particularly between schools that had experienced actual suicide cases or attempts and those that had not (Dueñas et al., 2025). The study highlights that the mere availability of guidelines is insufficient without targeted training, resources, and structured implementation support, underscoring the need for stronger system-level frameworks to guide schools' suicide prevention efforts (Dueñas et al., 2025).

There has been research to identify the barriers to implementation of suicide prevention programs within educational settings. Porter et al. (2023) explored secondary school principals' knowledge of suicide prevention programs, their perceptions of logistical and cultural barriers, and their reasoning for adopting or not adopting such programs in their schools. Principals identified limited staffing, time constraints, perceptions of school responsibility for student mental health, and lack of knowledge about available suicide prevention resources as key barriers to program adoption (Porter et al., 2023). These logistical, cultural, and knowledge-based barriers reflect leadership perceptions that may hinder the implementation of these standards, while simultaneously highlighting the critical need for such standards to exist.

Policy-level interventions have demonstrated that they can combat some of the existing implementation barriers. Rosenblum et al. (2025) evaluated the impact of gatekeeper training laws (GTLs) on the prevalence of suicide prevention training among school staff. Their findings showed that GTL mandates were associated with a 13.7 percentage point increase (95% CI [7.7, 19.8]) in the proportion of public secondary schools where the lead health education teacher received suicide prevention training, compared with states without such mandates (Rosenblum et al., 2025). Event study analyses indicated that these effects were sustained across all post-mandate periods, suggesting that policy-level standards can meaningfully increase training reach and engagement (Rosenblum et al., 2025).

School-Based Suicide Prevention Policies

School-based suicide prevention policies are an important step in the implementation of suicide prevention interventions. There is a need to work on advocating for these policies to be developed or further integrated into schools (Kann et al., 2016). Thus, to do this effectively, it is important to look at what challenges institutions and schools face when trying to establish these types of interventions. Cultural barriers remain a significant barrier in implementing school-based suicide prevention policies due to factors such as stigma and language (Balaguru et al., 2013).

When implementing school-based initiatives, one review found that addressing underlying risk factors such as substance use and psychological distress is essential for prevention (Balaguru et al., 2013). Moreover, the same review found that interventions teaching problem-solving and coping skills are beneficial as well. In the review, interventions were less effective when they focused on clarifying myths and failed to engage caregivers and peers. Other factors reducing their effectiveness were their short duration, lack of external psychosocial support, and not addressing confidentiality concerns. Finally, Interventions that are too resource-intensive make it difficult for schools to engage in implementation. (Balaguru et al., 2023).

Another challenge identified by another systematic review of school-based suicide prevention interventions was the lack of input from both students and staff during the stages from design, implementation, and finally in outcomes (Walsh et al., 2023). They additionally reported that many of these interventions lacked analysis or reporting on contextual factors about the communities the interventions were targeted toward. Lastly, although gatekeeper trainings in schools have shown to lead to reduced suicidality, these outcomes are not sustained for long periods (Walrath et al., 2015). This signals a need for long-term suicide prevention programming in schools. Thus, research supports the development of school-based suicide prevention policies that aim to address underlying risk factors, consider contextual characteristics and create a cohesive collective effort around supporting youth experiencing suicidality (Singer et al., 2019c).

School-wide Initiatives

The CDC (1994) and SPCNY (2022) recommend school-wide initiatives, including gatekeeper training, general suicide education, peer support, and screening protocols. Meta-analyses confirm that while program effectiveness varies, tiered interventions improve knowledge and help-seeking and reduce suicidal ideation and attempts (Walsh et al., 2022; Miller et al., 2009).

- School Gatekeeper Training – for school personnel to learn to identify students at risk and how to respond.
- Community Gatekeeper Training — for community members in contact with youths.
- General Suicide Education — teaches students about warning signs and how to seek help and often incorporates activities to develop self-esteem and social competence.
- Screening Programs — Questionnaires and other screening instruments are used to assess risk and provide further assessment and treatment; repeated measures may be used to assess change or program effectiveness.
- Peer Support Programs — Programs that are designed to foster peer relationships and competency in social skills with high-risk youth.
- Crisis Centers and Hotlines — Trained volunteers provide phone counseling and other services to suicidal persons. These programs may offer a “drop in” crisis center visit or make a referral to other mental health services.
- Restriction of Access to Lethal Means — Activities that are designed to restrict access to handguns, drugs, and other means used for attempting suicide.

School-Based Suicide Prevention Programs

Meta-analyses and systematic reviews have found mixed results on the effectiveness of school-based suicide prevention programs at reducing suicidal ideation and attempts (Cusimano & Sameem, 2011; Miller et al., 2009; Walsh et al., 2022). There also exists a wide variety of programs with different scopes, methods, and efficacy. Some of the programs include:

- **Sources of Strength Program**: A universal support-approach youth mental health promotion and suicide prevention program that offers training and curriculum for student peer leaders and adult advisors. This program aims to build socioecological protective influences across a full student population through utilizing student peer leaders to influence at-risk students, apply strategic messaging campaigns, and modify norms within student populations around adult-youth communication and help-seeking behavior (Wyman et al., 2010). A recent randomized controlled trial evaluating the outcome of this program at 22 US high schools showed that the program reduces youth and young adult suicide rates (Wyman et al., 2025). Some of the limitations of this program include that the program did not reduce rates of suicide attempts among students with more severe histories of sexual violence; another limitation is that the intervention did not show significant improvements in smaller, rural schools (Wyman et al., 2010)

- **Youth Aware of Mental Health (YAM)**: A European intervention that was found in a randomized-controlled trial to reduce suicide attempts and severe suicidal ideation in school-based adolescents (D. Wasserman et al., 2015), it has been adapted at some US schools with promising results (Lindow et al., 2020; Trivedi et al., 2022; C. Wasserman et al., 2018). The YAM intervention is a universal primary prevention intervention designed to raise mental health awareness about risk and protective factors associated with suicide, including knowledge about depression and anxiety, and to enhance the skills and emotional resiliency needed to deal with adverse life events, stress, and suicidal behaviors (D. Wasserman et al., 2010). YAM is implemented via interactive lectures, booklets, posters, and role-playing sessions. Limitations to YAM include that YAM's universal implementation approach might limit its efficacy among cultural and ethnic minority students (Weissman et al., 2024) and that YAM's reliance on external mental health professionals can limit its implementations among schools with limited resources.
- **QPR (Question, Persuade, Refer) Gatekeeper training**: A widely implemented training that equips educators, staff, and students with the skills to recognize warning signs, engage in supportive dialogue, and refer at-risk individuals to appropriate services. QPR is not designed specifically for the school environment, but studies have shown evidence that the training is effective in increasing intention to intervene (Aldrich et al.,2004), as well as self-efficacy and suicide prevention knowledge of gatekeepers (Litteken & Sale, 2018; Sullivan et al., 2024). One limitation of available QPR research is that the training is often tested on ethnoracially homogeneous samples.
- **Signs of Suicide (SOS)**: SOS is a school-based suicide prevention initiative that combines education and screening to identify at-risk students. Research has shown that the SOS program is effective in lowering rates of suicide attempts and increasing knowledge and adaptive attitude about depression and suicide among adolescents (Aseltine & DeMartino, 2004; Schilling et al., 2016). SOS provides a curriculum that includes lessons on raising awareness of depression and suicide, helping students identify the warning signs and risk factors of depression in themselves and others, as well as encouraging help-seeking behavior using the ACT (Acknowledge, Care, Tell) technique (SOS signs of suicide for parents, 2025).
- **Family Acceptance Project (FAP)**: FAP is a research, intervention, education, and policy initiative established at San Francisco State University to prevent health and mental health risks and to promote well-being for LGBTQ children and youth. Though not directly a suicide prevention program nor a school-based program, FAP provides training, consultation & program development for agencies, institutions, congregations, and communities. FAP promotes positive LGBTQ young adult mental and physical health developments, which is a barrier against suicidal ideation and attempts (Ryan et al, 2010).

Suicide Risk and Stigma among Neurodivergent Individuals

Increased suicide risk and stigma among neurodivergent individuals underscore the need for targeted, adapted, and system-level prevention strategies. Neurodivergent individuals, particularly those with intellectual and developmental disabilities (IDD), face elevated mental health risks alongside persistent stigma and systemic barriers that often limit access to appropriate care. A 2024 multi-state qualitative study found that fragmented coordination between IDD and mental health agencies frequently results in reactive, crisis-driven collaboration rather than proactive prevention, creating systemic gaps in care for people with co-occurring IDD and mental health conditions (Stone et al., 2024). Stakeholders also identified diagnostic overshadowing, often due to the assumption that people with IDD cannot experience genuine mental health concerns, as a persistent barrier that undermines appropriate identification and treatment (Stone et al., 2024).

Partnering with organizations such as the Office for People with Developmental Disabilities (OPWDD) is therefore critical to addressing this siloed system and improving coordinated care. Partnering with organizations like OPWDD at a system level likely enhances impact because OPWDD manages services for individuals with developmental disabilities, including autism, through a wide statewide network of nonprofit providers, allowing for extensive reach and uniform implementation (New York State Office for People with Developmental Disabilities [OPWDD], 2026). Additionally, national suicide prevention guidelines endorse this strategy, highlighting that sharing resources and collaborating across sectors can lead to greater preventive effects than any organization working alone (U.S. Department of Health and Human Services [HHS], 2024).

Within this context, adapted interventions are particularly important. A pilot feasibility randomized controlled trial (RCT) showed that autism-adapted safety plans are both feasible and acceptable for autistic individuals at risk of self-harm or suicide (Rodgers et al., 2024). The study evaluated real-world implementation using measures such as recruitment, retention, engagement, and usability, finding that the approach was well-tolerated and easy to deliver in routine care settings. These findings indicate that adapted safety planning can enhance suicide prevention pathways for neurodivergent individuals by offering a structured, accessible tool for crisis coping and help-seeking (Rodgers et al., 2024).

Additional evidence from the START model (a coordinated crisis-prevention and clinical support framework for people with IDD and mental health needs) indicates that integrated, partnership-based care is linked to significant improvements in mental health symptoms and notable reductions in psychiatric hospitalizations and emergency department visits (Kalb et al., 2019). This further supports the value of cross-system collaboration, such as partnerships with organizations like OPWDD, rather than isolated interventions.

Workplace Initiatives

CARES UP

New York's CARES UP (Creating Awareness and Resilience in EMS and Uniformed Personnel) initiative targets law enforcement, fire, EMS, dispatch, corrections, and veterans' services. It supports peer support networks, resilience training, and suicide prevention education through modest grants (New York State Office of Mental Health, 2023). Adapting initiatives like CARES UP to diverse high-risk groups may be feasible and acceptable, particularly when they leverage peer support and partnerships with unions or professional associations (New York State Office of Mental Health, 2023). Early outcome indicators—such as self-reported reductions in stress and high levels of training satisfaction— for other types of stress reduction training are encouraging (Waters & Ussery, 2007). However, stigma remains a significant barrier. A New York survey found that 80% of first responders cited stigma as a major obstacle to seeking help, despite high levels of stress and suicidal ideation in this population (New York State Office of Mental Health, 2023). As a result, effective programs combine peer or skills-based training with stigma reduction campaigns.

Suicide Prevention Programs for Law Enforcement

Programs like Canada's Road to Mental Readiness (R2MR) in law enforcement and the UK's Blue Light Programme have aimed to reduce stigma through education and leadership engagement. The Blue Light Programme (2015–2019) delivered mental health training to over 5,000 UK emergency service managers, significantly improving their confidence in discussing mental health and supporting staff—an attitudinal shift that was sustained months later. Participants reported a more open culture around mental health, although evaluators noted that broader cultural change is a longer-term process requiring sustained effort and senior leadership buy-in (Carleton et al., 2018; Mind UK, 2021). The CARES UP model is well-aligned with these global examples.

Peer programs have proven particularly effective in high-stress occupations. Studies show that employees in these roles are more likely to confide in peers than in supervisors or counselors. For example, nearly half of police officers in one study used peer support services, and over half reported improved personal or work-related outcomes (Waters & Ussery, 2007). These programs increase help-seeking intentions, lower stigma, and improved job functioning, normalize mental health conversations, and offer accessible, culturally competent support. Evidence for peer-led programs is robust regarding feasibility and acceptability, especially in unionized, high-risk professions.

Overall, the strength of evidence for efficacy is moderate. Improvements in intermediary outcomes—such as mental health knowledge, confidence, and help-seeking intentions—are well documented (Carleton et al., 2018). Additionally, some correlation between peer program implementation and reduced suicide risk has been observed, such as in Australian mining and construction sectors following the rollout of peer-led initiatives like MATES (Gullestrup et al., 2011; King et al., 2023). However, rigorous evaluations—particularly randomized controlled trials—remain relatively scarce. Notably, cluster randomized trials (e.g., MATES in Manufacturing) are currently underway to address this evidence gap (King et al., 2023). Overall, integrating peer-led, culturally tailored mental health support in high-risk sectors represents a promising practice, with strong feasibility and growing empirical support for its positive impact on workplace mental health.

Suicide Prevention Programs for the Construction Workers
The construction industry consistently shows among the highest suicide rates across occupational sectors. Australia's MATES in Construction program has become a globally recognized model, offering on-site awareness training, peer "Connectors," a 24/7 helpline, and case management. Early evaluations show strong contractor uptake (67% of sites approached agreed to participate), improved worker preparedness to assist at-risk peers, and high utilization of services (Gullestrup et al., 2011).

A five-year review in Queensland showed a 7.9% reduction in suicide among construction workers following implementation. While this trend did not achieve statistical significance, it diverged from the rising rates observed in the broader male population. A 2023 systematic review found favorable results for the MATES program in improving mental health literacy and stigma reduction, though randomized trials are still needed (King et al., 2023).

Policymakers in New York City have echoed these efforts. The Building Trades Employers' Association (BTEA) has proposed requiring mental health training within mandated safety programming—including the addition of mental health discussions during on-site orientations—arguing that such integration would be a cost-neutral way to expand suicide prevention in a high-risk field. They note that hundreds of thousands of workers already undergo mandatory safety training, and failing to include a mental health module represents a "wasted opportunity to save lives" (NYC Health + Hospitals, 2022).

Overall, the construction sector's experience shows promising outcomes—such as improved awareness, high participation rates, and potential reductions in suicide—when suicide prevention is treated as a core component of workplace safety. However, stronger evidence from controlled studies is needed to firmly establish efficacy. Implementation to date has relied on broad industry partnerships—among unions, employers, and government—to enforce compliance. Early compliance data are encouraging (e.g., most sites willingly adopt programs) but institutionalizing these practices as standard contract requirements will require sustained political will and oversight.

Risk Factor: Unemployment
Unemployment is a well-documented risk factor for suicide, with meta-analyses indicating a ~70% higher risk relative to employed individuals (Milner et al., 2013). This risk is particularly high during the first five years following job loss. Outreach via unemployment offices, job centers, and labor departments is a promising strategy. Staiger et al. (2017) found that unemployed individuals often avoid help due to stigma, low mental health literacy, and fears of being seen as "weak." However, job center personnel were frequently viewed as potential allies, especially when trained in mental health first aid. This suggests that unemployment office personnel can serve as a crucial link to care when appropriately trained. One commonly proposed strategy is to provide job center staff with training in basic mental health first aid and resource referral, enabling them to sensitively guide job seekers to counseling or crisis services (Staiger et al., 2017). In some regions, pilot programs have embedded mental health counselors within workforce development offices or distributed information about the 988-crisis line and local clinics alongside unemployment benefits (OECD, 2021).

Although formal evaluations of these specific interventions are limited, similar outreach efforts targeting unemployed populations have demonstrated some effectiveness in improving mental health service uptake and reducing distress (Staiger et al., 2017; OECD, 2021). For instance, pilot programs (e.g., Britain's IAPT Employment Advisor pilot) and U.S. cross-agency efforts show promise in increasing service uptake among unemployed individuals (OECD, 2021). Interventions at this interface are considered low-cost and scalable. Challenges include stigma and low perceived need, but framing support in empowering, non-clinical terms help increase uptake. This strategy is feasible, supported by epidemiological data, and underutilized despite its potential reach and low resource burden.

Workplace Culture
Workplace culture is a critical determinant of whether employees seek support. Psychological safety—the belief that it is safe to speak up about stress or mental health—correlates strongly with early help-seeking and reduced

stigma (Edmondson & Lei, 2014). Companies investing in stigma-free cultures (e.g., via the NAMI StigmaFree Workplace Toolkit) report improved openness, engagement, and retention (NAMI, 2022). Meanwhile, efforts to improve EAP utilization and transform workplace culture are essential to ensuring that mental health resources are not only available but actually used. Studies have found that EAP engagement correlates with reduced absenteeism, improved functioning, and lower depression and anxiety symptoms (Richmond et al., 2017). Formal partnerships with external providers (e.g., clinics, nonprofit counseling centers) allow employers to offer employees a direct pathway to high-quality mental health services. Such memoranda of understanding (MOUs) improve continuity of care, especially for employees whose needs exceed EAP capacities. The workplace suicide prevention strategies reviewed here are supported by varying degrees of empirical evidence, from modest observational studies to more robust systematic reviews. While gaps remain—particularly in randomized trials and long-term outcomes—the overall evidence base supports the implementation of these approaches, especially when they are adapted to the specific contexts of high-risk industries, stigmatized populations, and under-resourced settings.

Community-Based Settings

Community-Based Programs

Community-based sites such as barbershops, faith organizations, schools, and public housing can be effective venues for engaging individuals who may not otherwise access formal care. For example, Barbershops can be important sites for engaging ethnoracially minoritized men in mental health and suicide prevention, with some scholars advocating for training Black barbers as mental health advocates who can act as gatekeepers and credible messengers (Gelzhiser & Lewis, 2023). The Confess Project is one of such initiatives, training barbers to be mental health advocates by providing social support and reducing mental health stigma for Black men and boys (Fraser, 2025). A 2022 qualitative study in California found that barbershops serving as informal mental health care settings allowed Black men to participate in conversations about their mental health, and that experience improved their psychological, emotional, and social well-being (Curry et al., 2022).

Credible Community-Based Messengers

Collaborating with local community-based organizations to identify, train, and support credible messengers is a promising strategy for suicide prevention. Peer-reviewed research highlights that individuals trusted within specific communities—such as veterans, youth leaders, or recovery group sponsors—can effectively serve as gatekeepers and messengers when appropriately trained. For example, DeBeer et al. (2023) reported positive outcomes from a veteran suicide prevention learning collaborative, where veteran-serving organizations implemented over 90 prevention activities, reaching thousands of veterans through peer-led interventions. Similarly, Anestis et al. (2021) found that veterans and law enforcement officers were perceived as highly credible messengers for firearm safety messaging, a key component of suicide prevention. Youth programs like Sources of Strength, which train adolescent peer leaders in suicide prevention, have demonstrated reductions in suicide attempts and increased help-seeking behaviors in school settings (Wyman et al., 2010). Systematic reviews further support lived experience peer support as a viable outreach strategy that improves engagement with at-risk individuals outside traditional healthcare environments (Schlichthorst et al., 2020). Together, these findings provide evidence that partnering with community organizations to train credible messengers can expand the reach and impact of suicide prevention efforts.

Partnerships with Non-Clinical Mental Health Supports

Partnerships with organizations that provide non-clinical mental health supports, such as social prescribing and community-based programs, show strong potential to expand access to treatment-adjacent and culturally responsive care. Social prescribing, a care delivery model connecting clients to community activities via formal prescription, allows primary care providers to refer patients to community activities and psychosocial supports that supplement medical care, helping to connect health and social services (Napierała et al., 2022). Across multiple systematic reviews, social prescribing programs, often delivered through link workers who connect patients to community resources, have been associated with improvements in well-being, mental health, loneliness, and quality of life, and in some cases have also reduced health care use and costs (Cooper et al., 2022; Kiely et al., 2022).

Partnership-based and community-driven interventions are especially relevant for populations that face structural and cultural barriers to care. Reviews of community-based interventions show that coalitions and multisector partnerships can reduce racial and ethnic health disparities by increasing reach, trust, and engagement in underserved communities (Castillo et al., 2019; McNeish, 2020). Community health worker (CHW) models, which are often embedded in trusted community organizations, have been particularly effective. CHW-delivered mental health interventions have improved symptoms across many studies, especially in underserved populations (Barnett et al., 2017). In the United States, these programs frequently serve Latine immigrant communities and are commonly delivered in Spanish, making them more linguistically and culturally responsive and increasing engagement and effectiveness (Gustafson et al., 2025).

Beyond individual outcomes, partnerships also create system-level benefits. When health systems collaborate with community organizations, they can build more flexible, transparent, and trust-based service networks that support shared decision-making and better coordination of care (Ball & Gibson, 2022). These kinds of partnerships help distribute responsibility for mental health support across clinical and non-clinical sectors, which is especially important when needs extend beyond what traditional medical care alone can address.

However, important implementation barriers remain. Primary care providers often lack the time, training, and capacity to identify and engage appropriate community organizations on their own (Aughterson et al., 2020). Studies of social prescribing show that link workers are essential for making these partnerships function, because they serve as bridges between clinicians and community services, helping patients navigate non-clinical supports and helping providers know what resources are available (Aughterson et al., 2020).

Community-based Prevention Initiatives

Evidence supports the effectiveness of community-based mental health and suicide prevention initiatives, particularly when interventions are structured and strategically coordinated. For example, Australia's Wesley LifeForce Networks program—a community suicide prevention network that helps local stakeholders develop suicide prevention strategies—was associated with a 7% reduction in suicide rates (Morgan et al., 2022). Similarly, community-driven interventions in Munich combining primary care training, public awareness, and patient support showed reduced suicide rates over five years (Mergl et al., 2023). Systematic reviews highlight mechanisms linked to better outcomes, such as means restriction, organizational policy changes, and community screening for depression, while finding limited evidence for gatekeeper training and awareness campaigns (Linskens et al., 2023). Other research underscores the potential to adapt clinical models like Zero Suicide to non-clinical settings, suggesting community-based services could integrate suicide risk screenings, collaborative safety planning, and means reduction (Ahmedani et al., 2025).

However, challenges remain. Community-based mental health efforts often face unstable funding, as seen with U.S. community mental health centers (CMHCs), which have reduced suicide rates, especially among non-white populations, yet continue to experience closures due to financial constraints (Avery & LaVoice, 2023; Hung et al., 2020). Additionally, while multi-component community interventions are common—incorporating peer support, coping skill development, and activity-based strategies—they can be difficult to implement and evaluate effectively due to their complexity (Mengell et al., 2024; Linskens et al., 2023).

Rural Community Mental Health and Suicide Prevention Initiatives

Partnerships with Firearm Retailers and Gun Clubs

Partnerships with firearm retailers and gun clubs are promising strategies to reduce suicide risk in rural areas. The Gun Shop Project, initiated by the New Hampshire Firearm Safety Coalition, distributes suicide prevention materials through gun stores and promotes voluntary, temporary off-site firearm storage (Gun Shop Project – Means Matter, 2024). A study on Colorado gun shops that participated in this project found that 14% of the stores examined had assisted with temporary secure storage, and 74% were willing to refuse a sale of a firearm or ammunition, and 70% were willing to direct customers to mental health services (Wright-Kelly et al., 2024).

Mobile Mental Health Units

Mobile mental health units are a promising and evidence-informed approach to addressing suicide risk in rural communities, where residents face disproportionately high suicide rates and significant barriers to care. Between 2000 and 2020, rural suicide rates increased by 46%, nearly double the rate in urban areas, underscoring the urgent need for outreach-based services (CDC, 2021). Peer-reviewed studies show that mobile units staffed with licensed clinicians and peer support specialists can effectively reach individuals who would not otherwise access care. For example, Project Rural Recovery in Tennessee found that one-third of clients would not have received services without the mobile unit, and 70% would have otherwise turned to emergency departments (Rural Health Information Hub, 2023). In addition to increasing access, mobile crisis teams have been associated with lower emergency department utilization and fewer psychiatric hospitalizations (Anderson et al., 2025). A national cohort study of veterans found that greater use of virtual mental health care—another means of increasing access in underserved areas—was associated with fewer suicide-related events (Tenso et al., 2024). These findings suggest that bringing services directly to rural populations through mobile units can help prevent crises and reduce suicide risk by overcoming the geographic and structural barriers that often delay or prevent treatment.

Peer support integration within mobile mental health units could further enhance their effectiveness, particularly in suicide prevention. Peer specialists can offer lived experience that fosters rapid rapport, reduces stigma, and instills hope—all of which are protective factors against suicide (Bowersox et al., 2021). National guidelines such as the U.S. Surgeon General's Call to Action recommend embedding peer support into all levels of suicide prevention care (U.S. Department of Health and Human Services, 2021). Although direct causal evidence linking mobile units to suicide rate reductions is still developing, multiple studies demonstrate that these programs improve crisis response, reduce overdose deaths, and increase engagement in behavioral health care (Newton et al., 2025; Anderson et al., 2025). Given the consistent findings on increased access, improved outcomes, and potential cost savings, developing and funding mobile mental health units—particularly those that integrate peer support—is a well-supported and impactful strategy to address suicide risk in rural and underserved areas.

Constraint: Workforce Shortages

Workforce shortages and retention issues are consistent limitations to implementations of mental health initiatives in rural areas. High turnover and burnout are often reported among primary care workers (HRSA, 2024). The National Health Services Corp (NHSC) was created in 1970 and has provided more than 1100 mental and behavioral health professionals to rural settings across the US, but only about half remained close to their original service site (Politzer et al., 2000).

Constraint: Geographical and Infrastructure Challenges

Geographical and infrastructure challenges can limit program implementations. Due to the geographical constraints, long travel distances are often required to reach clinics or support services. Additionally, many rural communities have limited internet connectivity, which can limit telehealth applications. Existing studies on suicide prevention interventions often lack empirical rigor (Younker & Radunovich, 2021). A 2021 systematic review of studies on mental health interventions on farmers only found one intervention that utilized an experimental design with a control group, with other studies typically employing self-report questionnaires regarding mental health literacy programs.

Faith-Based Initiatives

Faith-Based and Culturally Responsive Suicide Prevention and Mental Health Efforts

Black churches have historically served as trusted, stabilizing institutions and are uniquely positioned to reach Black youth in non-stigmatizing ways. Programs like HAVEN Connect ("Helping to Alleviate Valley Experiences Now") reflect best practices in culturally responsive suicide prevention—combining spiritual resources with evidence-informed mental health education (U.S. Department of Health and Human Services [HHS], 2023). The incorporation of faith leaders, peer support, and biblically grounded messaging helps foster a sense of meaning and belonging—both identified as key protective factors against suicide in Black adolescents (Walker et al., 2017).

The HAVEN Connect program embeds suicide prevention within Black churches in New York State and serves Black adolescents aged 13–19. Funded by AFSP and evaluated in New York, the pilot across three congregations

reported high engagement, with 87% of youth recommending the program to peers and nearly all expressing increased preparedness to manage life's challenges and employ healthy stress-reduction strategies after participation (Joshua et al., 2023). Designed to reinforce protective cultural and spiritual factors—such as community cohesion, faith-based teachings, and open discussion of mental health—the program aligns with research showing that integrating interventions into trusted Black church settings enhances relevance, reduces stigma, and strengthens coping and help-seeking behaviors among youth (Mindsite News, 2025). As one of the first randomized, community-engaged efforts of its kind, HAVEN leverages sermons, Bible study, and Sunday school in culturally consonant ways to support emotional resilience and suicide risk reduction—making it a promising model for scaling church-based youth mental health initiatives.

Faith-based suicide prevention initiatives such as Soul Shop™ and NAMI's Bridges of Hope represent promising, culturally responsive approaches to reducing stigma and improving early intervention in underserved communities. Soul Shop's one-day workshops equip faith leaders to integrate suicide prevention into their ministries by offering training rooted in cultural humility and lived experience, with tailored versions for Black and Hispanic congregations (American Foundation for Suicide Prevention [AFSP], 2022). Similarly, NAMI's Bridges of Hope provides brief educational presentations that increase awareness of mental illness within congregations and connect attendees to local mental health services (National Alliance on Mental Illness [NAMI], 2024). These models are grounded in community-participatory approaches and have been associated with increased help-seeking, reduced stigma, and strengthened protective factors like hope, belonging, and trust in supportive relationships (Ali et al., 2022). When embedded within trusted community institutions like churches, these workshops can bridge longstanding cultural and structural gaps in mental health access.
Though limited in peer-reviewed evaluations, early evidence and federal guidance support the integration of such programs into suicide prevention efforts. For example, the Soul Shop™ initiative has been featured by the Suicide Prevention Resource Center (SPRC), with anecdotal reports suggesting that trained clergy have effectively identified suicide risk, intervened in crises, and connected individuals to care (SPRC, 2023). These outcomes reflect best practices outlined in federal resources such as HOPE: A Guide for Faith Leaders, which calls for training clergy and lay leaders to support youth mental health and suicide prevention in faith-based settings (U.S. Department of Health and Human Services [HHS], 2024).

While Bridges of Hope and Soul Shop™ have yet to undergo rigorous evaluation in peer-reviewed literature, they reflect a critical movement toward culturally grounded, spiritually informed mental health promotion. Their implementation in familiar, community-anchored spaces can be especially impactful in addressing suicide risk among racially, ethnically, and linguistically diverse populations that may otherwise be disconnected from formal mental health systems.

Despite their potential, faith-based initiatives face several limitations and implementation challenges. While many state suicide prevention plans endorse FBC involvement, they often fail to outline actionable steps or provide clear models for how religious organizations can operationalize recommended roles, such as postvention support or gatekeeping (Kopacz et al., 2019). Despite the recognition of several different themes comprising FBC engagement, most plans offered limited direction on how these roles should be operationalized. In addition, while some evidence supports the effectiveness of chaplain training programs like MHICS, there is a need for more rigorous, longitudinal research to determine whether these efforts translate to sustained reductions in suicidal behavior or improved mental health outcomes over time (Wortmann et al., 2023).

Suicide Prevention: Peer-to-Peer Support Models

Peer Support Interventions

Peer support interventions provide social connection and shared understanding that can reduce suicide risk in vulnerable groups. For example, new mothers experiencing postpartum depression, which elevates maternal suicide risk (Yu et al., 2024), benefit from structured peer support groups. A recent meta-analysis found that peer-delivered interventions for perinatal individuals led to significantly lower depression scores and a ~30% reduction in new cases of postpartum depression compared to controls (Huang et al., 2020). These programs are often feasible and scalable because they rely on trained peer volunteers and can be culturally tailored to meet the needs of diverse communities. Birthing individuals using peer support programs also report feeling less isolated and more

empowered to seek professional help, potentially mitigating suicidal ideation, which is reported in up to 19% of those with postpartum depression (Yu et al., 2024).

Peer support is also critical for LGBTQIA+ youth, who face elevated suicide risk due to stigma and marginalization. Safe peer spaces and affirming peer networks have demonstrated protective effects. For instance, students in schools with a Gay–Straight Alliance report significantly lower suicide attempt rates than those without such clubs (14% vs. 18%) (CDC, 2020). Additionally, the presence of even one accepting adult in the life of an LGBTQ youth is associated with a 40% reduction in suicide attempts (The Trevor Project, 2019). Community-based peer organizations, such as P-FLAG, also play a vital role by supporting both LGBTQ youth and their families, reducing rejection and increasing connectedness (Ryan et al., 2010). Collectively, these studies support the development and expansion of peer support programs as an effective strategy to reduce isolation, foster help-seeking, and lower suicide risk in high-need populations.

Peer-led and Peer-focused Strategies

Peer-led and peer-focused strategies have demonstrated effectiveness in reducing suicide risk among youth. One of the most well-studied models is Sources of Strength (SoS), a peer leadership program where diverse student leaders promote positive coping and encourage peers to seek help when struggling. A randomized controlled trial across 18 U.S. high schools found that SoS significantly increased peer leaders' adaptive norms around suicide and willingness to refer suicidal peers to trusted adults (Wyman et al., 2010). Subsequent studies found that these benefits extended to the broader student population: students in SoS schools showed greater acceptance of help-seeking and improved perceptions of adult support (Wyman et al., 2010; Ashrafioun & Pigeon, 2019). Additionally, a larger cluster-randomized study demonstrated that SoS implementation led to a 29% reduction in suicide attempts across participating schools over an 18-month follow-up period (Wyman et al., 2025).

Complementary to school-based peer interventions, parent and community peer support models also play a vital role. Parent support networks, particularly those that help parents of at-risk or bereaved youth build coping and communication skills, are shown to protect against long-term suicide risk in adolescents. A longitudinal study of a parenting-focused grief support intervention found a 60% reduction in suicide attempts among youth whose surviving parent participated in the program, with the effect sustained up to 15 years later (Sandler et al., 2010). Additionally, community-based clubhouse models offer peer-driven emotional support and structured activities for youth outside of school. These clubhouses—often co-led by youth and adults—foster connectedness, promote help-seeking, and reduce stigma (Georgia Department of Behavioral Health and Developmental Disabilities, 2022). Youth participants frequently report feeling safer and more understood in these peer-based environments than in clinical settings (Halsall, 2022). Together, these programs illustrate how multi-level, peer-centered approaches—including peer ambassador programs, parent-led networks, and youth-run clubhouses—can foster coping, emotional well-being, and social connection for adolescents at risk of suicide.

Peer-Support Networks

One of the most widely implemented models is the Local Outreach to Suicide Survivors (LOSS) Team, which pairs trained peer loss survivors with clinicians or crisis responders to provide immediate outreach following a suicide death. Research has shown that survivors who receive proactive LOSS Team outreach engage in supportive services significantly sooner—on average within 39 days—compared to those without such outreach, who may wait several years before seeking help due to stigma and isolation (Campbell, 2009; Hendricks County LOSS Team, 2023). This is essential because people bereaved by suicide are themselves at heightened risk for suicidal ideation, suicide attempts, and prolonged grief disorders (Jordan & McIntosh, 2011). By providing compassionate, lived-experience-based support, peer-led postvention efforts can serve as a bridge to professional care and a source of immediate hope in the aftermath of a suicide loss.

National suicide prevention guidelines now recognize postvention as a vital component of a comprehensive suicide prevention strategy. The Responding to Grief, Trauma, and Distress After a Suicide report from the Survivors of Suicide Loss Task Force (2015) emphasizes that engaging trained peer volunteers to provide emotional support and resource linkage can mitigate the psychological impact of suicide on family, friends, and communities. Individuals who have participated in peer-based postvention programs report feeling less alone, more supported,

and more open to seeking formal help (Campbell, 2009). Importantly, some research suggests that peer support providers also experience personal healing and growth through their involvement in postvention efforts, reinforcing the value of these programs not only for recipients but for the community as a whole (Jordan & McIntosh, 2011). Scaling peer-led postvention networks like LOSS across New York State could promote early intervention for suicide loss survivors and reduce the risk of suicide contagion in affected communities.

Peer-Mentorship

ASIST is a widely implemented gatekeeper training that teaches individuals to recognize suicide warning signs and provide immediate, supportive intervention. A large-scale evaluation found that ASIST-trained crisis counselors were significantly more effective in reducing callers' distress, suicidality, and hopelessness during hotline calls than non-trained peers (Gould et al., 2013). A cost–benefit analysis of California's statewide ASIST initiative projected that for every $1 invested in training teachers, clergy, first responders, and community members, the state saved over $1,100 in averted suicide-related costs—equivalent to preventing an estimated 140 deaths and 3,600 suicide attempts annually (Ashwood et al., 2015). These findings show that standardized peer training programs are both impactful and economically sustainable, particularly when supported by state infrastructure and funding.

A peer mentorship model must also create formalized peer-support structures in workplaces and communities. Workplace-based suicide prevention programs such as MATES in Construction in Australia illustrate this well: peers are trained as "connectors" who spot risk signs and initiate supportive conversations. A 2023 systematic review found that MATES improved suicide literacy, reduced stigma, and enhanced willingness to seek and offer help, especially among high-risk male workers (Gullestrup et al., 2023).

Peer support networks in community spaces can have similar benefits. For instance, peer mentorship models within veteran communities and first responder organizations have been associated with increased social connection, improved mental health self-efficacy, and decreased psychological distress (Mercier et al., 2023). These programs work because people are more likely to confide in someone they identify with—whether it's a coworker, fellow veteran, or community member—than in formal clinical settings. A statewide mentorship framework combining ASIST or similar training with localized peer networks in schools, workplaces, and cultural organizations could build the social infrastructure needed to reduce suicide risk at scale.

Other Peer-Based Suicide Prevention Services

A 2021 scoping review found that peer-based suicide prevention services involve varied peer roles—such as gatekeeping, on-demand crisis support, and acute care interventions—but noted a lack of rigorous evaluation (Bowersox et al., 2021). While most studies lacked effectiveness data, peer support was generally seen as feasible and acceptable, especially as a complement to formal care. Similarly, a 2020 review found limited evidence on the design, implementation, and effectiveness of lived experience peer support programs, highlighting a persistent gap in the literature (Schlichthorst et al., 2020). Bowersox et al. (2021) note that, despite limited evidence, some peer-based interventions show promise. Gatekeeper training appears to increase awareness and confidence in responding to suicide risk, while peer-led programs targeting high-risk groups are associated with reduced suicide risk, though causality is unclear. Peer supporters often use therapeutic techniques similar to those of trained clinicians, and recipients value their support. These approaches may effectively reach individuals who are unwilling or unable to engage with formal mental health services.

A 2020 systematic review examining the effectiveness of one-to-one peer support in mental health services found that while one-to-one peer support may have modest positive effects on self-reported recovery and empowerment, as well as potential effects on measures of working alliance between service users and mental health workers, it does not appear to significantly impact clinical symptoms such as symptoms or hospitalization (White et al., 2020) Analysis also indicated that peer support might enhance social network support, suggesting its value in promoting connection and engagement among individuals using mental health services (White et al., 2020). However, the review emphasized the need for more rigorous research, improved reporting of outcomes, and targeted evaluations of specific peer support models to better understand their effectiveness and implementation.

A 2014 review assessing the effectiveness of peer support services for individuals with serious mental illnesses found moderate evidence supporting their impact (Chinman et al., 2014). The review analyzed 20 studies across

three service types: peers added to traditional services, peers in existing clinical roles, and peers delivering structured curricula. While methodological limitations were noted, studies of peers added to services and delivering curricula consistently demonstrated positive outcomes, including reduced inpatient service use, improved provider relationships, greater engagement in care, higher levels of empowerment, and increased hopefulness for recovery. The effectiveness of peers in existing clinical roles was mixed, with one study reporting a negative impact on hospitalizations. Per Chinman et al. (2014), the effectiveness of peers was as effective as that of non-peers. Further, peer services were more effective than just traditional ones alone in ameliorating psychological distress and psychosocial functioning. These findings support the expansion of peer support services within mental health systems, particularly through policy efforts to integrate peer roles into covered services. Future research should focus on refining methodological rigor and clarifying the specific contributions of peer support models to ensure effective implementation.

Community Coalitions

Community-Based Suicide Prevention Coalitions

Community coalitions play a central role in suicide prevention by uniting diverse stakeholders to address risk factors and promote protective strategies tailored to specific populations. The National Strategy for Suicide Prevention identifies Michigan's PRiSMM program as a model coalition bringing together male-dominated industries, faith-based groups, and media organizations to deliver gender-specific interventions. Similarly, SAMHSA's Native Connections program demonstrates how culturally rooted, community-driven coalitions can leverage Indigenous family structures to support Native American youth while addressing broader systemic barriers such as poverty and limited behavioral health access (National Strategy, 2024).

Despite these examples, challenges remain in evaluating the effectiveness of community coalitions in suicide prevention. A 2021 qualitative study noted that while most research emphasizes implementation and capacity-building, there is limited evidence assessing outcomes or identifying key factors that contribute to coalition success (Reifels et al., 2021). SAMHSA guidance highlights that successful coalitions should be community-led, culturally sensitive, and focused on upstream factors such as social determinants of health. Best practices include involving individuals with lived experience, fostering cross-sector collaboration, aligning efforts with local data, and strengthening evaluation capacity to promote sustainability and lasting impact.

Resource sharing and strategic planning contribute to the long-term sustainability of community coalitions. A 2024 analysis of 68 anti-drug coalitions in Pennsylvania and Missouri found that the density of information and multiplex resource-sharing ties (including personnel, funding, and materials) was significantly associated with perceived coalition sustainability over time (Gaddy et al., 2024). Additionally, a systematic review of community health coalitions targeting social determinants of health reported that several coalition characteristics—particularly best-practice planning, communication, and health promotion implementation—were positively linked to community outcomes and coalition effectiveness, reinforcing the value of routine strategic meetings and resource discussions

Evidence supports the role of community coalitions as an effective strategy in suicide prevention efforts. Castillo et al. (2019) highlight that multi-sector partnerships, lay health worker engagement, and community-delivered services—common features of suicide prevention coalitions—are linked with improved mental health and social outcomes, particularly when interventions address upstream social determinants such as housing, education, and interpersonal violence. Although few initiatives operate fully at the community or policy level, sustained impact depends on long-term investment in training, infrastructure, and equitable collaborations between communities and healthcare systems. Further illustrating this point, Reifels et al. (2021) examined LifeForce Suicide Prevention Networks in Australia, finding that community-led coalitions characterized by structured processes, regular meetings, and broad engagement help enhance member skills, coordination among service providers, and community awareness of suicide prevention. Together, these findings underscore that community coalitions can strengthen suicide prevention capacity through cross-sector collaboration and sustained local involvement.

Priority Area 7. Enhancing data collection and utilization

Timely and Accessible Surveillance Data to Identify and Address Disparities

NYS Suicide and Self-Harm Dashboard

Access to timely suicide and self-harm data is critical for identifying trends, understanding disparities, and informing prevention strategies. Currently, the NYS dashboard is limited to data from 2017–2019, which restricts its relevance for immediate decision-making. International evidence shows that more frequent and timely data can enable faster policy responses. Baran et al. (2021) describe how Ecuador, Japan, and Poland leveraged near-real-time data from police agencies, available within one month of a suicide death, leading to quicker enactment of prevention policies and changes to media reporting practices. Turnbull et al. (2024) found that real-time surveillance (RTS) systems in England provided suicide data that closely mirrored official statistics released much later, underscoring the reliability of provisional data. Similarly, Pirkis et al. (2021) analyzed data from 21 countries and found that more frequent reporting helped identify trends during the COVID-19 pandemic, reinforcing the utility of timely data during periods of significant societal disruption. In contrast, national vital statistics systems often have reporting lags of several months to a year due to the need for coroner and medical examiner investigations.

Feasibility challenges persist, however: lag in civil registration systems, lack of infrastructure, and inconsistent data collection standards can hinder timely updates. Stakeholder breakout group participants also raised concerns about feasibility, noting that improvements to the state dashboard would require coordination across multiple data sources and agencies.

Real-time Data for Immediate Intervention

Real-time data systems can help healthcare providers intervene more quickly with individuals at risk of suicide. By reducing the time between data collection and intervention, these systems offer the potential for life-saving action in clinical and community settings. Benson et al. (2023) reviewed five real-time surveillance systems across New Zealand, Australia, England, and Ireland. They found that verified provisional data, reported anywhere from hours to a few weeks after the incident, was essential in identifying emerging trends, suicide clusters, and at-risk populations. The researchers emphasized that embedding surveillance systems within agencies like police departments enabled faster data flow and response times. However, they also stressed the importance of a flexible infrastructure that can accommodate new data variables and evolving public health needs.

Patel et al. (2024) demonstrated how U.S.-based real-time proxies, including emergency department visits, social media activity, and mental health screening scores, can be used to predict suicide fatalities using machine learning models. While promising, this approach showed greater accuracy in states with higher suicide counts and stronger internet access, raising concerns about equity in lower-resourced or rural areas. Together, these findings support the development of real-time or near-real-time data systems that can be integrated into provider workflows. However, breakout group participants emphasized the need for technical capacity, data-sharing agreements, and resource investment to make these systems feasible and actionable in practice.

Standardized Medical Investigations

Coroners and Medical Examiners may vary in how they determine suicide as the manner of death (MOD), and suicide deaths are still likely undercounted (Stone 2017), with equivocal MODs likely to default to accidental or undeterminable deaths. This may be due in part to differences in jurisdictions and burden of proof for suicide determinations, differences in how individual offices operate and adherence to guidelines (versus individual medical examiner office operating procedures for example), external pressures such as from a decedent's family, and potentially differences in training and expertise between medical examiners and coroners (Stone 2017). The use of autopsies may also differ between coroner offices and medical examiners, impacting suicide determinations (Fernandez & Jayawardhana 2024); use of psychological autopsies, which can provide additional information in the suicide determination, especially establishing motive, intent, and soundness of mind may also differ (Olson 2006; Knoll 2009). The reporting of demographic information on the decedent may be inconsistent and inaccurate as well due to a lack of standardization of what sociodemographic information and clinical variables are recorded (Cheung Merry, & Sundram 2015; Jha, Ahuja, & Wani 2022). The variance between individual offices and jurisdictions impacts the reliability of suicide data reporting and makes accurate assessments and comparisons difficult.

Increased standardization of medical investigations may help to create more reliable reporting. Guidelines on death classifications from the National Association of Medical Examiners (NAME) have existed since 2002, though their uptake and enforcement is scattered (Stone 2017). The National Violent Death Reporting System (NVDRS)

offers a standardized procedure that can be used by medical examiners and coroners to ensure consistent reliable reporting; this is consistent with the recommendations of the Data and Surveillance Task Force of the National Action Alliance for Suicide Prevention (2014) calling for standardized death investigations practices. Continuing education and standardized training can help keep coroners and medical examiners up to date on the latest best practices (Stone 2017). Increased use of psychological autopsies in equivocal cases may also help clarify suicide determinations.

Coordinating with coroner's offices or medical examiner offices to standardize and implement guidelines may be challenging due to organizational and administrative structures (Hanzlick 2006). Administratively, these offices are not usually under health departments; instead, they may be under law enforcement or forensic science departments. Public health departments may not be part of their established working relationships. Fernandez & Jayawardhana (2024) also note differences in operating budgets between coroner offices and medical examiner offices may influence the likelihood of an autopsy being performed, and potentially the accuracy of suicide reporting. External pressures to avoid suicide determinations also exist, such as from next of kin and life insurance payouts, and potential litigation issues may also reduce suicide reporting (Stone 2017). Psychological autopsies also lack standardization (Knoll 2009 IV; Pouliot & de Leo 2006), though recommended frameworks exist (e.g., Snider, Hane, & Berman 2011). Psychological autopsies can be biased due to the availability of informants, potentially excluding those who were socially isolated (Cheung, Merry, & Sundram 2015) for example.

In addition to the studies directly supporting prioritized recommendations, a broader body of research highlights the structural features and design considerations that shape the effectiveness of suicide surveillance systems. Benson et al. (2023) compare five international real-time surveillance models and emphasize that systems embedded directly within original data sources enable the fastest reporting and most responsive interventions.

Their findings underscore the value of flexible infrastructure that allows for rapid provisional data entry and future adjustments to include new risk indicators. However, they also caution that delays in data input, lack of standardization, and inconsistent workflows across jurisdictions can significantly hinder the speed and utility of surveillance systems.

Other studies highlight the promise and limitations of using proxy indicators or digital data to supplement traditional systems. Patel et al. (2024) found that machine learning models using search trends, social media activity, and mental health screening scores could accurately predict suicide rates in states with robust internet access and high suicide frequency but underperformed in less populous or underserved areas. Similarly, Pirkis et al. (2021) and Baran et al. (2021) note that while timely data can improve situational awareness and policy response, countries or regions with fewer timepoints or lower incidence may struggle to detect meaningful trends. These findings show that data equity, source reliability, and statistical robustness are important considerations when designing real-time surveillance infrastructure.

Community-based and Qualitative Data

Youth Risk Behavior Survey (YRBS)

Limited school participation is a major limitation of the Youth Risk Behavior Survey (YRBS), undermining its ability to produce representative adolescent health data in the U.S. National response rates have declined since 2011, dropping below the CDC's 60% threshold in 2021 and reaching a historic low of 35.4% in 2023, largely due to school district refusals, active parental consent requirements, misinformation about survey content, and logistical burdens on schools (Mpofu et al., 2021).

Evidence supports several strategies to overcome these barriers. Research shows that using passive (opt-out) parental consent significantly increases student participation while reducing administrative burden, compared to opt-in models (Pokorny et al., 2001; Spence et al., 2015). Proactive communication to counter misinformation and streamline survey logistics, such as combining surveys or using web-based administration, are additional best practice shown to improve response rates (Mpofu et al., 2021).

Despite the promise of these approaches, significant implementation challenges remain. Districts may resist perceived mandates due to competing instructional priorities, ongoing skepticism about survey content, or administrative capacity limitations. Moreover, opt-out consent procedures, while effective, may not be permitted in all jurisdictions due to policy constraints. Sustained investment in communication strategies, stakeholder engagement, and school-level incentives will likely be required to overcome entrenched barriers and rebuild confidence in the YRBS process.

Data Transparency

A scoping review of public perception on the use of electronic health records found three key areas to address that promote trust among the public: Autonomy, Comprehension, and Data Protection (Papadopoulos 2024). Data transparency, which falls under Comprehension, describes the need for clear and concise communication regarding what data are being recorded, who has access to the records, and how those data are used by those who have access; the lack of transparency in this area has led to participant distrust. Data protections include concerns about confidentiality (that their sensitive data are not identifiable and linked back to them), privacy (that their data are accessed or obtained by unauthorized parties), and security (that is, lack of information about security measures).

A clear informed consent process with sufficient opportunities for participants to have their concerns addressed is a must in safeguarding and developing trust. Consents should be clear on the limits of confidentiality and potential clinical actions if they are determined to be at imminent risk. Emphasizing clinical action being dependent on level and risk and noting that reporting of suicidal thoughts will not automatically result in hospitalization may improve willingness to report symptoms accurately. Requesting permission to contact emergency contacts in the event of imminent risk can also encourage a collaborative process to manage risk and demonstrate partnership with the participant (Hom 2016). The consent documents themselves should use language that is understandable to the community being solicited and be non-technical, and font size should be sufficiently large, especially when working with potential participants with vision impairment. The document should not be too lengthy and should include a brief summary or set of frequently asked questions can help with comprehension (Shivayogi 2013).

Worth noting is that certain populations may have different attitudes towards security and health data sharing. For example, the Papadopoulos (2024) review found in some cases older participants were less concerned with data security and more willing to share their information compared to younger participants, as were those less educated compared to those more educated. Approaches to ensuring trust in data collection and research may demand a more nuanced approach depending on the participant or community being engaged.

Adopting an adaptive consent model along with a community-based participatory research (CBPR) approach can not only promote greater transparency and trust, but also long-term engagement with participants (Blom 2025). Adaptive consent models give participants the opportunity to update or withdraw consent with any changes in circumstances or updated information. CBPR methods involve participants in all steps of research studies, from planning to data collection to dissemination, and ensure research is responsive to the community. Recommendations on how best to involve people with lived experiences of suicide in co-producing research also exist (Krysinska 2023) and can be more widely applied to all aspects of data collection and use across research, evaluation, and other contexts.

Research Challenges

Qualitative and community-based research offers nuanced insights into suicide prevention initiatives but also presents specific challenges. Ranahan and Keefe (2022) found that gatekeeper training in a rural Canadian community fostered both openness and hesitancy in discussing suicide, shaped by participants' perceptions of healthcare interactions and lived experiences. These methods provide context that standardized surveillance tools may miss—such as stigma, family dynamics, or culturally specific beliefs about suicide and mental health. Techniques like member checking and asset mapping can strengthen trust and data validity (Brockie et al., 2023; Lightfoot et al., 2014). In particular, cultural asset mapping has been used in Indigenous-focused community-based participatory research (CBPR) to identify community strengths, enhance trust between researchers and participants, and improve the sustainability of prevention strategies. However, methodological issues such as inconsistent

sampling, varying response rates, and differing definitions complicate prevalence estimates across communities (Burless & De Leo, 2001). Owens et al. (2014) noted that while suicide audits collect valuable local data, their application to actionable prevention strategies is often unclear. This highlights a persistent challenge in translating community-informed insights into concrete interventions without greater coordination and capacity.

Additionally, standardized procedures like structured questionnaires may hinder rapport in qualitative settings, and participants may invest significant personal resources before engaging in sensitive research (Ranahan & Keefe, 2022). Routine clinical procedures, such as lengthy intake forms or structured assessments, can interrupt the development of rapport, leading some participants to withdraw or withhold important information. Ranahan and Keefe (2022) suggest that rapport can be better built during initial engagement, such as allowing participants time to share their story during recruitment or by clearly framing the parameters of the interview process (e.g., during consent or audio setup). Despite these challenges, qualitative data are uniquely suited to identifying protective factors not easily captured by large-scale surveys, such as school connectedness or cultural identity. These strengths underscore the need for mixed-methods approaches in suicide prevention planning.

Importantly, community-based methods support equity-informed evaluation practices by shifting power to communities most impacted by suicide risk. Co-design and participatory action research models, where community members help shape study questions, methods, and dissemination, can ensure that findings reflect local values and lead to more accepted and sustainable solutions (Israel et al., 2005). To strengthen data quality, researchers often use triangulation (e.g., combining interviews, observations, and document analysis), inter-rater reliability checks, and multiple rounds of member checking to improve rigor and transparency. These strategies help address concerns about variability in qualitative methods and promote more credible, community-driven prevention strategies.

Data on Risk and Protective Factors

Data Collection on Loneliness

Loneliness is a well-established risk factor for suicidal thoughts, attempts, and deaths across age groups. Salas-Gonzalez et al. (2023)'s scoping review found both subjective loneliness and objective social isolation consistently linked to suicide risk, independent of mental illness or financial stressors. Rahman et al. (2024) observed particularly heightened risk among young adults aged 15–34, where loneliness or living alone was associated with over 16 times greater odds of suicide. Among older adults, loneliness contributes to increased depression and suicide risk, though peer outreach interventions have shown promise in reducing these outcomes (Conwell et al., 2021). In clinical populations, such as individuals with schizophrenia, loneliness is associated with worsened mental health and suicidality, moderated by social support and self-esteem (Lim et al., 2022). These findings support calls for enhanced data collection, including revising large-scale surveys like the BRFSS to incorporate more comprehensive measures of loneliness and social isolation (Wang et al., 2022), as brief, single-item assessments may not fully capture the nuances needed to inform effective suicide prevention strategies.

Suicide Fatality Review Committees

Emerging evidence suggests that suicide fatality review committees can play a meaningful role in improving suicide prevention strategies by identifying system-level gaps and informing targeted interventions. For example, Kohlbeck et al. (2024) documented outcomes from Milwaukee's Suicide Review Commission, where committee recommendations led to concrete actions such as distributing prevention materials to local businesses and improving visibility of crisis resources. Similarly, the Ohio Department of Health (2024) reported that its statewide suicide fatality review framework helped expand local review teams, with findings used to enhance service coordination and training programs. Pennsylvania's Act 101 of 2022 formalized this process, requiring county-level teams to produce annual reports with recommendations aimed at improving services and community resources to reduce suicide deaths (Pennsylvania General Assembly, 2022). While long-term impacts on suicide rates remain to be established, committees consistently generate actionable insights that shape public health responses and system reforms.

Suicide fatality reviews have been implemented at both state and local levels across the United States, with varying structures and mandates. Ohio and Pennsylvania use county-based models supported by state guidance and

legal frameworks, ensuring confidentiality protections and accountability through reporting requirements (Ohio Department of Health, 2024; Pennsylvania General Assembly, 2022). Maryland has established a statewide Suicide Fatality Review Committee that analyzes patterns and proposes statewide policy changes (Maryland Department of Health, 2022). Local efforts, such as those in Humboldt County, California, and Milwaukee, Wisconsin, demonstrate that even absent state mandates, communities can effectively organize review teams to address region-specific risks and needs (Humboldt County Department of Health & Human Services, 2022; Kohlbeck et al., 2024). Across these models, a consistent feature is the multidisciplinary nature of review teams, bringing together healthcare, law enforcement, mental health services, and community organizations to confidentially examine individual cases and generate prevention-focused recommendations.

Protective Factors Data

Evidence indicates key risk and protective factors for suicide and suicidal ideation, though research has focused more on risk than strengths-based factors (Ki et al., 2024). Holman and Williams (2022) used network analysis across New Zealand, UK, and US samples, identifying feeling depressed, hopelessness, and perceived burdensomeness as risk factors with the highest strength centrality, and self-esteem and social support as the most central protective factors. Similar findings were reported among Hong Kong adolescents, where hopelessness and anxious-impulsive depression were most central, while resilience, self-efficacy, and positive relationships acted as protective factors (Li & Kwok, 2023). Social support is broadly protective (Kleiman & Liu, 2013), but its impact depends on context; for transgender individuals, only support from a significant other mitigated the impact of discrimination on suicidal ideation (Trujillo et al., 2017). Other protective factors include purpose in life, resilience, positive relationships (Ki et al., 2024), and meaning in life, though the latter has been studied mainly in undergraduate samples (Kleiman & Beaver, 2013).

Challenges include reliance on single-item measures for protective factors, which limit statistical sensitivity and fails to capture qualities like type or timeframe of social support (Ki et al., 2024). Additionally, there is a need for clearer and more standardized conceptualizations of risk vs. protective factors, as many studies conceptualize risk factors as deficits in factors that would otherwise be characterized as protective (Ki et al., 2024).

Data Sharing

Sharing Health Data

Research indicates that while participants are generally supportive of sharing health data, their willingness depends on factors such as the purpose of sharing and the receiving entity. A systematic review of 116 studies found higher support for non-profit research uses compared to for-profit or government health agency uses, with biobank data sharing receiving the lowest support (Cascini et al., 2024). Method of data exchange also influences acceptability—participants preferred direct provider-to-provider exchanges (Esmaeilzsadeh, as cited in Cascini et al., 2024).

Anonymization techniques, such as removing names and addresses, may further increase willingness to share (Hunter, as cited in Cascini et al., 2024), though informed consent language can impose limitations on data sharing, including restrictions on topics, retention duration, and usage (Meyer, 2018). Despite these variations, no consistent sociodemographic patterns were found to predict data sharing preferences (Cascini et al., 2024). However, concerns about privacy and data misuse remain prominent, underscoring the need for carefully structured cross-agency data sharing practices that address participant concerns and enhance public trust.

Data Repositories

Several reviews highlight significant challenges related to data standardization and integration across systems, underscoring the need for centralized repositories. Cascini et al. (2024) identified issues such as a lack of standardization, missing or incomplete data, and inconsistent sociodemographic definitions that hinder effective data utilization. Specifically in the context of suicide prevention, Bennett-Poynter et al. (2025) found wide variability in how electronic suicide data are collected and defined, with limited attention to data quality, equity, and fairness—particularly when digital tools like AI are involved. These gaps suggest a critical need for centralized systems that standardize and consolidate relevant data streams. Supporting this, the Action Alliance Research Prioritization Task Force has recommended suicide-related data sharing as a priority area (Colpe & Pringle, 2014). Additionally, Owens et al. (2014) documented a gap between suicide audit efforts and their practical application in prevention planning, highlighting the importance of not only collecting data but ensuring mechanisms exist to translate insights

into actionable policy. Establishing centralized reporting systems and repositories—such as a public health data warehouse modeled after Massachusetts' initiative—could help address these challenges in New York State.

Internet Search Data

Emerging evidence highlights other critical areas relevant to data sharing for suicide prevention. For instance, internet search data has been explored as an indicator of suicide risk, with Chinese researchers suggesting that platforms like Google could help identify at-risk individuals and link them to services—though such monitoring may also drive users into private or encrypted spaces, complicating prevention efforts (Cheng et al., 2012). Publicly accessible research repositories such as the Suicide Prevention Trials Database, which compiles data from 140 trials conducted between 1980 and 2023, exemplify efforts to improve transparency and accessibility in suicide research (O'Neil et al., 2025). These developments underline both the potential and the ethical complexity of using digital and publicly available data for suicide prevention beyond traditional healthcare systems.

Evaluate the Effectiveness of Programs/Interventions

Systematic Evaluation

While suicide prevention efforts have expanded significantly, the evidence supporting many approaches remains limited or mixed. Updating on Mann et al. (2005)'s systematic review of suicide prevention strategies, Zalsman et al. (2016) conducted a systematic review and found additional evidence for some suicide prevention approaches, and a lack of sufficient evidence or methodological inadequacies for others. Stronger support exists for strategies like restricting access to lethal means and providing follow-up after suicide attempts, while school-based programs, gatekeeper trainings, and awareness campaigns often lack rigorous evaluation or focus on indirect outcomes. Evaluations frequently rely on nonrandomized designs, especially in programs for Indigenous youth, where cultural tailoring is common, but process evaluations and validated outcomes are rare (Harlow et al., 2014). Programs may be more effective when targeting related behavioral or social issues, such as depression or substance use (Miller et al., 2009), and ROI analyses suggest school-based interventions can yield community-level benefits (Kinchin et al., 2020). Systematic, long-term evaluations using appropriate metrics are essential to refine, sustain, and scale effective suicide prevention efforts.

Community-based suicide prevention strategies can benefit from more rigorous evaluations to improve efficacy. In a systematic review of Signs of Suicide (SOS) and Yellow Ribbon (YR), both suicide prevention programs targeting youths, little evidence was found to support their use (Wei et al., 2015). While the programs did increase knowledge and improve attitudes, the authors note that knowledge and awareness alone are insufficient to prevent suicides or increase help-seeking behavior. The authors suggest using other proxies, such as emergency room visits or all-cause hospitalizations, to assess suicide prevention programs instead.

8. Appendix C: Suicide Prevention Task Force Methods and Members

The Suicide Prevention Task Force is co-chaired by Dr. Audrey Erazo-Trivino, the Associate Commissioner of the Office of Prevention and Health Initiatives, and Dr. Rosa Gil, the Executive Director of Comunilife - Life is Precious. The co-leads for the Suicide Prevention Task Force are Jennifer Dailey and Sabrina Howard, both from the Office of Mental Health. A New York State Office of Mental Health advisory group was convened to collaborate with the Suicide Prevention Task Force to consult on their findings and recommendations. The membership of the Suicide Prevention Task Force is comprised of more than 30 members from diverse backgrounds including subject matter experts, community-based organizations, individuals with lived experience, youth and peer advocates, and individuals with experience working with high-risk populations including rural, BIPOC youth, and working-aged men.

Areas of Priority for the 2024-25 Suicide Prevention Task Force included:

- Populations at Risk: Advancing Suicide Prevention Equity in New York State
- Building Health System Competencies and Pathways to Care: Zero Suicide 2.0
- Suicide Prevention in Children and Youth
- Advancing Workplace Suicide Prevention
- Measuring Outcomes

The Suicide Prevention Task Force convened 7 two-hour virtual sessions between May 2024 and April 2025. Topics included current suicide prevention activities, populations at risk, Zero Suicide Model, suicide prevention in children/youth, suicide prevention in the workplace, and suicide data in New York State. The Suicide Prevention Task Force meetings included presentations and identification of key questions on specific areas of focus, facilitated small group discussions focused on priority area, and synthesizing and organizing key discussion points, recommendations, as well as new questions. Suicide Prevention Task Force members also attended small group discussions to discuss and rank the proposed recommendations. The groups for the small group discussions were organized by areas of interest or random assignment.

The Suicide Prevention Task Force leadership met from October 2023 through April 2025. Suicide Prevention Task Force members provided ongoing feedback regarding the content and progress of the Task Force during regular check-ins at the meetings.

The NYSPI team compiled an initial list of recommendations derived directly from members' discussions during the Task Force meetings. This list was organized by strategic direction and shared with Task Force members in advance of the final meeting on April 23rd, 2025. During this final Task Force meeting, designated breakout groups reviewed recommendations proposed under a specific strategic direction (e.g., community-based recommendation, data utilization stigma, etc.) and identified which ones they would prioritize. Members were asked to discuss and prioritize recommendations based on their assessment of the recommendation's potential impact on reducing suicide risk disparities, its actionability given the resources and partnerships that would be required, and OMH's specific role in coordinating implementation. Members were also invited to propose additional recommendations not yet represented.

After these open-ended discussions, members were also asked to complete a survey in which they rated each recommendation along two dimensions: impact and actionability. For each recommendation, the mean score was calculated (0-5 scale) for each dimension, as well as a total combined mean score and used these averages in the subsequent prioritization process. These survey ratings were then triangulated with the breakout group discussions by examining both the numerical endorsement patterns (e.g., 4 out of 7 members in the breakout discussion identified a recommendation as most impactful and actionable) and the qualitative feedback provided.
Using this integrated approach, each recommendation was labeled as having "strong support," "moderate support," or "weak support," with the subset of recommendations having the most consistent strong support across both discussion groups and surveys being identified to reflect the Task Force's endorsement for prioritization. This information was all shared with OMH who used it to determine feasibility and resources needed to categorize these items as recommendations, considerations, or aspirations.

Task Force members reviewed the draft report and provided feedback in 2026.

Suicide Prevention Task Force Leadership

- Audrey Erazo-Trivino, PsyD, Associate Commissioner, Office of Prevention & Health Initiatives, NYS Office of Mental Health (co-chair)
- Rosa Gil, DSW, Executive Director, Comunilife - Life is Precious (co-chair)

Suicide Task Force Members

- Mildred Alvarado, Project Lead, "Future in Ag" at Cornell Small Farms
- Wilma Alvarado-Little, MA, MSW, Associate Commissioner and Director of the Office of Minority Health and Health Disparities Prevention, NYS Department of Health
- Michael Bauer, MS, Director, Bureau of Occupational Health and Injury Prevention, NYS Department of Health
- Jay Carruthers, MD, Director, Suicide Prevention Center of New York, NYS Office of Mental Health
- Marie Considine, MPA, Executive Director, NAMI Westchester, Inc.
- Yeates Conwell, MD, Professor of Psychiatry and Co-Director of the Center for the Study and Prevention of Suicide at University of Rochester
- Beatriz Coronel, MA, Assistant Vice President, Comunilife – Life is Precious
- Jennifer Dailey, Prevention Specialist and Trainer, Office of Prevention and Health Initiatives, NYS Office of Mental Health
- Latise Hairston, PhD, Founder/Chief Impact-Diversity Officer, HOPE Consulting
- Tricia Hartnett, Deputy Director, Office of Prevention & Health Initiatives, NYS Office of Mental Health
- Ibet Hernandez, LMSW, Organizational, Trauma-Informed Consultant
- Pete Hill, Director of Special Initiatives, Native American Community Services of Erie & Niagara Counties, Inc.
- Sharon Horton, Executive Director, NAMI NYS
- Sabrina Howard, CARES UP Project Manager, Suicide Prevention Center of New York
- Misha Kessler, Advocate & Social Entrepreneur in Mental Health & Suicide Prevention
- Christa Labouliere, PhD, Suicide Prevention – Training, Implementation, & Evaluation (SP-TIE) Program, New York State Psychiatric Institute
- Michael Lindsey, PhD, MSW, MPH, NYU Silver School of Social Work
- Pamela Perez-Morris, PhD, Professor of Applied Psychology, NYU Steinhardt School of Culture, Education and Human Development
- Jill Pettinger, PsyD, Deputy Commissioner Division of Statewide Services, NYS Office for People With Developmental Disabilities
- Narolin Reyes, Counseling and Assessment Specialist – Bilingual Education, PNW BOCES
- Renee Rider, M.Ed., Director of the School Resource Center, MHANYS and the Assistant Commissioner, NYS Education Department
- Precious Riehl, MA, Diversity, Equity, Inclusion & Accessibility Program Manager, NYS Office of Children and Family Services
- Darin Samaha, LMSW, Director of Community Services, Schenectady County
- Isaiah Santiago, Youth Advocate
- Victor Schwartz, MD, Senior Associate Dean for Wellness & Student Life at CUNY School of Medicine
- Arielle Sheftall, PhD, Associate Professor, Department of Psychiatry, University of Rochester
- Christine Shields, LCSW-R, Associate in Instructional Services, NYS Education Department
- Sebrena Tate, MOH, Research Coordinator, Division of Social Solutions & Services Research, The Nathan Kline Institute for Psychiatric Research
- Joseph Tobia, Family member affected by suicide
- Peter Wyman, PhD, Director of the Network Health and Prevention Program, and Co-Director of the Center for Study and Prevention Suicide
- Patricia Zuber-Wilson, Associate Commissioner, Office of Prevention, NYS Office of Addiction Services and Supports

New York State Psychiatric Institute (NYSPI)

- Oscar Jimenez-Solomon, PhD, MPH, Assistant Director, Center of Excellence for Cultural Competence; Assistant Professor, Department of Psychiatry, Columbia University
- Daniela Tuda, PhD, LCSW, Research Scientist, Center of Excellence for Cultural Competence
- Ana Stefanic, PhD, Associate Research Scientist, Center of Excellence for Cultural Competence
- Kenzie Potter, BA, Research Coordinator, Center of Excellence for Cultural Competence; Research Scientist
- Francesca Reilly, BA, Research Assistant, Center of Excellence for Cultural Competence
- Laura López-Aybar, PhD, Research Scientist, Center of Excellence for Cultural Competence
- Poorvi Sethi, MA, Research Assistant, Center of Excellence for Cultural Competence
- Peter Lam, MPH, Data Manager & Analyst, Center of Excellence for Cultural Competence
- Roberto Lewis-Fernandez, MD, Director, Center of Excellence for Cultural Competence; Professor, Department of Psychiatry, Columbia University

New York State Office of Mental Health Advisory Committee

- Rebecca Baitsholts, Mental Health Program Specialist 2, Division of Integrated Community Services for Children and Families
- Emily Bancroft, Mental Health Program Specialist 2, Division of Integrated Community Services for Children and Families
- Meghan Baxter, LCSW, Mental Health Program Specialist 2, Division of Integrated Community Services for Children and Families
- Joseph Erdman, Legislative Coordinator
- Nancy Hollander, PsyD, Assistant Commissioner, Division of Adult Community Care Group
- Dorota Kearney, LMHC, Mental Health Program Specialist 3, Division of Adult Services
- Maureen Morrison, CNYPC Director of Suicide Prevention
- Matthew Perkins, MD, Medical Director, Division of Integrated Community Services for Children and Families
- Stephanie Rodriguez, Mental Health Program Specialist 2, Bureau of Rehabilitation Services
- Talia Santiago-Bonds, MPH, Chief Diversity Officer & Director, Office of Diversity & Inclusion and Bureau of Reasonable Accommodation
- Loretta (Lora) Santilli, MPH, Director of Operations, Office of the Chief Medical Officer
- Tiara Springer-Love, LMSW, Mental Health Program Specialist 2, Division of Integrated Community Services for Children and Families
- Tony Trahan, Coordinator for Rural Behavioral Health
- Allison Trujillo, LCSW-R, Program Specialist, Office of Prevention of Health Initiatives
- Carrie Wong, Director Mental Health/Criminal Justice Collaboration Unit, Division of Forensic Services

Suicide Prevention Task Force Meeting Topics

Meeting	Topics Covered
May 1. 2024	• Level Set on past and present: • The OMH Suicide Prevention Center of NY • 2019 NYS Task Force Report and progress • 2024 National Strategy for Suicide Prevention • Scope of the problem • Role of provider & crisis care systems • Role of community-based prevention • Schools, Community Organizations, & Employers • Barriers/challenges • Small Group Discussion: In your agency or area of expertise, what is the most important systemic gap/barrier in suicide prevention? What solutions do you suggest to address this gap/barrier?
June 12, 2024	• Summary of the discussion from Task Force Meeting #1 • Q&A Presentation • What are the most important drivers of disparities in suicide risk? How do these factors play out in the lives of individuals and communities? • What types of strategies have the potential of reducing disparities and fostering equity in suicide prevention? • Large Group Discussion: Considering the populations with suicide disparities (at risk) and the key drivers of disparities… • What strategies for promoting equity in suicide prevention via policy, practice, and funding are missing from the list? • Which strategies have the greatest potential of promoting equity in suicide prevention for multiple populations with disparities? • Targeted Universalism • Small Group Discussion: Identify gaps in policy, practice, and funding for advancing equity in suicide prevention. For the population at risk (groups listed below), what barriers will we face in putting into action key strategies to promote equity? • Working aged men (uniformed personnel and veterans, and aging men) [ages 25-64] • Black, Hispanic and multi-racial youth and young adults (ages 13-34) • LGBTQIA+ youth and adults (ages 13-49) • Maternal mental health • Rural older men (ages 49+)

August 14, 2024	• Summary of discussion from Task Force Meeting #2 • Zero Suicide model • Health Equity Integration in the Zero Suicide Model • Small Group Discussion: What barriers do populations with suicide risk disparities face in accessing suicide prevention services within the Zero Suicide Framework, and how can we overcome these obstacles through outreach, engagement, data, and policy efforts to ensure equitable access to care? How can the Zero Suicide Framework be adapted to better address the unique cultural, social, and economic needs of populations with suicide risk disparities? What role can community leaders and stakeholders have in this process?
October 30, 2024	• Summary of the discussion from Task Force Meeting #3 • Suicide Prevention in Children and Youth • Comunilife: LIFE IS PRECIOUS™ AN EQUITY SUICIDE PREVENTION PROGRAM FOR LATINA ADOLESCENTS • Small Group Discussion: What specific recommendations for programs, policies, funding, and data should be made to NYS to improve youth suicide prevention efforts statewide in the areas of stigma, community-based interventions, workforce training & education, social determinants of health, access to & quality of suicide prevention care?
December 11, 2025	• Summary of the discussion from Task Force Meeting #4 • The Role of the Workplace in Suicide Prevention • Small Group Discussion: Discuss suicide prevention in the workplace related to: • Stigma • Community-based interventions • Workforce training and education • Social determinants of suicide • Access to quality care in suicide prevention
February 12, 2025	• Summary of the discussion from Task Force Meeting #5 • Overview of suicide data in New York • Provider perspectives on evaluating SPSP Programs • Advocate shared their story • Small Group Discussion: • Beyond data on suicide deaths and behaviors, what additional types of data would be helpful for each stakeholder group to better identify: Sources of cumulative (higher) risk, Risk and protective factors, Opportunities for intervention • How can we engage relevant stakeholders (e.g. schools, police departments, health insurance providers) to provide new, enhanced, or more timely data to inform suicide prevention efforts? • If stakeholders had access to new, enhanced or more timely data, what could they do with that data to improve their suicide prevention efforts? What are the best methods for disseminating and communicating these data to each stakeholder group?

April 23, 2025	• Summary of the discussion from Task Force Meeting #6 • Final Task Force Report Development • Cross cutting themes and priority areas • Small Group Discussion about the Strategic Planning Task Force Recommendations

9. Appendix D: References

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Turning Strategy into Action

THE NYS OFFICE OF MENTAL HEALTH'S COMPREHENSIVE ACTION PLAN FOR SUICIDE PREVENTION

2026-2030

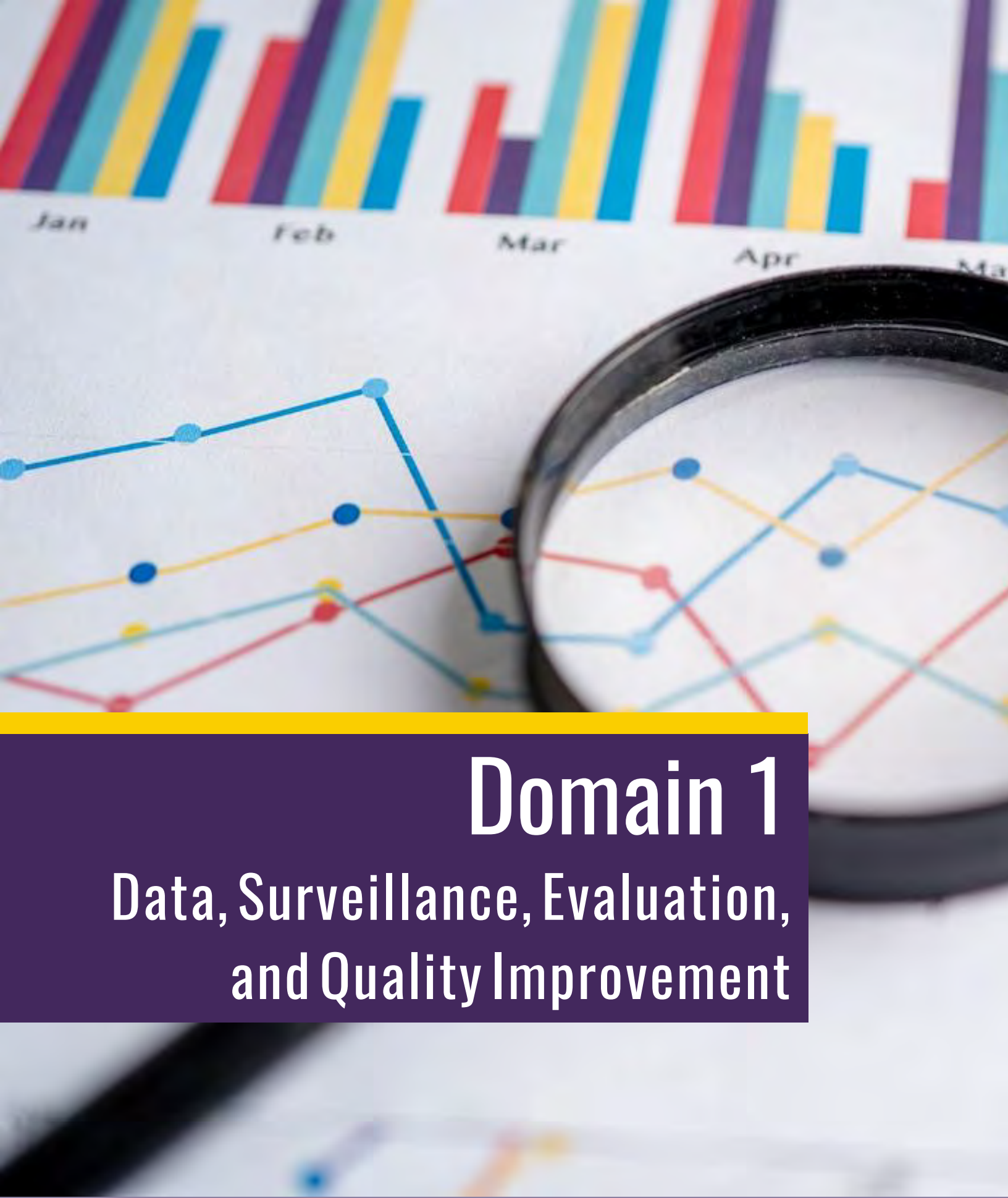
Introduction

New York State is committed to reducing suicide attempts and deaths and strengthening its suicide prevention efforts through strategic, coordinated action. As part of this commitment, the New York State Office of Mental Health (OMH), in collaboration with the New York State Suicide Prevention Task Force and the New York State Suicide Prevention Council, subject matter experts, and individuals with lived experience, developed a comprehensive and prioritized Action Plan, titled Turning Strategy into Action: The NYS Office of Mental Health's Comprehensive Action Plan for Suicide Prevention.

This Action Plan serves as a companion to 1,700 Too Many: New York State's Strategy for Suicide Prevention (2026–2030) and the New York State Suicide Prevention Task Force Report: Findings and Recommendations to Reduce Disparities. It translates the strategy's broad goals and the task force's recommendations focused on addressing disparities in suicide risk into specific, measurable actions that will be implemented over the next four years. The plan outlines targeted objectives guided by data and shaped by community voices that OMH's Suicide Prevention Center (SPCNY) will lead, coordinate, and/or track. In advancing these objectives, OMH will work in partnership with Council members, other state agencies, local governments, community-based organizations, and individuals with lived experience to create a foundation for sustainable, long-term suicide prevention efforts.

The development of this Action Plan reflects the critical need for clear, actionable steps in achieving New York State's suicide prevention goals. However, it is also designed with flexibility in mind. Given that circumstances, emerging priorities, and new insights may evolve, the Action Plan will remain adaptable to the changing needs of individuals, families, and communities across the state. The Action Plan and the accompanying metrics will be reviewed annually by the New York State Suicide Prevention Council, and updates will be made as needed to reflect new priorities or data. This approach enhances the responsiveness and proactiveness of the state's suicide prevention efforts in addressing emerging trends and needs.

Together, the New York State Strategy for Suicide Prevention, the New York State Suicide Prevention Task Force Report, and the Action Plan — collectively known as the ***New York State Roadmap for Suicide Prevention*** — reflect the state's commitment to a coordinated, community-informed, and impactful approach to suicide prevention that drives meaningful, lasting change.



Domain 1

Data, Surveillance, Evaluation, and Quality Improvement

I OMH in collaboration with partners, including NYS Department of Health (DOH) andother external agencies, will execute at least one discrete action per year that contributes to suicide data improvement (e.g. webinars, resource sharing), including overall improvements and those that improve data used to identify or track suicide disparities. Data improvement includes aspects such as the timeliness of data release, quality of mortality data, and local availability of data for prevention initiatives. OMH will also continue to collaborate with the OMH Office of Population Health and Evaluation on efforts to improve collection of suicide-related information within OMH data sources. ***(Goal 1; Rec 41, 42)***

Performance Measures

- Number of discrete actions towards suicide data improvement executed per year

II OMH will develop capacity to create and implement two mortality surveillance plans that integrate multiple data sources at multiple levels and encompass the continuum from suicide risk to morbidity and mortality outcomes across the life course. The first surveillance plan will focus on suicide mortality as the most distal outcome, statewide, while the second plan will monitor a broader range of mortality outcomes, such as unintentional injuries and natural causes, among New Yorkers receiving behavioral health services. Both plans will identify and monitor populations with suicide disparities (i.e., those with higher or increasing rates), including those defined geographically. ***(Goal 1)***

Performance Measures

- Completion of surveillance plans and presentation to Suicide Prevention Council
- Number of Data User Agreements executed to facilitate data access and linkage

III OMH will seek to build on its initial suicide fatality review pilot by exploring partnerships that advance development of suicide fatality review committees across the state. ***(Rec 44)***

Performance Measures

- Number of concrete steps taken that contribute to advancing SMR work in NYS (e.g. meetings with outside organizations, relevant trainings)

IV OMH and the NYS Suicide Prevention Council Data Workgroup will develop and disseminate an inventory of suicide related data sources covering the population of New York, which will describe available data sources, the information they contain, including information on populations with suicide disparities, and how they can be accessed. The inventory will help to promote suicide-related data transparency and facilitate data-driven suicide prevention decision-making. Additionally, OMH and the Data Workgroup will produce population profiles that integrate suicide related data across multiple data sources to describe suicide morbidity and mortality among populations with suicide disparities in New York that will be publicly released at least once per year. Community and Council feedback will be sought to strengthen the relevance and utility of these profiles. ***(Goal 2; Rec 43)***

Performance Measures

- Sharing of completed data inventory with Suicide Prevention Council
- Public dissemination of data inventory per Council recommendations
- Number of population profiles released per year

V OMH will continue ongoing monitoring and evaluation of its suicide prevention programming by ensuring that 100% of programs receiving at least $250,000 in annual funding systematically collect data to inform program monitoring and evaluation efforts. Evaluation will assess program outcomes among populations with suicide disparities. OMH will also continue to support program evaluation and implementation research efforts led by external partners by serving as consultants and/or collaborators, as needed. Additionally, OMH will collaborate with the New York State Suicide Prevention Council to monitor progress on performance measures outlined in this action plan, actively participating in at least one review per year. ***(Goal 3; Rec 45)***

Performance Measures

- Percent of OMH SPNCY suicide prevention programs receiving at least $250,000 in annual funding that collect data for program monitoring and evaluation per year
- Proportion of evaluations that include assessment of outcomes among populations with suicide disparities
- Number of OMH Action Plan performance measures monitored per year

VI OMH will conduct, promote and support research that strengthens suicide prevention efforts and deepens understanding of social disparities in suicide across New York. This approach includes consultation, translation, and encouraging and facilitating collaboration and connection between academic, government, and community partners. Each year, OMH will engage with at least two (2) research projects and contribute to at least one research-related product, such as abstracts, posters, or articles. ***(Goal 4)***

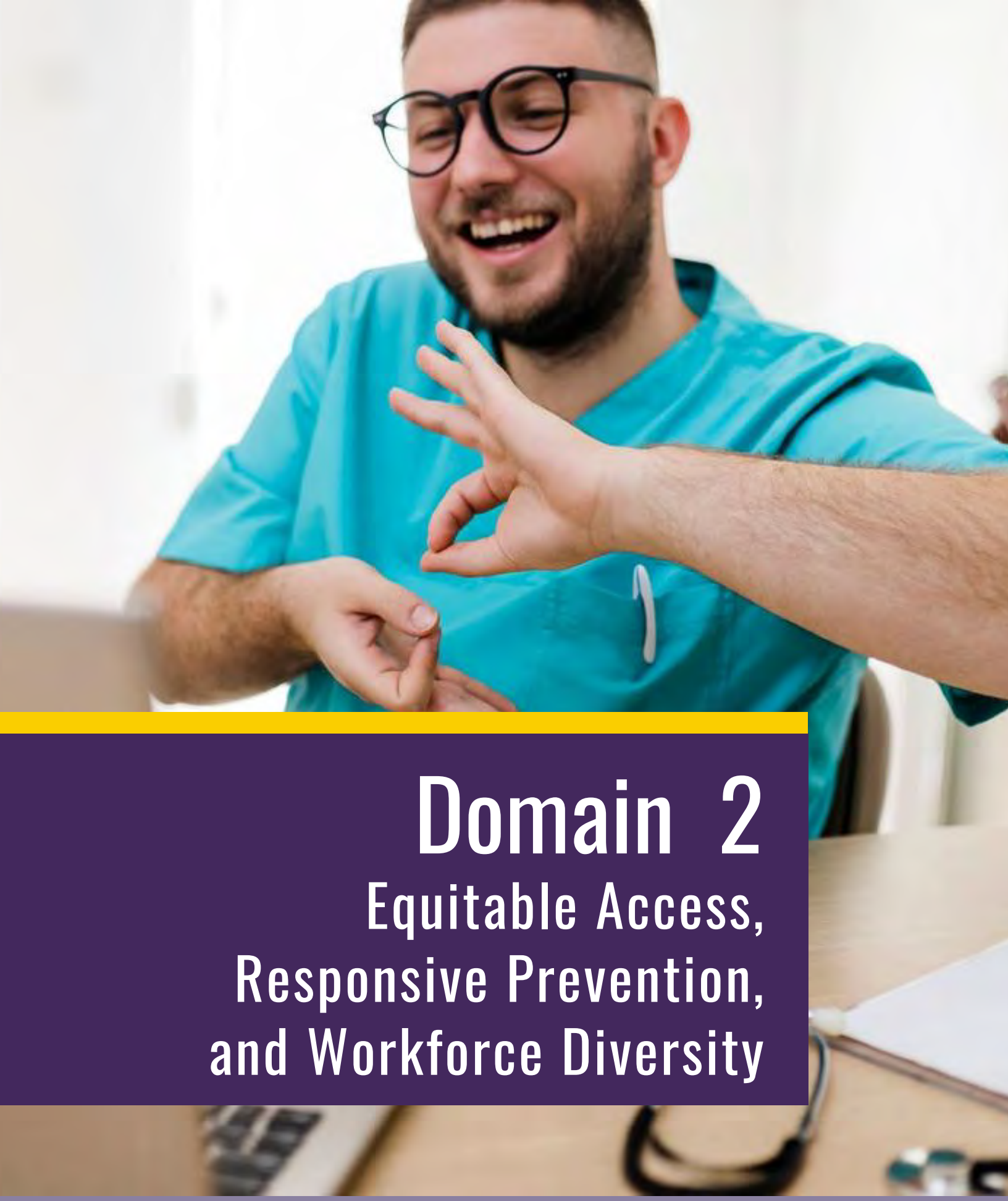
Performance Measures

- Number of suicide prevention related research projects conducted, promoted, or supported per year
- Number of research-related products with contribution by OMH SPCNY staff per year
- Number of research-related products with contribution by OMH SPCNY staff per year that include information on suicide risk disparities

VII OMH will share suicide-related data with the public through multiple channels including the OMH SPCNY website, social media, and print and training materials. These efforts will help ensure that OMH SPCNY's growing network is informed about recent trends while promoting awareness of communities with suicide disparities. ***(Goal 17; Rec 2)***

Performance Measures

- Number of times per year suicide data-related information on the OMH SPCNY website and in print materials is reviewed and updated as needed
- Number of clicks accessing the data-specific materials released, annually
- Number of social media impressions for social media posts dedicated specifically to suicide data and trends



Domain 2

Equitable Access, Responsive Prevention, and Workforce Diversity

VIII OMH, in partnership with New York State Psychiatric Institute (NYSPI), will conduct a review of evidence-informed strategies that address suicide risk factors, including those that are connected to social determinant of health, such as housing instability, financial insecurity, and limited access to culturally responsive care. OMH will work with other state agencies to raise awareness of suicide risk factors that are connected to the services and communities that the agencies support. OMH will further support these agencies in developing action plans that incorporate targeted suicide prevention strategies. ***(Goal 6; Rec 5, 16, 32,34)***

Performance Measures

- NYSPI review of evidence-informed strategies that address suicide risk factors connected to social determinant of health completed
- Number of state agencies engaged by OMH for awareness raising
- Number of participating agencies with a completed action plan
- Number of state employees completing suicide prevention training through the state Learning Management System (SLMS)

IX OMH SPCNY will establish a Suicide-centered Advisory Group of Lived Expertise (SAGE) composed of paid consultants with suicide-centered lived experience, including those who have experienced suicidal thoughts, survived a suicide attempt, supported a loved one through a suicidal crisis, or been bereaved by suicide. OMH SPCNY will encourage diverse membership, including representation from populations with suicide disparities. These consultants will use their expertise and lived experience to provide guidance and recommendations for designing, implementing, and evaluating OMH SPCNY suicide prevention projects. ***(Goal 5; Rec 6, 7)***

Performance Measures

- Establishment of SAGE
- Number of contracted SAGE members
- Number of OMH SPCNY projects informed by SAGE members annually

X OMH will take coordinated and targeted steps to create opportunities for high school and college students, including those from underrepresented communities, to pursue careers in behavioral health services. This will include developing partnerships with K–12 and higher education institutions to promote mental health career pathways through internships, mentorships, and other experiential learning opportunities, with the goal of increasing diversity in the behavioral health workforce. ***(Goal 7; Rec 8)***

Performance Measures

- Number of meetings with NYSMHA regarding the Grow Your Own program
- Number of OMH-organized colloquia for master level social work and mental health students focused on mental health topics
- Number of CUNY and SUNY schools participating in the Evidence Based Practice social work and mental health counseling program
- Number of CUNY and SUNY schools participating in the Evidence Based Practice social work and mental health counseling program that serve high proportions of students from underserved communities

XI OMH will partner with SUNY and/or CUNY to expand internship opportunities for students enrolled in a mental health program. These partnerships will focus on supporting students from underrepresented communities to increase diversity in the workforce. ***(Goal 7; Rec 9)***

Performance Measures

- Number of webinars and/or in-person sessions per semester for the purpose of preparing EOP students for internships, receiving feedback about the program, and/or professional development
- Number of attendees at webinars and/or in-person sessions per year for the purpose of preparing EOP students for internships, receiving feedback about the program, and/or professional development

XII OMH will create a mental health credential specifically for paraprofessionals along with free access to an associated required training curriculum. ***(Goal 7; Rec 10)***

Performance Measures

- Number of people obtaining the Credentialed Mental Health Support Specialist at different levels
- Number of trainings created to address service gaps

XIII OMH will continue to promote awareness and accessibility of language access initiatives that make state-provided mental health services and resources available in the most common languages spoken in New York State. Additionally, OMH will continue to expand the availability of suicide prevention training and resources in multiple languages to increase accessibility for New Yorkers with limited English proficiency. This includes translating school-based training materials, family resources, and promotional campaigns, with an emphasis on commonly spoken languages across the state. ***(Goal 5; Rec 23)***

Performance Measures

- Number of individuals utilizing language access services
- Number of languages utilized to deliver mental health services
- Number of languages into which vital documents have been translated
- Number of languages into which OMH SPCNY trainings/documents have been translated

XIV OMH SPCNY will explore, support, and promote the implementation and development of new best practice or evidence-based interventions, programs, and initiatives that address suicide risk among populations with suicide disparities, particularly in areas where current gaps exist, to help ensure that all communities have access to effective, culturally responsive, trauma-informed, and relevant suicide prevention strategies. This may include the creation of new training programs and promotion of promising programs and interventions. ***(Goal 8; Rec 25, 38)***

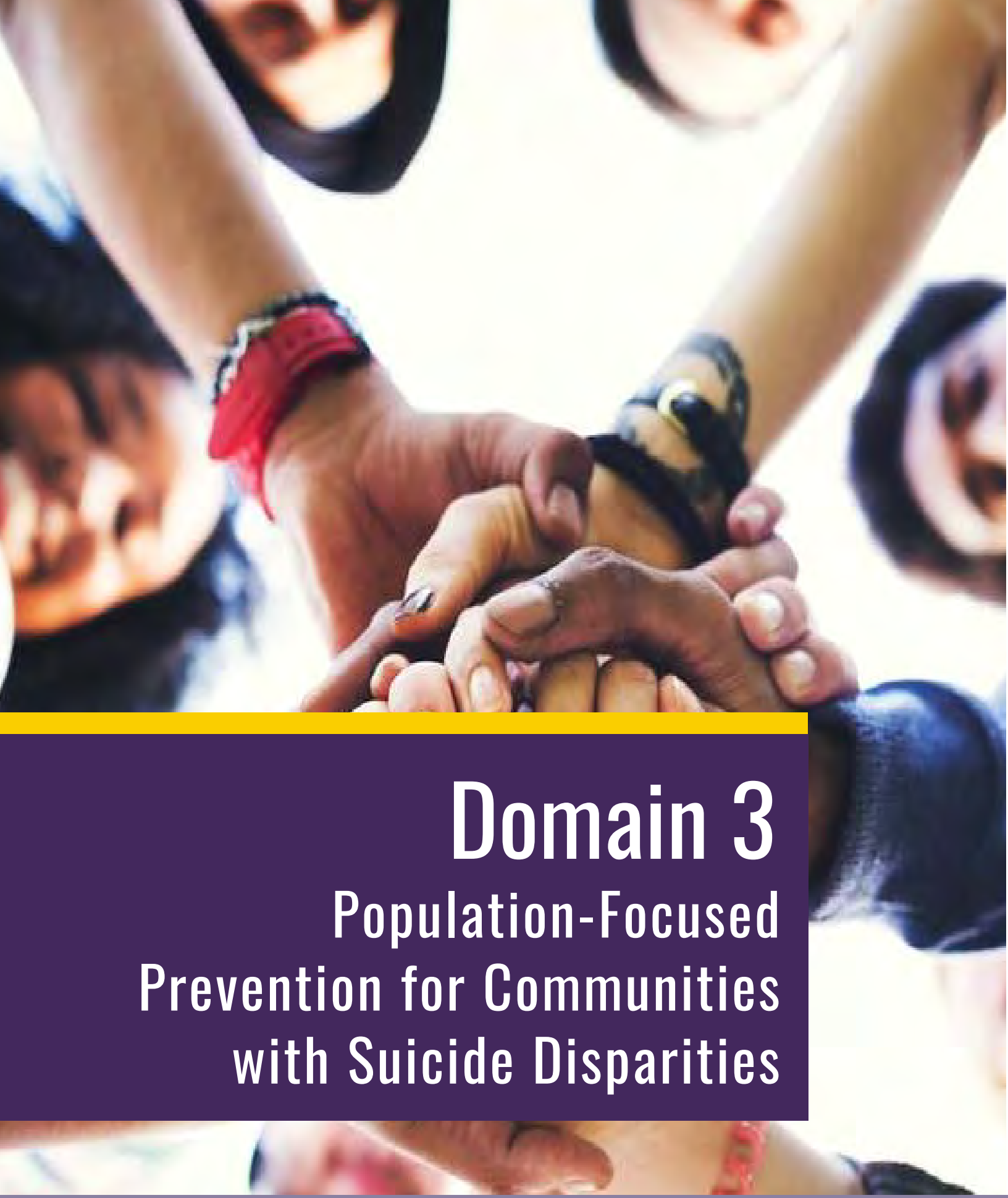
Performance Measures

- Number of new programs/initiatives/trainings supported by OMH SPCNY that address suicide risk among populations with suicide disparities in NYS

XV OMH SPCNY will review its procurement process with an equity lens to help ensure that need-based criteria are considered and lower resource communities can compete for funding where appropriate. A policy will be developed to formalize this commitment and guide its implementation. ***(Goal 5; Rec 26)***

Performance Measures

- Number of suicide prevention procurements per year where need- based criteria were utilized or reflected in the procurement design



Domain 3

Population-Focused Prevention for Communities with Suicide Disparities

XVI OMH SPCNY will work alongside community organizations and individuals, particularly youth and organizations within the Black community, to co-develop and strengthen the messaging of suicide prevention trainings and resources, to enhance cultural relevance and resonance with the community. Additionally, OMH SPCNY will increase the number of school-based trainers who represent the Black community, helping to increase cultural congruence between trainers and Black youth. ***(Goal 12; Rec 24)***

Performance Measures

- Number of black youth-focused resources/trainings that have been co-developed/reviewed by representative(s) of the Black community
- Number of new school-based trainers who identify as part of the Black community

XVII OMH SPCNY will enhance suicide prevention messaging and resources by partnering with individuals and organizations from the Hispanic community to increase cultural relevance in materials for Hispanic youth. This includes translating school-based training materials and youth and family specific resources into Spanish to improve access to suicide prevention information. Additionally, OMH SPCNY will work to increase the number of school-based trainers from the Hispanic community who are fluent in Spanish, expanding the reach and availability of suicide prevention trainings for schools and youth-serving organizations that support Hispanic youth. ***(Goal 12; Rec 24)***

Performance Measures

- Number of youth-specific resources/trainings translated into Spanish
- Number of new school-based trainers who speak Spanish and identify as part of the Hispanic community

XVIII OMH SPCNY will partner with New York-based LGBTQIA+ organizations to develop and disseminate a training program focused on helping participants understand the challenges LGBTQIA+ youth face, including the long-term mental health impacts of rejection and bias. This will include the development of a "train the trainer" model, that will equip trainers (youth-serving adults in health, education, and juvenile justice) with the knowledge and skills necessary to spread the program statewide, with the aim of increasing access to affirming, supportive resources for LGBTQIA+ individuals across New York State. ***(Goal 12; Rec 24)***

Performance Measures

- Development of training program curriculum
- Number of individuals trained
- Development of train the trainer model and materials
- Number of trainers successfully trained

XIX OMH, SPCNY working alongside rural community members, county coalitions, and organizations, will develop tailored resources to enhance suicide awareness and prevention in rural areas. These resources will reflect the perspectives and recommendations of rural residents, including those with lived experience related to suicide. Key efforts will focus on strengthening connections with rural-based community organizations and providers to distribute mental health resources, raise awareness of region-specific barriers to services, and improve access to support. Additionally, OMH SPCNY will continue to support county suicide prevention coalitions in promoting firearm safe storage and lethal means safety. ***(Goal 12; Rec 24, 37)***

Performance Measures

- Creation of specific materials/trainings for rural communities
- Number of bi-annual county coalition meetings that discuss firearm safety activities and programming
- Number of rural counties that received OMH funding for suicide prevention programming

XX OMH will focus on building meaningful relationships with Indigenous communities and tribal nations across New York State to discuss suicide prevention efforts. This will involve connecting with Indigenous communities to learn about their strengths, needs, priorities, and cultural values, especially as they relate to the concepts of suicide and suicide prevention. When invited by Tribal Nations, OMH will meet with community leaders and members to discuss opportunities for collaboration on suicide prevention initiatives, including the development and promotion of culturally relevant materials and approaches, guided by the direction, knowledge, and priorities of Indigenous communities. This relationship-building process will prioritize transparency, respect, inclusivity, and community-driven solutions, ensuring that OMH's efforts align with and are guided by the values and goals of the Indigenous communities in New York State, recognizing and honoring the sovereignty of all tribal nations. ***(Goal 12; Rec 24)***

Performance Measures

- Number of relationships built with Tribal Nations in New York State

XXI OMH SPCNY will engage with veteran-serving and military organizations across New York State to assess existing suicide prevention efforts, identify unmet needs, and strengthen collaboration. These efforts will focus on enhancing communication, coordination, and resource-sharing to support veterans, active-duty service members, and their families. ***(Goal 12)***

Performance Measures

- Number of veteran-serving and military organizations engaged with OMH SPCNY to foster collaboration

XXII OMH SPCNY will develop and carry out marketing campaigns aimed at increasing mental health and suicide prevention awareness among working-aged men to reduce stigma and encourage help-seeking. These campaigns will also seek to raise awareness of the unique barriers and challenges faced by working-aged men. Feedback from individuals from male-dominated industries (e.g. construction, first responders) will be collected regarding the impact of the messaging. ***(Goal 12; Rec 2)***

Performance Measures

- Number of digital campaigns launched aimed at Working Aged Men
- Estimated reach of digital marketing campaigns
- Number of ad clicks to access campaign materials

Domain 4
Community Engagement and Stigma Reduction

XXIII OMH will continue to promote awareness of the 988 Suicide & Crisis Lifeline through the development and dissemination of engaging materials, targeted media content, and strategic communications. This will also include the distributing of resources and promotional materials tailored to communities with suicide disparities. ***(Goal 17; Rec 1)***

Performance Measures

- Number of specific populations (e.g., youth, rural communities, Spanish-speaking individuals, workplaces) with tailored 988 promotional materials
- Number of 988 print material requests filled

XXIV OMH will collaborate with diverse communities, including those with lived experience, to develop targeted communication efforts that promote help-seeking behaviors, reduce stigma surrounding mental health and substance use, and offer education on mental health and crisis resources. This will include sharing stories of help, hope, and healing through safe, culturally- and community-responsive messaging strategies that challenge misconceptions and normalize conversations around mental health. These co-developed communication strategies and campaigns will also leverage social media and digital platforms, recognizing their reach among youth, as well as expand into non-traditional settings where at-risk populations are likely to be engaged. ***(Goal 17; Rec 2, 3, 4)***

Performance Measures

- Number of 'stories of hope and healing' videos released annually
- Number of views of 'stories of hope and healing' videos released on social media platforms
- Number of campaigns launched in community settings (e.g., barbershops, faith communities, laundromats, recreation centers)
- Estimated reach of campaigns launched in community settings

XXV OMH SPCNY will engage with news media outlets and other media organizations to encourage and promote safe, accurate, and responsible reporting on suicide, as well as the portrayal of positive mental health and effective coping strategies. This effort will include providing media professionals with guidelines and best practices for reporting on suicide and mental health. ***(Goal 17)***

Performance Measures

- Creation of safe messaging guide for public and media outlet use
- Number of news media outlets and media organizations guide is shared with

XXVI OMH SPCNY will strengthen and expand partnerships with community-based organizations that provide support and programs designed to decrease risk and increase protective factors for suicide, prioritizing organizations that serve populations affected by suicide disparities. These partnerships will be intentionally structured and maintained through purposeful collaboration, with all parties committed to working jointly with OMH SPCNY toward clearly defined projects and objectives. ***(Goal 13; Rec 36)***

Performance Measures

- Number of new contracts or memorandum of understandings (MOUs) in place with community-based organizations established annually

XXVII OMH will collaborate with experts to develop and disseminate a comprehensive, data-informed guidance resource that outlines evidence-based strategies to reduce suicide attempts and deaths at high-risk public locations such as bridges, rail platforms, and other transit settings. This resource will offer practical recommendations for implementing effective lethal means safety measures, including environmental modifications, strategic signage, surveillance enhancements, and coordinated crisis response protocols. The guidance will be tailored to meet the needs of state and local agencies, transit authorities, and community organizations, supporting a unified, proactive approach to mitigating suicide risk in these vulnerable areas. ***(Goal 14)***

Performance Measures

- Completion of the lethal means guidance document
- Number of organizations provided with guidance document

XXVIII OMH SPCNY will collaborate with firearm safety instructors, retailers, and gun ranges to integrate evidence-based suicide prevention content into licensed firearm instructional programs and within firearm retail environments. OMH SPCNY will also provide community-based lethal means safety trainings. ***(Goal 14)***

Performance Measures

- Number of individuals trained in community lethal means safety
- Number of licensed firearm instructors incorporating OMH suicide prevention content into concealed carry permit classes

XXIX OMH will develop and implement a standardized framework to help state agencies and employees, community members, local organizations, and coalitions identify, select, and access appropriate suicide prevention trainings. Trainings will be available through OMH SPCNY via in-person, virtual, and online platforms. OMH will distribute the framework statewide and support organizations in identifying and selecting the most appropriate trainings for their communities. A key focus will be cultivating credible messengers through community helper trainings, equipping community members to recognize individuals at risk, share prevention resources, and connect people to services in ways that reflect the cultural context of those they serve. To increase access to in-person training for all New Yorkers, OMH SPCNY will also expand its statewide trainer network, building local capacity to deliver trainings at the community level. ***(Goal 15; Rec 17, 18, 35)***

Performance Measures

- Development of standardized training strategic framework
- Number of community helper suicide prevention trainings provided by OMH SPCNY
- Number of community helper trainings provided in-person
- Number of individuals trained by OMH SPCNY and the trainer network
- Number of community trainers in OMH SPCNY Trainer Network

XXX OMH SPCNY will develop and promote workplace-focused suicide prevention programs, tools, and resources aimed at strengthening protective factors, including peer support and connectedness, promoting mental well-being, encouraging help-seeking behaviors, reducing stigma, and fostering supportive, resilient work environments. Special emphasis will be placed on engaging high-risk industries, including but not limited to construction and uniformed personnel, as well as workforce training and development centers, as key access points for those entering these industries. These efforts will be achieved through the provision of technical assistance and the development of toolkits, training, guidance documents, and other supportive materials. All programming and resources will be informed by industry-specific insights and feedback to enhance cultural relevance and operational effectiveness across diverse workplace contexts. ***(Goal 16; Rec 11, 19, 20, 33, 39)***

Performance Measures

- Number of high-risk industry workplaces/training centers receiving training and/or technical assistance from OMH SPCNY
- Number of high-risk industries for which at least one industry-specific resource (e.g., toolkit, training, guidance document) was developed or adapted
- Number of peer support programs supported through CARES UP initiative

XXXI OMH SPCNY will continue to promote the importance of meaningful social connections, both among youth and between youth and trusted adults. To advance this effort, OMH SPCNY will encourage the adoption of connection-building programs by school districts and youth-serving organizations. ***(Goal 10)***

Performance Measures

- Percent of relevant school-based trainings that include information about the importance of connection building

XXXII OMH SPCNY will improve awareness of upstream suicide prevention strategies, such as social-emotional learning curricula and programs designed to increase protective factors among youth, by emphasizing their importance in OMH SPCNY trainings delivered to schools and youth-serving organizations. ***(Goal 11)***

Performance Measures

- Percent of relevant school-based trainings that include information about the importance of upstream suicide prevention strategies
- Number of schools supported by OMH to implement Sources of Strength

XXXIII OMH SPCNY will continue to promote and expand youth-specific suicide prevention training initiatives and resources that support schools and youth-serving organizations in developing and implementing suicide prevention protocols, including providing tiered (universal, selective, indicated) suicide prevention training for all school staff and enhanced, role-specific trainings. OMH SPCNY will enhance existing school-based trainings with tailored content that addresses the unique strengths, identities, and needs of diverse communities. Further, OMH will expand its network of school-based trainers to enhance statewide training access. OMH SPCNY will also continue to amplify materials developed in collaboration with the New York State Education Department (NYSED), by including the existing companion of in all school-based training content. ***(Goal 9; Rec 12, 14, 15, 30, 31)***

Performance Measures

- Number of existing school-based OMH trainings that are modified with tailored content for specific communities
- Number of OMH SPCNY school-based trainings provided annually
- Number of individuals trained in OMH SPCNY school-based trainings annually
- Percentage of NYS counties that receive OMH SPCNY school trainings annually
- Number of new OMH SPCNY school-based trainers

XXXIV OMH SPCNY will collaborate with diverse community partners to train a statewide network of new postvention facilitators who reflect a broad range of communities and backgrounds, including those with suicide-centered lived experiences. This will help to ensure postvention support is community-driven and delivered by trusted voices and those with lived experience while expanding accessibility across New York State. OMH SPCNY will also increase awareness and utilization of postvention resources in hospitals, schools, and community settings through targeted outreach and dissemination of best practices. To strengthen local responses, SPCNY will conduct presentations for county suicide prevention coalitions and provide guidance on postvention strategies, including the importance of including those with lived experience, while encouraging and supporting counties to develop region-specific postvention resource guidance that include culturally relevant, locally grounded supports. ***(Goal 18; Rec 40)***

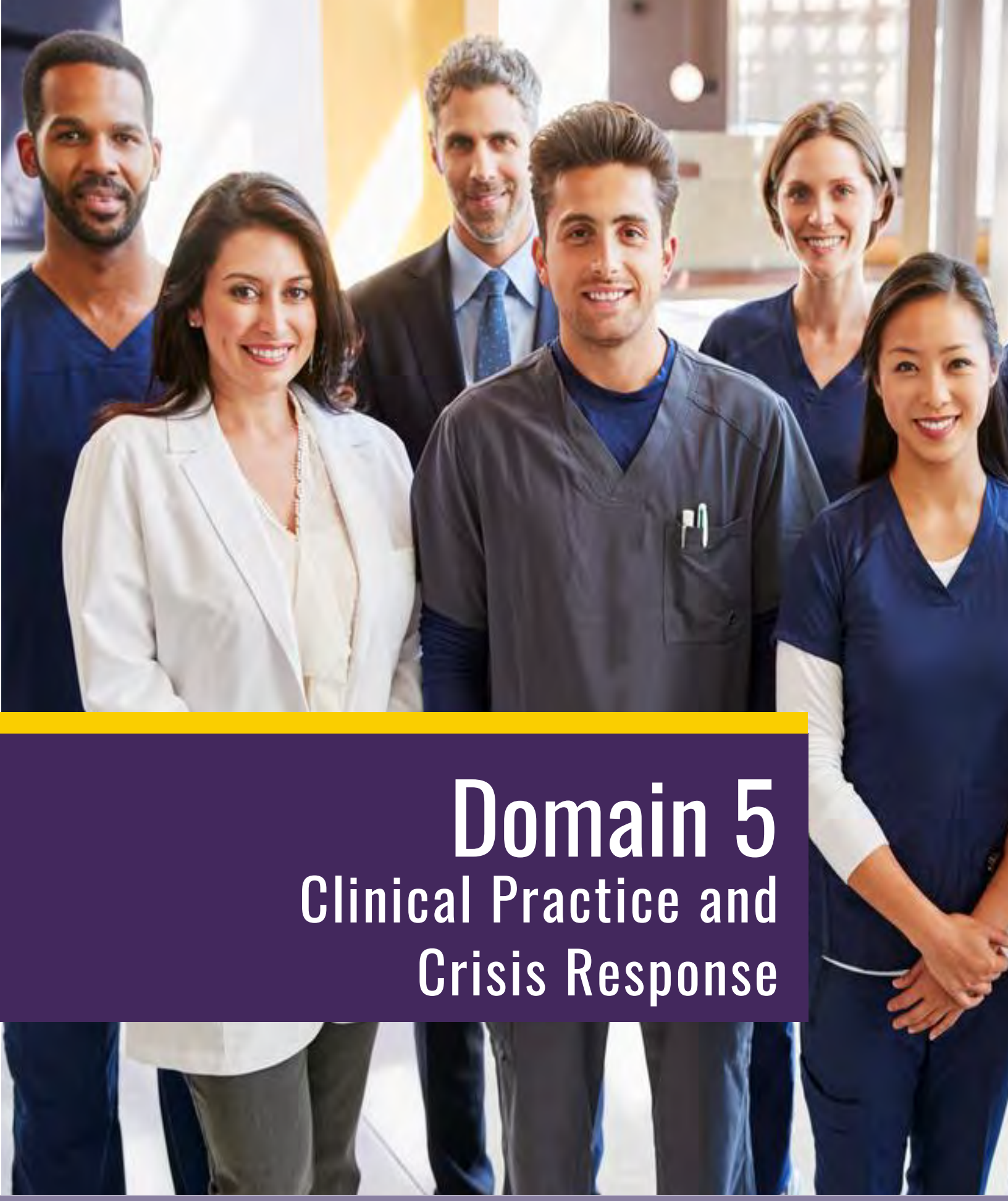
Performance Measures

- Number of postvention trainings per year
- Number of facilitator trainings held per year
- Number of new postvention facilitators per year
- Percentage of postvention consultation requests fulfilled
- Number of presentations provided to coalitions on postvention best practice

XXXV OMH SPCNY will conduct targeted outreach to funeral homes across New York State to provide postvention information regarding funeral home staff roles in supporting individuals bereaved by suicide. This outreach will direct funeral home staff to postvention-specific resources and trainings that equip them with the knowledge and skills needed to offer effective, compassionate support to grieving families. Additionally, OMH will encourage funeral homes to establish referral pathways to local mental health and behavioral health services, ensuring that families are connected to timely and appropriate support. ***(Goal 18)***

Performance Measures

- Number of presentations provided to funeral homes, including to associations, conferences, etc.
- Number of funeral homes sent postvention guidance materials



Domain 5
Clinical Practice and Crisis Response

XXXVI OMH will continue a multifaceted effort to increase access to evidenced-based suicide prevention interventions, including in school and community-based settings, and working with NYSED on expansion of mental health services, including telehealth, in accordance with all applicable NYS statutory and regulatory requirements for telehealth services. ***(Goal 19; Rec 21)***

Performance Measures

- Number of licensed school-based mental health centers offering a telehealth service option
- Number of OMH licensed clinics (non-school based) offering a telehealth service option

XXXVII OMH will continue to pursue expansion of the Collaborative Care Model (CoCM), the most evidenced model for integrating behavioral health services into primary care settings and include technical assistance and support for suicide safer care best practices for practices implementing CoCM. ***(Goal 19; Rec 27)***

Performance Measures

- Number of new primary care practices approved to participate in the NYS Medicaid Collaborative Care Program
- Number of primary care provider webinars covering best practices in suicide safer care per year

XXXVIII OMH will continue to promote adoption of pediatric primary care programs, like HealthySteps, whose goal is to buffer children against the most harmful effects of trauma. ***(Goal 11; Rec 28)***

Performance Measures

- Number of new practices participating in the HeathySteps NY program per year
- Number of new youth-serving practices approved for the NYS Medicaid Collaborative Care Program

XXXIX OMH, in partnership with Columbia University's Center for Practice Innovations: Suicide Prevention – Training, Implementation, & Evaluation (SP-TIE) team, will expand and enhance statewide training to increase availability of culturally infused suicide prevention training for healthcare professionals across New York State. These trainings will equip healthcare professionals with knowledge and resources to better provide culturally responsive care to populations they support. ***(Goal 7; Rec 13, 29)***

Performance Measures

- Number of new or updated trainings developed and released

XL OMH SPCNY will collaborate with SP-TIE and other clinical training partners to promote best practices in suicide safer care. This will include ensuring at least one online training in each of the six core components of a suicide-safer care approach to healthcare is free and publicly available. These core components will include suicide screening, suicide risk assessment, suicide-specific safety planning, lethal means counseling, suicide-specific treatment planning, and monitoring & follow-up through care transitions. ***(Goal 19; Rec 22)***

Performance Measures

- Number of actions taken to promote best practices in suicide-safer care
- Number of core components for which online training has been developed and made publicly available online

XLI In collaboration with its clinical training partners, OMH SPCNY will deliver lethal means safety trainings to healthcare systems across the state to ensure that these systems are equipped with the skills and knowledge to increase safe storage practices among individuals at suicide risk. These live (synchronous) trainings will be provided directly to healthcare providers, including those that serve populations with suicide disparities. ***(Goal 19)***

Performance Measures

- Number of lethal means safety trainings delivered to healthcare providers
- Number of clinical providers trained in lethal means safety
- Proportion of NYS counties where clinical providers have received training in lethal means safety

XLII OMH will systematically collect and assess existing guidance and best practices in suicide-safer care, including those grounded in the Zero Suicide Framework, adapting them to meet the unique needs of various healthcare settings across New York State. This process will involve collaboration with subject matter experts, healthcare partners, and individuals with suicide-centered lived experience. Where available, electronic health record (EHR) system-specific guidance will be incorporated to support practical implementation at the point of care. Findings and adapted best practices will then be disseminated statewide through multiple channels, including the OMH website and webinars and presentations, to promote broad reach across diverse healthcare contexts. ***(Goal 19; Rec 22)***

Performance Measures

- Number of suicide-safer care best practice guides disseminated for specific healthcare settings (e.g. inpatient, outpatient clinics, emergency departments, primary care, etc.)
- Number of agencies accessing guidance

XLIII OMH SPCNY will conduct a comprehensive review of existing standards related to suicide prevention for all behavioral healthcare service types licensed by OMH. SPCNY will then work with OMH to align service standards with current best practices in suicide prevention. Additionally, OMH SPCNY will provide guidance to other behavioral health state licensing agencies to encourage them to align service standards with current suicide prevention best practices. ***(Goal 19)***

Performance Measures

- Number of standards reviewed
- Number of proposed changes to standards

XLIV OMH will work to ensure that 988 centers will have established formal relationships with all local 911 Public Safety Answering Points (PSAPs) across New York State, with clearly defined protocols for the safe and efficient transfer of calls from 911 to 988 in appropriate scenarios. This collaboration will foster a seamless transitions in crisis situations, enhancing the safety and effectiveness of the response and ensuring that individuals in mental health crises are directed to the appropriate support services. ***(Goal 20)***

Performance Measures

- Number of local 911 PSAPs that have formal relationships with 988 centers across New York State, and have clear, written protocols for the safe and efficient transfer of calls

XLV OMH will ensure crisis support is available in every region through 988, mobile crisis teams, and crisis stabilization centers, providing a comprehensive and coordinated system of care for individuals experiencing mental health crises. Additionally, OMH will ensure all 62 counties in NYS will have mobile crisis teams available to respond to individuals in mental health crises within the community. ***(Goal 20)***

Performance Measures

- Number of regions in New York State with 988, mobile crisis teams, and crisis stabilization centers operational
- Number of counties with mobile crisis teams

XLVI OMH will develop and implement a comprehensive crisis learning management platform accessible to all crisis response system workers. This platform will provide thorough training on suicide prevention protocols, including assessment, intervention, suicide specific safety planning, lethal means safety counseling, and follow-up, ensuring that all workers are equipped to deliver effective suicide prevention interventions. ***(Goal 20)***

Performance Measures

- Completion of the development and launch of the crisis learning management platform
- Number of crisis service workers who complete the suicide prevention training on the platform

Appendix A

Goals of the New York State Strategy for Suicide Prevention

The goals listed below are drawn from the New York State Strategy for Suicide Prevention. Action items throughout this Action Plan reference these goals by number (e.g., “Goal 15”).

No.	Strategy Goal
1	Advance data quality and integration to facilitate comprehensive understanding of suicide and related mortality in New York.
2	Increase utilization of multiple data sources and dissemination of actionable information to address suicide risk among populations with suicide disparities in New York.
3	Continually evaluate programs and advance implementation research to improve suicide prevention in New York.
4	Conduct, promote, and support research that provides actionable information to guide suicide prevention in New York.
5	Improve and expand access to effective, evidence-based suicide prevention initiatives by reducing barriers to care, using data driven decision-making, and ensuring programs are responsive to the strengths, needs, and lived experiences of communities across New York State.
6	Address the social, economic, and environmental conditions that contribute to suicide risk across communities in New York State.
7	Develop and support a healthcare and crisis response workforce that is well-trained, resourced, and equipped to provide equitable, responsive suicide prevention services across care settings and populations.
8	Increase support for academic and community-led research focused on advancing equitable, evidence-informed suicide prevention strategies, and strengthen cross-sector collaboration to improve the dissemination and practical application of research findings and promising practices.
9	Improve the availability and access to youth-specific suicide prevention trainings, information, and resources for schools, families, and organizations serving youth
10	Implement evidence-based programs that strengthen youth social connectedness.

No.	Strategy Goal
11	Advance upstream suicide prevention by expanding early intervention strategies and strengthening protective supports for children and youth.
12	Develop, implement, and improve access to comprehensive suicide prevention strategies that address the needs of communities with suicide disparities.
13	Establish effective, broad-based, collaborative, and sustainable suicide prevention partnerships
14	Promote lethal means safety among people at risk of suicide.
15	Strengthen community-based suicide prevention by implementing and supporting policies and programs in places where people live, work, learn, play, volunteer, and worship.
16	Develop and integrate suicide prevention, mental wellness, and crisis response into workplace values and culture through the implementation of sustainable organizational programs, practices, and policies that support and promote worker well-being at all levels
17	Develop and disseminate effective suicide prevention messaging informed by research and guided by best practices.
18	Develop and implement postvention strategies and programs within organizations, communities, and healthcare settings to support healing and recovery following a suicide death, ensuring timely access to resources and support services.
19	Implement and integrate effective suicide prevention services as a core component of health care.
20	Improve the quality and accessibility of crisis care services across all communities in New York State, ensuring that individuals in every region have access to timely and effective behavioral health support during suicidal crises.

Appendix B

Recommendations of the New York State Suicide Prevention Task Force

The recommendations listed below are drawn from the New York State Suicide Prevention Task Force Report: Guidance to Address Disparities in Suicide Risk and Prevention. Recommendations are referenced throughout this Action Plan by number (e.g., "Rec. 37"). The numbering below corresponds to the numbering used in the full Task Force Report.

No.	Task Force Recommendation
1	Disseminate information about the New York State 988 Suicide & Crisis Lifeline at a variety of community locations to promote awareness of services and supports
2	Utilize social media platforms to reduce stigma and raise awareness about available mental health resources
3	Determine how to tailor public awareness campaigns to address local community needs in New York State
4	Expand public awareness campaigns that reduce stigma to nontraditional settings where at-risk populations are likely to be reached
5	Conduct a review of evidence-informed strategies to address financial hardship—including housing instability, food insecurity, unemployment, and problem debt—as a social determinant of suicide, to inform future state prevention initiatives.
6	Amplify the voices of individuals with lived experience—particularly from disproportionately affected populations—within suicide prevention programming/efforts to inform equitable strategies and policies that improve access and quality of care
7	Collaborate with individuals with lived experience when evaluating suicide prevention programs
8	Develop partnerships with K–12 and higher education institutions to promote mental health career pathways, including internship and mentorship opportunities, with a focus on engaging students from low-income and ethnoracially diverse communities to strengthen workforce diversity
9	Explore state-sponsored recruitment and retention incentives for students from underrepresented communities to increase workforce diversity

No.	Task Force Recommendation
10	Expand the use of paraprofessional staff to bridge service gaps and connect at-risk populations to mental health resources in rural and high-need areas, ensuring equitable service distribution
11	Promote that BOCES of New York State and other training and development centers adopt Community Gatekeeper and Brief Intervention suicide prevention trainings for individuals entering trade professions
12	Continue to promote warning sign identification and early intervention methods into suicide prevention training modules
13	Promote training on cultural humility as part of continuing education requirements for mental health professionals
14	Expand the availability of universal, tiered suicide prevention training for all school staff, including enhanced, role-specific training for school counselors and psychologists
15	Develop tools/materials to enhance trainings to improve awareness of warning sign identification for students with developmental and intellectual disabilities
16	Promote suicide prevention training through existing learning management systems, such as the New York Statewide Learning Management System (SLMS) for state employees, and track completion. Consider making the training a biannual requirement for all state personnel
17	Support the delivery of in-person suicide prevention and mental health trainings to mitigate depersonalization and loss of connection associated with standardized and online platforms
18	Offer suicide prevention training to key personnel in non-clinical settings to strengthen early identification and referral
19	Expand access to suicide prevention training for uniformed personnel through programs such as The CARES UP initiative
20	Promote mental health safety training in high-risk professions, such as construction (e.g. including suicide prevention within mandated OSHA courses)
21	Expand telehealth availability in schools and community clinics to reduce barriers to mental health care access
22	Promote the adoption of Zero Suicide Framework and other evidence-based practices within hospital systems and across individual providers

No.	Task Force Recommendation
23	Ensure awareness of the language access initiatives that ensure mental health services provided by the state are available in the most common languages spoken in New York State
24	Collaborate with linguistically and ethnoracially diverse communities to develop culturally appropriate mental health resources and educational materials
25	Explore culturally grounded and trauma-informed models, including evidence-based practices to reduce disparities among most impacted populations
26	Modify the Office of Mental Health Request for Proposal (RFP) process to promote health equity. This can help diversify the range of interventions available and ensure that resources are allocated more effectively to underserved communities
27	Promote standardized screening for suicidal ideation and depression within primary care settings to identify individuals at risk
28	Explore and promote outreach models such as HealthySteps within primary care to reduce ACEs (adverse childhood experiences), a well-established driver of suicide risk, by embedding behavioral health services in pediatric practices to expand reach and reduce stigma by offering services to everyone
29	Develop guidance to ensure the Zero Suicide model is implemented in a culturally responsive manner
30	Work with schools to develop and implement suicide screening protocols that use validated, suicide-specific screening tools to identify students at risk and support triage, care planning, and follow-up
31	Amplify materials developed in conjunction with the NYSED that encourage all NYS school districts to develop a suicide prevention policy
32	Partner with organizations such as OPWDD to explore ways to address suicide risk and stigma among neurodivergent individuals
33	Establish partnerships with organizations working in high-risk industries to encourage and promote mental wellness and help-seeking behavior
34	Partner with Department of Labor and unemployment offices to provide suicide prevention training and resources to staff assisting individuals who are unemployed, underemployed, or exiting the workforce, and at risk of suicide
35	Train and support credible messengers to deliver outreach, share resources, and connect people to services through partnerships with local community-based, non-clinical organizations

No.	Task Force Recommendation
36	Develop partnerships with organizations that provide non-clinical, culturally and linguistically responsive, community-based supports to promote mental health, prevent suicide, and support recovery (e.g., wellness programs, peer services, social supports, and skill-building opportunities)
37	In rural areas, encourage suicide prevention coalitions to partner with local gun stores and hunting clubs to promote safe firearm storage and share suicide prevention resources
38	Promote faith-based and culturally responsive suicide prevention and mental health efforts in churches, mosques, temples, and community centers to strengthen protective factors and connect individuals to support
39	Promote peer support programs and networks for diverse groups who are considered at risk for suicide
40	Support the development and implementation of peer-support networks to provide community-driven and peer-led postvention interventions
41	Continue to advocate with NYSDOH for more frequent updates to the NYS Suicide and Self-Harm Dashboard
42	Collaborate with medical examiner/coroners' offices to standardize medical suicide death investigation practices to improve the quality of suicide mortality data
43	Promote suicide-related data transparency about how data is collected, used, stored and protected to build trust among vulnerable populations
44	Explore partnerships in support of establishing fatality review committees to examine the circumstances of individual suicide deaths
45	Evaluate suicide prevention programs and initiatives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YORK
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Mental Health