Office of Mental Health

Implementation of Suicide Prevention Task Force Recommendations

Report 2023-S-37 | December 2025

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Office of Mental Health (OMH) implemented the recommendations made by the New York State Suicide Prevention Task Force to facilitate greater access, awareness, collaboration, and support of effective suicide prevention activities. The audit covered the period from April 2019 through May 2025.

About the Program

Suicide is a complex issue related to multiple risk factors, including relationship, job, school, or financial concerns; mental illness; substance use disorder; social isolation; historical trauma; and barriers to health care. OMH's mission is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbances. OMH prioritizes saving lives and reducing the devastating impact of suicide on individuals, families, and communities. OMH's Suicide Prevention Center of New York (SPCNY) is the State's lead entity in suicide prevention. In September 2016, SPCNY issued its 2016-17 State Suicide Prevention Plan (Plan) entitled "1,700 Too Many." Based on 2014 data, the Plan highlighted suicide as a significant national public health problem, reporting that over 42,770 persons died by suicide nationally and that it was the tenth leading cause of death among all age groups.

According to Centers for Disease Control and Prevention (CDC) data, as of February 2016, New York State had one of the lowest suicide rates in the nation, at 8.6 suicides for every 100,000 individuals, compared to 13.4 per 100,000 nationally. However, New York saw a 32% increase in suicide deaths over the previous decade, with suicide rates showing significant disparities among different groups and consistently ranking as one of the leading causes of death for young people.

In November 2017, the State convened the New York State Suicide Prevention Task Force (Task Force). The Task Force comprised a diverse group of experts to review current services and policies, identify gaps and promising solutions, and make recommendations to facilitate greater access, awareness, collaboration, and support of effective suicide prevention activities. In April 2019, the Task Force released a report, "Communities United for a Suicide Free New York" (Task Force Report), which focused on reviewing current programs, services, and statewide suicide prevention policies in order to identify gaps in resources and strengthen coordination between State and local partners, with an emphasis on vulnerable populations at greater risk for suicide. The Task Force Report included a total of 27 primary recommendations, many of which included multiple sub-recommendations. Many of the recommendations issued by

According to the U.S. Health and Human Services' 2024 National Strategy for Suicide Prevention:

The United States lost nearly 50,000 lives to suicide in 2022. Furthermore, 13.2 million people reported seriously considering suicide and 1.6 million reported a suicide attempt.

Populations disproportionately impacted by suicide and suicide attempts include veterans, racial and ethnic minority groups, people with disabilities, LBGTQ+ populations, and youth.

Between 2018 and 2021, suicide rates increased among non-Hispanic Black or African American populations ages 10-24 (36.6% increase) and ages 25-44 (22.9% increase). Other populations ages 25-44 had increases in suicide rates, including non-Hispanic Native American and Alaska Native (33.7% increase), non-Hispanic multiracial (20.6% increase), and Hispanic (19.4% increase).

the Task Force required collaboration between OMH and other public and private entities, including communities, hospitals, mental health providers, health care systems, and the Department of Health (DOH). OMH was responsible for coordinating a Steering Committee open to other State agencies with important roles in suicide prevention, such as the Office of Addiction Services and Supports and DOH, to guide the statewide implementation of the Task Force's recommendations.

Key Findings

While OMH has made progress in addressing the recommendations in the Task Force Report, since the Task Force's inception in 2017 and through 2023, New York's suicide rate has remained relatively unchanged, with COVID-19 era stressors likely contributing to the lack of progress. OMH has addressed portions of the Task Force's recommendations to enhance suicide prevention efforts in New York State, including identifying and incorporating core elements of suicide prevention into its regional framework, involving key stakeholders, and providing guidance to schools on developing policies for suicide prevention for planning and programming. However, OMH could do more to ensure the State will achieve its goal of reducing suicide mortalities. For example:

- OMH does not currently have any processes or benchmarks to track or monitor the implementation of the Task Force recommendations and their outcomes (if any). Ongoing evaluation of Task Force recommendation implementation would allow OMH to understand individually, or as a whole, whether actions are moving the State toward its overall prevention goals.
- OMH could improve documentation of the efforts OMH takes to implement Task Force recommendations to substantiate decisions and preserve a history of decisions and actions taken to justify or drive future actions to implement the Task Force Report's recommendations.
- OMH does not track efforts made by other agencies to improve the accuracy and completeness of core suicide surveillance data, which makes it difficult to coordinate and facilitate data sharing and to provide direction for statewide, regional, and local efforts.

OMH officials state they are committed to taking actions to reduce suicide mortality and morbidity and that new tools and sources of support to address those challenges have been developed in recent years. However, OMH officials expressed that they face certain challenges in implementing the recommendations, including no additional funding or statutory authority tied to the initiative and that actions to reduce suicide mortality and morbidity rely primarily on voluntary partnerships. Further, nearly a year after the Task Force released its Task Force Report, in March 2020, the COVID-19 pandemic was declared, which derailed many of OMH's efforts, as it needed to focus its resources to respond to the pandemic.

Key Recommendations

- Develop and implement practices to monitor, evaluate, and document efforts to implement Task Force and/or other specified recommendations for suicide prevention activities.
- Develop practices to improve accuracy and completeness of core suicide surveillance data and information sharing.

Office of the New York State Comptroller
Division of State Government Accountability

December 16, 2025

Ann Marie T. Sullivan, M.D.
Commissioner
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Dear Dr. Sullivan:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled *Implementation of Suicide Prevention Task Force Recommendations*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

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Glossary of Terms

Term	Description	Identifier
OMH	Office of Mental Health	*Auditee*
CDC	Centers for Disease Control and Prevention	*Federal Agency*
DOH	Department of Health	*State Agency*
National Strategy	U.S. Health and Human Services' 2024 National Strategy for Suicide Prevention	*Key Term*
Pandemic	COVID-19 pandemic	*Key Term*
Plan	New York State Suicide Prevention Plan	*Key Term*
PSYCKES	Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid	*System*
SPARCS	Statewide Planning and Research Cooperative System	*System*
SPCNY	Suicide Prevention Center of New York	*State Office*
Steering Committee	Multi-agency committee responsible for guiding the statewide implementation of the Task Force's recommendations	*Key Term*
Task Force	New York State Suicide Prevention Task Force	*Key Term*
Task Force Report	Communities United for a Suicide Free New York	*Report*
VA	U.S. Department of Veterans' Affairs	*Federal Agency*

Background

Suicide is a complex issue related to multiple risk factors, including relationship, job, school, or financial concerns; mental illness; substance use disorder; social isolation; historical trauma; and barriers to health care. The Office of Mental Health's (OMH) mission is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbances. OMH prioritizes saving lives and reducing the devastating impact of suicide on individuals, families, and communities. OMH's Suicide Prevention Center of New York (SPCNY) is the State's lead entity in suicide prevention. SPCNY's mission is to promote, coordinate, and strategically advance suicide prevention with the aim of reducing suicide attempts and deaths among New Yorkers through combining clinical and public health approaches. SPCNY provides suicide prevention training and technical assistance to several groups across the State, including health systems, communities, and schools. SPCNY also works to advance the State's Suicide Prevention Plan (Plan)—a proposal that addresses the suicide epidemic affecting New Yorkers.

In September 2016, SPCNY issued its 2016-17 Plan entitled "1,700 Too Many." Based on 2014 data, the Plan highlighted suicide as a significant national public health problem, reporting that over 42,770 persons died by suicide nationally and that it was the tenth leading cause of death among all age groups. According to Centers for Disease Control and Prevention (CDC) data, as of February 2016, New York State had one of the lowest suicide rates in the nation, at 8.6 suicides for every 100,000 individuals, compared to 13.4 per 100,000 nationally; however, New York saw a 32% increase in suicide deaths over the previous decade.

NYS Data on Suicide Deaths

Approximately 1,700 suicide deaths (sixth highest among all states).

75% of suicide deaths were men.

84% of suicides were among White individuals, 7% among Black individuals, and 7% among Hispanic individuals.

New Yorkers 45-64 years old had the highest rates of suicide deaths (followed national trend).

Suicide was the second leading cause of death among youth ages 15-24.

In November 2017, the State convened the New York State Suicide Prevention Task Force (Task Force). The Task Force comprised a diverse group of experts to review current services and policies, identify gaps and promising solutions, and make recommendations to facilitate greater access, awareness, collaboration, and support of effective suicide prevention activities. The Task Force divided its work into three work groups: Youth and Families, Adults, and Data Systems. It also focused on higher-risk groups within specific populations, including Latina youth, the LGBTQ+ community, and veterans.

In April 2019, the Task Force released a report, "Communities United for a Suicide Free New York" (Task Force Report), focused on reviewing current programs, services, and statewide suicide prevention policies in order to identify gaps in resources and strengthen coordination between State and local partners, with a focus on vulnerable populations at greater risk for suicide. The Task Force's recommendations span four domains, including:

1. **Strengthen Foundations for Public Health Suicide Prevention Approaches**

   Recommendations designed to prepare local communities with resources and expertise to assess their local needs and identify and implement research-informed prevention programs.

2. **Build Health System Competencies and Pathways to Care**

   Recommendations focused on strengthening pathways to care and building health care systems' competencies regarding suicide.

3. **Improve Surveillance Methods/Tools and Access to Timely Data**

   Recommendations intended to improve the timeliness and availability of suicide data for New York communities to track regional trends and related behaviors critical in suicide prevention.

4. **Infusion of Cultural Competence Throughout Suicide Prevention Activities**

   Recommendations intended to address the needs of the State's diverse population across the full range of suicide prevention activities, including tailoring services to address differences in race, gender, sexuality, and nationality. Also meant to address sub-group populations in rural and urban communities such as Latina youth, the LGBTQ+ community, and veterans.

The Task Force Report included a total of 27 primary recommendations, many of which included multiple sub-recommendations (see the Exhibit at the end of the report). Many of the recommendations issued by the Task Force required collaboration between OMH and other public and private entities, including communities, hospitals, mental health providers, health care systems, and the Department of Health (DOH). The recommendations were designed to strengthen local communities' capacity, with New York State's support, to provide effective suicide prevention practices and build connected and resilient communities, as competent communities are essential for addressing local risk factors and can tailor their prevention activities to address local needs and populations at greater risk. OMH was responsible for coordinating a Steering Committee open to other State agencies with important roles in suicide prevention, such as the Office of Addiction Services and Supports and DOH, to guide the statewide implementation of the Task Force's recommendations.

Nearly a year after the Task Force released its Task Force Report, the COVID-19 pandemic (pandemic) was declared in March 2020, resulting in stay-at-home orders and social isolation. This led to increases in suicide risk factors, including new or worsening mental health symptoms, increases in substance use, loss of friends and family to the pandemic, and job and economic instability.

According to the U.S. Health and Human Services' 2024 National Strategy for Suicide Prevention[1] (National Strategy), suicide rates in the U.S. increased 12.7%

1 U.S. Department of Health and Human Services (HHS), National Strategy for Suicide Prevention. Washington, DC: HHS, April 2024.

between 2012 and 2022. The National Strategy highlighted that social and economic risk factors, such as poverty, financial strain, and relationship challenges, as well as reduced access to mental health resources and care persist, and improvements are needed in data, prevention, treatment, services, workforce, and research related to suicide. Additionally, emerging issues, including the effects of social media on mental health, the connection between suicide and substance use, and the unique challenges faced by diverse populations, call for immediate attention.

Although New York State has one of the lowest per capita suicide rates in the nation (see Figure 1), suicide is the 11th leading cause of death, but the second leading cause of death among individuals between the ages of 25 and 34, and the third leading cause of death among youth and young adults between the ages of 15 and 24. In 2021, New York lost 1,660 individuals to suicide.

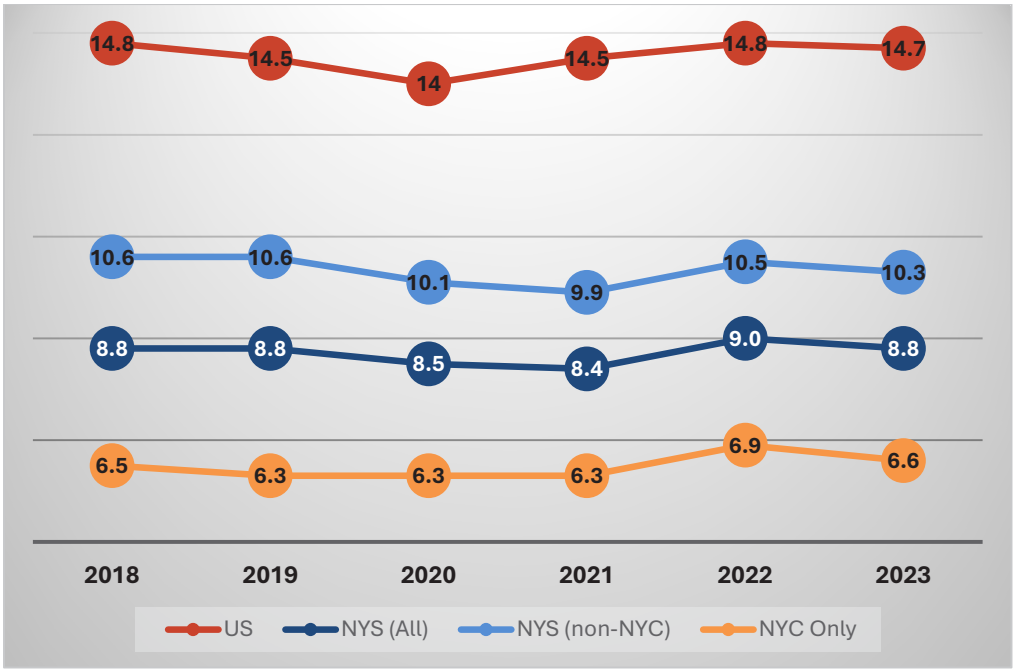
According to the National Strategy:

The U.S. lost nearly 50,000 lives to suicide in 2022. Furthermore, 13.2 million people reported seriously considering suicide and 1.6 million reported a suicide attempt.

Populations disproportionately impacted by suicide and suicide attempts include veterans, racial and ethnic minority groups, people with disabilities, LBGTQ+ populations, and youth.

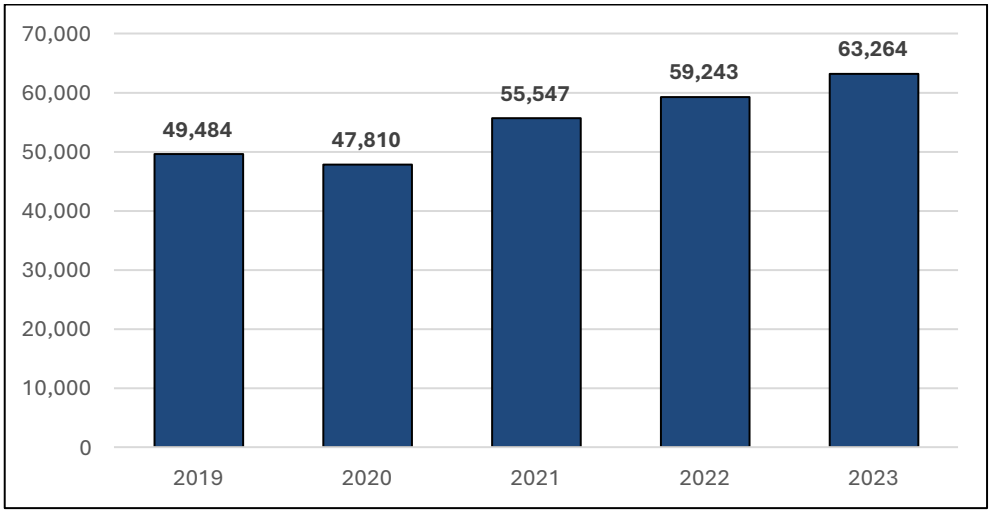
Between 2018 and 2021, suicide rates increased among non-Hispanic Black or African American populations ages 10-24 (36.6% increase) and ages 25-44 (22.9% increase). Other populations ages 25-44 had increases in suicide rates, including non-Hispanic Native American and Alaska Native (33.7% increase), non-Hispanic multiracial (20.6% increase), and Hispanic (19.4% increase).

Figure 1 – Suicide Rates in U.S. and New York State, 2018–2023 (Deaths per 100,000 Population)



New York State also saw a steady rise in suicide-related emergency room visits outside New York City between 2019 and 2023, according to DOH data. Figure 2 shows such visits increased by 27.8% between 2019 and 2023, with over 63,200 suicide-related emergency room visits in 2023.

Figure 2 – Suicide-Related Emergency Department Visits, 2019–2023 (Excluding New York City)



Audit Findings and Recommendations

OMH has made progress with addressing the Task Force's recommendations to enhance suicide prevention efforts in New York State, including identifying and incorporating core elements of suicide prevention into its regional framework; involving key stakeholders (e.g., State government partners, law enforcement, health care); underscoring the need for involvement of local government agencies to leverage expertise; emphasizing diverse cultural and high-risk groups; and providing guidance to schools on developing policies for suicide prevention for planning and programming. However, OMH could do more to ensure the State will achieve its goal of reducing suicide mortalities.

Since the Task Force's inception in 2017 and through 2023, New York's suicide rate has remained relatively unchanged, with COVID-19 era stressors likely contributing to the lack of progress. Despite OMH's efforts, New York State's suicide rate saw slight increases between 2020 and 2023 (8.5 to 8.8 per 100,000 population) after showing a decline between 2019 and 2020 (8.8 to 8.5 per 100,000 population). Further, data published by the CDC[2] highlights suicide increases among certain racial and ethnic groups. The data indicated that, between 2018 and 2021, the suicide rate among non-Hispanic Native American or Alaska Native individuals increased by 26%, by 19% among Black individuals, and by 7% among Hispanic individuals. These statistics show OMH needs to continue to develop and enhance its suicide prevention programs for individuals belonging to underserved communities, including ethnic and minority populations, LGBTQ+ youth, and young adults.

OMH officials expressed that they face certain challenges in implementing the recommendations, including no additional funding or statutory authority tied to the initiative and that actions to reduce suicide mortality and morbidity rely primarily on voluntary partnerships. Officials state they are committed to taking actions to reduce suicide mortality and morbidity and that new tools and sources of support to address those challenges have been developed in recent years. For example, in November 2023, the Task Force was reconvened to re-evaluate New Yorkers' suicide prevention needs with the goals of addressing concerns of social isolation, depression, and anxiety arising from the pandemic with a renewed focus on assisting at-risk populations disproportionately impacted by suicide or suicide ideation.

While we recognize OMH's efforts and the effect of these challenges on OMH's ability to address Task Force recommendation implementation, we identified opportunities for OMH to improve its oversight and position itself to better guide its partners in achieving the State's overall goal of reducing suicide deaths. We also determined that OMH has opportunities, as detailed below, to improve its communication and coordination with suicide prevention partners, including both State and local entities, to ensure effective prevention measures are identified and implemented and current data is shared and analyzed.

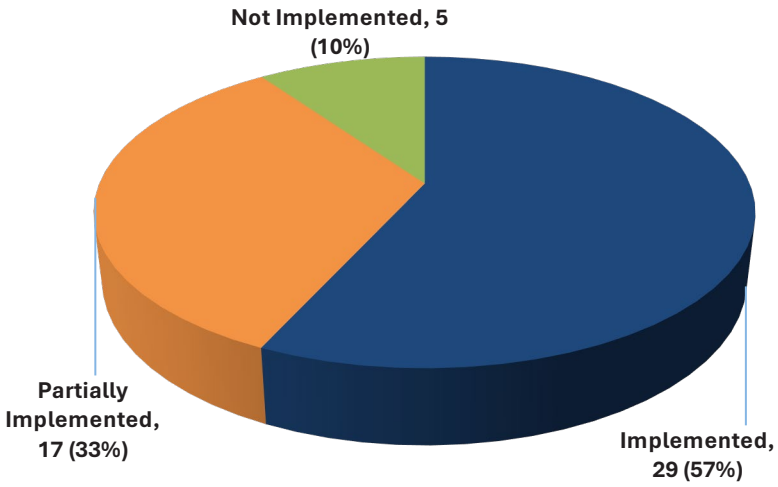
2 Stone DM, Mack KA, Qualters J. *Notes from the Field*: Recent Changes in Suicide Rates, by Race and Ethnicity and Age Group — United States, 2021. MMWR Morb Mortal Wkly Rep 2023;72:160–162. DOI: http://dx.doi.org/10.15585/mmwr.mm7206a4.

Task Force Recommendation Implementation and Oversight

The Task Force developed 27 primary recommendations, many of which include multiple sub-recommendations. Including both primary and secondary recommendations, we identified 100 individual Task Force recommendations. We selected 51 of the 100 recommendations (those that OMH had a significant role in implementing) to review and determine whether OMH had implemented them. Further, for the 51 recommendations selected, we reviewed recommendations related to key overall areas, including monitoring and oversight of implementation (30), communication among suicide prevention partners (13), and data gathering and utilization (8).

We determined OMH has made progress with its Task Force recommendations, implementing or partially implementing 46 of the 51 (90%) recommendations we reviewed, as shown in Figure 3 (see the Exhibit at the end of this report for a complete list of recommendations and their implementation status).

Figure 3 – Implementation Status of Selected Recommendations



However, because the Steering Committee, rather than OMH or any other specific entity, is primarily responsible for implementing the Task Force's recommendations, the implementation statuses of many other recommendations are unknown and not monitored by OMH. For instance, for most matters regarding the timeliness and availability of suicide-related data, OMH officials referred us to DOH.

Further complicating tracking of recommendation implementation is the inadequate documentation of the OMH-coordinated Steering Committee's efforts. While meetings were initially scheduled to implement Task Force recommendations, after the pandemic started, they became less scheduled and were not documented. Additionally, for the activities that were documented, it is unclear whether all

relevant agencies were represented on the Steering Committee and what, if any, actions were taken to implement many of the Task Force's recommendations. For example, OMH provided meeting notes for seven Steering Committee meetings conducted during the period from May through October 2019. Three did not have an attendance list, and the four that did, did not include representatives from all Steering Committee members. Additionally, the meeting minutes stated that "recommendations have been put into a workplan document and will be implemented in phases." However, the work plan OMH provided did not address all relevant recommendations, and many of the listed items did not indicate the party assigned to carry out the recommendation or have target/completion dates. Documentation preserves evidence to substantiate decisions; better documentation of the Steering Committee meetings and actions would preserve the history of the Steering Committee's decisions and could justify or drive future actions to implement the Task Force Report's recommendations. This is particularly relevant when unforeseen circumstances like the pandemic interrupt activities.

OMH also does not currently have any processes or benchmarks to track or monitor the implementation of the Task Force recommendations and their outcomes (if any). Ongoing evaluation of Task Force recommendation implementation would allow OMH to understand individually, or as a whole, whether actions are moving the State toward its overall suicide prevention goals.

Monitoring and Oversight of Implementation

While OMH had a role in implementing the 51 recommendations we selected for review, many Task Force recommendations involved coordinating actions with other suicide prevention partners and entities to make progress toward the State's overall suicide prevention strategy. With multiple organizations involved, strong monitoring and oversight of the steps toward the implementation of these recommendations, as well as the outcomes of such actions, is necessary.

To evaluate OMH's implementation efforts, we identified 30 of the 51 selected recommendations that required OMH monitoring and oversight. We determined that 26 of the 30 (87%) recommendations were either implemented (22) or partially implemented (4). The remaining four recommendations were not implemented (13%).

Implemented

OMH implemented 22 monitoring- and oversight-related recommendations through actions including:

- Developing and providing guidance.
- Promoting the sharing of data, including hosting webinars on its analysis of suicide data.
- Making strategic investments in suicide prevention programs that target risk and factors for suicidal behavior, including over $700,000 for the Sources of

Strength program, which assists schools and other youth organizations with developing coping resources.

- Administering $13.5 million in federal grants to develop and disseminate technical assistance and support for overcoming workforce shortages and to expand the Zero Suicide initiative, a systemic approach to integrating suicide prevention into the health care system.

Partially Implemented

OMH partially implemented four recommendations regarding:

- Highlighting the prevention of suicide attempts and deaths in Local Mental Health Services Plans.
- Increasing access to enrollment in the U.S. Department of Veterans' Affairs (VA) system to improve competency of civilian health care workers in providing treatment to veterans.
- Developing mechanisms to better identify veterans and provide information on benefits.
- Identifying a strategy for State agencies to ask their customers if they have served in the military and, if so, seek permission to share contact information with the New York State Division of Veterans' Affairs.

According to OMH officials, the first Local Mental Health Services Plan following the Task Force Report was for 2020, at which time OMH included a survey on suicide prevention that was initially required but ultimately changed to voluntary at the onset of the pandemic.

OMH officials also provided interagency correspondence and meeting notes showing that steps had been taken to address the recommendation to increase access to enrollment in the VA system, and that there had been an intention to collaborate with the Office of Temporary and Disability Assistance and local offices to further promote the utilization of the VA system. However, according to OMH officials, this process was interrupted by the start of the pandemic.

Not Implemented

The following four recommendations were not implemented:

- The Task Force recommended that OMH ensure that all Local Mental Health Services Plans address suicide prevention services; however, OMH officials stated that they do not track the inclusion of suicide prevention work in the county plans on an ongoing basis. Efforts to implement this were put off due to the pandemic.
- The Task Force recommended that OMH and its SPCNY, in conjunction with the State Education Department and other relevant stakeholders, create recommendations for required core competencies for health care training programs. According to OMH officials, no formal recommendations have been

made to health care training programs on required core competencies. Despite some states mandating training for practitioners, OMH's position is that there is no evidence that those programs have led to reductions in suicide attempts or deaths.

- The Task Force recommended gathering input from diverse populations with a multigenerational view on how technology allows individuals to feel more connected. OMH cited a lack of identified funding as the reason this input was not obtained.
- The Task Force recommended that OMH explore using the Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES) to identify individuals with veteran status so it could be recognized when these individuals visit locations such as emergency rooms and homeless shelters. OMH officials stated that they do not have a method of identifying individuals with veteran status in PSYCKES; however, if there were a national file of veterans, and a data-sharing agreement could be developed where OMH could receive a file that could be refreshed monthly, OMH stated it could develop such a feature.

OMH does not currently have any processes or benchmarks to track or monitor the implementation of the Task Force recommendations and their outcomes (if any). Ongoing evaluation of Task Force recommendation implementation would allow OMH to understand whether actions, individually or as a whole, are moving the State toward its overall prevention goals. If certain recommendations are ineffective or unachievable actions, improved monitoring and benchmarks would assist OMH in identifying and addressing issues early on. Coupled with improved documentation of the outcomes and pitfalls in implementation of the recommendations, OMH would be in a better position to learn from mistakes or limitations and improve efforts in the future.

Communication Among Suicide Prevention Partners

With the State's support, certain Task Force recommendations were geared toward strengthening local communities' capacity to provide effective suicide prevention practices and build more connected and resilient communities. The Task Force believed competent communities were essential in addressing differences in local risk factors and tailoring programs to address local needs and at-risk populations. We identified 13 of the 51 recommendations that were geared toward enhancing communication and coordination of suicide prevention issues and initiatives. Of these, OMH implemented seven, partially implemented five, and has not implemented one.

Implemented

Of the seven recommendations OMH implemented, four related to OMH incorporating core elements into its regional prevention framework, including:

- Involving key stakeholders (e.g., State government partners, law enforcement, health care).

- Emphasizing local government agencies to leverage expertise.
- Emphasizing diverse cultural and high-risk groups.
- Providing guidance to schools on developing policies for suicide prevention for planning and programming.

Additionally, OMH implemented three other recommendations as follows:

- Funding nearly 9,000 training sessions each year in suicide-specific interventions.
- Highlighting elevated rates of suicide attempts and the growing rate of suicides among Latina adolescents during the annual NYS Suicide Prevention Conference.
- Developing a universal behavioral equity tool—a self-assessment completed during OMH licensing visits—that tasks licensed providers with certifying their competency in matters related to diversity, equity, inclusion, and accessibility.

Partially Implemented

Other aspects of the regional prevention framework have been only partially implemented. For instance, the Task Force recommended that local communities promote suicide prevention by forming key partnerships for regional coordination as well as developing technical assistance from the State to support using data at a county level to identify trends in suicide deaths and to inform planning and targeting of resources. Through its website, OMH provides links to resources that counties can use and has hosted webinars showing its own analysis of suicide-related deaths in the State. While this might prove useful to counties for identifying trends in suicide deaths and for planning and targeting resources, the linked county-level resources are outdated (from 2020 or earlier). OMH officials stated that the responsibility for data dissemination necessary to update information on their website is DOH's and, therefore, OMH is unable to provide this information on its website and linked resources. County data availability is discussed in more detail in the next section of the report.

Additionally, the Task Force recommended the development of criteria and a process for local communities to engage in a structured planning and resource coordination process to receive a State designation as a partner in "Communities United to Prevent Suicide." However, OMH officials stated that the designation process went defunct as OMH shifted its resources to respond to the pandemic. Efforts to develop a statewide assessment of local suicide prevention approaches, along with a webinar series that would have provided technical assistance related to the designation process, were also suspended. OMH officials stated that OMH disseminates suicide prevention best practices in communities in other ways, such as quarterly meetings with suicide prevention coalitions, implementing a pilot of Local Outreach to Suicide Survivors teams that are an active best practice for responding to the aftermath of suicide and are being used in seven local coalitions, and the 2024 Suicide Prevention Conference for community coalitions focused on best practice sharing.

OMH regulations mandate that OMH-licensed mental health providers report suicide attempts through the New York State Incident Management Reporting System, which addresses part of the Task Force's recommendation to develop guidelines for health systems and providers in reporting suicide attempts and self-harm diagnosis codes. However, according to OMH officials, this regulation applies only to licensed providers, and not general health systems (e.g., providers that primarily provide physical health or primary care services).

Not Implemented

The one recommendation we reviewed regarding coordination of suicide prevention issues and initiatives that OMH did not implement involved creating an advisory panel of county mental hygiene directors to provide feedback and guidance to the State on incentivizing implementation at the local level of regional best practices for using data to inform suicide prevention. Officials stated that a State suicide prevention plan is currently being developed to align with the latest National Strategy for Suicide Prevention released in April 2024, which would address portions of this recommendation.

Improved communication and coordination with State and local suicide prevention partners would help ensure effective prevention measures are identified and implemented.

Data Gathering and Utilization

Local suicide prevention processes best meet the needs of communities when communities have access to accurate, complete, and timely data. This data allows communities to appropriately identify local trends and attend to their own individual circumstances. We identified eight of the 51 recommendations related to obtaining and/or analyzing suicide prevention data. OMH stated that these recommendations were a statewide goal, and that it has no statutory authority to implement specific data-related requirements. Furthermore, DOH is responsible for collecting and maintaining mortality data. Despite this, OMH has made some progress in implementing these recommendations, partially implementing each of the eight.

One Task Force recommendation broadly charged OMH with "improving the accuracy and completeness of core suicide surveillance data reporting." However, officials explained this is difficult without strengthening the State's current decentralized coroner/medical examiner system, which it has no authority over, and which results in inconsistency in death investigations, toxicology testing, and certification, with significant variations at the county level. Authority over this information lies with DOH. OMH implemented a pilot program for counties to engage in suicide fatality reviews and provided toolkits to counties online, but ultimately, with no authority over the coroner/medical examiner system, the program was unsuccessful.

OHM does not track efforts made by other agencies to improve the accuracy and completeness of core suicide surveillance data, which makes it difficult to coordinate

a Steering Committee meant to facilitate data sharing and to provide direction for statewide, regional, and local efforts. We recommend OMH work with DOH and other partners to improve key data systems where practicable to improve accuracy and completeness of core suicide surveillance data reporting and to document the results of these efforts.

Other recommendations focused on data sharing across datasets most relevant to suicide prevention (e.g., the Statewide Planning and Research Cooperative System [SPARCS][3] and OMH's New York State Incident Management Reporting System) and improving complete key demographic data, such as race/ethnicity, veteran status, and sexual minority status for suicide deaths and attempts in administrative datasets. According to OMH officials, the data plan they are developing focuses on identifying methods for sharing and linking records between agencies for public health surveillance purposes, indicating that DOH would perform the data linkages and that OMH aims to increase the utilization of linked data through agreements with DOH. As such, OMH has sought, and received, increased access to relevant suicide prevention data from DOH through three data use agreements, paving the way for improved data dissemination. This includes receiving approval in January 2025 (April 2025 for New York City) for the full State set of mortality data to be shared with OMH. The other two agreements allow sharing of syndromic (near real-time routine health data used for generating information on public health) and SPARCS linked data sets.

Additionally, local communities were tasked with increasing the accuracy of LGBTQ+ suicide data to inform planning, intervention, prevention strategies, and research by identifying and supporting a statewide use of best practices for collecting sexual orientation and gender identity information for all State deaths. Although the recommendation was focused on localities, for its part, OMH developed a webinar for State medical examiners, coroners, law enforcement, and others that intended to aid these groups with reporting sexual orientation and gender identity information on death certificates.

While we found multiple suicide-related data reports available on the OMH, SPCNY, and DOH websites, several contained outdated data (2018 or earlier), while others had more recent data that was indistinguishable from older data due to the way it had been aggregated. Further, updated publicly available county-level data that includes status information about sexual orientation and gender identity; veteran, pregnancy, housing, or marital status; or known circumstances surrounding the death, is generally not available. In some instances, some information about one status or another was available, but these sources often lacked enough detail or current data to make them useful for directing county-level actions. In other instances, the data is technically available, but due to its public availability, the values are redacted (reported as "suppressed"), resulting in limitations on the type of analysis that could be completed.

3 SPARCS is a DOH-managed comprehensive all-payer data reporting system collecting patient-level detail on patient characteristics, diagnoses and treatments, services, and charges for each hospital inpatient stay and outpatient visit.

To assess the extent of localities' coordination with OMH and their access to suicide-related data and information, in September 2024, we sent a survey to county public mental health officials for all 57 counties outside New York City as well as the New York City Department of Health and Mental Hygiene. We received responses from 56 counties indicating:

- 22 counties (39.3%) did not have access to the number of suicide deaths in their county for calendar year 2023
- 45 counties (80.4%) did not have access to the number of self-harm/ suicide-related hospitalizations in their county for calendar year 2023
- 36 counties (64.3%) did not have access to the number of self-harm/ suicide-related emergency department visits in their county for calendar year 2023
- 37 counties (66.1%) did not have access to the number of suicide hotline contacts in their county for calendar year 2023

OMH stated the results reflect the reality that the timeliness of suicide data often varies considerably by county. According to OMH officials, one county, which has one of the most active suicide prevention coalitions in the State, was able to release its 2024 suicide data in March 2025 during its annual coalition's meeting. OMH generally agrees that more needs to be done to improve the timeliness of suicide data at the local level.

Overall, OMH officials contend that many of the Task Force recommendations were aspirational, and there was no direct funding or statutory authority to support their implementation. Moving forward, OMH plans to release its New York State Suicide Prevention Plan in fall 2025 and its SPCNY action plan by the end of 2025, with the goals and objectives covering a 5-year period. However, OMH expressed that it lacks authority to direct State or local action and must rely on voluntary partnerships aided by SPCNY technical assistance and support.

While we recognize these challenges, as well as OMH's success with many of the recommendations it had a role in implementing, improved documentation and use of performance measures or benchmarks may not only provide a better view of how much has been achieved and what hasn't been as successful, but could also help OMH plan ways to fully implement more of the remaining recommendations to reach the State's goal of reducing the number of suicide deaths. Additionally, stronger coordination with suicide prevention partners at the local and State level and continuing efforts to promote data sharing as part of that coordination would address a key area of the Task Force's recommendations by equipping counties with the specific information they need to help address underserved communities and the changing mental health needs caused by the pandemic. Officials stated OMH will begin to use performance measures for monitoring and tracking implementation progress, including committing other State agencies to specific measurable actions aimed at advancing the State's Plan and suicide prevention.

Recommendations

1. Develop and implement practices to monitor, evaluate, and document efforts to implement Task Force and/or other specified recommendations for suicide prevention activities.
2. Work with DOH to disseminate more timely, raw data on suicide deaths in the State to the public.
3. Develop practices to improve accuracy and completeness of core suicide surveillance data and information sharing. This may include but not be limited to:
    - Obtaining accurate, complete, and timely suicide prevention data.
    - Increasing coordination efforts with counties to ensure access to relevant and timely information.
    - Promoting the ability for counties and the State to share best practices for suicide prevention and awareness of the State's suicide prevention goals.
    - Working with other State agencies to improve data accuracy or systems.

Audit Objective, Scope, and Methodology

The objective of our audit was to determine whether OMH implemented the recommendations made by the Task Force to facilitate greater access, awareness, collaboration, and support of effective suicide prevention activities. The audit covered the period from April 2019 through May 2025.

To accomplish our objective and assess related internal controls, we reviewed the recommendations made by the Task Force, interviewed agency officials, and reviewed documentation provided by OMH in support of its implementation of Task Force recommendations. As discussed in the report, we developed and disseminated a survey to local public health entities to determine the communication between OMH and localities in suicide prevention efforts, as well as to ascertain the quality of suicide data available.

We used a non-statistical sampling approach to provide conclusions on our audit objective and to test internal controls and compliance. We selected a judgmental sample. However, because we used a non-statistical sampling approach for our tests, we cannot project the results to the respective populations. Our sample, which is discussed in detail in the body of our report, includes a judgmental sample of 51 of 100 recommendations, based on perceived OMH involvement, to test for the implementation status of the recommendations.

OMH relies on data provided by DOH for its efforts to implement Task Force recommendations. As our audit focused on OMH's actions, we determined that testing the reliability of the DOH data was out of scope. Instead, we presumed its reliability was sufficient for OMH's purposes. Certain other data in our report was used to provide background information. Data that we used for this purpose was obtained from the best available sources, which were identified in the report. Generally accepted government auditing standards do not require us to complete a data reliability assessment for data used for this purpose.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for the purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of OMH's oversight and administration of Task Force recommendations.

Reporting Requirements

We provided a draft copy of this report to OMH officials for their review and formal written comment. We considered their response in preparing this final report and have included it in its entirety at the end of the report. OMH officials generally agreed with the recommendations and have indicated actions they will take to address them.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office of Mental Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Exhibit

Task Force Report Primary Recommendations

Recommendations	Status
Domain 1: Strengthen Foundations for Public Health Suicide Prevention Approaches	
1. The State will identify core elements of a regional suicide prevention framework based on the public health prevention approach using surveillance and a range of interventions; incorporate them into technical assistance through OMH and The Suicide Prevention Center (SPCNY). This will include the formation of regional advisory groups comprised of local county leaders throughout the state to identify actionable and sustainable motivators and methods to engage partners in building active local suicide prevention coalitions.	**Partially Implemented**
1.a. Local communities should promote suicide prevention by forming key partnerships for regional coordination, data review/surveillance and planning, including: i. Through technical assistance from State agencies, create and support a culture of using data at a county level to identify trends in suicide deaths and attempts to inform planning and targeting of resources.	**Partially Implemented**
1.a.ii. Bring in key partners (State government partners, law enforcement, crisis response, schools, healthcare, behavioral healthcare, non-profits, media, consumers and/or survivors, families, faith-based organizations) to be involved in the review and planning process.	**Implemented**
1.a.iii. Leverage the new NYS Health Connector Suicide and Self-Harm Dashboard to pilot data review and share examples of a successful collaboration-review process. This resource assembles the most relevant data for suicide prevention at one website, broken out by county across the State. Identify the best local approach for a 'real-time' surveillance system for suicide deaths/attempts to create a coordinated outreach system.	**N/A**
1.b.i. Emphasize the importance of local government agencies such as mental health, health, substance abuse, and law enforcement as critical to leverage expertise and provide coordinating personnel and continuity by leveraging statewide organizations of local government agencies to build local leadership.	**Implemented**
1.c. Emphasize the engagement of diverse cultural and high-risk groups and a need for the tailoring of programming to local community needs.	**Implemented**
1.d. Provide State guidance to schools on the development of model comprehensive policies for suicide prevention, intervention and postvention as a basis for any suicide prevention planning and programming.	**Implemented**
1.e. Operationalize with examples of best practices such as Chemung County's approach, which emphasizes coordination and a range of prevention programming: training in risk detection and referral, extension of clinical services in community settings, secondary and primary prevention programs.	**N/A**
1.f. Use local data and knowledge of the community to identify local prevention needs and match with research-informed prevention programming.	**N/A**
1.f.i. Encourage collaborations between school districts, regional Boards of Cooperative Educational Services of New York State, Office of Alcoholism and Substance Abuse Services providers, Aging Services and other technical assistance organizations to support prevention programming.	**N/A**
1.f.ii. Create workgroups to identify suicide prevention needs of sub-populations identified by the community (e.g., LGBTQ youth, Latina youth and families, veterans).	**N/A**
1.f.iii. Link prevention to the placement of clinical services in key community settings (e.g., schools, primary care offices, courts) to reduce barriers to care and link to prevention efforts.	**N/A**

1.f.iv. Build collaborations with large regional youth mental health treatment and residential services.	**N/A**
1.g. Invite the advisory group to evaluate the Suicide Prevention Model/Framework with benchmarks. The Task Force recommends the formation of a subcommittee of experts and local stakeholders to develop criteria and a process for local communities to engage in a structured planning and resource coordination process to receive a NYS designation as a partner in Communities United to Prevent Suicide.	**Partially Implemented**
2. The State should make strategic investments in research-informed prevention programs that target risk and protective factors for suicidal behavior: (a) social-isolation/connectedness; (b) problem behaviors including substance use and antisocial behaviors; (c) coping skills, help-seeking.	**Implemented**
2.a. For youth, this includes programs that reduce school behavior problems such as the Good Behavior Game; build a positive school climate and reduce interpersonal violence (Partnerships in Education and Resilience); build social connectedness; and enhance help-seeking skills, such as Sources of Strength programming and emotion-regulation skills through tools such as Dialectical Behavior Therapy (DBT)-informed curriculum.	**Implemented**
2.b. Prioritize new strategies to reduce bullying and cyber-bullying, which are problems that schools are struggling to address and research shows can have long-term adverse impact on emotional well-being and health including increasing risk for suicidal behavior.	**Implemented**
2.c. Promote the sharing of examples between localities of successful prevention implementation-sustainability as “data” to encourage other communities/regions.	**Implemented**
2.d. The Task Force recommends the New York State Suicide Prevention Council examine common elements of Evidence Based Practices to make recommendations to adapt programs for specific populations.	**N/A**
2.e. To address the urgent need for prevention programs that build adult coping skills and social connectedness, engage the help of the New York State Suicide Prevention Council to monitor research and new programs to identify candidates for pilot work (e.g., University of Rochester work on reducing isolation in older adults).	**N/A**
3. One avenue toward engaging the wider community in suicide prevention is through workforce education. OMH will develop a suicide prevention training to be administered through the Statewide Learning Management System (SLMS) as one of the mandatory trainings for NYS employees: a. The training would address the issues of suicide risk as well as how to respond to coworker, family member, or neighbor who may be exhibiting signs of distress for employees who are not in the mental health field. b. The training could be subsequently offered to counties and local communities to be shared with the wider workforce.	**Implemented**
4. Given the enormous amount of premature mortality associated with suicide and opioid overdose deaths, NYS agencies will identify steps to advance synergistic prevention activities.	**Implemented**
4.a. Identify shared risk and protective factors and prevention approaches promising in reducing suicidal behavior and opioid addiction.	**Implemented**
4.b. Pilot “braided” funding as an alternative to what historically has been siloed funding to identify new efficient, broader prevention approaches.	**Implemented**
Domain 2: Build Health System Competencies and Pathways to Care	
5. The OMH Suicide Prevention Office with assistance from State agencies will support and expand efforts at integrating suicide prevention into	**N/A**

health and behavioral healthcare settings, sometimes referred to as the "Zero Suicide model." a. This means supporting health and behavioral healthcare providers in the adoption of systematic suicide safer care delivery through technical assistance, training and implementation support. b. Systematic suicide safer care delivery includes screening, increased detection, and care pathways and follow-up monitoring for those at elevated risk.	
6. Localities should integrate suicide prevention efforts in a comprehensive crisis system. a. As part of a comprehensive system review and service planning process with regions and localities to develop and enhance crisis systems, and modeled after the "Crisis Now" approach, OMH will ensure that all county plans address suicide prevention services.	**Not Implemented**
7. Localities should identify and share core elements of best practice clinical care for suicide specific services tailored to age; support via payment arrangements for new models such as Value-Based Payment (VBP) in which providers are reimbursed based on patient health outcomes.	**N/A**
7.a. Health care is notorious for the slow pace of making effective interventions widely available and consistently delivered. Target regulatory, financing and programmatic barriers to hasten adoption.	**N/A**
7.b. State agencies will provide guidance for health systems and providers on reporting suicide attempts and intentional self-harm diagnosis codes (ICD-10) to allow for tracking trends across the State.	**Partially Implemented**
7.c. Incorporate support and encouragement for health systems to track individuals with suicide attempts who receive care in their systems in order to highlight the need for optimal transitional care and access to evidence-based interventions.	**N/A**
7.d.i. Localities will develop components and standards for clinical care for key constituent groups/ages, drawing on specific examples of strong local programming provided through State technical assistance and support. For youth, a comprehensive approach such as Columbia University Child/Adolescent Psychiatry Community services framework which collaborates with families, pediatricians, primary care offices, and specialists. a. Home-based intervention and psycho-education for families and caregivers; suicide-specific treatment approaches such as Dialectical Behavioral Therapy (DBT); outreach to engage high-risk disengaged youth (Person in Need of Supervision [PINS], homeless); school-based services to increase access; collaboration with regional youth mental health treatment and residential services. b. Encourage collaborations between school districts, regional Boards of Cooperative Educational Services of New York State (BOCES), the Office of Alcoholism and Substance Abuse Services (OASAS) providers, colleges, shelters, hospital emergency departments, and other technical assistance organizations.	**N/A**
7.d.ii. For adults, utilize OMH technical assistance to identify suicide-specific treatments (e.g., DBT, Cognitive Behavioral Therapy - CBT tailored interventions) and training opportunities for local providers. • Develop partnerships with substance abuse treatment agencies, agencies that serve high-risk groups in community (e.g., homeless, isolated seniors).	**Implemented**
8. Include suicide prevention as part of the Governor's transformation of the State's Medicaid System to a Value-Based (VBP) Model. VBP contemplates a change in reimbursement of health care services which is based on outcomes.	**N/A**

8.a. OMH would coordinate expert recommendations to promote the most effective services, ongoing performance measurement, and access.	**N/A**
8.b. State agencies would ensure reimbursement of the most critical and effective services.	**N/A**
9. The State will develop training guidelines that incorporate core competencies for healthcare providers as well as address the benefits of training the general public.	**Implemented**
9.a. Create and share training recommendations for local communities to strengthen the suicide prevention competence of the healthcare workforce and general public. i. Tailor training recommendations to the needs of providers and populations served. ii. Incorporate training to build competencies in evidence-based assessment of mental health problems and suicide risk in medical providers, home visitors, emergency medical services, crisis and emergency department staff, substance use treatment providers and behavioral health workers.	**Implemented**
9.b. Support and expand programming aimed at building behavioral health capacity that includes suicide prevention competency in primary care settings. This requires ongoing knowledge and skills development to manage mild to moderate behavioral health needs in practices and may include phone and face-to-face consultations. i. Building capacity is an important, concrete step taken by the State to expand the competence of primary care providers with potential to reduce crises and smooth pathways to care. ii. Examine potential for linkages with tele-psychiatry initiatives. iii. Support evaluation of these programs.	**Implemented**
9.c. OMH and the Suicide Prevention Center (SPCNY), in conjunction with State Education Department and other relevant stakeholders, should create recommendations for required core competencies for health care training programs. i. 20% of States mandate that health care providers complete suicide prevention training and an additional 15% recommend training. Adapt best practices for New York State.	**Not Implemented**
10. The State will provide technical assistance to localities to develop a framework for county/community integrated programming responding to community-specific needs to include the development of ethical and practical guidelines to promote communication among healthcare, families and community organizations.	**Implemented**
10.a. Identify healthcare system(s), county and regional agencies to coordinate.	**N/A**
10.b. Develop collaborations between emergency departments, crisis services, and other health care providers (e.g., health and mental health centers) to ensure rapid follow-up after discharge and to provide alternatives to emergency department care and hospitalization when appropriate.	**N/A**
10.c. Local needs assessment for culturally tailored services (e.g., culturally attuned programming for Hispanic/Latino youth and families).	**N/A**
10.d. Build in information sharing at key transition and intake points.	**N/A**
10.e. Involve families, pediatricians and other healthcare providers.	**N/A**
10.f. Standards for communication with families and key youth-serving settings following suicidal behavior	**N/A**
10.g. Incorporate cultural competence, language accessibility, translation services.	**N/A**
Domain 3: Improve Surveillance Methods/Tools and Access to Timely Data	
11. Improve the accuracy and completeness of core suicide surveillance data reporting.	**Partially Implemented**

11.a. Explore additional funding earmarked to explicitly support Medical Examiner and County Coroner death reporting, including suicide and opioid overdose deaths, prioritizing the most pressing needs statewide.	**N/A**
11.a.i. NYS Department of Health (DOH), with partners, will coordinate ongoing continuous Quality Improvement efforts to improve accuracy and completeness of New York Violent Death Reporting data, including data derived from death certificates, medical examiner/coroner offices, and law enforcement. Identify methods to improve coding on death certificates to ensure suicides are accurately captured. • Develop a centralized state office to improve completion of the death certificate: assisting with standardizing causes of death to produce accurate counts; providing technical assistance/training to medical examiner and county coroners in interpretation and coding of autopsy/toxicology results and the completion of death certificates; and collecting data for suicide case fatality reviews. • Develop, train, and support implementation of standards for classifying deaths as accidental and undetermined including overdose deaths. • Identify and support state-wide use of best practices for collecting under-reported demographic data (e.g., race/ethnicity, veteran and sexual orientation and gender identity) for suicide death and attempt records. • Provide ongoing training for key New York Violent Death Reporting agencies for counties, including New York City, aimed at standardizing case investigation methods and reporting for underreported demographic data. • Develop legislation that allows coroners and medical examiners to access medical records, information from Qualified Entities, and data from the prescription monitoring program to understand past medical history. • Support through the provision of technical assistance on best practices the piloting of local/regional suicide fatality reviews.	**N/A**
12. The State should increase access to data that informs state and local suicide prevention and support a culture of data informed suicide prevention at the local level.	**N/A**
12.a. NYS Department of Health (DOH) will provide a centralized clearinghouse in the form of an interactive "Suicide Dashboard" for the most relevant state and county-level suicide-related surveillance data.	**N/A**
12.b. The State will provide technical assistance and training to community groups on the dashboard, including the 57 counties with existing suicide prevention coalitions.	**N/A**
12.c. With technical assistance from OMH, and in accordance with all state and federal laws surrounding confidentiality, communities will pilot suicide fatality reviews in select areas whereby a multidisciplinary group of professionals and community members evaluate the circumstances leading to suicides to improve community and service systems and to take action to prevent suicide. Summarize and disseminate findings in an annual report to community stakeholders aimed at policy changes that improve community suicide prevention.	**Implemented**
12.d. Develop a plan for the sharing of regional best practices in the use of data informed suicide prevention across the State, such as at the annual NYS Suicide Prevention Conference, the annual conference of mental hygiene directors, and other appropriate venues.	**Partially Implemented**
12.e. Create an advisory panel of county mental hygiene directors to provide feedback and guidance to the State in incentivizing implementation at the local level of recommendations contained in this plan and to disseminate best practices to other counties.	**Not Implemented**
12.f. Qualified Entities are regional health information networks that tie together electronic medical and pharmacy records so participating providers can share	**N/A**

patient specific data, such as discharge summaries, lab tests, diagnoses, and pharmacy records to allow improvements in coordinated care. The State should work with Health Information Exchanges to make suicide-prevention relevant data more accessible to end users. For example, while adhering to all applicable federal and state privacy laws, health and behavioral healthcare providers should be able to quickly ascertain if an individual has received treatment for a mental illness, or has had a suicide attempt in the past. Consent forms need to be incorporated into mental health and substance use disorder practices to allow sharing of this data.	
13. The State should improve data timeliness: support timely data that meets both community need for rapid emergency response and long-term surveillance aimed at understanding trends.	**N/A**
13.a. Support use of a "near real-time data" surveillance system for communities.	**Partially Implemented**
13.b. The State and New York City health departments should collaborate to develop, test, and disseminate a common syndromic definition for suicide attempts to allow near real-time reporting in emergency rooms statewide.	**N/A**
13.c. Review of other databases, including emergency medical services transport, SafeACT rapid reporting, and data available at the community level such as 911 dispatches, as potentially useful models of real-time data reporting that supports a local response.	**N/A**
13.d. Review current work flows for State suicide death reporting, including toxicology reporting, and make recommendations on reducing the data lag.	**Partially Implemented**
13.e. Creation of centralized NYS laboratory for standardized toxicology reporting.	**N/A**
13.f. Counties should work with their data providers such as coroners/medical examiners, behavioral health providers, and hospital emergency departments to identify local issues affecting the timeliness and quality of data collection.	**N/A**
14. The State should foster and support data sharing across the datasets most relevant to suicide prevention.	**N/A**
14.a. Several databases managed by New York State contain information highly relevant to suicide prevention—for example, the All Payer Database, Statewide Planning and Research Cooperative System (SPARCS), Vital statistics, Medicaid, New York Incident Management Reporting System (NIMRS). Methods to allow sharing and linkage of records between agencies for public health surveillance purposes need to be identified.	**Partially Implemented**
14.b. Rather than having state agencies rely on separate parallel reporting systems for tracking suicide attempts and deaths, efforts should be made to utilize one universal system to be used by the State and its licensed providers.	**Partially Implemented**
Domain 4: Infusion of Cultural Competence Throughout Suicide Prevention Activities	
15. Incorporate the use of technology into program development and design.	**N/A**
15.a. Gather input from diverse populations with a multi-generational view on how the use of technology allows individuals to feel more connected.	**Not Implemented**
15.b. Focus on the development of applications for crisis and therapeutic support services.	**Implemented**
16. The State should incentivize improving the completeness of key demographic data for suicide deaths and attempts, including race/ethnicity [veteran and sexual minority status], in administrative data sets. This information is critical to the goal of reducing disparities.	**Partially Implemented**
17. Targeting communities with the larger Latina adolescent populations in New York State, The State should convene and facilitate community forums with key stakeholder groups.	**N/A**

17.a. Even when supportive services are available, Spanish-speaking only parents or other primary caregivers may not know about them, if informational materials appear in English only. Similar to Executive Order 26 for state agencies, community groups should make vital documents available in languages other than English, including Spanish, and raise awareness among Latino families of local resources by publicizing them through Spanish-language media	**N/A**
17.b. Create a digital clearinghouse devoted to housing resources available to communities working to reduce suicide deaths and attempts among Latina adolescents, including how to access trainings and best-practice programs.	**Implemented**
18. Strategies to highlight increased risk to the Latina adolescent community should be combined with improved data collection and utilization by local communities in planning suicide prevention services for improved outcomes within this community.	**N/A**
18.a. In concert with the NYS DOH Prevention Agenda 2019-2024 cycle, highlight the prevention of suicide attempts and deaths, (especially in communities with relatively large Latina adolescent populations) in the 2019 Local Mental Health Services Plans.	**Partially Implemented**
18.b.Highlight the elevated rates of suicide attempts and the growing rates of completed suicides among Latina adolescents, including in the next revision of the NYS Suicide Prevention Plan and at the annual NYS Suicide Prevention Conference in Albany	**Implemented**
19. The State and Localities should encourage and support all primary care providers caring for children around adherence to the latest American Academy of Pediatricians' Guidelines for Adolescent Depression in Primary Care (GLAD-PC).	**N/A**
20. Increase training expectations and opportunities to incorporate LGBTQ in cultural competence trainings, technical assistance, and regulatory review.	**N/A**
20.a. It is critical to encourage crisis and suicide prevention hotlines to provide culturally competent services for diverse LGBTQ communities. Crisis Prevention Centers, especially those with text and chat messaging available, play an important role in suicide prevention. To ensure that crisis and suicide prevention programs are following the recommendation to assess suicide risk, it is important to promote accreditation as well as Train the Trainer.	**N/A**
20.b. Statewide mandated training on cultural competence (as found on Statewide Learning Management System) should be updated to include LGBTQ communities and OMH Field Offices need to include expectations around LGBTQ competency training in their licensing visits to agencies. Thus, professional education settings will provide trainings on LGBTQ competence (i.e., knowledge, awareness, and skills), unique experiences based on LGBTQ diversity, and promote inclusive language in schools and public settings.	**Implemented**
20.c. Schools are key settings for education, promoting youth-adult bonds, family education, and creating a culture of diversity and acceptance. It is important to identify best-practices for school policies and programming and encourage local coalitions to promote; support practices for schools and other youth- and family-serving organizations in addressing bullying; and require that teachers, staff, and administrators complete diversity and inclusion training to help them recognize their own biases, strategies to negotiate conflicting beliefs, and to encourage schools to provide continuing education on diverse cultural histories.	**N/A**
20.d. Incorporate into OMH Suicide Prevention Office (SPO) coalition training: strategies and recommendations for local coalitions to engage with religious and community leaders for collaborative training in cultural competency as well as	**Implemented**

implicit bias and to use messaging to promote acceptance in families and prevent bullying.	
20.e. Create and disseminate information on community as well as on-line resources to match specific population needs (e.g., community, connection, healthcare information, family support, salient identities). Developing trainings that encourage LGBTQ self-advocacy as well as communication of their unique needs in healthcare and other settings.	**Implemented**
21. LGBTQ competencies in health care systems need to be improved across the board.	**N/A**
21.a. The State should support the development and dissemination of trainings for health care systems and health care provider education settings (e.g., physician, social work programs) to address: (a) Strategies to collect SOGI data from LGBTQ patients across cultures and (b) Creating welcoming and affirming environments (e.g., preferred name/ pronouns, more inclusive language, all gender restrooms, affirming images, recognizing intersecting identities, etc.).	**Implemented**
21.a.i. Healthcare systems must determine how often SOGI information should be systematically collected, what barriers to collecting this data exist, and develop experiential trainings that not only teach, but monitor how SOGI data is collected. OMH will review regulations and explore training opportunities as well as soliciting input from the LGBTQ communities about how best to operationalize this including the education of LGBTQ patients about how this data will promote more affirming health care practices.	**Partially Implemented**
22. There is a critical need for accurate data on LGBTQ suicide to inform planning, intervention, prevention strategies, and research. Once LGBTQ suicide and death data is available, state/local policy makers and researchers will be able to investigate means of death, suicide rates, and strategies to tailor suicide prevention approaches to unique subgroups (e.g., LGBTQ, people of color, age cohorts), etc. Toward that goal, local communities can increase the accuracy in the following ways: a. Identify and support state-wide use of best practices for collecting information on sexual orientation and gender identity (SOGI) for all NYS deaths. b. Support the New York State Inter-Agency Task Force that is working to identify and support best practices for obtaining SOGI information. c. Ensure that SOGI data is available for the National Violent Death Reporting System (NVDRS) and death certificates; thus, medical examiners, county health officials, coroners, and law enforcement offices will require training to collect and code SOGI data. Similarly, it is equally important to collect SOGI data in electronic medical records to improve care and ensure that data is available for death records.	**Partially Implemented**
23. OMH should support a partnership with the Family Acceptance Project.	**Implemented**
24. The Task Force recommends that New York State Pass the Gender Expression Non-Discrimination Act.	**N/A**
25. Most Veterans in New York State do not receive their healthcare through the VA system. New York State will address the need to increase access to enrollment into the VA system for those who are eligible while improving the competency of civilian healthcare workers in providing treatment and meeting the specific needs of Veterans for those who do not receive VA services.	**Partially Implemented**
25.a. New York State will develop mechanisms to better identify Veterans and provide information on VA benefits.	**Partially Implemented**
25.a.i. New York State will identify a strategy for state agencies to ask all customers the following question: “Have you ever served in the military?” and obtain permission to share their contact information with the NYS Division of	**Partially Implemented**

Veterans' Affairs (DVA). If permission is not given, state agencies will be able to provide a pamphlet encouraging the individual in accessing VA eligibility counseling. There is potential for NYS Information Technology Services (ITS) to develop a data solution to surveil state agencies to flag information and funnel to the DVA.	
25.a.ii. Provide support for the work of the DVA call center, which ultimately assists respondents in scheduling appointments with Veteran Benefit Advisors who are local to the caller.	**N/A**
25.a.iii. OMH will explore the utilization of the Psychiatric Services and Clinical Knowledge Enhancement System to identify those with Veteran status to identify those individuals during visits to such locations as emergency rooms and homeless shelters.	**Not Implemented**
25.b. State agencies will coordinate to develop a curriculum for healthcare workers to increase their understanding of the unique needs of the Veteran population.	**Implemented**
26. New York State agencies will increase collaboration at events designed for individuals experiencing the transition period from active military to veteran status as this has been identified as a time of high risk. These events are an opportunity to provide mental health support as well as assist individuals in obtaining benefits. In addition, OMH and the New York State Division of Veterans' Affairs will increase their presence at Yellow Ribbon and deployment events.	**N/A**
27.a. New York State will address the need to engage and educate the veterans, families, and the wider community as well as decrease isolation by veterans in the following way: OMH will coordinate training with the State Division of Veterans' Affairs. OMH offers a number of suicide prevention trainings each year, many of which may benefit those working with veterans.	**Implemented**
27.b. New York State will address the need to engage and educate the veterans, families, and the wider community as well as decrease isolation by veterans in the following way: Improve the dissemination of information to Veterans and their support systems through the development of a social media campaign. The development of online content should include information for veterans, families, and friends on mental health and resources. This campaign could be launched on Veterans Day as a collaborative effort of state, federal, and military agencies.	**Implemented**
27.c. New York State will address the need to engage and educate the veterans, families, and the wider community as well as decrease isolation by veterans in the following way: Promote Veterans-Focused Suicide Prevention community conversations in each of the REDC regions annually, bringing relevant stakeholders together in a collaborative effort to decrease isolation in the Veterans community.	**N/A**

Note: N/A indicates a recommendation that auditors did not review.

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Agency Comments

NEW YORK STATE | Office of Mental Health

KATHY HOCHUL
Governor
ANN MARIE T. SULLIVAN, M.D.
Commissioner

September 16, 2025

Heather Pratt, CFE
Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Heather Pratt:

In accordance with Executive Law § 170, the following are the responses from the Office of Mental Health (OMH) to the Office of the State Comptroller's (OSC's) draft audit report entitled, "Implementation of Suicide Prevention Task Force Recommendations" (2023-S-37).

OMH appreciates the interest in advancing suicide prevention in New York State as demonstrated by the work that went into the audit report referenced above. It is gratifying to see much of the suicide prevention work done by OMH and its partners reflected in OSC's findings. We also appreciate the acknowledgment that a majority of the 2019 suicide prevention task force report recommendations were acted on despite the challenges posed by the pandemic. OMH remains committed to prioritizing the most impactful and data-informed actions to reduce suicide morbidity and mortality among New Yorkers.

Much has changed since the release of the 2019 report and there have been over 13,000 new peer-reviewed articles published in suicide prevention literature. The COVID-19 pandemic fundamentally altered how OMH implements suicide prevention programming, and the 988 Suicide and Crisis Lifeline was launched with other once in a generation reforms to the behavioral health crisis system. Accordingly, OMH is adjusting to this changing landscape. In 2024, OMH reconvened the latest Suicide Prevention Task Force to re-evaluate the suicide prevention needs of New Yorkers. Concurrently, OMH's Suicide Prevention Center of NY (SPCNY) has engaged its Suicide Prevention Council in re-writing and updating the New York State Strategy for Suicide Prevention with release scheduled for fall 2025. Modeled after the 2024 comprehensive National Strategy for Suicide Prevention, the 20 goals and associated objectives in the State Strategy serve as a blueprint for all groups engaged in suicide prevention work across the state.

OMH agrees with each of OSCs recommendations, and our responses are as follows:

OSC Recommendation 1: Develop and implement practices to monitor, evaluate, and document efforts to implement Task Force and/or other specified recommendations for suicide prevention activities.

OMH 30-Day Response: The State Strategy for Suicide Prevention referenced above is accompanied by an action plan detailing OMH's approach to meeting all 20 strategic goals and provides annual performance metrics for monitoring and evaluating progress. Once released, OMH will work to develop a mechanism to document internal efforts towards implementation.

OSC Recommendation 2: Work with DOH to disseminate more timely, raw data on suicide death in the State to the public.

OMH 30-Day Response: OMH agrees that the timeliness of the release of mortality data needs improvement and will be recommending such in the forthcoming updated State Strategy for Suicide Prevention mentioned previously. Further, we are working to increase the availability of data to inform suicide prevention efforts across the state. Specifically, OMH will work with DOH and the New York City Department of Health and Mental Hygiene to develop an operational use case for OMH to support a formal data exchange agreement promoting more timely data sharing and reporting. In the interim, OMH will continue to work with our partner agencies to develop data profiles. For example, a population profile on suicide risk among working-age men in New York was recently released, and a similar report focused on adolescents is currently being developed.

OSC Recommendation 3: Develop practices to improve accuracy and completeness of core suicide surveillance data and information sharing. This may include but may not be limited to:

- obtaining accurate, complete, and timely suicide prevention data.
- increasing coordination efforts with counties to ensure access to relevant and timely information.
- promoting the ability for counties and the State to share best practices for suicide prevention and awareness of the State's suicide prevention goals.
- working with other State agencies to improve data accuracy or systems.

OMH 30-Day Response: The OMH action plan previously mentioned includes multiple actions that address the need for improvements to data quality and dissemination. These include developing guidelines for monitoring the quality and timeliness of New York's suicide data; developing a system for suicide surveillance within OMH; developing an inventory of suicide related data sources, their characteristics, and how they are accessed to facilitate public use; producing and disseminating population suicide profiles for public release; and increasing suicide related data available on the OMH SPCNY website. OMH has also promoted intra-county data sharing for suicide prevention, which may face fewer barriers to timeliness. OMH is committed to taking available actions to increase the timeliness, quality, and dissemination of actionable suicide data for New York State.

Regarding sharing best practices in suicide prevention, this will be done through a number of methods including but not limited to: the annual suicide prevention conference; mini-grants to community partners who commit to implementing from a selection of best practices; regional county coalition meetings; within actions funded by federal grants; and a learning collaborative for counties that covers best practices in suicide prevention data collection and use, community and schools programming, healthcare (i.e., the Zero Suicide model), and workplace for occupations at elevated risk, such as construction and first responders.

Please let us know if you have any questions or require additional information concerning the above.

Sincerely,

Ben Rosen Digitally signed by Ben Rosen Date: 2025.09.17 12:29:06 -04'00'

Benjamin Rosen
Acting Executive Deputy Commissioner

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