Consulting Report for Tompkins County Suicide Prevention Coalition Data Subgroup

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A. Summary

This report examines the Tompkins County Suicide Prevention Framework. The data presented is focused on findings from individual interviews conducted with the Lethal Means Subgroup, Zero Suicide Subgroup, and the Youth Focus Subgroup of the Tompkins County Suicide Prevention Coalition (TCSPC). The interviews followed a standardized interview protocol pre-approved by Ms. Danielle Eiseman, Professor for the Consulting for Nonprofits graduate course under the Public Administration subject at Cornell University in Fall 2022. This report was created through an academic perspective on consultation for Ms. Eiseman's course with the aim of supporting the TCSPC in data procurement. This report includes a literature review, data and methodology section, as well as data analysis and recommendations.

B. Literature Review

1. Background

The field of sociology and suicidology have produced rich scientific knowledge since Émile Durkheim's initial systematic observations on the subject of suicide in 1897 (Mueller et al., 2021). While Durkheim viewed suicide as a sign of society's overall collapse comparable to homicide or alcohol abuse (Mueller et al., 2021), the expanding body of work now enables us to pinpoint areas in need of preventive intervention. One such area observed when discussing the impact of suicide on society is Socio-Economic Status or SES which intersects with many of the societal facets mentioned above. Socioeconomic status is frequently linked to neighborhood contextual influences, which raises the likelihood of exposure to a variety of hardships, including stressors like financial strains, job changes, family strife, etc. Low SES correlates with worse outcomes in terms of suicide rates. (Nock, 2017)

In line with SES, another area where research on the impact of fatal and non-fatal suicide incidents on society converges, is the economic losses incurred. Institute of Medicine et al. broadly divide the economic impact on society into 4 categories:

- The cost of emergency intervention, which is borne by the society rather than just the healthcare sector due to increased healthcare prices that are ultimately passed on to employees and taxpayers.
- The impact on the economic productivity of those who are suicidal
- The impact on the economic productivity of those impacted by suicide
- The impact on the economic productivity of those who die by suicide

Thus the economic cost of suicide is seen from the perspective of human capital and the lifetime work loss incurred due to suicide (Sawada et al., 2018) (Institute of Medicine et al., 2002). The convergence of research methodologies on socio-economic factors is repeatedly noticed in research pertaining to suicide as both a cause and outcome of fatal and non-fatal suicide incidents. This highlights the cyclical influence that the economic impacts of suicide have on its prevalence.

The cost to society, on the other hand, is viewed from the perspective of human beings and their role in broad networks that comprise individuals, social groups, and even nation-states. In such a network, fatal and non-fatal suicide incidents affect society through a domino or ripple effect, with the waves of impact moving outward ("The Ripple Effect of Suicide | NAMI: National Alliance on Mental Illness", n.d.). While losses related to suicide can be drastically felt by people in the intimate circle, its impact can be measured across multiple facets of society including governance, law, religious faith, economy, sociology, and medicine (Feldman, 2019) ("Means Matter - Who?", 2017) (Sawada et al., 2018). Similar to the overlap and complications in accounting for the impact, the risk of suicide too is significantly influenced by multiple factors including biological, psychological, social, and cultural factors (Institute of Medicine et al., 2002). It is, therefore, necessary to have a comprehensive understanding, based on logic and reason, of how these facets of society interact in order to effectively implement suicide prevention. Even if researchers around the world unanimously agree that logic and reason must be used to examine all the aspects that contribute to this complicated and highly emotional issue, research on suicide is often impacted by the limited availability of data, as well as difficulties in acquiring accurate and valid information (Institute of Medicine et al., 2002) (Feldman, 2019) (Nock, 2017).

2. Policy

In order to address the cost of suicide, nations and states develop policies related to suicide prevention and continuously revise them to achieve advancement. Based on international policy and practice in suicide prevention, suicide prevention strategies usually include public education, dealing with factors associated with mental illness, prevention, detection, and treatment of mental illness, attention to the role of alcohol and drugs, control of access to suicide means, assessment and treatment of parasuicide, and providing support to high-risk groups (Jenkins & Singh, 2000). The federal government of the United States, through the U.S. Department of Health and Human Services (HHS), proposed scientific suicide prevention strategies that mainly focus on the following aspects: promote public awareness toward suicide; establish a national coordinating body to facilitate the advancement of the national strategies; reduce the stigma of using services of mental health, substance abuse, and suicide prevention; develop community-based suicide prevention programs and link communities to mental health and substance abuse services; reduce access to means of self-harm and suicide; promote effective clinical and professional practices; improve portrayals of suicide, mental illness, and substance abuse in the media; promote research on suicide and suicide prevention including funding and training grant; expand reporting and surveillance systems (DeMartino et al., 2003).

In the U.S., most suicide prevention policies are at the state level, and the nation plays a role in giving recommended strategies, so there can be a lag in transiting recommendations into local policies. 43 out of the 50 states had revised their state suicide prevention plan within 5 years after the *National Strategy for Suicide Prevention* was released in 2012, but 7 states lacked an updated plan (Graves et al., 2018). There are also large variations in the scope and content of policies because not all recommendations are able to be included in policies. For example, as of 2017, only 20% of states had passed legislation mandating suicide prevention training among healthcare professionals and 14% of states recommended the training (Graves et al., 2018).

Nevertheless, with the various suicide prevention policies becoming prevalent, Marzetti et al. (2021) analyzed the eight UK suicide prevention policy documents in use between 2009 and 2019 and found that people who attempt suicide are narrowly defined and suicide behavior is conceptualized. Policies usually regard suicide as individual pathology that separates from the larger public context, and primarily focus on clinical efforts on mental health support and crisis intervention. These strategies lack the potential to create long-term suicide prevention because they cannot improve structural and contextual conditions that make life more livable. The policies on suicide prevention should engage across several policy areas instead of just focusing on psychological approaches. The HHS of the U.S. is doing better in considering more aspects in the large context, such as reducing social stigma and improving portrayals in media. Besides, there are many other aspects to consider, such as the social and material inequalities that lead to higher risks among people without priority (Marzetti et al., 2021). The New York State recommends infusing cultural components through suicide prevention approaches for racial minority groups (Cuomo, 2019). There is still plenty of space for research and policy advancement in the large context.

3. Zero suicide model/Suicide Prevention

Zero Suicide is a term used to describe emerging strategies and frameworks aimed at improving how healthcare systems provide suicide care. These models are centered around the idea that with the correct interventions, suicide deaths are preventable for persons receiving behavioral health support and care through healthcare systems. This model emerged as a response to several research findings that indicated that many people who die by suicide seek healthcare services up to a year prior. By rebuilding the response strategies and care given to people experiencing suicide ideation, healthcare systems can actively decrease suicide deaths. A wide variety of literature have been published on studies done on different methodologies for suicide prevention. It is important to determine the feasibility of a methodology while considering the context and resource capabilities of the healthcare systems that are wished to be applied. One of the largest evaluations of the Zero Suicide approach conducted in outpatient behavioral health was covered in the Zero Suicide article by Christa D. Labouliere in 2010. In this literature, it is clear that there are significant barriers to suicide patients receiving adequate and appropriate care, such as affordability of health insurance as well as access to healthcare. (Labouliere et al., 2018).

The National Strategy for Suicide Prevention narrows down the potential causes for suicide deaths that occur despite receiving care to be inadequate detection of suicide risk and lack of implementation of evidence-based suicide-specific interventions. There is however a shift in focus in the field moving from focusing on the prediction of suicidal behaviors towards a more holistic approach that focuses on prevention while incorporating suicide risk assessments that weigh distal and proximal risk and protective factors (Labouliere et al., 2018). Another frequently overlooked prevention methodology is ensuring that the intensity of care that patients experiencing suicide ideation receive is increased during high-risk periods when they are experiencing increased ideation. This is typically done in conjunction with frequent reassessments for these high-risk patients, (Labouliere et al., 2018)

In contrast, a variety of different strategies are being implemented outside of the US with the common goal of suicide prevention. In 2017 the *Public Health Research & Practice Journal* in Australia challenged the idea of introducing an entirely new framework for suicide prevention. This article applies systems thinking theory and methodology to suicide prevention. In this context, the center of focus is on making the existing suicide prevention channels more efficient and effective (Fitzpatrick & Hooker, 2017).This approach is centered around identifying the current suicide prevention methods as being part of a bigger system that is made up of parts. The goal is to improve the coordination and integration within and between these existing systems; by doing this policymakers and local suicide prevention groups can be on the same page regarding the result and support needed for different suicide-related initiatives (Fitzpatrick & Hooker, 2017). The advantages of integrating state and national-level suicide prevention services allow for more collaboration and tackle inefficiencies that are created by silos across suicide prevention.

C. Data and Methodology

I. Research Plan

The Tompkins County Suicide Prevention Coalition has encountered several barriers to acquiring sufficient data required to improve policy on mental health and suicide prevention. Based on the request made by Ms. Lynsay Ayer from the TCSPC, we conducted research to determine the data needs and priorities within the TCSP Coalition and summarized the results in a final report. The several subgroups of the coalition mainly focus on the use of data sources, the zero suicide model, reducing youth suicide, limiting access to lethal means, and policy improvement. We have gained an understanding of suicide prevention and the zero suicide model by studying the impact of suicide on the overall society, the situation around mental health and suicide prevention policies in the U.S., and an analysis of the zero suicide model through our literature review. In data collection, we focused on the following questions:

1. What are the focuses and current tasks in each subgroup in the TCSP Coalition?
2. What are the data needs and priorities for each subgroup in the TCSP Coalition?
3. What are the barriers they have faced in terms of acquiring data?

We obtained qualitative data to answer these two questions by conducting an interview with each of the subgroup leaders. For each subgroup, we aimed to find out their data needs and barriers. There are five main subgroups within the Coalition, and we obtained the contact information of all the subgroup leaders from Ms. Zoe Lincoln, the TCSPC's Steering Committee Coordinator. The subgroups that were approached for interviews are listed below:

1. Zero Suicide Workgroup: aims to advance quality improvement for suicide care in all Tompkins County healthcare and behavioral health settings. We contacted and interviewed Mr. Scott MacLeod.
2. Youth Focus Workgroup: aims to reduce suicide attempts in the youth population, including students attending colleges in Tompkins County. We contacted Ms. Sara Tarrow, and interviewed Mr. Scott MacLeod.

3. Lethal Means Workgroup: aims to reduce access to lethal means for suicide within high-risk demographic populations as determined by national, state, and local data. We contacted and interviewed Ms. Kaitlynn Tredway.
4. Policy/Advocacy Workgroup: Advocate for policies and practices designed to prevent suicides in the community. We contacted Ms. Sally Manning, but could not secure an interview.

Ms. Lynsay Ayer of the Data Subgroup worked with us and introduced us to the issues surrounding data collection. She also established the scope of work for this report.

II. Data

Logic and reason are important to examine all the aspects that contribute to this complicated and highly emotional issue of suicide prevention. However, the limited availability of data on mortality and morbidity, inaccuracies in statistics, as well as methodological difficulties in acquiring accurate and valid information often impacts study on suicide prevention (Institute of Medicine et al., 2002) (Feldman, 2019) (Nock, 2017). In line with this, the TCSP coalition work groups or data sub-groups have also encountered several barriers in acquiring sufficient data required to improve policy on mental health and suicide prevention. The goal of this project is to determine TCSP's data needs and priorities, and establish how data will help in implementing suicide prevention and the zero suicide model. However, our consulting group's work will only focus on the data needs and priorities of the TCSPC. The methodology we sought to answer the following research questions included interviewing members of the TCSPC the sub-groups.

In addition to interviews, other methods of data collection, including surveys, use of literature, theory, and case studies are prescribed as potential methodologies for future consultation groups to establish how data will help in implementing suicide prevention and the zero suicide model.

DATA

Research Question	Analysis	Methods	Participants	Details	Strenghts	Weaknessess	Use	Preparation
1. What are the data needs and priorities in each subgroup in the TCSP Coalition?	Requirement Analysis	Interviews	TCSP Data Sub Commitees	For qualitative and quantitative analysis. The identified key stakeholders are 5 TCSP Data Sub Commitees. Each of the 5 Sub Commitees will be interviewed one-on-one on their data needs and priorities.	**(1)** First hand information on the obstacles in the way of data collection. **(2)** First hand information on the data required	**(1)** Potential difficulties in scheduling meetings/ time conflicts.	Help us with: **(1)** Description of the data requirements. **(2)** Description of potential issues and obstacles encountered while collecting data.	**(1)** Script **(2)** Set: (a) Location - virtual/ in-person, date/time. (b) Invitations (c) Reminders (d) Gather RSVPs **(3)** Consent **(4)** Transcribing and coding/ text analysis of the interview **(5)** Data analysis
		Surveys	TCSP Data Sub Committees	For quantitative data (if necessary)	**(1)** Survey for qunatitative analysis will help reveal patterns through quantitative analysis. **(2)** It will help us bolster or support the data requirements and priorities of the subgroups. **(3)** Patterns that emerge might help us connect our findings to theory/ literature.	**(1)** Small sample **(2)** Participants might or might not be completely engaged with answering a questionnaire.	**(1)** Aid us with statistical analysis.	**(1)** Prepare questionare **(2)** Circulate **(3)** Follow up/ reminders **(4)** Data Analysis

DATA

Research Question	Analysis	Methods	Participants	Details	Strenghts	Weaknessess	Use	Preparation
2. How can that data help improve policy on mental health and suicide prevention in Tompkins County?	Analysis to support the importance of data requirement in suicide pervention	Use of literature/ Theory		The qualitative and quantitative data procured will be analysed with literature and theory on *"data and suicide prevention"* to understand how availability of data can help implement the zero suicide model. Existing TCSP suicide prevention policies will also be parallely evaluated.	**(1)** The analysis will be more benifical to the clients when it is rooted in tested theories and literature.	**(1)** After conducting the interviews and surveys, we might have limited time to connect our findings to literature.	**(1)** Aid us with supporting our findings through theory.	**(1)** Find suitable literature, theory, and policy realted documents. **(2)** Show where the pattern that emerge from interviews and surveys fit into existing lierature and research on data and suicide prevention.
		Case studies		Case studies will be refered as a means to establish why data availability will help implement suicide prevention.	**(1)** Case studies will help us further support why data is needed to effectively implement suicide prevention.	**(1)** Limited examples of successful suicide prevention cases connected with data avilability.	**(1)** Aid us with supporting our findings through examples.	**(1)** Find suitable case studies. **(2)** Show how data availability supported these examples.

III. Scope and Comprehensiveness

The scope of this research is limited to Suicide Prevention Work Groups within the Tompkins County Suicide Prevention Coalition. Research is specifically limited to Tompkins Country and the Data Coalition due to the scope and perimeters set by the client and the initial project outline. Among the five sub-groups considered for interviews, we did not have a chance to interview the Policy/Advocacy Workgroup which aims to advocate for policies and practices designed to prevent suicides in the community. Our contact point was Ms. Sally Manning, but we could not successfully schedule an interview. Similarly, the interview with the Youth Focus Subgroup was carried out with Scott MacLeod (from the Zero Suicide Subgroup) who represented Sara Tarrow of this subgroup. As mentioned in our Research Plan, interviews were conducted with a team member of each of the following subgroups:

1. Tompkins County Suicide Prevention Lethal Means Workgroup
2. Tompkins County Suicide Prevention Zero Suicide Workgroup
3. Tompkins County Suicide Prevention Youth Focus Workgroup

The interviewing process lasted one month due to time constraints. Time constraints are set by the Consulting For Non-Profits PADM 5900 coursework completion period, stipulated within the Cornell University academic course syllabus for which this project was completed. Interview questions were determined by a formal interview protocol approved by our instructor Ms. Danielle Eiseman. Interviews were conducted with members of the above-mentioned sub-groups based on the following questions:

1. What are the focuses and current tasks of the sub-group in the TCSP Coalition?
2. What are the data needs and priorities of the sub-group?
3. What are the barriers faced by the sub-group in acquiring data?

The data gathered in this report are based on the interviews that we were able to complete with the various subgroups within the given time constraints. Data collected from interviews were

used to determine the data needs of each of the three sub-groups. The data obtained are summarized in the section below.

D. Data Analysis and Recommendations

I. Lethal Means Subgroup

Goals and Priorities

The primary goal of the Lethal Means Subgroup is to reduce access to lethal means within high-risk demographic populations as determined by national, state, and local data (TCSPC, n.d.). The subgroup also aims to promote and facilitate suicide prevention programming related to death by the most used lethal means. According to previous data from 1979-2010, self-inflicted gunshot was the major cause of suicide death in Tompkins County ("Suicide statistics for Tompkins County", n.d.). This is an indication that firearm safety is a major area of concern. Based on the Action Plan in the Lethal Means Subgroup shared by the subgroup lead, the current focus is to increase firearm safety through firearm safety education and gunlock distribution. The first task is creating outreach letters describing goals and reasons. Secondly, the subgroup is also creating flyers to go along with their gunlock distribution. These flyers cover lethal means safety in households, and are created by utilizing materials available in the VA. The distribution plan for educational materials on gunlocks is already in place. These outreach efforts are aimed to cover a range of communities within Tompkins County. With the outreach letter, flyers, and distribution plan almost in place, the final step is to conduct the outreach.

Target offices and institutions for outreach include healthcare agencies, gun clubs, county offices, libraries, police departments, schools, Cornell University as well as Ithaca College. The subgroup intends to distribute the educational materials created to the above-mentioned groups. Outside of a few select healthcare agencies, the Lethal Means Subgroup has yet to complete outreach to other identified target groups.

When conducting the outreach, it is important to determine whether the target audience is receptive to the educational materials and whether they indicate a willingness to adopt suggested initiatives. Another step the subgroup is considering taking at a later stage is providing community training on lethal means safety. After the December meeting the subgroup's hope is to finalize plans and materials and be ready to conduct the distribution of gunlocks and educational materials to people in the county.

Data Needs Priority

The primary data need for the Lethal Means Subgroup depends on keeping up with the data on lethal means patterns in Tompkins County. Their focus is firearm safety, primarily because gunfire is the most used suicide means in Tompkins County. They prioritize the fact that the lethal means are prone to change and would change the focus in the action plan accordingly. The data gathered was obtained from 1979-2010. In Tompkins County from 1979 to 2010, the firearm was the major contributor towards suicide (44%), followed by hanging, strangulation, suffocation (24%), and

poisoning and overdose (13%) ("Suicide statistics for Tompkins County", n.d.). Since this data is outdated, Ms. Kaitlynn and Ms. Sally are trying to reach out to obtain the new numbers and patetrns.

Data Recommendations

Besides the primary data needed on lethal means used in Tompkins County, our consulting team looked at the data source and identified additional data types that can be beneficial for the Lethal Means Subgroup. The website "Ithaca Is Fences" where the subgroup gained the data on lethal means, only has an overall rate for each lethal means used. Since the primary goal of the Lethal Means Subgroup is to reduce access to lethal means within high-risk demographic populations, it is important to identify the high-risk populations by looking at the data and demographic characteristics. For example, questions on what the most used lethal means are in different gender, races, ages, and educational levels, can help the subgroup in creating different educational materials based on these distinctions for teenagers, young adults, older adults, or the elderly population. Similarly, if the means used by men and women are different, the subgroup may consider creating a safety plan for the most used means by men and women respectively. If the means used by different races or ethnic groups vary significantly, the subgroup may pay more attention to vulnerable groups when distributing materials in the communities.

Although there might be no existing data set on lethal means in Tompkins County that has been organized by demographic characteristics, the data on New York State from 1978 to 2016 is available. The original data on the website "Ithaca Is Fences" was sourced from the Center for Disease Control and Prevention (CDC). It provides death statistics search in New York State from 19778 to 2016 under different categories including time, cause, age, gender, race, urbanization, etc. Tompkins County should have a very similar situation to New York State, but more peer comparisons between Tompkins County and New York State is required to prove this.

Another kind of data that can be useful for the Lethal Mean Subgroup is the projection of changes in trends over time. Identifying the changes in the most used lethal means over time and exploring the possible reasons for the changes can be helpful in understanding the whole picture and being prepared for changes in the future.

Barriers and Limitations

The most significant barrier the Lethal Mean Subgroup needs to overcome is the unavailability of current data. Although Ms. Kaitlynn and Ms. Sally are preparing to reach out to obtain new numbers, they are unsure about whether they can obtain them and when they can receive them. As Mr. Scott mentioned in his interview, it would be the Data Subgroup's priority to obtain data that the Lethal Mean Subgroup may need.

Another barrier in obtaining data mentioned by Ms. Kaitlynn is related to the confidentiality problem. It can be hard to form relationships with offices that have data in their hands. Offices can be reluctant to provide data for confidentiality issues. Conversations must be built to let offices understand the goals and needs of the TCSPC and the Subgroups. However, the conversations are not easy. Sometimes, the offices understand that the subgroup wants the data not people's identities, but they can still be reluctant because they are unsure about how the Coalition will protect the

confidentiality. This problem is applied to not only the Lethal Mean Subgroup but also all the subgroups. Except for the published data and data that do not have restricted access, other data from offices and agencies may contain identities that lead to obstacles to obtaining.

II. Zero Suicide Subgroup (Mental Health Subgroup)

"Zero Suicide" is a model that is focused on healthcare entities and providers. The Zero Suicide Subgroup follows a strategic plan and acts according to the goals and priorities listed here. It is important to note that the TCSPC focuses on the zero suicide model, along with other means of achieving suicide prevention. This includes work like public communication or outreach, which is not part of the zero suicide model.

Goals and Priorities

The Zero Suicide Subgroup aims to advance quality improvement in suicide care in all Tompkins County health care and behavioral health settings. The subgroups' top priorities include:

- Ensuring that the zero suicide model is implemented across health care in Tompkins County.
- Promoting and facilitating the implementation of the zero suicide model in major health care and behavioral health settings.
- Facilitating implementation in primary care practices and in clinical therapy practices.

In order to achieve these goals, the subgroup has implemented the following measures:

- The "zero suicide steering committee" has been formed encompassing senior healthcare leaders from TC to support the zero suicide subgroup's priority. The committee is expected to perform independently. They will be meeting with the subgroups four times a year to update the coalition on the work that they are doing.
- The role of a "zero-suicide coordinator" has been established to work with the steering committee and the Zero Suicide Subgroup. The coalition is still looking to secure funding for the coordinator position. At present, Ms. Zoe Lincoln, a Health Fellow in the County Health Department has been appointed to this position. She will be working with the steering committee and essentially serving as a liaison back to the TCSP coalition.

Having established the steering committee and zero-suicide coordinator, the role of the sub-group now is to monitor and support the work of the steering committee and proactively initiate any useful direction to the steering committee. In addition to this, the subgroup also aims to:

- Identify the training needs of staff and locate resources that can support those training needs.
- Hold public events to introduce the Zero Suicide Model and introduce the concept of suicide prevention to the public.

Data Needs Priority

The primary data need of the Zero Suicide Subgroup is finding mortality-related data. Most specifically, data on suicide deaths in Tompkins county that have occurred over a particular spectrum of time, identified by age, gender, race, education level, and other relevant parameters. As mentioned in our literature review, the cost of suicide on society is viewed from the perspective of human beings and their role in broad networks that comprise individuals and social groups. Therefore data identified by age group, gender, race, access to education, etc. will tell the coalition where exactly, within the broad network, it needs to focus all of its work. Ms. Zoe Lincoln is working with Tompkins County's health department to improve the quality of data in this regard.

Data Recommendations

In addition to the primary data requirements, data on the following are recommended:

- Data on suicide attempts
- Crisis call helpline data including 911, 988, and other helplines, establishing what percentage of the crisis calls are suicide-related calls.
- Data on the current training levels of health care workers in suicide prevention, looking specifically at data from 3-4 providers as a subset and analyzing the data every two years to see if the level of training improves.
- Data on the comfort level of the practitioners, to identify if all practitioners trained in suicide prevention are comfortable in that role. An example would be the New York State Office of Mental Health surveys which asks physicians the following questions: a) What is your level of training/ your level of education in treating suicidal patients? b) What is your level of post-grad training? c) What is your comfort level?

Barriers and Limitations

The most significant barrier related to data on mortality is the fact that the assertation of the cause of death is somewhat subjective. The examiner has the discretion on how they want to identify that and there is no means to regulate the identification and reporting process. The data thus produced is therefore not completely reliable. In addition, all the data that exists on suicide can be traced to the county medical examiners and the health department. Data can also be obtained from tip points like 988, 911, emergency rooms, etc. Despite the availability of such data, it is not collated and categorized very well. There is no defined body dedicated to holistically collecting data on suicide attempts. This is the most significant barrier faced by the zero-suicide subgroup. On a secondary level, data sourcing is limited to surveys. While this has proven to be inefficient, there are no alternative means identified.

III. Youth Focus Subgroup

Goals and Priorities

The Youth Focus Subgroup aims to reduce suicide attempts in the youth population through schools, colleges, and community groups. It also prioritizes offering gatekeeper training, such as methods related to first aid, successfully identifying youth in their level of struggle, steering youth to the right resources, and encouraging them to get support.

Data Needs Priority

The primary data needs for Youth Focus Subgroup are the same as the Zero Suicide Subgroup's data needs, based on ou interview with Scott.

Data Recommendations

The Youth Focus Subgroup's other data needs are based on K to 12 school districts and colleges. Their data needs primarily include data on staff equipped to deal with the mental health of their students:

- Data on the level of training among staff members in suicide prevention training and gatekeeper training.
- Identifying data related to the staff's level of concern for their students.
- Data on the level of comfort among staff in dealing with students who have mental health issues

In addition to data on staff at educational institutions, the Youth Focus Subgroup would also require analysis of the youth risk data collected by the Center for Disease Control and Prevention (CDC) and other organizations, peer comparison of youth risk related data with other counties in New York State, and peer comparison of data between Cornell University and other institutions.

Barriers and Limitations

The Youth Focus Subgroup prioritizes suicide prevention in K-12 schools and colleges in Tompkins County. Between the two kinds of institutions explored by the Youth Focus Subgroup, colleges have a much more robust system of collecting and categorizing data related to suicide. However, schools lack in this regard. This is the most significant barrier encountered by the Youth Focus Subgroup.

IV. Other Significant Barriers Identified

In addition to the barriers shared by the coalition subgroups significant red tapisms were observed surrounding procuring, and sharing of suicide-related data. These findings are based on research completed by Ms. Zoe Lincoln. These barriers are as follows:

- Coalition and subgroup structure

  The coalition and subgroups are groups of volunteers. Some of these members belong to organizations that allow them access to the data that the coalition may desire to have. For example, a coalition volunteer who works for the VA might be a potential source. However, since the members are participating on a volunteer basis and often cannot share data without a formal agreement, their proximity to the required data is not beneficial to the TCSPC. Similar barriers surround procuring of the data required by TCSPC. These barriers are most commonly identified in data sourcing with government organizations.

- Data vetting processes

  A large percentage of the data needed by the coalition and subgroups have a long and tedious vetting process. For example, when dealing with death or mortality data, there is often a police investigation if the death is deemed to be related to suicide. Alongside toxicology labs which must complete a cycle of being sent out and tested, the results will also need to be shared back with the toxicology labs in order for the process to be completed and the results to be finalized. Due to these delays, the data that is accessible is not actionable. Other than time-related issues, difficulties in obtaining actionable data are often downstream and at the surface level. For example, the available data often neglects influential factors such as socioeconomic status.

- Gaps in data

  Small counties such as Tompkins County often have thresholds that data must meet before it is deemed "publicly reportable". Thresholds can be 10, 15, 20+, etc. depending on the data point. If the data does not meet these thresholds it must be suppressed to maintain confidentiality. This creates gaps in the data and makes it difficult to determine areas for prevention focus. Additionally, the available data is not refined for a sub-county basis such as delineation through zip code. The available data, therefore, lacks specificity and does not paint a picture accurate enough to facilitate effective prevention or invention.

- Continuity of Reporting

  Reporting around suicide fatalities and suicidality is appearing to be incomplete and inconsistency.

  For example,

  There is a check box on death certificates that asks if the decedent was hospitalized in the last 2 months. Ms. Zoe Linclon's research uncovered that often this box is left blank, even though this information could be important for data reporting and analysis. Additionally on the certificate is a check box to indicate veteran status – sometimes the box is checked, sometimes a number is written in, and sometimes it's left blank.

  These data inconsistencies negatively affect the quality of the data available, therefore compromising the possibility of using this data for decision making.

- Evaluation

  Prevention and intervention initiatives must be consistently evaluated in order to determine their effectiveness and the proper allocation of time and resources. Sound evaluation methodologies rely heavily on quality data however the unavailability of timely data and incomplete and inconsistent data diminishes the quality of the data available. This makes it difficult to evaluate the effectiveness of the current programs and delays the TCSPC's ability to respond to evolving prevention and intervention needs within the county.

V. Future Direction

The consulting team carried out data collection on the TCSPC's data requirements and the barriers to obtaining the required suicide-related data from government agencies, as well as other stakeholders within Tompkins Country. For the next step, it will be important to focus on a specific request that was made by Mr. Scott MacLeod, asking future consulting groups to point the TCSPC to specific data sources. This direction is valuable since reliable data sources are crucial to driving suicide prevention initiatives and strategies, as well as for the evaluation of many of TCSPC's goals. Therefore looking forward, it would be important to begin this process by determining data sources, the feasibility of obtaining the data, as well as the accuracy of that data. This data will be used to inform and support recommendations that will be put forward to support the Coalition.

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Appendix A

Script

- **PREPARATION:**

1. Email confirming participation (date, time, and duration), and consent to being recorded.
2. Reminder email
3. Read on the works or area of work of the sub-group and refine questions

- **INTERVIEW:**

1. Script (Zero Suicide Workgroup) Scott MacLeod: thesophiefund2016@gmail.com

    a. Introduction: "Hello, I am —. I will be leading our interview today. My colleagues — and — are here with us today. I'd like to start by thanking you for making the time to speak with us. Just to confirm, we'd like to keep this interview to (duration) and it will be recorded. Does that still work for you? Great. Participating in this interview is voluntary. You can leave at any time or skip any question as you want. If you need a break or would like to stop at any time, please let me know. During this interview, I'll ask you a few questions about the Data Workgroup and your data requirements.
    b. Question 1: "Please brief us on the role of the Zero Suicide Workgroup in the Coalition, your priorities, and your goals."
    c. Question 2: "What is the role of the workgroup in contributing to the zero suicide model?
    d. Question 3: "What are your data requirements or needs, and please brief their priorities."
    e. Question 4: " What are the setbacks you've faced in terms of acquiring the required data?"

2. Script (Youth Focus Workgroup) Sarah Tarrow: sarahtcss@racker.org

    a. Introduction: "Hello, I am —. I will be leading our interview today. My colleagues — and — are here with us today. I'd like to start by thanking you for making the time to speak with us. Just to confirm, we'd like to keep this interview to (duration) and it will be recorded. Does that still work for you? Great. Participating in this interview is voluntary. You can leave at any time or skip any question as you want. If you need a break or would like to stop at any time, please let me know. During this interview, I'll ask you a few questions about the Data Workgroup and your data requirements.
    b. Question 1: "Please brief us on the role of the Youth Focus Workgroup in the Coalition, your priorities, and your goals."
    c. Question 2: "What is the role of the workgroup in contributing to the zero suicide model?"
    d. Question 3: "What are your data requirements, and please brief us on your priorities."

e. Question 4: " What are the setbacks you've faced in terms of acquiring the required data?"

3. Script (Lethal Means Workgroup) Kaitlynn Tredway: kaitlynn.tredway2@va.gov

   a. Introduction: "Hello, I am —. I will be leading our interview today. My colleagues — and — are here with us today. I'd like to start by thanking you for making the time to speak with us. Just to confirm, we'd like to keep this interview to (duration) and it will be recorded. Does that still work for you? Great. Participating in this interview is voluntary. You can leave at any time or skip any question as you want. If you need a break or would like to stop at any time, please let me know. During this interview, I'll ask you a few questions about the Data Workgroup and your data requirements.
   b. Question 1: "Please brief us on the role of the Lethal Means Workgroup in the Coalition, your priorities, and your goals."
   c. Question 2: "What is the role of the workgroup in contributing to the zero suicide model?"
   d. Question 3: "What are your data requirements, and please brief your priorities."
   e. Question 4: " What are the setbacks you've faced in terms of acquiring the required data?"

4. Script (Policy/Advocacy Workgroup) Sally Manning: sallymcss@racker.org

   a. Introduction: "Hello, I am —. I will be leading our interview today. My colleagues — and — are here with us today. I'd like to start by thanking you for making the time to speak with us. Just to confirm, we'd like to keep this interview to (duration) and it will be recorded. Does that still work for you? Great. Participating in this interview is voluntary. You can leave at any time or skip any question as you want. If you need a break or would like to stop at any time, please let me know. During this interview, I'll ask you a few questions about the Data Workgroup and your data requirements.
   b. Question 1: "Please brief us on the role of the Policy/Advocacy Workgroup in the Coalition, your priorities, and your goals."
   c. Question 2: "What is the role of the workgroup in contributing to the zero suicide model?"
   d. Question 3: "What are your data requirements, and please brief their priorities."
   e. Question 4: " What are the setbacks you've faced in terms of acquiring the required data?"

Appendix B

Transcript of Interview with Kaitlynn Tredway on November 23, 2022

Vimbai
My first question for you is could you briefly tell us the role the lethal mean workgroup has in the coalition? And I'd also like to find out what your priorities and what are some of your goals are.

Kaitlynn
Create the lethal means safety work group looking at some of the data that one of our members found a little while back. Essentially, firearm safety is one of our most pressing concerns because the numbers of suicide, the self-inflicted gunshots in Tompkins County here are relatively high so that is kind of our focus. I'll pull up the action plan. This is kind of what our action plan is. So our focus is increasing the lethal mean safety. Our goal is to increase firearm safety, and then we have optional strategies for that. The first is firearm safety education and the next one is gunlock distribution. So some of the action items we are currently working on is creating an outreach letter, kind of explaining our goal. We're also creating something like a flyer type thing to go along with our gunlock distribution. And then some of these were utilizing things that are already available through the VA, so the fire is actually going to be kind of like a brochure that talks about lethal means safety in the household. The outreach letter is essentially just describing goals that we have and why we're doing this in Tompkins County. So in order to do these things, we created a distribution plan for the educational materials for the gunlock as well. And then something that we've thought about doing as well is training, a whole thing training in the community for lethal mean safety. So that's kind of where we were at. You know it is still very in the early stages for everything, but we are working on the fire letter right now, and the distribution plan is in place. We are going to get the educational materials and gunlocks out there.

Vimbai
Okay! Looks really extensive. I'm so surprised you said you are just starting. Looks really extensive. That's awesome.

Kaitlynn
It sounds a lot like the background work, the base work, strategic planning, kinds of stuff. I'm not physically in Tompkins County and so we're trying to kind of gather around. I'm also going to have a maternity leaving in January. We're trying to schedule a meeting for hopefully in December to finalize things and actually get the gunlock to people in Tompkins County, to get it out there to be distributed.

Vimbai
When you say outreach, I know you mentioned some outreach materials, where are you giving these to, or what's your outreach target?

Kaitlynn
I can share my distribution plan.

Vimbai
That will be helpful. Thank you.

Kaitlynn
Let me pull that out. And that gives you an idea about all the places we are looking at or targeting. Some of them we already have contact with, through the coalition, so lots of like the healthcare agencies and things like that are where they were going to be doing this. But some of the other individuals, like the school we have on here and also like the Gun Club and things like that, we haven't had contact with. So my idea is that we will start with those healthcare agencies and then kind of move from there in regard to making contacts. We do have a few categories: gun club, county offices, libraries, police department, health care agencies. I guess these are the majorities who we've made contact with this far, and also school district as well as well, the Cornell and Ithaca College. So that kind of touches on where we're planning to distribute them, but we just haven't implemented that outreach to them to see if they would be receptive to receiving them.

Vimbai
Ok, awesome. Are you seeing a lot of gun violence stuff in school because you have a lot of schools on here.

Kaitlynn
Obviously safety is the purpose. So yes, our focus is suicide, but it could also be promoted for for firearm safety in general too.

Vimbai
OK.

Kaitlynn
So, this is something we still have to finalize, like what exactly the educational materials we want to out there, but some of the educational materials do talk more specifically about not necessary suicide safety but gun safety in general.

Vimbai
Okay, awesome. What will you say your priorities are because we talked about your goals and things you are trying to do.

Kaitlynn
I think our priority in the community is just to educate lethal means safety and in turn reduce death by suicide, especially by firearms, but in general, reduce death by suicide.

Vimbai
Ok, awesome. And I think the next question for you is what role do you think the workgroup has in contributing to the zero-suicide model.

Kaitlynn

So, I'm also part of the zero-suicides group. Within the VA, we have a structure that similar to zero-suicide. I'm not super familiar with the model just yet and still have to do a bit more research. In general, I mean we're working toward that concept of zero-suicide and that's our ultimate goal is to eliminate suicide in the community.

Vimbai
Awesome. Thank you. I guess another thing I want to know from you is what your data requirements are? And can you talk a little bit about those data requirements, which one is your priority, which one are you really focus on getting as soon as possible?

Kaitlynn
Like I shared in my email, I think really the only data requirement that we really have is just keeping up with the data on lethal means, what means are being used for suicide in Tompkins County and to make sure that our action plan is on point with what's going on in the community. That's so important. We get to a point where firearms aren't the primary means. Then we would probably want to take a look at our action plan and kind of pivot that to what strategic plan we want to focus on for what means is happening most in the community. So that would be our priority, and I think really the only one that we necessarily need.

Vimbai
Where have you previously obtained those data?

Kaitlynn
One of our group members actually obtained the data. It's a website. Let me open real quick. It's the "Ithaca is Fences". I can share with you guys.
http://www.ithacaisfences.org/suicide-statistics-for-tompkinscounty.html#:~:text=Distribution%20of%20means%20of%20265,for%20only%2011%25%20of%20suicides
The numbers that we were looking at were from 1993 to 2010, so they are kind of outdated. I had talked to Sally about that there is a current MOU with this office to obtain these numbers, but I guess you guys are on it!

Vimbai
Yes, we are definitely trying to get that for you guys. Okay, that's awesome. Previously when you guys were going out to get these data, what types of setbacks have you faced in acquiring the data you need?

Kaitlynn
For this specific data, I just think sometimes it's hard to form those relationships because of confidentiality and things like that. In a lot of offices, not specifically in Tompkins County but I think in counties I cover at large sometimes, it can be quite hard to have those MOUs or understanding between these offices. We don't necessarily want to know who these people are. We just want to use that data to support our initiatives. So kind of being able to have that conversation and decipher between what they kind of think we were and our goals are is so important, and sometimes it's a hard conversation to have.

Vimbai
My final question I have for you is that I want to find out are there any other organizations in Ithaca that are also working towards? I understand you are obviously working with VA, so I know you kind of have the perspective on people who are currently serving. I want to know do you have any other organizations that you work with that are looking at this particular demographic here in Tompkins County? You know things like stop soldier suicide that type of thing?

Kaitlynn
We have a variety of different agencies across our entire touchment area. I can't think of any Ithaca specific offices on top of my head, but there are a plethora of different organizations that we are working with. We have a partnership with SU through their veterans program and a variety of different other community agencies.

Vimbai
Yea, Thank you so much Kaitlynn and that's all we have for you! We will take these data and try to do our best on our end to bring value. Because of the time constraint, even if we don't do everything within this semester, we will hand it over to some other students next semester. We will continue to see what can be done about it. Feel free to reach out if you have anything to inform us anyway or help us do this. It will be great.

Kaitlynn
Sounds good!

Appendix C

Transcript of Interview with Scott Macleod on December 3, 2022

Scott MacLeod
The prevention of suicide as it relates to the health care services in the community. So 0 suicide is really a model that is focused on healthcare entities or providers. But you have lots of things that you can do to promote suicide prevention in the healthcare sphere that's not necessarily 0 suicide. So our work group is focused on 0 suicide at the moment. But it's not all we will be doing. and like one of the things we'll be doing, for example, in our next, we will be discussing the possibility of holding some public forums to introduce the public to what's available in the community for suicide prevention for individuals to educate themselves, to get training, and to introduce them to the 0 suicide model but that's kind of like public information, public communication outreach. So it's not necessarily part of the 0 suicide model.

Vimbai Mudangwe
01:21
Okay, awesome. Thank you for making that distinction for us. I think that's pretty important and if you're comfortable, I would like to begin the interview. So, as I previously mentioned. My name is Vimbai, and I will be leading on interview today. We'd like to keep this interview to 30 to 40 min, or whatever you're comfortable with. And I want to remind you that participating in this interview is very voluntary, and you can leave at any time we'll skip any question that you want and if you need to take a break. Please do let us know. And during this interview, i'm going to just ask you a few questions regarding the data work group and some of your data requirements. And the first question I have for you, Scott, is to please brief us on the role of the 0 suicide work group. and I know that you've already kind of covered that. Could you tell us a little bit about like the priorities that the subgroup has, and your goals as well?

Scott MacLeod
02:26
Yeah, I think to be more helpful to you, allow me to pull up our strategic plan, because what we do follows that strategic plan perfectly. I'm sorry I wasn't prepared for this because I thought this was going to be more of a discussion than an interview per se. So I didn't have this.

Vimbai Mudangwe
03:35
No, that's completely fine. They just have us, you know stick to a pre-approved interview Protocol

Scott MacLeod
03:42
Just I wasn't really. I thought you were just contacting us to consult on how you can best support the coalition in these areas. So I was not aware of how this was going to go, but that's fine. I just wanted to would have called this up before. That's completely fine. So I'm sorry. Why would you repeat your question again?

Vimbai Mudangwe
04:21
Yeah, sure. I was just asking if you could please brief us on some of the group's priorities as well as your goals.

Scott MacLeod
04:33
Yeah. So so our work is supporting the goal of the strategic plan. I assume that you see that so? that goal is basically to advance quality improvement for suicide care in all compass, county health, care, and behavioral health settings so that's the overarching goal. But then we have specific objectives, and one of them is to promote and facilitate help facilitate the implementation of the 0 suicide model in major health care and behavioral health settings and also to promote and facilitate implementation in primary care practices and in clinical therapy practices. So we are very focused on implementing. And you know, seeing the suicide model implemented across health care. One of our which has already been achieved was to form a 0 Suicide Steering Committee which had its first meeting on November 11, and that steering committee is made up of senior healthcare leaders among the main providers in Thomas County, and they will be working to collaborate and coordinate the implementation of 0 suicide in their entities as well as across health care systems and accounting. And another goal, we add, was to another objective we had was to point to a suicide coordinator for the county which we have done. so that's part of our coalition goal and our work group is designed to push that go forward. And now, as relates to now that we've got the work, the steering committee working, and we have a coordinator working with it during committee. Our work now is really just to monitor the work of that steering committee and support that steering committee as best we can. So we're looking at things like helping to identify training gaps because to be implementing 0 suicide. A big part of the well-trained staff is generally lacking in suicide prevention training. And so we're. We're working to identify training needs and identify resources that can provide those training. That's pretty much what we're doing in the group for health care. As I mentioned earlier, we are exploring the possibility of having public events to introduce a 0 suicide model to the general public to, you know, introduce the concept of suicide prevention in general to the public.We're looking at possibly working with the youth group I'll talk about after to bring Suicide Prevention awareness to schools, 12 schools, and to the college campuses. So that's what I get to the health care group. Talk about the youth group now, or is that separate?

Vimbai Mudangwe
08:14
No, you can go ahead and talk about the group as well.

Scott MacLeod
08:19
Yeah. So they used to you know, the overall goes to reduce the side of terms in the youth population including the students attending local colleges in Thomas County, like Cornell, so our objective is there too. For me, it facilitates suicide activities in schools and the community, in general, to do the same on college campuses and to promote it will take gatekeeper training, such as the method of first aid. in other words. that youth group is designed to promote suicide, prevention, education, but also to a limited training because gatekeeper trading. It's so important

for people who are serving the community of students. It's often, you know, educators, for example maybe be the best people to identify…struggling a bit, struggling a lot, and if they have training in how to identify somebody in their struggles, and to be able to steer them to the right resources and to encourage them to get support. That could be life saving role that that person can play. So we're really that. That's one of the things that we're working with, You know. You probably are aware that this strategy you put on this last February. The workgroup really only got going and so, you know, we have lightning speed on implementing our plans, we're still working on a lot of these things. We have made a lot of progress on that 0 suicide steering committee and coordinator. The providers talking about this and working with the TCSPC itself have no implementation in our role. We are not a health care agency, we're a coalition of well-intended people who are trying to, bring suicide prevention and to, you know, kind of advocate for, those who are in a position to advance greater efforts for suicide prevention.

Vimbai Mudangwe
11:31
Okay. So 2 questions. One. You spoke about having that steering committee up and running, in terms of like oversight, Are you guys taking care of that like, who's to see, how are they doing? How is everything going with that?

Scott MacLeod
12:24
No, the steering committee would be under the purview of the health care work group.

Vimbai Mudangwe
12:28
Okay.

Scott MacLeod
12:30
And you, you would ask me, I think, about what is the role of the workgroup over the searing committee. So it kind of came together organically after advocacy by the Sophie Fund and by the coalition at large. But the idea for this, the steering committee was that the leading healthcare providers, and Thomas County, for example, the hospital. for example, the County Mental Health clinic. for example, family and children. the idea really was that they would take ownership of this and that we encourage them to create the steering committee. But once they agreed to create it the idea really was that they would run it themselves and that it would not be a committee of the Suicide Prevention coalition, it would be independent, but we requested, and I believe that they are going to approve, that that they report to the coalition 4 times a year about the work that they're doing. And so our work will be monitoring those report backs that they do and then we have. You know we have the right as a coalition to do whatever we want. So one thing we will be doing is that we feel that there is a need or demand. We will not wait for the coalition. We won't wait for the steering committee to request things from us that they can do. We will initiate things with the steering committee if we think that it's useful for them to have that input. For example, if we identify training opportunities we would let them know about that. Maybe they already figured that out themselves. But we would proactively support the hearing committee in that way. We have a health fellow in the County Health Department who has been

appointed to be the steering Committee's Coordinator or the 0 Suicide Coordinator, and she will be working with the steering committee and essentially serving as a liaison back to our coalition.

Vimbai Mudangwe
14:53
Oh, nice is that Zoe?

Scott MacLeod
That's Zoe.

Vimbai Mudangwe
Okay, okay, that's awesome. And now that I'm finding out that you guys simply you guys the coalition don't really have an influence and don't play an implementation role. My question would be, then, from an evaluation perspective, because you guys are pushing out all these great initiatives. How how do you guys obtain the data to see how you're doing? Because essentially what you're doing is you're pushing all these great initiatives and putting them up in the hope in that all the relevant stakeholders will implement them. But how do we know? Are there any numbers that you get back in terms of like how the suicide rates are doing like? How do you know that what you are doing is working? If that makes sense, is there any data that you get back?

Scott MacLeod
15:40
Yeah, no, that's a very good question. So have you seen the strategic plan?

Vimbai Mudangwe
15:46
I think we have. But I've been going through so much information, Scott. If you have it, you can just drop it in the chat. That will be so great. I pretty much live in this project, so I'm just looking at the information all the time. I don't know what I've seen, and I haven't seen anymore.

Scott MacLeod
16:06
Yeah, so that's the plan. I just put it in there. Yeah, so every one of the 5 goals has an evaluation plan. The evaluation will depend on what the goal was and what is needed to evaluate that command that goal. So if I go to goal 2 which is, you know, the group, the work group on health care. You'll see that it's for evaluation. We want to determine the number of healthcare and behavioral health providers who are committing to adopting the model. At what stage are their implementation efforts? Yes, things have happened already, right? And then we're looking to get funding for that coordinator position going forward. So that's something that's very, you know tangible as well. and then we'll make some kind of a subject to judgment about whether they have actually created meaningful collaborations to move 0 suicide forward. But on those first points that we will be relying on Zoe and the steering committee itself to report back on. Have they committed to having the individual providers who make up the steering committee? Have they committed to adopting the model? Yes or no. if yes, at what stage are they in their implementation efforts? There, there, there's a whole, as you know. There's a whole protocol, a

series of protocols for implementation. So it's not going to be you know. done with a flick of a switch overnight. It's a step-by-step process. And one of the things regarding the implementation level or stage level would be your workforce trained to implement. Have you adopted the specific care Protocols… all for the model we are using? Or are you still using outdated protocols? So those things are fairly easy to determine. But we'll be relying on the self-reporting at this point to tell us where they are.

Vimbai Mudangwe
18:57
Okay, yeah, alright, awesome. Just a little bit concerned because I was like. You know, you guys are doing all this great work, and it would be great to kind of see how how it's going to see if you need to readjust the plan, or if there's anything else that needs to be done.

Scott MacLeod
19:10
Yeah, I would. I would add something there. I mean, you bought a really pivotal point when you made that remark. So we're not boring you with the whole long story of our initiative. The Sophie Fund launch the 0 Suicide initiative to Tompkins County in October of 2017. We brought the healthcare leaders togethe for a very high level briefing by one of the developers of the model themselves. So would that be the watershed declaration. I can email you some stuff that has this timeline in it. So we initiated that the Suicide Prevention Coalition, then took up the initiative, and they adopted it in 2018 and we had, I believe, 7 providers in Thomas County step up to say, we will commit to working toward implementation. And then what happened after that's not really that clear, because there was not really any follow-up by the coalition. The coalition had some growing page if I can put it that way, and, we had some transitions and leadership with the coalition. They would take the leadership. But then we had the COVID-19 impact on the bandwidth of healthcare providers. And so we really had a couple of years there, where although the county had moved to a step up to 0 suicide, it kind of withered away to really not being very cohesive initiative. And so, What happened? As COVID was lifting a bit, the Sophie fund in 2021, basically did a 0 suicide initiative 2.0 to bring back those healthcare leaders, the new generation of those healthcare leaders to relaunch the initiative. And then we had a series of 5 presentations and training over the course of 6 months to kind of put this back on the radar of everyone. And then the last one of those meetings which were last July in 2022. That was when the healthcare leaders agreed to form a steering committee to take it forward. Unlike what happened in 2017-18, we now have a mechanism for driving the initiative, and we have the coordinator. We hope that the Steering Committee will send the coalition these reports 4 times a year to update us about their progress. So there is this kind of accountability and implement sort of evaluation mechanism which we lacked initially.

Vimbai Mudangwe
22:30
Oh, thank you for that, Scott. I guess my next question for you. I'm just getting back to the protocol here. I wanted to find out from you what are the data requirements or needs that you know the 0 suicide subgroup, and that your subgroup has. And then please, could you just tell us what the priorities are in terms of that data?

Scott MacLeod
22:56
So that's sort of what I wanted to have a conversation with you about, because i'm not sure. So we have a data work group that I believe you've worked with. Yes, so a lot of the data that we need for the health care work group and the youth work group is the same data. I believe that the data work group is working on this. So that would be like the mortality data like we need to know. We need to have the best information that we can get about suicide in Thompkins County over a spectrum of time. We need to have a breakdown of that data by age, gender, by by race, by you know, education level, I mean everything imaginable. We need to have that data really, as a starting point for everything. The coalition is doing alright. We have some data, but it seems to be very incomplete. And I know Zoe is working with the Health Department to try to improve that data. I don't know how much she's able to share with you or has shared with you. But that's a key thing like that. If we were to have accurate data, we were able to see that in the last 5 years there were 20 suicides in Thomas County, and 18 of them were college students attending the local colleges. It tells us that's where our coalition needs to focus a lot of its work. But if we found that 18, this is obviously hypothetical, or of course, of course, if we're 18 out of 20 you know, were school age, African American girls, that tells us hey, there's a problem in this community, and our coalition really needs to get a handle on that and see what how we can support that. That. So the data is so important for all those reasons. I've had ideas about..Maybe this is a very long-range project, but I've had ideas about how other types of data can be useful for the coalition and for our work groups. Besides the actual death data you know, suicide, a tip data crisis calls to crisis service lines 9 11 one that relates to suicide or not relates to suicide. For example, what percentage of calls to 988 are just crisis calls as opposed to suicide calls? And then, another thing that I think the health care you would like to see, but this is really, for the whole coalition is things like, what are the training levels presently at. Maybe even we just take 3 or 4 providers as a subset to focus on. But like at the hospital, what percentage of clinicians there are actually trained in the 0 suicide protocols right? What is it currently like right now? how many finishes do they have? and how many of them have been trained in these various protocols? Let's do another survey in 2 years to see if that's improved. So that's the kind of other data that I think could be quite useful. Another thing that's very important, I think, is knowing the comfort levels of clinicians. For example. you might be trained in treating patients with suicide allergies. You might not be comfortable doing that. This is an obstacle to our ability as a community to successfully support our patients who are suicidal. So that this is, the New York State Office of Mental Health has done surveys where they asked physicians those 2 questions: what's your level of training? Well, what's your level of education in treating suicidal patients? What is your level of post-grad training? what is your comfort level? And those answers really help to provide us with knowledge of: Where work needs to be done. Because, let's say, for example, a 100% of the have been trained, but only 25% are comfortable with the cap suicidal patients, and we need to find ways of educating and trading those to have a better comfort level. So those are a couple of things that go beyond just death. The same would go for the youth group, you know. I think ideally we'd like to have numbers of how many school staff there identified as people to deal with the mental health of their students. And then, once we have a number of how many, let's say Tompkins County, 100 staff members at the various schools throughout the county. This is your job to work on the mental health of our students. How many of them were trained in suicide? Prevention? How many of them have gatekeeper training? And another thing on the use side, I think that would be useful is, we do have youth risk data. That's

done by the CDC. As well as we have some local versions of that. I think the analysis of that data would be very useful to have. And there, there may be a way that this is, these are taken by the youth themselves. I could see our coalition doing a kind of parallel survey of school staff to ask school staff about their level of training and their level of concern for their students, their level of comfort in dealing with students who have mental health issues that's probably a longer-term project that we'd have to get the schools to agree to. They're generally reluctant to take on more surveys. We, the Coalition, tried to get them to participate in this kind of survey, and really couldn't get it, so we dropped it for the time being. But that's another kind of data point that I think would be useful for us. It would be very useful for us, if you actually made recommendations, on what kind of data avenues we should be approaching. What? What, what do you see? As valuable ways of acquiring data? It could be interesting for us.

Vimbai Mudangwe
32:26
Okay I'll share what you've told me today with our professor. Her name is Danielle, and she's the one who's kind of hitting this project, and see if that's something that she will take into consideration in terms of like, maybe reshaping the project for the following semesters, because I could see how that would be very helpful because this is just coming together of minds. They might be some of the data points that somebody might think of that. Just listening to you, now I was like, oh, yeah, I could see how that would be a data point that would be really helpful, especially regarding things like the training at the schools just looking at Cornell. I recently was looking at their website. For that, I don't know if you're aware of the work that the scoring center seems to be doing, or it seems to be saying that they're supposed to be doing, and I know a lot of that was focused around education and training of staff regarding different things like mental health. social. So that type of thing. But I don't know how effective that has been, or you know how many people are actually taking part in that. And even just thinking about what you mentioned, where you said that you want to know which staff are actually dedicated specifically to mental health issues. Do you think that they have staff there that are using like regular staff or also looking at mental health issues, or they don't have designated mental health training? I know they have some that they list on the website, maybe 12 of them. From what I see, they've got pictures up there, but that's actually a new thing that I hadn't thought about like, do they also have regular staff tending to mental health patients or potential mental health patients? And if so that would not be particularly a good thing, because they don't have the training or the comfort levels we just discuss. So that would be again a pain point.

Scott MacLeod
34:17
Are you referring to Cornell specifically?
Yeah. So in my remarks earlier I was thinking I was really referring more to the K through 12 school districts because the college campuses have dedicated health centers, and they have better health staff like in the capital which you are familiar with. And so that's kind of another area I think our coalition in our work group wants to be engaged with the college campuses, about what they're doing, and how we support their efforts. But, frankly speaking, their efforts are pretty robust compared to what's happening in the school districts.

Vimbai Mudangwe

35:08
Oh, okay.

Scott MacLeod
35:09
You know, like there's no school district that has a mental health clinic you know. So they have a social worker who would be trained for students who have mental health issues, and they would have, maybe a disability coordinator. But that's a lot different than you know where you have. You can set up regular appointments, and you have really trained pretty well-trained staff in those in those centers like, for example, at Cornell. I know that all the Cornell counselors and the clinicians and mental health clinicians They've been trained in the most up-to-date suicide prevention…What do you call it?... Not treatment per se, but you know the screening process. And how to engage people who are at risk of suicide in those basic early stages. Counseling sessions are made for people with serious suicidality. They're going to need more than a college counseling center. They're going to need a private therapist that they can see on a regular basis, but that being said, the colleges have a much more robust system than the school districts have for treating mental health. Not sufficient, in my opinion, but it's it's considerably more robust than you would have in this whole district. So as for the college campuses. I mean, I think, that the same survey, or the same data collection could be done on the college campuses like there's a wide discrepancy or disparity. It would serve the coalition well for us to be able to know in more graduate detail what is going on on the campuses for supporting students with mental health issues for the coalition that for now, students, if we want to, just look at Cornell students. All Don't only receive mental health services from the Cornell Health Center, Many coordinate students to support in downtown clinics or in private clinic private practices downtown. Colleges have arrangements with outside providers to be a type of outsourcing of mental health services. So it's done by Cordel employees. It's done by people with a contract with Cornell, so the fact that the community, one way or the other, is involved in supporting our local college students. That makes it a concern of the coalition that we can't just say, okay, you guys are a college. You've got your own deal going on. We don't really need to. We don't really care what you're doing it. It's it. The college is too bled into the community, and vice versa for us to say that it's not you know, of concern to the coalition. So we definitely would like to have that kind of data from the coalition as well.

Vimbai Mudangwe
39:13
Yeah, that would be. That's awesome. That's a lot of like eye-opening. Information. Thank you. My next question and final question for you is, what are the setbacks you've faced in terms of acquiring the required data for either subgroup? When you guys let's say you want mortality rates and that kind of stuff like what is what are the main issues?

Scott MacLeod
39:36
Defer to Zoe, because I believe that she is at the pivot point of working on this very issue, because of the data, whatever data exists, it has to come from the County Medical examiner and the healthy partners if there, if there is, if they're not keeping good records, that's another issue. But assuming that they are keeping good records. there's really little that the coalition can do

except as the Health Department for the data. I believe it was not so. She would know better than me, but I think it was not really collected and collated very well until now, and maybe they're going to improve that. But whatever data is available, you have to come from the Health Department. And so my knowledge, you know of the data, it was not good until now. it was really just that it wasn't a priority to focus on collecting data for suicide prevention purposes. That data is in the archive somewhere. Somebody needs to go in there and pull it out. Another problem with data in general is that, as you can see, the cause of a death is somewhat subjective. I think just this is a national issue, where somebody could die of a drug overdose, and if they didn't leave a suicide note, if they did, it somehow obviously fly that they were planning to die by suicide. It could be suicide. It doesn't mean it's not because they didn't do that, but it also could just be an accidental overdose. And I think that there are signs when it's intentional like, if there's a massive amount of drugs that were taken, even if you don't know that. That would probably indicate that it was a suicide death. But you could have a medical examiner who just wants to be careful. You'll PIN this stigma on this desk that knows themselves. So if they're not 100%, sure they may error on the side of, although that probably is suicide. So if you look at data across the country, we probably have a lot of other reporting particularly when you look at the nexus between addiction and suicide, there's a lot of addiction desk that most likely, or suicide. But if they did leave a note. The examiner really has a kind of, you know, discretion, how they want to identify that, so that that that that exam could be very religious, and maybe they want to be careful, and how they would put that on the death certificate. you may have some conservative counties, where it's very much stigmatized suicide, and they may not want to put that out there that we have suicides in our county. In rural counties, there may be intellectual families. You'll have a problem with that family. So many ways that these could be underreported

Vimbai Mudangwe
43:36
Hmm. Yeah. All right. I think you've given us so much to work with here on the spot, and I think as a takeaway, I think we're going to definitely need to touch that touch base with Zoe just to kind of understand more about what's going on with getting that data from the Health Department and working with the medical examiner and the kind of stuff she's been facing. But yeah, I think for me that's all I have for you today, and if you're open I can always shoot you some questions, and then, if we have anything, and you can just get to it when you get to it. I know you're quite busy.

Jiayi He
44:13
I have another question. Are there any actual barriers to acquiring data in the youth population or other barriers that the youth focus group has in acquiring data?

Scott MacLeod
44:31
So we we would be needed to rely on that that generalized data or suicide deaths and suicide attempts and so that getting that data is not the responsibility of the health care work group or the youth group, it's really the data group that's focused on that.

Unknown Speaker
44:55
Okay.

Scott MacLeod
44:56
We, as a youth group, don't have any special problems other than we're waiting for the data group to advance our knowledge of the data.

Vimbai Mudangwe
45:16
All right.

Scott MacLeod
45:19
I just wanted to say regarding the youth. you know other data, things that we would love to see is once we have some… Oh, going back to suicide attempts. I'm not well aware that anybody really collects that in kind of a holistic way. I don't believe the County Health Department does. So that's potentially a risk. This a rich area for your project to help us with suicide attempts, because there is data out there. But some of these to pull together. I mean our our coalition can do it. But if this is something that you're consulting on you got the suicide prevention, crisis line in Ithaca. You've got 988. You got the 911 number. You've got emergency rooms that have suicide attempt people arriving for treatment there. So it would really be important to try to get some data on suicide attempts. And then I wanted to mention another data issue. I would really like to be able to, particularly where you are concerned. I really like to be able to look at pure comparison like once we like, for example, in Thompkins County we have a kind of a youth risk survey that's done, and it gives some pretty good information about self-harming and suicidal thoughts and things like that. I'd really love to compare that data with peer counties in upstate New York and even with statewide and national figures. We want to know, Do we have a problem, a special problem with youth depression, anxiety, and suicide, aid, ideation, discounted or not. That kind of peer comparison would be really important for us. In the same way, I would love to be able to compare mental health data with peer institutions. I don't know if that's possible, but that could be very interesting for our coalition to know about and for Cornell about it they don't already know. Yeah, I think that would be a big piece there. The first one is our suicide prevention page and a lot of information there about suicide prevention. I think that there's a timeline in there about so much funds work, but also work that's been done on the page as well. That has a lot of information about what has been done in Thompkins County regarding the the 0 Suicide initiative.

Vimbai Mudangwe
48:25
That's perfect. Thank you so much, Scott, and then feel free to send me that stuff that you said you could send me in terms of the timeline. But if there's anything that is not on the website…

Scott MacLeod
48:41

I just did it. It's it. That's the most complete written information you will find on suicide Prevention and 0 to the side of Tompkins County. Okay.

Vimbai Mudangwe
48:59
Okay, so it's gonna be okay, that's perfect. Yeah, i'll definitely have a look and kind of see where we're at.

Scott MacLeod
49:02
do a deep dive. No other agency or organization has put this kind of material together before.

Vimbai Mudangwe
49:10
Okay. Okay, that's great. Okay, we should do that. Let me know if there's anything that you think of that would be of any help, Scott, or anything that you feel like you guys need. Maybe I can put forward to my professor in terms of modifying the projects going forward. But yeah, other than that, Thank you so much for your time

Scott MacLeod
I apologize for the difficulty in getting this first connection going. But I am at your service any time

Vimbai Mudangwe
49:48
I appreciate that Scott and i'll let you know if i'm kind of so working on this going into next semester for my other project. Then I think definitely you would be a useful contact to have.

Scott MacLeod
No, I would like to know more about that. I would like to support you if we can.

Vimbai Mudangwe
Okay, that's awesome. I'll be sure to shoot you an email kind of see where I've definitely mapped out some stuff, so I might throw you a link to the map, and if you can point out anything that i'm missing, or something that shouldn't be somewhere that will be extremely helpful.

Scott MacLeod
Be happy to do that. Thank you so much. Thanks. Guys really appreciate your work.

Vimbai Mudangwe
50:22
Thank you. Thank you.

Scott MacLeod
50:30
Take care. bye, bye.