

suicide prevention strategic plan

SANTA CLARA COUNTY SUICIDE PREVENTION ADVISORY COMMITTEE | JUNE 2010



This document is dedicated to Santa Clara County residents who have lost their lives to suicide, those who have experienced the tragic loss of a loved one by suicide, those who are survivors of suicide attempts, and those who may contemplate suicide now or in the future. May this document serve to inspire individuals, organizations and communities to implement strategies needed to protect our county's greatest resource—our residents.

This work is intended to honor and memorialize all whose loss and struggle has inspired us to take action.

Santa Clara County Suicide Prevention Advisory Committee

Co-Chairs

Hon. Liz Kniss, Santa Clara County Supervisor, District 5
Victor Ojakian, Santa Clara County Mental Health Board Member

Santa Clara County Board of Supervisors
Hon. Ken Yeager, District 4, President
Hon. Dave Cortese, District 3, Vice President
Hon. Donald F. Gage, District 1
Hon. George Shirakawa, District 2
Hon. Liz Kniss, District 5

County Executive
Dr. Jeffrey Smith

If you or someone you know or love is in crisis, there are services, resources and help available at Santa Clara County's -

Suicide and Crisis Services (SACS) Hotline
Toll-Free
1-855-278-4204

National Suicide Prevention Lifeline
1-800-273-TALK (8255)

For Veterans
1-800-273-TALK (8255) press 1

Additional resources also are listed on the Santa Clara County's Mental Health Department website: www.sccgov.org/spac under the Suicide Prevention and Local Resources section on the Suicide Prevention Resources page.

Giving People Help and Hope
Santa Clara County Suicide Prevention Action Plan

TABLE OF CONTENTS

A Message from Supervisor Liz Kniss and Vic Ojakian,
 Co-Chairs of the Santa Clara County
 Suicide Prevention Advisory Committee..... 9

Santa Clara County Suicide Prevention Advisory Committee
 Members and Staff List with Special Acknowledgements.....10

Introduction 13

I. Why We Care..... 17

- The Impact of Suicide in Santa Clara County..... 17

II. What We Did 21

- The Committee Planning Process..... 21
- The Planning Approach..... 22
- Planning Steps..... 25

III. What We Learned..... 29

- Language Counts..... 29
- Local and National Suicide Data..... 30
 - Suicide by Age..... 31
 - Suicides by Lesbian, Gay, and Bisexual Individuals..... 32
 - Suicide by Race and Ethnicity..... 33
 - Suicide by Gender..... 33
 - Suicide by City 34
 - Suicides among Custody Populations..... 35
 - Suicides by Military Personnel—Active Duty, National Guard,
 Reservists and Veterans..... 36
 - Other Possible Correlations: More Data Is Needed..... 38
- Suicide Risk and Mental Illness..... 41
- Suicide Risk and Alcohol Consumption..... 43
- Suicide Risk Factors and Warning Signs..... 44

▪	Factors that May Protect Against Suicide.....	45
IV.	Review and Summary of Local Needs.....	49
▪	Local Needs Across the Lifespan.....	49
▪	Additional Strategies: Community Education and Information.....	55
▪	Additional Strategies: Communication Practices.....	55
▪	Additional Strategies: Policy and Governance Advocacy.....	56
▪	Additional Needs: Data Monitoring and Evaluation.....	57
▪	Local Suicide Resources: A Range of Services.....	57
▪	Pending and Future Additional Prevention Resources.....	58
▪	What Experts Recommend.....	59
▪	Best Practices – Evolving Knowledge.....	59
V.	What We Recommend – Five Overarching and Interconnected Prevention Strategies.....	63
▪	Strategy One - Implement and coordinate suicide prevention and intervention programs and services for targeted high risk populations.....	64
▪	Strategy Two - Implement a community education and information campaign to increase public awareness of suicide and suicide prevention	68
▪	Strategy Three - Develop local communication “best practices” to improve media coverage and public dialogue related to suicide.....	72
▪	Strategy Four - Implement policy and governance advocacy to promote systems change in suicide awareness and prevention.....	75
▪	Strategy Five -Establish a robust data collection and monitoring system to increase the scope and availability of suicide-related data and to evaluate suicide prevention efforts.....	79
VI.	Next Steps.....	85
VII.	Appendix.....	87
▪	Attachment 1: Suicide in Santa Clara County by Zip Code, 2000-2006 Suicide-Homicide Comparison Table.....	89
▪	Attachment 2: Santa Clara County Community Agencies and Programs that Interface with Suicide Attempters, Victims, and Loved Ones.....	93
▪	Attachment 3: Best Practices Recommendations.....	97
▪	Attachment 4: Summary of Public Forum Input.....	103
▪	Attachment 5: Palo Alto Unified School District Suicide Prevention and Mental Health Promotion Policy.....	125
▪	Attachment 6: References.....	131

A Message from County Supervisor Liz Kniss and Victor Ojakian Co-Chairs, Suicide Prevention Advisory Committee

Suicide devastates families and takes a tremendous toll within communities. Our nation loses approximately 30,000 lives to this tragedy each year. Every 16 to 18 minutes another person dies by self-inflicted causes. In Santa Clara County, death by suicide occurs, on average, every three days.

When someone dies by suicide, the tragedy isn't limited to the loss of life and human potential. The heartbreaking pain, intense grief and overwhelming sorrow loved ones experience are complicated by feelings of anger, shock, and second-guessing.

The issue of suicide was brought to the forefront of our communities' attention in 2009, prompted by the suicide of four adolescents in a less than six-month period. With a renewed focus on coordinated and effective suicide prevention services throughout Santa Clara County, the Board of Supervisors supported development of an action based strategy through a broad-based group of expert-professionals from a wide range of fields.

Vic Ojakian and I are pleased to have served as Co-Chairs of this dynamic group of individuals and organizational representatives. Vic is a member of the Santa Clara County Mental Health Board, a former Mayor of Palo Alto and, along with his wife Mary, a national advocate for improved prevention services since they lost their son to suicide in 2004.

The Suicide Prevention Advisory Committee diligently reviewed data, listened to experts and community members, and studied best practices in prevention and response in order to formulate an action plan in Santa Clara County. We would like to extend our sincere gratitude to the individuals who served on this committee for their significant contribution to the development of this draft plan.

In addition, we thank members of the public who attended committee meetings and/or participated in the April 28, 2009, Public Forum at which the data, deliberative process and preliminary conclusions of the Suicide Prevention Advisory Committee were enriched. Our thanks go out to each and every one of you who devoted your time, energy and expertise to this critically important endeavor.

While the current plan is a working document that is subject to change as it continues to be reviewed by the community – it is nevertheless an important blueprint for next steps. I urge all Santa Clara County residents to read this plan, think about ways in which you can add to its recommendations and/or help to implement its recommendations, and become active in this vital effort to save lives.

Hon. Liz Kniss, Supervisor, District 5

Victor Ojakian

SANTA CLARA COUNTY SUICIDE PREVENTION ADVISORY COMMITTEE

This broad and diverse group of individuals, representing a cross-section of our county, dedicated six months to create this plan. The work of this committee was imbued with the passion that comes, in large part, from personal experience with the pain of suicide. More than 60% of the individuals in this committee have either lost a loved one or friend to suicide or have attempted to take their own lives but, fortunately for us, lived so they could share their knowledge and achieve our goal to reduce the number of deaths by suicide.

Members:

Jeff Arnold, M.D.
Santa Clara Valley Medical Center Emergency Room

Maryann Barry
Santa Clara County Custody Health Services

Dennis Burns
Palo Alto Police Department

Ginny Cutler
EMQFF Child and Adolescent Mobile Crisis Program

Robert (Bob) Garner
**Santa Clara County
Department of Alcohol and Drug Services**

Mitch Gevelber, M.D.
**Santa Clara Valley Medical Center,
Adolescent Medicine**

Kelly Green, Alternate
San Mateo County Transit District

Michael Haberecht, M.D., Ph.D.
Stanford Counseling and Psychological Services

Melanie Hale, M.S., LCSW
Foothill College

Tiffany Ho, M.D.
**Santa Clara County
Mental Health Department**

Hope Holland
**Suicide Attempt Survivor / California Network of
Mental Health Clients/ Santa Clara Chapter of
National Alliance on Mental Illness**

Don Johnson, Member
**Mental Health Department's Ethnic and Cultural
Community Advisory Committee**

Jennifer Jones
**Suicide Attempt Survivor / Santa Clara County
Mental Health Department's Consumer Affairs**
Sheila Mitchell
Santa Clara County Probation Department

Dave Newman
Law Enforcement Liaison, South County

Bernie (Deacon) Nojadera
**Interfaith Advisory Committee,
Diocese of San Jose**

Cary Matsuoka
Santa Clara County Superintendents' Association

ThuHien Nguyen, Ph.D.
**Santa Clara County Mental Health Department,
Mental Health Services Act
Cultural Competency Coordinator**

Erin O'Brien
Association of Mental Health Contract Agencies

Joseph O'Hara, M.D.
**Santa Clara County
Medical Examiner-Coroner Office**

Mary Ojakian
American Foundation for Suicide Prevention

Chris Pacheco
Council on Aging Silicon Valley

Dan Peddycord, R.N., M.P.A./H.A.
Santa Clara County Public Health Department

Hon. Joe Pirzynski, Vice Mayor
**Town of Los Gatos,
Santa Clara County Cities Association**

Janin Rimper
Suicide and Crisis Services Volunteer

Amari Romero-Thomas
211 Santa Clara County, United Way Silicon Valley

Mark Simon
SamTrans, Caltrain, San Mateo County
Transportation Authority

David Sisson
Suicide Attempt Survivor/ Community Member

Wiggys Sivertsen
San José State University

Kevin Skelly
Palo Alto Unified School District

Pamela Smith Martin
Hospital Council of Northern and Central California

Tasha Souter, M.D.
Veterans Administration Hospital, Trauma Recovery

Nicole Squires
Policy Aide to Supervisor Kniss

Eddie Subega
Santa Clara County
Suicide and Crisis Services (Hotline)

Paul Taylor, Alternate
Momentum

Kris Wang, Alternate
Santa Clara County Cities Association

Lorraine Zeller, Alternate
Survivor and Peer Mentor

Staff:

Nancy Dane Peña, Ph.D., Director, Santa Clara County Mental Health Department

Elena Tindall, M.Ed., Santa Clara County Mental Health Department Prevention and Early Intervention Consultant
and temporary Liaison to the State Office of Suicide Prevention

Ky Le, Santa Clara County Mental Health Department Mental Health Services Act Manager

Jean McCorquodale, Mental Health Department Consultant

Tracy Hern McGreevy, Photographer

And, with Special Thanks to:

Interpreter- for simultaneous translation

EMQ for hosting meetings

Christine Nguyen for assistance at the public forum

CTI for Suicide Prevention Website Support

MIG, Inc. for graphic design and meeting facilitation

Introduction

When someone dies by suicide, the loss of that precious human life and the loss of that person's potential is only one of the anguishing outcomes: There can be no more heartbreaking pain than having a loved one end his or her life. Along with intense grief from the gaping hole in one's life, there is overwhelming sorrow about the loss that is typically mixed with a surplus of other tormenting emotions.

In Santa Clara County, death by suicide is the 10th leading cause of death. Our County ranks 54th out of California's 58 counties (with 58 being the worst) in the rate of adolescent self-inflicted injury.¹ Death by suicide occurs, on average, every three days; and there are 2 suicide attempts every day, and an estimated 14 suicidal gestures every day in Santa Clara County.

This troubling reality of suicide in Santa Clara County stands in stark contrast to our positive identity—to our sense of pride in being the largest member of the economic region called Silicon Valley, a world leader in development of new technologies and industries, where our cities are frequently ranked among the highest in the nation in overall health and safety. We pride ourselves as being civic-minded and welcoming of all who choose Santa Clara Valley as their home; and yet, one out of every ten deaths is the result of someone taking their own life.

This plan is the effort of many who endeavor to understand the enigma of suicide in Silicon Valley and to take a stand, together as a community, to prevent it. Our belief is one death by suicide is one death too many. One person struggling with despair and the contemplation of taking his/ her own life is one person too many.

Our mission is to bring community awareness to the issue of suicide and to engage a community effort to stop it. Additionally, as we do so, we hope to enlist the public in our effort to contribute to the success of other communities that endeavor to take action to prevent suicide.

We have organized the following report so that you, the reader, will understand how we went about our planning work, what we learned about suicide as we planned, and how we arrived at the five overarching recommendations of this Plan. Those recommendations, discussed in detail in Section V. What We Recommend, focus on community-wide education, policy development, data collection and evaluation, communication and media practices, and an array of suicide prevention programs and services. Some of the services recommended for all ages include:

- Screening and referral resources in primary care and other caregiving settings
- Training for professionals, service providers and community members on identification and response to individuals at risk
- Crisis Hotline and a single, countywide access point/telephone number
- Accessible, affordable and appropriate crisis, counseling and support services
- Mobile crisis unit
- Self-help centers in communities

- Phone consultation services
- Post-incident care for individuals and families after a 5150 episode (involuntary admission to residential psychiatric care for up to 72 hours)
- Public recognition of individuals who connect people at risk of suicide to resources
- Incorporating individuals who have survived their own attempts to die by suicide and individuals who have lost a loved one to suicide in the efforts to increase awareness and prevention

The Suicide Prevention Advisory Committee is proposing broad recommendations to:

- One:** *Implement and coordinate suicide intervention programs and services for targeted high risk populations*
- Two:** *Implement a community education and information campaign to increase public awareness of suicide and suicide prevention*
- Three:** *Develop local communication “best practices” to improve media coverage and public dialogue related to suicide*
- Four:** *Implement a policy and governance advocacy initiative to promote systems change in suicide awareness and prevention*
- Five:** *Establish a robust data collection and monitoring system to increase the scope and availability of suicide-related data and evaluate suicide prevention efforts*

Each of these broad recommendations, once endorsed by the Mental Health Board and local stakeholders and approved by the Board of Supervisors, will be developed into implementation plans, including well defined deliverables with budgets and specific procurement recommendations. It is expected that a significant portion of the funding for the plan components will be funded through Mental Health Services Act (MHSA) Prevention and Early Intervention Statewide Project funds; however, it also is anticipated that funding will be sought from other community resources, insuring this is truly a community-supported effort.

These recommendations and strategies are described in more detail beginning on page 63. In response to public feedback, this document has been designed to provide an overview in the introduction of the recommendations, followed by the details of how these recommendations were selected, and culminating in a more detailed explanation of each strategy and next steps. The Next Steps section of this document begins on page 85.

Please join us in a community-wide education and action campaign to reduce the unnecessary loss of life from suicides. Join us in choosing hope and action over hopelessness and inaction. **You can help** by learning about warning signs, reaching out to friends and family who are in distress with encouragement and information about ways to seek help, breaking the taboo by discussing suicide, and sharing the most important assets we have as human beings: empathy, comfort, support for our fellow human beings and the knowledge and ability to act as needed.

I. Why We Care

I. Why We Care

Most people are surprised to learn that **every year** more than one million deaths worldwide are caused by suicides; and **every year** there are an additional 10 to 20 million suicide attempts, often accompanied by serious injuries. Even in our own County, suicide is the leading cause of death by fatal injury.² The numbers are truly too large for us to ignore.

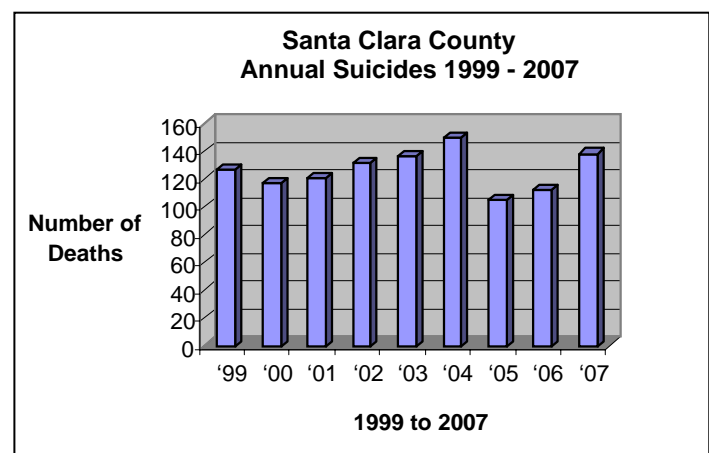
While suicide is confounding, **suicide is usually preventable**, given the right education, services and supports. Prevention for natural disasters and communicable diseases is typically centered on risk reduction. Likewise, prevention for suicide must be centered on risk reduction through a variety of means. Suicide is most often a fatal complication of different types of mental illnesses which are treatable. Just as with diseases of the body, the earlier treatment is sought, generally the better the outcome and the lower the risk of other complications. We are inspired by the success Australia has had in reducing the number of deaths among youth ages 16-24 by 57%³ and of the total national population by 30%⁴ between 1999-2005. We know that we, too, can make a difference in reducing suicide deaths in Santa Clara County.

As we did our planning, we learned that most services focus on intervention during a crisis, such as counseling someone who talks about taking their life, rather than on true prevention and earlier intervention. Most programs that play a role in preventing suicides do so only indirectly. As we did our research, it became clear that an effective community suicide prevention effort must consist of multiple strategies that knit together a comprehensive effort to impact suicide through broad, community-level education, public policies, formal media communication practices, and an array of coordinated and accessible culturally and socially relevant services. Fundamentally, the most significant prevention strategy is for a troubled person to be able to seek help and talk about how they are feeling with someone they trust. Offering this support and encouragement to get help is something we are all capable of doing. (Suicide and Crisis Services (SACS) Hotline, Toll-Free 1-855-278-4204; National Suicide Prevention Lifeline – 1-800-273-TALK [8255]).

The Impact of Suicide in Santa Clara County

An important step in our process was gaining an understanding about suicide in Santa Clara County.

In 2007, the most recent year for which this data is available, the suicide rate in Santa Clara County was 7.8 per 100,000.⁵ In contrast to the 7.8 suicide rate, the homicide rate in the same year was 2.6 per 100,000.⁶ **Many more people kill themselves than are killed by others** and



this is consistent with national data that show suicide is the 8th leading cause of death in the U.S., compared to homicide which is the 13th leading cause of death.

The 7.8 per 100,000 suicide rate equates to 140 individuals⁷ who lost their lives in 2007 due to their personal despair and loss of hope. Among older people (65+ years), the rate jumps to 14.8 per 100,000.⁸ Among males, the rate soars to 18.5 per 100,000.⁹

In addition, over the period 1999 through 2006, there were 5,971 suicide attempts, an average of 750 suicide attempts per year. Most attempt survivors had used poisoning or cutting/piercing as the means. Whites lead in the number of attempters (3,435 or 58% of attempters), followed by Hispanics (1,142 or 19%), and Asians (912 or 15%). Females attempted at almost twice the rate of males (3,925 to 2,046). Almost half of all attempters were in the age group of 21 to 44 years old.

In Santa Clara County, the hospitalization rate for self-inflicted injury among children and youth ages 5 to 20 is 30.6 per 100,000.¹⁰ This is the rate of self-inflicted but non-fatal injury hospitalizations and includes suicide attempts well as self-mutilation. This equates to more than 100 children and youth each year who so seriously hurt themselves or try to kill themselves that they require hospitalization.

This above data alone should serve as the community's "wake-up call" because we know, too, that 30% to 40% of persons who complete suicide have made a previous attempt. Although the majority of people who die by suicide have not tried before to take their life, nevertheless, a serious suicide attempt is a clear risk factor for suicide death.¹¹ The risk of completed suicide is more than 100 times greater than average in the first year after an attempt—80 times greater for women, 200 times greater for men, 200 times greater for people over 45, and 300 times greater for white men over 65.¹²

A Closer Look at Who We Are

- Santa Clara County population 1,857,621; sixth largest county in California; largest among 9 Bay Area counties
- 95% of the population is urban
- 15 cities
- San Jose is the largest city: population 1,006,892; 3rd largest city in California; 10th largest city in the U.S.
- Santa Clara County residents are:
 - 7.5% under 5 years of age,
 - 16.8% 5 to 17 years,
 - 64.9% 18 to 64 years,
 - 10.8% 65 years and over,
 - median age is 34.
 - 7,000 people are homeless in Santa Clara County
- Ethnicity:
 - White (Non Hispanic) 38%
 - Asian 31.2%
 - Hispanic 26%
 - Black 2.9%
 - American Indian and Alaska Native .8%
 - Native Hawaiian and Other Pacific Islander .4%
 - Two or More Races 2.7%
 - More than 100 languages and dialects are spoken
- In 2007, SCC became one of only 10 counties in the U.S. where more than 50% of residents speak a language other than English at home.
- A community-wide survey of the county's five largest immigrant groups revealed that immigrants from China (60%), Mexico (48.9%) and Vietnam (47.6%) were most likely to report not enough English as a barrier to obtaining services and education.



II. What We Did

II. What We Did

The Committee Planning Process

The **Santa Clara County Suicide Prevention Advisory Committee (SPAC)** is a 36-member, broad-based group of experts in the field; professionals in related fields such as educators and school administrators, law enforcement, public transportation, public officials, and many others; specialists in various age groups; mental health consumers and family members from diverse cultures and backgrounds; suicide attempt survivors; individuals surviving the death of a loved one by suicide; and concerned members of the public. More than 60% of the members have personal experience with either the loss of a loved one to suicide or as suicide attempt survivors. The personal knowledge of loss by suicide infused the committee's efforts with a particularly deep commitment to saving lives.

The SPAC was formed as a result of a recommendation from the Mental Health Department to create a local planning group for the purpose of developing a local suicide prevention plan and the acceptance of this recommendation by the Board of Supervisors' Health and Hospital Committee at its meeting of September 16, 2009. Already Santa Clara County, like other California counties, had contributed substantial amounts of its local MHS A Prevention and Early Intervention funding allocation to the California Department of Mental Health (DMH) to support state-administered, statewide projects. In December 2008, the Board of Supervisors assigned \$1.9 million in PEI funds to DMH annually for four years. One of these statewide projects was the development of the *California Strategic Plan on Suicide Prevention*. The *Strategic Plan* was intended to guide the development of future statewide as well as local suicide prevention efforts. Thus, with Board of Supervisors approval and under the leadership of the Health and Hospital Committee Chairperson Liz Kniss, the SPAC was established to create a local Santa Clara County suicide prevention plan.

The SPAC held its first meeting on December 9, 2009. Between December 2009 and May 2010, the committee met the second and fourth Wednesday of every month. Members of the public also attended the meetings and their participation was welcomed in all of the discussions and deliberations, including the "break-out" sessions which followed the whole-group dialogues and focused on needs and strategies by age categories.

On April 28, 2010, the SPAC's findings and preliminarily selected strategies were shared more broadly with the community at an extensively publicized and well attended Public Forum. Translators provided live translations from English into Santa Clara County's additional four threshold languages (Mandarin, Vietnamese, Spanish and Tagalog) and one of the break-out groups was conducted entirely in Vietnamese to better insure that all who wished to contribute were able to do so.



The Mental Health Department website was an important, ongoing communication link between SPAC members, staff and the public. On the website's Suicide Prevention page, meetings were publicized; all data and information that was shared at the SPAC meetings were available on an ongoing basis; and summaries of steps taken and preliminary decisions were presented. During the six-month SPAC planning period, the website received a total of 4,291 visits for a combined total of 6,954 "views," which is defined as the number of times visitors viewed particular pages.

The final plan will be forwarded to the Santa Clara County Mental Health Board in July 2010 for its review and further solicitation of public comment. It is anticipated that the plan will be submitted for review by the Board of Supervisors in August 2010. Implementation efforts will commence after formal approval by the Board of Supervisors.

The Planning Approach



The SPAC members were informed by the California Suicide Prevention Plan and studied both its approach and recommendations. They also were informed by each other and the vast experience of the group and other participants who came to share personal stories and information. It was clear at the onset of the planning process that the work was a matter of the heart as much as it was strictly an effort in strategic planning. From the first

evening, members moved through the planning process in a way that honored the deep emotional impact of suicide while they absorbed data and information and brainstormed about the needs in our community. This quality within the planning group resulted in guiding values for the planning work that were arrived at from the beginning of the process.

Guiding Values

- 1. Suicide is a community problem. It cannot be addressed effectively by only one system or agency.**
- 2. The plan should be informed by the people most affected by suicide—the survivors, the family members, the loved ones.**
- 3. People involved in this work should feel engaged.**
- 4. Suicide risk factors should be considered for every age group across the lifespan.**



5. *The resulting plan should not duplicate existing efforts but rather leverage them.*
6. *The community should own this plan.*
7. *The work must be culturally sensitive and competent.*
8. *The plan and efforts must be focused on continuous process improvement.*
9. *It is important that the plan is informed by public input.*

Planning Goals

Also, early in the process SPAC members agreed upon the following goals for the prevention plan:

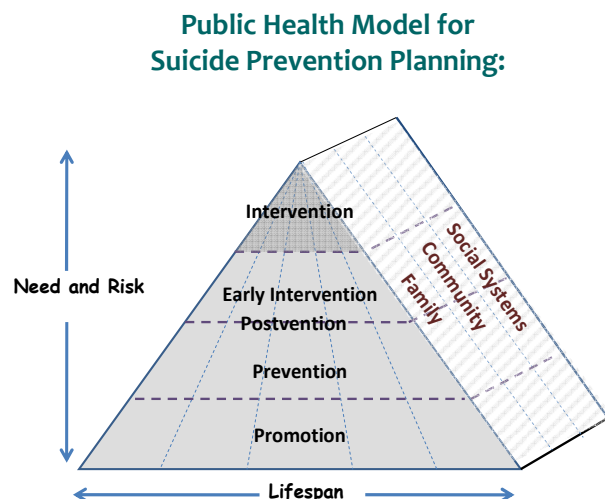
1. **Reduce deaths** from suicide in Santa Clara County.
2. **Increase awareness** of why people contemplate suicide and how to access available resources.
3. **Improve monitoring** of suicides using clear and comprehensive data.
4. **Empower people to respond** to a person who is considering suicide through training and education.

Conceptual Framework

During the process of developing a planning approach, the committee members were offered a conceptual framework to assist their thinking about suicide prevention that had proven successful with the County Mental Health Department’s (MHD) public planning efforts related to the Mental Health Services Act. The approach incorporates a lifespan perspective within an adapted public health model that aligns a continuum of health needs (in this case suicide) with levels of **promotion, prevention, postvention, early intervention, and intervention strategies**. The postvention strategy was added to the standard public health model to accommodate a strategy unique to suicide which is described below.

This framework allowed the committee and other stakeholders to consider suicide prevention needs from multiple perspectives—age, need and risk, intervention strategies, and recipient or target of the strategies discussed.

Working definitions of various types of interventions were utilized, again drawing from public health definitions used to differentiate types and intensities of



interventions. The committee also was informed that, generally speaking, strategies that are more preventive in nature are usually less expensive per individual served and can reach many more individuals than intervention strategies. By their nature, strategies that are more intervention focused serve fewer people for a higher cost per person served.

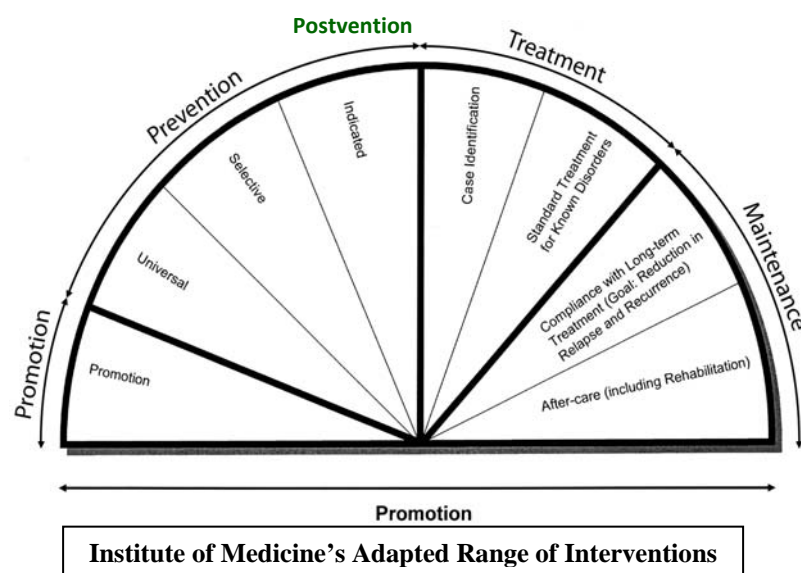
Promotion. While there is no precise, universally accepted definition of health *promotion*, the MHD utilizes the common characterization of promotion as “the enhancement of the capacity of individuals, families, groups or communities to strengthen or support positive emotional, cognitive and related experiences.”¹³ Strategies for mental health promotion are related to improving the quality of life and potential for health rather than amelioration of symptoms and deficits.

Prevention is concerned with avoiding disease, while promotion is about advancing health and well-being. Promotion and prevention overlap and should be complementary activities. “To prevent,” of course, means “to keep something from happening.” The Institute of Medicine prevention category is divided into three classifications—universal, selective and indicated. Universal prevention strategies address the entire population (local communities, schools, neighborhoods). In the context of mental health, selective prevention strategies target subsets of the total population that are deemed to be at risk for mental illness by virtue of their membership in a particular population segment (victims of child abuse, witnesses to traumatic events, etc.) Indicated prevention strategies are designed to prevent the onset of mental illness in individuals who do not meet diagnostic criteria for mental illness but who are showing early signs of distress (changes in thoughts, emotions or conduct).

Postvention consists of interventions after a suicide has occurred aimed at reducing the impact of suicide on surviving friends and relatives, as being exposed to the death of a loved one by suicide is itself a risk factor that greatly increases one’s risk of suicide, especially in youth.¹⁴

Early intervention involves identification of warning signs for individuals at risk for mental health problems and intervening early to mitigate factors that put them at further risk for developing mental disorders. Early intervention can prevent problems from worsening.

Intervention is used to describe practices and programs that are offered to individuals who are experiencing health problems



such as mental illness, and typically is associated with “treatment” and ongoing care provided by practitioners with specialized training in treating health conditions such as mental illness, substance abuse, and physical illness.

Planning Steps

The planning team designed and facilitated the committee process in a manner that the group followed ten planning steps in preparing the plan. It was agreed that the initial phase of plan development would focus on high level recommendations that would be further shaped into an implementation plan once approved. The planning steps are listed below:

1. Established plan goals
2. Identified personal values and guiding principles
3. Reviewed local, state and national data on suicide



4. Brainstormed needs across the lifespan
5. Aligned needs by age to available data, risk populations, and potential strategies
6. Identified additional plan strategies beyond those that are age and population-related



7. Organized recommendations into five overarching strategies
8. Held a public forum for dialogue and input on the committee work
9. Incorporated the public input into the plan
10. Adopted a finalized plan for Mental Health Board review and Board of Supervisors approval.



III. What We Learned

III. What We Learned

Committee members learned from members who had first-hand experience with the tragic loss of life by suicide or attempting their own suicide that language counts.

Language Counts

To ensure the most emotional support possible, consider the following:

- People "**die by suicide**" not by "committing suicide."
- There is no "successful suicide" only a "**completed suicide**".
- There is probably **someone in your own personal network of family and friends who has first-hand knowledge of the pain of suicide**- regardless of income, race, or country of origin.
- **Suicide attempt survivors.** Individuals who have survived a prior suicide attempt.
- **Suicide survivors.** Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide. Among the general public this term is also used to mean suicide attempt survivors.
- **Suicidal act** (also referred to as **suicide attempt**). Potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.
- **Suicidal behavior.** A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.

Resources for immediate assistance for you or someone you love who is struggling with suicide or despair

Suicide and Crisis Services (SACS) Hotline
Toll-Free 1-855-278-4204

National Suicide Prevention Lifeline
1-800-273-TALK (8255)

For Veterans
1-800-273-TALK (8255) press 1

Traditionally, our society has not encouraged open and honest discussion about suicide and what leads people to contemplate suicide. Moreover, cultural norms influence how we communicate about suicide, and these norms can lead to unintended negative consequences. Wording can communicate our deepest bias. People who have survived their own suicide attempts or who are grieving the loss of a loved one by suicide are acutely sensitive to the judgments communicated by word choice, for example:

- People "**die by suicide**" not by "committing suicide." The word commit often is associated with crime or sin.
- There is no "successful suicide" only a "**completed suicide.**" Success in our American culture is an achievement to be celebrated and applauded. Death by suicide is not a success, it is a loss.

Language was recognized as affecting a large number of people. Sixty percent of the committee members, a broad cross-section of our county, have had personal experience with suicide and **there is probably someone in your own personal network of family and friends who has first-hand knowledge of the pain of suicide**—regardless of income, race, or country of origin.

The committee adopted the language that the developing field of suicidology is promoting and recommending. Additional guidance and resources are provided in the insert to the left, **Language Counts**.

Local and National Data

It is evident that individuals or a group cannot meaningfully “fix” a problem they do not fully understand. With this understanding, the committee Co-Chair Vic Ojakian led the group in a review of who dies by suicide, what common problems the suicide victims faced, other risk factors, and warning signs. While many of the committee members have significant experience and expertise in some aspects of suicide and with certain age or other population groups, the data review process gave everyone a similar foundation of basic knowledge. Several questions were considered as data was reviewed, including:

- 1. Who is dying by suicide?**
- 2. Who is at risk of suicide?**
- 3. What factors may contribute to suicide?**
- 4. What are the warning signs of suicide?**
- 5. What factors may protect against suicide?**
- 6. What resources are available in our community to address suicide and suicide risk?**
- 7. What do experts recommend are “best practices” in suicide prevention?**
- 8. What are the critical needs and recommended strategies for our community?**

In keeping with the overall planning approach, an emphasis was placed on studying suicides and contributing factors by age groups across the lifespan. Other data provided information about suicides by gender, race and ethnicity, and various categories of high risk. While available data was limited, further collection and analysis will continue during the Plan implementation phase.

For example, it was learned that Santa Clara County was selected as one of three sites in California to participate in a California Violent Death Reporting System.¹⁵ A 2005 study of these data revealed that at least one of the following circumstances was identified in 80% of the suicides:

- The most frequently noted circumstances were associated with mental health problems, especially for females and young people.
- Females (22%) more often had an alcohol or drug problem than males (14%).
- Males were much more likely to have a job problem (10%) than were females (0%).
- Male suicides were twice as likely to be precipitated by intimate partner relationship problems (18%) than female suicides (9%).
- Suicide victims ages 45 and older were more likely to have a physical health problem that contributed to the suicide (38%) than victims under age 45 (6%).

In addition to research and review of available data, the committee also discussed the lack of many types and categories of data that would better inform professionals as well as the public about danger signs. One of the committee’s five key recommendations supports ongoing data

collection and efforts to encourage more detailed recordkeeping, data analysis, and availability of information related to suicides.

Suicide by Age

Children and Youth. In 2005, 270 children (ages 10 through 14) in the U.S. completed suicide.¹⁶ Suicide is the fourth leading cause of death among children between the ages of 10 and 14 years.¹⁷ Between 1999 and 2007, nine 10 to 14 year olds in Santa Clara County died of suicide.¹⁸

Youth and Young Adults. In Santa Clara County, among teenagers ages 15 through 19, suicide is the third leading cause of death.¹⁹ Santa Clara County's 2005-07 suicide rate average among youth ages 15 through 24 was 7.0 per 100,000.²⁰ That is consistent with national figures, as

shown in the box on the following

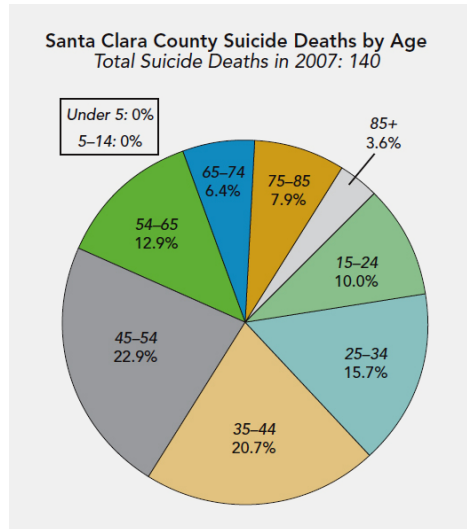
page.²¹ For the nine year period 1999-2007, 113 Santa Clara County youth (15-24 years old) died of suicide, the majority, almost 75%, were males.²²

Nationally, suicide is the second leading cause of death among college students.²³ College students have an "increased incidence of depression," according to a study from the Suicide Prevention Resource Center.²⁴

Another study reports that "students experience more stress, more anxiety, and more depression than a decade ago. Some of these increases were dramatic. The number of students seen each year with depression doubled, while the number of suicidal students tripled, and the number of students seen after a sexual assault quadrupled."²⁵

However, while some college-related factors may contribute to suicidal behavior, it is important to note that same-aged youth who are *not* in college are actually at a higher risk for suicide attempts than are college students.²⁶

Adults. The largest number of deaths by suicide occurs in the adult age group. It is also our county's largest age group (25-65 year olds) at 55.6% of the total population.



National Figures on Youth and Suicide

- Suicide ranks as the third leading cause of death for young people (ages 15 through 19 and 19 through 24); only accidents and homicides occur more frequently.
- Approximately 12 young people between the ages of 15 through 24 die every day by suicide.
- Every 2 hours and 11 minutes, a person under the age of 25 completes suicide.
- Among 15 through 24 year olds, suicide accounts for 12.3% of all deaths annually (CDC, 2008).
- In 2005, 32,637 people completed suicide. Of these, 4,212 were completed by people between the ages of 15 and 24.
- For every completed suicide by youth, it is estimated that 100 to 200 attempts are made.
- In 2007, 14.5% of students (grades 9-through 2) had seriously considered suicide in the previous 12 months—18.7% of female students and 10.3% of male students (CDC, 2008).
- In the past 60 years, suicide rates have quadrupled for males 15 through 24 years old and have doubled for females of the same age.

Youth Suicide Fact Sheet
www.suicidology.org

Among that group (ages 26 through 59), the biggest number occurs in the 45 to 54 year-old category, according to national data. This equates to 7,426 deaths or a rate per 100,000 of 17.19.²⁷ For adults, there is a “clear and direct relationship between suicide and unemployment. At the individual level, unemployed individuals have between two and four times the suicide rate of those employed.”²⁸ For the nine year period 1999-2007, 810 Santa Clara County adults (25 through 64 years old) died of suicide, the majority, almost 75%, were males.²⁹

Older Adults. National data show that the elderly comprise 12.6 percent of the population yet account for 16 percent of suicides. However, even this may not reflect the true total. Suicide by senior citizens is thought to go unrecognized more than with other age groups. For the nine year period 1999-2007, 203 older adults (25-64 years old) in Santa Clara County died of suicide, the majority, almost 75%, were males.³⁰

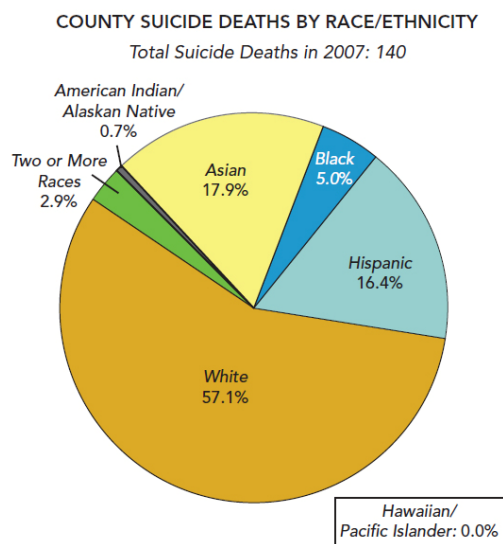
Older white men have the highest suicide rate of all age groups. Among males, adults age 75 years and older have the highest rate of suicide (rate 37.4 per 100,000 population).³¹ Most elderly suicide victims are seen by their primary care provider a few weeks prior to their suicide attempt and diagnosed with their first episode of mild to moderate depression.³²

Suicides by Lesbian, Gay, Bisexual and Transgender Individuals

The majority of research on lesbian, gay, and bisexual people who attempted suicide concludes that young LGBT people have a significantly higher risk of attempting suicide than heterosexual young people and that most attempted suicides among LGBT people occur during adolescence or young adulthood.^{33 34}

Suicide attempt rates (over the course of a person’s lifetime) range from 52.4% (9th and 12th grade) for lesbian and bisexual females to 29% for gay and bisexual (9th and 12th grade) males.³⁵ This is in comparison with heterosexual suicide attempt rates of 4.6%, according to the National Comorbidity Survey.³⁶ Nationally, LGB teenagers have been found to be more than three times (3.41) as likely to attempt suicide as other youth, and young men are at particular risk.³⁷ One significant factor that may increase this risk is the stigma around LGBT identity and the fear of being “found out.” These youth experience a perceived or actual loss of a peer group or of family support resulting in social alienation from the groups that might otherwise provide protective support.

There has been a paucity of data examining the high vulnerability of LGBT youth to suicide attempts. This lack of data demonstrates the need for further assessment from both a public health and a social justice perspective. An understanding of the impact of isolation from peers



and family and the attendant shame and low self-esteem experienced by LGBT youth also may provide insight into the risk of suicide for other groups of youth experiencing social alienation and a lack of family/community support.

Suicides by Race and Ethnicity

In the developing field of suicidology, little is known of how everyday stressors such as racism can impact a group or individuals. That said, according to the available data reviewed, suicide rates vary by race and ethnicity. In Santa Clara County, the suicide rate for Blacks/African Americans is 15.0 per 100,000, American Indians/Native Americans is 13.0 per 100,000, Whites is 10.7 per 100,000, 2 or more races is 9.3 per 100,000, Asian is 5.2 per 100,000 and Hispanic is 5.1 per 100,000.³⁸

However, these data only provide a partial picture. The table below compares data on Santa Clara County’s racial and ethnic diversity to the percentage of total suicide deaths in Santa Clara County in 2007. While the rates of suicide are probably underreported, combined we begin to see a fuller picture of our county in relation to suicide risk.

Comparison table between racial and ethnic make-up of Santa Clara County as a percentage of population and as a percentage of total suicide deaths³⁹		
Race and ethnicity	Total percentages of Santa Clara County population 2007	Percentages of total suicide deaths in Santa Clara County 2007
White	47.1%	57.1%
Asian	26.9%	17.9%
Hispanic	25.4%	16.4%
Black/African American	2.6%	5%
2 or more races	2.4%	2.9%
American Indian	0.4%	0.7%
Hawaiian/Pacific Islander	0.7%	0.0%

Suicides by Gender

A woman takes her own life every 90 minutes in the U.S., but it is estimated that one woman attempts suicide every 78 seconds.

- Women attempt suicide three times as much as men.
- The higher rate of attempted suicide in women is attributed to the elevated rate of mood disorders among females, such as major depression and seasonal affective disorder.
- Although women attempt suicide more often, men complete suicide at a rate four times that of women.
- More women than men report a history of attempted suicide, with a gender ratio of 2:1.
- Firearms are now the leading method of suicide in women, as well as men.
- Suicide is more common among women who are single, recently separated, divorced, or widowed.

- The precipitating life events for women who attempt suicide tend to be interpersonal losses or crises in significant social or family relationships.⁴⁰

Suicides by City

These data are based on zip code data being correlated to city boundaries as closely as possible. Please note that zip code and city boundaries are not always contiguous and that there may be some inaccuracies for this reason. Nevertheless, it is informative to look at suicide rates by Santa Clara County cities. This reveals that the relationship of socioeconomic status and suicide is not clear. It might be expected that structural social inequalities, which result in groups of people with poor access to resources, including social capital, would lead to higher rates of suicide, since this occurs for other indicators of poor physical and mental health. However, data reveal that the highest rates of suicide appear to be in higher income areas of the county, with the highest rates of suicide being in Palo Alto, Los Altos/Los Altos Hills, Sunnyvale and Morgan Hill; while lower rates in general are in Milpitas, Santa Clara and San Jose. However, a closer look at suicides by zip codes reveals that frequent numbers of suicides are found in both higher income areas as well as in certain lower income neighborhoods.

Please see Attachment 1 in the Appendix for numbers of suicides by zip code and a comparison of suicide deaths with homicides.

Table 1. Suicide Rates by Santa Clara County Cities, 2000 - 2006

City	Population	2000	2001	2002	2003	2004	2005	2006	Total	Avg. /Yr.	Rate per 100,000
Campbell	36,984	1	2	4	4	4	1	7	23	3.28	8.5
Cupertino	55,000	4	2	1	2	2	2	4	17	2.43	4.4
Gilroy	48,448	5	5	5	2	3	4	3	27	3.86	7.97
Los Altos / Hills	36,065	1	6	4	6	2	1	8	28	4.0	11.09
Los Gatos	28,971	4	2	0	3	4	5	1	19	2.71	9.35
Milpitas	65,235	3	2	3	4	6	6	1	25	3.57	5.47
Monte Sereno	3,511	0	0	0	0	0	0	0	0	0	0
Morgan Hill	37,066	0	3	7	6	4	3	3	26	3.71	10.00
Mountain View	71,947	7	11	7	9	8	3	4	49	7.0	9.73
Palo Alto	62,108	4	10	6	6	15	8	8	57	8.14	13.1
San Jose	953,058	65	47	61	65	73	60	47	418	59.7	6.26
Santa Clara	110,700	8	6	5	6	6	5	7	43	6.14	5.55
Saratoga	30,815	3	2	3	3	9	1	0	21	3.0	9.74
Sunnyvale	133,458	13	17	16	13	18	10	10	97	13.4	10.04
Unincorporated	98,244	0	0	0	0	0	0	0	0	0	0
Total County	1,771,610	118	115	122	129	154	109	103	850	121.4	

During the seven years that were reviewed, 2000 through 2006, certain zip codes more frequently had higher numbers of suicides, for example, 95086 and 95123. It is unclear, what, if any, these zip codes have in common. Would the pattern hold over a longer period of analysis? Much work remains to be done to more fully understand the dynamics of suicide.

Suicides among Custody Populations

Several interesting questions are raised when reviewing data about suicides among in-custody populations. For example, youth entering juvenile facilities are at greater risk of suicide than similar youth in the U.S. population; however, the suicide rate in U.S. juvenile facilities in 2002 was nearly equal to the rate for similar youth in the general population.

The presence of increased risk factors among juvenile justice-involved youth can be confirmed with Santa Clara County data. Emotional problems were cited as the most significant underlying factor contributing to their delinquency by both boys and girls in custody with the Santa Clara County Probation Department. Forty percent of boys and 58% of girls in custody said “something very bad or terrifying” had happened to them. Nearly one-quarter of all girls surveyed as they entered juvenile hall said they wished they were dead.⁴¹ Of all boys interviewed, 81% had one or more trauma factor noted, compared to 91.7% of the girls.⁴² Among out-of-custody boys on probation supervision, 95.6% had at least one trauma factor noted, while more than one-quarter (26.7%) of boys had three or more trauma factors noted. However, *all* girls reported at least one trauma factor, and 72.7% noted four or more trauma factors in their histories.⁴³

How does this translate into suicides or attempted suicides? According to the Santa Clara County Probation Department’s Institution Incident Report database, which was first implemented in September 2004, there have been no deaths by suicide during the period since then among youth in custody. The decrease in suicide attempts is attributed to changes made in overall custody program and protocol, as well as changes made to the suicide risk protocol and response by the Mental Health staff in the Hall. Mental Health staff and Probation Juvenile Hall staff have received more training in trauma-informed care and all staff members are involved in increased care coordination for youth considered at risk.

Suicide attempts by youth in custody were as follows:⁴⁴

Youth in Santa Clara County Probation Department Custody	
<u>Year</u>	<u>Number of Attempted Suicides</u>
2004	7
2005	39
2006	11
2007	5
2008	0
2009	3
	Total 65

Nationally, the suicide rate in jails has decreased 70% from 1983 to 2003 and has decreased 50% in prisons over the same time period. In 2002 the suicide rate in local jails (47 per 100,000 inmates) was more than three times the rate in State prisons (14 per 100,000 inmates).⁴⁵ However, the suicide rate in both settings remains high.

It takes the courage and strength of a warrior to ask for help. Help is available for veterans 24 hours a day.

*VA Suicide Prevention Hotline number is:
1-800-273-TALK (8255). Push "1" for Veteran services*

*Veteran Suicide Chat Service at
www.suicidepreventionlifeline.org*

*VA Palo Alto
Telephone Care Line 800-455-0057*

*VA Palo Alto
Main Number 650-493-5000*

Military personnel and veterans are not the only ones who can seek help. Military members, spouses, and their families who need assistance with locating services in their area can contact:

***Military One Source 800-342-9647
or www.militaryonesource.com***

In California, between 2001 and 2006, there were 190 suicides by inmates in California. This is far fewer than the number of deaths by illness but much greater than any other cause, including more than double the number of homicides.⁴⁶

In Santa Clara County, during the years 2000 through 2009, there were 212 suicide attempts in the Main Jail and 81 suicide attempts at Elmwood. During that same time period, there were 12 completed suicides in the Main Jail and two completed suicides at Elmwood.⁴⁷

Suicides by Military Personnel—Active-Duty, National Guard, Reservists and Veterans

With our nation's current level of international military engagements, the active-duty military personnel, National Guard, reservists and veterans are another group identified as facing higher risk for suicide. The number of suicides among active-duty personnel has been rising, with 147 reported suicides in the Army from January through November 2009—an increase from 127 in the same period of 2008. Among non-active-duty reserve soldiers, 50 suicides were reported in 2008; but the number had risen to 71 during the first 11 months of 2009.⁴⁸

The Navy reports "For the past 10 years, it (suicide) has been the second or third leading cause of death

among active duty Sailors."⁴⁹

According to "Suicide Rivals The Battlefield in Toll on U.S. Military" by Jamie Tarabay as reported by National Public Radio on June 26, 2010, "Nearly as many American troops at home and abroad have committed suicide this year as have been killed in combat in Afghanistan. Alarmed at the growing rate of soldiers taking their own lives, the Army has begun investigating its mental health and suicide prevention programs." However, the article goes on to say that the tough challenge is "changing a culture that is very much about 'manning up' when things get difficult."

Other experts agree that, similar to the general public, one of the main reasons that military personnel do not seek help with mental and emotional health issues is due to stigma and fear

that seeking help will negatively impact their careers. "A study published in the New England Journal of Medicine in 2004 showed that of those active duty service members who screened positive for a mental health problem (PTSD, major depression, generalized anxiety disorder), only 23-40% sought mental health care. Perceived barriers to seeking treatment included fear of being seen as weak, of being treated differently by unit leadership, and of other members of their unit having less confidence in them."⁵⁰

Correspondingly, veterans, regardless of when they served or in which branch, are twice as likely as the general population to die by suicide, according to an article in the Journal of Epidemiology and Community Health (July 2007).⁵¹ Suicides among United States military veterans ballooned by 265 from 2005 to 2007, according to statistics released by the Veterans Affairs (VA) department. The VA estimated that in 2005, the suicide rate per 100,000 veterans among men ages 18-29 was 44.99, but jumped to 56.77 in 2007.⁵²

"Of the more than 30,000 suicides in this country each year, fully 20% of them are acts by veterans," said VA Secretary Eric Shinseki. "That means on average 18 veterans die by suicide each day. Five of those veterans are under our care at VA." Suicide rates among veterans in all four branches of the military service are significantly higher than in the general population.⁵³

Veterans are more likely than the general public to use firearms as a means for suicide. "The odds of firearm use (among suicide decedents) among male and female veterans were 1.3 and 1.6 times higher, respectively, than among their nonveteran counterparts

If you are a veteran or know a veteran in need of medical or mental health services, the following resources are available:

Suicide Prevention Lifeline	800-273-8255 (TALK)
VA Palo Alto:	
Main Number	650-493-5000
Telephone Care Line	800-455-0057
Returning Veterans Coordinator	650-493-5000 x60007
Addiction Consultation Team	866-717-1978
Homeless Veterans Rehabilitation	800-848-7254
Men's and Women's Trauma Recovery	650-614-9997 x24692

VA Palo Alto Website

<http://www.palo-alto.med.va.gov>

VA Palo Alto on Facebook

<http://www.facebook.com/vapahcs>

Veteran Suicide Chat Service

www.suicidepreventionlifeline.org

National Center for PTSD

www.ncptsd.va.gov

VA Palo Alto Health Care System Locations:

Palo Alto Division located at 3801 Miranda Avenue, Palo Alto, CA 94304; phone: 650-493-5000.

Menlo Park Division located at 795 Willow Road, Menlo Park, CA 94025; phone: 650-614-9997.

San Jose CBOC located at 80 Great Oaks Boulevard, San Jose, CA 95119; phone: 408-363-3000.

Monterey CBOC located at 3401 Engineering Lane, Seaside, CA 93955; phone: 831-883-3800

Capitola CBOC located at 1350 N. 41st St., Suite 102, Capitola, CA 95010; phone: 831-464-5519

Local Vet Center Locations:

Peninsula Vet Center located at 2946 Broadway Street, Redwood City, CA 94062; phone: 650-299-0672

San Jose Vet Center located at 278 North 2nd Street, San Jose, CA 95112; phone: 408-993-0729

after adjusting for age, marital status, race and region of residence.”⁵⁴

U.S. Census data show there are 106,430 veterans in Santa Clara County.⁵⁵ Approximately 40,000 of that number are veterans of the Vietnam-era service, however, the theaters of service for an increasing number are Iraq and Afghanistan.

Data compiled for the Veterans Administration Palo Alto Health Care System show that among its patients there were 126 suicide attempts and 1 completed suicide from October 2007 through September 2008. There were 96 suicide attempts and 7 completed suicides from October 2008 through September 2009. There were eight attempts and zero completed suicides in December 2009 alone.

Other Possible Correlations: More Data Is Needed

Varying levels of forensic analysis often may be needed to determine if a death was caused by suicide, homicide, accident or natural causes. More extensive collection, maintenance and analysis of data related to suicides will be key to ongoing efforts to effectively prevent suicides and to decision-making about where to allocate prevention resources.

Suicides by Occupation. Dr. John Q. Baucom, Ph.D., writes in his book, *Fatal Choice*, "More professionals commit suicide than others. Farm workers have the lowest incidence among occupational groups. Dentist and physicians take their lives at the rate of 6½ to one over the general population. Lawyers commit suicide at a ratio of five to one over the general population." A web site, straightdope.com, cites an unnamed California study which found that dentists were surpassed in suicide rates only by chemists and pharmacists. Presumably, a Washington State study found that dentists had a suicide rate second only to shepherders and wool workers. However, our review could not substantiate that these data are accurate.

One of the largest studies on this topic was conducted by the National Institute of Occupational Safety and Health (NIOSH) in 1995, which concluded that the medical field definitely has a higher suicide rate. But beyond that, NIOSH researchers said the picture is equivocal: Often the studies are only of one geographic area, sometimes they have methodological problems, and sometimes they contradict each other.

In another study, a sociology researcher at the University of California, Riverside, Augustine Kposowa, Ph.D., looked at records over nine years for about half a million people of whom 545 died by suicide. After controlling for such variables as age, income, race, marital status and region of residence, he found that only laborers and the unemployed had significantly higher risks. On the other hand, he found "dramatic" differences for suicide among the industries where people work. At highest risk were those in mining, business and repair services, wholesale and retail trade and construction. Again, which, if any, of these data are accurate is unclear and there is no data to examine whether these conclusions apply to Santa Clara County.

Police-Involved Suicides. Some of the first research into "suicide by cop" was completed by

Sgt. Rick Parent of the Delta Police Department in British Columbia. Parent's research of 843 police shootings determined that about 50% were victim-precipitated homicide. Police defined victim-precipitated homicide as "an incident in which an individual bent on self-destruction engages in life threatening and criminal behavior to force law enforcement officers to kill them."⁵⁶ Again, further research is needed to determine the extent to which this type of suicide occurs in other locations.

Suicides by Police Officers. Research has been limited; but there are some indications that there are approximately 450 law enforcement suicides per year nationally, versus 150 officers who die annually in the lines of duty.⁵⁷

Suicides Labeled as Auto Accidents. The real percentage of suicides among car accidents is not reliably known, Studies by suicide researchers indicate that "vehicular fatalities that are suicides vary from 1.6% to 5%." Some suicides are misclassified as accidents because suicide must be proven. "It is noteworthy that even when suicide is strongly suspected but a suicide note is not found, the case will be classified an accident."^{58 59}

Some researchers believe that suicides disguised as traffic accidents are far more prevalent than previously thought. One large-scale community survey (in Australia) among suicidal persons provided the following numbers: "Of those who reported planning a suicide, 14.8% (19.1% of male planners and 11.8% of female planners) had conceived to have a motor vehicle "accident." Of all attempters, 8.3% (13.3% of male attempters) had previously attempted via a motor vehicle collision."⁶⁰

Other Misidentified Suicides. It is unknown how many suicides are not classified as intentional deaths on their death records. However, some means of suicide are believed to be more commonly unreported. For example, it is believed that some portion of fatal poisonings coded as unintentional or undetermined are actually suicides. Under-reporting of suicide has been attributed to factors such as pressure from families and subjectivity among coroners and medical examiners. As compared with firearms and suffocation, suicide by poisoning is considered to be particularly susceptible to underreporting. The rapid rise in unintentional poisonings in recent years has led some to wonder whether part of this increase represents misdiagnosed suicides.⁶¹

Suicide Clusters and Suicide "Contagion." A suicide cluster is defined as multiple deaths by suicide that occur within a defined geographical area and fall within an accelerated time. These clusters consist of more than three victims, typically ranging from 13 to 24 years old, and occur

Providing Hope and Help: SACS Hotline

Darcy (a SACS volunteer) took a cell call from a hysterical college graduate who was driving on the freeway with a loaded gun at her side. The caller said she was going to shoot herself because she did not get into the medical school that she wanted. The caller's husband was in Iraq and the caller had no support system in this area and was under a lot of stress. Darcy was able to calm the caller down by gaining her trust through offering care and concern. The caller agreed to drive herself to the hospital while Darcy stayed with her on the phone. Approximately three years later, the caller called back to thank Darcy and to tell her that she had become a pediatrician.

**Santa Clara County's 24-Hour Toll-Free
Suicide And Crisis Services (SACS) Hotline:
1-855-278-4204**

within approximately a one-to-two-year period. Contagion is the process in which the death by suicide of an individual influences an increase in the suicides of others. Exposure to another individual's suicide can precipitate imitative suicidal behavior.⁶²

College years: Identification of a friend in crisis

I was 19 and in my first year of college. I ran often with a dorm-mate who lived just across the hall. His name was "Billy." One Friday afternoon just before Thanksgiving break, Billy asked to go on a run with me. He said "I really need to talk to someone." He didn't say about what. I indicated that I was just packing up to leave for the holidays but I'd take a rain check. He seemed more disappointed than what I would have expected. I left for the holiday. Billy stabbed himself to death two days later. I've never forgotten the "window of opportunity" I so blindly missed that Friday afternoon. To this day I feel a sense of responsibility for the outcome and a great deal of shame for my inability to hear a cry for help and my failure to be a friend.

How impactful exposure to suicide is as a risk factor for suicide is an active area of research. A 1996 study was unable to find a relationship between suicides among friends,⁶³ however, a 1986 study found clusters of suicide among teenagers following the televising of news stories regarding suicide. These clusters are thought to account for 5% of teenage suicides.⁶⁴

Between 1984 and 1987, journalists in Vienna covered the deaths of individuals

who jumped in front of subway trains. The coverage was extensive and dramatic. In 1987, a campaign alerted reporters to the possible negative side effects of such reporting and suggested alternative strategies for coverage. In the first six months after the campaign began, subway suicides and nonfatal attempts dropped by more than 80%. The total number of suicides throughout Vienna dropped as well.⁶⁵

The Centers for Disease Control and Prevention (CDC) reports that suicide clusters account for 100-200 deaths annually. Suggestions for minimizing suicide contagion include understanding the "circles of vulnerability" in order to identify those most at risk after a suicide has occurred in the community. "Circles of vulnerability include individuals who:

- Had a negative interaction with the victim shortly before the suicide occurred and who perhaps even encouraged it
- Were in a suicide pact but backed out at the last minute
- Realize now that they missed the obvious warning signs of suicide
- Were suicidal at another time, regardless of whether they had know the victim
- Have mental health problems."⁶⁶

Homicide-Suicides. Murder-suicide perpetrators appear to be vastly different from perpetrators of homicide alone. Whereas murder-suicide perpetrators were found to be highly depressed and overwhelmingly men, other murderers were not generally depressed and were more likely to include women in their ranks.⁶⁷

Suicide Risk and Mental Illness

Of the 14.8 million Americans who live with depression, the majority will not attempt suicide.⁶⁸ However, research has shown a definite correlation between depression and suicide, as well as a significant association with all mood disorders and suicide. Varying studies have shown that between 60% and 90% of suicide victims had a psychiatric illness at the time of their death. Most common are mood disorders (depression, bipolar disorder, borderline personality disorder, etc.) and substance abuse.^{69 70 71 72 73} When both mood disorders and substance abuse are present, the risk for suicide is much greater, particularly for adolescents and young adults.⁷⁴



Children and Youth. Among Santa Clara County parents who participated in a 2006 survey commissioned by the Lucile Packard Foundation for Children’s Health, 5.8% were “very concerned” about their child’s level of depression and an additional 14.1% were “somewhat concerned.”⁷⁵ At the same time, one-quarter to one-third of seventh, ninth and eleventh graders reported symptoms of depression (feeling so sad or hopeless for at least two weeks during the previous year that they stopped doing some regular activities).⁷⁶ Further, 16.3% of the seventh, ninth and eleventh graders reported



they seriously considered, and 8.2% reported they actually attempted, suicide during the previous year.⁷⁷

Nationally, more teenagers die by suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.⁷⁸

Young Adults. Some experts estimate that about 25% of all young people suffer from depression by the time they are 24, however, very few seek help. Depression affects one out of six college students; and, as mentioned previously, suicide is the second leading cause of death among college students.⁷⁹ Again, same-aged youth and young adults who are *not* in college are actually at a higher risk for suicide

Factors that May Contribute to Suicidal Behavior among Young Adults Transitioning to Financial Independence

- Major life transitions, such as leaving home for the first time, may exacerbate existing psychological difficulties or trigger new ones.
- Real or perceived stress may contribute to the development of stress disorders—including suicidal behaviors.
- Parental pressure to succeed academically or professionally
- Economic pressure to successfully complete a course of education and training in a shorter period of time may increase stress.
- Mounting financial burdens, worries about time away from careers and being out of the workplace, and uncertainties about the future job market (especially for those pursuing research and academic careers) are additional stressors for students in college, graduate programs, vocational and technical schools.

attempts than are college students.⁸⁰

Adults. In 2005, California Health Interview Survey data showed that 18% of adults in Santa Clara County reported they needed help for emotional or mental problems; however, only 8% of adults had seen a health professional for these problems.

A review of Santa Clara County Mental Health Department Call Center records show that less than 30% of the people who seek services from the Department’s system receive mental health treatment. Coupled with this, a large-scale epidemiological study shows that less than 30% of people with psychiatric disorders seek treatment.⁸¹ Taken together—less than 30% of those who need services seek services—and—less than 30% of those who seek services receive services—it is readily apparent that there is a significant unmet need for mental health treatment, including depression and additional mood disorders among others.

Older Adults. Depression, one of the conditions most commonly associated with suicide in older adults,⁸² is a widely under-recognized and under-treated medical illness. Studies show that many older adults who die by suicide—up to 75%—visited a physician within a month before death.⁸³ These findings point to the urgency of improving detection and treatment of depression to reduce suicide risk among older adults.

In today’s society older adults are at risk for isolation, loneliness, and depression as their family members move away and they leave the workforce. A recent study of Santa Clara County older adult participants in congregate nutrition programs found that the primary reason for participation in the program is socialization.⁸⁴ In 2006, 16.2% of Santa Clara County adults age 65 and older reported having one or more days per week when their mental health was not good.⁸⁵

Warning Signs - National Suicide Prevention Lifeline

There are a few warning signs that clearly indicate that someone is struggling with the decision to injure themselves:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself.
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means.
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person.

However, many warning signs go unrecognized by others or are minimized by the people who sense that there is something wrong with the person exhibiting these signs:

- Repeated expressions of hopelessness, helplessness, or desperation.
- Seeing no reason for living or having no sense of purpose in life.
- Making threats.

If someone you know or love is exhibiting worrying behaviors, symptoms, or choices that are a change and these changes remain for more than a period of a few days, then you can help by asking them how they are feeling. Often people recognize one or two “odd” things/ changes, but don’t ever consider suicide as a possibility. Whatever the manner someone you know or love is showing worrying behaviors or thoughts, the best thing loved ones can do is ask “Are you thinking about suicide as an option?” Many people fear that by asking that they might be “suggesting” suicide to the person. On the contrary, it allows a person who is considering it an opportunity to ask share their feelings, find that someone else really cares, and seek help. By asking you can help them consider other options, such as calling a crisis hotline, seek help from a doctor, faith leader, or mental health clinician.

National Suicide Prevention Lifeline

1-800-273-TALK (8255) or

1-800-273-TALK (8255) press 1 for Veterans

In addition, in Santa Clara County, one-fourth of seniors are also caregivers. Caregivers are at high risk for depression, with approximately 11% of full-time professional caregivers reporting a major depressive episode in the past year compared to 7% for all occupations.⁸⁶ Studies show that 16% of caregivers report a decline in their health after taking on the caregiver role, and about half of caregivers who care for someone with Alzheimer's disease develop psychological distress.

Lesbian, Gay, Bisexual, Transgender Individuals. Depression and suicide also appear to significantly affect members of the LGBT community. A Santa Clara County 2005 Lesbian Gay, Bisexual and Transgender Needs Assessment and Report on Emotional Well-Being and Mental Health was conducted and prepared by the Billy DeFrank LGBT Center. Among respondents, 22% stated that within the past year they needed help for depression and 7% said they needed suicide prevention help.

Military Personnel—Active Duty, National Guard, Reservists, and Veterans. Although local statistics on mental illness and co-occurring disorders among veterans are scarce (i.e., the Mental Health Department does not capture data on veteran status), the high incidence of mental illness among veterans is well documented by other sources. The National Alliance on Mental Illness (NAMI) Veterans Resource Center reports that more than 100,000 combat veterans sought help for mental illness since the start of the war in Afghanistan in 2001, about one in seven of those who have left active duty since then, according to VA records. Almost half were PTSD cases.⁸⁷ The total of mental health cases among war veterans grew by 58% from 63,767 on June 30, 2006, to 100,580 on June 30, 2007, VA records show. The mental health issues include PTSD, drug and alcohol dependency, and depression.⁸⁸

Recent data from the Defense Medical Surveillance System from self-assessments since 2005 of service members who served in Iraq show that 50% of US Army National Guardsmen and some 45% of US Army and Marine reservists have reported mental health concerns.⁸⁹ Of all those using VA health care, 30% suffer from depressive symptoms, two to three times the rate of the general population.⁹⁰

Again, it is critical to review statistics about depression with the knowledge that research has shown up to 90% of people who kill themselves have depression and/or another diagnosable mental or substance abuse disorder with a depressive component.⁹¹ With this in mind, it is particularly alarming to recognize that more American adults suffer from depression (14.8 million)⁹² than coronary heart disease (7 million), cancer (6 million) and AIDS (200,000) combined.⁹³

Suicide Risk and Alcohol Consumption

In Santa Clara County, 17.6% of adults responding to the Public Health Department's Behavioral Risk Factor Survey engaged in binge drinking within the previous 30 days, and 2.7% of the respondents' answers classified them as heavy drinkers or at risk of heavy drinking patterns.⁹⁴

Among the many other reasons this is worrisome (liver and heart disease, increased chances of certain cancers, etc.), alcohol dependence is an important risk factor for suicidal behavior. Suicide completers have high rates of positive blood alcohol, and intoxicated people are more likely to attempt suicide using more lethal methods. Further, alcohol may be a significant factor in suicides among individuals with no previous psychiatric history.⁹⁵ It has been found that alcohol intoxication increases suicide risk up to 90 times, in comparison with abstinence.⁹⁶

Alcohol is involved in an estimated 30% of suicides.⁹⁷ Alcohol causes depressed mood, lowers inhibitions, and impairs judgment, any or all of which may make vulnerable people more likely to act on suicidal plans. These same factors (lowered inhibition and impaired judgment) are also associated with domestic violence and abuse, other factors that are believed to increase the likelihood that suicide will occur.

Suicide Risk Factors and Warning Signs

Experts tell us that there are many circumstances that can contribute to someone's decision to end his/her life, but a person's feelings about those circumstances are more important than the circumstances themselves. All people who consider suicide feel that life is unbearable. They have an extreme sense of hopelessness, helplessness, and desperation. In addition, with some types of mental illness, people may hear voices or have delusions which prompt them to kill themselves. If you or someone you know experiences these, there are services that can provide support and guidance: **National Suicide Prevention Lifeline- 1-800-273-TALK (8255) and Santa Clara County's Suicide and Crisis Services (SACS) 24-Hour Crisis Hotline: Toll-Free 1-855-278-4204.**

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Prevention Resource Center identifies three categories of risk factors: biopsychosocial, environmental, and sociocultural. SAMHSA literature stresses the importance of understanding these well-documented risk factors because the impact of some risk factors can clearly be reduced by certain interventions (i.e., medication for depression). Other risk factors cannot be changed (i.e., a previous suicide attempt), however, awareness by friends and family of the heightened risk, particularly during periods of

SAMSHA* Categories of Risk

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relationship or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Socio-Cultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behaviors
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma, the family can work this out alone)
- Exposure to the influence of others who have died by suicide, including through the media

*Substance Abuse and Mental Health Services Administration

recurrence of significant stressful life events, should lead to strengthened social support.

In addition to risk factors, a number of organizations devoted to suicide prevention publish lists of warning signs, with the objective of helping people recognize common indicators in order that they can offer support and assistance that will cause the person to reconsider their suicidal plans. Among the many such organizations that have developed warning sign lists are Suicide.org, American Foundation for Suicide Prevention, SAVE (Suicide Awareness Voices of Education), Centers for Disease Control and Prevention Injury Center, American Association of Suicidology, and the National Suicide Prevention Lifeline.

Factors That May Protect Against Suicide

Protective factors buffer individuals from suicidal thoughts and behavior. To date, protective factors have not been studied as extensively or rigorously as risk factors. Identification and understanding of protective factors are, however, equally as important as research concerning risk factors. Identified protective factors against suicide are:

- Effective clinical care for mental, physical, and substance use disorders
- Easy access for a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation.⁹⁸

Young at Heart

I am 65 years old and I have been severely depressed for at least 60 of them. My parents have been positive I carried some "family genetic defect that goes back for over 120 years." They said as much to me and calling me a "nasty little son of a bitch". They abused me emotionally and sexually and made me feel responsible for it and eventually made me available to a homosexual man. I never was able to overcome the personal stigma and emotional breakage I suffered then or the power my mother held over me until I was almost 60 when I finally gave up and tried to kill myself. I suffered in every way possible during those years—not being able to finish college, and being unable to hold a decent job for many years. I had to rely on my parents for support, which only helped me in one way. My mother kept me in virtual servitude, even when I finally did get a job.

The gist of this is that the emotional breakdown I suffered so many years ago lasted until I was past 60 when, to get away my horrific memories and the constant badgering of my mother, I made two nearly completed suicide attempts, which finally got me into the Barbara Aarons Wing at Valley Med Center and into quality psychiatric care. I even "graduated" from Catholic Charities' FSP Older Adult program almost a year ago. I finally learned that I was not responsible for the things that happened to me and that I might just have been sane in an insane world or family. I am well, with my medication and occasional adjustments to it. Now, I am a 65 year old adolescent looking forward to life.

IV. Review and Summary of Local Needs

IV. Review and Summary of Local Needs

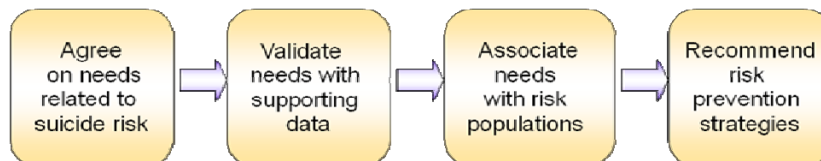
The committee and staff members' research on suicide risk factors, populations at high risk, available resources, and effective programs is consistent with the American Foundation for Suicide Prevention's Best Practices Registry recommendation for a data-driven planning process that "typically will involve multiple stakeholders in a process of assessing local needs, assets, and readiness, and choosing interventions that match local problems and circumstances."

Local Needs across the Lifespan

The SPAC members agreed to utilize age groupings that worked well in the Mental Health Department's Mental Health Services Act (MHSA) planning processes. These groups are:

1. **Children and Youth Ages 0 through 15**
2. **Youth and Young Adults Ages 16 through 25**
3. **Adults Ages 26 through 59**
4. **Older Adults Ages 60 and over**
5. **Strategies Applicable Across Age Groups.**

The charge of the SPAC was to examine the risk factors most prevalent within each of the age groups that may contribute to the consideration or decision to take one's own life; second, to match each of these age groups with targeted high risk sub-groups or "priority populations" among those age groups based on the data review; and third to recommend strategies most appropriate to diminish risk among that population group/s in the context of Santa Clara County's demographics. A simple "logic model" was utilized for the work:



The SPAC members devoted a portion of each meeting to discussions in break-out groups by these age categories. For each age category, the **Identified Needs and Concerns** were derived from discussion of known suicide risk factors and identification by committee members of the highest priority needs and concerns to be addressed in Santa Clara County. Likewise, the **Recommended Priority Populations** reflect examination of data and decisions about which groups within each population category are at highest risk or highest need for focused prevention and intervention efforts.

Finally, the **Recommended Strategies** were developed to respond to the **Recommended Priority Populations** and were selected based upon reviews of effective and promising programs and the insights and expertise of the SPAC members. While priority populations were the focus, it was with the understanding that prevention strategies that reduce the suicide risk for high-risk groups also will provide the benefit to the general population.

1. Identified Needs and Concerns

- Inadequate sense of control in a life phase when youth have limited control over their lives
- Difficulty accessing available mental health services, education and support to prevent substance abuse
- Lack of strong resiliency skills to cope with failure and disappointment, bullying, and breakups
- Inadequate defined support, connections to community, unconditional acceptance, and sense of communal responsibility for safety
- Low feelings are perceived as abnormal
- Lack of self-esteem, sense of accomplishment, and sense of hope
- Lack of respect for peers, adults, and themselves

2. Recommended Priority Populations

Children and youth experiencing:

- Academic difficulties; changing schools; life milestones
- Immigration concerns; refugee experience; acculturation stress; linguistic and/or cultural differences
- Trauma (sexual, physical, emotional, exposure to violence)
- Suicide of friends; suicide attempts; mental illness; substance abuse
- Separation from family; homelessness
- Juvenile justice/foster care system involvement
- Gender identity issues—lesbian, gay, bisexual, transgender, queer, or questioning
- Neglect and/or without nurturing adult

3. Recommended Strategies

- Accessible mental health counselors in schools
- Screenings of youth for risk of suicide and other mental health concerns
- Targeted counseling for youth who have lost a loved one to suicide
- Enhanced mental health resources, school curriculum, and parent initiatives
- Identify coping mechanisms, access points, and connectors for youth to address life challenges
- Programs to protect youth from social and geographic isolation and barriers to peer interaction
- Programs that teach resiliency
- Programs and services that enable children and youth to cope with failure and disappointment, bullying, and breakups
- Training for those who interact with at risk youth (community leaders, clinicians, physicians, family members, police, teachers, peers, and others)
- Accessible, youth-centered crisis line; and single, countywide access point/telephone number for youth at-risk
- Provide teens with support groups for youth dealing with teen suicide
- Provide prevention opportunities: Youth to become engaged in public service; school staff to be dynamic and caring; youth centers; develop students' own skills to deal with emotional challenges.
- Educate parents and foster parents to recognize a child's emotional needs and know the resources available to assist when child is in crisis.
- Publicly recognize individuals who connect people at risk of suicide to resources
- Ensure post-incident care for individual and family after a 5150 episode (forced admission for psychiatric observation)

1. Identified Needs and Concerns

- Sense of physical and emotional isolation from family, social network and/or peers
- Stigma associated with mental health and substance abuse services and suicide prevention
- Inadequate identification of mental health issues by self and others (caregivers, medical providers, etc.)
- Paucity of service resources and difficulty accessing age-appropriate and linguistically available services (inadequate referrals, poor connections, barriers to qualify, difficult to afford, language barriers)
- Transitioning between being dependent on others to being financially independent without an adequate support network

2. Priority Populations

Young people experiencing:

- Suicide of friends; previous attempts; thoughts of suicide
- Academic difficulties; immigration concerns; refugee experience; acculturation stress; linguistic and/or cultural differences
- Transition from dependence to financial and personal independence, regardless of educational level or pursuits
- Trauma (sexual, physical, emotional, exposure to violence)
- Mental illness; substance abuse; co-occurring conditions
- Homelessness; alienation from family
- Juvenile/adult criminal justice involvement; transitioning from incarceration to reintegrating with society
- Foster care system involvement
- Gender identity issues—lesbian, gay, bisexual, transgender, queer, or questioning

3. Recommended Strategies

- Screening and timely intervention of those at risk of suicide
- School-based, culturally relevant intervention services, including consultation for educators and parents, and peer to peer support
- Peer stipend program for youth to promote intervention and treatment services
- Training, support and educational materials for parents, partners, and family members and educators regarding safe handling of young adult life challenges and crises (Example: educational suicide help hotline)
- Accessible and comfortable spaces for adults at-risk of suicide, such as a mobile crisis unit, satellite self-help centers, and/or a community lounge space
- Age-appropriate crisis hotline
- Support groups for youth dealing with teen suicide
- Prevention opportunities, such as youth becoming engaged in public service; school staff to be dynamic and caring; youth centers; other ways for students to develop skills to deal with emotional challenges
- Previous attempters to share their stories to encourage others to seek help and have hope for improved life satisfaction
- Public recognition of individuals who connect people at risk of suicide to resources
- Post-incident care for individuals and families after a 5150 episode (forced admission for psychiatric observation)

1. Identified Needs and Concerns

- Inadequate identification of mental health issues by self and others (peers, medical providers, etc.)
- Paucity of service resources and peer support strategy assistance as well as difficulty accessing available services
- Stress associated with life transitions, life events and trauma
- Stigma associated with mental health and substance abuse services and suicide prevention
- Cultural perspectives on mental health challenges and suicide
- Lack of safe welcoming places and opportunities to ask for assistance and services

2. Priority Populations

Adults experiencing:

- Decreased functioning, isolation, disabilities or poor health
- Trauma (sexual, physical, emotional, exposure to violence)
- Suicide of friends; suicide attempts
- Mental illness; substance abuse; and co-occurring conditions
- Loss of income and/or a loved one
- Criminal justice system involvement
- Homelessness
- Gender identity issues: lesbian, gay, bisexual, transgender, queer, or questioning
- Veterans

3. Recommended Strategies

- Screening and assessments for risk of suicide
 - Support for adults at risk of suicide
 - Tools to safely handle life challenges and manage crises, such as cognitive-behavioral theory and thought stopping.
 - Accessible counseling and crisis services
 - Mobile crisis unit
 - Self-help centers in communities
 - Training, support and educational materials for friends, family members and employers regarding safe handling of personal challenges and crises, (Example: educational suicide help hotline)
 - Previous attempters sharing their stories to encourage others to seek help and have hope for improved life satisfaction.
 - Collaboration between military personnel, veterans organizations and the Veterans Administration to make sure all veterans receive services and to design, implement and coordinate the most effective possible services
 - Work with business leaders and organizations to promote mental health awareness and education
 - Public recognition of individuals who connect people at risk of suicide to resources
 - Post-incident care for individuals and families after a 5150 episode (forced admission for psychiatric observation)
-

Older Adults Ages 60 and Above

1. Identified Needs and Concerns

- Inadequate identification of mental health issues by self and others (caregivers, medical providers, etc.)
- Paucity of service resources and difficulty accessing available services (inadequate referrals, poor connections, barriers to qualify, difficult to afford, lack of transportation)
- Loss or diminishment of independence, role, and physical health; loss of loved ones; physical difficulty in getting to services
- Stigma associated with mental health and substance abuse services and suicide prevention
- Cultural perspectives on death and dying; differing definitions of a life of value; and cultural taboos against discussing end of life
- Psycho-social stressors can lead to increased risk not only of suicide but of homicide-suicides

2. Priority Populations

Older Adults who are:

- Caucasian males
- Over 75
- Isolated or grieving (widows/widowers), experiencing a loss in relationships or other significant change
- Experiencing a loss of sustainable income and/or personal resources
- Functioning poorly, have disabilities or poor health
- Experiencing immigration concerns; refugee experience; acculturation stress; linguistic and/or cultural differences
- Coping with trauma (sexual, physical, emotional, exposure to violence, veteran)
- Mentally ill; abusing medication, drugs, or alcohol

3. Recommended Strategies

- Education, informing materials, and consultation support to primary care providers
 - Depression screening, referral, linkage and follow-up services through primary care providers
 - Accessible, age-appropriate counseling and treatment services
 - Accessible senior-focused crisis line; and single, countywide access point/telephone number
 - Home visitation follow-up services and linkage of homebound seniors to services
 - Senior-focused intervention for depression, death and dying issues
 - Public recognition of individuals who connect people at risk of suicide to resources
 - Post-incident care for individuals and families after a 5150 episode (forced admission for psychiatric observation)
-

1. Identified Needs and Concerns

- Paucity of service resources and difficulty accessing available services
- Difficulty accessing available mental health services, education and support to prevent substance abuse
- Stigma associated with mental health and substance abuse services and suicide prevention
- Cultural perspectives on mental health challenges and suicide
- Lack of safe of welcoming places and opportunities to ask for assistance and services

2. Priority Populations

Individuals experiencing:

- Trauma (sexual, physical, emotional, exposure to violence)
- Suicide of friends; suicide attempts
- Mental illness; substance abuse; and co-occurring conditions
- Juvenile/criminal justice system involvement
- Immigration concerns; refugee experience; acculturation stress; linguistic and/or cultural differences
- Homelessness; significant loss of social and/or economic support
- Gender identity issues: lesbian, gay, bisexual, transgender, queer, or questioning
- Transitions

3. Recommended Strategies

- Screening and referral resources in primary care and other caregiving settings
 - Training for professionals, service providers and community members on identification and response to individuals at risk
 - Crisis hotline and single, countywide access point/telephone number
 - Accessible, affordable and appropriate crisis counseling and support services
 - Mobile crisis unit
 - Self-help centers in communities
 - Consultation phone services
 - Ensure post-incident care for individuals and families after a 5150 episode (forced admission for psychiatric observation)
 - Public recognition of individuals who connect people at risk of suicide to resources
-

Additional Strategies: Community Education and Information

The committee recognized the importance of broadly increasing knowledge of the risk factors and warning signs for suicide while promoting help-seeking. By enhancing awareness of sources of help and reducing stigma associated with seeking help, these activities should prevent deaths by suicides as well as self-injury while trying to die by suicide. Increased knowledge has been shown to create substantial change. Mothers Against Drunk Driver's (MAAD) success in changing drunk driving from a person or family's secret shame into a community responsibility with their "Friends Don't Let Friends Drive Drunk" campaign is the recommended model for Santa Clara County's suicide prevention public education campaign. This strategy will include one universal message for the entire community. In addition, other targeted measures will be developed to engage smaller groups targeting youth, older adults, different language speakers, etc.

An educational campaign targeting improved physician assessment for suicidal risk and management of that risk also is recommended for implementation. Suicide data highlighted many areas of special concern. One example is data showing that a large portion of elderly persons who die by suicide had seen a health care professional within a relatively short period of time prior to their death.

A key concern that was raised by the committee is that in implementing an AdCouncil type public awareness campaign, these activities should be linguistically and culturally appropriate for our diverse community. It also should be broad in the means used to communicate. Youth and young adults are more receptive to internet technologies and social networking. For seniors, radio or television may be the media of choice. Some immigrant groups get their information primarily from foreign language radio, television and press. Others look to daily newspapers or listen to radio. Whatever approach is used, consideration for preferences, including social media, will be considered to most effectively reach the widest possible audience.

Additional Strategies: Communication Practices

In addition to reviewing needs of populations from a lifespan perspective, the committee members explored other critical areas that must be addressed in order to implement an effective suicide prevention effort in Santa Clara County. The Committee benefitted from several members who had been addressing the youth suicides in Palo Alto. Lessons learned include that for any comprehensive suicide prevention campaign to work, two essential elements should be included in the communication practices: 1) a coordinated communication strategy, and 2) educating all forms of media—television, radio, print, social network, internet, and other forms of media concerning the importance of adherence to the guidelines for reporting deaths by suicide, using the recommendations from the Suicide Prevention Resource Center's Safe Reporting Guidelines.

While the community education and awareness campaign is its own strategy with the dual

objectives of 1) increasing community awareness of suicide, and 2) encouraging people to seek help for themselves or loved ones, it is important that it include the establishment of a body that will have oversight and coordinating responsibility of the Communication Practices Work Group. The group's role will be to 1) ensure the development of defined, clear, concise, paradigm-shifting message for all efforts; 2) ensure adherence to the guidelines for responsible communication on issues pertaining to suicide and that messaging is consistent across all media campaigns and efforts; 3) coordinate education on reporting suicide; and 4) establish and maintain a permanent website that is available for all to visit at www.sccgov.org/spac.

Media Education and Engagement

By and large, the bulk of the work will relate to educating the media and formal public communication.

Research has shown that graphic, sensationalized or romanticized descriptions of suicide deaths in the news and social media and the internet can contribute to suicide contagion, sometimes referred to as “copycat” suicides, “media-related suicide contagion,” or “cluster suicides,” and other similar terms. In addition to the danger of this phenomenon, media reports on suicide can also be a source of misinformation, for example, when suicide is attributed to a single event, such as the loss of a job or a relationship with no mention of underlying factors such as the individual's depression, substance abuse, or lack of access to treatment for these conditions.

In contrast, responsible coverage of suicide can educate wide audiences about the likely causes of suicide, its warning signs, trends in suicide rates, recent treatment advances and other ways suicide can be prevented. Stories about well-known figures who have successfully sought treatment for depression, alcoholism and other conditions that convey suicide risk can also be a powerful impetus for readers to address such issues in their own lives.

Additional Strategies: Policy and Governance Advocacy

There is considerable infrastructure to be created for a prevention campaign to function effectively and for effective monitoring and evaluation activities to proceed. However, the development of this countywide infrastructure depends upon advocacy for supportive, enabling policies and legislation.

Safe Media Reporting on Suicide Guidelines: What to Do

Always include a referral phone number and information about local crisis intervention services.

Emphasize recent treatment advances for depression and other mental illness. Include stories of people whose treatment was life-saving or who overcame despair without attempting suicide.

Interview a mental health professional who is knowledgeable about suicide and the role of treatment or screening for mental disorders as a preventive strategy.

Emphasize actions that communities can take to prevent suicides.

Report on activities coordinated by your local or state suicide prevention coalition.

Guidelines provided by the
Suicide Prevention Resource Center
www.sprc.org
1-877-GET SPRC (1-877-438-7772)

Individuals function within a larger system beyond their families. For example, children spend their days in schools, child care centers, youth centers, juvenile justice system, or alone. Adults spend the majority of their days at work, in higher education or vocational training schools, in the criminal justice system or alone. Without the support and active participation of these larger systems in adopting simple measures, any prevention campaign would be seriously hampered. Simple measures such as creating, adopting, and implementing policies regarding the awareness and identification of individuals in emotional crisis or dealing with a mental illness is a simple, effective step.

Again, the planning committee recognized that this will be an ongoing activity and will require additional investments of time and resources for successful implementation.

Additional Strategies: Data Monitoring and Evaluation

As the SPAC reviewed national information about suicide and suicide risk, it became clear that nowhere in our nation is detailed information available at the local level in a way that provides policy makers and stakeholders with the amount of information needed to accurately describe the profile of who is at risk of suicide. Further, there is no clear way in which those suicide prevention efforts that currently are in place, or may be implemented with approval of this plan, can be evaluated for their effectiveness without a clearly defined, measurable monitoring and evaluation process in place.

The data monitoring strategy will include overseeing the coordination, collection, and reporting of useful data in close partnership with the

Medical Examiner and Coroner's Office. With the large, dissimilar number of agencies that are mandated to report self injury and "proven" suicides, there is much work to be done to agree on basic data needed; establish or adapt existing processes for reporting, collecting, and analyzing that data in a timely manner; and monitor data to evaluate the success of these efforts.

I don't want to die: The good work of SACS

Bob (a SACS volunteer) took a call from a teenage girl who wanted to be called Zee (not the caller's actual name). Zee was extremely distraught because she was having problems with her mother who was mentally ill. Zee called because she had just consumed an entire bottle of medications. Zee was hysterical because she decided that she didn't want to die after all, but she was too afraid to go downstairs and tell her father that she had taken all of her medications. After gaining Zee's trust and calming her down, Bob was able to convince Zee to go downstairs with the empty bottle and to turn it upside down in front of her father so he could see that all of the medications were gone. Bob told her that she didn't need to say anything to him. Then Bob asked Zee to call him back after she had done this. Zee called back about 10 minutes later and told Bob that she and her parents were in the car on their way to the hospital's emergency room.

Local Suicide Resources: A Range of Services

As a part of the process of determining local priorities, the SPAC assessed available local resources. Several Santa Clara County Mental Health Department programs were identified as contributing to the reduction of suicides. Moreover, these programs already are consistent with the recommendations of the *California Strategic Plan on Suicide Prevention*. A full listing

of agencies, programs and services that interact with individuals who die by suicide are listed in Attachment 2 in the Appendix. Some of the programs are specific to suicide prevention, such as the County-operated Suicide and Crisis Services (SACS), a 24-hour hotline staffed by a combination of paid and unpaid volunteers that respond to 35,000 calls per year from the community. As is common with many crisis hotlines, a small percentage of the calls are for immediate suicide interventions. The bulk of calls are for non-suicidal crisis help and information, which helps to prevent individuals from reaching the point of considering suicide.

SACS also provides support groups and other support programs in collaboration with community-based programs operated by Kara and the Bill Wilson Center's Centre for Living with Dying. The EMQ Crisis Team provides in the field crisis intervention services to children and adolescents; and the County's Emergency Psychiatric Services (EPS) provides 24-hour emergency intervention to individuals who require immediate psychiatric treatment, often meeting involuntary treatment criteria as "danger to self."

Pending and Future Additional Prevention Resources

In addition to these existing programs, the County's efforts to reduce suicides will be further enhanced when the Mental Health Services Oversight and Accountability Commission (MHSOAC) facilitates the implementation of the Statewide Suicide Prevention Program. The County will benefit through previously approved assignment of local MHSOAC funds to this statewide effort. Approximately \$13.7 million in local MHSOAC funds have been assigned for several statewide projects, including Suicide Prevention, Stigma and Discrimination Reduction, and School Mental Health Initiatives.

In addition, the Mental Health Department is currently implementing several projects approved by the MHSOAC in our local Prevention and Early Intervention Plan. Those projects include:

- **"Early Onset of Mental Illness"** – a prevention and early intervention program focusing on the needs of transition-age youth who may be experiencing at risk mental states (ARMS) or the onset of serious psychiatric illness with psychosis (e.g., schizophrenia). One study found that 15% of participants in an early psychosis program attempted suicide before beginning treatment.
- **Primary Care Behavioral Health Integration** - A project to integrate early intervention behavioral health services within primary care clinics to meet the emerging needs of adults and older adults. The project will use the Improving Mood—Promoting Access in Collaborative Treatment (IMPACT) model.
- **Outreach and Engagement** – a grassroots "gatekeeper" and mental health literacy program that trains key community members to be more aware of and responsive to early signs and symptoms of emotional distress.
- **Community Investment Initiative** - Programs that enable underserved communities to develop and implement campaigns to reduce stigma and discrimination concerning mental illnesses within their communities so that individuals are more willing to promptly seek help.

Moreover, these are only a few of the programs that will be included in the County's overall Prevention and Early Intervention (PEI) Plan. Through the PEI Plan, the Mental Health Department intends to bring mental health awareness into the lives of all members of the community and move the mental health system toward a "help-first" approach. The County's plan also will be coordinated with several state-administered, statewide PEI projects, including Suicide Prevention, Student Mental Health Initiative, Stigma and Discrimination Reduction, and Ethnically Specific Interventions. Together, statewide projects and local county PEI plans will create a system of prevention and early intervention services throughout the state.

What Experts Recommend

“Prevention efforts should ultimately reduce risk factors and promote protective factors. In addition, prevention should address all levels that influence suicide: individual, relationship, community, and society. Effective prevention strategies are necessary to promote awareness about suicide and to foster a commitment to social change.”⁹⁹ Santa Clara County’s Suicide Prevention Plan, when taken as a *coordinated* and interwoven *set of strategies and efforts*, will act in concert to prevent suicide. Individuals as well as organizations will have a role to play to contribute to the success of this effort. Our entire community as a whole has an active choice—to value each life and recognize that even one life lost to suicide was a preventable death.

Best Practices—Evolving Knowledge

The Suicide Prevention Resource Center (SPRC), in collaboration with the American Foundation for Suicide Prevention (AFSP), maintains a Best Practices Registry (BPR). This project is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the BPR is to identify, review, and disseminate information about best practices that address specific objectives of the National Strategy for Suicide Prevention. The BPR has three sections: Section I: Evidence-Based Programs (including 1a: SAMHSA’s National Registry of Evidence-Based Programs and Practices; and 1b: SPRC/AFSP Evidence-Based Practices); Section II: Expert and Consensus Statements; and Section III: Adherence to Standards.

Attachment 3 in the Appendix outlines ten prevention programs that address suicide and are currently listed on the NREPP registry: National Strategy for Suicide Prevention Ten Prevention Programs. In addition to the ten listed programs, the American Foundation for Suicide Prevention: Suicide Prevention Resource Center’s Evidence-Based Practices list contains an additional two.

As we make gains in breaking the taboo of suicide, we have an opportunity to learn more and contribute to the nascent and ever changing field of suicide prevention best practices.

V. What We Recommend:

Five Overarching and Interconnected Prevention Strategies

V. What We Recommend:

Five Overarching and Interconnected Prevention Strategies

The SPAC has identified five overarching recommendations, referred to as strategies that comprise the core of the Suicide Prevention Plan. These recommendations are born out of the values of the committee, the data and information reviewed and presented in this report, the personal experiences shared, and the feedback from the public forum. They are consistent with the American Foundation for Suicide Prevention Best Practices Registry suggestion, “In general, practitioners will achieve greater results by creating comprehensive approaches involving multiple layers of coordinated components.”

Strategy One - *Implement and coordinate suicide prevention and intervention programs and services for targeted high risk populations*

Strategy Two - *Implement a community education and information campaign to increase public awareness of suicide and suicide prevention*

Strategy Three - *Develop local communication “best practices” to improve media coverage and public dialogue related to suicide*

Strategy Four - *Implement policy and governance advocacy to promote systems change in suicide awareness and prevention*

Strategy Five - *Establish a robust data collection and monitoring system to increase the scope and availability of suicide-related data and to evaluate suicide prevention efforts*

While the basis for each strategy is summarized in the previous assessment section of this report, specific preliminary objectives for each strategy are outlined below. It is expected that once the broad strategies recommended in this plan are approved, an implementation plan will be written for each strategy. The implementation plan will further refine the objectives of each strategy as well as the steps to implementation and the budget requirements.

To ensure the successful project coordination and management, the Mental Health Department intends to hire a full-time Suicide Prevention Coordinator and Liaison to State Office of Suicide Prevention. That selection process has begun, and it is expected that someone will be hired for that role by August or September 2010.

Strategy One – Implement Suicide Intervention Programs and Services for Targeted High Risk Populations

Desired Outcomes

1. Decrease in the number of completed suicide acts.
2. Decrease in the number of attempted suicides.
3. Increase in the availability of culturally and linguistically appropriate and affordable intervention services in a variety of venues.
4. Improved and earlier identification and engagement of people dealing with mental illness.
5. Improvement in referral relationships to access appropriate care.
6. Increase in help-seeking behavior from individuals with mental illness and from those who are connected to individuals with mental illness.
7. Increase in support services to the family members and social network of individuals with mental health issues.
8. Improvement in quality of life for individuals and their loved ones who are dealing with mental illness.
9. Increase in diversity of services and programs that are tailored to high risk populations—youth, elders, internet, face-to-face.

Target Populations

1. Populations with highest risk of engaging in suicidal behavior (identified in section V. Review and Summary of Local Needs)
2. Individuals supporting persons at risk of suicide, such as significant others, family members, caregivers, professionals, clergy/faith leaders
3. Key service providers, such as mental health clinicians and primary care physicians, clergy, faith leaders, law enforcement
4. Community members

Current Activities and Recent Gains

Independent of this committee’s activities, other agencies are working to reduce and eliminate suicide. Discussed in more detail in Appendix 2, the following are summaries of ongoing intervention activities occurring in our county and possible next steps:

- Suicide and Crisis Services (SACS). This County program provides residents with access to a 24-hour telephone hotline. Operated primarily by 100 volunteers and with less than \$90,000 in annual funding, the program fields over 35,000 calls annually from suicidal clients, concerned family members and other residents in crisis. Approximately ten percent of calls are from individuals with suicide ideation. Recommendation: Evaluate if the community would be better served if SACS attained national Lifeline accreditation or whether to simply unify the three distinct phone numbers into one and expand the current program. [SACS consolidated its numbers to 1-855-278-4204. Feb. 2011]

Strategy One - Continued

- Survivors of Suicide Group and grief /loss support programs operated by Kara and the Bill Wilson Center's Centre for Living with Dying. Recommendation: Identify how more groups can be established throughout the county and increase efforts to recruit moderators to provide this service.
- SACS staff members provide training to various community organizations on suicide assessments and crisis intervention. Due to repeated budgetary restrictions, available staff to provide such valuable training is very limited. Recommendation: Seek alternative means and additional funding sources to be able to double or triple current trainings.
- County Mental Health Services. This County program provides an array of mental health services to primarily Medi-Cal beneficiaries and those who are uninsured. Approximately 22,000 children, adolescents, young adults, adults and seniors receive services annually through a network of County-operated and contracted programs.¹⁰⁰ Services range from outreach, peer advocacy, and case management to clinical care and support in a variety of community, outpatient, residential and day programs.
- Community-based organizations (CBOs). CBOs account for approximately half of the public mental health system's capacity, and they are a key component of the entire public safety net. These CBOs address county residents' behavioral health needs, including mental health concerns that involve the risk of suicide. The CBOs also leverage other funding sources and operate a variety of programs that address behavioral health needs that are not funded by the County Mental Health Department, such as the Status Offender Services network.
- EMQ's Families First Child and Adolescent Mobile Crisis Program. This program responds to the serious emotional trauma of minors, offering services in the home, at school and in the community. The EMQ Team responds 24/7 and often facilitates hospitalization and/or crisis intervention services to suicidal children and youth with other community agencies for long-term care and assistance. There is only one team that covers the entire county. Recommendation: 1) Investigate how this model could be expanded or replicated by other agencies. 2) Identify how this model could be expanded to provide similar services to adults.
- Emergency Psychiatric Services (EPS). Operated at Valley Medical Center, EPS is the single psychiatric emergency receiving center in the county. The program is key in responding to acute mental health crises that often involve risk of suicide. The 24/7 EPS program provides intervention services to individuals experiencing acute psychiatric episodes and who may be a danger to themselves or others. Annually, approximately 7,500 individuals arrive at EPS on "5150 holds," brought by law enforcement officers and others. The large majority of involuntary holds specify the "danger to self" criteria.

Strategy One - Continued

Mental Health Urgent Care (MHUC). This voluntary, unlocked, County-run program also provides residents with crisis intervention services. Services at MHUC, which are available to walk-ins, are provided daily from 8 am to 10 pm. Clients, family members, law-enforcement agencies and other first responders are encouraged to use MHUC to meet the needs of individuals experiencing severe emotional or psychological distress, including thoughts of self-harm. Recommendation: Promote this service more broadly to increase utilization.

- Police Crisis Intervention Training (CIT). In partnership with law enforcement agencies, the MHD is continuing to enhance law enforcement officers' abilities to manage crises involving mentally ill residents. In addition to reducing the need for using deadly force, this program can save lives by giving officers tools they can use when encountering individuals who intend to lose their lives by intentionally threatening police officers (i.e., suicide by police). Recommendation: 1) provide CIT training for cadets, and 2) collaborate with law enforcement to ensure that more officers receive Crisis Intervention Training (CIT).
- Golden Gateway. In addition to providing intensive case management and therapy to severely mentally ill older adults, this program conducts extensive outreach to and mobile assessments of homebound or shut-in seniors who would benefit from mental health services. Golden Gateway's services are important for preventing suicides in California. Adults aged 75 and over have the highest rates of suicide (California Strategic Plan on Suicide Prevention, June 2008).
- Self-Help Centers. These County programs offer drop-in, self-help and peer support for mental health consumers. Three programs provided in North, Central and South County locations offer the opportunity for consumers to find support and compassion within a supportive peer-run setting.
- Ethnic and Cultural Community Advisory Committees (ECCACs). Based on a similar philosophy to the self-help centers, the ECCACs are family and consumer support teams from eight ethnic and cultural communities.
- Gatekeeper Training. This will provide training to individuals in the community to increase the community's ability to refer friends and loved ones to appropriate resources at an earlier point in an individual's emotional crisis.
- Integrating Behavioral Health Services in Primary Care. The Mental Health Department will announce a Request for Proposal to support integrating behavioral health services in community-based, primary care settings by January 2011. Service delivery should begin by July 2012 and is intended to impact 4,200 individuals a year.

Strategy One - Continued

- Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Project 3- Prevention and Early Intervention for Early Onset Psychosis (in Youth and Young Adults 16-25). This Request for Proposal was announced June 7, 2010. Service delivery of early identification and treatment services should begin in October 2010. It is intended to provide countywide intervention and treatment services to 30 new clients a year.

Recommended Actions

Convene an implementation committee to accomplish the following:

- Conduct further research on specific practices for possible implementation and their costs
- Provide detailed analysis of available resources and service gaps
- Convene and implement a subcommittee for each age group
- Finalize recommended strategies
- Develop process and performance metrics for recommended/adopted strategies
- Prioritize specific strategies in regard to available funding and leveraging opportunities
- Identify strategies to procure and implement funding for selected strategies
- Prepare strategic implementation plan to be informed by public process

Strategy Two – Implement a Community Education and Information Campaign to Increase Public Awareness of Suicide and Suicide Prevention

Desired Outcomes

The Community Education and Information Campaign will focus on achieving the following outcomes:

1. Increased awareness of mental health issues, including depression and suicide
2. Increased public awareness of suicide
3. Improved identification of people who are feeling suicidal
4. Improved public knowledge of how to respond to a person who is feeling suicidal
5. Increased awareness of how to engage in and access support services, grief counseling services, and postvention services
6. Decreased judgment or blame associated with suicidal thoughts and feelings

Target Populations

This strategy involves a community-wide suicide prevention and awareness campaign to reach:

1. General public of all ages
2. Medical providers and support staff
3. Mental health clinicians and support staff
4. Clergy and faith leaders
5. Caregivers
6. In-home support workers and others who work with seniors and the disabled
7. Family members

Current Activities and Recent Gains

- Assigned a temporary suicide prevention project coordinator and liaison to California Office of Suicide Prevention. Recommendation: Mental Health Department hires a suicide prevention project coordinator/liason to the California Office of Suicide Prevention.
- Improved communications with the Santa Clara County Medical Examiner-Coroner's Office with the Survivor's of Suicide Program operated by the County, to ensure surviving families are better informed of available grief support services.
- Instituted a dedicated website to suicide prevention on the Mental Health Department's website: www.sccgov.org/spac with a focus on informing the public of this effort and improving awareness. Recommendation: Evaluate and determine the audience for the website, the main objectives for the website going forward, and the best manner to promote this website throughout the county.

Strategy Two - Continued

- Promoted an existing youth-focused (16-24 years) suicide prevention website www.reachout.com. Following the success of its Australian website, which proved instrumental in reducing the rate of youth suicide in Australia by more than half,¹⁰¹ the Inspire USA Foundation launched its American website from its San Francisco-based offices in March 2010. Reachout.com is an interactive website for young people that deals with coping with mental health problems; dealing with suicide and self-harm; drugs, alcohol and tobacco; family relationships; friend and peer relationships; becoming independent; loss and grief; maintaining good health; romance, sexuality and pregnancy; school pressures; and violence. The Executive Director was a guest speaker at one of the SPAC's meetings and is eager to partner more in our county's suicide prevention efforts. Recommendation: Promote this website broadly.
- Caltrain, an active partner in this effort, has agreed to make available advertising space on their trains, stations and buses for the specific use of this public education and awareness campaign. Recommendation: Work in close partnership with local transportation agencies, including VTA, to identify available means for communicating outreach message to ridership. Also, forge a tri-county or more partnership to share the cost of the outreach campaign, beginning with San Mateo and San Francisco Counties.
- Our county's school districts and County Office of Education have been actively involved in the effort to reduce youth suicide and raise awareness among their staff on how to recognize students in emotional distress or crisis and how to intervene and provide support. Recommendation: 1) Support schools in engaging their communities in dialogues about mental health and suicide prevention. 2) Track which school districts are adopting suicide prevention policies.
- Enlisted clergy, other faith leaders and lay leaders in the faith community to join in this effort. One of the committee's members, Bernie (Deacon) Nojadera represented Interfaith Connections and related the committee's goals, learning and activities to members of that group. More concentrated work can be done. Recommendation: Collaborate with the faith community to promote mental health awareness and suicide prevention in their ministry and outreach.
- Conducted a well attended Suicide Prevention Public Forum to obtain public comments and suggestions about suicide prevention and how to develop greater community awareness.

Recommended Actions

- Utilize multi-media tools in health care settings to promote awareness of mental health issues and suicide. Target Implementation Date: FY 2012 with award and implementation of Prevention and Early Intervention projects.
- Support efforts such as Onyourmind.net, a youth-oriented website that provides a safe and anonymous place for teens to get information and support from other teens. Youth are able to talk about anything on their minds, including relationships, school, depression,

Strategy Two - Continued

stress, suicide, friends, parents, cutting, identity, and health. They also can submit a question to be answered on the Q&A page or connect to resources for additional information and support.

- Enlist clergy, other faith leaders and lay leaders in the faith community to join in this community education and awareness effort. The elderly often have more regular contact with clergy and church members than with any other individuals or organizations. Seniors have the highest church attendance rates across all age groups, and clergy often are the first professional groups to which people turn when they have personal problems.¹⁰² Moreover, clergy and other faith leaders are among the few whose responsibilities regularly take them into homes and care facilities. Target Implementation Date: September 2009, after the Board of Supervisors has approved the Plan.
- Build on current, successful MHSa-supported efforts to coalesce the clergy and other faith leaders around efforts to better recognize and respond to emerging mental health needs and to recognize and combat signs of elder abuse, either caused by self-neglect or perpetuated by others. All of these endeavors recognize that Santa Clara County is one of eleven counties in California predicted to experience the greatest population growth among its seniors.¹⁰³ Target Implementation Date: September 2009, after the Board of Supervisors has approved plan.
- Enlist suicide attempt survivors, suicide survivors (individuals who have lost a loved one to suicide), and suicide prevention collaborative members to conduct a “Listening Campaign” at multiple locations throughout the county. This follows the model implemented by the U.S. Army to solicit feedback on the emotional pulse of their communities. Additionally, this activity encourages awareness and discussion of mental health issues, suicide prevention and available resources. Recommendation: Kick off this effort after the Suicide Prevention Coordinator has been hired by the Mental Health Department.
- Gatekeeper Training. There are many models available. Recommendation: Identify and adopt the version or versions that would be most effective for our county to serve dual functions: 1) increase awareness and identification of individuals in need or emotional duress; and 2) improve community involvement in seeking support for individuals in emotional crisis or need.
- Recommendation: Create a Communications Plan Work Group, discussed in Strategy 3, to play an advisory role in the following Community Education and Information activities:
 - Create, replicate and implement a variety of tools and techniques to better inform people about suicide, suicide prevention, and mental health awareness.
 - Explore feasibility of creating a new PSA campaign or utilize and promote existing PSAs. For example, the AdCouncil has a current teen suicide prevention

Strategy Two - Continued

campaign sponsored by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

- Ensure the Community Education and Information Campaign will include multi-media outlets as well as evaluating if new spots should be created or if we should promote and utilize existing campaigns. For example, “We’ve Been There” is an existing television spot with a partner “We’ve Been There” radio spot. “Angry Hurt Helped” and “Hopeless Lost Inspired” are some campaigns developed for print media. Social networking sites, as well as outdoor and interactive elements will need additional messaging created or existing messaging identified to be considered for possible use.
 - Ensure leveraging of existing and available media productions that promote awareness. For example: More Than Sad Films, produced by the American Foundation for Suicide Prevention (AFSP) in partnership with the New York State Office of Mental Health. This 25-minute film and manual is part of an educational program to help teachers and other school personnel learn more about teen suicide and how they can play a role in its prevention.
 - Enlist a collaborative effort with our neighboring counties, San Mateo and San Francisco, to participate and perhaps leverage resources for a Silicon Valley-wide multi-media campaign.
-
- Develop concise, clear messaging vehicles to quickly convey information.
 - Give a voice to suicide attempt survivors and individuals who have lost a loved one to suicide (suicide survivors) so they can become a positive force in the community and prevent future suicides.
 - Educate systems that involve large populations on suicide prevention and response.
 - Encourage and coordinate opportunities for groups to share cultural and familial perspectives on death and dying.

Strategy Three - Develop Local Communication “Best Practices” to Improve Media Coverage and Public Dialogue Related to Suicide

Desired Outcomes

1. Creation of a coordinated communication strategy that
 - Ensures the development of a clear, concise, paradigm-shifting message for all outreach efforts;
 - Ensures that the guidelines for responsible communication on issues pertaining to suicide are adhered to by media and agencies; and
 - Ensures consistency in public messaging.
2. Educate various sectors of our economy: for-profit, government, non-profit.
3. Increase knowledge in local media on the importance of responsible reporting about suicide as measured by adherence to Safe Reporting on Suicide guidelines (see page 56).
4. Obtain agreement and follow-through among key media outlets (traditional and non-traditional) to coordinate public news releases strategically to address periods when suicide risk is higher and to respond appropriately to suicide deaths, clusters, and suicide-homicide deaths.
5. Obtain agreement and follow-through among key media outlets (traditional and non-traditional) to ensure the utilization of resource directories on local suicide prevention and crisis services in multiple languages.
6. Obtain agreement and follow-through among key media outlets to ensure all materials are linguistically and culturally appropriate for Santa Clara County’s residents.
7. Maintain a dedicated suicide prevention website and clarification of its target audience and purpose.

Target Populations

1. Local media outlets—traditional and non-traditional
2. Public Information Officers (PIOs) in government and business
3. Human resources departments, employee assistance services, unemployment offices, and Social Security Offices

Current Activities and Recent Gains

Fortunately, there are abundant, credible sources of information about concrete ways to improve the media coverage of suicides and reduce the rate of reporting activities precipitating additional suicides or attempts. The result of a collaborative effort was the development and

Strategy Three - Continued

release of a consensus document, *Reporting on Suicide: Recommendations for the Media*¹⁰⁴.

- National advocate for suicide prevention and member of the SPAC, Mary Ojakian, along with SPAC member Mark Simon, participated in Project Safety Net and helped to organize a round table discussion among several local publishers on the importance of adopting the guidelines on safe reporting on suicide.
- A website dedicated to suicide prevention was established on the Mental Health Department's website, www.sccgov.org/spac, listing resources and describing activities of the Suicide Prevention Advisory Committee. Recommendation: A Suicide Prevention Project Coordinator should ensure that the website is in alignment with messaging defined by the Work Group and in alignment with best practices to the fullest extent possible.
- Assigned project coordination responsibilities to the liaison to the California Department of Mental Health's Office of Suicide Prevention.

Recommended Actions

The Suicide Prevention Advisory Committee (SPAC) recommends the following activities to ensure an effective **Communications Plan**:

1. Convene a Communications Plan Committee, chartered to:
 - Develop a Communications Plan appropriate for the diverse residents of Santa Clara County.
 - Define one to three clear, concise, paradigm-shifting priority messages (e.g., MADD's "Friends don't let friends drive drunk").
 - Using local community input, tailor the above paradigm-shifting messages for different targeted populations, i.e., language, age, etc.
 - Educate media and local reporters about safer protocols on reporting suicide attempts and deaths. The SPAC recommends the utilization of the "*Safe Reporting on Suicide Guidelines*," prepared by the Suicide Prevention Resource Center. These guidelines are recommended for promotion and utilization in Santa Clara County. Dissemination of these guidelines should be one aspect of this strategy. Engaging in discussions with each of the media outlets should be the emphasis.
 - Consider and review the potential of existing efforts to raise awareness for possible inclusion in this strategy. Some examples for consideration include a training workshop targeting reporters and media personnel offered by the American Foundation for Suicide Prevention (AFSP) and the Substance Abuse Mental Health Services Administration's (SAMHSA) "Picture This: Depression and Suicide Prevention," a publication targeting media personnel.
 - Consider fostering a broad coalition including neighboring counties that all share the Silicon Valley's media communications, to include San Mateo and San Francisco Counties, to leverage funding and resources.

Strategy Three - Continued

- Work with social networking companies.
- Continue work on development and implementation of PSAs, news releases, web-based information, and other media/materials.

Strategy Four - Implement Policy and Governance Advocacy to Promote Systems Change in Suicide Awareness and Prevention

Desired Outcomes

While specific measurable outcomes need to be developed for this strategy, in general terms, goals of this strategy are to:

1. Increase public awareness of suicide as a public health problem within an organization by promoting adoption of policies and programs that either work to prevent suicide or respond to emotional crises.
2. Promote local, state, and federal policies and programs that prevent suicide.
3. Disseminate information to individuals in the community regarding the Santa Clara County Suicide Prevention Plan and its recommended activities.
4. Build partnerships with other local suicide prevention and mental health agencies, governments, media, and other organizations with a stake in public health.
5. Help remove the stigma associated with suicide by bringing the subject out in the open and discussing what can be done to prevent it.
6. Recruit individuals and organizations to advocate for policy change and/or adoption in their workplace or community site.
7. Change laws—see ***Recommended Actions*** below.
8. Advocate for prevention funding.

Target Populations

The committee's recommended strategies in this category include advocacy on behalf of:

- Partnerships between primary care and mental health professionals;
- Partnerships with support organizations and service providers (e.g., churches, employee assistance programs, schools, National Alliance on Mental Illness, etc.) to raise awareness and create a welcoming environment for those at risk of suicide;
- Strong networks of support organizations and service groups (e.g., a network of youth-supporting organizations and service groups);
- Active participation across sectors, industries, and groups in implementing strategies (e.g., education, healthcare, non-profit, for-profit, government);
- Legislative or policy changes in government and institutions, with a goal of convincing as many systems as possible to play key roles in suicide prevention;
- Broad adoption of policies mandating cultural and linguistic competency;
- Standardization of reporting requirements across sectors and agencies; and
- Possible certification of a countywide hotline with National Suicide Prevention Center's Lifeline.

Strategy Four- Continued

Current Activities and Recent Gains

- Palo Alto Unified School District Board of Education adopted a policy for suicide prevention in their school district at their meeting June 1, 2010, and Los Gatos Union High School District is working on a similar policy.
- Palo Alto Unified School District has shared their policy and Articles of Regulations implementation guidelines. All districts have been requested to create a comparable policy.
- Partnered with the County Medical Examiner-Coroner's Office to improve data collection for future psychological profiling activities of those identified as dead by suicide.
- County Medical Examiner-Coroner's Office provided the first-ever comprehensive investigative reports for all suicides that occurred in 2009 to be able to begin to analyze and possibly use in future psychological profiling efforts.
- County Medical Examiner-Coroner's Office is considering the adoption of a new policy that they annually prepare investigative reports for all suicides that occurred in the previous year for subsequent analysis of the data.
- Revamped training for involuntary suicide prevention holds—5150/ 5250.
- In partnership with law enforcement agencies, the Mental Health Department is continuing to enhance law enforcement officers' abilities to manage crises involving mentally ill residents through Police Crisis Intervention Training (CIT). In addition to reducing the need for using deadly force, this 40-hour program can save lives by giving officers tools they can use when encountering individuals who intend to lose their lives by intentionally threatening police officers (i.e., suicide by police). Recommendation: 1) Advocate for more required mental health training for cadets, and 2) advocate for law enforcement agencies to require that more officers receive Crisis Intervention Training (CIT).
- Our county's school districts have been actively involved in the effort to reduce youth suicide and to raise awareness among their staff on how to recognize students in emotional distress or crisis and how to intervene and provide support. Recommendation: Advocate and monitor adoption until all school districts adopt and implement a policy.
- PEI Project 5 - Suicide Prevention. The Interim Suicide Prevention Oversight Committee will write PEI Project 5 - Suicide Prevention Proposal for submission to the Oversight and Administration Committee (OAC) for approval. This proposal will include funding for a Suicide Prevention Coordinator. Anticipated submission date for the new project is August to September 2010. Approval for the new project is expected by July 2011.
- The Mental Health Department will request joining the California Mental Health Services Authority (CalMHSA) in August 2010, with acceptance anticipated for October 2010, at which time the Mental Health Department will be able to represent Santa Clara County in the California Mental Health Services Act discussions and deliberations concerning the:
 - Student Mental Health Initiative
 - State suicide prevention efforts and programming, and
 - Ethnic specific programs.

Strategy Four- Continued

Recommended Actions

We will identify and work with local organizations, including schools and school districts, to support suicide prevention efforts. This will be part of an ongoing effort to identify, share and leverage resources, to provide other forms of assistance as feasible and desirable, and to move toward the objective of comprehensive adoption and implementation of effective suicide prevention measures in all key venues.

The American Foundation for Suicide Prevention (AFSP) suggests several tools for learning more about effective advocacy. The SPAC recommends that these tools be considered when detailing the specific activities of this strategy. The references include:

- National Mental Health Association’s Advocacy Primer
- Grassroots Tool Kit: A manual on event planning, coalition building, and grassroots advocacy from the Leadership Conference on Civil Rights
- Advocate’s Guide to Grassroots Organizing During a Congressional Recess from the Leadership Conference on Civil rights, and
- Speak, Out! A Guide to Advocacy regarding Mental Health Policy from the Mental Health Association of Westchester County.

Some specific actions suggested by the AFSP in the area of advocacy include, but are not limited to, the following:

1. Strengthening legislation on veteran and military suicide prevention to promote longitudinal research on the rates and develop anti-stigma campaigns and continue to expand suicide prevention programs to assist members, returning veterans and their family members.
2. Adoption of legislation and other policy directives to encourage the National Institutes of Health Agencies to invest more substantially in research related to suicide, suicide prevention, and survivors of suicide loss or suicide attempts.
3. Appropriations at the maximum attainable level for the National Violent Death Reporting System.
4. Implementation of Mental Health Parity and Health Insurance Reform.
5. Reauthorization of and appropriations for the Substance Abuse and Mental Health Services Administration (SAMHSA).
6. Adoption of legislation to allow the Golden Gate Bridge Authority (and other local jurisdictions) to use federal funds for bridge suicide prevention barriers.
7. Adoption of legislation that aims to reduce bullying and cyber-bullying.
8. Adoption of legislation to establish Depression Centers of Excellence.

Strategy Five - Establish a Robust Data Collection and Monitoring System to Increase the Scope and Availability of Suicide-Related Data and to Evaluate Suicide Prevention Efforts

This strategy develops and sustains processes for collecting and analyzing state and local data that will help establish local program priorities and evaluate the impact of suicide prevention strategies.

Desired Outcomes

Proving that this plan is making a difference by reducing the number of deaths by suicide can only be accomplished by collecting data and monitoring the activities of the plan and its outcomes. In order to do this the following goals must be met:

1. Expand reporting on suicide attempts and deaths;
2. Increase accuracy in reporting of data related to suicide and prevention activities;
3. Increase the convergence of data reported by various entities;
4. Increase availability of comprehensive data on suicide-related activities in Santa Clara County; and
5. Establish and define a centralized monitoring body of suicide prevention activities and outcomes.

Target Population

1. General public
2. Policy makers and funding entities
3. Local public health monitoring system
4. Implementation entities

Current Activities and Recent Gains

- Partnered with County Medical Examiner-Coroner's Office to improve data collection for future psychological profiling activities of those identified as dead by suicide.
- County Medical Examiner-Coroner's Office provides to the committee a compilation of the routine investigation reports for all reported suicide deaths on a yearly basis, beginning with 2009 deaths.
- Collected and conducted a preliminary review of suicide data for Santa Clara County including by zip code, city, and a variety of social factors.
- Conducted preliminary needs assessment of high risk population groups.

Strategy Five - Continued

Recommended Actions

Local efforts, as recommended by the SPAC, will be defined more specifically and completed during the implementation phase. They include:

1. Identify a Monitoring Team to
 - a. Oversee plan implementation,
 - b. Identify resources and funds,
 - c. Produce an implementation schedule,
 - d. Select and begin meetings of a Suicide Prevention Oversight Committee (SPOC),
 - e. Devise plan for continuous data collection and analysis,
 - f. Develop and report standards for monitoring and measuring plan outcomes, and
 - g. Elicit public input on strategies and funding priorities;
2. Determine specifically what additional data are needed to accurately monitor the number of lives lost to suicide;
3. Define baselines for strategies in existence at that time;
4. Conduct a review of all suicide prevention resources in County;
5. Define or refine planning and process metrics to track prevention and intervention strategies;
6. Review and interpret data on lives lost to suicide;
7. Work for the creation of a Santa Clara County Suicide Death Review Committee; and
8. Monitor the Plan's implementation to ensure that efforts continue across various systems as part of a countywide approach to reduce suicide.

The committee recommends achieving the desired outcomes by establishing a monitoring system as described by "National Strategy for Suicide Prevention, Goals and Objectives for Action," an outline adopted by the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration and the National Mental Health Information Center, which includes the following:

- Track trends in rates,
- Identify new problems or additional data required,
- Provide evidence to support activities and initiatives,
- Identify risk and protective factors,
- Target high risk populations for interventions, and
- Assess the impact of prevention efforts.

Strategy Five - Continued

Additionally, the committee recommends:

- Establishing a Death Review Panel and process to review reports of all deaths by suicide, and possibly suspected suicide in order to create psychological profiles of those at risk.
- Create an annual report based on psychological profile findings to contribute to the knowledge of suicide in Santa Clara County.
- Learn from past suicides and suicide attempts to prevent similar situations in the future.
- Conduct a comprehensive assessment of mental health services and standards in the county.
- Identify what additional data is required for our county's suicide prevention efforts.
- Identify leading causes of suicide in Santa Clara County to assist in identifying priorities for means restriction, as appropriate.
- Develop and maintain a current database of academic articles, data, and other resources on suicide.
- Monitor high-traffic, youth-oriented websites to assess suicide-related content and take action where needed. (Examples of online sites include: YouTube, Facebook, and Twitter.)
- Inventory existing social and medical service centers, such as hospitals and medical clinics, to determine gaps and best practices in the mental health system.
- Monitor outreach activities offering support for previous suicide attempters.
- Conduct a comprehensive assessment and determine methods to reach and provide for those at-risk of suicide.

Potential sources for data

- Nationally, suicide surveillance data come from death certificates. This vital statistics information is available from the National Center for Health Statistics, Centers for Disease Control and Prevention. Medical examiner databases also provide some information related to suicide. The information on rates available from vital statistics databases obviously does not include those deaths misclassified as homicides or accidents, and an unknown number of others misclassified as natural causes but which may actually be suicides. Information available from death certificates is limited and is not always complete. Prevention efforts would be enhanced by more comprehensive information. However, such information is not now systematically collected.
- Data on suicide attempts must come from sources designed for other purposes, such as trauma registries and uniform hospital discharge data sets. Trauma registries provide detailed information about the nature and severity of an injury, the treatment provided, and the status of the patient on discharge from the hospital. However, most trauma registries include only "major" trauma cases, those that require at least a three-day hospital stay. Moreover, many suicide attempts do not lead to traumatic injuries (e.g.,

Strategy Five - Continued

overdoses of medicines). Thus, trauma registries have only limited information on suicide attempts.

- A uniform hospital discharge data set is another potential source of information on suicide attempts. As suggested by its name, a hospital discharge data set provides information only about those suicide attempts that resulted in hospital treatment. Not all states require either trauma registries or uniform hospital discharge data.

The State of Oregon is unique in that a 1987 law requires hospitals treating a child under the age of 18 for injuries resulting from a suicide attempt to report the attempt to the Oregon Health Division. This data source provides important information for youth suicide prevention programming in Oregon.

- Other possible sources of data on suicide attempts include mental health agencies, psychiatric hospitals, poison control centers, universities and colleges, child death review team reports, emergency departments, and surveys. Limitations exist for all of these data sources, such as lack of detail on the circumstances surrounding the suicide attempt. Detailed information is important because it may lead to increased knowledge of how suicides can be prevented in the future.

VI. Next Steps

VI. Next Steps

The desired outcomes for each of the five recommended strategies in the Suicide Prevention Strategic Plan (the Plan) cannot be achieved through isolated actions or services. The scope of the problem and the need for community-wide support necessitates long-term, sustained and coordinated effort by many stakeholders. There is no time to waste. The goal of this section is to commit Santa Clara County to concrete actions that will tangibly improve suicide prevention activities in the County by December 31, 2010. These actions will lay the foundation for full implementation of the Plan.

Infrastructure. These actions are intended to create the requisite infrastructure to implement, coordinate and report on suicide prevention efforts throughout the county.

- 1) **Establish a Suicide Prevention Oversight Committee (SPOC).** The SPOC will advise the Board of Supervisors on the implementation of the Plan and will submit semi-annual progress reports to the Board of Supervisors' Health and Hospital Committee (HHC). The SPOC will work closely with the Mental Health Department (MHD), which will serve as the lead agency in coordinating suicide prevention services/activities throughout the county.
- 2) **Hire a Suicide Prevention Coordinator.** To ensure timely facilitation and ongoing support for implementation of the Plan, the MHD will designate one full-time staffperson as the County's Suicide Prevention Coordinator.¹ This staff person also will serve as the County's liaison to the California Office of Suicide Prevention.
- 3) **Form Four Work Groups.** As indicated in the Plan, the SPOC will form four work groups, each of which will plan for, oversee, and report on the implementation and effectiveness of its assigned strategies. The following four work groups will develop implementation plans for each strategy:
 - a) An **Intervention Strategies** work group (Strategy 1) will compile a comprehensive overview of existing and needed intervention strategies. It will coordinate a system of suicide prevention services.
 - b) A **Communications Practice** work group (Strategies 2 and 3) will have oversight over all resulting communication projects and activities related to suicide prevention, both locally and regionally, including a Community Education Campaign.
 - c) A **Policy and Governance** work group (Strategy 4) will advocate for the adoption of suicide prevention policies and protocols among agencies, systems and organizations throughout the County.
 - d) A **Data Committee** (Strategy 5) will define the Plan's data requirements, sources and reporting processes.

¹ This assumes that the Board of Supervisors and the State will approve a fifth MHSA Prevention & Early Intervention project.

Early Implementation. Upon approval from the Board of Supervisors, the MHD will proceed with the following actions which will either immediately reduce suicides or develop new funding sources for suicide prevention activities.

- 1) **Develop Formal MHSA PEI Project for Suicide Prevention.** The MHD will develop a fifth Prevention and Early Intervention (PEI) Project for Suicide Prevention and hire a full time (1.0 FTE) Suicide Prevention Coordinator. If approved by the State, “PEI Project 5” will fund approximately \$800,000 in new suicide prevention activities annually for three to four years. Funding from this project will support activities in each of the Plan’s five strategies, laying the foundation for new services and resource development. The SPOC will devise a process to apportion available funding to each of the five strategies.
- 2) **Implement Listening Campaigns.** The Suicide Prevention Coordinator will begin implementing “Listening Campaigns” to promote mental health and suicide prevention awareness. The Listening Campaigns also will serve as an ongoing vehicle for incorporating residents’ input into the Plan’s implementation.
- 3) **Make Formal Connections to Statewide Suicide Prevention Efforts.** The MHD will actively coordinate with and leverage existing statewide suicide prevention efforts, including the activities of the California Mental Health Services Authority (CalMHSA). The MHD’s goals are to influence the development of statewide programs and to ensure that local funds—which have been assigned to support statewide PEI projects—have an impact on local efforts.
- 4) **Implement Approved Suicide Prevention-Related PEI Plans.**
 - a) **“First Break” Treatment Programs.** Under PEI Project 3, the MHD will initiate services to help individuals, especially for adolescents and Transitional Age Youth (16-25), address the onset of serious psychiatric illness (with psychotic features).
 - b) **Community Education and Training.** Under PEI Project 1, the MHD will increase mental health literacy and reduce stigma and discrimination within underserved cultural communities by implementing Mental Health First Aid programs.
 - c) **Integrated Behavioral Health.** The MHD will implement early intervention services in community-based, primary care clinics to serve approximately 4,200 patients annually (once fully operational).
 - d) **Gatekeeper Training.** The MHD will implement “gatekeeper” programs for older adults.

The above concrete actions will augment current suicide prevention efforts. Modifications or expansion of the aforementioned programs will be influenced by the SPOC as it implements the Plan’s five strategies.

VII. Appendix

Attachment 1: Suicide in Santa Clara County by Zip Code, 2000-2006 Suicide-Homicide Comparison Table

Attachment 2: Santa Clara County Community Agencies and Programs that Interface with Suicide Attempters, Victims, and Loved Ones

Attachment 3: Best Practices Recommendations

Attachment 4: Summary of Public Forum Input

Attachment 5: Palo Alto Unified School District Suicide Prevention and Mental Health Promotion Policy

Attachment 6: References

Attachment 1. Suicides in Santa Clara County by Zip Code, 2000-2006, and Suicide-Homicide Comparison Table

ZIP	CITY	2000		2001		2002		2003		2004		2005		2006	
		SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM
94022	Los Altos	1	0	3	0	0	0	0	0	0	0	0	0	3	0
94024	Los Altos	0	0	3	0	4	0	6	0	2	0	1	0	5	0
	L.A. & L.A. Hills Totals	1		6		4		6		2		1		8	
94040	Mountain View	2	0	6	0	2	0	5	1	4	1	1	0	3	0
94041	Mountain View	4	0	0	0	1	0	0	0	2	1	0	0	1	0
94043	Mountain View	1	0	5	1	4	1	4	0	2	0	2	0	0	1
	M.V. Totals	7		11		7		9		8		3		4	
94085	Sunnyvale	0	0	0	0	0	0	4	0	0	0	0	0	3	0
94086	Sunnyvale	9	2	8	0	11	2	7	3	7	1	3	2	4	0
94087	Sunnyvale	4	0	4	0	3	1	2	0	9	0	4	1	1	0
94089	Sunnyvale	0	0	5	0	2	0	0	0	2	1	3	0	2	1
	Sunnyvale Totals	13		17		16		13		18		10		10	
94301	Palo Alto	2	0	2	0	2	0	3	2	7	0	1	0	2	0
94303	Palo Alto	2	5	5	5	2	4	1	9	4	4	4	11	0	7
94304	Palo Alto	0	0	0	0	0	0	0	0	0	1	0	0	0	0
94305	Stanford	0	0	1	0	0	0	0	0	0	0	1	0	0	0
94306	Palo Alto	0	1	2	0	2	0	2	0	4	2	2	0	6	1
95002	Alviso	0	0	0	0	0	0	0	0	0	0	0	0	0	0

ZIP	CITY	2000		2001		2002		2003		2004		2005		2006	
		SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM
95008	Campbell	1	0	2	0	4	0	4	1	4	0	1	3	7	0
95014	Cupertino	4	0	2	0	1		2	0	2	0	2	0	4	0
95020	Gilroy	5	7	5	3	5	1	2	2	3	0	4	2	3	1
95030	Los Gatos	0	0	2	0	1	0	3	0	1	1	2	0	3	0
95032	Los Gatos	4	0	2	0	0	0	3	0	4	0	5	0	1	0
95035	Milpitas	3	1	2	1	3	0	4	3	6	2	6	3	1	1
95037	Morgan Hill	0	1	3	0	7	0	6	0	4	1	3	1	3	0
95046	San Martin	0	0	0	2	1	0	1	0	0	0	0	0	1	0
95050	Santa Clara	2	2	3	0	1	2	5	0	1	2	2	2	1	2
95051	Santa Clara	6	0	2	0	4	3	1		4	0	2	3	6	0
95054	Santa Clara	0	0	1	1	0	0			1	1	1	2	0	0
	S.C. Totals	8		6		5		6		6		5		7	
95070	Saratoga	3	1	2	0	3	0	3	1	9	5	1	1	0	1
95110	San Jose	3	0	0	2	0	0	3	1	0	1	0	2	0	0
95111	San Jose	5	3	4	0	1	2	6	2	3	2	8	1	3	2
95112	San Jose	3	3	2	3	9	1	5	4	3	3	3	0	5	1
95113	San Jose	0	0	0	1	0	0	0	0	1	0	2	0	1	0
95116	San Jose	1	3	1	3	3	5	1	2	3	4	2	4	6	1
95117	San Jose	5	0	1	0	2	0	2	0	3	1	1	0	2	4
95118	San Jose	0	2	2	1	2	0	0	2	4	4	1	1	2	0
95119	San Jose	0	0	0	0	0	0	1	1	0	0	0	0	2	1
95120	San Jose	2	0	2	0	7	3	0	0	2	1	0	0	6	0
95121	San Jose	3	0	3	1	1	0	1	1	1	1	0	0	0	1
95122	San Jose	3	1	1	2	1	3	1	4	1	5	4	3	1	6
95123	San Jose	7	2	3	2	5	1	3	1	10	0	8	0	2	0
95124	San Jose	4	0	4	0	3	0	8	0	6	0	8	1	3	1
95125	San Jose	9	1	3	1	2	1	5	1	8	1	4	0	2	1
95126	San Jose	1	1	1	4	2	0	3	1	4	1	2	0	1	0

ZIP	CITY	2000		2001		2002		2003		2004		2005		2006	
		SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM	SUI	HOM
95127	San Jose	1	2	4	3	3	7	6	5	5	1	5	3	1	4
95128	San Jose	4	1	3	1	1	1	5	1	0	1	2	0	2	0
95129	San Jose	0	0	1	1	6	0	1	0	2	0	2	3	0	0
95130	San Jose	2	0	1	0	0	0	1	0	1	1	0	0	1	0
95131	San Jose	2	1	3	0	0	0	0	1	1	0	0	0	0	0
95132	San Jose	3	1	2	0	5	2	3	1	4	0	1	1	3	1
95133	San Jose	1	1	0	1	1	1	1	0	1	2	1	3	1	2
95134	San Jose	0	0	0	0	1	0	1	1	3	0	1	0	0	1
95135	San Jose	2	0	1	0	1	0	2	0	1	0	0	0	0	0
95136	San Jose	1	1	3	0	1	0	3	0	1	1	2	0	1	1
95138	San Jose	0	0	0	0	0	0	1	0	2	0	0	0	0	0
	<i>S.J. Totals</i>	65		47		61		65		73		60		47	
TOTAL		120		120		125		133		156		112		109	



California Department of Finance, Demographic Research Unit, Estimates of Population of California Cities, 2006:

Campbell	36,984
Cupertino	55,000
Gilroy	48,448
Los Altos and Los Altos Hills	36,065
Los Gatos	28,971
Milpitas	65,235
Monte Sereno	3,511
Morgan Hill	37,066
Mountain View	71,947
Palo Alto	62,108
San Jose	953,058
Santa Clara	110,700
Saratoga	30,815
Sunnyvale	133,458
Unincorporated	98,244
Total County-2006 Estimate	1,771,610

Attachment 2. Santa Clara County Community Agencies and Programs that Interface with Suicide Attempters, Victims, and Loved ones

Program Name	Description
Suicide and Crisis Services (SACS) Operated by: County Mental Health Department	<p>This county program provides residents with access to a 24-hour telephone hotline. Operated primarily by 100 volunteers and with less than \$90,000 in annual funding, the program fields over 35,000 calls annually from suicidal clients, concerned family members and other residents in crisis. Approximately 10% of calls are from individuals with suicide ideation. SACS also supports grieving families and friends through its Survivors of Suicide Group and partners with grief /loss support programs operated by Kara and the Bill Wilson Center's Centre for Living with Dying. Several times each year, SACS staff members provide training to various community organizations on suicide assessments and crisis intervention.</p>
County Mental Health Services Operated by: County Mental Health Department	<p>This county program provides an array of mental health services to primarily Medi-Cal beneficiaries and those who are uninsured. Approximately 22,000 children, adolescents, young adults, adults and seniors receive services annually through a network of County-operated and contracted programs.¹⁰⁵ Services range from outreach, peer advocacy, and case management to clinical care and support in a variety of community, outpatient, residential and day programs.</p>
Community-based organizations (CBOs) Operated by: County Mental Health Department	<p>CBOs account for approximately half of the public mental health system's capacity, and they are a key component of the entire public safety net. These CBOs address county residents' behavioral health needs, including mental health concerns that involve the risk of suicide. The CBOs also leverage other funding sources and operate a variety of programs that address behavioral health needs that are not funded by the County Mental Health Department, such as the Status Offender Services network.</p>
EMQ's Families First Child and Adolescent Mobile Crisis Program Operated by: County Mental Health Department	<p>This program responds to the acute psychological crises of minors, offering services in the home, at school and in the community. The EMQ Team responds 24/7 and often facilitates hospitalization and/or crisis intervention services to children and youth who are suicidal.</p>
Emergency Psychiatric Services (EPS) Operated by: County Mental Health Department	<p>Operated at Valley Medical Center, EPS is the single psychiatric emergency receiving center in the county. The program is key in responding to acute mental health crises that often involve risk of suicide. The 24/7 EPS program provides intervention services to individuals experiencing acute psychiatric episodes and who may be a danger to themselves or others. Annually, approximately 7,500 individuals arrive at EPS on "5150 holds," brought by law enforcement officers and others. The large majority of involuntary holds specify the "danger to self" criteria.</p>
Mental Health Urgent Care (MHUC) Operated by: County Mental Health Department	<p>This voluntary unlocked county-run program also provides residents with crisis intervention services. Services at MHUC, which are available to walk-ins, are available daily from 8 am to 10 pm. Clients, family members, law enforcement agencies and other first responders are encouraged to use MHUC to meet the needs of individuals experiencing severe emotional or psychological distress, including thoughts of self-harm.</p>

Police Crisis Intervention Training (CIT)	In partnership with law enforcement agencies, the MHD is continuing to enhance law enforcement officers' abilities to manage crises involving mentally ill residents. In addition to advocating for more required mental health training for cadets, the MHD is working to ensure that all officers receive Crisis Intervention Training (CIT). In addition to reducing the need for using deadly force, this 40-hour program can save lives by giving officers tools they can use when encountering individuals who intend to lose their lives by intentionally threatening police officers (i.e., suicide by police).
Operated by: County Mental Health Department	
Golden Gateway	In addition to providing intensive case management and therapy to severely mentally ill older adults, this program conducts extensive outreach to and mobile assessments of homebound or shut-in seniors who would benefit from mental health services. Golden Gateway's services are important for preventing suicides in California. Adults aged 75 and over have the highest rates of suicide (California Strategic Plan on Suicide Prevention, June 2008).
Operated by: County Catholic Charities	
Self-Help Centers	These county programs offer drop-in self-help and peer support for mental health consumers. Three programs provided in North, Central and South county locations offer the unique opportunity for consumers to find support and compassion within a supportive peer-run setting.
Operated by: County Mental Health Department	
Ethnic and Cultural Community Advisory Committees (ECCACs)	Similar to the philosophy of self-help centers, the ECCACs are family and consumer support teams from eight ethnic and cultural communities who offer support and linkage to services.
Operated by: County Mental Health Department	
Toll Free Veterans' Suicide Prevention Hotline	1-800-273-TALK (8255), and press "1". The Department of Veterans Affairs' (VA) The Veterans Health Administration (VHA) has founded a national suicide prevention hotline to ensure veterans in emotional crisis have free, 24/7 access to trained counselors. To operate the Veterans Hotline, the VA partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Suicide Prevention Lifeline. Veterans can call the Lifeline number, 1-800-273-TALK (8255), and press "1" to be routed to the Veterans Suicide Prevention Hotline.
Operated by: Department of Veterans' Affairs	
Veteran Suicide Chat Service	www.suicidepreventionlifeline.org . Veterans may use Veterans Chat without identifying themselves or revealing any personal information unless the person chooses to do so. Mental health clinicians on the Veterans Chat do not provide treatment or care. The clinicians will only provide information on services, guidance and assistance, and helpful online resources via Veterans Chat. If the VA mental health clinician with whom you are chatting decides that you are a danger to yourself and crisis intervention is needed, we will ask you to provide a phone number where VHA Suicide Hotline staff may make contact you. However, even at this time, you do not have to provide that information.
Operated by: Veterans Administration	
VA Palo Alto and Menlo Park Division	The Veterans Administration, while not organized by counties, provides a comprehensive array of medical and mental health services for veterans through the VA Palo Alto Health Care System. Available mental health services include 80 acute psychiatric beds; mental health emergency services; voluntary residential rehabilitation programs for PTSD, substance abuse, and homeless services; outpatient mental health treatment including specialty services designed for women veterans and OIF/OEF recent returnees, intensive case management, and specialized evidenced-based
Operated by: Veterans	

Administration	<p>interventions for family therapy, PTSD, and addiction treatment. Suicide Prevention Coordinators at the Palo Alto VA track and coordinate intervention and care services for veterans who are at high risk for suicide. Services are provided at a number of VA sites including Palo Alto, Menlo Park, San Jose, Monterey, Capitola, as well as at Vet Centers located in Redwood City and San Jose.</p> <p>Suicide Prevention Lifeline 1-800-273-8255 (TALK) press 1 for veterans Veteran Suicide Chat Service www.suicidepreventionlifeline.org</p> <p>VA Palo Alto Telephone Care Line 800-455-0057 VA Palo Alto Main Number 650-493-5000</p>
Outpatient Care Clinic	<p>Community-based outpatient clinic in San Jose and local Vet Centers. The suicide coordinators at the Palo Alto VA track and coordinate intervention and care services for veterans who are at high risk for suicide.</p>
Operated by: Veterans Administration	

Attachment 3. Best Practices Recommendations

National Strategy for Suicide Prevention Ten Prevention Programs	
Program Name	Description
1) American Indian Life Skills Development/Zuni Life Skills Development	The curriculum includes anywhere from 28 to 56 lesson plans covering topics such as building self-esteem, identifying emotions and stress, increasing communication and problem-solving skills, recognizing and eliminating self-destructive behavior, learning about suicide, role-playing around suicide prevention, and setting personal and community goals. The curriculum typically is delivered over 30 weeks during the school year, with students participating in lessons 3 times per week. Lessons are interactive and incorporate situations and experiences relevant to American Indian adolescent life, such as dating, rejection, divorce, separation, unemployment, and problems with health and the law. Most of the lessons include brief, scripted scenarios that provide a chance for students to employ problem solving and apply the suicide-related knowledge they have learned.
2) CARE (Care, Assess, Respond, Empower)	CARE (Care, Assess, Respond, Empower)--formerly called Counselors CARE (C-CARE) and Measure of Adolescent Potential for Suicide (MAPS)--is a high school-based suicide prevention program targeting high-risk youth. Includes a 2-hour, one-on-one computer-assisted suicide assessment interview followed by a 2-hour motivational counseling and social support intervention. The counseling session is designed to deliver empathy and support, provide a safe context for sharing personal information, and reinforce positive coping skills and help-seeking behaviors. CARE expedites access to help by connecting each high-risk youth to a school-based caseworker or a favorite teacher and establishing contact with a parent or guardian chosen by the youth. The program also includes a follow-up reassessment of broad suicide risk and protective factors and a booster motivational counseling session 9 weeks after the initial counseling session. The goals of CARE are threefold: to decrease suicidal behaviors, to decrease related risk factors, and to increase personal and social assets. CARE assesses the adolescent's needs, provides immediate support, and then serves as the adolescent's crucial communication bridge with school personnel and the parent or guardian of choice. The CARE program is typically delivered by school or advanced-practice nurses, counselors, psychologists, or social workers who have completed the CARE implementation training program and certification process. Although CARE was originally developed to target high-risk youth in high school--particularly those at risk of school dropout or abusing substances--its scope has been expanded to include young adults (ages 20 to 24) in settings outside of schools, such as health care clinics.
3) CAST (Coping and Support Training)	CAST (Coping And Support Training) is a high school-based suicide prevention program targeting youth 14 to 19 years old. CAST delivers life-skills training and social support in a small-group format (6-8 students per group). The program consists of 12 55-minute group sessions administered over 6 weeks by trained high school teachers, counselors, or nurses with considerable school-based experience. CAST serves as a follow-up program for youth who have been identified through screening as being at significant risk for suicide. In the original trials, identification of youth was done through a program known as CARE (Care, Assess, Respond, Empower), but other evidence-based suicide risk screening instruments can be used. CAST's skills training sessions target three overall goals: increased mood

	<p>management (depression and anger), improved school performance, and decreased drug involvement. Group sessions incorporate key concepts, objectives, and skills that inform a group-generated implementation plan for the CAST leader. Sessions focus on group support, goal setting and monitoring, self-esteem, decision-making skills, better management of anger and depression, "school smarts," control of drug use with relapse prevention, and self-recognition of progress through the program. Each session helps youth apply newly acquired skills and increase support from family and other trusted adults. Detailed lesson plans specify the type of motivational preparation, teaching, skills practice, and coaching activities appropriate for at-risk youth. Every session ends with "Lifework" assignments that call for the youth to practice the session's skills with a specific person in their school, home, or peer-group environment.</p>
<p>4) Columbia University TeenScreen</p>	<p>The Columbia University TeenScreen Program identifies middle school and high school-aged youth in need of mental health services due to risk for suicide and undetected mental illness. The program's main objective is to assist in the early identification of problems that might not otherwise come to the attention of professionals. TeenScreen can be implemented in schools, clinics, doctors' offices, juvenile justice settings, shelters, or any other youth-serving setting. Typically, all youth in the target age group(s) at a setting are invited to participate.</p> <p>The screening involves the following stages:</p> <ol style="list-style-type: none"> 1. Before any screening is conducted, parents' active written consent is required for school-based screening sites and strongly recommended for non-school-based sites. Teens must also agree to the screening. Both the teens and their parents receive information about the process of the screening, confidentiality rights, and the teens' rights to refuse to answer any questions they do not want to answer. 2. Each teen completes a 10-minute paper-and-pencil or computerized questionnaire covering anxiety, depression, substance and alcohol abuse, and suicidal thoughts and behavior. 3. Teens whose responses indicate risk for suicide or other mental health needs participate in a brief clinical interview with an on-site mental health professional. If the clinician determines the symptoms warrant a referral for an in-depth mental health evaluation, parents are notified and offered assistance with finding appropriate services in the community. Teens whose responses do not indicate need for clinical services receive an individualized debriefing. The debriefing reduces the stigma associated with scores indicating risk and provides an opportunity for the youth to express any concerns not reflected in their questionnaire responses.
<p>5) Emergency Room Intervention for Adolescent Females</p>	<p>Emergency Room Intervention for Adolescent Females is a program for teenage girls 12 to 18 years old who are admitted to the emergency room after attempting suicide. The intervention, which involves the girl and one or more family members who accompany her to the emergency room, aims to increase attendance in outpatient treatment following discharge from the emergency room and to reduce future suicide attempts. A review of the literature suggests that factors related to treatment noncompliance following a suicide attempt include family discord, maternal psychopathology, attempter depression, and negative experiences with emergency room staff. The intervention consists of three components designed to improve the emergency room experience for the adolescent and family, thereby changing the family's conceptualization of the suicidal behavior and expectations about therapy. First, a two-hour training is conducted separately with each of the</p>

	<p>six groups of staff working with adolescents who have attempted suicide. Second, the adolescents and their families watch a 20-minute videotape, filmed in Spanish and dubbed in English, that portrays the emergency room experience of two adolescents who have attempted suicide. Last, a bilingual crisis therapist delivers a brief family treatment in the emergency room.</p>
<p>6) Lifelines Curriculum</p>	<p>Lifelines is a comprehensive, school-wide suicide prevention program for middle and high school students. The goal of Lifelines is to promote a caring, competent school community in which help seeking is encouraged and modeled and suicidal behavior is recognized as an issue that cannot be kept secret. Lifelines seeks to increase the likelihood that school staff and students will know how to identify at-risk youth when they encounter them, provide an appropriate initial response, and obtain help, as well as be inclined to take such action.</p> <p>Lifelines includes a set of components to be implemented sequentially: a review of resources and establishment of administrative guidelines and procedures for responding to a student at risk; training for school faculty and staff to enhance suicide awareness and an understanding of the role they can play in identifying and responding to a student with suicidal behavior; a workshop and informational materials for parents; and implementation of a curriculum for students, the Lifelines Curriculum, to inform students about suicidal behavior and discuss their role in suicide prevention.</p> <p>The research reviewed for this summary assessed only the Lifelines Curriculum, the last component to be implemented in the larger Lifelines program. It consists of four 45-minute or two 90-minute lessons that incorporate elements of the social development model and employ interactive teaching techniques, including role-play. Health teachers and/or guidance counselors teach the lessons within the regular school health curriculum. The Lifelines Curriculum was developed specifically for students in grades 8-10 but can be used with students through 12th grade.</p>
<p>7) PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial)</p>	<p>PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) aims to prevent suicide among older primary care patients by reducing suicidal ideation and depression. The intervention components are: (1) recognition of depression and suicide ideation by primary care physicians, (2) application of a treatment algorithm for geriatric depression in the primary care setting, and (3) treatment management by health specialists (e.g., nurses, social workers, and psychologists). The treatment algorithm assists primary care physicians in making appropriate care choices during the acute, continuation, and maintenance phases of treatment. Health specialists collaborate with physicians to monitor patients and encourage patient adherence to recommended treatments. Patients are treated and monitored for 24 months.</p> <p>Implementation of the program relies on educating primary care physicians to recognize symptoms and apply a clinical algorithm based on depression treatment guidelines for older patients from the American Psychiatric Association, the Agency for Healthcare Research and Quality, and the Texas Department of Mental Health. The recommended first line of treatment is citalopram, a selective serotonin reuptake inhibitor (SSRI). If citalopram does not achieve the desired result, other medications may be added or substituted. Interpersonal psychotherapy may also be used in addition to or instead of pharmacological treatment.</p>

8) Reconnecting Youth

Reconnecting Youth: A Peer Group Approach to Building Life Skills (RY) is a school-based prevention program for students ages 14-19 years that teaches skills to build resiliency against risk factors and control early signs of substance abuse and emotional distress. RY targets youth who demonstrate poor school achievement and high potential for school dropout. Eligible students must have either (1) fewer than the average number of credits earned for all students in their grade level at their school, high absenteeism, and a significant drop in grades during the prior semester or (2) a record of dropping out of school. Potential participants are identified using a school's computer records or are referred by school personnel if they show signs of any of the above risk factors. Eligible students may show signs of multiple problem behaviors, such as substance abuse, aggression, depression, or suicidal ideation.

RY also incorporates several social support mechanisms for participating youth: social and school bonding activities to improve teens' relationships and increase their repertoire of safe, healthy activities; development of a crisis response plan detailing the school system's suicide prevention approaches; and parent involvement, including active parental consent for their teen's participation and ongoing support of their teen's RY goals.

The course curriculum is taught by an RY Leader, a member of the school staff or partnering agency who has abilities as a "natural helper," has healthy self-esteem, is motivated to work with high-risk youth, and is willing to comply with implementation requirements.

9) SOS Signs of Suicide

SOS Signs of Suicide is a 2-day secondary school-based intervention that includes screening and education. Students are screened for depression and suicide risk and referred for professional help as indicated. Students also view a video that teaches them to recognize signs of depression and suicide in others. They are taught that the appropriate response to these signs is to acknowledge them, let the person know you care, and tell a responsible adult (either with the person or on that person's behalf). Students also participate in guided classroom discussions about suicide and depression. The intervention attempts to prevent suicide attempts, increase knowledge about suicide and depression, develop desirable attitudes toward suicide and depression, and increase help-seeking behavior.

10) United States Air Force Suicide Prevention Program

The United States Air Force Suicide Prevention Program (AFSPP) is a population-oriented approach to reducing the risk of suicide. The Air Force has implemented 11 initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors. AFSPP's 11 initiatives include:

- Leadership Involvement
- Suicide Prevention in Professional Military Education
- Guidelines for Use of Mental Health Services
- Community Preventive Services
- Community Education and Training
- Investigative Interview Policy
- Critical Incident Stress Management
- Integrated Delivery System (IDS)
- Limited Privilege Suicide Prevention Program
- Behavioral Health Survey
- Suicide Event Surveillance System

**American Foundation for Suicide Prevention: Suicide Prevention Resource Center's
Evidence-Based Practices**

Program Name	Description
1. Reduced Analgesic Packaging	In response to an increasing number of self-poisonings with analgesics (acetaminophens and salicylates) in the United Kingdom, Parliament passed legislation in 1998 limiting the pack sizes of these drugs. Before the legislation, pharmacies could sell unlimited amounts of analgesic tablets. After legislation, pharmacies were limited to 32 tablets per sale and non-pharmacy outlets were limited to 16 tablets per sale. In addition to packaging limits, specific printed warnings about the dangers of overdose with these analgesics were included with all sales.
2. Emergency Room (ER) Means Restriction Education for Parents	<p>The goal of this intervention is to educate parents of youth at high risk for suicide about limiting access to lethal means for suicide. Education takes place in emergency departments and is conducted by department staff (an unevaluated model has been developed for use in schools). Emergency department staffs are trained to provide the education to parents of child who are assessed to be at risk for suicide. Lethal means covered include firearms, medications (over-the-counter and prescribed), and alcohol. To help with the safe disposal of firearms, collaboration with local law enforcement or other appropriate organizations is advised. The content of parent instruction includes:</p> <ol style="list-style-type: none"> 1. Informing parent(s), apart from the child, that the child was at increased suicide risk and why the staff believed so; 2. Informing parents that they can reduce risk by limiting access to lethal means, especially firearms; and, 3. Educating parents and problem solving with them about how to limit access to lethal means.

Additional Evidence-Based Practices from literature review

A Model Community Education Program on Depression and Suicide in Later Life	A Model Community Education Program on Depression and Suicide in Later Life , developed by Clara Pratt, PhD, Vicki Schmall, PhD, Willetta Wilson, PhD, and Alida Benthin, MA, Oregon State University Gerontology Department. This is a 3-hour multimedia program on depression and suicide in later life. Designed for families, older adults, and service providers, the program provides information and teaches skills needed to recognize and respond to depression and suicidal behavior in the elderly. Compared with a
--	---

control group, program participants had significant gains in knowledge and in their intent to take appropriate action in support of a depressed person.

Gatekeeper Training

The **QPR** Institute offers comprehensive suicide prevention training programs, educational and clinical materials for the general public, professionals, and institutions. (QPR stands for how to Question, Persuade and Refer someone emitting suicide warning signs.) QPR is taught by certified instructors in a minimum of one hour, but often extended to two hours for role-play and practice. The adult learning program teaches lay and professional gatekeepers how to recognize a mental health/suicide emergency, how to Question the validity of suicidal communications, and how to Persuade and Refer someone at-risk to the next level of intervention. The goal of gatekeeper training is to enhance the probability that a potentially suicidal person is identified and referred for assessment and care before an adverse event occurs. Across our county there are several institutions already providing this training such as Foothill College.

Somewhat related to this is **ACT**, which also was recommended by committee members. Initiated in 2007, a Navy suicide prevention campaign asks sailors to "ACT" now to save a life. ACT is a three-step process designed to help determine if someone is suicidal and to prevent them from hurting themselves. It stands for: Ask- ask the person if they are thinking of hurting themselves, Care- listen and let the person know they are not alone, and Treatment- get your shipmate to help as quickly as possible; such as the duty officer, chaplain, friend, medical personnel, or others who can help.

Attachment 4. Input from Public Forum

Summary of Public Forum Comments and Input:

On April 28, 2010, the **Santa Clara County Suicide Prevention Public Forum** drew **108 community participants, 6 of whom were monolingual Vietnamese speakers, and 2 were bilingual Mandarin/English** and requested the use of interpreters. The purpose of this forum was to provide an opportunity for the community to provide feedback on the work completed by the Suicide Prevention Advisory Committee and to have their comments inform the Plan.

Participants were offered multiple methods to provide their feedback:

- Writing comments on Post-It notes which were placed directly onto the posters of the work completed to date,
- Comment Cards, and
- Small discussion groups facilitated by Advisory Committee members.

While not every comment was able to be included in the plan, all comments are recorded verbatim below.

The vast majority of the comments fall into one of the six themes summarized below:

- **Youth who are transitioning from dependent minor status to independent young adult status—regardless of being enrolled in secondary education or in the workforce.**
- **Parental education.** The public recommended trainings geared to parents and foster parents to recognize their child’s inner turmoil, address the issue of youth who are raised more by nannies and have low parental involvement in their lives.
- **Geographic isolation.** Some strategies should address the issue of geographic isolation for youth as well as older adults already included in the plan.
- **Sharing stories.** Participants recommended that individuals who had survived their own attempted suicide share their stories to educate and inspire people.
- **Public recognition of life savers.** Participants recommended that individuals who help bring people in crisis to an intervention resource be publicly recognized with a certificate or award as a means to raise the profile of suicide prevention and encourage others to consider doing the same.
- **Stress and stressors, transitions and dysfunction in personal relationship skills.** Several individuals commented on homicide/suicides preceded by stressors combined with poor coping and anger management skills. Some stressors discussed were the pressure to achieve and succeed; divorce; loss of job; racism; all prejudicial behaviors; reentry into

society after criminal justice involvement. This issue/need should be framed as, for lack of a better description a “tipping point.”

Below is a transcript of the small group discussions based on notes taken by Advisory Committee members. Before each comment/question an empty box means we have not identified or addressed the main point of the comment. **A black “X” indicates that the comment submitted had already been discussed and included in the Suicide Prevention Plan prior to the Public Forum. A blue “X” underlined indicates inclusion in the plan after the public forum.** Those comments without an “X” and not included in the plan at this point may be considered again during the implementation phase of the process.

Santa Clara County’s Mental Health Department hired consulting group MIG to draw a 12’ wide, 4’ tall summary of the night’s input that is referred to in the notes below as a Wall Summary. This graphic illustration is included on the Santa Clara County Mental Health Department’s Suicide Prevention website—www.sccgov.org/spac .

Addressed by committee?	Comment or question Group 1
X	Encourage the community to talk about suicide and for those who have experienced or attempted suicide to be able to share their stories.
X	[We need] a systematic approach for all ages. One that connects the steps, address all ages, honors those who died through suicide with the gift of their stories.
<u>X</u>	Need an instrument that would enable the community to understand the journey one takes in even contemplating suicide - let alone attempting or even completing suicide
X	Be creative and use social network sites
X have the category	Prevention strategies should be a separate category - not placed under intervention
	Missing best practices in state of California like Healthy Start- offer education at a younger age.
X- PEI, Integration efforts	Multidisciplinary [approach] is key, look at [what] already exist[s] i.e. student study teams like the Education Model SST (student study teams) utilizing multi-disciplinary experts
X	Stories [are] very powerful, they can touch the heart; stories [can be used] to prevent/ intervene as a means [of] outreach community is a real experiences/ nurture the story and honor an individual.
X- Requested data	Is there research specific to cluster/ “copycat” suicides?
X	Alcohol/ substance use, meth[amphetamine] [induces a] morbid way of

	thinking and [morbid] emotions, but [they are] not always connected. It may entail body chemistry.
X	Working in jails- the Mercury News is not on the front page. <i>(Scribe's not sure-Suppose is that suicide in jails is not given much media attention but that it's a real issue)</i> Jail is high risk population
X	Regarding the elderly, most see their doctor. How many doctors ask directly questions of life and death and refer [them to mental health].
X	Use of community centers to provide a safe environment where youth are able to discuss, talk about the topic of suicide and support discussion with those who've experienced traumatic events- [they can] speak about how they coped.
X	PTSD [is] connected to suicide
X	Positive aspect- social networking sites or dollars, resources are cost effective ways of reaching out and educating after an event. Questions [can be] asked, [ie.] how is this affecting you?, etc.
X	Problems [can] be worked out via [public] health model rather [than] a disease model.
X- Listening Campaign	P[alo] A[lto] [is] using creative strategy - talking to youth. [They have organized] 3 youth focus sessions and asked and learned from the youth. Listen to the wisdom of the youth.
X	PA hosted a youth gathering - youth were invited via social network sites - youth showed up and openly talked about the crisis of suicide and the reality of suicide from a young person's point of view
<u>X</u>	Los Gatos [is an] isolated community. Folks [are] worried about [their] children because of the isolation. [There is no] outreach and they're hurting. Outreach in geographically isolated areas
<u>X</u>	Strategy: School Districts with physically isolated students dealing with trauma (i.e. suicide or cluster of suicides) can connect with other districts to share what is being done re: outreach to geographically isolated community members, students who live in the isolated area of the Loma Prieta School District.
X	Violence- Domestic Violence [and] homicide [are] linked to suicide: ie. Vietnamese families killed by father who in turn kills himself.
X	Companies are utilizing experts to provide workshops for employees who are to be laid off - coping strategies, stress release techniques, etc. so that laid off employees will have the ability and tools to cope with the anger and transition instead of having the rage prompting the laid-off employee return to their former place of employment with weapons, killing co-workers and possibly themselves. Recommend policy and governance with for-profit training and awareness
X- Communication practices	[This requires a] paradigm shift. [Suicide is a] public health issue. [We need] understanding. The need for propaganda (mass public awareness campaigns) [like were used for] child seats in cars, smoking, etc. [This requires a] long term

	approach. Paradigm shift may take time but in time suicide will not be seen as an option.
X	Bring youth and adults together. Use fishbowls (held in a safe environment). Develop [a] dialogue, share honestly and be heard. Adults [need to] listen when there's an opportunity to provide feedback after the youth have shared- [this applies to] numerous topics [like] identity, sexuality, substance use, Mental health, depression, stress. Allow [the youth] freedom to give [their] voice. Provide tools for communication utilizing fishbowl strategy, community centers, and social networking sites.
X	[Adults need to] remember back to [their] youth [when we were asking] what's the meaning of life? Where's the spirit? Is there no value in one's life? Where is this going? [All the] outside influences [that affect them] economy, the government, people's spirit is dying. Neighborhoods, racial groups, a lot of faiths, are not valued anymore. Where's one's [own] identity? [Do you] Find meaning in your work? [All of this needs to be] attached to the spiritual component. Allow the spirit of life (faith) to penetrate.
X	[Suicide prevention/ everything] starts with policy. In Santa Clara County [we] need to declare the value of life. All groups [are] affected. Need to be grounded- all of life is valuable. Perhaps [we're] afraid to talk about the spirit. Talk[ing] to those who are hopeless or [in a] hopeless state is not that helpful (is that what was said?). [People] need the connection, reflective relationships, need to be valued and appreciated. All endeavors [should] come out of that.
<u>X</u>	Workers who are just collecting a paycheck vs. workers who are engaged, happy, vivacious. Such agencies/ institutes are welcoming, warm and those who use the facilities are in turn happy, passionate, i.e. teachers who have a passion that spirit shows.. The opposite is true as well, Vivacious work force
X	Students do not have tools to deal with life. Adults need to come in and hopefully they possess the tools needed. Kids gravitate to exciting teachers.
<u>X</u>	Police Department in Los Altos (kids) parents [are] very disengaged, kids [are] being raised by nannies. [Parents don't know that their] kids are suffering from a tragic event, using drugs, mentally ill. Parents connect with our children.
	Police: Speaker shared feeling sad, compassion and sympathy when responding to a suicide call that involves a youth. However police often have little or no compassion and often even feel anger when responding to a suicide or attempted suicide call of an adult. Behaving this way is used as a means of getting a reaction from family members, spouse, significant other. Differentiated police response to suicide (of youth versus adult)
Group 2- This group (comments below) consisted of representatives from Redwood Middle School, the Director of Health Services from West Valley College, representatives from an Independent Living Program, a representative from Elmwood Correctional Facility, and a few community members. The group mainly discussed building a common language, educating on	

all levels, better training volunteers, and providing more resource centers .	
Addressed by committee?	Comment or question
<u>X</u>	One resident feels that parents do not have tools for prevention . We need to have early education, awareness, and focus on mental health. Suggestion: Offer information once the mother gives birth at the hospital.
X	We need to develop a method to help the community understand that mental health is OK. Promote help seeking behavior
<u>X</u>	Elmwood representative feels that we need to educate within the correctional facility and help women cope with their emotions as they readapt into society .
X	A local feels many (community members) believe that more awareness would lead to more suicidal cases—we must somehow lower the stigma , and we need more educators to be involved to help increase awareness. “Silence is killing them”. Stigma reduction
<u>X</u>	Another local would like to see more involvement with survivors . Professionals have great knowledge about the subject, but having a resource with the same experience will have a larger impact and understanding. Sharing stories, peer programs
X	We need to train more volunteers who want to prevent, educate, and aid mental health.
	A representative from independent Living Program states that there is a lack in financial aid . We have resources outreaching to schools. However, we have forgotten about those who are not in schools . Perhaps, we should build resources in Juvenile facilities too. <ul style="list-style-type: none"> • Where are other resource centers other than schools? • Can we provide financial aid to help those with mental health issues?
X	We have sex education, drivers’ education, etc. But we don’t have a program for mental health? Awareness and education
X	We do have a program called Mental Health First Aid—perhaps we need more promotion.
Group 3- Participants (comments below): Community Member (wife of a man who committed suicide); Doctor; LACY Member (Social Worker); Council Member, Palo Alto (son had mental health issues); Community member (son committed suicide); Community Member-2 nd Harvest Food Bank; Mental Health Social Worker; School Psychologist; School Counselor	
X	The group discussed the need to have forums that include not only psychologists and social workers but also family members of suicide victims and those who have attempted suicide to discuss their personal experiences, system failures and warning signs . Listening Campaigns
X/ <u>X</u> / <u>X</u>	Many of our group discussed the need to have a strong prevention strategy and to have discussions with children when they are young and the need to have talking points for pre-teens .
<u>X</u>	Our group also discussed the importance of sharing personal experiences and

	warning signs. Share personal stories
X	Our group discussed the lack of availability of services/resources at schools and the need to have a 24 hour telephone number to call to access mental health services.
X	We also discussed the need to have teens understand when they have to make a call to someone when they suspect that their friend is having difficulty. This might put adolescents in a bad position however when someone's life is in jeopardy it is critical to call someone who can slow things down and make an assessment (adult, law enforcement, teacher, counselor, mental health professional, clergy). So an education strategy designed to educate young people about getting their friend help would be an asset and would be a valuable asset for our youth.
X	One group member was very complimentary of the QPR.
X	The Doctor wanted to hear more about how we can communicate within the various communities to ensure that people are not slipping through cracks.
X X	The matter of de-stigmatizing mental health was discussed widely. We also talked about how we need to have a paradigm shift-much like how our community has changed its views on drunk-driving. We thought that we could learn some lessons from MADD and that they could be a model for changing the discussion on mental health in the community.
Addressed by committee?	Comment or question Group 4
X	Some of our group was surprised about the data on the frequency of suicide among seniors.
<u>X</u>	A couple of group members remarked that there was a need to have post-incident care or post 5150 care to ensure that family members and the patient were aware of the resources available and that they were not experiencing destructive tendencies.
X	Our entire group agreed about the importance of the community ownership and that we all have a responsibility.
X	One of the Community members announced that Stanford University Medical School has a Bi-Polar Education Forum involving families, educators and researchers .
X	Another community member recommended the City of Palo Alto's Family Resource Center which offers monthly meetings to discuss resources available to the community .
Webinar X- CIT	Fremont Unified School District in Sunnyvale has done a Webinar on Suicide Prevention , approximately 20 minutes long and it discusses how resources can be accessed. They have also developed a Crisis Intervention Team at the schools with multi-discipline resources available.
X	A community member recommended that there should be specialized training for counselors at schools when there is denial amongst parents regarding the

	mental health issues involving their children.
	We had a lively discussion about respecting the privacy of children while being concerned about their mental well-being.
X	A group member recommended having a guest speaker named Kevin Hines come and talk about his experiences being bi-polar. Share personal stories
X	One community member recommended that there be training given to physicians about the type of medications that they prescribe to their patients and how some could have adverse effects on them and even promote suicidal thoughts. Training would recommend that spouses/family members would receive information about certain types of medication and the warning signs. Provide support to Primary Care for mental health issues.
X	We also discussed the need for additional information, awareness and training for Parents, Teachers, Firefighters and the clergy to identify those at-risk and how to access services.
X	Plan is well written. I came to see how [such a plan] can be effectively implemented in ethnic/ cultural communities. [The] rec[ommendation]s are summaries, but [the] specifics needed (sic) to take back to [the] communities.
X	Emotions and emotional awareness aren't taught. [We need to] teach emotional awareness/ intelligence. [The] education system can teach emotional awareness; and should be] supporting [youth] exposed to suicides. Youth sometimes suicide through drug abuse or car crashes. Kids now feel more helpless and hopeless. Don't know how to fit in. Drug and alcohol use is up. Prevention dream: Health Education would be taught in schools and address emotions. Kids need tools.
X	Fo[ster] Parents aren't mandated to take MH awareness and it's needed. Foster parents [in] (her experience) [are] in it for [the] money. ([She is a] former foster child) Depression, self mutilation [is] ignored. Focus on foster parents. Lots of training on MH awareness. Public media messages on where to get help.
X	*NAMI Member- Parents and Teachers [should work together as] allies. -Teach teachers about [the] onset of mental illness in youth. -[Has trained] 1 school thus far. Raise awareness among educators
X	Stigma to suicide. People don't want to talk about [it], even within groups that should be comfortable with it. *Suicide [is] "taboo" within mental health. Mental health professionals, consumers, and their family members should be more willing to talk about suicide, with the ease they have discussing a diagnosis.
	Challenge to confidentiality and talking to family members, [HIPPA] creates barriers. Can doctors inform family members? How do they address [the] risk?
X	Suicide cross[es] economic barriers. Suicide [Has a] huge impact on families. office of Human Relations Commission will be focusing [on] disseminating prevention information.
X	[I] Became involved because of Palo Alto Suicides. Effectiveness of means

	restriction as [a] prevention strategy. Focus [should be on] bridge barriers, train track monitors. People today lack emotional connections, need to connect with people. Increased caring, increased communication
X	Schools have a huge role to play [in] [re-defining] norms, de-stigmatizing help seeking.
X	Latino community does not want to acknowledge or talk about [suicide]. [Latinos] need more information in community. Culturally appropriate prevention information is needed.
X	Lot of education [is] missing. Don't use the word "commit" suicide because using "committed" [makes it seem like a] crime and [reinforces] stigma. Should use "died by suicide". Change terminology
X	Kids don't feel there's a stigma, they talk about it. Adults don't want to talk about [suicide]. De-stigmatize
X	Schools have cut student support staff. Teachers have no training and are not equipped. Educate all teachers. Don't just [train] special education [teachers], support staff need to know [and] recognize the signs.
X	The entire community must be trained, neighbors, shops, families. [This should be framed as a] public health approach.
X	Media should always inform where to get help.
Addressed by committee?	Comment or question Group 5
X	Q: What are the political benefits to bringing the issues to people's awareness? A: There's believed to be an awareness problem there's a belief there's a lot of stigma connected to suicide though people are reluctant to speak out about what they are feelings.
X	Q: What are the political benefits to bringing the issues to people's awareness? A: There's believed to be an awareness problem there's a belief there's a lot of stigma connected to suicide though people are reluctant to speak out about what they are feelings.
X	Q: Everyone has limited budgets, is there good information about efforts that save the most lives...? A: The committee has taken the position that it's a public health problem in all communities. It's tactics/ design is to raise awareness and address what

	strategies are most effective to prevent suicide.
X	C: There are various components to address the problem but we as a community need to gather all the various components to address the problem ; people need to be able to talk about it.
X	C: Loved ones need to sacrifice the time to share; with their family members; time to express concern ; loved; etc. to let the individuals know that “they care about them” they will be missed.
X	C: Concerns around teenagers because of programs being cut; kids not being able to access counselors or help due to the cuts. Age appropriate access to care
X	C: Due to oversized classes and lack of funding teachers can not address the problems at hand. Schools united in awareness- budget and time limitations
X	C: General overall consensus on expansion of community led services and programs and/ or peer-led programs .
X	C: Communication seems the overarching gap like with education; desensitizing stigma make it easy for people to talk about. The media needs to be used as an outlet or resource ; we need to build relationships with media people and they need education and sensitivity developing relationships with media.
X	C: School age kids- Offer Mental Health First Aid to be able to train the school staff to help deal with these issues.
X	C: Parents can take simple steps; do little things like having dinner with a child that will make a difference.
X	C: Several members felt that strengthening and using " natural " community resources such as church, clubs, etc would be helpful so people could get help there either instead of MH providers or in addition to MH provider help.
X	C: We have around us everyday access to people who have attempted suicide. Why aren't they the “go to” people leading our efforts to finding the answers of where things broke down and what would have helped them to “not” follow through with an attempt. Attempters Sharing their Stories
Addressed by committee?	Comment or question Group 6
<u>Policy and Governance Advocacy</u>	
X	Partnership between primary care and mental health care professionals is <u>critical</u> .
	Policy and governance advocacy may put too many regulations in place. This regulation's category is too broad . This may inhibit individuals from seeking care.
X	More support of primary care is needed. Individuals may not reach out to MH professionals.
X	Doctors and mental health care is not working together which is detrimental. HIPPA [due to HIPPA/ or has HIPPA become a barrier to care]. They are

	currently two separate entities that need to be one. Concern that HIPPA inhibits MH Professionals from other providers; mandated which would impact policy procedure. Division on whether would be a good thing or negative. Concern to maintain confidentiality while maximizing collaborative care.
X	Public Policy takes away the humanity. [We need to] always go back to [the reality] that it's about people. Regulations and policy should not become barriers in and of themselves.
X	Protection of the individual [is a] double-edged sword. [Need to] Open up communication. Becomes less private and less people will seek help. Policies such as mandates for reporting or asking questions may increase concern for confidentiality and may discourage people from seeking help. [Need to find a policy that is] more open [in sharing patient's information with loved ones] but still protecting privacy.
X	Hospitals don't report suicide attempts. Should be mandated that hospitals report suicide attempts and that those individuals receive follow up care that is standard protocol.
X	Root causes [for suicide] need to be looked at.
<u>Community Education & Implementation</u>	
X	Outreach- Paramedics, EMS, and EMTs have no idea of [the] existing hotlines. Law Enforcement and firefighters receive little education on these issues. May benefit from in service-type training.
X	[EMS are] taught [to] treat the injury, not the person. Felt that the SACS training was very helpful. By recognizing potential mental illness, helps to interact.
X	Law enforcement/ EMT/ Fire fighters, (first responders) [need to have] condensed in-service type training [and] in-depth [trainings]
<u>Intervention</u>	
X	Caltrain needs to evaluate entrances where [people] in duress can enter [the train tracks] Means Restriction
X	[Schools need to] Address bullying at schools. Parents need to be responsible as well. [Need] outreach for child [or youth] who is being bullied to let them know [what] resources [are in] place.
	[Need] a call box at the tracks.
Addressed by committee?	Comment or question- Monolingual Vietnamese Group 7
X	One member shared he attempted suicide when, after being diagnosed of MH, his family insisted that he stayed in an institution and not come home. stigma
X	One member shared he attempted while using drugs substance use
X	One member shared she thought seriously about suicide when she came to this country, without family members, lost her job and was evicted. Social isolation, refugee/ immigrant experience

X	One member shared her husband attempted suicide due to family situation (divorce) and is now paralyzed on one arm. Loss of loved one
Cultural issues	
X	Recognition that Vietnamese families put a lot of pressure/expectation on family members for achievement levels, education levels, marriage social roles and pressure
X	Severe stigma around Mental Health issues due to cultural belief that Mental Illness is shameful, punishment, karma; we do not get services for loved ones but hide the condition.
Policy and Governance advocacy	
	We ask for more compassion from the legal system , that people who commit crimes and admit fault be forgiven, or they are led to suicide
X	Strict immigration laws causes distress in individuals and families, some are led to self-sacrifice/sacrifice
X	Unemployment have caused to families to die in group. Drop in economic level
X	There is a lot of stress in the workplace which can lead to suicide
Practical suggestions	
	An easy-to-remember short hotline number such as 5-1-1
X	Recognize, give award to people who have prevented another person from attempting suicide.
Addressed by committee?	Comment or question Group 8
X	Gathering Data- [It] really struck [a] cord about finding out the why. If we know [the] why we may be able to figure out why not.
X	Stigma applies to mental illness. Hope to change viewpoint and educate [the] public about [the] crisis of suicide; bring it out of the closet. Important for gaining political and institutional support.
X	TV advertising for prevention.
X	Actuarial costs of suicide in dollars and cents. Young people are worth \$1.5 million dollars for [the] economy. Talk about the money saved by providing prevention programs. If we can sell products we should be able to sell something good like suicide prevention.
X	Cultures- [In many cultures] mental health [is] taboo. Advertise [messages promoting] seeking mental health [services] would reduce suicide.
X	Prevention is not broken out sufficiently in the plan. Would like to focus on

	suicide prevention rather than intervention. How do we make children feel connected and supported? [ie. Examples of ways to connect youth] Service Learning, Building friendships, asset building- like Project Cornerstone. Prevention beyond Intervention.
X	To do this, educate parents in families where mental health taboo exists. School may be [the] best place to introduce this. Suggested 15-20 minutes as part of curriculum.
X	We talked about what we are doing to talk positively and supportive. What are we doing to empower them [youth], to give them [youth] voice, make them [youth] feel supported, develop friendships. Need to positively message this to the community. We are teaching kids about eating healthy, exercising, we should be teaching them about how to take care of their emotional needs.
X	Decrease isolation for older communities.
X	Gangs, family issues, drugs, prison
X	Concern regarding how medical establishment passes out antidepressants without education and [these] can increase [risk of] suicide. We need to get to medical establishment[’s buy-in].
	Concern regarding drug company advertisements that suggest that pills fix everything.
X	[Older Adults struggle with the] Feeling of [their] being a burden. [Suicide should not be considered as a] selfish act.
X	[Older Adults struggle with the] Feeling of overcoming death and pain.
X	Middle aged: Poor economy, lost jobs.
Strategies	
X	Workplace education to provide education [on mental health issues and suicide awareness], similar to Air Force Academy efforts- getting MH services is not a bad thing. Identity may be wrapped up in job and if one loses job, [people experience a] feeling of lost identity. [Stress is magnified by being] Combined with loss of insurance. [Advocate for a] Law on [requiring businesses to issue a] page of contacts and information regarding insurance options and resources . This could also be available as posters in unemployment offices.
X	Support groups for people feeling suicidal.
	Offer trainings for Senior Management – services available and general awareness on issues like domestic violence (to avoid homicide/ suicide); depression, etc.
X	Train critical professions on suicide prevention and awareness: Cops, Teachers, Clergy. They Need to understand when to turn folks over to other services.
Cultural Issues:	
X	Difficult to seek outside help for mental health. [Culture dictates that people are] supposed to be able to treat [themselves] within the family. Cultural values, stigma
X	[It is] Essential to have someone from the same culture reach out within a

	culture. Culturally appropriate outreach/ inreach within a community
X	Spread the word in mosques, churches, temples, etc. Clergy would likely welcome resources.

Comment Cards

Comment Card	In Plan?	Comment/ Question
A.		Everything was very good information and how to help other to live better and happy.
		Communication Practices: Communications and more resources and work shops like this is (sic) very outstanding.
	X	Intervention Strategies: [Offer] Programs after school and more counseling.
		Other Comments: Very good.
B.	X	Policy & Governance: Mental Health, Domestic Violence, Alcohol and Other Drugs, Violence in the workplace/ school all share common prevention themes. Address issues of general community well-being that would be the foundation of community well-being in the media campaign.
	X	Community Education: Need to include [the] entire community[,] so that means engaging workplace/ employers, like HP, IBM, Bank of America et al. Their issue is workplace violence/ suicide. What does Employee Assistance Program (EAP) do?
	X	Communication Practices: If IBM says being a good parent is a corporate value and supports that, parents [employed there] will listen.
C.	X	Policy & Governance: Leaders must be first educated about what needs to be & how they can help.
	X	Community Education: Information should be reliable where people can get it & in multiple places- all media forms, schools, etc.
	X	Communication Practices: Educate & advocate not using the word "commit" in context of suicide (negative).
	X	Data Collection and Monitoring Activities: Mental autopsies of victims & attempters. Psychological profiles
	X	Intervention: Access to means to self harm should be restricted as much as possible. Teachers & schools should help is de-stigmatizing mental health. Means Restriction
		Other comments: Thanks for your work on this.
D.	X	A big effort, but not new and effective plans. From now on, cigarette smokes (sic) is pushed into death end. No more place for them to smoke. Non-smokers take advantages and harassed cigarette addicts a lots (sic) Be careful!!!! (sic) Paradigm Shift
	X	Community Education: To educate people is not effective is to give people awards , even though it's just a letter from authority or a certificate.
		Communication Practices: Authorities and specially psychiatrists & case

		manager act according to work rules, but not help consumers with all their hearts. Please educate them first.
	X	Data Collection and Monitoring Activities: [Is] Needed but don't go into personal detailed information.
	X	Intervention: Prevention is more priority. Need hotline personelle (sic) to be able to help people in trouble some suggestion to get out of it <u>practically</u> . Don't ignored. (sic) And remember to follow up . It may recur.
	X	Other comments: I has (sic) some problems myself that can't be told. Please think about some ways to detect or discovered (sic) a person's suicidal thought. Public Awareness and Empowerment
E.		Other comments (0-15, 16-24): We need emergency phones that connect to suicide prevention at the [train] tracks in Palo Alto. Kids would not want to use their own cell phones for that because they do not want to leave any trace.

Santa Clara County Suicide Prevention Public Forum
POST-IT NOTES
From Poster Boards

I. Policy and Governance Advocacy	
1. New Strategies	
	Consider putting (real) phones on hot spots so people can call for help when feeling suicidal.
X	Additional idea: National Suicide Hotline. Consider idea to create a national number such as 1-800-CHOOSE LIFE (or local city number that transfers to hotline #).
	Preserve continuity of services: exclude County-contracted services from the General Fund.
X	Really focus on schools – even at the elementary school level.
X	Consider an advocacy day (SACS) during May or other suicide awareness month
X	Need to build bridges with law enforcement and other first responders.
<u>X</u>	Bring a victim to share a story (if possible). It will help to change and enforce positive change.
a) Edits to Strategies	
X	Raising awareness and educating everyone of all systems and partners of their key roles and explaining what the key note is.
b) Additional Comments	
X	Countywide hotline is not new. In fact, it can't exist (sic- function well) when the receivers or staff on the other side are not necessarily culturally and/or linguistically competent!!! It would be more practical or personal to contract out with community-based ethnic group or entity to do it. To be model friendly, use grassroots not just contract agencies or county employee hotline, etc.
c) Wall Graphic	
	There are pros and cons of all policies
X	Look at the root cause of individuals who die by suicide
X	There are political benefits of increased awareness
X	Suicide is a public health problem
X	Partnership with primary health care professionals – this is critical
	Government shouldn't be too heavy handed

X	Hospitals must report suicide attempts
X	Leverage funding and get the “best bang for our buck”
	Immigration rules are tremendous on the individuals – need to integrate more compassion

II. Community Education and Information	
a) New Strategies	
	Right focus re: recreation centers after school. Not try to shut them down, no money for the education.
	Have a forum of “experts” of people who committed suicide. Tell what went wrong. Ask therapists to attend, but the first speakers should be survivors.
X	Have special programs that worked in the past. Ask community what will work.
X	Have special programs that target youth families.
X	Make prevention and intervention strategies more accessible to concerned friends and relatives. (Aggressive campaign – poster boards, community presentation)
X	More volunteer program, keep them [youth] busy and out of gangs
X	Include community education workers that speak the many languages spoken in this community.
X	Training and police officers responding to 5150 calls.
X	Have more training to target youth.
X	Sounds good the plan will work out well. Encourage the loved one to talk about it.
b) Edits to Strategies	
	For grief counseling, lower the requirements to be helped. Educate people that crisis line is also for mental health support.
c) Additional Comments	
X	Your suggested strategies for community education and information are excellent. People need to be desensitized to the subject to feel empowered.
	SACS does outreach we used to do more than now. Volunteers for this are difficult to keep the same 2 or 3 people were doing all the outreach talks.
X	Make sure you publicize as much as possible. Get support from City Councils and get the word out to the public.
d) Wall Graphic	
X	24-hour telephone service, center
X	Educate peers to take next step, training

	<ul style="list-style-type: none"> ○ Parents ○ Teens, pre-teens ○ Teachers ○ Firefighters
X	Access points for resources, schools
X	Tools for communication <ul style="list-style-type: none"> ○ Fishbowl technique ○ Social networking sites
X	Heighten awareness
X	Need to repair communication break down
X	Normalize conversation around suicide
X	Advertising for prevention

III. Communication Practices	
	a) New Strategies
	Reassuring the victim that everything is confidential.
<u>X</u>	Have forum with suicide attempters. Talk about their experiences.
<u>X</u>	Better educate foster parents particularly. Social workers, teachers on how to spot ones in trouble.
X	Have talks and trainings in the schools. Involve the youth in trying to define messages.
	Everyone who wants a job in the County Psychology Department needs to go through SACS training first.
X	Your strategies for communication practices are excellent. I would only add developing strategic relationships with the media – otherwise it’s “whatever bleeds, leads!”
X	Use communication resources that connect with youth.
	Respecting the privacy of the victims of suicide is key, especially for minors.
X	It’s good! I think to use authentic community leaders who are much familiar to the residents and cultural groups of their own communities would be much more effective judge than the county.
<u>X</u>	Encourage the attempts to talk about his/her crisis.
X	Every 1st responder: police, fire, EMT – gets SACS training.
X	Use communication resources that connect with specific communities.
	b) Additional Comments
	Perhaps obituaries or death notices might say: “was so depressed he committed suicide” (and did it by....)
	c) Wall Graphic

X	Change paradigm – DUI, smoking
X	Gift of story
X	Welcoming, vivacious spirit
X	Media is a resource Needs to be educated, how to communicate message
X	Churches and temples – places other than schools
X	Hotline number is too long – need a 3 digit number!
X	Public health issue
X	Develop common language

IV. Data Collection and Monitoring	
	a) New Strategies
	List failures of the treating therapists and doctors. List anti-depression medication the person was taking. List medications on which the person suicided.
	Use things that work/didn't work. Then find solutions.
X	Collect statistics on suicide attempts. Especially teens.
X	Ensure continuum of data collection and analysis cross systems.
X	From the current data, you had online I noticed specific zip codes with high rates of suicide this information is critical to developing targeted messages for each community.
X	Encourage the attempter to talk about his/her crisis.
	Start keeping data on how many suicides were taking Paxol and other SSU medications for bi-polar
	b) Additional Comments
X	Psych[ological] autopsy.
	c) Wall Graphic
X	[Monitor?] Caltrain entrance sites
X	Examine, study group deaths

V. Intervention Strategies	
	a) All Ages
	Resist the effort to medicate[.] [Mental Health?] centers closely monitored
X	Make it not-taboo to talk about
	b) Wall Graphic
X	Community ownership

X	Take time with the individual
X	Cultural differences – severe stigma against mental health Same cultures need to support each other E.g. Vietnamese culture
X	Honor, aware people for work with suicide prevention
X	Stigma in discussing suicide even in mental health profession.

<u>Children and Youth Ages 0 to 15</u>	
	a) New Strategies
X	Listen to them and need to respond to bullying
X	Bullying at schools by peers on (sic- to) a teachers and administrators.
X	Training with at-risk to hear their concerns and how they would like to be listened to.
X	Developmental Asset Building for youth – Project Cornerstone
	Teen support groups for survivors of teen suicide.
	Youth involved in community service.
X	Involve schools in planning prevention pre K through Grade 12
	Additional idea – introduce the season(s) for non-violence (begun by Gandhi’s grandson in 1997 at the United Nations to schools. Give teens and teachers idea to incorporate suicide prevention into the nonviolence curriculum. Utilize PSA’s radio and television.
X	Advertise, advertise, advertise. Foster parents especially.
X	Racism leads to feelings of low self-esteem, depression, helplessness, etc. This continues for all ages.
X	Increase curriculum involving self-esteem and ethics or “telling” someone older about a potential problem, encourage. Also teach “responsibility age-specific level”
X	Important not to “single out” at risk kids. Better to make broad strokes.
	Have teachers compliment students example: “Good question, Joe!”
	Developmental Assets: Project Cornerstone.
X	Use social networking potential.
	b) Edits to Strategies
X	You forgot prevention: should be a separate category.
X	Include reaching out to students experiencing academic difficulties
	Prevention strategies should be formulated: Youth Developmental Assets; Caring school environment; Service Learning
	c) Additional Comments
X	Racism against Latinos is high!

X	I think the most important thing is a societal shift to isolating individuals less. This is a cultural issue. E.g. computer culture.
X	Listen to youth! Be a friend not a stranger!
	d) Wall Graphic
X	Parents need to connect with kids, youth, teens
X	Bullying in schools: outreach, parent support needed
X	Dinner with your children
X	Educate – healthy foods, exercise
X	Empower kids, youth, teens

Youth and Young Adults Ages 16 to 24	
	a) New Strategies
X	Moving, family relations, unsatisfying work – pressure once returned to house of origin
X	Parent-child communication training workshops including teens and parents
X	Internet
X	Youth forums: to hear our youth – what do they day they need?
X	Peer counselors opportunities to get trained in age-specific ways in crisis intervention and discussing the “ethic” or “telling”
	Community service for youth
X	Training and police officers responding to 5150 calls
X	Services list of therapists – hospital with adolescent units
	Peer to peer college student training and education – early detectional screening in college health services
X	Making resources, help lines more obvious and culturally sensitive
X	Strong need for prevention strategies. Should be called out!
X	Include bullying issues
X	Educate parents about how to address mental health issues – that may emerge when their students are away at college
	To finish the high school and get the diploma or GED
	Tell teachers to compliment students, e/g/ “Hey Joe, that was a good question!”
	Like peer stipend program – may listen to them more than adult
X	Treating suicide as a medical issue it could be argued is culturally biased already...However, I think if you look at your whole program you do not focus on the medical side only.
X	If screen people, where are the therapists/hospital beds to put them if needed?
X	Comprehensive health, curriculum including social, emotional health
	School nurses should be involved!
X	Education! Training of educators, community leaders, parents, youth about signs and calls for help!
X	Individuals with physical disabilities – including but not limited to injuries that changes an individuals life? Exp – head injury, parapalegic, quadrapalegic, stroke, etc.
X	Immigration or refugee concerns acculturation stress linguistic cultural riff
X	More information on suicide prevention is needed in Spanish

X	Training targeting high school/community college (administrators, discipline, guidance counselors, staff)
X	More sensitive and compassionate media coverage needed
	b) Edits to Strategies
	We need prevention! Separate category
	c) Additional Comments
X	Listen to youth! Make connections, be a friend.
	d) Wall Graphic
	Budget cuts in schools impact counseling. Need community-based counselors/peers

<u>Adults Ages 25 to 59</u>	
	12-step model
X	No cost counseling or crisis services
X	Intervention strategy for adults – tie your intervention with de-stigmatizing desensitizing to subject normalizing seeking help and providing hope
	Class versus counseling – and counseling when needed
X	Peer to peer college student training
X	Provide training for family members
X	Include adults experiencing job loss and time period out of work
X	College faculty training (higher education)
X	Work place problems – may be the 1 st place where problems are noticed. Include training supervisors, etc.
X	Single, middle-age me
X	Need to provide targeted resources to returning serve members who are at high risk for suicide. Their families are also at high risk for violence, depression and suicide.
	Wall Graphic
X	Job loss Provide unemployed with resources, information Mandate provision of information
	Parent’s impact on entire family
X	Foster parents
X	Parents need resources, tools to help prevent suicide

<u>Older Adults Ages 60+</u>	
X	Add priority populations. Health or family health of suicide identification or attempts.

	Additional idea – fundraisers such as a wing into life golf tournament for schools, community organizations, or contract agencies.
X	Make homebound services/disabled a priority!! For outreach and address isolation issue.
X	I like the idea of a mobile unit(s). I think advertising in all forms of media (TV, radio, newspapers, magazines, etc.) is necessary.
	a) Additional Comments
	The “forgotten” population. I’ve heard it said that they are underserved by the new PEI Plan.
	b) Wall Graphic
X	Community ownership of plan is important!
X	Connect with people
X	Reality affects society, people
X	Stigma of seeking help, change this!
X	Separate prevention and intervention
	Medicine side effects impact suicide risk

Attachment 5. Palo Alto Unified School District Suicide Prevention and Mental Health Promotion Policy

Students

BP 5141.52

SUICIDE PREVENTION AND RELATED MENTAL HEALTH PROMOTION

The Board of Education recognizes that suicide is a major cause of death among youth and should be taken seriously. In order to attempt to reduce suicidal behavior and its impact on students and families, the Superintendent or designee shall develop preventive strategies and intervention procedures.

The Superintendent or designee shall involve school health professionals, school counselors, administrators, other staff, parents/guardians, students, local health agencies and professionals, and community organizations in planning, implementing, and evaluating the district's strategies for suicide prevention and intervention.

Prevention and Instruction

Suicide prevention strategies shall include, but not be limited to, efforts to promote a positive school climate that enhances students' feelings of connectedness with the school and is characterized by caring staff and harmonious interrelationships among students.

The district's instructional and student support program shall promote the healthy mental, emotional, and social development of students including, but not limited to, the development of problem-solving skills, coping skills, and resilience.

The Superintendent or designee may offer parents/guardians education or information which describes the severity of the youth suicide problem, the district's suicide prevention efforts, risk factors and warning signs of suicide, basic steps for helping suicidal youth, reducing the stigma of mental illness, and/or school and community resources that can help youth in crisis.

Staff Development

Suicide prevention training for staff shall be designed to help staff identify and find help for students at risk of suicide. The training shall be offered under the direction of district staff and/or in cooperation with one or more community mental health agencies and may include information on:

1. Research identifying risk factors, such as previous suicide attempt(s), history of depression or mental illness, substance use problems, family history of suicide or violence, feelings of isolation, interpersonal conflicts, a recent severe stressor or loss, family instability, and other factors.
2. Warning signs that may indicate suicidal intentions, including changes in students' appearance, personality, or behavior.
3. Research-based instructional strategies for teaching the suicide prevention curriculum and promoting mental and emotional health.
4. School and community resources and services for students and families in crisis and ways to access them.
5. District procedures for intervening when a student attempts, threatens, or discloses the desire to die by suicide.

BP 5141.52

SUICIDE PREVENTION AND RELATED MENTAL HEALTH PROMOTION (continued)

Intervention

Whenever a staff member suspects or has knowledge of a student's suicidal intentions, he/she shall promptly notify the principal, another school administrator, psychologist, or school counselor. The principal, another school administrator, psychologist, or counselor shall then notify the student's parents/guardians as soon as possible and may refer the student to mental health resources in the school or community.

Students shall be encouraged through the education program and in school activities to notify a teacher, principal, another school administrator, counselor, or other adult when they are experiencing thoughts of suicide or when they suspect or have knowledge of another student's suicidal intentions.

The Superintendent or designee shall establish crisis intervention procedures to ensure student safety and appropriate communications in the event that a suicide occurs or an attempt is made by a member of the student body or staff on campus or at a school-sponsored activity-

Also see:

- cf. 4131 – Staff Development*
- cf. 5022 – Student and Family Privacy Rights*
- cf. 5125 – Student Records*
- cf. 5030 - Student Wellness*
- cf. 5141 – Health Care and Emergencies*
- cf. 5137 – Positive School Climate*
- cf. 5143 – Nondiscrimination/Harassment*
- cf. 6142.8 - Comprehensive Health Education*
- cf. 6164.2 – Guidance/Counseling Services*

Policy
adopted: June 1, 2010

PALO ALTO UNIFIED SCHOOL DISTRICT
Palo Alto, California

SUICIDE PREVENTION AND RELATED MENTAL HEALTH PROMOTION

Prevention and Instruction

The District’s suicide prevention curriculum shall be designed to help students to:

1. Identify and analyze signs of depression and self-destructive behaviors and understand how feelings of depression, loss, isolation, inadequacy, and anxiety can lead to thoughts of suicide.
2. Identify alternatives to suicide and develop coping and resiliency skills.
3. Learn to share feelings and get help when friends are showing signs of suicidal intent.
4. Identify community crisis intervention resources where help is available and recognize that there is no stigma associated with seeking mental health, substance abuse, gender identity, or other support services.

Staff Development

1. Annual in-service suicide prevention training will be conducted in order for the district staff to learn to recognize the warning signs of suicidal crisis, to understand how to help suicidal youths, and to identify community resources. All staff will learn to identify potentially suicidal students, to take preventative precautions, and to report suicide threats to the appropriate authorities. Training will be offered under the direction of trained district counselors/psychologists.
2. Staff shall promptly report suicidal threats or statements to the principal or to a trained district counselor/psychologist, who shall promptly report threats or statements to the student’s parents/guardians and take appropriate action until the parent or guardian arrives.

Intervention

Immediate Intervention for a Suicide Threat or Attempt

When a suicide attempt or threat is reported, the principal or designee shall:

1. Ensure the student’s physical safety by one of the following, as appropriate:
 - a. Securing immediate medical treatment if a suicide attempt has occurred.
 - b. Securing law enforcement and/or other emergency assistance if a suicidal act is being actively threatened.
 - c. Keeping the student under continuous adult supervision until the parent/guardian and/or appropriate support agent or agency can be contacted and has the opportunity to intervene.
THE STUDENT MUST NOT BE LEFT ALONE.

SUICIDE PREVENTION AND RELATED MENTAL HEALTH PROMOTION (continued)

2. Designate specific individuals to be promptly contacted, including the school counselor, psychologist, nurse, superintendent, and/or the student's parent/guardian, and as necessary, local law enforcement or mental health agencies.
3. Document the incident in writing as soon as feasible.
4. Follow up with the parent/guardian and student in a timely manner to provide referrals to appropriate services as needed.
5. Provide access to counselors or other appropriate personnel to listen to and support students and staff who are directly or indirectly involved with the incident at the school.
6. Provide an opportunity for all who respond to the incident to debrief, evaluate the effectiveness of the strategies used, and make recommendations for future actions.
7. Document the steps taken in the student's record.
8. Develop an effective plan for reintegration of the student into school following the crisis.

Intervention after a Death Suggested to be Suicide

When a tragedy occurs and a student dies, the principal or designee shall:

1. Contact the Superintendent. District Office staff will contact other schools and remind them to identify and provide counseling to any student who might have known or been connected in any way with the student who died.
2. Call an emergency staff meeting to relay known information and formulate appropriate procedures for supporting students, staff, and parents. The death should not be called a suicide. This is a legal determination that can only be made by the coroner's office. It should be referred to as a death or a tragic death.
3. Talk with students who were in class with the student by going to that classroom.
4. Contact other students who might know the student in direct, one-to-one conversations.
5. Provide counseling support to students. Contact additional psychologists/counselors to increase the available support. Have a place available for students to go to (Support Room) and walk around campus to be available for any student needing support. Counselors should follow the student's schedule and be available to assist the students and teachers in those classes. Students must be allowed to grieve, but there should be no large group gatherings such as an assembly. Students should not be allowed to congregate in groups without adult supervision. Identify any students who might be at risk and call them in to talk.
6. Contact the family to express condolences and to let them know what the school is doing. Ask when the family would like the student's personal items returned to them. The student's locker should be cleaned out and contents returned to the parents at an appropriate time.

SUICIDE PREVENTION AND RELATED MENTAL HEALTH PROMOTION (continued)

7. Designate a spokesperson who will respond to questions and inquiries from the media and work with the media to assure responsible reporting (see American Foundation for Suicide Prevention guidelines).
8. School will be conducted as usual to the greatest extent possible. In no case should school be canceled.
9. Prepare a note to send home to parents indicating that a tragic death has occurred and that post intervention procedures and counseling has begun.
10. Schedule a parent meeting as soon as possible to help parents deal with the issue and to advise them how to help students.

Also see:

- cf. 4131 – Staff Development*
- cf. 5022 – Student and Family Privacy Rights*
- cf. 5125 – Student Records*
- cf. 5030 - Student Wellness*
- cf. 5141 – Health Care and Emergencies*
- cf. 5137 – Positive School Climate*
- cf. 5143 – Nondiscrimination/Harassment*
- cf. 6142.8 - Comprehensive Health Education*
- cf. 6164.2 – Guidance/Counseling Services*

Approved: June 1, 2010

PALO ALTO UNIFIED SCHOOL DISTRICT
Palo Alto, California

Attachment 6. References

- ¹ Behavioral Risk Factor Survey, Santa Clara County 2004 Chartbook, Santa Clara County Public Health Department, 2004
- ² California Department of Health: Epic Data
- ³ <http://www.sprc.org/grantees/statetribe/2010/7B%20Inspire%20USA%20handout.pdf>
- ⁴ Ibid
- ⁵ Center for Health Statistics—Vital Statistics Query System.
http://www.applications.dhs.ca.gov/vsq/screen4a.asp?cnty_cd=43&YEAR_DATA=2007&Criteria=1&Res_occ=Residence&Birth_Death=Death&stats=2&cod_cd=424 Retrieved 3/4/10.
- ⁶ California Department of Public Health, County Health Status Profiles 2009, retrieved 3/9/10
- ⁷ Number is based on the above-established rate.
- ⁸ Center for Health Statistics—Vital Statistics Query System.
http://www.applications.dhs.ca.gov/vsq/screen4a.asp?cnty_cd=43&YEAR_DATA=2007&Criteria=1&Res_occ=Residence&Birth_Death=Death&stats=2&cod_cd=424 Retrieved 3/4/10.
- ⁹ Ibid
- ¹⁰ California Department of Public Health, Center for Health Statistics, Vital Statistics Query System. <http://www.applications.dhs.ca.gov/vsq/default.asp>. Retrieved 3/3/10 through kidsdata.org
- ¹¹ The Trust about Suicide: Real Stories of Depression in College.
http://www.afsp.org/files/College_Film//factsheets.pdf Retrieved 3/4/10
- ¹² Mental Health America Suicide Fact Sheet. <http://www.mentalhealthamerica.net/go/suicide> Retrieved 3/4/10
- ¹³ Ray Hodgson, Tina Abbasi, Johanna Clarkson. 1996. Effective mental health promotion. *Health Education Journal*, 55, 55-74
- ¹⁴ National Strategy for Suicide Prevention, US Dept. of Health and Human Services, 2001, p 41
- ¹⁵ Sanford C and Hedegaard H (editors). Deaths from Violence: A Look at 17 States -- Data from the National Violent Death Reporting System. December 2008.
- ¹⁶ Youth Suicide Fact Sheet. www.suicidology.org. Retrieved 4/22/10.
- ¹⁷ CDC. Suicide among children, adolescents and young adults—United States, 1980-1992. *MMWR Morbidity Mortality Weekly Report* 1995; 44(15):289-91
- ¹⁸ California EpiCenter database
- ¹⁹ Behavioral Risk Factor Survey, Santa Clara County 2004 Chartbook, Santa Clara County Public Health Department, 2004
- ²⁰ Santa Clara County Youth Suicide Rate 2005-2007. California Department of Public Health, Center for Health Statistics, Vital Statistics Query System.
<http://www.applications.dhs.ca.gov/vsq/default.asp>. Retrieved 3/3/10 through kidsdata.org
- ²¹ Youth Suicide Fact Sheet. www.suicidology.org. Retrieved 4/22/10.
- ²² California EpiCenter database
- ²³ American Foundation for Suicide Prevention,
http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=E2464DF6-0397-BD56-A8E232923B04ED5C Retrieved 3/4/10

-
- ²⁴ Potter, L., Silverman, M., Connorton, E., & Posner, M. (2001). Promoting mental health and preventing suicide in college and university settings. Suicide Prevention Resource Center. Retrieved October 15, 2007, from www.sprc.org/library/college_sp_whitepaper.pdf.
- ²⁵ Benton, S. A., Robertson, J. M., Wen-Chih Tseng, Newton, F. B., & Benton, S.L. (2003). Changes in counseling center client problems across 13 years. *Professional Psychology: Research and Practice*, 34(1), 66–72.
- ²⁶ *Picture This: Depression and Suicide Prevention*. Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the Entertainment Industries Council, Inc. http://www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf. Retrieved 4/14/10
- ²⁷ Santa Clara County Suicide Prevention Advisory Committee Basic National Data, presented by Victor Ojakian on January 13, 2010. [http://www.sccmhd.org/SCC/docs/Mental Health Services \(DEP\)/attachments/National_State_Data_on_Suicide_slides_Mtg_1_13_2010.pdf](http://www.sccmhd.org/SCC/docs/Mental Health Services (DEP)/attachments/National_State_Data_on_Suicide_slides_Mtg_1_13_2010.pdf). Retrieved 4/23/10.
- ²⁸ American Association of Suicidology: *Suicide and the Economy*. Available at <http://www.suicidology.org/web/guest/current-research>. Accessed May 19, 2010.
- ²⁹ California EpiCenter database
- ³⁰ Ibid
- ³¹ The National Alliance on Mental Illness. Communities: Major Depression. Available at: http://www.nami.org//Template.cfm?Section=major_depression&template=/Forums/TopicDisplay.cfm&ForumID=1&ForumActiveFlag=Y&TopicActiveFlag=Y. Accessed August 13, 2007.
- ³² *Picture This: Depression and Suicide Prevention*. Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the Entertainment Industries Council, Inc. http://www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf. Retrieved 4/14/10
- ³³ Kulkin, H., E. Chauvin, & et al. (2000). Suicide among gay and lesbian adolescents and young adults: a review of the literature. *Journal of Homosexuality*, 40(1), 1-29.
- ³⁴ Remafedi, G., J. A. Farrow, et al. (1991). Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics*, 87(6), 869-875.
- ³⁵ Eisenberg, M. E., & Resnick, M.D. (2006). Suicidality among gay, lesbian and bisexual youth: The role of protective factors. *Journal of Adolescent Health*, 39(5), 662-668.
- ³⁶ Kessler, R., Borges, G., & Walters, E. (1999) Prevalence of and risk factors for lifetime suicide attempts in the national comorbidity survey. *Archives of General Psychiatry*, 56, 617-626
- ³⁷ The Archives of Pediatric and Adolescent Medicine (May 1999)
- ³⁸ Ibid
- ³⁹ *Data Summary Sheet on Suicide Deaths and Non-Fatal Self-Inflicted Injuries*. California Department of Mental Health, Office of Suicide Prevention. (2007).
- ⁴⁰ American Foundation for Suicide Prevention. http://www.afsp.org/index.cfm?fuseaction=home.viewpage&page_id=04ECB949-C3D9-5FFA-DA9C65C381BAAEC0, retrieved 6/26/10
- ⁴¹ Court addresses causes of juvenile delinquency, *San Jose Mercury News*, November 23, 2002

⁴² Huskey & Associates in association with National Council on Crime and Delinquency, *Profile of In-Custody Minors in Santa Clara County, CA*, Santa Clara County Probation Department, Preliminary Findings, July 17, 2008

⁴³ Huskey & Associates in association with National Council on Crime and Delinquency, *Profile of Out of Custody Minors*, Santa Clara County Probation Department, Preliminary Findings, September 2, 2008

⁴⁴ Data provided by the Santa Clara County Department of Probation, 4/15/10

⁴⁵ Office of Justice Programs, Bureau of Justice Statistics. *Suicide and Homicide in State Prisons and Local Jails*, Christopher J. Mumola, August 21, 2005, NCJ 210036.

<http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1126>

⁴⁶ Ibid

⁴⁷ Data provided by the Santa Clara County Department of Correction, 4/5/10

⁴⁸ Ibid

⁴⁹ New Navy Program Encourages Sailors to "ACT" to Prevent Suicide. Navy.mil (Official Website of the U.S. Navy) Story Number: NNS061203-09. Release Date: 12/4/2006 9:01:00 AM. Retrieved 4/22/10

⁵⁰ Charles W. Hoge, M.D., et. al, Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care, *The New England Journal of Medicine*, July 1, 2004, Vol. 351, No 1

⁵¹ Kaplan, M.S., Huguet, N., McFarland, B.H., & Newsom, J.T. (2007), Suicide among male veterans: a prospective population-based study, *Journal of Epidemiology and Community Health*, 61(7), 619-24.

⁵² Eli Clifton, U.S.: Suicide Rate Surged Among Veterans, Washington, Jan 13, 2010

⁵³ Ibid

⁵⁴ Mark S. Kaplan, DrPH, Bentson H. McFarland, MD, PhD, and Nathalie Huguet, PhD, Firearm Suicide Among Veterans in the General Population: Findings From the National Violent Death Reporting System, *The Journal of TRAUMA® Injury, Infection, and Critical Care*, Volume 67, Number 3, September 2009

⁵⁵ American Fact Finder. TM-P044. Percent of Civilian Persons 18 Years and Over Who Are Veterans: 2000, Universe: Civilian population 18 years and over, Data Set: Census 2000, SF 3

⁵⁶ Parent, Richard 2004. "Aspects of Police Use of Deadly Force In North America - The Phenomenon of Victim-Precipitated Homicide," Ph.D. thesis, Simon Fraser University

⁵⁷ USA Today. Suicide rate jolt police culture. 2/8/2007

⁵⁸ Selzer, M. L., & Payne, C. E. (1992). Automobile accidents, suicide, and unconscious motivation. *American Journal of Psychiatry*, 119, p 239

⁵⁹ Dennis L. Peck, Kenneth Warner (Summer, 1995). Accident or suicide? "Single-vehicle car accidents and the intent hypothesis."

⁶⁰ Murray, D.; de Leo, D. (Sep 2007). "Suicidal behavior by motor vehicle collision." *Traffic Injury Prevention* 8 (3): 244–7. doi: 10.1080/15389580701329351. PMID 17710713

⁶¹ <http://www.menstuff.org/issues/byissue/unintentional-suicide.html>. Retrieved 4/21/10.

⁶² Scott Poland, District Administration, Solutions for School District Management, "Preventing Cluster Suicides," October 2009

⁶³ Brent DA, Moritz G, Bridge J, Perper J, Canobbio R (May 1996). "Long-term impact of exposure to suicide: a three-year controlled follow-up". *Journal of the American Academy of*

Child and Adolescent Psychiatry **35** (5): 646–53. doi: 10.1097/00004583-199605000-00020. PMID 8935212

⁶⁴ Phillips DP, Carstensen LL (September 1986). "Clustering of teenage suicides after television news stories about suicide." *New England Journal of Medicine*. 315 (11): 685–9. PMID 3748072.

⁶⁵ *Picture This: Depression and Suicide Prevention*. Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the Entertainment Industries Council, Inc. http://www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf. Retrieved 4/14/10

⁶⁶ American Association of Suicidology, Scott Poland, Prevention Director, "Preventing Cluster Suicides," *District Administration Solutions for School District Management*, October 2009

⁶⁷ American Roulette: Murder-Suicide in the United States. Violence Policy Center.

⁶⁸ *Picture This: Depression and Suicide Prevention*. Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the Entertainment Industries Council, Inc. (EIC), under subcontract to ENCORE Management Corporation, contract number 280-02-0701, with SAMHSA, U.S. Department of Health and Human Services (HHS). Anne Mathews-Younes, Ed.D., Government Project Officer. http://www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf. Retrieved 4/14/10

⁶⁹ Robins, E. (1981). *The final months: A study of the lives of 134 persons*. NY: Oxford University Press.

⁷⁰ Barraclough, B., & Hughes, J. (1987). *Suicide: Clinical and epidemiological studies*. London: Croom Helm.

⁷¹ Conwell, Y., Duberstein, P.R., Cox, C., Herrmann, J.H., Forbes, N.T., and Caine, E.D. (1996). Relationships of age and axis I diagnoses in victims of completed suicide: a psychological autopsy study. *American Journal of Psychiatry*, 153, 1001–1008.

⁷² Brent, D.A., Perper, J.A., Moritz, G., Allman, C., Friend, A., Roth, C., & et al. (1993). Psychiatric risk factors for adolescent suicide: a case-control study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32 (3), 521–529.

⁷³ Shaffer, D., Gould, M.S., Fisher, P., Trautman, Ph., Moreau, D., Kleinman, M., & et al. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry*, 53 (4), 339–348.

⁷⁴ Potter, L., Silverman, M., Connorton, E., & Posner, M. (2001). Promoting mental health and preventing suicide in college and university settings. Suicide Prevention Resource Center. Retrieved October 15, 2007, from www.sprc.org/library/college_sp_whitepaper.pdf.

⁷⁵ Kidsdata.org, a program of the Lucile Packard Foundation for Children's Health

⁷⁶ Kids in Common 2007 Santa Clara County Children's Report

⁷⁷ Santa Clara County Department of Public Health and WestEd. *California Healthy Kids Survey 2005-2006*.

⁷⁸ *Picture This: Depression and Suicide Prevention*. Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the Entertainment Industries Council, Inc. http://www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf. Retrieved 4/14/10

-
- ⁷⁹ American Foundation for Suicide Prevention, http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=E2464DF6-0397-BD56-A8E232923B04ED5C. Retrieved 3/4/10
- ⁸⁰ *Picture This: Depression and Suicide Prevention*. Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the Entertainment Industries Council, Inc. http://www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf. Retrieved 4/14/10
- ⁸¹ Regier, D.A., Farmer, M.E., Rae, D.S., et al. (1993). One-month prevalence of mental disorders in the United States and sociodemographic characteristics: The epidemiologic catchment area study. *Acta Psychiatrica Scandinavica*, 88, 35-47.
- ⁸² Conwell Y, Brent D. Suicide and aging. I: patterns of psychiatric diagnosis. *International Psychogeriatrics*, 1995; 7(2): 149-64.
- ⁸³ Conwell Y. Suicide in later life: a review and recommendations for prevention. *Suicide and Life Threatening Behavior*, 2001; 31(Suppl): 32-47.
- ⁸⁴ Health Trust, Health Aging Initiative. <http://www.healthtrust.org/initiatives/aging/facts.php>. Retrieved 4/23/10.
- ⁸⁵ Santa Clara County Public Health Department, Epidemiology and Data Management, 2005-2006 Behavior Risk Factor Survey Santa Clara County Chartbook; 2004 Adult Health Status Report. <http://sccphd.org/portal/>
- ⁸⁶ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (October 11, 2007). *The NSDUH Report: Depression among Adults Employed Full-Time, by Occupational Category*. Rockville, MD.
- ⁸⁷ "Veterans Stress Cases Up Sharply," USA Today, Oct. 18, 2007, http://www.usatoday.com/news/washington/2007-10-18-veterans-stress_N.htm
- ⁸⁸ Ibid
- ⁸⁹ Defense Medical Surveillance System, Post Deployment Health Self-Assessment of Service Members Who Had Served in Iraq, *Behavioral Health Services for Veterans and their Families*, February, 2008, p.1.
- ⁹⁰ Leonard, Power Point Presentation, "Welcome to the Veteran Services Town Hall Meeting."
- ⁹¹ All about Depression, Suicide and Depression. http://www.allaboutdepression.com/gen_04.html Retrieved 3/4/10
- ⁹² *Picture This: Depression and Suicide Prevention*. Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the Entertainment Industries Council, Inc. (EIC), under subcontract to ENCORE Management Corporation, contract number 280-02-0701, with SAMHSA, U.S. Department of Health and Human Services (HHS). Anne Mathews-Younes, Ed.D., Government Project Officer. http://www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf. Retrieved 4/14/10
- ⁹³ The Trust about Suicide: Real Stories of Depression in College. http://www.afsp.org/files/College_Film//factsheets.pdf Retrieved 3/4/10
- ⁹⁴ Santa Clara County Public Health Department, Behavioral Risk Factor Survey, 2005-2006
- ⁹⁵ Oxford Journal of Medicine: An International Journal of Medicine, Volume 99, Number 1, Pp. 57-61

⁹⁶ Hufford M. R., Alcohol and suicidal behavior. *Clinical Psychology Review* 2001; 21:797–811.

⁹⁷ Natalie Staats Reiss, Ph.D., and Mark Dombeck, Ph.D. Factors Contributing To Suicide Risk, Updated: Oct 24th 2007

⁹⁸ Protective Factor List Published by the U.S. Public Health Service 1999

⁹⁹ Centers for Disease Control and Prevention, Suicide Prevention Scientific Information: Prevention Strategies.” <http://www.cdc.gov/ncipc/dvp/Suicide/Suicide-prvt-strat.htm>. Accessed 5/12/10.

¹⁰⁰ Santa Clara County Mental Health Department 2009 data

¹⁰¹ <http://www.sprc.org/grantees/statetribe/2010/7B%20Inspire%20USA%20handout.pdf>

¹⁰² Clebsch, W. A., Jaeckle, C. R. 1983

¹⁰³ Community for a Lifetime, 2005

¹⁰⁴ Developed in a collaborative effort among American Foundation for Suicide Prevention (AFSP), the Annenberg Public Policy Center, the National Institute of Mental Health, the Office of the Surgeon General, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the American Association of Suicidology, the World Health Organization and several other agencies.

¹⁰⁵ Santa Clara County Mental Health Department 2009 data