

Annual Report 2012

suicide prevention strategic plan

SANTA CLARA COUNTY SUICIDE PREVENTION OVERSIGHT COMMITTEE | OCTOBER 2012



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
1-855-278-4204
Toll-free, 24/7

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

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

Additional resources are listed on the Santa Clara County's Mental Health Department website: www.sccmhd.org/sp on the Suicide Prevention Resources page.

“Is Suicide a Choice? No.

Choice implies that a suicidal person can reasonably look at alternatives and select among them. If they could rationally choose, it would not be suicide. Suicide happens when all other alternatives are exhausted -- when no other choices are seen.”

Adina Wroblewski

Author: [Suicide: Survivors, A Guide for Those Left Behind](#)

Prepared for the Board of Supervisors, on behalf of
Nancy Peña, Ph.D., Director of Mental Health Department and
Co-Chair of the Suicide Prevention Oversight Committee

Santa Clara County Suicide Prevention 2nd Annual Report

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SANTA CLARA COUNTY SUICIDE PREVENTION OVERSIGHT COMMITTEE

The Oversight Committee represents a cross-section of people who meet every other month to oversee the implementation of the Suicide Prevention Strategic Plan and the work of the various Workgroups. The commitment of this committee demonstrates the passion that comes, in large part, from personal experience with the pain of suicide and a desire to save more lives and reduce suicide deaths in the county.

Members:

Jo Coffaro Hospital Council of Northern & Central California	Shashank Joshi, M.D. HEARD Alliance/ Lucille Packard Children's Hospital at Stanford
Leslie Barry Connors Momentum for Mental Health	Wes Mukoyama, LCSW Mental Health Board Alum Council on Agency Advisory Board
Pattie DeMellopine, R.N. Office of County Supervisor Liz Kniss	Joseph O'Hara, M.D. Santa Clara County Medical Examiner-Coroner Office, Suicide Prevention Advisory Committee Alum
Michael Donohue Kara Grief Services	Victor Ojakian, Co-Chair Mental Health Board Chair Survivor of Suicide Loss Suicide Prevention Advisory Committee Alum
Meg Durbin, M.D. HEARD Alliance/ Palo Alto Medical Foundation	Mary Ojakian, R.N. American Foundation for Suicide Prevention Suicide Prevention Advisory Committee Alum Survivor of Suicide Loss
Kathy Forward National Alliance on Mentally Illness	Nancy Peña, Ph.D., Co-Chair Mental Health Department Suicide Prevention Advisory Committee Alum
Bruce Copely Robert (Bob) Garner Stephen Betts Santa Clara County Department of Alcohol and Drug Services	Anthony Ross Outlet Program
Michael Haberecht, M.D., PhD. Stanford Counseling and Psychological Services, Suicide Prevention Advisory Committee Alum	Anandi Sujeer Mandeep Baath Santa Clara County Public Health Department
Sandra Hernandez Mental Health Department, Integrated Behavioral Health and Cross Systems	Mike Torres Council on Aging, Silicon Valley
John Hirokawa Santa Clara County Office of the Sheriff	Wiggys Sivertsen San José State University Suicide Prevention Advisory Committee Alum
Lisa Jafferries Kaiser Permanente	Kris Wang City of Cupertino/Santa Clara County Cities' Association
Mark Eastus Kevin Jensen Santa Clara County Office of the Sheriff Santa Clara County Medical Examiner-Coroner	

And, with Special Thanks to:

Santa Clara County Medical Examiner and Coroner's Office, for their partnership in prioritizing this work by sharing essential data to help create the first ever baseline profile of the suicide deaths in Santa Clara County, and commitment to expand our understanding, in part, by the use of this data. Especially:

Joseph O'Hara, MD, Lead-Medical Examiner and champion of this effort from the planning phase to present

Cpt. Kevin Jensen, Santa Clara County Office of the Sheriff Santa Clara County Medical Examiner-Coroner Office, who provided us with the initial data set

Cpt. Mark Eastus Administrative Director/ Coroner, and the staff who have supported this data sharing

Anita Jhunjunwala Mukherjee, MS, EdD, former Suicide Prevention Associate and **Victor Ojakian** SPOC Co-Chair, who developed this initial 3 year baseline data report of Santa Clara County suicide deaths.

Members of the Data Workgroup

Members of the Intervention Workgroup

Members of the Policy & Governance Advocacy Workgroup

Elena Tindall, MA Ed., first Suicide Prevention Coordinator for this effort, who coordinated and assisted in the development and growth of this work with the community partners, advocates, and consumers.

MIG, Inc. for graphic design

Staff:

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

Sandra Hernandez, LCSW, Division Director, **Santa Clara County Mental Health Department**

Elena Tindall, M.Ed., Santa Clara County Suicide Prevention Coordinator, Liaison to the State Office of Suicide Prevention, (August 2010-August 2012) **Santa Clara County Mental Health Department**

Marc Giudici, MS, PhD, Interim Santa Clara County Suicide Prevention Coordinator, Interim Liaison to the State Office of Suicide Prevention, (August 2012-present) **Santa Clara County Mental Health Department**

Anita Jhunjunwala Mukherjee, M.S., Ed.D. Santa Clara County Suicide Prevention Associate (September 2010-June 2012) **Santa Clara County Mental Health Department**

Jean Kaelin, MPA Santa Clara County Suicide Prevention Associate, (March 2012- present) **Santa Clara County Mental Health Department**

Lan Nguyen, MA Suicide and Crisis Services (SACS) Manager, (March 2012-present), **Santa Clara County Mental Health Department**

Suicide Prevention Initiative 2nd Annual Report

Letter of Welcome

We are grateful to the Santa Clara Board of Supervisors and its partners in this community for assisting in bringing needed attention to the problem of suicide in our county. It is on broad agreement that we as a community must be proactive in averting this preventable loss. With their support we are able to implement a strategy that ensures the message of hope and prevention reaches those who live and work in this county.

Suicide is a devastating tragedy in terms of the lives lost and the emotional heartbreak for which family members and loved ones are forced to endure. The reality is that most suicidal people do not want to die; most desperately want to escape their pain and want to find a way to live a pain free peaceful life. Sadly, the fact is that every 15 minutes in this country we lose someone to suicide. It is true that not all deaths are preventable, but to die by suicide at any age is a terrible loss of human life, especially as the majority of deaths occur in the demographic group of working adults. Further, the costs of suicide are overwhelming to our community and workplace, and the damages to the families and those who care for them are devastating. Suicide is one of the most preventable forms of death. SCC is motivated to reduce these senseless losses in our community by 40% among adults, and 50% among youth by 2021, duplicating the success Australia had using a similarly multi-pronged strategy. This Annual Report chronicles the achievements and work completed to reduce this premature loss over the past year.

Nancy Peña, PhD
**Co-Chair, Suicide Prevention
Oversight Committee (SPOC)**

Victor Ojikian,
**Co-Chair, Suicide Prevention
Oversight Committee (SPOC)**

Annual Report Executive Summary

This summary of the Second Annual Report highlights some major achievements accomplished over the period of between October 2011 and September 2012 (the period of the SP Annual Report), and next steps, organized by strategy of the adopted Suicide Prevention Strategic Plan. The activities outlined in this report are funded by the Mental Health Services Act (MHSA)- Prevention and Early Intervention (PEI), and is referred to as Project 5: Suicide Prevention in the SCC PEI Plan.

The Annual Report, submitted to the Health and Hospital Committee, is submitted on behalf of the Santa Clara County's (SCC) Suicide Prevention Oversight Committee (SPOC) and its three workgroups: Suicide Prevention and Intervention Workgroup, Data Workgroup, and Policy and Governance Advocacy Workgroup. A fourth and final workgroup, the Regional Communications Workgroup, will be launched by the middle of 2013. The comprehensive activities implemented in support of the Suicide Prevention Strategic Plan are referred to in the document as the Suicide Prevention Initiative (SP Initiative).

Strategy 1. Implement and Coordinate Suicide Intervention Programs and Services for High-Risk Populations

The primary objective of Strategy 1 is to prevent suicide deaths through effective suicide intervention services; and earlier identification and intervention of high-risk individuals. These objectives are the core focus of the SACS Hotline volunteers and staff, staff and vendors of the SCC Mental Health Department (MHD), and the dedicated efforts of the Intervention Workgroup members.

This strategy's key tasks are:

- Identify means to weave age-focused suicide prevention/ intervention/ postvention activities into the normal work and services currently being offered across industries and sectors.
- Create and maintain a comprehensive directory of current suicide prevention/intervention/ postvention activities and services available in SCC for use by the Suicide Prevention Coordinator.
- Produce a directory of services for survivors of suicide loss and suicide attempt survivors residing in SCC.
- Provide SCC residents with access to a 24-hour telephone suicide and crisis hotline through the SCC Suicide and Crisis Services Hotline (SACS).
- Enhance SACS services to meet American Association of Suicidology hotline standards.

Achievements:

- Completion by all members of the Intervention Workgroup of the one-hour online suicide prevention and intervention training called Question-Persuade-Refer, commonly referred to as QPR (more on QPR in Strategy 2).
- Continued partnership with the Ethnic and Cultural Communities Advisory Council outreach workers to actively promote suicide awareness in their stigma reduction and mental health promotion work.
- Development of a members' directory to facilitate and promote collaboration.
- Increased awareness of the Facebook Suicide Alert function, launched early in 2012.
- Introduced an emerging framework of recovery for Suicide Attempt Survivors, developed by one of the workgroup's members, a suicide attempt survivor, modeled on the stages of recovery from mental illness. These non-linear stages were validated by other suicide attempt survivors and shared with San Mateo County's SP Initiative and more broadly through the California Office of Suicide Prevention.
- Hired a dedicated SACS Manager to oversee the transition of the SACS into a nationally accredited Lifeline suicide hotline, funded in part through a grant awarded to SCC Mental Health Department (MHD) by the California Mental Health Services Authority (CalMHSA).
- Provided early intervention and crisis intervention support to 32,791 individuals, over 70% of whom were either suicidal or callers in crisis, through the SACS.
- Promoted a "Suicide Prevention Mobile Phone Application" for acutely suicidal individuals adopted by one of the vendors of the CalMHSA state-wide suicide prevention effort.

Next Steps:

- Complete a user-friendly suicide prevention/ intervention/ postvention directory.
- Recruit more bilingual Suicide and Crisis Hotline volunteers.
- Obtain American Association of Suicidology's certification of the SCC Hotline by end of 2012- early 2013.
- Define a pilot program to support suicide attempters leaving an Emergency Department.

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

The objectives of Strategy 2 are to implement a community education program and create an information campaign to increase public awareness of suicide and suicide prevention. This objective is primarily achieved through the combined efforts of the SP Staff and the SP Intervention Workgroup.

This strategy's key tasks are:

- Increase awareness of depression and suicide, and that suicide is preventable.
- Empower community members to identify and respond to a person who is feeling suicidal.
- Ensure increased awareness of how to access support services.
- Promote SACS hotline broadly, targeting SCC's rural areas and demographics- as outlined in CalMHSA grant.

Achievements:

- Launched SCC's community education campaign on suicide prevention through a one-hour online training- Question-Persuade- Refer (QPR), reaching over 1,800 adults in Santa Clara County (SCC), and an additional 60 mental health professionals and faith leaders who completed a two-day training Applied Suicide Intervention Skills Training (ASIST).
- Defined a process for the efficient administration of large groups accounts (100 trainings or more) for the online suicide prevention training Question-Persuade-Refer (QPR).
- Release of the CalMHSA awareness campaign "Know the Signs", a component of the broad social marketing effort developed for statewide launch in November. This campaign is designed to be leveraged and tailored by all local efforts.
- Assessed and identified the rural areas in SCC for targeted outreach to promote greater awareness of SACS.
- Engaged the identified groups and community leaders in order to understand the community's perspective on suicide;
- Partnered with San Mateo County in planning a rural community outreach effort.
- Trained local health care providers in suicide assessment questions and suicide prevention.
- Promoted the SCC SP Initiative and SACS hotline through a variety of local outreach efforts: presentation and trainings, tabling at community events and health fairs.

Next Steps:

- Initiate the "listening campaign"- a series of small group discussions designed to discuss the SP strategies, assess, and discover the needs of underserved targeted at-risk groups in Santa Clara County.
- Provide community trainings of QPR.
- Distribute 15,000 QPR online trainings.
- Expand suicide assessment trainings to more health care providers.

Strategy Three: Develop Local Communications Best Practices to Improve Media Coverage and Public Dialogue Related to Suicide

The objectives of Strategy Three are centered on broadly cultivating media agreement to report on suicides in alignment with established “Best Practices”, and to foster a positive public dialogue related to suicide and the prevention of suicide. These objectives are primarily achieved through the efforts of the SP Staff and the SP Intervention Workgroup.

This strategy’s key tasks are:

- Establish and maintain a dedicated suicide prevention website.
- Launch a fourth workgroup- the Communications Workgroup.
- Create a coordinated communication strategy.

Obtain agreement among key media outlets to educate staff and adhere to reporting standards in alignment with the “Best Practices”¹.

Achievements:

- Created a dedicated suicide prevention section in the MHD’s website.
- Partnered with the SCC Health and Hospital System’s Public Information Officer and partners to provide two *Communicating with Media training for Elected Officials* trainings, to 27 individuals representing 6 different SCC cities. Trainings held 9/2011 and 1/2012.
- Release of CalMHSAs- funded “Media Outreach Toolkit for Social Marketing” state-wide (9/2012).
- Identified timeline to launching the final workgroup: Communications Practices Workgroup (estimated mid 2013).

Next Steps:

- Convene the Regional SP Communications Workgroup by August 2013- following release of the CalMHSAs developed SP Broad Social Marketing Toolkit and the successful recruitment of a permanent SP Coordinator.
- Define and develop charter on local communication Best Practices to improve media coverage and public dialogue related to suicide.
- Utilize the “Toolkit for Social Marketing” to achieve the following:
 - build a strong foundation for the Regional Suicide Prevention Communication Workgroup;
 - guide selection of strategies best suited for SCC’s diverse community;
 - enhance local media’s awareness and adherence to the best practices when reporting on suicide deaths;

¹ Available online at www.ReportingOnSuicide.org and www.AFSP.org/media

- define a systematic process to monitor media reports on suicide and suicide prevention.

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

This strategy recognizes the significance of policy change and its potential to prevent deaths by suicide. By adopting suicide prevention policies, cities and agencies are empowered to prioritize their role in promoting healthier communities and provide the infrastructure for the necessary collaboration to raise awareness in their community. This objective is primarily achieved through the efforts of the SP Staff and the SPOC.

This strategy's key tasks are:

- Implement policy and governance advocacy to promote system change in suicide awareness and prevention, both directly and through partnership.
- Reduce stigma associated with suicide by framing this as a public health problem.
- Promote adoption of policies and programs that either work to prevent suicide or respond to emotional crises.

Achievements:

- Adoption of a SP Policy by the City of Mountain View in July 2012.
- Adoption of a Proclamation recognizing September 9 - 15, 2012 as "National Suicide Prevention Week" by the City of Mount View, and "Suicide Prevention Week" by the City of City of Palo Alto.

Next Steps:

- Continue with policy advocacy among the remaining 13 SCC Cities, school districts, businesses, and other entities in SCC.
- Provide technical assistance to any entity interested in exploring and possibly adopting a suicide prevention policy.

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. This objective is primarily achieved through the combined efforts of the SP Staff and the SP Data Workgroup.

This strategy's key tasks are:

- Increase the convergence of data reported by various agencies through their participation in the Data Workgroup.
- Establish a robust data collection process and monitoring system.
- Analyze and interpret data collected to identify leading causes of suicide and broadly disseminate those findings throughout the county.
- Develop and maintain a current database of suicide related data in SCC.

Achievements:

- Established a diverse and robust Data Workgroup.
- Establishment of a systematic process whereby the SCC Medical Examiner/Coroner (MEC) redacts and shares MEC reports of all recorded suicide deaths and shared with the SP Coordinator and Associate, and by extension, the Data Workgroup.
- Developed a robust data collection process and analyzed data from 2009-2011.
- Created the first ever comprehensive baseline on SCC suicide deaths.
- Completed the 2009-2011 Analysis of Suicide Data of Santa Clara County Report (Data Report), available on the www.sccgov.org/sites/mhd website (on the Suicide Prevention home page and Data Workgroup page).

Next Steps:

- Identify potential uses for this seminal body of work, and associated next steps.
- Highlight key issues that can be addressed by the various workgroups.
- Create a monitoring process that may evaluate the efficacy of the individual strategies on the overall deaths.
- Develop a process to analyze completed suicide notes in the hopes of potentially identifying improvements to the intervention and outreach efforts.

Suicide Prevention Initiative 2nd Annual Report

The first year, (2011, of the Suicide Prevention Initiative (SP Initiative) focused on establishing the necessary administrative infrastructure for this important effort: forming the various workgroups, finalizing the customization of the online suicide prevention training module; hiring key staff; and defining the goals for each component.

In its second year, the Santa Clara County (SCC) Suicide Prevention (SP) Strategic Plan's implementation efforts, referred to throughout this document as the SP Initiative, were able to realize some significant gains. A few of the significant achievements realized between October 2011 and October 2012 (the period of this report) include the successful launch of a community education campaign on suicide prevention that reached over 1,800 adults in Santa Clara County (SCC); defining a process for the efficient administration of large groups accounts (100 or more) for the online suicide prevention training; the hiring of a dedicated manager to oversee the suicide and crisis hotline and its certification with Lifeline; the City of Mountain View's adoption of a formal suicide prevention policy (bringing the number of cities with a suicide prevention policy to two); a ten-fold increase in requests for suicide prevention training from last year; and significantly, the release of the pioneering comprehensive Analysis of 2009-2011 Suicide Data of Santa Clara County report, attached to this Health and Hospital Committee report and available in full on the dedicated suicide prevention website: www.sccgov.org/site/mhd under the Suicide Prevention-Local Activities and Resources page, as well as on the Data Workgroup page.

The second year was also marked by significant staffing changes-the smooth transition of the dedicated SP staff (SP Coordinator and SP Associate), without break in the numerous activities of this effort and the hiring of a full-time manager for the SCC Suicide and Crisis Services (SACS) Hotline. At the time of this report, the recruitment process for a permanent SP Coordinator was still underway and an Interim Suicide Prevention Coordinator was hired in August 2012.

As these accomplishments demonstrate, a robust suicide prevention effort is achieved through the shared ownership and cooperation among every sector of our community. No one agency can make as significant an impact as can be achieved when all of us weave suicide prevention and awareness into our work and personal lives.

The updates provided in this report follow the five strategies of the SCC Suicide Prevention Strategic Plan (SPSP). The five strategies of this broad community effort are:

Strategy 1. Implement and coordinate suicide intervention programs and services for high-risk populations.

- Strategy 2. Implement a community education and information campaign to increase public awareness of suicide and suicide prevention.
- Strategy 3. Develop local communication “best practices” to improve media coverage and public dialogue related to suicide.
- Strategy 4. Implement a policy and governance advocacy initiative to promote systems change in suicide awareness and prevention.
- Strategy 5. Establish a robust data collection and monitoring system to increase the scope and availability of suicide-related data and evaluate suicide prevention efforts.

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

The primary objective of Strategy 1 is to prevent suicide deaths through effective suicide intervention services; earlier identification and intervention of high-risk individuals; increasing help-seeking behavior from those affected; and improvement in quality of life for individuals and loved ones who are dealing with mental illness and suicidality.

These objectives are the core focus of the SACS Hotline volunteers and staff, staff and vendors of the SCC Mental Health Department (MHD), and the dedicated efforts of the Intervention Workgroup members. While SACS provides the core of intervention services, the staff of the SP Initiative and the community members of the SCC Suicide Prevention Intervention Workgroup, though primarily focused on community education (Strategy 2), have contributed a developing framework of the suicide attempter’s recovery to the field of suicidology.

Suicide and Crisis Services (SACS) Hotline

A critical component of any community education program is training that empowers anyone to play a role in helping to prevent suicide. Suicide as a public health issue could not be adequately addressed solely by mental health professionals and medical doctors. It requires a community commitment to view this as a public health issue and knowledge of key resources, particularly the kind available 24 hours a day, 7 days a week, with no insurance requirement, or other barriers to access the service. That cost-free resource in Santa Clara County is the **SACS Hotline, 1-855-278-4204.**

As with any acute crisis situation, immediate access to care is paramount. The SACS and Mental Health Urgent Care Clinic, both operated by the SCC Mental Health Department (MHD), are the backbone of our

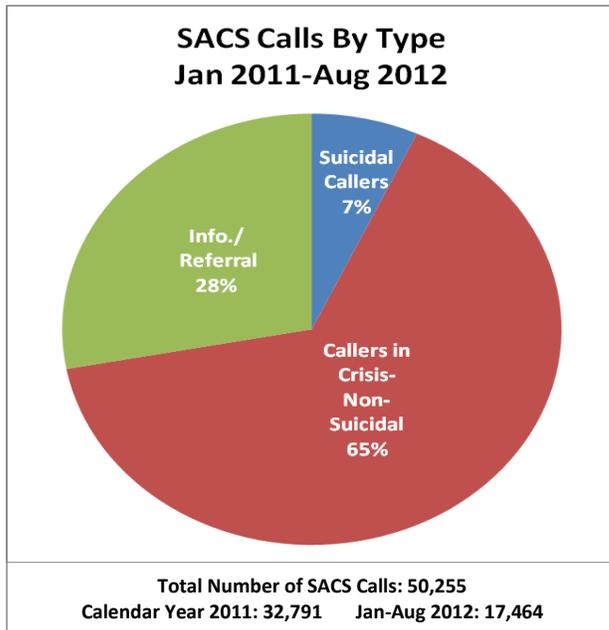
**Suicide and Crisis
Services Hotline**
Toll-Free
1-855-278-4204

**Mental Health Urgent
Care Walk-Ins Welcome**
(408) 885-7855

County’s Suicide Intervention services. While SACS is available 24 hours a day, the Mental Health Urgent Care clinic welcomes walk-ins and operates extensive hours seven days a week, providing brief assessments, connection and referral to mental health providers in the county, and also provides time-limited mental health support services.

SACS’s highly trained volunteer-crisis counselors are available to assist individuals in crisis by providing immediate and confidential emotional support, crisis assessment suicide intervention services, and referrals to callers. At present, the majority of SACS volunteers are monolingual English speakers, with a contracted translation service available for languages not spoken by the volunteers on duty.

In an effort to enhance services for our diverse county, SACS is currently working to recruit more bilingual volunteers with a target of enhancing Spanish language competency to meet the caller needs based on caller demographics. Other language competencies are also desired, but the focus currently is on Spanish. At the time of this report, the SACS has 11 volunteers who are bilingual in English and at least one of the five threshold languages for county services: English, Spanish, Vietnamese, Mandarin and Tagalog/ Filipino. A significant accomplishment resulting from the SP Initiative, SACS through the Intervention Workgroup partnered with a local agency to recruit more Mandarin speaking bilingual hotline volunteers- the Chinese American Coalition for Compassionate Care, an agency that provides end of life supportive services for the senior population.



The pie chart on the left (SACS Calls By Type) shows the combined totals of the types of calls received between January 2011 through August 2012- a total of 50,255 calls. Of the 32,791 calls received for the Calendar Year 2011, 72% of all calls received were from callers in crisis- both suicidal and emotional crisis. The distribution of the calls received is made up of 7% (2,269) suicidal callers at various risk levels, 65% (21,358) from callers in crisis who were not suicidal, and 28% (9,164) of the callers were seeking either information or referrals to needed services.

Of the calls received between January and August 2012, a similar breakout of the 17,464 calls received to date is shown, with 7% (1,194) suicidal callers, 66% (11,570) callers in crisis- non-suicidal, and 27% (4,700) information and referral breakout respectively.

Prior to March 2012, the SACS had only one full-time staff person responsible for recruiting, training, supervising and managing the more than 100 trained volunteers and coordinating SACS's community outreach and training. In order to accomplish the goals of enhancing these hotline services to meet the digital generation's needs, actively increase the number of bilingual volunteers, and meet the hotline enhancement goals of the three-year grant from the California Mental Health Services Authority (CalMHSA) (awarded August 2010), the Mental Health Department (MHD) hired a dedicated full-time SACS Manager in April 2012. The SACS Manager oversees the transition of the SACS hotline into a nationally accredited Lifeline suicide hotline with a commitment to meet the standards for accreditation by August 2013. The first step in this process is having the accreditation examiner visit SACS. This visit occurred in October 2012, which highlighted the remaining areas for improvement needed for accreditation.

In August 2011, the SCC MHD entered into a three year grant agreement to enhance the Bay Area's suicide and crisis hotlines. Administered by San Francisco Suicide Prevention (SFSP), this CalMHSA-funded grant coordinates the enhancement of four of the Bay Area's crisis hotlines: SFSP, SCC SACS, Contra Costa Crisis Center and StarVista of San Mateo County. (For more extensive information on this, please read the full grant posted on the dedicated Suicide and Crisis section of the MHD's website: (www.sccgov.org/site/mhd)). Wherever possible, any outreach activities conducted by the Suicide Prevention (SP) Initiative staff is also leveraged to meet the outreach goals of this grant. In the first year of the Agreement, these four Bay Area Partnership agencies collaborated to enhance their crisis hotlines through the development and achievement of the following deliverables during fiscal year FY 2012:

Deliverable No. 1: Electronic Crisis Counseling- SCC SACS met FY 12's goals: initiate the accreditation process and assess. Next year's goals (FY 13) are to attain American Association of Suicidology accreditation, obtain the data infrastructure to meet those informational systems needs required by accreditation, and improve the SACS website. The website's improvement is being managed by Health and Hospital System.

SACS is working to procure a software solutions system that will enable staff and volunteers to systematically track client data information, generate needed statistics and reports, and have capabilities for live-chat and text services. The RFP for this system is scheduled to be issued in November 2012. The target date for software system implementation is between March-April 2013.

Deliverable No. 2: Rural Outreach- SCC SACS met FY 12's goals: SACS, in partnership with StarVista of San Mateo County, researched and identified three rural outreach strategies in an effort to increase SACS Calls from rural residents. The strategies to be used in FY 13 are 1) assess and identify the makeup of the rural areas that will be engaged; 2) engage the identified groups and community leaders in order to understand the community's perspective on suicide; and 3) partner in planning a comprehensive outreach effort. (To read the recommendations in more detail, please read the full

report Rural Populations Outreach: Strategies in Suicide Prevention Education, located at <http://www.sfsuicide.org/prevention-strategies/statistics/>.

Deliverable No. 3: Warm Line Outreach- SCC SACS met FY 12's goals when it researched and developed a contact list of more than 10 warm line agencies in Santa Clara County. Letters of Cooperation with some of the identified agencies were developed and training was provided in the area of crisis assessment and suicide prevention to the volunteers and staff of the warm lines. Per this grant, a warm line is defined as a hotline or support line that does not have a focus on suicide crisis. The training focuses on developing the warmline's staff and volunteers with the necessary skills to identify suicidal callers and effectively transfer them to the SACS for the specialized support needed. In FY 13 SACS will continue to develop Letters of Cooperation and will train at least 80% of the ten identified warm line agencies.

Deliverable No. 4: Increase Outreach to Target Populations- The targeted population outreach campaigns are a group deliverable, among all four participating hotlines, and are timed in nine month periods. Due to the lack of a SACS Manager, and the need to develop more partnerships with the LGBTQ community, limited outreach and promotion of SACS was achieved in the first nine months (August 2011-March 2012) to the intended target groups, LGBTQ and Adolescents. The independent outreach conducted by local municipal suicide prevention efforts provided outreach to the adolescent target population in those communities.

For the second nine month period (March-December 2012), the target populations are African American and Senior/ Older Adults. During this period initial efforts to provide targeted outreach to these two populations is underway, and a full report on this and the final two target groups, Transition Age Youth and Latinos, will be available in next year's annual report.

Intervention Workgroup Activities for Suicide Intervention

The SCC Intervention Workgroup is one of the three Suicide Prevention Workgroups. Its primary focus is achieving Strategy 2- Community Education and Awareness building.

This workgroup contributed to suicide intervention through the following activities:

- Creating a comprehensive directory of current suicide prevention/intervention/postvention activities and services available in SCC. This work is ongoing.
- Creating a comprehensive directory of services for survivors of suicide loss and suicide attempt survivors residing in SCC. This work is ongoing.
- Increased awareness of the Facebook Suicide Alert function, which was launched in early 2012.

- One key accomplishment is the development of an emerging framework for Suicide Attempt Survivors. This novel framework was identified by one of the workgroup's members- a suicide attempt survivor. He modeled the framework based on his personal journey and on the stages of recovery from mental illness.

These stages, while non-linear, were validated by the other suicide attempt

The stages in recovery which I experienced in my own journey from suicide attempter to wellness*

Stages in Recovery from Suicide to Wellness

1. Stable Recent Attempter

- One whose suicidal ideations have been subdued due to medication as well as hospital therapy. Not positive about living, but cooperative about not dying.

2. Life Neutral

- Stable, with medication and therapy, willing to be helped, but, still, very unsure.

3. Life Positive

- Wanting to be alive, hoping to learn how to avoid crisis ideations.

4. Enjoying the Process of Living

- Well with understanding and support, perhaps with medication and continuing therapy. Living without continual fear of impending crisis.

****These stages assume strong initial therapy and a structured treatment plan already in place prior to becoming stable.***

***It does not assume a strictly linear progress over a defined time frame
The journey from point zero to point one is discussed below.***

survivors. This framework was shared in a preliminary report our to the California Office of Suicide Prevention Liaison meeting in May of 2012 and again in a July 2012 meeting regarding San Mateo County's suicide prevention effort. In September 2012 the California Office of Suicide Prevention (OSP) Liaisons meeting was held. The OSP staff hosted a webinar, focusing on suicide attempter support groups for recent attempters and the "Stages of Recovery from Suicide to Wellness" to the State Suicide Prevention Liaisons. OSP intends to share this framework with national suicide prevention efforts, including the Suicide Prevention Resource Center and the American Association of Suicidology.

There were goals that were not achieved in the first year that will be completed as part of 2013's workplan. One of these goals is the completion of a user-friendly suicide prevention/ intervention/ postvention directory (initial discussions were held, and language selected). Another goal is to launch the listening campaigns to raise awareness of the five strategies while getting feedback from the community on this effort.

Primary Care based Behavioral Health

As part of the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funded projects, the Primary Care-Behavioral Health project (SCC PEI Project 4) funded three community health clinics to integrate one full-time Integrated Behavioral Health director/ program manager, a consulting psychiatrist, a full-time behavioral health clinician (either a licensed clinical social worker or psychologist), and a part-time peer partner (a staff member who provides support to the behavioral health clinicians). These staff members were embedded into the existing primary care clinic to collaborate with primary care providers to treat patients various needs. The three clinics awarded the contract in November 2011 were Asian Americans for Community Involvement, Gardner Family Health Network- to integrate two of their four clinics (South County and St. James clinics), and MayView Community Health Center.

As a direct result of the SP Initiative, the contract includes a suicide prevention component- Case Finding of homebound adults aged 60 and older, who may be suffering from depression, suicide assessment training for the primary care providers, and completion of suicide prevention training by all staff. As of this time, all three clinics have hired their clinical staff, and launched their programs between June and July 2012.

To date, it is too early in the implementation to learn much about the percentage of older adults registered with their clinics are homebound and dealing with depression. All three clinics have begun to schedule the required suicide prevention training. Gardner has completed its mandatory suicide prevention training for all staff, as well as the suicide assessment training for the primary care providers. All will complete these trainings by the next Annual Report.

Next Steps:

The first order of business for SACS is to obtain accreditation, and acquire the information system necessary to support the reporting functions that accreditation requires. Additionally, SACS will continue work on the remaining two years of the CalMHSA grant to enhance the electronic crisis counseling services available to residents of SCC, as well as increase the percentage of hotline volunteers who are bilingual.

As part of the Prevention and Early Intervention (PEI) Plan, funds were designated for SACS to develop and provide a new suicide intervention program for individuals discharged from an Emergency Room after a suicide attempt. Developing a partnership with an emergency department willing to collaborate on this service, as well as developing a new program for this subgroup of patients, will require advocacy and time. Therefore it is the goal to design a new program, and identify a partner Emergency Department by October 2013.

The Emergency Psychiatric Services (EPS) Department of Santa Clara County Valley Medical Center will implement the practice of the nurses making follow up calls to

clients discharged from EPS. Response from suicide attempter survivors in the Intervention Workgroup supported this intent as their personal experience reinforces that that many times people in crisis are treated in an emergency setting, and then sent out on their own with little or no support or follow up. A well check call after discharge would be a very positive reinforcement and important step in suicide prevention and intervention, post release from EPS.

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

The community education and information campaign is a dual pronged approach. The objectives of Strategy 2 are to implement a community education program and create an information campaign to increase public awareness of suicide and suicide prevention throughout the county. The community education effort is being addressed locally through the efforts of the dedicated suicide prevention staff, the intervention workgroup, and the policy and advocacy efforts.

Unlike the other workgroups with a fixed membership, this workgroup has a more fluid membership as it is intended that many people will participate, weave in suicide prevention measures into their system, and encourage new individuals to join and continue the work, thereby spreading a competency throughout our county. Members meet monthly and represent a diverse group of individuals, agencies, and educational institutions.

Educating a community to be more aware of suicide, dispel commonly held myths, dispelling or reducing stigma, and empowering ordinary individuals to prevent suicide is the primary objective of this prevention strategy and workgroup. In order to



[Suicide Is Preventable.org](http://SuicideIsPreventable.org)

successfully reduce the number of lives lost to suicide and suicide attempts, the entire community of SCC must first be educated to recognize a potentially suicidal person, be empowered to ask if a person is suicidal, and provided with resources to refer the individual in crisis to at any time of day or night.

The information campaign "Know the Signs" was created by CalMHSA-funded contract and is one component of the broad social marketing campaign that is being designed for this effort's information campaign. The campaign is designed to be leveraged and tailored by all local efforts. Another component is the Toolkit of Suicide Prevention Social Marketing, and will provide include canned television and radio public service announcements in English and Spanish. To date, the campaign has identified the logo and tagline- Know the Signs (on this page), with input from stakeholders throughout the state of California. The local SP Initiative will leverage the CalMHSA provided material,

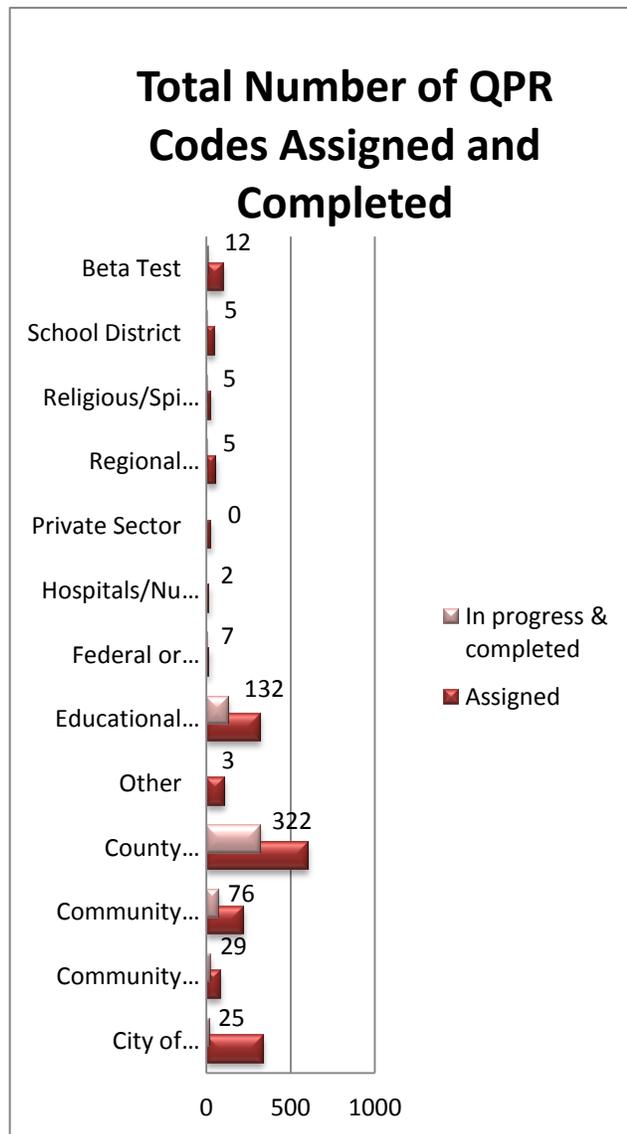
which can be customized to some extent. CalMHSA will provide these materials by late November 2012, delayed from the original intended release date of August 2012. The two primary training opportunities funded with MHSA PEI one-time funds are Question-Persuade- Refer (QPR) and Applied Suicide Intervention Skills Training (ASIST).

Given the goal of educating over 40,000 SCC residents in suicide prevention by end of June 2014, a broad community commitment is required to achieve this goal.

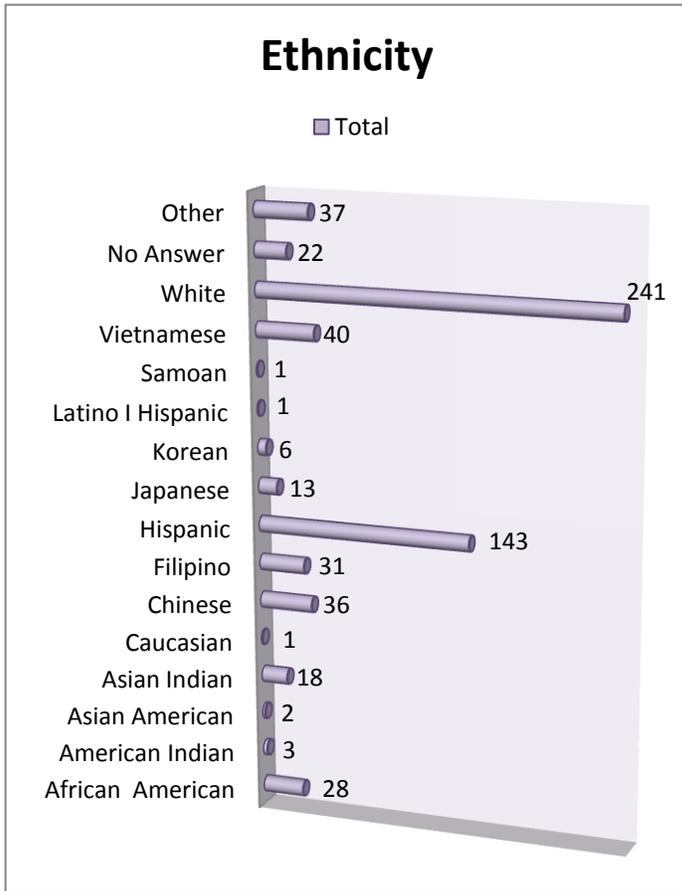
QPR

QPR, modeled after CPR training, provides an introduction to suicide that empowers the participant to recognize the possible cues that someone is suicidal; Question the potentially suicidal person, Persuade the individual to agree to seek help and not harm or kill him/herself; and Refer an individual at-risk of suicide to an appropriate resource. Given the multiple considerations for accessing appropriate help, the SACS toll-free hotline (1-855-278-4204), Mental Health Urgent Care (408-885-7855), and 911 are provided as primary resources for immediate suicide intervention services.

After completing the extensive customization of the online training in January 2012, the QPR training was Beta tested by approximately 90 individuals by February 2012, when it was determined to be ready for distribution. Large-scale distribution began in April 2012, with an initial large group request to train over 400 staff members in QPR. As the Total Number of QPR Codes Assigned and Completed chart right demonstrates, the actual numbers of distributed QPR trainings that were begun or completed has been considerably more modest (less than 2,000 were distributed) than the effort’s stated goal of distributing 13,000 of the 40,000 available online QPR Trainings in calendar year 2012. (Numbers on chart are of QPR codes in progress or completed.) These trainings are targeted for the residents of SCC and individuals who



may work in SCC. As of August 2012, 1,997 QPR Codes have been distributed. Of those, one-third (623) have been completed (550) or are in progress (73). The community



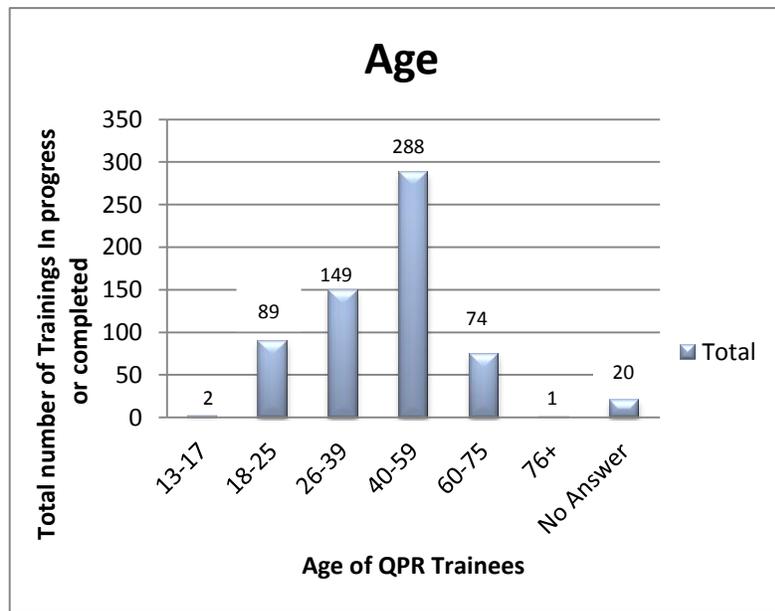
education campaign and the members of the Intervention Workgroup are committed to bringing this training to a diverse range of our community. Diversity is defined by the following seven dimensions of diversity: ethnicity, age, educational level, city of residence, language, immigration status, and sexual orientation.

The Ethnicity chart to the left documents the diversity of ethnicity of the various QPR Trainees who have started or completed the online training. This demonstrates that this training has benefitted from a multicultural distribution strategy.

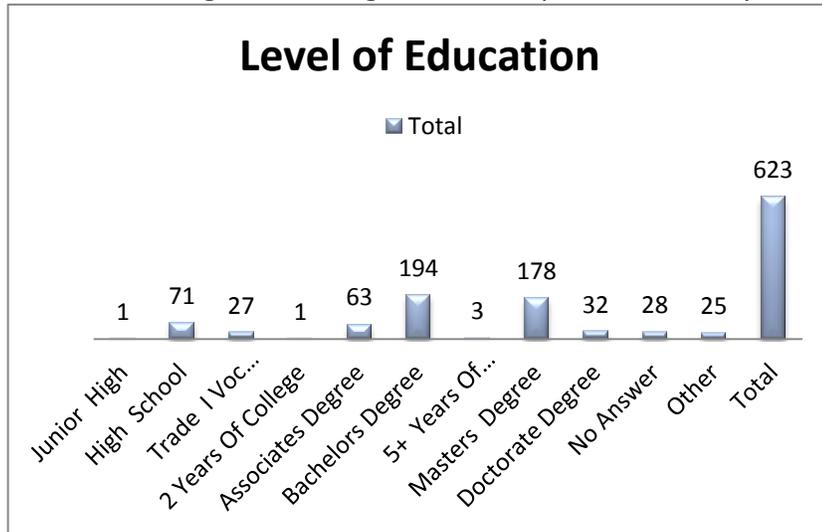
The Age chart below demonstrates that the bulk of

those QPR trainees are in the age group most negatively impacted by suicide deaths-

adults 30 and older, which is a significant achievement. To date, residents in 10 out of 15 cities have residents or employees who have completed the QPR training. Furthermore, guidelines originally developed that required entities (such as schools and cities) to first develop Suicide Prevention policies before being rewarded with the free QPR training codes, have been reevaluated. With experience the approach and expectation has changed. It is



clear that in many instances, the dialogue for change will develop more naturally if the training/educational components are first introduced to a few key individuals as an enticer, with the award of a larger number of trainings being rewarded upon adoption of the policies. As we see in the Level of Education chart right, the trainings are being completed by individuals with a broad spectrum of education levels in our County.



As demonstrated, a key obligation of this effort, is the broad distribution of the training to our diverse community. The significant driver of the number of QPR trainings has been agency buy in. The SCC Public Health Department required the training of its entire staff. The SCC Mental Health Department mandated the training for all of its community workers and peer support workers, as did the SCC Department of Drug and Alcohol Services (DADS). More recently, SCC Department of Parks and Recreation has requested 210 trainings for their park rangers and maintenance workers. San Andreas Regional Center has requested 100 accounts. The City of Sunnyvale/Public Safety Officers (PSO) will begin taking this course in October with 200 accounts given to the Sunnyvale PSOs.

These bulk accounts have required flexibility and close monitoring. Experience shows that codes distributed without a mandate to complete and follow-up from within their own organization, have a lower than 35% rate of completion. Fortunately, after the experience with the Public Health Department’s 400 plus QPR training effort, the SP Staff now have an appropriate and tried framework to support other large group accounts.

There is also a need to develop a more structured and focused effort for the QPR Instructor Course Self Study (QPR Instructor) training kits throughout the county to reach the diverse population through various means and avenues. There are numerous agencies, organizations, and communities throughout the county that could and should have QPR Instructors embedded in their agencies/ organizations/ communities. The partner to the individual training is the QPR Instructor self-study

“It [QPR online training] was invaluable... it means a great deal to be better equipped. Thanks for this opportunity. [I] Truly (*sic*) look forward to [being] part of this effort.”

modules. These will embed the training capacity into certain structures and organizations. One hundred QPR Instructor self-study modules were procured (August 15, 2011). To date, two agencies have expressed interest in receiving this training within the existing guidelines, that the agencies document the QPR Training in a staff position's job description and identify a training strategy for their staff and or community/ clients.

A third component to the community education effort are the face to face QPR trainings that are available upon request. While several onsite QPR trainings were offered this year (interreligious organizations and communities, the National Alliance on Mental Illness SCC chapter, and the Council on Ageing Senior Peer Advocate Program (SPA) for older adults), the goal for next year is to double the number of on-site QPR Trainings that are offered in the calendar year 2013.

With the PEI Primary Care Based Behavioral Health efforts, a customized training for primary care professionals was developed to dispel stigma and myths concerning suicide, to reinforce the public

health framing of this issue, and to reinforce the assessment skills the medical providers have prior to making a referral to their behavioral health colleagues. In doing so, our medical providers can feel more confidence in assessing acuity, and it reinforces their willingness to support the patients' health, while preventing suicide.

"The QPT training was very informative. My idea of suicide was totally different. Wow this training exposed me to a different understanding of suicide. Thank you"

While QPR is a brief training for the masses, Applied Suicide Intervention Skills (ASIST) training, while also geared to the non-mental health professional, requires a significant time investment of 16 hours. Due to this time requirement, this training is primarily targeted to youth workers, faith leaders, support workers, and mental health professionals as a focus on suicide prevention and intervention. This group of the public is more able and likely to dedicate two full work days to this training. Unlike the 2011 ASIST training, in 2012, three ASIST trainings were provided, with only 59 of 90 registrants completed the training (in 2011, 89 of 90 registrants completed the training using a very different registration process). An evaluation of the registration process used in 2012 will need to be completed to ensure that this training is maximized to the greatest degree possible. As funding allows, more ASIST trainings will be offered, and the trainings that our partner San Mateo County offers will be made available to the residents of Santa Clara and Alameda counties as space allows.

Next Steps:

San José State University (SJSU) and the SCC SP Initiative will collaborate in the execution of SJSU's CalMHSA Student Mental Health Initiative grant in Calendar Year 2013. This promises to be a robust community education effort to elevate the awareness of suicide among a diverse student body and staff.

The QPR training will leverage the experience of large account administrations acquired from this first year, to help reach the goal of distributing 13,000 QPR training codes, with an expectation, based on QPR Institute's data, that approximately 50% of individuals who request codes will complete codes. Some key target groups for QPR Training in 2013 will include, but is not limited to: Meals on Wheels drivers and staff, the Santa Clara County Department of Aging and Adult Services, and faith communities.

The SP Staff will work with QPR Institute to develop more language versions of their training, leveraging the members of the Intervention Workgroup to provide translation services.

The Suicide Prevention Oversight Committee will revisit the guidelines to the QPR Instructor Self Study distribution strategy to help guide the focused push to train more QPR Instructors throughout SCC.

Strategy Three: Develop Local Communication Best Practices to improve media coverage and public dialogue related to suicide

The goal of this strategy is to improve the media coverage and public dialogue related to suicide in its reporting practices. Creation of a coordinated communication strategy would ensure the development of a clear, concise, and paradigm-shifting message for the media and for all outreach efforts when reporting and education about suicide.

"This information helped me change my mindset as a Public Information Officer on how to present information on an incident where someone died by suicide."

Due to two key issues,

- CalMHSA's production of a unified Broad Social Marketing Campaign to be used state-wide and

- Anticipated transition of Suicide Prevention Coordinator and Associate, the effort to create and host a regional suicide prevention Communications Workgroup has been delayed pending the completion of both of these issues. At present, the recruitment for the new Suicide Prevention Associate was completed in March 2012, and the transition for that role was successfully completed by May 2012. The recruitment effort for the Suicide Prevention Coordinator has been more challenging and at present, not yet advanced to the final interview stage. An interim SP Coordinator has been hired, pending the completion of the recruitment effort, which is hoped to be completed by December 2012.

Secondly, the CalMHSA funded broad social marketing campaign "Toolkit", created for use by all county suicide prevention awareness efforts in California, has been delayed until the end of November 2012. This toolkit will be one of the underpinning documents for the Regional Suicide Prevention Communication Workshop to work with as it determines strategies for raising awareness and working with and monitoring media reports on suicide prevention.

In the interim, the staff of the SP Initiative has collaborated with the Health and Hospital System’s Public Information Officer (PIO), the Cities Association of Santa Clara County and the County Office of Education to host a Suicide Prevention Workshop for Public Officials training in January 2012 at the Sunnyvale City Council chambers. This interactive workshop is designed for public officials (municipal, school, and public safety) and PIOs. Attendees at this function were City Council Members, School Board Trustees, Mayor, PIOs, and police officers. By and large, as with the first training offered in 2011, the evaluations stated that the time spent in the workshop on understanding the key elements of what should and should not be in a public statement, as well as the exercise in crafting a sample statement in small groups was valuable. Additional trainings will be ongoing, with the City of Mountain View volunteering to host the next workshop.

Next Steps:

With the release of the CalMHSA developed SP Broad Social Marketing Toolkit and the successful recruitment of a permanent SP Coordinator, the Regional SP Communications Workgroup can be convened. The charter to Develop Local Communication Best Practices to improve media coverage and public dialogue related to suicide will then be possible to address.

“Every public official should take advantage of these workshops to stem the tide of suicides in our community.”
-Mayor Mike Kasperzak,
Mountain View

The SP Staff will schedule another SP Workshop for Elected Officials with the City of Mountain View and HHS PIO as our partners.

Strategy Four: Implement Policy and Governance Advocacy to Promote Systems Change in SA and Prevention

Suicide Prevention Policy Adoption

Policy change is a vital component of this effort. By adopting suicide prevention policies, cities and agencies are empowered to prioritize their role in promoting healthier communities and provide the infrastructure for the necessary collaboration to raise awareness in their community.

Advocating for policy implementation requires persistence, education, and patience, as it comes slowly and incrementally. This year, the City of Mountain View joined the City of Palo Alto in adopting a Suicide Prevention Policy. This type of work requires approaching suicide prevention in a new way. With the help of the SP Staff to provide technical assistance and support, this initiative’s goal is for every city in SCC to adopt a SP policy.

Advocating for adoption of suicide prevention policies and adoption of supportive workplace policies is an ongoing and challenging task. To that end, the SP Initiative has

entered into a partnership with the SCC Chapter of National Alliance on Mental Illness (NAMI). The SP Initiative is supportive of NAMI SCC's outreach efforts to the for-profit sector. In the majority of cases, NAMI will lead the effort in educating Human Resources Managers with the rationale and means to for taking steps to make their organizations more friendly to employees living with depression, anxiety, and other mental illnesses. In doing so, these companies will be successful in maintaining a highly skilled and experienced workforce and it is expected that the affected workforce. In some cases, the SP Staff or SP Initiative volunteers will lead in the outreach.

Psychological Autopsies

In December 2011, as part of an effort to embed more training in psychological autopsies, an in-depth post-mortem review or investigation into suicide deaths, five members of the three existing Death Review groups (Child, Senior and Domestic Violence) completed a two-day training on conducting Psychological Autopsies. As a result of this, the SP Staff received an invitation to work with the Child Death Review Team (CDRT) and offer policy language that could connect the two efforts in a meaningful way. The goal of the proposed policy is to better leverage the CDRT's mission to learn from the reviews and identify any public health issues or campaigns that may be deemed necessary. Additionally, this policy could formally leverage the CDRT reviews with the ongoing SP Initiative by informing the SP Staff of schools and systems affected by the youth suicides under review, while maintaining the privacy of the individual person. If successful, systems that may not have been able or willing to prioritize suicide prevention and postvention activities, may be provided critical support and technical assistance as a result.

Next Steps

Much is needed in terms of policy adoption and governance advocacy. To start with, all 15 cities of Santa Clara County are faced with suicide deaths and the resulting turmoil and damage that leaves for the survivors of the suicide loss. Yet only two cities, Palo Alto and Mountain View have formally adopted suicide prevention policies.

More work is needed and more advocacy and technical assistance will be provided to any entity interested in exploring and possibly adopting a suicide prevention policy.

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

Establishing a baseline and the creating a workflow to collect reliable data on an ongoing basis is critical to any effort that hopes to reduce suicide deaths and attempts, and to document and demonstrate that effect. Up to now, only minimal data exists at the State and Federal level to assist any local suicide prevention effort. The Data Workgroup is charged with establishing a robust data collection process, and developing a monitoring system of the suicide prevention deaths. In less than one year of meeting,

the Data Workgroup has accomplished the first task: developing a robust data collection process and analyzing the available data.

This unique success has been made possible through the partnership with the SCC Medical Examiner/Coroner (MEC) who has agreed to set up a process where the Medical Examiner's reports of all suicide deaths are redacted (removing any personally identifying information of the deceased), and shared with the SP Initiative staff. This process allows the SP Staff to mine the reports for information not otherwise publicly available through the various databases, based on state and federal reporting requirements.

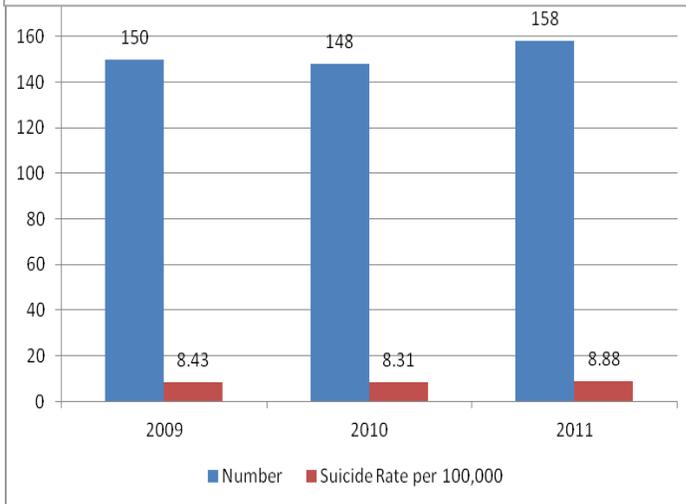
In addition to the currently available data of gender, age, date of death, means of death, race/ ethnicity, we are now able to report on data collected during the investigation, including information that is currently unavailable on the databases. This includes mental health conditions, marital/ relationship status, drug and alcohol usage, presence of a suicide note/ communication, and if the person was known to have attempted suicide previously. While this data is not consistently collected at every investigation for a variety of reasons, having the ability to have some insight into these additional factors helps to inform the overall SP Initiative of the most significant factors that may push individuals into the risk of suicidality. The SCC MEC and SCC SP Initiative collaboration is a model that other counties should consider implementing if they can achieve that level of inter-agency cooperation that SCC has realized.

The biggest achievement for 2012 was the creation of the **2009-2011 Analysis of Suicide Data of Santa Clara County Report (Data Report)**, available at the www.sccgov.org/sites/mhd website on the Suicide Prevention tab and Data Workgroup page. This report was produced to further the strategy of establishing a robust data collection and monitoring system. The following section was developed as a separate report, to be utilized as SCC's baseline of suicide deaths, on which evaluation of the suicide prevention effort's efficacy can be assessed.

No data is perfect. While relying on case reports by MEC investigators, there is an understanding that these reports are based on the deaths of decedents that occurred in SCC; and the observations and opinions of those being questioned -- often family members, spouses, neighbors, classmates, coworkers, etc, not the decedent. Further, due to the needs of the investigation, the additional data provided is not consistently provided across all investigations. Details such as marital/ relationship status, whether suicide note (on paper, posted on a social media site, or by text) was found and its contents, and the events that led to death were sometimes but not always mentioned.

For a full understanding of the level of detail now available from our groundbreaking baseline data report on suicide deaths in SCC, please read the full report (available on the www.sccgov.org/sites/mhd website on the Suicide Prevention main page and Data Workgroup page). Below are some highlights of the data contained in this

Figure 1: 2009-11 Suicides in Santa Clara County: Counts and Rates per 100,000

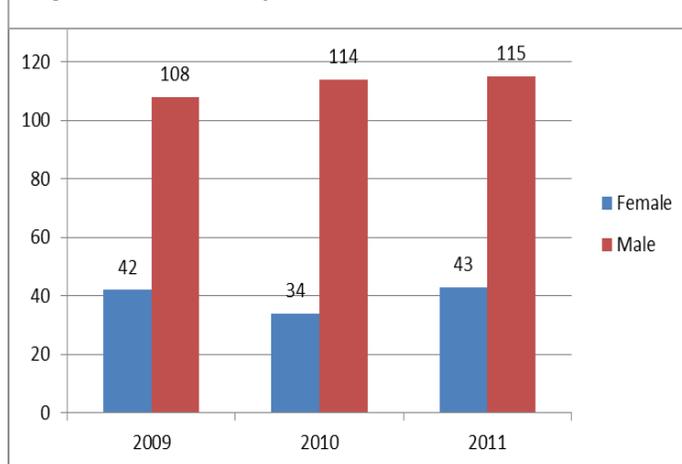


comprehensive report. Please note, all Figure and Table numbers are maintained in alignment with the Data Report, so numbering sequences will not be complete. When reading reports on suicide deaths, some information is provided in the traditional percent of population comparison, some information is more meaningfully discussed as counts, which conveys a sense of the magnitude of the occurrence through raw numbers, and yet others can only be discussed in a meaningful manner using rates per 100,000, which

measures the probability of an event, like a suicide death, occurring in particular area, city², or region or across different populations. Following these definitions and the standards in the field of suicidology, our data is presented in one of these three standards, to communicate the data effectively.

As communicated in Figure 1 above, the number of suicides in SCC in 2009, 2010 and 2011 were 150, 148, and 158 respectively. With a county population of 1.78 million (U.S. Census Bureau: American Fact Finder, 2011), the average rate of suicides over the last three years (2009-2011) is 8.54 per hundred thousand. This is the baseline rate for the SP Initiative. Comparatively, based on the available 2009 national suicide statistics (American Association of Suicidology, 2012), the rate is 12.0 for the United States (36,909 deaths), and is 10.3 for California (3,823 deaths).

Figure 2: Suicides by Gender and Year



While SCC's baseline rate may be below the State's and National level, it is significant to note that the rate has increased since the initial report of a rate 7.4 in for the calendar years 2000-2006, in the SCC Suicide Prevention Strategic Plan.

Figure 2 above, demonstrates that SCC reflects national trends that males die in higher rates than women. What the MEC is not able to provide, and what the Data Workgroup

²<http://neocando.case.edu/cando/index.jsp?genlfo=aquired9/24/2012>. Definitions of Rate versus Cont for applied social sciences. Provided by Case Western Reserve University.

is working to achieve, is the establishment of a process to begin to systematically collect any available data on suicide attempts, understanding that any attempt data collected will be only a small percentage of the whole.

This Initiative was launched in response to the youth suicide cluster Palo Alto suffered in 2009. Figure 3 below (original numbering system is maintained from the full Data Report),

Figure 3: Suicides by Age Relative to Census 2010 data

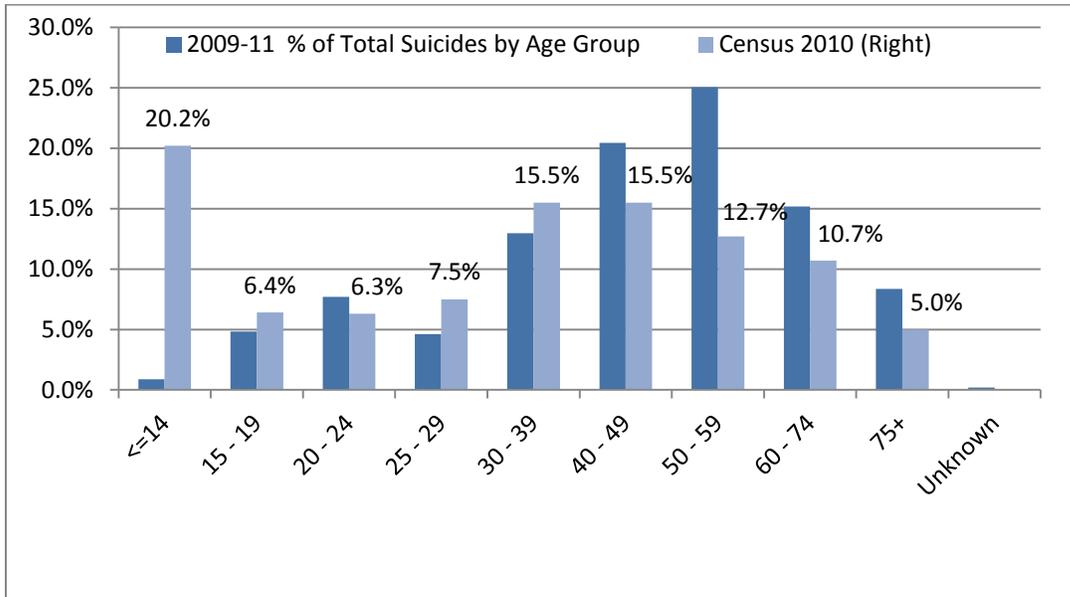


Figure 6: Suicides by Race or Ethnicity Relative to Census 2010 Data

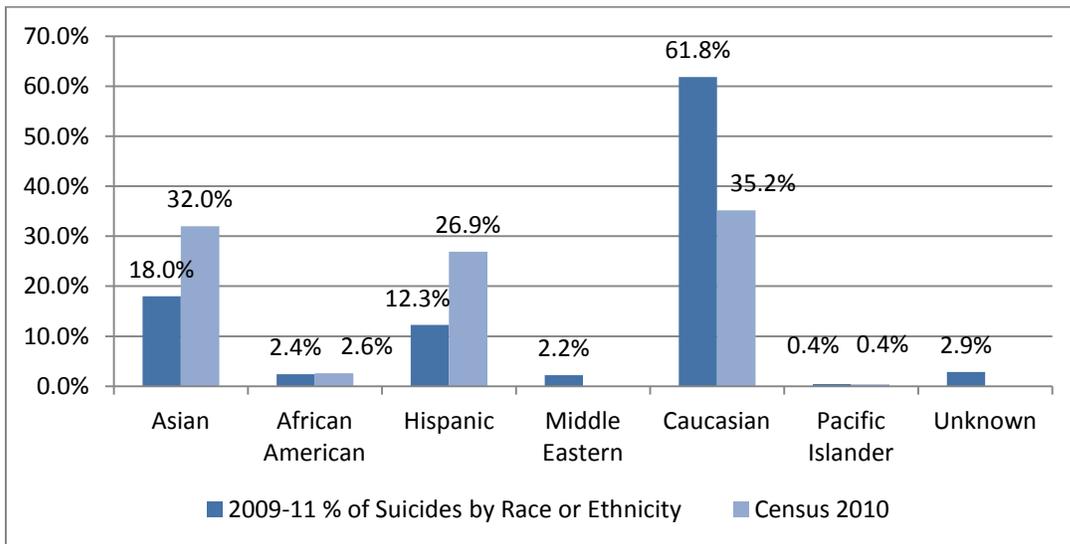
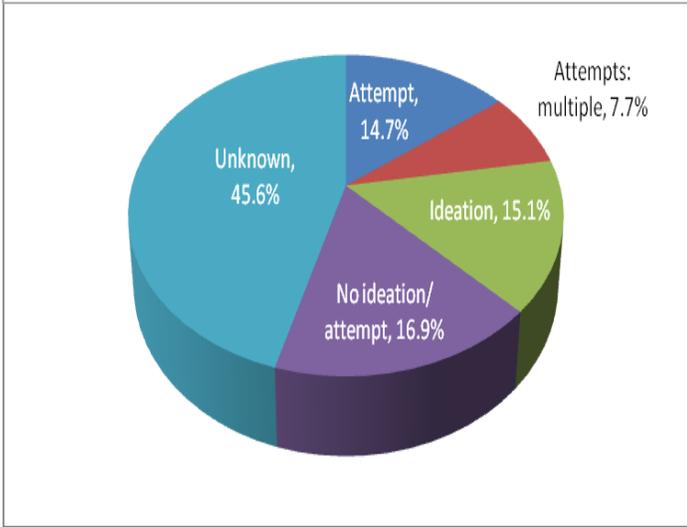


Figure 18: Percentage of 2009-11 Suicides by Prior Attempts



demonstrates that SCC conforms to national and State of California data, where the majority of suicide deaths are adults between the ages of 30 and over. For the diverse and multicultural county that SCC is, ethnicity reports are only broadly informative. Figure 6 on the preceding page (original numbering system is maintained from the full data report); reveal some interesting comparisons of incidence of suicides by ethnicity in comparison to the

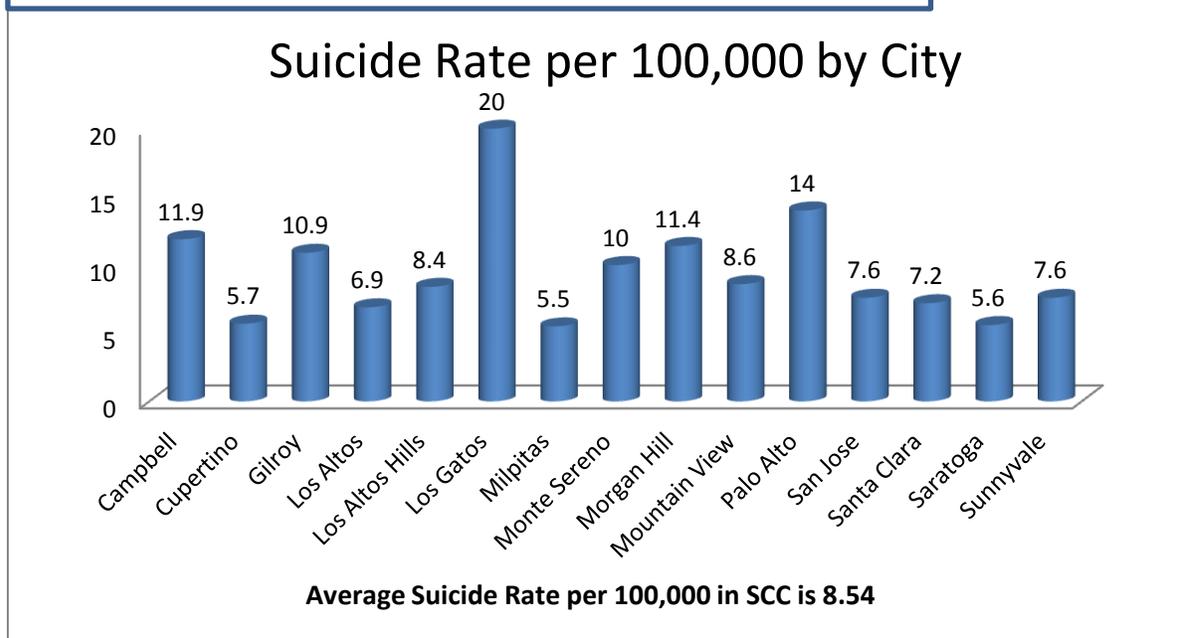
Census 2010 data. With current reporting requirements and race/ ethnicity definitions in use at the State and Federal level, more detailed information, while desirable, is currently not possible. Yet this level of information may be helpful in outreach efforts.

Figure 18, above, is an example of data that had not been previously available from existing sources. The existence of prior suicide attempts is a known risk factor for suicide deaths, and for the first time, this information is now available to us based on the portion of MEC reports where that information was a) asked by the ME Investigator, b) known by the person(s) interviewed, and c) documented in the case report. While no data is perfect, having this information empowers our effort to be more directed in its efforts and outreach, and be led by the data available.

Figure 12: Suicide Rate by City illustrating SCC Baseline Rate of 8.4, on the following page, is a powerful and informative example of data lifted from the SCC Data Report. Using this data to inform our prevention and outreach efforts will be instrumental in helping to define strategies and outreach efforts that will be meaningful and help us save more lives.

More information is available in the full Data Report, including details on any possible significant findings on time of year or day and number of suicide deaths, relationship status at time of death, presence of mental health or drug/ alcohol use/ misuse or addiction, and more. For greater information and for the complete recommendations generated by the Data Workgroup, please read the full Data Report available on the Department of Mental Health’s Website on the Suicide Prevention and Local Resources pages.

Figure 12: Completed Suicides by City



Next Steps:

The core task of the Data Workgroup is to establish a monitoring system to evaluate suicide prevention efforts. With the completion of the first step, identify a baseline of suicide deaths in SCC, next year’s focus will be to explore and identify the kind of monitoring required, metrics or proxy metrics to evaluate ongoing SP efforts, and initial efforts at implementing those systems and reviews.

The SP Initiative, SCC Mental Health Department, and MEC will collaborate on a new project. MEC is evaluating and categorizing suicide notes/ communications left by individuals who have completed suicides. The MHD and Data Workgroup will work to identify a mental health professional to study and analyze these notes, for the meaningful use that they may contain, in conjunction with the case report. The suicidal communications collected between 1983 to the present will be studied. It is hoped that this data will help to give a broader understanding of suicidology for the purpose of refining the prevention efforts of the SP Initiative, and help in the creation of psychological autopsies for some individuals.

Ultimately the data in the Data Workgroup’s Analysis of Suicide Data of Santa Clara County aspires to:

- a) Inform policy makers, community residents and systems of the extent of suicide in our society.
- b) Identify possible directions needed in the suicide awareness outreach and education efforts, and help to identify questions to better understand, and potentially recommend activities that may be needed.

Based on the information contained in the Data Report:

- Suicide prevention is everyone's responsibility. All of our cities had suicides in 2009-11. City officials, as decision makers and community leaders, must help promote suicide prevention. This will require education and perseverance as our leaders harbor the same denial and stigma as their own communities.
- QPR and other training for city officials would be helpful.

