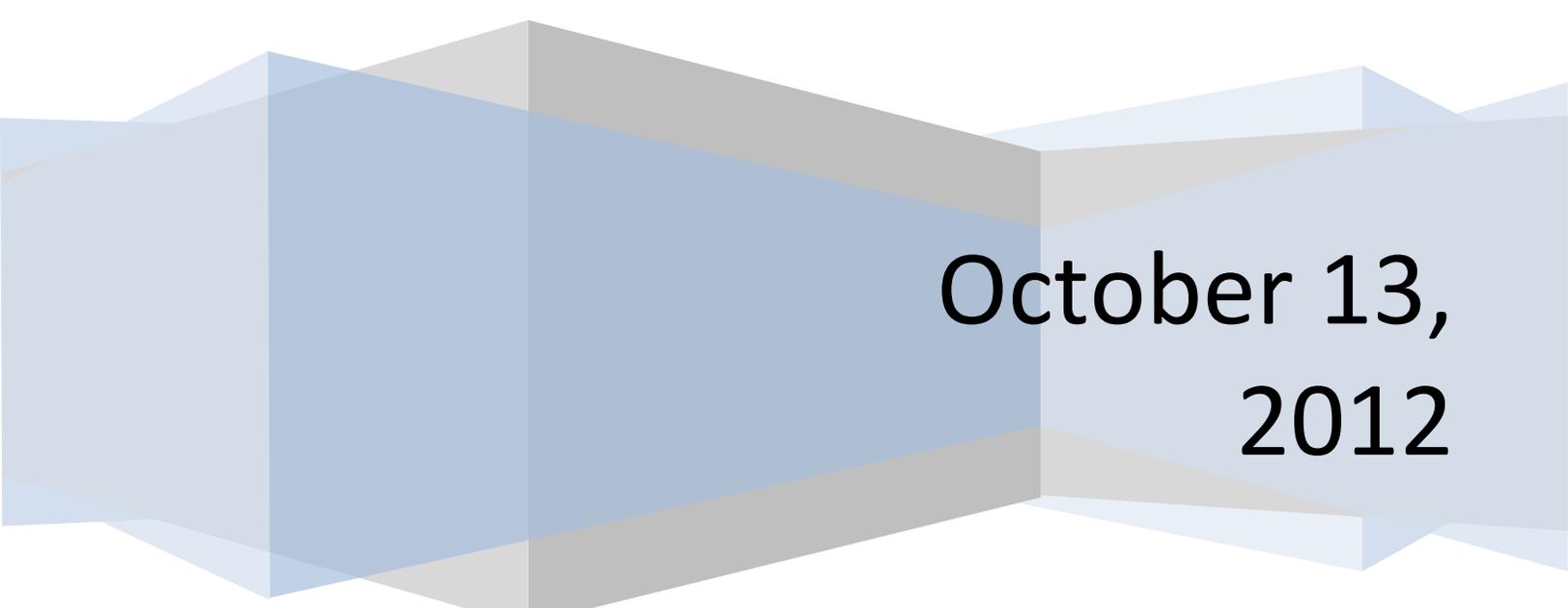


Santa Clara County Mental Health Department

Analysis of 2009-2011 Suicide Data of Santa Clara County

Suicide Prevention Initiative



**October 13,
2012**

**Santa Clara County Suicide Prevention Oversight Committee
Analysis of 2009-11 Suicide Data**

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**Prepared on Behalf of
Santa Clara County Mental Health Department
By**

**Hon. Victor Ojakian
Dr. Anita Jhunhunwala Mukherjee**

SANTA CLARA COUNTY DATA WORKGROUP ADVISORY COMMITTEE

The Data Workgroup represents a cross-section of agencies that collect data, are responsible for treating individuals in crisis, and who are responsible for reporting data to State and Federal authorities. This workgroup provides the information necessary for the Santa Clara County Suicide Prevention Initiative to guide and direct its prevention and community education efforts based on available data, and ultimately, to evaluate the effectiveness of this effort. Their commitment to maintaining a focus on suicide deaths and attempts is valuable work for our effort to significantly reduce the number of suicide deaths in our county.

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And, with Special Thanks to:

Santa Clara County Medical Examiner and Coroner's Office, for their partnership in prioritizing this work, the sharing of 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 since the planning phases to present,

Cpt. Kevin Jensen former Administrative Director/ Coroner (2011-02/2012), who provided us with the initial data set

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

Anita Jhunhunwala 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,

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.

Letter of Introduction

SANTA CLARA COUNTY SUICIDE PREVENTION OVERSIGHT COMMITTEE Analysis of 2009-2011 Suicide Data

It has been said many times by suicide attempt survivors, “I did not want to end my life, I wanted to end my pain”. For that reason, some state that it should be called “painicide” instead of suicide; they so desperately wanted their pain to end. Suicide devastates families and cripples communities, and is preventable. Nationally an astonishing 36,909 completed suicide annually, which translates to an annual suicide rate of 12.0 per 100,000. In Santa Clara County, the range of annual suicides per year is between 5.6 and a staggering 21.5 per 100,000. These figures have fueled the dedicated members of this group to find better ways to reduce this form of preventable death.

This report of suicide completions in Santa Clara County is the most comprehensive report of data of its kind. It includes valuable information specific to age, race, marital status, time of year/day, means and background factors of those who have completed suicide over the past three years. Additionally, this data report contains specific information about rates in individual cities and towns in the County. This is an invaluable source of information to better understand trends, specific needs areas and groups. The intention of this report is to determine baseline information of completed suicides in Santa Clara County. Although not perfect, these data help us to ask the right questions and points us in the right direction to fully deploy our Suicide Prevention efforts. Further, the report offers a foundation to evaluate the effort’s effectiveness in attaining our primary goals: Decrease the number of suicide deaths by 40% among adults, and 50% in youth by 2021. The detailed information contained in this report is essential in identifying the needs and developing effective intervention and prevention strategies.

This work could not have been completed without the generous and dedicated work of the Santa Clara County’s Medical Examiner and Coroner’s office. Thank you to Joseph O’Hara, M.D. (Santa Clara County Medical Examiner-Coroner Office, Suicide Prevention Advisory Committee Alum and active member of the Data Workgroup), Mark Eastus and Kevin Jensen (Santa Clara County Office of the Sheriff; Santa Clara County Medical Examiner-Coroner Office), for the countless hours preparing the data for this work and supporting the ongoing collaboration. We are fortunate to have such an advocate and ally of our mission and work in suicide prevention in Santa Clara County.

Shashank Joshi, M.D.
Co-Chair
HEARD Alliance/ Lucille Packard Children’s
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Jo Coffaro
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Santa Clara County Suicide Prevention Oversight Committee Analysis of 2009-11 Suicide Data

A strategy in the Santa Clara County (SCC) Suicide Prevention (SP) Strategic Plan recognizes the importance of data collection and analysis. Strategy Five states: *“Establish a Robust Data Collection and Monitoring System to Increase the Scope and Availability of Suicide Related Data and to Evaluate.”* This report was produced to further this strategy.

Methodology Employed in Analysis

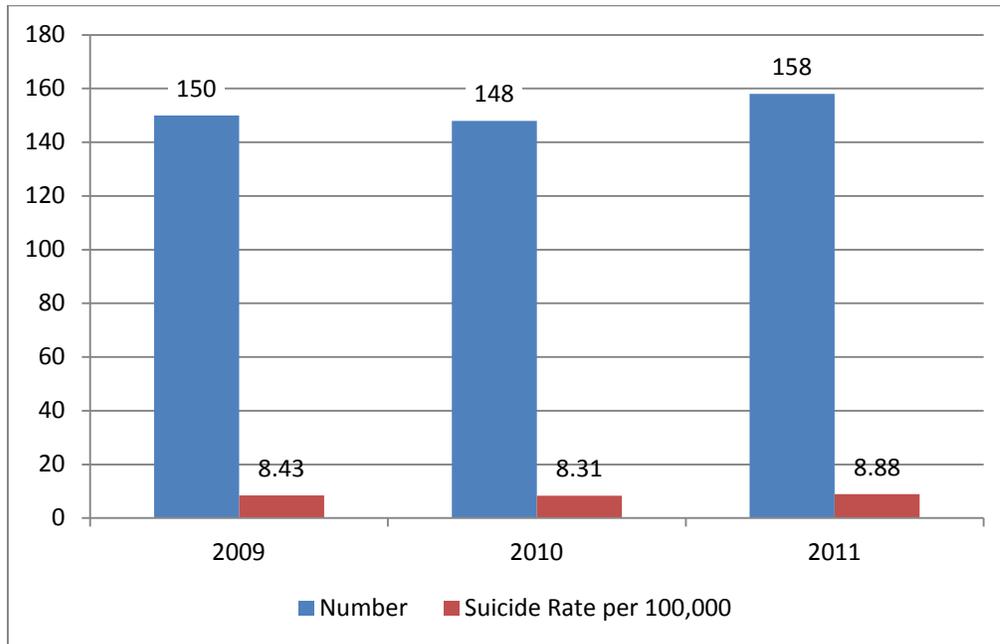
The SCC Suicide Prevention Oversight Committee (SPOC) is fortunate to have a County Medical Examiner/Coroner’s Office (MEC) that understands the significance of sharing data to inform this county-wide suicide prevention effort. MEC provided redacted case reports for suicide deaths in the calendar years (CY) 2009 through 2011 to SCC Mental Health Department (MHD) which allowed SPOC and the suicide prevention data workgroup to analyze these suicide deaths in some depth.

Relevant data from the paper copies of redacted case reports provided by MEC were first entered in spreadsheets. Data categories were defined as necessary for analysis.

No data is perfect. While relying on case reports by MEC investigators, there is an understanding that these reports are based on observations and opinions of those being questioned -- often family members, spouses, neighbors, classmates, coworkers, etc. Further, one major issue was the lack of consistency in the data provided. For example, medical history was often (but not always) redacted, which made analysis based on physical and mental health background difficult. Details such as marital status, whether suicide note was found and its contents, and the events that led to death were sometimes but not always mentioned.

What follows in this report is information on suicides in CY 2009-11 based on a variety of factors such as age, gender, place of death, and means employed. It reflects the impressions and observations based on a review of the suicide death data. The report highlights different demographic and background variables and provides data for each one. Each section then includes some possible recommendations meant to reduce future suicides.

Figure 1: 2009-11 Suicides in Santa Clara County: An Overview



Number and Rate of Suicide Deaths

As shown in Table 1 (on page 3) and Figure 1 above, the number of suicides in SCC in 2009, 2010 and 2011 were 150, 148, and 158 respectively. In 2010, although 150 reports were provided, two were duplicates of other reports. 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, therefore, **8.54 per hundred thousand**, a rate slightly more than the 2007 rate (7.8) noted in the SCC Suicide Prevention Strategic Plan. Comparatively, based on 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).

This year and the last few years have had some of the highest numbers of deaths by suicide in SCC in recent times. In the SCC Suicide Prevention Strategic Plan, Table 1 on page 34 lists suicide deaths by cities from 2000 to 2006 and tabulates the totals. The annual average over this seven year period was 121.4 suicides. The 2009-11 deaths by suicide clearly exceed this average. Only in 2004, when there were 154 suicides, was there a death total in the range of the last three years.

Demographic Factors

The suicide data from 2009-2011 will be analyzed based on the demographic factors of the decedent in this section. Specifically, gender, age, race or ethnicity, and marital status or relationships of the person will be examined.

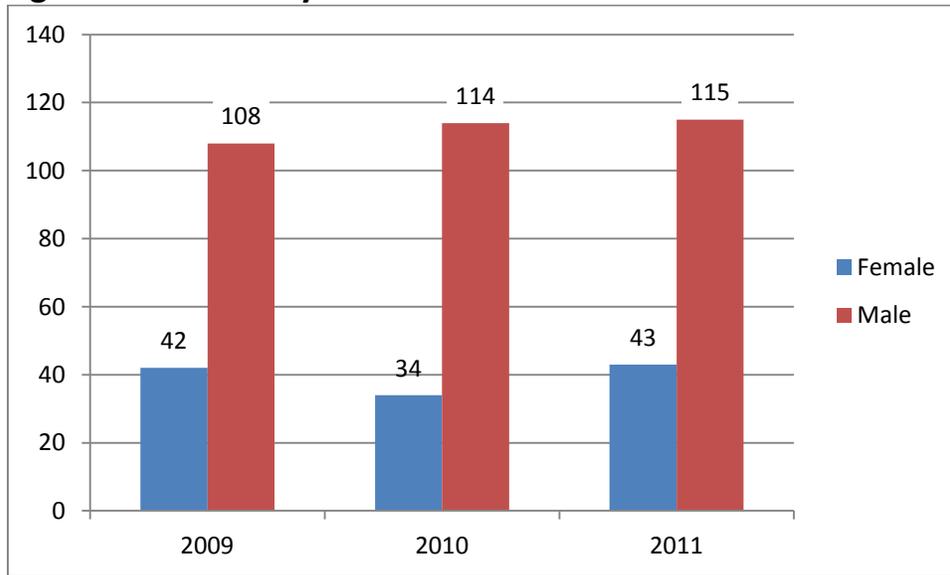
Gender

As shown in Table 1 below, and Figure 2, following page, every year more males than females died of suicide. Nationally, about 75-80% of deaths by suicide are by males, and that is similar to the rate in SCC for all three years. Specifically, for 2009, the national rate was 3.7 male deaths for every female death (American Association of Suicidology, 2012), whereas the average rate for SCC was 2.83, which is somewhat lower than the national male-female ratio. This rate, however, has not been consistent over the period studied – there was an increase from 2.57 in 2009 to 3.35 in 2010, and a reduction to 2.67 in 2011. Although more men die than women, as per national statistics, three times more women make suicide attempts compared to men (American Association of Suicidology, 2012). In SCC, however, we do not yet have access to the attempts data.

Table 1
Suicides by Gender and Year

	Female		Male		Total Number	Suicide Rate per 100,000
	Number	%	Number	%		
2009	42	28%	108	72%	150	8.43
2010	34	23%	114	77%	148	8.31
2011	43	27%	115	73%	158	8.88
Total	119	26%	337	74%	456	8.54

Figure 2: Suicides by Gender and Year



Recommendations:

- One way to reduce male suicides is by promoting treatment in a manner that appeals to this demographic. In 2010, about sixty seven percent (67%) (76 out of 114 cases) of the male decedents were identified as having a mental health need. Only a little over ten percent (10%) appeared to be in treatment (see Table 12). The SP Intervention Committee needs to discuss and seek solutions. In most cases, however, mental health need and the treatment status are not provided on the case reports, which need to be addressed by the data workgroup.
- As with many of the factors, a public awareness campaign is needed to reduce stigma in seeking treatment. Overcoming the idea that it is not “manly” to get help or that a person can shake off suicidal ideation or a mental health need must be reframed. Part of this approach should provide information and resources at locations men frequent.
- Investigators should specifically inquire about a decedent’s mental health condition and whether a person was in treatment. (Case reports about females almost always indicated a mental health condition – about 80% of the cases (27 out of 34 cases in 2010)).

Age

Table 2 below shows the suicides by age category, and Table 3, following page, provides the break down by gender and age. Conforming to national and State of California data, the majority of SCC suicide deaths were either by adults aged 30-59, or by older adults. More than one in four (25.1%) of the suicides were by individuals between the narrow age range of 50-59 years (see Table 2 and Figure 4). Another quarter (23.6%) of the suicides were in the older-adult group (60 years and above). The age range of 40-49 is another vulnerable range with one in five (20.4%) suicides. There were no suicides by children up to the age of 12 years in any of the years. For the Adolescent age-group, 13-19 years, in the period 2009-11: there were a total of 26 deaths. The young adult age-group of 20-24 years, with 35 deaths, seems to be much more vulnerable compared to the adjacent age periods of either 15-19 years or 25-29 years (Table 2 and Figure 4).

Table 2 below and Figure 3 on the following page; show the census 2010 population in each age group. As shown in red on Table 2, the most vulnerable population in SCC is the age group of 50-59, which represents 12.7% of SCC population, and represents 25.1% of the completed suicides in SCC. The adjacent age-groups of 40-49 and 60-74, and 75+ marked in yellow, also died in numbers larger than their census percentages.

Table 2
Suicides by Age Relative to Census 2010 data

Age	2009 Number	2010 Number	2011 Number	Total Number	Total %	Census 2010 %
<= 12	0	0	0	0	0.0%	<=14 years
13 - 14	1	1	2	4	0.9%	20.2%
15 - 19	9	1	12	22	4.8%	6.4%
20 - 24	11	12	12	35	7.7%	6.3%
25 - 29	7	9	5	21	4.6%	7.5%
30 - 39	21	22	16	59	13.0%	15.5%
40 - 49	30	35	28	93	20.4%	15.5%
50 - 59	34	36	44	114	25.1%	12.7%
60 - 74	23	20	26	69	15.2%	10.7%
75+	14	12	12	38	8.4%	5.0%
Unknown			1	1		
Total	150	148	158	456	100.0%	

Figure 3: Suicides by Age, Relative to Census 2010 data

Santa Clara County Completed Suicides (Blue)

National Average Census Data Completed Suicides with percentage (Red)

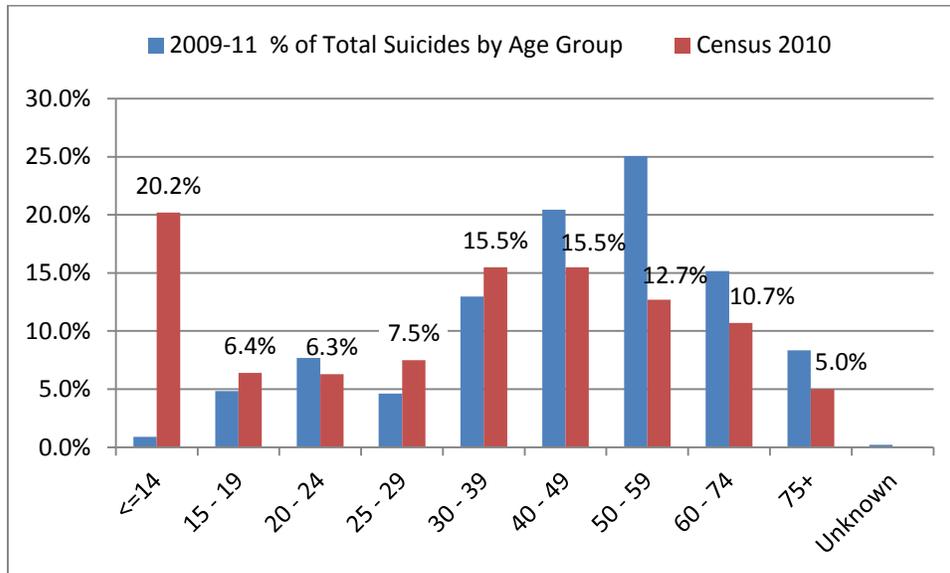
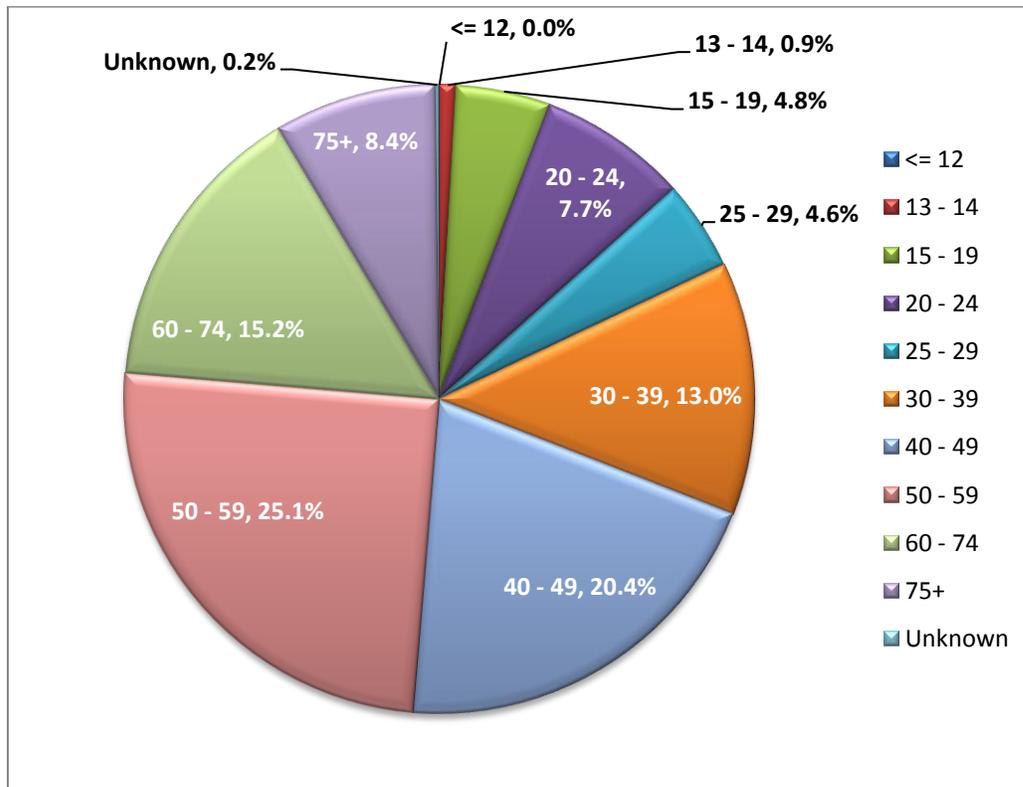


Table 3

Suicides by Age and Gender

	2009		2010		2011		Total	
	Female	Male	Female	Male	Female	Male	Female	Male
<= 12	0	0	0	0	0	0	0	0
13 – 14	1	0	1	0	0	2	2	2
15 – 19	2	7	0	1	4	8	6	16
20 – 24	3	8	1	11	2	10	6	29
25 – 29	2	5	3	6	1	4	6	15
30 – 39	2	19	2	20	5	11	9	50
40 – 49	9	21	11	24	11	17	31	62
50 – 59	13	21	10	26	8	36	31	83
60 – 74	4	19	2	18	10	16	16	53
75+	6	8	4	8	2	10	12	26
Total	42	108	34	114	43	114	119	336

Figure 4: Percentage of 2009-11 Suicides by Age Category



Recommendations:

- A public awareness campaign aimed at middle-age residents possibly could help reduce suicides. There should be more effort to involve and train businesses, unions, and employment centers on suicide prevention.
- Older adults need to be contacted at not only senior centers or senior lunch programs but strategies to reach home-bound seniors also need to be explored. A few older adults at care facilities took their lives in SCC. Care facilities need to receive some awareness training.
- It may be beneficial to incorporate information from effective evidence based practices, PRISME (SAMHSA), PROSPECT (NIMH), and IMPACT (Hartford Foundation), when developing outreach strategies for this population.
- For young people there is often talk about working with schools. Information and training should be also provided to YMCAs, Boys & Girls Clubs, etc. -- places frequented by young people.

Race or Ethnicity

Although most case reports received from MEC has race/ethnicity of the individual, it was missing from some of the 2009 case reports (Table 4). Nationally, in 2009, out of 36,909 deaths, 33,425 were by white individuals; i.e. 90% of national suicide deaths in 2009. In contrast, on an average, 61.9% of those who died by suicide in SCC are Caucasians (Table 4 below, Figures 5 and 6 - on following page). This implies that a higher percentage of non-white individuals take their lives in SCC compared to the national average. Part of it can be attributed to the diversity of this county's population (see Table 4 and Figure 6). The Asian population has the second highest number of suicides (18%) in SCC; this is inconsistent with national data which report Asians having a low number of suicides. Suicides by Hispanics were 12.8%, the third highest rate of completed suicides in SCC. (Table 4, Figures 5 and 6).

Table 4

Suicides by Race or Ethnicity Relative to Census 2010 Data

	2009 Number	2010 Number	2011 Number	Total Number	%	SCC 2010 Census (%)
African American	4	4	3	11	2.4%	2.6%
Asian	25	29	28	82	18.0%	32.0%
Caucasian	90	97	95	282	61.8%	47%
						White but not Hispanic=35.2%
						White and Hispanic=11.8%
Hispanic	17	16	23	56	12.3%	26.9%
						(any race)
Middle Eastern	1	2	7	10	2.2%	not available
Pacific Islander	0	0	2	2	0.4%	0.4%
Native American						
Unknown	13	0	0	13	2.9%	
Total	150	148	158	456	100.0%	

Note that according to the 2010 census, a person's Hispanic status is collected independently of his/her race. As a result, a person could be both Caucasian and Hispanic, or both Asian and Hispanic. This is why, the column on SCC 2010 census (%) in Table 4 adds up to more than 100. The biggest difference is amongst Caucasians, 11.8% were Hispanic and white while 35.2% were white but not Hispanic. African-Americans comprise 2.6% of the county population, and 2.4% of suicide deaths. Finally, coroner case reports identify 2.2% of the suicide deaths as that of persons having Middle Eastern background, but SCC census data does not have Middle Eastern as a category.

Figure 5: Percentage of 2009-11 Suicides by Race or Ethnicity

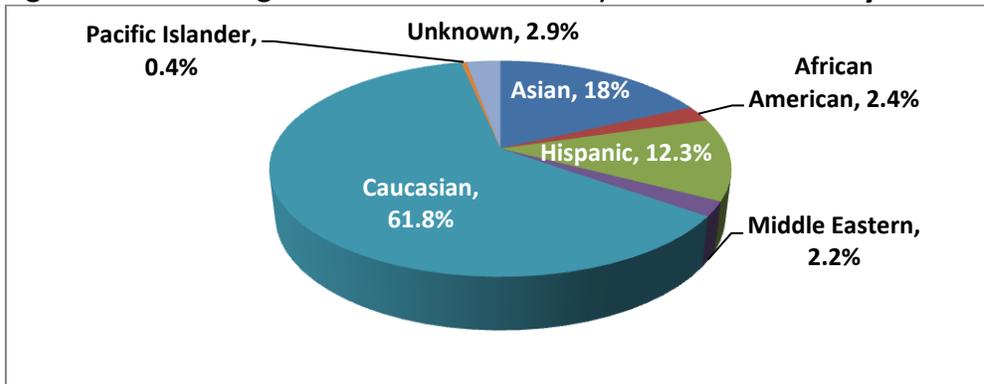
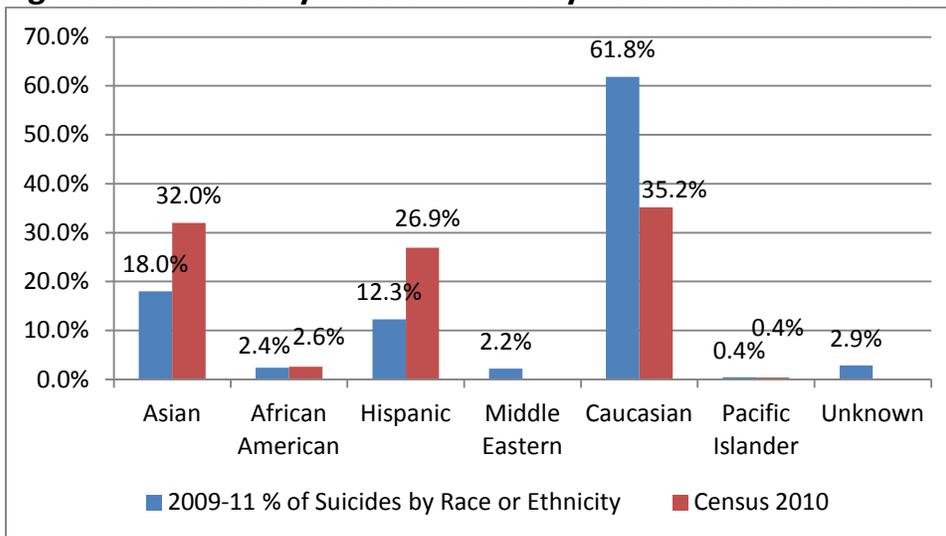


Figure 6: Suicides by Race or Ethnicity Relative to Census 2010 Data



Recommendations:

- In national data the Asian community typically has one of the lowest suicide rates and number of suicides. Not in SCC. More needs to be done to let our Asian community know about mental health care and the possibility of a loved one, friend, or associate dying by suicide. Working with local ethnic agencies and the faith community seems imperative.
- Research shows that significant diversity exists between different Asian ethnicities. Therefore, the different census categories should be captured separately in the coroner case reports. That would allow better outreach in these various ethnic communities.

- Many racial or ethnic groups provide cultural barriers to getting a mental illness or diagnosis of suicidality and treatment. These barriers need to be better understood and methods devised to overcome culturally imposed limitations for seeking help. May be a focus group approach having discussions with various ethnic communities could produce ideas. This would include a discussion with our Ethnic and Cultural Community Advisory Committees (ECCACs).
- Population reports developed with MHSa for Reducing Disparities may possibly be informative in this area. Some examples of these reports are: http://www.aahi-sbc.org/Afi-Am_Population_Report_.php, and <http://www.nativehealth.org/content/publications>
- Providing various ethnic based faith leaders with Question, Persuade, Refer (QPR) online suicide prevention training promoted by SCC MHD and other suicide prevention/intervention trainings such as Applied Suicide Intervention Skills Training (ASIST) could be useful.

Marital Status or Relationship

Literature suggests that a relationship loss (for example, if a person is alone or lonely, recently lost a spouse or friend or loved one, or there was recent relationship difficulties) might increase the risk of suicide.

Table 5

Marital Status or Relationships

	2009	2010	2011	Total	
	Number	Number	Number	Number	%
Boyfriend/girlfriend/live-in partner	8	7	8	23	5.0%
Divorced	14	19	16	49	10.7%
Married	30	45	31	106	23.2%
Recent break-up/separating	6	6	9	21	4.6%
Separated/estranged	11	4	12	27	5.9%
Single	44	53	56	153	33.6%
Widowed	5	7	10	22	4.8%
Unknown	32	7	16	55	12.1%
Total	150	148	158	456	100.0%

As Table 5 (previous page) indicates, approximately one third (33.6%) of the decedents were single while 4.8% were widowed. Another 16.9% were divorced, separated or estranged while 4.6% had a recent break-up or were separating at the time of death. Conversely, 28.2% of the decedents had a relationship, either married (23.2%), or with a domestic or live-in partner (5%). Note that in some cases those who are shown as divorced also had a boyfriend/girlfriend. Thus, these categories were overlapping and not mutually exclusive.

Figure 7: Male versus Female Suicides 2009-11: Marital Status or Relationships

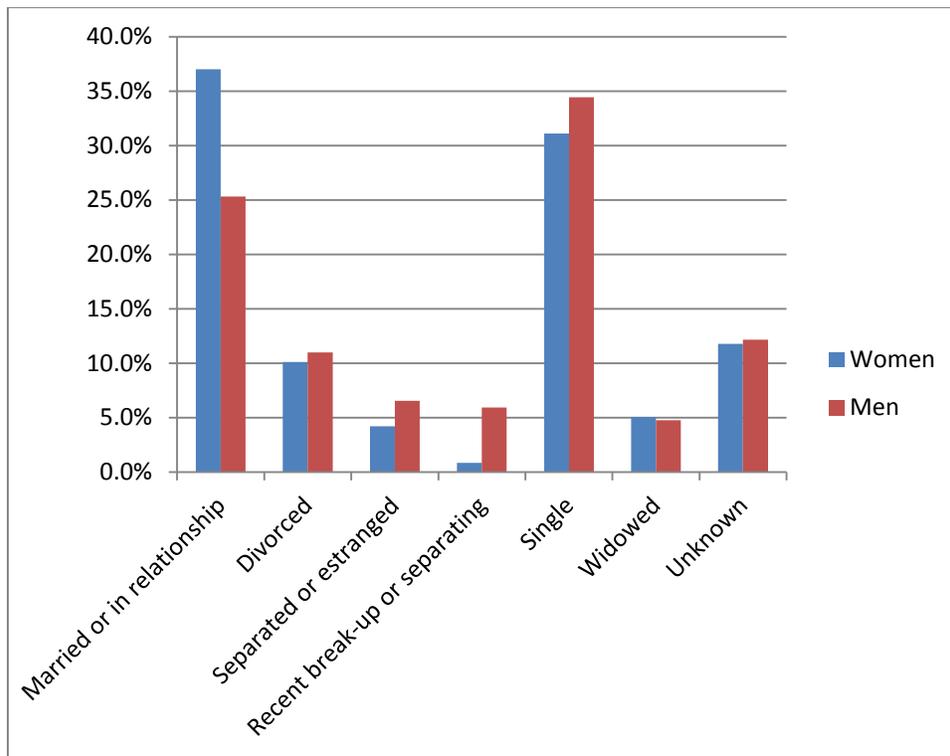


Table 6
Male versus Female Suicides 2009-11: Marital Status or Relationships

	Suicides 2009-11			
	Women		Men	
	Number	%	Number	%
Boyfriend/ girlfriend/live-in partner	8	6.7%	15	4.5%
Married	36	30.3%	70	20.8%
Divorced	12	10.1%	37	11.0%
Separated/ estranged	5	4.2%	22	6.5%
Recent break-up/separating	1	0.8%	20	5.9%
Single	37	31.1%	116	34.4%
Widowed	6	5.0%	16	4.7%
Unknown	14	11.8%	41	12.2%
Total	119	100.0%	337	100.0%

Approximately 11% of cases did not indicate a relationship status. Compared to 2009 there was far less unknown data in 2010 (see Table 5, page 10) but it increased again in 2011.

Figure 8: Male Suicides -- Marital Status or Relationships

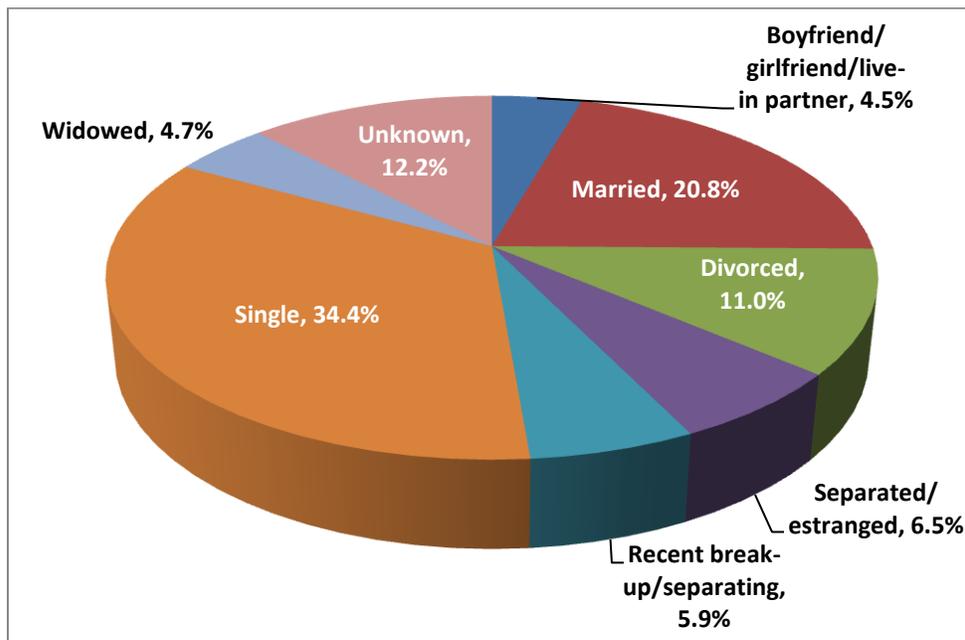
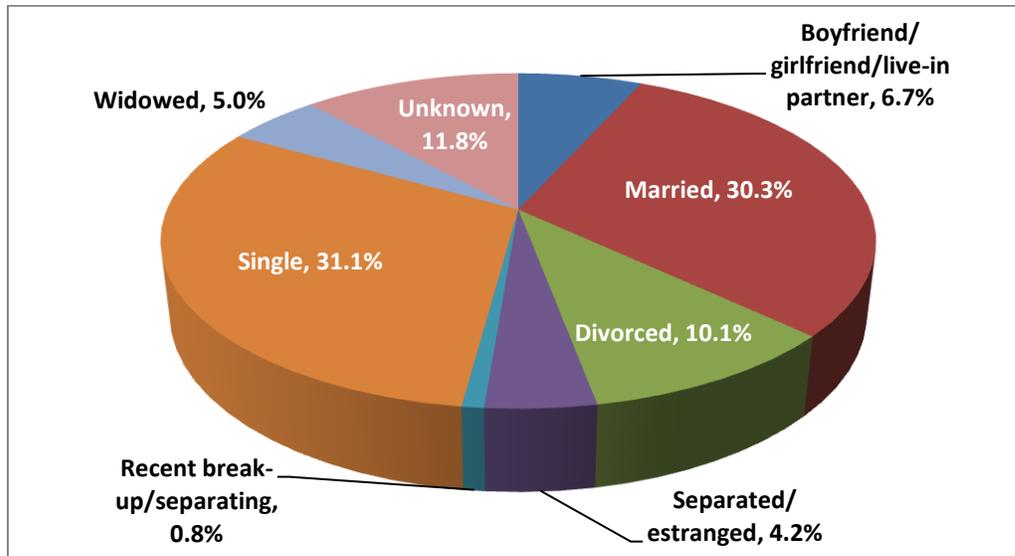


Table 6 and Figures 7, 8 (previous pages), and Figure 9 below depict how marital status of those who died differed for men and women. More married women (30.3%) seemed to have completed suicide compared to married men (20.8%). Whether this is simply by chance or is significant needs to be further studied.

Figure 9: Female Suicides -- Marital Status or Relationships



Recommendations:

- First, 12.1% of those whose relationship is unknown need to be addressed by recommending that all MEC case reports should indicate relationship status. Second, 59.6% of those who do not have a relationship completed suicide compared to 28.2% of those who were in relationship (Note however, that in some cases, those identified as widowed or divorced also had a current relationship which may not have been captured). This seems to support that relationship reduces risk of suicide, and innovative ways of reaching out to those who are isolated needs to be devised.
- More attention has to be paid to people in transition where people’s relationships are jarred – those who recently divorced, had a loved one die, ended a relationship with a boy or girl friend, etc. May be providing some training, like QPR, to groups working with people in this situation would be helpful.

When did the Deaths Occur?

The suicide deaths were analyzed based on when they occurred in this section. Whether specific months of the year or time of the day are significant will be discussed.

Time of year

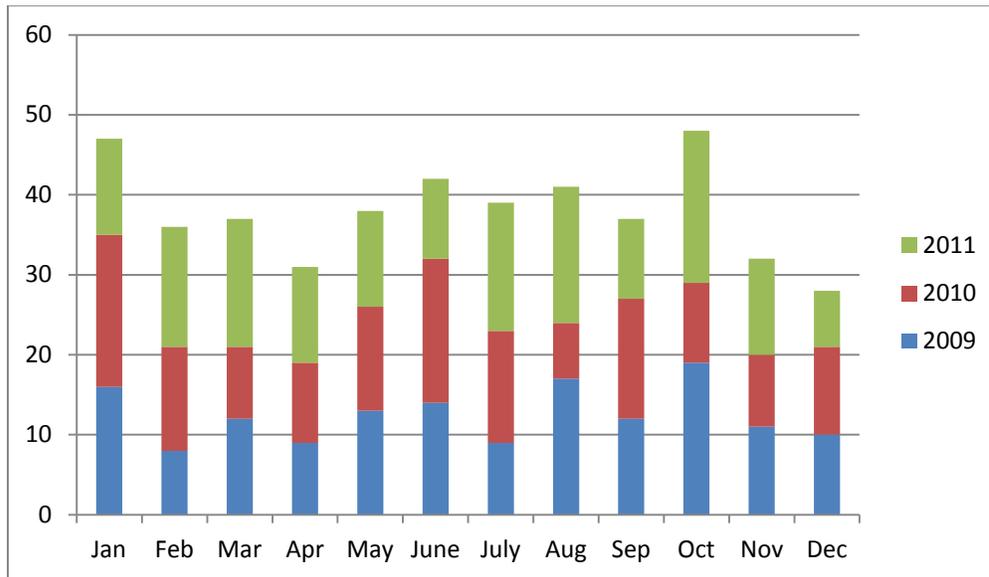
Table 7 below and Figure 10 on the following page; show the number of suicides by month. It is difficult to draw any conclusion about time of year affecting suicides. October and January, are the months with highest number of suicides – 48 and 47 respectively in the three year period studied. In 2010, June was the second highest month with eighteen (18) deaths, but in 2011 there were fewer deaths, ten (10). All other months had almost ten (10) deaths for the month, except August 2010 and December 2011 with seven (7) deaths each. By contrast August 2009 and August 2011 had one of the highest numbers of suicides with seventeen (17) deaths each. The lowest percentage of deaths reported are in December (6.1%) followed by April (6.8%).

Table 7

Suicides by Month

	2009	2010	2011	Total	
	Number	Number	Number	Number	%
Jan	16	19	12	47	10.3%
Feb	8	13	15	36	7.9%
Mar	12	9	16	37	8.1%
Apr	9	10	12	31	6.8%
May	13	13	12	38	8.3%
June	14	18	10	42	9.2%
July	9	14	16	39	8.6%
Aug	17	7	17	41	9.0%
Sep	12	15	10	37	8.1%
Oct	19	10	19	48	10.5%
Nov	11	9	12	32	7.0%
Dec	10	11	7	28	6.1%
Total	150	148	158	456	100.0%

Figure 10: 2009-11 Suicides by Month



Recommendations:

- It would be beneficial for a process to be established with MEC so that suicides identified for previous years are shared with SCC MHD in a timely manner so that the reports can be updated.

Time of day

There is no predominate time of day for suicides in the county. Deaths occurred at all times of the day. The differences between the number of deaths in the middle of the morning and the late evening hours were nominal. Every hour of the day had a suicide. The case reports have time of incident as well as time of death. Perhaps time of incident, which has so far not been looked at, needs to be further studied to understand whether individuals attempt more at specific hours.

Where did the Deaths Occur?

Within the county, are there areas where deaths are concentrated, and where do the deaths take place – a person’s residence or elsewhere? These are the subjects of investigation in the subsections that follow.

City of Residence

As evident from Table 8 below and Figure 11 on the following page, all SCC communities were affected by a suicide in the period of CY 2009 – 11. All 15 cities lost a resident to suicide and 11 of the cities had 10 or more deaths in 2009-11. San Jose represents half the county’s population, and about half of the suicide deaths in this period. The 75 suicides by San Jose in 2010 is possibly their highest number of suicides in the last ten years. With 32 suicides, Sunnyvale had the highest number of deaths after San Jose, which is expected as Sunnyvale is the second largest city in the county. Palo Alto and Santa Clara each experienced at least 25 deaths in this three year period.

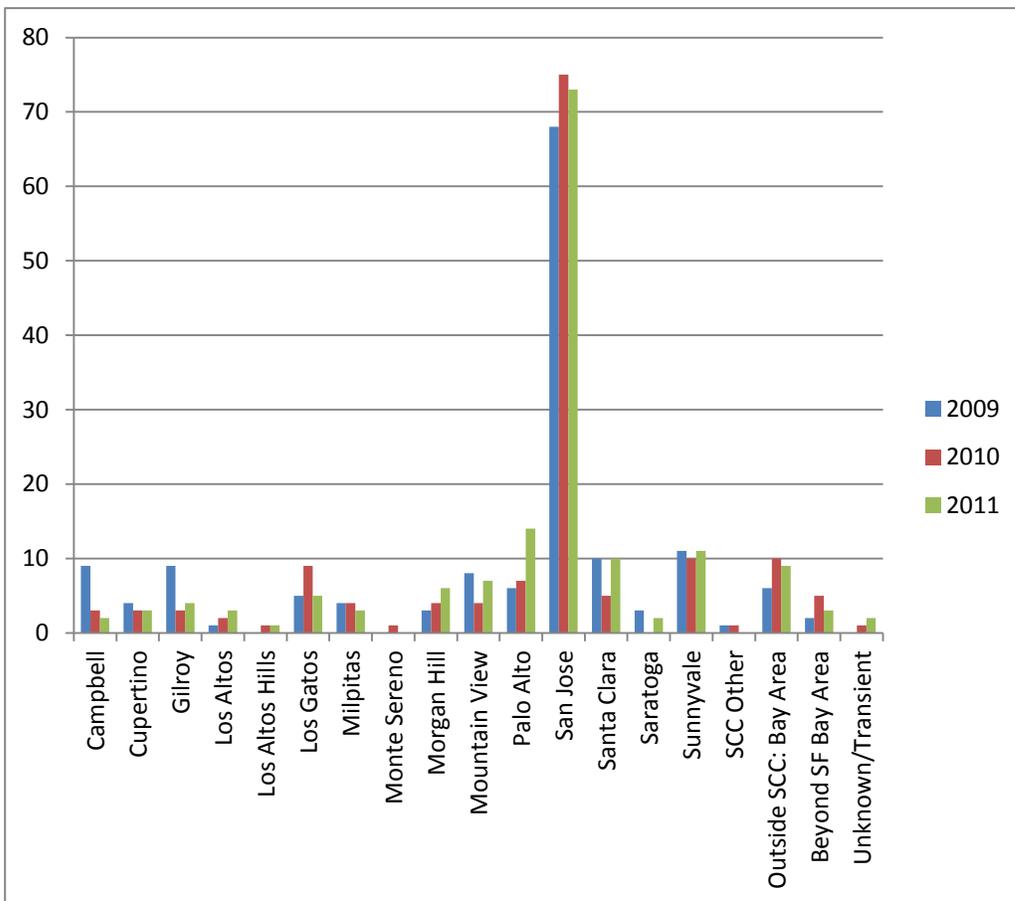
Table 8
Suicides by City Relative to Census 2010 Data

	2009	2010	2011	Total	%	Census 2010 Population
	Number	Number	Number	Number		
Campbell	9	3	2	14	3.1%	39,349
Cupertino	4	3	3	10	2.2%	58,302
Gilroy	9	3	4	16	3.5%	48,821
Los Altos	1	2	3	6	1.3%	28,976
Los Altos Hills	0	1	1	2	0.4%	7,922
Los Gatos	5	8	5	18	4.0%	29,413
Milpitas	4	4	3	11	2.4%	66,790
Monte Sereno	0	1	0	1	0.2%	3,341
Morgan Hill	3	4	6	13	2.9%	37,882
Mountain View	8	4	7	19	4.2%	74,066
Palo Alto	6	7	14	27	5.9%	64,403
San Jose	68	75	73	216	47.4%	945,942
Santa Clara	10	5	10	25	5.5%	116,468
Saratoga	3	0	2	5	1.1%	29,926
Sunnyvale	11	10	11	32	7.0%	140,081
SCC Other	1	1	0	2	0.4%	
Outside SCC: Bay Area	6	10	9	25	5.5%	
Outside SCC: Beyond SF Bay Area	2	5	3	10	2.2%	
Unknown/Transient	0	2	2	4	0.9%	
Total	150	148	158	456	100.0%	1,781,642

Table 8, previous page, also shows the census 2010 figures for each city. Census, however, has Census Designated Places (CDP) and Census County Subdivisions, which does not necessarily map into cities. Hence, the total population of cities shown does not match that of the county. Further, the county has unincorporated areas, which are not shown in the table.

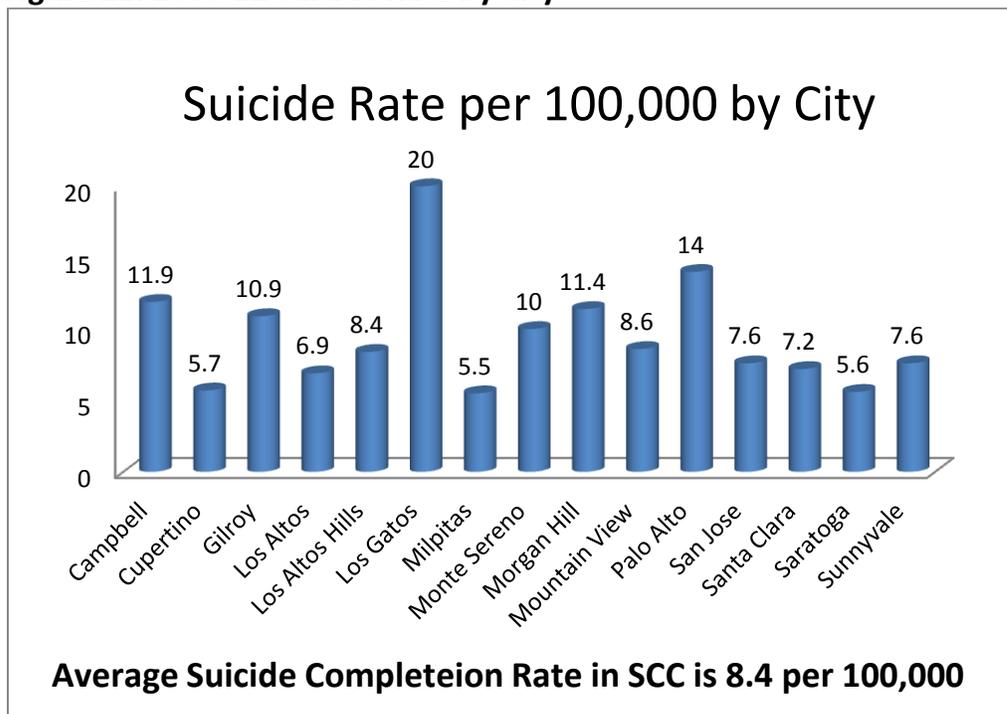
The MEC reports cannot comprehensively reflect all suicides for SCC. The reality is that some SCC residents die outside of our county, and some suicides in SCC are of non-SCC residents. However, as Table 8 (previous page) and Figure 11 below depict, most -- more than 90% -- of SCC suicides were by county residents. Twenty five suicides (5.5%) were by people residing in adjoining Bay Area counties while 10 (2.2%) were by individuals outside the Bay Area. For four deaths, the city was unknown or the deceased were transients.

Figure 11: 2009-11 Suicides by City



Another measurement used for comparison of suicide deaths are rates per 100,000 which measures the probability of an event, like a suicide death, occurring in particular area, city¹, or region or across different populations. This enables comparisons to be made across different areas. The SCC suicide rate for CY 2009-11 is 8.54 suicide deaths per 100,000 residents. The rate for CY 2000-2006 (per the SCC Suicide Prevention Strategic Plan) was 7.4, meaning the current rate has increased since 2006. Figure 12 below shows the average suicide rate for each city, and its surrounding unincorporated areas, based on zip codes. The county-wide rate of 8.54 for CY 2009-2011 as a comparison. (The rate of 8.4 suicide deaths per 100,000 residents was selected as the baseline, instead of the lower rate in the Suicide Prevention Strategic Plan to maintain consistency throughout the report, which is based on the data provided by the MEC.) As can be seen from this figure, several cities exceed the SCC average rate. The cities with the highest rates are Los Gatos (21.5), Palo Alto (14.0), Campbell (11.9), and Morgan Hill (11.4). San Jose was slightly under with a rate of 7.6.

Figure 12: 2009-11 Suicide Rate by City



¹ <http://neocando.case.edu/cando/index.jsp?tPage=genInfo>- acquired 9/4/2012. Definitions of Rate versus Count for applied social sciences. Provided by Case Western Reserve University.

To understand whether there are specific areas within a city that are more vulnerable and whether there is a clustering effect, deaths have been analyzed based on zipcodes. Table 9 below shows only those zipcodes where the number of suicides exceed ten (10) in the three year period of CY 2009-11. As is evident, a large number of San Jose zipcodes are shown. The zipcode 95020 in Gilroy had the highest number of deaths sixteen (16) followed by 95127 and 95124 in San Jose, each with fourteen (14) deaths.

Table 9
Zip codes in SCC with more than 10 Suicides in the period 2009-11

		2009	2010	2011	Total
		Number	Number	Number	Number
95020	Gilroy	9	3	4	16
95127	San Jose	2	8	4	14
95124	San Jose	2	8	4	14
95123	San Jose	2	4	7	13
95050	Santa Clara	7	1	5	13
95037	Morgan Hill	3	4	6	13
95008	Campbell	8	3	2	13
95136	San Jose	2	6	4	12
95128	San Jose	8	2	2	12
95121	San Jose	1	7	4	12
94087	Sunnyvale	1	5	6	12
95125	San Jose	4	3	4	11
95116	San Jose	6	2	3	11
95035	Milpitas	4	4	3	11
94086	Sunnyvale	4	3	4	11
94040	Mountain View	5	1	5	11
95132	San Jose	2	4	4	10
95120	San Jose	1	5	4	10
95112	San Jose	4	3	3	10
95111	San Jose	3	2	5	10
95014	Cupertino	4	3	3	10
94306	Palo Alto	4	2	4	10
94301	Palo Alto	1	4	5	10

Recommendations:

- Currently the SCC Suicide and Crisis Hotline is operated and is a recourse for residents in SCC 24 hours a day/ 7 days a week, and is in the process of being fully accredited by the American Association of Suicidology (AAS).
- 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. Getting them to do this is another matter since they harbor the same denial and stigma as others.
- QPR and other training for city officials would be helpful.
- Events where city council members and city managers are debriefed on the SCC Suicide Prevention Strategic Plan can be organized.
- Develop a group of supportive city council members, school board, and county supervisors to promote the need for local ownership.
- With recent funding provided to California County Superintendents Educational Services Association for Student Mental Health, this may be a good opportunity to reach out to local superintendents of schools. Contact information: Kate Osborn kosborn@accsesa.org
- Palo Alto's focus has been on youth well-being and youth suicide prevention. In 2009-11 they had a high suicide rate and almost all the suicides were by older adults. This data and suicide prevention should be discussed with the Palo Alto Police Chief and senior agencies so strategies for older adults can be devised.
- Los Gatos reported the highest suicide rate in the county. Los Gatos is actively involved in outreach efforts and looking for effective ways to reduce the prevalence of suicide in their community. Similar to Palo Alto, a discussion and planning session with police and various agencies of this city may be useful.
- Campbell, Morgan Hill, and Gilroy are other cities that have high suicide rate, and hence require further attention.

Place of Incident or Death

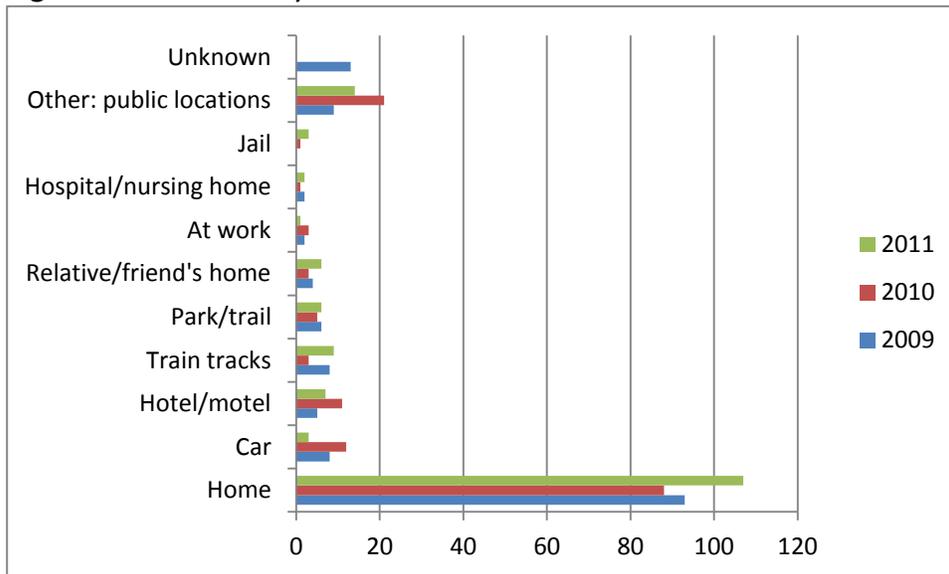
Suicides occur in a variety of places; however these deaths predominately occur in the person's own residence. In most cases the MEC case reports indicate the location where the incident took place as well as the location where the death eventually occurred. For example, a decedent could overdose at home, could have been found alive, and taken to hospital, where he/she died. Technically in this case, home is the place of incident and hospital the place of death. For this report, the place of incident was chosen for analysis and is sometimes also referred as place of death.

Almost two in three (63.2%) suicides of the county occurred in an individual's residence, most frequently in the bedroom, but also commonly in the garage, backyard, or bathroom (see Table 10 below and Figure 13 on following page). Dying in their own car parked in a public location was another common occurrence. Several individuals also chose to book a hotel or motel room to kill themselves; in several such cases, they were reported missing by family members. A few deaths (2.9%) occurred at a family or friend's residence, typically by people resident outside the county and visiting their family or friend in SCC.

Table 10
Suicides by Place of Incident

	2009	2010	2011	Total	
	Number	Number	Number	Number	%
Home bedroom	27	37	52	116	25.4%
Home garage	13	17	16	46	10.1%
Home inside other	33	21	26	80	17.5%
Home outside: yard/shed/pool	20	13	13	46	10.1%
Car	8	12	3	23	5.0%
Hotel/motel	5	11	7	23	5.0%
Train tracks	8	3	9	20	4.4%
Park/trail	6	5	6	17	3.7%
Relative/friend's home	4	3	6	13	2.9%
At work	2	3	1	6	1.3%
Hospital/nursing home	2	1	2	5	1.1%
Jail	0	1	3	4	0.9%
Other: public locations	9	21	14	44	9.6%
Unknown	13	0	0	13	2.9%
Total	150	148	158	456	100.0%

Figure 13: Suicides by Place of Incident



Other common location for suicides was in public places, the most common amongst which were the train tracks. Caltrain was the most common but Valley Transit Authority (VTA) light rail tracks and Amtrak stations were also used. Since this type of death received more public attention it is worth reviewing this data as a distinct situation. In 2010 there were three (3) suicides on train tracks down from eight (8) suicides in 2009, but in 2011 nine (9) deaths were recorded on the track, again a relatively large number.

Public parks, well-used parking lots, and open space trails were other common locations. Public venues such as an outdoor theater and amusement park, or cemetery were also used. Finally there were some suicides in locations like nursing homes, jail, and work places.

Recommendations:

- Since most suicides take place in the home, help seeking methods may need to be accessible in homes. This may be through media programs, mailers or Public Service Announcements (PSAs).
- Though being the scene of a more limited number of suicides, hotel and motel personnel could use some gatekeeper training and the crisis hotline information.
- The train tracks remain quite common in the county. Efforts must be made to collaborate with Caltrain, VTA, and Amtrak to reduce such deaths.
- Again as previously mentioned, there may be some value in posting the crisis hotline number in public places and freeway overpasses.

- Jumping from the public garages is another common method that needs to be addressed.
- For thirteen (13) deaths in 2009, location data is missing, which needs to be corrected.

How did the Deaths Occur?

In suicide prevention the term commonly used to describe the way people take their lives is the “means”. To address this factor the concept discussed is means restriction. In this section, the suicides in the county will be analyzed based on means of death to understand what kind of means restrictions will be required in the county.

Table 11
Suicides by Means of Death

	2009	2010	2011	Total	
	Number	Number	Number	Number	%
Asphyxiation	8	6	9	23	5.0%
Asphyxiation: used helium	0	7	2	9	2.0%
Cutting/stabbing	5	3	7	15	3.3%
Drowning	3	2	0	5	1.1%
Drugging/poisoning	20	25	36	81	17.8%
Firearm	55	40	47	142	31.1%
Hanging	42	48	43	133	29.2%
Immolation/burning	3	1	1	5	1.1%
Jumping	4	9	2	15	3.3%
Train collision	7	3	9	19	4.2%
Other Means	3	4	2	9	2.0%
Total	150	148	158	456	100.0%

Means of Death

Nationally, and in the State of California, the most common means used is a firearm. Approximately 50% of suicides nationwide in 2009 were by firearms (American Association of Suicidology, 2012). As shown in Table 11 above, in SCC, 31.1% of the suicides were by firearms in the period under study, which is well below the national and state percentages. A common assumption is that males die at a higher rate of suicide than females because males use more lethal means. This is supported by SCC data as higher percentage of men use firearms compared to women.

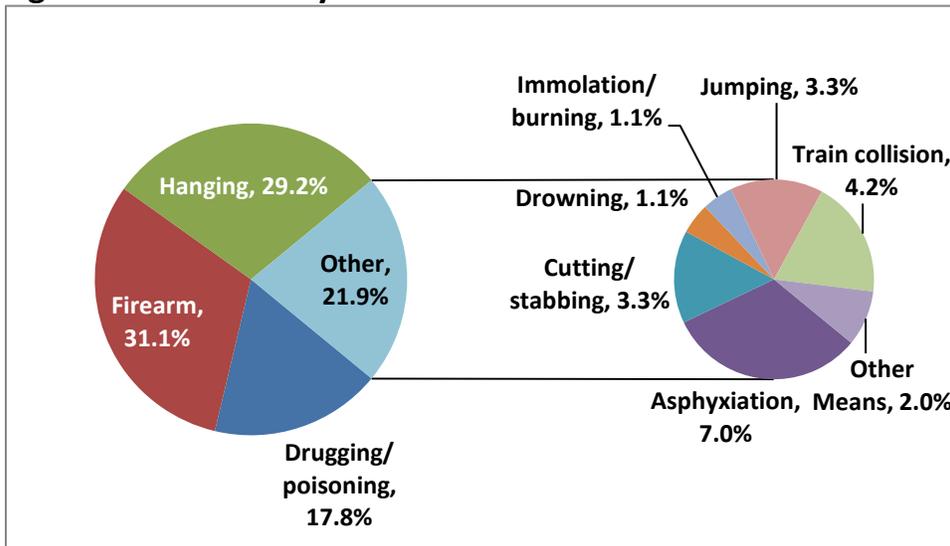
As stated, in recent years the most common means of suicide in SCC is use of firearm, followed closely by hanging representing 29.2% of completed suicides in SCC (See Table 11 and Figure 14). Medication overdoses or poisoning is the third most common method with 17.8% deaths in 2009-11.

Though a variety of other means didn't have double digit percentages they provide some troubling concerns. Asphyxiation accounted for 7% of the deaths; more out of the ordinary were several suicides using a unique method – the use of plastic bags, tubing and helium. Web based how-to death sites may be the source of why this means has become more common and this requires further investigation.

More jumping from structures occurred in 2010 (9 suicides) than in 2009 (4 suicides) but this method reduced to two (2) in 2011. Half as many deaths by standing in front of an oncoming train occurred – three (3) deaths in 2010 versus seven (7) deaths in 2009. There was a substantial increase to nine (9) such deaths in 2011.

Finally though not a common means, two (2) deaths in 2010 involved people driving their cars into structures. Sometimes it is stated that this type of death is difficult to classify as a suicide. In both these cases notes were left.

Figure 14: Suicides by Means of Death



Recommendations:

- When firearms are the means of death, the recommendations vary from educating people to removing firearms from homes to safe storage techniques such as separating the storage of the firearm and bullets. Since the majority of SCC suicides used means other than firearms, a variety of approaches need to be considered. It is difficult to restrict means when ropes, cords, and the like are used in hangings and knives for cutting. The best approach may be education, a communications campaign, and training so people are aware of mental health treatments and local resources.
- Wide spread knowledge of systems to better monitor and limit the medication provided to individuals, especially individuals expressing suicidal ideation, is needed.
- A program to inform and educate SCC businesses selling helium is needed. If they are willing, these shop keepers should be provided QPR training.
- How-to kill oneself websites should be monitored so there is an understanding of the means being proposed and how to respond to minimize these suggestions.
- Posting signs with the crisis hotline number, like Caltrain does at certain locations, should be considered for other locations -- like parking garage structures, freeway overpasses, and other high rise public structures.

Background Factors

The impact of various background factors including health, employment status, and history of prior attempts or ideation will be examined in this section. Al

Mental Health/Drug and Alcohol Usage

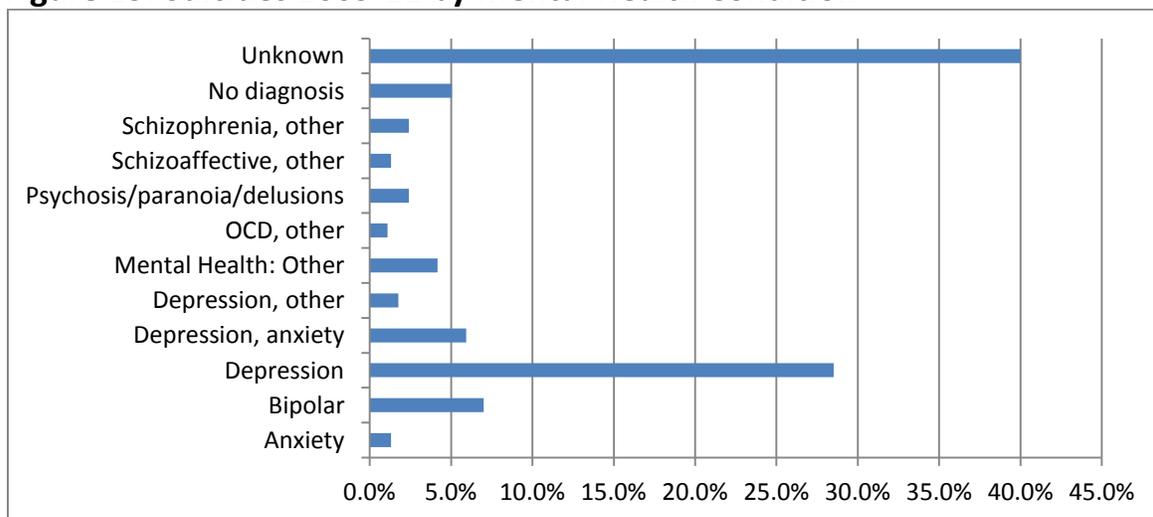
Often in suicide prevention literature the presence of a mental illness or alcohol/substance use is considered to be a significant risk factor. The National Violent Death Reporting System found that nearly half of suicide cases involve at least one documented mental health diagnosis (Center for Disease Control and Prevention, 2006). It is estimated that as many as 90 % of individuals who complete suicide had a diagnosable mental illness or substance use disorder (National Institute of Mental Health, 2003). The number is somewhat reduced for youth, where some suggest between sixty percent (60%) to seventy five percent (75%) of the cases involve a mental health or alcohol or substance use.

Table 12
Mental Health Condition

	2009	2010	2011	Total	
	Number	Number	Number	Number	%
Anxiety	2	2	2	6	1.3%
Bipolar	9	14	9	32	7.0%
Depression	47	43	40	130	28.5%
Depression, anxiety	6	11	10	27	5.9%
Depression, other	5	0	3	8	1.8%
Mental Health: Other	5	6	8	19	4.2%
OCD, other	3	2	0	5	1.1%
Psychosis/paranoia/delusions	2	8	1	11	2.4%
Schizoaffective, other	1	2	3	6	1.3%
Schizophrenia, other	3	7	1	11	2.4%
No diagnosis	10	9	4	23	5.0%
Unknown	57	44	77	178	40.0%
Total	150	148	158	456	100.0%

In the 2009-11 case reports the MEC investigators indicated any mental health, alcohol, or substance abuse diagnoses or issues if the information was clearly present (see Table 12- previous page and 13- following page). The investigator was dependent on a contact person - a loved one, friend, neighbor, or others – to provide this information. In at least some cases this person(s) did not know or was unaware of a health matter. Further, in many cases, medical history was specifically redacted in the case reports provided, and therefore, no analysis was possible.

Figure 15: Suicides 2009-11 by Mental Health Condition



It was helpful when a person’s medications were available and listed, this offered insight to their medical condition. This was provided in several case reports, especially when a person was found dead in their residence, not as often when a person died elsewhere, such as a hotel, motel, public park, or roadway. In a number of case reports the medications were clearly anti-depressants or anti-psychotic drugs. Often there was no inquiry into medication or health/mental health situations when the death occurred outside a person’s residence.

The largest number of people who completed suicide had some symptomology of depression. Approximately 36.2% of the cases noted the decedent had symptoms of depression, and in some cases, dual diagnosis (condition of a person considered to be suffering from a mental illness and a substance use congruently) (Table 12 and Figure 15). Another 7% had some indication they were being treated for bipolar disorder while 6.1% indicated schizophrenia or schizoaffective disorder or some form of delusional disorder. Another 4.2% of the cases provided some indication the decedent had some condition, whether angry outbursts, stress, or just a general remark that they were having mental difficulties.

In 5% of the cases, people interviewed said there was no mental illness. Again this data is limited because people questioned often could not provide information. Further, almost 40% of the reports had no statement about a mental illness.

Table 13
Drug and Alcohol Usage

	2009	2010	2011	Total	
	Number	Number	Number	Number	%
Alcohol	3	16	10	29	6.4%
Alcohol, drugs	0	15	9	24	5.3%
Drugs	1	11	10	22	4.8%
Other addictions	0	3	0	3	0.7%
Substance abuse	27	0	2	29	6.4%
No Abuse	17	7	6	30	6.6%
Unknown	102	96	121	319	70.0%
Total	150	148	158	456	100.0%

Other significant factors associated with suicides are alcohol or substance abuse and lack of treatment. As shown in Table 13 above, a majority of the case reports (70%) provided no information on this factor. In a small number of cases (6.6%), there were notes indicating a person did not have an alcohol or drug problem. In 2009-2011, alcohol abuse was indicated in 6.4% of the cases, drugs in 4.8% of the cases, and co-occurring alcohol and drug abuse in 5.3% of the cases. In some reports, a chronic gambling addiction was noted.

Similarly, there is very little indication if a person was receiving treatment. In 2010, 68% of the reports don't address if treatment is being received, probably because the information is not readily available or required. About 16% of the case reports note either some form of treatment, including individuals attending a support group. Another 16% of the cases indicate that decedents were not receiving treatment (Table 14 on following page). In 2011, in several cases, it was indicated that the individual dying by suicide was just released from a treatment center within the past week or even the same day.

Figure 16: Percentage of 2009-11 Suicides by Drug & Alcohol Usage

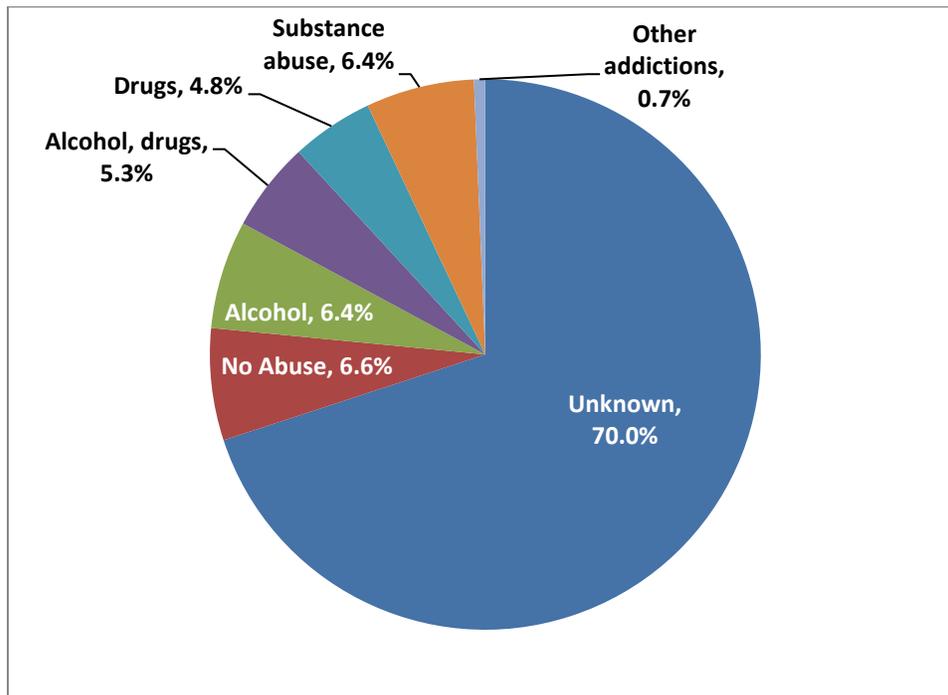


Table 14
Status of Treatment Received

Treatment	2010			
	Female Number	Male Number	Total Number	%
Yes	8	13	21	14.2%
Yes and in support group	0	1	1	0.7%
Extensive left over meds - not taking them	0	1	1	0.7%
Previous medical record	0	1	1	0.7%
No	6	17	23	15.5%
Refused treatment	1	0	1	0.7%
Unknown	19	81	100	67.6%
Total	34	114	148	100.0%

Recommendations:

- As mentioned for other factors, it would be useful if investigators persisted in determining if a mental health and/or substance/alcohol abuse condition existed and if a person was being treated.
- Medication history of the person was specified in less than 10% of the cases. It would be helpful if medications were recorded in every case. Further, even when recorded, in many cases, the information was specifically redacted in paper reports provided to SCCMHD. MEC can be requested to not redact medical background of the person.
- Consideration of including psychological autopsy training for SCC employees offered through AAS. This training has been well received in Contra Costa County.
- More information and awareness on depression and available resources and treatment need to be conveyed to the public. In several of the case reports there were comments made about depression, indicating it was present, but there was no awareness to have it treated. Further, as noted above, in some cases, the person was just released from the treatment center, which indicates that the process used for evaluating if the person is ready to be released needs to be re-evaluated.
- All those working with mental health and substance/alcohol abuse consumers need to be aware of the potential for suicide. The subtleties of people’s symptoms make this difficult and constant training and vigilance is needed. The SCC SP Intervention Workgroup should discuss how to best improve awareness about depression, its potential for the fatal outcome of suicide, and convey the need for treatment.

- Consider working with primary care providers as some populations seek help with primary care providers first. Studies show that people of Latino and Asian heritage describe/express their symptoms of mental illness by physical symptoms.
- A program to overcome the stigma and taboos against seeking treatment is needed.
- The current work to develop more collaboration between primary care and mental health providers could assist in getting more people with mental health needs and suicidal ideation into treatment. This relationship needs to be seriously promoted.

Suicidal Communication

In discussing what communications are provided by people who take their lives, the standard used is whether or not a written note was found. In filing case reports in SCC, the investigators attempt to find a note and indicate if a note was found. Often, though not for all suicides, where the death occurred outside the place of residence -- in a hotel/motel room, public place, jumping from a public structure, etc. – the reports do not indicate if a note was sought.

Nationally studies suggest only about one in six of those who died by suicide left a written note. As Table 15 below and Figure 17 on the following page indicate, on average, in 35.5% of cases, no note was found, in 34.6% of the cases, a note was left, and in another 24.3% of the cases, it is not known whether or not a note existed. Further, in some cases, the suicidal note was left on their computer.

The way to communicate one's death is changing with modern technology. Though not clearly indicated in case reports, there is some indication of this change. In 3.3% of all cases, people who died by suicide made a phone call, posted email, sent a text message, or commented on social networking media sites their intentions to kill themselves. In another 2.2% of cases, specific verbal comments were made about dying. Thus, in some form or other, many who took their life made comments about their lives being worthless and they being failures, what in suicide prevention are called warning signs or sometimes "invitations".

Table 15
Suicide Notes or Communication of Suicide

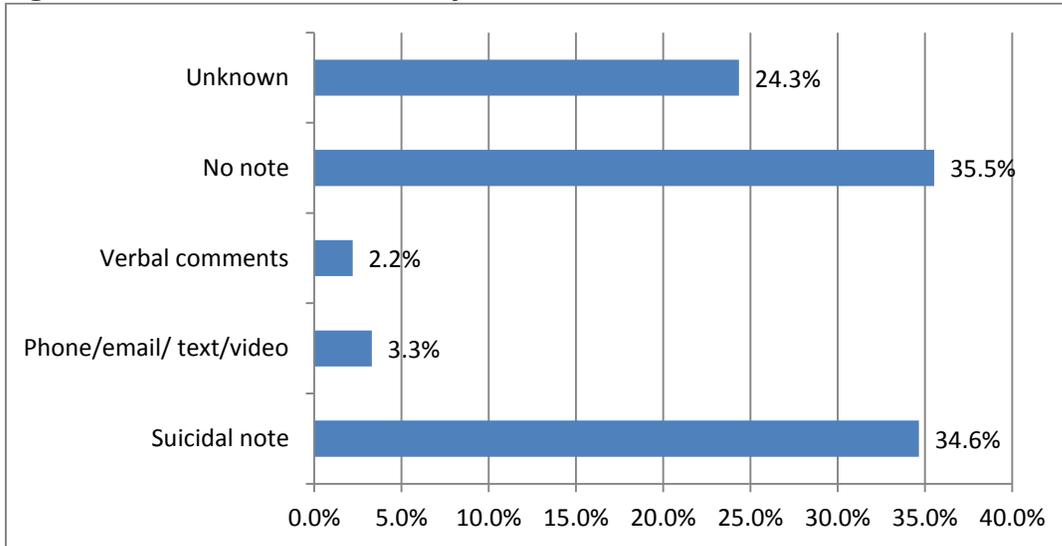
	2009	2010	2011	Total	
	Number	Number	Number	Number	%
Suicidal note	35	65	58	158	34.6%
Phone/email/ text/video	2	3	10	15	3.3%
Verbal comments	1	5	4	10	2.2%
No note	73	46	43	162	35.5%
Unknown	39	29	43	111	24.3%
Total	150	148	158	456	100.0%

Recommendations:

- The suicide prevention literature emphasizes that a person communicating thoughts of taking their life need to be taken seriously – very seriously. We almost need a slogan that makes it common knowledge to act when someone says they are thinking of taking their life.
- Several of the communications noted the decedent felt they were a personal failure, whether as a student, or in getting employment, etc. Institutions (schools, businesses, governments, etc.) should be made aware of this circumstance and understand the need to provide help when such comments are heard.
- There may be some benefit for the county or SPOC to have social network accounts and convey messages of help and resources.
- It may go without saying that social networking businesses need to be engaged in suicide prevention work. Again, maybe a focus group discussion and offering some QPR training could be useful. Some social media companies are currently being funded by CalMHSA to do some social media work with ReachOutHere.org, a website which seeks to address stigma and support youth.
- QPR training of a wide range of residents is needed.
- And, again, under any circumstance, investigators should seek a note and indicate its availability or lack of availability. They should also search if computer messages were left and if how-to websites were searched / bookmarked, which they already seem to be doing in many but not all cases.
- An analysis should be performed on the existing notes to see if certain characteristic can be determined that can be used to devise prevention programs.

- Given that those who die of suicide may or may not leave a “suicide note”, the presence or absence of a note upon death should not be a critical criterion for identifying suicide as the cause of death.

Figure 17: Suicides 2009-11 by Suicidal Communication



Prior Attempts

Information on prior attempters is important. Prior attempters are considered at significantly higher risk of future attempts and die by suicide at slightly more than three times the rate of the general population. To be clear, most people who attempt suicide go on to live, but a high number of suicidal deaths are completed by people who had previously attempted suicide.

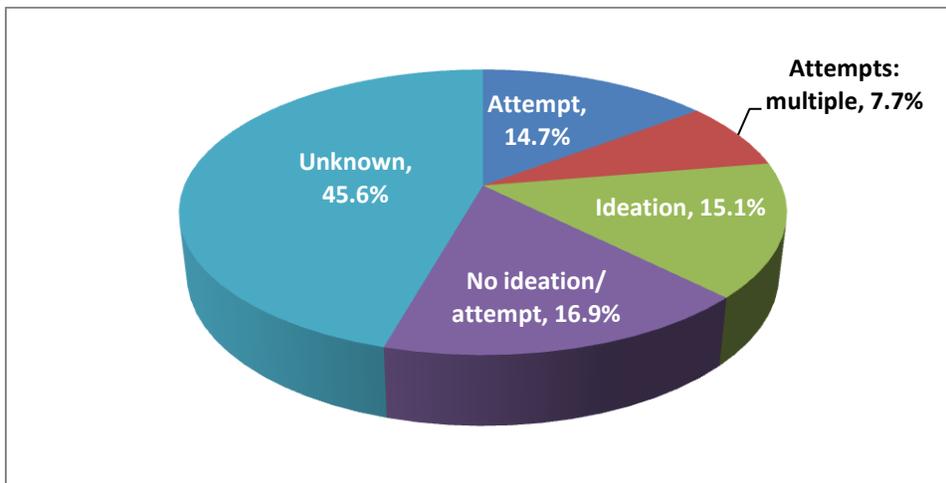
The data on SCC prior attempters is limited to cases where people divulge this information. Often the key source for this information -- family, friends, and loved ones -- don't always know. In some cases the question may not be asked or may not seem necessary to ask during the investigation. In 2009-2011, the data (Table 16 and Figure 18 on the following page) indicated that one in four who died, were prior attempters. Further, 7.7% had made multiple attempts. Another 16.9% were not prior attempters whereas 15.1% expressed some form of suicidal ideation, and several made open threats to take their life. There was no way to make a determination on the remaining 45.6% decedents, due to lack of information. This implies that the percentage of those who had prior attempts could be much higher if data were available in every case.

Table 16

Prior Attempts of Suicide

	2009	2010	2011	Total	
	Number	Number	Number	Number	%
Attempt	27	28	12	67	14.7%
Attempts:multiple	10	8	17	35	7.7%
Ideation	17	26	26	69	15.1%
No ideation/ attempt	32	28	17	77	16.9%
Unknown	64	58	86	208	45.6%
Total	150	148	158	456	100.0%

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



Recommendations:

- Because a significant number of suicides were by prior attempters, a follow up approach to support living prior attempters is needed. One approach might be what Contra Costa's crisis hotline staff does. They periodically call a list of prior attempters to check their status.
- A program focused on prior attempters is needed so that people feel comfortable seeking help and treatment when needed. One approach may be to provide a support group.
- Consider a special call line or a select sub-number of the existing hotline could be set up for prior attempters, similar to the national Suicide Prevention Lifeline sub-number for veterans.
- Better promotion of SCC's Survivors of Suicide (SOS) Program.
- Work closer with Suicide and Crisis Services (SACS) to ensure family members and those who attempt suicide are provided with local resources prior to being discharged.

Employment Status

Recent economic turmoil, increased unemployment and record foreclosure rates have spurred media inquiries about whether these changes will lead to increased suicides. SPRC conducted a literature review of relevant research published in the past two decades. The review shows that a strong relationship exists between unemployment, the economy, and suicide. A common "chain of adversity" can begin with job loss and move toward depression through financial strain and loss of personal control. In fact, this chain leads to myriad financial, social, health and mental health outcomes—all of them negative. The most common (but by no means the only) mental health outcome is depression, which significantly increases suicide risk. The associated financial outcomes (such as mortgage foreclosures and loss of retirement security) have not been researched with respect to suicide. However, the potential link is that for vulnerable individuals, losses (whether real or anticipated) that result in humiliation, shame, or despair can trigger suicide attempts.

The SCC data on employment status and person's occupation was often (36.4% cases) not available (see Table 17, next page and Figure 19, page 36). It is difficult to definitively draw conclusions from this variable. About a quarter (26.6%) of the suicides involved people who were employed. A wide range of occupations was recorded with no one occupation showing a predominance of the deaths.

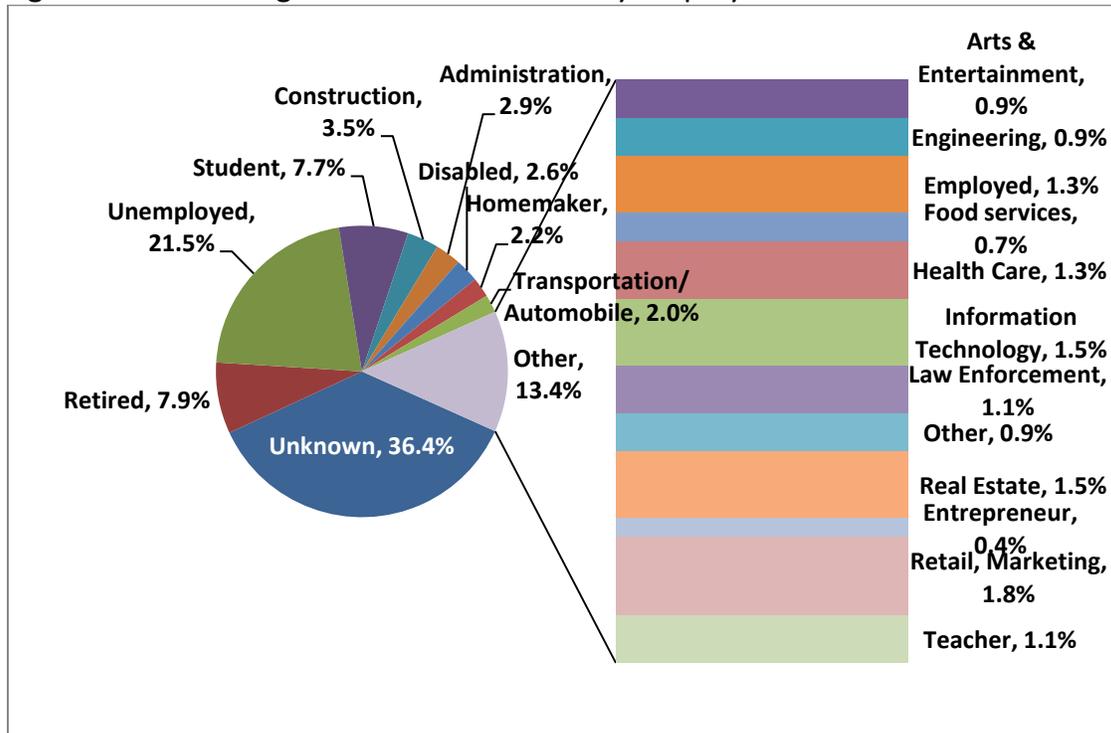
In the three year period under study, two common factors for suicides were that individuals were unemployed (21.5%) or retired (7.7%) (see Figure 19 page 36). In several cases the decedent was out of work and expressed that he or she had no prospects for employment.

Table 17
Suicides 2009-11 by Employment Status

	2009	2010	2011	Total	
	Number	Number	Number	Number	%
Administration	3	6	4	13	2.9%
Arts & Entertainment	3	0	1	4	0.9%
Construction	6	6	4	16	3.5%
Disabled	2	4	6	12	2.6%
Employed	1	3	2	6	1.3%
Engineering	2	2	0	4	0.9%
Entrepreneur	0	1	1	2	0.4%
Food services	0	1	2	3	0.7%
Health Care	2	1	3	6	1.3%
Homemaker	3	5	2	10	2.2%
Information Technology	2	3	2	7	1.5%
Law Enforcement	1	2	2	5	1.1%
Other	2	1	1	4	0.9%
Real Estate	1	4	2	7	1.5%
Retail	3	1	1	5	1.1%
Retired	10	16	10	36	7.9%
Sales & Marketing	1	0	2	3	0.7%
Student	13	11	11	35	7.7%
Teacher	3	1	1	5	1.1%
Transportation/ Automobile	3	2	4	9	2.0%
Unemployed	27	32	39	98	21.5%
Unknown	62	46	58	166	36.4%
Total	150	148	158	456	100.0%

Another significant category of people affected were students with 7.7% of the deaths. In many of these cases the individuals believed they were doing very poorly or failing in school.

Figure 19: Percentage of 2009-11 Suicides by Employment Status



Recommendations:

- Recommendations for this factor are difficult to make since the data is limited.
- Working with businesses and employers could be helpful. They might benefit from QPR training.
- Similarly there could be benefits to providing awareness training to employment agencies, temporary help agencies, and retirement centers.
- Several decedents had a law enforcement background. SCC police departments should be made aware of online resources like *Preventing Law Enforcement Officer Suicide: A Compilation of Resources and Best Practices* at <http://www.theiacp.org/tabid/299/Default.aspx?id=1033&v=1>
- Unemployment agencies could provide local mental health resource-lists.
- Educators could be trained in signs of suicidality to look for characteristics such as sudden behavior changes.

RESOURCE LISTING - NUMBERS MOST FREQUENTLY USED

(Where not listed, area code is 1-408)

Santa Clara Suicide and Crisis Hotline: 1-855-278-4204

CHILDREN – YOUTH

Children Protective Services	299 - 2071	Child abuse reporting
Alum Rock Counseling Center (24 Hrs)	294 - 0579	Adolescent crisis counseling (mobile)
Bill Wilson Center	243 - 0222	Adolescent counseling and shelter
Eastfield Ming Quong Mobile	379 - 9085	Crisis counseling for children (mobile)
Planned Parenthood	287 - 7532	Parent training, education, and health care
Teen Center	370 - 9990	Teen and family counseling

DRUGS & ALCOHOL

GATEWAY	1- 800 - 488 - 9919	Drug/alcohol linkage services
Alcoholics Anonymous (24 Hrs)	374 - 8511	Peer support groups to stop using alcohol
Narcotics Anonymous	998 - 4200	Peer support groups to stop using drugs
Pathway Society (24 Hrs)	244 - 1834	Comprehensive Drug/Alcohol services
AL – ANON	379 - 1051	Family Support Group
Smoking Cessation Line	1 - 800 - 662 – 8887 (800-NOBUTTS)	California Smokers Help Line

HOTLINES

Community Solutions (24 Hrs)	683 - 4118	Crisis hotline
RAPE CRISIS (24 Hrs)	287 - 3000	Rape crisis hotline
Youth Crisis Hotline	1 - 800 - 999 – 9999	Youth support and referrals
National Hotline	1 - 800 - 784 - 2433	1 - 800 - SUICIDE
Spanish Speaking Hotline	1 - 800 - 572 - 2782	Crisis hotline
24/7 teen line	1 - 888 - 247 - 7717	24 Hours teen hotline
CONTACT	850 - 6125	Crisis hotline and Parental stress hotline
Friendship line (24 Hrs)	1- 800 - 971 - 0016	Crisis hotline for senior citizens
Alzheimer’s Hotline (24 Hrs)	1 - 800 - 272 - 3900	Alzheimer’s education, info., & support
Anti – Hate Line	279 - 0111	Discrimination Complaints
Sex Addicts	(510) 273 - 9878	Sexual issues
Unity Prayer (1-800-NOW-PRAY)	1 - 800 - 669 - 7729	Confidential prayer support

EMERGENCY FOOD

Harvest Food Bank	266 - 8866	Provides food for the needy
Food Connection	266 - 8950	Provides resources for getting food

EMERGENCY SERVICES

Emergency Psych Services	885 - 6100	Psychiatric Consultation
Urgent Care Program (871 Enborg Ct)	885 – 7855	Emergency Psychiatric Assessments
Mental Health Call Center (SCC)	1-800-704-0900	Access to mental health services
Valley Medical Center (VMC)	1-888-334-1000	Emergency medical consultation
Sheriff	911 or 299 - 3233	Sheriff information/response
Poison Control	1-800-662-9886	Emergency response to poison
Adult Protective Services (APS)	1-800-414-2002	For Reporting Elder Abuse
San Mateo Medical Center	(650) 573 - 2662	Emergency Psychiatric Services

EMERGENCY SHELTER

Battered Women’s Support Network	1-800-572-2782	Support services for battered women
Next Door (24 Hrs)	279 - 2962	Shelter for battered women
Reception Center	294 - 2100	Emergency shelter and meals
Salvation Army	282 - 1175	Emergency shelter and meals for males only
City Team “Males”	288 - 2153	Provides emergency shelter and meals
24-hour shelter	1-800-774-3583	Provides referrals for shelter

OTHER REFERRALS

Information/referrals-United Way	211 & 248 - 4636	United Way information & referrals
Billy De Frank Center (Gay/Lesbian)	293 - 2429	Provides Gay & Lesbian support services
Center for Living with Dying	243 - 0222	Support services for grieving individuals
Kara (Palo Alto)	(650) 321 - 5272	Support services for grieving individuals
Grieving pet loss	262 - 2133	Grieving the loss of a pet
Adult Education Programs	723 - 6400	For continuing education opportunities
Victim Witness	295 - 2656	Assistance for victims of a crimes
Transgender social events	984 - 4044	Social events
Bay Area Legal Aid	283 - 3700	Domestic Violence, Housing etc
Veterans Center	993 - 0729	Comprehensive services for veterans
Gamblers Anonymous	1-800-287-8670	Assist individuals to quit gambling
Stuttering Foundation of America	1- 800-992-9392	Resources for stutterers & therapists

NON- PROFIT COUNSELING

ACT	287 - 2640	Reunification counseling for abused children
Adult and Child Guidance Center	292 - 9353	Individual and family counseling
Almaden Valley Counseling	997 - 0200	Teen, Adults, & Families
Alum Rock Counseling Center	294 - 0500	Family counseling
Bill Wilson Center (Bilingual)	243 - 0222	Individual and family therapy
Catholic Charities (Bilingual)	944 - 0469	Individual and Family Counseling
Center for Healthy Development	985 - 8115	Family therapy & Domestic violence groups
Christian Counseling	559 - 1115	Counseling
JFK Counseling	524 - 4900	Counseling Services
Parenting (YMCA)	295 - 4011	Support, education, therapy & referrals
Process Therapy Institute	358 - 2218	Individual and Family therapy
Pacific Grad School	(650) 961 - 9300	Counseling Services
San Jose State Family Counseling	924 - 5670	Individual and family counseling
Ujima Youth (African American)	928 - 1700	Youth and family counseling
ACCI (Asian Community Counseling)	975 - 2730	Individual and family counseling

MENTALLY ILL

National Alliance on Mental Illness (NAMI)-Santa Clara Chapter	453 - 0400	Support services for families of mentally ill
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VETERAN ADMINISTRATION HEALTH CARE

Veteran’s Crisis Line	800-273-8255(Press 1)	National Veteran suicide prevention line
National Call Center For Homeless Veterans	877-AID4-VET (1-877-424-3838)	National Veterans Homeless Hotline
Veteran’s Administration Palo Alto Health Care System Addiction Treatment Services Resource Line	1-866-717-1978	VA Palo Alto Addiction Treatment Services
Veteran’s Administration Palo Alto Health Care System Telephone Care Line	800-455-0057	VA Palo Alto Toll Free Number
Veteran’s Administration Palo Alto Health Care System Main Number	650-493-5000	VA Palo Alto General Number

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