



COUNTY OF SANTA CLARA  
**Behavioral Health Services**  
Supporting Wellness and Recovery

**2019-20 Suicide Prevention Annual Report**  
**Reporting Period: July 2019-June 2020**

## Table of Contents

<a href="#">Background</a>	2
<a href="#">FY20 highlights by numbers</a>	3
<a href="#">Suicide data and discussion</a>	4
FY20 progress on program objectives	
• <a href="#">Objective 1: Increase early identification and support for people thinking about suicide</a>	12
• <a href="#">Objective 2: Increase use of mental health services</a>	15
• <a href="#">Objective 3: Strengthen community suicide prevention and response systems</a>	22
• <a href="#">Objective 4: Reduce access to lethal means</a>	31
• <a href="#">Objective 5: Improve messaging about suicide in the media</a>	32
<a href="#">Conclusion and recommendations</a>	34
<a href="#">Acknowledgments</a>	36
<a href="#">Attachments</a>	38
<a href="#">References</a>	40

## BACKGROUND

Established in 2010, the Santa Clara County Suicide Prevention (SP) Program designs, implements, and evaluates population-based, public health approaches to reducing and preventing suicides. Suicide prevention in the County is guided by the County’s Suicide Prevention Strategic Plan, which was passed by the Board of Supervisors in 2010. The plan recommends the below five evidence-based public health strategies to guide a comprehensive community effort to prevent suicide.

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

The SP Program coordinates the Suicide Prevention Oversight Committee (SPOC) and five Workgroups, which are each tasked with supporting a different strategy of the County Suicide Prevention Strategic Plan: Interventions (Strategy One), Communications (Strategies Two and Three), Policy (Strategy Four), Data (Strategy Five), and the South County Suicide Prevention Workgroup (regional focus). SPOC oversees and approves the work of the Workgroups.

This annual report covers the period of Fiscal Year 20: July 1, 2019 to June 30, 2020.

## FY20 SUICIDE PREVENTION HIGHLIGHTS BY NUMBERS

**11** school districts participating in the Schools for Suicide Prevention partnership

**795** text conversations received over the County Crisis Text Line

**1,281** community members reached with suicide prevention and mental health resources, through 30 community outreach events attended

**3,670** people trained to be community helpers for suicide prevention and mental health

**32,451** calls received by the Suicide and Crisis Services hotline

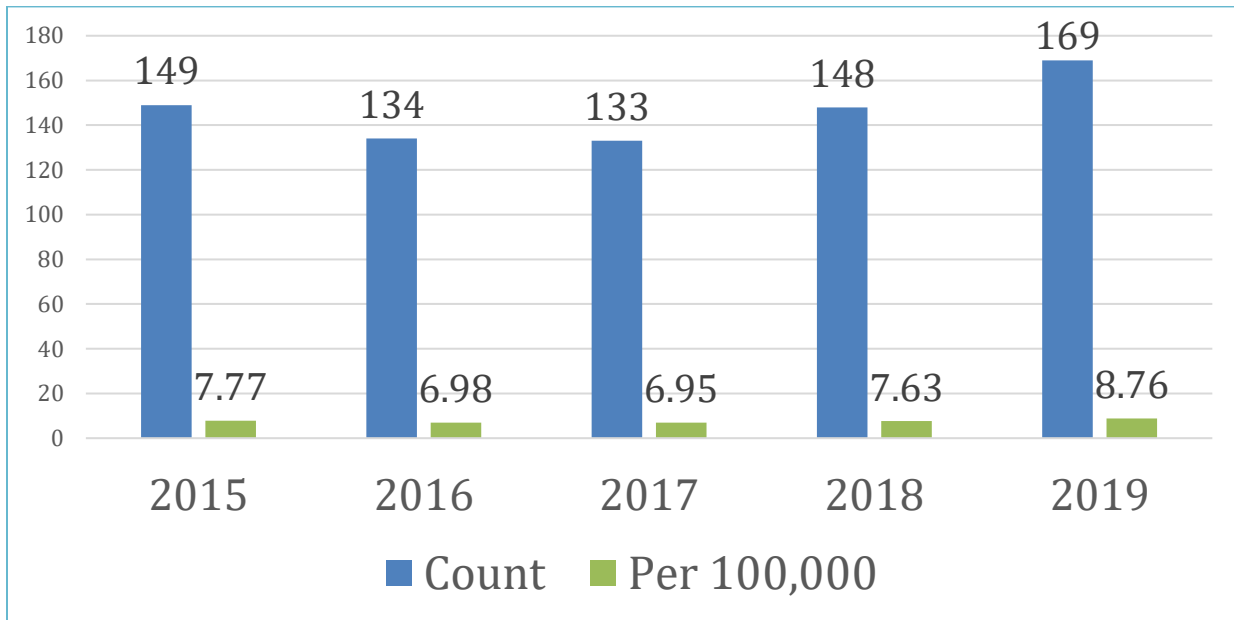
**339,937** YouTube views of the “Benjamin” suicide prevention campaign for older adults

**3,174,272** impressions of the social media campaign promoting Crisis Text Line, as a response to the COVID-19 pandemic

## SUICIDE DATA AND DISCUSSION

*Suicide deaths: After a three-year decline from 2014-17 (155 in 2014, 149 in 2015, 134 in 2016, and 133 in 2017; see Figure 1), the County's suicide count and rate increased to 148 deaths (7.6 per 100,000) in 2018. Initial analysis of 2019 suicide death data indicates that the increase continued last year, with 169 deaths (8.8 per 100,000, see Figure 1). The County's suicide rate continues to be lower than the California state suicide rate, which was 10.9 per 100,000 in 2018 and which has increased each year since 2015 (2019 state suicide data is not yet available) (Centers for Disease Control and Prevention, 2020).*

*Figure 1. 2015-2019 suicides in Santa Clara County*



**As of August 2020, a comparison of suicide death counts indicates that suicide deaths did not increase during the COVID-19 pandemic. From January to August 2019, 113 suicide deaths occurred in the County, compared with 106 deaths during the same period in 2020.** (Note that these numbers may increase for two reasons: 1. The Medical Examiner-Coroners' Office still has pending cases for 2020, and 2. This data does not include suicide deaths of County residents occurring outside of the County; this data is captured by the state.) However, the initial death counts from 2020 suggest that the increases seen in 2018 and 2019 are sustaining in 2020, regardless of the COVID-19 pandemic. The Behavioral Health

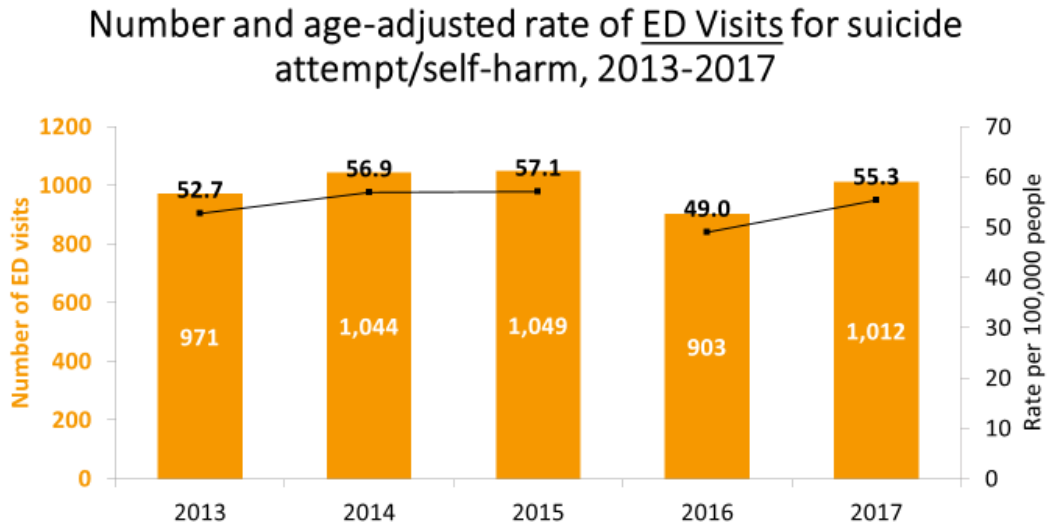
Services Department's (BHSD's) Decision Support team is in the process of analyzing the 2019 data, and the Suicide Prevention Data Workgroup is working on additional analyses to better understand the increase since 2018.

*Suicide attempts and ideation:* Between 2014-17, the County's suicide death rate saw a slight decrease. In contrast, the FY19 annual report shared that the suicide Emergency Department (ED) and hospitalization rate for attempts and ideation increased during the period of 2007-14. To better understand this increase, in FY20, the Data Workgroup conducted an in-depth review of the suicide attempt and ideation data that is available from the state's Office of Statewide Health Planning and Development (OSHPD), through the County's Public Health Department (PHD). As part of this review, the Data Workgroup examined suicide attempt and ideation data from 2014-17 (the same period as the noted decrease in deaths). **The Data Workgroup also determined what additional data and analyses could help to understand the increase during this period. These analyses can be organized around three main research questions: 1. Why did a suicide attempt occur** (e.g., from where were suicidal individuals brought to the ED; what mental and physical health diagnoses did individuals present with)? **2. What occurred during the suicidal individuals' stay in the ED** (e.g., were the length of stays appropriate; what type of care was assigned)? and **3. What occurred after the ED visit (e.g., where were individuals discharged to)?** The Data Workgroup also requested analyses of these three research questions disaggregated by cultural/demographic variables.

In January 2020, the PHD presented the initial suicide attempt data analysis to the Data Workgroup, using 2013-17 data. This analysis included counts and rates of ED visits and hospitalization rates for suicide attempts or ideation, disaggregated by the demographic variables sex, age, and race/ethnicity. **During 2014-17, the overall ED visit rate for suicide attempts stayed relatively flat (see Figure 2). The increase in ED visits was attributed to an increased number and rate of visits for suicidal ideation (see Figure 2).** Past increases in suicide attempts in the 2007-14 period may be consistent with the increase in suicide ideation rates from 2014-17. Literature has long shown that the history of a previous attempt is the strongest predictor for future suicidal behavior, including ideation (Beautrais, 2004). The increased rate may also be attributed to increased disclosure

by/identification of community members thinking about suicide, or increased reliance on the ED as a response to suicidal ideation. The Data Workgroup’s additional analysis will seek to better understand the driving factors behind the increase in ED visits for suicidal ideation.

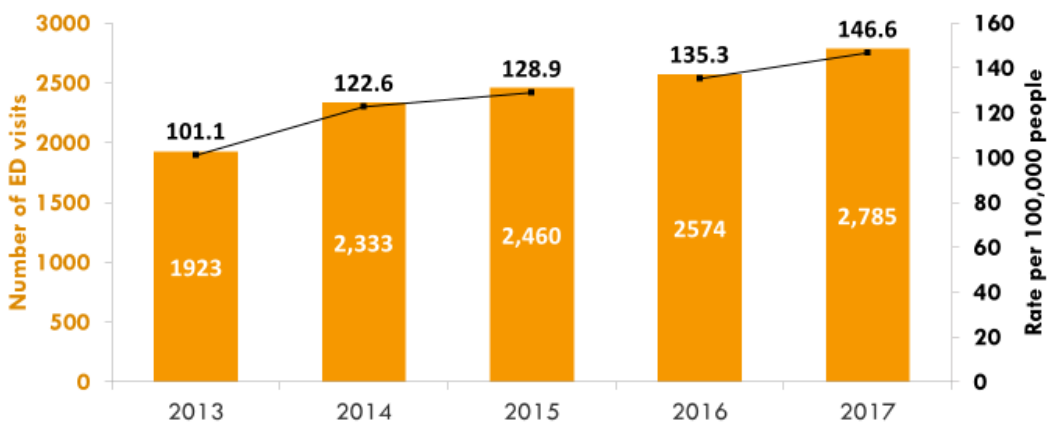
Figure 2. Emergency department visits for suicide attempt and ideation, 2013-17



Source: Office of Statewide Health Planning and Development, 2013-2017 Emergency Department Data

Note: In each graph above, the colored bars represent the number and the black line represents the age-adjusted rate per 100,000 people.

### Number and age-adjusted rate of ED Visits for suicide ideation harm, 2013-2017



Source: Office of Statewide Health Planning and Development, 2013-2017 Emergency Department Data

Note: In each graph above, the colored bars represent the number and the black line represents the age-adjusted rate per 100,000 people.

After January 2020, the PHD's work on this data analysis stopped short because of the pandemic and the PHD epidemiologists' need to focus on COVID-19 data and disaster response. Through its partners at Palo Alto University (PAU), the Data Workgroup is now developing a proposal to the Institutional Review Board (IRB) to directly obtain suicide attempt data for analysis. Importantly, ED visits and hospitalizations do not represent all suicide attempts or ideation, but are indicative of more serious self-harm incidents. The Data Workgroup will also continue to pursue additional data sources for suicide attempts and ideation.

### County populations impacted by suicide

*Sex, age, and race/ethnicity (suicides among older white men):* **Men continue to die by suicide at higher rates than women** (11.91 per 100,000 among men, compared with 3.25 per 100,000 among women, in 2018). While suicide rates among older adults decreased from 2014-2018, **seniors 75 years and up still had the highest suicide rates in 2018** (12.81 per 100,000 for 75-84 years and 13.33 per 100,000 for 85+ years), compared with other age groups. **From 2014-2018, the white/Caucasian population accounted for the largest number (445) of County suicide deaths**, followed by the Asian (127) and Hispanic/Latinx (106) populations. In 2018, the white/Caucasian population had a suicide rate of 14.52 per 100,000, which was the second-highest rate after Pacific Islanders (67.00 per 100,000).

**The most common demographic patterns seen in County suicide deaths mirror national-level suicide data.** The higher number of deaths among older white men has been attributed to a range of factors, including social norms around suicide and aging, and the suicide method used. These factors are further discussed below.

**Traditional cultural norms for masculine identity** can translate into an unwillingness to seek behavioral health services and/or treatment among men (Suicide Prevention Resource Center, 2016). One report found that the most notable cultural belief among men is the belief that it is not “manly” to seek or receive treatment for mental health issues (U.S. Department of Health and Human Services, 2012). “Cultural expectation on gender roles limit males’ options when



faced with stress, crisis or loss, thus increasing their risk for self-endangering or self-harming behaviors” (Coleman, Kaplan, & Casey, 2011). Feelings of shame from not meeting gender role expectations can exacerbate the restriction of emotional expression, vulnerability, and help-seeking behaviors (Pollack, 2006).

**Chronic medical conditions** begin developing as individuals enter their 40s and continue to increase with age (Blackwell, Lucas, & Clarke, 2014). In a study examining the association between major physical health issues and suicide, many conditions, such as back pain, sleep disorders, and traumatic brain injury, were all associated with suicide risk, with significantly increased risk in association with multiple chronic health conditions (Ahmedani et al., 2017). According to Schiff et al. (2015), “physical health conditions were one of four risk factors associated with suicides by men...who were not identified as having mental health or substance abuse problems, which provides some evidence that chronic medical conditions can contribute to suicide risk even in the absence of depression.” Research shows that helplessness and hopelessness about pain, more so chronic pain, and the desire to escape from pain are psychological processes that are crucial to understanding the relationship between suicidality and chronic pain (Tang & Crane, 2006). Of the County’s suicide decedents in 2018, 38.5% had reported physical health conditions at the time of their death, with hypertension and pain (e.g., from osteoporosis, arthritis, gout) as the most frequently reported conditions. (Only 13.5% of decedents had no known physical conditions, and 48% were unknown or not included in the death report.)

Researchers suggest that higher suicide rates among white older men in the US cannot be attributed solely to adversities associated with aging, such as poor health, poverty, depression, and isolation. The primary rationale is that older men have less exposure to these aging adversities compared with older women, as do European Americans, compared with racial/ethnic minorities. Instead, **a cultural perspective on the social meaning and permissibility of suicide has been used to help explain higher suicide rates among older white men.** Some studies have shown that European Americans believe that suicide by older adults is more permissible than suicide by younger individuals, and that suicide is more reasonable or socially acceptable when it is a response to physical illness or disability (Canetto, 2020). According to Stice and Canetto (2008), “considering

that physical illness is more common among older adults than among young adults, cultural beliefs about the logic of suicide under condition of physical illness may be particularly meaningful and powerful as a prescription for older adults.” In addition, in the US, male suicide is largely viewed as a male act, and older male suicide, in particular, tends to be described as deliberate, if not rational (Canetto, 2020). These norms around suicide contrast with beliefs and norms about aging as being undignified and unmasculine. Canetto also found that among European Americans, male suicide in response to impersonal problems, such as illness, tends to be viewed more positively than suicide as a response to interpersonal problems.

*Suicide method (men and firearms):* According to Harvard Means Matter, firearms are the most lethal and most common method of suicide in the U.S., and more people who die by suicide use a gun than all other methods combined. Among men aged 65 and older in the U.S., guns are the most common method of suicide, accounting for nearly 80% of such deaths (CDC, 2018). **In Santa Clara County, the use of a firearm as the means for suicide increases with age, with about 50% of decedents 65 years and older using firearms as the means for suicide. Firearms are also the most common means for suicide among white/Caucasian decedents in the County (used in 40% of white/Caucasian suicides, from 2014-2018), and among male decedents (used in 38% of suicides, from 2007-2016, compared to 11% of female suicides).** According to Kaplan, McFarland, and Huguet (2009), the male pattern of suicidality also includes impulsive attempts with lethal means, often while under the influence of a substance.

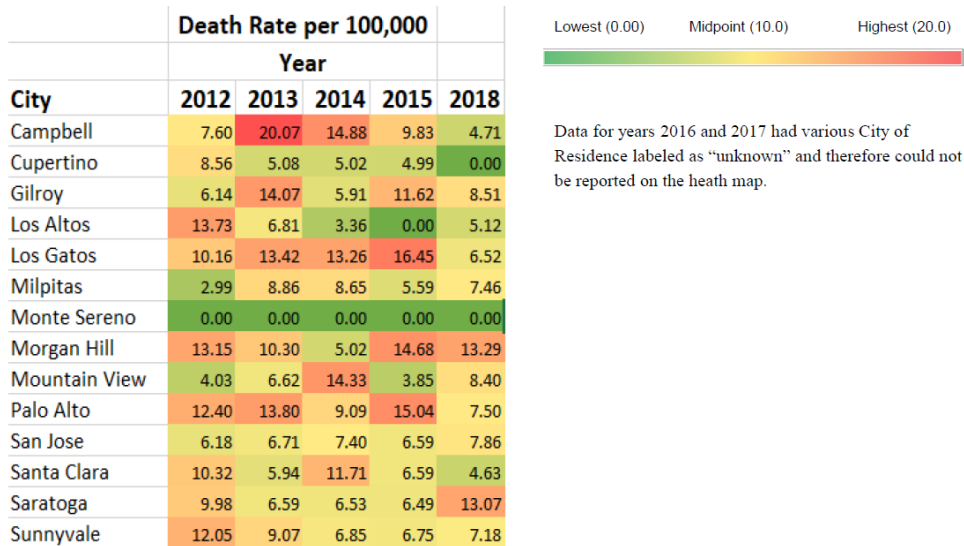
*Effect of Deaths with Dignity Statute:* **Deaths with dignity**, or physician-assisted deaths, are not classified as suicides by the Medical Examiner-Coroners’ Office and therefore are not included in the suicide death data provided.

*City of residence (suicide rate of Los Gatos):* In the period of 2007-16, the City of Los Gatos had the highest rate of suicide deaths (21.3 per 100,000) among the County’s cities (although 51% of suicide decedents in this period were from the City of San Jose). Research on the relationship between socioeconomic status and suicide is limited and has produced mixed and inconclusive results. While many studies find a higher risk for suicide among males with a lower education level and

occupations requiring lower skill levels, other studies either report the opposite effect or have not found this pattern at all (Fernquist, 1991-1994). However, **Los Gatos’s suicide death rate could be attributed to a confluence of risk factors that are associated with the County’s highest number of suicide deaths, as discussed above.** The City of Los Gatos has a majority white/Caucasian population (78.6% in 2018, according to the US Census Bureau), the highest percentage of white/Caucasian residents of cities in the County, and a relatively higher percentage of residents 65 years and older (18.8%). In addition, according to 2016 Public Health Department data, Los Gatos is among the five County cities with the highest percentage of adults reporting that they keep firearms in or around the home (23%).

While the suicide rate of Los Gatos increased from 2012-15, in 2018, the city’s suicide rate was down to 6.5 per 100,000 (see Figure 3). Suicide data by city of residence was not available for years 2016-17, but the Data Workgroup will continue to track this trend in subsequent years.

*Figure 3. Suicide rates by city of residence, 2012-15 and 2018*



Source: U.S. Census Bureau, 2014-2018 American Community Survey 5-Year Estimates  
 Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates  
 Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates  
 Source: U.S. Census Bureau, 2009-2013 5-Year American Community Survey  
 Source: U.S. Census Bureau, 2008-2012 American Community Survey

*Other cultural groups affected:* In its work, the SP Program includes an equity and culturally competent focus on suicide prevention. For example, based on high rates

of suicide among the Pacific Islander/Native Hawaiian community, despite its relatively smaller numbers in the County, in FY20, the Interventions Workgroup began exploring outreach to this community. In addition, **in August 2020, the SP Program, in partnership with Palo Alto University and the Medical Examiner-Coroner's Office, published a study in *Death Studies* journal, showing that hanging was the most common method for suicide among youth and non-white racial/ethnic groups in the County.** In FY21, the SP Program intends to embark on ligature restriction in addition to its ongoing gun safety work (see Obj. 4).

Importantly, **different populations are affected by suicide attempts, compared with suicide deaths.** More women attempt suicide than men in the County (200.9 visits per 100,000 for females, compared with 156.5 visits per 100,000 for males, in 2014), and youth ages 15-24 and African American residents have the highest rates of emergency department visits for suicide attempts and/or ideation, compared with other age and racial/ethnic groups in the County. See Obj. 3 for a description of the SP Program's school-based youth suicide prevention partnership. The program is also supporting a number of initiatives specific to the African American population, such as cultural town halls on racial equity and mental health, and a resource on suicide and Black boys.

## FY20 PROGRESS ON PROGRAM OBJECTIVES

### **Objective 1: Increase early identification and support for people thinking about suicide**

#### Community helper trainings (Strategic Plan Strategy One)

The SP Program offers eight community helper trainings in suicide prevention (see Figure 5). These trainings' main goals are to teach participants how to identify the warning signs of suicide or a mental health crisis, and how to support and refer individuals in crisis to seek professional help. **From July 2019 through June 2020, the program trained 3,670 community members and/or service providers through community helper trainings.** The year's training numbers were significantly impacted by COVID-19, as all in-person sessions were put on hold after shelter-in-place orders went into effect on March 16, 2020. The SP Program has pivoted its training offerings by providing four of the eight trainings virtually via Zoom.

As part of ongoing cultural competency efforts with Palo Alto University (PAU), during FY20, the SP Program and PAU partners continued piloting the original *Be Sensitive, Be Brave (BSBB)* culturally competent training content. These trainings include introductions to mental health and suicide prevention and are tailored to address the training needs of the County's diverse community members, as identified by the SP Program. The 11 pilot BSBB trainings hosted in FY20 solicited feedback from participants to support the refining of materials. Audiences included the general community and partners from NAMI FaithNet, Project Safety Net, and the *allcove* Youth Advisory Group. For FY21, the PAU team will transition from the piloting phase into expanding trainer bandwidth and supporting the growth of training offerings.

**In aggregate, across all trainings offered, participants reported statistically significant improvements in eight outcome measures related to knowledge, attitudes, and preparedness around being community helpers for suicide prevention** (see Figure 4). Four of the outcomes showed an average and statistically significant increase of 0.9 points (on a five-point scale) from pre- to post-training. These outcomes included the following:

- I am aware of the resources necessary to refer someone in a suicide crisis;
- I have the skills necessary to support or intervene with someone thinking about suicide; and
- I feel prepared to help people from diverse cultural backgrounds with their suicidal distress.

Figure 4. Change in community suicide prevention helper training measures, July 2019-June 2020

Variables	Pre- Training (N=1897- 2283)		Post- Training (N=1117- 1206)		t-test	Cohen's <i>d</i>	Effect size
	M	SD	M	SD			
I know the warning signs for suicide.	3.55	.88	4.38	.71	-28.06***	-.90	Large
I am able to identify someone who is at risk for making a suicide attempt.	3.36	.91	4.27	.76	-29.64***	-.94	Large
I feel prepared to discuss with someone my concern about the signs of suicidal distress they are exhibiting.	3.41	.99	4.27	.76	-25.63***	-.86	Large
I am aware of the resources necessary to refer someone in a suicide crisis.	3.34	1.00	4.34	.72	-30.88***	-.98	Large
I am confident in my ability to make a referral for someone in a suicide crisis.	3.31	1.01	4.26	.78	-28.28***	-.91	Large
I have the skills necessary to support or intervene with someone thinking about suicide.	3.18	1.01	4.17	.78	-29.75***	-.95	Large
I understand and can identify a number of ways in which culture affects how suicide is expressed and experienced.	3.29	.96	4.06	.83	-23.56***	-.78	Medium
I feel prepared to help people from diverse cultural backgrounds with their suicidal distress.	2.97	.98	3.94	.85	-28.28***	-.93	Large
Mean Score, all 8 items	3.30	.76	4.22	.65	-35.57***	-1.08	Large

**Note.** M=Mean. SD=Standard Deviation. Scores: 1=Strongly Disagree, 2=Disagree, 3=Neither disagree or agree; 4=Agree; 5=Strongly Agree. \*\*\*  $p < .001$ .

**Note re: interpretation tips:** Any t-test value that has \*\*\* next to it is showing that there is a change that is more significant than chance. For example, we see that in “1. I know the warning signs for suicide” goes from an average

of 3.55 on the pre-survey (most people chose either 3=Neither disagree or agree to 4=Agree) to a 4.38 on the post-survey (most people chose 4=Agree to 5=Strongly agree) with a significant t-test value of -28.06 (meaning the change from 3.55 to 4.38 was significant enough that it is likely NOT due to chance).

**Note re: Cohen's d:** Small effect size if  $d \geq .2$ , medium effect size if  $d \geq .5$ , large effect size if  $d \geq .8$  (meaning 1 group scored .8 standard deviations above the other group)

*Figure 5. FY20 suicide prevention and mental health helper trainings*

<b>Name</b>	<b>Description</b>	<b>Group(s) Trained in FY20</b>	<b>Number of Trainings Hosted</b>
<i>Question, Persuade, Refer (QPR)</i>	Basic helper training teaching the QPR method of asking the suicide Question, Persuading the individual to get help, and Referring the individual to local resources.	Law enforcement (CIT), college students (nursing, general education), school personnel, older adults, parks, and recreation staff	40 completed (in-person, virtual)
<i>Be Sensitive, Be Brave: Suicide Prevention</i>	Participants explore tailored content to define suicide, identify specific warning signs and how to talk about suicide with compassion to account for cultural differences.	Youth advisory group (high school students), older adult faith group, general community	5 completed (in-person, virtual)
<i>Kognito At-Risk</i>	Simulated online conversations in grade-level specific modules on how to address mental health distress with students and parents.	Elementary, middle, and high school educators and staff	10 school districts participated (1,612 staff trained)
<i>Applied Suicide Intervention Skills Training (ASIST)</i>	Two-day training involving intensive work on supporting suicidal individuals, in order for service providers like mental health professionals and nurses to better serve community members and support colleagues.	Mental health professionals, school counselors, RNs, faith leaders, hospital staff, general community members	7 completed, 3 cancelled due to COVID-19 (April-June)
<i>Suicide to Hope</i>	Training is a follow-up to ASIST and focused on supporting clients using a growth and recovery model following suicide attempts.	Mental health clinicians (school and community partners)	1 completed, 1 cancelled due to COVID-19 (May)
<i>SP201: Suicide Prevention and Clinical Management for Diverse Clientele</i>	Participants learn to assess suicide risk, safety plan, case conceptualize, and treatment plan for managing suicide risk in diverse populations.	Behavioral Health Services Department clinicians	2 completed (in-person, virtual)
<i>Youth Mental Health First Aid</i>	Training includes an overview of risk factors and warning signs for common mental health challenges and teaches a 5-step mental health action plan to help youth in both crisis and non-crisis situations.	Youth-serving community members, school staff and mental health leads,	4 completed, 2 cancelled due to COVID-19

<i>Be Sensitive, Be Brave: Mental Health</i>	Participants learn to define mental health, identify signs of mental distress and mental health resources, and how culture and diversity affect mental health.	Youth advisory group (high school students), parents, faith community, general community	6 completed (in-person, online)
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**Objective 2: Increase use of mental health services**

In FY20, the SP Program and Data Workgroup worked to improve the evaluation of this objective in a couple of ways. First, the SP Program completed the contracting process to engage an agency to evaluate annual suicide prevention public awareness campaigns. Second, the Data Workgroup partnered with the PHD on their annual Behavioral Risk Factor Surveillance Survey (BRFSS). The Data Workgroup collaborated with PHD epidemiologists to design the BRFSS Behavioral Health Module, to include questions about knowledge and use of County mental health services, as well as help-seeking behaviors for mental health and suicidality. This survey was conducted at the end of 2019, with 1,030 respondents. The PHD began to analyze the results in January 2020, but these efforts stalled due to COVID-19. The Data Workgroup confirmed with the PHD that BRFSS data could not be transferred to another organization to complete the analysis.

Community education and information (Strategic Plan Strategy Two)

In FY20, the SP Program’s Communications Workgroup planned, developed, launched, and evaluated a mass media campaign to support suicide prevention among older adults in the County. The campaign’s primary objectives for the older adult population were to improve knowledge of suicide prevention resources; to improve attitudes toward seeking help for suicide; to increase help-seeking behavior through suicide prevention resource utilization; and to increase community awareness of older adults struggling with their mental health and suicide ideation.





The campaign ran from July 9, 2019 to October 21, 2019 and was comprised of print materials and radio, digital (online), and social media advertisements. These assets promoted the County Suicide and Crisis Hotline and a campaign-specific web page, [www.scchope.org](http://www.scchope.org), designed to address the campaign objectives. The campaign’s reach data are included in the table below (see Figure 6). According to US Census Bureau estimates (2018), **116,329 male adults aged 65 and older reside in Santa Clara County.**

Figure 6. “Benjamin” older adult campaign reach and impressions

Medium (Campaign Ad Run Dates)	Metric	Campaign Website Visits Attributed
Digital (7/12 – 10/21)	4,862,357 impressions	2,628
YouTube Ad (7/17 – 9/14)	1,642,509 impressions	3,451
	339,937 full video views	
Facebook <sup>a</sup> (7/17 – 9/28)	723 individuals reached	NT
Radio (7/9 – 9/18)	792,200 individuals reached	2,884 <sup>b</sup>
Print (7/19 – 8/16)	49,500 <sup>c</sup> individuals reached	NT

a. Unpaid, organic posts from County account made 1-2 times per week during the campaign

b. Determined by the number of visits occurring within an 8-minute time window of the ad airing

c. Total weekly readership for print media in which campaign ads appeared

NT Not Tracked

To assess the impact of the campaign, calls to the Suicide and Crisis Hotline during the campaign months July, August, and September in 2019 were compared to the same months in 2018. This three-month span in 2019 showed a total increase of 268 calls to the hotline, compared to the same period in 2018. Furthermore, **the**

**share of 2019 hotline calls made by the target audience (age 55 and older) was far greater than the respective proportion in 2018.** The percentage of calls to the hotline by adults age 55 and older increased from 22.2% in July 2018 to 30.2% in July 2019; from 16.5% in August 2018 to 28.9% in August 2019; and from 19.7% in September 2018 to 30.0% in September 2019. This increase in hotline utilization indicates a strong campaign impact and increased help-seeking behavior among the target audience. **Additionally, from August 1, 2019 to September 26, 2019, the campaign website received 12,693 visits and 13,563 page views,** reflecting wide reach and receptivity to seeking help online.

In addition to public awareness campaigns, the SP Program offers two trainings: *Youth Mental Health First Aid* and *Be Sensitive, Be Brave: Mental Health* (see Figure 5), both designed to educate and reduce stigma about mental health. In FY20, the SP Program trained 157 community members and providers in these two trainings.



Community outreach in FY20 focused on reaching transitional-aged youth (16-25), middle-aged adults (45-55), and older adults (65+). Activities included tabling (photo, left), resource fairs, partnership-building with community-based organizations and colleges, and expanding the volunteer program. Due to COVID-19, several tabling events were cancelled, as well as the

second annual Santa Clara County Suicide Prevention Conference, scheduled for May 2020. The SP Program pivoted its community outreach efforts by transitioning to virtual events and outreach phone calls.

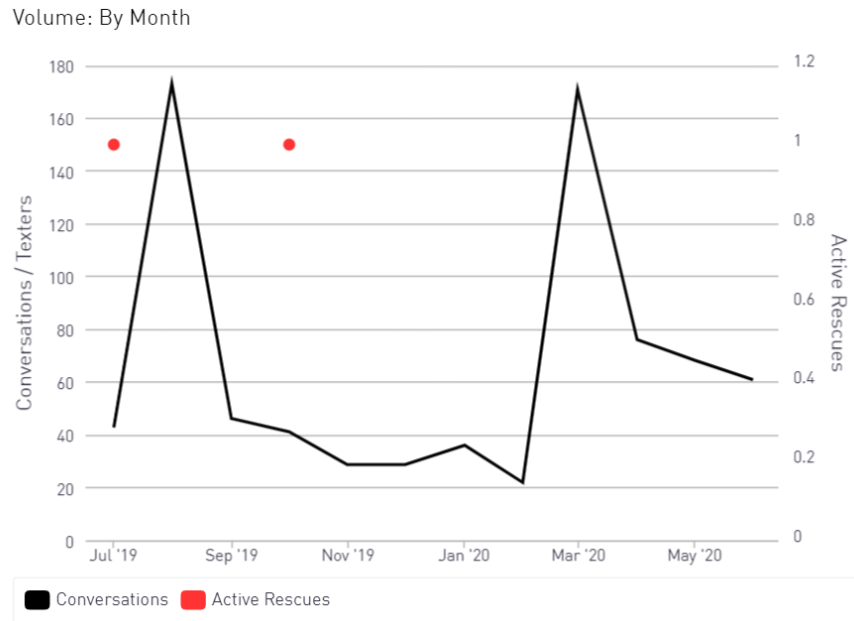
- **30 tabling events attended**
- **1,281 people reached with resources through tabling events**
- 1 mental health resource fair hosted at Eastridge Mall in September 2019, for Suicide Prevention Month
- 5 volunteers recruited and onboarded to support community outreach efforts (bringing the SP Program's volunteer base to 11 individuals)
- Outreach materials updated and translated:

- Mental health guide for immigrants brochure, (see Attachment 1)
- Handout on LGBTQ+ mental health and suicide prevention resources (see Attachment 2)
- 54 outreach phone calls made to local skilled nursing facilities, offering suicide prevention resources and trainings
- 11 virtual town halls held with different cultural communities, on the topic of mental health and COVID-19, during May’s Mental Health Awareness Month. The town halls reached at least 470 individuals live and the recordings have had more than 2,200 views on the Behavioral Health Services Department’s Facebook page. Cultural groups reached include Chinese, Korean, Nepali, Hispanic/Latinx, Vietnamese, Indian, and the LGBTQ+ and youth communities.

Suicide and crisis services (Strategic Plan Strategy One)

*Crisis Text Line (CTL):* The County BHSD partners with CTL, a free crisis intervention service via SMS message, where roughly 75% of users nationally are under age 25 (crisistrends.org). **Community members may text RENEW to the national CTL number, 741741, to access trained volunteer crisis counselors via text message (free, 24/7, anonymous). In FY20, 795 text conversations by 630 texters took place under the County’s CTL.** Large increases in CTL usage were seen in August 2019, when the shooting at the Gilroy Garlic Festival occurred (173 conversations), and in March 2020, when the COVID-19 shelter-in-place order initially took effect (171 conversations, see Figure 7). The increases in usage lowered but remained higher-than-average in April through June 2020 (76, 68, and 61 conversations, respectively).

Figure 7. FY20 volume of Crisis Text Line conversations, by month



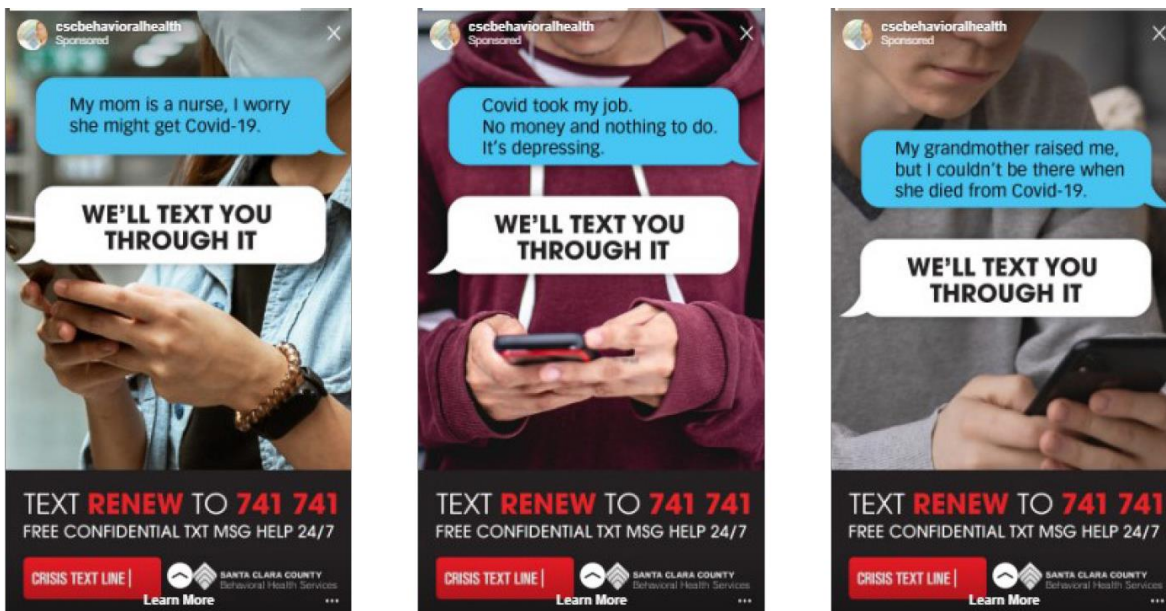
The top issues discussed on the County CTL were anxiety/stress, relationships, depression/sadness, school, and COVID-19 (see Figure 8). The CTL reaches a larger percentage of cultural minorities compared with their representation in the County. For example, in FY20, 47.4% of texters reported being of Hispanic, Latinx, or Spanish origin; 55.3% reported being LGBTQ+; and 23.8% reported having Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD). In terms of age, 32.5% of texters reported being age 17 or younger, while 47.5% reported being age 18-34.

Figure 8. Top issues discussed on County Crisis Text Line, in FY20

Issue	% of conversations	Issue	% of conversations
Anxiety/Stress	44.1%	Sexual Assault(*)	3.6%
Relationship	33.8%	Grief	3.2%
Depression/Sadness	28.0%	Bullying	2.5%
School(*)	26.0%	Abuse, physical	2.1%
COVID-19	24.7%	Social Media(*)	1.9%
Isolation/Loneliness	18.9%	Abuse, sexual	1.1%
Suicide	15.2%	Eating Body Image	0.5%
3rd Party	5.1%	Gender Sexual Identity	0.5%
Self Harm	5.1%	Deaf/Hard of hearing	0.0%

Finances(*)	5.0%	Abuse, unspecified	0.0%
Abuse, emotional	4.6%	Military(*)	0.0%
Substance Abuse	3.9%		

As a response to COVID-19 and the increase in CTL conversations, the Communications Workgroup executed a social media campaign promoting CTL. The campaign targeted County youth and young adults who had family members who were healthcare workers; who had lost relatives due to COVID-19; and/or who had suffered economic hardship. **Airing from June 12 to July 10, 2020, the social media campaign (ads, below) created 3.1 million impressions through mobile banner ads, Facebook, Instagram, Snapchat, and YouTube.**



### Suicide and Crisis Hotline (Strategic Plan Strategy One)

Run by Suicide and Crisis Services (SACS), **the Suicide and Crisis Hotline received a total of 32,451 calls from July 1, 2019-June 30, 2020 (see Figure 9).** This number represents a 29.5% increase from the 25,067 calls received in FY19. The increase is attributed to increased staffing on the hotline. The SACS team was able to recruit more volunteers to answer calls on the hotline in FY20; in addition, the state allocated funds to enhance staffing capacity in answering National Suicide Prevention Lifeline calls, which are routed through local hotlines, including Santa Clara County's.

There was no significant change in SACS call volume due to COVID-19. However, many callers expressed high levels of anxiety due to many uncertainties. Most issues and concerns shared during the calls were related to the rapid spread of COVID-19, job loss and financial losses, and relationship issues and uncertainties due to the shelter-in-place order.

Figure 9: SACS hotline call volume, FY20

<b>CRISIS CALLS</b>	<b>JUL</b>	<b>AUG</b>	<b>SEPT</b>	<b>OCT</b>	<b>NOV</b>	<b>DEC</b>	<b>JAN</b>	<b>FEB</b>	<b>MAR</b>	<b>APR</b>	<b>MAY</b>	<b>JUN</b>	<b>TOTAL</b>
<b>Suicide in Progress</b>	1	5	3	0	2	1	3	0	2	1	4	3	<b>25</b>
<b>High Risk</b>	18	14	36	20	22	21	39	15	31	16	11	21	<b>264</b>
<b>Medium Risk</b>	123	85	107	126	116	86	111	100	92	87	60	81	<b>1,174</b>
<b>Low Risk</b>	1,338	975	1,150	1,299	1,167	1,031	1,017	1,032	1,175	1,188	1,732	1,566	<b>14,670</b>
<b>NON-CRISIS CALLS</b>	<b>JUL</b>	<b>AUG</b>	<b>SEPT</b>	<b>OCT</b>	<b>NOV</b>	<b>DEC</b>	<b>JAN</b>	<b>FEB</b>	<b>MAR</b>	<b>APR</b>	<b>MAY</b>	<b>JUN</b>	<b>TOTAL</b>
<b>No Risk of Suicide but need Support</b>	1,538	1,080	1,649	1,758	1,632	958	1,412	1,377	1,260	778	1,264	1,135	<b>15,841</b>
<b>Informational (Triage, Misc)</b>	54	45	37	33	37	22	33	32	23	16	75	70	<b>477</b>
<b>Total</b>	<b>3,072</b>	<b>2,204</b>	<b>2,982</b>	<b>3,236</b>	<b>2,976</b>	<b>2,119</b>	<b>2,615</b>	<b>2,556</b>	<b>2,583</b>	<b>2,086</b>	<b>3,146</b>	<b>2,876</b>	<b>32,451</b>

<b>Definitions</b>
Suicide in Progress: Caller is engaging in suicidal behavior
High Risk: Caller has a past history of a suicide attempt, currently has suicide ideation. He/she is able to describe a plan and access to mean to killing oneself
Medium Risk: Caller has a past history of a suicide attempt. Currently not suicidal but is depressed.
Low Risk: Caller has no history suicide attempt, currently not suicidal, has a history of mental health treatment/services and needs support
No Risk of Suicide but need support: Caller has no history of suicide attempt, currently not suicidal, no history of mental health services but needs support
Informational/triage/misc: called for information and referrals to community resources

In FY20, 31 unduplicated clients participated in the Survivors of Suicide (SOS) support group, which convenes weekly in San Jose. The last SOS support group

was held on March 2, 2020 due to the COVID-19 pandemic. In addition, Suicide and Crisis Services’ (SACS’) Emergency Department (ED) Patient Support Program provides face-to-face contacts with patients who received medical treatment at the ED of Santa Clara Valley Medical Center (VMC) due to self-harm injuries/behaviors or suicide attempts. In FY20, SACS staff made initial contacts and provided follow-up services to 55 individual clients at VMC’s Emergency Department. SACS staff has not been able to see clients at VMC’s Emergency Department since Shelter-in-Place mid-March this year.

**Objective 3: Strengthen community suicide prevention and response systems**

Schools for Suicide Prevention (S4SP) partnership (Strategic Plan Strategies One, Four)

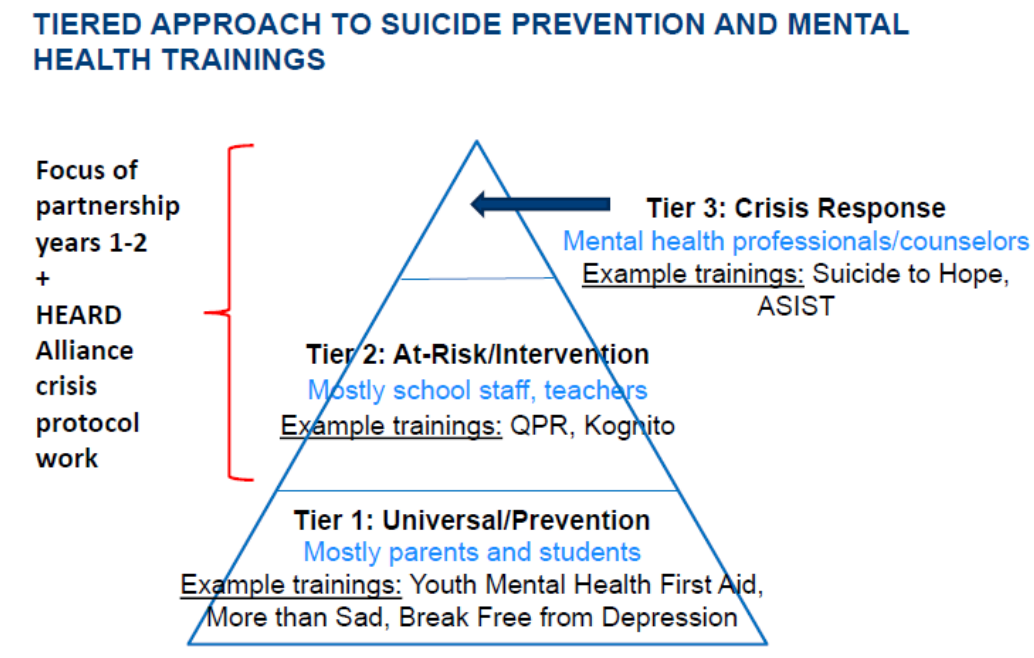
State policies AB2246 and AB1767 mandate that public schools serving grades K-12 adopt policies addressing suicide prevention, crisis response, and student mental health. The SP Program launched the first year of the school-based suicide prevention partnership in 2018 as a response to a needs assessment conducted with districts on their progress with implementing these policies. In FY20, the SP Program kicked off the second year of the partnership, named it Schools for Suicide Prevention (S4SP), and expanded district participation to include five additional districts (see Figure 10).

*Figure 10. School districts participating in S4SP partnership*

Pilot Year (2018-2019)	Year 2 (2019-2020) * new districts	
<ul style="list-style-type: none"> <li>• Alum Rock Union</li> <li>• Santa Clara Unified</li> <li>• Mountain View Whisman</li> <li>• Los Gatos-Saratoga High School District</li> <li>• Santa Clara County Office of Education (SCCOE) Alternative Education</li> <li>• Milpitas Unified</li> <li>• Morgan Hill Unified</li> </ul>	<ul style="list-style-type: none"> <li>• Santa Clara Unified</li> <li>• Mountain View Whisman</li> <li>• Los Gatos-Saratoga High School District</li> <li>• SCCOE Alternative Education</li> <li>• Milpitas Unified</li> <li>• Morgan Hill Unified</li> </ul>	<ul style="list-style-type: none"> <li>• Los Gatos Union *</li> <li>• SCCOE Special Education *</li> <li>• Sunnyvale Elementary *</li> <li>• East Side High School Union (+ Escuela Popular Charter)*</li> <li>• Palo Alto Unified *</li> </ul>

The S4SP partnership encourages school districts to follow a comprehensive, tiered approach to trainings in suicide prevention and mental health (see Figure 11), also known in the education field as Multi-Tiered Systems of Support (MTSS). This approach ensures that school personnel and mental health professionals (Tiers 2 and 3) are first trained to handle referrals of students who may be struggling with suicide, because student referrals tend to increase after students and families have received training (Tier 1, see Figure 11). As a result, the first two years of S4SP participation emphasize development among school staff of skills to identify and manage warning signs of student mental health crises.

*Figure 11. Multi-Tiered Systems of Support approach to school-based suicide prevention efforts*



The SP Program provides trainings appropriate for each tier of work. The main helper training for Tier 2 work is the Kognito online health simulation trainings, which the SP Program offers through a cost-sharing arrangement with the County Office of Education and each participating school district.





**In the 2019-20 academic year, more than 1,600 school staff were trained in online Kognito modules.** Completed simulations included the Kognito “At Risk” and “Trauma-Informed Practices” (screenshot, left) modules, which allow users to practice simulated

conversations about mental health with students and parents. **In two years of the partnership, nearly 4,000 teachers and staff have been trained in Kognito, in 12 County school districts.**

Pre-, post-, and follow-up training survey results from the *Kognito At-Risk* online training indicated statistically significant differences in respondents’ preparedness to support students with psychological distress (see Figure 12). School staff who took the training reported more preparedness and confidence to recognize signs of psychological distress, and to support the student through discussion and referral to mental health services.

*Figure 12. Mean preparedness and self-efficacy measures reported by users of Kognito At-Risk online training (for elementary, middle, high school educators)*

**Combined preparedness measures**

	Mean	Std. Deviation	F-value	Post hoc tests
Pre	3.23	.69	34.99***	All are significantly different from each other
Post	4.08	.61		
Follow Up	3.75	.71		

*Notes.* 5-point scale. Combined 5 measures. Sample measures: How would you rate your preparedness to: Recognize when a student is showing signs of psychological distress; Discuss with a student your concern about the signs of psychological distress they are exhibiting; Recommend mental health support services to a student exhibiting signs of psychological distress

**Combined self-efficacy measures**

	Mean	Std. Deviation	F-value	Post hoc tests
Pre	3.01	.59	6.99**	Pre and post are significantly different
Post	3.36	.54		
Follow Up	3.16	.44		

Notes. 4-point scale. Combined 5 measures. Sample measures: I feel confident in my ability to: Discuss my concern with a student exhibiting signs of psychological distress; Recommend mental health support services to a student exhibiting signs of psychological distress; Help a suicidal student seek help

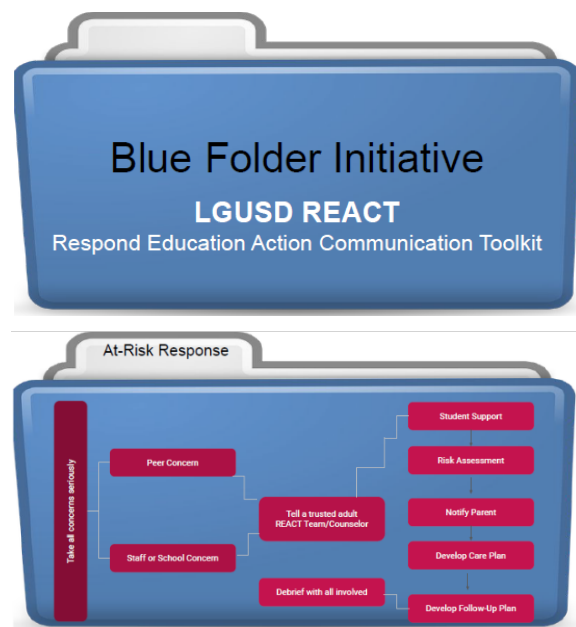
Pre-, post-, and follow-up training survey results from the *Kognito Trauma-informed* online training indicated statistically significant differences in respondents' confidence in supporting students with psychological trauma or distress (see Figure 13). School staff who took the training reported more confidence in their ability to recognize signs of psychological trauma or distress; to support the student through discussion and referral to mental health services; and to implement trauma-informed approaches in their teaching.

Figure 13. *Self-efficacy measures reported by users of Kognito Trauma-informed online training*

	Pre-Test Mean (SD)	Post-Test Mean (SD)	Follow -Up Mean (SD)	ANOVA <i>F</i> -test	Post hoc
<b><i>Self-Efficacy: I feel confident...</i></b>					
I feel confident in my ability to recognize when a student is showing signs of psychological trauma or distress	3.54 (.92)	4.03 (.69)	3.98 (.70)	16.20***	Pre is sig diff than post and follow up
I feel confident in my ability to discuss with a student my concern about the signs of psychological trauma or distress they are exhibiting	3.44 (.81)	4.00 (.71)	3.92 (.72)	21.95***	Pre is sig diff than post and follow up
I feel confident in my ability to motivate students exhibiting signs of psychological trauma or distress to seek help	3.48 (.81)	4.01 (.68)	3.88 (.77)	15.95***	Pre is sig diff than post and follow up
I feel confident in my ability to use communication strategies to help a student exhibiting signs of psychological trauma or distress feel safe	3.51 (.78)	4.00 (.69)	3.86 (.73)	14.70***	Pre is sig diff than post and follow up
I feel confident in my ability to teach students activities to manage their stress and emotions	3.43 (.91)	3.81 (.79)	3.72 (.81)	7.85**	Pre is sig diff than post and follow up

I feel confident in my ability to implement trauma informed approaches in teaching	3.23 (.89)	3.83 (.79)	3.55 (.83)	17.48***	All sig diff
<b>Composite Self-Efficacy</b>	<b>3.44 (.74)</b>	<b>3.95 (.65)</b>	<b>3.82 (.68)</b>	<b>24.25***</b>	<b>Pre is sig diff than post and follow up</b>

Note. Items were on a 4-point scale. \*  $p < .05$ , \*\*  $p < .01$  \*\*\*  $p < .001$  Post hoc tests were conducted with a Bonferroni adjustment. N=64-65



As a result of its work with the HEARD Alliance under the S4SP partnership, Los Gatos Union School District developed the “Blue Folder Initiative,” a quick-reference compendium of mental health protocols and resources for district staff.

While rolling out a variety of mental health trainings, districts also focus on aligning suicide and crisis response forms and protocols, with technical support from Stanford University’s [HEARD Alliance](#). Districts must complete this crisis response work before moving on to Tier 1 prevention measures, and crisis response work may require more than one school year to fulfill. In FY20, ongoing assistance from the HEARD Alliance included reviewing existing protocols and procedures, advising on the formation of crisis response teams at each school site, and piloting parent education on mental health and suicide prevention. **In FY20, the HEARD Alliance team completed more than 30 consultations with administrators and staff from all 11**

**participating districts.** District progress on the partnership goals is summarized below (see Figure 14).

Figure 14. School district progress on S4SP goals/tasks

District goals/tasks, Year 1 of partnership Intervention: Establish a crisis response system	Number of districts completed or status
<input type="checkbox"/> Train all teachers and staff in the Kognito “At Risk” module	3 of 5 new districts; extension provided for 1 district
<input type="checkbox"/> Identify and put together Crisis Response Teams (CRT)	9 of 11 districts

<input type="checkbox"/> Send CRT members/mental health staff to ASIST	Ongoing participation by district staff and administrators
<input type="checkbox"/> Review crisis response protocol forms against K-12 Toolkit forms	10 of 11 districts
<input type="checkbox"/> Revise/adapt/develop crisis response protocol forms	9 of 11
<input type="checkbox"/> Train CRT members and all mental health staff in crisis response protocol forms	5 of 11 districts; others in progress
<input type="checkbox"/> Begin using updated protocol forms in live situations with students	4 of 11 districts; others pending protocol training in FY21
<b>District goals/tasks, Year 2 of partnership Mental Health Promotion: Integrate upstream and/or Tier 1 (parent/student) trainings</b>	<b>Number of districts completed or status</b>
<input type="checkbox"/> Train any new teachers and staff in Kognito “At Risk”	5 of 6 continuing districts
<input type="checkbox"/> Ensure Year 1 tasks are completed and any new mental health staff are trained in new protocol forms	5 of 6 continuing districts engaged with rollover work from Year 1 tasks
<input type="checkbox"/> Train all teachers/staff in upstream Kognito training (e.g., Trauma-Informed Practices)	5 of 6 continuing districts
<input type="checkbox"/> Integrate student Kognito training (e.g., Friend 2 Friend)	Extension provided for 2 districts
<input type="checkbox"/> Develop/introduce parent education series in mental health and suicide prevention (e.g., BSBB Mental Health, Youth Mental Health First Aid, workshops, panels)	1 district

**The SP Program’s conference abstract proposal titled “Preventing Youth Suicides: A multi-sector school-based partnership” was accepted for a workshop at the American Association of Suicidology’s 2020 Annual Conference in Portland, OR.** Due to COVID-19, the conference presentation took place virtually to more than 60 participants in April 2020. The presentation highlighted steps to developing the S4SP partnership and tips to support the advancement of public/private partnerships to address youth suicide prevention.

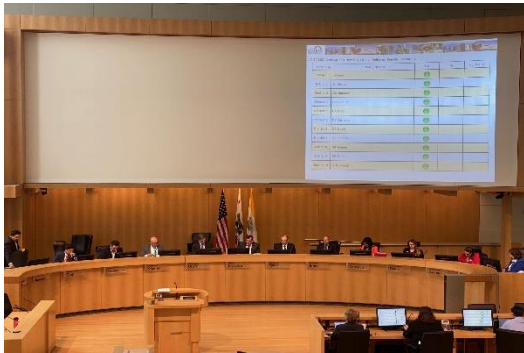
Engaging with health systems (Strategic Plan Strategy One)

Conducted in FY19, a process evaluation of the SP Program included a recommendation to expand the SP Program’s work “downstream” to include an additional focus on clinical interventions for suicide. Health care and behavioral health systems play an important role in suicide prevention, both in terms of identifying and treating individuals at risk. Older adults, in particular, may not have mental health providers but are likely to be seeing doctors for physical health conditions on a regular basis. Among older adults who die by suicide, approximately 77% see a primary care provider within their last year of life, and 58% do so within their last month of life (Luoma, Martin & Pearson, 2002).

Furthermore, The Joint Commission adopted a National Patient Safety Goal on Suicide Prevention in Healthcare Settings, effective July 1, 2019.

In FY20, the SP Program began to engage with the Santa Clara County Health and Hospital System on suicide prevention efforts. **In partnership with PAU, the SP Program piloted the clinical training, “Suicide Prevention 201: Advancing Suicide Prevention and Clinical Management for Diverse Clientele” with 98 BHSD clinicians and managers.** In addition, the SP Program took initial meetings with primary care staff at Valley Medical Center (VMC) to discuss the best ways to engage with VMC clinics on suicide prevention efforts.

#### City-level collaborations (Strategic Plan Strategy Four)



*San Jose:* In FY19-20, the SP Policy Workgroup continued to advocate for the passage of a suicide prevention policy by the City of San Jose. City Council unanimously passed the policy on March 3, 2020 (photo, left). The policy was intended to resemble a similar policy from the City of Palo Alto, as well as the County's Suicide Prevention

Strategic Plan. Under the new policy, the City of San Jose will:

- inform its current and former employees of prevention and identification methods;
- ensure that public safety response protocols to suicide attempts on City facilities are updated;
- collaborate with the County of Santa Clara to promote suicide awareness and prevention events and resources; and
- coordinate with outside agencies to increase awareness of and reduce deaths by suicide.

San Jose joins six other cities in the County—Morgan Hill, Sunnyvale, Milpitas, Palo Alto, Mountain View, and Los Gatos—that have adopted suicide prevention policies, all with the support of the SP Policy Workgroup.

*Milpitas:* Following the passage of a city suicide prevention policy in 2018, the city of Milpitas established a suicide prevention task force called HOPE (Helping Others Process Emotions) and began offering suicide prevention trainings for Milpitas city staff and residents. The task force, which meets monthly, includes Milpitas community members, local faith community leaders, the Milpitas Vice Mayor, various city officials, and representatives from Milpitas Unified School District, National Alliance on Mental Illness (NAMI), Counseling and Support Services for Youth (CASSY), Kaiser Permanente, and Child Advocates of Silicon Valley, as well as a Coordinator from the SP Program. In the reporting period, the task force expanded its suicide prevention efforts through increased community outreach and event promotion, in addition to its continued offering of suicide prevention gatekeeper trainings.

The task force's FY20 accomplishments are as follows:

- Established task force goals to guide concrete prevention efforts;
- Held gatekeeper trainings for the local Milpitas community;
- Created a tentative marketing plan to effectively target quarterly prevention work to specific city populations based on suicide death data;
- Reviewed suicide data and selected target populations for the work: Populations chosen were veterans and first responders, teens and young adults, seniors and those bereaved by suicide, and LGBTQ+ and cultural minorities;
- Proposed specific activities in each quarter to address each respective population selected, and drafted marketing language to promote prevention activities for each quarter;
- Established and sustained strong social media presence through promoting its prevention efforts along with other County efforts;
- Evaluated Milpitas city protocols on communication with family and next-of-kin of suicide decedent in order to better support those affected by a suicide death;
- Engaged with County partners to find new task force members, particularly from the LGBTQ+ community, to ensure cultural competency in its work.

*Palo Alto:* The SP Program supports and collaborates with Project Safety Net (PSN) on youth suicide prevention efforts in Palo Alto. The SP Program

participates on PSN's Leadership Team, and PSN's Executive Director participates on the County's Suicide Prevention Oversight Committee. In FY20, the SP Program collaborated with PSN and Palo Alto partners on outreach and helper trainings.

*South County:* The South County Suicide Prevention Workgroup formed in September 2017 in response to the EpiAid report on youth suicides, which found that Morgan Hill had the second-highest rate of youth suicides in the County. In FY20, the workgroup was co-chaired by the Suicide Prevention Manager and Morgan Hill Police Chief (MHPD) (*until April 2020*). The departure of MHPD Chief Swing led to a transition in roles within the workgroup. His replacement is Community Solutions Division Director Marianne Marafino, with continued co-chairing support from the Suicide Prevention Manager and Coordinator.

Examples of the workgroup's FY20 accomplishments follow:

- Held **gatekeeper trainings** for youth-serving organizations in South County (e.g., Community Solutions, Morgan Hill Unified, Morgan Hill Community Services);
- Continued **improvements to mental health continuum of care for youth:** Supported Morgan Hill Unified in strengthening suicide crisis response system through Kognito/HEARD Alliance partnership;
- **Gathered and reviewed multiple sources of data** to identify risk and protective factors for suicide and guide workgroup's strategies (e.g., EpiAid, Project Cornerstone Developmental Assets, 5150 trend reports from Community Solutions and Morgan Hill PD);
- To address Coroner data identifying middle-aged men as a high-risk population, a subgroup was formed to engage the faith community as the entry point for mental health conversations. With the goal of promoting mental health discussions and stigma reduction, the **faith subgroup created talking points to support interfaith leaders**. Representation in the subgroup included members from County Suicide Prevention, Morgan Hill Police Department, Community Solutions, NAMI Faithnet, Morgan Hill Bible, and West Hills Community Church;
- Morgan Hill and Gilroy Police Departments met with law enforcement liaisons and Mobile Crisis Response Team manager(s) to discuss **aligning**

**protocols when seeking support during mental health crises** and opportunities to test how this strategy looks during a call;

- In response to shelter-in-place, the workgroup pivoted from a review of all local services and developed a time-sensitive **COVID-19 Resources and Services one-pager**.

#### **Objective 4: Reduce access to lethal means**

##### Gun safety (Strategic Plan Strategies Two, Four)

Firearms are the second most used means for suicide in the County and the most lethal means overall. The SP Program participates in the County's Gun Safety and Violence Prevention (GSVP) team, which is a workgroup of the Public Health Department's (PHD's) PEACE Partnership for violence prevention and community safety in East San Jose. Other GSVP participating agencies include the District Attorney's Office, PHD, and the City of San Jose.

The GSVP team stopped meeting in early 2020 as the PEACE Partnership and PHD focused its work entirely on the COVID-19 pandemic. In the first half of FY20, the SP Program supported gun safety efforts in the following ways:

- Gave out gun safety brochure at outreach events and trainings;
- Incorporated information about the Gun Violence Restraining Order at community suicide prevention trainings;
- With the GSVP team, distributed approximately 500 suicide prevention outreach materials and free gun locks at two gun buyback events in Gilroy (December 2019) and in Sunnyvale (February 2019);
- With the Communications Workgroup, designed focus groups with gun owners to gather information to develop a gun safety/safe storage public awareness campaign in FY21.

##### Ligature restriction (Strategic Plan Strategy One)

Since 2018, hanging has exceeded firearms as the most common method of suicide in the County, representing 38.5% of suicides in 2018 and 29.6% in 2019. Hanging is also the most common method for suicide among youth and non-white racial/ethnic minorities in the County. The SP Data Workgroup and Oversight



Committee’s recommendations from the 2018 data report include adding a focus on ligature restriction, which is an area of suicide prevention that is not well-researched or understood, particularly with regard to community interventions. The SP Program will embark on this effort in FY21.

### **Objective 5: Improve messaging about suicide in the media (Strategic Plan Strategy 3)**



The volume and content of media coverage on suicides can influence suicidal behavior, depending on how well the media adheres to safe messaging guidelines for reporting on suicide. These guidelines were created by national suicide prevention and media groups to help inform

reporters on how to safely report on suicide. The SP Communications Workgroup takes on a range of efforts to monitor and improve safe messaging in the media, described in the below sections.

To evaluate the progress of these efforts, since 2018, the SP Program has been developing a safe messaging assessment tool that rates articles and publications on their adherence to the safe messaging guidelines. In 2018, the SP Program used the assessment tool to conduct a baseline media analysis study, which evaluated how well local and national media adhered to the safe messaging guidelines in the wake of two high-profile celebrity suicides. In FY20, the SP Program formed a partnership with Stanford University’s Center for Youth Mental Health and Wellbeing and Palo Alto University to revise and strengthen the safe messaging assessment tool, as well as publish the tool and disseminate it in various formats with the media and suicide prevention fields. The results of this collaboration will allow for more targeted work with the media by the Communications Workgroup; drive more accurate evaluation of the SP Program’s work with the media; and

allow other media and suicide prevention professionals to clearly assess the media and evaluate their own efforts with safe messaging.

### News media monitoring and response

In 2019, the SP Program continued to systematically track and respond to local media coverage on suicide, working with the Communications Workgroup as a Media Response Team. **Through weekly monitoring of the media, in FY20, the SP Program reviewed 90 local articles on suicide and responded to reporters**

HOME > STANFORD > Stanford says employee who killed himself hadn't been fired

### **Stanford says employee who killed himself hadn't been fired**

© December 9, 2019 7:00 am

**of 17 of these articles**, either reminding them about the safe messaging guidelines (example, left) or thanking them for following the guidelines.

### Media education and relationship-building

The SP Program works directly with the media by providing trainings and education about safe messaging, and by providing safe content on suicide prevention through interviews and press releases about the program's work. **In the reporting period, Communications Workgroup members conducted interviews and/or provided information about mental health or suicide prevention for 18 local media stories.**

In 2019, the SP Program's Communications Workgroup opted to begin making presentations to individual newsrooms about safe messaging, instead of holding annual trainings, which were a larger investment and traditionally not well-attended by media staff. In FY20, as a result of the City of San Jose's passage of a suicide prevention policy, a safe messaging meeting/training was arranged with San Jose City Public Information Officers. The meeting was postponed due to the onset of the COVID-19 pandemic. Discussions to virtually conduct this meeting began again in FY21.

## CONCLUSION AND RECOMMENDATIONS

During the reporting period, the SP Program grew in the six strategic areas that were proposed in the 2017 and 2018 annual reports. The six areas are listed below, along with recommendations/goals to progress further in each of the areas in FY21.

- a) **Grow and strengthen the program to be able to better and more comprehensively serve the population across the lifespan.**
  - Deepen efforts with older adults, for example, by working with primary care providers and faith-based organizations.
  - In response to rising rates, explore ways to engage with middle-aged adults in suicide prevention.
  
- b) **Continue to support efforts to strengthen services and the continuum of care as related to suicide.**
  - Increase the number of clinicians trained to provide grief support following suicide loss.
  - Engage with clinicians in suicide prevention through trainings and consultations, particularly within the County's Health System.
  
- c) **Increase primary prevention efforts by incorporating upstream, public health strategies that focus on building resilience factors and on improving environmental factors.**
  - Build upon the school-based suicide prevention partnership by engaging with school districts on implementing social-emotional learning.
  - Add promoting social connectedness as an outcome objective (plus related activities) in the SP Program's logic model.
  - Explore ligature means restriction for hangings, which are the top means used for suicide in the County.
  
- d) **Focus on sustainability of efforts, namely through capacity-building for SP.**
  - Continue building the SP Program volunteer base and stakeholder participation in Workgroups in order to increase community participation in suicide prevention.

- Continue and expand online training and training-of-trainer efforts.
  - Support cities in implementing suicide prevention efforts, particularly once cities have passed suicide prevention policies.
- e) **Ensure all SP efforts are culturally competent** in order to better serve the diverse communities in the County.
- Continue incorporating cultural competency concepts into trainings, communications campaigns, and research/evaluation.
  - Respond to cultural data analyses and engage with cultural populations that are inequitably affected by suicide, e.g., Black boys and the LGBTQ+ community.
- f) **Move towards regular/continuous program monitoring and improvement** by increasing and streamlining evaluation of program activities, and by building a data and evaluation system for suicide data and SP efforts in the County.
- Incorporate consistent evaluation measures for activities under all program objectives, with a focus on outcome measures.
  - Increase gathering of evaluation data in all SP Program efforts.
  - Continue working with the Data Workgroup to identify and advocate for further data collection and analysis to inform suicide prevention efforts.

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**Kathy Forward**  
National Alliance on Mental Illness

**Chris Miller**  
Interventions Workgroup Co-Chair  
(from April 2020)

**Paul Muller**  
Data Workgroup Co-Chair

***BHSD Administrative Oversight***

Director: Toni Tullys, MPA (until April 2020)

Director: Sherri Terao, Ed.D. (from May 2020)

Director, Alcohol, Drug, and Access Services: Bruce Copley, MA  
Mental Health Services Act Senior Manager: Evelyn Castillo Tirumalai, MPH

***Suicide Prevention (SP) Program Staff***

Manager: Mego Lien, MPH, MIA

Coordinators: Jasmine Lopez, MA; John Donoghue, MPH

Community Outreach Specialist: Evelyn Quintanilla

Associate: Claudia Espino Romero

***Suicide and Crisis Services (SACS) Staff***

Manager: Lan Nguyen, MA

Volunteer Supervisor: Eddie Subega, LMFT

**Thank You**

**Santa Clara County Board of Supervisors**

**Members of the Data Workgroup**

**Members of the Interventions Workgroup**

**Members of the Communications Workgroup**

**Members of the South County Suicide Prevention Workgroup**

**SACS and SP Volunteers**


# ATTACHMENTS

## Attachment 1. Mental health for immigrants brochure (Vietnamese)

### Quý vị có đang lo lắng cho người thân quen có thể đang bị khủng hoảng tâm trí không?

Hãy làm những điều sau đây:

- 1 Nói chuyện riêng với họ và cho biết vì sao quý vị lo lắng. Đặt những câu hỏi có tính gợi mở để câu trả lời không thể chỉ là "có" hoặc "không". Sau đó hãy chú ý lắng nghe.
- 2 Đề nghị giúp đỡ và mở thêm hy vọng hồi phục. Cho họ biết là việc chống chọi với bệnh tâm trí cũng rất phổ biến và hiện có nhiều nguồn giúp đỡ.
- 3 Chia sẻ các nguồn hỗ trợ. Cho biết các thông tin về những nơi có thể trợ giúp.
- 4 Tiếp tục theo dõi. Hỏi xem họ muốn được giúp như thế nào và làm theo gợi ý của họ.



### Các nguồn giúp đỡ cho người nhập cư

- Soạn thảo một kế hoạch khẩn cấp phòng khi có người thân bị trục xuất.
- Chia sẻ kế hoạch này với thân nhân đang sống trong nước.
- Các tổ chức và những người có thể giúp đỡ về y tế, pháp lý và các nhà thờ (bác sĩ, luật sư và cha xứ.)





Văn Phòng Liên Lạc Giúp Đỡ Người Di Dân  
Có các nguồn giúp đỡ cho người nhập cư.  
<http://bit.ly/iknowyourrights>

Mạng Lưới Phản Ứng Nhanh  
**408-290-1144**  
Để được giúp đỡ lập tức nếu nhân viên di trú ICE đến nhà, nơi làm việc hoặc quanh khu vực đang cư trú, hoặc để báo cáo một cuộc truy quét.

Luật sư các tổ chức bất vụ lợi giúp đỡ pháp lý cho người nhập cư  
<http://bit.ly/Legalservices>

Để tìm người bị ICE bắt giữ qua mạng  
<https://locator.ice.gov/odls/#/index>

## HƯỚNG DẪN VỀ SỨC KHỎE TÂM TRÍ CHO NGƯỜI NHẬP CƯ



## Attachment 2. LGBTQ+ resource (English and Spanish)

### Wellbeing & Suicide Prevention Resources for the LGBTQ+ Community

**Get Services**

**The Q Corner**  
Offers peer services to support LGBTQ+ community members and allies to access resources, referrals, social and community building activities, mentoring, and training.  
(408) 977-8800, TheQCorner@hhs.sccgov.org  
sccbhsd.org/theQCorner  
1075 E. Santa Clara Street, San Jose  
Serves: All ages

**LGBTQ Wellness**  
Supports the mental health of LGBTQ community members and allies by providing outreach, education and advocacy services.  
(408) 841-4300  
452 S. 1st Street, San Jose  
lgbtqwll.org  
Serves: Adults

**The LGBTQ Youth Space**  
A community drop-in center and mental health program for LGBTQ+ and ally youth and young adults who live in Santa Clara County.  
(408) 343-7940  
452 S. 1st Street, San Jose  
youthspace.org  
Serves: Ages 13-25

**Bill Wilson Center LGBTQ Connections**  
Provides a safe drop in space, support groups, and services to connect to housing, education, and mental health resources.  
(408) 925-0233  
693 S. 2nd Street, San Jose  
billwilsoncenter.org/services/all/lgbtq-outreach.html  
Serves: Ages 18-25

**Outlet, Adolescent Counseling Services**  
Outlet empowers LGBTQ+ youth through support services, leadership training, community education and advocacy.  
(650) 424-0852 x107  
590 W. El Camino Real, Mountain View  
acs-teens.org/what-we-do/outlet/  
Serves: Ages 13-18

**Billy DeFrank LGBTQ+ Community Center**  
Provides community, leadership, advocacy, services and support to the Silicon Valley's LGBTQ People and their Allies.  
(408) 293-3040  
938 The Alameda, San Jose  
defrankcenter.org  
Serves: Adults

**Avenidas LGBTQ Seniors Initiative**  
New programs and services in the areas of Socialization and Health Education/ Cultural Competency through strategic partnerships with LGBTQ organizations.  
(650) 289-5417, tkingery@avenidas.org  
avenidas.org/programs/lgbtq-seniors-initiative/  
Serves: Older adults

**Social Services Agency: Department of Family and Children's Services**  
LGBTQ Social Worker who provides support, advocacy, education, and resources related to LGBTQ youth involved in the child welfare system.  
(408) 501-6889, lgbtq@ssa.sccgov.org  
Serves: Students and families

**Sexual and Gender Identities Clinic – The Gronowski Center**  
Affordable and affirming psychological services for individuals who identify as LGBTQ as well as those questioning their sexual orientation or gender identity.  
(650) 961-9300  
5150 El Camino Real, Building C, Suite 15, Los Altos  
palcoaltou.edu/gronowski-center/sexual-gender-identities-clinic  
Serves: Youth and adults

**Talk to Someone**

**Crisis Text Line**  
Crisis Text Line is free, 24/7 support for those in crisis. Text from anywhere in the US to access a trained Crisis Counselor.  
Text LGBTQ to 741741  
Serves: Youth & Adults

**SAGE National LGBT Elder Hotline**  
The SAGE LGBT Elder Hotline is available 24 hours a day, 7 days a week, in English and Spanish, with translation in 180 languages.  
(877) 360-LGBT (5428)  
Serves: Older Adults

 COUNTY OF SANTA CLARA  
Behavioral Health Services  
Supporting Wellness and Recovery

### Recursos para la Prevención del Suicidio en la Comunidad LGBTQ+

**Para Obtener Servicios**

**“Gaylesta”, La Asociación de Psicoterapeutas para la Diversidad Sexual y de Género**  
Servicio de referencia con proveedores de una amplia gama de capacitación y experiencia especializados en la comunidad LGBT.  
gaylesta.org  
Para: Todos

**“Outlet”, Servicios de Consejería para Adolescentes**  
“Outlet” empodera al LGBTQ+ a través de servicios de apoyo, capacitación sobre liderazgo, educación comunitaria e intercesión.  
(650) 424-0852, extensión 105  
590 W. El Camino Real,  
Mountain View  
projectoutlet.org  
Para: edades de 13 a 18 años

**LGBTQ Youth Space (Espacio Juvenil LGBTQ)**  
“Youth Space” es un centro comunitario y programa de salud mental para LGBTQ+ y aliados de jóvenes y adultos jóvenes que vivan en el condado de Santa Clara.  
(408) 343-7940  
452 S. 1st Street, San Jose  
youthspace.org  
Para: edades de 13 a 25 años

**Centro Comunitario “Billy DeFrank” para Lesbianas y Gays**  
Brinda una comunidad, liderazgo, intercesión, servicios y apoyo a

**Bienestar LGBTQ**  
Apoya la salud mental de los miembros y aliados de la comunidad LGBTQ al proporcionar servicios de divulgación, educación e intercesión.  
(408) 343-7944  
452 S. 1st Street, San Jose  
lgbtqwll.org  
Para: Adultos

**Para Obtener Más información**

**Recursos LGBTQ**  
Acceso a una lista de recursos compilados por los Servicios de Salud Mental del Condado de Santa Clara.  
sccbhsd.org/lgbtq  
Para: Jóvenes y Adultos

**“It Gets Better” (Todo Mejora)**  
El Proyecto “It Gets Better” es una campaña que comparte historias para mostrar a las personas jóvenes LGBT, la felicidad y el potencial que sus vidas pueden alcanzar.  
itgetsbetter.org  
Para: Adolescentes

**Centro Nacional de Ayuda LGBT**  
Sirviendo al LGBTQ al brindar apoyo local gratuito y confidencial, así como recursos locales.  
LCBThotline.org  
Para: Jóvenes y Adultos

**Centro Nacional de Recursos sobre el**



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