COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

2020-21 Suicide Prevention Annual Report
Reporting Period: July 2020-June 2021

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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 21: July 1, 2020 to June 30, 2021.

FY21 SUICIDE PREVENTION HIGHLIGHTS BY NUMBERS	
11	school districts* participated in the Schools for Suicide Prevention partnership
473	conversations with 297 texters* took place over the County Crisis Text Line
751	school staff, health care providers, and behavioral health clinicians received technical support consultations in suicide prevention and crisis response
10,073	people trained to be community helpers for suicide prevention and mental health
38,324	calls received by the Suicide and Crisis Services hotline
50,540	unique visitors* to suicide prevention resource webpages
21,461,435	impressions of 2 suicide prevention public awareness campaigns* for English-, Spanish-, and Vietnamese-speaking adults in Santa Clara County

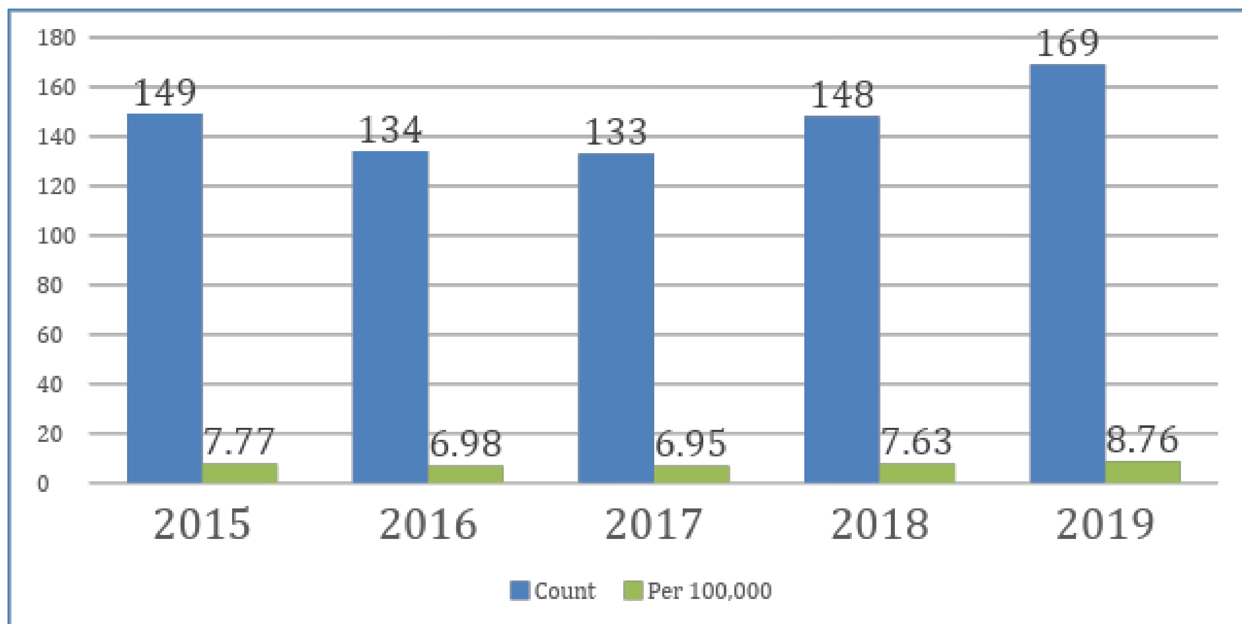
* unduplicated numbers

SUICIDE DATA AND PREVENTION PROGRAM EVALUATION

Suicide Death Data

After a three-year decline from 2014-17, the County's suicide count and rate increased to 148 deaths (7.6 per 100,000) in 2018 and 169 deaths (8.8 per 100,000) in 2019. The 2019 count and rate represent a 10-year high for the County. Initial 2020 data analysis indicates a count of 164 suicide deaths (census data not yet available to calculate 2020 rates; see Figure 1). This data shows that suicides in the County did not increase during the first year of the COVID-19 pandemic; however, suicides had already increased in the year prior. The County's suicide rate continues to be lower than the California state age-adjusted suicide rate, which was 10.7 per 100,000 in 2019 (2020 state suicide data is not yet available) (Centers for Disease Control and Prevention, 2021).

Figure 1. 2015-2019 Suicides in Santa Clara County



Demographic Trends and Risk Factors

Beginning with 2019 data, the Suicide Prevention (SP) Program and Data Workgroup initiated deeper analysis of County suicide death data in an attempt to understand more of the driving factors behind the increase in suicides. In addition to examining demographic characteristics of suicide decedents, the data team coded and analyzed historical and precipitating stressors associated with suicides

and looked into the types of substances used in overdose suicides, which also increased in 2019. Figure 2 summarizes the 2019 data observations, related programmatic recommendations made by the Data Workgroup, and status of implementation. Increases in suicides were noted overall and among both females and males; in older adults (ages 65+) and young adults (ages 25-34); in the Asian and Black/African-American communities; and by drugging/poisoning as the method. The analysis of historical and precipitating stressors indicated that following mental and physical health, the most common types of stressors associated with suicides were relationship-related (especially intimate partner conflicts) and job-related.

Figure 2. 2019 Suicide Data Observations and Recommendations

	Data Observations	**Programmatic Recommendations**	**Status/Responsible Parties**
Overall	10-year high in suicide count (169) and rate, sustained in 2020 (164 count).	Conduct deeper data analysis with 2019 data, e.g. sub-analysis of stressors and overdose suicides. No apparent effect of COVID-19 on suicide deaths in 2020.	Done
Gender	Second consecutive year with increase in rate among **females**. Slight continued increase in **males**.	Watch **female suicide rate** and provide programmatic recommendations if increase continues for a third year in 2020. Support county efforts to gather and analyze **SOGI data** on suicide deaths (e.g. ME-C, Trans Care Coalition).	In progress In progress
Age	**Count** highest in 25-64 age groups. **Rates** generally increase by age. Increases in **85+, 65-74, and 25-34** age groups. Second consecutive year of decrease in **15-24 rate**. Lowest rate among **10-14** group, but increased almost 2x from 2018.	Continue **older adult** as well as **school-based/youth** prevention efforts. Expand prevention efforts to **young adults**.	School-based partnership, Communications Workgroup, Interventions Workgroup
Race/ ethnicity	Highest count consistently among **white** population, with highest count among 45-64 age group and steady rate increase by age. Highest rate consistently among **Pacific Islander** population, though 2019 rate is back down to 2015 level. Highest counts	Continue efforts to set and implement prevention programs among **white population**, especially middle- to older-age Continue targeted outreach efforts with **Pacific Islanders**, particularly among TAY/young adults and older adults. Increase targeted efforts with **Asian** communities, particularly among TAY/young adults and older adults.	Communications/ Interventions Workgroups Interventions Workgroup In progress In progress

	among 15-34 (7); highest rates among 15-34 and 55-84. **<u>Asian</u>** count (43) and rate (6.1 per 100,000) near-doubled from 2018 to 2019. Highest count among 15-34 and decrease by age; highest rates among 75+ and 15-24. **<u>Hispanic</u>** count and rate steady from 2018. Second consecutive year of increase in suicides among **<u>Black/African American</u>** population.	Watch rate/count among **<u>Black/African-American</u>** community and provide programmatic recommendations if increase continues for a third year in 2020.	
Zip codes and city of residence	Zip codes with highest 2015-19 aggregate counts: South County, South San Jose, Campbell; Milpitas, Mountain View, Alum Rock Cities with highest 2019 rates: Campbell, Los Gatos, Los Altos (and Monte Sereno with 1 death) **<u>Asian rates (count):</u> San Jose (66), Milpitas (10), Sunnyvale (8), Mountain View (5), Palo Alto (5), Santa Clara (4),** Campbell (1), Cupertino (1), Los Altos (1), Morgan Hill (1), Saratoga (1) **<u>Latinx/Hispanic rates (count):</u> San Jose (62), Sunnyvale (5)**, Campbell (2), Morgan Hill (2), Los Altos (1), Gilroy (1), Milpitas (1), Santa Clara (1) **<u>Black rates (count):</u> San Jose (8),** Gilroy, Palo Alto, Milpitas, Sunnyvale – all but SJ have count of 1 **<u>Pacific Islanders:</u>** San Jose, Sunnyvale, Mountain View, Milpitas, Campbell	**<u>Provide city-level data</u>** to councils and taskforces to inform city/regional suicide prevention efforts. Pursue **<u>suicide prevention policy</u>** in Campbell. **<u>Targeted outreach for cultural communities</u>** could be focused in these cities: - Asian – San Jose, Milpitas, Sunnyvale, Mountain View, Palo Alto, Santa Clara - Latinx/Hispanic – San Jose, Sunnyvale - Black – San Jose - Pacific Islanders – San Jose, Sunnyvale, Mountain View, Milpitas, Campbell	In progress Done (Santa Clara, Cupertino, others in progress) In progress

Method	**<u>Hanging</u>** most common method for second consecutive year. Hangings most common among all race/ethnicities, except Black and white (firearms most common). **<u>Firearms</u>** about half the percentage of national suicides by firearm. Firearm usage increases by age; hanging and jumping higher among youth and decrease with age. **<u>Drugging/poisoning</u>** increasing and higher than prior years (18%, compared to 13% and 9% in 2018 and 2017). Sub-analysis of 2019 overdose data showed 68% (21) prescription medications, 10% (3) sodium, 13% (4) other, 10% (3) unknown. Drugging/poisoning more common among Black and Native American groups.	Continue **<u>hanging means safety efforts</u>**, especially among younger age groups and non-white, non-Black race/ethnicities. **<u>Firearm safety efforts</u>** could have more concentrated focus with white and Black groups, and older age groups. **<u>Drugging/poisoning</u>** data can inform SUPS' opioid overdose prevention efforts.	In progress
Stressors/risk factors	**<u>Historical stressors</u>** (occurred more than one year prior to death): **Mental Health** was the leading historical stressor, followed by **Physical Health** and **Relationships**. Among Relationship stressors, the most common was **Intimate Partner Problems**. Among Situational stressors, the most common was **Job Stress**. **<u>Precipitating stressors</u>** (occurred less than one year prior to death): **Mental Health** was the leading precipitating stressor, followed by **Relationships** and **Physical Health**. Among Relationship stressors, the most common was	Address **<u>healthy relationships/intimate partner problems</u>** in prevention efforts. Consider/continue outreach to work places to address **<u>job stress</u>**? Conduct further analysis, particularly: ▪ Relationship issues by age, marital status ▪ Experience of multiple stressors, e.g. co-occurring with mental health	In discussion with Interventions Workgroup In discussion with Data Workgroup

	Intimate Partner Problems. Among Situational stressors, the most common was **Job Stress**.		

Suicide Attempts and Ideation Data

In FY20, the Data Workgroup worked with the Public Health Department (PHD) to obtain and analyze 2014-17 data from the state's Office of Statewide Health Planning and Development (OSHPD) on hospitalizations and Emergency Department visits for suicide attempts and ideation. From January 2020, the PHD's work on this data analysis ceased because of their epidemiologists' need to focus on COVID-19 data and disaster response. In FY21, through its partners at Palo Alto University (PAU), the Data Workgroup developed a proposal to the Institutional Review Board (IRB) to directly obtain suicide attempt and ideation OSHPD data for analysis. The IRB proposal was completed and submitted in the beginning of FY22.

Suicide Prevention Program Evaluation

The SP Program experienced significant growth from FY19-FY21 (see Figure 3). **While funding expenditures grew by 14% in FY20 and by 1% in FY21, the (duplicated) number of individuals served increased by 410% from FY19 to FY20 and by another 192% from FY20 to FY21. As a result, the cost per (duplicated) person served decreased from $1.13 per person in FY19 to $0.09 per person in FY21.**

Figure 3. Cost per Person Served by Suicide Prevention Program, FY19-21

FY 2019			**FY 2020**			**FY 2021**		
Duplicated* N = 1,444,909			**Duplicated* N = 7,369,249**			**Duplicated* N = 21,525,755**		
Number Served	Program Expenditure	Cost per Person	Number Served	Program Expenditure	Cost per Person	Number Served	Program Expenditure	Cost per Person
1,444,909	$1,635,593	$1.13	7,369,249	$1,861,691	$0.25	21,525,755	$1,885,929	$0.09

******This program cannot differentiate among duplicated individuals as no Protected Health Information (PHI) is collected among trainings, outreach activities, and communications campaigns. The same individuals may have participated in a number of the group services listed above. The reach of different communication campaign materials are also duplicated; i.e., the same individual may have seen the campaign different times and on different*

channels. Campaign exposure is largely measured by impressions, which refer to the number of times a number of individuals have been exposed to a public awareness campaign.

In the meantime, program staffing grew by only one additional team member during the three-year period. The growth in people served was driven in large part by the hiring of a staff person to oversee communications, and the subsequent growth in size and number of public awareness campaigns that were executed each year. However, the growth of the School for Suicide Prevention partnership also resulted in four more school districts and 6,412 (duplicated) more school staff participating in Kognito online simulation trainings from FY19 to FY21. In addition, the SP Program introduced new initiatives during the three-year period, such as training and consultation work with the County Health System.

Coupled with the expansion of programming was a significant and continual effort to improve outcomes evaluation of SP Program activities using evidence-based methods. The program increased its investment in evaluation activities and began working with various external partners to improve its evaluation activities. Some examples of evaluation successes during the reporting period include the following: engaging with an evaluation agency to evaluate suicide prevention public awareness campaigns at least once a year; partnering with the Stanford University Center for Youth Mental Health and Wellbeing to develop TEMPOS, the first evaluation tool of its kind that allows for evaluation of safe messaging efforts across time, articles, and publications; developing culturally-tailored suicide prevention and mental health community trainings in partnership with Palo Alto University and building an evidence base of the trainings' effectiveness compared to other gatekeeper/helper trainings; and collaborating with Youth Community Service and the Search Institute to develop an outcomes evaluation plan for primary prevention efforts to build community connectedness among youth and their parents. The evaluation outcomes are reported by program objective in the following sections of this report.

FY21 PROGRESS ON PROGRAM OBJECTIVES

Objective 1: Strengthen suicide prevention and crisis response systems

Schools for Suicide Prevention (S4SP) Partnership

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 S4SP partnership in 2018 as a response to a needs assessment conducted with districts on their progress with implementing these policies. In FY21, the SP Program kicked off the third year of the partnership, and expanded reach to include three new district partners (see Figure 4).

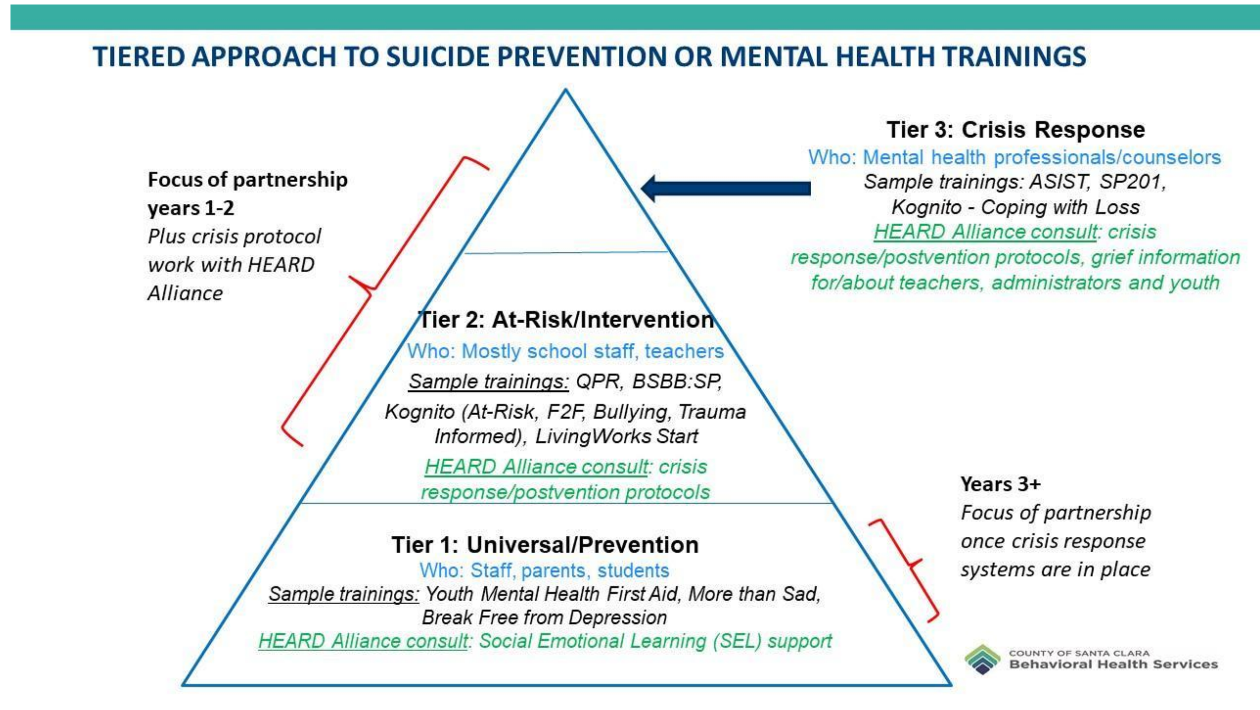
Figure 4. School Districts Participating in S4SP Partnership

Pilot Year (2018-2019)	**Year 2 (2019-2020) *** ***new districts***	**Year 3 (2020-2021) ****new districts***
• Alum Rock Union • Santa Clara Unified • Mountain View Whisman • Los Gatos-Saratoga High School District • Santa Clara County Office of Education (SCCOE) Alternative Education • Milpitas Unified • Morgan Hill Unified	• Santa Clara Unified • Mountain View Whisman • Los Gatos-Saratoga High School District • SCCOE Alternative Education • Milpitas Unified • Morgan Hill Unified • Los Gatos Union * • SCCOE Special Education * • Sunnyvale Elementary * • East Side High School Union (+ Escuela Popular Charter)* • Palo Alto Unified *	• Evergreen Elementary * • Berryessa Union * • Los Gatos-Saratoga High School District • Milpitas Unified • Morgan Hill Unified • Mountain View Los Altos* • Mountain View Whisman • Los Gatos Union • Palo Alto Unified • Santa Clara Unified • Sunnyvale Elementary

The S4SP partnership encourages school districts to follow a comprehensive, tiered approach to trainings in suicide prevention and mental health (see Figure 5), 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 5). As a result, S4SP participation emphasizes

skills development among school staff to identify and manage warning signs of student mental health crises.

Figure 5. 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 trainings for Tier 2 work are 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.

For the 2020-21 academic year, the shift to virtual learning significantly increased usage of Kognito modules. **More than 5,000 school staff* (duplicated) and 3,000 students were trained in online Kognito modules.** Completed simulations included: At-Risk, Trauma-Informed Practices (screenshot, below), Resilient Together (Postvention), Building Respect (Bullying Prevention), and the Friend 2

Friend peer module. **In three years of the partnership, nearly 12,000* teachers, staff and students have been trained in various Kognito simulations across 15 County school districts.** **Indicates duplicated numbers, with school staff completing multiple Kognito simulations.*

Pre- and post- training survey results from the Kognito "At-Risk" online training indicated statistically significant changes in suicide prevention-related competencies (see Figure 6). School staff who took the training reported increased confidence in supporting students who are in distress and increased awareness of referral resources.

Figure 6. Change in Self-Report of Suicide Prevention-Related Competencies for Kognito At-Risk Online Training (for elementary, middle, high school educators)

	Pre-Training		Post-Training				
Variables	M	SD	M	SD	t-test	Cohen's d	Effect size
1. I know the warning signs for suicide	3.46	0.84	4.12	0.60	-36.09***	0.80	Large
2. I am able to identify someone who is at risk for making a suicide attempt	3.29	0.84	4.02	0.64	-40.06***	0.89	Large
3. I feel prepared to discuss with someone my concern about the signs of suicidal distress they are exhibiting[1]	--	--	--	--	--	--	--
4. I am aware of the resources necessary to refer someone in a suicide crisis	3.47	0.93	4.18	0.60	-34.98***	0.78	Large
5. I am confident in my ability to make a referral for someone in a suicide crisis	3.37	0.96	4.08	0.66	-34.61***	0.77	Large
6. I have the skills necessary to support or	3.05	.96	3.92	0.72	-43.39***	0.97	Large

intervene with someone thinking about suicide							
7. I understand and can identify a number of ways in which culture affects how suicide is expressed and experienced	3.16	0.97	3.71	0.85	-26.52***	.59	Medium
8. I feel prepared to help people from diverse cultural backgrounds with their suicidal distress	2.84	0.98	3.65	0.86	-40.13***	0.90	Large
Mean Score, 7 items	3.23	0.75	3.96	0.58	-49.42***	1.10	Large

Notes. M=Mean. SD=Standard Deviation. [1]Item 3 was not included in measures for Kognito trainings. Scores: 1=Strongly Disagree, 2=Disagree, 3=Neither disagree or agree; 4=Agree; 5=Strongly Agree. *** $p < .001$.

HEARD Alliance

Intervention in a Suicidal Crisis during COVID-19 for Schools

Tips for teachers, staff, and parents/caregivers

http://www.heardalliance.org/

Actions to be taken by Schools and Districts

Outbreaks can be stressful, and everyone reacts differently. Signs of distress can result in behavioral changes to watch for and monitor in children and adolescents/teens.

- Identify 'at-risk' and/or vulnerable students and check-in with these students regularly.
- Coordinate a plan and designate a qualified school staff member who will schedule an online check-in meeting with identified students of concern.
- Update or create Safety Plans for at-risk youth.
- Use the My3 app to ensure the student has a Safety Plan on their phone or computer
- Designate a staff member(s) to schedule regular check-in meetings with the known at-risk and/or vulnerable students as needed.
- Provide online education and/or resources for all teachers, families and students about risk factors, warning signs and protective factors for suicide (see resources at end of this document).
- Inform/remind teachers, families and students about additional stresses experienced during this pandemic-- such as increased anxiety and sadness, changes in routines, isolation and decreased socialization of all kinds (teams, dances, clubs, etc.) financial hardships, food insecurity, loss of relationships, loss of important life milestones such as proms and graduations, losses due to illnesses, potential increase in child abuse, etc.

As a result of requests to support mental health through virtual platforms, the HEARD Alliance developed a quick-reference compendium of mental health resources for staff and families.

While rolling out their choice of mental health training simulations, districts concurrently focus on refining suicide and crisis response forms and protocols, with technical support from Stanford University's HEARD Alliance. Districts must complete Tier 2-3 crisis response work before moving on to Tier 1 prevention measures, and crisis response work may require more than one school year to fulfill. During the reporting period, many of the partnership goals/tasks were put on hold given the COVID-19 pandemic and the increased focus on supporting virtual education. Assistance from the HEARD Alliance pivoted to address district requests around virtual intervention and mental health support for school communities due to the pandemic.

In FY21, the HEARD Alliance team completed 46 consultations and trainings with 519 administrators and staff from 11 participating districts. District activities are summarized below.

Figure 7. FY21 HEARD Alliance District Support

District	Support provided	Activity highlights per district
Berryessa Union	4 trainings with 35 attendees total	Initial K-12 Toolkit trainings for mental health personnel and administrators; District overwhelmed & unable to do more
Evergreen Elementary School District	4 consults with 19 attendees total	Crisis intervention forms and protocols reviewed; Consulted with district crisis response team (CRT); site CRTs in progress
Escuela Popular Charter School (ESUHSD)	5 trainings, 3 parent nights, 2 consults with Director	Provided Spanish-speaking professional for parent nights about youth mental health; Crisis intervention & concern forms and protocols provided and reviewed
Los Gatos Union	5 consults with 30 total attendees, 3 planning meetings with 3 district counselors, 5 parent presentations, ~250 parents	Met with counseling team regarding school climate & social emotional learning (SEL) presentations for parents; Presented to 5 parent groups educating parents on SEL, mental health and coping during COVID-19
Los Gatos Saratoga HS	2 consults, 2 attendees total	Planning meeting in preparation for ‘21-‘22 school year
Milpitas Unified	6 consults, 9 attendees total	Provided resources for student mental health policy, forms & protocols; SEL guidance and support for planning implementation; CRT roles, policy implementation & evaluation; Planning to train site CRT & staff about referral process in Fall
Morgan Hill Unified	4 consults/training with 31 attendees total, 1 parent night	Met with principles regarding processes for site team; School site virtual parent training on how to reopen school & address student emotional well-being
Mountain View – Los Altos	1 training, 360 staff trained 10 consults, 19 staff supported at each of the consults	Presented to staff on suicide prevention response; Supported return to in-person presenter request; Provided postvention response support
Mountain View Whisman	2 consults with 6 total attendees, 1 meeting to review resource/training/forms with 2 attendees	Resources, protocols, & forms provided & reviewed; Planning for training CRTs; Reviewing SEL trainings for next year
Palo Alto Unified	Support/ training planned for 2021-22	Support/training planned for 2021-22
Santa Clara Unified	2 consults with 2 attendees each	Resources provided
Sunnyvale Elementary	1 document review, no meetings	Reviewed District Safety Document

Central to HEARD Alliance consultation efforts is the refinement of suicide and crisis response forms and protocols at the district level. Districts are then tasked with communicating this information to staff to ensure proper response to student crises. The following data results indicate that three months after taking the *At-Risk for Elementary, Middle and High School Educators* training, participants felt significantly more confident in knowledge of their schools' protocols for suicide prevention for low-, medium-, and high-risk students, as well as those students who are re-entering school after a suicidal crisis (see Figure 8).

Figure 8. Kognito Participants' Confidence in Knowledge of School Suicide Prevention Protocols

Combined Analysis (All 3 Levels Combined – ARES, ARMS, & ARHS)

Item	Pre-Test Mean (SD)	Follow Up-Test Mean (SD)	Sample Size (N)	Paired Samples T-Test
Please rate how much you agree/disagree with the following statements that begin with, "I am confident that I know my school's protocol for a student":				
Who is at low risk for suicide (e.g. those who show some warning signs of suicide and/or have thoughts of killing themselves, with no immediate intent to act on those thoughts)	3.28 (1.1)	3.72 (.96)	185	− 5.41***
Who is at moderate to high risk for suicide (e.g. those who have serious suicidal thoughts or who behave with the intent to die, or those who have attempted suicide in the past)	3.24 (1.0)	3.80 (.93)	183	− 7.00***
Who is at extremely high risk for suicide (e.g. those who have voiced intent to attempt suicide and have access to lethal means to do so)	3.24 (1.1)	3.79 (1.0)	182	− 6.86***
Who is re-entering school after a suicidal crisis	2.88 (1.0)	3.36 (1.0)	181	− 5.87***

Note. * Indicates $p < .05$, ** indicates $p < .01$, *** indicates $p < .001$

Health Systems

Research supports the idea that deaths by suicide may be effectively prevented by focusing on clinical settings. For example, studies have shown that suicidal individuals are likely to encounter medical services within the weeks or months prior to a serious suicide attempt or death; 45% are seen by the primary care

provider (PCP) in the month prior to dying by suicide, and 60% are seen by their PCP in the preceding year (Ahmedani et al., 2014; Bongar & Sullivan, 2013; Walker et al., 2019). By contrast, only about a third engage with mental health care providers in the year prior (Ahmendani, et al., 2019), leaving PCPs as the most common point of contact (Luoma et al., 2002). Emergency departments also see a preponderance of suicidal individuals at the heights of their suicidal crises, and represent important opportunities to intervene and prevent a suicide death (Roelands, et al, 2017).

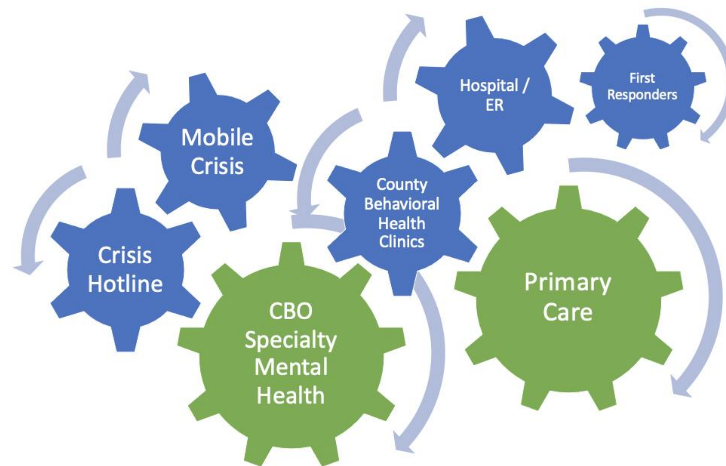
Though potential points of intervention are well-known, many systemic challenges often thwart what would need to be a multidisciplinary effort to address patient needs. A systematic review by Boukouvalas et al. (2019) and a needs assessment survey of US pediatric residency programs by Schoen et al. (2019) demonstrated that medical providers, even including mental health professionals (e.g., social workers), rated their own preparation to assess for and manage suicide risk as inadequate. Moreover, the past decade of culture and suicide research has yielded new advances and new recommendations for culturally competent suicide prevention (e.g., Chu, Goldblum, Floyd, & Bongar, 2010; Chu, Floyd, Diep, Pardo, Goldblum, & Bongar, 2013; Chu et al., 2017; Leong, & Leach, 2010; Wong, Maffini, & Shin, 2014). However, systematic implementation of these cultural recommendations has been minimal to date, and gaps in implementation of culturally competent suicide prevention are evident nationwide.

Effective July 2019, the Joint Commission updated the National Patient Safety Goal (NPSG) 15.01.01, with the aim of improving the quality and safety of care for those who are identified as high-risk for suicide. In addition, in 2017 California passed Assembly Bills AB89 and AB1436, requiring that mental health professionals receive at least six hours of training in suicide prevention. At the county level, in FY18, one key recommendation from a process evaluation of the SP Program/SPOC was to expand the scope and reach of SPOC's programmatic efforts to downstream clinical-side efforts (i.e. service providers).

In FY21 the SP Program contracted with Drs. Joyce Chu and Chris Weaver (clinical psychologists and professors at Palo Alto University with expertise in suicide prevention for cultural populations and in forensic psychology, respectively) to pilot-test culturally competent downstream implementation

support for primary care and behavioral health clinical sites seeking to enhance their system-wide suicide services. The overarching goal is to ensure a coordinated and culturally-responsive system of clinical care (i.e., addressing multiple systems of care depicted in Figure 9) that comprehensively detects, assesses, and treats suicidal thoughts and behaviors with attention to recovery orientation and cultural competency for the diverse populations of Santa Clara County.

Figure 9: A Coordinated and Culturally Responsive System of Clinical Care for Suicide



Note: Green denotes overarching target pilot sites for Year 1

In order to demonstrate viability of the downstream suicide prevention work during the pilot/proof-of-concept year, the SP Program, Dr. Chu, and Dr. Weaver targeted pilot collaboration sites that represented key entities within the County of Santa Clara's Health System that manage diverse suicidal clients, namely Ambulatory/Primary Care and Behavioral Health Services Department (BHSD) clinics. As such, Year 1 deliverables and outcomes included forming 1-3 collaborative relationships with sites from Behavioral Health and Ambulatory Care, and providing the sites with a selection of 12 consultation functions (see Figure 10). These 12 consultation functions were developed based on organizational practices from the evidence-based Zero Suicide Framework (Layman et al., 2021; Turner et al., 2021; Zero Suicide Institute, 2018; 2020).

Figure 10. List of Health System Organizational Consultation Functions / Services

Function / Service #	Description
1	Mobilize efforts (e.g, increase awareness, foster buy-in) to analyze and refine or improve downstream suicide assessment, stabilization, and recovery services.
2	Identify gaps, strengths, and priorities for organizational improvement through collection and analysis of qualitative and quantitative needs assessment data.
3	Conduct consultation meetings on system improvements as indicated
4	Identify and implement the need for program adaptations, changes, or additions in the areas of culture and diversity (i.e., to prevent suicide and promote recovery in the diverse populations of the County).
5	Assist in development of suicide-relevant policies and procedures
6	Determine needs for training of clinic staff, providers, or other relevant stakeholders
7	Provide ongoing consultation regarding initial and booster training, and education
8	Collaboratively customize screening and assessment tools. Streamline processes to balance effectiveness with feasibility.
9	Implement evidence-based practices to assure referral, safe discharge, continuity of care and recovery to meet and exceed legal, ethical, and clinical standards.
10	Assess and modify forms and clinical notes to optimize clinical care, minimize clinician burden, and address legal and ethical standards.
11	Track outcomes on system improvements through collection and analysis of evaluation data.
12	Consult on the setup of a program evaluation and data collection, monitoring, and analysis system.

This work is grounded in a foundation of culture/diversity and community-based participatory approaches. As such, the potential scope of work is flexible and subject to the guidance of the clinical sites, ultimately enhancing adoption of systemic changes. Actual implementation of the consultation functions was site-specific, collaboratively determined, and tailored to fit each organization's identified needs.

Year 1/FY21 goals were exceeded with the establishment of six active collaborations spanning two main overarching entities (Ambulatory/Primary Care and Behavioral Health clinics) that provide suicide care within the County of Santa Clara Health System (see Figures 11a and 11b). A variety of custom (site-specific) consultation services and functions were performed.

Together, these activities and outcomes demonstrated the viability of, and represent substantial progress in, this organizational consultation and systems transformation effort.

Figure 11a: Description of Downstream Suicide Prevention Efforts in ***Ambulatory Care****, Pilot / Proof-of-Concept Year 1 (FY21)*

Name of Site	Status	Description of Downstream Work in FY2021	Functions/ Services Performed in FY2021 (numbers correspond to Figure 10)	Next Steps
Primary Care Behavioral Health (PCBH)	Active	Performed a needs assessment via: 1) collection of qualitative and quantitative data from PCBH providers about strengths and gaps in suicide practice; 2) review of suicide screening, assessment, and management workflow documents; 3) review of suicide screening and assessment tools. Shared results of the needs assessment with the PCBH team, and provided education to all PCBH providers, reviewing core concepts of culturally responsive suicide screening, assessment, stabilization, and intervention.	1, 2, 3, 4, 5, 6, 7, 8, 9, 11	Troubleshoot screening and referral processes from nursing/medical to PCBH providers, and streamlining how PCBH providers will support other medical services during a suicidal crisis. Further education on the use of the Columbia protocol along with development of paperwork templates.
Milpitas Primary Care Clinic	Active	Established a collaborative relationship with key clinic leaders. Performed a needs assessment via: 1) collection of qualitative and quantitative data from Milpitas team members about strengths and gaps in suicide practice; 2) review of suicide screening, assessment, and management workflow documents; 3) review of suicide screening and assessment tools. Identified key pain points (e.g., culturally responsive questioning, workflow issues, screening gaps, etc.) Presented needs assessment results and recommendations / potential action items to Milpitas leadership. Collaboratively identified key representative stakeholders for a lead suicide workgroup to move the work forward.	1, 2, 3, 4, 6, 11	Work stalled in January through June 2021 because of clinic shutdown (for COVID-19 emergency vaccination assistance). Upon clinic re-opening in June 2021, the collaborative leadership group was re-established and work is re-starting.
Complex Care Nursing (RNs)	Active	Established a collaborative relationship with key complex care nursing team leaders. Collaboratively identified goals of supporting and educating nurses to screen for suicide risk and provide appropriate referrals and resources. Collected baseline systems improvement data. Educated complex	1, 2, 3, 4, 5, 6, 7, 8, 10, 11	Troubleshoot (with Dr. Jodi Pinn and the PCBH team) pain points / barriers in the process of referring suicidal patients to PCBH for more thorough assessment and management. Subsequently return to the complex care nurses with

		care nursing team on how to ask suicide questions in a culturally responsive manner, screen (using the Columbia protocol), and refer and provide resources. Collaboratively identified pain points in the referral process / warm handoff between complex care nursing to PCBH.		updates about the referral process, and connect PCBH and Complex Care nursing team to build trust, collaboration, and coordination of care.
Referral and Population Health Nursing (LVNs)	Active	Established a collaborative relationship with key referral and population health nursing team leaders. Collaboratively identified goals of supporting and educating nurses to screen for suicide risk and provide appropriate referrals and resources. Collected baseline systems improvement data. Educated nurses how to ask suicide questions in a culturally responsive manner. Identified a need to define the referral and population health nursing team's scope of work re: suicide screening and the use the Columbia protocol, given professional boundaries re: LVN duties.	1, 2, 3, 4, 5, 6, 7, 11	Nursing team leadership to follow-up with medical team to determine appropriate scope of suicide screening for the LVN team, and identify who in the system will perform suicide screening of ideation, intent, plans, and means (including potential use of the Columbia). Follow-up to LVN team after this determination of scope of work, along with additional information re: process of referring suicidal patients to PCBH.
Ambulatory Care Quality Impro-vement	On reserve	Met with the Ambulatory Care Quality Improvement team to assess their role in establishing, assuring, and improving clinical standards and processes for suicide care. Gathered information about suicide assessment tools available to ambulatory care within Epic and MyHealthOnline (e.g., PHQ9, Safety Health Assessment, Columbia, and an adolescent tool CRAFT 2.1 in process). Discussed potential of low adoption of these tools by clinical providers.	1, 2, 6	Leaders from Ambulatory Care Quality Improvement can operate on a "reserve" basis, and could be called in as a support or a collaborator in future direct-clinical service suicide improvement efforts (e.g., assist in adaptations or changes to tools/paperwork, or assist in efforts to improve providers' use of suicide-related tools)

Figure 11b: Description of Downstream Suicide Prevention Efforts in ***Behavioral Health****, Pilot / Proof-of-Concept Year 1 (FY21)*

Name of Site	Status	Description of Downstream Work in FY2021	Functions/ Services Performed in FY2021 (numbers correspond to Figure 10)	Next Steps
Momentum for Mental Health (*Contracted behavioral health community-based organization (CBO)*)	Active	Initiated collaboration and assembled a suicide prevention workgroup consisting of key players across the organization. Collaboratively tailored a needs assessment survey for Momentum and sent the survey out for participation organization-wide. The survey was completed by 111 staff stakeholders, and needs	1, 2, 3, 4	Present recommendations from needs assessment survey and collaboratively identify / develop / execute action items for FY22

		assessment results were analyzed and shared with the Momentum suicide prevention workgroup.		
Needle Exchange Program (*Public Health / STD/HIV Prevention & Control*)	Active	Initiated collaborative effort with key leaders. Reviewed and shared initial impressions / questions / recommendations for the Needle Exchange Program's initial suicide policy and procedures draft, created by a consultant. The Santa Clara suicide prevention program provided a suicide prevention community outreach training for staff.	1, 5, 6	Convene with key program leaders and their consultant to define appropriate roles for different staff in matters of suicide, and revise suicide policy and procedures accordingly in collaboration with their consultant.
Quality Improvement, Quality Assurance, and Clinical Standards	On reserve	Held exploratory meetings with key leaders in the Clinical Standards, Quality Assurance, and Quality Improvement departments. Discussed potential gaps in suicide training and practice, with opportunities to increase the auditing of suicide-related crisis practices as an avenue to improve service, and provide training to different staff members to improve screening, assessment, and management. Also identified many strengths in assessment and safety planning. The team concluded that the most preferred approach to improve suicide prevention and recovery is to work directly with the clinical service teams. QI / QA / Clinical Standards could support these efforts from their systems evaluation perspective when indicated and relevant.	1, 2	Leaders from QI / QA / Clinical Standards (whose scope of work is county behavioral health system-wide) can operate on a "reserve" basis, and could be called in as a support or a collaborator in future direct-clinical service suicide improvement efforts.
Community Solutions, Inc. (*Contracted CBO)*	Inactive	Reached out to explore potential collaboration; did not receive a response.	N/A	Try at another time to re-initiate a collaboration

Spirituality and Mental Health Policy

Spirituality is an integral part of the human experience. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies the spiritual as one of its Eight Dimensions of Wellness that can positively impact well-being. Many of the identified protective factors that help prevent suicide are developed as part of an individual's spiritual or religious life. These include a sense of purpose or meaning in life, connectedness to a community and social institutions, problem-

solving and coping skills, and beliefs that discourage suicide. These attributes of spirituality are also an integral part an individual's mental wellness recovery goals. In addition, religion and spirituality have the ability to promote or damage mental health. An awareness of religious matters by mental health practitioners is necessary in order to inquire about and address the needs of clients in recovery as well as to promote inclusiveness of all people who may seek services.

In FY21, the Suicide Prevention Policy Workgroup researched and developed a policy for BHSD to support the incorporation of clients' spirituality as they recover from mental health conditions. The activities undertaken by the workgroup include the following:

- Conducted a **literature review** to identify the value of including a client's spiritual beliefs in the achievement of their mental health recovery goals;
- **Reviewed the behavioral health policies from three California counties** about the "Integration of Spiritual Interests in Recovery and Wellness";
- **Interviewed local faith leaders** regarding concerns/barriers and hopes/recommendations for improvement regarding faith/spirituality and County services;
- **Gathered feedback regarding the draft policy** from key stakeholders at a SPOC meeting and from other key BHSD staff;
- **Incorporated feedback into policy language** and finalized the draft;
- **Submitted policy draft to BHSD executive leadership** for consideration.

Regional/City-level Collaborations

San Jose

During this reporting period, the City of San José worked to implement its City Council Policy on Suicide Prevention, which was established on March 3, 2020. Under the policy, the City promotes strategies and resources provided by Santa Clara County as well as the Suicide Prevention Resource Center, under the following guiding framework:

1. **CITY EMPLOYEES.** The City shares with its current employees and its Retiree Associations information that helps staff and retirees gain a better understanding of the causes of suicide and learn the appropriate methods for identifying and preventing the loss of life.

- The City shared with these groups the City's Suicide Prevention Annual Report and a reminder of the City's free Employee Assistance Program.

2. **CITY FACILITIES.** The City works to ensure that its public safety protocols governing the City's response to a suicide attempt on City facilities is reviewed annually to ensure all internal procedures are updated and address any needed support for employees that may be witnesses to such events.
   - The City reviewed its Standard Operating Procedure and made no changes.
   - Public Information Officers were trained in safe messaging techniques, as described in #4 below.
3. **CITY RESIDENTS.** The City actively collaborates with the Santa Clara County government to disseminate information including event information and resources as they become available.
   - The City provided several suicide prevention resources in its FLASH REPORT #148 on February 17, 2021.
   - The City shared a communication with residents regarding suicide prevention during Mental Health Awareness Month in May 2021.
4. **COORDINATION WITH OUTSIDE AGENCIES.** The City coordinates and collaborates with county, regional and state efforts that advance the goals of the Strategic Plan.
   - Safe Messaging Training was conducted in September 2020 for the City's Public Information Officers by the County of Santa Clara's Behavioral Health Services staff and Suicide Prevention Manager.
   - A city representative from the City Manager's Office began participating in bi-monthly meetings of the County's Suicide Prevention Oversight Committee (SPOC) to ensure increased collaboration on activities and messages to San José residents.

Milpitas

In the reporting period, the city of Milpitas HOPE (Helping Others Process Emotions) Task Force accelerated its suicide prevention work by more active community engagement, and by asserting a role in city operations concerning suicide. The task force continues to meet monthly and in FY21 was comprised of Milpitas community members, local faith community leaders, local veterans, various Milpitas 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 FY21, the task force built on the previous year's work through defining prevention strategies, planning and offering new community events, and increasing task force influence in city suicide prevention operations. FY21 HOPE task force accomplishments follow:

- Promoted HOPE and County **events addressing mental health and suicide prevention**;
- Recruited and welcomed new members that **represent communities previously unrepresented** on task force, including LGBTQ+ and veteran communities;
- Created work groups prioritizing efforts in **specific Milpitas subpopulations disproportionately impacted by suicide**;
- Increased visibility through sustained **social media engagement** and through **development and launch of task force webpage**;
- Facilitated scheduling of and city official attendance at **safe SP Program training on safe messaging on suicide**;
- Planned and hosted 10 **mental health town halls for various subpopulations** in local Milpitas community;
- Established **support groups for LGBTQ+ and older adult communities**;
- Crafted official city **condolence letter, to be shared following receipt of death report, with family and next-of-kin** of suicide decedents that resided in Milpitas; and
- Drafted and submitted for city council consideration **suicide postvention Standard Operating Procedures proposal** for the city.

Palo Alto

During the reporting year, Project Safety Net (PSN) received notice recognizing them as a 501c3 nonprofit organization. The focus of the first year was spent establishing PSN's business infrastructure while remaining responsive to community/partner-initiated issues. Key collaboration activities included:

- Launching the **Partners Council,** which primarily leads the coordination of coalition initiatives, drives program/event planning, and responds to community issues; and
- Supporting the **2021 Suicide Prevention Conference** as part of the planning committee.

South County

The South County Suicide Prevention Workgroup formed in September 2017 in response to the Epi-Aid report on youth suicides, which found that Morgan Hill had the second-highest rate of youth suicides in the County. In FY21, the workgroup was co-chaired by the Suicide Prevention Coordinator and Community Solutions Division Director. Examples of the workgroup's FY21 accomplishments follow:

- Created **mental health resources website** for the South County community (Mental Health Resources | City of Morgan Hill, CA - Official Website);
- Hosted **service provider presentations** to increase awareness of local and County supports;
- Revised the local **COVID-19 Resources and Services one-pager** created in FY20 as needed to provide the most up-to-date information to the community.
- Explored multiple means for **improving and increasing communication across agencies** and supporting the ease of sharing information and time-sensitive resources.

Objective 2: Increase use of mental health services

Community Education and Information (Public Awareness Campaigns)

In FY21, the SP Program's Communications Workgroup planned, developed, and launched two public awareness campaigns to support suicide prevention in the County. The Program also began ensuring that a cultural component was a part of every campaign and evaluating campaigns through comprehensive surveys of target audiences. Evaluation survey data were analyzed, reviewed, and archived to inform future suicide prevention work and campaign efforts.

The first campaign promoted prevention among older adults, primarily Vietnamese- and English-speaking, with smaller-scaled promotion among Mandarin- and Spanish-speaking older adults. The second campaign supported suicide prevention among middle-aged Spanish-speaking and English-speaking men, as a response to the COVID-19 pandemic. Both campaigns' primary objectives 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 those struggling with their mental health and suicidal ideation.

Campaign 1: Older Adults

The first campaign ran from September 3 to October 21, 2020 and was comprised of print materials and television, radio, digital, and social media advertisements in Vietnamese. Digital advertisements were displayed to users through geotargeting methods, which enabled selective campaign ads to display to the target audience

when their Internet searches indicated risk for depression, unemployment, recent job loss, or support to family or friends encountering those circumstances. These ads promoted the National Suicide Prevention Lifeline and a campaign-specific web page, www.scchope.org/vi. Additionally, the campaign included in-language radio advertisements promoting the National Lifeline and one of three campaign-specific web pages: www.scchope.org in English, www.scchope.org/zh in Chinese, and www.scchope.org/es in Spanish. (Each campaign webpage now remains active.) Reach data are included in Figure 12 below. According to 2019 US Census Bureau estimates, **478,940 adults aged 55 and older reside in Santa Clara County.**

Figure 12. Campaign 1 (Older Adult) Reach and Impressions

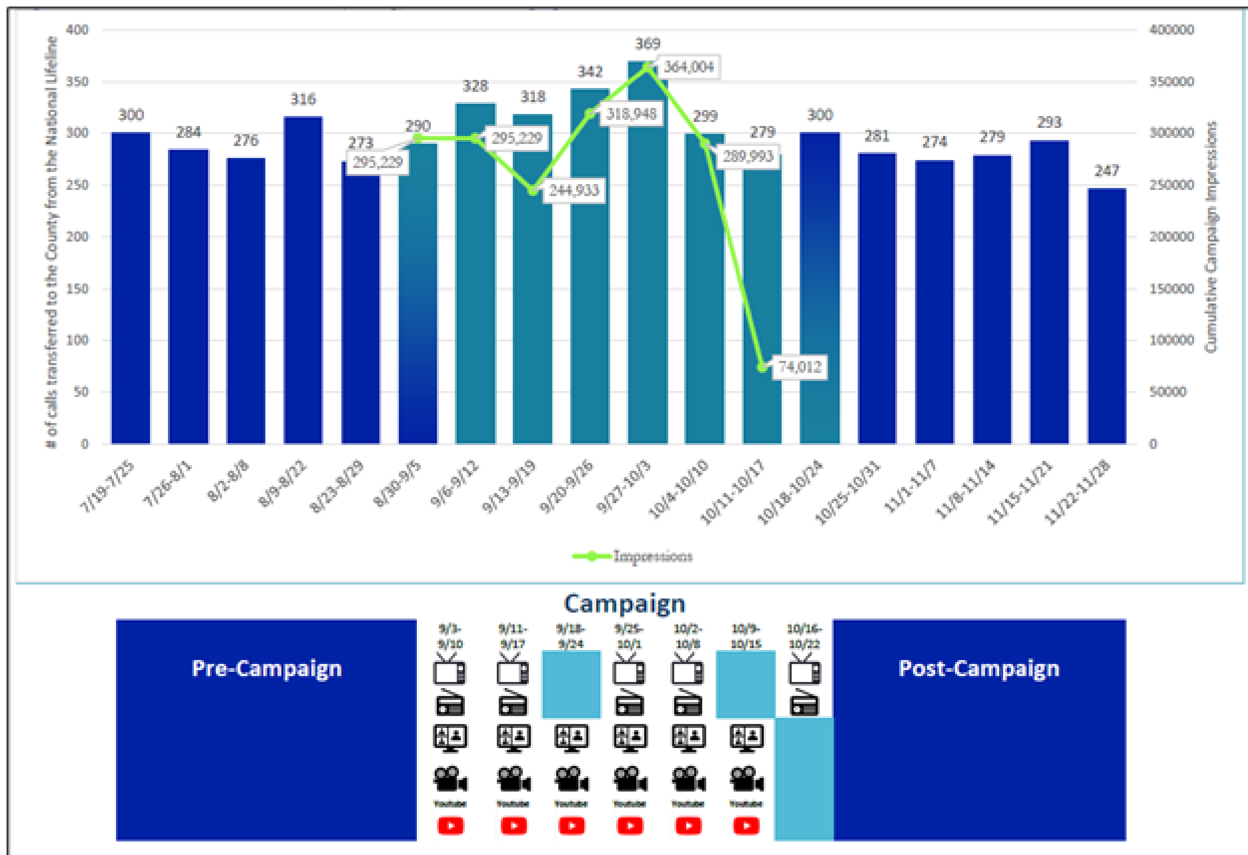
	Total impressions	Webpage visits	Webpage views	Video views	Television spots	Radio spots
Vietnamese	1,882,366	5126	8360	12,367	115	248
English	2,030,081	5841	9042	9,764	NA*	75
Spanish	41,100	66	72	NA*	NA*	92
Chinese	198,352	45	51	NA*	NA*	56
Campaign totals	4,151,899	11,078	17,525	22,131	115	471

**NA: Not Applicable – in-language television and/or radio ads were not produced as part of campaign*

To assess the impact of the first campaign, calls to the Suicide and Crisis Hotline during the campaign weeks in September and October 2020 were compared to the same weeks in 2019. This two-month span in 2020 showed a total increase of 80 calls to the hotline, compared to the same period in 2019. The hotline also received more calls during the first four weeks of the campaign compared to the five weeks

before and following the campaign (see Figure 13). **Calls to the hotline reached their highest volume at the campaign's exposure peak (the most ads on the most media outlets). Additionally, from September 2, 2020 to August 12, 2021, campaign webpages received 12,089 visits and 18,766 page views,** reflecting wide reach and receptivity to seeking help online.

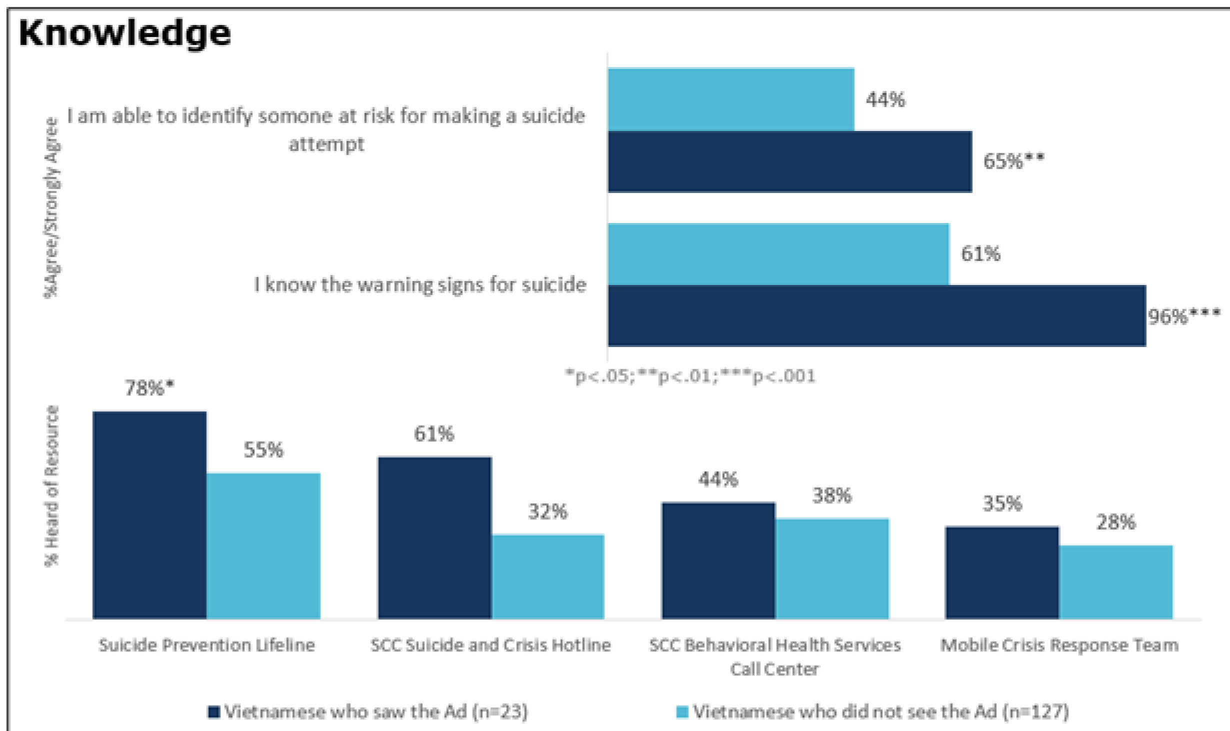
Figure 13. Suicide and Crisis Hotline Call Volume before/during/after Campaign 1 (Older Adult)



Campaign evaluation surveys were designed for and distributed to older Vietnamese adults and influences such as family and friends. Fifteen percent of survey respondents recalled seeing or hearing the campaign, with each person reporting exposure to the campaign about three times. Results showed that those who recalled the campaign generally held more positive and less negative attitudes toward seeking help for suicide or mental health. This group was also more likely to say they would seek help, especially from multiple resources. Furthermore, survey data indicated that **Vietnamese respondents who saw or heard campaign**

ads or materials were: more informed of suicide prevention resources, more aware of suicide warning signs, and more able to identify individuals at risk for suicide than those who did not see or hear the campaign (see Figure 14).

Figure 14. Campaign 1 (Older Adult) Survey Results: Knowledge about suicide and resources



Campaign 2: Middle-Aged Men

The second campaign was developed and launched specifically in response to the COVID-19 pandemic, with the intent to support suicide prevention as many County residents struggled with increased stress, anxiety, and other mental health issues. The campaign ran from December 21, 2020 to February 21, 2021 and was comprised of print materials and radio, digital (online, including audio streaming), and social media advertisements in English and Spanish. The SP

Program utilized geotargeting, as well as mobile phone geofencing methods, to disseminate the digital advertisements to the target audience. Digital geotargeting allowed for campaign ad distribution to members of the target audience who had Internet search patterns indicating mental health issues, suicidality experience, depression, recent job loss, financial stress, and need for government assistance. Mobile geofencing helped further ensure that the campaign audience was reached through display of campaign ads to any person using their smartphone while at any of 74 locations in the county. Geofencing locations, which were identified by community stakeholders to be frequently visited by the target audience during the COVID-19 pandemic, included food centers, markets, pharmacies, stores, places of worship, schools, community centers, and medical care sites (including COVID-19 testing locations). The ads promoted the National Suicide Prevention Lifeline and two campaign-specific web pages, www.scchope.org/help and www.scchope.org/ayuda. (Each campaign webpage remains active.) Reach data are included in the table below (see Figure 15). According to US Census Bureau estimates (2019), **278,484 male adults aged 35-54 reside in Santa Clara County.**

Figure 15. Campaign 2 (Middle-aged Men) Reach and Impressions

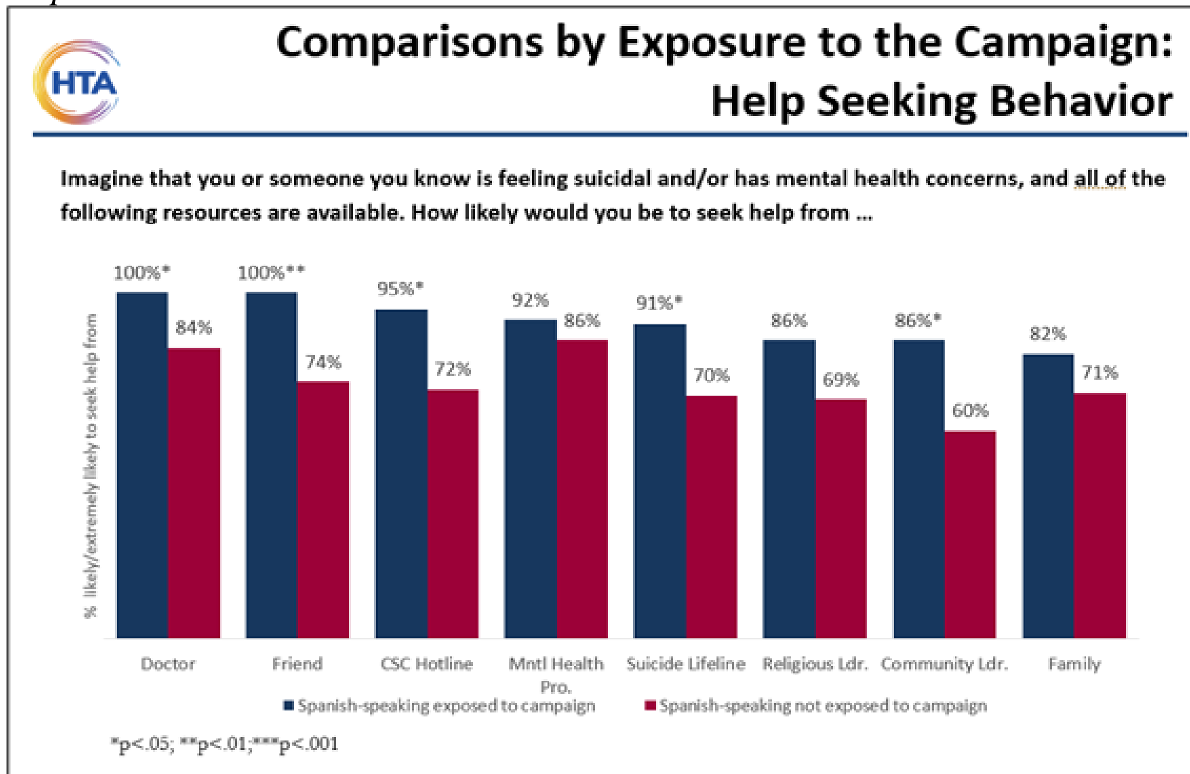
	Total impressions	Webpage visits	Webpage views	Radio spots
Spanish	8,221,566	19,379	25,611	189
English	9,087,988	20,083	27,660	446
Campaign totals	17,309,554	39,462	53,271	635

To assess the impact of the campaign, calls to the Suicide and Crisis Hotline during the campaign weeks were compared to the same weeks in the prior year. These periods showed a total increase of 146 calls to the hotline, compared to the same timeframes of the prior year. Amidst the peak of the campaign from January to February 2021, among those who provided their demographic information, **hotline calls made by White/Caucasian individuals increased 62%. Over this time,**

calls made by Hispanic/Latinx individuals increased 182%. At the same time, calls from African American/Black and Asian individuals remained flat (0% increase). The demonstrable uptick in calls made by the races/ethnicities comprised of campaign target audiences suggest that the campaign had some impact on increasing help-seeking behavior among the target audiences.

In the campaign evaluation, 30% of survey respondents recalled seeing or hearing the campaign, with each person exposed to an ad approximately four times. Similar to Campaign 1, survey results demonstrated that those who recalled the campaign generally hold more positive and less negative attitudes toward seeking help for suicidality or mental health. **The same group was significantly more likely to say they would seek help (see Figure 16).** Respondents **who saw or heard campaign ads or materials were also more informed of suicide prevention resources, more aware of suicide warning signs, and more able to identify individuals at risk for suicide** than those who did not see or hear the campaign.

Figure 16. Campaign 2 (Middle-Aged Men) Survey Results: Likelihood to seek help



Community Helper Trainings

The SP Program offers six community helper trainings in suicide prevention and mental health (see Figure 17). 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. **In FY21, the program trained 10,073 (duplicated) community members and/or service providers through community helper trainings.**

As the County continued to adhere to COVID-19 protocols, all in-person offerings were shifted to virtual platforms (Zoom) and adjustments were made to enhance training opportunities. To supplement offerings, the in-person Applied Suicide Intervention Skills Training (ASIST) was converted into LivingWorks Start online licenses. The new training offering became available in April 2021 and will run through FY22. This year also saw the phasing-out of two trainings offerings, Youth Mental Health First Aid and suicide to Hope, based on prior years' evaluation data, assessment of training needs for the County, and availability of new training offerings—Be Sensitive, Be Brave and SP201—that better align with community needs.

Figure 17. FY21 Suicide Prevention and Mental Health Helper Trainings

Name	Description	Group(s) Trained in FY21	Number of Trainings Hosted
Question, Persuade, Refer *(QPR)*	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, parks and recreation staff	6 completed (in-person, virtual)
LivingWorks Start *(April 2021-June 2021)*	Multi-modal interactive training simulations and scenarios to learn and practice how to recognize when someone is in distress, increase comfort with supporting an individual in crisis and how to connect them to an intervention provider.	General community, partner organizations	50 online codes issued
Be Sensitive, Be Brave: Suicide Prevention	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	31 completed (virtual)

SP201: Suicide Prevention and Clinical Management for Diverse Clientele	Participants learn to assess suicide risk, safety plan, case conceptualize, and treatment plan for managing suicide risk in diverse populations.	BHSD clinicians, school mental health professionals	3 completed (virtual)
Be Sensitive, Be Brave: Mental Health	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	5 completed (virtual)
Kognito "At-Risk" Module *(*additional modules for ongoing partner districts)*	Simulated online conversations in grade-level specific modules on how to address mental health distress with students, peers, and parents.	Elementary, middle, and high school educators and staff, High school students	11 school districts participated *(8,791 staff and students trained)*

In aggregate, across all trainings offered, participants reported statistically significant improvements in eight self-reported suicide prevention competencies related to knowledge, attitudes, and preparedness around being community helpers for suicide prevention (see Figure 18).

Figure 18. Change in Self-Report of Suicide Prevention-Related Competencies for Trainings, July 2020-June 2021

	Pre-Training		**Post-Training**				
Variables	**M**	**SD**	**M**	**SD**	**t-test**	**Cohen's d**	**Effect size**
1. I know the warning signs for suicide	3.49	0.84	4.16	0.60	-41.38***	0.83	Large
2. I am able to identify someone who is at risk for making a suicide attempt	3.30	0.85	4.06	0.63	-46.02***	0.93	Large
3. I feel prepared to discuss with someone my concern about the signs of suicidal distress they are exhibiting[1]	3.22	1.07	4.22	0.58	-20.97***	1.01	Large
4. I am aware of the resources necessary to refer someone in a suicide crisis	3.46	0.93	4.23	0.60	-40.91***	0.83	Large
5. I am confident in my ability to make a referral for someone in a suicide crisis	3.36	0.96	4.12	0.67	-40.19***	0.81	Large
6. I have the skills necessary to support or intervene with	3.05	.97	3.96	0.72	-49.17***	0.61	Large

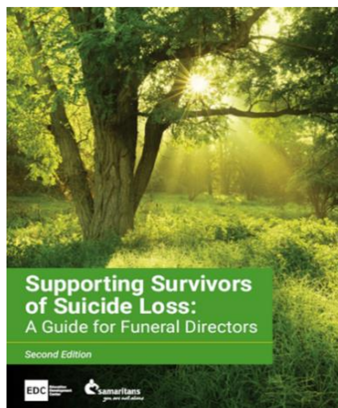
someone thinking about suicide							
7. I understand and can identify a number of ways in which culture affects how suicide is expressed and experienced	3.18	0.97	3.79	0.84	-31.77***	1.00	Large
8. I feel prepared to help people from diverse cultural backgrounds with their suicidal distress	2.85	0.98	3.71	0.85	-46.36***	0.94	Large
Mean Score, 7 items (excluding #3)	3.24	0.75	4.00	0.58	-57.52***	1.16	Large

Notes. M=Mean. SD=Standard Deviation. [1]Item 3 was not included in measures for Kognito trainings. 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 3.49 on the pre-survey (most people chose either 3=Neither disagree or agree to 4=Agree) to a 4.16 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 3.49 to 4.16 was significant enough that it is likely NOT due to chance).

Note* re: Cohen's *d: A measure of the effect size of the difference between two pre-training and post-training mean scores, measured in standard deviations.

Community Outreach



Due to the COVID-19 pandemic, in-person outreach opportunities were no longer available in FY21. The SP Program pivoted its outreach efforts to phone-banking and virtual resource presentations instead, with a priority of reaching older adult in-home support workers and funeral directors. Program volunteers made phone calls to 53 funeral homes and 10 in-home support agencies to offer resources and trainings, and as a result **the SP Program mailed materials 21 funeral homes and two in-home support agencies.** These materials included the Educational Development Center's "Supporting Survivors of Suicide Loss: A Guide for Funeral Directors" (image, above). In addition, the SP Program provided two resource presentations for the community, in partnership with the San Jose Public Library, and translated

and updated the mental health brochure for immigrants, which was created in partnership with the County Office of Immigrant Relations (see image, above).

Outreach to the Pacific Islander Community

Engaging the Pacific Islander community was prioritized by the Interventions Workgroup in FY21, as recent data identified the community as having the highest rate of suicide in Santa Clara County. An ad hoc committee was created with Essence of Mana, an organization from San Mateo County, serving as a cultural broker. **In FY21, the committee organized and offered a virtual mental health talanoa (a common term in this community to refer to a talk on any topic) for the local Pacific Islander community.** Seven members of the Pacific Islander community attended the event on June 30, 2021. A review of self-care was provided, and poll questions were asked to begin gathering information about the community's thoughts, attitudes, and beliefs about mental illness and suicide. As next steps, a survey based on the talanoa responses is being created to gather further information to inform engagement and suicide prevention with the Pacific Islander community.

Suicide Prevention Conference

On May 3rd and 10th, 2021, the SP Program held the 2nd Annual Suicide Prevention Conference. Nearly 160 suicide prevention professionals and advocates attended the virtual event, which had a theme of increasing cultural humility in suicide prevention. Attendees included advocates, partner organizations, neighboring counties, Program workgroup chairs, and mental health leaders.

Workshop sessions covered trauma and grief, wellness and self-care, faith, and means restriction. In a post-conference survey, attendees expressed gratitude and confirmed that their expectations were met and often exceeded, particularly due to the variety of session topics. Conference sessions were recorded and available at https://bhsd.sccgov.org/programs-services/suicide-prevention-crisis/suicide-prevention-events.

Crisis Services

Suicide and Crisis Services Hotline

Run by Suicide and Crisis Services (SACS), **the Suicide and Crisis Hotline received a total of 38,324 calls in FY21 (see Figure 19). This number represents an 18% increase from the 32,451 calls received in FY20.** The increase is attributed mainly to the impacts of the COVID-19 pandemic. The SACS Hotline was able to handle this increase in call volume, due to the fact that staff and volunteer crisis counselors continued to go in and take on crisis calls during the pandemic.

Many hotline callers expressed high levels of anxiety due to many uncertainties during the COVID-19 pandemic. The most common issues and concerns shared during the calls were related to the spread of COVID-19 and not knowing when things would be "normal" again.

Much of the increase in calls could be attributed to younger callers. For callers in the elementary- to high-school age range, "school" was the most common complaint: students not getting enough direct help from teachers, parents not supporting students with their schoolwork, students failing school, and students missing face-to-face contact with their friends. Family issues also seem to intensify as teenagers who already had unhealthy relationships with parents were forced to stay home all day long, making these situations worse.

College-aged young people reported that they were either stuck in dorms and away from their families, or back at home away from campus and missing their friends. Many of them reported feeling that they were missing out on the whole college experience. Depending on the college major, those who required hands-on training were limited to how they could study. Young adults mainly called about financial issues, relationship issues, and stress related to COVID-19 limitations.

Figure 19. SACS Hotline Call Volume, FY21

CRISIS CALLS	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	TOTAL
Suicide in Progress	3	2	2	2	2	1	4	2	0	1	3	1	**23**
High Risk	19	14	19	28	17	18	17	9	12	3	18	19	**193**
Medium Risk	107	103	152	144	125	150	124	122	95	36	144	139	**1,441**
Low Risk	1,708	1,168	1,412	1,356	1,142	1,143	1,136	1,312	1,167	587	1,408	1,214	**14,753**
NON-CRISIS CALLS													
No Risk of Suicide but need Support	1,283	1,182	1,607	1,850	1,620	1,408	1,920	1,605	2,254	2,573	1,749	1,624	**20,675**
Informational (Triage, Misc)	241	161	192	98	70	70	49	77	56	60	87	78	**1,239**
Total	**3,361**	**2,630**	**3,384**	**3,478**	**2,976**	**2,790**	**3,250**	**3,127**	**3,584**	**3,260**	**3,409**	**3,075**	**38,324**

Definitions

- 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 means to killing self
- 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

Crisis Text Line

The County BHSD partners with Crisis Text Line (CTL), a free crisis intervention service via text message. **Community members may text RENEW to the national CTL number, 741741, to access trained volunteer crisis counselors by text (free, 24/7, anonymous). In FY21, 473 text conversations by 297 texters took place under the County's CTL.** Monthly CTL volume stayed between 20 and 60 text conversations per month (see Figure 20). During the COVID-19 pandemic year, CTL usage among adolescents decreased (from 32.5% in FY20 to 15.4% in FY21), while usage among transitional-aged youth and young adults increased (from 47.5% in FY20 to 58.9% in FY21). The top issues discussed were anxiety/stress, relationships, depression/sadness, school, and suicide (see Figure 21).

The County's CTL continues to reach a larger percentage of cultural minorities compared with their representation in the County. For example, in FY21, 47.1% of texters reported being of Hispanic, Latinx, or Spanish origin; 40.5% reported being LGBTQ+; 16.7% reported veteran status; and 25% reported having autism.

Figure 20. FY21 Volume of Crisis Text Line Conversations, by Month

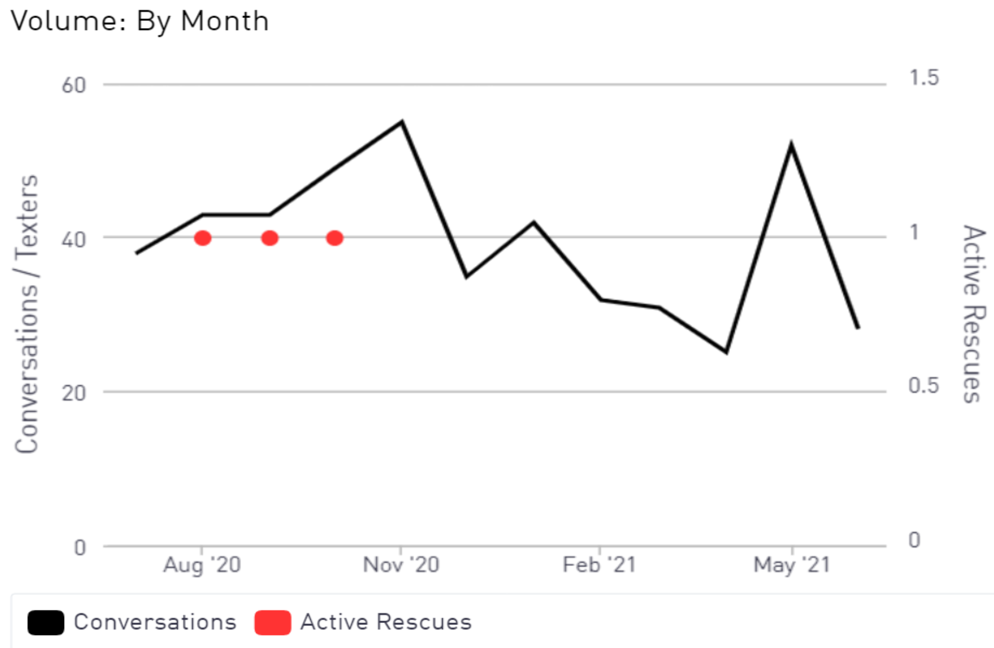


Figure 21. Top Issues Discussed on County Crisis Text Line in FY21

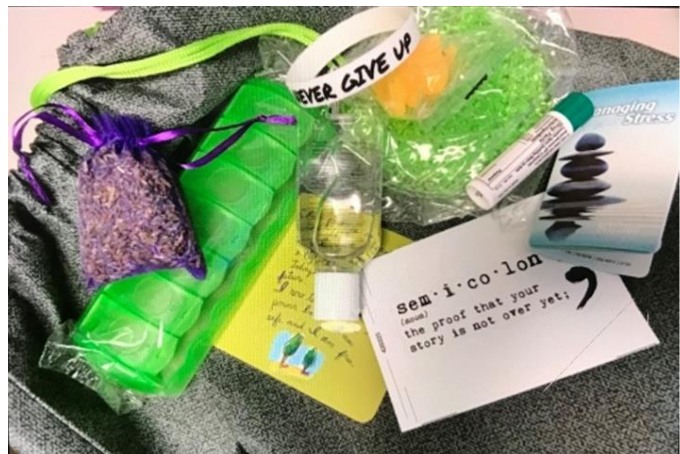
Issue	**% of conversations**	**Issue**	**% of conversations**
Anxiety/Stress	32.7%	Abuse, emotional	3.4%
Relationship	32.0%	COVID-19	3.4%
Depression/Sadness	29.3%	Social Media(*)	2.4%
School(*)	26.0%	Abuse, physical	1.9%
Suicide	15.0%	Eating Body Image	1.9%
Isolation/Loneliness	13.2%	Abuse, unspecified	1.5%
3rd Party	12.0%	Bullying	1.1%
Finances(*)	8.0%	Abuse, sexual	1.1%
Self Harm	7.5%	Gender Sexual Identity	0.8%
Grief	4.5%	Racism	0.5%
Sexual Assault(*)	3.8%	Deaf/Hard of hearing	0.0%
Substance Abuse	3.8%	Military(*)	0.0%

Postvention/Grief Support

In FY21, the SP Program finalized a contract for grief support services and trainings with Bill Wilson Center (BWC) for Living with Dying. The goals for this new contract are as follows:

- **Develop training curriculum to increase the capacity of the BHSD staff to provide grief support services following critical incidents and loss, including suicide.** The training was developed in partnership with the Interventions Workgroup at the end of FY21, and the first training was held in September 2021.
- **Provide community grief support/postvention services to community groups and County partners affected by suicide or loss on request**, e.g. when a school district experiences the death or suicide of a student.

Another component of SACS services is the weekly Survivors of Suicide (SOS) support group. Since COVID-19 became a pandemic, the last SOS support group was held on March 2, 2020. SACS offered to hold the support group virtually, but none of the group members expressed interest in this opportunity.



In addition, 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. Because of COVID-19 safety measures, SACS staff was limited as to when and how they could come in and see the patients at ED. **In FY21, SACS staff made initial contacts and provided follow-up services to 26 individual clients at the ED.**

Care bags are a suicide prevention strategy for individuals who are discharged after being hospitalized due to suicidal ideation or a suicide attempt—a time when suicide risk is heightened. **In FY21, the SP Program's Interventions Workgroup partnered with Valley Medical Foundation and Emergency Psychiatric Services (EPS) to prepare and provide 240 care bags to EPS**

patients at discharge. The care bags include self-care items such as affirmation cards, lavender-scented satchels, and printed resources (see image, above).

Objective 3: Reduce access to lethal means

Gun Safety

Firearms are the second most used means for suicide in the County and the most lethal means overall. With the goal of preventing suicides by firearm, the SP Program seeks to reduce firearm access among County residents in a couple ways. First, the SP Program participates in the County's Gun Safety and Violence Prevention (GSVP) workgroup, a new District Attorney's Office iteration of a previous workgroup headed by the Public Health Department's (PHD's) PEACE Partnership. Other GSVP participating members include officials from PHD, the County Probation Department, the City of San José, the San José Police Department, Supervisor Cindy Chavez's Office, and Moms Demand Action. The GSVP team began meeting again in January 2021 following a brief pause due to the COVID-19 pandemic.

Second, in FY21, **the SP Program set out to advance access reduction efforts through a public awareness campaign promoting gun safety and safe storage among County firearm owners**. The Program began campaign development by conducting focus groups to gather information on the most effective messaging to reach gun owners. Following focus groups, the campaign was delayed because the SP Program diverted resources to quickly develop a public awareness campaign supporting suicide prevention among middle-aged men in response to the COVID-19 pandemic (see p. 31). However, the Program re-initiated safe storage campaign work towards the end of FY21. Creative development is in progress as the Program applied focus group information and the most recent County data on suicide by firearm to inform the campaign's development. The SP Program anticipates launching the campaign in late fall of 2021.

In addition to these efforts, **the SP Program supported gun safety efforts through its coordination with the County BHSD social media team following the shooting at the Santa Clara Valley Transportation Authority railyard in May 2021**. The Program ensured promotion of mental health and suicide prevention resources by County accounts for those impacted by the incident. SP team members also shared resources with County and external networks to support the community.

Hanging Means Restriction

The use of ligatures in suicides is usually classified as a means/method of death. In suicide prevention it is common to refer to the way individuals take their lives as the means (method), and the effort to prevent means is commonly referred to as means restriction. Depending on the means used, means restriction can have some readily-available, effective techniques that prevent or retard usage. Some means, like firearms and jumping from structures, can be limited by restricting access and have a growing evidence base as to the effectiveness of means restriction. Since ligatures and ligature points are widely available and difficult to limit access to, this means/method presents unique challenges and requires extraordinary responses.

County suicide death data indicated a change from firearms to hangings/ligatures as the most common means of suicide in the County in 2018, 2019, and 2020 (hangings accounted for 40.9% of suicides in the County in 2020). **In FY21, SPOC initiated a process to review the existing literature on hanging means restriction and to brainstorm safety strategies that could be adapted from clinical settings and applied to community settings.** The work included a clinical roundtable convened in January 2021, three literature reviews conducted by workgroup members, and follow-up presentations and discussions at SPOC and SP workgroup meetings. From these efforts a series of hangings means restriction recommendations and conclusions were compiled. Conclusions included the following:

- **Ligature restriction is very difficult**, if not impossible. Very little research exists, and this effort by SPOC is innovative. Ligature means safety efforts need to take place in concert with broader suicide prevention work.
- There is **no one-size-fits-all approach**. Strategies need to be tailored for different audiences.
- **Creating messaging for the general community is a complicated, delicate process**. Avoid "putting ideas in people's heads," sensationalizing suicides by hanging, and information getting into the hands of the suicidal person.
- **Work should be done collaboratively** across SPOC workgroups.

As next steps, SPOC will ask a selection of the original clinical roundtable members to vet the conclusions and recommendations, before they are shared with respective SPOC workgroups for implementation in FY22.

Objective 4: Improve messaging in media about suicide

WATCH LIVE

HEALTH & FITNESS

Bay Area experts share advice on talking to children and teens about mental health, suicide

SHARE
TWEET
EMAIL

By Kris Reyes

HEALTH BUILDING A BETTER BAY AREA
1-800-273-TALK (8255)
SUICIDE PREVENTION LIFELINE

EMBED <> MORE VIDEOS

ABC7 News reached out to doctors helping families daily with mental health issues. We asked them to share their best advice on how to have a conversation about this challenging topic.

SAN FRANCISCO (KGO) -- Even though we're closing in on a return to school the isolation is hitting children especially hard. We've learned that in the past two weeks, two different middle school students in Marin County died by suicide.

While researchers have yet to link these to the pandemic, it is clear that parents and caregivers are grappling with ways to help their kids through these difficult times.

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 (see reportingonsuicide.org). The SP Communications Workgroup takes on a range of efforts to monitor and improve safe messaging in the media.

To evaluate the progress of these efforts, in 2018, the SP Program began developing a safe messaging assessment tool to help rate media articles on adherence to the safe messaging guidelines. The Program used the assessment tool to conduct a baseline media analysis study, which evaluated local and national media guideline adherence following two high-profile celebrity suicides in 2018.

In FY21, the SP Program set out to revise and strengthen this evaluation tool through a partnership with the Stanford University Center for Youth Mental Health and Wellbeing and Palo Alto University. **This partnership revamped the assessment tool, creating the Tool for Evaluating Media Portrayals of Suicide (TEMPOS) to allow media professionals, public health officials, researchers, and suicide prevention experts to assess adherence to the recommended guidelines with a user-friendly, standardized rating scale.** The scale can be used to monitor changes in reporting over time and how reporting varies across articles, authors, and publications. The SP-Stanford-PAU partnership developed TEMPOS in consultation with field experts, including those involved in creating the "Recommendations for Reporting on Suicide." During development in FY21, an update to the 2018 SP Program baseline analysis was completed to prepare

TEMPOS for possible publication and dissemination to media and mental and public health professionals. The SP Program plans to use TEMPOS to conduct comparison analyses of its safe messaging efforts going forward, tentatively beginning with another analysis in FY22. Yearly and other periodic analyses will help establish an outcome measure for media adherence to safe messaging guidelines, both locally and nationally.

TEMPOS will help to promote 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.

Media Monitoring and Education

Dramatic photo: Deputy saves man dangling from Gold Country bridge

By Bay Area News Group

Mercury News 2021-02-09

In FY21, the SP Program responded to 34 local and national reporters regarding their articles on suicide and mental health. Responses either reminded journalists of the importance of safe messaging guidelines or thanked them for following guidelines. **The Program received 13 follow-up communications from journalists contacted, some resulting in continued dialogue on media reporting on suicide.**

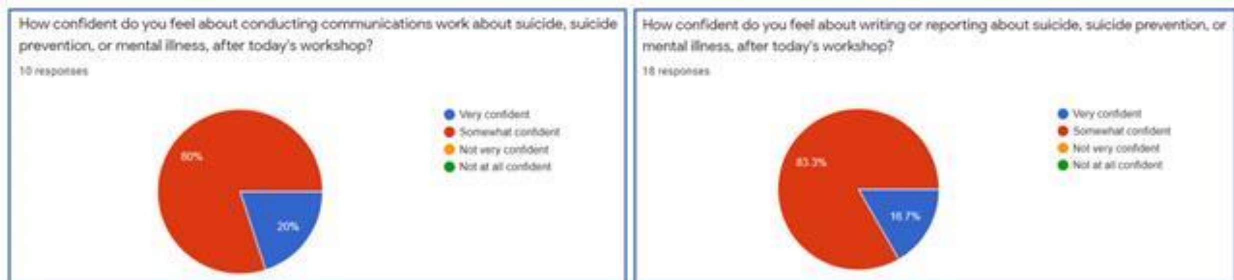
The SP Program also works directly with the media by providing trainings and education about safe messaging, and by providing safe content on suicide prevention through interviews and press releases about the program's work. **In FY21, Communications Workgroup members conducted interviews and/or provided information about mental health or suicide prevention to local media on 13 occasions.**

To encourage safe discourse in the public, and to further engage with media on safe reporting, the SP Program expanded its training efforts addressing safe messaging on suicide in FY21. The Program created and began offering safe reporting trainings to student journalists, public communications officials, and potential spokespeople in the county, as well as to media professionals. **In FY21,**

the SP Program provided four safe messaging trainings in the County. Trainings were attended by a total of 78 city officials, public communicators, law enforcement, school staff, suicide prevention task force members, and local high school students and peer leaders.

Post-workshop survey data indicated that 89% of respondents were somewhat or very likely to apply the safe messaging guidelines in their work. All who responded to the post-training survey stated that they understood the potential impact of reporting on suicide contagion. Additionally, 100% of respondents reported feeling either somewhat or very confident writing or reporting about suicide, suicide prevention, or mental illness, after the trainings (see Figure 22). The Program continues to offer and promote these trainings in FY22.

Figure 22. Safe Messaging Post-Training Survey Results



Objective 5: Create supportive community environments

Youth Connectedness Initiative (YCI)

The YCI project with Youth Community Service (YCS) aims to foster protective factors that include self-efficacy, positive relationships, connectedness, and community engagement among youth and families in the Palo Alto/North County community. In FY21, the YCI contract was transferred from School-Linked Services to be within the purview of BHSD's Suicide Prevention (SP) Program. Formed as a response to the CDC Epi-Aid report on youth suicide, YCI's vision aligns with the SP Program's ongoing upstream youth suicide prevention efforts.

Using the Search Institute's Developmental Relationships Framework (DRF) as a guide to inform and evaluate work for the new academic year, Peer Leaders selected "Express Care" and "Expand Possibilities" as the DRF elements of choice. Additionally, the YCI team identified three target audiences for their efforts: youth Peer Leaders, youth activity participants, and adults (family members, parents, etc.). With 22 Peer Leaders driving this effort, the virtual format of FY21 activities allowed for increased engagement and outreach through social media platforms. A snapshot of activities for the targeted audiences are below:

Figure 23. YCI Program Activities by Audience

YCI Peer Leaders	Peers/Youth	Community (parents, intergenerational families)
● Hosted informational presentations from local agencies. Topics included: mental health, suicide prevention, youth-led community engagement, healthy relationships, mental wellness and body image ● Trained in Be Sensitive, Be Brave series ● Safe messaging training ● 2 students served as panelists following community Angst documentary screening ● Presented at Gunn High School Wellness Conference	● Suicide prevention awareness campaign, Sexual assault awareness campaign, Effects of body image on mental health ● Developed Title IX video to reduce help-seeking stigma ● Hosted community mental health panel discussion ● Developed informational video on suicide prevention in collaboration with Palo Alto Unified School District ● Instagram Live with mental health professionals	● Weekly Mindful and Meditation offerings ● Service project: Child Advocates and Foster 5K fundraiser (virtual cheer squad for event) ● Make A Difference event: discussions about issues such as the election and housing, mental health, and education access ● Bill Wilson Center collaboration: households created personal care kits ● Service Across Ages: worked with Reach Potential Movement to gather personal hygiene items for families living in RVs in Mountain View

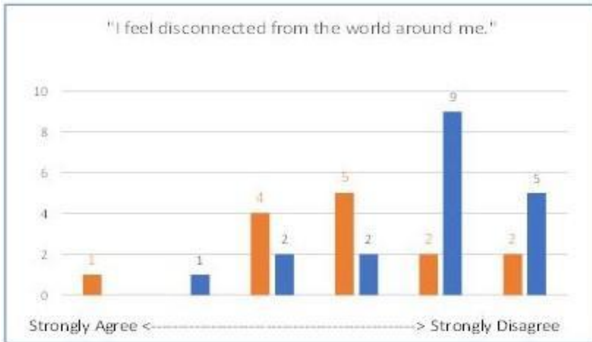
• AAPI Month panel discussion facilitation		

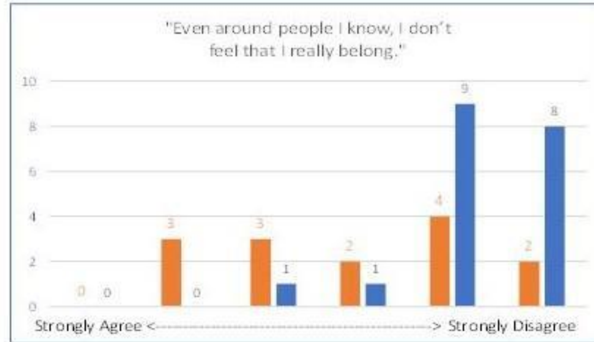
In FY21 there was a direct focus on strengthening the YCI Program's evaluation and data collection process, based on revised outcome goals. YCI Peer Leaders (N=19) along with a comparison group of non-program participants (N=14) were surveyed to assess YCI's impact on their knowledge and attitudes around belonging, sense of connectedness, and well-being. Reporting varied as some survey measures were based on qualitative and not quantitative responses.

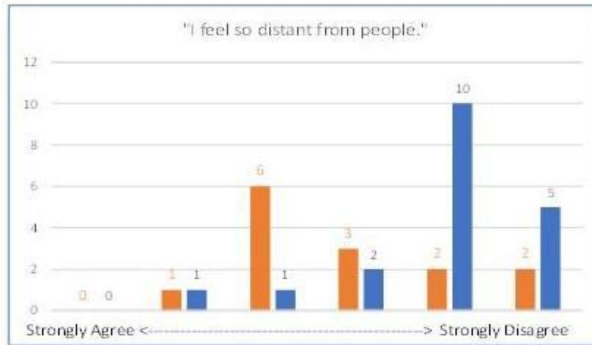
YCI program participants reported an overall positive program experience, with 79% rating their experience a 4 (highest) on a 4-point Likert scale, as well as high confidence in their newly acquired abilities to plan and execute YCI projects for peers and adults.

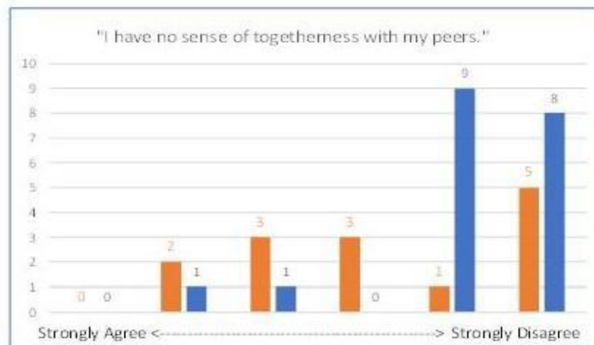
Participants were also asked to respond to statements about sense of belonging, social connections and relationships with peers, groups, adults, and society at-large. **When compared to YCI Peer Leader responses, more non-program participant responses reported feelings of social distance and disconnection, suggesting that YCI may have positively impacted participants' sense of belonging and social connection. YCI participants also demonstrated detailed understanding and interpretations of key DRF concepts, their proficiency with DRF vocabulary, and their ideas and experiences applying program principles and tools in their daily lives. Lastly, nearly all survey respondents agreed that their own actions related to the DRF elements "expressing care" and "expanding possibilities" had increased since starting the YCI program (see Figure 24).**

Figure 24. YCI Peer Leader Evaluation Survey Data









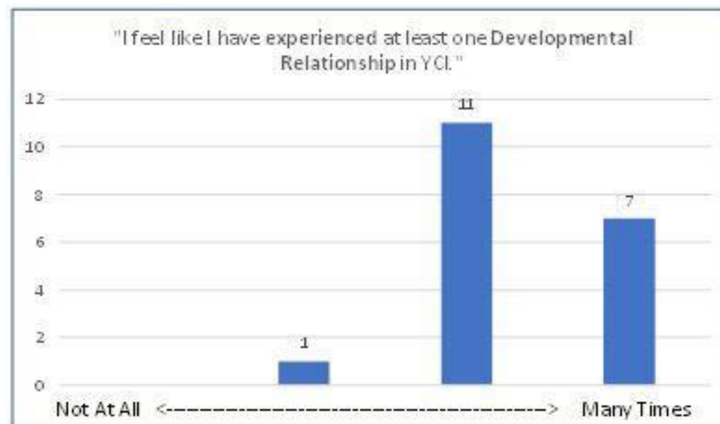
*What is the **Developmental Relationship Framework** and how is it related to YCI?*

"A developmental relationship is a connection between youth and an adult or between peers that positively impacts an individual's identity and mindset."

"Gap closing between different aspects of the community through a variety of events."

"The Developmental Relationship Framework includes connecting and inspiring the people around you. YCI is related to the term because through it the community comes closer together."

"The ways that I connect with others are through open mindedness and compassion for those who have struggled in one way or another. I was able to integrate those core values of unification through YCI and the project we led there."



CONCLUSION AND RECOMMENDATIONS

From FY19-21, the SP Program experienced significant growth that exceeded growth in its budget and staffing. This growth allowed the Program to meet the goals/recommendations put forward in its 2017, 2018, and FY20 annual reports. These recommendations included the following:

- Grow and strengthen the program to be able to better and more comprehensively serve the population across the lifespan;
- Continue to support efforts to strengthen services and the continuum of care as related to suicide;
- Increase primary prevention efforts by incorporating upstream, public health strategies that focus on building resilience factors and on improving environmental factors;
- Focus on sustainability of efforts, namely through capacity-building for SP;
- Ensure all SP efforts are culturally competent in order to better serve the diverse communities in the County;
- 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.

Looking ahead, the SP Program has a number of goals and challenges to address, particularly around sustaining its current level of work, continuing to explore innovative interventions to address the increase in suicide deaths, and ongoing program evaluation efforts. These goals include the following:

- Sustain/grow current efforts, including evaluation and data-driven approaches:
    - Develop a database of local, culturally relevant, evidence-based suicide prevention public awareness campaign materials.
    - Through the schools-based partnership, explore effective ways to incorporate and evaluate upstream social-emotional learning comprehensively across school systems.

    - Continue to understand and improve systems-level suicide prevention outcomes and how to measure them, specifically in schools and health systems.
    - Re-run some program evaluations in order to compare progress to the baselines that have already been conducted, e.g. using TEMPOS to assess recent safe messaging efforts, and re-running the BRFSS to assess use of behavioral health services at a population level.
- Address additional 2019 data recommendations:
    - Explore efforts with workplaces and relationships (25-34 age group).
    - Further develop hanging means safety work and an associated logic model/evaluation plan for means safety efforts.
- In 2021, the SP Program joined the Substance Use Prevention Services Program under one Prevention Services Division within the County of Santa Clara's Behavioral Health Services Department. The division's goals include increasing collaboration on, and the impact of, primary prevention efforts between the two programs. Some joint program and evaluation efforts will arise from this work, for example, combining efforts to promote and evaluate social/community connectedness.

- Continue pursuing data and analyses on suicide deaths, attempts, and ideation in order to improve understanding of suicide and inform suicide prevention efforts.

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Members of the Communications Workgroup
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Members of city-level suicide prevention taskforces
SACS and SP Volunteers