PROGRAM NAME

PEI Suicide Prevention Program

PREVENTION & EARLY INTERVENTION (PEI) 3-YEAR EVALUATION REPORT DATA: FY2019 (JULY 1, 2018) – FY2021 (JUNE 30, 2021)

1. Program Description

Describe the program description, status, priority/target population(s) and service category.

We suggest using the program description language and service category information published in the MHSA 3-year reports found at the links below:

FY18-20 3-year plan: https://bhsd.sccgov.org/sites/g/files/exjcpb711/files/mhsa-bos-approved-fy18-fy20-plan.pdf

FY21-23 3-year plan: https://bhsd.sccgov.org/sites/g/files/exjcpb711/files/Santa_Clara_MHSA-Three-Year-Plan_FY21-FY23%20Adopted-June-2-2020.pdf

Description: The Suicide Prevention Strategic Plan (SPSP) aims to increase suicide prevention for everyone. Through early intervention, education, and awareness, this plan seeks to reduce risk of suicide among all age groups in the County. The plan consists of five distinct but related strategies:

- Implementation and coordination of suicide intervention programs and services for targeted high-risk populations
- Implementation of a community education and information campaign to increase public awareness of suicide and suicide prevention
- Development of local communication "best practices" to improve media coverage and public dialogue related to suicide
- Implementation of policy and governance advocacy to promote systems change in suicide awareness and prevention
- Establishment of a robust data collection and monitoring system to increase the scope and availability of suicide-related data and evaluation of suicide prevention efforts

This plan aims to provide comprehensive suicide prevention and awareness activities countywide. The SPSP's five strategies have multiple recommendations, all of which will be implemented over time with input from the Suicide Prevention Oversight Committee (SPOC) and its work groups.

Status: Continuing

Stakeholder priorities and target populations addressed:

Children ages 0-15

- F&C.1 Examine cultural responsiveness
- F&C.2 Increase accessibility
- F&C.3 Expand school-related services and staffing
- F&C.4 Explore innovative outreach efforts

Transitional-aged youth

- TAY.3 Develop services tailored to TAY-specific needs
- TAY.4 Increase workforce recruitment, education, and training from TAY communities

Adults and older adults ages 26-59, 60+

- AOA.1 Culture and diversity needs
- AOA.2 Consider the need for a broader offering of post crisis intervention
- AOA.3 Assess points of coordination and collaboration
- AOA.5 Improve adult/older adult workforce recruitment, training, and retention

Service category: PEI – Suicide Prevention

2. Program Indicators

Please provide a few sentences describing what this program is intended to do in relation to the Prevention & Early Intervention Domains. In other words, how will the program direct their services & activities to address at least one of the 7 negative outcomes defined in the Welfare and Institution Code 5840?

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their home

Established in 2010, the Suicide Prevention Program has the mission of reducing and preventing suicides in Santa Clara County, by bringing community awareness to the issue and engaging in community prevention efforts. The program takes a public health approach to suicide prevention and engages in strategies across the prevention continuum (i.e. primary prevention, intervention, and postvention) and the socio-ecological model (individual/relationship to community/societal levels).

3. Program Goals, Objectives & Outcomes

We suggest using the language utilized in the MHSA 3-year reports found at the links below:

FY18-20 3-year plan: https://bhsd.sccgov.org/sites/g/files/exjcpb711/files/mhsa-bos-approved-fy18-fy20-plan.pdf

FY21-23 3-year plan: https://bhsd.sccgov.org/sites/g/files/exjcpb711/files/Santa_Clara_MHSA-Three-Year-Plan_FY21-FY23%20Adopted-June-2-2020.pdf

Program goal: Reduce and prevent suicide deaths in Santa Clara County.

Program objectives, activities, and outcomes:

Objectives	Activities	Short-term outcomes	Medium-term outcomes	Long-term outcomes
1: Strengthen community suicide prevention and crisis response systems	Trainings and consultations: - S4SP partnership (school districts) - County Health System (Primary Care/ Behavioral Health, Behavioral Health and contractors)	a) Increase knowledge among helpers and mental health providers about warning signs for suicide and resources. b) Increase knowledge/ understanding of best-practice crisis response protocols among health care providers and school administrators. c) Increase knowledge/ understanding of best-practice suicide assessment and clinical management	a) Increase self-efficacy among helpers and mental health providers to help someone who is in suicidal distress. b) Increase self-efficacy of using best-practice crisis response protocols among providers and administrators. c) Increase self-efficacy among mental health providers of using best-practice suicide assessment and clinical management.	a) Increase use of best-practice crisis response protocols and practices among health providers and school administrators. b) Increase use of best-practice suicide assessment and clinical management skills among mental health providers.

		among mental health providers. d) Identify strengths and gaps in suicide screening, assessment, and management at behavioral health clinics.	d) Increase organizational support and training around suicide assessment and management for behavioral health clinics. e) Increase number of people identified and connected to help.	
2: Increase use of mental health services	Helper/mental health trainings Public awareness campaigns Community outreach Services	a) Increase knowledge about mental health/ illness and suicide. b) Increase knowledge about available mental health and suicide prevention resources. c) Increase preparedness to identify and help someone who is experiencing psychological/suicidal distress.	a) Improve attitudes/ reduce stigma around mental illness, suicide, and use of mental health services. b) Improve attitudes towards supporting people who are experiencing psychological distress. c) Increase self-efficacy to identify and help someone who is experiencing psychological/suicidal distress. d) Increase number of people identified and connected to help.	a) Increase help-seeking for mental health/suicide.
3: Reduce access to lethal means	*In process of being defined*			
4: Improve safe messaging in the media about suicide	Rapid local media response regarding articles addressing suicide Development of tool to evaluate article/media adherence to safe messaging guidelines Safe messaging trainings for media, local officials, youth Media interviews about suicide or suicide prevention	a) Increase knowledge among media and communications officials about safe messaging guidelines. b) Increase confidence among media and communications officials to apply safe messaging practices in reporting work.	a) Improve attitudes of media and communications officials toward incorporating safe messaging practices. b) Increase likelihood of media to apply local safe messaging principles in reporting. c) Increase likelihood of media and communications officials to share and discuss safe messaging guidelines/practices with media colleagues.	a) Improve average adherence to safe messaging guidelines for local media articles, local reporters, and local outlets, when compared to prior years, as measured by safe messaging evaluation tool. b) Increase presence of de-stigmatizing language around suicide and mental health resources in local media stories.

5: Increase supportive community environments for vulnerable populations (currently youth only)	Youth Connectedness Initiative (YCI): - Presentations on mental health and related topics - Panel discussions - Mindfulness meditation - Social media campaigns and informational videos -Multi-generational family service projects	a) Increase reported knowledge about Developmental Relationship Framework (DRF) element(s) among Youth Peer Leaders. b) Increase reported knowledge about DRF element(s) among youth participants. c) Increase reported knowledge about DRF element(s) among parent participants.	a) Improve reported attitudes and strengthen intention to implement DRF element(s) among Youth Peer Leaders. b) Improve reported attitudes and strengthen intention to implement DRF element(s) among youth participants. c) Improve reported attitudes around and strengthen intention to implement DRF element(s) among parent participants.	a) Increase actions by Youth Peer Leaders as they relate to DRF element(s). b) Increase in reported receipt of DRF element(s) by Youth Peer Leaders from their peers and parents.

4. Clients Served & Annual Cost per Client Data

Please consult with PEI Manager (Roshni Shah) and MHSA Finance Team (Tina Cordero, Vince Robben and Amber Ma) to verify the actual expenditures as reported in our Annual Revenue & Expenditure Reports (ARER). These costs should be utilized to calculate the cost per person.

We suggest using the language utilized in the MHSA 3-year reports found at the links below:

FY18-20 3-year plan: https://bhsd.sccgov.org/sites/g/files/exjcpb711/files/mhsa-bos-approved-fy18-fy20-plan.pdf

FY21-23 3-year plan: https://bhsd.sccgov.org/sites/g/files/exjcpb711/files/Santa_Clara_MHSA-Three-Year-Plan_FY21-FY23%20Adopted-June-2-2020.pdf

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 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.

5. Evaluation Activities

All PEI programs must address at least one or more of the strategies below. Please indicate which strategy/strategies your program utilized.

Strategies including:

- Access and Linkage
- Improving Timely Access to Services for Underserved Populations
- Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory

Additionally, for the 3-year PEI evaluation report, detailed information on the outcomes and how outcomes were measured need to be described. In narrative form, please describe the following:

Per section 3730 of the PEI regulations, Suicide Prevention Programs at the County shall select and use a validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific Program. Please state the method and activities to be used to change attitudes and knowledge, including the timeframes for the measurement. Per PEI regulations, Suicide Prevention Program activities can include, but are not limited to, public and targeted information campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, survivor-informed models, screening programs, suicide prevention hotlines or web-based suicide prevention resources, and training and education.

For each Program, the methods of measuring outcomes, should be one or a combination of the following:

- Evidence-based practice standard or promising practice standard
    - If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness, explain how the practice's effectiveness has been demonstrated and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.
- Community and or practice-based evidence standard
    - If the County used the community and/or practice-based standard to determine the Program's effectiveness, describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

Please explain which standard you used in detail and provide any supporting documentation, such as survey instruments, tools, peer-reviewed journals, etc., if available.

The Suicide Prevention (SP) Program utilizes strategies that aim to increase Access and Linkage to mental health services. Program activities are also designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory. The below table includes detailed narrative on how program outcomes are measured. (See Section 3 for list of program outcomes by objective.)

Objectives	Activities	Evaluation Activities
1: Strengthen community suicide prevention and crisis response systems	Trainings and consultations: Schools for Suicide Prevention (S4SP) partnership	The SP Program uses **evidence-based and promising practice standards** to evaluate its school-based suicide prevention efforts. School districts participating in the partnership train their teachers and staff in gatekeeping/helper skills using online Kognito simulation modules, which include pre-, post-, and 90-day follow-up surveys assessing knowledge, attitudes, and behaviors around supporting students who are in psychological distress. Kognito measures are based on the validated Gatekeeper Behavior Scale (Albright, Davidson, Goldman, Shockley & Timmons-Mitchell, 2016). Kognito surveys also include the SP Program's eight standardized training outcome measures for knowledge, attitudes, self-efficacy/behavior, and cultural competency around suicide and acting as a gatekeeper/helper. These outcome measures align with the core components and competencies of suicide prevention gatekeeper

		trainings, as identified in the literature through research conducted by the SP Program and Palo Alto University's Multicultural Suicide and Ethnic Minority Mental Health Research Group (see attached document, "Mapping Suicide Gatekeeping Training Gold Standards and Cultural Guidelines"). In addition to staff gatekeeper training, S4SP school district administration receive technical support from the HEARD Alliance on additional suicide prevention efforts, primarily crisis response protocols and forms. This technical support is delivered based on the HEARD Alliance's K-12 Toolkit for Mental Health Promotion and Suicide Prevention (www.heardalliance.org/help-toolkit), a compendium of evidence-based and best-practice tools supporting school-based suicide prevention and crisis response. The Kognito pre- and follow-up surveys include questions assessing staffs' knowledge of their district's crisis response protocols for students at low-, moderate-, and high-risk for suicide. The HEARD Alliance also tracks the number and progress of school districts they work with on implementing best-practice crisis response protocols, as an additional outcome of the school-based consultations. Reference Albright, G. L., Davidson, J., Goldman, R., Shockley, K. M., & Timmons-Mitchell, J. (2016). Development and validation of the Gatekeeper Behavior Scale: A tool to assess gatekeeper training for suicide prevention. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 37*(4), 271–280. https://doi.org/10.1027/0227-5910/a000382
	Trainings and consultations: County Health System (Primary Care/Behavioral Health, Behavioral Health and contractors)	In FY21 the SP Program contracted with Drs. Joyce Chu and Chris Weaver to pilot-test downstream implementation support for primary care and behavioral health clinical sites seeking to enhance their system-wide suicide services. This work is grounded in research that supports the idea that deaths by suicide may be effectively prevented by focusing on clinical settings. The outcome evaluation methods for this work are based on **evidence-based practice standards**. In order to demonstrate viability of the downstream suicide prevention work during the pilot/proof-of-concept year in FY21, 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 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. 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). In addition, the consultation functions themselves include data and evaluation support at the clinical site level, such as collection and analysis of needs assessment data to identify gaps, strengths, and priorities for organizational improvement; collection and analysis of evaluation data to track outcomes on system improvements; and 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. Nonetheless, 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. Two of the Primary Care and one Behavioral Health site implemented detailed needs assessments, which provide baseline data against which future years' work can be compared. Additionally, Dr. Chu and Dr. Weaver collected baseline systems improvement data from two additional nursing sites. The evaluation tool utilized for the organizational needs assessments and outcome measurements over time is based on the Zero Suicide Framework's Organizational Self-Study and

		Workforce Survey of staff knowledge, practices, and confidence in suicide prevention-related competencies (Zero Suicide Institute, 2018; 2020). The competencies measured in this survey are based in evidence-based practices for suicide care, and supported by emerging science (e.g., Layman et al., 2021; Turner et al., 2021). References Layman, D. M., Kammer, J., Leckman-Westin, E., Hogan, M., Goldstein Grumet, J., Labouliere, C. D., ... & Finnerty, M. (2021). The relationship between suicidal behaviors and zero suicide organizational best practices in outpatient mental health clinics. Psychiatric services, appi-ps. Turner, K., Sveticic, J., Almeida-Crasto, A., Gaee-Atefi, T., Green, V., Grice, D., ... & Stapelberg, N. J. (2021). Implementing a systems approach to suicide prevention in a mental health service using the Zero Suicide Framework. Australian & New Zealand Journal of Psychiatry, 55(3), 241-253.
2: Increase use of mental health services	Helper/mental health trainings	The SP Program uses an **evidence-based standard** to determine the effectiveness of its training program. During the reporting period, the Program offered up to nine trainings in mental health and suicide prevention helper (gatekeeper) skills. Trainings are evaluated using pre- and post-training online surveys, which are completed by participants at the beginning and end of each training. Across the surveys for each training type, the Program incorporated eight standardized outcome measures for knowledge, attitudes, self-efficacy/behavior, and cultural competency around suicide and acting as a gatekeeper/helper. These outcome measures align with the core components and competencies of suicide prevention gatekeeper trainings, as identified in the literature through research conducted by the SP Program and Palo Alto University's Multicultural Suicide and Ethnic Minority Mental Health Research Group (see attached document, "Mapping Suicide Gatekeeping Training Gold Standards and Cultural Guidelines"). SP Program training evaluation data is compiled and analyzed in aggregate and by training type at the end of each fiscal year. This evaluation data has informed the SP Program's decision to phase out certain helper trainings and introduce others. The Program aims to incorporate follow-up survey data as a long-term evaluation goal for trainings.
	Public awareness campaigns	The SP Program uses an **evidence-based standard** to determine the effectiveness of its public awareness campaigns. The Program develops, implements, and evaluates 1-2 suicide prevention public awareness campaigns per fiscal year. These campaigns strive to utilize a culturally competent approach to raise public awareness through repeated exposure; and improve attitudes, knowledge and behavior by pulling from a combination of the best available research in the field, contextual evidence gathered through stakeholder feedback and community data sources, and experiential evidence drawing from the expertise of those who are part of the campaign development team. An evaluation agency works closely with the Program and media agency partners to implement an evaluation designed to monitor program implementation, assess participant outcomes, and demonstrate program effectiveness. The evaluators begin with a thorough literature review in pursuit of the latest evaluation research from similar campaigns and initiatives. They then develop an evaluation plan to track progress toward the specified outcomes and gather the data that is needed to inform future decision-making. Learning questions are aligned with the Program's logic model; each of the campaign-related outcomes has one or more evaluation measures associated with it. Campaign analytics data and longitudinal hotline call volume data are used to explore correlations between the campaign and any changes in behavior. However, the primary data source is a survey developed by the evaluator to address the specific campaign objectives. To the extent possible, questions from validated instruments are used or modified to ensure that the survey is based on existing knowledge and practice. Each evaluation utilizes a retrospective pre-/post-intervention survey to help assesses reach, reaction among the target

		audience, as well as knowledge, attitudes, and likelihood to seek help for suicidal ideation and mental health challenges. Outcomes are compared between survey respondents who report having been exposed to the campaign versus respondents who report no campaign exposure. Outcomes are also compared between cultural groups, such as U.S.-born and non-U.S.-born, or Spanish-speaking and non-Spanish-speaking survey respondents. In addition, although the survey is customized to address the unique aspects of each campaign, some items remain consistent across all campaigns to serve as another point of comparison. Evaluation data is collected in paper and online format from the middle of each campaign's airing to a few weeks after the campaign has ended. The aim is to collect the number of surveys that is statistically representative of each campaign's target audience size in the county. The evaluation agency analyzes the data and presents a report back to the Program and stakeholders a few months after each campaign has ended. This evaluation data informs further public awareness and communication efforts by the SP Program, particularly efforts to reduce stigma and increase help-seeking among cultural communities.
	Community outreach Suicide and crisis services	The SP Program regularly conducts community outreach through tabling at events and calls to providers. The outcomes of community outreach efforts alone are not measured, but are considered as part of all of the activities described in this section that are working to increase use of mental health services. The SP Program has partnered with the county's Public Health Department (PHD) to measure population-level progress on the long-term outcome of increasing help-seeking. In 2019 the Program partnered with PHD's epidemiology team to run the Behavioral Risk Factor Surveillance System (BRFSS)'s mental health survey module (see survey, attached). BRFSS is an **evidence-based practice standard**, and measures for the mental health module were developed based on validated mental health survey instruments. Due to turnover and limited staffing during the COVID-19 pandemic, the BRFSS mental health module has not yet been re-run in the county. However, additional data on use of mental health services is provided directly by the services associated with the SP Program, namely Crisis Text Line and the Suicide and Crisis Hotline. Crisis Text Line provides the SP Program with access to a real-time data dashboard that shows usage of the county's service, along with texter demographics. The Suicide and Crisis Hotline provides call volume and demographics by request, and particularly to compare any effect on call volume while public awareness campaigns are on-air.
3: Reduce access to lethal means	*Outcomes in process of being defined*	
4: Improve safe messaging in the media about suicide	Rapid local media response regarding articles addressing suicide Development of tool to evaluate article/media adherence to safe messaging guidelines Safe messaging trainings for media, local officials, youth	Research shows that media adherence to the "Recommendations for Reporting on Suicide" (reportingonsuicide.org) can help to decrease the spread of suicidal behavior. The Recommendations draw upon more than 50 international studies on suicide contagion and were developed by leading experts in the fields of suicide prevention, journalism, and public health. However, current methods of measuring adherence to the Recommendations are not standardized and use binary measures for adherence (e.g. Yes/No, Present/Not Present) across several safe messaging characteristics. Current measurement methods make it difficult for suicide prevention programs to evaluate progress on safe messaging over time and across programs. Furthermore, binary measures of adherence fail to capture nuances in adherence to certain safe messaging guidelines, such as "Framing of Suicide" or "Sensationalism." The SP Program has used a mix of **evidence-based standards** and **promising practice standards** to develop an evaluation tool for its safe messaging efforts. To address the challenges associated with evaluating safe messaging efforts, the Program partnered with Stanford University's Center for Youth Mental Health and Wellbeing and developed the Tool for Evaluating Media Portrayals of Suicide (TEMPOS, see attached PDF). The TEMPOS measures were developed directly from the "Recommendations for Reporting on Suicide," assessing adherence to each of the ten safe messaging recommendations on a three-point

	Media interviews about suicide or suicide prevention	numerical scale and allowing for each article and publication to receive average ratings for safe messaging adherence. The tool was developed in consultation with field experts, including those involved in creating the "Recommendations for Reporting on Suicide." TEMPOS purpose, content, and application are endorsed by these experts as both necessary and innovative for suicide prevention advancement. As a baseline measurement for its safe messaging efforts, the SP Program applied TEMPOS to a dataset of 226 suicide-related news articles from June 2018, when Anthony Bourdain and Kate Spade died by suicide and the CDC issued its annual suicide data report. An update to this analysis was completed in FY21, in alignment with upgrades to TEMPOS to prepare it for 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. In the meantime, the Program continues to collect pre/post survey data from the safe messaging trainings it conducts with media professionals, potential spokespeople, and high school journalism students in the county. Additional efforts are under way to provide safe messaging trainings to college students, particularly those pursuing media communications and journalism. The Program also conducts regular monitoring of the local media and response to reporters for stories on suicide, and tracks reporters' responses to these outreach efforts. From FY19 through the end of FY21, the Program communicated directly with local, and some national, reporters on 85 articles addressing suicide and mental health.
5: Increase supportive community environments for vulnerable populations (currently youth only)	Youth Connectedness Initiative (YCI): - Presentations on mental health and related topics - Panel discussions - Mindfulness meditation - Social media campaigns and informational videos -Multi-generational family set knorvice projects	YCI uses an **evidence-based standard** to determine the effectiveness of its programming. The initiative was developed using guiding principles from the Search Institute's Developmental Relationships Framework (DRF). The DRF was created based on research showing that young people who experience strong developmental relationships across different parts of their lives are more likely to show signs of positive development in many areas, including increased academic motivation; increased social-emotional growth and learning; increased sense of personal responsibility; and reduced engagement in a variety of high-risk behaviors. Each semester of programming, YCI peer leaders select a different DRF element of focus (e.g. Express Care, Expand Possibilities, Provide Support) and design activities that aim to foster the DRF element. In FY21, the SP Program worked with YCI to develop a logic model and evaluation plan that address the initiative's three target audiences: YCI peer leaders, the broader youth community, and parents. Using the DRF as guidance, YCI staff developed short-, medium-, and long-term outcomes for each of their target audience groups. Program outcomes include understanding of the DRF, self-efficacy and attitudes towards incorporating DRF elements, and experiences of giving or receiving the DRF elements in youth's or parent's lives. For youth and parent participants, YCI staff incorporated post-activity surveys that include measures supporting their program outcomes. In addition, YCI staff conducted a year-end survey with YCI peer leaders to request their feedback on the program's success and assess its impact on their knowledge and attitudes surrounding belonging, sense of connectedness and well-being. Because DRF evaluation tools from the Search Institute were not yet available in mid-2021, YCI staff created their own survey instrument to evaluate YCI in FY21. This instrument included a set of 11 Likert-scale responses to statements about social connectedness, group belonging, and relationships with adults; as well as three binary questions regarding YCI awareness and school attendance; five open-response questions about the DRF; and nine Likert-scale questions measuring participants' engagement with program skills in their daily lives. The Likert-scale questions on social connectedness were validated measures pulled from The Social Connectedness Scale (attached). To inform an assessment of program impact, a comparison

		group of 14 students from Palo Alto high schools who did not complete YCI but who attended other YCS programs also voluntarily completed the survey, and their responses provided a baseline against which YCI participant feedback was compared. These evaluation results will inform future YCI iterations as well as other forthcoming YCS program offerings, particularly as YCI seeks to expand its services to more school districts across the county.

6. Demographic Data

For each fiscal year below, please complete the demographic data below as required by the state regulations. If you did not collect indicators for any of these variables for a given fiscal year, please write "Not available" and include a few sentences explaining why the data were not collected.

	FY 2019		FY 2020		FY 2021	
Age Group	**# Served**	**% of Served**	**# Served**	**% of Served**	**# Served**	**% of Served**
0 – 15 years	86	2.0%	15	0.3%	1860	27.0%
16 -25 years	515	12.0%	452	10.2%	2154	31.3%
26- 59 years	3154	73.7%	1948	44.1%	2494	36.3%
60+ years	277	6.5%	162	3.7%	179	2.6%
Prefer not to answer	127	3.0%	74	1.7%	193	2.8%
Unknown	123*	2.9%	1241+528*=1769	40.0%		
Unduplicated Total**	4282	100%	4420	100%	6880	100%

**Reported in different age groupings*

***PHI is not collected in prevention activities, so unduplicated counts cannot be determined.*

	FY 2019		FY 2020		FY 2021	
Race	**# Served**	**% of Served**	**# Served**	**% of Served**	**# Served**	**% of Served**
American Indian or Alaska Native	21	0.6%	10	0.3%	73	1.7%
Asian	743	21.0%	576	15.9%	1096	25.1%

Black or African American	112	3.2%	97	2.7%	131	3.0%
Native Hawaiian or Other Pacific Islander	37	1.0%	22	0.6%	50	1.1%
White/ Caucasian	1460	41.3%	1217	33.6%	2059	47.2%
Other	613	17.4%	36	1.0%		
More than one race	250	7.1%	224	6.2%	234	5.4%
Prefer not to answer	296	8.4%	197	5.4%	718	16.5%
Unknown			1241	34.3%		
Unduplicated Total	3532	100%	3620	100%	4361	100%

	FY 2019		FY 2020		FY 2021	
Ethnicity	**# Served**	**% of Served**	**# Served**	**% of Served**	**# Served**	**% of Served**
Hispanic or Latino:						
Caribbean	6	0.3%	4	0.5%	2	0.2%
Central American	31	1.6%	31	3.5%	13	1.0%
Mexican/ Mexican-American/ Chicano	395	19.8%	523	59.8%	447	34.0%
Puerto Rican	8	0.4%	15	1.7%	4	0.3%
South American	26	1.3%	29	3.3%	44	3.4%
Hispanic/ Latino (undefined)	62	3.1%	251	28.7%	745	56.7%

Other Hispanic/ Latino	1471	73.6%	21	2.4%	58	4.5%
Hispanic or Latino Subtotal	1999	100%	874	100.0%	1313	100%
Non-Hispanic or Non-Latino as follows:						
African	45	1.5%	54	1.5%	5	0.2%
Asian Indian/ South Asian	91	3.0%	72	2.0%	165	5.6%
Cambodian	3	0.1%	6	0.2%	6	0.2%
Chinese	187	6.1%	108	3.0%	212	7.2%
Eastern European	83	2.7%	51	1.4%	114	3.9%
European	580	18.9%	449	12.4%	696	23.8%
Filipino	107	3.5%	103	2.9%	196	6.7%
Japanese	39	1.3%	22	0.6%	69	2.4%
Korean	30	1.0%	25	0.7%	59	2.0%
Middle Eastern	27	0.9%	20	0.6%	32	1.1%
Vietnamese	73	2.4%	95	2.6%	203	6.9%
Non-Hispanic/ Non-Latino (undefined)	479	15.6%	343	9.5%		
Other Non-Hispanic/ Non-Latino	499	16.3%	297	8.2%	590	20.1%
Non-Hispanic or Non-Latino Subtotal	2243	73.2%	1645	45.5%	2347	99.2%
More than one ethnicity	428	14.0%	332	9.2%	15	0.6%

Prefer not to answer	395	12.9%	260	7.2%	4	0.2%
Unknown	N/A	N/A	1375	38.1%		
Unduplicated Total	3066	100%	3612	100%	2366	100%

	FY 2019		FY 2020		FY 2021	
Gender (Assigned at Birth)	**# Served**	**% of Served**	**# Served**	**% of Served**	**# Served**	**% of Served**
Male	719	26.4%	663	17.0%	686	21.4%
Female	1898	69.7%	1872	48.1%	2330	72.8%
Prefer not to answer	107	3.9%	114	2.9%	178	5.6%
Unknown			1243	31.9%	5	0.2%
Unduplicated Total	2724	100.0%	3892	100.0%	3199	100%

	FY 2019		FY 2020		FY 2021	
Gender (Current)	**# Served**	**% of Served**	**# Served**	**% of Served**	**# Served**	**% of Served**
Male	968	27.0%	772	17.4%	1143	22.3%
Female	2472	68.9%	2271	51.1%	3624	70.6%
Transgender (Male to Female)	*N/A – only general Transgender response option was given this year*	*N/A – see left*	1	0.0%	3	0.1%
Transgender (Female to Male)	*N/A – see above*	*N/A – see left*	2	0.0%	3	0.1%
Transgender (Undefined)	3	0.1%	26	0.6%		
Genderqueer	15	0.4%	22	0.5%	5	0.1%

Questioning or Unsure	2	0.1%	2	0.0%	6	0.1%
Another gender identity	15	0.4%	5	0.1%	18	0.4%
Prefer not to answer	113	3.1%	104	2.3%	331	6.4%
Unknown			1241	27.9%		
Unduplicated Total	3588	100.0%	4446	100.0%	5133	100%

	FY 2019		FY 2020		FY 2021	
Sexual Orientation	**# Served**	**% of Served**	**# Served**	**% of Served**	**# Served**	**% of Served**
Gay or Lesbian	49	1.7%	64	1.4%	71	2.2%
Heterosexual/ Straight	2315	81.3%	2450	55.4%	2545	79.6%
Bisexual	72	2.5%	71	1.6%	87	2.7%
Questioning/ Unsure	14	0.5%	10	0.2%	19	0.6%
Queer	19	0.7%	18	0.4%	21	0.7%
Another sexual orientation	7	0.2%	8	0.2%	6	0.2%
Prefer not to answer	294	10.3%	281	6.4%	450	14.1%
Unknown	78*	2.7%	1241+277*	34.3%		
Unduplicated Total	2848	100.0%	4420	100.0%	3199	100%

*Reported as one category, LGBTQ

	FY 2019		FY 2020		FY 2021	
Primary Language	**# Served**	**% of Served**	**# Served**	**% of Served**	**# Served**	**% of Served**

English	3077	85.1%	2272	58.4%	2811	85.2%
Spanish	283	7.8%	185	4.8%	112	3.4%
Vietnamese	48	1.3%	31	0.8%	71	2.2%
Chinese	90	2.5%	20	0.5%	52	1.6%
Tagalog	28	0.8%	17	0.4%	31	0.9%
Farsi	10	0.3%	3	0.1%	9	0.3%
Other	81	2.2%	92	2.4%	150	4.5%
Prefer not to answer			31	0.8%	65	2.0%
Unknown			1241	31.9%		
Unduplicated Total	3617	100%	3892	100%	3301	100%

	FY 2019 *In FY19, question asked was Veteran Status Yes/No*		**FY 2020**		**FY 2021**	
Military Status	**# Served**	**% of Served**	**# Served**	**% of Served**	**# Served**	**% of Served**
Active Military			11 *In FY20, response options were "Currently active duty" and "Currently reserve duty or National Guard"*	0.4%	11 *In FY21, response options were "Currently active duty" and "Currently reserve duty or National Guard"*	0.4%
Veteran	55	2.0%				
Served in Military			61 *In FY20, response options were "Previously served and honorable/ separation or general/other discharge" and "Served in*	2.3%	60 *In FY21, response options were "Previously served and honorable/ separation or general/other discharge" and "Served in*	1.9%

			another country's military"		*another country's military"*	
Family of Military						
No Military			2472 *In FY20, response option was "Never served"*	93.2%	2973 *In FY21, response option was "Never served"*	93.1%
Prefer not to answer	80	2.9%	95	3.6%	130	4.1%
Unknown/Other	2582 *Reported as "No Veteran Status" in FY19*	95%	12	0.5%	21	0.7%
Unduplicated Total	2717	100.0%	2651	100.0%	3195	100%

	FY 2019		FY 2020		FY 2021	
Disability*	**# Served**	**% of Served**	**# Served**	**% of Served**	**# Served**	**% of Served**
Difficulty seeing	116	4.2%	76	2.8%	76	2.4%
Difficulty hearing or speaking	20	0.7%	31	1.1%	30	0.9%
Other communication disability					5	0.2%
Cognitive	75 *In FY19 was "Mental Domain"*	2.7%	59 *In FY20 response options were "Learning disability, developmental disability, and dementia"*	2.2%	61 *In FY21 response options were "Learning disability, developmental disability, and dementia"*	1.9%

Physical/ Mobility	21	0.8%	32	1.2%	14	0.4%
Chronic Health Condition	50	1.8%	66	2.4%	70	2.2%
Other non-communication disability	35	1.3%			2	0.1%
No Disability	2299	83.2%	2295	84.1%	2661	83.0%
Prefer not to answer	148	5.4%	116	4.3%	258	8.0%
Unknown		0.0%	53 *In FY20 reported as "Other"*	2.0%	28 *In FY21 reported as "Other"*	0.9%
Unduplicated Total	2764	100.0%	2728	100.0%	3205	100%

*Participants may choose more than one option for Disability.

7. Group Services Delivered

This number refers to the unduplicated number of participants receiving group services per year. If group services are not offered by your program, please indicate "N/A".

For Suicide Prevention Programs, the County may also separately report available numbers of individuals reached, including demographic breakdowns. An example would be the number of individuals who received training and education or who clicked on a web site.

For each fiscal year, please provide a summary narrative of the types of group services delivered and the target population(s) served.

FY 2019			FY 2020			FY 2021		
Duplicated* N = 1,444,909			Duplicated* N = 7,369,249			Duplicated* N = 21,525,755		
Number of Groups	**Attendance**	**Average Attendance per Group**	**Number of Groups**	**Attendance**	**Average Attendance per Group**	**Number of Groups**	**Attendance**	**Average Attendance per Group**
47 outreach events attended	1,357 received resources	28.9 received resources per event	30 outreach events	1,281 received resources	42.7 received resources per event	2 virtual outreach events	15	7.5
			11 virtual mental health town	470 people	42.7 people	2 rounds of outreach calls to older	63 calls	31.5 calls per round

			halls for cultural communities	+ 2,200 Facebook views	+ 200 Facebook views	adult providers (in-home supports and funeral homes)		
1 Crisis Text Line service	123 texters	123 texters	1 Crisis Text Line service	528 texters	528 texters	1 Crisis Text Line service	297 texters	297 texters
6 Youth Mental Health First Aid trainings	99	16.5	4 Youth Mental Health First Aid trainings	49	12	*Youth Mental Health First Aid not offered due to COVID-19 pandemic*		
5 Be Sensitive, Be Brave trainings	255	51	12 Be Sensitive, Be Brave trainings	756	63	36 Be Sensitive, Be Brave trainings	951	26
62 QPR trainings	1,461	23.5	41 QPR trainings	1,019	25	6 QPR trainings	173	29
Kognito trainings in 7 school districts	2,379	340 trained per district	Kognito trainings in 11 school districts	1,631	148 trained per district	Kognito trainings in 11 school districts	8,791	799 trained per district
8 ASIST trainings	193	24	7 ASIST trainings	170	24	*ASIST not offered due to COVID-19 pandemic*		
2 suicide to Hope trainings	39	19.5	1 suicide to Hope training	13	13	3 SP201 clinical trainings	158	53
2 safeTALK trainings	44	22	1 safeTALK training	25	25	*safeTALK no longer offered*		
Online QPR trainings (individual)	815	815	Online QPR trainings (individual)	909	909	Online QPR trainings (individual)	2,307	2,307
LivingWorks Start not offered						LivingWorks Start (individual)	50	50
1 public awareness campaign – Public location (Gilroy DMV)	50,388 individuals reached	50,388 individuals reached	1 public awareness campaign – radio	792,200 individuals reached	792,200 individuals reached	2 public awareness campaigns – radio	923,634 impressions **	461,817 impressions**

1 public awareness campaign – social media (Facebook, Instagram, Snapchat, Pandora)	1,200,000 impressions**	1,200,000 impressions**	1 public awareness campaign – Facebook	723 individuals reached	723 individuals reached	*Facebook not part of campaigns*		
1 public awareness campaign – Public transit	187,500 individuals reached	187,500 individuals reached	1 public awareness campaign – Print	49,500 individuals reached	49,500 individuals reached	*Print/outdoor not part of campaigns*		
YouTube not part of campaign			1 public awareness campaign – YouTube	339,937 video views 1,642,509 impressions**	339,937 video views 1,642,509 impressions**	1 public awareness campaign – YouTube	22,131 video views 455,472 impressions**	22,131 video views 455,472 impressions**
Online/digital not part of campaign			1 public awareness campaigns – Online (digital)	4,862,357 impressions**	4,862,357 impressions**	2 public awareness campaigns – Online (digital)	19,221,698 impressions**	9,610,849 impressions**
Television not part of campaign			*Television not part of campaign*			1 public awareness campaign - Television	235,635 impressions**	235,635 impressions**
Spotify not part of campaign			*Spotify not part of campaign*			1 public awareness campaign – Spotify (online streaming)	624,996 impressions**	624,996 impressions**
Website not part of campaign			1 public awareness campaigns – Webpage	12,693 visits	12,693 visits	2 public awareness campaigns – Webpages	50,540 unique visitors	25,270 unique visitors
1 safe messaging training	10	10	*Safe messaging trainings not conducted*			4 safe messaging trainings	78	20
10 suicide prevention consultations/ trainings for school	74	7	30 suicide prevention consultations/ trainings for school	216	7	46 suicide prevention consultations / trainings for school	519	11

administrators and staff			administrators and staff			administrators and staff		
						8 health care and behavioral health sites that received clinical suicide prevention consultations	232	29 per site
1 Suicide Prevention Conference	172	172	*Suicide Prevention Conference not held due to COVID-19 pandemic*			1 Suicide Prevention Conference (virtual)	160	160

*****This program cannot differentiate among duplicated individuals as no 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 impressions do not refer to distinct individuals who were reached by the campaign; rather, impressions refer to the number of times a number of individuals have been exposed to a public awareness campaign.

8. Detailed Outcomes

Please include as much outcome information as you have available for your program by fiscal year. This should include:

- The indicators utilized
- Percent improvement (From pre- to post- results)
- The method and activities to be used to change attitudes and knowledge, including time frames for the measurement
    - This includes the names and references of the survey tools used to measure the outcomes
- Any summary narrative explaining the outcome data, any information on data collection, and any observations made by the program in the outcome and data collection process

If you need any samples or suggestions on how to include your detailed outcome information, please contact PEI Manager Roshni Shah.

FY19

Outcome: Increase early identification and support for people thinking about suicide

Change in suicide gatekeeper measures across all trainings, January-June 2019

Measures (Scores range from 1=Strongly Disagree to 5=Strongly Agree)	**Pre-Training**		**Post-Training**		**t-test**
	M	**SD**	**M**	**SD**	

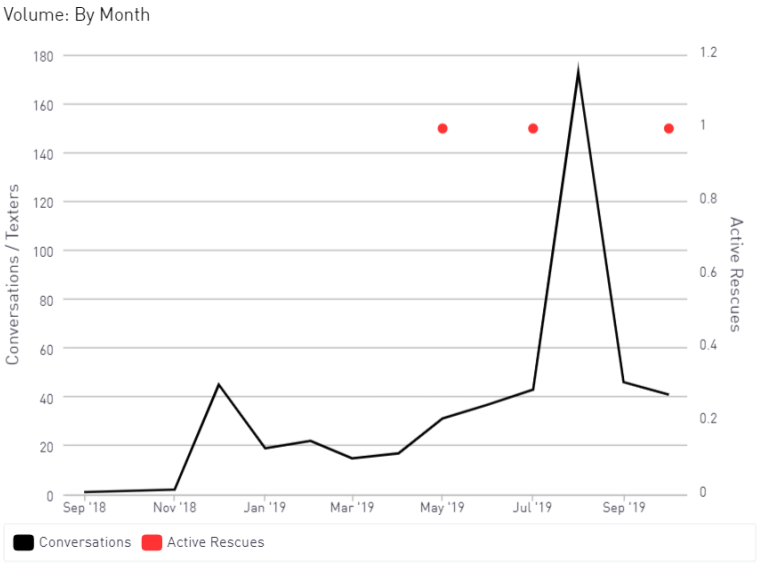
I know the warning signs for suicide. (N=2508)	3.16	.835	4.06	.816	-58.01***
I am able to identify someone who is at risk for making a suicide attempt. (N=2510)	2.92	.816	3.97	.765	-73.30***
I feel prepared to discuss with someone my concern about the signs of suicidal distress they are exhibiting. (N=713)	3.44	1.03	4.22	.794	-16.23***
I am aware of the resources necessary to refer someone in a suicide crisis. (N=2508)	3.04	.917	4.10	.663	-62.39***
I am confident in my ability to make a referral for someone in a suicide crisis. (N=2507)	3.07	.929	4.12	.742	-64.42***
I have the skills necessary to support or intervene with someone thinking about suicide. (N=2510)	2.74	.893	3.93	.812	-74.56***

Note. M=Mean. SD=Standard Deviation. *** $p < .001$

Outcome: Increase use of mental health services

- **Crisis Text Line**

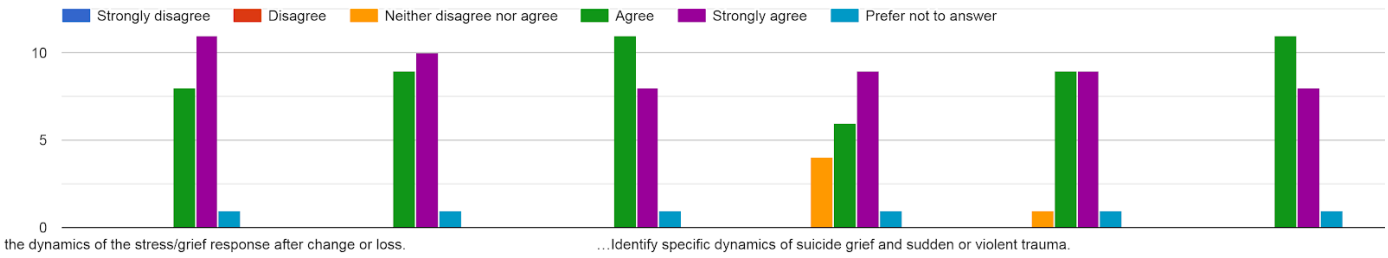
  From May 27 to June 30, 2019, the CTL campaign had achieved an estimated 1.2 million impressions on social media, reached 187,500 people through light rail ads, and reached another 50,388 people via a screen at the Gilroy DMV office. As of August 2019, 227 text conversations had taken place under the County's CTL code word RENEW. In FY20, 300 text conversations were reached under the code word, and CTL granted the SP Program access to a customized data dashboard with aggregated, population-level data on text conversations exchanged under RENEW. A spike in text conversations was seen in August (below), presumably associated with the mass shooting at the Gilroy Garlic Festival.



- **Campaign to increase help-seeking among older adults**

  Evaluation results are available in FY20.

- **Grief support services – post-training survey results**



(From left to right):

- *Identify dynamics of stress/grief response after loss*
- *Recognize behaviors, thoughts, feelings related to grief/loss*
- *Articulate/ practice effective techniques for responding to grief*
- *Identify dynamics of suicide grief and sudden/violent trauma*
- *Recognize/ articulate stress responses in self and co-workers*
- *Apply principles of stress management in home and work environments*

Outcome: Strengthen community suicide prevention and response systems

- **<u>School-based suicide prevention partnership</u>**

Change in Gatekeeper Measures: Kognito

Measures *(scores range from 1=Strongly Disagree to 5=Strongly Agree)*	**Pre-Training**		**Post-Training**		
	Mean	**SD**	**Mean**	**SD**	**t-test**
1. I know the warning signs for suicide. (N=1794)	3.03	.755	3.96	.808	-4.57***
2. I am able to identify someone who is at risk for making a suicide attempt. (N=1794)	2.77	.703	3.87	.725	-5.65***
3. I feel prepared to discuss with a student my concern about the signs of psychological distress they are exhibiting. (N=636^; N=418^^)	2.75^ 2.71^^	.689 ^ .701^^	3.92^ 3.90^^	.732^ .776^^	-78.33***^ -60.60***^^
4. I am aware of the resources necessary to refer someone in a suicide crisis. (N=1791)	2.93	.864	4.03	.593	-5.40***
5. I am confident in my ability to make a referral for someone in a suicide crisis. (N=1793)	2.98	.872	4.07	.707	-4.99***
6. I have the skills necessary to support or intervene with someone thinking about suicide. (N=1793)	2.57	.784	3.86	.787	-6.38***
7. I understand and can identify a number of ways in which culture affects how suicide is expressed and experienced. (N=1788)	2.68	.831	3.72	.870	-5.62***
8. I feel prepared to help people from diverse cultural backgrounds with their suicidal distress. (N=1784)	2.34	.730	3.62	.912	-6.27***

Notes. SD=Standard Deviation ***p < .001 ^ data from high school educators ^^ data from middle school educators

Figure 12. Mean ratings by Kognito training participants: "I am confident that I know my school's action plan for a student…" (Items were on a 5-point scale, Strongly Disagree (1) to Strongly Agree (5))

	Pre-Test Mean (SD)	Follow-Up Mean (SD)	t-test
At low risk for suicide, e.g., those who have shown signs of emotional distress	E 3.07 (1.14)	E 3.58 (.94)	E 3.63**
	M 3.41 (1.04)	M 3.76 (.98)	M 2.74**
	H 3.25 (1.03)	H 3.82 (.81)	H 4.44***
At medium risk for suicide, e.g., those who have expressed suicidal thoughts	E 2.88 (1.13)	E 3.48 (.96)	E 5.49***
	M 3.33 (1.02)	M 3.71 (.97)	M 2.75***
	H 3.27 (1.02)	H 3.79 (.86)	H 3.80***
Who has made a suicide attempt	E 2.64 (1.11)	E 3.08 (1.01)	E 3.65***
	M 3.03 (1.08)	M 3.73 (1.08)	M 3.06***
	H 3.06 (1.09)	H 3.51 (1.02)	H 3.21**
Re-entering school after a suicide crisis	E 2.49 (1.08)	E 2.90 (.99)	E 3.73***
	M 2.84 (1.13)	M 3.31 (1.07)	M 3.43***
	H 3.00 (1.12)	H 3.43 (1.09)	H 3.09**

Notes. *** $p < .001$; ** $p < .01$; E: elementary; M: middle school; H: high school; N(E)=73, N(M)=69-70, N(H)=77

Outcome: Improve messaging in the media about suicide

- July 12, Mercury News: Editorial: Bay Area county's suicide prevention effort is working
- June 14, SF Gate: County sees slight drop in suicides despite increase nationwide
- June 14, Patch: Suicide rate drops in Santa Clara County
- June 12, KCBS: Santa Clara County suicide rate bucking state and national trend

FY20

Outcome objective 1: Increase early identification and support for people thinking about suicide

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

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

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

	Pre-Training (N=1897-2283)		Post-Training (N=1117-1206)				
Variables	M	SD	M	SD	t-test	Cohen's *d*	Effect size
I know the warning signs for suicide.	3.55	.88	4.38	.71	-28.06***	-.90	Large
I am able to identify someone who is at risk for making a suicide attempt.	3.36	.91	4.27	.76	-29.64***	-.94	Large

I feel prepared to discuss with someone my concern about the signs of suicidal distress they are exhibiting.	3.41	.99	4.27	.76	-25.63***	-.86	Large
I am aware of the resources necessary to refer someone in a suicide crisis.	3.34	1.00	4.34	.72	-30.88***	-.98	Large
I am confident in my ability to make a referral for someone in a suicide crisis.	3.31	1.01	4.26	.78	-28.28***	-.91	Large
I have the skills necessary to support or intervene with someone thinking about suicide.	3.18	1.01	4.17	.78	-29.75***	-.95	Large
I understand and can identify a number of ways in which culture affects how suicide is expressed and experienced.	3.29	.96	4.06	.83	-23.56***	-.78	Medium
I feel prepared to help people from diverse cultural backgrounds with their suicidal distress.	2.97	.98	3.94	.85	-28.28***	-.93	Large
Mean Score, all 8 items	3.30	.76	4.22	.65	-35.57***	-1.08	Large

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

***Note re: interpretation tips*:** Any t-test value that has *** next to it is showing that there is a change that is more significant than chance. For example, we see that in "1. I know the warning signs for suicide" goes from an average of 3.55 on the pre-survey (most people chose either 3=Neither disagree or agree to 4=Agree) to a 4.38 on the post-survey (most people chose 4=Agree to 5=Strongly agree) with a significant t-test value of -28.06 (meaning the change from 3.55 to 4.38 was significant enough that it is likely NOT due to chance).

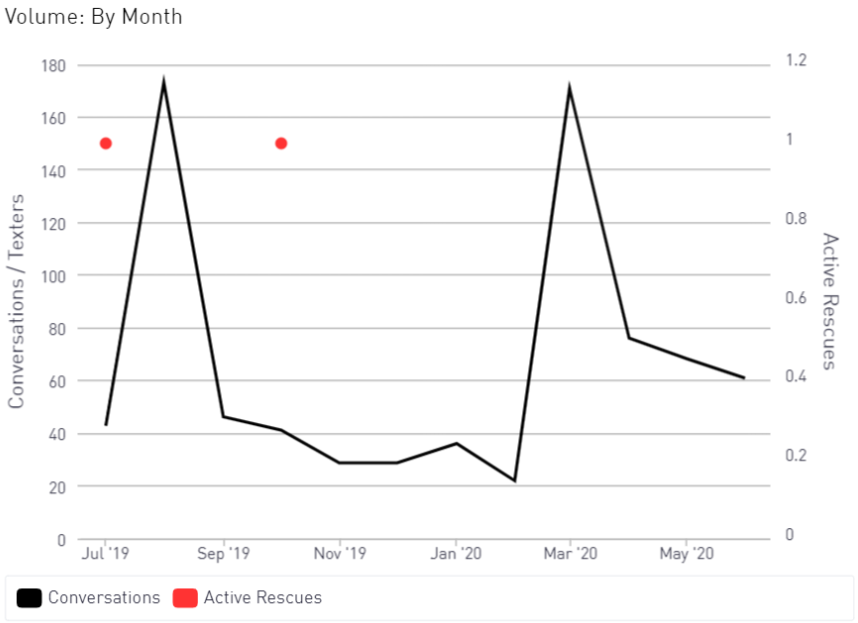
***Note* re: Cohen's *d*:** Small effect size if $d \geq .2$, medium effect size if $d \geq .5$, large effect size if $d \geq .8$ (meaning 1 group scored .8 standard deviations above the other group)

Outcome objective 2: Increase use of mental health services

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

- **Campaign to increase help-seeking among older adults**
  To assess the impact of the campaign, calls to the Suicide and Crisis Hotline during the campaign months July, August, and September in 2019 were compared to the same months in 2018. This three-month span in 2019 showed a total increase of 268 calls to the hotline, compared to the same period in 2018. Furthermore, the share of 2019 hotline calls made by the target audience (age 55 and older) was far greater than the respective proportion in 2018. The percentage of calls to the hotline by adults age 55 and older increased from 22.2% in July 2018 to 30.2% in July 2019; from 16.5% in August 2018 to 28.9% in August 2019; and from 19.7% in September 2018 to 30.0% in September 2019. This increase in hotline utilization indicates a strong campaign impact and increased help-seeking behavior among the target audience. Additionally, from August 1, 2019 to September 26, 2019, the campaign website received 12,693 visits and 13,563 page views, reflecting wide reach and receptivity to seeking help online.

- **Suicide and crisis services**
  FY20 volume of Crisis Text Line conversations, by month



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

Outcome objective 3: Strengthen community suicide prevention and response systems

- **School-based suicide prevention partnership**

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

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

Combined preparedness measures

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

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

Combined self-efficacy measures

	Mean	Std. Deviation	F-value	Post hoc tests

Pre	3.01	.59	6.99**	Pre and post are significantly different
Post	3.36	.54		
Follow Up	3.16	.44		

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

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

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

	Pre-Test Mean (SD)	Post-Test Mean (SD)	Follow-Up Mean (SD)	ANOVA *F*-test	Post hoc
Self-Efficacy: I feel confident…					
I feel confident in my ability to recognize when a student is showing signs of psychological trauma or distress	3.54 (.92)	4.03 (.69)	3.98 (.70)	16.20***	Pre is sig diff than post and follow up
I feel confident in my ability to discuss with a student my concern about the signs of psychological trauma or distress they are exhibiting	3.44 (.81)	4.00 (.71)	3.92 (.72)	21.95***	Pre is sig diff than post and follow up
I feel confident in my ability to motivate students exhibiting signs of psychological trauma or distress to seek help	3.48 (.81)	4.01 (.68)	3.88 (.77)	15.95***	Pre is sig diff than post and follow up
I feel confident in my ability to use communication strategies to help a student exhibiting signs of psychological trauma or distress feel safe	3.51 (.78)	4.00 (.69)	3.86 (.73)	14.70***	Pre is sig diff than post and follow up
I feel confident in my ability to teach students activities to manage their stress and emotions	3.43 (.91)	3.81 (.79)	3.72 (.81)	7.85**	Pre is sig diff than post and follow up
I feel confident in my ability to implement trauma informed approaches in teaching	3.23 (.89)	3.83 (.79)	3.55 (.83)	17.48***	All sig diff
Composite Self-Efficacy	**3.44 (.74)**	**3.95 (.65)**	**3.82 (.68)**	**24.25*** **	**Pre is sig diff than post and follow up**

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

In addition, school district progress on the partnership goals is summarized below (see Figure 14).

Figure 14. School district progress on S4SP goals/tasks

District goals/tasks, Year 1 of partnership Intervention: Establish a crisis response system	Number of districts completed or status
Train all teachers and staff in the Kognito "At Risk" module	3 of 5 new districts; extension provided for 1 district
Identify and put together Crisis Response Teams (CRT)	9 of 11 districts
Send CRT members/mental health staff to ASIST	Ongoing participation by district staff and administrators
Review crisis response protocol forms against K-12 Toolkit forms	10 of 11 districts
Revise/adapt/develop crisis response protocol forms	9 of 11
Train CRT members and all mental health staff in crisis response protocol forms	5 of 11 districts; others in progress
Begin using updated protocol forms in live situations with students	4 of 11 districts; others pending protocol training in FY21
District goals/tasks, Year 2 of partnership Mental Health Promotion: Integrate upstream and/or Tier 1 (parent/student) trainings	**Number of districts completed or status**
Train any new teachers and staff in Kognito "At Risk"	5 of 6 continuing districts
Ensure Year 1 tasks are completed and any new mental health staff are trained in new protocol forms	5 of 6 continuing districts engaged with rollover work from Year 1 tasks
Train all teachers/staff in upstream Kognito training (e.g., Trauma-Informed Practices)	5 of 6 continuing districts
Integrate student Kognito training (e.g., Friend 2 Friend)	Extension provided for 2 districts
Develop/introduce parent education series in mental health and suicide prevention (e.g., BSBB Mental Health, Youth Mental Health First Aid, workshops, panels)	1 district

Outcome objective 5: Improve messaging in the media about suicide

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

FY21

See Section 5: Evaluation Activities for descriptions of the methods, activities, and survey tools used to change attitudes and knowledge, including time frames for measurement.

Outcome objective 1: Strengthen community suicide prevention and crisis response systems

- **School-based suicide prevention partnership**

The partnership encourages school districts to follow a comprehensive, tiered approach to trainings in suicide prevention and mental health. This approach ensures that school personnel and mental health professionals 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. The main helper trainings for this work are the Kognito online health simulations, which are paired with HEARD Alliance technical assistance focused on refining suicide and crisis response forms and protocols.

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

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 intervene with someone thinking about suicide	3.05	.96	3.92	0.72	-43.39***	0.97	Large
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. *** $p < .001$.

In FY21 the Stanford HEARD Alliance supported 11 districts and more than 500 staff members with consultations and trainings (46 total). See below for a summary of support and activity details highlighting district progress.

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 31 attendees total 1 parent night*	*Met with principals 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 Kognito *At-Risk for Elementary, Middle and High School Educators* training, participants felt slightly but statistically significantly more confident in knowledge of their schools' protocol for suicide prevention for low-, medium-, and high-risk students, as well as those students re-entering school after a suicidal crisis.

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 $p < .001$

- **County Health System trainings and consultations**

The aim of the pilot year/FY21 of work was to determine the viability of performing the following program evaluation or consultation functions as collaboratively determined with targeted clinical sites/teams: organizational assessment, staff education, data and evaluation, incorporation of cultural and diversity considerations, integration of evidence-based innovative approaches to culturally competent suicide assessment and management, and modification of screening and assessment protocols, clinical documentation, or intervention practices.

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. Two of the Primary Care and one Behavioral Health site implemented detailed needs assessments, which provide baseline data against which future years' work can be compared. Additionally, Dr. Chu and Dr. Weaver collected baseline systems improvement data from two additional nursing sites. The evaluation tool utilized for the organizational needs assessments and outcome measurements over time is based on the Zero Suicide Framework's Organizational Self-Study and Workforce Survey of staff knowledge, practices, and confidence in suicide prevention-related competencies (Zero Suicide Institute, 2018; 2020). The competencies measured in this survey are based in evidence-based practices for suicide care, and supported by emerging science (e.g., Layman et al., 2021; Turner et al., 2021).

Outcome objective 2: Increase use of mental health services

- **Community Helper Trainings**

In aggregate, across all trainings offered, participants reported statistically significant improvements from pre- to post-training in eight self-reported suicide prevention competencies related to knowledge, attitudes, and preparedness around being community helpers for suicide prevention.

Change in Self-Report of Suicide Prevention-Related Competencies for trainings, July 2020- June 2021

	Pre-Training (N=434-2479)	Post-Training (N=434-2479)

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 someone thinking about suicide	3.05	.97	3.96	0.72	-49.17***	0.61	Large
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.

- **<u>Public awareness campaigns</u>**

In FY21, the SP Program's Communications Workgroup planned, developed, and launched two mass media public awareness campaigns to support suicide prevention in the County. During the fiscal year, to support of its goal to ascertain, record, and report outcomes, the Program also began evaluating suicide prevention 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-scale promotion among Mandarin- and Spanish-speaking older adults. The second campaign supported suicide prevention among middle-aged Spanish-speaking and English-speaking men. 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 suicide ideation.

<u>Campaign 1: Older Adults</u>

The first campaign ran from September 3, 2020 to October 21, 2020 and was comprised of print materials and television, radio, digital (online), and social media advertisements in Vietnamese. These assets promoted the National Suicide Prevention Lifeline and a campaign-specific web page, www.scchope.org/vi, designed to address the campaign objectives. Additionally, the campaign included radio advertisements promoting the national lifeline and one of three campaign-specific web pages: www.scchope.org in English assets, www.scchope.org/zh in Chinese assets, and www.scchope.org/es in Spanish assets. (Each campaign webpage remains active to support suicide prevention in the County.) With Vietnamese-and English-speaking older adults being the primary target audience, the Suicide Prevention Program strategically utilized its budget to evaluate the campaign's reach among those audiences. Reach data are included in the table below (see figure below). According to US Census Bureau estimates (2019), 478,940 adults aged 55 and older reside in Santa Clara County.

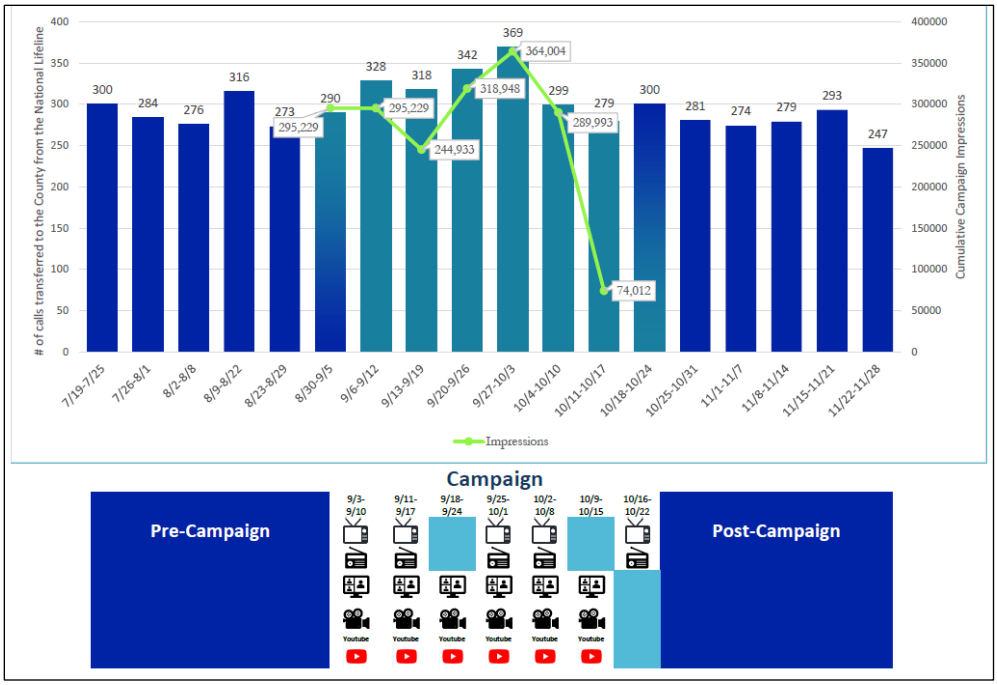
Campaign 1 (Older adult) reach and impressions

	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 ad was not produced as part of campaign

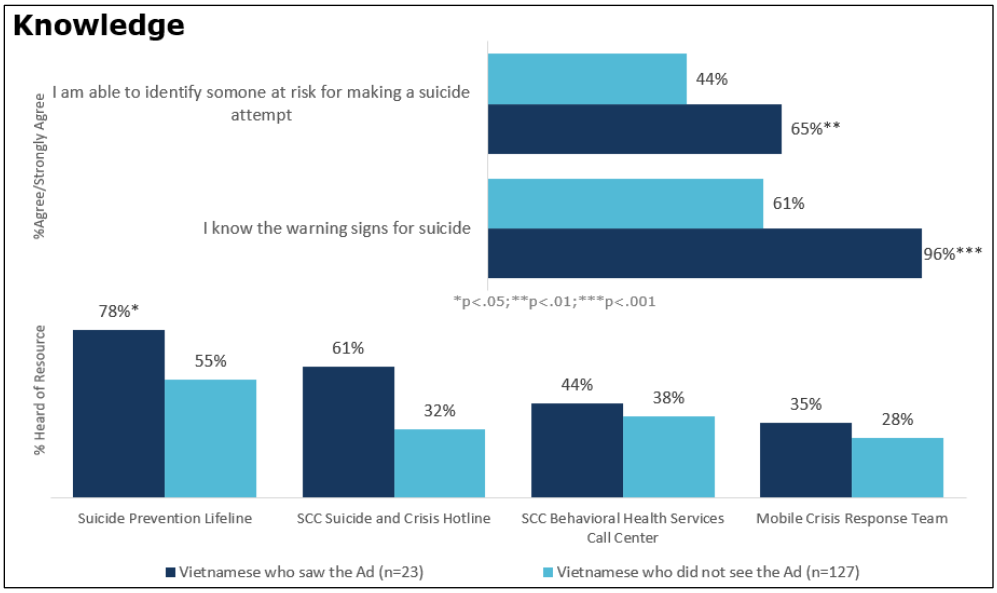
To assess the impact of the first campaign, calls to the Suicide and Crisis Hotline during the campaign weeks in September and October 2020 were compared to the same weeks in 2019. This two-month span in 2020 showed a total increase of 80 calls to the hotline, compared to the same period in 2019. The hotline also received more calls during the first four weeks of the campaign than the five weeks before or the five weeks following the campaign (see figure below). As shown in the below figure, 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.

Campaign 1 (older adult) call volume before, during, and after the campaign



Campaign evaluation surveys were designed for and distributed to older Vietnamese adults and influences such as family and friends. Fifteen percent of respondents recalled seeing or hearing a campaign ad, with each person exposed to an ad around 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 better able to identify individuals at risk for suicide than those who did not see or hear the campaign (see figure below).

Campaign 1 (older adult) survey results: knowledge of suicidality and resources



Campaign 2: Middle-Aged Men

The second 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. These assets promoted the National

Suicide Prevention Lifeline and two campaign-specific web pages, www.scchope.org/help and www.scchope.org/ayuda, designed to address the campaign objectives. (Each campaign webpage remains active to support suicide prevention in the County.) Both during and after the campaign, the Program evaluated reach among the target audience. Reach data are included in the table below (see figure below). According to US Census Bureau estimates (2019), 278,484 male adults aged 35-54 reside in Santa Clara County.

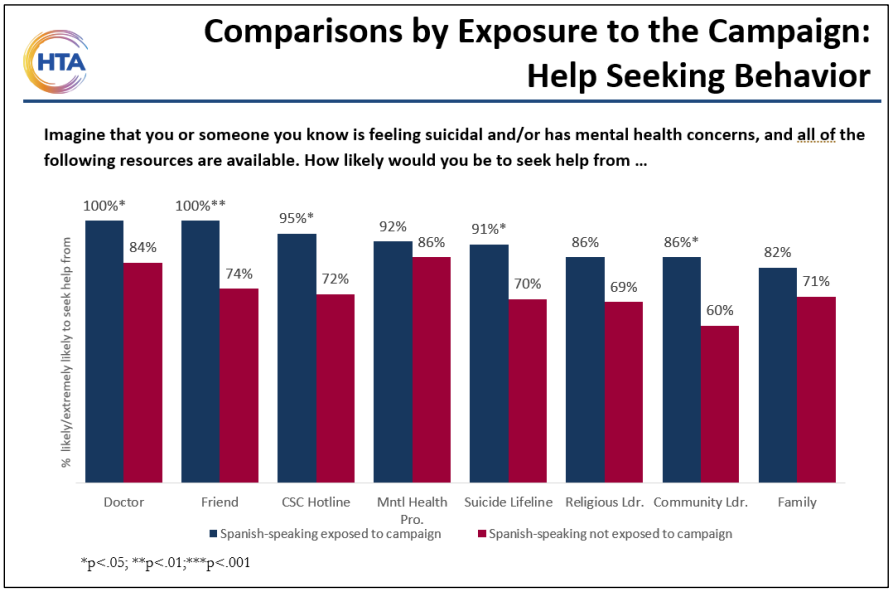
Campaign 2 (middle-aged men) reach and impressions

	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 second campaign, calls to the Suicide and Crisis Hotline during the campaign weeks (in December 2020, January 2021, and February 2021) 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%. These increases were seen as 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 indicate a robust campaign impact and increased help-seeking behavior among the target audiences.

Campaign evaluation surveys were designed for and distributed to older Spanish-speaking middle-aged men and influences such as family and friends. Thirty percent of survey respondents recalled seeing or hearing a campaign ad, 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 suicide or mental health. The same group was significantly more likely to say they would seek help (see figure below). Finally, like the first campaign, 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.

Campaign 2 (middle-aged men) survey results: likelihood to seek help for suicide or mental health



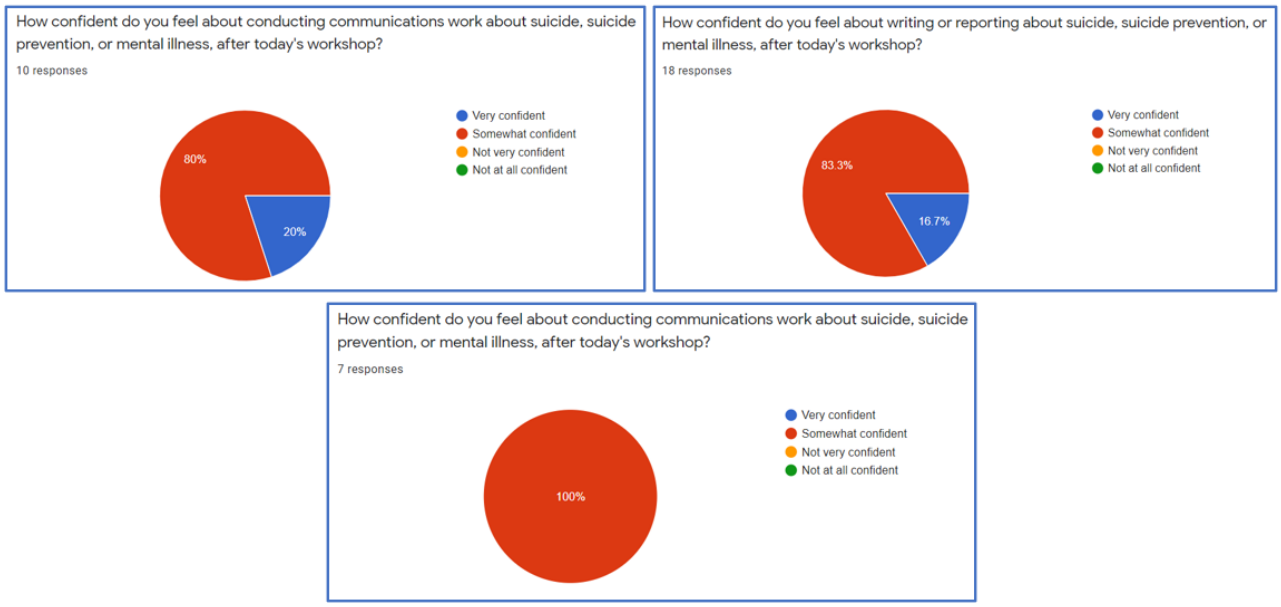
Outcome objective 3: Reduce access to lethal means

To date the SP Program has made scattered efforts in the area of firearm safety and is in the process of researching and discussing with stakeholders the appropriate strategies to take for hanging means restriction. As a result, the outcomes and evaluation plan for this objective are still in the process of being defined.

Outcome objective 4: Improve safe messaging in the media about suicide

To address the challenges associated with evaluating safe messaging efforts, the SP Program partnered with Stanford University's Center for Youth Mental Health and Wellbeing and developed the Tool for Evaluating Media Portrayals of Suicide (TEMPOS). The TEMPOS measures were developed directly from the "Recommendations for Reporting on Suicide," assessing adherence to each of the ten safe messaging recommendations on a three-point numerical scale and allowing for each article and publication to receive average ratings for safe messaging adherence. As a baseline measurement for its safe messaging efforts, the SP Program applied TEMPOS to a dataset of 220 suicide-related news articles from June 2018, when Anthony Bourdain and Kate Spade died by suicide and the CDC issued its annual suicide data report. An update to this analysis was completed in FY21, in alignment with upgrades to TEMPOS to prepare it for publication and dissemination to media 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.

In the meantime, the Program continues to collect pre/post-training survey data from the safe messaging trainings it conducts with media professionals and potential spokespeople in the county. In FY21, the Program provided four safe messaging trainings 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 understand 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.



The Program also conducts regular monitoring of the local media and response to reporters for stories on suicide, and tracks reporters' responses to these outreach efforts. In the most recent fiscal year, 34 separate communications were conducted with local and national reporters regarding their articles addressing suicide and mental health. Of those communication efforts, the Program fielded 13 follow-up messages, some resulting in continued dialogue, cementing rapport with journalists.

Outcome objective 5: Increase supportive community environments for vulnerable populations (currently youth only)

- **Youth Connectedness Initiative (YCI)**

For FY21, there was a direct focus on strengthening the YCI Program's evaluation and data collection process based on their outcome goals. The chart below reflects quarterly progress based on outcomes indicated for three audiences: Peer Leaders, youth activity participants, and adult activity participants. The reporting varies as some survey collection was based on qualitative and not quantitative responses.

PEER LEADERS			
	Short term: Increase reported knowledge about DFR element(s) among Peer Leaders.	**Medium term: Improve reported attitudes around and strengthen intention to implement DRF element(s) among Peer Leaders.**	**Long-term: Increase actions by youth Peer Leaders as they relate to DRF element(s).** **Increase in reported receipt of DRF element(s) by youth Peer Leaders from their peers and parents.**
Q1 **DRF Element: "Express Care"**	Peer Leaders spent initial meetings learning about the Developmental Relationship Framework. Discussion centered around deciding which elements resonated with their work in the community.	N/A, outcome revised after Q1	N/A, outcomes revised after Q1
Q2 **DRF Element: "Express Care"**	Peer Leaders engaged with the Developmental Relationship Framework (DRF) regularly and linked their work back to the selected DRF weekly meetings.	Through consistent conversation and framing of the DRF in meetings, students were steeped in the DRF and its connection to positive outcomes for youth.	Peer Leaders' work for their peers is rooted in the DRF. The actions that they take as a group provide practice. For example, in meetings, the peer leaders work together as a collective unit and provide support for one another; the group does weekly check-ins to see how everyone is doing.
Q3 **DRF Element: "Expand Possibilities"**	Peer Leaders engaged with the DRF when they co-produced the "Call to Action" video alongside program coordinator. The video breaks down each of the elements for the adult viewer with specific actionable items such as "tell me it is okay to make mistakes."	YCS staff frame interactions with the Peer Leaders through a DRF. The Peer Leaders have consistent reminders of the elements, particularly "expand possibilities" in their meetings and check ins. The Peer Leaders knowingly implement the DRF elements in their work with the community.	Each of the projects the Peer Leaders implemented were rooted in a deep care for their peers and a desire to connect them with the best resources available for issues prevalent among youth in our community.
Q4 **DRF Element: "Expand Possibilities"**	Peer Leaders (19) were surveyed to assess understanding and implementation of key framework concepts. Individual responses submitted reveal YCI participants' detailed understanding and interpretations of key Framework concepts, their proficiency with Framework vocabulary and their ideas and experiences applying program principles and tools in their daily lives.	Peer Leaders expressed their appreciation of expanding possibilities for them to share their thoughts and perspectives on mental health and prepared statements for the city council.	Peer Leaders share that they have taken their experiences and the knowledge they have gained as YCI Peer Leaders and applied it to their lives outside the program. They reported that their collaboration and interaction with invited professionals and adult coordinators have been positive experiences and expanded their possibilities to collaborate and learn from a wider network of adults.

YOUTH PARTICIPANTS		
	Short term: Increase reported knowledge about DRF element(s) among youth participants.	**Medium term:** Improve reported attitudes around and strengthen intention to implement DRF element(s) among youth participants.

Q1 **DRF Element: "Express Care"**	IP, Planning meetings discussing communication plans, Grounding projects in DRF - community panel discussion, video on suicide prevention in partnership with Wellness Centers, and an Instagram Live discussion with a mental health professional.	N/A, outcome revised after Q1
Q2 **DRF Element: "Express Care"**	Express Care underpins the work of the Peer Leaders, with the connection made through the content of the offerings. For example, the video with the Paly Wellness Center outreach worker, with questions asked centered on concern and care for others and oneself.	With the projects the Peer Leaders put into action this quarter, they added to the community conversations around suicide prevention, mental health, and sexual assault. These projects are an expression of care from the Peer Leaders but also provided tools for youth participants to care for themselves and others.
Q3 **DRF Element: "Expand Possibilities"**	Through awareness campaigns, Peer Leaders expanded possible ways to address common issues like sexual assault and eating disorders among their peers. Of the nine (9) youth that responded to the initial survey, six (6) reported that they are likely to use the information provided by the Peer Leader Instagram account. Seven (7) of the nine (9) respondents indicated they learned something related to support for their peers and mental health.	Projects implemented contributed to conversations on sexual assault and body image. Through these projects, students expressed care for their peers facing these challenges or someone who may be affected. The Peer Leaders' awareness campaigns always connect their peers with resources to get help, expanding the possibilities of care for both themselves and the people within their networks. Students who responded to our survey after the Wellness Conference indicated a plan to implement supportive DRF actions. Similarly, all students who responded to the winter Instagram survey indicated actions they could take to express care (the DRF for the previous semester) to others in their lives.
Q4 **DRF Element: "Expand Possibilities"**	Through social media posts and community events, youth participants have indicated that they have increased their understanding of how they can Expand Possibilities for others. One youth participant from the Instagram Survey stated: "*Has taught me how to be an ally to others*." One youth participant from the Minari movie night stated: "*There's a lot more things than you think you can do*".	Youth participants were asked to indicate their intention to share what they have learned and to implement the DRF element on a scale from 1 – 4 (4 Very Likely). From survey responses from Instagram and community events, all four respondents reported 3.

ADULT PARTICIPANTS		
	Short term: Increase reported knowledge about DRF element(s) among adult participants.	**Medium term: Improve reported attitudes around and strengthen intention to implement DRF element(s) among adult participants.**
Q1 **DRF Element: "Express Care"**	Through the initial service project, families engaged with each other in service while also expressing care for community members running for Child Advocates' fundraising event.	N/A, outcome revised after Q1
Q2 **DRF Element: "Express Care"**	The Parent Program's packaging used the Express Care language explicitly and is reflected in the surveys completed by the Bill Wilson Center project participants. 100% of those surveyed agreed that the project showed them ways to express care to the community and have an intent to express care again in the next month.	Each Morning Mindfulness Meditation session incorporated relationships, intentions, and connection to the DRF. The ongoing goal is for participants to practice making intentions to help them follow through with enacting elements of the DRF during the week.
Q3 **DRF Element: "Expand Possibilities"**	Peer Leaders developed a newsletter project, for adult allies to continue disseminating information around activities and efforts.	Service Across Ages (formerly Family Service Projects) saw an increase in participation for the project in partnership with Reach Potential Movement.

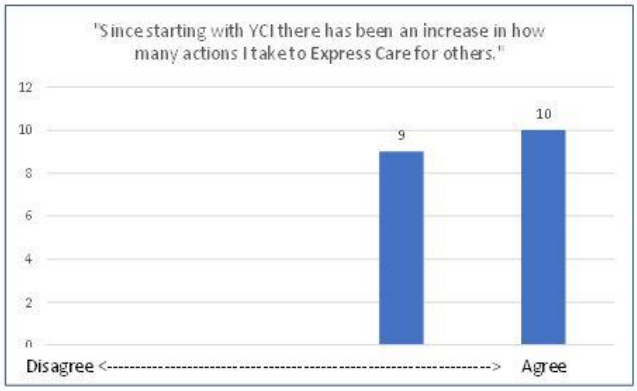
Q4 **DRF Element: "Expand Possibilities"**	Community and parent engagement event surveying reflects ways in which they can support youth. Adults participants indicated through surveys that they identified actions to Expand Possibilities for youth. One adult workshop participant stated: "Don't lecture, ask open ended questions, express pride."	Adult participants were asked to indicate their intention to implement the DRF element on a scale from 1 - 4 (4 Very Likely). From survey responses from workshops and Service Across Ages, the four respondents reported 3 or 4.

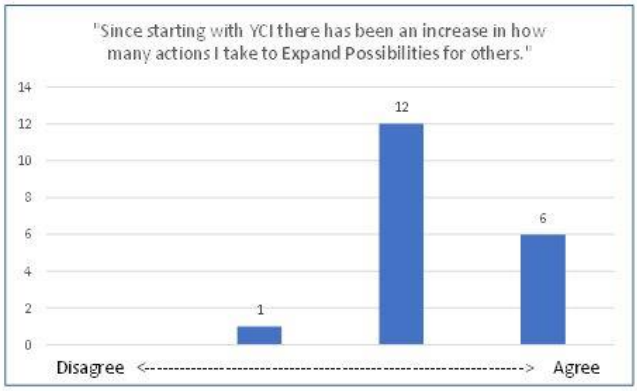
YCI Peer Leader Survey Evaluation

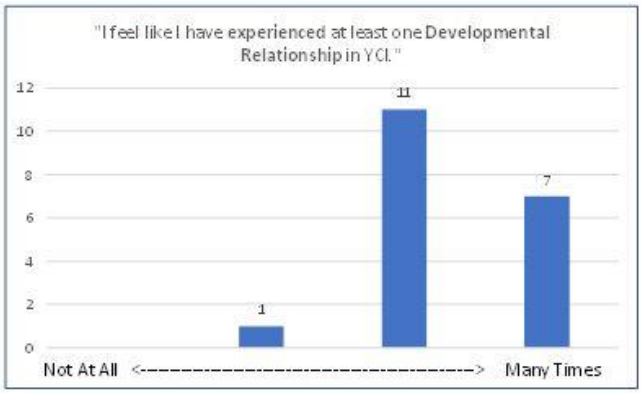
YCI Peer Leaders (19) along with non-Peer Leader Program participants (14) were surveyed to assess the Program's impact on their knowledge and attitudes around belonging, sense of connectedness and well-being. Using the Search Institute's Developmental Relationships Framework (DRF) as a guide to inform and evaluate work for the new academic year, Peer Leaders selected "Express Care" and "Expand Possibilities" as the DRF elements of choice for the school year.

Receipt of Expressions of Care, Expanded Possibilities, and Activation of Skills with Others

The final set of quantitative survey items asked YCI participants to reflect on their receipt and perceptions of actions related to DRF elements "expressions of care" and "expanded possibilities" from their experience with the DRF in YCI. Regarding their own actions related to expressing care and expanding possibilities, nearly all respondents agreed that they had increased since starting the YCI Program (see figures below):







Understanding and Implementation of Key Framework Concepts

A set of open-ended survey questions asked respondents to describe components of the Developmental Relationship Framework (DRF). Individual responses submitted reveal YCI participants' detailed understanding and interpretations of key Framework concepts, their proficiency with Framework vocabulary, and their ideas and experiences applying program principles and tools in their daily lives.

*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."

9. Evaluation Summary

This is the narrative section to provide a summary of your program's evaluation for FY2019 – FY 2021. You may also include any qualitative data, such as client experiences; program success; program barriers and challenges; implementation challenges; and any other narrative information that you feel will help convey the program's intentions and highlight the program's efforts.

Please limit the summary section to no more than 3 paragraphs, if possible.

The Suicide Prevention Program experienced significant growth over the three-year reporting period. 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. In the meantime, program staffing grew by only one additional team member during the reporting 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 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 reporting 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.

Looking ahead, the SP Program has a number of evaluation goals and challenges to address (see below):

- Further develop means restriction work, including hanging means safety and an associated logic model/evaluation plan;
- 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;
- Develop a database of local, culturally relevant, evidence-based suicide prevention public awareness campaign materials;

- Continue to understand and improve systems-level suicide prevention outcomes and how to measure them, specifically in schools and health systems;
- 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 logic model and evaluation efforts may arise from this work, for example, combining efforts to measure outcomes on social/community connectedness.