



Suicide Prevention Action Plan Needs Assessment

What Is Known About Suicide in
San Diego County

March 2011



a project facilitated by:
**COMMUNITY HEALTH
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**A County of San Diego Behavioral Health
Services Project funded by the Mental
Health Services Act (MHSA)**



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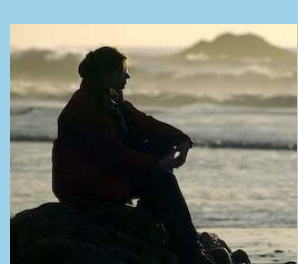
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Acknowledgements

The County of San Diego Mental Health Services (MHS) would like to thank Community Health Improvement Partners and Harder+Company Community Research for their work on the needs assessment and for the development of this report. In addition, MHS would like to thank the many individuals and organizations who assisted in the design, implementation, and analysis of this needs assessment. The success of the Suicide Prevention Needs Assessment was dependent on the participation of service providers, County staff, and community members throughout the County. We would like to gratefully acknowledge the following for their contributions to this study:

- The members of the Suicide Prevention Action Plan Committee (SPAP-C), who provided valuable input throughout the design of this project and who will continue to be instrumental during the action planning process. In particular, we would like to thank the co-chairs Carol Skiljan and Beth Sise for their time and assistance during every step of the project.
- We would also like to thank the San Diego County Emergency Medical Services Branch for providing up to date statistics regarding suicide and self-injury in San Diego County.
- The service providers who participated in recruitment efforts and provided meeting space for focus groups and individual interviews. Conducting our discussions in a familiar and convenient setting for clients helped ensure that we received quality feedback and input.
- County staff, contractors and community providers who provide invaluable feedback via data collection efforts such as online surveys, stakeholder interviews and provider focus groups. Special thanks go to the Behavioral Health Education and Training Academy (BHETA) for their help with the design and dissemination of the online training survey.
- Community members who participated in focus groups and individual interviews. Their contribution gives voice to how suicide impacts individual communities and the County at-large; their valuable feedback is reflected in this report.

Introduction



Suicide is a leading cause of non-natural death for all ages in San Diego County, second only to motor vehicle crashes.¹ Suicide claims the lives of roughly one San Diegan per day, outnumbering homicides by more than 2 to 1. Suicide takes an emotional toll on families and affects the wellbeing of the larger community. It is estimated that one suicide affects the lives of at least six other individuals, causing extreme loss and grief, social stigma, and in some cases, an increased risk for additional suicides. Suicide also carries an economic toll, which is borne by social services, hospitals, primary care, and education sectors. The cost of suicides and suicide attempts in California is estimated to be as high as \$4.2 billion per year.²

An in-depth examination of the statistics reveals that suicide is more prevalent among certain populations and age groups. In San Diego County, adults between the ages of 25 and 54 have the highest *number* of suicides. (a total of 1,824 suicides between 1998-2007, accounting for 56.2% of all suicides throughout the county).³ When looking at these numbers in proportion to the total population, Caucasian men over the age of 65 have the highest *rate* of suicide (37.8 per 100,000 or 522 suicides between 1998 and 2007). The California Strategic Plan on Suicide Prevention recommends that rather than a “one size fits all” approach to preventing suicide, services and programs should be designed to “effectively meet the needs of individuals of all ages and from diverse racial, ethnic, cultural, and linguistic backgrounds”.⁴

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This needs assessment document, “What Is Known About Suicide in San Diego County,” explores specific needs of key targeted groups to provide County Mental Health Services, key partners, and stakeholders with vital information to prevent future suicides, suicide attempts and suicidal behavior. This information will be used during planning meetings to develop the goals and strategies for a local Suicide Prevention Action Plan for San Diego County Mental Health Services.

Background and Purpose

The National Strategy for Suicide Prevention advocates a public health approach to suicide prevention, including key formative steps of collecting information about local suicide rates and causes.⁵

In addition, the California Strategic Plan on Suicide Prevention recommends that each County “develop a local suicide prevention action plan with the input of a diverse, representative group of stakeholders”.⁶ The State

¹ Community Health Improvement Partners. *Suicide in San Diego County: 1998-2007*. Web. 1 Dec. 2010. <http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf>.

² California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010. http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSPSP_V9.pdf.

³ Community Health Improvement Partners. *Suicide in San Diego County: 1998-2007*. Web. 1 Dec. 2010. <http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf>.

⁴ California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010.

⁵ Suicide Prevention Resource Center. *Suicide Prevention: A Public Health Approach*. Substance Abuse and Mental Health Services Administration (SAMHSA). Web. 1 Sept. 2010. <<http://www.sprc.org/library/phasp.pdf>>.

Suicide Prevention Action Plan Committee

Since 1999, the CHIP Suicide Prevention Work Team (SPWT) has been focused on preventing suicides and their devastating consequences in San Diego County. Since the award of the grant, the SPWT has been renamed the Suicide Prevention Action Plan Committee (SPAPC) and its purpose is to inform the action planning process, including the Needs Assessment. The committee meets monthly and is open to all interested in participating in the action planning process. For more information on the SPAPC, please contact Holly Salazar, CHIP Director of Strategic Outcomes at hsalazar@sdchip.org or (858) 609-7966.

Plan further recommends that each local plan should design and implement a comprehensive assessment of existing county suicide prevention services and supports and detect major gaps in services.

In 2009, the Community Health Improvement Partners (CHIP) made a successful application to the County of San Diego Mental Health Services that resulted in CHIP being designated as the lead organization to coordinate the efforts of the local planning process to develop a Suicide Prevention Action Plan. Funded under the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI), CHIP was charged with the development and dissemination of a suicide prevention action plan to increase understanding and awareness of suicide and reduce the stigma associated with suicide and suicidal behavior. In addition, CHIP's contract includes some funding for implementation of the strategic initiatives outlined in the Suicide Prevention Action Plan. Because of their continued work on suicide prevention since 1999 (see text box), CHIP was well positioned to oversee the local action planning process. CHIP

contracted with Harder+Company Community Research to design the needs assessment, oversee data collection efforts and facilitate the Action Plan process

The overall purpose of the needs assessment is to provide local data and evidence to inform individuals, organizations, and agencies across San Diego County to take a strategic approach to suicide prevention at the local level. Specific objectives were to:

- Examine suicide rates among different population groups in San Diego County;
- Identify gaps in existing local suicide prevention services and supports;
- Assess County suicide prevention training for staff & contractors;
- Explore current best practice models;
- Identify opportunities for enhancing collaboration among local suicide prevention providers and initiatives; and
- Provide recommendations for a strategic, coordinated suicide prevention action plan.

Report Overview

The needs assessment design was separated into two components:

- **County-level** focused on the capacity of County funded suicide prevention programs, projects, and contractors. This component included an inventory of suicide prevention services in San Diego County, assessment of the technical capacity of the Crisis Line, and examination of the current level of collaboration of services.
- **Community-level** was designed to get feedback on existing supports and service gaps throughout the community from key stakeholders, providers, and community members. This component of the Needs assessment focused on learning more about the needs of the key target communities: Asian Pacific Islander, Native American, Latino, Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTQI), Survivors, Transition-Age Youth, and Older Adults.

⁶ California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010.

The needs assessment results are provided in two sections. The first section, Results by Population Groups, reviews suicide statistics in San Diego County as well as presents key findings for each of the targeted communities. The System Level Results section summarizes information on existing services and supports throughout San Diego County, identifies existing provider knowledge and attitudes regarding suicide prevention, as well as identifies gaps in services.

Methods



This Needs Assessment was designed to examine existing data sources as well as strategically collect information to learn more about specific target populations as well as answer questions about the system of care in San Diego County. This section provides an overview of the data sources references throughout the report.

The information in this report was gathered from three primary sources:

1. Scientific literature relating to suicide and suicide prevention efforts
2. Existing local, state and national statistical data on suicide and suicidal behavior
3. Surveys, individual interviews and focus groups with providers and community leaders with an interest in suicide prevention

The Suicide Prevention Needs Assessment engaged roughly 900 individuals in the data collection process. This includes over 80 community members and consumers of services

Review of the Literature

A wide variety of scholarly articles in journals regarding mental health, suicidality, suicide prevention, and psychology were reviewed to gather information about specific risk and protective factors within each of the key target populations. Reference books and other published materials were examined in order to identify existing best practice models related to suicide prevention. In addition, past needs assessments or other community-based reports were consulted to identify existing information about each key target population as well as general information regarding suicide and suicide prevention. A list of online resources cited can be found in Appendix A.

Existing Statistical Data

National statistics on suicide and intentional injury were consulted. In addition, large scale studies regarding mental health or related risk factors were consulted, including the Youth Risk Behavior Survey (YRBS) and the California Health Interview Survey (CHIS).

Locally, CHIP, along with County of San Diego Emergency Medical Services (EMS), compiles the report “Suicide in San Diego County” which provides comprehensive suicide rates across regions and age groups based on Medical Examiner data. EMS also provided emergency department and hospital discharge data as indicators of suicide attempts.

Many community providers willingly shared existing data about programs or communities, including the formative research used to shape the County’s Mental Health stigma and discrimination reduction and suicide prevention campaign, data regarding calls to the Access & Crisis line and a recent needs assessment of survivors done by the local chapters of the American Foundation for Suicide Prevention. Additional resources include fact sheets and recommendations from advocacy and support agencies such as Mental Health America and The American Foundation for Suicide Prevention.

Primary Data Collection

A mixed methods approach of collecting closed-ended survey data (quantitative) and open-ended stakeholder input (qualitative) was utilized at both the County and Community level. Qualitative methods were used to allow for in-depth and thorough feedback from key stakeholders. Qualitative methods such as focus groups are widely used in the investigation of applied research problems and are recognized as distinct research methods.⁷ All tools were developed with input from CHIP, the SPAPC co-chairs and approved the County prior to their release. A copy of each tool can be found in Appendix B.

County Level Data Collection

The County level component of the needs assessment was designed to examine existing county suicide prevention services and supports and the major gaps.

Training Survey

The purpose of the training survey was to inform County Mental Health Services (MHS) about current participation in suicide prevention training and to identify suicide prevention training needs. Behavioral Health Education and Training Academy (BHETA), the organization responsible for most of MHS staff and contractor training, was planning their training assessment at the same time as this effort. In an attempt to maximize responses to both surveys and reducing the burden on County and contractor staff, the two training surveys were combined and distributed jointly. A link to the online survey, along with a letter describing the survey, was distributed via the County to all County Behavioral Health staff and contracted organizations. In order to highlight the importance of the survey and encourage individuals to respond, the survey was sent out by the County Mental

Exhibit 1.1: Training Survey Distribution Summary

Department	Recipients
County of San Diego Staff, Behavioral Health Services (n=152)	
Behavioral Health Services	59 (38.8%)
Mental Health Services	69 (45.4%)
Alcohol and Drug Services	24 (15.8%)
County Contractors (n= 360)	
Adult/Older Adult Mental Health	142 (39.4%)
Children Mental Health	129 (35.8%)
Alcohol and Drug Services	89 (24.7%)

Exhibit 1.2: Training Survey Respondent Summary (n=734)

Behavioral Health Services Department	Responses (n=726)
Children Mental Health	336 (46.3%)
Adult/Older Adult Mental Health	314 (43.3%)
Alcohol and Drug Services	76 (10.5%)
Position	Responses (n=734)
Direct Services	479 (65.3%)
Manager	124 (16.9%)
Support Services	85 (11.6%)
Director	31 (4.2%)
Other	15 (2.0%)

Health Director. The survey was distributed to 152 County staff and 360 contractors. The lead staff were then encouraged to further distribute the survey to their staff. Exhibit 1.1 shows the distribution across County departments within Behavioral Health.

A total of 734 individuals responded to the survey. Exhibit 1.2 shows the breakdown of respondents by County Department and role. The survey was

anonymous in that respondents did not have to provide their name or specific agency. In addition, the County

⁷ Bender, Deborah E. and Ewbank, Douglas (1994) 'The focus group as a tool for health research: issues in design and analysis', Health Transition Review, 4: 1, 63-79

did not track whether those who received the survey email completed the survey. Therefore, it is not possible to calculate a response rate. However, the fact that the number of survey responses exceeds the distribution list indicates that the survey was widely distributed.

Interviews with Prevention and Early Intervention (PEI) Contractors

Eleven contractors receiving County MHSA PEI funding related to suicide prevention were contacted and participated in interviews.⁸ The purpose was to gather information about existing prevention services, specifically those related to suicide, current capacity, existing training as well as training needs. A total of twelve interviews were conducted, including two of the Alcohol and Drug contractors.

Focus Group with Health Promotion Specialists

A focus group was conducted with County Regional Health Promotion Specialists in order to obtain a more in-depth perspective about services provided in San Diego County regarding suicide prevention and intervention, training provided and available to contractors working for the County of San Diego. The focus group was held during a standing meeting. A total of six individuals participated in the focus group representing the central, east, north and south regions of the County. Two participants were from Aging and Independent Services.⁹

Discussions with County Staff

The needs assessment design included interviews with Behavioral Health Services leadership; these interviews will be completed in early 2011 and the report will be updated to include their feedback.

Community level

At the community level, data was collected to find out more about existing services and supports, as well as gaps, throughout specific communities in San Diego County. This included feedback from providers beyond County contractors as well as input from community members. Specific communities were outlined by the County in the funding application either because suicide rates are higher than County averages for that group, or because existing information was limited so more data was needed to understand the needs of that population. The target populations included in this needs assessment are listed in Exhibit 1.3. Additional groups may be identified during the action planning process; additional information may be collected to fill in gaps in knowledge as needed.

Exhibit 1.3: Needs Assessment Target Populations

Asian Pacific Islander (API)
Latino
Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex (LGBTQI)
Native American
Older Adults
Survivors (includes survivors of suicide attempts as well as those who have lost a loved one to suicide)
Youth (specifically transition-age 18-24)

The following are the methods used to gain input from a broad range of community providers, stakeholders, and community members from each of the target populations.

Community Provider Survey

The purpose of this survey was to gather information relevant to suicide prevention from community organizations throughout San Diego, and to assess existing services, knowledge and attitudes regarding suicide, and the extent agencies collaborate with other agencies involved with suicide prevention.

⁸ Most interviews were conducted over the phone and were approximately 30 minutes long. To accommodate schedules, some of the interviews took place in person.

⁹ The PEI funding supports seven full time Health Promotion Specialists. Source: County communication.

A link to the online survey was emailed to over 500 community providers via Survey Monkey ranging from mental health professionals and representatives of the business community, senior centers and aging services, faith communities, school communities, law enforcement, and military. The distribution list was compiled using the registration for the CHIP kick-off event, Suicide Prevention Action Plan Committee (SPAPC) participants, as well as mental health agency listings provided by 211 San Diego and the Access & Crisis line.

Exhibit 1.4: Community Provider Survey Respondent Summary (n=161)

Type of Organization*	Responses (n=159)
Nonprofit Organization	71 (41.3%)
Government/Public Agency	58 (33.7%)
Community Organization	11 (6.4%)
Education System	8 (4.7%)
Hospital System	6 (3.5%)
Funder/Foundation	2 (1.2%)
Nonprofit Consultant	2 (1.2%)
Position	Responses (n=161)
Direct Services	60 (37.3%)
Manager	44 (27.3%)
Director	27 (16.8%)
Administrative	16 (9.9%)
Board Member	5 (3.1%)
Other	9 (5.6%)

*Total exceeds 100% as responses were not mutually exclusive.

The survey was confidential with the exception of a question regarding collaboration between agencies in which respondents were asked to provide their agency name. Respondents could enter a drawing to receive a \$50 Visa gift card and asked if willing to participate in follow-up efforts. Some agencies opted out of providing their contact information for either the follow up interview or the collaboration question on the survey; therefore a response rate cannot be calculated.

A total of 161 individuals responded to the survey. Respondents came from a wide variety of organizations and positions (Exhibit 1.4). Most were from a nonprofit organization or government/public agency (41.3% and 33.7% respectively) and provided direct services (37.3%).

Professional Networking Model

In order to assess the baseline level of collaboration among local agencies in San Diego providing mental health and suicide prevention services, a series of questions was added to the survey based on the Levels of

Levels of Collaboration Scale

- 1. No Interaction:** not aware of this organization, not currently involved in any way
- 2. Networking:** loosely defined roles, little communication, no shared decision making
- 3. Cooperation:** provide information to each other, somewhat defined roles, formal communication
- 4. Coordination:** share information, defined roles, frequent communication, some shared decision making
- 5. Collaboration:** share ideas, share resources, frequent and prioritized communication, decisions are made collaboratively

Collaboration Scale. The scale identified five levels of collaboration described in the text box: *No Interaction (0)*, *Networking (1)*, *Cooperation (2)*, *Coordination (3)* and *Collaboration (4)*.

The professional networking item was made up of a list of 17 agencies currently providing suicide prevention services.¹⁰ The scores from the survey item were mapped using a network mapping

¹⁰ This list was not an exhaustive list of suicide prevention providers but rather an initial core list to assess baseline associations between agencies. It was made up of the MHSA funded Prevention and Early Intervention contractors that have a suicide prevention focus as well as key partners identified to be providing services specific to suicide prevention.

software. The initial analysis of findings is based on how each of these core agencies rated their relationship to each other.

Additionally, the overall level of association of all agencies to the core list of 17 was analyzed. The findings from this item, as well as detailed instructions for reading the maps, can be found on page 57.

Community Stakeholder Interviews

Confidential interviews were completed with 41 community stakeholders representing a wide array of service providers and community leaders. Many of the individuals interviewed had participated in the community provider survey and were able to provide additional details about their agency's services and perceived system-level supports and gaps. Additional stakeholders were contacted to ensure a cross section of input from leaders in each of the target populations, as well as key sectors such as treatment, primary medical care, faith-based services, law enforcement, and school-based services. The intent of the interview was to assess the extent to which suicidality is an issue for their clients, barriers to suicide prevention in San Diego County and what opportunities exist for improvement when it comes to meeting the suicide prevention needs of their target population(s). A majority of interviews were completed over the phone and each lasted roughly 30 minutes.

Focus Group and Interviews with Target Community Members

With the aim of providing rich, in-depth information about suicide prevention from a range of members from each of the target populations, six focus groups were held with 87 participants to learn unique perspectives and identify needs and gaps in suicide prevention services. Most of the groups were conducted in English with translation available for non-English speakers. Participants from each target populations were recruited through service providers who serve that community. Several groups utilized existing groups and meeting times. Exhibit 1.5 on page 9 provides additional details about each of the focus groups.

Data Analysis

Quantitative survey data was entered into SPSS and analyzed using standard statistical procedures. For each analyzed variable, data is presented as *valid percents*, which eliminate missing cases. Therefore, the totals for specific variables may not equal the overall sample size if some respondents left that item blank. The n-size for each variable is presented in the data tables and charts.

In most cases, descriptive analysis (frequencies) is provided. For the County Training Survey and Community Provider Survey, Analysis of Variance (ANOVA) was used to test for statistical significance between groups regarding summary scores for confidence and suicide knowledge. Findings are noted as "statistically significant" are based on a $p\text{-value} < 0.5$ and indicate that the groups being compared were truly different from one another and that the difference is not by chance alone.

Focus group and interview data were analyzed using content analysis, an approach which comprehensively examines participant commentary for trends and emerging themes. This method also allowed direct participant statements that either supported or contradicted quantitative findings to be highlighted in order to provide a more in-depth examination of client needs and gaps in services.

Exhibit 1.5: Community Focus Group Details

Population	Location	Description of participants	Language
Asian Pacific Islander	Community Clinic in South Region.	16 participants <ul style="list-style-type: none"> 84% female Most were 70 years or older 	English (Tagalog translation provided by co-facilitator)
Native American	Existing support group for tribe elders at clinic on reservation in North Inland Region of San Diego County. Co-facilitated with Director of Human Services.	25 participants <ul style="list-style-type: none"> 40 and older Predominantly male (only 1 female) All military veterans 	English
Latino	Promotoras (community leaders) from a community collaborative located in South Region of San Diego County.	21 participants <ul style="list-style-type: none"> 18 Female 3 Male Predominantly working age adults 	Spanish
LGBTQI	Existing support group for LGBTQI at community center in Central Region.	10 participants <ul style="list-style-type: none"> All Latino men 19-26 years old 	English and Spanish
Older Adults	Senior Center in Chula Vista. Additional individual interview at Apartment Complex in South region	9 participants (one participated in individual interview) <ul style="list-style-type: none"> 50% male All Caucasian All over 50 years of age 	English
Survivors	Existing support group for survivors of suicide loss in North San Diego County	6 participants <ul style="list-style-type: none"> 2 Male, 4 Female All Caucasian 	English
Transition-Age Youth	Not yet conducted; results will be shared in report update.		

Limitations

This needs assessment has a number of limitations that should be considered when reviewing and interpreting the results.

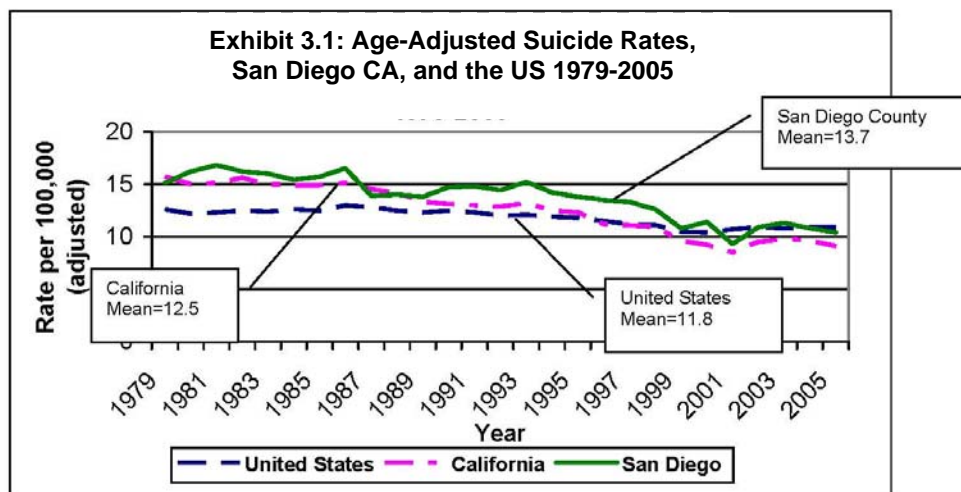
- Data collection efforts relied on convenience sampling techniques to recruit participants. This non-random approach prevents the generalization of findings to the larger population. For example, a majority of the respondents were recruited from community service agencies, and therefore the findings may not be as relevant for individuals who do not access the service system.
- There may have been some “response bias,” in which some respondents may have recorded what they thought to be the “correct answer,” due to difficulty in talking about sensitive issues or other reasons.
- The Community Provider Survey provides a snapshot of organizations throughout San Diego rather than a full inventory of services. The service information presented in the System-Level of this report (page 47) summarizes responses from this survey but is not an exhaustive listing of all available suicide prevention services in San Diego County.
- The information that is reported here was collected within San Diego County and may not be generalizable to other regions or populations.

Results by Population Groups



Suicide is the second leading cause of non-natural death in San Diego County, only slightly behind motor vehicle crashes, and followed by drug overdoses and falls.¹¹ Statistics over the past several years show that the age-adjusted rate in San Diego has been consistently higher than in the state of California or Nationwide (Exhibit 3.1).¹²

To better identify ways to lower the suicide rate in San Diego County, the risks and needs of specific populations must be identified and understood. This section provides an overview of the statistics related to suicide and intentional injury in San Diego County, as well as a brief overview of the risk and protective factors for suicide. Results for each target community are also presented. Statistics presented in this section were gathered from several local and statewide sources. Rather than restating each source in great detail, the most relevant points are included. For a list of links to online versions of each resource, see Appendix A.



Source: CHIP Suicide in San Diego County: 1998-2007

Overview of Suicide in San Diego County

In 2007, there were a total of 356 deaths from suicide in San Diego with a rate of 11.5 per 100,000¹³, higher than the state rate (9.9 per 100,000) but the same at the national rate (11.5 per 100,000)¹⁴. The male suicide rate is more than three times higher than females. Additionally, men are at greater risk of dying by suicide as they get older while women are at higher risk between the ages of 45 and 54.¹⁵ The following is a summary of additional information related to suicide in San Diego County. All statistics are from the Suicide in San Diego County Report.¹⁶ Unless otherwise specified, suicide rates are per 100,000 in the population.

¹¹ Community Health Improvement Partners. *Suicide in San Diego County: 1998-2007*. Web. 1 Dec. 2010. <http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf>.

¹² An age-adjusted rate allows for comparisons between groups with different age distributions.

¹³ Ibid.

¹⁴ National Vital Statistics Reports, Vol. 58, No. 19, May 20, 2010. Web 31 Jan. 2011.

<http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf>

¹⁵ Community Health Improvement Partners. *Suicide in San Diego County: 1998-2007*. Web. 1 Dec. 2010.

<http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf>.

¹⁶ Ibid.

Age

- The average annual suicide rate among youth (15-24 years) from 1998 to 2007 is 7.9. While still high, the suicide rate among youth has declined over the past 20 years and is lower than state and national averages.
- The average suicide rate for working-age adults (25-64 years) from 1998-2007 is 14.5.; higher than state and national averages, but on the decline over the last 20 years.
- The average suicide rate for older adults (65 years or older) is 20.3; higher than state and national averages, but on the decline over the last 20 years.
- Adults and older adult marital status is strongly associated with suicide risk. Those who were divorced, widowed, or single had a higher risk of suicide than those who were married. Among working-age men, those who were divorced or widowed were four times more likely to die by suicide than those who were married. Among older adults, widowed men were four times more likely to die by suicide than married men; the rate was three times higher for divorced older men than married older men.

Geographic Distribution

- The suicide rate is highest in Central and East regions of the County (12.1 and 12.5, respectively) and lowest in the South region (7.8).
- For youth, the suicide rate is highest in the East region (9.7) and lowest in the South (4.7).
- Among working-age adults, the suicide rate was highest in the Central region (17.9) and lowest in the South region (10.3).
- Among older adults, the suicide rate was highest in the North Coastal region (22.9) and lowest in the South (17.5).

Race/Ethnicity

- The suicide rate is highest among Whites (16.7), followed by the Black population (7.3), Asian/Other (5.5) and Hispanic (3.7).
- Rates among youth are fairly even across race/ethnic groups; it is highest among White and Black males (17.0 and 14.5 respectively), followed by Asian/Other males (8.4) and Hispanic males (6.3).
- The rate among working-age adults is highest among White males (28.6), followed by Black males (15.9), Asian/Other males (12.2) and Hispanic males (9.3).
- Almost 95% of suicides in older adults were White.

Suicide Methods

- Firearms are the leading method of completed suicide (41%); this is also the most common method used by men (47%) while women tend to use drugs or poisons to die by suicide (42%).
- Although still the leading cause, suicides by firearms have decreased by 27% over the last 20 years while the number of suicides by hanging/asphyxia have increased by 66% and the number of drug overdose and poisoning has nearly doubled.

Toxicology

- Of those tested, 56.4% of men and 67.5% of women tested positive for alcohol and/or drugs at the time of their death. Nearly one-third (30.2%) of suicide victims tested positive for alcohol.¹⁷

¹⁷ The actual number with positive toxicologies might be higher as the routine screen does not test for many prescription or over the counter drugs.

- This trend is fairly similar among youth and working-age adults. However, older adults were less likely to have positive toxicology results: only 37.7% of older men and 58.1% of women had positive results for alcohol and/or drugs.

Other Factors

- Overall, suicide rates do not vary greatly by month in San Diego. Among youth, the highest number of suicides occurs in March and the lowest in July. There is not a strong seasonal trend among working-age adults, although the average number per day increases in the spring and reaches its maximum point in August. January has the highest number of suicides per month among older adults, while February and November had the lowest.
- Cases in which a person takes somebody's life before ending their own make up 1.6% of all suicides over the past 20 years. The majority are done by men (90%) using firearms (93%); the majority of homicide victims were significant others with a history of relationship issues.

Screening for Depression

Each year, the Behavioral Health Work Team of CHIP and its partners, including the County, conduct a Depression Screening Week in an attempt to reach out to the community and refer those in need to services. In fall 2010, 435 screenings were conducted throughout the County. Providers who participated in this effort observe that while there were less screenings conducted this year, a higher number of cases warranting follow-up were identified.

The following is a summary of this effort:

- Screenings were predominantly among women (69.4%) and adults 25-64 (69.3%)
- Most were Hispanic (41.8%) or White (23.0%).
- 33.5% showed no to minimal risk and 21.0% showed mild risk
- Almost half showed moderate to severe risk (45.5%)

Source: Community Health Improvement Partners (CHIP)

Overview of Self-Injury in San Diego County

An indicator of suicide attempts is self-injury data. In San Diego County, Hospital Emergency Department discharges as well as hospitalizations due to self-injury are recorded.

Hospital Discharges

Self-inflicted injury from San Diego hospital discharge data (CA OSHPD) indicates a rate of 43.7 injuries per 100,000. This rate is higher among women than men (48.1 vs. 39.2) and youth (64.2 for ages 15 to 24 vs. 57.9 for 25-34). Self-injury rates were highest in Central (63.4) and lowest in the North Central region (28.0)¹⁸

Emergency Department Discharges

Emergency Department (ED) discharge data shows a self-injury rate of 78.1.¹⁹ Self injury increased 14.9% from 2007 to 2008. Of the 2,450 ED discharges with a self-inflicted injury, 15 resulted in a completed suicide where the patient died in the ED.²⁰

¹⁸ County of San Diego, HHSA, Public Health Services, Community Health Statistics Unit. *San Diego County Profile by Region*. Web. 29 Nov. 2010. < http://www.sdcountry.ca.gov/hhsa/programs/phs/documents/CHS-CommunityProfile_County_2010.pdf>.

¹⁹ Ibid. Please note that emergency discharges only include patients who come to the emergency room and are then release and does not include patients admitted to the hospital.

The self-injury rate in EDs is higher for women (106.7) than men (74.3) and is highest in younger populations (215.7 for 15-19 years; 158.6 for 20-24 years and 107.5 for 25-34 years).²¹ This rate was lower in North Inland, North Central and South regions but much higher in East County (136.1).²² The most common mechanism of injury was drugs, medicine or poison (61.4%), followed by cutting instruments (26.2%), hanging/strangulation (2.6%) and firearms/explosives (0.6%).²³

Risk factors for Suicide

As highlighted in the California Strategic Plan on Suicide Prevention, risk factors for suicide vary among individuals and across age, cultural, racial and ethnic groups. These risk factors range from bio-psycho-social factors such as mental disorders, substance use, and history of trauma/abuse to sociocultural factors such as lack of social support, isolation, and stigma associated with help-seeking behavior.²⁴ Most people who attempt or complete a suicide had one or more warning signs prior to the suicide attempt. Warning signs include symptoms such as expressing feelings of hopelessness and withdrawing from family and friends as well as distinct signs of suicidal ideation such as threatening to hurt or kill oneself. Similarly, there are protective factors that can reduce the likelihood of suicide. These include social connectedness, family relationships, parenthood and religious activities and beliefs.

²⁰ Community Health Improvement Partners, County of San Diego, Emergency Medical Services, and Hospital Association of San Diego and Imperial Counties. *Emergency Department Discharge Patient Summary: Aggregate Report*. August 2009. <<http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/EMS-EDAggregateReport2008.pdf>>.

²¹ Ibid.

²² County of San Diego, HHSA, Public Health Services, Community Health Statistics Unit. *San Diego County Profile by Region*. Web. 29 Nov. 2010. <http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/CHS-CommunityProfile_County_2010.pdf>.

²³ Community Health Improvement Partners, County of San Diego, Emergency Medical Services, and Hospital Association of San Diego and Imperial Counties. *Emergency Department Discharge Patient Summary: Aggregate Report*. August 2009. <<http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/EMS-EDAggregateReport2008.pdf>>

²⁴ For a comprehensive list of risk factors and warning signs for suicide, please consult page 10 of the California Strategic Plan on Suicide Prevention http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSPSP_V9.pdf.

Community Beliefs Regarding Mental Illness and Suicide

To inform the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funded Mental Health Stigma and Discrimination Reduction Campaign, a random digit dial survey was conducted with 602 San Diego adult residents and 19 adolescents. It produced a baseline snapshot of community beliefs associated with mental illness and stigma. Key survey findings include:

Perceptions about Mental Illness

- Generally, the survey indicated widespread stigma related to mental illness.
 - Roughly half believe that people with mental health problems are not as productive as others (52%), are more likely to be dangerous (48%) and that they should not be allowed to care for children (47%).
 - The majority of survey respondents (73%) noted that opportunities for those with an identified mental illness would be limited if others knew about mental health issues.
- Despite this stigma, the majority of participants (89%) expressed that families should not keep mental illness a secret. Men were more likely than women to express this belief (92% vs 86%).
- The majority of participants (80%) also believe that mental illness does not reflect poorly on a family. However, participants of Hispanic background were less likely to feel this way (63%).
- A large majority (89%) said they would feel comfortable talking to a friend or family member about their mental health. However, 45% said they would be afraid to tell people if they had a mental health problem and men were more likely to be afraid to tell people than women.
- 60% agreed that the community has resources for mental health problems. Non-white and Hispanic respondents were less likely to feel this way.

Perceptions about Suicide

- 93% agree that suicide is preventable.
- 58% believe they can recognize warning signs of suicide in other people. This finding was highest among those in treatment or who know someone in treatment, females, those younger than 65, and those familiar with messaging or ads.
- 81% say they know where to get help if someone in their family showed warning signs of suicide; this was highest among those who have had treatment or know someone in treatment as well as those familiar with messaging or ads.

Community-Level Results

The community-level component of the needs assessment focused on several key target populations in an effort to identify gaps in services and opportunities for improvement for those groups most at risk as well as learn more about populations where not as much data exists. The populations that were the focus of this needs assessment were:

- **Age Groups:** Transition-Age Youth (18-24) and Older Adults
- **Community Groups:** Asian Pacific Islander (API); Latino; Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex (LGBTQI); Native American and Survivors

These seven target populations were initially identified by the County, either because they had higher rates of suicide (i.e., older adults, Native Americans) or because more information was needed to meet their needs (i.e., LGBTQI, API, Latino). This is by no means meant to be an exhaustive list of target population; as we continue through the action planning process, more populations may be identified and addressed.

A summary of the data collected for each of the target populations is provided. The results in the section are based on a number of different data collection methods (details about the methods are in the Methods section on page 4).

For each target population, data was reviewed from the following sources:

- **Literature search** of key articles and studies
- **Secondary data** available to the needs assessment team, including: 2010 census results; Community Health Improvement Partners Suicide in San Diego County 1998-2007; statistics provided by the County of San Diego, Health & Human Services Agency (HHS); The Hospital Association of San Diego and Imperial Counties, and the County of San Diego Emergency Department Discharge Surveillance (EDDS) data; California Department of Mental Health California Strategic Plan on Suicide Prevention.
- **Community stakeholder interviews** conducted by the needs assessment team
- **Focus groups with target population members** conducted by the needs assessment team
- **A survey of county funded mental health service providers** conducted by the needs assessment team

Note that throughout this section, “region” refers to the six Health and Human Services Agency regions that are divided by zip code. For detailed maps, see Appendix C. In addition, unless otherwise specified, suicide rates are per 100,000 in the population.

The summaries provided here are not intended, nor should be construed, as being a definitive accounting of the issues. Rather, it is a starting point to outline some of the key and emerging issues related to different target populations. The community will be invited to add additional information to this assessment at community forums and meetings. To participate in these meetings, or to submit additional data, background, or feedback, please contact either:

Holly Salazar Director of Strategic Outcomes Community Health Improvement Partners 858-609-7966 hsalazar@sdchip.org	Casey Mackereth Research Associate Harder & Company Research 619-398-1980 cmackereth@harderco.com
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“Anyone from an ethnic minority culture would be at higher risk because of the stressors in their life. That is my professional opinion.”
– Mental Health Provider
Director

Focus on Youth

Nationwide, 6.3% of students attempted suicide one or more times in 2009.²⁵ Broken down, the statistics are even more sobering:

- Each year, in the United States, there are approximately 10 youth suicides for every 100,000 youth.²⁶
- Each day in the U.S., there are approximately 12 youth suicides.²⁷
- Every 2 hours and 11 minutes in the U.S., a person under the age of 25 dies by suicide.²⁸

Suicide among youth is more severe within subpopulations. Boys are more likely than girls to die from suicide: of the reported suicides in the 10 to 24 age group, 83% of the deaths were males and 17% were females. Cultural variations in suicide rates also exist, with Native American/Alaskan Native and Hispanic youth exhibiting the highest rates of suicide-related fatalities nationwide.²⁹

For more information on how target communities were selected and how data for this section was collected, see page 15.

Youth Quick Facts:

- Approximately 15.3% of the population identified as youth (15 to 24 years of age).
- Suicide rates for 15-24 year olds: 7.9 suicides per 100,000 people.
- Suicide rates in San Diego County are slightly lower than National rates.
- Suicide rates were highest in East region and lowest in South region.

What does available San Diego data tell us about youth?

Approximately 15.3% of the population in San Diego County is aged 15 to 24 years old (7.1% are 15 to 19 years old).³⁰ Suicide is the third leading cause of non-natural death among youth ages 15 to 19, slightly behind motor vehicle crashes and homicide.³¹ While suicide rates in teens and young adults over the past two decades have declined, they remain at unfortunately high levels.³² From 1998 through 2007, a total of 355 suicides (a mean rate of 7.9 suicides per 100,000 people) were completed among youth 15 to 24 years old in San Diego County.³³

The San Diego youth suicide rate (10.3) is slight below the California average of 10.5.³⁴

Suicide rates among youth ages 15-24 was highest in the East region (a rate of 9.7) and lowest rate in the South region (a rate of 4.7).³⁵

²⁵ Department of Health and Human Services, Centers for Disease Control and Prevention. *Youth Risk Behavioral Surveillance – United States, 2009*. Morbidity and Mortality Weekly Report 59.SS-5 (2010). Web. 11 Dec. 2010. <<http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>>.

²⁶ American Association of Suicidology. Youth Suicide Fact Sheet (2008). Web. 11 Dec. 2010. <http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-24.pdf>.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Centers for Disease Control and Prevention Injury Center. *Youth Suicide* (2008). Web. 11 Dec. 2010. <<http://www.cdc.gov/ncipc/dvp/suicide/youthsuicide.htm>>.

³⁰ U.S. Census Bureau, Census 2010. Web 20 Dec. 2010. <<http://factfinder.census.gov/servlet/DatasetMainPageServlet>>.

³¹ Community Health Improvement Partners. "Suicide in San Diego County 1998-2007." Retrieved from: http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf

³² Ibid.

³³ Ibid.

³⁴ Ibid.

³⁵ Ibid.

The leading method of completed suicides among young males was firearms and for females, hanging/asphyxia.³⁶ Equally concerning among youth is suicidal thoughts, intentionality, and self harm statistics. In 2009, 6.0% of surveyed San Diego City School students reported attempting suicide and 13.9% considered suicide at least once during the previous 12 months.³⁷ In 2008 alone, 312 youth ages 15 to 24 years (a rate of 64.2) were hospitalized with a self-inflicted injury.³⁸ In that same year, 908 youth ages 15 to 24 (a rate of 186.8) were discharged from the emergency department (ED) with a self-inflicted injury.³⁹ Females ages 15-19 had the highest rate of self-inflicted injury (291 per 100,000) while the rate for males ages 15-19 was 147 per 100,000.⁴⁰ Positive toxicology results for alcohol and/or drugs were found in 53.7% of male and 57.1% of female suicide victims age 15 to 24, indicating that substance abuse is a risk factor for this age group.⁴¹

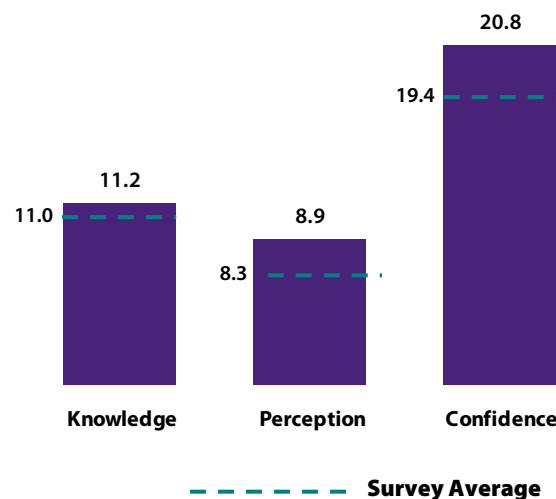
What do stakeholders know and say about youth?

The Community Provider Survey asked providers key questions regarding their knowledge of risk factors, perceptions of suicide, and confidence in their ability to address suicide. On average, providers who serve Transition Age Youth (TAY) exhibited scored higher than the general service provider population for knowledge of risk factors, perception of suicide, and confidence in their ability to address suicide for their target population scores (see Exhibit 3.2).

Youth population service providers noted differences based on sexual identity and ethnic affiliation. For example:

- One stakeholder commented on the high rates of suicide among Native American youth.⁴²
- Another stakeholder cited a mid-1990 Center for Disease Control survey that noted that 49% of San Diego's Filipino American youth exhibited a high level of suicidal ideation.
- Stakeholders felt that local Latino/a teen suicide rates have increased as a result of rising mental health problems.
- The suicide rate among LGBTQI youth is perceived to be high but stakeholders feel it is not increasing.

**Exhibit 3.2:
Youth Service Providers Knowledge, Perception
& Confidence Services**



³⁶ Ibid.

³⁷ Youth Risk Behavior Survey Results (2009). San Diego High School Survey Summary. Accessed 6 December 2010 <<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>>

³⁸ County of San Diego, HHSA, Public Health Services, Community Health Statistics Unit. *San Diego County Profile by Region*. Web. 29 Nov. 2010. <http://www.sdcountry.ca.gov/hhsa/programs/phs/documents/CHS-CommunityProfile_County_2010.pdf>.

³⁹ Community Health Improvement Partners, County of San Diego, Emergency Medical Services, and Hospital Association of San Diego and Imperial Counties. *Emergency Department Discharge Patient Summary: Aggregate Report*. August 2009. Web. 7 Dec. 2010. <<http://www.sdcountry.ca.gov/hhsa/programs/phs/documents/EMS-EDAggregateReport2008.pdf>>.

⁴⁰ Ibid.

⁴¹ Ibid. Note: "Drugs of Abuse" includes methamphetamine, opiates, cocaine, cannabinoids, and benzodiazepines.

⁴² For American Indians and Alaska Natives (AIANs) aged 15-24, suicide is the second leading cause of death with a prevalence rate of suicide at 2.4 times the national rate, or about 20 deaths per 100,000 individuals. Locally, the rate among this population is too low to calculate. For more information on suicide among Native Americans, please see page 34.

The school system and environment was another major area of concern and opportunity for stakeholders. Students spend approximately one-third of their waking hours in school. Stakeholders noted that the school environment can engender both risk and protective factors for youth. Bullying in schools is a major risk factor that was mentioned by a number of providers, school based and otherwise.

Stakeholders noted that bullying across all schools is starting at a very young age, however, schools are also addressing these issues head on, through programs like Suicide Prevention Education and Awareness Program (SPEAK). SPEAK is a school-based intervention that provides training and education for faculty, staff and parents, as well as conducting student assemblies throughout the San Diego Unified School District. Stakeholders stressed the importance of education for everyone – staff, faculty, families and students.

Drug use is another key risk factor for this population and that is on the rise.⁴³ This drug use may set a dangerous course for youth. In fact, a stakeholder at County Alcohol and Drug Services sees increasing numbers of young adults who as youth became addicted to oxycontin and methamphetamine, both of which are powerful mind altering substances that can increase suicidal tendencies.

A school based psychologist noted that youth suicide rates can be turned around. One stakeholder shared that 95% of students who get “real help and ongoing care, improve and can return to a high quality of life.” However, they also noted that there are few available services that specialize in youth mental health, especially if the youth requires financial assistance to pay for the service. “There aren’t many [youth mental health service providers] ...not just in San Diego [but in other places]. People don’t know where they can go.” This lack of service is compounded by the need for culturally appropriate services. Consequently, providers noted the difficulty in obtaining needed services: “How can anyone who is culturally, language and resource isolated be expected to navigate this system.”

What does the target population say about themselves?

Youth between ages 18-25 participated in a focus group and shared their experiences with suicide and suicidal ideations among their peers. The youth expressed the importance of socializing and building relationships with other people their age. They appreciated being able to attend peer support groups with other youth because “it’s a safe place to be and there are others who understand your situation.” However, when talking about personal matters such as depression, they preferred one-on-one counseling over group settings and regretted that there were not enough of these services in San Diego County.

Regarding barriers to services, the youth noted transportation as a problem because they did not drive and the bus was too expensive or did not always service the area they needed to reach. They also expressed difficulty finding programs that were affordable without insurance and frustration with the lack of one-on-one services. Participants shared their experiences of waiting in line in the cold just to sign up for services.

To reach other youth, participants suggested having older youth speak at schools since they felt that young people are more open to listening to other youth than to older adults. The participants also shared that teachers could be more encouraging and notice when a student is withdrawn and take action to help them. One youth said, “teachers need to know what’s going on when there’s trouble and ask. When someone’s really quiet and seems like something is going on they should notice and speak to them. Usually it just gets bottled up and can come out in a crazy way.” Flyers in buses, fast food restaurants, 7-Eleven, malls, doctor’s offices and other places that youth frequently visit were also recommended as a way to reach youth.

⁴³ According to the California Health Interview Survey, drug use is not on the rise but in fact might be decreasing. This observed trend in San Diego among providers may need to be further explored.

What barriers were identified by stakeholders and focus group participants?

The major barriers reported include:

- The lack of funding for overarching, repeated observation at schools.
- Inconsistent and fragmented approaches, particularly in the schools. “[There are] so many options and programs that it’s hard to select a prevention program to implement. For example, in the schools, there are different curricula and programs in each school district.”

What opportunities for improvement were identified by stakeholders and focus group participants?

Opportunities for successfully engaging youth in suicide prevention included:

- Start young with education and de-stigmatization programs.
- Facilitate the implementation of Senate Bill 543 that allows teens to access mental health screening and initial care without parental consent (effective in January 2011)⁴⁴.
- Share information about at-risk youth across sectors. For example, one school district uses the GOALS Program (Global Oversight Assessment Linking System) which allows sharing of student information among mental health providers, non profit organizations, schools and law enforcement.
- Increase forums and curricula, such as the Signs of Suicide curriculum, at schools.⁴⁵

⁴⁴ Teen Health Law: Information for California Providers of Adolescent Health Services. Web 10 March 2011.

<http://www.teenhealthlaw.org/fileadmin/teenhealth/teenhealthrights/ca/SB_543_2010.pdf>

⁴⁵ SOS Signs of Suicide® Prevention program is an award-winning, nationally recognized program designed to teach middle and high school-age students how to identify the symptoms of depression and suicidality in themselves or their friends, and encourages help-seeking. More information can be found at: <http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/>

Focus on Older Adults

Comprising 13 percent of the U.S. population, individuals age 65 and older accounted for nearly 16 percent of all suicide deaths in 2007.⁴⁶ Within this older adult group, Caucasian men ages 85 and older have the highest rates of suicide (more than five times the national U.S. rate, at 51.1 per 100,000).⁴⁷ In California, adults over the age of 85 have the highest suicide rate of all age groups in the state, at a rate of 22.5 per 100,000.⁴⁸ This fact becomes more concerning as older adults are becoming a larger proportion of the state's growing population, particularly as the baby boomers approach age 65. In 2000, the population of Californians over the age of 65 was over 3.6 million; in 2010 it is projected to be over 4.4 million; and in 2020, it may exceed 6.3 million. Today, approximately 11.2% of the San Diego population is aged 65 or older.⁴⁹

For more information on how target communities were selected and how data for this section was collected, see page 15.

What does available San Diego data tell us about older adults?

Suicide is the second leading cause of non-natural death for older adults ages 65 and up (preceded only by falls).⁵⁰ The suicide rate among older adults has been generally higher in San Diego County than in either the state of California or the United States overall since 1979.⁵¹ From 1998 to 2007, there were a total of 656 suicides (a mean rate of 20.3 suicides per 100,000 people) among older adults ages 65 and up.⁵² Gender was a major factor in suicide among older adults: the male suicide rate was more than three times higher (a rate of 37.8) than the rate among females (a rate of 7.2) in San Diego County, and increased dramatically in older age groups (rate of 38.5 for adults over 85).⁵³ The suicide rate among older adults was highest in the North Coastal region, the lowest rate was in the South region.⁵⁴ Firearms were by far the leading method of completed suicide among older adult men, accounting for 72%. Among older women, however, only 31% were attributed to firearms, with 39% due to drugs/poisons.⁵⁵

Older Adults Quick Facts:

- Approximately 18.4% of the San Diego population identified as older adult.
- Suicide rate: 20.3 per 100,000 people.
- Suicide rates were highest in the North Coastal region and lowest in South region.
- Older adult males are more likely to commit suicide than females.

⁴⁶ Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System Injury Mortality Report*. Web. 01 Feb. 2011. <<http://www.cdc.gov/injury/wisqars/fatal.html>>

⁴⁷ Office of Minority Health. *Suicide and Suicide Prevention 101* (2008). Web. 11 Dec. 2010. <<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=136>>.

⁴⁸ California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010. http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSP_SP_V9.pdf

⁴⁹ U.S. Census Bureau, Census 2010. Web 20 Dec. 2010. <<http://factfinder.census.gov/servlet/DatasetMainPageServlet>>.

⁵⁰ Community Health Improvement Partners. *Suicide in San Diego County: 1998-2007*. Web. 1 Dec. 2010. <http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf>

⁵¹ Ibid.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Ibid.

⁵⁵ Ibid.

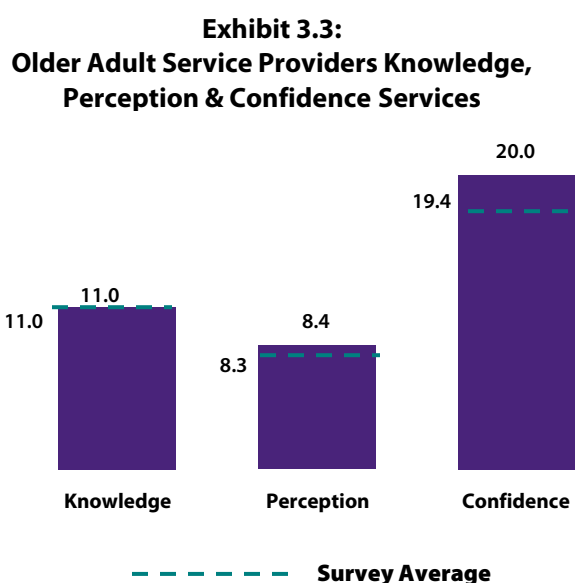
The role of substance use and abuse among older adults who completed suicide is evidenced in the high rate of positive toxicology results for alcohol and/or drugs of abuse among suicide victims (37.7% of male and 58.1% of female suicide victims age 65 and older).⁵⁶ It is important to note that most of the positive toxicologies were for prescription, rather than illicit drugs.

Among older adults (65 and up), those who were divorced, widowed, or single had a higher risk of suicide than those who were married.⁵⁷ Older adults reported a higher suicide rate than youth, and lower self harm rates, suggesting that older adults were more likely to complete a suicide attempt than their younger counterparts. In 2008, 78 older adults ages 65+ (a rate of 21.9 per 100,000 older adults) were hospitalized with a self-inflicted injury and 54 adults ages 65+ (a rate of 15.2 per 100,000 older adults) were discharged from the emergency room with a self-inflicted injury.^{58, 59}

What do stakeholders know and say about older adults?

The Community Provider Survey asked providers key questions regarding their knowledge of risk factors, perceptions of suicide, and confidence in their ability to address suicide.

On average, providers who serve older adults exhibited scores similar to the general service provider population for knowledge of risk factors and perceptions regarding suicide scores; but above the average in their confidence to address suicide for their target population score (see Exhibit 3.3).



Service provider stakeholders interviewed for this project noted that older adults are at a very high risk for suicide and perceive the risk is higher for low-income individuals who lack access to care.⁶⁰

Stakeholders and focus group participants alike noted that a major contributor to suicidal thoughts among the older population is isolation: as on API focus group participant shared, “Many seniors are depressed because they’re left alone in their houses. They don’t get to go out and socialize with others.” Service providers noted that Medicare and Medi-Cal continue to reduce reimbursement rates for mental health professionals.

Consequently, fewer providers are available. The lack of providers who assist seniors without Medicare also creates a bottleneck in the system of care. One provider noted that some of her clients with private insurance had difficulty finding referrals through 211.

⁵⁶ Ibid.

⁵⁷ Community Health Improvement Partners. *Suicide in San Diego County: 1998-2007*. Web. 1 Dec. 2010. <http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf>

⁵⁸ County of San Diego, HHSA, Public Health Services, Community Health Statistics Unit. *San Diego County Profile by Region*. Web. 29 Nov. 2010. <http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/CHS-CommunityProfile_County_2010.pdf>.

⁵⁹ Ibid.

⁶⁰ According to the California Strategic Plan on Suicide Prevention, lack of availability of quality mental health care can contribute to higher suicide rates. In addition, depression rates are higher among isolated older adults, such as those receiving in-home care of living in institutions. There is limited data as to whether income plays a role in suicide risk.

Stakeholders also noted that primary medical care providers are an excellent entry point because of the chronic medical conditions of the older adult population that places them in regular contact with providers. However, one stakeholder observed that the physical health providers are more taxed in their work and less likely to ask

“Several times a week, I consult with a senior who has had serious intent or has attempted suicide”
- Senior center clinician

about mental health problems. As a result, these providers may be disinclined to ask about suicide and mental health issues because an affirmative response takes more time than they have. Other providers who could be trained as early identifiers for suicide risk among older adults includes Meals on Wheels, senior centers, nutrition sites, and the faith community.

What does the target population say about themselves?

Generally, the older adults who participated in the focus group were not familiar with prevention services for seniors who were depressed or suicidal. They noted that seniors who are living alone may not notice their increasing depression, and unless they are visited by a friend or participating in regular activities, the identification of their depression often does not happen. This is particularly true for seniors who lose their spouses. Participants noted that the loss of a spouse may cause a deep depression and older adults may not know that they can ask for help. One participant knew that he was getting depressed and turned to the VA. “I was feeling so bad that one day I had to pull off the road because I was crying so hard.” The doctor at the VA recommended the bereavement group. “In the group, I could talk about my feelings; everyone did. The Chaplain and social workers were there to help us.” This group helped him move past his depression and to even get a job. As he said, “this probably saved my life. Working kept me busy and from feeling isolated.”

Most focus group participants said that they did not know where to turn for information services and were not familiar with the Access and Crisis line. While several were aware of 211, they did not view this as a viable resource for people who were in crisis. They wanted a number that would offer immediate suicide counseling and prevention. The participants, who were recruited through a senior center, said that they relied on the senior center for support and information. When seniors did know of a service, they noted that limited financial resources would prohibit them from accessing it unless Medicare covers the cost.

Finally, medication management was an issue. Assistance with taking medication regularly was noted as important for those who are depressed. Some people may have trouble remembering to take their medication, particularly those who take more medication as they age. Senior housing or treatment facilities can assist with this issue.

In the end, one of the most important activities that could be done for the older adult population is to show caring and kindness through calling and visiting programs. One man shared a story about a friend who had been delivering food and support to other people and then he completed suicide. “He was supporting other people, but no one was supporting him. No one noticed that he was in need.” He and others repeated that the best intervention is to “Call people and let them know that you will listen. It is a little thing that can make a big difference.” Knowing that someone cares was a repeated theme for effective suicide prevention for seniors. For that reason, seniors were more likely than other groups interviewed for this assessment to recommend volunteer prevention intervention models which could create networks of people to provide support to seniors who were alone and/or in poor health.

What barriers were identified by stakeholders and focus group participants?

The major barriers reported by seniors include:

- Not recognizing the signs of depression in themselves (and others).
- Lack of knowledge about available services.
- Lack of finances to pay for mental health services.
- Changes in MediCal and Medicaid reimbursements for mental health services.
- Transportation/proximity of services.

What opportunities for improvement were identified by stakeholders and focus group participants?

Opportunities for successfully engaging the older adults in suicide prevention included:

- Greater education and outreach to provide seniors, particularly isolated seniors and those living alone, with information and referral.
- Encourage seniors to be involved in senior centers, church, and other groups so they are not isolated and depressed.
- Support groups in convenient locations so seniors can meet regularly. These should be facilitated by experts who can handle emotional issues that may arise.
- Restart the County's training program on suicide prevention for providers and include 211 responders. Stakeholders recommended including key providers that interact with the older adult population, such as Meals-on-Wheels drivers on the signs of depression and give them materials to distribute. The Union of Pan Asian Communities PEI funded Positive Solution Program partners with resources like Meals on Wheels to reach isolated seniors.
- Identify people who need a home visitor.
- Train service providers in how to better work with the older adult populations. Maximize the "certificate in geriatric mental health" program, which trains professionals in aging who need mental health training and mental health providers in aging issues.⁶¹ Many County mental health services currently address the needs of older adults. Part of the County Workforce Education and Training (WET) funding provides peer specialist training, peer advocacy training, and support for conference attendance to older adults.⁶² In addition the Union of Pan Asian Communities (UPAC) Positive Solutions Program targets homebound seniors over 60 with minor depression or at risk of becoming depressed and provides outreach through key partners such as Senior and community centers, Vista Senior Nutrition Program, Meals on Wheels-North County, and Aging and Independent Services (AIS).⁶³

"I am amazed at how many health care providers think that depression is a normal part of aging so they don't do anything about it... ignore depression in older adults because they think "of course she wants to die, she's old and sick" so help is not accessed"

-Senior health provider

⁶¹ The Certificate in Geriatric Mental Health is intended to increase understanding of the acute and chronic mental health needs of older adults. Many continuing education programs offer this certificate.

⁶² <http://sandiego.networkofcare.org/contentFiles/1MHSA-WET-Program-Summary-11.2.10-1.pdf>

⁶³ <http://www.upacsd.com/services/mentalhealth.php>

Focus on Asian Pacific Islanders

The Asian Pacific Islander (API) community is highly diverse. The U.S. Department of Labor, Office of Federal Contract Compliance Programs defines Asian Pacific Islander as: "A person with origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Republic and Samoa; and on the Indian Subcontinent, includes India, Pakistan, Bangladesh, Sri Lanka, Nepal, Sikkim, and Bhutan."⁶⁴ In San Diego, the API population is predominantly Filipino, followed by Vietnamese and Chinese.⁶⁵

In general, suicide rates for the API community in the United States are lower than other groups. However, it is higher among certain subpopulations. API older adults, for example exhibit a higher suicide rate than the national average and 15.9 percent of U.S.-born Asian-American women have contemplated suicide in their lifetime, exceeding national estimates.^{66, 67} It is also of note, that a 2009 study demonstrated that the percentage of Asian-Americans who reported thinking about suicide increased the longer they lived in the U.S. and that young Asian-Americans, between 18 and 34, had the highest estimates of thinking about (11.9%), planning (4.38%) and attempting suicide (3.82%) of any age group. Studies have also shown that APIs are the least likely of all races to seek help for their distress and when they seek professional help; their symptoms are likely to be more severe.⁶⁸

API Quick Facts:

- Approximately 9.4 (%) of the San Diego population identifies as API.
- The API community is predominantly Filipino (49.6%), followed by Vietnamese (13.7%) and Chinese (11.7%).
- Suicide rate: 5.45 per 100,000.

For more information on how target communities were selected and how data for this section was collected, see page 15.

What does available San Diego data tell us about the API community?

The API community comprises 9.4% of the San Diego population, and is the County's second largest minority group behind persons of Hispanic or Latino origin.⁶⁹ The largest discrete API communities are Filipinos and Vietnamese, however, smaller tight knit communities, such as Chinese and Japanese are also present, each having their own dynamics, history, and cultural considerations that relate to suicide prevention. The cultural elements of the API community are also further diversified by immigrant status and length of time in or acculturation to the larger, western-American culture.

⁶⁴ Princeton University. Human Resources Self-Service Glossary of Terms (2004). Web. 6 Dec. 2010. <<http://web.princeton.edu/sites/oitdocs/Help/HRSelfService/HRSS-Glossary.htm>>.

⁶⁵ County of San Diego, HHSA, Public Health Services, Community Health Statistics Unit. *San Diego County Profile by Region*. Web. 29 Nov. 2010. <http://www.sdcountry.ca.gov/hhsa/programs/phs/documents/CHS-CommunityProfile_County_2010.pdf>.

⁶⁶ LaVeist, Thomas A. "Minority populations in Health: An Introduction to Health Disparities in the United States. Jossey-Bass. 2005

⁶⁷ "US-Born Asian-American Women More Likely To Think About, Attempt Suicide, Study Finds." Science Daily Mag., Aug. 18, 2009. Web. 11 Dec. 2010. <<http://www.sciencedaily.com/releases/2009/08/090817190650.htm>>.

⁶⁸ Office of Minority Health. *Suicide and Suicide Prevention 101* (2008). Web. 11 Dec. 2010. <<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=136>>.

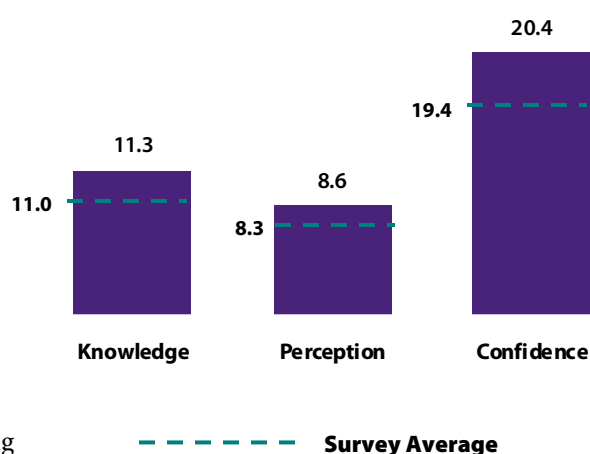
⁶⁹ U.S. Census Bureau, Census 2010. Web 20 Dec. 2010. <<http://factfinder.census.gov/servlet/DatasetMainPageServlet>>.

Data related to suicide that is specific to the San Diego API community is limited. From 1998 to 2007, there were a total of 211 suicides (a rate of 5.45 suicides per 100,000 people) among Asians/Other (almost half were Filipino or Vietnamese).⁷⁰ Suicide among San Diego County’s API youth was the third highest of all ethnic/racial groups (preceded by White and Black). From 1998-2007, 28 Asian/Other males (a rate of 8.4) and 7 Asian/Other females (a rate of 2.3) ages 15-24 died by suicide.⁷¹

What do stakeholders know and say about API community?

The Community Provider Survey asked providers key questions regarding their knowledge of risk factors, perceptions of suicide, and confidence in their ability to address suicide. On average, providers who serve the API community exhibited higher scores than the general service provider population for knowledge of risk factors, perception of suicide, and confidence in their ability to address suicide for their target population scores (see Exhibit 3.4).

**Exhibit 3.4:
API Service Providers Knowledge,
Perception & Confidence Services**



Stakeholders noted that cultural considerations of the different API communities are a major factor in suicide prevention. One provider noted, “In the API communities, the concern has been among youth and older adults, especially for the older adults because of the cultural shifts from what is expected...Respect for elders is a very important value and that is often lost among API communities as they acculturate.” The importance of acculturation was repeated by other stakeholders who noted that a high level of intergenerational conflict among older and younger generations. Another contributing factor is what has been termed the “model minority” pressure – the pressure some Asian-American families put on children to be high achievers both academically and professionally. “The major stressors are issues related to cultural differences, family shame if not doing well in school, and a desire to make the family proud.” Additionally, each population within the API group has unique cultural dynamics to consider in relationship to risk factors. As one stakeholder shared, “even though Cambodians are not a large ethnic group in SD County, they have large mental health needs and are more likely to seek services. However, they are a population that has high stigma. So the intervention has to adapt to their needs maybe having the intervention to be presented orally.”

What does the target population say about themselves?

API focus group participants noted the importance of understanding cultural dynamics both across the API community as well as the distinct cultural considerations of API subpopulations. One stakeholder commented on how the closely connected communities act as the first line of support. “Most Filipinos relate to each other first. They go to their relatives and friends first, and it takes a lot of talking to help them. It takes a lot of asking and telling before you can convince. We can be hard to convince a lot.” Yet, API stakeholder and focus group participants alike noted that any targeted prevention effort must take into account, “the diversity within the API community such as the different literacy levels. Any intervention has to be tailored to the population that you work with.”

⁷⁰ Community Health Improvement Partners. *Suicide in San Diego County: 1998-2007*. Web. 1 Dec. 2010. Note: Additional breakdown of API suicide provided via email communication with County EMS.

⁷¹ Ibid.

What barriers were identified by stakeholders and focus group participants?

An analysis of the stakeholder and focus group results specific to the API population listed the following barriers:

- Stigma: “Many of the patients don’t want to go when they are first referred...it takes till the 2nd or 3rd visit. One focus group participant shared that oftentimes the recommendation to see a doctor is met with the concern of, “Why? Am I crazy or something?”
- Language barriers.
- Transportation.
- Lack of resources to provide linguistically and culturally tailored services for subpopulations within the API community.
- Lack of information and understanding of mental health services/professionals among API communities.
- Not addressing associated issues such as drug use.
- Not engaging the public health department.

What opportunities for improvement were identified by stakeholders and focus group participants?

Opportunities for successfully engaging the community in suicide prevention included:

- Utilize places where the community socializes.
- Create opportunities for the API community to provide their own support (with associated training and support).
- Develop intergenerational interventions between youth and elders.
- Having psychologist in school-settings.
- Provide suicide risk screening tools in primary language to primary care settings.
- Outreach/Educate communities via Public Service Announcements (PSAs), flyers, community clinics, schools, community centers, home health care facilities.
- Train culturally and linguistically competent professionals and resources.

A Note about Barriers

“The SPEAK program is funded to serve Vietnamese and Latino youth but our outreach efforts may impact other ethnic groups. We do not have the resources to serve them. We see the same issue with the EMAS program. It is funded to serve Filipino, Latino, and refugee elders. But in our outreach we may find Koreans or Cambodians that could benefit from the program but we cannot serve them.”

- API community stakeholder

“Because of stigma against mental health, oftentimes with these populations it is much more effective to link prevention efforts to other activities. For example, in the EMAS project we are offering general health information for seniors but within the framework, we are adding mental health prevention strategies (stakeholder).

- API community stakeholder

Focus on Latinos

Suicide is the third leading cause of death for Latino youth aged 10-24 years, occurring predominately among males (CDC, 2004). However, the National Household Survey on Drug Abuse cites the disturbing upward trend of suicide risk among U.S. born Latina youth, aged 12-17 years.⁷²

The Latino population in San Diego County is the fastest growing segment of the population. Approximately one out of every four San Diego County residents is Latino (26.7% of the San Diego population).⁷³ Latinos have the highest concentration in San Ysidro, where they comprise 75.8% of the population.⁷⁴ Similar to other ethnic groups of focus for the needs assessment, the Latino community is not one dimensional. While the largest concentration of Latinos is of Mexican descent, concentrations from both Central and South America are present in San Diego County. Furthermore, a major contextualizing factor for this community is immigration status, particularly due to the number of undocumented individuals (usually of Mexican descent) within the County. Note that throughout this section, the ethnic category of Latino and Hispanic is used interchangeably, reflecting the varying terminology of the source documentation.

Latino Quick Facts:

- Approximately 26.7% of the population identifies as Latino.
- Geographic concentration: South region (notably San Ysidro and Otay Mesa).
- Suicide rate: 3.66 per 100,000.

For more information on how target communities were selected and how data for this section was collected, see page 15.

What does available San Diego data tell us about the Latino community?

From 1998 through 2007, 296 suicides (a rate of 3.66 suicides per 100,000 people) were completed by individuals identified as Hispanic.⁷⁵ Unlike other target populations, suicide attempts among Latinos are most prevalent in young females under the age of 18 and, at least in California, least common in the 55 to 64 years of age range. Within the youth age range (under the age of 18), surveys demonstrate that Latina (female) students reported more suicidal ideation and behaviors than their White or African American female peers.⁷⁶

When looking at suicide attempts, it is noted that 263 self-identified Hispanics were hospitalized with a self-inflicted injury in 2008 (a population rate of 28.0 per 100,000).⁷⁷

⁷² Substance Abuse and Mental Health Services Administration. (2003). *Risk of Suicide among Hispanic Females Aged 12 to 17*. Web. 22 Sept. 2010. <<http://www.oas.samhsa.gov/2k3/LatinaSuicide/LatinaSuicide.pdf>>.

⁷³ U.S. Census Bureau, Census 2010. Web. 20 Dec. 2010. <<http://factfinder.census.gov/servlet/DatasetMainPageServlet>>.

⁷⁴ San Diego County Hispanic Chamber of Commerce. Hispanic Demographics. Web. 13 Dec. 2010. <http://sdchcc.com/index.php?option=com_content&task=view&id=22&Itemid=38>.

⁷⁵ Community Health Improvement Partners. "Suicide in San Diego County 1998-2007." Retrieved from: http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf

⁷⁶ California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010. http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSP_SP_V9.pdf

⁷⁷ County of San Diego, HHSA, Public Health Services, Community Health Statistics Unit. *San Diego County Profile by Region*. Web. 29 Nov. 2010. <http://www.sdcountry.ca.gov/hhsa/programs/phs/documents/CHS-CommunityProfile_County_2010.pdf>.

In that same year, 534 self-identified Hispanics (a rate of 56.8 per 100,000) were discharged from the emergency room with a self-inflicted injury.⁷⁸ These self-harm results are particularly of note given the disproportionate number of Latinos who were eligible to receive free to low-cost mental health services compared to those who accessed those mental health services: Latino adults comprise 59% of the target population (defined as San Diego Uninsured or Medicaid under 200% FPL) but only 22% of the adult population is receiving mental health services.⁷⁹

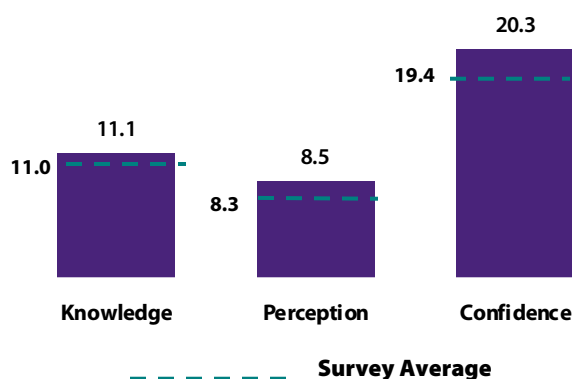
What do stakeholders know and say about Latino community?

The Community Provider Survey asked providers key questions regarding their knowledge of risk factors, perceptions of suicide, and confidence in their ability to address suicide. On average, providers who serve the Latino community exhibited scores slightly higher than average knowledge scores related to their general knowledge of risk factors and perception of suicide score; but lower in their confidence to address suicide for their target population score (see Exhibit 3.5).

Providers noted that a major consideration for the San Diego Latino population is their legal status. This status not only is a stressor in daily life, but may inhibit them in accessing needed prevention and mental health services: “Often if the children are documented and the parents are not or the whole family is undocumented, they do not seek assistance or talk to the nurse or counselors. They are afraid of the increased scrutiny on the family.” While providers noted Latino’s resistance to seek mental health services, it maybe lessening over time as people are responding more positively to mental illness screenings.

In one provider’s experience, back in the 1990s when she provided direct services for Latinos, they would feel offended that she would even ask questions about doing harm to self or others. Now, they respond with more information to the screening questions.

**Exhibit 3.5:
Latino Service Providers Knowledge,
Perception & Confidence Services**



What does the target population say about themselves?

Focus group participants acknowledged the stigma associated with mental health services and reiterated that informal forms of support are more widely available. While community members may be hesitant to seek mental health services, many participate in nutrition services or programs, their child’s school programs, emergency preparedness, and parenting classes which could be gateways to support services. These “natural settings” were suggested as the most effective way to address mental health needs within the community setting. “The community does not go to large agencies. They talk to a neighbor, a friend, maybe a nurse at the school. This is when a *promotora* enters – as a leader – he/she can explain things.” The natural settings approach also emphasizes the importance of personal connections and reputation within the community. Community members are eager to share the names of those people who have helped them and are just as eager to share the names of those who have not.

⁷⁸ Ibid.

⁷⁹ A Report for San Diego County Mental Health. Progress Towards Reducing Disparities, Five Year Comparison FY 2001-2002 to FY 2006-2007. Web. 11 Dec. 2010. <http://www.co.san-diego.ca.us/hhsa/programs/bhs/documents/Disparities_Report_FY01-02_to_FY06-07_04-28-09.pdf>.

Focus group participants also noted the importance of educating the whole community so that they can advocate for themselves and understand warning signs: “One good idea would be to have classes for the parents about depression because sometimes we just don’t know. For me, my daughter was depressed and I did not know what depression was.”

Participants described effective services for the Latino community as an issue of “match.” Community members equated professional experience with age of the provider, and frequently did not trust young providers. Additionally, language and cultural understanding was core. While they agreed that Spanish speaking mental health professionals are important, they also noted the need for these providers to communicate mental health problems in a way that is appropriate to the community. For example, participants noted that the word “suicide” is not used very often by community members. They instead use words such as “depressed”, “stressed” or “overwhelmed.” They identified that these words were better received by community members and they may open up the conversation.

What barriers were identified by stakeholders and focus group participants?

An analysis of the stakeholder and focus group results specific to the Latino population listed the following barriers:

- Stigma/unwillingness to see a mental health professional. “Latinos are not used to going to psychologists.”
- Availability of services. Providers may refer for mental health services, but resources were frequently limited, had long wait lists, or they did not qualify for mental health services.
- Match of service provider to client, by age, language, and cultural approach.

What opportunities for improvement were identified by stakeholders and focus group participants?

Opportunities for successfully engaging the community in suicide prevention included:

- Increase the capacity of community members to serve as peer to peer service providers (i.e., promotoras).
- Provide “platicas” or talks at schools and other natural settings.
- Utilize the native language and words that are appropriate to the community.

Focus on LGBTQI

The Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex community (LGBTQI) is the most diverse of all the community groups reviewed for this assessment. It crosses both gender and ethnicity. It includes both those who are open about their identity and those who have not outwardly identified themselves.

Data from numerous national studies (including the National Longitudinal Study of Adolescent Health, National Lesbian Health Care Survey, National Latino and Asian American Survey, and the Urban Men's Health Study) demonstrated that lesbian, gay, and bisexual individuals, particularly adolescents and young adults, have significantly higher rates of suicidal ideation and suicide attempts than their heterosexual counterparts.⁸⁰ Gender-specific analyses have found sexual orientation to be a stronger independent predictor of suicide attempts in young males than in young females. Several studies (including one large-scale U.S. survey, the National Comorbidity Survey) have reported that the gender pattern for suicidal ideation is opposite that for suicide attempts, with risk of suicidal ideation higher among lesbian/bisexual women and risk of suicide attempts higher among gay/bisexual men.⁸¹

Research within California confirms the national data: in a survey of over 2,800 men who either identified as gay or bisexual or as having had sex with other men, over 20 percent of respondents had made a suicide plan and another 12 percent had attempted suicide at least once, typically before age 25. This represents a three-fold increase in risk among gay and bisexual men compared to men in the general population.⁸²

Many population-based studies have also linked elevated risk of suicide attempts in lesbian, gay and bisexual populations to higher rates of mental disorders, although there is increasing evidence that other factors, notably, sexual orientation related stigma, prejudice, and discrimination may also play a role.⁸³ Coping with stigma and discrimination based on sexual orientation is a particularly challenging issue for adolescents and young adults.

LGBTQI Quick Facts:

- Sexual orientation is not captured in U.S. Census data or other population studies.
- Geographic concentration: Central region (notably the Hillcrest neighborhood).
- Sexual orientation is not documented by the county Medical Examiner.

⁸⁰ California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010.
http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSP_SP_V9.pdf

⁸¹ Haas, Ann P., et al (2011) 'Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations', *Journal of Homosexuality*, 58: 1, 10 — 51
<http://dx.doi.org/10.1080/00918369.2011.534038>

⁸² California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010.

⁸³ Haas, Ann P., et al. (2011) 'Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations', *Journal of Homosexuality*, 58: 1, 10 — 51

A survey of over 1,700 California youth ages 12 to 18 years found that those who identified as lesbian, gay, or bisexual were at elevated risk for a range of health and mental health problems, especially those youth who reported being less comfortable with or uncertain about their sexual orientation.⁸⁴

For more information on how target communities were selected and how data for this section was collected, see page 15.

What does available San Diego data tell us about the LGBTQI community?

Despite this elevated risk, the monitoring of health and wellbeing indicators for the LGBTQI community is lacking. Some researchers have attempted to determine whether these groups are overrepresented among those who die by suicide, using “psychological autopsy” reports of family and friends to determine the victim’s sexual orientation. Several studies using this method have been published. One, in particular, focused on young adult male suicides in San Diego. The study concluded that same-sex sexual orientation is not disproportionately represented among suicide victims. However, to date, psychological autopsy studies that have examined sexual orientation have used relatively small samples and have identified very few suicide victims as having minority sexual orientation.⁸⁵

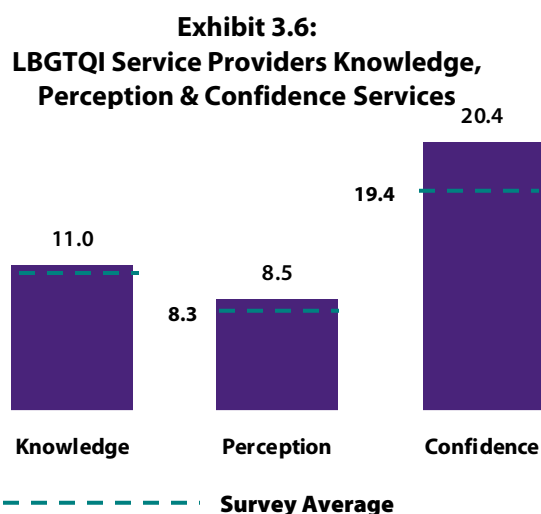
Over the past decade, there is ample evidence that across the lifespan, LGBTQI people commonly experience discrimination in the form of personal rejection, hostility, harassment, bullying, and physical violence. In fact, only one local study identified for this assessment included suggestive evidence about the extent of the concern of suicide in the LGBTQI community. At highest risk are youth and those adults who report severe bullying in their youth. Due to the paucity of information, the extent of the issue in this targeted community can only be surmised.

What do stakeholders know and say about LGBTQI?

Stakeholders shared that suicide may be on the increase for this population: in the latter 4 to 5 months of 2010, The Center (the core community service for the LGBTQI community) reported that suicidal ideation calls increased by almost 50%.

The Community Provider Survey asked providers key questions regarding their knowledge of risk factors, perceptions of suicide, and confidence in their ability to address suicide. On average, providers who serve the LGBTQI community exhibited scores slightly higher than average knowledge scores

related to their general knowledge of risk factors score, perception of suicide score; and confidence to address suicide for their target population (see Exhibit 3.6).



⁸⁴ California Department of Mental Health. California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution. Web. 30 Sept. 2010.

http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSP_SP_V9.pdf

⁸⁵ Rich, C. L., Fowler, R. C., Young, D., & Blenkush, M. (1986). San Diego suicide study: comparison of gay to straight males. *Suicide and Life Threatening Behavior*, 16(4), 448–457.

Service providers noted that the LGBTQI community is a “multiple stigmatized population that is at very high risk, from youth through senior and especially HIV infected”. Service providers were highly connected to the nuances of the populations they serve. For example, one service provider noted the approach of working on multiple levels: “We work with Latino/a youth who are struggling with not being accepted in their families and discriminated against at school. In Latino culture, family is the most important thing and not being accepted in the family is very very hard.” Because of the multi-layered considerations of cultural and sexual identity, providers who address the needs of the LGBTQI community must be highly skilled on multiple fronts: “Even if a provider has some Spanish, it may not be sufficient to talk with clients about the sensitive issues of gay, Latino family, youth, and suicide. A miscommunication could be very bad.” This ability to address multiple concerns means that while the providers interviewed for this assessment felt confident in their ability to provide the needed services, they recognized their own need to be continually trained.

“It’s complicated. We are depressed but we try to make sure no one notices it - get drunk, dance, flirt - people liked that personality. They think ‘oh he likes to have fun’but for some reason I want to get so drunk, to numb something. It’s so hard for some people to realize.”
- Focus group participant

In particular, service providers noted that the transgender population requires special consideration since concerns may be different. For example, stakeholders noted that therapists do not know about the transitioning process and often say youth have a diagnosable disorder that is “treatable.” This assessment could only identify one organization that specifically works with transgender community members.

What does the target population say about themselves?

The assessment team conducted a focus group with LGBTQI identifying Latino youth; efforts to conduct a focus group with a non-ethnically focused LGBTQI group are still underway. While the results may highlight issues that are specific to the participant’s ethnic and age characteristics, they offered both general feedback about LGBTQI concerns as well as the importance of addressing both age and ethnicity within efforts to assist the LGBTQI community.

Focus group participants emphasized the importance of relationships in either supporting or impeding mental health. They identified support groups and more informal interventions as desired and likely to appeal to community members. As one participant stated: “I kinda needed this [support group]. Meeting people . . . it saved me from anything stupid I could have done to myself.” They discussed that support groups allowed them to be around people “like me”: “Although I go to school there and some [students] may have the same major and the same interests. I want to be around people that come from the same background.”

“LGBTQI youth have the added stigma in addition to mental illness. And both of these things you cannot see so no one pays attention.”
- Service provider

Participants also spoke about the impact of family on their mental well being. For those who identified their families as rejecting them due to their sexual orientation, they noted the need for support from outside the home through activities such as informal support groups. Even focus group participants who were supported by their families suggested that they were not entirely accepted and consequently, felt isolated. One participant stated: “Because I am gay – it had an impact – you can’t do certain things because the family still does not accept you and it is difficult to express what you feel. You keep it hidden.”

Identity suppression was echoed by many members of the focus group who stated that they did not want to burden family members with their problems. As another focus group member stated: “[At my house], I have rage inside of me and I cover it up. I’m a little clown in the house but really deep inside I feel [awful]. I just don’t want [my family] to worry about it.”

Focus group participants also identified risky behavior, including alcohol and other substance use, as common among youth dealing with feelings of rejection by both family and peers. They identified high risk behavior such as un-safe sexual behavior and cutting as signs that someone may need help.

“How easily accessible is the information of how to hurt versus how to help?”
- LGBTQ Stakeholder

What barriers were identified by stakeholders and focus group participants?

Barriers to suicide prevention and mental health services include:

- Community stigma related to sexual orientation, particularly among communities of color.
- Communities of color have less recognition and primary intervention into the mental health issues surrounding LGBTQI and suicide.
- Lack of cultural understanding and competence in service providers, administrators, and program designers.
- Target population does not always self-identify.
- Providers do not ask about sexual orientation, hampering effective referrals.
- The different stages of the “coming out” process necessitate different levels of support.
- The cost of mental health services.
- Family rejection and isolation.

What opportunities for improvement were identified by stakeholders and focus group participants?

Opportunities for successfully engaging the community in suicide prevention included:

- Build on teen mobile clinics to support teens who are living at home
- Work at reducing stigma regarding mental health – “talk about it as maintaining your health, not that you are crazy.”
- Schools can play a major role in destigmatizing LGBTQI issues.
- Meal delivery program for older adults can be an opportunity to access the senior population.
- Increase support groups in other areas of the County.
- Increase support and acceptance with these populations, both generally and specifically, within the family of the target population.
- Provide training on the impact of factors such as HIV on suicide risk. One contractor shared an experience of a recent suicide of an HIV positive client and felt that health issues had played a role in the suicide. This provider felt that knowing more about how to address concerns about HIV/AIDS would help increase his ability to address suicide risk for future clients.

Utilize technology: Social networking sites and chat rooms for anonymous forms of communication; teletherapy via Skype and public service announcements in movie theatres.

Focus on Native Americans

San Diego County has more Indian reservations than any other county in the United States. However, the reservations are very small, with total land holdings of about 193 square miles of the 4,205 square miles in San Diego County.⁸⁶ Of the approximately 20,000 Native Americans who make up the 4 tribal groups that live in San Diego County (Kumeyaay/Diegueño, the Luiseño, the Cupeño, and the Cahuilla), only a small percentage live on reservation land (roughly 11%).⁸⁷

Approximately 0.9% of the population in San Diego County identifies as American Indian and Alaska Native.⁸⁸ The Native American community is not tracked as a distinct race/ethnicity category in local suicide statistics but instead is grouped under other categories. Therefore, the only data available are State and national statistics. For American Indian and Alaska Native (AIAN) populations, the age adjusted suicide rate was 20 per 100,000, 91 percent higher than for all races in the U.S. (11 per 100,000).⁸⁹ For AIANs aged 15-24, suicide is the second leading cause of death with a prevalence rate of suicide at 2.4 times the national rate, or about 60 deaths per 100,000 individuals. Overall, violent deaths, unintentional injuries, homicide and suicide account for 75 percent of all mortality within 15-24 year old age range for AIAN.⁹⁰

For more information on how target communities were selected and how data for this section was collected, see page 15.

Native American Quick Facts:

- Approximately 0.9% of the population identifies as Native American.
- More reservations in San Diego County than any other county, most are concentrated in the East and North Inland Regions.
- Local suicide rate unknown; 20 per 100,000 in California
- Youth exhibit a suicide rate 2.4 times the national rate.

What does available San Diego data tell us about the Native American community?

The Centers for Disease Control and Prevention report 21 suicides among AIAN in San Diego County between 1999-2007, a rate of 6.8 per 100,000, lower than the overall rate in the County⁹¹. These low numbers make it difficult to track suicides among Native Americans at a local level. National data indicate that AIAN youth are at a disproportionately high risk of suicide compared to non-Native youth. Suicide is the leading cause of death among AIAN between 15 and 24 years of age, and from 1999 to 2004, young men in this population had a higher suicide rate (27.99 per 100,000) than any other racial and ethnic group of the same age⁹².

⁸⁶ University of San Diego. *Indian Reservations in San Diego County*. Web. 11 Nov. 2010.

<<http://www.sandiego.edu/nativeamerican/reservations.html>>.

⁸⁷ San Diego State University Library. *The Indians of San Diego County and Baja California*. Web 4 Jan. 2011.

<<http://infodome.sdsu.edu/research/guides/calindians/insdcnty.shtml>>.

⁸⁸ U.S. Census Bureau, Census 2010. Web 20 Dec. 2010. <<http://factfinder.census.gov/servlet/DatasetMainPageServlet>>.

⁸⁹ Office of Minority Health. *Suicide and Suicide Prevention 101* (2008). Web. 11 Dec. 2010.

<<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=136>>.

⁹⁰ Ibid.

⁹¹ CDC Wonder, Compressed Mortality, 1999-2007 Results. Web 01 Feb. 2011. <<http://wonder.cdc.gov/>>

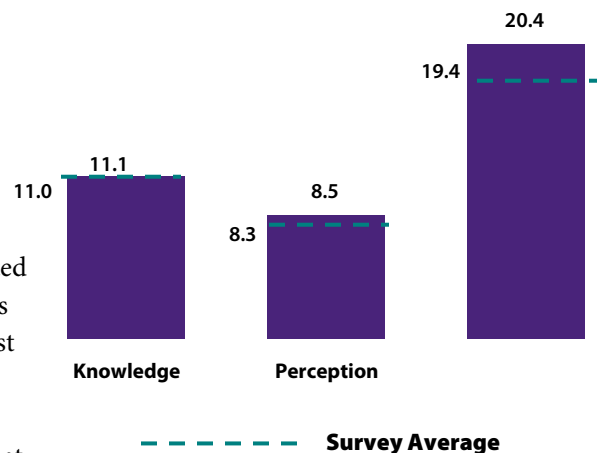
⁹² California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 08 Feb. 2011.

What do stakeholders know and say about Native American community?

The Community Provider Survey asked providers key questions regarding their knowledge of risk factors, perceptions of suicide, and confidence in their ability to address suicide. On average, providers who serve the Native American community exhibited scores slightly higher than the general service provider population for knowledge of risk factors score, perception of suicide score; and confidence in their ability to address suicide for their target population (see Exhibit 3.7).

Service provider stakeholders interviewed for this study noted that a major barrier to developing strong preventive services for the Native American community is the history of distrust between Native Americans and public entities such as law enforcement and County services. This distrust is based on centuries of conflictive relationships and policy decisions that have negatively impacted native communities. A mental health stakeholder noted, that “Another [barrier] is stigma regarding mental health; especially when people come from the outside and tell the community what is wrong with them.” A stakeholder from law enforcement shared, “[This historic distrust] makes it challenging for law enforcement to work with the Native American population. [We don’t receive] many suicide calls but lots of criminal investigations.” If the relationship between Native American communities and public entities could be reset, through concerted, authentic attempts to bridge the divide, improved services and help could be provided to native communities and could ultimately improve suicide rates.”

Exhibit 3.7:
Native American Service Providers Knowledge, Perception & Confidence Services



What does the target population say about themselves?

Focus group participants noted that each tribe and reservation has unique circumstance, cultural considerations, and histories that should be taken into account when considering a meaningful suicide prevention strategy. Thus, like other targeted communities, they noted that the current assessment does not capture all of the nuances of the Native American population in San Diego County. For example, rural and urban Native American communities have different needs. There is a lack of access to services in the unincorporated rural areas of San Diego, both in the number of facilities as well as their ability to access potentially distant locations. Conversely, those individuals living off the reservation may not have the same cultural connections as those who do. Other issues included:

“The veterans are respected and seen as warriors in the community. They are leaders and suicide prevention efforts should involve them.”

-Focus group participant

- Concerns of alcohol and drug use.
- Discomfort in talking about suicide.
- The close knit nature of native communities, in which individuals may not be comfortable at the tribal clinic where the doctor may be from the community.
- Recent concerns with cutting among youth.

The focus group participants also noted that when considering suicide within the Native American population, the number of accidental deaths should be included. Of concern is the stigma associated with mental health related problem. Specifically, there maybe individuals lost to suicide, but because of the stigma associated with suicide their death is categorized differently.

Perhaps the most important finding from the process of setting up the focus group as well as the results is the deep seated suspicion of the Native American community for the overall process of determining their “need.” They noted that for decades, if not centuries, the government and service providers have come to “fix” their issues, but have not shown an authentic commitment to a solution.

They noted that successful engagement requires commitment, consistency, trust, and presence. They further identified the following elements to consider in a prevention approach among the native San Diego communities:

- Collaboration with someone from the community is essential for any success
- Engaging local leaders from each tribe as cultural brokers
- Ensuring the process is culturally driven and lead by the community
- Be respectful of cultural protocol (agendas and data collection tools are not well received by community; use a strengths-based approach when addressing the community as opposed to a deficit-approach)

“I do not know that the County is aware of what is happening in these communities. I had not heard of this effort until [the needs assessment team] contacted me. So I am not sure what kind of effort the County is doing to get the community involved on this issue... If you do not put in your time to build trust and a presence in the community, you will not be listened to.”

-Mental Health Outreach Worker

What barriers were identified by stakeholders and focus group participants?

An analysis of the stakeholder and focus group results specific to the API population listed the following barriers:

- Mistrust of County and local universities
- Mistrust in the way that data is used to reflect their communities
- Western intervention models lack of cultural relevance
- Lack of trained professionals in a holistic, culturally competent model of care
- Transportation to receive care (particularly for rural populations)
- Stigma related to mental health and suicide

What opportunities for improvement were identified by stakeholders and focus group participants?

Opportunities for successfully engaging the community in suicide prevention included:

- Integrate elders as “navigators” and mentors for their communities, especially with youth.
- Train and empower Native American community members to identify high-risk individuals
- Provide culturally appropriate services on the reservation
- Build on the existing County MHS Prevention and Early Intervention (PEI) funded program: the Collaborative Native American Initiative. This program is provided by the Indian Health Council that is currently working to integrate suicide prevention into existing community programs.
- Promote community wellness through the involvement in cultural and social activities known to support individual and community resilience.
- Utilize recommendations from County funded Breaking Down Barriers with Native Americans document (prepared by local MHA affiliate)

- Create a model for people in recovery to integrate back into the native communities.
- Provide money to the communities so that they can provide services locally.
- Support programs that instill pride in the community and among youth
- Provide resources to instill self-worth and pride in the community, especially among youth.
- Provide resources to assess the efficacy of interventions.

Focus on Survivors

Engaging those who have been directly impacted by the tragedy of suicide can be a powerful tool to prevent suicide and future attempts and to support those who have lost a family member, friend, colleague, or loved one to suicide. One stakeholder defined “survivor” as including “all people impacted by suicide: attempters, family, anyone who has experienced this loss.” A growing body of literature substantiates the effectiveness of services and supports offered by individuals directly impacted by mental illness, such as warm lines and peer-run support centers. Organizations like the California Network of Mental Health Clients and the National Alliance on Mental Illness (NAMI) are important sources of support, advocacy, and education for mental health clients and their family members.

An estimated six people are seriously, emotionally or mentally impacted by a suicide.

Source: California Strategic Plan on Suicide Prevention

Suicide attempters: For every one completed suicide, there are an estimated 25 attempted suicides overall; among youth, the ratio of completed to attempted suicides may be as high as 1:100 to 1:200.⁹³ About one-third of people who attempt suicide will repeat the attempt within 1 year, and about 10% of those who threaten or attempt suicide eventually kill themselves. In a study of survivors of suicide attempts, almost half reported that less than one hour had passed between their decision to complete suicide and the actual attempt. Another 24 percent indicated it was less than five minutes. The crisis leading up to suicide and suicide attempts is often short-lived, containing some impulsivity and ambivalence. Restricting access to lethal means increases the time between the impulse to complete suicide and the act itself, allowing opportunities for the impulse to subside or warning signs to be recognized and interventions to occur.⁹⁴

“You see Latinos, blacks, skinny, fat, gay, straight. It affects a lot of people. With mental health, we’re still trying. If we give people coping skills - I think it’s a start.”

-Focus Group Participant

Survivors of suicide loss: The emotional cost of suicide has both immediate and far-reaching effects on families and communities. It is estimated that each suicide seriously impacts at least six other people. In addition to grieving the loss of the individual who took his or her own life, survivors – family members, caregivers, and friends – may themselves be at increased risk of suicide. The stigma associated with suicide may lead to reluctance to talk about the problem or to seek out social supports and mental health services.⁹⁵

⁹³ Community Health Improvement Partners. *Suicide in San Diego County: 1998-2007*. Web. 1 Dec. 2010.

<http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf>

⁹⁴ Scripps Health: Suicide and Suicidal Behavior. Web. 11 Dec. 2010. <<http://www.scripps.org/articles/1841-suicide-and-suicidal-behavior>>.

⁹⁵ California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010.

http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSP_SP_V9.pdf

For more information on how target communities were selected and how data for this section was collected, see page 15.

The Importance of Postvention: Support for Loved Ones

The American Society of Suicidology reports over 33,000 suicides occur annually in the USA. They also estimate that for every suicide there are at least 6 survivors.⁹⁶ As part of the Needs Assessment process, a focus group was held with members of Survivors of Suicide Loss (SOSL), a local organization that provides support, advocacy, and education services regarding suicide loss and suicide prevention. Participants were asked about existing barriers and opportunities for improvement to the services available to both themselves and their loved ones.

What do survivors of suicide loss identify as needs?

The conversation with SOSL members included barriers experienced by family members who sought services for their loved one as well as services available to the survivors of suicide loss.

“A coworker had lost a friend to suicide and every year he did the walk and one year he had asked me to sponsor him, not knowing that when I wrote the check it would be something I would need two years later.”

-Focus Group Participant

For most focus group participants, the person who completed suicide was in treatment with a mental health professional at the time of their death. Some had been formally diagnosed with a mental illness (bipolar disorder, depression), while in other cases, there was no formal diagnoses but high symptomology. “A friend and even my wife thinks maybe he was an undiagnosed schizophrenic. I think he was depressed.” Focus group participants were asked what barriers to services they encountered. However, instead of discussing service barriers, participants focused the discussion to their inability to help their loved one. The two quotes are characteristic of the SOSL discussion:

I don't think someone wakes up and decides to kill themselves. It's a combination of a lot of pain. With my brother, we tried to support him. Coulda woulda shoulda- we can spend our lives doing that.

Throughout [my son's] life he came to me - he would call me to ask for help. The night he took his life, he didn't. If they want to take their lives, they will . . . when they want to take his life they will.”

Focus group participants offered several suggestions for improving services to those living with the loss of a loved one due to suicide:

- **Support groups** – Group members identified cost as a potential barrier for access to services and generally there are very limited services for survivors of suicide loss. Participants stated that SOSL was a lifeline, that volunteers were available at all times and that this support was often provided to them at a time where they felt like they did not know what to do. They also stated that group allowed them to talk about suicide in an open way rather than facing the discomfort of others when they tried to bring it up.
- **Support the delivery of services by faith groups/religious groups** – Some group members identified the role of a religious or faith community in helping them heal from the loss of a loved one. They felt that this kind of support could also benefit people impacted by depression or suicidal thoughts.

⁹⁶ American Association of Suicidology. *Survivors of Suicide Fact Sheet* (2007). Web. 11 Dec. 2010.

<http://www.suicidology.org/c/document_library/get_file?folderId=229&name=DLFE-82.pdf>.

- “I was raised Lutheran and I believe these people are really hurting and I believe that if they had a belief it would help them. It’s helped me.”
- **Teen groups** – SOSL began a teen group for teens who experienced the loss of a loved one. This group has been dedicated to providing information and support to assist in the grieving and healing process and group members recommended expanding these kinds of services for teens. “For my [children] it’s really hard to talk to peers” but the teen group has created an environment of a shared experience for the teens.

Survivors of Suicide Loss also identified the following approaches to reducing suicide:

- **Recognize that many people struggling with suicidal thoughts and behaviors may act like they are fine.** Participants spoke about the importance of recognizing that even with all the education and services regarding risk factors, individuals contemplating have already developed the ability to hide how they feel. As mentioned previously, most of the loved ones were in treatment with a mental health professional and in some cases the family members report that everyone thought their loved one was better. But, as one group member stated, “They dress up and go to work everyday. They’re not babbling on the streets.” Yet another participant noted, “We know they’re actors. They don’t tell the people that are closest to them.”
- **Public Education and Increased Awareness** – Focus group participants spoke about the importance of people knowing about the symptoms of depression or signs that someone needs help. Another group member stated that if mental health and services were “advertised as much as [erectile dysfunction medicine] it would reduce the stigma. In Ireland there are ads on sexually transmitted diseases, alcoholism, mental health while here it’s almost at a denial stage. Suicide is hushed conversation.”
- **Involve people who have survived the loss of a loved one** – Participants also spoke about the possibility of having SOSL members or other people who have survived the loss of a loved one join the support groups or services available to people who are contemplating suicide or struggling with feelings of depression or suicidal thoughts. They felt that this could help open a frank discussion about the impact of suicide.

“We don’t know how to prevent it. We tried everything and we beat ourselves up because we thought we missed it. But if you come up with three things that prevent it then I’d be pissed because I want my son back.”

-Focus Group Participant

Focus on Veterans

According to the 2009 American Community Survey, civilian veterans were estimated to make up 11.6% of the adult San Diego County population.⁹⁷ Although veterans were not a distinct population to examine throughout the needs assessment, it became clear that the unique needs of this population should to be addressed. The following is an overview of local statics as well as stakeholder input.

San Diego County is home to not only Marine Corps Base Pendleton, the Corps' largest training facility on the west coast⁹⁸, but the county also includes the 2000 land acres and 326 acres of water that make up Naval Base San Diego. With a plant value of approximately \$2.1 billion, the naval base is the workplace for 30,000 workers that help to provide not only services to the ships, but power, water, steam, and communication lines to the pier-side of the ships as well⁹⁹. In addition to the active military presence, civilian veterans also comprise a significant portion of the county's population.

Several studies have examined the relationship between veteran status and suicide risk on national and state levels. A national study of more than 800,000 depressed veterans between 1999-2004 reported a suicide rate seven times higher than the baseline risk in the general population. Additionally, elevated rates were detected in groups known to be higher risk, including male, White, and those having a substance use diagnosis. The data from this study also suggest that younger veterans were at a higher risk than older veterans. Post-Traumatic Stress Disorder (PTSD) was found to be a protective factor, presumably because a diagnosis warranted access to psychosocial treatment.¹⁰⁰ Research indicates that when untreated, PTSD greatly increases the risk of suicidal behavior¹⁰¹

An analysis of official death certificates on file at the State Department of Public Health indicated that between 2005 and 2008, 2,678 veterans completed suicide in California; a rate more than double than that of state residents with no military service. The data shows that veterans of Iraq and Afghanistan were two and a half times as likely to commit suicide as Californians of the same age with no military service.¹⁰²

Quick Facts

- **234,959 veterans living in San Diego County.**
- **67,233 veterans served by VASDHS (FY10).**
- **34 suicides among veterans reported in San Diego from 7/1/2009 to 9/30/2010.**
- **157 suicide attempts among veterans reported in San Diego from 7/1/2009 to 3/30/2010.**

⁹⁷ Selected Social Characteristics in the United States: 2005-2009. American Community Survey. Web. 11 February 2011. http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=05000US06073&-qr_name=ACS_2009_5YR_G00_DP5YR2&-ds_name=ACS_2009_5YR_G00_&-lang=en&-redoLog=false&-sse=on

⁹⁸ Marine Corps Base Camp Pendleton. *Fact Sheet Marine Corps Base Camp Pendleton (2011)*. Web. 11 February 2011. <http://www.pendleton.usmc.mil/press/kit.asp>.

⁹⁹ CNIC Naval Base San Diego. *History*. Web. 11 February 2011. <http://www.cnic.navy.mil/SanDiego/About/History/index.htm>.

¹⁰⁰ Zivin, K., Kim, H. M., McCarthy, J. F., Austin, K. L., Hoggatt, K. J., Walters, H., et al. (2007). Suicide mortality among individuals receiving treatment for depression in the veterans affairs health system: Associations with patient and treatment setting characteristics. *American Journal of Public Health*, 97, 2193-2198.

¹⁰¹ Army Health Promotion Risk Reduction Suicide Prevention Report 2010.

¹⁰² Source: <http://www.baycitizen.org/veterans/story/after-service-veteran-deaths-surge/>

In addition, suicide among the oldest veterans was roughly double that of younger veterans, indicating that World War II veterans are at higher risk than those who served in Iraq or Afghanistan.¹⁰³ According to this study, a total of 334 veterans completed suicide in San Diego County between 2005-2008; 7% were youth (18-24), 55.4% were adults (25-69) and 22.2% were older adults (70+).¹⁰⁴

What does available San Diego data tell us about veterans?

According to the VA San Diego Healthcare System (VASDHS) records, 234,959 veterans are currently living in San Diego County, roughly 8% of the San Diego population and 12% of veterans in California (1,972,000). Of those veterans, just fewer than 30% receive services from VASDHS (67,233 in Fiscal Year 2009-2010).

VASDHS tracks reported suicides as well as suicide attempts. From the 14-month period between July 1, 2009 and September 30, 2010, 34 suicides among veterans were reported. An additional 157 suicide attempts by veterans were reported during July 1, 2009 and March 30, 2010. Reports of suicide attempts and completions are submitted to the VA suicide prevention program via VASDHS staff and sometimes via the Medical Examiner's Office. However, there may be some events that not reported to the VA.

A significant number of the 235,000 veterans living in San Diego County are new veterans from the wars in Iraq and Afghanistan. The VA Medical Center in San Diego reports more than 26,000 of those newer veterans are enrolled with them. Approximately half of returning veterans seek medical help from the VA, so an estimated 50,000 recent veterans could be living in San Diego¹⁰⁵.

What do stakeholders know and say about veterans?

Veteran service providers indicate that resources and services are being used by some veterans and their families, but they feel there is a large percent of the group that are not accessing services. This gap of resource utilization may be due to a lack of understanding. A stakeholder suggested that a veteran who is accustomed to having access to on-base services may not be prepared to obtain access to services in the community unless a spouse has a private insurance coverage. Another key point from a respondent is to consider the sensitivity of this population. It is important not to cast a negative shadow on this group when remembering the service they have performed and to recognize the risk factors that accompany it. One interviewee noticed that recently more suicide among veterans is being reported in San Diego County. This provider also revealed that Caucasian males aged 60 and over, who live alone and meet criteria for a mood disorder and/or exhibit substance abuse issues are at an increased risk of suicide by firearms.

What barriers were identified by stakeholders?

The major barriers that were identified include:

- **Easy access to means.** Stakeholders shared that military services makes access to firearms easier. In addition, stakeholders shared that there is easy access to medications and street drugs that can be lethal if overdosed.
- **Competition for services along with everyone else.** Unless a veteran is married to a spouse that has private insurance, they do not have access to services other than the VA. A stakeholder believes that as many as 180 veteran families apply for welfare services every month.

¹⁰³ The Bay Citizen. *Veteran Suicides: See Data in Your County* (2011). Web. 4 February 2011.

<http://www.baycitizen.org/veterans/interactive/veterans-day-compare-suicide-rate-1/>

¹⁰⁴ Ibid.

¹⁰⁵ KPBS. *Young Veterans Call San Diego Home* (2010). Web. 5 February 2011.

<http://www.kpbs.org/news/2010/nov/11/san-diego-veterans-iraq-afghanistan/>

- Additionally, veterans with other than honorable discharge will not likely receive services other than the emergency room or other community organizations.
- **Loss of identity.** It can be difficult to transition from active military duty to a civilian veteran role “irrespective of combat and trauma.” This adaption may also place increased stress on the family.
- **Services are not tailored to specific needs.** For example, one stakeholder noted that VA services are not gender-specific. Many female veterans may be coping with sexual trauma but access male dominated VA clinics and medical settings.

What opportunities for improvement were identified by stakeholders?

Opportunities for improving the suicide prevention efforts for this target group include:

- A majority of the military lives off base; therefore, suicide prevention efforts tailored to this community should also be implemented off base.
- Civilian veterans should have access to services in the community that are specific to their needs.
- All clinics should ask a client if they, a significant other, or caregiver has served in the military.
- Include the National Guard –they do not have VA benefits unless they have been federalized for more than 365 days.
- Education for general public about veterans, suicide risk, and the warning signs is needed.
- Community providers need more education about what services are available for their patients who are also veterans.
- Staff at local hospital emergency departments should be educated to contact veteran services when they are caring for a veteran to share information about medications, history, current physician, etc.

Summary

The summary of the different target populations offers a useful framework to begin a more comprehensive community conversation about the best approaches to suicide prevention in San Diego County. The assessment team anticipates that additional information, as well as nuances in the existing information, will be collected during the community forums and action planning process. However, a number of common patterns emerged from this initial review that should be explored in the next phase of the action planning process:

- + **Target communities are not homogeneous.** For example, the overall API suicide rate is relatively low, but exceedingly high among youth and older adults. The LGBTQI community is cross-cut by issues of age, race/ethnicity and how “out” an individual is with their family and peers. Consequently, best practices are most effective when tailored to the specific needs of targeted communities.
- + **Cultural competence is not just linguistic.** All groups noted the importance of not just speaking the native language, but understanding the cultural context in which individuals at risk of suicide live. This applies to both racial/ethnic groups as well as those of age and sexual orientation.
- + **Service providers among target populations exhibit a high level of knowledge, perception, and confidence.** In nearly all cases, service providers scored higher than the general provider population for knowledge, perception and confidence. This suggests that target communities’ service providers are poised to provide needed services given appropriate resources. Targeted training for providers who have not had as much experience regarding suicide but who will be involved in future prevention efforts is indicated.
- + **Universal and targeted public outreach is needed.** Most target populations noted the need for general knowledge about the warning signs of suicide. Providing basic identification tools for both the general and targeted populations, with a strong destigmatizing campaign, appear to be an important consideration.
- + **Authentic, transparent, and regular communication is needed.** Effective suicide prevention strategies hinge on increased regular communication between the County, providers, and key ethnic/racial populations. Developing stronger, open communication that results in shared strategies to improve services will improve services and strengthen ongoing relationships.

System Level Results



In 2000, Healthy People 2010 set a target of 5.0 suicides per 100,000 population. There is much work to be done to reach this goal.¹⁰⁶ A successful system of suicide prevention is one where programs are “designed to effectively meet the needs of individuals of all ages and from diverse racial, ethnic, cultural, and linguistic backgrounds.”¹⁰⁷ Rather than working independently to meet the needs of the target population, providers must be coordinated in order to leverage resources and ensure that people receive needed services. It is expected that increased awareness about mental health issues and outreach for prevention efforts will result in an increased demand for services, furthering the need for a well-run system of suicide prevention.

This section provides a preliminary assessment of the existing suicide prevention services in San Diego and examines assets as well as gaps in services. To accomplish this, the following components are examined:

- Knowledge regarding suicide prevention and training needs
- Existing services
- Barriers to services
- Agency coordination
- Gaps

By identifying the existing strengths in the system and opportunities for improvement, strategies can be developed that target the system as a whole and make the greatest impact.

Training Needs

In order to fully understand training needs, current provider knowledge and attitudes regarding suicide, two separate, online surveys were distributed to County staff and contractors, and community providers (for information on how data was collected, see Methods Section on page 4). Both surveys included a series of questions were asked to assess:

- Recognition of suicide risk factors
- Identification of statements regarding suicide; and
- Confidence in addressing suicide risk.

Best Practices in Training

Research has shown that “skill-based” and “action-oriented” trainings produce greater gains than information alone. Activity-based trainings can help providers “demonstrate appropriate helping competencies in simulations, and [they] report being comfortable when helping”. Best practices recommend that trainings include mock assessment or intervention role-plays and that “booster” trainings be provided “every 2 to 3 years”.*

*Source: Reducing Suicide: A National Imperative

¹⁰⁶ Community Health Improvement Partners. *Suicide in San Diego County: 1998-2007*. Web. 1 Dec. 2010. <http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf>

¹⁰⁷ California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010.

http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSP_SP_V9.pdf

The data in this section was gathered from the County Training Survey and the Community Provider Survey (see Methods on page 4 for information) Community Provider survey and are presented by topic and by three survey respondent groups:

Group 1: County Mental Health Staff or Contractors (n=650)

Group 2: County Alcohol and Drug Staff or Contractors (n=76)

Group 3: Non-County funded Community Providers (n=75)

Additionally, County Behavioral Health staff and Contractors (Groups 1 and 2) provided information on recent training participation as well as interest in future trainings. Information provided by Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Contractors regarding training is also provided.

Current Capacity to Address Suicide Risk

Respondents were asked about their experience working in Behavioral Health and addressing suicide risk. Most participants have been working in Behavioral Health for at least one to five years with many working in Behavioral Health for more than ten years (Exhibit 4.1). Additionally, most participants had been in their current role for more than one year.

The majority of Mental Health Services (MHS) and Alcohol and Drug Services (ADS) respondents had experience related to suicide (Exhibit 4.2).

Most respondents stated that their organization had a suicide risk protocol or procedure (80.6% for MHS and 87.2% for ADS). Almost all felt the protocol was useful or somewhat useful (96.7% for MHS and 90.6% for ADS). However, both groups felt they needed more training on how to implement the protocol with their clients (67.4% and 79.7% respectively for MHS and ADS).¹⁰⁸

Exhibit 4.1: Years of Experience

	Group*		
	Group 1 (County MHS)	Group 2 (County ADS)	Group 3 (Community)
Years in Behavioral Health			
< one year	12.6%	3.9%	Not measured
1-5 years	47.2%	38.2%	
6-10 years	21.5%	28.9%	
> 10 years	18.6%	28.9%	
Years in Current Position			
< one year	29.2%	15.8%	14.7%
1-5 years	51.2%	55.2%	34.7%
6-10 years	12.8%	18.4%	25.3%
> 10 years	6.8%	10.5%	25.3%

Exhibit 4.2: Experience Related to Suicide

Dimension of Experience	County Department	
	MHS	ADS
Organization has a suicide risk assessment protocol	80.6%	87.2%
Need more training on suicide risk assessment protocol	67.4%	79.7%
Ever been called upon to help a client who is suicidal	66.8%	72.5%
Assessed a client for suicide risk	74.1%	78.3%
Assessed 1-5 clients	46.2%	72.2%
Assessed 6-10 clients	15.3%	9.3%
Assessed 11 or more clients	38.5%	18.5%

¹⁰⁸ Not all data shown in Exhibit 4.2; see Appendix D for full tables.

In addition, most respondents had been called upon to help a client who was suicidal and had assessed a client for suicide risk in the past year. The number of clients varied by department; the majority of MHS staff had assessed more than five clients while ADS staff tended to assess fewer clients (Exhibit 4.2).

Overall, the majority of respondents stated that less than 50% of their clients exhibited one or more factors that make them more likely to attempt suicide, with 60.5% of MHS respondents and 75.4% of ADS respondents saying that less than 50% of their clients exhibited suicide-related factors. There were very few respondents with more than 90% of their clients exhibiting suicide factors (4% and 7.2% respectively for MHS and ADS).

Confidence to Address Suicide

All three provider groups (County MHS, County ADS, and Community Providers) were asked how confident they were in their ability to deliver suicide prevention services. Ratings were similar across groups; each group expressed the most confidence

in referring clients who exhibited signs of suicidality to support groups, recognizing suicide risk factors in clients, and talking to clients about suicide risk factors. Conversely, providers expressed less confidence in their ability to complete a suicide risk assessment with a client, provide a direct intervention to a client exhibiting risk factors for suicide, and integrate culturally responsive intervention strategies in suicide prevention (Exhibit 4.3).¹⁰⁹

Additional analysis was conducted to examine how factors such as experience, position type, and department impact confidence level. For County MHS respondents mean scores varied by position, years in the field as well as experience working

with suicidal clients. Support services had a lower confidence level than other positions while those with more years working in Behavioral Health and experience with suicidal clients had higher confidence levels than those with less years in Behavioral Health or less experience related to suicide.¹¹⁰

Exhibit 4.3: Self Reported Confidence to Address Suicide

How confident are you in your ability to:	% very confident/somewhat confident		
	Group 1 (County MHS)	Group 2 (County ADS)	Group 3 (Community)
Refer clients showing signs of suicidality to support services	90.3%	97.1%	96.9%
Recognize suicide risk factors in clients	88.3%	92.7%	87.7%
Talk to clients/patients about suicide risk factors	84.9%	89.9%	87.7%
Complete a suicide risk assessment with a client	80.2%	82.6%	75.4%
Provide a direct intervention to client exhibiting risk factors	78.5%	85.5%	75.4%
Integrate culturally responsive intervention strategies in suicid prevention	69.8%	72.1%	70.7%
Total Mean Score (out of 24)*	19.18	19.18	19.36

*Total mean score is the average total score of all items on listed.

¹⁰⁹ Positive response categories consist of “Very confident” and “somewhat confident;” negative response categories consist of “not very confident” and “not at all confident.”

¹¹⁰ Results are statistically significant with p-value<.05; for full statistical findings, please see Appendix D.

"I've talked to thousands of people throughout my career. You hear that someone is just fine...then you hear that person committed suicide. Even their best friend would say that. I'm not sure what [can be done]... If people want to let you in, you can help. If they're giving me something to pick up on, I can pick up on it. But if not, there's not much I can do."

-PEI Contractor

Years in current position did not affect the total mean score for MHS respondents. In addition, scores did not vary between staff from Adult/Older Adult and Children's Mental Health Services. For ADS respondents, the only factor that affected confidence score was whether respondent had assessed a client for suicide; those that had showed a higher level of confidence than those that had not.

Position was also a factor that affected confidence levels for community providers; Managers and Board

Members had the highest average confidence level while Administrative positions had lower levels. Community providers showed a consistent level of knowledge across years in current role, as well as number of clients served annually.

Similar confidence-related questions were asked of the ten PEI contractors. Results are comparable with the above findings: the majority of contractors were very confident or extremely confident in all areas except for making referrals. In fact, only half of PEI contractors expressed confidence in making referrals, a marked difference from the other groups. Contractors explained that they rated their confidence level in making referrals fairly low because of a lack of available information about existing services and referral sources. Contractors suggested that referral lists should be readily available, with contact numbers and names of people to talk to for wraparound services for families. In addition, Contractors felt there was not always an available referral source. One contractor shared that while a resource was available, he was not confident in the capacity of the referring party to treat his clients.

Two additional contractors, who rated their confidence as low, shared that additional training would help increase their confidence in addressing suicide among clients. The first wanted hands-on training to prepare for crisis situations (e.g. role playing and learning about hospital protocols). The second stated that he could use training in all aspects of suicide related services as these skill areas were not part of his job and he had recently and unexpectedly been pulled into a crisis that he was unprepared for.

Knowledge of Key Risk Factors

Participants were asked to select from a list of factors that, according to the research literature, are associated with increased suicide risk (Exhibit 4.4). The data across the three groups was fairly consistent, indicating a fairly high level of familiarity with basic risk factors for suicide. Group 3 (non-County funded providers) had the highest level of knowledge, as seen by the individual risk factor scores as well as the mean summary score. The majority of participants correctly identified most risk factors with the exceptions of Caucasian Ethnicity, Family Discord and Turmoil, Native American Ethnicity, and Recent Disciplinary Crisis Resulting in Humiliation. This indicates that providers may not be aware of the latest statistics regarding suicide in San Diego County and may need additional training on which communities are most at risk. More training about how environmental factors, such as humiliation, impact suicide risk may also be needed.

Additional analysis was conducted to examine how factors such as experience, position type, and department impact providers' knowledge of suicide risk. These factors did not affect scores for County ADS and community providers who showed a consistent level of knowledge across position, years in current role, as well as number of clients served annually.

On the other hand, County MHS respondents mean scores did not vary by years in current position but did vary based on position; managers had a statistically significant higher mean score (10.49) than other groups while those working in Support Services had a lower mean score (8.62).¹¹¹ Experience in working with suicidal clients also had a positive impact on knowledge of suicide risk factors. For County MHS respondents, mean scores were higher for those that had conducted a suicide risk assessment than those who had not (10.17 and 9.14 respectively). The same was true for number of clients displaying suicide risk: the higher the number of clients, the higher the level of knowledge. Scores did not vary between staff from different departments (Adult/Older Adult and Children's Mental Health Services).

Exhibit 4.5: Knowledge of key statements regarding suicide

Risk Factor	Correct Answer	Correct Answers per Group*		
		Group 1 (County MHS)	Group 2 (County ADS)	Group 3 (Community)
If you ask someone directly "Do you feel like killing yourself?" it will likely lead that person to make a suicide attempt.	False	96.9%	92.8%	93.9%
Once a person has made up their mind to kill him/herself nothing can be done to stop them.	False	93.8%	92.8%	92.4%
A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted.	True	90.7%	85.5%	93.9%
People who talk about suicide rarely attempt suicide.	False	86.6%	79.7%	89.4%
There is a strong link between drug/alcohol use and suicidal ideations	True	85.8%	88.4%	93.9%
Suicide is among the top 10 causes of death in the U.S.	True	85.1%	84.1%	87.9%
A time of high suicide risk in depression is at the time when the person begins to improve.	True	72.4%	62.3%	80.3%
Suicide rarely happens without warning.	True	63.0%	65.2%	71.2%
Most people who die by suicide have a diagnosable mental illness at the time of their death.	True	56.1%	55.1%	66.7%
The tendency toward suicide is not genetically (i.e., biologically) inherited and passed on from one person to another.	True	44.8%	46.4%	42.4%
A person who is suicidal neither wants to die nor is fully intent on dying.	True	21.8%	18.8%	19.7%
Total Mean Score (out of 11)	N/A	7.97	7.71	8.32
*Valid Percent				

¹¹¹ Results are statistically significant with p-value<.05; for full statistical findings, please see Appendix D.

Attitudes Regarding Suicide

Survey participants were asked to determine whether a set of 11 statements regarding suicide were true or false. Similar to the identification of risk factors, there were similar results across all three groups (Exhibit 4.5). Community providers showed the highest level of knowledge with an overall mean score of 8.32.

The majority of all three groups (between 79.7% and 93.8%) recognized the false statements and showed awareness of the link between substance use and suicide ideation, and the link between suicide and previous attempts. There were several true statements that the majority of respondents in each group incorrectly marked as false: *A person who is suicidal neither wants to die nor is fully intent on dying; The tendency toward suicide is not genetically (i.e., biologically) inherited and passed on from one generation to another*; and *Most people who die by suicide have a diagnosable mental illness at the time of their death*.

Analysis was conducted to examine differences in overall mean score across groups. Similar to the findings regarding risk factors, County MHS scores varied by position. Managers and Directors had a higher mean score than other positions such as Direct Service or Support Services. There was no difference based on years in current position or years in the field. For ADS, there was no difference based on position or years of experience. Community providers also showed a consistent level of knowledge across position, years in current role, as well as number of clients served annually.^{112,113}

Among MHS providers, summary scores varied by level of experience regarding suicide. Those that had conducted a suicide risk assessment had higher scores than those who did not. In addition, those with a higher percentage of clients exhibiting risk factors for suicide tended to have higher summary scores. These trends were not observed for ADS providers.

These findings indicate that training on basic suicide risk factors is needed for MHS direct services and support services staff. Targeted training to dispel myths such as the assumption that someone who is suicidal is fully intent on dying is needed for all groups. This information can increase knowledge about suicide as well as increase confidence in providers' ability to address suicide risk in the clients they serve.

"People do not commit suicide because they have been asked about it. It is ok to ask the question: 'Are you contemplating committing suicide?' Anyone answering the telephone, who works at the County level (including all receptionists) should receive and be required to attend suicide prevention training. They should be trained to ask the questions and look out for the warning signs."
-PEI Contractor

¹¹² Results are statistically significant with p-value<.05; for full statistical findings, please see Appendix D.

¹¹³ Number of clients served was only collected for Group 3.

Past and Future Training

This section summarizes survey findings from the Training Assessment Survey as well as highlights input from PEI contractors, stakeholders, and focus group participants regarding current training capacity and training needs.

Training received to date

Provider training is valued by existing contractors; many of the PEI contractors shared that training was helpful for providing information on available resources, reviewing suicide risk factors, and teaching about suicide risk assessment and how to manage high-risk clients.

Stakeholders shared that County Behavioral Health contracts to outside agencies for most, if not all, provider training. Most providers were familiar with the Behavioral Health Education and Training Academy (BHETA) and stated that their trainings are informative. However, most trainings are not specifically devoted to suicide prevention and, rather, suicide may be addressed in relation to other topics such as treating depression or working with youth. As one stakeholder shared, “We get more broad-based suicide prevention training. I would not say the suicide prevention piece is intensely focused.” Training survey respondents echoed this finding as most who had participated in trainings related to suicide stated that they were not via the County funded partners (Exhibits 4.6 and 4.7). Additionally, training survey respondents said that suicide prevention training was not adequate when integrated into other training topics (60.8% for MHS and 55.1% for ADS). PEI contractors shared that they are encouraged, but not required by the County to attend any specific content training.

Survey respondents were asked about the types and frequency of trainings they had attended in the past. As can be seen in Exhibit 4.6, fewer MHS respondents attended trainings on suicide, suicidality, suicide prevention, suicide risk assessment, or intervention for a client threatening suicide than their ADS counterparts. For the most part, the trainings occurred within the last four years, and were provided through agencies other than San Diego County or County contracted training providers. The large majority of trainings were provided by a wide range of sources in the community. Respondents identified numerous sources and curricula used. Responses suggest that, of those who could remember, approximately half of the providers have not participated in County-provided training; instead their education came from academic programs, continuing education or in-house training. The other half was trained through a wide variety of programs and agencies.

Exhibit 4.6 MHS Suicide Related Training Participation

MHS Training on Suicide, Suicidality or Suicide Prevention			
% attended (n=578)	Time of training (%) (n=335)		% Provided by County or Contractor (n=335)
58.0	<1 year ago	34.3	19.7
	1-4 years ago	48.7	
	5-9 years ago	13.1	
	>10 years	3.3	
	n/a	0.6	
MHS Training on Suicide Risk Assessment			
% attended (n=578)	Time of training (%) (n=281)		% Provided by County or Contractor (n=281)
48.6	<1 year ago	29.2	20.6
	1-4 years ago	55.2	
	5-9 years ago	13.2	
	>10 years	2.5	
	n/a	0	
MHS Training on Intervention for a Client Threatening Suicide			
% attended (n=578)	Time of training (%) (n=222)		% Provided by County or Contractor (n=220)
38.5	<1 year ago	26.6	19.1
	1-4 years ago	54.6	
	5-9 years ago	14.9	
	>10 years	4.1	
	n/a	0	

Exhibit 4.7 ADS Suicide Related Training Participation

ADS Training on Suicide, Suicidality or Suicide Prevention			
% attended (n=69)	Time of training (%) (n=50)		% Provided by County or Contractor (n=50)
72.5	<1 year ago	12	20.0
	1-4 years ago	48.7	
	5-9 years ago	13.1	
	>10 years	3.3	
	n/a	0.6	
ADS Training on Suicide Risk Assessment			
% attended (n=69)	Time of training (%) (n=38)		% Provided by County or Contractor (n=38)
55.1	<1 year ago	29.2	10.5
	1-4 years ago	55.2	
	5-9 years ago	13.2	
	>10 years	2.5	
	n/a	0	
ADS Training on Intervention for a Client Threatening Suicide			
% attended (n=69)	Time of training (%) (n=30)		% Provided by County or Contractor (n=28)
43.5	<1 year ago	3.3	14.3
	1-4 years ago	54.6	
	5-9 years ago	14.9	
	>10 years	4.1	
	n/a	0	

Recommended Training Topics

- Suicide prevention, including suicide prevention in teens and LGBT Youth (15)
- Self-harm, self-injury and self-mutilation prevention, including self injurious behavior in adolescents (7)
- Formal training in Dialectical Behavior Therapy Therapy (6)
- Suicide intervention, including emergency and crisis intervention (5)
- Suicide risk assessment (4)
- Motivational interviewing (4)
- Eye Movement Desensitization and Reprocessing (EMDR) (2)

A total of 100 County respondents identified where they had been trained for suicide, suicidality, or suicide prevention. Of these, approximately half named their academic degree program (e.g., college and graduate courses), continuing education units (CEUs) or in-house training (e.g. speaker for clinical staff). The remainder mentioned at least 63 different entities or programs as the source of their training, ranging from private individuals to foundations and government agencies, suggesting low uniformity in curricula (a list of training providers mentioned in descending order can be found in Appendix D).

PEI contractors interviewed exhibited a mixed level of awareness of training opportunities. Only one interviewee knew of, and had attended, a suicide prevention workshop a year ago. Three did not know of any training opportunities. The others cited the following reasons for not attending any County or County-funded trainings: did not need it (training needs are met in-house); the subject was not pertinent; and it was not required. Those who were aware of training opportunities generally agreed that they were accessible even if they do not attend.

Many PEI Contractors shared that in addition to external trainings, their staff receives some form of suicide training or is already trained when hired. Of the 10 contractors interviewed, four offered training specifically related to suicide while others shared that training might be “very general” or “broad-based”.

Trainings mentioned by PEI Contractors spanned topics such as recognizing warning signs of suicide, assessment of suicidality, suicide intervention, co-occurring disorders, and identifying high risk groups. Five contractors explained that their staff receives some training related to suicide, but that it is not

suicide-specific. Of the two contractors that indicated their agency offered no suicide-related training, one explained that it was not needed (because therapists are already trained) and the other did not remember any

in-house training and was not aware of any in the community.

“[The training] gives us a very cut-and-dry way to deal with [suicide] in the moment, but it doesn’t go into pathology or too much more or where suicide is coming from or why people do it but more what to do in a matter of crisis intervention. Later on ...you have to answer a test and you have to actually pass the test in order to satisfy the requirements of [training].”

-PEI Contractor

Interest in Future Training Topics

County MHS and ADS providers also identified training areas that complemented those provided by Behavioral Health Services (i.e. skill based training that supports the integration of primary care, dual diagnosis, culture, and spirituality). There were over 100 suggestions covering a variety of behavioral health areas. Among these were 13 requests specifically related to suicide and 10 were specifically for suicide prevention training. Responses for additional suicide prevention training were accompanied by requests for training in Dialectical Behavior Therapy (DBT) and Motivational Interviewing, with a respondent noting that these should be a requirement for all staff working with clients. Other training areas included: risk assessment, group therapy, cultural specific therapy (such as Cuento Therapy) brief strategic therapy and solution and focused therapy.

Respondents to this question also listed the following skills training: suicide intervention, early intervention awareness, working closely with primary care settings, staff burnout and self-care, and handling suicide ideations.

Participants were also asked what other training would help them become more effective in their work. There were over 320 suggestions for behavioral health services in general (e.g., systems issues, collaboration) including 26 specific comments regarding suicide related training. Again, suicide prevention was overwhelmingly the most frequent request. The text box above summarizes the most frequently-mentioned areas, in descending order. Survey participants also requested trainings on topics such as ethics, working with LGBT or foster youth, interacting with suicidal callers on the crisis hotline, bullying in schools, and integration with other community providers.

Contractors were asked for recommendations regarding 1) internal training and 2) the provision of training for service providers in general. Feedback was similar to survey findings and provides insight as to why providers believe modifications to trainings are needed. Below are the top nine recommendations made by survey respondents, grouped by the assessment team:

1. **Make trainings mandatory.** Contractors interviewed felt strongly that all staff should be required to attend suicide prevention trainings. Contractors also stated there should be a system-wide suicide training that is required by all County employees, regardless of if they are related to MHS or ADS. These required trainings, including suicide prevention, should be written into all Requests for Proposals (RFPs).
2. **Increase training frequency:** There should be more frequent and more in-depth suicide prevention training opportunities. As staff members gain experience they start to have more questions about their clients. Although their supervisors are there to support them, respondents noted that a formal setting where they can ask questions and learn about the most recent trends, high-risk groups, and other factors is invaluable. Some respondents noted trainings could be as simple as an interactive computer program for all county employees to watch a set number of times a year. These should be offered in multiple languages.
3. **Tailor content based on experience.** Trainings should be separated into basic training and higher level training for topics such as co-occurring disorders. Experienced staff who have taken the basic training several times should be offered more advanced learning, at a higher level of science and new information.
4. **Support providers' mental and emotional health.** Training around suicidality should address: coping with counter transference and the anxiety of working with suicidal clients, including training on appropriate reactions for direct-service staff when initially dealing with a suicidal individual; developing a supportive process within the agency to help staff members cope and maintain their own mental health, treatment of suicidal behaviors and mental health treatment, and managing the chronically suicidal.
5. **Give providers tangible skills.** Agencies should provide training on safety plans for clients who are suicidal. Non-clinical staff in community organizations may not know what to do when a client is suicidal. *"I would definitely think of what to do...a safety plan training for clients that are suicidal. For example, I know that calling [about calling 911], knowing what the hospital procedure is would also be helpful for us to have an idea. [Some clients know how to] say the right thing to get out of [an involuntary psychiatric hold] but then they get out and come back here."* Providers also shared that they appreciate "hands on experience" from survivors of suicide attempts as well as survivors of suicide loss.
6. **Provide training and support after a suicide occurs.** There should be training and support available for agencies dealing with a completed suicide, including a coping plan for employees. Community organizations need to be prepared for the worst and need a clear understanding of their role. A contractor recounted a tragic incident, questioned whether specialized training would have helped prevent the suicide, and whether the agency was in any way responsible (see textbox).

7. **Focus on dual-diagnosis populations.** Specialized prevention trainings should be tailored for dual-diagnosis populations (e.g., populations with schizophrenia and drug use, etc.) “It would be important for the mental health specialists to give training to ADS treatment programs because they do have a different population with schizophrenia and to prevent people from getting hospitalized. They have amazing interventions that the Adult/Older Adult program specialists are not benefiting from.”
8. **Address current issues.** Training and data on bullying (including cyber bullying, via twitter, texting, sexting, etc.) should be provided. Bullying was particularly noted as a major risk factor and in need of attention (how adults can respond to bullying; what kind of education the children need; how school staff can intervene).

Collaboration among Providers

A review of best practices in suicide prevention approaches highlights the importance of coordinated services and inter-agency collaboration.¹¹⁴ Several stakeholders identified existing partnerships between organizations. A stakeholder from law enforcement reported having a “great relationship” with faith based organizations as well as the schools to “identify the juvenile risks, which are a whole different ball game. We work very closely with cyber bullying.” Another stakeholder from a school-based program reported collaborating with community organizations to identify parents to participate in programs: “We find, especially with the lower income populations or where kids are bussed into schools outside of their geographical area, parents either don’t have transportation or generally are reluctant to go to school meetings so we’re going to try to reach them in their community organizations.”

“Given the experience that we had a year ago, with the suicide of a resident, the problem is that we don’t know if we could have caught it [with specialized training], what is our role if someone is likely to be at risk for suicide? This is an area where we do not know as much as we should about support, early identification of people at risk or handle the situation in case someone does.”

– PEI Contractor

Some stakeholders shared that there could be better coordination between County agencies, specifically County Mental Health Services (MHS) and Alcohol and Drug Services (ADS). One stakeholder shared that “the integration of ADS and MHS is more symbolic than operational”. Another shared that “ADS programs are getting a lot more clients with co-occurring disorders and they are not as prepared as mental health programs to address those issues so it would be really important to have a stronger collaboration between MHS and ADS in the county.” A third stakeholder shared that for the past three to five years, groups of MHS and ADS providers have been attending trainings together. As clients receiving services from each system may have co-occurring needs, this training is a “great way for providers to build relationships” and for organizations “to be more responsive.” This collaboration between providers helps to maintain knowledge of what services are provided where, to obtain information about new or updated services, and to build and strengthen relationships between each system.

¹¹⁴ Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, Board on Neuroscience and Behavioral Health. *Reducing Suicide: A National Imperative*. Ed. SK Goldsmith, TC Pellmar, AM Kleinman, WE Bunney. Washington, D.C.: The National Academies Press: 2002.

The community provider survey asked respondents to rate their relationship with a core list of 17 providers of suicide prevention services in San Diego County.¹¹⁵ This professional networking question is based on the Levels of Collaboration Scale. The scale identifies five levels of collaboration described in the text box: *No Interaction (0)*, *Networking (1)*, *Cooperation (2)*, *Coordination (3)* and *Collaboration (4)*. Results of this exercise are presented in this section.

Professional Networking Survey:

Summary of Findings

The scores from the surveys were mapped to graphically display the relationships between providers. The following network maps capture the nature of the reported relationships between the 17 listed agencies and illustrate interactions among agencies that provide suicide prevention services in San Diego County.

Levels of Collaboration Scale

1. **No Interaction:** not aware of this organization, not currently involved in any way
2. **Networking:** loosely defined roles, little communication, no shared decision making
3. **Cooperation:** provide information to each other, somewhat defined roles, formal communication
4. **Coordination:** share information, defined roles, frequent communication, some shared decision making
5. **Collaboration:** share ideas, share resources, frequent and prioritized communication, decisions are made collaboratively

Interpreting the maps: Each point on the map represents an agency. The lines between points represent how respondents from each agency rated their level of collaboration (i.e., a rating of 1, 2, 3 or 4 on the Levels of Collaboration Scale). Below are four features to consider when interpreting the maps.

- **Interaction.** A map is created by drawing lines between two agencies when one agency reports any interaction with another agency (i.e., a rating of 1, 2, 3 or 4 on the Levels of Collaboration Scale), with an arrow identifying the direction of the rating (i.e., from the agency making the rating with the arrow pointing to the other agency). When two agencies have the same rating of their level of interaction, the line between them will have bi-directional arrows and will be represented by a thicker line, indicating that both agencies have given the same rating. In general, higher levels of interaction correspond to a greater sharing of information and resources as well as mutual or cooperative decision-making between agencies.
- **Density.** When looking at a network in its entirety, an important quality is the degree to which all members in the network are connected. **Density** describes the entire network and is defined as the proportion of the number of reported interactions to the total number of possible interactions in a network.
- **Placement of agencies on the map.** Network maps illustrate relationships among different agencies in a system of interactions along the Levels of Collaboration scale. It is important to note that the maps portray not only *direct* interactions (agencies interacting directly with one another), but also *higher-order interactions* (agencies that are connected to each other by virtue of interacting with a common agency). In a way, this is akin to the “six degrees of separation” phenomenon, wherein people are connected to each other by knowing someone in common. The placement of agencies on the maps reflects the results of a statistical analysis of both direct and indirect ties between all agencies in the network.
- **Closeness.** *Closeness* is the measurement of the number of direct connections an individual organization has with other network members. Agencies with a high degree of closeness have the most direct connections with other agencies and are placed nearer to the center of the map.

¹¹⁵ This list was not an exhaustive list of suicide prevention providers but rather an initial core list to assess baseline associations between agencies. It was made up of the MHSA funded Prevention and Early Intervention contractors that have a suicide prevention focus as well as key partners identified to be providing services specific to suicide prevention.

A higher number of direct connections can signify that agencies are exposed to more information from other agencies. Information can spread more quickly where there are high degrees of closeness and, as a result, agencies with closer connections to others in the network may be better able to mobilize resources. Agencies that are closer to each other tend to be more reachable by other agencies. Agencies with lower closeness scores may be at a disadvantage because they may not as readily exchange information or coordinate services.

Reading the Maps

Squares: Represent agencies.

Lines: Represent interactions between two agencies. Thick lines represent reciprocal interactions, where both agencies reported the same Collaboration Score.

Arrows: Show the direction of an interaction and whether the relationship between two agencies is reciprocal or non-reciprocal. Arrows point from the responding organization to the agency with which they report an interaction.

Colors and Placement: Represent the “closeness” of each agency. Agencies that are closest to other agencies are shaded red. These are the agencies that have the most direct connections with other network members and are placed at the center of the network. Agencies with lower closeness scores are shown in order of closeness by blue, yellow, green and gray shading, respectively, and are placed farther from the center of the network.

Greatest to fewest interactions:     

Collaboration among core agencies

The following network maps capture the nature of the reported relationships between the 17 core agencies and illustrate interactions among agencies that provide suicide prevention services in San Diego County. Two agencies did not complete the survey. This is important because a complete assessment of a network's strength and level of collaboration depends on all partners rating their respective relationships. Because two contractors did not complete the survey, we are only able to assess how other organizations perceive their relationship. To preserve confidentiality, the agencies are not identified by name on the maps.

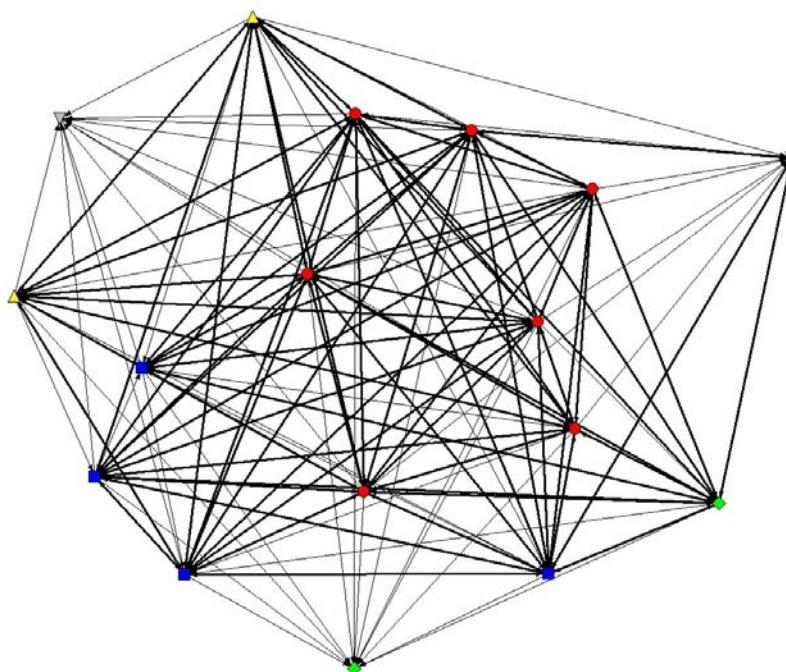
Exhibit 4.8: Interaction Between Core Agencies

Level of Interaction	No. of Interactions	% of Interactions
Networking	75	37.1%
Cooperation	74	36.6%
Coordination	23	11.4%
Collaboration	30	14.9%
Total	202	100%
<i>No interaction</i>	<i>104</i>	<i>-</i>

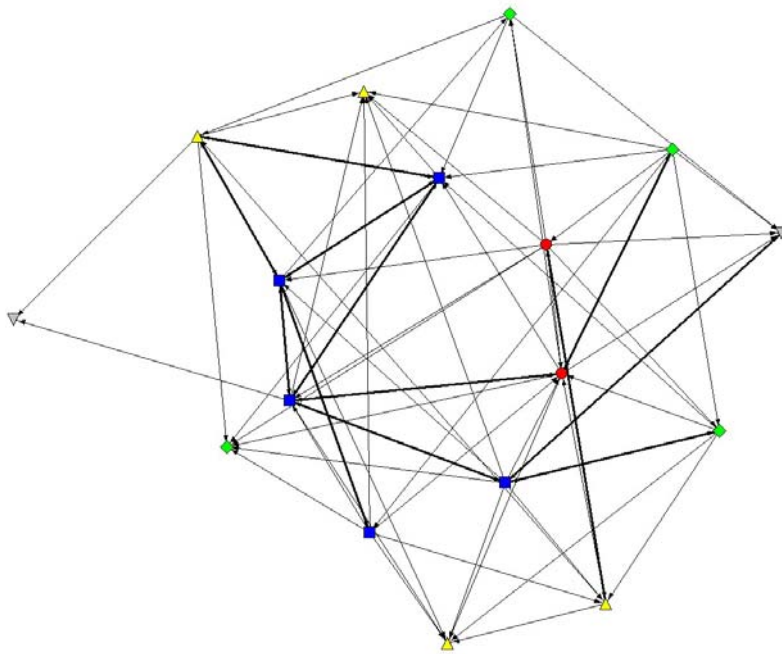
Overall, out of 306 possible ties, or relationships, there were 202 existing ties reported, giving the network a 66.0% density. Table 4.9 below summarized the number of interactions between core agencies. About one third of the reported relationships were at the networking level (37.1%), one-third at cooperation (36.6%), and the remaining were coordination or collaboration level interactions (26.3%).

Map 1 displays the entire network of relationships among the 17 partners on the network list of agencies. The network appears to be moderately dense (66.0%) with many connections between agencies. The seven agencies identified in red have the highest closeness scores and have many direct connections to other agencies in the network. The high number of thick lines represent a high level of reciprocity between the agencies with higher closeness scores. The agencies on the outskirts of the network appear to have more thin lines and, therefore, less agreement about their level of collaboration with other agencies.

Map 1: Full network map



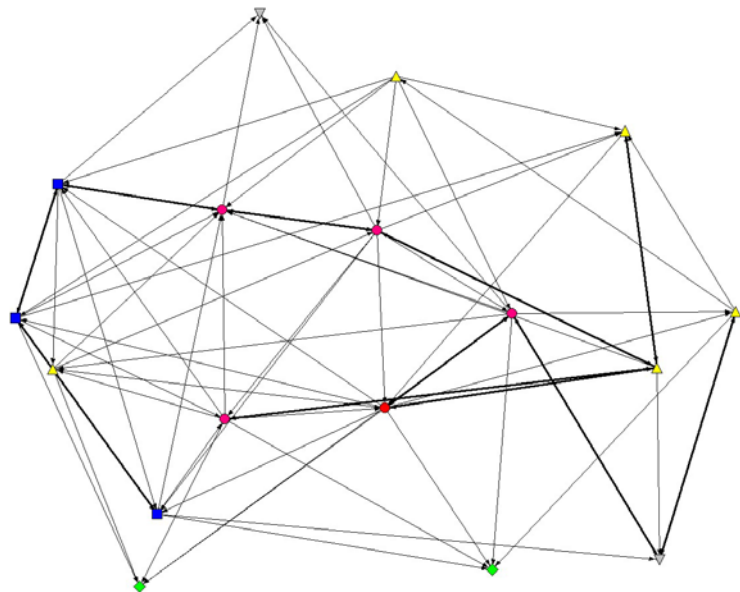
Map 2: Networking Map



Maps 2 and 3 illustrate the reported relationships between agencies at the *Networking* and *Cooperation* levels. Almost three quarters (73.7%) of all reported interactions are at these two levels which indicates that, currently, most of the core agencies that provide suicide prevention services in San Diego County are interacting at lower levels of collaboration. The agencies with the highest closeness scores in Map 2 may be different than the full network because they are the agencies who have the most “Networking” level interactions with other agencies.

The density of the map begins to change at the *Cooperation* level with less ties between the agencies and more indirect relationships where agencies are connected through other agencies. The “star” pattern begins to emerge at this level as there are multiple ties from a few agencies, indicating that there are a few key players in the network serving as the nodes for transferring resources and information to other agencies. “Star” patterns indicate inefficient flow of resources and are generally not desirable for collaborative networks.

Map 3: Cooperation Map



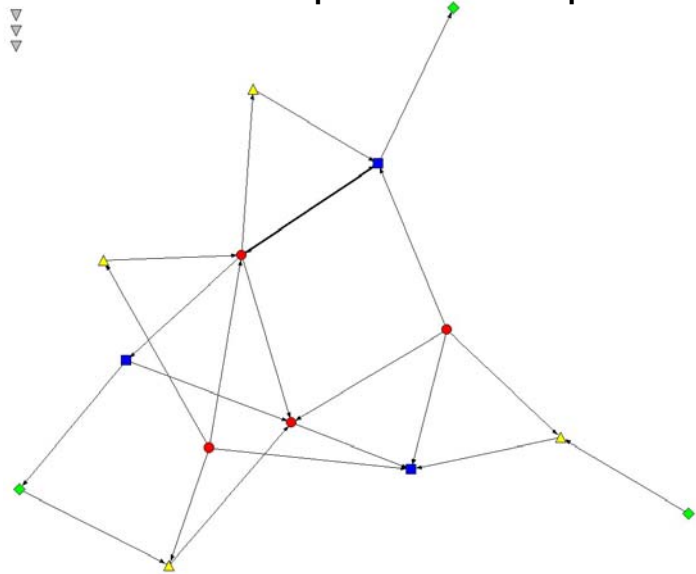
Maps 4 and 5 show the interactions at the highest levels of collaboration, *Coordination* and *Collaboration*. These maps are much less dense and there are a few isolated agencies in Map 4 that do not have ties with any others at this levels, shown on the map as gray squares in the upper left corner. The isolated agencies do not report any *Coordination* interactions and other agencies do not report *Coordination* interactions with the isolated agencies. Both maps changed in shape from the previous maps and there are more outlying agencies that are only connected to the rest of the group through their relationship with a single agency. Only one reciprocal relationship exists in both maps, meaning most agencies do not agree on their interaction at the higher levels of *Coordination* and *Collaboration*. Less reciprocity results in less confidence that the reported interaction

represents the true nature of the interactions between agencies. The star pattern is evident in Map 5 by the red agency that connects to the three green agencies on the right side of the map, as well as to multiple agencies in the center of the map. At the *Collaboration* level, this red agency is a major hub that connects multiple agencies and could be a major source of resources and information. However, it is worth noting that all of the lines point outwards from that agency so they perceive collaborative relationships with multiple agencies who do not agree.

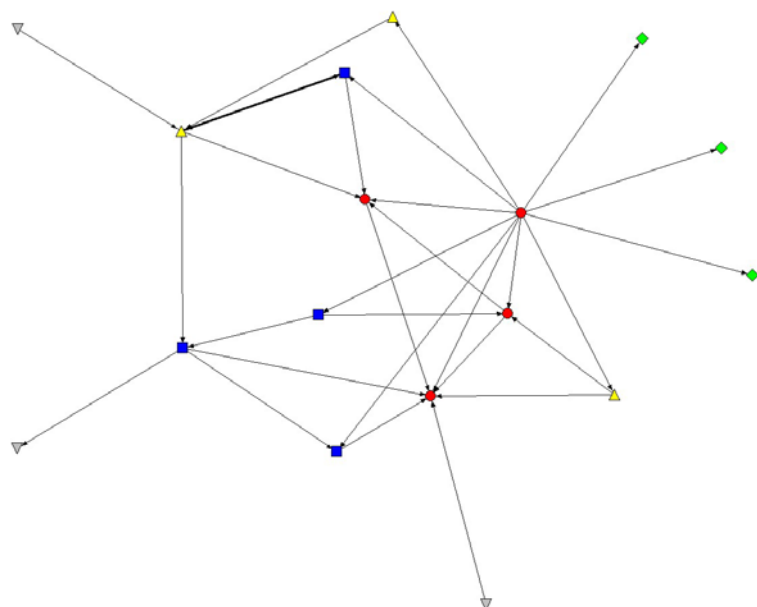
Conclusion

This information provides a picture of the existing network of suicide prevention services in San Diego County. The network is small but fairly connected at the *Networking* and *Cooperation* levels. However, most agencies at the *Coordination* and *Collaboration* levels are connected only through key agencies that likely serve as hubs of resources and information and there is very limited reciprocity at the higher levels, resulting in less confidence in the relationships reported at these levels.

Map 4: Coordination Map



Map 5: Collaboration Map



Collaboration across Community Providers

A total of 160 providers rated their relationship to each of the 17 core agencies in the network of suicide prevention providers. Exhibit 4.9 shows, on average how other community providers rate their relationships with each of the 17 agencies. All agencies were rated at the *Networking* or *Cooperation* levels, indicating that while providers are aware of these key players in suicide prevention, they have limited communication and no shared decision-making or formal collaboration opportunities.

Exhibit 4.9: Level of interaction of community providers with key suicide prevention agencies

Level of Interaction	Number of Agencies
No Interaction: Not aware of this organization, OR not currently involved in any way, either formally or informally	No agencies
Networking: Aware of organization, loosely defined roles, little communication, no shared decision making	10 agencies (58.8%)
Cooperation: Provide information to each other, somewhat defined roles, formal communication, no shared decision making	7 agencies (41.2%)
Coordination: Share information, defined roles, frequent communication, some shared decision making	No agencies
Collaboration: Share ideas, share resources, frequent and prioritized communication, decisions are made collaboratively	No agencies

Preliminary Data on Existing Services

Suicide prevention strategies range from media campaigns aimed at the general public, to screening programs to identify and assess at-risk groups, to assessment and treatment for those that evidence early warning signs of suicide risk. Studies have shown that integrated prevention models that “incorporate all levels of prevention and include targets of reduction of mental illness and promotion of mental health” across a system of care can have the biggest impact.¹¹⁶ For example, the Perfect Depression Care Initiative in Michigan’s Henry Ford Health System is an integrated approach where all patients are assessed for depression and provided services based on need. This initiative dramatically reduced suicides from the annual rate of 89 per 100,000 to no suicides over a two year period.¹¹⁷

Community survey respondents provided information about the services they provide. Additionally, stakeholders provided insight into existing services. The information presented in this section is not an exhaustive account of available services and supports in San Diego County, but rather a snapshot of some of the services available that match best practice prevention efforts. Where appropriate, a table comparing documented best practices to local prevention efforts is included. A full inventory of existing suicide prevention services will be conducted as part of the action planning process.

Regional Breakdown of Services

Has Offices located in:

- All Regions (16.1%)
- East (29.2%)
- South (33.5%)
- Central (67.7%)
- North Central (29.2%)
- North Coastal (29.8%)
- North Inland (27.3%)

Provide services in:

- All Regions (42.2%)
- East (58.4%)
- South (59.0%)
- Central (77.6%)
- North Central (54.7%)
- North Coastal (54.7%)
- North Inland (53.4%)

Service Entry Points

PEI contractors reported that clients came to them primarily from MHS, ADS, and the criminal justice system. Other sources included other County departments, such as Aging and Independent Services; private practitioners (psychologists and psychiatrists); hospitals, such as Rady Children’s Hospital; senior centers; and other community providers.

Many stakeholders and community members felt that early screening and crisis intervention opportunities are being missed. They gave numerous suggestions for entry points to prevention services. Social programs for seniors, including clubhouses, nutrition sites, Meals on Wheels, and senior centers are places where staff could be trained to observe changes in the clients. Other occupations that could serve as entry points include mail carriers (e.g. they may notice unusual accumulations of mail), caregivers for people with chronic illness, and outreach workers (people are more likely to talk to them because they are from the same community).

Involving the faith community was a recurring theme because people often turn to the church for spiritual support and the leaders could be made aware of existing services. Emergency Departments may also be a good entry point, as one stakeholder alluded that some motor vehicle accidents involving drugs and alcohol serve as masked suicide attempts. While much is being done in schools in terms of suicide prevention, it is important to train all levels of staff including janitors and food service employees (“everyone should know signs of depression and suicidality”). Other entry points include community resources such as homeless shelters,

¹¹⁶ Carl C. Bell, Jerome Richardson, and Morris A. Blount Jr. (2005). Suicide Prevention. In J. R. Lutzker (Ed.), *Preventing Violence: Research and Evidence-Based Intervention Strategies* (217 – 237).

¹¹⁷ Tracy Hampton. Depression Care Effort Brings Dramatic Drop in Large HMO Population’s Suicide Rate. *JAMA*, Vol 303. No 19, pg 1903.

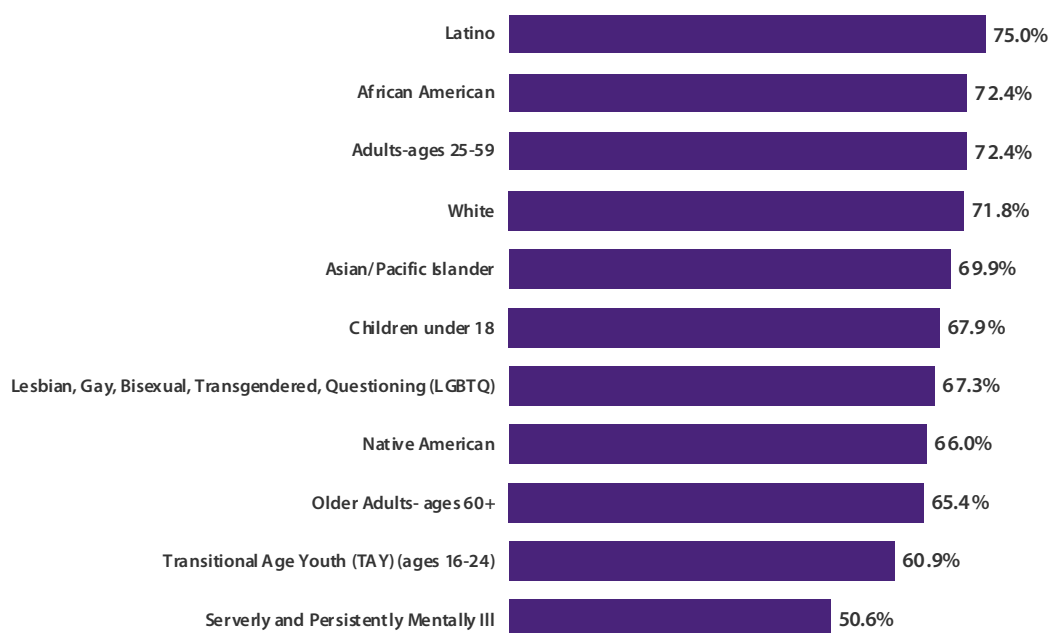
rehabilitation centers, residential youth facilities, libraries (which are frequently visited by the homeless and unemployed) and first responders.

Service populations

The organizations included in the Community Provider Survey varied in size, from small agencies serving less than 100 clients annually to large agencies serving over 10,000 clients per year. Over half of all respondents (55.4%) reported that their agency served between 100 and 4,999 clients annually. PEI Contractors shared that their agencies serve between 50 and 450 clients a year through direct service, and over 6,000 clients through non-direct service (i.e., advocacy and research).

Services are provided throughout the County with the highest percentage of services provided in East, South and Central regions (see textbox on previous page). Community Providers identified a wide variety of client populations served ranging from specific ethnic or age groups to people in crisis situations. Exhibit 4.10 shows the target groups, listed by frequency of responses.¹¹⁸

Exhibit 4.10: Percent of Organizations that Provide Services to Identified Target Populations



Most providers serve multiple populations and several provide county-wide services to all groups. Stakeholders clarified that while they may target a specific group, such as Latino/a youth, their services are open to youth of all backgrounds. Stakeholders frequently noted the importance of understanding how to serve culturally diverse populations in addition to speaking the native language of the client.

In addition to the categories stated, providers shared that they also serve homeless individuals, victims of domestic violence and trauma, and people with disabilities. Prevention and Early Intervention contractors, whose services include suicide prevention, serve specific target populations including: patrol officers; veterans; reserves; military; National Guard and their families; caregivers for older adults and allied professionals who serve older adults; people with substance abuse problems and co-occurring disorders; and the adult male incarcerated population.

¹¹⁸ Percentages total more than 100% because respondents were allowed to select more than one target group.

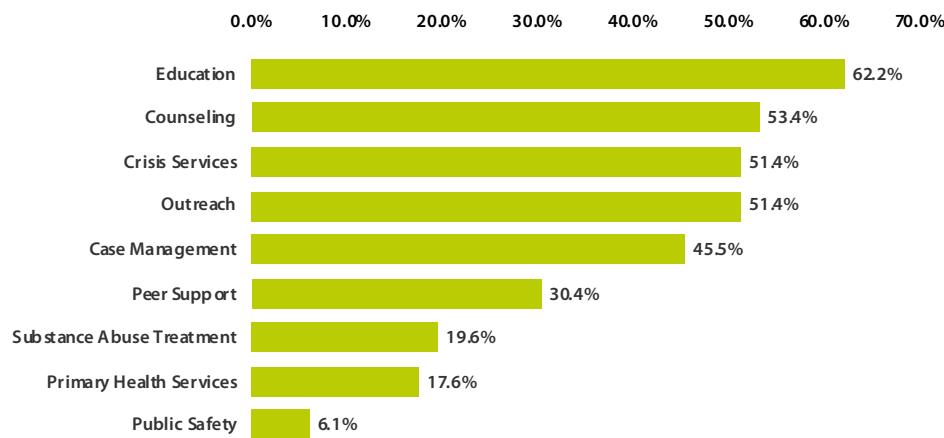
Current Practices

Provider survey respondents offer a wide variety of services (Exhibit 4.11). The most common service types reported include education, counseling, and crisis services. More specialized services, such as substance abuse treatment, represent 5% of all services.

This distribution of services lends context to the qualitative findings in this report. For example, it is not surprising to have more qualitative comments regarding education and less about substance abuse or public safety.

A review of services provided by agency shows that the majority of agencies (62.2%) provide education, and approximately half offer counseling and crisis services (53.4% and 51.4%, respectively). Outreach and case management are provided by 51.4% and 45.5% of the agencies, respectively, while approximately one third provide peer support (30.4%). Less than 20% provide substance abuse treatment (19.6%), primary health services (17.6%) and public safety (6.1%). The following chart illustrates the percentage of agencies providing specific services.

Exhibit 4.11: Services Provide by Community Survey Respondents*



*Categories are not mutually exclusive.

Outreach/ Public Awareness

Media campaigns to promote specific prevention efforts have been successful in smoking cessation, HIV prevention, and cancer screening. However, widespread suicide prevention campaigns are frequently not common due to fear of imitation. Best practices recommend that efforts be targeted to reduce the glorification and romanticizing of suicides in the media and focus on stigma reduction and awareness. Additional education efforts can promote awareness of suicide among the general public as well as outreach to connect people to services.¹¹⁹

¹¹⁹ Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, Board on Neuroscience and Behavioral Health. *Reducing Suicide: A National Imperative*. Ed. SK Goldsmith, TC Pellmar, AM Kleinman, WE Bunney. Washington, D.C.: The National Academies Press: 2002.

Best Practices for Outreach/Public Awareness	Existing San Diego Outreach/Public Awareness Approaches
Targeted efforts to reduce glorification and romanticizing of suicide	Mail and internet newsletters
	Speaker's bureau for community, schools, law enforcement, and emergency responders
	Community events such as: <ul style="list-style-type: none"> ▪ National Survivors of Suicide Day, Out of the Darkness Community walk (attended by over 500 participants) ▪ Distributing information and event flyers through local venues (e.g., libraries and vendors.)
Education tailored to specific community groups	<ul style="list-style-type: none"> ▪ Communication through the media, such as the Media Recommendations project, or through videos such as the "More than Sad" program aimed at teens ▪ Mental health education to older adults and caregivers of older adults
Outreach to connect community members to services	<ul style="list-style-type: none"> ▪ Interactive Screening Programs (pilot program currently run at UCSD Medical School) ▪ Attendance at health fairs to provide depression screenings. These events are a good opportunity of doing face-to-face promotion of the issue because people do not always pay attention to written materials.

Stakeholders noted that local public awareness efforts appear to be working because the community at large is increasing talking more about suicide and the importance of prevention efforts seems to be better understood. They noted effective bus stop bench and mid-day television public announcements. Stakeholders also highlighted the importance of advocacy work such as the promotion of policies and legislation that impact suicide and prevention and research for new studies regarding suicide prevention.

Reducing Access to Means

The literature cites the importance of universal measures that can be used to reduce the availability of common tools for suicide.¹²⁰ Reducing access to firearms, the most common means of suicide, can have a great impact. One study showed that suicide rates by firearms were much higher for those that had purchased a gun in the past year.¹²¹ Studies show that the presence of a gun in the household increases youth suicide risk; studies show that warning parents who have taken their child to the emergency room for a suicide attempt about suicide risks and providing education about reducing access to firearms, drugs and other means can reduce the likelihood of another suicide attempt.¹²² Other restriction efforts can include limiting access to fatal dosages of medication and restricting access to tall buildings and bridges.

¹²⁰ Ibid.

¹²¹ Ibid.

¹²² Kruesi, M. J. *Intervention Summary: Emergency Department Means Restriction Education* (2010). National Registry of Evidence-Based Programs and Practices. Web. 13 Dec. 2010. <<http://nrepp.samhsa.gov/ViewIntervention.aspx?id=15>>.

Despite the importance of this step in suicide prevention, counseling regarding means restriction, such as locking up guns, rarely occurs. Best practice literature cites few examples of studies regarding these efforts.¹²³ This was the case in speaking to stakeholders as most did not mention this approach when discussing suicide prevention efforts. The only program noted to include this component was the Veterans Administration suicide prevention program which distributes gun locks to patients as well as modifies hospital environments to ensure that patients cannot hurt themselves; this includes blocking access to low hanging pipes and glass that can be broken.

Training

Provider training ensures that those providing services are well-equipped to recognize signs and symptoms of suicide as well as provide adequate intervention. Training that is “skill-based” and “action oriented” produce greater gains than information alone and can help providers “demonstrate appropriate helping competencies in simulations, and report being comfortable when helping”. Best practices further recommend that trainings include mock assessment/intervention role-plays and that “booster” trainings be provided “every 2 to 3 years”.¹²⁴

Suicide Prevention Contracts*

Suicide prevention contracts, verbal or written commitments to avoid self-destructive behavior and communicate suicidal thoughts to counselors, are widely used in all mental health settings as risk management tools, but they remain poorly evidenced.

Stakeholders interviewed did not discuss suicide prevention contracts as part of their services. One stakeholder did share that the VA suicide prevention program includes a safety contract that records triggers for crisis and who to call for help.

*Source: Reducing Suicide: A National Imperative.

Best Practices for Training	Existing San Diego Training Approaches
Skill-based and action oriented trainings as well as booster trainings	<p><i>Note: No training explicitly followed best practice guidelines. General trainings noted by stakeholders included:</i></p> <ul style="list-style-type: none"> • Suicide prevention training in schools to students, staff, and families • In-service training to teachers and staff on signs of suicide ideation • Enhanced training for professionals, including online classes and webinars. • The Geriatric Mental Health Certificate Program, a new MHSA-funded program that trains professionals in aging services who need mental health training and mental health providers in aging issues. • Police officer training on how to work with the mentally ill. • Training to community providers, (gatekeepers including: police officers, religious based organizations) as well as general public on who is most at-risk for suicide.

¹²³ Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, Board on Neuroscience and Behavioral Health. *Reducing Suicide: A National Imperative*. Ed. SK Goldsmith, TC Pellmar, AM Kleinman, WE Bunney. Washington, D.C.: The National Academies Press: 2002.

¹²⁴ Ibid.

Hotlines and Crisis Centers

Hotlines typically provide anonymous or non-anonymous phone counseling services for people in crisis, such as those contemplating suicide. There is limited research on the effectiveness of hotlines and crisis centers in actually reducing suicide; some studies show reduction in suicide rates while others show no change.¹²⁵

Best Practices for Hotlines and Crisis Centers	Existing San Diego Hotlines and Crisis Centers Approaches
No best practice identified	Access Line & Crisis Line: 24 hour toll-free crisis line
	Courage to Call: Veteran-staffed 24/7 helpline that provides comprehensive mental health information, support, access and/or referrals to veterans
	Survivors of Suicide Loss: Help line for survivors of suicide loss
	The Trevor Project: 24-hour, toll free confidential suicide hotline for gay and questioning youth
	211 San Diego

Almost half of Community Provider survey respondents (48.1%) indicated that their agency or program was listed with the Access & Crisis Line. The remainder either did not know (24.4%) or indicated it was not listed (27.6%). Most of the PEI contractors (seven out of 10) were aware of, or had some form of contact with the Access & Crisis Line and referred clients to it as needed. Unlike 2-1-1, it is not easy to remember the phone number for the Access & Crisis Line (one provider could only remember the last four digits).

Over half of respondents of the Community Provider survey (59%) indicated their organization was listed with 211 San Diego. The remainder either did not know (23.1%) or indicated it was not listed (17.9%). Almost all PEI contractors said their agencies were listed with 211. Providers shared that not everyone is aware of 211, although it has served the community since 1997, and existed as InfoLine for many years prior. There was some concern about the adequate level of training 211 call line volunteers have to handle crisis calls. One provider stated that 211 is supposed to do a “warm hand-off” to the Access & Crisis Line, but felt that this does not always occur and as a result, 211 volunteer staff handle crisis calls. Another provider was under the impression that 211 only provides information for referrals for people who are Medi-Cal eligible or with very low income. This provider felt that clients with insurance cannot find resources through this system.

Information about the Access & Crisis Line

Call results for 2009-2010:

- 89,000 total calls
- 14,000 calls directly into Crisis Queue
- 97% of calls are answered by an operator within 45 seconds
- 800 calls included a law enforcement referral
- Call handle times range from one minute to an hour and half
- Approximately 20% of calls are suicide related; those with a plan with high lethality represent approximately 5% or less of calls.
- Suicide related calls are usually adults aged 18-25 years and older adults over 60 years.

¹²⁵ Carl C. Bell, Jerome Richardson, and Morris A. Blount Jr. (2005). Suicide Prevention. In J. R. Lutzker (Ed.), *Preventing Violence: Research and Evidence-Based Intervention Strategies* (217 – 237).

“Suicide prevention.” *Preventing violence: Research and evidence-based intervention strategies*. Ed. Lutzker, John R. Washington, D.C.: American Psychological Association, 2006.

“A lot of times when I’ve done a screening or talked to people from the community it’s amazing, they still don’t know what [211] is. [They don’t know] what services are out there ...people still aren’t hearing [about 211] and I’m not sure why.”

-Health Promotion Specialist

Some providers also shared that there is confusion among the general population between 211 and the Access & Crisis Line.

Counseling & Support

Services geared towards individuals identified as being at-risk tend to be tailored to the specific needs of specific populations. For example a

youth counseling program might focus on enhancing a youth’s sense of personal control while a support group for survivors of suicide loss might help reduce guilt and shame associated with suicide.

Given that 90% of suicide occurs in people with a diagnosable mental illness at the time of the attempt, treatment such as drug and psychotherapy to manage the underlying mental disorder can have an impact. Studies show that medication alone is not sufficient. There are limited studies examining which long-term interventions show the most benefits. Literature suggests that integrated behavioral and physical health programs make the greatest impact. In addition, programs that include targeted assessments as well as follow-up with the same provider tend to have the greatest impact.¹²⁶

Best Practices for Counseling and Support	Existing San Diego Counseling and Support Approaches
Few studies to examine impacts of interventions; best practices include assessment and integration of physical and behavioral health	Suicide assessments in the mental health arena. These are increasing due to regulatory changes and are completed by a variety of staff.
	Mental health assessments (suicide, substance abuse); Incredible Years Evidence Based for adults and children (mental health assessments) ¹²⁷
	Community support groups for those at risk: <ul style="list-style-type: none"> Union of Pan Asian Communities (UPAC) clubhouse model where clients with a psychiatric diagnosis can attend.
	Group therapy, individual therapy and psychoeducation
	Groups available for specific populations: <ul style="list-style-type: none"> Adult and teen survivors of suicide loss (such as the Survival Outreach program)¹²⁸, Intergenerational programs for the API community
	Case management programs (including those for clients with substance abuse problems and HIV)

¹²⁶ Ibid

¹²⁷ The Incredible Years are research-based, proven effective programs for reducing children's aggression and behavior problems and increasing social competence at home and at school. More information can be found at: <http://www.incredibleyears.com/>

¹²⁸ The American Foundation for Suicide Prevention’s Survival Outreach program provides trained local volunteers to provide support and resource information to those who have lost someone to suicide. More information can be found at: http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=45225B03-FBF2-AEBB-C260FDE7B93D1BCF

Best Practices for Counseling and Support	Existing San Diego Counseling and Support Approaches
	Staff advocate for clients – Example: when social workers see a problem with a child, they refer for counseling, treatment or medications.
	Substance abuse screening, intervention and treatment services (specific population approaches, such as for the LGBTQI community)

School-based programs:

School-based programs have been shown to enhance skills such as problem-solving, coping and personal control. Efforts may also be geared toward training school personnel to recognize warning signs of suicide as well as efforts to control bullying. Best practices support skills-based training prevention programs as well as increased accessibility to services. Longer-term interventions are recommended; research has shown that short-term interventions are not as effective and might be harmful as they provide inadequate time to address the issues raised. Single presentation programs, such as videos depicting suicide can also be potentially harmful as they can cause distress or potentially motivate imitation behavior.¹²⁹

One stakeholder reported that San Diego City Schools had already seen a preschooler and a fifth grader attempt suicide.

-Stakeholder report

Given these results, experts recommend screening for those at-risk rather than universal approaches targeted at all students. In addition, programs that are integrated into “broader health promotion programs . . . directed at preventing other self-destructive behaviors, such as alcohol and substance abuse” are recommended.¹³⁰

One stakeholder described the positive outcomes generated from a school-based program, noting that when teens are assessed, offered appropriate intervention and long-term care, they return to school much better. There is an improvement in affect, grades, and attendance. She estimated that 95% of students who get real help and ongoing care improve and return to a high quality of life. She concluded: “The key is addressing the underlying mental health issues.”

¹²⁹ Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, Board on Neuroscience and Behavioral Health. *Reducing Suicide: A National Imperative*. Ed. SK Goldsmith, TC Pellmar, AM Kleinman, WE Bunney. Washington, D.C.: The National Academies Press: 2002.

¹³⁰ Ibid

Best Practices for School-based Programs	Existing San Diego School-based Programs Approaches
<p>Best practices include:</p> <ul style="list-style-type: none"> ▪ Long-term interventions ▪ Targeted to those most at-risk ▪ Integrated into broader health promotion programs such as substance abuse prevention 	<p>The Suicide Prevention Education and Awareness Program (SPEAK) is offered through the San Diego Unified School District (approximately 75 schools) and is focused on suicide prevention. Training and education is provided for faculty, staff and parents, as well as through student assemblies. Specialty teams are created on each campus.</p>
	<p>Yellow Ribbon Suicide Prevention Program® is a community-based program primarily developed to address youth/teen/young adult suicide (ages 10-25) through public awareness campaigns, education and training and by helping communities build capacity. The program helps reduce stigma associated with asking for help and strengthens the link between young people and professional help.</p>
	<p>A “socio-emotional curriculum” for elementary and middle schools that teaches skills to manage one’s own mental health challenges, enable children to learn how to cope better, be at reduced risk, and understand depression and suicide better when they are later caring for older adults and much later, becoming older adults themselves.</p>

Crisis Management and Response

These interventions include strategies to respond to a crisis situation such as someone who is actively suicidal and provide immediate assistance to prevent the suicide get them into immediate treatment. Best practices regarding this level of intervention was not found in the literature. Stakeholders shared that there is a lack of standardized requirements for crisis intervention training.

What Providers Said is Available in San Diego

- Psychiatric Mobile Response Team (PERT): pairs a San Diego Police Department officer who has undergone special training with a mental health clinician to respond on-scene to situations involving people who are experiencing a mental health related crisis and have come to the attention of law enforcement. The goal is to provide the most clinically appropriate resolution to the crisis by linking people to the least restrictive level of care that is appropriate and to help prevent the unnecessary incarceration or hospitalization of those seen.
- Law enforcement responds to suicides in progress that impact public safety with negotiation teams. One stakeholder praised the Sheriff’s Department for doing an excellent job with crisis response and management. Most crises are resolved with the positive outcome of preventing a suicide. Good communication among law enforcement personnel who work in crisis across the area exists.
- Post-crisis support: Negative outcome situations (death) entail extensive post-event debriefing with outside negotiators or mental health professionals, The Sheriff’s Department’s legal team and crisis staff meet to look at what could have been done differently, how to learn from the event and possible exposure to liability. Lawsuits are an issue so protocols are followed closely.

Barriers to Services

Stakeholders were asked to share their views on barriers to suicide prevention services. The most prominent barriers were around stigma, lack of available services and staffing issues. These issues are connected to the factors that increase suicide risk, such as stigma, isolation, and undiagnosed mental illness.

- **Stigma:** Simply talking about suicide decreases stigma. Stakeholders reported that some people may feel that “depression is a sign of weakness,” it creates shame and they don’t seek help.

Chemical dependency/addiction and suicide continue to be topics that carry a lot of stigma. The combination is even worse. During assessments providers should be trained to approach suicidal issues with clients in a sensitive manner. General shame prevents people from talking about these issues so many are afraid to ask for help.

- **Lack of available/appropriate services:** Budget cuts and the financial crisis have led to further reductions in services. As one stakeholder commented, *“When you cut mental health funds, more people will end up hurting themselves and others.”* Programs are being cut that are critically important for people who are already at higher risk, including school-based programs and support services for low income populations. County Mental Health Services have been reduced; one stakeholder was disturbed about what options are left for teens at risk, saying: “What will we do now?” Most available resources are for loss after suicide and there are fewer resources for those at risk and those who attempted. There used to be a “crisis line” that offered counseling at the time of the call. It no longer exists and the available crisis line only offers counseling if the person indicates serious threat to self and mainly makes referrals. Youth are not adults and do not have as many options for treatment or long-term care. Stakeholders shared that often it seems like Emergency Departments don’t know what to do with teens.
- **Insufficient follow-up care:** It has been documented that people who have been hospitalized and then released have an increased suicide risk after discharge. Additionally, the wait time for mental health services can be very long. For example, stakeholders shared that some teens cannot access services because their family is undocumented and has no insurance/limited access to healthcare. Some go to places like community clinics for walk-in care but no long-term mental health options exist for them. Also, teens don’t seek assistance or talk to the nurse or counselors because they are afraid of the increased scrutiny of the family.

“... sometimes [clients] would be on the waiting list so long that by the time [we] called them they would be like, ‘I didn’t ask for anything.’ They didn’t even remember.”

– Focus group participant

“We’ve also found that there aren’t enough services available. I struggle between how do you outreach when you say hours have been cut from these programs? A lot of these programs are seeing crisis. They’re doing intervention at a point when a person is at their wits end whereas the population that we see more or generally may have mental health issues but they’re not at crisis. They could use a support group or even materials that speak to them specifically. We can’t refer them always to websites because not all of them are computer savvy or even have access to computers. I think it’s that balance of linking that client but if that service is not available we really need something for them.”

– Focus group participant

- **Limited access to services.** Many clients cannot afford fees and without insurance they cannot pay. This includes Community College students, who cannot afford services and are often uninsured. Transportation issues were mentioned often: it is difficult to access public transport when depressed or anxious. Foster parents may be unwilling to drive child to treatment. Additionally, clients often have no childcare, particularly single parents.
- **Staffing Issues:** Many stakeholders felt that general health providers are overburdened, due to budget cuts and other restraints, and are therefore less likely to ask about mental health problems. They are disinclined to ask about suicide and mental health issues because a “yes” response takes more time than they have. One stakeholder, a school nurse, reported working with 2,300 students. When one student has a crisis, there is no one to see the other students.

Language and Culture Barriers

- Many therapists don’t have language skills that are advanced enough for them to work with non-English speaking clients.
- There are limited resources for people who speak languages other than English, especially youth.
- The history of distrust makes it challenging for law enforcement to work with the Native American population.

Lack of Community Awareness

- People do not know about what services are available to them when they are having an issue. Everyone should know “*where to go, how to go, and that it’s ok to go*” for help.
- The general community tends to ignore depression in older adults because it believes “of course she wants to die, she’s old and sick” so help is not accessed.

System Issues

- Public Health vs. Behavioral Health: *“One of the biggest barriers from my perspective is that the issues of prevention should really be addressed within the public health department. That is where the prevention efforts should take place. They are the ones that need to be at the table. [...] The issues that we were raising when it came down to it did not meet the standards for treatment that the behavioral health department has. Their mandate is to provide treatment and not prevention.”*
- Healthcare: Clients do not always get referrals through their primary medical care providers. Reasons cited were that medical providers are not comfortable with mental health issues, are not trained, not paying attention, and/or are overburdened.
- Parental consent: Contradictions exist within the system of parental consent. Students with complaints related to social-emotional issues cannot get help without parental consent because the provider may not be a district employee. Conversely, if a student has a serious mental health or substance use problem, providers can only work directly with the student. They have no authority to contact a parent.
- Health Insurance: Medicare continues to reduce reimbursement rates for mental health professionals, hence fewer providers offer services. Insurance companies are reducing reimbursement.
- Foster care system: Foster parents are not included in the therapy experiences with the foster child. These families/parents may not be aware of all the issues surrounding the child who is referred into care by the social worker.

Summary

System-level data shows that there are several existing supports such as a wide variety of provider training and many existing services that are based on best-practices. In addition, several barriers to services and opportunities for improved services were identified by stakeholders and community members. The data presented here highlights opportunities to build upon the existing system and further enhance collaboration between agencies, increase referrals to needed services, and modify programs to include best practices. Key factors to be explored during the action planning process include:

- + **Provider Training.** It is clear that many providers value training and show a high level of basic knowledge regarding suicide. While training does take place, it is often not specific to suicide prevention and is not required as part of County funding. Providers who work with clients who exhibit suicide-related risk factors have a higher level of knowledge than those who do not, implying that targeted training to those who might be the first to interact with a client, is needed.
- + **Collaboration and Coordination:** It is clear that most providers are aware of the key players currently providing suicide prevention services but more can be done to enhance the level of collaboration. Leveraging resources and identifying opportunities to further coordinate services can increase the capacity of the system to identify and serve those in need.
- + **Existing services.** There is a wide range of existing services regarding suicide prevention in San Diego County. Many are comparable to best practices. The full inventory of services will help promote awareness of existing services among the various providers as well as identify gaps to be addressed in the action planning process.
- + **Integrated approaches.** Much attention is being focused on national as well as local level to programs that integrate primary healthcare with behavioral health. Increasing these programs in San Diego might help identify those most at-risk for suicide and connect them to services. In addition, programs that fold issues related to suicide into broader health topics such as substance use or into social support programs can make a big impact.

Discussion of Findings

This report summarizes current statistics about suicide and self-injury throughout San Diego County in order to identify those groups most at-risk. Best practice literature helps create a framework of what is possible and provides inspiration for future efforts throughout the County. Key stakeholders and community members provided insight based on their experiences to further identify service gaps and barriers as well as made recommendations on how services can be improved.

The existing data on suicide and self-injury shows that in San Diego County, women have the highest rate of suicide *attempts* while men have the highest rate of suicide *completions*. Additionally, youth have the highest rate of self-injury while older adults have the highest suicide rate. Among all groups, substance use plays a major role in intentional injury and suicide. While suicide rates within many communities have decreased over recent years, rates still remain high and in many cases above State and National Averages, highlighting the importance of targeted approaches to address individual community needs.

System-level data collection shows that there are many important suicide prevention efforts currently underway in San Diego County. Providers have a high level of knowledge regarding suicide risk factors but there are opportunities for targeted training, especially in improving providers' confidence to address the needs of someone who exhibits these risk factors. In addition, there are opportunities for improved coordination and collaboration between service providers.

The primary data collected from providers, stakeholders and community members for this report is a snapshot of how suicide impacts various communities throughout San Diego County. While not a complete inventory of all services and gaps, it provides key insight into what is working and opportunities for improvement. Recommendations for further study include:

- **Conduct a thorough inventory of available services.** The Community Provider survey collected valuable service information from 161 individuals. Expanding this information can not only help identify further system gaps and supports but also provide an in-depth resource guide for providers to use when referring clients to services.
- **Expand the Community Voice:** The community focus group process was limited in that it allowed for one focus group within each target community. However, as identified in this report, each community is diverse and the individual needs of each group may not have been fully captured.
- **Identify Opportunities to Demonstrate Success.** As suicide prevention strategies are implemented throughout the county, it is important that indicators of success be identified and tracked so that the outcome of these efforts can be documented. This will provide important information so that mid-course corrections can be made in order to maximize impact.

This needs assessment report lays the foundation for the Suicide Prevention Action Planning Process for San Diego County. It is expected that the information collected through this process with help to identify strategic changes that can be implemented in order to successfully prevent suicides throughout the county.

Appendix A: Suicide Prevention Online Resources

1. [American Association of Suicidology: Survivors of Suicide Fact Sheet \(2007\)](#)
2. [American Association of Suicidology: Youth Suicide Fact Sheet \(2008\)](#)
3. [CDC: Youth Risk Behavioral Surveillance – United States, 2009](#)
4. [CDC-Injury Center: Youth Suicide \(2008\)](#)
5. [CDMH: California Strategic Plan on Suicide Prevention](#)
6. [CHIP Report- Suicide in San Diego County: 1998-2007](#)
7. [County of San Diego- HHSA: San Diego County Profile by Region](#)
8. [Office of Minority Health: Suicide and Suicide Prevention 101 \(2008\).](#)
9. [U.S. Census Bureau: Census 2010](#)

Appendix B: Data Collection Tools

A mixed methods approach of collecting quantitative and qualitative data was utilized to conduct the CHIP 2010 Comprehensive Needs Assessment at both the County and Community level. All tools were developed with input from CHIP, the SPAPC co-chairs and approved by the County prior to their release. A copy of each tool can be found below.

The following tools are included in this Appendix:

- Training Survey
- Interview Protocol: Prevention and Early Intervention (PEI) Contractors
- Focus Group Protocol: Health Promotion Specialist
- Community Provider Survey
- Interview Protocol: Community Stakeholder
- Focus Group Protocol: Asian Pacific Islander (API)
- Focus Group Protocol: Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) Youth
- Focus Group Protocol: Older Adults
- Interview Protocol: Survivors of Suicide Attempts
- Focus Group Protocol: Survivors of Suicide Loss

Training Assessment Survey (Part of larger training survey)

The purpose of these questions is to inform County Mental Health about suicide prevention training.

Your responses to this survey are completely confidential; your name or organization will not be linked to the information you provide.

1. According to the research literature, which of the following factors are associated with increased suicide risk? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Prestigious/wealthy family background | <input type="checkbox"/> Native American ethnicity |
| <input type="checkbox"/> Gay or lesbian sexual orientation | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Break up of important peer relationship |
| <input type="checkbox"/> Family discord and turmoil | <input type="checkbox"/> History of suicide attempts |
| <input type="checkbox"/> Permissive parents | <input type="checkbox"/> Depressive or other psychiatric disorder |
| <input type="checkbox"/> Victim of physical or sexual abuse in childhood | <input type="checkbox"/> Large family |
| <input type="checkbox"/> Recent disciplinary crisis resulting in humiliation | <input type="checkbox"/> Caucasian |

2. Please mark whether the following statements are true or false:

	True	False
a. People who talk about suicide rarely attempt suicide. (F)	<input type="checkbox"/>	<input type="checkbox"/>
b. The tendency toward suicide is not genetically (i.e., biologically) inherited and passed on from one generation to another. (T)	<input type="checkbox"/>	<input type="checkbox"/>
c. A person who is suicidal neither wants to die nor is fully intent on dying. (T)	<input type="checkbox"/>	<input type="checkbox"/>
d. Most people who die by suicide have a diagnosable mental illness at the time of their death. (T)	<input type="checkbox"/>	<input type="checkbox"/>
e. If you ask someone directly "Do you feel like killing yourself?" it will likely lead that person to make a suicide attempt. (F)	<input type="checkbox"/>	<input type="checkbox"/>
f. There is a strong link between drug/alcohol use and suicide ideation. (T)	<input type="checkbox"/>	<input type="checkbox"/>
g. Suicide rarely happens without warning. (T)	<input type="checkbox"/>	<input type="checkbox"/>
h. A time of high suicide risk in depression is at the time when the person begins to improve. (T)	<input type="checkbox"/>	<input type="checkbox"/>
i. Once a person has made up their mind to kill him/herself, nothing can be done to stop them. (F)	<input type="checkbox"/>	<input type="checkbox"/>
k. A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted. (T)	<input type="checkbox"/>	<input type="checkbox"/>
l. Suicide is among the top 10 causes of death in the U.S. (T)	<input type="checkbox"/>	<input type="checkbox"/>

3. Approximately what percentage of your current clients exhibit one or more factors that make them more likely to attempt suicide?

☐ 0% ☐ Less than 10% ☐ 10-20% ☐ 21-50% ☐ 51-75% ☐ 76-90% ☐ More than 90% ☐

I do not provide direct service

4. Have you ever assessed the risk of a suicidal client? ☐ Yes ☐ No

4a. If yes- how many clients have you assessed for suicide in the past year?

☐ 1-5 ☐ 6-10 ☐ 11 or more

5. Have you ever been called upon to help a client who is suicidal?

☐ Yes ☐ No

6. How confident are you in your ability to:	Very Confident	Somewhat Confident	Not very Confident	Not at All Confident
a. Recognize suicide risk factors in clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Complete a suicide risk assessment with a client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Provide a direct intervention to a client exhibiting risk factors for suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Refer clients showing signs of suicidality to support services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Talk to clients/patients about suicide risk factors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Integrate culturally responsive intervention strategies in suicide prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Does your organization have a suicide risk assessment protocol or procedure?

☐ Yes ☐ No

If YES -

7a. How useful is the suicide risk assessment protocol or procedure?

☐ Very Useful ☐ Somewhat Useful ☐ Not Very Useful ☐ Not at all Useful

7b. Do you need more training on how to implement the protocol with your clients?

☐ Yes ☐ No

8. Have you ever attended training on the topic of suicide, suicidality or suicide prevention?

☐ Yes ☐ No

If YES:

8a. How long ago was the training on suicide, suicidality or suicide prevention?

☐ Less than one year ago ☐ 1-4 years ☐ 5-9 years ☐ 10 or more years

8b. Was the training on suicide, suicidality or suicide prevention provided by the County of San Diego or a County training contractor?

☐ Yes ☐ No ☐ Unsure

If NO or Unsure:

8c. Please indicate the trainer or training title: _____

9. Have you ever attended training on suicide risk assessment?

☐ Yes ☐ No

If YES:

9a. How long ago was the training on suicide risk assessment?

☐ Less than one year ago ☐ 1-4 years ☐ 5-9 years ☐ 10 or more years

9b. Was the training on suicide risk assessment provided by the County of San Diego or a County training contractor?

☐ Yes ☐ No ☐ Unsure

If NO or Unsure:

9c. Please indicate the trainer or training title: _____

10. Have you ever attended training on intervention for a client threatening suicide?

☐ Yes ☐ No

If YES:

10a. How long ago was the training on intervention for a client threatening suicide?

☐ Less than one year ago ☐ 1-4 years ☐ 5-9 years ☐ 10 or more years

10b. Was the training on intervention for a client threatening suicide provided by the County of San Diego or a County training contractor?

☐ Yes ☐ No ☐ Unsure

If NO or Unsure:

10c. Please indicate the trainer or training title: _____

11. Is suicide prevention adequately integrated into other training you receive?

☐ Yes ☐ No

12. For each of the following topics, please let us know if you would be interested in receiving more information (please mark all that apply)

	Suicide risk information and statistics	Suicide Prevention Strategies and Interventions
a. Children under 18		
b. Transitional Age Youth (TAY) ages 18-24		
c. Adults – ages 25-59		
d. Older Adults – ages 60+		
e. Severally and Persistently Mentally Ill		
f. Child Welfare Service (CWS) involved parents		
g. Latino		
h. Asian/Pacific Islander		
i. Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)		

Thank you for completing this survey. This information will be used to put together guidelines and a plan for future trainings.

Interview Protocol: Prevention and Early Intervention (PEI) Contractors

Hello, my name is _____ and with me today is _____ and we are with Harder+Company Community Research. As you may know, we have been hired by Community Health Improvement Partners (CHIP) to assist them in the development of a comprehensive Suicide Prevention Action Plan. Part of the development of the plan is the completion of a Needs Assessment. The purpose of the Needs Assessment is to assess existing San Diego County suicide prevention services and supports as well as identify gaps in suicide prevention training among professional staff and contractors.

The purpose of this focus group is to provide CHIP with information about services you provide regarding suicide prevention and intervention, training provided by your organization as well as training available to you as a contractor for the County of San Diego. Your answers will be kept confidential and will only be used to provide collective feedback to CHIP.

Do you have any additional questions before I begin?

We would like to start by getting to know a little bit more about you and would like you to share with us your name, the agency with which you work as a Health Promotion Specialist and how many years experience you have in the field.

The last time that I was here, we had the opportunity to start a conversation about the clients that you are seeing on a daily basis at your different community locations.

1. Can you tell me about the community location where you provide services? (Probe: home visits, schools, resource centers)
2. Referring to the funding provided for PEI (Health Promotion), what are the primary services you offer?
 - a. What is the identified target population(s)?
 - b. Where are you receiving referrals from? *(Identify County agencies, non-profits, community partners – try and get specific names if possible)*
 - c. What areas of the County do you serve?
3. Are you finding that you have the information you need in order to provide suicide prevention services to the clients that you are seeing? What do you find are the primary needs of these clients?
 - a. If NOT, what do you think would help you in meeting these needs?

You had also mentioned at the last meeting that the type of cases you were working with seemed more intense and/or severe than in the past.

4. What makes these cases “more severe”? What are the circumstances that you think are contributing to this increased severity? (Probe: Are the more depressed? More at-risk? More financial crisis?)
5. Is there anything that would make you feel more confident in your ability to help these families/clients?
6. Are your clients facing barriers when trying to receive suicide prevention or intervention services?
 - a. If yes, what are these barriers? What can be done to overcome these barriers? (Probe: cultural considerations, stigma)

Training

Now as you know, CHIP is particularly interested in learning more about trainings available to service providers in San Diego County specifically regarding suicide – this may be suicidality in general, suicide prevention, or mental health treatment of suicidal behaviors.

The next set of questions is focused specifically on training provided by *YOUR ORGANIZATION*.

7. What kind of training, if any, does your organization provide to staff members regarding suicide? Again this may be suicidality in general, suicide prevention or mental health treatment of suicidal behaviors.
 - a. *Follow-up/Probe:* Are these training required of all staff? Are they provided in a group setting/individually? (If not required of all staff, what additional staff should be included in these trainings?)
 - b. How frequently are these trainings provided? About how many people participate in this training?
8. What recommendation/s would you make regarding training that might be offered internally to your organization’s staff?

Now we are going to talk a little more broadly, about training provided by San Diego County to contractors.

9. What kind of training does the County of San Diego make available to you as contractors regarding suicide? Again this may be suicidality in general, suicide prevention or mental health treatment of suicidal behaviors.
 - a. *Follow-up/Probe:* Are these training required of you as contractors? Are they provided in a group setting/individually?
 - b. How frequently are these trainings provided? About how many people participate in this training?
10. If there are trainings provided by the County that are available to you, do you find that these trainings are accessible to you as a service provider?

- a. If YES, can you please identify some of the ways that the County has made these trainings accessible?
 - b. If NO, can you please identify some of the issues/barriers that make the training not readily accessible to you as a service provider? What would you recommend be added/modified to make training more accessible?
11. If you have attended a suicide related training, what has been the most valuable thing you have gained from the suicide related trainings provided by your organization? From the County?
12. If you had the chance to improve training for service providers working with clients in the areas of suicide prevention and early intervention, what would you recommend be modified? What would you like to see added? Who would you like to see provide the training?
13. In your experience, who is currently most involved in impacting suicide prevention education and information in the County of San Diego? (Probe for stakeholder types?)

Who do you think is missing from the table in conversations regarding suicide prevention and education?

Focus Group Protocol: Health Promotion Specialists

Hello, my name is _____ and I work at a research organization called Harder+Company Community Research. I will be the facilitator for today's focus group. This is _____ and s/he also works with me at Harder+Company. We are here today because we are working with an organization named Community Health Improvement Partners (CHIP). They have asked us to talk to people in the community about what they know about services in San Diego that help people who may be struggling with depression or suicidal thoughts or behaviors.

*The focus of our conversation today will be to learn more about the services you provide as **promotoras** and your experiences in helping community members link to services when they may be struggling with depression or suicidal thoughts.*

Your participation in today's focus group is voluntary. Additionally, the information you share with us will be confidential. We will only report what you say to us a group and won't use your name but say something like "service providers stated." No names or identifying information will be shared.

Your time and input is really valuable; thank you for sharing it with us.

If it is alright with everyone, we would like to record the conversation. We want to be sure we note down everything you say and that we get it right! Like we said before, we won't use the information to link your name to your comments. Is that ok, or does anyone object?

Before we get started I'd like to suggest some guidelines for our conversation today:

- *There are no right or wrong answers.*
- *Everyone has an equal chance to speak.*
- *Every opinion counts – we are going to respect what everyone says.*
- *Please do not interrupt one another. It is important that you speak one at a time since _____ is going to be taking notes and that is impossible if we're talking all at once!*
- *What's said here stays here.*
- *What's said here does not affect your relationship with CHIP or the County of San Diego.*

How do those guidelines sound to everyone? Can we agree to those for today?

Do you have any additional questions before I begin?

We would like to start by getting to know a little bit more about you and would like you to share with us your name, and how many years experience you have as a *promotora*.

[Collect names and assign ID #]

We'd like to start today by learning more about what you do as promotoras in the Chula Vista community.

1. Can you talk a little about the kinds of services you provide as a *promotora*?
 - a. What is the identified target population(s) for these services?
2. Can you tell me about the location where you provide these services? (*Probe: home visits, schools, resource centers*)
 - b. How do community members hear about the services you provide?
3. How frequently do you work with a family or client struggling with depression? With thoughts of suicide?
 - c. What services are provided for clients struggling with depression? With thoughts of suicide?
4. For those of you who work with people who are struggling with depression or thoughts of suicide, do you find that you have the information you need in order to help these clients?
 - d. If YES, what kinds of information has helped you feel prepared?
 - e. If NOT, what do you think would help you in meeting these needs?
5. What types of services do you think need to exist or be provided in order to address the needs of people struggling with depression or suicidal thoughts?
 - f. Do you feel that these services exist in San Diego County now?
 - i. If yes, who provides them?
 - ii. If no, why do you think they are not in SD County?
 - g. Do you feel that there are enough of these services are available when people need them? Do you think that these services are accessible to people meaning that people can get to them easily?
6. Are your clients facing barriers when trying to receive suicide prevention or intervention services?
 - h. If yes, what are these barriers? What can be done to overcome these barriers?
(*Probe: cultural considerations, stigma*)

Now we would like to talk more generally about efforts to improve services for clients.

7. Now thinking more overall, what would you want people who provide services to know about helping Latinos who are struggling with depression and/or suicidal thoughts? Is this different for Latinos? Latino youth?

8. In your experience, who is currently most involved in impacting suicide prevention education and information in the County of San Diego? (Probe for stakeholder types?)
9. Who do you think is missing from the table in conversations regarding suicide prevention and education?

Community Provider Survey

The County of San Diego Mental Health Services has contracted with Community Health Improvement Partners (CHIP) to develop a Suicide Prevention Action Plan. As part of this process, CHIP is conducting a Needs Assessment to understand what services and supports exist and what is needed for providers, community members, and those at risk for suicide.

The purpose of this survey is to gather information relevant to suicide prevention from community organizations throughout San Diego, and to assess the extent agencies collaborate with other agencies involved with suicide prevention.

In addition to completing the survey, we ask that you would forward it to up to 3 members of your line staff. All who complete the survey will be entered in a drawing to receive a \$50 Visa gift card.

Your participation is voluntary and there is no penalty or risk to you if you decide not to participate or decide not to answer a given question. Your individual responses to the survey questions will be kept confidential. Please note that Question 18 measures the level of collaboration between agencies so your organization's connection to other agencies will be reported but you will not be identified as the person who completed the survey for your agency.

When you have completed the survey, you can enter a drawing to win a \$50 Visa gift card by providing your name and address. You may also enter your contact information to be included in follow up efforts to collect additional information. Your entry is confidential and after the drawing and follow up interviews, we will delete your name and address and keep no record of it.

The survey takes 10-15 minutes to complete.

If you have questions about this survey, please contact Allison Wolpoff, Harder+Company Community Research, awolpoff@harderco.com or (619) 398-1980.

Thank you for participating in this important survey.

SECTION 1: AGENCY BACKGROUND

The first set of questions asks about you and your agency.

1. Which of the following categories best describes your agency? (Please check all that apply)

- ☐ Government/Public Entity
- ☐ Community organization
- ☐ Funder/Foundation
- ☐ Nonprofit organization
- ☐ Social enterprise
- ☐ Nonprofit consultant
- ☐ Other → please specify: _____

2. Is your agency and/or program listed with the Access and Crisis Line?

- ☐ Yes
- ☐ No
- ☐ Don't know

3. Is your agency and/or organization listed with 2-1-1 San Diego?

- ☐ Yes
- ☐ No
- ☐ Don't know

4. Who should Access and Crisis or 211 contact to update your agency's information?

Name:

Title:

Telephone Number:

Email Address:

5. What is your current role in your organization?

- ☐ Director
- ☐ Manager
- ☐ Administrative
- ☐ Direct Service
- ☐ Other (please specify)

6. How many years have you been in your current role?

- ☐ Less than one year
- ☐ 1-5 years
- ☐ 6-10 years
- ☐ More than 10 years

7. What client population(s) does your agency serve? (Please check all that apply)

- ☐ Children under 18
- ☐ Transitional Age Youth (TAY) (ages 16-24)
- ☐ Adults – ages 25-59
- ☐ Older Adults – ages 60+
- ☐ Severely and Persistently Mentally Ill
- ☐ Child Welfare Service (CWS) involved families
- ☐ Lesbian, Gay, Bisexual, Transgendered Questioning (LGBTQ)
- ☐ Latino
- ☐ Native American
- ☐ Asian/Pacific Islander
- ☐ African American
- ☐ White
- ☐ Other (please specify) _____

8. Does your organization keep or track any data related to suicide or suicidal behavior for the target population(s) you serve?
- ☐ Yes
 - ☐ No
 - ☐ Don't know
9. Where in San Diego County does your agency have local offices? (Please check all that apply)
- ☐ East
 - ☐ South
 - ☐ Central
 - ☐ North Central
 - ☐ North Coastal
 - ☐ North Inland
10. Where in San Diego County does your agency offer services? (Please check all that apply)
- ☐ East
 - ☐ South
 - ☐ Central
 - ☐ North Central
 - ☐ North Coastal
 - ☐ North Inland

SECTION 2: PRIMARY SERVICE INFORMATION

11. Which of the following services does your agency provide (Please check all that apply)
- | | |
|--|--|
| <input type="checkbox"/> Education | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Crisis Services | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Peer Support | <input type="checkbox"/> Substance Abuse Treatment |
| <input type="checkbox"/> Primary Health Care | <input type="checkbox"/> Public Safety |
| <input type="checkbox"/> Outreach | <input type="checkbox"/> Advocacy |

☐ Other (please specify) _____

12. Please provide a brief description of your services.

13. **Approximately** how many clients do you serve annually?

- ☐ 0-99
- ☐ 100-999
- ☐ 1000-4999
- ☐ 5000-9999
- ☐ 10,000+

**SECTION 3: UNDERSTANDING OF SUICIDE RISK FACTORS, ATTITUDES AND CONFIDENCE
REGARDING SUICIDE PREVENTION**

14. Do you work for the County of San Diego or does your agency receive funding from the County of San Diego to provide behavioral health services?

- ☐ Yes (skip to Q18)
- ☐ No (proceed to Q15)

15. According to the research literature, which of the following factors are associated with increased suicide risk? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Prestigious/wealthy family background | <input type="checkbox"/> Native American ethnicity |
| <input type="checkbox"/> Gay or lesbian sexual orientation | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Break up of important peer relationship |
| <input type="checkbox"/> Family discord and turmoil | <input type="checkbox"/> History of suicide attempts |
| <input type="checkbox"/> Permissive parents | <input type="checkbox"/> Depressive or other psychiatric disorder |
| <input type="checkbox"/> Victim of physical or sexual abuse in childhood | <input type="checkbox"/> Large family |
| <input type="checkbox"/> Recent disciplinary crisis resulting in humiliation | <input type="checkbox"/> Caucasian |

16. Please mark whether the following statements are true or false:

	True	False
a. People who talk about suicide rarely attempt suicide. (F)	<input type="checkbox"/>	<input type="checkbox"/>
b. The tendency toward suicide is not genetically (i.e., biologically) inherited and passed on from one generation to another. (T)	<input type="checkbox"/>	<input type="checkbox"/>
c. A person who is suicidal neither wants to die nor is fully intent on dying. (T)	<input type="checkbox"/>	<input type="checkbox"/>
d. Most people who die by suicide have a diagnosable mental illness at the time of their death. (T)	<input type="checkbox"/>	<input type="checkbox"/>
e. If you ask someone directly "Do you feel like killing yourself?" it will likely lead that person to make a suicide attempt. (F)	<input type="checkbox"/>	<input type="checkbox"/>
f. There is a strong link between drug/alcohol use and suicide ideation. (T)	<input type="checkbox"/>	<input type="checkbox"/>
g. Suicide rarely happens without warning. (T)	<input type="checkbox"/>	<input type="checkbox"/>
h. A time of high suicide risk in depression is at the time when the person begins to improve. (T)	<input type="checkbox"/>	<input type="checkbox"/>
i. Once a person has made up their mind to kill him/herself, nothing can be done to stop them. (F)	<input type="checkbox"/>	<input type="checkbox"/>
k. A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted. (T)	<input type="checkbox"/>	<input type="checkbox"/>
l. Suicide is among the top 10 causes of death in the U.S. (T)	<input type="checkbox"/>	<input type="checkbox"/>

17. How confident are you in your ability to:	Very Confident	Somewhat Confident	Not very Confident	Not at All Confident
a. Recognize suicide risk factors in clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Complete a suicide risk assessment with a client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Provide a direct intervention to a client exhibiting risk factors for suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Refer clients showing signs of suicidality to support services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Talk to clients/patients about suicide risk factors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Integrate culturally responsive intervention strategies in suicide prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 4: INTERACTIONS WITH OTHER AGENCIES THAT PROVIDE SUICIDE PREVENTION SERVICES

The next set of questions asks about your experience interacting with agencies and programs in San Diego that provide suicide prevention services. This is not an exhaustive list of all providers in San Diego County but rather a concise list of organizations that are funded the County of San Diego to provide suicide prevention services or agencies whose core mission/service area is suicide prevention.

18. Using the scale below, please choose the ONE level of interaction that best describes how your agency currently interacts with each of the following agencies. If it is your agency, please leave the line blank.

	No Interaction 0	Networking 1	Cooperation 2	Coordination 3	Collaboration 4
Agency	-not aware of this organization, OR -not currently involved in any way, either formally or informally	-aware of organization -loosely defined roles -little communication -no shared decision making	-provide information to each other -somewhat defined roles -formal communication -no shared decision making	-share information -defined roles -frequent communication -some shared decision making	-share ideas -share resources -frequent and prioritized communication -decisions are made collaboratively
San Diego County Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Health Improvement Partners (CHIP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
San Diego County Alcohol and Drug Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Systems, Inc.: Courage to Call	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optum Healthcare: Access & Crisis Line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
San Diego Unified School District: Suicide Prevention Education Awareness and Knowledge (SPEAK)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Union of Pan Asian Communities: Positive Solutions Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health Education and Training Academy (BHETA): Aging Well Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
UC San Diego: Bridge to Recovery Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
County Health and Human Services Agency (HHSA): Health Promotion Specialists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indian Health Council: Collaborative Native American Initiative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Research Foundation: Psychiatric Emergency Response Team (PERT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Survivors of Suicide Loss (SOSL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yellow Ribbon Suicide Prevention Program, San Diego Chapter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Trevor Project, San Diego Chapter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providence Community Services: Kick Start	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
San Diego County Office of Education (SDCOE): Safe Schools Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. We will be conducting several follow-up interviews to obtain more in-depth information.
Are you interested to participate in a 20-30 minute follow-up interview?

☐ Yes

☐ No

Thank you for completing this survey!

20. Would you like your name to be entered into the drawing to win a \$50 VISA gift card?

☐ Yes

☐ No

Please provide your contact information below. This information is collected so we can follow up with you (if you agreed) and so that we can enter you in the drawing for the Visa gift card. It will not be used in reporting results.

Your Name*:

Your Email Address*:

Your Position/Title*:

Your Agency:

Your

Program/Department:*

Interview Protocol: Community Stakeholders

Hello, my name is _____ and I am with Harder+Company Community Research. We have been hired by Community Health Improvement Partners (CHIP) to assist them in the development of a comprehensive Suicide Prevention Action Plan. Part of the development of the plan is the completion of a Needs Assessment. The purpose of the Needs Assessment is to assess existing San Diego County suicide prevention services and supports as well as identify gaps in suicide prevention training among professional staff and contractors.

We are interested in speaking to you today about suicide prevention in San Diego County. This includes services related to prevention and intervention for all of the various signs and symptoms related to suicide risk.

Everything you say today is completely confidential; your name will not be attached to what you say and will not be reported in a way that could identify you or your individual program. We will be writing up a summary for CHIP of all the responses we receive. With this in mind, we encourage you to be open and honest today.

Your time and input is very valuable; thank you for sharing it with us. We anticipate that this interview may take approximately 30 minutes.

If it is alright with you if I type notes while we talk? I want to be sure to note down everything you say and that I get it right! If I don't capture something that you say, I may ask you to repeat or clarify just so that I capture everything accurately.

Finally, before we get started, do you have any questions?

Agency Background

Note to interviewer: Please review answers from Community Survey prior to interview. Questions 1 and 2 will only be asked to clarify responses.

1. What are the primary services your organization offers? What is your role at your organization?
2. What target populations does your agency serve? (CHIP identified target populations include API, Latino, LGBTQ, Older Adults, TAY, Survivors of Suicide Attempts)
 - i. For providers who work with all populations: Is there a higher representation of certain group (see list above) among your service population?
3. On a scale of 1 to 10 with 1 being not at all a priority and 10 being the highest priority, how important is suicide prevention in the work that you do? Why?
 - j. Could you briefly explain how you are involved with suicide prevention? [PROBE: Which agencies are you affiliated with? How are you involved with these agencies? How are you involved in mental health services in general?]
Note: Can ask about individual experience as well as agency's role in suicide prevention.

4. To what extent would you say that suicidality is an issue for the clients in the target population you serve?
 - k. In your experience working with [target population], would you say that the incidence of suicide is increasing or decreasing? What do you think is causing this change?
Note: focus on predominate target population for those who serve multiple groups.
 - l. For those working with multiple target groups, are the trends different among specific groups? Is suicide risk different among various groups with regard to age, ethnicity, geography, etc.?
5. Which agencies or providers currently act as key entry points to prevention services for your clients who may be at risk for suicide?
 - m. Which agencies or providers could be entry points for prevention services? Who else crosses paths with [target population]?
6. What do you see as the barriers to suicide prevention in San Diego County?
 - n. Are there specific challenges to suicide prevention among [target population]?
7. What are providers doing **right** in terms of meeting the suicide prevention needs of [target population]? PROBE: What improvements have you seen at your own agency? Are you aware of any local best practices or approaches that should be identified in moving forward?
8. What **opportunities exist for improvement** when it comes to meeting the suicide prevention needs of [target population]?
 - a. In your opinion, what would be the best way to make these improvements?
[PROBE: facilitation, technical assistance, external or internal support?]
9. How can agencies better collaborate to help meet the needs of clients in need of suicide prevention services? What strategies would you suggest to increase collaboration?
10. Do you have any experiences you would like to share, either challenges or successes, regarding suicide prevention, intervention, or postvention?
11. Is there anything else you would like to add related to suicide in San Diego County?

Thank you very much for sharing your time with us. We look forward to sharing the results of the needs assessment with you and your agency. Please feel free to contact Allison Wolpoff/Marianna Corona at Harder+Company 619.398.1980 if you have any additional questions about the interview.

[If people want additional information]

If you want additional information about the Suicide Prevention Action Plan Committee, you can contact Aron Fleck, Director of Programs at Community Health Improvement Partners (CHIP) at (858) 614-1558 or afleck@hasdic.org.

The next SPAP-C meeting will be held on Thursday, December 2nd 12:00 – 1:30 pm
Health Services Complex –Rosecrans, Coronado Room 3851 Rosecrans Street, San Diego, CA 92110.

We hope you can join us for the Suicide Prevention Forum where we will release the results of the Needs Assessment and obtain community feedback. The forum will be held on 1/20/11; we can send you details and sign-up information.

If you need suicide prevention services, you can contact 2-1-1 or the Access & Crisis Line: 1-800-479-3339

Focus Group Protocol: API (Filipino)

Hello, my name is _____ and I work at a research organization called Harder+Company Community Research. I will be the facilitator for today's focus group along with [Operation Samahan staff]. We are here today because we are working with an organization named Community Health Improvement Partners (CHIP). They have asked us to talk to people in the community about what they know about services in San Diego that help people who may be struggling with emotional health issues such as depression or suicidal thoughts or behaviors.

We need information from you to help understand what individuals from the Filipino community may need if they ever find themselves feeling depressed or suicidal. We also hope you will share your thoughts with us about how the county can do a better job of getting the message out about what services they offer so that it reaches those who need it most.

Before we begin, have any of you participated in a focus group?

A focus group is a group of people that get together to talk about their ideas on a specific topic. Everyone in the group is considered an expert because you are the ones that know the most about what you need and how to best get services.

For those of you who have not participated, there are a couple of guidelines that will help make the conversation easy for everyone to talk and share their thoughts and opinions.

Discussion Guidelines:

- Remember you are the expert! You are the most knowledgeable of what it's like to be someone of Filipino origin living in San Diego right now. That's why you have been chosen to participate today.
- There is no right or wrong answer, just your ideas. Please respect that others might disagree with you. It is perfectly fine to have a different opinion from others in the group, and you are encouraged to share your opinion even if it is different.
- Everyone should have an equal chance to speak, and no one should dominate the conversation. Please speak one at a time and do not interrupt anyone else.
- It's ok if you don't have an answer or opinion about a particular question. It is important for us to know that too. "I don't know" is an ok thing to say.
- Do not hesitate to ask questions if you are not sure what we mean by something.
- Because time is short and we have a lot of questions to get through, I may need to interrupt you to give everyone a chance to speak, or to get through all of the questions.
- Everything we discuss today is completely confidential. Our notetaker will be taking notes but it's only to make sure that we get your comments as accurate as possible. *ASK IF WE CAN RECORD AS WELL*

Your participation in today's focus group is voluntary which means you do not have to participate or answer any questions you do not feel like answering. The information you share with us will be confidential. We will only report what you say to us a group and won't use your name but say something like "one focus group member said." No names or identifying information will be shared. In addition, your participation will not affect you receiving services now or in the future.

We realize that the issues that we will talk about today may be sensitive and may create some strong emotional responses. *If you begin to feel uncomfortable please let me know or [Staff from Operatoin Samahan] to step into another room with you to address these emotions.* Also please remember that your participation is voluntary and you can skip a question at any time.

Does anybody have any questions before we begin?

Let's start by going around the room and introducing ourselves. Please tell us your first name, age and your favorite artist to listen to right now.

History

1. Can you tell me a little about how you got involved with Operation Samahan?
 - a. How did you hear about the organization?
 - b. About how long have you been receiving services here?

Next we would like to talk about how people from the Filipino community cope with emotional health concerns.

Personal Issues Encountered by Community

2. What types of issues do you or other people your age face regularly in life that make them feel stressed out, anxious, angry, depressed, or even suicidal? (Probe: issues around adapting/acculturating, health problems. family stress, economic burden)
3. Think about a regular day for you and for someone from your community. We want to know, who would be the first to notice if you or someone from your community were having emotional problems including feeling depressed or having suicidal thoughts or behaviors?
 - a. How would you or someone from your community be helped if they are having emotional problems?
4. How would individuals from your community respond if they were offered services to cope with emotional health problems? (What would be the best way to offer these services?)

Next, we'd like to ask what you think about services for individuals struggling with emotional problems like depression and suicidal thoughts/behaviors.

Services

Now I'd like to ask you about types of services or programs that could help individuals from your community that struggle with emotional concerns. I'm going to give you a few examples:

- + A support group where you can talk to people your age who are dealing with the same issue.

- + Training key members from your community on how to recognize early warning signs among their peers and how to help

- + A confidential "hotline"

- + Education to help community members know what services already exist and how to find those services

- + Talking one-on-one with a counselor

5. Now that I've given you that list, are there any other kinds of services that you think people from your community need if they are depressed or having suicidal thoughts? Remember, it doesn't do anybody any good if no one wants to use the service.

- a. Do you feel that these types of services exist in San Diego County right now?

- i. If yes, who provides them?

- ii. If no, why do you think they are not in SD County?

- b. Do you feel that enough of these services are available when people need them?

- c. Do you think it's easy for people to get the help they need? If not, why?

6. Where do you feel that services should take place?

- a. Where would you or your peers feel comfortable getting these kinds of services?

- b. What about schools, why or why not. (Also probe for other locations such as faith-based, medical, etc.)

7. Are there things that make it hard to get the services they need? (Probe: Barriers such as transportation, stigma, language, cultural practices, etc.)

8. What would people from your community need so they could feel comfortable asking for that help for emotional problems?

9. If you had a friend who told you he was thinking of hurting himself, what would you tell him?

- a. Where would you tell him to go for help? Where would you send them?

10. What is the best way to get the word out about services for individuals who may be feeling depressed or having suicidal thoughts?

Age-related Involvement

Besides what services should be offered, we want to know about what role you think the community could play to make sure everyone gets the help they need so that they don't hurt themselves.

11. How important do you think it is to have people from different age groups participating in helping others who may be depressed or thinking about suicide?
12. In past year, community and providers were concerned about rates of suicidal ideation among Filipino youth? Are you aware of this? If so, is it still a concern? Are you aware of efforts to help youth? From your perspective, were the efforts successful?

Systems/Overall

13. What should service providers do to ensure that the community seeks services when they are having emotional health issues, including suicidal thoughts?
14. Now thinking more overall, what would you want people who provide services to know about helping Asian Americans/Pacific Islanders who are struggling with emotional health problems like depression and/or suicidal thoughts?
- a. What community resources (e.g., local leaders, community centers, spiritual centers, cultural organizations) does the community use when they experience emotional problems?
 - b. What does CHIP need to do to gain community cooperation for suicide prevention?
15. In general, what do you and people your community need to lead a healthy life?
16. What is the community doing well now to lead a health life? (What are the protective factors?)

Those are all the questions I have. Is there anything else you would like to add? Thank you for your participation in today's group. Your feedback is very helpful!

Focus Group Protocol: LGBTQI Youth

Hello, my name is _____ and I work at a research organization called Harder+Company Community Research. I will be the facilitator for today's focus group. This is _____ and s/he also works with me at Harder+Company. We are here today because we are working with an organization named Community Health Improvement Partners (CHIP). They have asked us to talk to people in the community about what they know about services in San Diego that help people who may be struggling with depression or suicidal thoughts or behaviors.

We need information from you to help understand what youth may need if they ever find themselves feeling depressed or suicidal. We also hope you will share your thoughts with us about how the county can do a better job of getting the message out about what services they offer so that it reaches those who need it most.

Before we begin, have any of you participated in a focus group?

A focus group is a group of people that get together to talk about their ideas on a specific topic. Everyone in the group is considered an expert because you are the ones that know the most about what you need and how to best get services.

For those of you who have not participated, there are a couple of guidelines that will help make the conversation easy for everyone to talk and share their thoughts and opinions.

Discussion Guidelines:

- Remember you are the expert! You are the most knowledgeable of what it's like to be a youth living in San Diego right now. That's why you have been chosen to participate today.
- There is no right or wrong answer, just your ideas. Please respect that others might disagree with you. It is perfectly fine to have a different opinion from others in the group, and you are encouraged to share your opinion even if it is different.
- Everyone should have an equal chance to speak, and no one should dominate the conversation. Please speak one at a time and do not interrupt anyone else.
- It's ok if you don't have an answer or opinion about a particular question. It is important for us to know that too. "I don't know" is an ok thing to say.
- Do not hesitate to ask questions if you are not sure what we mean by something.
- Because time is short and we have a lot of questions to get through, I may need to interrupt you to give everyone a chance to speak, or to get through all of the questions.
- Everything we discuss today is completely confidential. Our notetaker will be taking notes but it's only to make sure that we get your comments as accurate as possible. *ASK IF WE CAN RECORD AS WELL*

Your participation in today's focus group is voluntary which means you do not have to participate or answer any questions you do not feel like answering. The information you share with us will be confidential. We will only report what you say to us a group and won't use your

name but say something like “one focus group member said.” No names or identifying information will be shared. In addition, your participation will not affect you receiving services now or in the future.

We realize that the issues that we will talk about today are sensitive and may create some strong emotional responses. We have Eric who you know from Bienestar and Hector from Mental Health America here with us today to address any of these emotions. *If you begin to feel uncomfortable please let me know and Eric or Hector can step into another room with you to address these emotions.* Also please remember that your participation is voluntary and you can skip a question at any time.

Does anybody have any questions before we begin?

Let's start by going around the room and introducing ourselves. Please tell us your first name, age and your favorite artist to listen to right now.

History

1. Can you tell me a little about how you got involved with Bienestar?
 - a. How did you hear about the organization?
 - b. About how long have you been participating? Attending support groups? Are there other ways you stay involved with them?

Our next couple of questions are about what people your age may be dealing with that could cause depression or thoughts of suicide.

Personal Issues Encountered by Youth

2. What types of issues do you or other people your age face regularly in life that make them feel stressed out, anxious, angry, depressed, or even suicidal? (Probe: grades, peer pressure, parent expectations, questioning sexuality, bullying)
3. Think about a regular day for someone your age.....there's school, then you may go to a job, an afterschool program, library, or home. Think about all the people you talk to everyday. We want to know, who would be the first to notice if a person your age was feeling depressed or having suicidal thoughts or behaviors?
4. Before you came to Bienestar, did you feel that the adults you interacted with everyday, such as teachers, school administrators, other school staff, co-workers would notice if you were sad, angry, anxious, or depressed?
 - c. If yes, who are these adults and what did they do to make you feel like they really were worried? (Trying to determine what system they belong to).
 - d. If no, why not?

Next, we'd like to ask what you think about services for youth struggling with depression and suicidal thoughts/behaviors.

Services

Now I'd like to ask you about types of services or programs that could help make sure that youth struggling with depression or thoughts of suicide get the help they need. I'm going to give you a few examples:

- + A support group where you can talk to people your age who are dealing with the same issue.
- + Training youth on how to recognize early warning signs among their peers and how to help
- + A confidential "hotline"
- + Education to help youth know what services already exist and how to find those services
- + Talking one on one with a counselor

5. Now that I've given you that list, are there any other kinds of services that you think people your age need if they are depressed or having suicidal thoughts? Remember, it doesn't do anybody any good if no one wants to use the service.
 - e. Do you feel that these types of services exist in San Diego County right now?
 - i. If yes, who provides them?
 - ii. If no, why do you think they are not in SD County?
 - f. Do you feel that enough of these services are available when people need them?
 - g. Do you think it's easy for young people to get the help they need? If not, why?
6. Where do you feel that services should take place?
 - h. Where would you or your peers feel comfortable getting these kinds of services?
 - i. What about schools, why or why not. (Also probe for other locations such as faith-based, medical, etc.)
7. Are there things that make it hard for youth to get the services they need? (Probe: Barriers such as transportation or is it more about what people will think if they find out/stigma?)
 - j. What would youth need so they could feel comfortable asking for that help?
8. If you had a friend who told you he was thinking of hurting himself, what would you tell him?
 - k. Where would you tell him to go for help? Where would you send them?
9. What is the best way to get the word out about services for youth who may be feeling depressed or having suicidal thoughts?

Youth Involvement

Besides what services should be offered, we want to know about what role you think other youth could play to make sure everyone gets the help they need so that they don't hurt themselves.

10. How important do you think it is to have people your age participating in helping other young people who may be depressed or thinking about suicide?
 - l. What should be the role of people your age in helping other young people who are depressed and may be thinking about suicide?
11. As I am sure you know, there has been a lot of news about bullying in the media recently and specifically about LGBT youth being bullied..
 - m. Have you ever witnessed a friend or peer being bullied? Where did it happen?
 - n. What has been your reaction? (Feelings, actions)
 - o. Who needs to be involved in stopping bullying?
 - p. What would you need to be able to stand up for those who may be getting bullied?

Systems/Overall

12. Now thinking more overall, what would you want people who provide services to know about helping youth who are struggling with depression and/or suicidal thoughts? Specifically LGBT youth?
13. In general, what do you think you and people your age in your community need to lead a healthy life? Probe: Are needs different for LGBT youth?

Those are all the questions I have. Is there anything else you would like to add? Thank you for your participation in today's group.

Focus Group Protocol: Older Adults

Hello, my name is _____ and I am with Harder+Company Community Research. As you may know, Community Health Improvement Partners (CHIP) is currently developing a Suicide Prevention Action Plan for the County of San Diego and we are working with them. Part of the development of the plan is the completion of a Needs Assessment. The purpose of the Needs Assessment is to assess existing San Diego County suicide prevention services and supports as well as identify gaps in these services and supports.

We need information from you to help understand what older adults may need if they ever find themselves feeling depressed or suicidal. We also hope you will share your thoughts with us about how the county can do a better job of getting the message out about what services they offer so that it reaches those who need it most.

The focus of our conversation today will be your experiences with seeking assistance for yourself or a family member or friends. What we want to learn is about the experience you may have had interacting with service providers or the services you would want to access should we need them.

Your participation in today's interview is voluntary. Additionally, the information you share with us will be confidential. We won't use your name but say something like "community member stated." No names or identifying information will be shared. In addition, your participation will not affect your eligibility for future services or programs.

We realize that the issues that we will talk about today are sensitive and may create some strong emotional responses. We have information for a crisis line or local providers if you need to talk with someone today to address any of these emotions. Also please remember that your participation is voluntary and you can skip a question at any time.

Do you have any questions before we begin?

So today, we're talking about your experiences with depression or thoughts of suicide over the past 5 years in San Diego. You can answer the questions for yourself, about your family or your friends. We want to focus on experiences for older adults but you can share about experiences of younger people too.

1. How many years have you lived in San Diego?
2. [What part of town do you live in? *Not asked if at residential site*]

So now I am going to begin asking questions about experiences older adults have with depression and thoughts of suicide.

3. Have you had any experiences with depression or suicidal thoughts? It could be yourself or a family member or a friend? Which experience do you want to talk about that will help us make the system better?

3a. Did you/family member/friend get any help?

If yes, what kind? How did that go? What was most helpful? What wasn't helpful? What do you wish had been available?

4. Did you/family/friend try to talk to a professional?

4a. If yes, were they helpful?

4b. If yes, what did they do what was most helpful?

4c. If no, what might they have done?

5. Think about a regular week and all the people you interact with.

a. Who would notice if you were feeling depressed?

b. What would they notice?

c. What do you think they could do to help you?

Now I want to ask for your advice about how we can better help older adults who are experiencing depression or suicidal thoughts.

6. What services do you think older adults struggling with depression or suicidal thoughts need?

7. Do you think that these services exist in San Diego County now?

7a. If yes, what agency provides them?

7b. Are there are enough of these services?

7c. Are they conveniently located?

7d. Are they open when people need them?

8. Have you heard of the Access and Crisis Line?

8a. Have you ever called this resource?

8b. If yes, was it helpful, not helpful?

8c. Have you used other resources or programs?

[Prompts: 211, a counselor, a mental health clinic, etc.]

8d. If yes, tell us about them.

Thank you for sharing so much information about your personal experiences. Now lets talk about older adults in San Diego in general. You may or may not be aware that older adults are the population most impacted by suicide.

9. What are some of the challenges to getting help for older adults struggling with depression and suicidal thoughts?

10. What are the barriers to accessing help for these people?

[Prompts]:

a. Transportation?

- b. Language
- c. Financial
- d. Insurance/Medicare

11. In your experience, are there certain groups of older adults with depression or suicidal thoughts who have more trouble than others getting the help they need? [prompts: people who live alone, men, disabled, etc.]
- 11a. If yes, who are they?
- 11b. What could be done to help them?

Prevention

12. What are some things that you think older adults can do to avoid depression and prevent suicide?
- a. What could help people to do this?
13. What do you think could be done to reach older adults who are reluctant to ask for help?
- a. Prompts – presentation at senior center, presentation at church, written materials.

Systems/Overall

14. What do you want service providers to know about helping seniors who are struggling with depression and/or suicidal thoughts?
15. Do you have any other thoughts or suggestions that you would like to share with us?

Thank you so much for your time and input.

Interview Protocol: Survivors of Suicide Attempts

Hello, my name is _____ and I am with Harder+Company Community Research. As you may know, the County and Community Health Improvement Partners (CHIP) is currently developing a Suicide Prevention Action Plan for the County of San Diego and we are working with them. Part of the development of the plan is the completion of a Needs Assessment. The purpose of the Needs Assessment is to assess existing San Diego County suicide prevention services and supports as well as identify gaps in these services and supports.

The County is very interested in hearing your experiences as community members who have been impacted by suicide. This may be your own experience with suicidal thoughts and behaviors as well as what you have learned about services available to people struggling with these thoughts. It is important to the County to include the voices of individuals impacted by suicidal behaviors in the Needs Assessment process.

The focus of our conversation today will be your experiences with seeking assistance for yourself. What we want to learn is about the experience you had locating and interacting with service providers.

Your participation in today's interview is voluntary. Additionally, the information you share with us will be confidential. We won't use your name but say something like "community member stated." No names or identifying information will be shared. In addition, your participation will not affect your eligibility for future services or programs.

We realize that the issues that we will talk about today are sensitive and may create some strong emotional responses. We have _____ from _____ here with us today to address any of these emotions. *ADD IN PLAN FOR ADDRESSING CRISIS If you begin to feel uncomfortable please let us know and _____ can step into another room with you to address these emotions.* Also please remember that your participation is voluntary and you can skip a question at any time.

Do you have any questions before we begin?

History

We are going to start today by talking a little about your experiences with service providers prior to you having suicidal thoughts or behaviors. We know from research that often people who start having suicidal thoughts have been feeling depressed for awhile.

1. When you think back to before you had suicidal thoughts/behaviors, at that time, did you think that you needed help?
 - a. If YES, what were some of the things that you noticed about yourself that suggested you needed help?
 - b. If NO, did you know that there might be help available?

2. At that time, had anyone expressed concern? Did family members or friends try and get you help?
3. In your experience, did someone miss a chance to help you? Do you feel like you tried to talk to someone and he/she did not know how to help? What might they have done in order to help you at that time? What would they have needed to know about you or asked you?

Part of what we would like to focus on today are the recommendations you would make as well as the concerns you continue to have regarding services for people struggling with depression and suicidal thoughts/behaviors.

Services

4. What services do you think need to exist or be provided in order to address the needs of people struggling with depression or suicidal thoughts?
 - a. Do you feel that these services exist in San Diego County now?
 - i. If yes, who provides them?
 - ii. If no, why do you think they are not in SD County?
 - b. Do you feel that there are enough of these services are available when people need them? Do you think that these services are accessible to people meaning that people can get to them easily?
5. What are some of the continued challenges for people trying to obtain help?
6. In your experience, are there certain groups of people who have more trouble accessing the services they need?
 - a. If yes, who and what might be done to address these specific needs?

Capacity of Providers

An additional area that we are looking at is the capacity of agencies and service providers to deliver appropriate and helpful services. We would like to hear your opinions and suggestions regarding the capacity of providers to provide helpful services to individuals who are depressed or struggling with suicidality.

7. Have you or someone in your family tried to access mental health services for you? For themselves?
 - a. If Yes – (SELF) – What services did you try and access? Were you successful? Did you feel that these services met your needs at the time?
 - b. If yes (Family member) - What services did they try and access? Were they successful? Did it seem like these services met their needs?
8. There are also numerous other systems and providers that interact with people who may be depressed or struggling with suicidal thoughts. Which service providers get it right in

terms of understanding suicidality and suicide risk? Was there anybody in particular who helped you?

- a. What makes them helpful? How do they show that they understand the signs of suicidality and know how to respond to these risks?
- b. Have you heard of the Access and Crisis Line? Did you ever use this resource? How was it helpful, not helpful? What about 211?
- c. Further probe about other resources or programs as needed

9. Are there providers who aren't as helpful? Why is that? What can providers do to be more helpful? (Probe: What do they need to do differently, what should they do to improve services, what do they need to know about suicide or mental health issues, etc)
10. Also, there are many people who are struggling with asking for help or identifying themselves as needing help. What recommendations might you make regarding the identification of people who might need help? What communities/groups would you identify as needing this type of outreach? How would you prioritize these? Where/With whom would you suggest this type of outreach begin?

Systems/Overall

11. Now thinking more overall, what would you want service providers to know about helping people who are struggling with depression and/or suicidal thoughts?

Focus Group Protocol: Survivors of Suicide Loss

Hello, my name is _____ and accompanying me today is _____. We are with Harder+Company Community Research. As you may know, Community Health Improvement Partners (CHIP) is currently developing a Suicide Prevention Action Plan for the County of San Diego and we are working with them. Part of the development of the plan is the completion of a Needs Assessment. The purpose of the Needs Assessment is to assess existing San Diego County suicide prevention services and supports as well as identify gaps in these services and supports.

CHIP is very interested in hearing your experiences as community members impacted by suicide. It is important to CHIP to include the voices of individuals and families who have been impacted by suicide loss in the Needs Assessment process as one of the goals of the plan will be to increase training available to community service providers so that they are able to assist community members struggling with depressive or suicidal thoughts and behaviors.

The focus of our conversation today will be your experiences with seeking assistance for yourself or your family member. What we want to learn is about the experience you had interacting with service providers.

Your participation in today's focus group is voluntary. Additionally, the information you share with us will be confidential. We will only report what you say to us a group and won't use your name but say something like "family members stated." No names or identifying information will be shared. In addition, your participation will not affect your eligibility for future services or programs.

We realize that the issues that we will talk about today are sensitive and may create some strong emotional responses. We have _____ from _____ here with us today to address any of these emotions. *ADD IN PLAN FOR ADDRESSING CRISIS If you begin to feel uncomfortable please let me know and _____ can step into another room with you to address these emotions.* Also please remember that your participation is voluntary and you can skip a question at any time.

Does anybody have any questions before we begin?

History

1. Can you tell me a little about how you got involved in Survivors of Suicide Loss?
 - a. How did you hear about the organization?
 - b. About how long have you been participating? Attending support groups? Volunteer?

We understand that [Survivors of Suicide Loss] is involved in suicide prevention and education and part of what we would like to focus on today are the recommendations you would make as well as the concerns you continue to have regarding services for people struggling with depression and suicidal thoughts/behaviors.

Services

2. What services do you think need to exist or be provided in order to address the needs of people struggling with depression or suicidal thoughts?
 - a. Do you feel that these services exist in San Diego County now?
 - iii. If yes, who provides them?
 - iv. If no, why do you think they are not in SD County?
 - b. Do you feel that there are enough of these services are available when people need them? Do you think that these services are accessible to people meaning that people can get to them easily?
3. What are some of the continued challenges people who have lost a family member to suicide face when trying to obtain help?
 - a. What challenges might a person who is actively suicidal face when trying to obtain help?
4. In your experience, are there certain groups of people who have more trouble accessing the services they need?
 - a. If yes, who and what might be done to address these specific needs?
 - b. Have you personally been impacted by stigma when trying to access services?

Capacity of Providers

An additional area that we are looking at is the capacity of agencies and service providers to deliver appropriate and helpful services. We would like to hear your opinions and suggestions regarding the capacity of providers to provide helpful services to individuals who are depressed or struggling with suicidality.

5. Have any of you had experiences with trying to access mental health services for your loved one? For yourself?
 - a. If yes (LOVED ONE) – What services did you try and access? Were you successful? Did you feel that these services met the needs of your loved one at the time?
 - b. If yes (SELF) - What services did you try and access? Were you successful? Did you feel that these services met your needs at that time?
6. Sometimes people look for support and help in non-mental health settings such as with doctors or at community clinics. Did you seek services either for yourself or for your loved one in a non-mental health setting?
 - a. PROBE: Did you ever seek help within your faith community? Did you find help there? What were the successes or challenges with receiving support from the faith community?
7. There are also numerous other systems and providers that interact with people who may be depressed or struggling with suicidal thoughts. Which service providers get in right in terms of understanding suicidality and suicide risk? What makes them helpful? How do

they show that they understand the signs of suicidality and know how to respond to these risks?

- a. Have you heard of the Access and Crisis Line? Did you ever use this resource? How was it helpful, not helpful? What about 211?
- b. Further probe about other resources or programs as needed

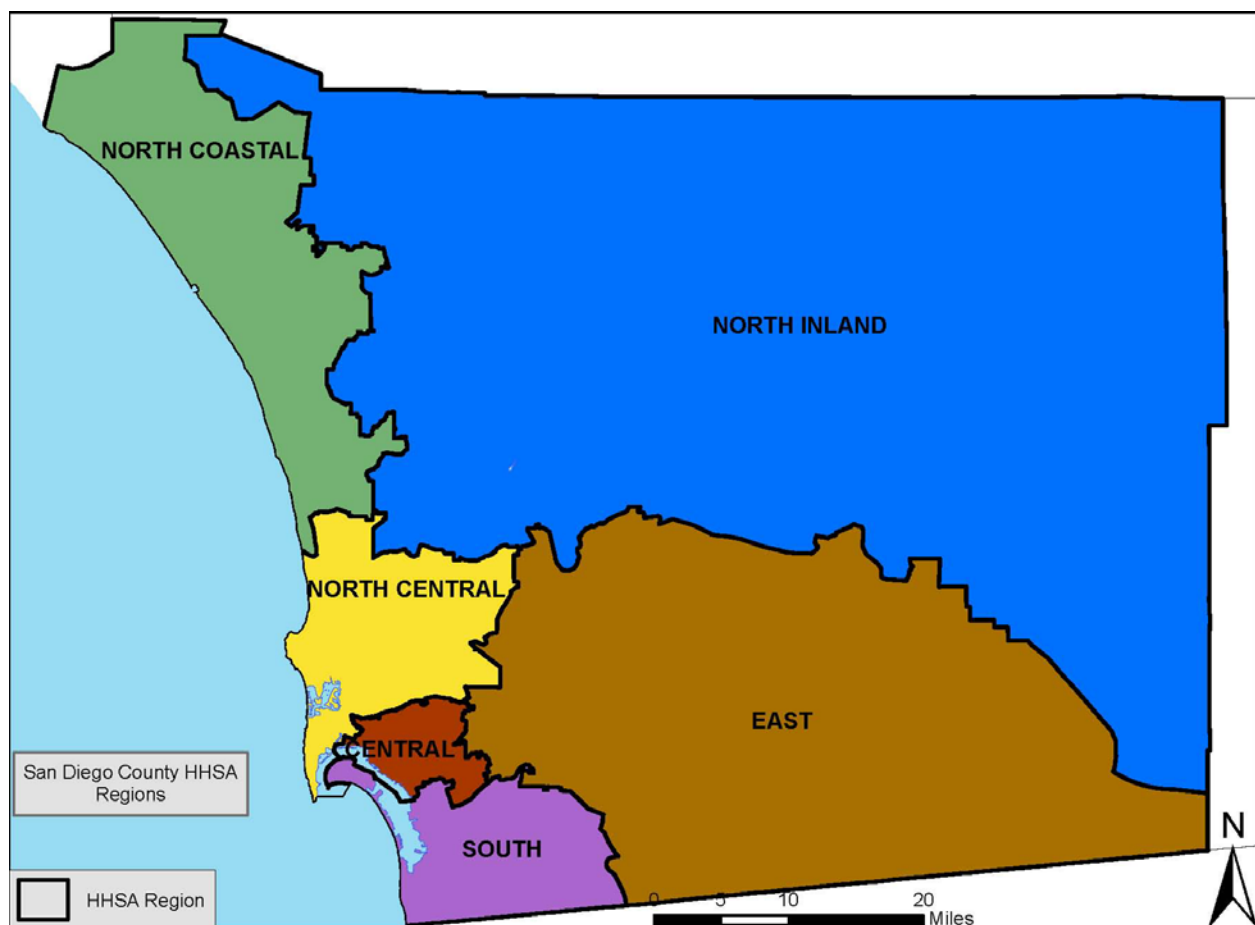
8. Are there providers who aren't as helpful? Why is that? Do you think they need training regarding suicidality and suicidal risk? If so, what do they need to learn to better help people at risk for suicide?
9. Also, there are many people who are struggling with asking for help or identifying themselves as needing help. What might lead you to believe or suspect that someone needs help?
 - a. Are there specific communities or groups that need targeted outreach? If YES, how would you prioritize these communities? Where/With whom would you suggest this type of outreach begin?

Systems/Overall

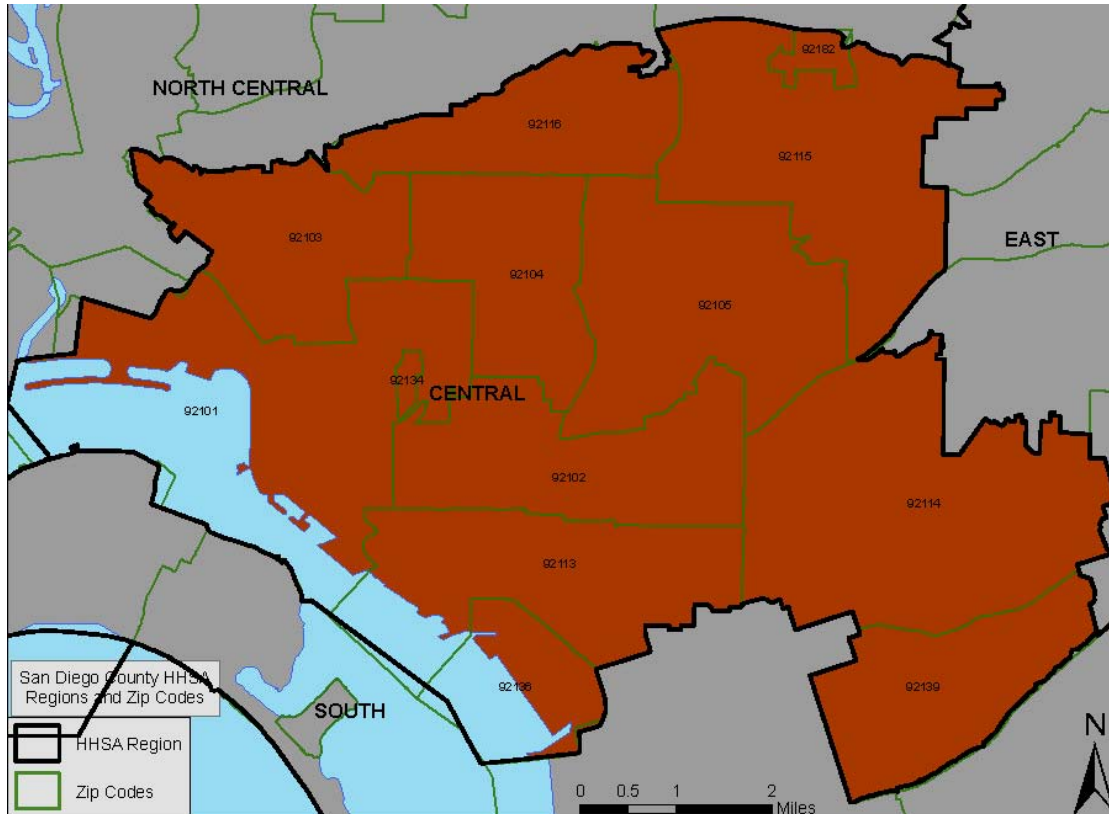
10. Now thinking more overall, what would you want service providers to know about helping people who are struggling with depression and/or suicidal thoughts?
11. In your experience, who is currently most involved in impacting suicide prevention education and information in the County of San Diego? (Probe for stakeholder types?)
12. Who do you think is missing from the table in conversations regarding suicide prevention and education?

Appendix C: Health and Human Service Agency Region Maps

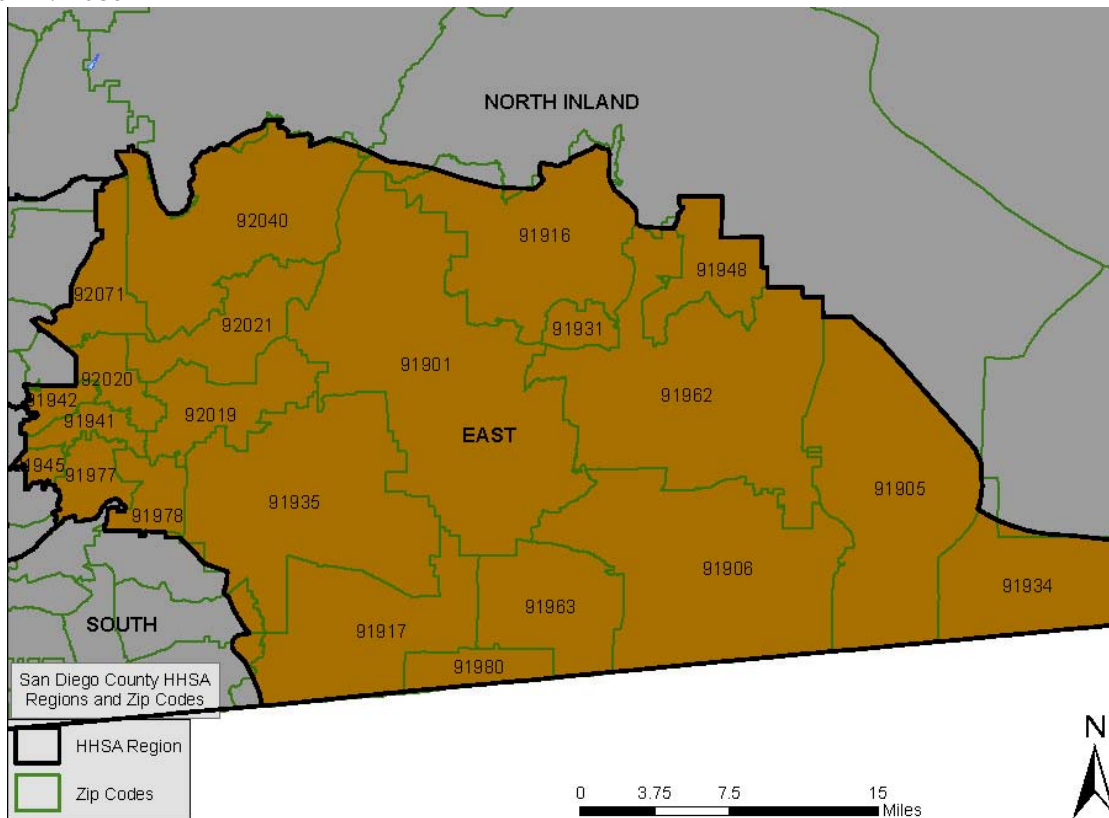
Overview of the 6 regions of San Diego County



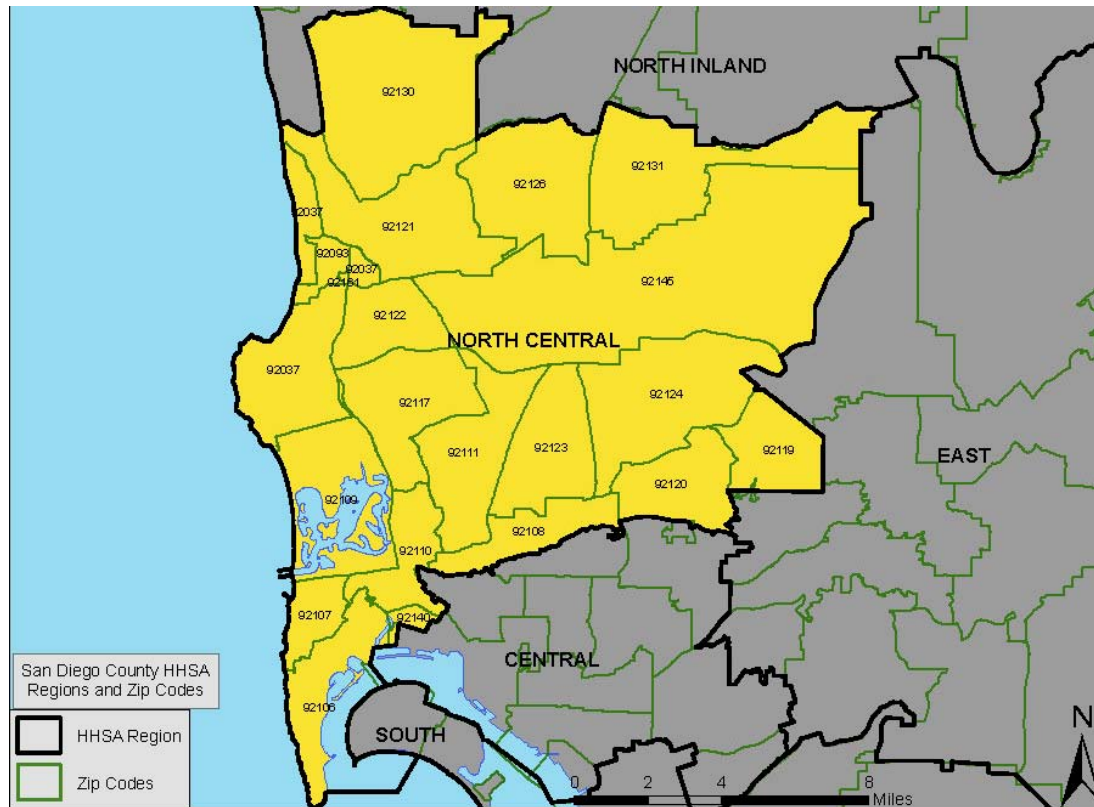
Region 1: Central



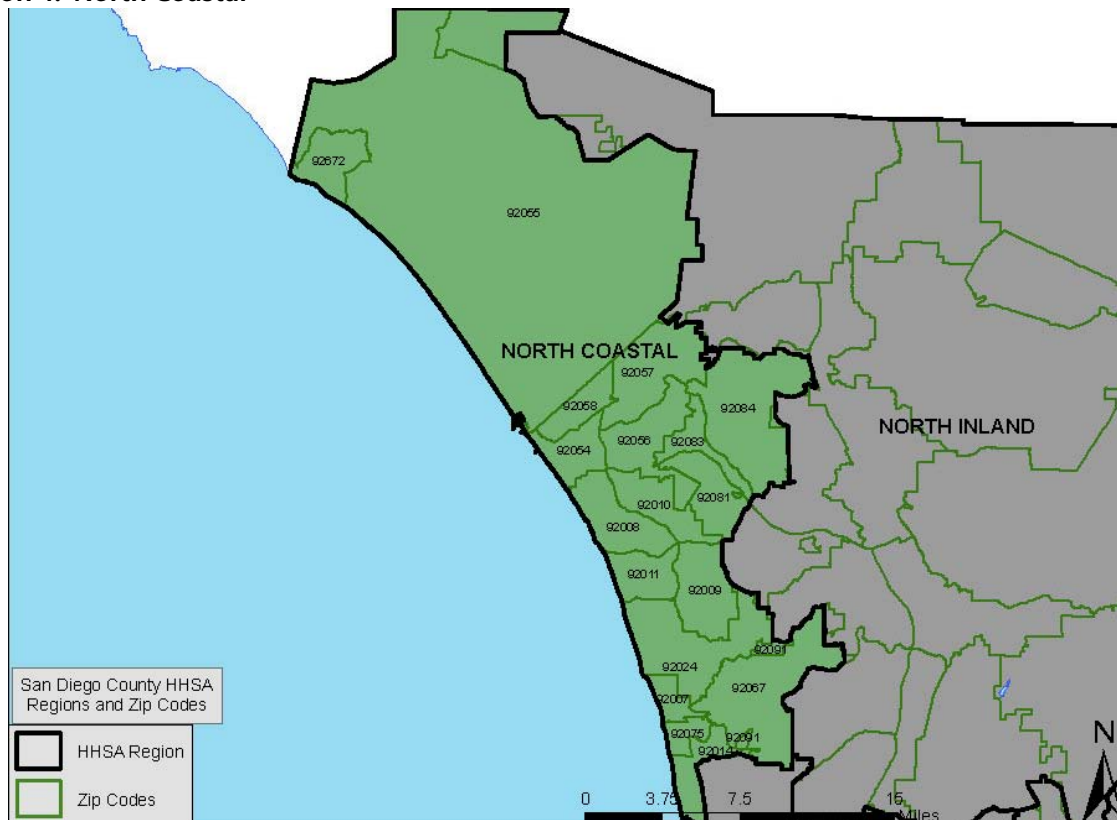
Region 2: East



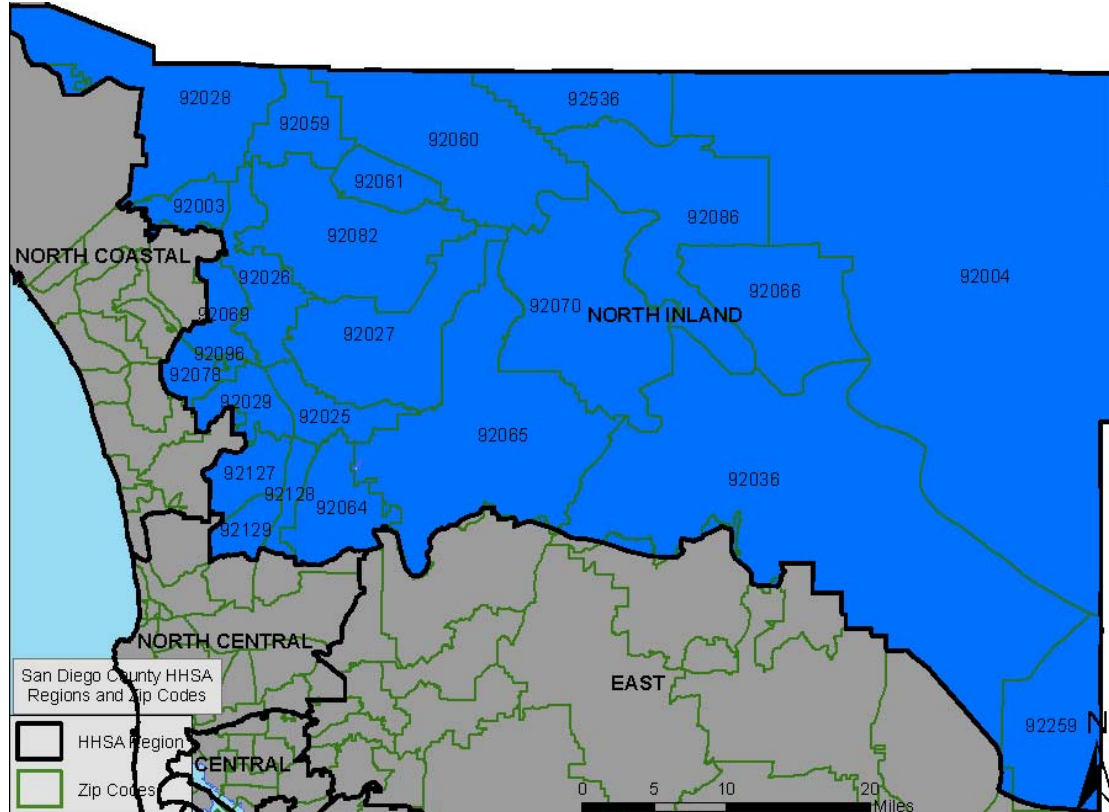
Region 3: North Central



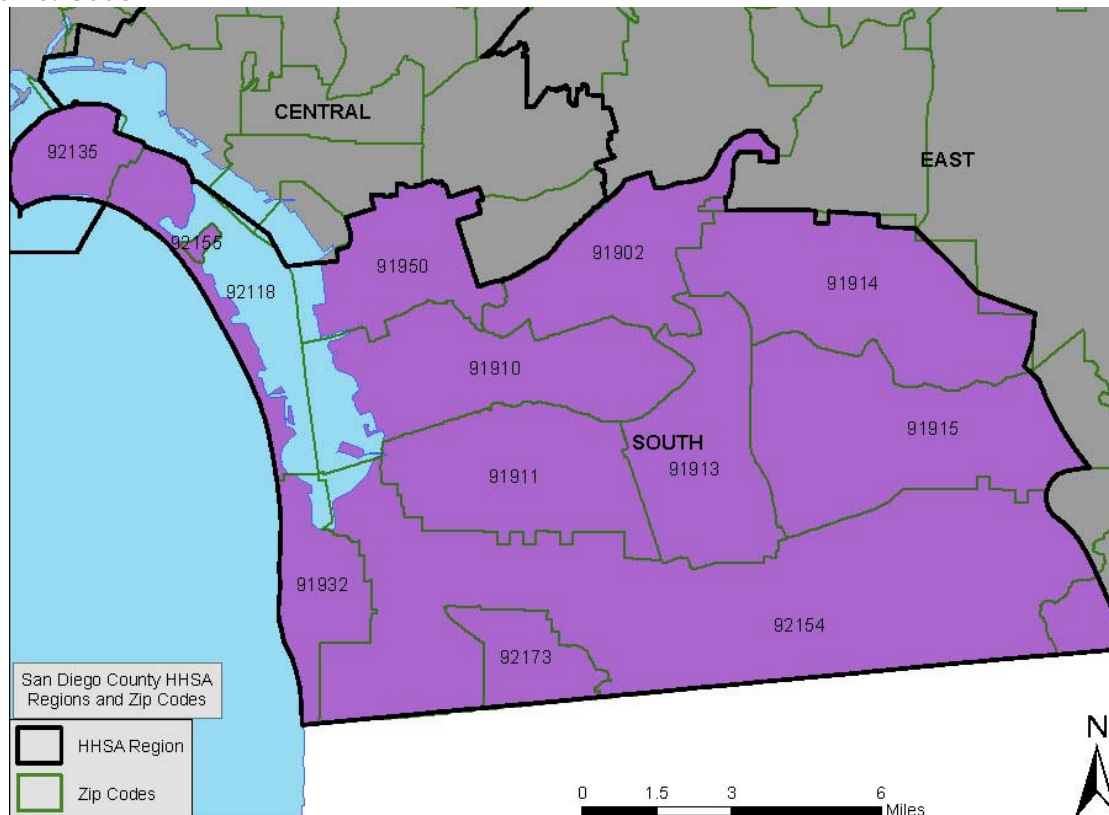
Region 4: North Coastal



Region 5: North Inland



Region 6: South



Appendix D: Quantitative Analysis Tables

Exhibit D.1: List of Suicide Prevention Training Providers

Agencies/Training Programs Mentioned by Participants of the Behavioral Health Services Training Needs Assessment

AATBS	Jack Klott (national expert on suicide prevention: "Stopping the Pain: Suicide and Self-Mutilation;" also trains through FRC and PESI)
Alvarado Parkway Institute	Kaiser Permanente
American Art Therapy Association	Linda Espinoza, MFT (South Bay Community Services Children's Mental Health Clinician)
American Assn for Marital Family Therapists (AAMFT)	M. David Rudd, PhD (Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals Rudd- trained at Skippis)
ASIST (LivingWorks Education)	Mental Health services (including MHS of Orange County and Commonwealth of Massachusetts)*
Association for Marriage Family Therapists	Mental Health Systems
Aurora Behavioral Health	MHRC -SPEAK Program
BEHTA (suicide prevention; suicide and self-mutilation)	National Center for Suicide Prevention
Bonnie Bear (suicide prevention)	New Haven Youth and Family Services
Broward County	New York State Department of Corrections*
CAARR	NMCSD
CADAC	PESI (Suicide prevention and self-harm; emergency mental health training; mental status exam and suicide risk assessment' also training through Jack Klott)
California Caregiver Resource Centers	PESTNI Risk Assessment and the Mental Status Exam [sic]
California Department of Corrections and Rehabilitation	Riverside County of Education*
CARTHA	San Diego Unified School District (S.P.E.A.K. Program)
Child Maltreatment Conference (sponsored by Chadwick Center)	San Diego Hospice
CHIP (Suicide in SD County)	San Diego Psychological Association
City of Fremont, CA (Youth and Family Services)	Sarah Koenigsberg (suicide prevention training)
CRF -Community Research Foundation (includes training from Jack Klott on Suicide Prevention and Cutting Behaviors)	SAY, Inc.
Crisis Response team in Santa Fe, NM*	Sharp Hospital (Suicide and Loss Prevention)

Cross Country Education (Emergency Mental Health: Assessment and Treatment)	SPAN
Department of Behavioral Health of San Bernardino*	St. Vincent de Paul Villages
Department of Defense, Marine Corps	Telecare, Inc.
Department of Veterans Affairs*	The Blues Project, California State University Northridge (volunteer program)*
ECOP	The Maple Counseling Center*
Episcopal Community Services	The National Council for Behavioral Healthcare Services (webinar)
Escondido Unified School District	Turning Point [Foundation?] (Sacramento)*
"Family Stress" (Center?)	United Health Group
"Friend to Friend" Clubhouse	VA Medical Center
Gerry Grossman (continuing education classes and BBS seminar training)	Webinar: National Counsel [sic]
Houston Council on Alcohol and Drugs*	Yellow Ribbon Suicide Prevention Program
International Critical Incident Stress Foundation (trainer was a police officer)	

Exhibit D.2: Experience Related to Suicide

	County Department	
	MHS	ADS
Have assessed the risk of a suicidal client	74.1%	78.3%
The suicide risk assessment protocol or procedure is very useful or somewhat useful	96.7%	90.7%
Less than 50% of clients exhibiting suicide-related factors	60.5%	75.4%
More than 90% of clients exhibiting suicide-related factors	4.0%	7.2%

Exhibit D.3: County Mental Health Services Confidence

Total Mean Score		19.2
Category	Mean Score	Significance
Mean Score by Position*		p<.001
Manager	21.3	
Director	20.6	
Other	19.8	
Direct Services	19.4	
Support Services	13.2	
Mean Score by Years in Current Position		p=.692
More than 10 years	19.6	
Less than a year	19.3	
6-10 years	19.3	
3-5 years	19.2	
1-2 years	18.7	
Mean Score by Years in Behavioral Health*		p=.001
More than 10 years	20.0	
5-10 years	19.9	
1-5 years	18.8	
Less than one year	18.0	
Mean Score by Mental Health Services Department		p=.912
Children's Mental Health Services	19.2	
Adult/Older Adult Mental Health Services	19.2	
Mean Score by Percentage of Clients who Exhibit Factors Related to Suicide*		p<.001
51-75%	21.0	
76-90%	20.6	
More than 90%	20.6	
21-50%	20.3	
10-20%	20.0	
Less than 10%	18.9	
0%	18.1	
I do not provide direct services	16.1	
Mean Confidence Score by Ever Assessed Client for Suicide*		p<.001
Yes	20.6	
No	15.0	

*significant at equal or less than .05

Exhibit D.4: County Alcohol and Drug Services Confidence

Total Mean Score		19.2
Category	Mean Score	Significance
Mean Confidence Score by Position		p=.496
Direct Services	19.5	
Manager	19.1	
Support Services	18.0	
Director	17.7	
Other		
Mean Score by Years in Current Position		p=.934
Less than one year	19.6	
1-2 years	19.4	
6-10 years	19.1	
3-5 years	19.0	
More than 10 years	18.5	
Mean Score by Years in Behavioral Health		p=.837
1-5 years	19.4	
5-10 years	19.3	
More than 10 years	18.9	
Less than one year	18.0	
Mean Score by Percentage of Clients who Exhibit Factors Related to Suicide		p=.112
76-90%	24.0	
More than 90%	20.6	
21-50%	20.1	
51-75%	20.0	
10-20%	19.0	
Less than 10%	18.9	
0%	17.8	
I do not provide direct services	17.3	
Mean Score by Ever Assessed Client for Suicide*		p=.001
Yes	19.8	
No	16.9	

*significant at equal or less than .05

Exhibit D.5: County Community Providers Confidence

Total Mean Score		19.4
Category	Mean Score	Significance
Mean Score by Current Role*		p=.033
Board Member	22.7	
Direct Service	20.2	
Director	19.7	
Manager	19.3	
Administrative	17.2	
Other	14.6	
Mean Score by Years in Current Role		p=.175
6-10 years	20.9	
Less than one year	19.5	
1-5 years	19.5	
More than 10 years	17.8	
Mean Score by Number of Clients Served Annually		p=.388
5,000-9,999	21.3	
1,000-4,999	20.4	
10,000+	18.9	
100-999	18.7	
0-99	17.8	

*significant at equal or less than .05

Exhibit D.6: County Mental Health Services Knowledge

Total Mean Score		9.9
Category	Mean Score	Significance
Mean Score by Position*		p<.001
Manager	10.5	
Direct Services	10.0	
Other	9.8	
Director	9.6	
Support Services	8.6	
Mean Score by Years in Current Position		p=.829
More than 10 years	10.2	
3-5 years	10.0	
1-2 years	9.9	
6-10 years	9.9	
Less than a year	9.8	
Mean Score by Years in Behavioral Health		p=.219
More than 10 years	10.1	
5-10 years	10.0	
1-5 years	9.9	
Less than one year	9.5	
Mean Score by Mental Health Services Department		p=.785
Adult/Older Adult Mental Health Services	9.9	
Children's Mental Health Services	9.9	
Mean Score by Percentage of Clients who Exhibit Factors Related to Suicide*		p<.001
More than 90%	11.0	
76-90%	10.3	
21-50%	10.3	
51-75%	10.2	
10-20%	10.1	
Less than 10%	9.7	
0%	8.9	
I do not provide direct services	9.4	
Mean Score by Ever Assessed Client for Suicide*		p<.001
Yes	10.2	
No	9.1	

*significant at equal or less than .05

Exhibit D.7: County Alcohol and Drug Services Knowledge

Total Mean Score		10.0
Category	Mean Score	Significance
Mean Score by Position		p=.952
Manager	10.1	
Direct Services	10.0	
Support Services	10.0	
Director	9.7	
Other		
Mean Score by Years in Current Position		p=.613
6-10 years	10.7	
Less than one year	10.0	
3-5 years	9.9	
More than 10 years	9.9	
1-2 years	9.8	
Mean Score by Years in Behavioral Health		p=.279
5-10 years	10.4	
Less than one year	10.3	
More than 10 years	10.2	
1-5 years	9.5	
Mean Score by Percentage of Clients who Exhibit Factors Related to Suicide		p=.692
76-90%	11.0	
51-75%	10.8	
I do not provide direct services	10.5	
21-50%	10.4	
0%	10.4	
Less than 10%	9.9	
More than 90%	9.6	
10-20%	9.5	
Mean Score by Ever Assessed Client for Suicide		p=.217
No	10.5	
Yes	9.9	

Exhibit D.8: County Community Providers Knowledge

Total Mean Score		11.0
Category	Mean Score	Significance
Mean Score by Current Role		p=.840
Board Member	11.3	
Director	11.3	
Manager	11.1	
Direct Service	11.0	
Administrative	10.6	
Other	10.0	
Mean Score by Years in Current Role		p=.747
6-10 years	11.3	
Less than one year	11.2	
1-5 years	11.0	
More than 10 years	10.6	
Mean Score by Number of Clients Served Annually		p=.864
5,000-9,999	11.4	
0-99	11.2	
100-999	11.1	
1,000-4,999	10.8	
10,000+	10.7	

Exhibit D.9: County Mental Health Services Attitude

Total Mean Score		8.0
Category	Mean Score	Significance
Mean Score by Position*		p=.012
Manager	8.4	
Director	8.2	
Direct Services	7.9	
Support Services	7.6	
Other	7.5	
Mean Score by Years in Current Position		p=.403
More than 10 years	8.3	
1-2 years	8.0	
3-5 years	8.0	
Less than a year	7.9	
6-10 years	7.8	
Mean Score by Years in Behavioral Health		p=.575
More than 10 years	8.1	
5-10 years	8.0	
1-5 years	7.9	
Less than one year	7.9	
Mean Score by Mental Health Services Department		p=.551
Children's Mental Health Services	8.0	
Adult/Older Adult Mental Health Services	7.9	
Mean Score by Percentage of Clients who Exhibit Factors Related to Suicide*		p=.033
More than 90%	8.4	
10-20%	8.3	
21-50%	8.2	
76-90%	8.0	
51-75%	8.0	
I do not provide direct services	7.8	
0%	7.7	
Less than 10%	7.7	
Mean Score by Ever Assessed Client for Suicide*		p<.001
Yes	8.1	
No	7.6	

*significant at equal or less than .05

Exhibit D.10: County Alcohol and Drug Services Attitude

Total Mean Score		7.7
Category	Mean Score	Significance
Mean Attitude Score by Position		p=.230
Support Services	8.5	
Manager	8.1	
Direct Services	7.6	
Director	6.8	
Other		
Mean Score by Years in Current Position		p=.097
1-2 years	8.3	
6-10 years	7.9	
Less than one year	7.6	
3-5 years	7.6	
More than 10 years	6.6	
Mean Score by Years in Behavioral Health		p=.581
1-5 years	8.0	
Less than one year	7.7	
5-10 years	7.7	
More than 10 years	7.4	
Mean Score by Percentage of Clients who Exhibit Factors Related to Suicide		p=.570
51-75%	8.5	
76-90%	8.5	
I do not provide direct services	8.2	
21-50%	8.1	
More than 90%	8.0	
Less than 10%	7.6	
10-20%	7.5	
0%	6.8	
Mean Score by Ever Assessed Client for Suicide		p=.596
Yes	7.8	
No	7.5	

Exhibit D.11: County Community Providers Attitude

Total Mean Score		8.3
Category	Mean Score	Significance
Mean Score by Current Role		p=.188
Board Member	9.3	
Director	8.9	
Direct Service	8.3	
Administrative	8.2	
Manager	7.8	
Other	7.4	
Mean Score by Years in Current Role		p=.115
6-10 years	9.1	
Less than one year	8.4	
More than 10 years	8.2	
1-5 years	7.9	
Mean Score by Number of Clients Served Annually		p=.108
0-99	9.8	
1,000-4,999	8.4	
5,000-9,999	8.3	
10,000+	8.3	
100-999	7.9	