Contra Costa County Suicide Prevention Committee

September 6, 2013

Dear Stakeholder:

Death by suicide is preventable. In 2011, 116 people died by suicide in Contra Costa County, an average of more than 9 individuals per month. When the Mental Health Services Act (MHSA) was passed in 2004, the voters of California called on the Mental Health community to initiate measures that would (among other objectives) address the tragedy of suicide. In Contra Costa County, the initial 3-year MHSA Plan outlined the formation of a **Suicide Prevention Committee** that was charged with drafting a County-wide plan aimed at reducing attempted and completed suicides. The membership of the Committee is a broad representation of many stakeholders. Among those groups and/or agencies participating are:

- Rainbow Community Center
- National Alliance for the Mentally Ill
- John Muir Behavioral Health
- Kaiser Permanente
- Veterans Administration
- Community Chaplain Resources
- Zero Tolerance for Domestic Violence
- Contra Costa Behavioral Health
- Contra Costa Regional Medical Center
- RYSE Youth Center
- Contra Costa Crisis Center
- Mt Diablo Unified School District (K-12)
- Individuals with Lived Experience of Suicide and Family Members

After more than two years of engaging in an in-depth analysis of current research and local conditions, the committee has now completed the **"Suicide Prevention Strategic Plan"** and is pleased to present it for your support and implementation. In it you will find strategies that will help prevent suicide. We ask that all stakeholders contribute their knowledge, commitment, and resources to help implement the County-wide strategies. Please support our efforts by broadly distributing this letter and the plan.

Sincerely

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Suicide Prevention Strategic Plan

Contra Costa County

September 2013

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Death by Suicide is Preventable: A Call to Action

The human tragedy of suicide transcends socioeconomic status, age, gender, and ethnicity. Suicide has an everlasting impact on the survivor. Family members and friends are left to process the loss of their loved one. As a result of the experience they are at an increased risk for suicide themselves. In Contra Costa County, on average, 112 Contra Costa County residents die by suicide every year which outnumbers homicide deaths. Suicide is the third leading cause of death for youth and, generally, those over 45 years of age are at greatest risk. The largest percentage of suicide deaths involve a gun. Suicide is preventable, most effectively, by limiting access to lethal means, including, but not limited to, guns. Suicides are preventable and these statistics can change if everyone takes action together.

This document provides a road map for our community to take action to prevent suicide. Death by suicide is a preventable public health problem. Within this document you will find effective strategies and supports to accomplish this worthy undertaking. Everyone can play a part, from family members to community leaders to policy makers; each person has an important role in preventing suicides. We should all be held accountable. For Contra Costa County, we call to action our Health Services Department, public officials, the private health providers and hospitals, community based organizations, professionals involved with public policy and individuals within our community to bring about the changes necessary to address this devastating community health issue of suicide.

Using the information gathered through the two-year committee process along with the Six Domains of Health Care Quality (Appendix A), the committee established a list of county-wide suicide prevention strategies. Together, this information led to the creation of the Suicide Prevention Strategic Plan for Contra Costa County. With these strategies in-hand, we can collectively reduce the stigma and shame around suicide, increase awareness of warning signs, be knowledgeable of special populations with disproportionately high risk, and implement trainings to equip people with the tools needed to help someone who may be thinking about suicide. We hope that this plan will foster public and private partnerships and make the issue of suicide a resource priority.

Funding for the planning and research of this Suicide Prevention Strategic Plan has been made possible through the Mental Health Services Act (MHSA). The MHSA community planning process in Contra Costa County identified suicide prevention as one of the major areas of focus for our Prevention and Early Intervention Plan. It is with great anticipation that this plan will motivate others to build on the foundation of work established by the dedicated efforts of the suicide prevention committee.

Working together, we can raise awareness and prevent suicide.

Acknowledgements

Over the course of more than two years, the members of the Suicide Prevention Committee demonstrated their commitment to reducing suicide by contributing time, talent and the invaluable lessons of lived experience, to the creation of this comprehensive Suicide Prevention Strategic Plan for Contra Costa County. It is with sincere gratitude that we acknowledge the journey of discovery that has ensued and the shared partnership that has developed, which has allowed individuals committed to the reduction of suicide to develop this plan. Each member was chosen to represent an important sector of our community and the committee grew as we came to understand the importance of a community wide approach to suicide prevention.

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Introduction

The Suicide Prevention Plan is intended to provide a broad audience with resources and strategies to prevent suicide in the community. The plan begins by outlining the relevant demographic information for Contra Costa County which includes age, ethnicity, geographic and socioeconomic distributions. To better understand the complexity of suicide, risk factors, warning signs and protective factors are detailed. Suicide data specific to Contra Costa County was reviewed to better understand its impact by geographic region and city, ethnicity, gender, age and primary method. Focus groups were conducted with Contra Costa County residents who have been impacted by suicide in various ways. The findings of the focus groups are outlined by sub-populations: Faith-based Community, LGBTQ Community, Youth, Youth Service Providers, Older Adults and the Native American Community. To further highlight high risk populations, the impact and occurrence of suicide in the following populations was explored in more detail: LGBTQ, those experiencing a mental illness, criminal justice involvement, older adults, and veterans. Lastly, the report concludes by outlining specific strategies that can be implemented to prevent suicide and additional local and national resources for more information.

Contra Costa County Demographics

Contra Costa County is the ninth most populous county in California, with its population reaching approximately 1,066,096 residents in 2011.[3] Contra Costa County is generally comprised of three distinct areas: West, Central and East County. Each region is geographically and demographically diverse. County-wide, approximately 70 percent of the population is Caucasian, approximately 15 percent are Asian and 10 percent are African American.[3] Additionally, nearly 25 percent of the total population identifies as being of Hispanic or Latino origin.[3] The median age is 36 years.[3] The population is fairly distributed across all age ranges with an average of 27 percent of the population in each of the following age categories: under 18 years; 25 to 44 years; and 45 to 64 years.[4] Nine percent of the population is between 18 and 24 years old and 12 percent is 65 years or older.[4] Lastly, almost 10 percent of Contra Costa County residents live in poverty; yet, the median household income is close to $80,000.[5,6]

Risk Factors and Warning Signs

Suicide is an important and preventable public health problem. The World Health Organization has estimated that 815,000 people worldwide died by suicide in the year 2000, far outnumbering the reported 520,000 homicide deaths.[7] Further, many suicides may not be included in official suicide statistics. Deaths due to lethal overdose of prescription or illegal drugs or single car collisions may not be documented as suicide. Suicide attempts are generally considered to be drastically underreported as many attempters never seek help or treatment after their attempt.[8,9]

RISK FACTORS

Suicide is an extremely complex issue in which multiple interacting risk and protective factors come into play. A risk factor, in this context, may be thought of as leading to or being associated with suicide; that is, people who experience the risk factors for suicide are at greater potential for suicidal behavior. However, it is important to note, many people may have these risk factors, but are not suicidal.

Biopsychosocial Risk Factors

- Mental Health Disorders
- Hopelessness
- Impulsive and/or Aggressive Tendencies
- History of Trauma or Abuse
- Alcohol and other Substance Use Disorders
- Previous Suicide Attempt
- Family History of Suicide

Environmental Risk Factors

- Job or Financial Loss
- Relational or Social Loss
- Easy Access to Lethal Means
- Local Clusters of Suicide that have Contagious Influence

Sociocultural Risk Factors

- Lack of Social Support and Sense of Isolation
- Stigma Associated with Help-Seeking Behavior
- Barriers to Accessing Health Care; especially Mental Health and Substance Abuse Treatment
- Certain Cultural and Religious Beliefs
- Exposure to, including through the media, and Influence of Others who may have died by suicide

Risk Factors For Suicide [10,11]

WARNING SIGNS

While risk factors tend to be associated with longer-term issues, warning signs refer to more immediate signs or symptoms in an individual. Recognition of warning has a greater potential for immediate prevention and intervention when those who are in a position to help know how to appropriately respond or know where to seek help.[12,13]

Signs of Acute Suicidal Ideation

- Threatening to hurt or kill themself
- Looking for ways to kill themself (e.g. seeking access to pills, weapons or other means)
- Talking or writing about death, dying or suicide if this is unusual for the person

Additional Warning Signs

- Expressing feelings of hopelessness
- Showing rage or anger or seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Indicating a feeling of being trapped - like there is no way out
- Increasing use of alcohol or drugs
- Withdrawing from friends, family or society

Warning Signs of Suicide [13]

PROTECTIVE FACTORS

There are several protective factors related to suicide. Protective factors reduce the likelihood of suicide. They can enhance resilience and may serve to counterbalance risk factors.[10,11] Protective factors are quite varied and include an individual's attitudinal and behavioral characteristics, as well as attributes of the environment and culture.[11,14] Social connectedness, family relations, marital status, parenthood, and participation in religious activities and beliefs (including negative moral attitudes toward suicide), may all be important protective factors.

Protective Factors Against Suicide

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical care and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservations

Protective Factors[12]

Who Dies by Suicide

The information presented in the following tables and figures is reflective of suicide data for Contra Costa County during calendar year 2011.

GEOGRAPHIC DISTRIBUTION

The largest *number* of suicides occurred among residents in the central region of the county (53) when compared to the west and east regions. Yet, the highest suicide *rate* is in the west region (14.7). (Table 1). The highest *number* of suicides occurred among residents of Concord (20), followed by Richmond (13) and Antioch (11). Suicide *rates* among residents of El Sobrante (55.3 per 100,000) and San Pablo (23.6 per 100,000) were significantly higher than the county overall (10.9 per 100,000). (Table 2).

Table 1: Suicides by Region

Region	Deaths	Percent	Rate
Central	53	46%	10.8
West	37	32%	14.7
East	26	22%	8.5
TOTAL	116	100%	10.9

Table 2: Selected Cities (Top 10 for Number of Deaths)

City	Deaths	Percent	Rate
Concord	20	17%	16.1
Richmond	13	11%	12.3
Antioch	11	9%	10.6
El Sobrante	7	6%	55.3
San Pablo	7	6%	23.6
Pleasant Hill	6	5%	17.8
San Ramon	6	5%	8.2
Brentwood	5	4%	9.6
Danville	5	4%	11.7
Pittsburg	4	3%	6.2
TOTAL	116	100%	10.9

Adjusted for population size of each city

RACE/ETHNICITY

Suicide and suicidal behaviors occur among all age groups and across all socioeconomic, racial, and ethnic backgrounds. The suicide rate in 2011 for Contra Costa County was higher than the rate for the state of California (10.9 compared to 10.3 per 100,000, respectively).[15]

In 2011, the greatest number of suicides occurred among Caucasians (86); nearly three-fourths of these (63) were males. Caucasians had the highest suicide rate (17.1 per 100,000); significantly higher than the rates for the county overall (10.9 per 100,000) and other racial ethnic groups. (Table 3) Caucasian men, between the ages of 45 and 64, account for the largest percentage of suicide deaths in Contra Costa County.

Table 3: Suicides by Race/Ethnicity

Race/Ethnicity	Deaths	Percent	Rate
Caucasian	86	74%	17.1
Latino	13	11%	4.9
Asian/Pacific Islander	12	10%	7.1
African-American	5	5%	4.8
TOTAL	116	100%	10.9

These are rates per 100,000 CCC residents

GENDER

In Contra Costa County, males are approximately three times more likely to die by suicide than females. Males had a higher number (79) and rate (15.2 per 100,000) of suicide when compared to females (37 and 6.8 per 100,000). (Table 4) However, it is crucial to note, women attempt suicide approximately three times as frequently as men.[12]

Table 4: Suicide By Gender

Gender	Deaths	Percent	Rate
Males	79	68%	15.2
Females	37	32%	6.8
TOTAL	116	100%	10.9

These are rates per 100,000 CCC residents

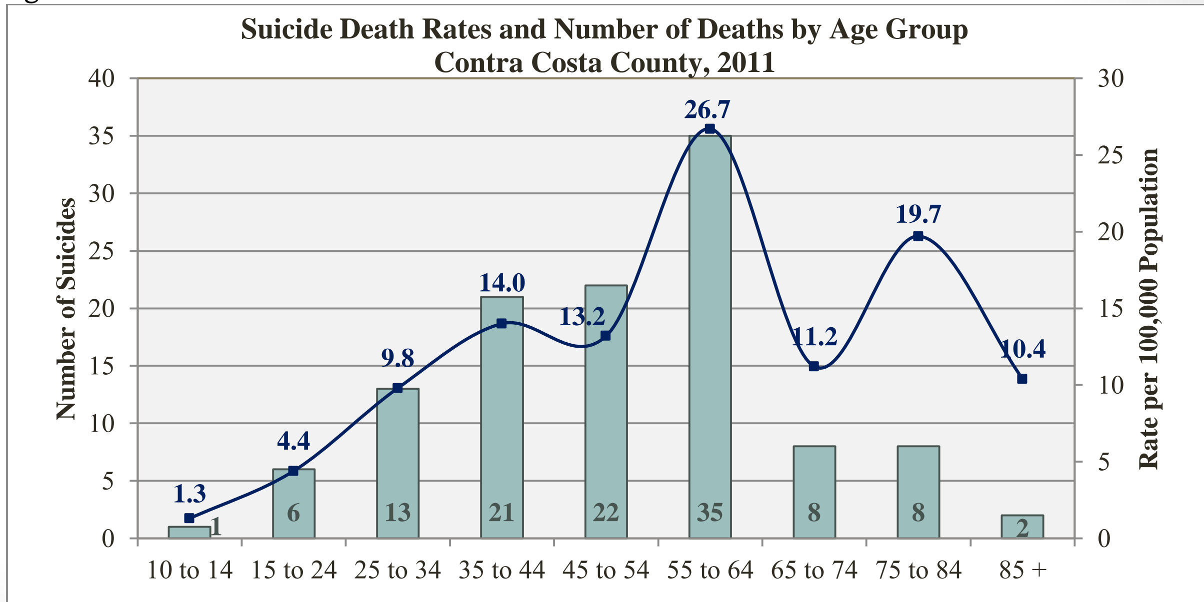
AGE

The largest percentage and the highest rate of suicides occur among residents between the ages of 55 and 64 (30% and 26.7, respectively). (Table 5) On average, the rate of suicide increases significantly with advanced age. (Figure 2) *(Note: 2011 data specific to Contra Costa County portrays a decreased risk with age; however, research and average trends show an increase risk with age.)*

Table 5: Suicide by Age Range

Age Range	Deaths	Percent	Rate
10 to 14	1	1%	1.3
15 to 24	6	5%	4.4
25 to 34	13	11%	9.8
35 to 44	21	18%	14.0
45 to 54	22	19%	13.2
55 to 64	35	30%	26.7
65 to 74	8	7%	11.2
75 to 84	8	7%	19.7
85 and older	2	2%	10.4
TOTAL	116	100%	10.9

Figure 2: Suicide Death Rates & Number of Suicide Deaths



SUICIDE BY METHOD

More than one-third of all suicide deaths involved a firearm (34%). Drug overdose (25%) and hanging (21%) were other common means of suicide in Contra Costa County. (Table 6). Men accounted for a larger percentage of the deaths by gunshot; whereas, women accounted for a larger percentage of deaths by drug overdose when compared to men. (Gender specific data not shown.)

Table 6: Suicide by Method

Method	Deaths	Percent
Gunshot	40	34%
Overdose	29	25%
Hanging	24	21%
Blunt Force	12	10%
Asphyxia/Mixed Method	7	6%
Other	4	3%

These are rates per 100,000 CCC residents
"Other" category includes poison and drowning

Perception of Suicide in Contra Costa County

Over the period of a few months several focus groups were conducted with residents representing important sub-populations of the community, some of which are considered at higher risk for suicide when compared to the population as a whole. Focus groups were organized with the following populations: Faith-based community, Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community, Youth and Youth service Providers, Older Adults, and the Native American community.

FAITH-BASED COMMUNITY

Many leaders in the faith-based community believe they are not prepared to deal with the issue of suicide in their congregations. Discomfort around the issue and how to address it effectively were key reasons for this doubt. Some religious leaders also voiced confusion about their role in addressing suicidal thoughts and the incorrect belief that suicidal people must be reported to the police. Congregants noted the pressure to fit in and to hide serious problems as limiting their comfort in reaching out. Some churches, they noted, "aim for a kind of perfection, whether it's spoken or not; you must be a certain way." Faith-based leaders and congregants alike, expressed their wish for creating a safe place within the churches and faith communities to talk about suicide and to train religious-based mental health counselors to address suicidality as meaningful prevention strategies. All agreed that spiritual leaders set the stage for the degree of openness by their willingness to address the issue of suicide honestly and directly with congregants.

LGBTQ COMMUNITY

Individuals identifying as lesbian, gay, bisexual, transgender, queer or questioning face heightened issues of stigma when their struggles are compounded by suicidal thoughts and mental health concerns. Reinforcing the work of the Family Acceptance Project, participants noted the need for support by family and friends as well as active engagement with culturally sensitive therapists and other mental health professionals. Parents' level of trust and rapport, healthy coping skills and activities, as well as safe environments to meet with other LGBTQ-identified individuals were named as key components in helping someone cope and resolve suicidal thoughts.

YOUTH

Teens and young adults reported that isolation and depression were key factors in suicidal behaviors for youth. Many were survivors of the suicide death of a family member or friend, losses that often left them confused and troubled. Acceptance by key adults and peers and having a safe person to trust with their feelings and struggles both at home and at school, were identified as meaningful buffers to suicidal despair. Many

youth found social media connections including blogs and Facebook as both helpful and not so helpful resources depending on their connections and sense of belonging. Most youth felt that schools needed to create a stronger culture of safety and trust. Many youth felt that helping others, volunteering and reaching out, helped them to feel more needed and engaged and less likely to contemplate suicide.

YOUTH SERVICE PROVIDERS

Youth service providers identified peer relationships, academic pressures and social/familial problems as significant stressors for youth. They further reported that teens and young adults often experience periods of hopelessness and a sense of a foreshortened future that fuels despair and can lead to thoughts of suicide. Parents with poorly treated mental health concerns and financial issues such as poverty and joblessness, may further compromise a youth's ability to cope. Youth service providers requested more skills training to deepen their intervention efforts and to bolster youth resilience to deal with difficult feelings and hardship.

OLDER ADULTS

Older adults named depression, isolation, loss of independence and increasing health concerns as significant contributors to thoughts of suicide. Unsatisfactory living conditions and the loss of meaningful work and other activities as they grew more dependent on others created deep feelings of loss and hopelessness for some, particularly if compounded by mental health concerns and family estrangement. Staying engaged in worthwhile endeavors, being connected with others, particularly family and friends, and receiving support of a mental health professional were all factors that older adults felt decreased the challenges of aging that might cause them to consider suicide.

NATIVE AMERICAN COMMUNITY

Cultural and familial ties were powerful life-promoting components for the Native American participants. Recognition of culturally sensitive approaches that respect elders, nurture family support and honor the family unit, and incorporate the use of the traditional medicine man were seen as helpful while the use of mainstream mental health professionals and psychotropic medications were viewed negatively. Participants noted the tender balance between relying on the strength and support of the family unit and the overwhelm that families can experience when trying to cope with a loved one who is suicidal.

The focus groups clearly highlighted the overall desire for education on this topic as participants felt compelled to help, but consider themselves unable to provide the support needed to people at risk. Community members reported their wish to be prepared for situations that may affect their own loved ones. People who shared their

own lived experience highlighted the importance of having someone they can trust to discuss their feelings without feeling judged.

Suicide in Special Populations

LGBTQ

Lesbian, gay and bisexual individuals, particularly adolescents and youth, have significantly higher rates of suicidal behavior when compared to their heterosexual counterparts.[16-20] Social support in a community of peers is especially important to this vulnerable population; even more so when family and school environments are stressful.

As previously mentioned, suicide is the third leading cause of death for people ages 15 to 24 years; however, more youth survive suicide attempts than actually die.[21,22] The overall rate of suicide among youth, ages 15 to 24 years, in California was 7.2 per 100,000 over the period of 2008-2010.[22] Contra Costa County's rate was higher than that in the state as a whole, 8.6 per 100,000, and higher than that of its neighbor, Alameda County, which was 6.8 per 100,000.[22] The Suicide Prevention Resource Center reviewed studies and reports about youth suicide and concluded that LGBTQQI2-S (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex and Two-spirit) youth are a high-risk group for suicide.[23] Their research indicates LGBTQQI2-S youth are two to four times as likely to attempt suicide as compared to heterosexual youth.[23] Therefore, it can be inferred that the expected rate of suicide for LGBTQQI2-S youth in Contra Costa County is 14 to 28 per 100,000 people.

Additionally, LGBTQ older adults are also at increased risk for suicide. Research findings revealed that lifetime victimization, financial barriers to health care, obesity, and limited physical activity independently and significantly accounted for poor general health, disability, and depression among LGBTQ older adults and thus increased risk for suicidal thoughts and behaviors. Internalized stigma was also a significant predictor of disability and depression. Many studies find social support and social network size serve as protective factors, decreasing the odds of poor general health, disability, and depression.

MENTAL ILLNESS

It is estimated that as many as 90 percent of individuals who died by suicide had a diagnosable mental illness or substance abuse disorder.[24] Certain psychiatric diagnoses increase the risk of suicide substantially. Some studies have revealed that up to 20 percent of individuals diagnosed with a major mood disorder, such as major depression or bipolar disorder, die by suicide.[12,25]

Furthermore, individuals with schizophrenia are more likely to die by suicide than individuals with other mental health diagnoses. Nearly 6 percent die by suicide, with

most suicide deaths occurring early in the illness and up to 40 percent attempting suicide at least once.[12,26,27] Co-occurring mental health and substance abuse further intensifies the risk of suicide.

CRIMINAL JUSTICE INVOLVEMENT

Nationally, the number of individuals with mental illness who are in jails and prisons is higher than those that are in psychiatric hospitals.[28] The rate of those with mental illness who are in jail is three times that of the general population; more than half of all prison and jail inmates have a mental illness.[29] The US Department of Justice reports that between 1994 and 2003, suicide was the second leading cause of death for individuals in custody.[12] The periods of highest risk for suicide among inmates are during the first month of incarceration and the first few weeks after release. Nearly half of all jail suicides occur within the first week of custody; almost 25 percent of these are on the date of admission or the following day.[12]

OLDER ADULTS

Older adults are disproportionally likely to die by suicide when compared to other age groups. The rate of suicide for older adults, when adjusted for population size, is much higher than other age groups, both nationally and locally. Research has shown, psychiatric illness is present in 71 percent to 97 percent of suicides among older adults with major depression being a common and likely diagnosis. Primary psychotic disorders including schizophrenia, schizoaffective illness, and delusion disorder, as well as anxiety disorders, tend to be present in lower proportions.[30]

Depression, one of the conditions most commonly associated with suicide in older adults,[31] is a widely under-recognized and undertreated medical illness. Studies show that many older adults who die by suicide, up to 75 percent, visited a physician within a month before death.[32] These findings point to the urgency of improving detection and treatment of depression to reduce suicide risk among older adults.

In addition to psychiatric illness, poor physical health, functional impairments and social factors, including isolation, grief, and financial stressors contribute to risk for suicide in later life.[30]

VETERANS

While only one percent of Americans have served during the wars in Iraq and Afghanistan, former service members represent 20 percent of suicides in the United States.[33] The Department of Veterans Affairs estimates 18 veterans die by suicide each day.[33]

Research indicates that there are multiple risk factors for suicide among military personnel when faced with civilian life after retirement and combat exposure. These individuals, mostly males, often carry the burden of stressful war experiences. They are very familiar with firearms, are at higher risk for physical health problems due to previous trauma, and are often facing family conflicts, social isolation, substance abuse issues, etc.[34-35]

Suicide Prevention County-wide Strategies

Create a countywide system of suicide prevention that includes assessment, triage, and warm hand-offs of individuals at risk.

- Enhanced screening and assessment of suicide risk as part of the initial mental health assessment.
- Create a system of triage including warm hand-offs, follow-up calls for attempters and those at risk for suicide and implementation of means restriction protocol.
- Decrease wait-times to first appointments within the County Mental Health System.
- Enhance discharge planning to adequately address suicide risk.
- Develop a support group for suicide attempters and victims of loss.
- Develop a mobile response team for adults.
- Foster interagency collaboration to promote standardized assessments of individuals at risk of suicide and facilitate smooth hand-offs between service providers.

Community Coordination and interagency collaborations

- Increase communication/collaboration between county systems and community service providers.
- Develop formal agreements within county health services departments and with community based organizations.
- Create a common language that can be used between systems.
- Increase access to services and supports for individuals in various cultural communities.
- Increase coordination and communication with the faith community.
- Enhance links between systems and programs to better address gaps in services and identify resources.

Implement education and training opportunities to prevent suicide.

- Increase training for primary care doctors on how to identify warning signs and people at risk for suicide. Other medical professions could include emergency department doctors, EMTs, public health nurses.
- Establish trainings in suicide prevention for mental health professionals – psychiatrists, psychologists, master-level therapists and social workers, psychiatric nurses, Access Line staff, etc.
- Increase training for non-professionals who interface with suicidal people. This could be teachers, schools administrators, members of the faith community, law enforcement personnel, etc.

- Increase awareness within the medical system to identify those at risk for suicide.
- Develop institutional support so that employees can practice what they learn in trainings.
- Create and air informational programs on the local community news channel Contra Costa Television (CCTV).

Educate communities to take action to prevent suicide.

- Promote information and resources about strategies that reduce access to lethal means (i.e. gun locks, blister caps on medication, bridge barriers, etc.)
- Increase awareness and create educational opportunities to promote greater understanding of the risk and protective factors related to suicide, and how to get help, by engaging local media.
- Develop and train peer and family advocates to recognize warning signs of suicide.
- Teach family members, caregivers, and friends of suicide attempters, as well as community helpers, to recognize, appropriately respond to, and refer people who are demonstrating warning signs.
- Develop web-based directory information on local suicide prevention and intervention services that includes information about how and where to access services and how to deal with common roadblocks.
- Support stigma reduction efforts at the state and local level.

Improve suicide program effectiveness and system accountability by following and implementing evidence based models for suicide prevention.

- Implement an evidence-based practice within the medical system to identify those at risk for suicide.
- Identify evidence-based and promising practices to work with individuals at risk for suicide that are experiencing co-occurring mental health and substance abuse issues.
- Implement evidence-based universal screenings for suicide in schools.

Ensure comprehensive program planning and evaluation

- Improve data collection on those who attempt suicide in the County.
- Develop a centralized database for suicide data.
- Continue to track suicide trends to inform program planning.
- Measure effectiveness in reducing suicide.
- Establish more sophisticated measures for tracking suicide attempters.
- Conduct ongoing focus groups with high-risk populations to continue to develop strategies to best meet their needs.
- Establish a suicide death review team for Contra Costa County.

Funding and Implementation Priorities Established by the Suicide Prevention Committee

Using the suicide prevention strategies previously listed, the committee established a list of prevention priorities. All the strategies are important at reducing suicide and one strategy alone will not solve the problem; however, using the Six Domains of Health Care Quality (Appendix A) along with knowledge gained during the committee process, the strategies below were rated as high-priorities for suicide prevention. Of greatest priority is to reduce access to lethal means (i.e. gun locks, blister caps on medication, bridge barriers, etc.) . Strategies to implement these suicide prevention efforts are detailed below.

The Six Domains of Health Care Quality[36] are: 1) Safe; 2) Effective; 3) Patient-centered; 4) Timely; 5) Efficient; 6) Equitable.

Create a countywide system of suicide prevention that includes assessment, triage, and warm hand-offs of individuals at risk

- Create a countywide system of suicide prevention that includes warm hand-offs, follow-up calls for attempters at risk of suicide, careful discharge planning and ensuring timeliness of access by decreasing wait times for services, and implementation of means restriction protocol for those at risk for suicide.

Community Coordination and interagency collaborations

- Increase access to services and supports for individuals at risk of suicide in various cultural communities and develop culturally appropriate resources for those experiencing health care disparities.
- Increase communications/collaboration between county systems and community service providers to provide a coordinated system of care to those at risk of suicide.

Implement education and training opportunities to prevent suicide

- Increase training for primary care doctors on how to identify warning signs and people at risk for suicide. Other medical professions could include emergency department doctors, EMTs, public health nurses, advice nurses, etc.
- Establish trainings in suicide prevention for mental health professionals – psychiatrists, psychologists, master-level therapists and social workers, psychiatric nurses, County Mental Health Access Line staff, peer and family advocates, etc.
- Increase training for non-professionals who interface with suicidal people. This could include teaching family members, caregivers, and friends of suicide attempters, as well as community helpers, to recognize, appropriately respond to, and refer people who are demonstrating acute warning signs. These could include teachers, schools administrators, members of the faith community, law enforcement personnel, etc.

Educate communities to take action to prevent suicide

- ➢ Promote information and resources about strategies that reduce access to lethal means (i.e. gun locks, blister caps on medication, bridge barriers, etc.)

Improve suicide program effectiveness and system accountability by following and implementing evidence based models for suicide prevention

- ➢ Identify evidence-based and promising practices to work with individuals at risk for suicide that are experiencing co-occurring mental health and substance abuse disorders.
- ➢ Implement evidence-based universal screenings for suicides in schools.

Ensure comprehensive program planning and evaluation

- Improve data collection on those who attempt suicide in the County including more sophisticated measures for tracking suicide.
- Measure effectiveness in reducing suicide attempters in each service system (i.e. educational system, medical system, and community based organizations)
- Establish a suicide death review team for Contra Costa County.

Community and National Resources

Many organizations focus on suicide prevention efforts and are determined to help those at risk as well as support the families and friends of at-risk individuals. The list of resources below is not exhaustive, yet it includes information about agencies providing valuable support to our community.

Local Support:

Contra Costa Crisis Center
1-800-833-2900 – Crisis & Suicide
1-800-837-1818 – Grief
www.crisis-center.org

NAMI (National Alliance on Mental Illness) Contra Costa
925-465-3864
www.namicontracosta.org

Statewide or National Support:

National Suicide Prevention Lifeline
1-800-273-TALK
1-800-SUICIDE

The Trevor Project
Suicide Prevention for LGBTQ Youth
1-866-488-7386

Know the Signs
www.suicideispreventable.org

Appendix A

The Six Domains of Health Care Quality[36]

A handful of analytic frameworks for quality assessment have guided measure development initiatives in the public and private sectors. One of the most influential is the framework put forth by the Institute of Medicine (IOM), which includes the following six aims for the health care systems.

1. **Safe**
   - Avoiding harm to patients from the care that is intended to help them.
2. **Effective:**
   - Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively.)
3. **Patient-centered:**
   - Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
4. **Timely:**
   - Reducing waits and sometimes harmful delays for both those who receive and those who give care.
5. **Efficient:**
   - Avoiding waste, including waste of equipment, supplies, ideas and energy.
6. **Equitable:**
   - Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.

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