MHSA Increased Allocation
Position Request
July 2012

3 FTE Mental Health Program Supervisor Positions

These positions will provide clinical oversight for the various Evidence-based Practices (EBP) implemented in the regional mental health clinics for children and adults. There are approximately ten EBP's implemented or in the planning process for implementation. To ensure model fidelity, EBP's require an intensive amount of program oversight and clinical supervision. Model adherence lends itself to improved client outcomes and overall program sustainability. The addition of the EBP Supervisors will ensure the programs are successful at providing treatment as outlined by the EBPs. These positions are approved in the MHSA Annual Plan Update for FY 12-13 under the Community Services and Support (CSS) component as part of the unspent funds request.

16 FTE Mental Health Clinical Specialist Positions

Three of the positions will support the implementation of the Rapid Access Program at each of the regional Adult Mental Health Clinics. Rapid Access will allow for same-day urgent appointments for consumers who are in need of medication support services, nursing services, individual or group therapy, case management and peer support services among other things. The overall goal is to increase access to timely services resulting in better health outcomes for those we serve. This will also allow us to meet JCAHO requirements to see patients who were hospitalized within 7 days of their discharge. These positions are approved in the MHSA Annual Plan Update for FY 12-13 under the Community Services and Support (CSS) component.

Three positions will expand the capacity of the existing Older Adult Intensive Care Management Teams. Each regional team provides linkage, advocacy, medication support and monitoring for elderly individuals living in the community. The teams are heavily impacted and began a waitlist for services. Additionally, the team in East County has expressed the need for a Spanish-speaking clinician as many of the consumers are monolingual Spanish speakers. Please request that one MHCS position be flagged as Spanish-speaking. These positions are approved in the MHSA Annual Plan Update for FY 12-13 under the Community Services and Supports (CSS) component.

Two positions would be located in the Primary Care Clinics and function as behaviorists offering mental health screening, referrals and short-term treatment to patients in the primary care setting. These positions are approved in the MHSA Annual Plan Update for FY 12-13 under the Prevention and Early Intervention (PEI) component.

Three positions will provide money management services for consumers needing such support. There would be one position assigned to each regional clinic. Currently, there are not enough clinicians to support all the consumers in need of this service. The additional three positions will relieve the burden on current staff and increase the capacity to provide a meaningful service. These positions are approved in the MHSA Annual Plan Update for FY 12-13 under the Community Services and Support (CSS) component as part of the unspent funds request.

Three positions will operate as Compliance Specialists in different parts of the mental health system. One person will be assigned to each of the following areas: Care Management Unit to focus on the Network Providers; Children's Mental Health System of Care; and Adult Mental Health System of Care. These individuals will be responsible for various quality assurance functions. These positions

are approved in the MHSA Annual Plan Update for FY 12-13 under the Community Services and Support (CSS) component as part of the unspent funds request.

Two positions will perform duties in line with Utilization Review. As the number of mental health contracts and programs increase so does the need for utilization review. These positions will perform chart reviews to ensure the consumer is receiving the appropriate level of care, ensure proper documentation and ensure Medi-Cal compliance. These positions are approved in the MHSA Annual Plan Update for FY 12-13 under the Community Services and Support (CSS) component as part of the unspent funds request.

1 FTE Clerk-Specialist Level

This position will perform clerical duties in support of the Utilization Review process (see request above). This position is approved in the MHSA Annual Plan Update for FY 12-13 under the Community Services and Support (CSS) component as part of the unspent funds request.

3 Registered Nurse–Experienced Level Positions at 0.5 FTE each (1.5 FTE Total)

The three RNs will work as part of the Rapid Access Program. Rapid Access will allow for same-day urgent appointments for consumers who are in need of medication support services, nursing services, individual or group therapy, case management and peer support services among other things. The overall goal is to increase access to timely services resulting in better health outcomes for those we serve. Additionally, the nurses will allocate a portion of their time to be available to the regional peer Wellness Coaches should an issue arise which requires nurse support. These positions are approved in the MHSA Annual Plan Update for FY 12-13 under the Community Services and Support (CSS) component.

5 FTE Community Support Worker II Positions

Two positions will be located at Psychiatric Emergency Services (PES) to offer support to families who have a family member accessing PES services. Families of children have expressed the need to have a person at PES responsible for helping families understand the process for their loved one while they are at PES. These positions will function much like the Adult Family Partners in the regional clinics. They will offer support, guidance, education regarding the legal process, psychoeducation and assistance with system navigation and referral to support services. The work hours for these positions will reflect the hours of the day when PES is most busy; typically between 2:00pm and 10:00pm, 7 days a week. These positions are approved in the MHSA Annual Plan Update for FY 12-13 under the Prevention and Early Intervention (PEI) component.

Three positions - one at each regional clinic - will be assigned to work specifically on providing transportation to consumers who receive services at the regional clinics. The addition of these peer positions will allow for the current CSW II positions to focus on peer-support and skill building activities. The Transportation Committee, comprised of Mental Health Commissioners, CPAW members, and Stakeholders, has highlighted the need for additional transportation resources in our communities. These positions are approved in the MHSA Annual Plan Update for FY 12-13 under the Community Services and Support (CSS) component as part of the unspent funds request.

CMHDA State Budget 2012-13 Fact Sheet:
Mental Health Services Act

AB 1467, the omnibus health trailer bill for the 2012-13 state budget, contains numerous changes to state law to implement the legislature's budget plan, including a number of amendments to the Mental Health Services Act (MHSA). AB 1467 was chaptered into state law on June 27, 2012 and is effective immediately. This fact sheet presents an overview of the provisions included in AB 1467 that amend the MHSA.

Human Resources, Education and Training Program

AB 1467 replaces the "department" with the Office of Statewide Health Planning and Development (OSHPD) to effectively task OSHPD with many of the education and training activities formerly coordinated by the Department of Mental Health (DMH). Additionally, the bill includes language to establish a deadline for the next five-year plan – now due by April 1, 2014. Lastly, AB 1467 includes a new required element to be included in the five-year plan related to the promotion of meaningful inclusion of diverse, racial, and ethnic community members who are underrepresented in the mental health provider network. (See Welfare & Institutions Code Section 5820)

Innovative Programs

AB 1467 amends the Act to include language from the Innovations Guidelines issued by DMH in 2009 (Information Notice 09-02). The new language effectively requires county plans to meet certain requirements, including choosing a primary purpose from four options provided, and choosing an approach from three options provided. The language also requires that innovative projects proven to be "successful" transition to another category of funding. Additionally, the bill retains the provision that county innovation plans be approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC). In order to better align with the new monthly distribution process, AB 1467 amends the language to direct counties to expend funds, rather than receive funds, for innovation programs upon approval by the MHSOAC. (See W&I Section 5830)

Prevention and Early Intervention

AB 1467 includes the addition of a new subdivision to this section to clarify and broaden the parameters for the expenditure of prevention and early intervention funds. Specifically, the new language declares that prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services. The bill also further emphasizes the role of MHSOAC guidelines in the state's continued implementation of this Part. (See W&I Section 5840)

Oversight and Accountability

AB 1467 expands the role of the MHSOAC to include new activities and assigned tasks in the areas of technical assistance and evaluation. Specifically, language is added to direct the MHSOAC to assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act in collaboration with the State Department of Health Care Services (DHCS) and in consultation with CMHDA. Similarly, language is added to require the MHSOAC to work in collaboration with DHCS and the Planning Council, in consultation with CMHDA, to design a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system. The California Health and Human Services Agency is to lead this planning effort. (See W&I Sections 5845 and 5846)

Integrated Plans for Prevention, Innovation, and System of Care Services

AB 1467 makes a number of important clarifications regarding the approval, submission, and required elements of the three-year program and expenditure plan and annual updates. First, the bill clarifies that three-year plans and annual updates are to be adopted by the county board of supervisors and submitted to the MHSOAC within 30 days

after board adoption. Second, the bill requires that the plans and updates include the following additional elements: 1) certification by the county mental health director to ensure county compliance with pertinent regulations, laws and statutes of the Act, including stakeholder engagement and non-supplantation requirements, and 2) certification by the county mental health director and the county auditor-controller that the county has complied with any fiscal accountability requirements, and that all expenditures are consistent with the Act. Additionally, AB 1467 deletes the process by which counties are informed of the amount of funds available for services, and instead adds new language instructing DHCS to annually inform CMHDA and the MHSOAC of the methodology used for revenue allocation to the counties. The bill also deletes the provision that the department shall establish the requirements for the content of the plans and charges DHCS and the MHSOAC, in collaboration with CMHDA, to jointly establish performance outcomes for services.

Lastly, AB 1467 also includes some additional language to augment the stakeholder engagement provisions. Specifically, the budget bill amends the stakeholder engagement requirements and adds new language to require counties to "demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations." Providers of alcohol and drug services and health care organizations are also added to the list of stakeholders to be engaged in the development of the three-year plan and update. (See W&I Sections 5847 and 5848)

Fund Distributions

While the changes AB 1467 makes to MHSA fund distribution sections are primarily technical, there are a couple of key changes to consider. Foremost, AB 1467 adds language to declare that the monthly distributions to counties are to be made pursuant to a methodology provided by DHCS. The bill also amends the provision that formerly required distributions to be based on the amount specified in the county plan, to instead require that counties base their expenditures on the plan and update. The bill also amends the provision around prevention and early intervention expenditures to delete the state's role in increasing the allocation of funds for this purpose. (See W&I Sections 5891 and 5892)

Development and Adoption of Regulations

AB 1467 amends the "state's" responsibility to direct DHCS, in consultation with the MHSOAC, to develop regulations as necessary for DHCS, the MHSOAC or other designated state and local agencies to implement the Act. (See W&I Section 5898)

Annual Revenue and Expenditure Report

AB 1467 adds Welfare and Institutions Section 5899, which codifies in statute the requirement that counties submit an annual MHSA revenue and expenditure report. According to the new section, DHCS is required to develop instructions for the report that counties should submit electronically to both DHCS and the MHSOAC. The new section also includes a description of the report's purpose and the intended areas for evaluation. While this report is a current requirement per the MHSA regulations (W&I Section 3510), this was not a requirement of the original MHSA. (See W&I Section 5899)

Suicide Prevention Strategic Plan

Contra Costa County

July 2012

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 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.

Aran Watson
RYSE, Community Mental Health Specialist

Ben David-Barr, MSW PhD
Executive Director,
Rainbow Community Center

Cesar Court, LMFT
Program Manager,
Older Adult Mental Health (Retired)

Charles Sahldana, M.D.
Director, Psychiatric Emergency Services

Devorah Levine, J.D.
Contra Costa Employment and Human Services

Guillermo Cuadra, LCSW
Program Manager,
Contra Costa Adult Mental Health

Heather Sweeten-Healey, LCSW
Program Manager, Older Adult Mental Health

James Wogan
Mt. Diablo Unified School District-
Foster Youth Services

John Allen, LMFT
Program Supervisor,
Contra Costa Adult Mental Health (Retired)

Judi Hampshire, LMFT
Crisis line/211/Chat Director, Contra Costa Crisis Center

Kanwarpal Daliwahl, MPH
Co-Executive Director (Retired), The RYSE Center

Kennisha Johnson, LMFT
Program Supervisor,
Contra Costa Adult Mental Health

Kevin Wright, LCSW
Suicide Prevention Coordinator,
Veterans Administration

Ross Andelman, M.D.
Medical Director, Contra Costa Mental Health

Shirley McGuff, LCSW
Social Services Manager,
John Muir Behavioral Health

Steve Blum, LMFT
Team Leader, Contra Costa Adult Mental Health

Stuart Buttlaire, M.D.
Kaiser Permanente,
Regional Director of Inpatient Psychiatry

Susie Moore, M.A.
Contra Costa Crisis Center, Grief Counseling Director

Tamara Hunter
Director, Putnam Clubhouse

Co-chairs:

Mary Roy, LMFT
Mental Health Services Act Program Manager

John Bateson
Executive Director, Contra Costa Crisis Center

Cory Pohley
Interim Executive Director, Contra Costa Crisis Center

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Introduction

Over the last five years, on average, 100 residents in Contra Costa County died by suicide each year. Overall, suicide is the tenth leading cause of death; however, among 15 to 34 year old, it is the third leading cause of death and the fifth leading cause of death among 35 to 54 year olds in Contra Costa County.[1] Additionally, more suicide deaths are reported than homicides. In 2009, 89 county residents were victims of homicide whereas 109 people died by suicide.[2]

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] Approximately 70 percent of the population are Caucasian, approximately 15 percent are Asian and 10 percent are African American.[3] Additionally, nearly 25 percent of the 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 are 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]

Contra Costa County is generally segregated into three distinct areas: West, Central and East County. Each region is geographically and demographically diverse. In 2009, in the Central region, White (64%) and Latino (20%) make up the majority. Similar to the Central region, but with more equality between ethnicities, the East region of the county is largely comprised of White (39%) and Latino (33%). In contrast, the West region of the county is predominately White (26%), Latino (24%), and African-American (24%).

Causes (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 year 2000, far outnumbering the reported 520,000 homicide deaths.[7] To further compound the issue, 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 known to be drastically underreported as many attempters never seek help or treatment after their attempt.[8,9]

RISK FACTORS

The cause of 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
- Implusive and/or Agressive 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 Influcence

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
- Showring 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

RACE/ETHNICITY

Suicide and suicidal behaviors occur among all age groups and across all socioeconomic, racial, and ethnic backgrounds. The crude suicide rate in 2009 for Contra Costa (10.39 per 100,000) is higher than California's crude rate (9.4 per 100,000).[15]

In 2009, the greatest number of suicides occurred among Caucasians (76); just over three-fourths of these (58) were males. Caucasians had the highest suicide rate (12.37 per 100,000); significantly higher than the rates for the county overall (10.39 per 100,000) and other racial ethnic groups. (Table 1) Caucasian men, between the ages of 45 and 54, account for the largest percentage of suicide deaths in Contra Costa County.

Table 1: Suicides by Race/Ethnicity

	Deaths	Percent	Rate
Caucasian	76	70%	12.4
Latino	15	14%	5.9
Asian/Pacific Islander	12	11%	7.7
African-American	5	5%	5.1
TOTAL	109	100%	10.4

"Total" row includes racial/ethnic groups not listed above
These are crude rates per 100,000 CCC residents

GENDER

In Contra Costa County, males are almost four times more likely to die by suicide than females. Males had a higher number (85) and rate (16.5 per 100,000) of suicide when compared to females (24 and 4.5 per 100,000). (Table 2) However, it is crucial to note, women attempt suicide approximately three times as frequently as men.[12]

Table 2: Suicide By Gender

	Deaths	Percent	Rate
Males	85	78%	16.5
Females	24	22%	4.5
TOTAL	109	100%	10.4

These are crude rates per 100,000 CCC residents

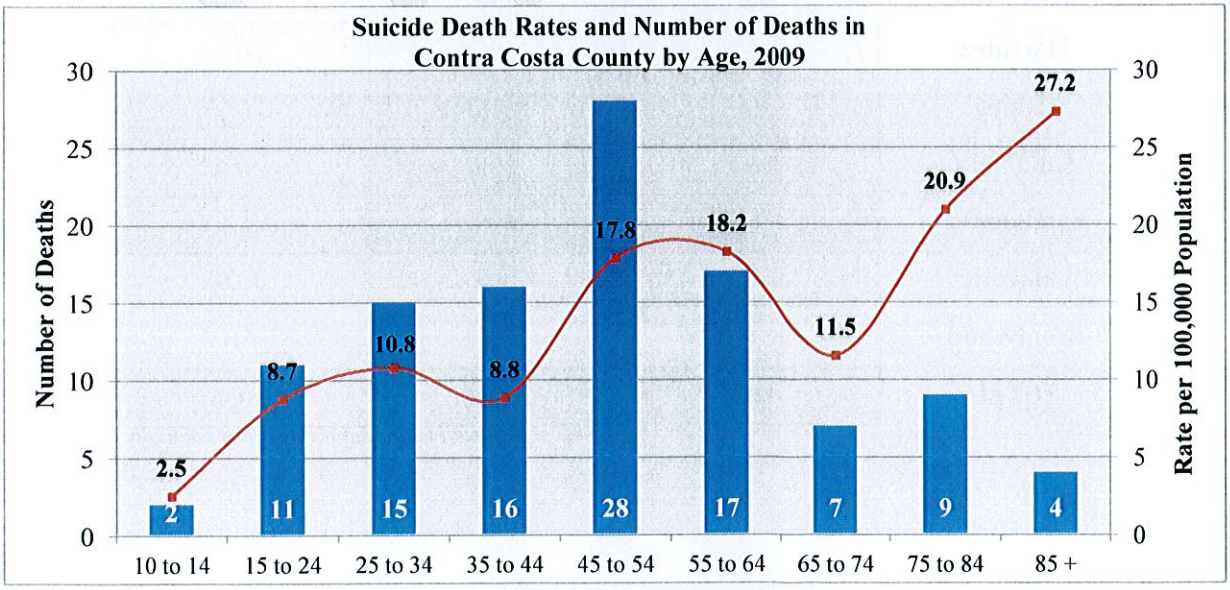
AGE

The largest percentage of suicides occur among residents between the ages of 45 and 54 (26%); however, the highest rate of suicide is among residents 85 years and older. (Table 3) The rate of suicide increases significantly with advanced age. (Figure 1)

Table 3: Suicide by Age Range

Age Range:	Deaths	Percent	Rate
10 to 14	2	2%	2.5
15 to 24	11	10%	8.7
25 to 34	15	14%	10.8
35 to 44	16	15%	8.8
45 to 54	28	26%	17.8
55 to 64	17	16%	18.2
65 to 74	7	6%	11.5
75 to 84	9	18%	20.9
85 and older	4	4%	27.2
TOTAL	109	100%	10.4

Figure 1: Suicide Death Rates & Number of Suicide Deaths



GEOGRAPHIC DISTRIBUTION

The largest number of suicides occurred among resident in the central region of the county (52) when compared to the west and east regions. Yet, the highest suicide rate is in the east region (11.2). (Table 4). The highest number of suicides occurred among residents of Concord (15), followed by Antioch (11), Walnut Creek (11) and Richmond (10). Suicide rates among residents of Lafayette (20.9 per 100,000) and San Pablo (20.6 per 100,000) were significantly higher than the county overall (10.4 per 100,000). (Table 5).

Table 4: Suicides by Region

	Deaths	Percent	Rate
Central Region	52	48%	9.7
East Region	30	28%	11.2
West Region	24	22%	9.8
TOTAL	109	100%	10.4

Total includes deaths not listed above (out of county deaths)

Table 5: Selected Cities (Top 10 for Number of Deaths)

City:	Deaths	Percent	Rate
Concord	15	14%	12.3
Antioch	11	10%	10.7
Walnut Creek	11	10%	17.1
Richmond	10	9%	9.6
Martinez	6	6%	16.7
Oakley	6	6%	16.9
San Pablo	6	6%	20.6
San Ramon	6	6%	8.3
Lafayette	5	5%	20.9
Brentwood	4	4%	7.8
TOTAL	109	100%	10.4

Adjusted for population size of each city

SUICIDE BY METHOD

Half of all suicide deaths involved a firearm (50%). Hanging (17%) and drug overdose (12%) 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 hanging and drug overdose when compared to men. (Gender specific data not shown.)

Table 6: Suicide by Method

Method	Deaths	Percent
Gunshot	54	50%
Hanging	19	17%
Drugs	13	12%
Asphyxia/Mixed Method	10	9%
Noxious Gas	6	6%
Other	7	6%

These are crude rates per 100,000 CCC residents
"Other" category includes jumping, poison and blunt force

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 then actually die.[21,22] The overall rate of suicide among youth, ages 15 to 24 years, in California is 6.9 per 100,000.[22] While Contra Costa County's rate is the same as for the state as a whole, 6.9 per 100,000, the rate is higher than its neighbor, Alameda County's, rate of 6.4 per 100,000.[22] The Suicide Prevention Resource Center reviewed studies and reports about youth suicide and concluded 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.

Moreover, recent research conducted in California, concluded the degree to which a family rejects or accepts their LGBTQQI2-S youth because of his or her sexual orientation during his or her adolescence has a correlation with the adolescent's health outcomes.[23] Adolescents who experienced high rejection were 8.4 times more likely to attempt suicide.[23] The increase in suicide and suicide attempts for this specific population of youth can be attributed to an increase the sociocultural risk factors that are present in the youth's lives. The social and internalized stigma that is intertwined with sexual identification of the youth can lead to isolation and rejection. Services available are inadequate to meet the needs of this population and the lack of a social support network further compounds the issue.[23]

MENTAL ILLNESS

It is estimated that as many as 90 percent of individual 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, suicide is the leading cause of death among individuals with Schizophrenia. Nearly 6 percent die by suicide, with most suicide deaths occurring early in the illness and up to 40 percent attempt 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, physical ill health, functional impairments and social factors 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 persons when faced with civilian life after retirement and combat exposures. These individuals, mostly males, often carrying the burden of stressful war experiences; are often 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 common languages 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.

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- 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 CCTV informational programs

Educate communities to take action to prevent suicide.

- Develop and train peer and family advocates in suicide assessment
- 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 acute 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.
- Create opportunities to promote greater understanding of the risk and protective factors related to suicide, and how to get help, by engaging and educating local media.
- 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.

- 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

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Funding and Implementation Priorities Established by the Suicide Prevention Committee

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, 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

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Community and National Resources

Many organizations focus on suicide prevention efforts and are determined to help those at risk and 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
925-938-0725 – TTD/TTY
www.crisiscenter.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

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